Surgical News

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS **NOV/DEC 2012**

HAPPY & SAFE FESTIVE SEASON

More than $1.5 million of Research Scholarships awarded! p44

Health & Cultural *Learning*

New eLearning modules

The College of Surgeons of Australia and New Zealand

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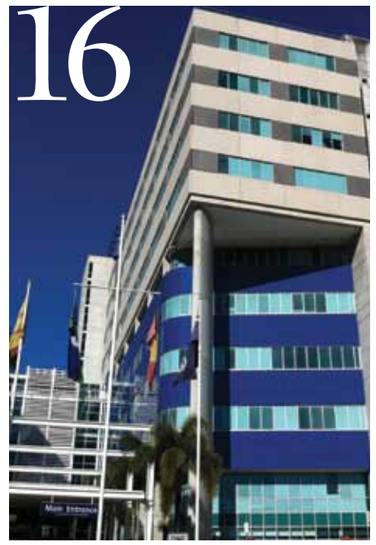

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T: +61 3 9249 1200 **F:** +61 9249 1219 **W:** www.surgeons.org
ISSN1443-9603 (Print) ISSN 1443-9565 (Online)

Published for the Royal Australasian College of Surgeons by RL Media Pty Ltd. ACN 081 735 891, ABN 44081 735 891of 129 Bouverie St, Carlton. Vic 3053.

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The College releases new Indigenous eLearning modules, p 22

President's Perspective

A new direction

Over the past two months I have been attending a number of meetings, both national and international. It has been a pleasure to be able to represent the College on the international stage and acknowledge the good standing in which this College is regarded. However, my focus has been deliberately more on the meetings in Australia and New Zealand.

While I have been involved in a number of discussions about the interface between the College and the various specialty societies, more numerous have been the discussions with Fellows who have been expressing their concerns about issues and remain keen to be involved with the various activities of the College.

The College is now re-visiting its Strategic Plan. Council needs to understand where our College will be in five, or even 10, years' time. What will be our relationship with the Specialist Societies? I am sure it will be different. What about our business plan, or key areas for advocacy?

Council needs to define the main areas it will focus on in the next few years. There is no doubt that we will still strive for ongoing excellence in surgical education and training as well as excellence for surgical practice. However, I believe the College's role will be to establish the overall framework for surgical training, and enable the specialty societies to deliver training within their areas of technical expertise.

The level of support will differ between the specialties. All the Societies deliver high quality training programs. Some require more direct support from the College to deliver these programs than others.

I hope the College will continue to provide appropriate infrastructure to deliver these courses such as its generic courses and the new e-learning platform. Utilisation of these resources by the College and by the Societies will reduce duplication, and, importantly costs for Fellows and Trainees.

A key role will be providing the skills that we require as Educators. The Academy of Surgical Educators has now been re-fashioned and is now chaired by Julian Smith with expert advice from Stephen Tobin in his new role as Dean of Education.

Providing resources to enable surgeons to develop appropriate skills as Educators is a major area of activity

for the College into the future. Some Fellows will want to develop skills to become an educator whilst others may use the Academy as a resource to further develop their educational interest.

Other Fellows have also questioned how to become more involved with our Courses as Instructors or our International Projects. I will deliberately profile these into the future editions of *Surgical News*.

Another ongoing theme that has been consistently raised with me is providing support to International Medical Graduates who need to be supervised and supported while they are assessed for comparability.

This is not only in the sense of their technical skills, but particularly in areas of understanding the Australian and New Zealand community and societal expectations. The requirements of the community and how that health care is delivered can be substantially different between countries. Indeed it is different across parts of Australia and New Zealand.

We need to have more effective support processes to ensure the introduction to our countries is far better. Currently we are letting down the International Medical Graduates, the community and ourselves by not being more involved in this area.

Personally I am a great advocate for increased involvement of local surgeons and hospitals in the selection of our Trainees. Although I fully understand the reason for national consistency and proper processes, the ability to identify good surgeons of the future and act as their mentor through various stages of their training and career is one of the fundamentals of our College. How we re-engage the local input more strongly in this process will need to be handled both fairly and transparently.

Mentoring Trainees and younger surgeons has worked well on a personal level and many Trainees and younger Fellows have mentors. Some may have more than one. The challenge is to assist those who would like a mentor, but seem unable to develop an appropriate relationship.

The formalised process adopted a few years ago was not a success and the College with strong input from RACSTA and the Younger Fellows will continue to work in this area to improve things.

I am particularly concerned about support for Younger Fellows. A number of Fellows have spoken to me about this issue since I started visiting Society and Regional Meetings. Often a Younger Fellow's first consultant appointment is away from their home city, in an unfamiliar environment and they feel professionally isolated.

Making decisions about sick or complex patients particularly while on call can be stressful, especially in those first few years. If they have a series of poor outcomes jurisdictional bodies may take an interest in their practice and often senior colleagues on these bodies lack insight into their circumstances. Hospital administrations are even less inclined to help.

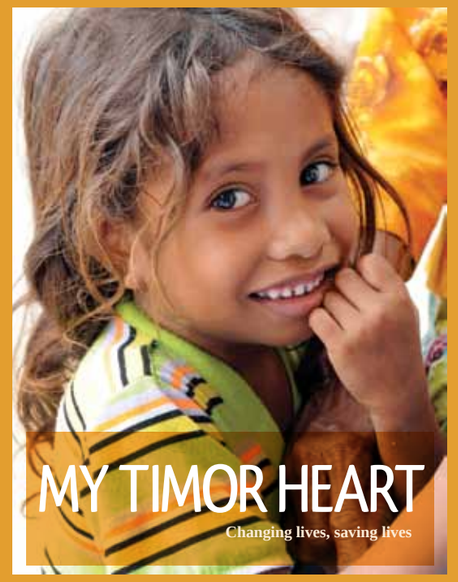
Our College needs to assist these young surgeons and provide the opportunity for them to express their concerns, provide assistance if needed and, as a Fellowship organisation, to be there for them. This is not to say we approve of unprofessional practice.

At the present time surgeons in trouble can always ring the Executive Director of Surgical Affairs. There is one for Australia and for New Zealand. Hopefully we can provide assistance through the Regional Committees in the future. As President I am always ready to assist, even if it is only to direct someone to the appropriate resources.

I have really enjoyed the active discussions I have now had with scores of Fellows and Trainees. Hopefully the emphasis of their discussions and the associated insights can now re-focus the strategic directions for our College.

This is the last *Surgical News* for the year and I would like to take this opportunity of wishing you all the best for the festive season and may good health be yours in the New Year.

Mike Hollands
President



The College is producing a book, called My Timor Heart, to celebrate our achievements in Timor Leste. My Timor Heart will recognise the extraordinary efforts of the medical volunteers in Timor Leste, and the life-changing impact their work has on people living in a country that continues to struggle with the legacy of years of civil war and violence. Using striking photographs and the words of the volunteers, the book tells the story of the many hundreds who have contributed to creating a healthier future for Timor Leste.

My Timor Heart is edited by Ellen Whinnett, the Walkley-award winning journalist and Head of news at the Herald Sun. All profits from the sale of the book will go directly to the Timor Leste Program and fund essential surgical services and training opportunities.

Contact Emily Salt at +61 3 9249 1230 or emily.salt@surgeons.org if you would like to purchase the book.

The book will be available to purchase from 10 December 2012 onwards.

Another successful year

A year of steady triumph and achievement

As the year draws to a close I think the College can look back on a record of steady achievement marked by the occasional triumph.

The centrepiece of the year was a quite extraordinary Annual Scientific Congress. As delegates flew out of Kuala Lumpur it was noted that, by any measure, this year's ASC was the most successful on record.

The more than 2,300 registrants attending the ASC constituted the highest ever attendance and the 153 convocating Fellows was the highest number in the College's history. The 707 research papers accepted into the ASC's scientific program was also the highest number on record. The Developing a Career in Academic Surgery (DCAS) program attracted its highest ever registration.

Fully a third of the Malaysian College of Surgeons, some 138 surgeons, attended the ASC, along with 29 of their Trainees and 66 Malaysian medical students. It was also pleasing to welcome 34 Australian and New Zealand medical students.

It was a personal pleasure to attend several regional Annual Scientific Meetings in 2012 and to learn of the great work being done by Fellows of the College across Australia and New Zealand.

In the area of public health policy, the College can point with pride to its involvement in two key issues. We welcomed the decision of the High Court of Australia to throw out challenges to the law requiring the plain packaging of tobacco products from December 1 this year.

While still the subject of litigation revolving around Australia's duties under international law, the College hopes plain packaging will be a lasting reality and one that leads to declining rates of smoking among the young. The College has advocated strongly for this initiative and is proud to have been at the forefront of a campaign aimed at reducing the incidence of eminently preventable illness.

The College is stepping up its campaign against another patently preventable social ill, alcohol fuelled violence, and I would like to acknowledge the work of the Trauma Committee in this space. Be it Daryl Wall in Brisbane, John Crozier in Sydney or Russell Gruen in Melbourne, there is always a Fellow at the cutting edge of trauma care ready and willing to go on air and warn of the consequences of alcohol abuse in and around licensed premises.

And as this campaign increasingly captures the attention of media, it begins to resonate with mums and dads concerned about the safety of their children. If we keep plugging away at this issue it will soon capture the attention of governments (and, perhaps more importantly, oppositions). The hotels and liquor lobbies might have clout, but concerned parents in their millions have votes.

I look forward to the day when the College can look back on its record of advocacy on this issue in much the same way we look back on our role in the road safety debates of the 1970s.

Engagement with the Commonwealth Department of Health and Ageing (DoHA) has been a major advocacy effort. A highlight of this was a visit to the College by a contingent from DoHA led by Janet Anderson, First Assistant Secretary, Acute Care Division. A joint discussion with members of PDSB incorporating Specialty Societies was productive and will serve to facilitate future communication.

The College continued its practice of writing to governments and oppositions in the lead up to elections, drawing their attention to the concerns of surgeons

"The College is stepping up its campaign against another patently preventable social ill, alcohol fuelled violence"

and their patients, and asking them to respond to these concerns. Once these responses have been received and assessed, the College issues a media release identifying what we see as the strengths and weaknesses of each party's health policies. The responses of the parties are also posted on the relevant regional page of the College website.

In 2012, we did this in the lead up to the Queensland, Northern Territory and Australian Capital Territory elections.

With an Australian Federal Election scheduled for late 2013, and this complicated by the proviso that Australia could be just one by-election from an unworkable parliament, next year promises to be very interesting. And with at least one jurisdiction – Tasmania – reliant on Federal Government handouts just to keep its public hospitals open, health will continue to grow in importance as an issue of public concern and a factor in political destinies.

May I take this opportunity to remind you that elections to College Council occur early next year, with ballot papers posted to all Fellows on 1 March and the ballot closing at 5pm on Friday, 5 April. The counting of votes occurs on Friday, 12 April.

I would encourage all Fellows to consider the contribution they could make to the work of the College and, through that work, to the future of surgery in Australia and New Zealand. How many times have you thought to yourself that some aspect of your work or the practice of surgery more generally, could be done better if only it was brought to the attention of the "powers that be" – be that the College Council, health departments or governments?

If you think you could make a difference, why not stand for Council? The Call for Nominations document should have arrived in your mailbox, or soon will do so. You have until Friday, 1 February, to get your nomination form back to the College. I look forward to seeing a large and diverse range of candidates standing for election.

Finally, I thank you for your support over the year and for the time some of you have taken to raise issues of concern with me. I wish you all the very best for the festive season and the New Year.

Michael Grigg
Vice President

ELECTION

OF COLLEGE COUNCILLORS 2013

Exercise your democratic prerogative!

Now, more than ever, the College needs the input of a wise and diverse group of Councillors. Those voting need to be able to express the views of the electorate by choosing from a wide-ranging group of nominees.

Give your colleagues the option of electing you.

Consider nominating for election to College Council.

Those elected will help shape the future of surgery, and surgeons, in Australia and New Zealand.

Nomination forms will be mailed to Fellows of the College in November.

Take care of yourself

The Director of Trauma at Brisbane's Princess Alexandra Hospital, Professor Michael Schuetz has pleaded with drivers to look after themselves. After continued receivals of horrific injuries from road crashes, the Professor said motorcyclists in particular need to take responsibility when they take the road. "This country has a hot climate, but I think thongs and shorts are not appropriate gear," Professor Schuetz said.

"The message is of course, stay on the road according to the rules, have the right gear, the right protection and listen to prevention recommendations."

***AAP Newswire*, October 11**

Journal in the news

An article in the October issue of the *ANZ Journal of Surgery* featured recently in Melbourne's *Herald Sun*. A recent review has revealed a drop in facial injuries after the introduction of new rules in the Australian Football League. The review also found that heavy blows are more likely to occur early in the season. Author Trainee surgeon Dr Jason Savage, said it may come down to an under-reporting of incidents. "The introduction in 2007 of a free kick for any front on contact to a player with his head over the ball or for high contact to a player may also have been a factor," he said. "Facial injuries at any level of the game raise concerns because they can cause temporary or permanent loss of function. And at the elite level, of course, they can threaten the length of a playing career and a player's earning potential," Dr Savage said.

***Herald Sun*, October 25**

Grow your own

The recovering of breast cancer patients after surgery is hoped to improve markedly with some successful in trials from Melbourne surgeons. Five women underwent the trial which redirected blood vessels with attached fat cells from under the arm to an acrylic breast shaped chamber, using the cells to regrow breasts following a mastectomy. Although unsuccessful in four instances, the fifth patient was a success. The Neopec technique is hoped to be used as an alternative to silicone implants. "Although not every patient succeeded, the fact that one has grown tissue to the extent it completely filled the chamber is an extremely positive finding that has given us enthusiasm and direction and potential for this," Professor Wayne Morrison said.

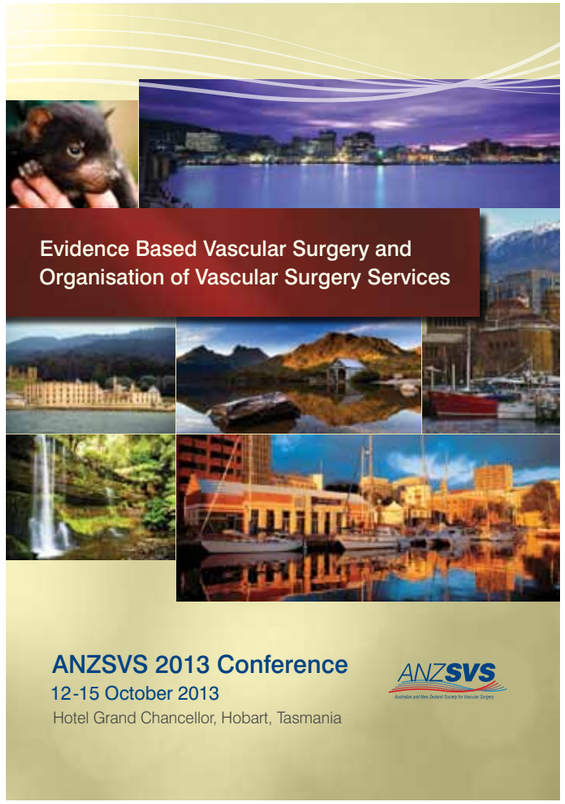
***The Age*, October 26**

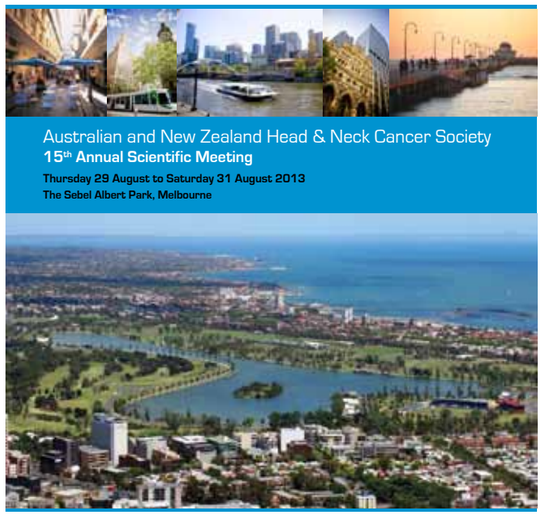
A woman has returned from a plastic surgery trip to Thailand scarred for life, with correction surgery costing about $100,000.

Medical tourism

The trip was said to have been booked by a Gold Coast cosmetic holiday provider, organising a breast lift and a small implant. However, Thai surgeons convinced her to go for a larger implant. Dr Ian McDougall said it was the worst surgery he had seen. "I don't know how some of these promoters can sleep at night." Dr McDougall said. The College has recently contributed to the Federal Government's Smart Traveller website on the subject of medical tourism.

***Gold Coast Bulletin*, October 27**





Friday 8 March 2013
Sofitel Sydney Wentworth, Australia

"Serving the Community:
Training Generalists and Extending Specialists"

Slow and steady

A steady build of a complex system will lead to success, says Dr Mukesh Haikerwal

As the first step in the gradual roll-out of the Federal Government's electronic health initiatives, more than 9000 Australians have registered for a Personally Controlled Electronic Health Record (PCEHR) since the system was launched in July.

Other components of the system now available to consumers include their MBS and PBS information, immunisation records and organ donor registration details. Healthcare organisations have been able to register since August to participate in the eHealth record system with a healthcare provider portal now in operation and some clinical documents have been loaded onto the PCEHR system in the lead implementation sites where software is available.

Dr Mukesh Haikerwal, the Head of Clinical Leadership and Engagement of lead organisation the National E-Health Transition Authority (NEHTA), said while the take up by consumers had been low, the small numbers had allowed for refinements to be initiated to the registration process to make it quicker and more user-friendly.

He said the NEHTA was in the process of working with IT companies to design and refine the software needed by healthcare providers to ensure meaningful clinical use and longevity with future platforms and compatibility between providers and electronic devices.

He said some of the software packages included Medical Director, Best Practice, ZedMed, Medtech32, Communicare, Practix and Genie.

Dr Haikerwal listed the steps of the ehealth roll out.

"First we have consumers registering for a personal record, then we connect that to Medicare data which began a few weeks ago, then we opened the portals for health providers, then they will register for organisation identification numbers over coming months; the software is being refined, training will need to be provided and finally everyone can become connected," he said.

"It is a slow process and that's not a bad thing in a way because it is extremely complex and we are working hard to ensure that all the technology is future proof and compatible so that no time or money is wasted.

"There is no doubt this will take years to fully roll out across all health sectors, but the benefits – in terms of patient care and information transfer – will be enormous."

Dr Haikerwal, a Melbourne GP and former Federal President of the AMA, described those benefits as joining up the dots of healthcare, inter-operability and the provision of better health outcomes through good clinical information transfer.

He said that while the initiatives were yet to impact on surgeons, all doctors could now receive their allocated Health Provider Identifier (HPI) through the Australian Health Practitioner Regulation Agency as part of the registration process.

HPIs will be assigned to all eligible healthcare providers and organisations and will be divided into two classes: Health Provider Identifier – Individual (HPI-I) for all medical and other health professionals involved in patient care; and Healthcare Provider Identifier – Organisation (HPI-O) for organisations such as hospitals, healthcare facilities and private consulting rooms.

