Surgical News

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS **NOV/DEC 2013**

The College of Surgeons of Australia and New Zealand

HAPPY & SAFE FESTIVE SEASON

More than $1.5 million of Research Scholarships awarded! p44

Help Ahoy

Sydney surgeon Mr Neil Thomson is one of thousands of volunteers who staff the Africa Mercy, a converted hospital ship. Each year the team treats thousands of patients from some of the poorest countries on earth. His incredible story starts on **page 36**

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

2014 Workshops & Activities

Professional development supports life-long learning. College activities are tailored to the needs of surgeons and enable you to acquire new skills and knowledge while providing an opportunity for reflection about how to apply them in today's dynamic world.

Supervisors and Trainers for SET (SAT SET)

25 February, Adelaide; 29 April, Melbourne

This course assists supervisors and trainers to effectively fulfil the responsibilities of their very important roles. You can learn to use workplace assessment tools such as the Mini Clinical Examination (Mini CEX) and Directly Observed Procedural Skills (DOPS) that have been introduced as part of SET. You can also explore strategies to help you to support trainees at the mid-term meeting. It is an excellent opportunity to gain insight into legal issues.

This workshop is also available as an eLearning activity by logging into the RACS website.

Process Communication (PCM) – Part 1

28 February – 2 March; Melbourne

PCM is one tool that you can use to detect early signs of miscommunication and turn ineffective communication into effective communication. This workshop can also help to detect stress in yourself and others, as well as providing you with a means to reconnect with individuals you may be struggling to understand and reach. The PCM theory proposes that each person has motivational needs that must be met if that person is to be successful. These needs are different for each of the 6 different personality types; each person represents a combination of these types, but usually one is dominant.

Keeping Trainees on Track (KToT)

4 March, Melbourne; 26 March, Gold Coast; 8 April, Sydney

This three hour workshop focuses on how to manage trainees by setting clear goals, giving effective feedback and discussing expected levels of performance. You can also find out more about encouraging self-directed learning at the start of term meeting.

Communication Skills for Cancer Clinicians

29 March, Melbourne

In four hours you will learn evidence-based, step-by-step communication skills that break down the challenge of delivering negative diagnoses to patients and relatives. A trained-actor steps in mid-way through the morning to run a role-play exercise where you practise newly-learned communication skills in a safe environment resembling a real-life scenario. Theoretical linking, plus a video and discussion, form other parts of the program offered in partnership with the Cancer Council Victoria.

Non-Technical Skills for Surgeons (NOTSS)

18 March, Adelaide; 15 April, Melbourne

This workshop focuses on the non-technical skills that underpin safer operative surgery. It explores a behaviour rating system developed by the Royal College of Surgeons of Edinburgh that can help you improve performance in the operating theatre in relation to situational awareness, communication, decision-making and leadership/teamwork. Each of these categories is broken down into behavioural markers that can be used to assess your own performance as well as your colleagues. This educational program is proudly supported by Avant Medical Group.

Polishing Presentation Skills

9 April, Brisbane

The full-day curriculum demonstrates a step-by-step approach to planning a presentation and tips for delivering your message effectively in a range of settings, from information and teaching sessions in hospitals, to conferences and meetings.

Contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit www.surgeons.org - select Health Professionals then click on Courses and Events www.surgeons.org/for-health-professionals/register-courses-events/professional-development

NSW

17 March, Sydney
National Simulation Health Educator Training (NHET Sim)

8 April, Sydney
Keeping Trainees on Track (KTOT)

QLD

26 March, Gold Coast
Keeping Trainees on Track (KTOT)

3 – 5 April, Gold Coast
Surgical Teachers Course

9 April, Brisbane
Polishing Presentation Skills

SA

25 February, Adelaide
Supervisors and Trainers for SET (SAT SET)

18 March, Adelaide
Non-Technical Skills for Surgeons (NOTSS)

31 March, Adelaide
Finance for Surgeons

VIC

24 February, Melbourne
National Simulation Health Educator Training (NHET Sim)

28 Feb – 2 March, Melbourne
Process Communication Model Part I

4 March, Melbourne
Keeping Trainees on Track (KTOT)

11 March, Melbourne
Academy Educator Studio Session

14 March, Melbourne
Conjoint Medical Education Seminar

15 March, Melbourne
Academy Educator Studio Session

29 March, Melbourne
Communication Skills for Cancer Clinicians

15 April, Melbourne
Non-Technical Skills for Surgeons (NOTSS)

29 April, Melbourne
Supervisors and Trainers for SET (SAT SET)

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ON THE COVER:
Neil Thomson on the Mercy Ship screening on SBS December 10, 8.30pm, Australia

President's Perspective

The bigger *picture*

Spare your time for the benefit of our wider neighbours

I have just returned from Mongolia. What a wonderful opportunity. I visited on behalf of the American College of Surgeons ATLS sub-committee to undertake a site visit for the promulgation of the ATLS (EMST) Program.

Mongolia has a population of 3 million in an area the size of Queensland. Over half of the population live in the capital, Ulaan Baator. Like Queensland, it relies heavily on agriculture and mining, but tourism is only just starting to develop. Many things we take for granted in Australia and New Zealand, such as hot water and toilets, are absent outside the capital.

I visited a number of hospitals in UB (as it is known), in the provinces or sums and in small villages. In the district hospital I visited, the most common surgical emergencies were injuries, appendicitis, cholecystitis, perianal sepsis and prolapsed thrombosed haemorrhoids. An interesting mix that probably reflects a diet of meat, dairy products and root vegetables.

I saw a number of patients, often with straightforward surgical problems such as dislocations, fractures and deep lacerations that were left untreated because there was a lack of specialist training, lack of resources and no understanding of triage or transfer.

All of this is magnified by a lack of all but the most basic radiology and pathology. Many doctors only receive basic medical training and complex problems are allowed to resolve naturally. Of course, those that do not, end up as long-term burdens on their families.

I have now visited a number of developing nations in South and East Asia. Facilities in many of these countries are basic to say the least. In the very poorest nations, on arrival at a hospital there is frequently no triage. You may be registered by a staff member, but that is no guarantee of seeing a doctor.

The Genghis Khan Equestrian statue on the Tuul River in Mongolia.

> ***"Specialist training programs are limited and in some countries non-existent"***

Generally you purchase your medications before treatment begins. Many hospitals have a very limited number of specialist doctors, usually medicine, surgery, obstetrics and gynaecology and paediatrics. There may be an orthopaedic surgeon or an ophthalmologist. Specialist training programs are limited and in some countries non-existent.

A simple dislocated shoulder inadequately treated may mean a lifetime of disability and unemployment for a young man and his family. Any form of sepsis may prove fatal. Doing the simple things well is so important when health resources are so limited.

Visiting these countries also serves as a reality check and makes me appreciate how much we have. Arguments about generalism and sub-specialisation seem less important. It also makes me determined that our College should do all it can to enhance capacity building in under-developed countries.

Why have I chosen to write about this topic? Hopefully it will make all of us appreciate the health care systems we enjoy in Australia and New Zealand. Perhaps more importantly, I want to thank all those surgeons who contribute to our College programs overseas, and also in affiliated programs, as surgeons, as educators and as mentors. I would also like to encourage those among you who could find the time to contribute to do so. What about a year as a surgeon in Timor Leste or the Pacific?

Mike Hollands
President

Another year out

All too quickly the end of 2013 is appearing on the horizon, giving us an opportunity to look back on another year of achievement for the College

Firstly I would like to add my congratulations to our new and returned Councillors following the recent elections: Spencer Beasley (Paediatric, NZ), Richard Perry (General, NZ), Phil Truskett (General, NSW), Sally Langley (Plastic and Reconstructive, NZ), Andrew Brooks (Urology, NSW) and Bruce Hall (Neurosurgery, QLD). The results will be tabled at the Annual General Meeting in Singapore on Thursday, May 8, 2014, when newly elected Councillors take office.

Speaking for myself and having been a Councillor for many years (too many some might say), I reflect on my time on Council as a singular privilege. I have had the opportunity to associate with many individuals of the highest calibre from our profession. This contact has been both refreshing and restorative.

Refreshing in that, without exception, these are men and women motivated to make a contribution to improve the professional world that they inhabit – and restorative in that I am continually invigorated by exposure to basic goodness, decency and values. I may not always have agreed with them about particular issues, but I am continually impressed by the inherent desire to preserve and serve the professionalism of surgeons.

Councillors give of their time pro bono, but so do many, many surgeons volunteer their services. Indeed our College and all that it entails is one of the great bastions of volunteerism in our material society. For surgeons it is almost second nature to volunteer – it is a mutually beneficial arrangement – incredibly useful for those being assisted and hopefully fulfilling for those assisting.

It has therefore been a difficult couple of years, now hopefully at an end, with the College being portrayed as some kind of enemy by some specialist societies. At times it has seemed that it has been necessary to create a "common enemy" in order to provoke solidarity. The College spends much of its time interacting with various and increasing numbers of regulatory authorities. Interpreting legislative requirements has been seen as a desire to thwart aspirational activity. Nothing could be further from the truth.

However, I have one caveat. As surgeons we face an increasingly hostile environment with threats to our professionalism. I am certain that solidarity as a profession will be vital and I am convinced that this solidarity is best achieved through the continued strength of our College.

The recent Council elections were electronic – a great success and considerably cheaper than paper-based elections. Although paper ballots were available, just five were requested. Some 27.5 per cent of the Fellowship voted, which is more than 5 per cent above the average response achieved in the past five Council elections and well above the 15 per cent average achieved by comparable organisations. In addition, effectively 100 per cent of responders commented enthusiastically on the speed, ease and efficiency of voting electronically compared with the paper-based system; a resounding endorsement for the new process.

There have been many advocacy challenges during 2013. For me, the one that stands out is the proposed $2000 limit on tax deductible costs of self-education – which, of course, includes surgical continuing professional development. Clearly our CPD is vital to ensuring Australian surgeons remain at the forefront of surgical techniques and technologies.

Without Fellows and Trainees being able to claim a reasonable level of tax deductibility, fewer will attend courses and Australia runs the risk of seeing its standards of surgical care diminish commensurately. The College, in concert with the AMA, the other medical colleges, as well as many other non-medical professional organisations joined together to oppose the introduction of this outrageous tax grab.

As you may be aware, the Labor Government deferred introduction of the proposal until July 1, 2015. The newly elected Abbott Government has not given any indications that they intend to alter this timeframe – nor have they indicated a desire to drop it.

The self-education expenses cap formed the centrepiece of the College's 'election manifesto'. As has been our previous practice, in the lead-up to the election the College sent both major parties a document outlining what we considered the major issues, our key concerns and proposals for their solution.

As I noted in our media release at the time, from the responses we received we had no choice, but to conclude that neither party had health as an election priority and their policy positions were essentially 'more of the same'. The Coalition's position regarding 'the cap' was that it could not immediately reverse "all of Labor's bad decisions", but the only prospect for change in the future was to change the government. One change has been effected – and we will be vigilant in the coming months to use every opportunity and all available avenues to have the cap proposal shelved permanently.

A happier highlight of the year was the very successful Annual Scientific Congress (ASC) in Auckland where the theme of innovation carried across the speakers, sponsors and presenters to ensure attendees could easily see the inroads being made and the possibilities for surgical practice in the future.

It bodes well for the ASC in Singapore in 2014 that our event is seen by our international visitors as 'world leading' in what it provides attendees. Time and time again, international visitors tell me how unusual, how unique and how impressive it is that the different surgical specialties meet together.

The 2014 ASC is running in conjunction with the Australian and New Zealand College of Anaesthetists' Annual Scientific Meeting and you can find out more about the event in this issue of Surgical News or on the College website.

Another key issue highlighted in 2013, and one that will be an ongoing item on the advocacy agenda for the College for the foreseeable future, is 'alcohol related harm'. This has a broader scope than 'alcohol fuelled violence' and allows us to look beyond the senseless domestic and public violence that seems to becoming so prevalent, so we can also address the issues from road trauma to the detrimental aspects of alcohol on personal health.

> ***"I have had the opportunity to associate with many individuals of the highest calibre from our profession"***

The three areas we want to address in this campaign can easily be remembered by the mnemonic 'HOT' that stands for 'Hours – Outlets – Taxes'. Generally speaking we are seeking to reduce the availability of alcohol by reducing the 'Hours' alcohol is available (who was it that said, "nothing good happens after 2am!"), reducing the density of 'Outlets' where alcohol is available and the introduction of stepped volumetric 'Tax' on alcohol.

We know that this will need to be a long and sustained campaign, but reminiscent of our previous campaigns including seat belts and bicycle helmets, if we can achieve similar success with our current campaign, it will be equally beneficial to the community we serve – if not more so.

On that note I would like to thank you for the support I have received throughout the year and to applaud those who give 'above and beyond' to the work of the College. Alas James McAdam, one of the Directors of the College and someone I have worked very closely with over the past two years, is moving on to become CEO of the O&G College. Most surgeons will not know how much work behind the scenes that James has undertaken for them. But I know. I am grateful and I will miss his decisive input, but I wish him well for the future.

My best wishes to you all for the festive season. I trust you will have a safe and enjoyable New Year and I look forward to our continuing successes in 2014.

Michael Grigg
Vice President

Surgery deaths fall

Surgery deaths in Western Australia have fallen over the past 10 years, according to an article featured in the Medical Journal of Australia. The fall has been linked to the increase of surgeon participation in the WA Audit of Surgical Mortality, headed by Clinical Director James Aitken. "We found a surgical mortality audit can change practice and improve outcomes," the article said.
***West Australian*, October 21**

Open speed trial

The Northern Territory Government is proceeding with open speed trials despite the protests of key health and safety bodies. The Police Federation of Australia, the NT Police Association and the Pedestrian Council of Australia along with the College are calling for a halt to the trials. The NT Representative for the College Trauma Committee has said the current 130km speed limit was already a "massive compromise".
***The Australian*, October 16**

Surgical Snips

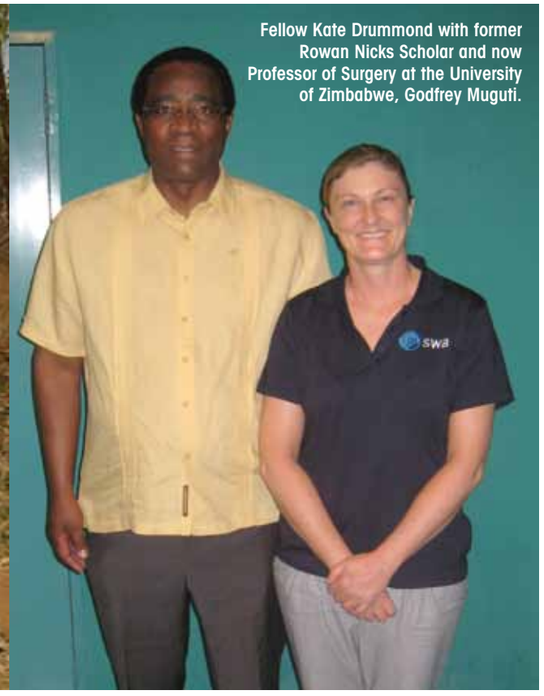
More quit on surgeon advice

Smokers are more likely to quit on advice from their surgeons rather than their family and friends, an article in the latest issue of the ANZ Journal of Surgery says. More than 25 per cent of patients quit more than 24 hours before their surgery. The College's Executive Director of Surgical Affairs said it was an important finding. "If the 'quit now' message has more of an impact when it comes from a surgeon, then we should ensure that message is delivered every time."
***Busselton Dunsborough Mail (WA)*, October 30**

Make quad bikes safer

The College Trauma Committee continues its call for further regulation on quad bikes following an article in the Medical Journal of Australia. The study revealed that children under 14 were most likely to end up injured from quad bike accidents. The College is advocating for speed restrictions and further design to prevent the bikes from rolling. (See the article in this issue, page 32.)
***Warragul Gazette (Victoria)*, September 24**

Support spreads far and wide



Fellow Kate Drummond with former Rowan Nicks Scholar and now Professor of Surgery at the University of Zimbabwe, Godfrey Muguti.

> *"All team members design and tailor lectures and workshops based around the skills that the local doctors, surgeons and trainees want to learn, which I think is critical."*

Helping others help themselves

In September, Melbourne Neurosurgeon Dr Kate Drummond travelled to Zimbabwe and Malawi to teach doctors and medical students as part of a team visit by Specialists Without Borders (SWB), an educational organisation established by Adelaide surgeon Mr Paul Anderson. While there, she met a former Rowan Nicks Scholar who is now Professor of Surgery at the University of Zimbabwe. Dr Drummond talks to *Surgical News* about the trip, her role as Chair of the Women in Surgery Section of the College and that interesting meeting.

What is your involvement in Specialists Without Borders and how long did you stay in Zimbabwe and Malawi?
I'm on the National Executive of the organisation and have gone on one trip each year since the organisation began. This year we undertook a three-day seminar in each country.