Each provider will also be allocated a security-based token to plug into personal or hospital computers to be called a National Authentication Service for Health (NASH) Token which is currently being designed.

The combination of the HPI and NASH Token will ensure certainty and security relating to the source of information during all information transfers between health care providers.

Dr Haikerwal said each HPI-I is unique with providers only needing one regardless of the number of qualifications attained or healthcare organisations worked for.

"The HPI-I and NASH Token will provide an accurate and secure foundation for sending and receiving messages and information to and from other providers electronically, which we believe will significantly improve health care delivery across Australia," Dr Haikerwal said.

"The costs associated with inadequate patient information are significant.

"It is estimated that ten per cent of hospital admissions are due to adverse drug events and that up to 18 per cent of medical errors are due to inadequate availability of patient information.

"Some surgeons and specialists are already receiving electronic referrals, pathology results and radiology reports through the use of secure messaging systems and I would encourage others to look into this because the sooner they begin, the more prepared they will be for the introduction of the HPI-I and NASH Token system."

Dr Haikerwal said he believed it would only be a matter of a few years before surgeons would be conducting patient and ward rounds using an iPad or similar device which could offer immediate access not only to pathology, imaging and pharmaceutical information and what the local IT system allows, but also to summary medical documents (from the PCEHR) of a particular patient including injuries, reactions to previous surgery and anaesthesia, allergies and drug reactions as well as reports from other specialists.

He said training would need to be provided to surgeons and their staff through the eHealth Learning centre as well as locally by government agencies.

"We are in the process of putting all the bits of a very complicated jigsaw together and while there will be a great many benefits from this system we understand the need to move cautiously and methodically," he said.

"It will take a few years to introduce all the aspects of the system and train the 800,000 health professionals currently working in Australia and we understand they will need support while they introduce and adapt to the changes."

In recent months NEHTA has also worked to design standards for the most commonly exchanged health information including:

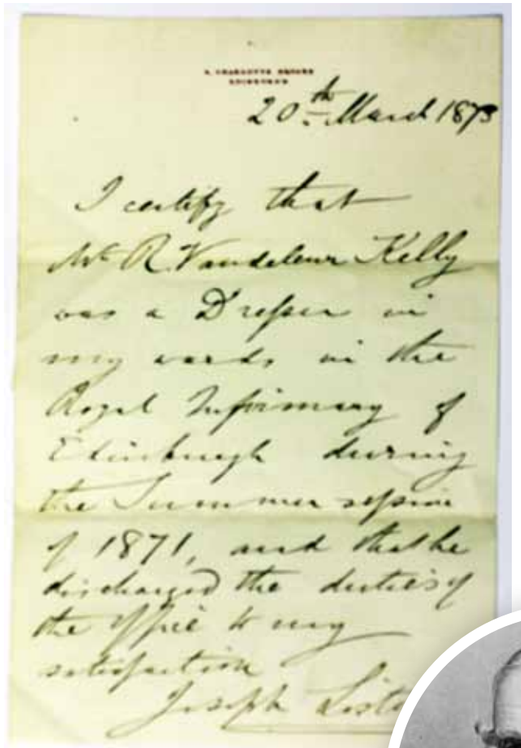
- e-Discharge – national specifications developed
- e-Referral – national specifications developed
- e-Specialist letters – national specifications developed
- e-Prescriptions (ETP) – national specifications being developed and built into the 5th Community Pharmacy Agreement
- e-Pathology – national specifications developed and built into the Pathology Funding Agreement for implementation from 2013.

Dr Haikerwal said surgeons seeking more information should visit the following websites: www.nehta.gov.au; www.ehealthinfo.gov.au and www.yourhealth.gov.au

With Karen Murphy

A Note from Lord Lister

Another important piece for the College collection



Above: The letter. Inset: Lord Lister

In August, the College was given the opportunity to acquire a letter of reference written by Joseph Lord Lister. It was for sale with a fine books dealer in Sydney. The letter is a one-page note in Lister's own hand, written on his letterhead with the address, '9, Charlotte Square, Edinburgh', at the top.

In this note, dated 20 March, 1873, Lord Lister gives a reference for a Mr R. Vandeleur Kelly, stating that Mr Kelly had acted as a dresser in his wards at the Edinburgh Royal Infirmary during the summer of 1871, and had performed his duties satisfactorily.

Now, two years later, Mr Vandeleur Kelly was seeking a post, and asked Lister for a reference. It may not be the most glowing of references, but understatement and conciseness were the style of the day, and any reference from someone of Lister's standing would have been a valuable possession.

Robert Vandeleur Kelly was born in Ireland in 1843, the son of a barrister. He was educated at Bonn (then in Prussia), and then in 1855 was sent to Australia to continue his education at The King's School, Parramatta, where the headmaster was his brother-in-law. After his schooling was completed he returned to Great Britain and studied medicine at Edinburgh, gaining his LM LRCP in 1873. It was at this time that Lister wrote the reference for him.

After spending some months working as a dispensary medical officer in Glasgow he moved back to Ireland, where he stayed for four years. He married in 1887. Then came an unstable period, when he moved continuously back and forth between Ireland and England. He gained his FRCS in 1880, and in 1883 became surgeon to the South Staffordshire Regiment.

In 1889 Vandeleur Kelly migrated to Sydney, and established a practice in the city. He was attached to the Sydney Hospital and frequently took on the role of Acting Government Medical Officer. He joined the Military Forces of New South Wales in 1889, attaining the rank of Surgeon Major in 1896.

Vandeleur Kelly was a founder of the St John Ambulance Association in New South Wales. In his military role he did much to develop the field ambulance services within the army. When war broke out in South Africa he was given the rank of brevet Lt-Colonel and commanded two contingents of the NSWAMC, the first embarking in January 1900, and the second in March 1901. He served with distinction in the Transvaal and the Orange River Colony, being Mentioned-in-Dispatches and appointed CB in 1902. His son also served in the same campaigns.

After the end of the Boer War he returned to Sydney and practiced at Auburn. He died of a stroke at Balmoral on 15 October, 1913, and was buried in Thirlmere Cemetery.* His full dress tunic is kept at the Australian War Memorial in Canberra.

When he asked Lister for a reference, Robert Vandeleur Kelly would have had little idea of where his life and profession would lead him. But he became a distinguished member of his profession far from home, in peace and war. The College is fortunate to have acquired this small, but important piece of memorabilia.

* Most of the biographical information on Vandeleur Kelly is taken from the entry in the Australian Dictionary of Biography.

To Grinch or not to Grinch

Christmas isn't all it's cracked up to be

There is one thing that really annoys me and that is Christmas. It is not the family gatherings and the well-wishing, nor the deeply felt religious celebrations. It is the lack of genuineness of it all.

We curmudgeons can be very grumpy about many things and premier among them is insincerity. We have a built in antenna that detects those who are having a lend of us. We know when you don't mean what you are saying or when your actions are covered by a thin veneer of genuineness.

Look at the presents that we give. Do we really want to spend $50 on that obnoxious child of second cousin Anthea? That's the one that kicked you in the shins last Christmas because you thought that a play station was wooden building blocks.

After all he is only 6 and how were you to know that that overpriced piece of electronic gadgetry was what he really wanted and that he knew how to use it. Do we want to buy more stuff for family and friends that they don't need and will re-cycle it to you next Christmas or give to the Salvo's?

What about the hypocrisy of church going? The priests and ministers may be pleased with the spike of attendance but how many of them are real believers. I would suspect that most of them are not sure or are having an each-way bet.

And as for the Christmas lunch – it is a health hazard! Too much turkey, too much grog, and too much physical exertion in the form of back-yard cricket for the couch potato brigade. Not to mention of course the marked rise in car accidents, relationship breakdowns and family disputes fuelled by the season of good will to mankind.

So why don't you do what we curmudgeons do – give no presents, remain absent from church, eat abstemiously, join the temperance league and be suitably grumpy about it all.

Unless of course you miss the carols at Midnight Mass, feel badly that you get no presents because you give none, feel undernourished with just a turkey sandwich and quite like that single Malt that cousin Anthea usually gives you. If that is the case then you may do what we curmudgeons do well – change your mind and be contrary.

In Memoriam

Our condolences to the family, friends and colleagues of the following Fellows whose death has been notified over the past month:

Howard Bye, Tas
Orthopaedic surgeon
John Moulton, NSW
General surgeon
Harold McComb, WA
Plastic and Reconstructive surgeon
Stanley Matthews, NZ
Orthopaedic surgeon
Bruce Johnson, Vic
General surgeon
Alexander Ferguson, NZ
Urologist
Reginald Kitchen, ACT
Urologist
Graham Cavaye, Qld
General surgeon
Lionel Jacobs, NSW
General surgeon
John Sage, NSW
Urologist

We would like to notify readers that it is not the practice of *Surgical News* to publish obituaries. When provided they are published along with the names of deceased Fellows under In Memoriam on the College website **www.surgeons.org** go to the Fellows page and click on In Memoriam.

Informing the College

If you wish to notify the College of the death of a Fellow, please contact the Manager in your Regional Office. They are

ACT: Eve.edwards@surgeons.org
NSW: Allan.Chapman@surgeons.org
NZ: Justine.peterson@surgeons.org
QLD: David.watson@surgeons.org
SA: Susan.Burns@surgeons.org
TAS: Dianne.cornish@surgeons.org
VIC: Denice.spence@surgeons.org
WA: Angela.D'Castro@surgeons.org
NT: college.nt@surgeons.org

A case in Plastic Surgery

Split skin graft to left leg

An elderly patient presented with a laceration of the leg requiring skin graft.

There was significant past history of alcoholic liver disease with varices, malaena, venous insufficiency, cardiomyopathy and chronic hyponatremia. There was a significant delay before admission and routine grafting, although there is no specific evidence this delay caused problems.

Shortly after surgery, the patient's legs and arms were noted to be oedematous with skin breakdown and ooze into the bed. Review by the plastic surgeons a week after surgery described complete skin graft take. A request for medical review was made at this time. The medical unit commenced albumin and Lasix. The patient began to mobilise and was being prepared for discharge.

Post discharge, the patient began to deteriorate with confusion and anaemia. A bleed into the buttock required correction of coagulopathy, transfusions and eventual embolisation of the bleeding vessel. There was progressive multiple-organ failure, ongoing bleeding and subsequent demise after withdrawal of active management.

Reviewer's comments

Thorough history taking and documentation of comorbidity is essential on admission. Early management and investigation of adverse changes such as oedema and falling haemoglobin is important.

The hospital record is reasonably thorough, though a few points are worth noting. A clear elucidation of the past history was not made until the final summary by the ICU. At this time, the cardiomyopathy and chronic hyponatremia were first documented. This is important as these may well have contributed to the multiple-organ failure.

The delay between admission and grafting probably did not contribute to the eventual outcome.

Despite significant and generalised oedema, medical review was not obtained for a significant period. The past history of cardiomyopathy was not elucidated at an appropriate stage of management.

The progressive fall in haemoglobin noted over the days prior to collapse was not investigated nor was consideration evidently given to ceasing anticoagulation until this collapse occurred. This was preventable, given the underlying chronic disease pattern.

Guy Maddern
Chair, ANZASM

Poison'd Chalice

I was home. I had cooked an old fashioned Sunday lunch – a rare chance to 'bond' with my female offspring before she finally departed the family abode – well, at least for more than a night at a time! My better half was away – a family matter that I was grateful to be excused from. Fortunately the on-call roster was the responsibility of one of the newly appointed consultants. That meant I was only going to be called if one of those 'old fashioned' operations was needed.

One advantage of thinning grey hair was the perception that you were still the master of some things, but generally those were the ways things were done 20 years ago. For the current crop of consultants, it was like speaking pre-anaesthetic or pre-antibiotic… What do you mean, 'you open someone up? You use a knife to cut someone!'

I looked across the lunch table at her to try and engage in some meaningful discussion, stuff to warm the soul and enlighten the mind. Surely her thumbs would wear out soon. Texting surfing, sighing at the responses… Why on earth are they called smart phones? Mind you iPads is not an inappropriate name!

I projected my voice across the table, not to anyone in particular. "I read an interesting study that stated the use of Facebook and other social media was contributing to an increase in narcissism." No response, so I tried again. "I hear that narcissism is on the rise. And that you people with the soon-to-be arthritic thumbs are the big offenders.

"Does anyone present know what narcissism is?" I asked.

My female offspring looked me squarely in the eye. That look that meant this was a dangerous topic – a look she had inherited from her mother. "Let me see," she said, "How do you feel about being a highly positive individual, particularly with regards your own skills? Do you see yourself as just a touch special particularly with regards those surgical skills? Do you expect special treatment in that hospital of yours because of that? Like to be successful? Not that you would ever be selfish about it…?

"You know," she said, "they are all things I admire about you. They are all narcissistic traits. Just think that I have inherited them all from you and I am now adding on the capacity to have multiple points of contact and opinion that endorse my good views about things. And it is all through this…" She waves the smartphone at me and I see her Facebook page blur in front of my eyes.

The day was meant to be about her and suddenly it was about me. It crossed my mind that as a parent, I was quite out of my depth. Where had my cute little daughter gone – the little girl who required both my protection and guidance?

But what was she saying to me? Is the surgical persona naturally narcissistic? Are we naturally exhibitionists and attention seekers? Is our drive to seek better outcomes for our patients just another form of dominance and attention-seeking behaviour? Where was all this going?

I could hear the words of Shakespeare in my ears from Hamlet Act 4. "We know what we are, but know not what we may be?" Possibly true. Maybe we are just naturally selfish? Certainly self important, but narcissistic as well? Where was that urgent call from the hospital requiring my immediate attendance? Never comes when needed.

Is narcissism an impediment to insight? Undoubtedly. Maybe we just want to be loved; is that why we do what we do?

The next day, my registrar and I were making our way to the Morbidity and Mortality meeting. Our resident had just texted to say he had worked longer hours than expected yesterday and was not able to attend that morning due to violation of the 'Safe Hours' rules. She (my registrar) commenced a tirade about the millennial generation. "Selfish, self-centred and self-satisfying brats."

It was quite a mouthful.

"Sounds a bit narcissistic," I responded to her. "You are not wrong," was her immediate retort. "And the millennial generation is now getting it bigger and bolder. "You know there is a song from the distant past that sums them up perfectly," she said. "You're so vain… Do not start me on their sense of entitlement and their lack of empathy. Wasn't like that, in my day…"

Your day, I thought – that was yesterday! My day on the other hand was in a different universe, an alternative time dimension…

Professor U.R. Kidding

The Challenge of *Relocation*

A personal perspective

Owen Ung used to spend an hour-and-a-half in Sydney traffic snarls every work-day morning. As head of Department of General Surgery and the Breast and Endocrine unit at Westmead Hospital his public commitments were substantial, along with consulting and private surgery out of Sydney Adventist, The Hills and Westmead Private Hospitals.

At the end of the day, he was lucky to see his four children before bedtime and rarely, if ever, was he home in time to share a family dinner.

Having built up a busy surgical practice and achieved academic promotion through the University of Sydney over more than 15 years, such sacrifices simply appeared to be the price he and his family paid for success. However, he received a phone call that forced him to challenge that assumption.

In 2008 he was approached by a senior colleague and former mentor asking him if he was interested in taking over the leadership of the Breast and Endocrine Unit at the Royal Brisbane and Women's Hospital (RBWH) upon the Brisbane surgeon's retirement.

The decision

The offer had appeal given that Associate Professor Ung had grown up and trained in Brisbane, yet it also had significant drawbacks; he was 48 and well established, his children were settled in schools and his family had social networks in Sydney.

But more confronting was the expectation he would face a likely drop to about a third of his previous income by walking away from a private practice that had been 15 years in the making. Associate Professor Ung said that while there may be many good lifestyle reasons for moving, the financial cost may be prohibitive.

"The realities of moving cities, the practicalities of supporting a family and the abrupt sacrifice of earnings required careful consideration," he said.

"Most of us grow into our incomes and lock into school fees, mortgages and other expenses and responsibilities.

"Once established, surgeons don't tend to move around much in Australia because we need a referral base from GPs and specialists to support our practice.

"In countries where there is a socialised health system, salaried specialists tend to move more readily as income levels mostly remain comparable and in the US, an academic surgeon with supported research infrastructure and a good salary might be head hunted and rewarded financially for taking up a new position.

"When you are a young surgeon starting out, you may be content to gradually grow your practice, but it is quite confronting to go back to that stage as an older surgeon. I anticipated a period of three to five years to re-build a practice.

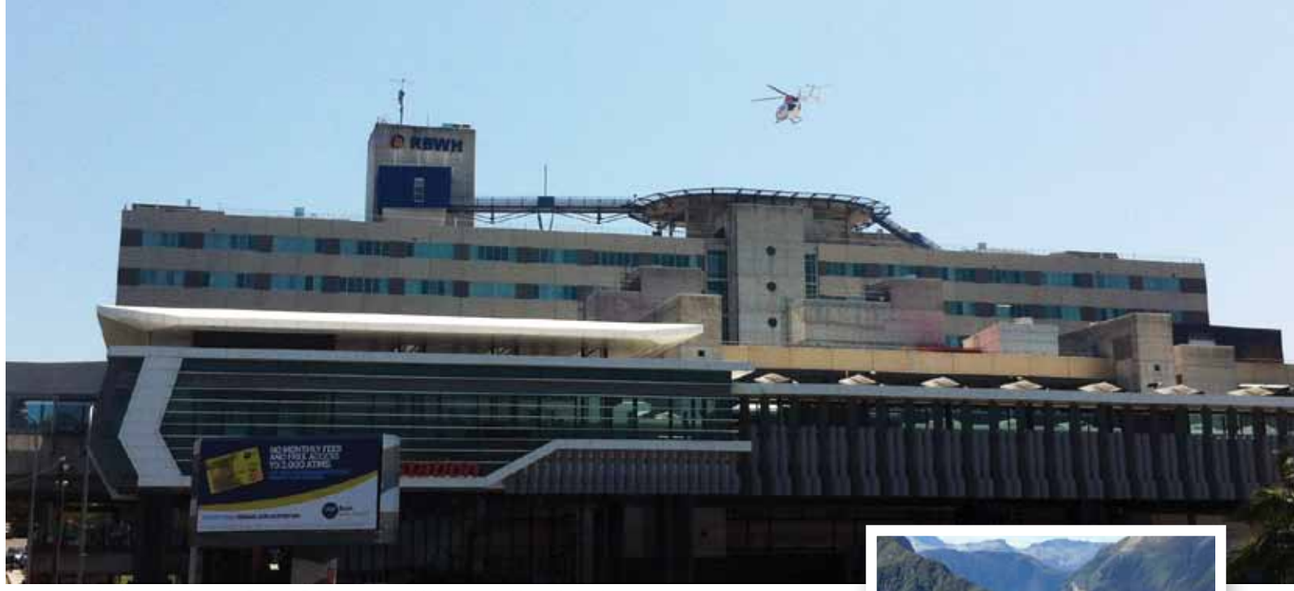
"Still, though I worked with fantastic colleagues in Sydney and had made wonderful friends, I did desire a lifestyle change. While Sydney is a great city, it can be gruelling to get around."

So after raising the idea with his family, and dealing with what he described as a degree of teenage angst and tears, Associate Professor Ung first began investigating the option proposed and then preparing for the move.

He implemented certain financial frugalities in the lead up and spent time in Brisbane talking to colleagues.

"I did an initial reconnaissance visit to see if I would be professionally welcome in Brisbane which I think is important," he said.

"You need to know you are not stepping on other's toes and that you can establish a practice in a convivial collegiate atmosphere.



Left and above: Royal Brisbane and Women's Hospital where A/Prof Ung is based. Inset: With his family.

"It was also a great pleasure to return to my Alma Mater, meet former colleagues and rejoin old networks.

"The senior colleague who had initially approached me was also very supportive and gave me two years to prepare before his retirement. When he did retire from operating, he continued to consult for a further 12 months. Sharing rooms allowed me to obtain an overflow of work from his referrers. This was useful in the period before his complete disconnection from practice and when I became reliant upon my own smaller, but growing referral base.

"I moved a year ahead of my family, as one daughter was completing her important Year 12. So even though it often felt too hard at times – particularly in the first year when I was commuting back and forth to Sydney with all the attendant expenses and lower income – appropriate planning eased the move."

Now Associate Professor Ung's family are well-established in a new home and in new schools. He heads his public unit and is a visiting specialist at RBWH, retains a 20 per cent FTE academic appointment with the University of Queensland medical school and has an enjoyable private practice out of the Wesley and St Andrews Hospitals.

Lifestyle, living close to work and amenities and freeing up more time for the family was the primary motivation for the move. Getting the professional aspects properly sorted helped make the aspiration a reality, he said.

Professionally, Professor Ung said there were three central aspects that pushed him through the decision-making process: he had the skills to replace the senior surgeon upon his retirement from a major teaching hospital; the UQ appointment offered him allowed for a continuation of his academic interests; and he was given the time and support to help re-establish a private practice.

"I made it a priority to spend time with people in the same sphere, to take on committee work and various roles within the public hospital while continuing my academic collaborations, because all of that helps establish your professional standing," he said.

"When you are new in town you can't expect to inherit a practice. Most of your mail-outs to GPs likely end up in their bins. GPs prefer to send patients to specialists they know and like, so you just have to accept that it will take some time."

Now three years into his new life and at age 51, Associate Professor Ung says all the worry, the initial travel and time away from his family and their anxiety at moving cities had been worth it and that the relocation had re-invigorated his life as a surgeon, academic, husband and father.

"I had to convince the family it would be a good move and that we'd ultimately be happy and they had to take a leap of faith," Associate Professor Ung said.

"That, at times, felt a heavy responsibility, yet at the same time the shift gave me the chance to redesign my working life so I could spend more time with them.

"Now I enjoy every fourth Friday off which I never had before. I don't allow work to encroach upon this sacred time. I have organised my operating schedules so that most of my patients can be released from hospital by the weekend so I have less interruptions during my time off.

"When you start out in practice, your working week evolves and over time your professional commitments can grow without any design or practical arrangement so to have the chance to re-map my future working life in a more orderly way was wonderful.

"It was also very important to be able to continue clinical research and teaching. I can continue to collaborate with my Sydney colleagues, participate in Australasia-wide clinical trials in the areas of breast cancer oncology and thyroid disease and develop new research collaborations through the University of Queensland.

"Some people may think it is all too hard to move around in Australia, but I would say it is worth exploring and not to be too put off by financial concerns. If you are self-assured and confident in your ability you will be able to develop a satisfying practice.

"Also, after 15 years in one environment, change can be invigorating – particularly at my age. I've estimated that this move will probably extend my target retirement age by a few years, but I'm spending less time stuck in traffic, more time with my family and enjoying the convenience and accessibility of a smaller city."

With Karen Murphy

The benefits of sunshine

A little bit of sun at the right time never hurt anyone

"Your bloods are great with the exception of your Vitamin D which is only 19nmol/L," I reported to Proud n' Pale. "I know it's winter, but that is not healthy." Proud n' Pale is one of those doctors who is obsessive about sunscreen, even when out for a walk at 7am. Some fear of melanoma is not unreasonable given the holes in the Ozone layer above our continent.

"You need more sunlight," I continued. "I am not recommending you get sunburned, but you need more exposure to sunlight and you should have a Vitamin D level at least above 50nmol/L. It's not only important for your musculo-skeletal health, but also for mental health, and preventing cardiovascular disease, cancer, stroke and metabolic diseases."

Proud n' Pale couldn't believe it as they were determined to avoid melanoma and to minimise the number of scars from BCC, SCC and 'dubious keratotic lesion' excisions over the next couple of decades.. Thus a low Vitamin D was being tolerated to the detriment of good health. No wonder Proud n' Pale often felt low and lacking in energy.

I suggested that as Proud n' Pale was now greying nicely into middle age, there's not much evidence that reasonable sun exposure affects melanoma risk, though the same is not true for SCC. Most increased risk for melanoma was incurred when young, by getting sunburnt, and not taking advice about wearing a hat, shirt or sunscreen when outside for long periods, particularly those prone to blistering sunburn.

Anti-sun messages may be appropriate for people who are very pale, but the anti-sun campaigns have probably caused more cancer, ill-health and unhappiness than can ever be prevented by a hat or slip, slop, slap.

The anti-cancer council may never admit it, but why keep mum despite the mounting evidence in the literature? Evidence that we need Vitamin D to prevent dementia, cognitive decline and maintain mental health. Vitamin D also has a whole host of other beneficial effects outside of the musculoskeletal system, which are often forgotten.

Vitamin D insufficiency is remarkably common and exceeds 40 per cent in adults, particularly working and elderly adults. Vitamin D stores can be measured by Vitamin D or 25-hydroxyvitamin D serum concentrations (25-OH D3).

Patients with documented deficiency (Vitamin D < 20nmol/L) are likely to need 600,000 iu administered over several weeks (600 iu/day) to replenish stores. Single large doses of 300,000-500,000 iu should be avoided, as they can be detrimental. Levels between 20 and 50nmol/L represent insufficiency.

In addition to the effects on bones, Vitamin D deficiency is associated with cardiovascular disease including hypertension and ischaemic heart disease. There are Vitamin D receptors in brain, prostate, colon, lung, the pancreas and immune cells. Proud n' Pale was thus at increased risk of cancer.

Now the role of Vitamin D in breast, colon and prostate cancer remains somewhat controversial. However, Vitamin D levels are inversely associated with the risk of colon cancer and Vitamin D decreases intestinal tumourogenesis in animal models, inhibits the proliferation of cultured human colon carcinoma cells and acts by regulating the expression of many genes by a variety of mechanisms.

Although claims have been that Vitamin D may protect against breast cancer, there is little evidence for this at present, despite the fact that breast epithelial cells possess the same enzymatic system as the kidney thus enabling local synthesis of vitamin D. Possible mechanisms for preventing cancer include Vitamin D-induced growth arrest and apoptosis of tumour cells or their non-neoplastic progenitors.

It wouldn't be reasonable to expect short-term clinical trials of Vitamin D given over a year or two to demonstrate efficacy in preventing cancer. The effect of deficiency is likely to be much longer than the attention span of a research team in pursuit of another publication.

The effects of Vitamin D deficiency occurs over decades, so we need long term cohort studies that are not limited by studying the association with a single reading. We need to study the impact of sustained or repeated deficiency every winter.

There is actually a Vitamin D deficiency pandemic. The rising incidence of many of our non-communicable diseases including diabetes may well be associated.

I hope Proud n' Pale will get out in the sun, at least for long enough to bring the 25 OH D3 level above 50nmol/ml. The darker the skin of the reader, the more time in the sun is needed. The more clothes you wear, the more you need to expose yourself. Sunshine and sunlight also make us all happier, and the Vitamin D created as a result of our exposure prevents cancer, promotes cardiovascular wellbeing and mental health. You might get a few more wrinkles, but it will stop you feeling so old.

And now if you will excuse me, I really must get out in the sun before my afternoon clinic.

References available on request.

Dr BB G-loved

A new era

New directions for the Academy of Surgical Educators

A future directions paper was tabled and discussed in detail at June Council and seven recommendations with respect to the future of the Academy of Surgical Educators and its governance structure were endorsed.

A new vision for the Academy has been refined by the Professional Development Committee and was discussed and expanded at a face to face Academy of Surgical Educators planning meeting in early October. Representatives from the Academy of Surgical Educators Board, Academy of Surgical Educators Advisory Committee and Surgical Teachers Education Program Committee, along with key College staff were invited to attend and contribute.

The planning meeting generated a high level discussion around the strategic direction, role, membership, and governance of the Academy and also developed a Terms of Reference for the new Academy of Surgical Educators Committee. The previous roles performed by the Academy of Surgical Educators Board, Advisory Committee and the Surgical Teachers Education Program Committee have now coalesced under the umbrella of the Academy of Surgical Educators Committee. The significant contribution made by the members of each of these entities has been publicly recognised at both the Professional Development Committee and Academy planning meeting.

Since the ASE membership drive was launched in February 2011, 161 individuals comprising 106 faculty and 55 members have joined the Academy. However, there was some uncertainty about the role of the Academy and how it differed from other educational entities within the College.

The Academy has now clarified that role by renewing its initial focus of supporting, enhancing and recognising surgical educators within the College. This will be facilitated through identifying the changing needs of the faculty and addressing those needs through the professional development activities offered.

The Academy will oversight the curricular development related to generic education and professional development of trainers, supervisors, faculty members, assessors and examiners across various Boards, Committees, the Court of Examiners, Professional Development and the Surgical Societies. The Academy will not encroach upon the roles and responsibilities of the College's educational departments, but will instead support these operations through the development and implementation of faculty training programs where appropriate.

It will continue to be the driving force behind the Surgical Education Program and educational Master Class programs at the Annual Scientific Congress and also research in the field of surgical education. Collaborations with other Colleges, Universities and educational bodies both domestically and abroad, will be explored.

Membership will continue to be open to all Fellows and Trainees committed to the role of Teacher/Scholar. Selected individuals external to the College who have strong surgical educational interests and expertise will be invited to join the Academy.

The Academy aims to meet the professional development needs of Fellows and Trainees in the domain of surgical educator, both now and into the future. If you are interested in becoming a member of the Academy, then please contact pd.college@surgeons.org or call +61 3 9249 1106.

Julian Smith
Chair, Professional Development
Chair, Academy of Surgical Educators
Stephen Tobin
Dean of Education

Global Burden of Surgical Disease

The Third International Medical Development Symposium

David Watters and Kiki Maoate chair the panel discussions. Below: Richard Leona and John Batten at the Cocktail reception. Inset: Wame Baravilala presents.

The College held its third triennial International Medical Development Symposium on 26-28 September. Specialists and leaders in global surgery and anaesthesia attended from North America, Europe, Asia and the Pacific to address the global unmet burden of surgical disease.

This was the first time that a global surgery and anaesthesia meeting of this scale had been held in this region of the world. It was an outstanding success, with the meeting agreeing to advocate for a World Health Agenda to reduce the Global Burden of Surgical Disease, and ensure that essential and emergency surgery and safe anaesthesia are seen as a basic human right.

This Symposium was jointly convened with the Australian Society of Anaesthetists, the Alliance for Surgery and Anaesthesia Presence (ASAP), the Harvard-based humanitarian surgery initiative and the International Society of Surgery. The meeting brought together surgeons, anaesthetists and other specialists, donors and policy makers, to discuss the global challenges facing surgery and anaesthesia.

Visiting speakers included Professor Eddy Rahardjo from Airlangga University, Surabaya, and Dr Ian Norton from the National Critical Care Trauma Response Centre, who spoke about disaster response, and Mr Pedro Monzon Barata (Cuban Ambassador to Australia), who spoke about the Cuban Medical Training Program.

Dr Kelly McQueen (ASAP) gave the College Triennial Lecture on the chronic unmet need of essential and emergency surgery and safe anaesthesia, and Dr Rich Gosselin (University of California) gave a stimulating presentation on the health economics of surgical intervention. Lord Tangi o Vaonukonuka (Tonga) spoke about aid effectiveness and local leadership in the Pacific.

The program also included presentations and discussion on workforce development, minimum standards, non-communicable diseases and trauma, including a talk by Dr Manjul Joshipura from the World Health Organisation (WHO) in Geneva on the WHO Global Alliance for Care of the Injured.

The first day focused on the global needs for surgery and anaesthesia, and on the second day, the meeting looked at strategies to respond to, and reduce the burden of surgical disease.

The conference addressed such topics as the measuring of unmet surgical need, the safety of surgery in low and middle income countries (LMIC), essential surgical care, and the role of organisations in training, support, advocacy, and research. The meeting highlighted that globally there is a high proportion of unmet, but potentially surgically-treatable pathology, resulting in death, deformity and disability.

In the past two decades (1995-2014) the Millennium Development Goals made no specific mention of disease, deformity and disability that can be corrected or reduced by surgery.

Yet the evidence supports the fact that the unmet burden of disease is significant.

The populations inhabiting the world's richest nations undergo 60 per cent of global surgical procedures whilst those living in LMICs receive only 3.5 per cent of the surgery.

Currently two billion of the world's population do not have access to emergency and essential surgical care. Those in need of emergency or essential surgery have no therapeutic alternative to a surgical procedure, which normally requires some form of anaesthesia.

There remain 74,000 operating theatres without a pulse oximeter; something that Lifebox, an anaesthetic Non-Government Organisation backed by the World Federation Society of Anaesthesiologists, is seeking to address, as highlighted by Canadian anaesthetist, Dr Angela Enright.

Surgical mortality audits will be critical to getting emergency and essential surgery and safe anaesthesia on the global health agenda. There has been significant collaboration and momentum since the meeting to advocate for perioperative mortality, an indicator of the safety and quality of surgery and anaesthesia, to be included as a basic health indicator similar to maternal and infant mortality.

Support for the development of surgical capacity in developing countries continues to be a priority, in order to address the workforce, facilities and resources required to deliver an emergency and essential surgical and anaesthetic service.

Prior to the meeting we hosted workshops on the Global Initiative for Emergency and Essential Surgical Care (GIEESC) and how to manage contaminated wounds in disaster settings. The outcome of these workshops will inform future Surgical News articles.

The Symposium speakers spoke on ways of measuring the unmet burden of surgical disease and the cost-effectiveness of surgical treatments. Surgical care has often been perceived to be expensive, but in reality can be delivered for $11-30 per Disability Adjusted Life Year (DALY) which is a similar cost to measles vaccination, providing bed nets for malaria prophylaxis or Vitamin A supplementation.

Surgery cannot be carried out without anaesthesia. The next stage is to advocate for safe, if minimum, standards for anaesthesia and surgery, together with the measurement of outcomes, particularly perioperative mortality.

It will be such advocacy for surgical and anaesthetic services with the ministries of health in our region that will turn our discussions into something of on-going value in addressing the global burden of surgical disease.

David Watters and Kiki Maoate

Aboriginal and Torres Strait Islander health outcomes continue to be at levels far below those achieved by non-Indigenous Australians. Although some gaps have narrowed, others have not improved and indeed, further deteriorated.

The Royal Australasian College of Surgeons acknowledges the challenges of Aboriginal and Torres Strait Islander health and is working to improve outcomes. Various strategies have been targeted including efforts to promote surgery as a career to Indigenous doctors, its work on the National Aboriginal and Torres Strait Islander Medical Specialist Curriculum Framework (in concert with the Committee of Presidents of Medical Colleges) and other Indigenous specific initiatives. The College has an Indigenous Health position and is currently developing a strategy with its Indigenous Health Committee to help address issues it can influence.

Through the Rural Health Continuing Education program, the Commonwealth Government has funded the creation of a series of Australian Indigenous Health and Cultural eLearning modules and an Indigenous Health and Cultural Learning Portal for Fellows, in an effort to improve indigenous health care delivery.

The eLearning modules aim to promote a multi-disciplinary approach of particular benefit to surgeons in rural and remote locations who care for Aboriginal and Torres Strait Islander patients. The modules focus on Indigenous-specific health issues and developing a support network to assist in resolving current and future specialist medical issues.

These modules will also be of value to metropolitan based surgeons with Aboriginal and Torres Strait Islander patients. The eLearning modules contain general information about Aboriginal and Torres Strait Islander health, while recognising the importance that clinicians connect with the community in which they work.

The eLearning modules contain a series of scenarios, interactive tools and resources to support a self-education and assessment journey. The modules are set out in an exploratory format enabling the user to move through and investigate topics at their own pace and in the order of their choosing.

Users will be able to record their thoughts at various points in the modules and also add notes from the indigenous health information provided. At the conclusion participants will be able to print a notation file for their own further reflection.

The three module topics include The Patient/Specialist Relationship, The Clinical Team and A Multi-Disciplinary Approach with an additional component, Food for Thought, containing themed information,
The themes include:

- The Current State – outlining some of the issues affecting the current state of Aboriginal and Torres Strait Islander Health and well-being.
- Patient Identification – explaining the importance of Patient Identification and specifies the guidelines for identifying Aboriginal and Torres Strait Islander patients.
- Attendance and Discharge – exploring the difficulties faced by Aboriginal and Torres Strait Islander patients and offers some practical strategies that the team and the individual can take to support patients.
- Traditional Medicine – introduces the concept of Dreamtime and suggests ways to effectively blend the western and Dreamtime belief systems.
- Informed Consent – further explores the Aboriginal and Torres Strait Islander culture and focuses on culture, time, language and communication.
- Strategies – describing six strategies that specialists and health care professionals can use to improve the standard of care they provide to Aboriginal and Torres Strait Islander patients.

The eLearning modules are available to Fellows and Trainees through the eLearning tab within the RACS Knowledge section on the My Page after log in to the website.

The College acknowledges the Awabakal Aboriginal Medical Services, Markeeta Douglas and Dr Jacob Jacob FRACS for their contribution to content development.

Indigenous Health and Cultural Competency Online Portal

The Network for Cultural and Health Education Portal (nichelearning portal), currently in development, will further support the self-education process. The portal will be open for public access and provide links to professional development activities and resources relevant to health care professionals working with Indigenous patients and communities. Fellows of all Colleges will be able to register for a My Page tailored to their specialty and interests.

Through these initiatives this network seeks to promote a series of outcomes including:

- Acknowledging the disparity in health outcomes between Indigenous and non-Indigenous Australians.
- Acknowledging the need for professional equality.
- Advocating awareness, facilitating outcomes and encouraging specialists to participate in working with Aboriginal and Torres Strait Islander communities and patients.
- Building and developing health workforce skills and services by providing and sharing access to resources and specialist knowledge.
- Focusing on addressing specific health issues that have a disproportional impact of Aboriginal and Torres Strait Islander communities and individuals.
- Promoting inclusion by encouraging collaboration between specialists, Aboriginal health workers, Aboriginal and Torres Strait Islander communities, patients and carers.
- Encouraging inter-professional forums and discussions sharing experiences, knowledge and insights.
- Promoting professional development education within the health sector.
- Improved collaboration to achieve goals.