What attracted you to joining the organisation and participating in such visits?
There are a number of aspects to the work of SWB that I found attractive including that we only visit upon invitation, that all trips are based around education and training and also because we always work with local partners.

All team members design and tailor lectures and workshops based around the skills that the local doctors, surgeons and Trainees want to learn, which I think is critical. We also base most of our work on small group learning modalities, particularly Structured Clinical Instruction Modules. This type of education is not broadly offered in African countries and is always extremely well received.

What specialties were represented in the recent visit?
This trip comprised a very broad range of specialties. Team members included a Psychiatrist, an Oncologist, an Intensivist, a neonatologist, two Anaesthetists, a radiologist, a number of General Surgeons, an ENT surgeon, a Urologist, two Orthopaedic Surgeons and myself.

This allowed us to cover a wide range of skills and training and on this trip we concentrated on triage, resuscitation, trauma assessment, urology, emergency airway management and assessment of head injuries.

What are the challenges facing surgeons, doctors and Trainees in countries such as Zimbabwe and Malawi?
The crux of the issue in such countries as Zimbabwe and Malawi is that they are resource-poor. They have very limited infrastructure to support continuing medication education or even to support the health system in general.

Any medical professional working in a resource poor environment faces challenges daily, yet still these very smart people do the best with what they have available. They don't have an ambulance system, they don't have emergency medicine systems and they certainly don't have the state-of-the-art technology that we take for granted and use every day. They are more likely to have to deal with power outages and drug shortages when the monthly budget has run out, but the doctors and students remain enthusiastic and committed, which is why it is such a pleasure to assist in their continuing professional development.

Did you get a chance to do any exploring this visit?
Not this time, although I have travelled extensively in Africa. My partner worked there for some time and I have been there on six or seven occasions, travelling through Kenya and trekking with gorillas in Rwanda.

Have you been impressed with the enthusiasm shown by surgeons and specialists for the work undertaken by Specialists Without Borders?
Yes indeed. The people I have travelled with on SWB trips always turn out to be extraordinary, with a commitment to patients, students and the profession that is inspiring. They also put enormous effort into designing and developing very dynamic, innovative teaching programs which are not only of great benefit to the doctors and students we are training, but which also allow us as team members to learn from each other.

Who was the Rowan Nicks Scholar that you met and what is his position?
He is Professor Godfrey Muguti, Professor of Surgery at the University of Zimbabwe. He also has a very busy clinical practice conducting extensive general and plastic surgery at the University Hospital.

When and where did he spend time in Australia?
He trained at the Westmead Hospital in Sydney in 1991 with the support and supervision of Professor John Fletcher, Professor Miles Little, Professor Stephen Dean and College President Michael Hollands.

Once we got talking, it became clear that we were both in the same hospital at the same time doing our training although our paths did not cross then, so it felt a bit extraordinary to meet up on the other side of the world.

Did he enjoy his time here and did it make a difference to the development of his later professional life?
He said it was one of the best years of his life and that he remembered his time here very fondly. In particular, he said he greatly enjoyed the experience of academic surgery and working with Australian colleagues at Westmead.

He is held in very high esteem in Zimbabwe and I felt glad that the College had offered him such support in the early years of his surgical career.

How long have you been the Chair of the Women in Surgery Section and why did you take on the role?
I've been Chair now for about two years, but have been on the committee since it was first established in 1994 and was the first Trainee to join. This committee has been involved in some very important initiatives implemented by the College, such as the Code of Conduct, the Flexible and Interrupted Training Policy and mentoring initiatives, and I was keen to continue that work.

There have also been other prominent College surgeons who have been leaders on the committee, such as Trish Davidson, Anne Colby and Deb Colville who I have long considered to be inspirational and I thought I'd like to give back to the profession as they did.

With Karen Murphy

In Memoriam

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

William Cadzow,
Queensland Fellow

George Choa,
International Fellow

Ken Millar,
Victorian Fellow

Peter Wilson,
NSW Fellow

Jack Indyk,
NSW Fellow

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.

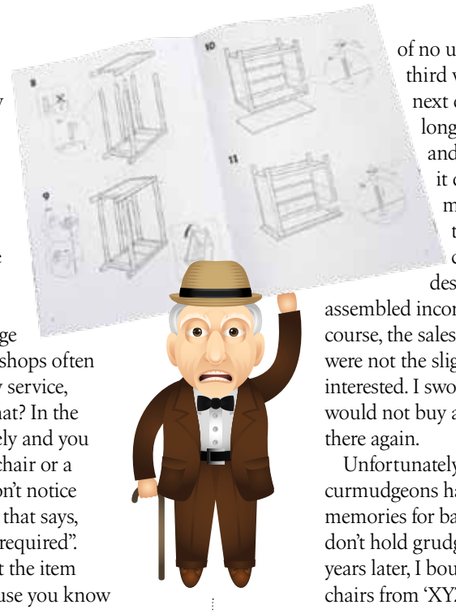
Informing the College

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: Daniela.Ciccarello@surgeons.org
TAS: Dianne.cornish@surgeons.org
VIC: Denice.spence@surgeons.org
WA: Angela.D'Castro@surgeons.org
NT: college.nt@surgeons.org

Some assembly required

Why are flat packs so difficult?



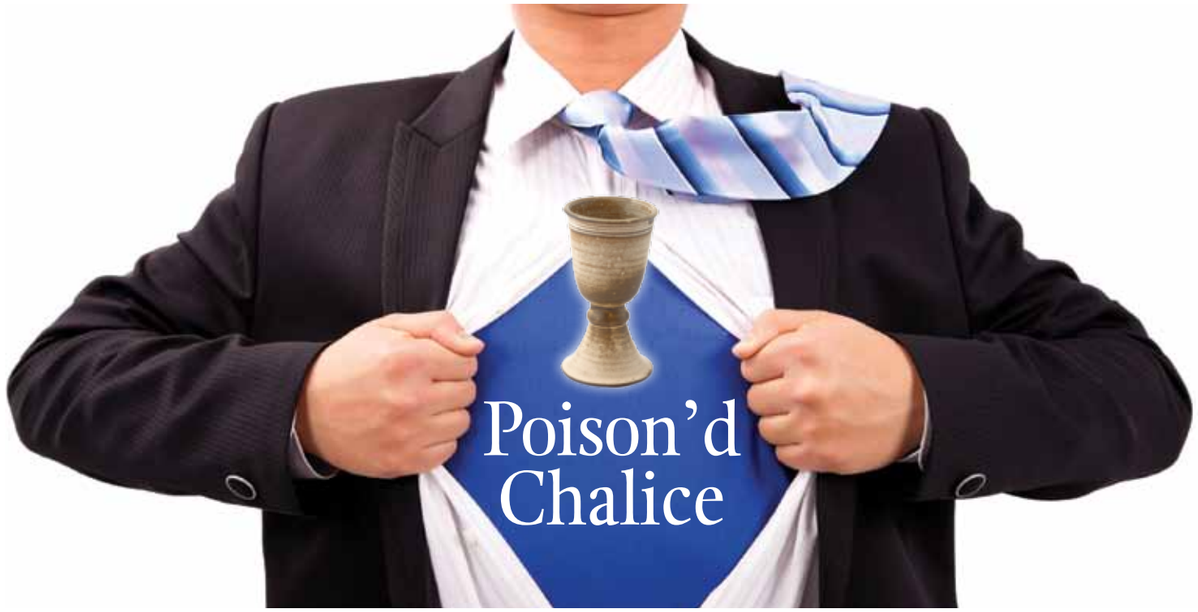
There is one thing that really annoys me and that is flat pack furniture – I am sure you know what I mean. We curmudgeons are fairly handy at doing things and relish the challenge of assembly. The shops often offer an assembly service, but who needs that? In the shop it looks lovely and you order a bed or a chair or a bookshelf and don't notice the small writing that says, "Some assembly required". When you collect the item from the warehouse you know that something is wrong when the three metre by four metre bookshelf is contained in a small enough package to fit into your car's back seat.

When you get home and unpack it all, there is a list of bits that you should have and often there is something missing. Back to the shop where they point out that the bit of cardboard rubbish that you threw out was a new age dowelling to hold the thing together. Of course, the instructions (if you have any) are either in Chinglish or by means of illustrations that are supposed to cross all languages, but are not interpretable by any person regardless of their linguistic ability.

I once bought a computer desk from 'XYZ Furniture' and had to go back to the shop twice to look at the assembled version and twice pulled it apart and re-assembled it. No matter how much I tried, I could not get it assembled such that the computer would fit in its allocated place. The instructions were of no use. On my third visit (the next day) I looked long and hard and eventually it dawned on me that all of the display computer desks had been assembled incorrectly. Of course, the sales people were not the slightest bit interested. I swore that I would not buy anything there again.

Unfortunately we curmudgeons have short memories for bad things and don't hold grudges. Some years later, I bought two 'tub' chairs from 'XYZ Furniture'. Yes, you know the story; screws missing, holes not drilled correctly and had to be re-drilled and legs not quite square.

The Swedish king of flat packs is of course the worst of the lot. I am sure that you know who I mean. Mrs Curmudgeon loves them and is often bringing back things from there – fortunately small things that don't need assembling. However, a few weeks ago she brought home two bookcases ("some assembly required"). I groaned – well not really as we curmudgeons don't do groan; we let it all out and complain with vigour. "It will be the same as 'XYZ'." Well not quite. All screws present and correct and a few spares, holes drilled with Swedish precision, book cases square when finished, assembled in half an hour and one very happy curmudgeon (not to mention Mrs Curmudgeon). No wonder Sweden can produce SAAB planes and Volvo cars. Oh, maybe not the cars – that is a topic for another day!



'I am The Hero - our rise and fall?'

I sat by the side of the bed. I remembered the first time that I had met her, many years ago. She had barged into the consulting room, dominating the space insisting that I address her formally while calling me by my first name if I was lucky; "Sonny" if I was not.

She had been belligerent, an obvious matriarch, used to overseeing her dynasty, commanding all that she saw. The archetypal difficult patient, but I had liked her immediately. Perhaps it was her refusal to be cowed, labelled by the diagnosis and the difficult road that lay before her. She had always demanded total honesty in our surgeon-patient interactions.

There had been no doctors in my family. Why had I decided upon medicine and then surgery as a career? I don't remember experiencing a particular calling – some divine decision being wondrously conveyed to me. Maybe by too much exposure to 'Marcus Welby MD' and even from the early days of 'E.R.', I had been persuaded that the surgeon could always triumph.

Ah, the truth of it emerges. I had wanted to be the 'Hero'; a dignified presence, possessing an ability to control chaotic situations and with an encyclopaedic knowledge of clinical situations. Facing seemingly impossible challenges and overcoming against all odds; producing miraculous recoveries resulting in patients who were endlessly grateful.

Perhaps I had been born a generation or two too late for this kind of adulation. There was a time when surgeons were much admired, could do no wrong or so I have been told. They were the days when surgery was a "one-stop-shop", not only skilled with the knife, but highly competent physicians and counsellors as well. No lump too big or too small, sort of thing...

Was it the advent of multi-disciplinary care and those essential multi-disciplinary meetings where everyone wanted their share of the glory? Maybe it was the endless sub-specialisation? Was it the complicated nature of all of those tablets, you know the ones for the heart rhythms, the fats, the blood pressures as well as the increasing number for the down days and the up days? Even the nicotine patches have pages of small print.

It reminds me of those lines from 'Measure for Measure' (Act 1, Scene 4): "Our doubts are traitors, and make us lose the good we oft might win by fearing to attempt." No wonder I now deliberately have a physician co-care for my patients and an anaesthetist also providing post-operative care. But there it was, when the name of responsibility was mentioned, how many other signatures had been on those orders or that script pad? Not quite the Marcus Welby MD look.

In fact my reality to be faced is that I never succeeded in being a hero – if indeed that is what I set out to be. I was feeling more like Hamlet from Act 2, Scene 2: "I have of late lost all my mirth, forgone all custom of exercises and indeed it goes so heavily with my disposition that this good frame, the earth, seems to me a sterile promontory". Like Hamlet, I may have succumbed to my nobility, tragic flaws and small errors of judgment...

And so I sat by the side of the bed. I held her hand. I saw how old she now was. Her spirit was indefatigable, but her body and the possibilities of modern medical science were now exhausted. Her family were also there, as well as my resident.

I explained that her journey was coming to an end. Not only me but the team that I lead had failed to identify any further possibilities. She mouthed a word of thanks for all my efforts, and shut her eyes. She held my hand and soon after, she breathed her last.

Professor U.R. Kidding

Case Note Review

Revision left total knee replacement - Laparotomy/ bowel resection/femoral herniorrhaphy

Follow the discussion online http://www.surgeons.org/182966.aspx

An elderly person with mild comorbidity (hypertension and gastro-oesophageal reflux) living independently at home was admitted for revision of a total left-knee replacement. The patient was transferred to rehabilitation unit after an uneventful surgery. Subsequent to transfer, the patient had episodes of nausea and vomiting. The intern notes indicate no abdominal examination was performed and no cause was suggested.

Over the next week the nausea and vomiting persisted. Occasional watery diarrhoea was noted and an infective cause was suggested. A fluid balance chart does not seem to have been kept over this time. A case note entry stated that suprapubic tenderness was present. Treatment centred around anti-emetics, and oral and intravenous (IV) fluids. Gastro-enteritis, side-effects of opiate analgesia or postoperative ileus, were listed as possible causes for persisting symptoms.

An abdominal x-ray done after a further period demonstrated distended bowel loops and this prompted a surgical referral. When a general surgical registrar reviewed the patient several days later and diagnosed an obstructed left femoral hernia, the patient was tachycardic and hypotensive.

At laparotomy, a strangulated left femoral hernia with perforated small bowel and extensive peritoneal soiling was found. In addition to repair of the femoral canal, a small bowel resection with end to end anastomosis and extensive abdominal lavage was performed.

Postoperative care was provided in intensive care. The day after the laparotomy, spreading abdominal cellulitis led to the wound being opened with discharge of haemoserous fluid with odour. The surgical team was informed and felt that further surgical intervention would be of no benefit. Over the next few days the patient become more acidotic with increasing inotrope requirements and required haemofiltration. Death subsequently occurred.

Reviewer's comments

The care provided by the medical rehabilitation unit (MRU) appears to have been inadequate; firstly in respect of fluid and electrolyte management, and secondly by failure to establish a cause for the ongoing vomiting, abdominal distension and constipation. The failure to involve a more senior surgeon in the assessment of the patient is worth noting. This led to a delay in the investigation for a possible surgical cause.

The outcome in this patient could have potentially been avoided if an appropriate and timely surgical referral had been made. The patient was in a rehabilitation unit for one week with anorexia, nausea, persistent vomiting, minimal bowel action and abdominal distension, without establishing a diagnosis. Postoperative ileus is an unusual complication of knee replacement and other surgically-related causes should have been considered.

The case notes are deficient, with no documentation of medical history and physical examination on the day of admission. The initial assessments appear to have been done by very junior staff. Appropriate investigations (e.g. CT scan) towards a diagnosis were not ordered.

Fluid balance was not recorded in a patient described as having daily vomiting and poor intake. Subsequent management in terms of surgical intervention and postoperative resuscitation in the ICU were appropriate, but there is a real likelihood that the outcome would have been different had the diagnosis been made earlier.

Guy Maddern
Chair, ANZASM

Induction for Trainees

A conference to welcome new Trainees

More than 200 new Trainees will begin the Surgical Education and Training (SET) program across Australia and New Zealand next year. Selection to surgical training is a competitive process, but arguably the first few years of training throws even more challenges. The transition to training demands a focus on attainment of the College's nine competencies, while often juggling new towns and cities, family commitments and external interests that allow each of us to reach our potential.

The College understands of the demands of this period, and is continually exploring ways to better support its Trainees and provide better training. The College's Trainees' association, RACSTA, provides Trainees with a voice and a connection with their College.

One of its most successful initiatives has been the introduction of an induction conference for all new SET Trainees – and the fourth conference will be held in Melbourne in November. The conference welcomes newly selected Trainees across New Zealand and Australia to meet fellow Trainees, surgeons, leaders of the College, and unlock some of the mysteries about training.

The event includes a full-day workshop in the skills lab, provides insight into the role of the College and respective training boards, gives important advice about examinations and study technique, and finishes with dinner where you can socialise with your new colleagues. The dinner guest speaker this year will be Dr Kellee Slater, FRACS surgeon and recently published author. She will share her tips and tricks to balancing surgical training, a family, and life.

RACSTA together with the College encourage all new Trainees to attend and are grateful for the support of surgical departments and RMO units around Australasia to allow attendance. It is an invaluable experience and sets a solid pathway for the rest of their surgical training.