Kelvin Kong
Chair, Indigenous Health Committee

For more information about the eLearning modules contact:
Martina MacKay, Project Officer
Ph (03) 9249 1157, martina.mackay@surgeons.org

Royal Australasian College of Surgeons

2014 Rowan Nicks Australian & New Zealand Exchange Fellowship

The Rowan Nicks Australian and New Zealand Exchange Fellowship is intended to promote international surgical interchange at the levels of practice and research, raise and maintain the profile of surgery in Australia and New Zealand and increase interaction between Australian and New Zealand surgical communities.

The Fellowship provides funding to assist a New Zealander to work in an Australian unit, or an Australian to work in a New Zealand unit, judged by the College to be of national excellence for a period of up to one year.

Applicants must have gained Fellowship of the RACS within the previous ten years on the closing date for applications.

Selection Criteria
The Committee will
– consider the potential of the applicant to become a surgical leader and ability to provide a particular service that may be deficient in their chosen surgical discipline.
– assess the applicants in the areas of surgical ability, ethical integrity, scholarship and leadership.

The Fellowship is not available for the purpose of extending a candidate's current position in Australia or New Zealand.

Value: Up to $75,000 pro-rata, depending on the funding situation of the candidate and provided sufficient funds are available, plus one return economy airfare between Australia and New Zealand.

Tenure: 3 - 12 months

Further Information
Application forms and instructions will be available from the College website from December 2012: www.surgeons.org
Closing date: 5pm Monday 6 May, 2013. Applicants will be notified of the outcome of their application by 30 October 2013.

Please contact:
Secretariat, Rowan Nicks Committee
Royal Australasian College of Surgeons
250 - 290 Spring Street, East Melbourne VIC 3002
Email: international.scholarships@surgeons.org
Phone: + 61 3 9249 1211 Fax: + 61 3 9276 7431

Hon Warren Snowdon, Federal Minister for Indigenous Health and Indigenous Health Chair Kelvin Kong in front of the Foundation for Surgery Surgical Simulation Van.

PACIFIC REGION

Indigenous Doctors Congress

A celebration of Identity and Culture and their connections to Indigenous Wellbeing, Alice Springs, 2-6 October

Recently it was my privilege to represent the College at an international gathering of Indigenous doctors, medical students and health practitioners from six nations in the Pacific region. Coming together for the 6th bi-annual conference of the Pacific Indigenous Doctors' Congress (PRIDoC), 300 delegates from Canada, North America, Hawaii, New Zealand and Australia gathered in Alice Springs to promote culturally safe research and clinical practices, build Indigenous capacity and contribute to improved health and well-being for their peoples. Our participation in PRIDoC was made possible through generous support from the College and the Foundation for Surgery.

The choice of Alice Springs as the venue, sat beautifully with the conference theme Connectedness, "acknowledging the bonds Indigenous peoples share, and significance of our connections to land and culture to the health and well-being of our communities".

Known as Mparntwe to the local Aboriginal custodians, Alice Springs and its surrounds is the spiritual and cultural home of the Arrernte people, connected to this country through caterpillar dreamtime stories and song lines that have been the foundation of social relations and community well-being for thousands of years before colonial settlement.

Welcome to Country ceremonies led by Arrernte elders opened PRIDoC proceedings, signalling the very culturally rich and moving conference program that was yet to come. The opening addresses were delivered by A/ Prof. Peter O'Mara, President of the Australian Indigenous Doctors Association (AIDA), and the Hon Warren Snowdon, Federal Minister for Indigenous Health.

Keynote speakers were prominent Indigenous educators, and included Jody Broun, Co-Chair of the National Congress of Australia's First Peoples, and A/Prof. Papaarangi Reid, Deputy Dean for the Faculty of Medical and Health Sciences, University of Auckland. The scientific program explored issues relating to models of service delivery, workforce and professional development, health issues, research priorities and critical policy issues in Indigenous health.

Delegates also had the opportunity to visit three local community organisations, the Western Desert Walytja Palantjaku Tjutaku or Purple House, the Akeyulerre Healing Centre and the Central Australia Aboriginal Congress. Purple House and its Purple Bus provide dialysis and support services for remote Aboriginal communities in Central Australia. Purple House was set up with funds raised by the communities of the Western Desert, through the auction of artwork. Initially services focused on meeting the needs of communities around Kintore, where 45 per cent of its population are tackling kidney disease. Today Purple House services extend to communities living in Western Australia and South Australia.

Among the conference presentations were two from the College. The first outlined our new professional development module in Australian Indigenous Health and Cultural Learning and was co-presented with Dr Nino Scuderi, co-opted AIDA member of our committee.

The second, gave an overview of the Indigenous Health and Cultural Learning Portal – the collaborative project between medical specialist colleges to share educational resources and facilitate multidisciplinary networking in Aboriginal and Torres Strait Islander health and cultural safety. Both papers were received well and generated discussion. Of great interest to delegates was the College Surgical Simulation Bus. Its presence was made possible by funds raised through the Foundation for Surgery

The conference dinners allowed delegates to enjoy performances of traditional dance and contemporary music inspired by the cultures of all of the First Nations partaking in the Congress.

An evening BBQ of local tucker along the dry sandy beds of the Todd River provided the perfect setting for performances of traditional dances by our Arrernte hosts. The Conference Gala Dinner was a spectacular repertoire of performances celebrating the Indigenous nations that were present.

From a personal perspective it was heartening to see so many new faces, a new generation of Indigenous students embarking on their journey into medicine. 2012 is the first year that Aboriginal and Torres Strait Islander enrolment in medical schools is in proportion to the ratio of Indigenous people in the Australian population. While this is fantastic achievement, the reality remains that retention and graduation rates remain low and further work and support is needed to reverse this trend.

PRIDoC grew from the desire of a few to create a space for all Indigenous doctors to celebrate identity, establish networks, build capacity and confidence in contributing to the improved welfare of their communities. Today it is an important event on the international Indigenous health calendar and is a forum growing in stature because of the depth in Indigenous knowledge, experience and expertise it convenes.

Our support is an opportunity to engage, to listen and learn and to have the dialogue with our Indigenous medical colleagues and communities to help us determine how best we can support and assist their aspirations in health outcomes and Indigenous well-being.

As an Aboriginal man, an Aboriginal doctor and Indigenous Fellow of the College, the experiences of PRIDoC give many reasons to smile, to be proud and celebrate the progress and achievements of the Indigenous health agenda so far.

But the close proximity to the conference venue of the Alice Springs Hospital, with its over-representation of Aboriginal patients, and the huge demand for dialysis services by Aboriginal people in its surrounds, is a sobering reminder of how much more needs to be done.

The College is committed to work through its Indigenous Health Committee to empower our Fellowship to help deliver better health outcomes for Indigenous people in Australia and New Zealand. We are joined in this task by both AIDA and TeORA (the Maori Medical Practitioners Association), who have been members of our committee since 2010.

The College through the Committee of Presidents of Medical Colleges has endorsed the National Aboriginal and Torres Strait Islander Medical Specialist Curriculum Framework. This presents us with new opportunities to act upon the commitments we have made to the Indigenous health agendas of both Australia and New Zealand.

The Committee would like to thank PRIDoC for their invitation to participate in this event, and congratulate the organising committee, and especially AIDA the host organisation, for an excellent and inspiring conference programme. I also extend my thanks to the College staff in the Melbourne, Adelaide and NZ offices who made our participation possible and a success.

Kelvin Kong
Chair, Indigenous Health Committee

Pacific Indigenous Community Representatives during Cultural Exchange dinner

Dr Nino Scuderi presenting at PRIDoC

For further information
... about PRIDoC 2012 visit www.pridoc.org
... about the IHC visit www.surgeons.org/about/governance-committees/committees/indigenous-health-committee or email indigenoushealth surgeons.org

Specialist Training Program

How the program works and what it includes

The Specialist Training Program (STP) is a Federal Government scheme which provides support to enable medical specialist Trainees to rotate through an expanded range of settings beyond traditional public teaching hospitals.

The program has been running since 2009 and was introduced in response to the changing way in which health care is delivered, with increasing services being provided outside the public sector, and the growing recognition that specialist training in Australia needs to adapt to these changes.

The overall aims of the STP are to:

- increase the capacity of the health workforce to train specialists;
- better train specialists with education that matches the nature of demand and reflects the way health services are delivered;
- support quality training posts that provide an educational experience that reflects current health care delivery and builds the overall training capacity in the system, by extending specialist training into new healthcare settings.

A total of 600 posts across all medical Colleges are currently funded under the STP. The STP will support an additional 150 posts through the 2013 application round and by 2014, a total of 900 posts will be receiving STP funding.

The STP project has two components:

1. Assessment of Private Hospital Posts for Surgical Training

The STP provides funding to support accredited surgical training rotations in an expanded range of settings beyond traditional public teaching hospitals. The aim is to increase the capacity of the health care sector to provide high quality training opportunities which provide the required educational experiences for surgical Trainees.

Hospitals may apply for Commonwealth funding of up to $100,000 (excluding GST) per FTE for each post. To be considered for funding, the post must be predominantly in the private sector, or in a rural setting, and accredited as suitable for training by the College.

There are currently 56 surgical training posts receiving funding under the STP project. An additional 15 posts have been supported by the College to receive funding from next year.

2. Infrastructure Projects to Increase Doctors Progressing to Fellowship

In addition to establishing specialist training positions, the STP also provides funding for the development of infrastructure projects to support the expansion of training into non-traditional settings, particularly in rural areas, and improve service delivery to trainees and IMGs. The Commonwealth has provided approximately $500,000 per annum (for the duration of the Agreement) for the College to develop and implement projects which meet these objectives.

There are currently seven projects being funded under this process, across various areas of the College.

NOTSS E-Learning Resource
This project will develop online learning resources for the NOTSS course, to provide course participants with access to additional learning resources both before and after participation in the one-day NOTSS course.

International Medical Graduates (IMGs) Adapting to Working in Australia
This project aims to contribute to the improvement of IMGs knowledge and understanding of the Australian medical working environment so that they are more readily able to adapt to the requirements and expectations. The project will develop appropriate high quality educational material for online publication.

SAT SET E-Learning Activities for Trainees and IMGs
This project involves the development of an additional SAT SET e-learning resource for Trainees and IMGs to assist them with understanding their roles and responsibilities around work placed assessment tools such as Mini-CEX and DOPS.

Preparation Course for the Fellowship Examination
This project will develop generic online examination preparation resources for Trainees and IMGs presenting for the Fellowship Examination. A series of online videos and commentary with example vivas and questions are planned in order to assist candidates in their preparation for the Examination. It is hoped that the development of these materials will significantly increase the resources available to IMGs and Trainees in rural posts to assist in their preparation for the Fellowship Examination.

IMG E-Learning Forum
The Project will provide an e-learning forum to assist IMGs with preparing for the Fellowship Examination. The forum is being piloted with General Surgery IMGs located around Australia, aiming to provide them with an opportunity to practice written examination answers, participate in group learning and undertake educational interaction with consultant surgeons (Subject Matter Experts).

Electronic Logbook and Audit Tool
This is a significant project involving the development of a secure online data portal to collect data on surgical procedures. The portal is designed to be an online Logbook record for SET training and IMG oversight purposes, which supports in-application workflow for review and approval (where required), a self-audit tool through use of the standard datasets and reports, a configurable audit tool to support a specialty-wide audit, and personal logbook record for Fellows.

Research into Training Needs of Specialist Training Program (STP) Trainees
This project aims to develop a simulation-based curriculum for improving multidisciplinary teamwork within the operative setting and to provide this to STP Trainees with rosters in STP environments.

Simon Williams
Censor-in-Chief

For further information about the STP project, please email stp.admin@surgeons.org.

A different training experience

A new regional hub for Trainees aims to attract surgeons to a way of life

In a country as vast as Australia, the provision of health services in regional areas has always brought unique rewards and challenges. General Surgeons in these cities and towns play a pivotal role in the health service and often make valuable contributions in many other areas of community life. However recruiting professionals to regional areas can be difficult and a gap is appearing in the surgical workforce throughout non-metropolitan areas of Australia.

In an effort to address this problem, The General Surgeons Australia (GSA) Victorian and Tasmanian Regional Sub-committee of the Board of General Surgery has recently approved the establishment of the first-ever Victorian regional training hub for general surgery. Using the principle that people trained in regional areas are more likely to remain or return to regional areas, the new hub will involve four regional hospitals: Geelong, Ballarat, Warrnambool and Hamilton. Metropolitan partnerships are being developed with St Vincent's Hospital and the Alfred Hospital, providing further specialised rotations.

The new training hub – called the South West Victorian Regional Hub – will begin next year, in 2013.

According to Geelong general surgeon Mr Glenn Guest, two SET1 Trainees have already been allocated to begin their training through the Hub next year with plans for up to 12 Trainees per year to be trained under the model by 2018.

He said the proposal was initiated by the general surgeons from across all four regional hospitals and has been strongly supported by other regional general surgeons throughout Australia.

"The latest workforce survey by the College reveals more than a dozen positions remain unfilled in regional Australia and the predictions from this survey estimate that in Victoria alone, 3.5 surgeons will retire each year from regional health services," he said.

"This situation has the potential to widen the gap between medical services available to people in regional Australia compared to their metropolitan counterparts.

"With the premise that training people in the regional areas may lead to more surgeons staying in those areas, the GSA's sub-committee and the College approved the setup of this new regional training hub."

Mr Guest said Melbourne's St Vincent's Hospital was one of the central support pillars of the initiative, and has agreed to act as metropolitan partner to provide the crucial support for Trainees to get exposure to tertiary and quaternary surgical specialties while offering rotations across the regional training hub to its own Trainees.

He said the Alfred Hospital will provide rotations within its world-class trauma unit to regional Trainees.

"The support of St Vincent's in particular has been crucial in getting this initiative off the ground and we believe the partnership will boost the training of both city and regional surgeons to the benefit of future patients," Mr Guest said.

"For the first time it allows Victorian regional surgeons to take direct ownership of surgical training while allowing Trainees to take more direct control of their careers."

Mr Guest said that until now, all surgical Trainees under the current SET program had to be attached to a training hub led by a major metropolitan hospital which, while offering excellent training, had the potential to discourage Trainees from considering regional areas for their long-term professional futures.

"Most Trainees are exposed to working in regional areas and very much enjoy these rotations. They get a taste of a surgical career outside the city where they work with surgeons who have a fulfilling and challenging professional career balanced with lifestyle opportunities sometimes not available in metropolitan areas," he said.

"Yet, by the time they have finished their training many younger surgeons have already begun laying down roots in the city with the demands of children, schools and the professional commitments of partners. This makes it more difficult to then relocate their families to a regional area.

"We believe that by making this training available to young doctors who already have a connection to regional life or a desire to create one, they may not have to face such a difficult choice.

"With the graduates of Deakin University Medical School in Geelong now taking up positions as doctors throughout Victoria, this initiative will allow those and many others to centre themselves in this area for their training.

"The challenge of reversing the workforce shortage is multifactorial, but the regional hub does have the potential to remove one major hurdle."

Mr Guest also acknowledged the support of Mr Matthew Croxford and Mr Sayed Hassen, the current and past Chairs of the Victorian and Tasmanian Regional Sub-committee and Ballarat surgeon Mr Bruce Stewart, for their hard work in helping to bring the Hub to fruition.

He also thanked the Boards of the GSA and the College for their strong support.

He said he expected general surgeons in other States and Territories to watch the roll-out and development of the new hub with interest.

"The sub-committee has taken this forward looking step knowing full well that this is not the only solution to the problem of regional Australia's workforce shortages; however, we do believe it has the potential to make a substantial difference in the long term," Mr Guest said.

"We look forward to the first Trainees beginning their surgical careers next year and future Trainees calling the South West Victorian region home, and inspiring them to continue their career in regional centres across Australia.

"With so many job opportunities now on the horizon we would also encourage all Trainees to consider a career in regional Australia where a surgeon can balance a fulfilling and successful career with time to enjoy a family and outside interests while providing their valuable skills to people in need."

With Karen Murphy

Royal Australasian College of Surgeons

2014 Rowan Nicks Pacific Islands Scholarship & 2014 Rowan Nicks International Scholarship

The Royal Australasian College of Surgeons invites suitable applicants for the 2014 Rowan Nicks Scholarships. These are the most prestigious of the College's International Awards and are directed at surgeons who are destined to become leaders in their home countries.

The Scholarships provide opportunities for surgeons to develop their management, leadership, teaching and clinical skills through clinical attachments in selected hospitals in Australia, New Zealand or South-East Asia.

Applicants for the Rowan Nicks International and Pacific Islands Scholarships must:
- commit to return to their home country on completion of their Scholarship;
- meet the English Language Requirement for medical registration in Australia or New Zealand (equivalent to an IELTS score of 7.0 in every category);
- hold a Master of Medicine in Surgery, or his/her country's post-graduate qualification in surgery. However, consideration will be given to applicants who have completed local general post-graduate surgical training, where appropriate to the needs of their home country.
- be under 45 years of age at the closing date for applications.

Applicants for the International Scholarship must be a citizen of one of the nominated countries listed on the College website from December 2012.

Applicants for the Pacific Islands Scholarship must be a citizen of the Cook Islands, Fiji, Kiribati, Federated States of Micronesia, Marshall Islands, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu or Vanuatu;

Selection Criteria
- The Committee will consider the potential of the applicant to become a surgical leader in the country of origin, and/or to supply a much-needed service in a particular surgical discipline.
- The Committee must be convinced that the applicant is of high calibre in surgical ability, ethical integrity and qualities of leadership.
- Selection will primarily be based on merit, with applicants providing an essential service in remote areas, without opportunities for institutional support or educational facilities, being given earnest consideration.

Value: Up to $36,000 pro-rata, plus one return economy airfare from home country

Tenure: 3 - 12 months

Application forms and instructions will be available from the College website from December 2012: www.surgeons.org
Closing date: 5pm Monday 6 May, 2013. Applicants will be notified of the outcome of their application by 30 October 2013.

Please contact: Secretariat, Rowan Nicks Committee
Royal Australasian College of Surgeons
250 - 290 Spring Street, East Melbourne VIC 3002
Email: international.scholarships@surgeons.org
Phone: + 61 3 9249 1211 Fax: + 61 3 9276 7431

New CPD Program launching in 2013

CPD Program: Spotlight on performance review

Maintaining currency of practice and participation in lifelong learning continues to be a strong College focus to ensure that Fellows maintain and enhance standards in surgery. Following wide consultation, a new Continuing Professional Development (CPD) Program will be launched in 2013.

The new CPD Program will operate on an annual basis, moving away from the current triennial model. With more simplified practice types and categories, Fellows will benefit from more timely evidence of compliance to assist in meeting the requirements of the Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Council of New Zealand (MCNZ). The new program will also tailor requirements to ensure that Fellows participate in activities relevant to their scope of practice.

The number of practice types has been reduced to reflect the type of work undertaken by Fellows. The practice types will be:

- Operative practice in hospitals or day surgery units
- Operative procedures in rooms only
- Operative practice as a locum only
- Clinical consulting practice only
- Other practice type (research, administration, academic, teaching, assisting etc.)

The number of categories has also been reduced to minimise repetitive data entry by Fellows:

- Category 1: Surgical Audit
- Category 2: Clinical Governance – Quality Improvement, Evaluation of Patient Care and Professional Advocacy
- Category 3: Performance Review
- Category 4: Maintenance of Knowledge and Skills.

Fellows will receive an information pack about the 2013 CPD Program in December, in preparation for commencement in January 2013. For more information about the new CPD Program, please visit www.surgeons.org.

New Category: Performance Review

A major enhancement to the CPD Program is the introduction of Category 3: Performance Review. This reflects an increasing international trend towards workplace based assessment: i.e. assessment of practice, in practice, by practitioners, peers and patients. It also reflects moves towards more direct involvement in formal assessments of surgeons by peers, other health professionals and patients as well as facilitating and formalising ongoing reflection on practice.

Current methods used for providing feedback and gathering evidence from the workplace include observations of clinical activities, discussion of clinical cases, analysis of performance data and multi-source feedback. Rather than focusing on traditional learning activities, the category encourages surgeons to seek feedback and analysis of their performance across the range of College Competencies and can include:

- Multisource feedback using a structured framework of surgical competencies (participants can claim 30 points in the year of the review, plus 30 points for a further two years)
- Development of a structured Learning Plan (10 points per annum)
- Patient Feedback Survey with action plan (15 points per annum)
- Recipient of a structured Practice Visit by a peer with evaluation and action plan (30 points per annum)
- Participation in a Practice Visit as a visitor (maximum of 10 points)
- Peer Review of three reports e.g. medico-legal, clinical etc (15 points per annum)

The majority of Fellows with a CPD requirement need to accrue 60 points of CPD activities for 2013. Undertaking activities within the Performance Review category is encouraged, but not compulsory. Fellows with limited time to engage in traditional professional development such as conference attendance, teaching and journal reading are encouraged to look to reflective activities to achieve their CPD requirements.

The principles for performance review activities are addressed in the Surgical Competence and Performance Guide. The guide was circulated to all Fellows in 2011 and describes the College's framework to assess the performance of surgeons in practice.

Multisource (or 360 degree) feedback involves assessment of aspects of a surgeon's performance made by a range of colleagues (department heads, medical directors, peers, Trainees, nursing and other specialists) and patients. Collecting and using data from multiple rating sources to gain insight into the current performance of an individual surgeon can identify strengths and weaknesses and inform positive change in practice.

Key to the process is the involvement of a colleague/mentor who receives the results and provides sensitive and specific feedback in a constructive way. The College is currently developing a Surgical Performance Assessment and Feedback eTool (based on the College Competency framework) which will be made available to Fellows in early 2013. The online tool will facilitate the performance assessment process enabling a paperless, confidential process with timely reporting, feedback and opportunity for reflection and development of action plans.

Practice visits will attract CPD points only when part of a structured program approved by the College. The program must arrange for nominated (not self-selected) visitors, using a standardised assessment system aligned to College Competencies and with appropriate feedback. Currently the only endorsed program is the New Zealand Orthopaedic Association program, however any society or group of surgeons could construct such a program for approval.

There are a range of patient feedback survey tools and templates available to support surgeons to carry out a formal survey in their practice setting. In order to claim CPD points for this activity, Fellows must collate results and document an action plan, which may include proposed changes in response to feedback.

Fellows solely engaged in medico legal work can receive valuable feedback on performance by arranging a peer review of reports. Three reports are required to be submitted for review by a colleague undertaking similar work in order for the 15 CPD points to be claimed. For more information about suggested criteria for assessment, please contact the Professional Standards Department.

Finalising the 2010 – 2012 Triennium

Fellows are reminded that they can complete their 2012 CPD Online Diary at any time, with statements being released to Fellows who are compliant with their practice requirements in February 2013. Please note that the closing date for submission of the 2012 hard copy recertification data form is 31 January 2013. All Fellows are urged to submit their 2012 data promptly to be eligible to receive both their 2012 Statement of Compliance and their 2010-2012 Triennium Certificate. This will be the final certificate issued as we move to an annual CPD Program in 2013.

If you have any questions regarding your compliance status or the 2013 CPD Program, please contact the CPD Recertification Officer at cpd.college@surgeons.org or on +61 3 9249 1282.

Graeme Campbell
Chair, Professional Standards

Younger Fellows FORUM

3 – 5 May 2013, Auckland, New Zealand

All Younger Fellows are invited to nominate for the 2013 Younger Fellows Forum. The Forum focuses on future challenges for surgical practice and the changing face of health care delivery. The core objective is to provide an environment that encourages Younger Fellows to address challenging issues relevant to personal, professional and collegiate life through discussion and debate. It is a great opportunity to share ideas and experiences. In 2013 discussion will focus on supporting underprivileged patients through leadership and health advocacy.

Attendance at the Forum and airport transfers to the venue are covered by the College.

Applications are open from 1 September to 8 December 2012.

Contact the Professional Development Department on +61 3 9249 1122

Work Life Balance

How do we judge when to say no?

With baby number five first coming (now arrived), two new college committees to sit on (now eight), and work as busy as ever, it was time to look seriously at work life balance. Am I on the right track? Or am I about to tip over?

Like all balancing and juggling acts, getting it right is not always easy. The balance between work life and home life will be different for everyone. Some are not happy unless they are continually occupied at work, others prefer to use salary as a passport to enjoying their life journey. Consciously deciding where to set the goal posts, with regular review as life circumstances change will help you understand what you want, and perhaps more importantly why you want it.

Understanding yourself, understanding what makes you happy and content (insight) is the first step. Understanding burnout (and how to avoid it) is the second. Making the choices to achieve the first whilst avoiding the second, is the third and critical step.

So what will make you happy? Is it money? Is it having the bills paid, having the mortgage paid? Or having enough passive income so you don't have to work?

Money buys choice. It is merely a means to an end rather than an end in itself. Those who don't appreciate this are destined to be forever stuck in the financial "rat race", never happy, and never knowing why. Money doesn't mean the end of work, rather it allows the choice to decide when and where you work, and what you can do when you're not working.

Warren Buffet, Gina Rinehart, Rupert Murdoch all have one thing in common, they are all so fabulously wealthy that they no longer need to work again ever, and all continue to work fabulously long hours, most long past regular retirement age. Perhaps they realise that work brings purpose, and purpose defines the person.

Whilst it is important to have enough money to support yourself during retirement, it is also important to enjoy yourself today. Consider how your life would change if you knew you only had one year left to live? What would you do differently? How would your priorities change?

Now the next question, how do you know you don't?

One thing is for sure, no one can see what's coming. Set your goals for financial success, but don't set the bar at unreachable levels, and when you achieve them take time to enjoy your success before planning your future goals further.

Is happiness then having enough free time to pursue hobbies? Is it spending time with family? Or is it a beer on the beach after a hard day's work?

The lifestyle of the rich is little different to those with more modest incomes. Only one TV can be watched at one time, one car driven at once, and one bed slept in at any one time. How expensive the sheets are makes little difference to your sleep, a Ferrari goes no faster than a Ford in traffic, and most French wines are vastly over-priced and over-rated (Alsace Rieslings excepted).

There is a huge industry designed to make you believe that your happiness depends on having more and more "stuff". It seems that you'd be missing out somehow if you didn't have that extra TV, appliance, gadget or whatever, and like a convertible it is always underwhelming when you do finally have it. "Stuff" in itself has no intrinsic worth and there should be no emotional attachment to it, as it can all be replaced in one form or another. Whilst a TV in the bedroom may be an excellent form of contraception, having more and more stuff will never make you happy. He who dies with the most "stuff" is still dead nonetheless... and now it's just someone else's stuff.

The only real difference between the lifestyle of the rich and the not so rich is the class of air travel you use. The perception that the wealthy are somehow living better, happier, and having more fun, is just that – only a perception. A look at Australia's wealthiest individuals mostly engenders a sense of pity rather than envy, with their expanding waistlines and dysfunctional families, it is clear that they have no better idea about what is important and how to achieve happiness than anyone else.

Burnout was first coined in the 60's from a book "the burnt out man". There are generally 12 phases of burnout: firstly the compulsion to prove oneself, then working harder, neglecting needs, displacement of conflict, revision of values, denial of problems, and withdrawal. This leads on to behavioural change, depersonalisation, emptiness, depression and finally burnout.1

Burnout is most common in highly motivated, dedicated and involved people who become exhausted, cynical and ultimately inefficient. Those surgeons most at risk are plastic and cardiothoracic Fellows, surgeons having a 50:50 public/private split, and female surgeons. 2

Beating burnout involves deciding those areas that are most important to you, giving them priority, focusing on maximising happiness and fulfilment, and above all being willing to compromise to achieve this.

Setting goals is important. Not setting goals is like setting off on a journey without having a destination in mind. No one can help you get there if you don't know where it is you want to go! As in all things (except flying economy), the journey is as important as the destination, and as much joy can be found in the doing as in the finishing.

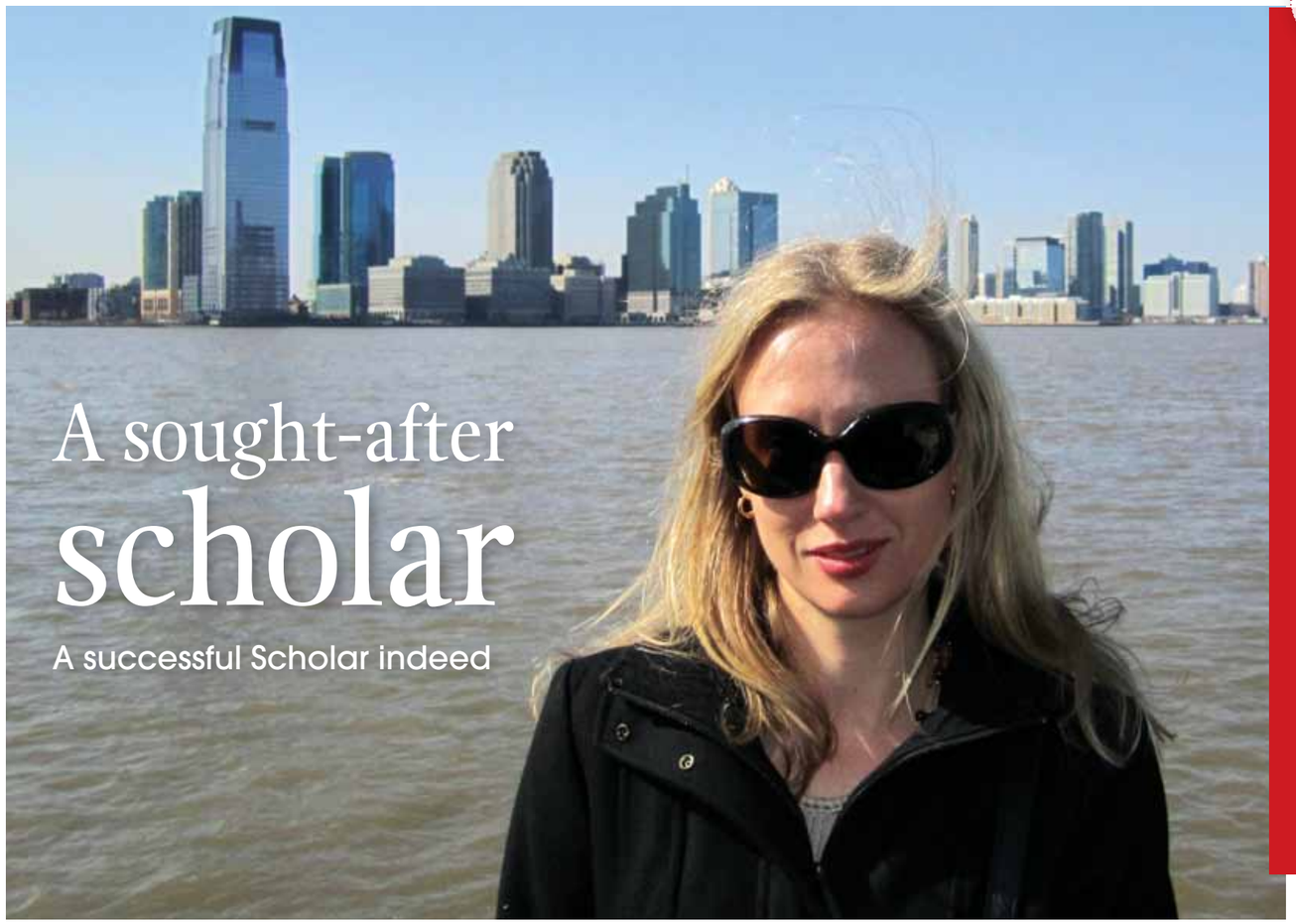
"Like all balancing and juggling acts, getting it right is not always easy"

Knowing why you have set your goals is as important as the ends in themselves. Understanding yourself and what motivates you will help you avoid endless poor life choices. Without purpose, our actions are simply a series of unfulfilling random events and our lives then become filled with random collections of 'stuff', lacking in any real value or worth.

Having the insight to define your purpose and exercising your choice to achieve those goals will help bring balance to both your work and your life.

Richard Martin
College Councillor

References:
1. Ulrich Kraft, "Burned Out", *Scientific American Mind*, June/July 2006 p. 28-33
2. Younger Fellows survey 2008



A sought-after scholar

A successful Scholar indeed

After receiving her FRACS in 2010, Otolaryngology Head and Neck Surgeon Dr Catherine Sinclair was offered and accepted two prestigious US Fellowships with funding support provided by the College through the Hugh Johnston Travel Grant.

The first was a Head and Neck Surgical Oncology and Microvascular Reconstruction Fellowship through the University of Alabama which Dr Sinclair described as having an oncological caseload unrivalled by many other tertiary centres in the US.

The second was a Laryngology/Neurolaryngology Fellowship at St Luke's Roosevelt Hospital in New York where Dr Sinclair worked under the supervision of Dr Andrew Blitzer, a world leader in the management of neurological disorders of the larynx.

So highly regarded was she upon completion of the two complementary Fellowships, Dr Sinclair was offered the position of Director of the Division of Head and Neck Surgery at St Luke's and Roosevelt Hospital, a role she commenced in July.

She is also now an Attending Surgeon in Head and Neck Oncology and Laryngology at Continuum Cancer Centres in New York. Dr Sinclair talks to Surgical News about her new roles, life in New York and the skills she intends to bring back to Australia.

When were you appointed Director of the Division of Head and Neck Surgery at St Luke's and Roosevelt Hospitals?

I was appointed Director after I completed the laryngology/neurolaryngology/voice Fellowship in June this year. St Luke's Roosevelt was particularly interested in me because of the fact I had done two Fellowships and because their Head and Neck Surgery division had been depleted by the departure of two established surgeons.

They wanted me to re-establish a head and neck presence, including thyroid and parathyroid surgery, on the West side of Manhattan as most of the major Head and Neck hospitals are on the East side. They are also very supportive of me starting a Head and Neck Robotic Surgery program at Roosevelt Hospital.

What were the main attractions of taking up the position?

Not only does the appointment mean that I can continue to develop my skills in this area, it also gives me the opportunity to continue my clinical research into tracheal reconstruction and transplantation and continue running existing clinical trials looking at novel uses for botulinum toxin in head and neck disorders.

What diseases or disorders do neurolaryngologists treat?

Neurolaryngologists treat neurological disorders of the larynx including spasmodic dysphonia, muscle tension dysphonia, oromandibular dystonia, essential tremor, and Parkinson's disease affecting voice – just to name a few.

My other areas of specialty are the treatment of benign and malignant diseases of the upper aerodigestive tract and head and neck as well as voice and swallowing disorders. I am particularly interested in endoscopic laryngeal surgery with an emphasis on voice preservation with management of malignant diseases; surgical management of thyroid and parathyroid diseases; endoscopic evaluation and management of swallowing disorders and neurological disorders of the larynx which encompasses in-office procedures such as vocal fold injection augmentation, laryngeal laser therapy and transnasal esophagoscopy.

How large is the Division of Head and Neck surgery?

I am starting the Division so at the moment it is just me! Hopefully we will expand over the next few years.

How did you feel when you were offered this position?

The appointment was a surprise and an honour. It was an unexpected affirmation of the work I've put in to my studies, both in clinical research and practice.

What is your role at the Continuum Cancer Centre?

I am an Attending Laryngologist and Head and Neck Surgeon with Continuum. I will also have an academic title of Assistant Professor through Einstein Medical College, but that appointment will not be effective for a few months.

What are the main skills you have gained that you could not have gained in Australia?

There are few Fellowship-trained laryngologists in Australia at the present time. At the time of my applications, it would thus have been very difficult to gain experience in voice/laryngology at a Fellowship level had I not travelled overseas.

Neurolaryngology is a rare area with very few worldwide experts. Andrew Blitzer (my supervisor for the laryngology Fellowship) is the world expert in diagnosis and management of neurological disorders of the larynx so it was an honour to learn from and work alongside him.

The great benefit of the Head and Neck Fellowship in Alabama was the sheer number of cases and exposure to streamlined head and neck pathology daily plus the breadth of head and neck pathology seen was different to what I saw during my ENT training in Australia.

The fellowship thus significantly expanded my horizons with regards to operative skills and efficiency and taught me new skills, particularly within the microvascular reconstructive realm.

What have been the highlights of your time in the US?

The highlights have been the vast breadth of knowledge and operative experience I have gained over the past two years. In addition, I am now heavily involved in a number of clinical research projects which are very exciting and have the potential to alter management of certain airway conditions.

In particular, we are doing research into tracheal reconstruction and transplantation in conjunction with the thoracic surgery team and Dr Marshall Strome, who did the first human laryngeal transplant back in 1998.

Did the Hugh Johnston travel grant help support you through both US Fellowships?

The cost of living in Alabama is much, much lower than in New York and thus I managed to live on the salary provided by the Fellowship when I was there. However, the Hugh Johnston Travel Grant funding was integral to my ability to complete the NY Fellowship.

How have you found life in New York?

New York is an exciting, but also a difficult city. The rapid pace can make day to day life more stressful than is perhaps necessary and it is important to get out of the city sometimes just to put everything back into perspective.

Overall, however, it is a stimulating environment in which to live and work and there are opportunities here – particularly in research – that cannot be overlooked. However, I still consider Australia my home and look forward to returning at some stage in the next few years.