The conference is held November 29 – 30 at the Royal Australasian College of Surgeons in Melbourne. For more information contact RACSTA@surgeons.org

Will Perry, Convener
SET 1 General Surgery New Zealand

Surgical Specialty	Accepted Offers
Cardiothoracic Surgery	6
General Surgery AU	82
General Surgery NZ	11
Neurosurgery	7
Orthopaedic Surgery AU	32
Orthopaedic Surgery NZ	9
Otolaryngology Head & Neck Surgery AU	20
Otolaryngology Head & Neck Surgery NZ	2
Paediatric Surgery	6
Plastic & Reconstructive Surgery AU	12
Plastic & Reconstructive Surgery NZ	2
Urology	16
Vascular Surgery	11

Happy *Birthday!*

EMST first course December 1988

EMST Committee 1988

The Early Management of Severe Trauma course hits its 25th year in helping patients

This year represents the 25th anniversary of the introduction of the College's flagship educational program, the Early Management of Severe Trauma (EMST) course, a program that has not only saved countless lives here and around the world, but has also revolutionised surgical education.

Being the local adaptation of the Advanced Trauma Life Support (ATLS®) course developed by the American College of Surgeons in 1978, the EMST course was introduced in Australia in 1988 and in New Zealand the following year.

Since the early 1980s, ATLS® and EMST instructors have trained more than one million doctors in 60 countries around the world in consistent techniques to treat severely injured patients within the first hours of injury.

Made a mandatory component of surgical training and Fellowship in 1993, more than 100 EMST courses are now provided annually throughout Australia and New Zealand not only to surgeons, but to anaesthetists, emergency physicians, intensivists, general practitioners as well as to many doctors in training .

In the past 10 years alone, 3,766 surgical Trainees or qualified surgeons have taken the EMST course in Australia, New Zealand, Samoa, Fiji and PNG, with Fellows now working with other national and international ATLS® Faculty providing instruction to medical colleagues in Indonesia, Thailand, Malaysia, Philippines, and Myanmar.

Next year, it is hoped that College Fellows will also be among the ATLS® Faculty teaching the course in Mongolia, Bangladesh and Korea.

The EMST course is a 2.5 day program that teaches the management of trauma patients in the first one to two hours following injury, and emphasises a systematic, clinical approach.

It is based on the ATLS® course, which was the brain child of American Orthopaedic Surgeon Dr James Styner who was piloting a light aircraft that crashed in 1976, a tragic accident that killed his wife and critically injured three of his four children.

According to a history of the ATLS® course, Dr Styner conducted initial triage of his children at the crash site, then flagged down a car to take them to the nearest hospital only to find the doors locked. However, even when medical care arrived he found the treatment given his children inadequate and inappropriate.

Later, he said: "When I can provide better care in the field with limited resources than what my children and I received at the primary care facility, there is something wrong with the system and the system has to be changed."

His determination to create that change resulted in the development of the ATLS® course.

No consistency

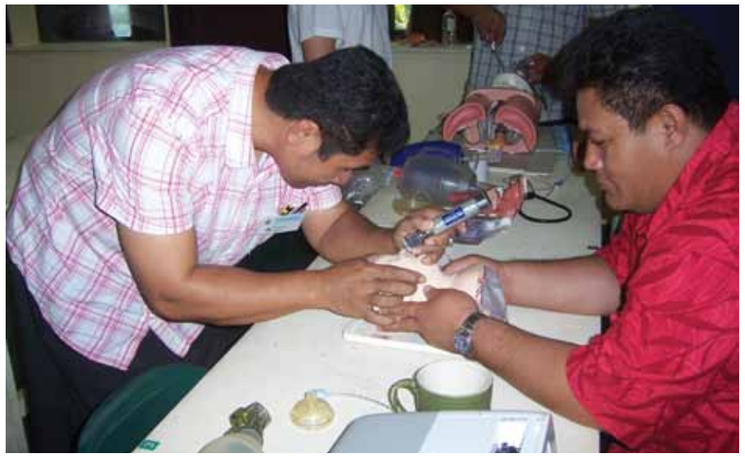
Former College Vice President and the first chairman of the EMST committee, Professor Stephen Deane, completed general surgery training in the US before returning to Australia, taking up a position at Westmead Hospital in Sydney in 1981.

He said that while some Fellows had taken the ATLS® course in North America by the mid 1980s, there was no consistency in Australia in the assessment of, and treatment given to severely injured patients.

In particular, he said patients were dying unnecessarily because of internal bleeding, head injuries or through the inadequate treatment of fractured ribs which compromised lung function.

"At Westmead we were seeing large numbers of road trauma patients and over a three-year period it became clear that we were losing patients that we shouldn't have been, that we were missing things that we shouldn't have been missing," Professor Deane said.

"I then began gathering statistics on patients that I believed could have been managed better; this developed into one of Australia's first broadly comprehensive clinical trauma registries.



"We also conducted an audit of patients who had died after suffering trauma with a particular focus on the effects of delay and transfer on mortality.

"It soon became clear that 30 per cent of patients who died after arriving at the hospital suffering severe trauma might have survived if their initial treatment had been more thorough, more skilled and more consistent."

Professor Deane said that other concerned senior Fellows then gave him support to push for the introduction of a trauma training course. After considerable negotiations between the College and the American College of Surgeons, it was decided to promulgate the ATLS® course under the banner Early Management of Severe Trauma. This allowed for minor changes reflecting both the language and medical practice in Australia and New Zealand.

He said that relatively small modifications were made to ensure the course was recognised as being relevant to Australasian practice and to avoid any confusion caused by the use of different terminology in Australia, New Zealand and the US.

A key seminar, to discuss how the treatment of severely injured patients in NSW could be improved, was held in Orange, NSW, in 1985 and trauma system development was occurring in Victoria around the same time. These were important contributors to the clinical and professional context in which educational packages needed to be developed.

The first EMST student course was held in Melbourne in 1988 and the first instructor course held at Westmead Hospital in Sydney one week later.

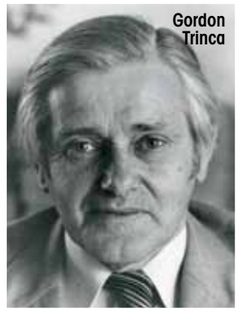
Professor Deane said that while the EMST student course content did not differ significantly from the ATLS® course, it was decided to significantly expand the EMST instructor course.

"I believe this one decision had a substantial flow-on effect across the College," Professor Deane said.

"This impact came from having highly skilled, non-surgical educators teaching us how to teach, which had never previously occurred systematically and was an event that changed the way many of us viewed surgical education across the board."

Professor Deane, ceased his leadership of the program in 1996 and ceased teaching in its courses in 2002. He has remained connected with EMST and ▶

American and Australian group at melbourne course c 1989



Gordon Trinca

international ATLS® throughout the 25-year history of EMST. He said that the original group of Fellows pushing for the introduction of EMST actively planned to change Australia and New Zealand and did so.

"We were particularly keen to offer EMST to regional surgeons, many of whom were enormously enthusiastic about it because so many had been called on to treat severely injured patients without the appropriate internationally recognised training," he said.

"By coming together as a College in this effort, we could then say to them that once they had done the EMST course, they could be confident in a system to treat such patients because of the strength of the international ATLS® program, and the endorsement of the College.

"Even though the introduction of the EMST course was all about the patients and getting better outcomes, I think it also improved the working lives of surgeons, anaesthetists and other specialists by giving them the skills and confidence which they needed to do their best.

"Often when I had taught an EMST course in a regional area I would think, while on the plane home, that the town which was home for a particular course participant would never be the same again and I am proud that the College took the view that we should offer this training wherever possible to whoever wished to take it."

Former College President Mr Ian Civil was Chairman of the EMST Committee from 1996 to 2002 and was one of the Fellows involved in pushing for the introduction of trauma training following his return to NZ in 1987 after completing a trauma Fellowship and becoming an ATLS® instructor in the US.

Now having taught almost 100 EMST courses, Mr Civil has received a number of awards in recognition of his support for the EMST course including a RACS Medal.

He said that over and above providing surgeons and other doctors with a standardised approach to dealing with severe trauma, one of the most important aspects of the introduction of the program was the support it gave to the fostering of collegiality and teamwork.

"This idea of interdisciplinary teamwork in both surgical education and the care of patients is absolutely mainstream now, but it wasn't when the EMST course was first introduced," Mr Civil said.

"Then it was more about the surgeon as a sort of iconic leadership figure, but the EMST course changed all this because we actively sought the involvement of our colleagues in other specialties and engaged them in both participation, and teaching, as part of the EMST Faculty."

"I have always been proud that the College so actively embraced the provision of such medical education across not just Australia and New Zealand but also to our regional neighbours.

"My involvement in the EMST course has certainly been one of my most sustained contributions to the College and to the care of injured patients."

Mr Civil also noted that involvement with the EMST program was not only about contribution to an education program, but EMST also provided invaluable experience for instructors and committee members.

"Many of us who have been members of the EMST committee – Stephen Deane, myself and Michael Hollands to name but a few – have also gone on to other leadership roles within and outside the College, so managing and being part of the EMST program developed many of us as leaders and as educators, while also teaching us skills in administration and governance."

The current President of the College, Associate Professor Michael Hollands, first became involved in the EMST course as an instructor in 1990 and was chairman of the committee from 2002 to 2008.

Under his leadership, international relationships were strengthened not only with our regional neighbours, but also with the American College of Surgeons.

"During that time we were offered, for the first time, the opportunity to participate in a revision of the ATLS® manual which was indicative of the respect given to Australian and New Zealand surgeons by our US colleagues in terms of our teaching and surgical expertise," Associate Professor Hollands said.

"We also devoted a great deal of effort in providing the EMST course across the region.

"I consider the EMST course as the gold standard of medical education, but it could never have been the success it is without the contribution and support provided by our colleagues in Anaesthesia, Emergency Medicine, Intensive Care, and their respective colleges."

With Karen Murphy

Lunchtime woes

Don't take your diet choices lightly

> *"I sat down to exchange some local medico-politics, despite the churning of my stomach"*

I was visiting a friend in the hospital the other day when I stopped by the canteen. There I bumped into a couple of senior surgeons to whom I often refer my cases. Mr Powt and Ms Tuffer were lunching in a quiet corner, but when I was invited to join them, I could hardly believe my eyes at their culinary selections. I know it wasn't as bad as taking a dose of trans-fats at a fast food outlet, but they had ignored every possible healthy choice on offer.

I sat down to exchange some local medico-politics, despite the churning of my stomach. Instead of a simple lean meat or fish accompanied by salad, their plates were loaded with carbohydrate, while anything proteinaceous had been richly fried and battered with Omega 6s.

If it tasted good, it certainly wasn't going to do them good, and I noticed their shirt and blouse buttons were struggling to maintain complete closure across their rather full, though not overly gross, abdomens. However, I kept my thoughts (and observations) private and let them enjoy their lunch.

A week later one of these two senior surgeons consulted me, for an annual health check. It was not surprising the blood pressure was high, the cholesterol 8.3mmol/L, and another couple of kilos had been gained for the second year in a row. I asked some questions about lifestyle (working too much), exercise (not as much as planned) and diet (I took a deep breath).

I wondered how honestly the diet would be reflected on; but to my surprise the deficiencies and excesses I had witnessed were duly acknowledged, not explained away as a celebratory feast (permissible), but reported to be typical of a regular lunchtime fix, a comforting convenience meal providing solace from the stresses of hospital practice.

There was no point in being sympathetic. Health over the decades is largely determined by what one eats. It was an appropriate time to make a serious attempt at persuading this particular surgical slouch to change.

I suggested the best options for a healthy diet were to consider either the Cretan (Mediterranean) or Nordic diets. This is particularly true for those of Caucasian descent, though there are also many healthy SE Asian options. Both are Omega friendly and both allow a remarkable quantity of tasty and normally consumed food. This is not rocket science, nor is it new.

As far back as 1956 12,763 men between the ages of 40 and 59 from seven countries were studied, with those in Crete and Corfu [Islands in Greece] having the lowest mortality, and particularly low rates of death from coronary artery disease. The Cretan proved the healthiest of those studied – a diet rich in olive oil, bread, fruit and vegetables with limited amounts of meat and some fish, washed down (thank goodness) with one or two glasses of wine.

Further studies have since confirmed the health benefits of the Mediterranean diet. Cretans today cultivate 35,000 olive trees and the natural product of the pressed olives is extra-virgin olive oil, rich in oleic acid, which lowers LDL and increases HDL, the so-called 'good' cholesterol.

It reduces blood pressure and, whether combined with the increased vegetable consumption or not, is associated with a lower risk of gastrointestinal and other cancers including breast cancer. It is beneficial in preventing or controlling diabetes. It is anti-inflammatory, contains antioxidant and is great for the skin. You can enjoy bread; only replace butter with olive oil.

The Nordic diet is equally healthy, being based on oily fish, rapeseed (canola) oil, wholegrain bread, berries, venison and brassica (cabbage, kale and brussel sprouts). Rapeseed oil has just 6 per cent omega 6 (compared with 14 per cent in olive oil) and Vitamin E, an antioxidant, which in harmony with others in the berries and brassica, scavenges those nasty free radicals that M warned Bond about in 'Never Say Never Again'.

The vegetables and wholegrain bread provide fibre, minerals and vitamins. Magnesium, the centrepiece of chlorophyll is present in the greens; while venison is a low fat protein source, rich in zinc, selenium, iron and copper.

As medical people know, it is very hard to convince anyone to change their diet, or at least not until they've suffered their first cardiovascular event. But I was surprised at how the bloods improved when repeated three months later – achieved by consuming oily fish twice a week, wholegrain bread, olive oil, more salad and brassica vegetables, more fruit and less red meat.

Although Mr Powt and Ms Tuffer still frequented the hospital café, they were recently spotted wielding chopsticks, tucking into Sushi. I also noticed those shirt and blouse buttons were no longer pouting; everything was looking just that little bit healthier.

Dr BB G-loved

What's different about the Fellowship Examination?

What are the key focuses of the exam today?

In 2013, the Fellowship Examination (FEX) remains the final, summative assessment of the Royal Australasian College of Surgeons training programs. However, there is much about this examination which makes it different from that experienced by surgeons who completed this examination even a decade ago. Briefly those differences fall into three categories: the key focus of the examination; the underlying educational principles; and the associated assessment tools that each specialty applies.

First, there is recognition that the FEX is most suited to assessing operative decision-making and judgment that is higher level surgical thinking, evaluation and synthesis of the evidence which supports a course of action in a given clinical scenario. Therefore the current FEX focuses on only three of the nine competencies – Medical Expertise, Communication, and Judgment – Clinical Decision Making.

That is, on clinically applied medical knowledge, effective and culturally appropriate communication, and the higher levels of cognitive function, such as clinical evaluation; adapting to complexity, uncertainty, and changing patient conditions, and flexibility in management plans. Questions are carefully constructed to encourage the candidate to demonstrate these higher levels of knowledge, skills and attitudes which are required to be a safe and competent surgeon in independent clinical practice.

This move away from what was previously examined in the FEX, for example, assessing basic science knowledge and patient examination skills, is in response to both the enhancement of earlier assessments, and the clearer definition of the required standards required of the 'competent' Trainee. See more information on the College website: http://www.surgeons.org/media/18726523/mnl_2012-02-24_training_standards_final_1.pdf

Second, regardless of the specialty, all of the seven components of the FEX cover the pre-defined curriculum and one or more of the surgical competencies. Every specialty has a clearly defined, and widely accessible, curriculum that encompasses everything that the Trainee is expected to learn during their training.

Specialty knowledge

The examination is aligned to that speciality curriculum by a blueprinting process, which ensures representative coverage of the content and avoids questions that are outside the scope of that curriculum. It also considers the level of cognitive function that each discussion entails with knowledge recall being at the lower end and complex evaluation at the high end of Bloom's taxonomy.

Third, each specialty has introduced a number of additional tools to both assess

Trainees at multiple intervals during SET training, and to assess across the spectrum of the nine competencies. Such assessments are undertaken to enable Supervisors to make judgements about the Trainee's knowledge and skills acquisition as well as the development of the non-technical competencies required of surgeons in today's society, and to provide confirmation of appropriate progress throughout the training program.

The assessment tools include the generic and specialty-specific surgical sciences examinations, speciality-specific in-training examinations, direct observations of professional activities and regular in-training reports. While most of the early examinations are 'hurdle requirements', the other assessments are accompanied by feedback and are designed to be formative, to help guide the Trainee's progression through the SET program.

Clearly not all competencies can be assessed by the FEX. Some of the competencies are more appropriately evaluated and signed off as having been achieved during training. For example, technical expertise and operative experience are better assessed through Direct Observation of Procedural Skills (DOPS), In-Training Assessments and the operative logbook, while the non-technical competencies are professional behaviours demonstrated and observed during clinical interactions with patients, colleagues and other health professionals.