With Karen Murphy

profile

HONOURS & AWARDS

2012 New York Laryngological Society award for best oral presentation at annual meeting

> American Laryngological Association Resident Research Award for paper entitled: A new paradigm for the management of essential vocal tremor with botulinum toxin

2010 / 2011 Hugh Johnson Travelling Scholarship, Royal Australasian College of Surgeons

2005 Clinical Committee Prize (Royal Australasian College of Surgeons) for highest score in FRACS Part 1 Australasian Clinical Examination

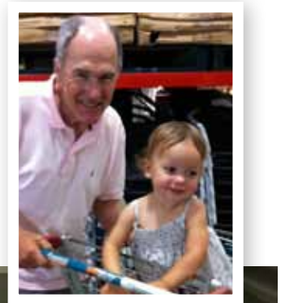
2004 Gordon-Gordon Taylor Medal (Royal Australasian College of Surgeons) for highest score in FRACS Part 1 Australasian Examination

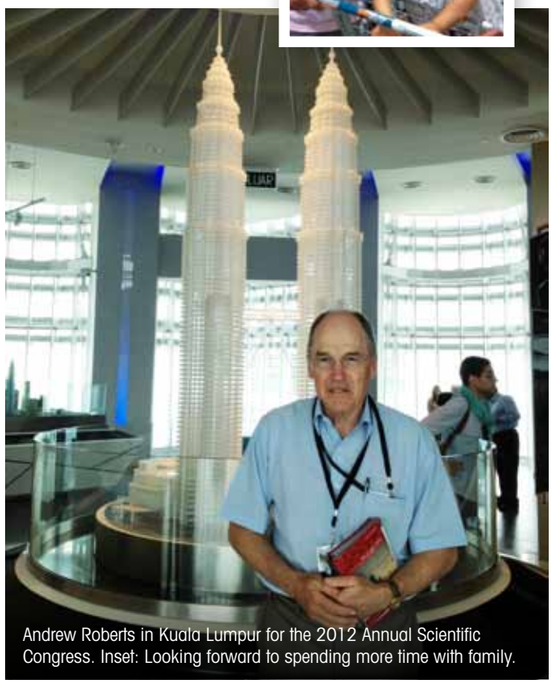
2002 Australian Medical Association medal for outstanding academic achievements and contribution to medical school activities.

ERRATUM:
The reference to Dr Darren Katz as a Victorian Fellow in the October issue was incorrect. Dr Katz is a Urology Trainee and has not yet been awarded the Fellowship.

Assessing IMGs

The College's Clinical Director of IMG Assessments, Mr Andrew Roberts, will step down from the position at the end of the year. He tells *Surgical News* about the challenges of the job and what lies ahead for him now





Andrew Roberts in Kuala Lumpur for the 2012 Annual Scientific Congress. Inset: Looking forward to spending more time with family.

How long have you been the College's Clinical Director of IMG Assessment and why have you decided to move on at this point in time?

I have been the College's Clinical Director of IMG assessments for five years which I have thoroughly enjoyed. During that time there has been the opportunity to introduce a number of new ideas and procedures, be part of improving the understanding of the IMG assessment processes within the College and hopefully enhance the communication between the specialty surgical boards and the IMG Department. It has also provided the opportunity to continue to develop a productive relationship with the AMC and AHPRA .

My decision to move on from this position is based partly on my belief that there is a finite time one can positively contribute to a committee of which one is a member or an organisation, particularly if this is in a predominantly administrative role. There is great benefit to be gained by the introduction of fresh enthusiastic people with fresh ideas.

In addition there is also a selfish reason, enabling me to have more time to spend with my family and particularly grandchildren, as well as travelling and pursuing a number of other extracurricular activities and interests. Although this position is formally less than a half-time appointment, in reality as a surgeon the time involved was sometimes a little more than that!

What were the challenges you faced in your role?

One of the challenges involved in this process is making a judgment as to the quality of the educational institution at which the applicant has completed his or her undergraduate medical studies. Even more important, however is where they have undertaken their surgical training and establishing whether or not the qualifications they may have obtained are comparable to Australasian qualifications.

There are no league tables across the world that reliably allow this judgment to be made. Some countries such as the US, Canada and the UK have training programs that are similar to Australasian programs. Each specialty board, however, finally decides whether or not they believe these programs to be comparable to our own.

Other countries' programs, particularly where the language of tuition is not English, prove a greater challenge to try and assess. It is in this group that the information provided with the submitted documentation and the information obtained at interview become so important in trying to accurately assess the applicant`s comparability to an Australasian surgeon.

This certainly has proved to be one of the challenges of the Clinical Director's role and another has been assessing an applicant`s non-technical competencies. Our College has a clearly defined framework to assess surgical competence and performance of Trainees and surgeons in this country. The College training and development programs contribute to ensuring that surgeons are proficient across the College's nine competencies.

The IMG assessment process makes every effort to work within this same framework. On occasions it can take an IMG a very long period of time to gain an understanding of the Australasian health system and, at times, it may prove extremely difficult to overcome the cultural differences between their own country and Australia.

It may become apparent that the IMG has had inadequate medical or surgical training and that they are clinically not at the level required. Notwithstanding these challenges, the aim and responsibility of IMG assessment is to be as certain as possible that the applicant is of a standard of safety and competence comparable to an Australasian trained surgeon in order to provide appropriate surgical care for their patients.

Another area of the Clinical Director`s role which has proved particularly interesting and at times challenging, has been being involved with problems that arise during an IMG's Clinical Assessment period. This has required a considerable amount of time liaising with specialty boards, hospital administrators and hospital consultants, councillors of the College, particularly members of the Board of Surgical Education and Training (BSET) and the IMGs themselves.

It was necessary, in these situations, to be able to bring a fair, unbiased and non-judgmental approach into the discussions with the aim of finding a solution that not only complied with the College guidelines, but assisted the IMG along the pathway to Fellowship of the College.

The House of Representatives Standing Committee on Health and Ageing recently tabled its report into registration processes and support for Overseas Trained Doctors. The College and you in particular, were involved in the inquiry's process. What was the experience like? Do you agree with the Committee's findings? Do IMGs require greater support?

The House of Representatives Standing Committee recently tabled its report titled "Lost in the Labyrinth". The College as well as the other specialist colleges had an opportunity to meet with the committee which was a valuable opportunity for them to gain an understanding of our processes, how we assess IMGs and what we provide for them. It also enabled us to present and discuss informally from a surgical perspective, the challenges faced by IMGs and ourselves.

It was certainly an interesting experience to be part of this inquiry and illustrated how face-to-face informal discussions can often provide much greater insights into issues that don't necessarily become evident in a more structured formal inquiry setting.

The committee concluded by making 45 recommendations in the report, many of which were already in place within existing College practice. Certainly the need for improved IMG support was highlighted, with which I would very much agree.

One area that was not explored in depth as much as it might have been, was the issue of better work place based assessment. If the appropriate funding could be made available an ideal method to assess IMGs would be to place them in 'dedicated' positions in designated centres around the country being supervised by College approved experienced assessors. Such an arrangement would allow quicker, more comprehensive and ultimately more cost-effective assessment than current arrangements.

The Australian Government has stated its intention to ensure the Australian healthcare workforce becomes entirely self-sufficient, that is to say not reliant in any way on healthcare professionals trained overseas. Do you think someone will still be doing your job 10 years from now?

I think this may be feasible in the field of surgery provided it is possible to overcome the mal-distribution of our surgical workforce. Now that more and more undergraduates are being exposed to rural practice during the course of their training there is a possibility that the specialist of tomorrow will be much more likely to accept positions away from the major metropolitan centres than has occurred in the past.

It may be necessary to improve and broaden the educational opportunities available for a surgeon`s family, establish readily available professional links between major metropolitan centres and a rural position on a regular basis and, possibly, provide financial benefits for practising in such areas. Should this happen there may not be a need for an IMG Clinical Director in the future!

One of the reasons for the Australian Government's commitment to a self-reliant healthcare workforce is the questionable morality of inviting doctors, trained at considerable expense in less developed countries where their expertise is desperately needed, to move to richer countries like Australia or New Zealand? Do you have a personal view on this?

I feel that such an ethical or moral question is a very personal one and not something that should be imposed by bureaucracies and government.

What lies in store for you now?

My role as the Clinical Director has been a wonderful way in which to make the transition from a very satisfying, at times hectic, life in vascular surgical practice towards retirement. Having been a Fellow of this College for over 40 years 'on the outside', it has been fascinating to have had the opportunity to see the College 'from the inside' and learn a lot about the administrative processes of this College of which I had been previously unaware.

There are many people working within the College of whom many Fellows are unaware, but who, in their own way, make a very valuable contribution to all that our College is trying to achieve. I am very grateful for all the assistance and help I have received from the staff members with whom I have worked during my time in this position at the College.

I have been very fortunate to have had the opportunity to make many friends, teach many Trainees and continue to learn in so many areas, both technical and non-technical, of the field of surgery.

I look upon retirement not as the end of one's professional life, but rather just another step taken when moving on to the next phase of one's life. That phase is going to give me the opportunity to pursue many extracurricular activities that I enjoy, and spend more time with my growing family as hopefully more grandchildren continue to arrive!

I expect to continue my lifelong interest in things Italian and am considering taking on the French language as one of my grandchildren is being brought up in a bilingual household. Although I anticipate indulging a little more in a much enjoyed pastime on the golf course, being involved in volunteer activities will continue to be very rewarding.

Travelling both within and out of Australia is something my wife and I have always enjoyed and we certainly hope to continue that in the future. With a little bit more time available now, I hope to be able to read the books I have always either wanted to read or felt I should have read. And, quite probably, having reached that certain age, I will attend some courses at the University of the Third Age (U3A)!

High Court extends medical manslaughter

Lessons from the Patel decision

The recent decision of the High Court of Australia in "Patel v The Queen" (2012) HCA 29 extends the circumstances in which doctors may be charged or convicted for manslaughter arising out of negligent medical treatment in Australia.

However, this should not create a scare campaign for doctors. Cases of medical manslaughter are rare with only a handful of such cases considered by the courts of Australia in recent decades.

Doctors, like other professionals, have been responsible for negligent acts and omissions for some time, according to a civil standard of liability. It is possible, but rare, that the conduct of a doctor is so heinous that it should merit a criminal charge.

In general terms, criminal negligence can apply where it is "culpable, exhibiting a degree of recklessness beyond anything required to make a man liable for damages and civil action. It must be such a degree of culpable negligence as to amount to an absence of that care for the lives and persons of others which every law abiding man is expected to exhibit" (R v Gunter) (1921) 21 SR (NSW) 282.

It must be such that "the act or omission must have taken place in circumstances which involves such a great falling short of the standard of care which a reasonable man would have exercised, and which involved such a high risk that grievous bodily harm would follow, that the act or omission merits punishment under the criminal law" (R v Shields) (1981) VR 717.

In the recent High Court decision, Dr Patel successfully appealed, and had his criminal conviction overturned. The court's decision was largely based on technical reasons, having regard to the way in which the prosecutors presented the case, and ultimately changed the nature of the prosecution part way through the trial. Having regard to those circumstances, the Court concluded that it would be a miscarriage of justice to allow the conviction to stand, and referred the matter back to the Supreme Court in Queensland for a retrial. Prosecutors in Queensland have confirmed that they propose to proceed with a retrial.

However, in reaching its decision, the High Court has also extended the circumstances in which criminal negligence can be considered. The Court has now confirmed that it can arise not just from the actual procedure or treatment carried out by the surgeon, but can include recommendations as to whether surgery should be undertaken or not, and include post operative care. The High Court has extended the concept of "surgical treatment" to give surgeons a wider duty for all of the actions, conduct and advice connected with the treatment itself. The High Court has said:

> *"Surgical treatment refers to all that is involved, from a recommendation that surgery should be performed, to its performance and the post operative care which is necessary to be given or supervised by the person who conducted the surgery".*

The Court acknowledges that there must still be a physical act of surgery, and a recommendation not to proceed with surgery would not necessarily give rise to criminal liability. However, a recommendation to proceed with surgery, which advice or opinion is formed in circumstances where the advice is grossly negligent, can certainly give rise to criminal culpability.

Such factors as the likely success of the surgery, likely impact on the life of the patient, co morbidities affecting the outcome of the surgery and the potential for serious complications post surgery might all be relevant to the decision as to whether surgery is recommended or not.

The Court has also suggested, with that final decision, that criminal accountability could apply where a surgeon recommends and undertakes surgery "which he knew, or should have known, to be beyond his powers". That is, not simply that the surgeon may be inexperienced, but that the surgeon recklessly carries out a procedure which, on an objective basis, is clearly beyond the scope of the surgeon's experience and expertise.

The High Court appears to have accepted that, for a successful prosecution, the question could be raised whether a competent surgeon would have decided to operate, and recommend surgery, and second, whether the decision to operate was so greater a departure from reasonable skill and professional expectation as to warrant criminal liability.

No doubt many surgeons and doctors will be alarmed at the suggestion that the High Court has so extended the potential for criminal prosecution in the case of medical treatment. However, surgeons and doctors have always been civilly liable for all aspects of their care of patients, including pre-op decision making and advice, and post-operative treatment. Logically, the High Court's conclusion that such an extension also applies to criminal liability should not, in one sense, be surprising. It is just that this is the first time that a superior court has done so.

No doubt there will be much further analysis of this decision by insurers and lawyers.

Michael Gorton,
College Solicitor

CONGRATULATIONS on your achievements

Associate Professor John Graham FRACS

Awarded ESR Hughes medal

John Campbell Graham graduated MB BS from the University of Sydney in 1972 and undertook surgical training at the Royal North Shore Hospital becoming a Fellow of the Royal Australasian College of Surgeons in 1978. He continued further training at the Cumberland Infirmary in Carlisle, UK in 1979 and from 1980 to 1982 was Research Fellow in Vascular Surgery with clinical appointment as Registrar at the Kings College Hospital, London.

John returned to Australia and in 1983 was Senior Surgical Registrar in Vascular and General Surgery at Flinders Medical Centre in Adelaide. In 1984, John became Professorial Registrar in Vascular Surgery at the Concord Repatriation Hospital in Sydney. From 1985 to 1992, John was Staff Specialist in Vascular and Transplantation Surgery at the Royal North Shore Hospital.

At the Royal North Shore Hospital, John was the Director of the Surgical Trauma Unit and Foundation Instructor with the Early Management of Severe Trauma Program of the Royal Australasian College of Surgeons. John was a member of the original group that went to the American College of Surgeons sponsored course in Nebraska and undertook the provider course and instructor course that was adapted by the College to become the EMST Course.

John Graham was a key player in the adaption, development and propagation of this course. The driving force for this energy for Mr Graham was to provide an educational experience for surgeons in the rural setting who are often called upon to manage major trauma within an under-resourced environment.

John is credited with developing the "Dingo Creek" concept which sets the scene of the course demonstrating a methodology of management when under stress when having reached the limit of resources. More than 20 years on, he continues as an instructor. As a transplant surgeon, John was also a member of the inaugural Liver Transplantation Unit at the Royal Prince Alfred Hospital.

In 1992, John became a Vascular and Renal Access Surgeon at the Lismore Base Hospital and began a rural vascular surgical practice of high quality with excellent clinical outcomes and active clinical research. He remains a Director of the EMST course and continues to instruct in the course. John was Secretary and then President of Provincial Surgeons of Australia from 1997 to 1998.

From 2001 to 2006, he was a Member of the Council of the Royal Australasian College of Surgeons representing Rural Surgery and from 2004 to 2006, he was Chairman of the Division of Rural Surgery of the College. During that time John was a member of the Surgical Workforce Working Party and Chair of the Indigenous Surgical Care Committee.

From 2006 to 2008, he became an elected Councillor of the College and was Chairman of the Ethics Committee.

In 2010 John became an Associate Professor of Surgery of the University of Western Sydney and Sub-Dean of the Lismore Rural Clinical School. He is also Deputy Director of Education for the North Coast. John has been a strong advocate for indigenous health and professional development.

John has always taken on all challenges with an infectious enthusiasm that inspires and motivates others. His contribution to the advancement of surgical education and rural surgery make him a worthy recipient of the ESR Hughes Award.

Citation kindly provided by Mr Joseph Lizzio FRACS

Mr Richard Barnett FRACS FACS

Royal Australasian College of Surgeons medal for service

The RACS Medal for Service to the College was inaugurated in 1976 to recognise singularly valuable and dedicated contributions to the College by Fellows and others. Its sole criterion is distinguished service to the affairs of the College

Richard Barnett graduated MB BS from the University of Sydney in 1966, undertook surgical training at the Royal North Shore Hospital from 1967 to 1973 and obtained the Fellowship in General Surgery in 1973. He undertook advanced plastic surgical training at the Mt. Vernon Hospital and University of London from 1973 to 1976 and was awarded the British Association of Plastic Surgeons European Travelling Fellowship in 1976. Richard returned to Australia and was appointed as a Visiting Medical Officer at Royal North Shore Hospital in 1976. He has been a member of numerous committees of the hospital and was Head of the Department of Plastic and Facio-Maxillary Surgery for 10 years. In 2002, he became HMO Emeritus at the hospital.

Richard's contribution to plastic surgery and to the College is legendary.

He was a member of the New South Wales Regional committee for eight years from 1984, holding the positions of Honorary Treasurer, Honorary Secretary and then Chairman from 1990 to 1992. Richard was Chairman when the NSW building in Surry Hills was acquired in 1991. In recognition of his distinguished service to the College he was awarded the NSW Regional Committee Merit Award and Medal in 2000 and in 2006 he was invited to deliver the Graham Coupland Lecture. In 2011, Richard was awarded the Australian Society of Plastic Surgeons' Medal, the highest award the Society bestows.

At various times he has been Chairman of the Division of Plastic Surgery, Member of the Board of Plastic Surgery, an office bearer of the Burns Society and scientific convenor of the College's Plastic Surgery meetings in 1985 and 1991. He has been Chairman of the NSW Committee of the Board of Plastic and Reconstructive Surgery. Mr Barnett was elected to the Council of the Australian Society of Plastic Surgeons in 1996 and was its President from 1997 to 2000. He initiated the reorganisation of the Society and its relationship with the College and was the Society's representative on the Council of the College in 2002. Richard was an examiner for many years, culminating in his appointment as Chief Examiner for Plastic & Reconstructive Surgery.

Richard has been a convenor and presenter at numerous meetings in Australia and overseas. He was a Visiting Lecturer of the Association of Plastic and Reconstructive Surgeons of South Africa Annual Scientific Congress in 1997 and is a Fellow of the American College of Surgeons. Richard has published articles and has delivered numerous presentations.

Mr Barnett became Chairman of the Plastic Surgery Education and Research Foundation in 2011 and has been Chairman of the AMOS Charity which raises money for Australian and overseas educational and medical purposes. Richard has been a highly regarded member of the MDA National Insurance Cases committee since 2009 and a member of the Underwriting committee since 2010.

Citation kindly provided by Mr Joseph Lizzio FRACS

Medical Ethics and Futility

Delegates to this year's joint WA/SA/NT Annual Scientific Meeting were privileged to hear a lecture on 'Medical Ethics and Futility' by barrister Mr Michael Nicholls QC

In this lecture Mr Nicholls addressed a series of difficult ethical questions that might confront the medical practitioner, questions born of the duty to preserve life but complicated by the need to distinguish between treatment which is medically 'heroic' and that which is 'futile'.

Mr Nicholls, who divides his time and practice between Perth and England, specialises in the areas of family law, international family law and medical ethics. He has kindly allowed the College to reprint his lecture notes in *Surgical News*.