> "The theme of the meeting is "Working together for our patients" and this certainly reflects the extensive interaction that has occurred between all specialities in the scientific content of the program"

Producing the best

This is very different from the past when the FEX was the only formal assessment undertaken during advanced surgical training, whereas today it is only one of a suite of assessment tools employed by the specialty training boards.

The Surgical Education and Training (SET) programs of all of the specialties continue to be designed to produce surgeons of high standard, capable of practicing safely at consultant level without direct supervision.

So, while there have been significant changes to the FEX, it remains a valid way of demonstrating to society, Fellows and the regulators that a Trainee has reached the expected standard of surgical competence to be licensed as a surgeon commencing independent, unsupervised clinical practice in the community.

John Batten
Chair, Court of Examiners

Singapore

On behalf of the executive and organising committee, we extend an invitation for you to attend the 83rd Annual Scientific Congress of the Royal Australasian College of Surgeons to be held at Marina Bay Sands Conference Centre in Singapore between May 6 and 9, 2014

For the first time in many years the meeting will be combined with the Annual Scientific meeting (ASM) of the Australian and New Zealand College of Anaesthetist (ANZCA). This event is likely to have a record number of delegates and is shaping up to be one of the most exciting ever in terms of the collaboration between anaesthetists and surgeons. The theme of the meeting is "Working together for our patients" and this certainly reflects the extensive interaction that has occurred between all specialities in the scientific content of the program.

By now all Fellows and Trainees should have received a copy of the provisional program and it is not too early to register for the congress. A provisional program and registration online can both be accessed through the Congress website asc.surgeons.org

While registering, it is important to bear in mind that there will be limited seats for the Congress dinner as well as the sub-speciality dinners; these will be allocated on a first come, first serve basis.

The Congress will formally open with the Convocation ceremony at 4.30pm on Monday, May 5, which will be followed by the President's welcome reception at 7pm. Fellows who have received their Fellowship in the past five years and have not previously convocated may apply to convocate. They will receive complimentary registration for the meeting. All eligible Fellows have been contacted by e-mail.

On Monday, May 5, before the Convocation Ceremony there are a number of important activities. The GSA Trainees Day and the Developing a Career in Academic Surgery course are high profile events that attract big attendances. In addition to these programs there will be a number of other workshop sessions.

The scientific program will run over four days from Tuesday, May 6 to Friday, May 9. In all, 32 section programs are being convened. For the first time in many years there will be an orthopaedic program. Our international and national faculty members will participate in the Scientific program as well as the Masterclass program, which this year has 24 separate sessions. There is sure to be one that relates to your area of practice.

Some of the highlights of the congress include the Plenary program:

- Working together for our Patients
- Registries:- How they can change Surgical Practice
- Applying evidence to surgery – can we, should we?
- Surgeons of the 21st Century – Professionals, Technicians or Tradesmen?

There will be a joint opening session and closing session with our anaesthetic colleagues.

Named Lectures

This year the speakers who will deliver the Named Lectures will generate great interest.

President's Lecture
Professor Keith Willett
John Mitchell Crouch Lecture
Professor Andrew Hill
BJS Lecture
Sir Bruce Keogh
ANZJS Lecture
Professor John Harris
Herbert Moran Lecture
Professor John Collins
James Pryor Memorial Lecture
Associate Professor Graeme Brazenor
Tom Reeve Lecture
Professor Robert Thomas
Mike Wertheimer Lecture
Col. James Ficke
American College of Surgeons
Professor Wei Zhou

Over the next few issues of *Surgical News* we will try and encapsulate the essence of the various section programs.

Surgical Oncology

Convened by Dr Cuong Duong the Surgical Oncology program will profile College visitors Professor Vernon Sondak from the H Lee Moffitt Cancer Centre and Research Institute who has a special interest in melanoma, cutaneous and soft tissue sarcomas.

Associate Professor Grant McArthur from the Peter McCallum Centre, Melbourne, also has a special interest in the treatment of melanoma and we look forward to the centre's involvement in the oncology program and to hear the latest developments in management of melanoma. Professor Simon Law who is Professor of Surgery at Queen Mary Hospital in Hong Kong will discuss the role of surgery in the era of multimodality therapy.

Colorectal Surgery

The three-day colorectal surgery program has been put together by Dr Ian Faragher and his team and is highlighted by visiting speakers from Australia and overseas. Professor Eric Dozois from the Mayo Clinic has a special interest in polyposis syndromes, inflammatory bowel disease and complex pelvic tumours.

Associate Professor Peter Sagar from Leeds has extensive experience in recurrent pelvic malignancy and Professor Cameron Platell from Perth will lead discussions on a wide range of colorectal topics including cancer survival outcomes.

The Mark Killingback prize for the best research paper by a Trainee or recent Fellow is always fiercely contested and the program will be enhanced by the colorectal Masterclass program.

Head and neck surgery

This program has been convened by Dr Elizabeth Sigston who has arranged an extensive program on head and neck malignancy. The international visitors are Professor Michael Walsh from the Royal College of Surgeons in Ireland and Associate Professor Stephen Lai from the MD Anderson Cancer Centre.

In addition to discussing current issues in various head and neck malignancies, the challenges of training head and neck surgeons of the future will be covered.

Trauma Surgery

Professor Russell Gruen has convened this section and the program is wide ranging and exciting. The visitors include Professor Avery Nathens from Toronto, Canada who has an interest in the effectiveness and quality of trauma care.

Dr Amit Gupta from India will discuss the complexity of a trauma service that has to deal with a million deaths per year while Dr Chiu Terk from Singapore will reflect on establishing a relatively new trauma service.

In addition there will be sessions that will cover resuscitation, neurosurgical trauma, the use of blood products and facial trauma.

We look forward to welcoming you in Singapore in May for an Outstanding Congress.

Martin Richardson,
Congress Convener
Sayed Hassen,
Scientific Convener

8 years of the SAAPM

What have we achieved?

The South Australian Audit of Perioperative Mortality (SAAPM) is an external, peer-reviewed audit of the process of care associated with surgically-related deaths. Since 2010, all states and territories participate as part of the national program, the Australian and New Zealand Audit of Surgical Mortality (ANZASM). SAAPM, which commenced in 2005, is funded by the South Australian Department of Health and Ageing, and operated by the Royal Australasian College of Surgeons.

A key feature of the audit is the Qualified Privilege declaration that encourages surgeon participation by strictly protecting the confidentiality of information gained through the audit. This protection is gained through a combination of state and Commonwealth legislation. The major aims of the audit are to monitor, improve and maintain the quality of care for patients through the reporting, feedback and continuing education of surgeons.

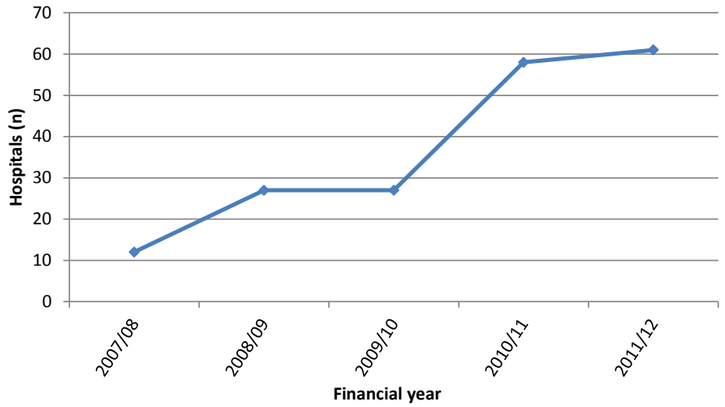


Figure 1: Number of hospitals participating in SAAPM 2007/8 to 2011/12

The story so far: activities and achievements

Audited cases: By the end of September 2013, almost 4,500 cases of surgical death had been reported to the audit and more than 4,100 of these cases had completed the full audit process since commencement of the activity.

Feedback provided to treating surgeons: The assessors' feedback was provided to the treating surgeon in all fully audited cases. In 161 (4 per cent) cases, a second-line assessment was deemed necessary and a detailed report, based on a comprehensive review of case notes, was provided.

Development of audit process and systems: ANZASM has developed a customised database, the Bi-national Audit System (BAS) that securely stores all of the data associated with each case and facilitates data analysis. BAS also allows the project staff to see, at a glance, how cases are progressing through the process and identify any bottlenecks, i.e. stages in which the process is being delayed. This ability greatly enhances efficiency.

Another notable initiative was the introduction of 'Fellows Interface' in 2010, which allows reporting surgeons and first-line assessors to complete forms online. This web-based system covers all data security issues to protect the privacy of the data; access to the system is controlled by username and password and communication between the client applications and the server is encrypted using industry standard security.

As a result of increased promotion by SAAPM, the usage of Fellows Interface has increased considerably in the past year; 84 per cent of first-line assessors and 46 per cent of treating surgeons now submit online. Enhancements to these systems, to improve the efficiency of the process and accessibility and ease of use for surgeons, are ongoing and will include the self-generation of notifications of death.

Participation: In South Australia, all public hospitals, and all but one private hospital, are participating in the audit. Figure 1 shows the increase in hospital participation since 2007/8 (no data were available for 2005/6 and 2006/7).

In terms of surgeon participation, almost all active SA RACS Fellows have provided signed consent to participate in the audit (340 of 343 – 99 per cent); no refusals have been received. To achieve such a high level of participation, gaining the trust and support of hospitals and surgeons has been critical. The ability to protect the confidentiality of the information through the Qualified Privilege declaration has been a key factor in achieving this. In addition, participation in the audit has now become a mandatory component of the College CPD certification process.

Audit findings

Annual Report: SAAPM publishes an annual report that presents and analyses audit data, provides recommendations and monitors performance in achieving the audit's objectives. An aspect of the data that is always of particular interest as an indicator of the quality of care, is the proportion of cases with serious clinical incidents. Serious clinical incidents are deficiencies of care that are identified by assessors and classified as 'areas of concern' or 'adverse events'.

Figure 2 below shows that the proportion of audited cases with serious clinical incidents increased steadily from 2006/7 to 2009/10, however this is likely to be related to the number and types of hospitals participating rather than a decline in the standard of care. During that period there were fewer hospitals participating and the data collected from those hospitals may not have been a representative sample regarding surgical mortality in SA. Since 2009/10, almost all hospitals in SA have been participating in the audit. The slight reduction in serious clinical incidents between 2009/10 and 2011/12, against a consistent number of surgically related deaths, is encouraging and these figures will be monitored closely over coming reporting years.

Individual surgeons report: Each year, SAAPM provides an individual report to each surgeon who had a surgical death audited in that year. These reports present comparative data (all surgeons and by specialty) relating to return of forms, number of deaths and clinical incidents.

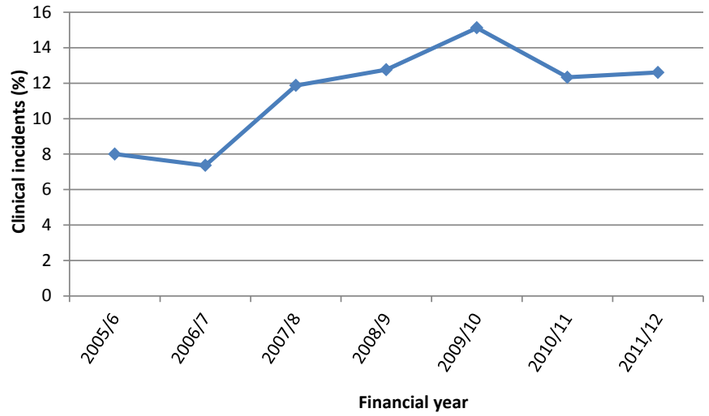


Figure 2: Cases with serious clinical incidents 2005/6 to 2011/12

Information is also provided on the surgeon's own cases, including details of each case (excluding identifying information such as name/URN) and a description of any clinical issues identified by the assessor. These reports were first produced in 2011 and feedback has been very positive (92 per cent of respondents to an evaluation survey indicated that they would like to continue to receive the reports).

Publications The audits have published a number of articles in peer-reviewed journals, both at a national level and through individual regional audits.

Educational

Case Note Review booklets: Compiled by ANZASM, these booklets describe selected cases drawn from the national pool and from a range of specialties, with a focus on the clinical lessons that can be learnt.

Workshop: SAAPM conducted a workshop in February 2012, entitled 'Recognising the Deteriorating Patient'. The workshop was well-attended, with an audience comprising surgeons, surgical Trainees and nurses. Presentations included 'Identifying the high risk surgical patient', 'Mistakes an ICU Consultant has to handle', 'The deteriorating patient' and 'Postoperative pitfalls', delivered by a variety of persons including nurses, surgeons and intensive care specialists.

In a post-workshop evaluation, the majority of attendees (87 per cent) felt that they were better able to pick up the signs of a deteriorating patient after attending the workshop and 92 per cent indicated that they would be interested in attending a similar event in the future. A number of successful educational workshops have been conducted by other regional audits and further workshops are planned.

In summary: what have we achieved?

Throughout the first eight years of SAAPM, the audit process has been continually developed and improved. The type of data collected has been ▶

refined in consultation with stakeholders. The audits now have a sophisticated, tailored database that stores all of the data associated with each case, from recording of notifications of death to data analysis as well as an interface that allows surgeons to enter data electronically.

For both the surgical community and the health administration authorities, peer-review of surgical deaths is vitally important to inform, educate and improve the care of patients. Findings have been disseminated through annual reports and articles and the education role has included individual reporting to the treating consultant surgeon, workshops and case note review booklets.

The audits will maintain a continuous improvement approach to maximise efficiency and best meet the needs of surgeons and other stakeholders. At the same time, now that the systems and processes have reached the current level of maturity and high levels of participation and support have been achieved, more attention can be focused on how best to utilise the valuable information gained, in collaboration with stakeholders.

Future directions

- Increased collaboration with SA Health, focusing on alignment of key initiatives.
- Maintaining and strengthening relationships with hospitals, including a potential role for the audits in contributing to hospitals' accreditation processes.
- Continuing to publish articles in peer-reviewed journals, utilising the national dataset. With a large national dataset that now spans many years, there is potential to investigate time trends, associations and mortality rates.
- An increased focus on targeted recommendations and education. SAAPM has already produced articles on specific areas of surgery, including ruptured abdominal aortic aneurysm and fractured neck of femur, and will continue to highlight issues relevant to specialties and procedures.

Glenn McCulloch
SAAPM Clinical Director

Further information

SAAPM website:
http://www.surgeons.org/for-health-professionals/audits-and-surgical-research/anzasm/saapm/

SAAPM Annual Report 2012:
http://www.surgeons.org/media/19984901/rpt_2013-06-17_saapm_annual_report_2012.pdf

ANZASM National Case Reviews Vol. 4:
http://www.entegy.com.au/ebooks/ANZASM/National_Case_Note_Reviews_May_2013/#/1/

Congratulations
on your achievements

The Rural Surgeons' Award acknowledges significant contributions to surgery in rural settings in New Zealand and Australia. The contribution will be in the form of conspicuous continued involvement of at least 10 years to the development of a high standard of surgery and commitment to quality assurance and ongoing education and training of the individual and other health care staff

MR DAVID BIRKS
Rural Surgeons' Award

David has been an outstanding ambassador for surgery throughout his career. He has been an inspiration to Trainees and has constantly been an advocate for not just rural surgery, but continuing surgical education.

Following his graduation from the University of Melbourne David's surgical career saw him gain a fellowship with the Canadian college, the Edinburgh College and finally the Australasian College in 1977. Upon gaining his Fellowship he relocated to Moe to work at Traralgon in the Gippsland region of Victoria. Here he and his wife Kaye have raised three children, two of whom have followed into the medical profession whilst the youngest has followed in his educational footsteps

He has provided surgical care to the population of Gippsland from this time until 2008 when he limited his practice. Throughout this time he also provided service to the Maryvale Private Hospital. Always happy to contribute, he was the Chair of the Division of Surgery at Latrobe Valley Hospital for 10 years, the Chair of the General Surgical Group at the Latrobe Regional Hospital for 10 years as well as the Clinical Dean for 15 years. In this time he helped develop the Gippsland Regional Cancer Services and acted as Co-Director from 2005-8.

Education has always been high on David's list of priorities. He became a senior lecturer in Surgery at Monash University in 1992. He was a foundation member for the Centre of Rural Health at Monash University and was acting Director of the Gippsland regional Clinical School. In 2004 he completed a Graduate certificate in Health Professional Education and in 2008 a Masters of Health Professional Education. His educational influence has not been limited to students and registrars; in 2011 he brought the NOTSS course to Australia and was the founding chair. Initially an EMST instructor and then Director, he migrated to the CCrISP faculty in 2004 and became faculty for the instructor course. From 2003-5 he was the college Education Fellow in residence and has been the convener for Surgical Education at the ASC in Hong Kong.

David was instrumental in the Rural Surgical Training Program and was the chair from 1997 to 2003. During this time he influenced numerous surgical Trainees and was a true mentor. There are a number of young rural surgeons who have David to thank for their career. Established rural surgeons will be aware of David's work with Ian Gunn in producing the "SCARS" audit which established that rural surgeons' outcomes in colorectal surgery were equal to those published in major centres. He has also represented rural surgeons as the chair of the Divisional Group of Rural Surgeons.

The rural surgical award is awarded to surgeons who have provided significant contributions to surgery in rural settings in either New Zealand or Australia. There have previously been six recipients and I can think of no surgeon more deserving of this award than David Birks.

Citation provided by Mr Tom Bowles

Engaging with our Indigenous medical colleagues

Foundation for Surgery
Passion. Skill. Legacy.

Participants look through the Mobile Surgical Unit with staff Meryl Altree and Guilherme Pena.

Beyond Cultural Awareness was the theme for the Australian Indigenous Doctors' Association (AIDA) annual symposium held recently in Canberra.

The Australian Indigenous Doctors' Association's (AIDA) invitation to bring together "members and friends ...to celebrate (our) achievements in Aboriginal and Torres Strait Islander health" was reflected in the warm reception and genuine appreciation shown to all the sponsors and delegates who supported the annual symposium in Canberra.

Through generous donations from Fellows, the Foundation for Surgery again supported the Mobile Surgical Unit (MSU) to be in attendance at the symposium. Driven by Meryl Altree and Guilherme Pena from Adelaide to Canberra and back, the MSU was well visited by the new cohort of Indigenous medical students. Meryl and Guil are well known to AIDA members. Their efforts have been openly acknowledged and their simulation education skills greatly valued.

Among the conference speakers were Dr Tammy Kimpton, President AIDA, who just this year graduated as a Fellow of the Royal Australian College of General Practitioners. The international keynote address was given by Dr Ole Mathis Hetta, a Saami doctor representing the Indigenous people of Northern Scandinavia.

Presentations by graduates and undergraduates offered unique perspectives on the Indigenous pathway through medicine. These were interspersed with colourful dance performances by the Wiradjun Echoes and Urban Zenadth Kes Torres Strait Islander Dance Group. Delegates also had the great pleasure of meeting traditional healers or Ngankari from the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, South Australia.

One highlight of the program was the Growing Indigenous Fellows workshop. Seven specialty colleges took part in a panel to discuss initiatives to encourage Indigenous Trainee recruitment and what constitutes the ideal mentoring program for prospective Trainees and also to support those already in specialty training.

The College presence at this symposium is a wonderful reflection of our developing partnership with not only AIDA, but its New Zealand counterpart TeORA, the Maori Medical Practitioners Association. In July this year I was honoured to give the keynote address at TeORA's annual symposium in Wellington.

This forum too was a great celebration of Maori achievements in medical workforce development and health service delivery. Our participation in forums such as these demonstrates that we do take Indigenous health seriously and importantly we are keen to support the work that is being done by groups such as AIDA and TeORA.

I sincerely thank the Foundation for Surgery and staff of the College for their wonderful support and commitment.

Kelvin Kong
Chair, Indigenous Health Committee

Top: Fellows Kelvin Kong and Jonathon Koea with Joanne Baxter, A/Prof of Maori Health at Otago University.

Bottom: Dr Tammy Kimpton, Matiu Rei (CEO, Te Rūnanga o Ngāti Toa Rangatira), Dr Kiriana Bird (Māori GP based at Te Taiwhenua Hauora, Hastings and Kelvin Kong(far right) with a participants at the TeORA symposium.

First electronic elections

A quicker and easier way to vote has been a success

Fellowship Elected Councillors

There were four Fellowship Elected Councillor positions to be filled.

Re-elected to Council are:
Spencer Beasley (Paediatric, NZ),
Richard Perry (General, NZ),
Phil Truskett (General, NSW).

Newly elected to Council is
Sally Langley (Plastic & Reconstructive, NZ).

Specialty Elected Councillors
Re-elected to Council is
Urology – Andrew Brooks (NSW).
Newly elected to Council is
Neurosurgery – Bruce Hall (QLD).

Congratulations to the successful candidates and sincere thanks to all candidates who nominated.

The pro bono contribution of Fellows has been and continues to be the College's most valuable asset and resource. We are grateful for their commitment.

The results will be tabled at the Annual General Meeting in Singapore on Thursday, May 8, 2014, when newly elected Councillors take office.

The first electronic elections to Council were successfully conducted with a record number of candidates and a record number of voters. Voter feedback was overwhelmingly positive. More than 99 per cent of 160+ responders commented enthusiastically on the speed, ease and efficiency compared with the paper-based system.

Paper-based voting was available; however, only five Fellows asked for it and only three returned their ballot paper.

Of the Fellowship, 27.5 per cent voted, contrasting favourably with an average of 15 per cent in comparable organisations and 22.1 per cent average for the College over the past five years.

Integrity of the process was verified by Mr Ralph Mackay of BigPulse.

Michael Grigg
Vice President

Changes ahead

The College considers the future of Elliott House, while Fellows and Trainees alike face new processes for their professional development

By now, many will be aware that the College's New Zealand Office has relocated to new premises in Courtenay Place. Elliott House, a building that has been owned by the College and was the New Zealand headquarters for 23 years, had been identified some time ago as potentially "earthquake prone". The Christchurch earthquake of February, 2011, highlighted the issue and suitable short term alternative accommodation has been found.

At the time of the move, several earthquakes were felt strongly in Wellington further serving to emphasise the issue. Although Elliott House does not fall below the threshold that would render it a "red-stickered" or uninhabitable building, it was felt that for staff and visitors wellbeing, it was prudent to move.

The next part of the process is to determine the long-term accommodation needs of the New Zealand Office. Ongoing rental and the sale of Elliott House is one option. The new premises in Courtenay Place certainly appear more modern, but are not without their own shortcomings. They rate at a higher percentage of the 'new building standard' (NBS) than Elliott House but, like many buildings in Wellington, are not at 100 per cent of NBS.

It would be fair to say that these premises suit as a temporary arrangement, but are not quite fit for purpose in the long term. Unstrengthened, the market value of Elliott House has diminished considerably since the Christchurch earthquakes. Strengthening and re-occupying Elliott House is another option. Technical feasibility and future proofing the internal organisation within the building are important considerations.

Costs, in the short and long term, are also important for both options. Decisions about future accommodation need to include co-location arrangements with specialist societies. Two currently reside within the NZ office premises and the NZ National Board would like to be able to engage with other surgical and medical groups regarding potential co-location.

Engineering, architectural, Historic Places Trust and Council reports, advice and costings are being sought for Elliott House; and costs and availability of rental premises (with parking) in the CBD are being reviewed. These will enable the College to make an informed decision about the way forward.

Medical Council of New Zealand (MCNZ) – CPD proposals

As was mentioned in the previous edition of Surgical News, the Chair of the MCNZ, Dr John Adams, has spoken publicly of the MCNZ's view that medical colleges should undertake more activities in monitoring "competence" of their members. MCNZ suggestions include Colleges undertaking an annual review of each member's CPD and, from that, identifying gaps and learning needs in developing a Professional Development Plan.

It also suggests that Colleges should conduct a Regular Practice Review (RPR) for any member who has not fulfilled the CPD requirements and for all those who meet certain risk factors. The factors spoken about relate to the length of time in medical practice, isolated practice and those in receipt of a number of complaints within a specified timeframe. MCNZ is still working on the details and will then consult widely before making its final decisions.

RPRs were discussed in more depth at the annual meeting of the MCNZ with medical colleges. The NZ Orthopaedic Association, the Royal Australian and NZ College of Obstetricians and Gynaecologists and the Royal NZ College of General Practitioners currently conduct practice reviews. For NZOA members it is compulsory once every seven years, while for our O&G and GP colleagues, this a voluntary undertaking.

There was considerable discussion of RPRs and whether they have been proven to be of value in ensuring competence. It was recognised that they could be quite costly in terms of time, infrastructure and human resources. Some contributors felt that rather than all practitioners being subject to these, those at most risk were more likely to benefit from practice review (e.g. those in solo practice or full-time private practice).

> *"The next part of the process is to determine the long term accommodation needs of the New Zealand Office"*

An audit of the RPR visits conducted thus far by both RANZCOG and NZOA is too small to allow informed discussion about the values of this undertaking. No matter the mechanism, however, it was agreed that ongoing maintenance of standards and delivery of care was an essential component of the medical profession and will continue to occupy the considerable energies of a number of regulatory bodies and many Colleges in addition to our own.

Changes to Post Graduate Years 1 & 2 (PGY 1 & 2)

MCNZ has approved a new curriculum framework for PGY 1 and 2 doctors and changes to intern run requirements that are to be introduced over the next two years. The new processes provide a more structured learning approach and are intended to add value to these first years out of medical school.

There will be a requirement for time in outpatient and community settings and increased emphasis on clinical work being directed to the learning needs of the individual. There is likely to be a move towards electronic portfolios, mentoring and career pathway planning. Runs are to remain of three months duration, may be focused on the intern's interest areas and will no longer be required to include Category A surgical and medical runs in order to achieve general scope registration.

For these changes to be successful they will require an induction of senior medical staff to ensure they understand the goals of the program. There may need to be some additional resources for mentoring and supervision and this is yet to be determined. It is obvious that liaison will need to continue between Health Workforce New Zealand, MCNZ and the DHBs who, as employers, need to be able to facilitate the new learning structure that is being put in place. Our College is looking to increase its links with pre-vocational doctors and it will be important for us to liaise closely with the MCNZ to ensure that our interests are aligned.

Nigel Willis
Chair, New Zealand National Board

EMERGING RESEARCH on quad bike dangers

The Trauma Committee continues to advocate for further education

"It was getting dark. I had been spraying fence-lines on my farm with herbicide. I still had about 50 litres in the tank mounted on the back of the quad bike and there were only the weeds in the creek to do. Although it was late I thought I would finish the job then head home.

I had ridden by the creek many times so was not worried by the slope. I began the task and was on the side of the slope when suddenly the strap holding the tank to the bike broke, the tank slid to the downhill side; the bike went over and so did I.

I hit the one spot on the creek-bed free of rocks with the bike rolling over my back and landing on its wheels next to me. With several grateful expletives I pushed the tank back on and went home. Enough for one day!

Incidents like this happen so fast you don't get time to react. I thought I could control the bike well, but this was not something you rehearse. I guess many of the experienced farmers who have been killed by low speed rollovers would have said the same.

Since this experience I have continued to ride the quad-bike – it is the mainstay vehicle used on our farm – but I am definitely more cautious."

– recounted by one of the authors.

Dr John Crozier, Deputy Chair, College 'National' Trauma Committee, Professor Danny Cass, Chair College Road Trauma Advisory Sub-Committee and Associate Professor John Graham, vascular surgeon from Lismore and past Chair Lismore Base Hospital Trauma Committee recently attended the Quad Bike Performance Project conference on behalf of the College in early October.

The meeting was held at the University of NSW and injury data and research work carried out by NSW University Transport and Road Safety Research Unit was presented. This research work has been funded by NSW WorkCover to approximately $1.3 million following concern about the number of farmers who have been killed riding quad bikes on farms. There are over 270,000 in Australia (80 per cent used in rural industries). The key takeaway messages were:

a) On-going research is needed of both deaths and serious injuries related to quad bikes to quantify the size of the problem. There appears to be two causes of death – high speed crashes (often younger males and associated with vehicle instability) and low-speed rollovers (such as farmers).

b) The manufacturers' instructions on quad bikes are very strict that no child under 16 should ride on an adult bike. Children do not have the necessary skills to control what is, at times, an unpredictable vehicle. The best way to ride a quad bike is to keep weight on your feet and redistribute weight as the machine negotiates the different terrains.

Quad bikes are particularly deceptive for a child as many quad bikes can be easily started and driven. Children have little understanding of the dynamic learning processes that occur on a bicycle or even a motorcycle where the rider must gain balance before they can readily ride the vehicle – i.e. there are many hours of toppling off before they start to gain any speed or control.

However, on a quad bike, where balance is not necessary to start or ride the vehicle, the very first unusual buck or strange movement of the vehicle will catch them completely unaware.

c) The quad bike is also called an 'All-Terrain Vehicle' (ATV) referring to its ability to handle different surfaces such as sand, dirt and mud, but it is not an all gradients vehicle.

In fact the manufacturers are quite adamant that these vehicles should not be ridden on uneven terrain or at speed over bumps. With speed, the vehicles become less stable with inherent oversteer on turning making them unstable when the surface becomes uneven.

d) Members of the College need to be aware of the foibles of quad bikes and the strict instructions as to their proper use. In particular we would like to stress again, and through all members of the College, no child under the age of 16 should ride an adult quad bike as they are physiologically ill-equipped to manage the sudden changes in dynamics that can occur with these large, powerful and heavy tractor-like bikes. Even expert riders should be aware of their instability on slopes and particularly when carrying loads or fluids.

Background

Since 2000 more than 150 Australians have died in quad bike incidents. Of the 23 quad bike deaths recorded in 2011, 18 occurred on farms, making quad bikes the leading cause of injury and death on Australian farms. The financial and human costs of quad bike fatalities and injuries on farms in Australia and New Zealand can no longer be tolerated. This situation is preventable.

L-R: Peter Dunphy, NSW WorkCover; Professor Raphael Grzebieta, UNSW; Dr Geroge Rechnitzer, UNSW; and the former NSW Minister for Finance and Services.

Without immediate action we will continue to see the number of quad bike deaths and injuries increase. Quad bikes are often not the most appropriate or safest vehicle and farmers should look at all options (e.g. tractor, utility vehicle, motorbike, side-by-side vehicle, horse).

Quad bikes are prone to rollover due to a lack of stability. This may result in death from head injuries, asphyxiation or serious chest injuries from being crushed and trapped by over-turned vehicles.

Quad Bike Performance Project

The Quad Bike Performance Project aims to develop a consumer safety rating system. This is part of a Heads of Workplace Safety Authorities (HWSA) strategy to reduce injuries and fatalities from quad bike use on farms. The results of the project will enable the development of a quad bike safety rating system for stability, handling and crashworthiness similar to the system used for motor vehicles.

This has the potential to lead to major improvements in vehicle design and safety, and a reduction in the number of on-farm fatalities and injuries. The Australasian New Car Assessment Program safety ratings empowers the consumer to make a choice with vehicle safety considerations factored in encouraging design change by the manufacturer, which might not otherwise occur.

The research project is being conducted by experts from UNSW's Transport and Road Safety Research Unit, TARS, led by Raphael Grzebieta, Professor of Road Safety at UNSW. The final report is expected at the end of this year.

Testing

This is the first time dynamic handling testing has been conducted on quad bikes, side-by-side vehicles and recreational quad bikes anywhere in the world. Sixteen commonly used vehicles are being assessed. Over 600 hundred tests have been conducted so far. Vehicles are driven at various speeds to assess how they respond to steering and terrain, and how this affects a rider's ability to maintain control and avoid a collision or rollover.

When combined with the project's static stability testing that uses a specially designed tilt-table to determine the likelihood of a vehicle rolling over, it will significantly increase the validity of the findings.

There is still scope to improve vehicle design especially to establish the causes of asphyxiation fatalities, which account for nearly 27 per cent of quad bike rollover deaths in Australia

The Royal Australasian College of Surgeons is one of the participant members of the Quad Bike Project Reference Group. Surgeons frequently provide care for those who survive quad bike incidents. For every death in a quad bike incident, there are on average 15 survivors with serious injury from other quad bike incidents. The College has a key role in facilitating data collection pertaining to quad bike injuries.

The College position paper on Quad Bikes is located on the College website.

Contributing Authors: John Crozier, Danny Cass & John Graham

Why do we tolerate this?

The culture of acceptance needs to change to encourage a new generation

The tension in the operating room is palpable when he walks in. Everyone takes a breath and shuts up, trying to fly under the radar. One of the senior nurses has been allocated to the theatre to keep everyone up-beat and the list going smoothly. Despite this, we all know there will be hiccups, some major: there always is with Dr Brown. And as his registrar I know I will be in the line of fire, again. I consciously take a breath and greet him with the most neutral "Good morning" that I can muster.

"What are YOU going to ruin MY day with today, Ima?" he snarls at me. Despite my best intentions of being calm and in control, just the tone of his voice makes me nervous and tense. I suppose Pavlov and his dogs were right – my fear response is conditioned to his voice. I run though the list of his patients and flag a few of the issues from the morning ward round.

He wants to know the albumin of one of the patients due for discharge. I can't recall her albumin and confess that I will need to look it up. A loud huff and eye roll ensue while I try to avert the situation by turning to the computer to check her albumin. The relevance of the serum albumin to her clinical situation is sketchy at best – and we both know it – but because of the power differential I dutifully look it up ... Questioning this would only inflame the situation.