Medical science has developed to a point at which we are all living longer, but that does not necessarily mean that we are living longer, healthier lives. Many of us are living longer lives with a disease which years ago would have killed us much sooner. Now it is chronic condition, being studied for the first time in such longevity.

The pursuit of the preservation of life has therefore brought about problems not encountered before, when there was nothing a doctor could do. Now a doctor might be able to do something to defer death – but should the doctor do it?

This leads to questions about a doctor's duty, what standards society expects from a doctor in carrying out that duty, and who decides if those standards have been fulfilled.

We are going to consider those problems in the context of medical treatment that might be thought of as being "futile".

It is necessary at the outset to distinguish between treatment that is futile, and treatment that is simply not available – or on offer. There are limits to autonomy – a patient has the power to choose between what is being offered, not to demand something that is not on offer: "Patients may not require that they be treated by non-medical means (a holiday in Tahiti) or be given scientifically futile treatment (such as pasque flower tea for cancer) or treated in ways that are inconsistent with the ways of medicine."1

There has been some concern expressed about the use of non-conventional therapies by patients – or more often, the parents of patients. The non-conventional therapy may be completely ineffective, but its futility does not really fall to be considered by a doctor, because a doctor is not offering it.2 It may, however, be of serious concern to child protection agencies.

By contrast, treatment that is potentially futile will usually be available – the question is whether it should be undertaken?

There is no doubt about who has to make that decision – again, there are limits on patient autonomy. A decision whether treatment is appropriate for a patient is ultimately one for the doctor, not the patient.

Futility and medicine

The first question is: what is "futility" in the context of medical treatment? There is a less than encouraging remark in "Ethics and Law for the Health Professions"3 to the effect that "Unfortunately, it has proven very difficult to provide a definition of futility that is both philosophically coherent and clinically useful."

However, my task is rather easier – I only have to consider law, not philosophy, although some clinical utility would probably be helpful.

The task of defining futility has not been made any easier by the perception that labelling treatment as "futile" is bound up with a number of emotive topics, including the allocation of limited resources, judgments about the worth or value of a life, and the autonomy of the patient.4

In the context of medicine, futility has been described as shorthand description for circumstances in which a patient (directly or through someone else) asks for certain medical treatment and the doctor refuses to provide it because it has little or no therapeutic value. The concept comes acutely into focus in end-of-life cases, especially when the patient is a small child.

Measuring value in medical ethics

There are number of measures of value in medicine – QUALYs, success rates (which includes concepts of probability), the "worth" of a life (Plato), the ability or lack of it to achieve desired goals ("normative futility"). "Best interests" is often used when considering children, if only because that is the statutory criterion, but is also necessary to appreciate that best interests may not be "collapsed into objective medical interests alone".5 "Best interests" has had a mixed reception in cases involving discontinuance of treatment – in the Bland6 case Lord Keith said that:

It is argued for the respondents, supported by the amicus curiae, that his best interests favour discontinuance. I feel some doubt about this way of putting the matter.

Whereas Lord Goff took a different view:

The doctor who is caring for such a patient cannot, in my opinion, be under an absolute obligation to prolong his life by any means available to him, regardless of the quality of the patient's life. Common humanity requires otherwise, as do medical ethics and good medical practice accepted in this country and overseas. As I see it, the doctor's decision whether or not to take any such step must (subject to his patient's ability to give or withhold his consent) be made in the best interests of the patient.

And then there is the 'benefits and burdens' approach.

The 'benefits and burdens' analysis

It would be helpful if there were a simple calculation of 'benefits and burdens', but it is acknowledged that appealing as it is, mathematical simplicity cannot be achieved. But there are circumstances in which the burdens seem to be completely out of proportion to the benefits, and if that is the case, then the proposed treatment is very likely to be regarded as futile.

The "benefits" approach seemed to have appealed to Lord Keith in the Bland case:

The fundamental question then comes to be whether continuance of the present regime of treatment and care, more than three years after the injuries that resulted in the P.V.S., would confer any benefit on Anthony Bland.

Michael Nicholls

References

1. R Schwartz: 'Autonomy, Futility and the limits of Medicine' (1993) 12 Bioethics News 31 (cited in "Law and Medical Practice" 3rd ed. Skebene, LexisNexis 2008.
2. In her paper 'Parents know best: Or do they? Treatment refusals in pediatric oncology', Dr Angela Alessandri gives an example of the parents of a child with a serious cancerous condition taking her abroad for treatment with "natural therapies".
3. 'Kerridge et al' The Federation Press, 2009, p316
4. 'Law and Medical Ethics', Mason, McCall Smith and Laurie, Butterworths, 6th ed. P 471.
5. Per Dr Angela Alessandri, op.cit.
6. Airedale NHS Trust v Bland [1993] AC 789.

The conclusion of Mr Nicholls' lecture will be published in the next issue of *Surgical News*.

More than $1.5 million awarded!

2013 Scholarship and Grant Recipients

The Board of Surgical Research thanks all applicants and congratulates the following successful recipients

Research scholarship & fellowship recipients

The College wishes to acknowledge and thank our benefactors and sponsors for their generosity in funding many of the following scholarships and grants.

Where indicated * scholarship recipients must procure 25 per cent of their scholarship from either their research department or by external award or donation.

John Mitchell Crouch Fellowship

Professor Russell Gruen – Vic

Professor Russell Gruen is Professor of Surgery and Public Health at Monash University, Director of the National Trauma Research Institute, and a General and Trauma Surgeon at The Alfred, Melbourne. Funds from the John Mitchell Crouch Fellowship will be used by Professor Gruen and his team to improve the safety of surgery in patients on anticoagulant therapy. In the Vitamin K Peri-Operative Warfarin Reversal (ViKPOWR) Study they aim to investigate the safety and effectiveness of a new non-heparin-based regimen for perioperative management of Warfarin in a broad range of elective general surgical, orthopaedic, urological, and other procedures in Victorian public and private hospitals.

Fellowship Value – $150,000

Surgeon Scientist Scholarship

Dr Regent Lee – NSW

Speciality: Vascular

Scholarship Value: $70,000

Topic: Plaque imaging and biomarker study

Supervisor: Professor Keith Channon

Eric Bishop Scholarship*

Dr Ajay Iyengar – Vic

Specialty: Cardiothoracic

Scholarship Value: $60,000

Topic: Detection and treatment of failure of the Fontan circulation

Supervisor: Associate Professor Yves d'Udekem

Raelene Boyle Scholarship – Sponsored by Sporting Chance Cancer Foundation*

Dr Lawrence Lau – Vic

Specialty: General

Scholarship Value: $60,000

Topic: 18F-FDG PET: A non-invasive tool to assess biology and tailor treatment for colorectal liver metastases

Supervisor: Dr Vijayaragavan Muralidharan

WG Norman Research Fellowship*

Dr Tiong Cheng Sia – SA

Specialty: General

Scholarship Value: $60,000

Topic: Pathophysiology underlying post-operative ileus: The role of serotonergic neurotransmission

Supervisor: Professor David Wattchow

Sir Roy McCaughey Surgical Research Fellowship*

Dr Julian Ip – NSW

Specialty: General

Fellowship Value: $60,000

Topic: Clinical and molecular aspects of adrenal tumorigenesis

Supervisor: Professor Stan Sidhu

Francis & Phyllis Thornell Shore Fellowship*

Dr Matthew Read – Vic

Specialty: General

Fellowship Value: $60,000

Topic: Understanding the genetic basis in the progression of Barrett's oesophagus to oesophageal adenocarcinoma

Supervisor: Dr Cuong Duong

Foundation for Surgery John Loewenthal Research Scholarship

Dr Alexander Cameron – SA

Specialty: Plastic & Reconstructive

Scholarship Value: $60,000

Topic: The role of flightless protein in scar formation

Supervisor: Professor Allison Cowin

Foundation for Surgery Reg Worcester Research Fellowship*

Dr David Liu – Vic

Specialty: General

Fellowship Value: $60,000

Topic: Targeted molecular therapies and predictive biomarkers in a novel orthotopic xenograft model of oesophageal carcinoma

Supervisor: Associate Professor Wayne Phillips

Foundation for Surgery Catherine Marie Enright Kelly Scholarship*

Dr Anannya Chakrabarti – Vic

Specialty: General

Scholarship Value: $60,000

Topic: Induction and exploration of gene regulation of dormancy in Breast Cancer Metastasis

Supervisor: Associate Professor Robin Anderson

Foundation for Surgery New Zealand Research Fellowship*

Dr Ryash Vather – NZ

Specialty: General

Scholarship Value: $60,000

Topic: Pathophysiology risk factors and management of postoperative gut dysfunction

Supervisor: Professor Ian Bissett

Foundation for Surgery Scholarship in Surgical Ethics*

Dr Joseph Smith – SA

Scholarship Value: $60,000

Topic: Surgery, ethics and climate change

Supervisor: Professor Guy Maddern

Foundation for Surgery ANZ Journal of Surgery Scholarship*

Dr Tinte Itinteang – NZ

Specialty: Plastic & Reconstructive

Scholarship Value: $60,000

Topic: Head and neck squamous cell carcinomas: The role of the primitive endothelium

Supervisor: Professor Swee Tan

Foundation for Surgery Richard Jepson Research Scholarship – INAUGURAL

Dr Nikhil Sapre – Vic

Specialty: Urology

Scholarship Value: $60,000

Topic: Integrated genomics and urinary miRNA profiling in bladder cancer: Role in diagnosis, risk stratification and surveillance

Supervisor: Associate Professor Christopher Hovens

Foundation for Surgery Peter King Research Scholarship*

Dr Kheng-Seong Ng – NSW

Specialty: General

Scholarship Value: $60,000

Topic: Towards a better definition and understanding of anterior resection syndrome

Supervisor: Professor Marc Gladman

Foundation for Surgery Research Scholarship*

Scholarship Value each: $60,000

Dr James Lee – NSW

Specialty: General

Topic: Plasma miRNA as systemic biomarker for recurrent papillary thyroid cancer

Supervisor: Professor Stan Sidhu

Dr Iwan Bennett – Vic

Specialty: Neurosurgery

Topic: Vascular biomarkers in malignant glioma

Supervisor: Dr Andrew Morokoff

Dr David Oehme – Vic

Specialty: Neurosurgery

Topic: Lumbar intervertebral disc regeneration using mesenchymal progenitor cells (MPCs)

Supervisor: Professor Graham Jenkin

Dr Penelope DeLacavalerie – NSW

Specialty: General

Topic: The impact of the mutated in colorectal cancer defect on treatment responsiveness in colorectal cancer

Supervisor: Associate Professor Maija Kohonen-Corish

Dr Ravi Jain – NZ

Specialty: Otolaryngology

Topic: The local inflammatory response to intramucosal S. aureus in chronic rhinosinusitis

Supervisor: Mr Richard Douglas

Foundation for Surgery Research Fellowship*

Dr Cherry Koh – NSW

Specialty: General

Scholarship Value: $60,000

Topic: Pelvic exenteration for the treatment of locally advanced primary rectal cancer and locally recurrent rectal cancer

Supervisor: Professor Michael Solomon

Foundation for Surgery Brendan Dooley/ Gordon Trinca Research Scholarship - INAUGURAL

Dr Corey Scholes – NSW

Scholarship Value: $10,000

Topic: Does surgical reconstruction restore knee function to resemble uninjured knees and prevent cartilage degeneration following multiple ligament injury?

Supervisor: Professor Qing Li

Travel Scholarship, Fellowship and Grant Recipients

Margorie Hooper Scholarship

Dr Broughton Snell – SA

Specialty: Plastic & Reconstructive

Scholarship Value: $65,000

Stuart Morson Scholarship in Neurosurgery

Dr Kristian Bulluss – Vic

Specialty: Neurosurgery

Scholarship Value: $30,000

Murray and Unity Pheils Travel Fellowship

Dr Philip Smart – Vic

Specialty: General

Fellowship Value: $10,000

Morgan Travelling Scholarship

Dr Michael Findlay – Vic

Specialty: Plastic & Reconstructive

Scholarship Value: $10,000

Hugh Johnston Travel Grants

Dr Kang Yuen Chung – Qld

Specialty: Urology

Grant Value: $10,000

Dr Indu Gunawardena – SA

Specialty: Otolaryngology

Grant Value: $10,000

Hugh Johnston ANZ Chapter American College of Surgeons Travelling Fellowship

Dr Stephen Smith – SA

Specialty: General

Grant Value: $8,000

Ian and Ruth Gough Surgical Scholarship

Dr Tony Palasovski – NSW

Specialty: General

Grant Value: $10,000

John Buckingham Travelling Fellowship – 2012

Dr Yi Chen – Vic

Specialty: Cardiothoracic

Grant Value: $3,000

James Ramsay Fellowships for Provincial Surgeons – 2012

Dr Jonathan Golledge – Qld

Specialty: Vascular

Fellowship Value: $3,000

Other Scholarships

The following lists external awards that Fellows and Trainees of the College have been successful in attracting from other organisations.

Preliminary Notice: Applications for 2014 scholarships will open in March 2013

NSA Research Scholarship Proudly Sponsored by De Puy Synthes

Dr Hamish Alexander

Specialty: Neurosurgery

Award Value: $35,000

Topic: Systems immunology analysis to delineate therapeutic benefit of adoptive T-cell therapy for glioblastoma multiforme

NSA Research Scholarship Proudly Sponsored by Neurosurgical Research Foundation

Dr Tom Morris

Specialty: Neurosurgery

Award Value: $50,000

Topic: Study of the effects of haptoglobin augmentation in the subarachnoid space on delayed ischaemia in an animal model of subarachnoid haemorrhage

GSA Pacific Island Travel Grant

Dr Damien Hasola – PNG

Specialty: General

Award Value: $3,000

To attend GSA ASM in Hobart, 2012

GSA Pacific Island Travel Grant

Dr Jack Mulu – PNG

Specialty: General

Award Value: $3,000

To attend GSA ASM in Hobart, 2012

OHNS Garnett Passe and Rodney Williams Memorial Foundation Scholarship

Victoria – Dr Luke Campbell

South Australia – Dr Vikram Padhye

Dr Cathy Ferguson
Outgoing Chair, Board of Surgical Research

Associate Professor Phillip Carson
Incoming Chair, Board of Surgical Research

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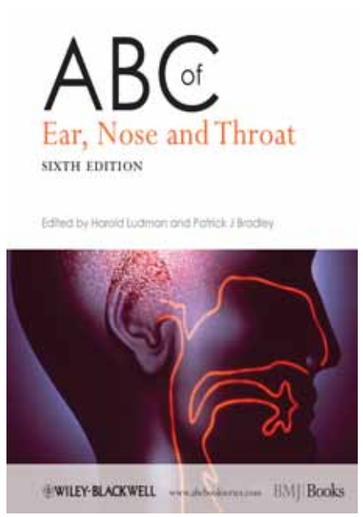


ABC of Ear, Nose and Throat, 6th Edition

Harold S. Ludman, Patrick Bradley (Editors)
9780470671351 | Pbk | 168 pages
November 2012

~~AU$54.95~~ | **AU$41.21**
Member Price

ABC of Ear, Nose and Throat is a long established best-selling guide to the management of common conditions of the Ears, Nose and Throat. It follows a symptomatic approach for evaluation and prioritisation of common presentations, and provides guidance on primary care assessment and management, and on when and why to refer for a specialist opinion. Fully revised to reflect the current practice of oto-rhino-laryngology and head and neck surgery, new chapters address the increasing specialization and improved understanding of the likely causes and specialist treatment for symptoms such as tinnitus, nasal discharge, nasal obstruction, facial plastic surgery, head and neck trauma and foreign bodies, and non-specialist assessment and examination. There is new content on rhinoplasty, pinnaplasty, non-melanoma skin tumours, thyroid disease and head and neck cancer, with many new full colour illustrations and algorithms throughout.

25% Discount

Dermatologic Surgery: Step by Step

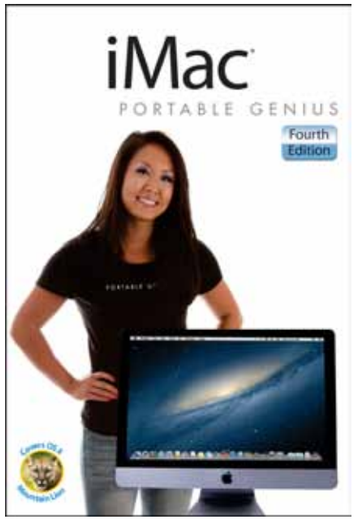
Keyvan Nouri (Editor)
9781444330670 | Hbk | 472 pages
November 2012

~~AU$230.00~~ | **AU$172.50**
Member Price

This manual offers detailed, step-by-step guidance to dermatologic surgical procedures. The coverage provides three main sections - General Dermatologic Surgery, Cosmetic Surgery, Lasers and Miscellaneous topics - over 60 chapters with a concise templated format. Each chapter features five sections: pre-operative care, step by step surgical technique, post operative care and follow up, complications, and prevention and management of complications. Filled with clear descriptions and illustrations (5-10 per procedure), this manual and accompanying DVD provides physicians with updated and easy-to-read information for quick review and reference.

CD-ROM/DVD and other supplementary materials are not included as part of the e-book file, but are available for download after purchase.

25% Discount



iMac Portable Genius, 4th Edition

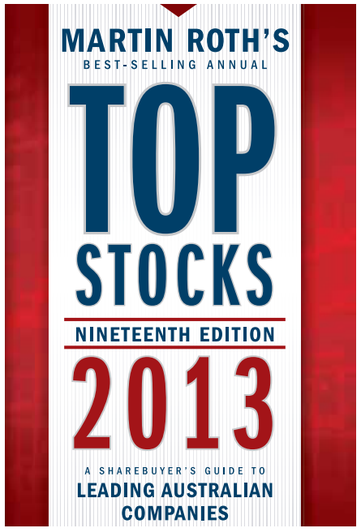
Guy Hart-Davis
9781118420638 | Pbk | 448 pages
September 2012

~~AUD $29.95~~ | **AU$22.46**
Member Price

Get to know the newest iMac, including OS X Mountain Lion. Completely updated to cover the latest iMac, the new edition of this savvy guide is just what you need to get the most out of your cool new computer. Veteran author Guy Hart-Davis reveals all the best tricks and tips, as he shows you how to set up and customize your iMac and get every bit of fun and smarts out of iLife, the Magic Mouse, OS X Mountain Lion, and more. Packed with useful tidbits, full-color screenshots, and great advice, iMac Portable Genius, Fourth Edition is the perfect guide, whether you're switching from an older Mac or migrating from a Windows PC.

- Explores the best ways to get the very most out of your new iMac, whether you're switching from an older Mac or migrating from a Windows PC
- Highlights all the latest bells and whistles, including OS X Mountain Lion, the new Magic Mouse, iLife applications, and more
- Covers troubleshooting and maintaining its related hardware and software.