"It's 38," I turn to say, but he has already moved on and it's the poor scout nurse who is now the new target.

"What do you mean you haven't done this before?" he shouts with exasperation. "We do this every bloody week! How is it that I always get the juniors with me?"

The scout nurse physically shrinks and busies herself opening more equipment. I notice her hands shaking and try to catch her eye and give her a knowing smile, but it helps little – the expensive stapler has fallen to the floor as she tried to place it on the sterile trolley and it lies there unsterile and wasted. "That should come out of your wages," he hisses under his breath. There is little wonder why the nurses all hate working in theatre two on a Wednesday morning.

With trepidation I make the incision for the first port, hoping to be guided by my boss, but knowing that's unlikely. I am expected to either do the case in its entirety or not at all – that much was made clear at the start of the term. Building up my repertoire with demonstrations or advice along the way was clearly not going to happen. We operate in awkward silence. The scrub nurse encourages me on with her eyes and I do the best I can in the circumstances. The patient is obese; I'm struggling to get a proper view and the scope light is temperamental.

I ask if I should put in an extra port or reposition things. "I don't know, you're doing the case," is the dismissive response. I proceed tentatively, but don't make the progress I normally would if I was doing the case with any of the other consultants in the unit. I eventually get my landmarks dissected and point them out for some reassurance before proceeding. All Dr Brown can manage is "Hurry up; I'm getting bored with this case already." I take this as code for "good, I agree, continue" – so I do.

My intern has popped into theatre between cases to update me on one of our unwell patients who is waiting an urgent scan. In my angst, I snap; "What's been going on? Get it sorted – now." My frustration at being treated like an imbecile all morning spills out and I unthinkingly pass it on to my intern.

And so it goes – the toxic workplace is created. Built on a culture of intimidation and fear that has gone unchecked for years, this surgeon knows that no-one would dare stand up to him. Surely he must realise what he is doing, but it seems he is too burnt out and the behaviours are too ingrained to try to remedy now. I wonder if he has any insight into the effects of his behaviour.

Everyone in the department knows what Dr Brown is like. He has a reputation that precedes him. Occasionally, he will take a liking to a new registrar and they will "sail through", but most of us, so I'm told, just endure it. Powerless to change much really – we are there for six months then gone, and ultimately our assessments, reputation, and career rest on this bully.

And how can someone like me influence this? I am just one small cog in a huge machine that is modern day health care. Surely it needs to come from the top down. But how is 'the top' supposed to do anything about it without something 'in writing'? For me to flag it to 'the top' would require me to put my neck on the chopping block – and to what end? I only have to survive three more months, surely that's possible? My focus is much less about learning and flourishing in this toxic environment than survival. Every day is a small victory and the end of rotation cannot come soon enough. Thinking about improving the situation for others is something that I could only contemplate after I have survived and moved on. Not for now.

To the outside world I've developed the leather skin required to survive surgical training, but internally I take it all in and just turn the music up loud in the car on the way home to cleanse myself of the day's troubles, trying to recharge before I have to do it all again tomorrow. My mum tells me she is disappointed in me: "How can I stand by and do nothing?" Surely with all the opportunities and experiences I've had I should refuse to accept this type of behaviour in the workplace. Mum is a manager: "It just wouldn't be accepted anywhere else," she says. She is trying to be supportive, but doesn't fully appreciate the world of surgery – a small world where reputation is everything.

So why is it that we accept bullying in surgery with such a collective blind eye? Surely we all have a responsibility to recognise it for what it is and say "no more"? Even if it is one of the more uncomfortable discussions that a surgeon should have with a colleague or issues to put in writing as a registrar? Even if it is at a potential personal cost?

Surely we owe it to our profession to act. After all, the hallmark of our profession is self-regulation. Can we say we don't bully, we won't bully and we won't tolerate bullying in our units, practices and hospitals?

Dr Ima Trainee

A documentary screening follows important surgical work of Mercy Ships in Africa

Hospital ship treats thousands of *Africans*

Three years ago, Sydney ENT surgeon Mr Neil Thomson heard from colleagues about a global charitable organisation behind the deployment of the world's largest, private hospital ship, a story that piqued his interest and led, ultimately, to his involvement.

That ship, the Africa Mercy, travels each year to a different West African port to treat thousands of patients from some of the poorest countries on earth, most of whom would otherwise remain without access to health care.

The current flagship of Mercy Ships, an organisation that has so far provided more than $1 billion worth of services and materials in developing nations, Africa Mercy was refitted in the UK in 2007 at a cost of approximately $60 million – the largest conversion of its kind ever undertaken in the country.

With six operating theatres, recovery/intensive care and low-dependency wards and with a total of 78 patient beds, the Africa Mercy provides approximately 7,000 surgical procedures onboard each year including cataract removal, tumour removal, cleft lip and palate reconstruction, orthopaedic surgery and obstetric fistula repair.

It is staffed via a massive logistical exercise in which 450 nurses, surgeons, doctors, anaesthetists, physicians, allied health professionals and support staff from around the world are rostered on and rotated in throughout the year.

Two years ago, Mr Thomson became one of those volunteers.

Usually giving a month of his time each year, he has now worked off the coast of Sierra Leone and Guinea and next year will work aboard the ship while it is docked in the waters of the Congo.

Later this year, his work on board the Africa Mercy will be featured in an Australian documentary called 'The Surgery Ship', scheduled to air on SBS in December.

"I particularly liked the idea behind this charity of people from countries that have great resources giving their time and expertise to help people from less fortunate parts of the world," Mr Thomson said.

"I thought that while I can't do a lot I can do a little and if lots of people did a little, something could be achieved and while the need is overwhelming, seeing the joy on the faces of the patients you've helped is amazing in itself.

"It is also wonderful to work in such a melting pot of nationalities and although the work is sometimes very hard emotionally, you hear very few complaints and there are some nurses that work there for the entire year without pay.

"From the first time I heard of this charity I was intrigued, yet at the start of my involvement it was difficult to take time away from my private practice in Gosford but now one of my Trainees has returned from Guys Hospital in London to join me, which is a wonderful help."

Mr Thomson said that the West African countries chosen for a visit by Africa Mercy were selected via strict criteria including that they were safe and that the population was stable enough to benefit, that the country was able to provide a suitable berth for the ship and was willing to waive visa requirements for volunteer staff.

He said once a country was chosen, the public was notified of the ship's arrival through public service announcements and notices to health clinics with patients considered appropriate for surgery onboard the Africa Mercy selected through a enormous screening process.

The notifications, he said, often resulted in thousands of people travelling for days or weeks to the designated port city where a large facility – from public buildings to sports stadiums – was made available for that screening process conducted by surgeons, physicians and nurses.

Having participated in such a process last year, which saw the arrival of 5000 desperate people, Mr Thomson said selecting patients for treatment was both a difficult and uplifting experience.

"The central policy at Mercy Ships that drives the choice in my field of ENT surgery is that we treat benign tumours and diseases that are obstructing airways," he said.

"This means that we sadly have to avoid malignant tumours because we are not in a position to offer adjunct therapies like chemotherapy; however, we sometimes do such procedures if there is intractable pain or intractable infection.

"This was the first time I have ever seen men wearing veils to cover their head and facial tumours, hiding the sort of gross pathology that comes from having no access to healthcare in childhood or even because the local witchdoctor or a tribal elder refused to give permission to seek treatment.

"There is no doubt that it can be an overwhelming experience to make such decisions, but you have to come to grips with what you can do, that you are only a small component in a major endeavour."

Mr Thomson said that walking onto the Africa Mercy was like stepping into a first world hospital with all the expected equipment, disposables and infection-control procedures.

He said two of the six theatres were devoted to eye surgery, with one concentrating on Head and Neck, one on Orthopaedics, one for Plastic Surgery and one for Gynaecology.

He said that each theatre treated between one or more patients each day depending on the complexity of the surgery.

He said he hoped to take a surgical Trainee with him on future visits.

"Life on board the ship has a flavour all its own, both professionally and socially, and dealing with extreme pathology, while confronting, can be extraordinarily rewarding," Mr Thomson said.

"During my last trip I worked with maxillofacial and plastic surgeons which meant that we got through a huge case load and wide variety of cases and our management was benefited by the expertise of each specialist.

"Given that we all live together on board the ship for the duration of our stay, we can collaborate very closely in planning how we tackle particular cases so that by the time patients get to theatre we have very detailed surgical treatment plans.

"Some of our patients have suffered enormously not only physically, but socially and emotionally because of the way they look; so the joy on their faces when they wake up after surgery and realise that the tumour really is gone is quite wonderful to witness."

Reluctant participant

Mr Thomson said that while he was initially reluctant to be part of the documentary, he put his reservations aside because of his support for the work done by Mercy Ships.

"I tried to avoid being on the documentary and when I was asked to participate in and to attend the patient selection day last year, I decided I didn't want the emotional drain of that and so changed my days," Mr Thomson said.

"Then the organisers on the ship contacted me to say they'd been delayed so that my new dates were perfect; so I felt like while I could run, I couldn't really hide.

"Finally I said yes because it is a cause I believe in and oddly once I'd accepted that, I just got on with the work and because the film crew lived each moment with us they become members of the team.

"I just decided that if my involvement could help raise awareness and support I'd be pleased to help.

"I've now sat through a screening of the documentary and I particularly like the fact that it doesn't present our work in some sort of holy glow; it doesn't show us as heroes, but just as ordinary people with particular skills doing what we can.

"It also demonstrates a dimension you rarely see in such documentaries which is the work that remains to be done."

'The Surgery Ship', produced and directed by Madeleine Hetherton and Rebecca Barry, is scheduled to screen in Australia on SBS on Tuesday, December 10 at 8.30.

With Karen Murphy

Mentoring
a multifaceted approach required

What is a mentor and why are they important to our careers?

Doctors are highly regarded in the community, not just for their specific knowledge of medicine, but also because they often have an excellent general knowledge as well. An inquisitive thirst for facts, and desire to know how things work, is essential to formulate solutions to patient problems.

Because of this broad knowledge base, we occasionally assume we understand a topic in detail, when in fact we actually know very little. Mentoring is a good example of this.

We all have an idea of what mentoring is, or should be. Many however, confuse mentoring with 'tutoring' and perhaps more commonly 'coaching' and one of the common mistakes of the past was to assign a 'mentor' to a poorly performing Trainee or student, when in actual fact what they needed was formal tutoring or coaching.

The term Mentor has come to mean "someone who imparts wisdom to and shares knowledge with a less experienced colleague". An underperforming Trainee often lacks the insight to appreciate the subtleties of this advice and needs a more structured remedial plan; the carrot being passing the term, the stick being potential failure.

To clarify, a Tutor is an instructor who gives private lessons, and a Teacher is one who educates groups. Coaches help you train so that you play at your peak, such that hopefully your team can win games, whereas Mentors help you choose which sport you're best suited to.

Often we also confuse mentors with role models. A Role Model is a person who serves as an example, one whose behaviour is emulated by others. A role model is thus more of a 'hero' figure and while every mentor must be a good role model, not all role models are necessarily good mentors.

So then it is clear that we must make the distinction between what mentoring is and what it isn't if we are to create a successful mentoring program for our College.

Mentoring can take many forms; it can be a brief encounter, or it can be a lifelong journey. It can be formally organised, or it can be an organic process that develops fortuitously between two people.

To be effective, a mentor must have no direct role in the assessment or progression of a mentee. Advice must be impartial and separate from direct career progression if it is to be a true mentoring relationship.

Clearly we know that a mentoring relationship can be extremely beneficial to the Mentee, and highly rewarding to the Mentor if it is a successful one. It is also clear that everyone can benefit from having a mentor throughout their career.

It is not just the Trainee and those beginning a surgical career that need mentoring, even senior surgeons can benefit from the knowledge and experience of those that have travelled the well-worn path transitioning out of surgery and into retirement.

So how to begin?

A successful mentoring program will not be a one-size-fits-all approach, it will need to be multifaceted and encompass both informal and more formal networking opportunities. It may be both "actual" as well as "virtual", and will need to recognise that people can be both mentors and mentees at the same time, as well as having different mentors for different situations – both at the same time and "over time" as personal situations change.

Mentoring relationships will come and go, some will be brief, and some will be lifelong. There will be many pieces to the puzzle, and the puzzle will not always necessarily be a complete one; the important thing is that mentoring opportunities are provided to the fellowship that desperately needs them.

Come and join the Younger Fellows Mentoring Network Session at the ASC in Singapore. Tuesday, May 6, at 5pm with refreshments. Bring your enthusiasm and an open mind to begin this important journey.

Richard Martin

2015 Rowan Nicks Pacific Islands Scholarship & 2015 Rowan Nicks International Scholarship
2015 Rowan Nicks Australia & New Zealand Exchange Fellowship

The Royal Australasian College of Surgeons invites suitable applicants for the 2015 Rowan Nicks Scholarships and Fellowships. These are the most prestigious of the College's International Awards and are directed at qualified surgeons who are destined to become leaders in their home countries.

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

The goal of these Scholarships is to improve the health outcomes for disadvantaged communities in the region, by providing training opportunities to promising individuals who will contribute to the development of the long-term surgical capacity in their country.

Application Criteria:
Applicants for the both 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 Australia or 7.5 in New Zealand, in every category);
- be under 45 years of age at the closing date for applications.

In addition, applicants for the International Scholarship must:
- hold a relevant post-graduate qualification in Surgery;
- be a citizen of Bangladesh, Bhutan, Cambodia, Indonesia*, Laos, Mongolia, Myanmar, Nepal or Vietnam

**With preference given to Indonesian applicants from outside the major capital cities of Jakarta and Surabaya who will return to practice in regional areas.*

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;
- hold a Masters of Medicine in Surgery (or equivalent). 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.

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 $50,000 for a 12 month attachment, depending on the funding situation of the candidate and provided sufficient funds are available, plus one return economy airfare from home country and support to attend the Annual Scientific Congress of the College, if the Scholar is in country at the time of the Congress.

Tenure: 3 - 12 months

The Rowan Nicks Australia and New Zealand 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 judged by the College to be of national excellence for a period of up to one year, or an Australian to work in a New Zealand unit using the same criteria.

Application Criteria:
Applicants must:
- have gained Fellowship of the RACS within the previous ten years on the closing date for applications.
- provide evidence that they have passed the final exit exam to allow them to obtain a Fellowship of the Royal Australasian College of Surgeons by the time selection takes place.

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 $50,000 for a 12 month attachment, depending on the funding situation of the candidate and provided sufficient funds are available, plus one return economy airfare between Australia and New Zealand and support to attend the Annual Scientific Congress of the College, if the Scholar is in country at the time of the Congress.

Tenure: 3 - 12 months

Application forms and instructions will be available from the College website from December 2013:
www.surgeons.org

Closing date: **Monday 2 June, 2014.**
Applicants will be notified of the outcome of their application by **30 October 2014.**

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

Surprising *Research*

The Trainee has found that exercise is not for everyone

A 2012 recipient of a Foundation for Surgery Scholarship, Dr Chris Delaney, used the attached funding to expand his research investigating the effects of exercise on the clinical, systemic and local biological responses in patients with intermittent claudication.

From the Latin word "claudicare", which means to limp, claudication refers to pain or cramping in the lower leg due to inadequate blood flow to the muscles, the most common cause of which is peripheral artery disease brought on by atherosclerosis.

A SET1 vascular Trainee, Dr Delaney undertook his PhD research to determine the most effective exercise regimen for patients with intermittent claudication, as measured by improvement in pain-free walking performance.

The research also assessed the impact of different exercise modalities on endothelial function, body composition and skeletal muscle protein expression as well as inflammatory cytokines.

He said that low-impact exercise was now the recommended first line treatment for intermittent claudication, largely because of the risks posed to such patients by surgery given that most have compromised immune systems caused by diabetes, long term smoking, high blood pressure and high cholesterol.

Surprisingly, he said that his findings suggested that, contrary to current thinking, such exercise could also lead to long term damage to the heart, musculo-skeletal system and major organs.

Working through the Flinders Medical Centre in South Australia and conducting his research through Flinders University, Dr Delaney examined 111 patients with intermittent claudication to assess the impact of treadmill-based exercise or in combination with resistance training.

Dr Delaney at work

As part of the research he assessed not just pain-free walking distance, but also assessed endothelial function by brachial artery flow mediated dilation, reactive hyperaemia index and by conducting muscle biopsies and serum analysis of nitric oxide levels and asymmetric dimethyl arginine.

He found that improvement in walking performance was not associated with an improvement in endothelial function and that a reduced bio-availability of nitric oxide associated with such exercise may have a detrimental impact on endothelial function and long-term health outcomes.

"Supervised exercise training is currently recommended as the first line of treatment for patients with intermittent claudication with meta-analyses demonstrating a significant improvement in walking performance," Dr Delaney said.

"Several mechanisms have been proposed to explain this, including stimulation of a pro-angiogenic response, skeletal muscle metabolic adaptation to ischaemic conditions and psychological improvements in pain perception.

"Yet we found that while such low-impact exercise could offer patients short-term pain relief, there are suggestions it could also lead to long-term adverse effects.

"This potential long term harm could arise from a reduction in the bio-availability of nitric oxide and also the presence of calpain proteases which have been linked with tissue atrophy following ischaemia-reperfusion injury.

"Claudication is essentially repeated low-grade exposure to ischaemia-reperfusion injury. Supervised exercise training, in particular treadmill-based training, may increase the frequency of exposure to ischaemia-reperfusion injury, leading to an increase in calpain proteolytic activity and muscle wasting. This is significant given that preservation of skeletal muscle is integral to healthy ageing."

Dr Delaney is conducting his PhD research under the supervision of Professor Ian Spark, Head of Vascular Surgery at Flinders Medical Centre.

He has written three papers describing his findings which are in various stages of the review process and is now in the process of writing a fourth paper on the inflammatory response of claudicants following treadmill exercise and the increased presence of inflammatory cytokines.

He said his findings of possible long-term detrimental impacts came as a surprise and could lead to changes in the treatment of intermittent claudication if larger studies were conducted that supported his findings.

"We were very surprised to find that exercise might be harmful given that I set out to try and find the optimal exercise regime," Dr Delaney said.

"We certainly didn't expect to find that patients were losing muscle mass because of the reperfusion injury, which is of considerable concern given that muscle mass is important to regulating the basal metabolic rate.

"Our results mean that we can say that while such treadmill walking can ease pain, that pain relief may come at the cost of long term health indices."

Dr Delaney said that if further studies supported his findings, vascular surgeons may begin to offer surgical intervention sooner than is now usually offered.

"Our findings do mean that maybe we should offer open or endovascular intervention to patients with intermittent claudication earlier," he said.

"We could go into the leg and use stents and balloons to improve blood flow, but we need much bigger numbers before we consider changing current treatment protocols.

"There would also have to be long-term follow-up studies conducted on such patients to track any adverse impacts over time in terms of disease progression and cardio vascular events.

"This is just a small trial; however, most other research in this field has concentrated only on walking performance so our work is unique in that we took a broader view and as such found processes at work that we were not expecting."

Dr Delaney said he hoped to have his PhD thesis completed by early next year after which he would be taking up a position at the Royal Adelaide Hospital as a SET2 Vascular Trainee.

Employed for the past two years as a Vascular Surgery Research Fellow at the Department of Vascular and Endovascular Surgery at the Flinders Medical Centre, Dr Delaney said the funding support of the College allowed him to expand the tests he could conduct and design or buy the equipment he needed.

He has also received funding support from Flinders University and two grants from the Foundation Daw Park Project.

Most recently, Dr Delaney presented the findings of his research at the Annual Scientific Meeting of the Australian and New Zealand Society of Vascular Surgeons, where he was awarded the prestigious Atrium Prize for best presentation by a Trainee.

With Karen Murphy

profile

Publication contributions by Dr Chris Delaney

> Spark JI, **Delaney CL**, Allan R, Ho MH and Miller, MD. (2013). Can fish oil supplementation improve endothelial function in asymptomatic offspring of patients with peripheral arterial disease? Open Access Journal of Clinical Trials, 5, pp.83-91.

> **CL Delaney**, JI Spark, J Thomas, Y-T Wong, L-T Chan, MD Miller. A systematic review to evaluate the effectiveness of carnitine supplementation in improving walking performance in individuals with intermittent claudication. Atherosclerosis. (In press)

> Allan RB, **Delaney CL**, Miller MD, Spark JI. A comparison of flow-mediated dilatation and peripheral arterial tonometry for measurement of endothelial function in healthy individuals and patients with peripheral arterial disease. Eur J Vasc Endovasc Surg. (In press).

> Miller M, **Delaney CL**, Penna D, Liang L, Thomas J, Puckridge P, Spark JI. A 3-year follow-up study of inpatients with lower limb ulcers: evidence of an obesity paradox. J Multidiscip Healthc. (2012) 5:181-6.

> **Delaney CL**, Russell DA, Iannos J, Spark JI. Is Endovenous laser ablation possible while taking warfarin. Phlebology. (2012) 27(5):231-4.

> **Delaney CL**, Saleem HA, Karapetis C, Spark JI. Curative resection and reconstruction of the inferior vena cava after extensive infiltration with low grade endometrial stromal sarcoma. Phlebology. Available online Feb 25th 2012.

Part Two

How to survive as a consultant surgeon

Things they never tell you

This is the second half of an article that originally appeared in the Journal of the Association of Surgeons of Great Britain and Ireland (No. 37, September 2012) and is reproduced here with permission. The first half ran in the October 2013 issue of Surgical News.

The clinical environment

The operating theatre, the outpatient department, the wards, and all the other areas in which you work, are all places where you and your practice are on display. You leave your mark on those who work with you in every part of the hospital, and rest assured they will talk about you to a greater or lesser extent when you are not there. Don't care? Fine, but be assured that, if you want to make the very best of each episode of healthcare, you need the co-operation and help of everyone else.

You need to learn quickly that if you treat people well, they are far more likely to go the extra mile for you when you need them to, and for the people they really like, they will fall over backwards to help. It just makes sense to remember to thank them regularly, be prepared to bring the occasional edible goody in for them, be generous at Christmas and just be as nice as you can be – they have to do pretty odious and boring stuff too, and the more appreciative you are, the happier they will be.

I never cease to be amazed at how some never grasp the simple truth of such things, and then wonder why getting things to work well seems like wading through treacle.

Your secretary

Regardless of whether you have the luxury of your own secretary or are asked to share one, your secretary is the one person who has the power to make life either a breeze or a nightmare for you. It is true that you may not have much of a choice in the early years, as you perhaps inherit your predecessor's, but this relationship is the one above all others that just has to work.

Invest time in the early days (and as often as needed thereafter) in talking and listening to each other, in an effort to understand what each party wants and needs. Walking a mile in each other's shoes is a pretty useful exercise to ensure that you maintain harmony and productivity. When it works well, it's a complete godsend; when it doesn't, it can ruin your respective days, so devote time and effort to ensure it can be the best it can be.

Have a life

Of course you will have a life outside the hospital and its business. This may be based in a family home, but even if not, your life outside the workplace is extremely important. Your family should be the most important thing in your life but, in the early days, you may find yourself feeling that, above all else, you need to get established in the best possible way at work, and life outside has to take second place. Beware! The secret is the balance, and if you get this wrong, everything suffers.

It isn't easy, as competing pressures may produce real tension at times. Your friends and partner and family will understand that a surgeon's life cannot be as predictable as many other professions, and that there will be many times when they will pushed into second place. If you are lucky in your choices of partner and friends, you will find yourself blessed that they tolerate your strange lifestyle, but recognise that it isn't good for you, or them, to let the pendulum swing too far in either direction.

If you think it might have, discuss it openly as soon as possible. Many have fallen at the unpleasant hurdles that await the unwary in these regards.

Final tidbits

Never be too proud to ask for help. You do not, and never will, have a moratorium on wisdom, and there will be many times when you will not be certain of the direction you should be taking. Ask those colleagues whose friendship you have carefully nurtured for these very moments. If they aren't around, be prepared, and humble enough, to ask even the most difficult of your peers (the ones who would rejoice at your so-called 'display of weakness'); they will probably be flattered and it may help to improve the longer-term relationship. It might be regarded as a sin to make a bad decision, but being too proud to ask for help in making that difficult decision could be regarded as a much greater misdemeanour.

Make yourself available at all times. Do not be afraid of listing your home number in the telephone directory, or freely giving out your mobile number and email address; you will save a lot of time and trouble if you do, and a readily contactable surgeon is worth their weight in gold. It may seem unduly risky and likely to result in you being bombarded when you want freedom and protection, but for the most part, your availability will mark you as a treasured and respected practitioner.

A colleague once gave me some great words of wisdom: "Get all your worrying done in the operating theatre and in the hospital, so you need to do less at home later". This seems to me to be a good principle. Conduct the operation correctly and to your fullest satisfaction the first time around and, whilst this won't stop you worrying later, at least you won't be able to beat yourself up thinking, 'I should have done that extra stitch!'

In any dispute or difficulty, when you find yourself cursing someone else's action and cannot understand why a co-worker has done something, stop before you explode, and just try to think of things from their perspective. There are some thoroughly devious people around, it's true, but most are 'honest injuns' just trying to do their best; people with other issues in their lives (as you have), and whose actions and statements will be influenced by those issues. Be quick to condemn and you will get more frustrated and irritated; see the world and the problem from their point of view for a moment and you will acquire tolerance and understanding, which will serve you well (and should delay those grey hairs a bit too).

Want to be the best you can be? A good way is to try to imagine what others might say about you. If they were to say, "He/she is great, but…", what would that "but" be? This should give you some idea as to which areas to work on – and it's a tad easier than the 360° appraisal process into the bargain.

The world is before you and you should have a very privileged existence doing one of the greatest jobs around – enjoy it.

Nick Markham
Director of Informatics, ASGBI

Making *Tea* under the Milky Way

Opus XXIX
Felix Behan
Victorian Fellow

This may seem an unusual title to introduce the story of my experiences spanning almost 40 years of Head and Neck meetings at the Royal Melbourne Hospital (RMH) and the important surgical personalities I met there. However, just wait, bide your time and all will be revealed.

John Hueston knew of my experiences in London in Head and Neck reconstruction at the Marsden, St George's and Westminster under the doyens of Head and Neck Oncology, Charlie Westbury, Henry Shaw and Ian Wilson. On John's suggestion, Benny Rank organised for Don Marshall and then Michael Long to go to Bakamjian's unit at Roswell Park, where they both gained post-graduate experience in the delto-pectoral flap.

The story goes that one day when Bakamjian was on holidays, his assistant inadvertently reversed the design, providentially creating a flap based medially on sternal intercostal perforators (the name was retained). John Hueston first invited me to attend these Monday morning meetings, which combined knowledge and exposure to establish high standards in Head and Neck reconstruction.

On vacation I was recently reading a summary of the life of the philosopher Descartes, who died in 1650 (the things you read on holidays). As the father of modern philosophy, including the metaphysical, he coined the phrase "cogito ergo sum" – I think, therefore I am. Based on this premise, the only certainty in life is one's own existence - Le Discours de la Methode.

Descartes applied the principles of geometry and algebra as the basis of his theses regarding the mechanisms of the universe. His metaphysical book Le Monde (1629) was published in the Netherlands, where Descartes was living beyond the tentacles of the Inquisition (unlike Galileo).

It has taken me umpteen visits to Paris to understand the origin of the name of the newspaper *Le Monde*, a left-leaning source of informed opinions compared with other publications which sometimes over-compensate with photo-journalism.

I began writing this account on a rainy autumn morning in Paris in October listening to Chopin's Polonaises, one of the greatest exponents of this Romantic art, not forgetting music motivates the emotions. On walking up the Rue des Martyres towards Montmartre (pour Désirs and Volupté) the day before, I happened to pass Renoir's residence in the Rue de Rochefaucaud, with a picture framer on the opposite corner.

Passing the Square d'Orléans, I noticed the plaque (see illustration) outside the place where George Sand and Chopin shared their existence. What an experience to have seen Chopin's home then to listen to his compositions. Rodney Judson (Brian Fleming's protégé in Head and Neck Surgery) and I spoke on the phone that day, which prompted me to finally put pen to paper to recall some aspects of those Head and Neck meetings.

When I returned home, Hugh Millar recalled to me that the old Peter MacCallum was the source of all major head and neck cancer referrals. Former specialists like Weary Dunlop and George Swinburne were the link between RMH and Peter Mac.

Later Peter Mac appointments included Brian Fleming, with Hugh Millar replacing George Swinburne, while I came in from the Western Hospital, replacing Michael Long. Earlier Hugh Millar was head-hunted from the Alfred by Benny Rank (then on the board) to come to RMH.

John Hueston was one of the prime instigators of these meetings and many pioneering procedures resulted. Temporal bone resections with Professor Andrew Kaye, David Wallace and Hugh Millar and free-flap reconstructions with Ian Taylor and Russ Corlett were landmark developments.

The fronto-ethmoidal excision of inner canthal tumours created the base for frontal flap reconstructions established by the late Bill Wilson in association with the ENT team. Tony Holmes and Hunter Fry contributed to the delto-pectoral reconstructions when John Hueston was not available.

At these 7.30am meetings I developed a high respect for Brian Fleming, whose reputation was outstanding both surgically and academically (thanks to Gordon Clunie). I first met Brian Fleming when he came with Michael Long to the Plastic Training Unit (VPSU) at PANCH in the 1970s to do the major oncological excisions. It was Michael Long who took me through my first block dissection of the neck using a scalpel (as Andrew Sizeland still does).

At RMH Brian Fleming, trained by Howard Eddy, was "chairman of the board". His opinions were invaluable, his experiences worldwide, his publications comprehensive and his courteous manner always welcome. His ABCD of Head & Neck Surgery went as follows:-
A – is it Anatomically resectable?
B – is it Biologically operable?
C – is it Clinically treatable? (Who wants a coroner's inquest for a bad decision?)
D – DXRT (palliative or curative) deep X-ray therapy.

He once said, "Of course, everything is resectable. You can even take the patient's head off" – said in jest, but reflecting his experience of when not to operate.

Brian frequently said there was no money in Head and Neck surgery. Without breaching confidentiality, he mentioned one day in a public forum at Peter Mac, that "after a career in surgery I own half my house in Hawthorn and a shack at Lonsdale". I recall his summary of costings for a major case (eight hours) requiring himself, Ian Taylor and his team one Saturday morning in the late 1970s amounting to $25,000. The public purse pays for surgical developments.

Contrast this with one of Brian's cases of a wealthy Toorak millionaire who on admission for a major resection decided to go in as a public patient. He was fully aware of the Medicare fine print which allows any Australian taxpayer to get the best treatment available for nothing (like the Mayo clinic), whatever his financial circumstances.

I had the same experience myself with a millionaire stockbroker wanting a major keystone reconstruction, and then a major farmer from the Western district played the same game. Our dedication governs our commitments.

Dick (not exophthalmos, but thyroid eye disease) Galbraith was another great personality – un bel ésprit. With a touch of humour he achieved great patient outcomes. I also met his junior David Kaufmann at these meetings, to whom I am grateful for his diagnostic skill which identified my impending blindness from an asymptomatic infected maxillary sinus (dental in origin). This was promptly drained by Andrew Sizeland and my vision has been intact since, thanks to both.

One Monday morning Dick recalled his recent experiences in Fiji. Flying in a small plane to an outlying island for more cataract sessions, a sudden storm enveloped the plane and they were flying blind (Dick's quote "Avoid the monsoons").

Their radio emergency request was answered by Big Brother upstairs (a reference to George Orwell's *1984* title on Totalitarianism). The American Air Force responded from a Super Constellation in the stratosphere, part of their global surveillance. With radio guidance they made a safe landing and Dick was still smiling some two weeks later.

> *"Passing the Square d'Orléans, I noticed the plaque outside the place where George Sand & Chopin shared their existence."*

Invaluable CT scans

On another occasion in 1977 Hugh Millar returned from an International Head and Neck meeting in Chicago (I think) to make the stunning announcement that CT scans would be the future of tumour diagnosis and assessment of nodal dissemination, determining treatment. Indeed this proved of monumental value and Brian Tress and his Radiology team continued this invaluable service over this 40-year span.

Bob Cooke and David Wiesenfeld supplied Oral and Maxillo-facial expertise, while Andrew Sizeland, Michael Guiney, Steve Kleid and Brian Costello were part of the later contingent with links to Peter Mac.

Thus, to repeat Descartes' observation "I think, therefore I am", would it be presumptive to conclude in view of the history above, that this could be paraphrased to say "we think, therefore we are" in the 21st century?

Now to explain my "Milky Way" title. Thanks to Sr Lanie Anson of 7 North, the mother hen of the unit who looked after the patients' welfare, but also organised tea for the troops at these meetings.

In this cramped environment, the milk and teabags were in one corner and ▶

the kettle in another, so that I would suspend the teabag on the surface of the milk, then fight my way to the hot water to drown the floating teabag.

The resultant milky cuppa initially looked singularly uninviting, but things improved. With no way to dispose of the teabag, it was left in situ, acting as a spoon. However, taste, flavour and appearance improved dramatically as the meeting progressed (now my signature technique for making tea).

In the English tradition, using a teapot you are either a MIF (milk in first) or a MIL (milk in last). The Queen's Royal Crown Derby tea service could withstand the thermal shock of boiling water on the base of the cup, with milk added later to taste.

Those of the lower socio-economic groups (90 per cent) were obliged to put milk in first to prevent the hot water from shattering the container. However this teabag technique allows permeation of the fat content of the milk to mollify the tannic bitterness.