25% Discount



Top Stocks 2013: A Sharebuyer's Guide to Leading Australian Companies

Martin Roth
9781118406250 | Pbk | 256 pages
October 2012

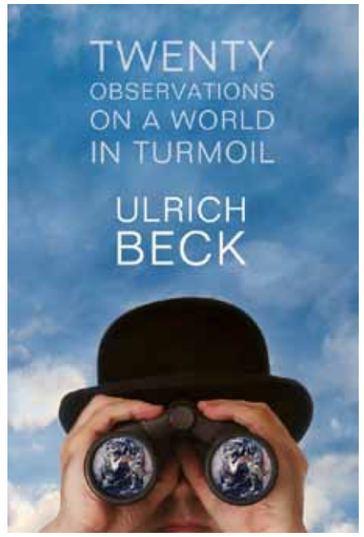
~~AU$29.95~~ | **AU$22.46**
Member Price

Australia's bestselling sharemarket title is back in a new 19th edition. In this new edition of Top Stocks, renowned financial journalist Martin Roth returns with his tried-and-tested analysis of the best public companies in Australia, based on low-risk and long-term value. Featuring clear and objective information on the performance and outlook of Australian companies across market sectors, it's an absolute must for Australian investors.

Presented in its trademark easy-to-read format, Top Stocks 2013 cuts through the noise and hype to assess every company on the same proven criteria, with a focus on profitability, debt levels, and dividends.

- Features individual, unbiased analysis of the latest results from Australia's top companies
- Includes comparative sales and profits data, as well as in-depth ratio analysis

25% Discount



Twenty Observations on a World in Turmoil

Ulrich Beck
9780745653976 | Pbk | 140 pages
September 2012

~~AU$24.95~~ | **AU$18.71**
Member Price

The world is a state of turmoil. From the financial crisis to the chaos in the eurozone, from the Arab uprisings to protests in Athens, Barcelona, New York and elsewhere, many of the familiar frameworks are collapsing and we have to find new ways to orient ourselves in a world undergoing rapid change. Of course, it is necessary for political leaders to address local issues and react to people's specific demands, but without a cosmopolitan outlook, such a reaction is likely to be inadequate. Ulrich Beck's Twenty-one Observations on a World in Turmoil is a demonstration of cosmopolitan politics in practice. It is more than a mirror: it is a magnifying glass that brings into focus the processes that are transforming our world and highlights the great challenges we face today. This clear and accessible book is written for a wide readership interested in the big changes taking place in our world today.

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To Order

RACS Members can now access the **25% discount*** by following the instructions:

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If you have previously ordered from the RACS Landing Page, then you can purchase direct from www.wiley.com by selecting the book of choice and then logging on.

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*Excluded from discount are School (Jacaranda) titles.

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Not all books promoted in Surgical News will appear on the RACS/Wiley Landing Page.

You can still order these, as with any other book, by finding it within **wiley.com**, after logging in.

*Excluded from discount are School (Jacaranda) titles.

The College finances and budget 2013

College Treasurer, Associate Professor Marianne Vonau, reports on the year ahead

The College Budget for 2013 was approved at the October meeting of Council. As Fellows' subscriptions and Trainees' fees are a key source of College funding, I thought it would be useful to outline the operations and initiatives planned for the year ahead, undertakings that add value to your ongoing engagement with the College.

The College activities are divided into 3 separate "businesses". Firstly, there are activities related to the College's core purpose, namely education and training as well as professional development and standards. This core business is funded from your subscription and training fees and provides for delivery of services that are of utmost relevance to your association with the College. Secondly, the College administers a significant suite of research, aid and audit projects that are externally funded, predominately by government agencies such as the Department of Health and Ageing and AusAID. These projects represent opportunities for many Fellows and Trainees to be directly involved in the delivery of multiple health programs across research, specialist training, international aid and audit. The third business activity centres mainly on the Foundation for Surgery, which provides scholarships for research and funds for international aid. These activities are funded through donations and bequests to the Foundation and serve as another avenue of contact between the Fellowship and the College.

The Budget process started in June with the integration of key budget parameters and strategic initiatives for 2013. Within this governance framework the budget is built up to fund the ongoing College activities and identify new initiatives to support the development of education, training and the eLearning experience.

Before outlining the key components of the budget I would like to briefly identify some areas of College activity during the current year which were of benefit to Fellows and Trainees.

College Activities in 2012

Among the initiatives delivered and being progressed were:

- The development of online resources to support surgical supervisors and trainees;
- A very successful Annual Scientific Congress in Kuala Lumpur, attended by a record number of registrants;
- Increased resourcing for library services;
- An upgraded and more user friendly Continuing Professional Development (CPD) online diary;
- Participation in the development of the elective surgery urgency categorisation review;
- The introduction of a Commonwealth funded Telehealth initiative, promoting use of video conferencing technology in the outpatient consult space;
- Revision of the strategic direction, role and governance of the Academy of Surgical Educators;
- Facilitation of 33 Professional Development workshops involving 641 participants comprised of 530 Fellows, 23 Trainees and 88 non-members;
- New and improved web services and facilities; and
- A bigger, new-look *Surgical News*.

Total College Budget – 2013 (2012 Budget Comparison)

	Budget 2013 $000s	Budget 2012 $000s	Increase / (Decrease) %
Revenue	55,930	52,690	6% ↑
Expenditure	55,139	51,349	7% ↑
Total Surplus	791	1,341	41% ↓

2013 Budget

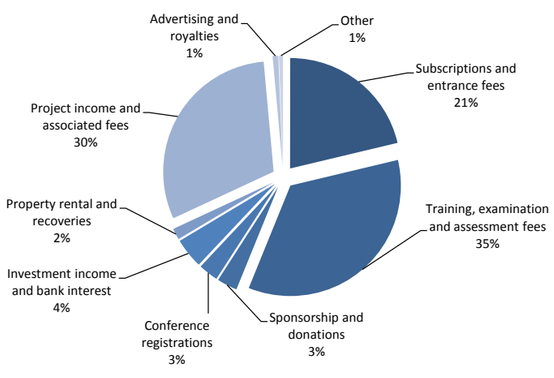
The College continues to maintain a strong financial position and has budgeted for a modest surplus of $791k or a 1.4% surplus return on projected revenue. The 2013 Budget ensures ongoing investment in Fellows' and Trainees' services and educational activities while ensuring the ongoing financial capability to maintain an overall organisational structure and the facilities appropriate for your professional College.

Key attributes of our budget strategy review and the budget processes were to:

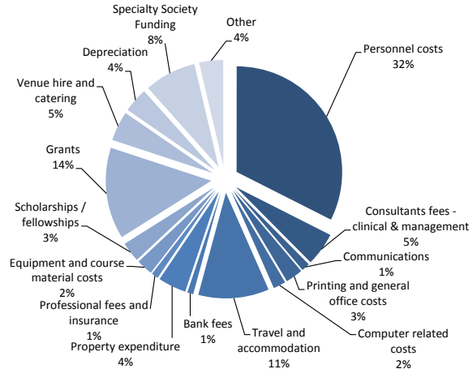
- Achieve a modest surplus return from operations;
- Ensure appropriate staffing resources to deliver objectives in line with the Strategic Plan 2011-2015 and maintain salary levels to the general market in accordance with the remuneration policy;
- Ensure project related activity is fully self-funded unless Council deems that the engagement in the project is considered to be of value to our strategic interests;
- Allocate 50% of surpluses on completed projects to the Foundation for Surgery for ongoing commitment to International Projects and Surgical Research;
- Ensure new key initiatives are assessed on the basis of adding value to Fellows and Trainees and are cost neutral by either generating additional income streams or achieving identifiable savings from existing expenditure;
- Peg subscription fee increases to CPI to ensure all Fellow related activities are fully funded from fees charged;
- Peg training, education and international medical graduate fees to the Education Price Index to ensure all training and educational expenditure is fully funded from fees charged; and
- Ensure all NZD denominated fees are charged at AUD equivalent to maintain equity in fee structure between the jurisdictions.

Main sources of revenue and expenditure are represented in the chart display below:

Budget 2013
Sources of Revenue



Budget 2013
Sources of Expenditure



"Within this governance framework the budget is built up to fund the ongoing College activities and identify new initiatives to support the development of education, training and the eLearning experience."

In addition to the delivery of core Fellowship services, training and education programs in 2013 the budget has funding provision for a number of key investment priorities including:

- Continuing to promote the FRACS brand as a quality mark standing for excellence in surgical care;
- Development and launch of the Keeping Trainees on Track online program;
- Launch of an online surgical competence and performance assessment module;
- Moving examinations to an improved IT platform that will provide greater efficiencies in the development and delivery of the Fellowship and other examinations;
- Another quality Annual Scientific Congress, in Auckland in 2013, that aims to be of relevance to surgeons in all specialties;
- Publication of a revised surgical audit guide;
- Active advocacy initiatives, with high level representations via College submissions on critical issues of public health policy, standards and protocols; and
- The ongoing development of new and innovative online resources to support Fellows, Supervisors and Trainees.

Balance Sheet

As at 31 December 2013, it is estimated that the College net assets will be $53,421k (2012 forecast - $52,630k). During the period, the Investment Reserve is budgeted to increase from $3,249k to $3,504k, generated from investment returns on funds not already committed to Research Scholarships and Grants or transferred to the Foundation for Surgery.

College Properties

The College owns properties in Adelaide, Brisbane and Melbourne in Australia as well as Wellington in New Zealand. Accommodation is leased for College offices in Adelaide, Sydney, Canberra, Hobart and Perth.

The College sold the Sydney property earlier this year and has relocated to leased premises. The College's Brisbane office has also relocated to leased premises with preliminary plans underway for sale of the Brisbane office, to be finalised in 2013.

Maintenance and repair of these properties has decreased to $265k compared to $411k in 2012 mainly due to restoration work of the south wing of the Melbourne property completed this year in addition to routine scheduled maintenance.

In Closing

As the year draws to a close the College continues to make significant progress towards completing the key activities outlined in the Strategic Plan. The proposed initiatives for 2013 will ensure that the College continues to meet these challenges next year.

I would like to thank my Deputy Treasurer, Mr Andrew Brooks, for his continued support during 2012 and his oversight of property related matters.

I would also like to extend my warm thanks to the Honorary Advisers of the College, Mr Brian Randall, Mr Michael Randall, Mr Anthony Lewis, Mr Stuart Gooley, Mr Reg Hobbs, Mr John Craven and Mr Chesley Taylor for their ongoing advice and support. Also the advice, excellent service and support from Mr Graham Hope, Investment Adviser, of J B Were have continued to benefit the College enormously.

The support provided by our Honorary Advisers over many years has been invaluable to the College and its Fellows.

Also I would like to thank the Resources staff and the Director, Mr Ian T Burke, for their commitment, support and hard work in assisting me in my role as Treasurer.

The budget will enable our College to continue investing in core areas of service to our Fellows and Trainees, with an ongoing commitment to focus on matters of strategic priority. The financial position of the College proceeds on a solid base and is in sound shape for the year ahead.

Associate Professor Marianne Vonau
Treasurer
November 2012

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
SUMMARY OF SUBSCRIPTIONS, EDUCATION & TRAINING AND OTHER FEES FOR 2013

		2013 AUST Fees AUD (Inc. GST)	2013 NZ Fees NZD (Inc. GST)
SUBSCRIPTIONS & ENTRANCE FEES			
#Annual Subscription - 2013 payable on 1 January 2013		$2,500	$3,400
Fellowship Entrance Fee payable in full (10% discount applies) or over 5 years - no CPI increase		$6,105	$7,774
EDUCATION & TRAINING			
Surgical Training			
Administration Fee - exam pending, interruption and deferral (SET)		$795	$1,075
Selection Processing Fee - (Note 6)		$680	$925
Selection Registration Fee		$460	$620
# SET Training Fee	*	$6,090	$8,960
Examinations			
Clinical Examination Fee	*	$1,890	$2,795
Fellowship Examination Fee	*	$6,850	$10,175
Generic Surgical Science Examination Fee	*	$3,295	$4,895
Orthopaedic Principles & Basic Science Examination Fee	*	$2,475	$3,670
Paediatric Anatomy and Embryology Examination Fee	*	$3,125	N/A
Paediatric Pathophysiology Examination Fee	*	$1,240	$1,840
Plastic and Reconstructive Surgical Science & Principles Examination Fee	*	$2,475	$3,670
Speciality Surgical Science Examination Fee	*	$1,650	$2,455
Skills Courses - refer to note 4			
ASSET Course		$3,280	$4,425
CCrISP Course		$2,735	$3,710
CLEAR Course		$1,340	$1,795
EMST Course - Provider		$2,735	$3,710
EMST Course - Refresher		$1,755	$2,360
Course Transfer Fee		$185	$245
Course Accreditation			
Course Accreditation Fee		$1,190	$1,595
PROFESSIONAL DEVELOPMENT WORKSHOPS & COURSES			
Polishing Presentation Skills		$500	N/A
Practice Management for Practice Managers		$590	N/A
Surgical Teachers Course (STC)		$295	N/A
Writing Reports for Court		$915	N/A
Leadership in a Climate of Change		$2,165	N/A
Strategic Direction		$1,925	N/A
AMA Level 4/5: Difficult Cases		$90	N/A
Building Towards Retirement - Fellow		$235	$315
Building Towards Retirement - Fellow & Partner		$340	$455
Sustaining Your Business		$2,220	N/A
Working Together: Surgeons and Administrators		$225	N/A
Process Communication Model		$1,255	$1,680
Occupational Medicine		$80	N/A
AMA Impairment		$90	N/A
Finance for Surgeons		$540	N/A
Strategy and Risk for Surgeons		$540	N/A
Acute Neurotrauma		$115	N/A
OTHER FEES			
Training Post Accreditation Fees		$3,590	$4,840
Peripheral Endovascular Therapy - Application Fee		$360	N/A
Re-Assessment Fee		$115	N/A
Appeals Lodgement Fee		$6,470	N/A
Distance Learning (Exam Preparation) Fee		$625	N/A
International Medical Graduates			
Paper Based Assessment Fee		$5,175	N/A
Paper Based Assessment & Interview		$7,830	N/A
Supervision / Oversight Fee- onsite		$6,340	N/A
Supervision / Oversight Fee - remote		$18,110	N/A
Document Assessment Fee - AoN subsequent to specialist assessment		$1,245	N/A
Document Assessment Fee - College endorsement for AoN (Area of Need)		$1,245	N/A
Assessment Fee - Reconsideration for Exceptional Performance		$2,485	N/A
Short Term Specified Training Position Application Fee		$995	N/A
Post Fellowship Education and Training			
Program Assessment Fee		$610	$830
Annual Administration Fee		$125	$160
MOPS - Maintenance of Professional Standards			
Australia & New Zealand		$2,715	$3,670

1. All fees are payable in either Australian or New Zealand Dollars as invoiced.
2. All New Zealand fees, including Examinations undertaken in New Zealand, are subject to the Goods & Services tax of 15.0%.
3. All Australian Fees will be subject to GST of 10% except those approved Education courses marked with an asterisk (*) which are not subject to Australian GST.
4. Examination & training fees for Australian based activities have been approved by the Australian Taxation Office as GST free for all courses relating to the awarding of the RACS Fellowship.
5. Subscriptions and Fees marked (#) may be paid to the College by 4 equal instalments during the year by AMEX, Diners, Visa or MasterCard credit cards only. Further details will be made available when fees are raised.
6. Specialty programs may charge their own selection processing fees, these fees will be published by the respective Specialty Society.

Surgical News Index/Volume 13/2012

Developing a Career in Academic Surgery

Monday 6 May 2013, 7.00am – 4.00pm

SKYCITY CONVENTION CENTRE
AUCKLAND, NEW ZEALAND

Who should attend?

This inspirational course is designed for surgical trainees, research Fellows and early career academics. It contains elements of interest for those from the stage of medical students to that of any surgeon who has ever considered involvement with publication or presentation of any academic work.

Association for Academic Surgery Invited Speakers will include:

Dr Carlton Barnett, University of Colorado, Denver, Colorado, USA

Dr Justin Dimick, University of Michigan, Ann Arbor, Michigan, USA

Dr Lillian Kao, University of Texas, Houston, Texas, USA

Dr Gregory Kennedy, University of Wisconsin, School of Medicine and Public Health, Madison, Wisconsin, USA

Dr Eric Kimchi, Penn State Hershey Surgical Specialties, Hershey, Pennsylvania, USA

Dr Timothy Pawlik, Johns Hopkins, Baltimore, Maryland, USA

Dr Rebecca Sippel, University of Wisconsin School of Medicine and Public Health, Madison, Wisconsin, USA

Dr Julie Ann Sosa, Duke University Medical Center, Durham, North Carolina, USA

Invited speakers will also include highly regarded faculty from Australia and New Zealand as in previous Courses.

Provisional Program

Session 1	**General Principles**		
	Introduction What is a Career in Academic Surgery? Research - How to Get Research Started - Ideas, Grants, Ethics and Collaboration Academic Surgery - The Essentials - Teaching, Leadership and Administration		
Morning Tea			
Hot Topic in Surgical Research - Stem Cells			
Session 2	**Tools of the Trade**		
	Bedside to Bench to Bedside Basic Science Randomised Clinical Trials Comparative Effectiveness Research Surgical Education/Simulation		
Lunch			
Keynote Presentation			
Session 3	**Concurrent Academic Workshops**		
	Workshop 1: Interactive Workshop on Issues in Research	**Workshop 2: Career Development**	**Workshop 3: Presenting Your Work**
Afternoon Tea			
Session 4	**A Career in Academic Surgery**		
	Choosing and Being a Mentor Work-Life Balance On the Shoulders of Giants		

Registration

Cost $265.00NZD inc NZ GST

Register on the ASC registration form or online at http://asc.surgeons.org.

There are 15 complimentary spaces available for interested medical students. Medical students should register their interest to attend by emailing dcas@surgeons.org

Further information

Conferences & Events Management
Royal Australasian College of Surgeons
T: +61 3 9249 1273 F: +61 3 9276 7431
E: dcas@surgeons.org

2012 Comments

"An excellent program, incredibly inspiring"

"An enjoyable and educational day"

Registrants receive a complimentary copy of Success in Academic Surgery (Part 1) edited by Herb Chen and Lillian Kao.

Presented by:
Association for Academic Surgery
in partnership with the
RACS Section of Academic Surgery

AAS Association for Academic Surgery

Royal Australasian College of Surgeons, Section of Academic Surgery

Proudly sponsored by:
Johnson & Johnson MEDICAL COMPANIES

NOTE: New RACS Fellows presenting for graduation in 2013 will be required to marshal at 3.30pm for the Convocation Ceremony.

The information is correct at the time of printing however the Organising Committee reserve the right to change the program without notice.

CPD Points will be available for attendance at the Course with point allocation to be advised at a later date.

The Royal Australasian College of Surgeons
Member Advantage Benefit Program

Member ADVANTAGE®

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Access specially negotiated rates and reduced excess liability for passenger vehicle rental in Australia, New Zealand and other locations worldwide. Quote RACS AWD number P203701 when making a booking.

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Explore the world with Intrepid Travel and save 10% off all land tours as part of your RACS benefits. Trek through the jungles of Borneo or experience the gourmet delights of Europe with a range of trips to cater to every style and budget.

Lifestyle experiences

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NZ Fellows & Trainees call +61 3 9695 8997

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