Finally, while I was still in Paris I passed a tea shop (Salon de Thé) at La Madeleine where Mariage Frères had 600+ varieties of tea on display, having been in business since 1854 (see illustration). A 250g packet cost as much as 15 Euros, whereas I buy my teabags for 10c a pop at the supermarket.

In conclusion, while catering for all tastes, I note Lin Yutang's quote from The Importance of Living - "There is something in the nature of tea that leads us into a world of quiet contemplation of life" – as we experienced in those Head and Neck meetings, mirroring many personalities reaching for the stars and their zenith..


Opus XXIX

Felix Behan
Victorian Fellow

In it together

Younger Fellows Forum 2013 – Work life balance & Indigenous Health issues

The 2013 Younger Fellows Forum was held from May 3 to 5, immediately preceding the Annual Scientific Congress at the Formosa Golf Resort, 30 minutes from central Auckland overlooking the picturesque Waitemata Harbour and associated islands.

The Forum provides an opportunity for Younger Fellows to come together to discuss and debate relevant issues and topics. The program also provides time for Fellows to get to know each other by participating in team-building activities, but above all, the Forum empowers Fellows to influence the way the College serves its Fellowship and the community, either as individuals or collectively.

The participants included guests from the College of Hong Kong, Thailand and Malaysia, President Associate Professor Michael Hollands, Councillors Cathy Ferguson, Spencer Beasley and Dean of Education Associate Prof Stephen Tobin. Fellows from throughout Australia and New Zealand attended covering Vascular, ORL, General and Orthopaedic specialties.

The Forum started with a Powhiri (welcome) by the Tangata Whenua (local people). This was a new experience for many of the Fellows at the Forum. It also set the scene for the weekend which was focussing on work-life balance and Indigenous Health issues. The Powhiri was followed by the delegates introducing themselves and voicing the three biggest issues that have faced them as Fellows.

Associate Professor Michael Hollands then addressed us on the topic of Our College: into the next decade. He posed three questions for us to consider over the weekend;

1. Where do we believe our College will be in five to eight years?
2. What do we want from our College?
3. How does our College remain relevant to our needs?


Delegates at the 2013 Younger Fellows Forum

These questions and the issues that the Fellows had voiced in the previous session provided great 'grist for the mill' over the successive days.

The program

The first day finished with a modified orienteering course that had us scampering over the grounds of the golf course while embarking on rock climbing, kayaking, pistol shooting – all at the same time as trying to answer a number of trivia questions and team focused problem solving.

The second day started with addressing the issue of Indigenous health in both Aotearoa New Zealand and Australia. We were first challenged by Associate Professor Papaarangi Reid on the current state of Indigenous Health in Aotearoa. This included the primacy of the claim that Indigenous groups to have their health needs met within a multicultural society. Dr Jacob Jacobs then spoke to us about his experiences in the Northern Territory and the degree of deprivation suffered by individuals living there. This was followed by Associate Professor Kelvin Kong who spoke to us on the role that our College, especially the Indigenous Health Committee, play in attempting to address these issues.

After lunch on the second day we turned our attention to work-life balance. We were addressed by Professor Andrew Hill about the rates of burnout amongst Fellows and ways to manage and prevent it. These practical tips were further explored by a presentation from Dr Antonio Fernando on Mindfulness, what it is and how to incorporate it into our lives. The final presentation of the day was from Dr Giri Mahadevan who talked to us about IT in Practice. Giri gave us some practical advice about what to look for and in various products for the office. He also helped us understand various privacy restrictions as they relate to the transfer and storage of data.

Dr Carlton Barnett represented the Association of Academic Surgeons (AAS, USA) as part of the Younger Fellows Leadership Exchange Program. He spoke on Day 3 about issues facing young surgeons in the USA. Some of these bore remarkable similarity to those confronting us in Australia and New Zealand. He was followed by Mr Richard Martin, Chair of the Younger Fellows Committee speaking on the Committee and the College and encouraging delegates to be involved in College activities.

The Forum concluded with a session to develop suggestions to report back to Council. These addressed areas brought up by participants in the first session and speakers over the subsequent days. Such topics were reformatting the Preparation for Practice course, investigating surgical coaching, cultural competence, Indigenous Health, and research.

Above all, we enjoyed ourselves and found the time productive and fruitful. We certainly felt that the objectives of the weekend had been met.

The 2014 Younger Fellows Forum will be held just before the RACS ASC, at the Hard Rock Hotel in Resort World, on the idyllic Sentosa Island. Discussion topics will include, but are not limited to, our College's activities for the underprivileged populations, especially in our neighbouring Asia-Pacific region, and the increasing demand for public disclosure of surgical outcome data. If past experience is anything to go by, it will be another fun-filled and fruitful meeting of the next generation of ANZ surgeons.

Nominations are now open, and will close at 5pm, 6 December 2013.

Nomination forms can be downloaded from: http://www.surgeons.org/media/20046770/2013_yf_forum_self_nomination.pdf

For further information, go to: http://www.surgeons.org/member-services/interest-groups-sections/younger-fellows-committee/younger-fellows-forum/

Email: **PDactivities@surgeons.org** or contact the Professional Development Department on **+613 9249 1122**

Andrew MacCormick
2013 Younger Fellows Forum Convenor)
Jon Morrow
2013 Younger Fellows Forum Co-convenor

e-Education for all

New e-learning resources

Since 2011 the Rural Health Continuing Education Program (Commonwealth of Australia) has funded major projects that have been managed by the College. In the November 2012 edition of *Surgical News* we reported on the Indigenous Health and Cultural Learning Online Portal and Australian Indigenous Health e-Learning Modules. Since then there has been great progress on two new projects – Management of Acute Neurotrauma in rural settings and Intercultural Competence.

Acute Neurotrauma

After the success of previous Acute Neurotrauma workshops, a revised project was developed with both an e-Learning and face to face workshop aspect to it.

The workshops run by Associate Professor Marianne Vonau and Dr Teresa Withers presented practical information about the management of acute neurotrauma with a demonstration of a burr-hole procedure using a Hudson brace. Workshop participants also had the opportunity to complete the procedure in small groups. These workshops have proven very popular and more funding to continue running these popular workshops has been sought.

The e-Learning package aims to provide strategies for the management of acute neurotrauma injuries prior to the patient being handed to a specialist medical team. The package provides an introduction to acute neurotrauma in a rural and remote setting exploring the incidence of head trauma and the factors influencing traumatic brain injury outcomes in the community. The package looks at the types of primary impact injuries and the most important secondary injuries, before reviewing the guideline and protocols for the initial management of acute Neurotrauma.

The online modules include a high quality video reference resource. The e-Learning package concludes with an opportunity to review the guidelines and protocols for the ongoing investigation and management of Acute Neurotrauma during the secondary survey and definitive care phase.

Five case study scenarios allow participants to consider the appropriate treatment path for the patient of each case study. These scenarios are designed to provide users the opportunity to synthesise and apply what they have learned in a practical way. Users are presented with different options and given feedback on their selections.

The College would like to recognise the invaluable contributions of Professor Peter Reilly, AO, FRACS; Associate Professor Marianne Vonau, OAM, FRACS; Dr Eric Guazzo, OAM, FRACS and Dr Teresa Withers, FRACS and the Neurosurgical Society of Australasia in the development of these modules.

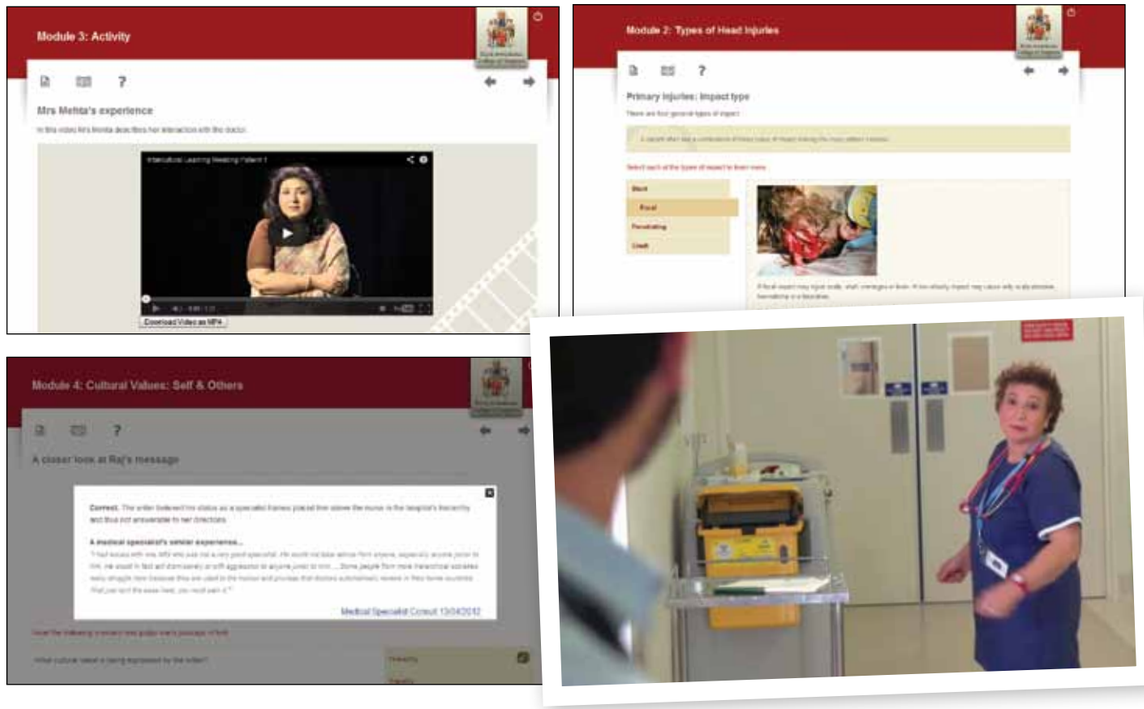
The Acute Neurotrauma e-Learning package can be accessed from the "My Page" of members. Go to the "RACS Knowledge" menu option and select "e-Learning".

Intercultural Competency for Medical Specialists

Australia and New Zealand are multicultural societies and through immigration, cultural diversity continues to grow. Providing appropriate screening, diagnosis, treatment, care and management for patients from such a wide range of backgrounds can be challenging for medical specialists and other service providers. Cross-cultural issues can make patient interactions difficult for some isolated practitioners and the need for further education in this area is clear.

The College partnered with 13 other medical colleges to lead the development of a professional development e-Learning resource dealing with intercultural competency for medical specialists. Special thanks go to Mr Mahiban Thomas, FRACS who chaired the medical College representatives for this project.

> *"There has been great progress on two new projects – Management of Acute Neurotrauma in rural settings and Intercultural Competence"*



The resulting e-Learning package contains six modules and associated activities, released in October 2013. The issues are common to rural and metropolitan specialists, Trainees and international medical graduates, so all specialist practitioners will find the package useful. The project was funded by the Commonwealth of Australia and has a focus on Australian specialists, but will be useful and accessible for New Zealand members as well.

The participating medical colleges identified cultural competence as an important competency for all medical specialists. Effective cultural competence skills help specialists to relate and communicate well with a range of patients and their families. Patients can be better advised of the range of treatments available to them and any associated risks so that valid consent can be obtained for treatment. It is important that specialists recognise the cultural factors that contribute to decision-making by patients and use appropriate communication styles to avoid poor outcomes.

Professional development in cultural competency and safety can assist in better understanding the behaviour and expectations of patients from diverse backgrounds, including race, ethnicity, nationality, class, gender and sexuality, and allow specialists to provide continuous improvements in clinical care.

The modules provide information on recognising cultural expectations; intercultural communication; the links among values, beliefs and behaviours; and strategies for cultural adaptation. They also include a range of activities to promote self-reflection regarding the impact of cultural issues on medical practice.

The Intercultural Competency e-Learning package can be accessed from the "My Page" of members. Go to the "RACS Knowledge" menu option and select "e-Learning".

For further information about the projects please contact: Andrew McLorinan at **andrew.mclorinan@surgeons.org**

We hope you will take advantage of these new eLearning packages for your professional development.

Cathy Ferguson
Chair, Fellowship Services Committee

The Sir William Manchester Memorial Symposium of

ART, HISTORY & PLASTIC SURGERY

14–16 March 2014
The Langham, Auckland

Convened by:
Dr Mike Klaassen FRACS

International keynote speakers include:
Dr Andrew Bamji
Prof Murray Meikle
Assoc Prof Michael Esson Prof Felix Behan FRACS Mr Brent Tanner

Local speakers include:
Dr Harvey Brown
Earle Brown FRACS
Darryl Tong FACOMS
Swee Tan FRACS

Registration Limited to the first 60 registrations

Fee: is $1000 incl GST
Full catering and handbook provided
Registrations close:
20 December 2013

To register contact:
Mike Klaassen
Selective Surgical Skills S3
PO Box 137301,
Parnell, Auckland 1052, New Zealand
P: +64 09 2158152
F: +64 9 3664698
E: m.klaassen@parnellsurgeon.co.nz

For more information visit: www.parnellsurgeon.co.nz

'Celebrating 100 years of the birth of modern plastic surgery, maxillofacial surgery, interdisciplinary collaboration and innovation for the restoration of facial disfigurement and burns - leadership, teamwork, planning with the vision of an artist and above all, winning the faith of their patients. Life saving and life giving surgical management that defied the impossible.' **MFK**

SimHealth 2013

The movement for more simulation in training

In September, Simulation Australia united its two annual national conferences, known as SimTecT and SimHealth, under one roof at the Brisbane Convention and Exhibition Centre. Associate Professor Wendy Babidge, from the Research, Audit and Academic Surgery Division of the College, was a member of the scientific committee for this conference, representing the surgical stream.

The conference theme, 'Crossing the Boundaries', challenged participants to consider the boundaries that exist in their context and how these have led to the development, adaptation or resolution of issues in education and training, research and professional collaboration using simulation.

The congress heard a number of keynote speakers including Dr Sonal Arora (Clinical Lecturer, Imperial College, London), Dr Jenny Rudolph (Associate Director, Institute for Medical Simulation at the Centre for Medical Simulation, Harvard, Boston), and Professor Guy Maddern (Professor of Surgery, The Queen Elizabeth Hospital, University of Adelaide).

Professor Maddern presented in the plenary session chaired by Associate Professor Babidge on 'Surgical Simulation: Has It a Future?', in which he discussed the mounting evidence for the incorporation of simulation into surgical training, the need for greater resources and the necessity for surgeons to identify and facilitate non-traditional training approaches.

A breakfast workshop entitled 'Surgical Team Simulation' was led by Professor Maddern and supported by Dr Guilherme Pena and Meryl Altree from the Research, Audit and Academic Surgery Division of the College. The issues involved in the development and organisation of a program of research surrounding non-technical skills training in the operating room were presented and discussed. Delegates were challenged to consider scenario development, briefing and debriefing, scoring tools, funding, logistics and recruitment.

A poster was presented by Dr Pena entitled 'Incorporating simulation into non-technical skills training for the operating room. Does it make a difference?' This presentation provided preliminary data from the current work being undertaken by the College in the area of non-technical skills development for the operating room.

Dr Pena also delivered a paper entitled 'What are the demographic predictors of basic skills acquisition on laparoscopic simulators?' This oral presentation focused on the rate of skills acquisition on various simulators which are influenced by different demographic characteristics of the participants. This work has implications for surgical education as it informs the selection of the most suitable laparoscopic simulators for specific populations of Trainees.

Associate Professor Babidge was invited to the SimHealth 2013 Research Summit on Friday, September 20, 2013, where individuals were brought together for a day to propose a thematic approach to healthcare simulation research and to generate a list of research areas for healthcare simulation relevant to Australia. The College will continue to be part of these important discussions.

Ian Bennett
Chair, RAAS

Developing a Career in Academic Surgery

Monday 5 May 2014, 7:00am – 4:00pm

SANDS EXPO AND CONVENTION CENTER
MARINA BAY SANDS, SINGAPORE

Provisional Program

Session 1	**A Career in Academic Surgery**
	What is a career in academic surgery? Academic Surgery – the essentials: 1. Research – How to get research started – ideas, grants, ethics and collaboration 2. Teaching, Leadership, Administration
Morning Tea	
Hot Topic in Academic Surgery: Overview of Comparative Effectiveness Research	
Session 2	**Career Development**
	I want to be an academic surgeon. What can I do as a: Medical Student Trainee - The pros and cons of fulltime surgical research during training Fellow Consultant
Lunch	
Keynote Presentation:	**Academic Leadership** **Carlos Pellegrini, President, American College of Surgeons**
Session 3	**Concurrent Academic Workshops**

Workshop 1: Tools of the Trade	**Workshop 2: Career Development Q & A**	**Workshop 3: Presenting Your Work**
Bedside to bench to bedside Basic science Randomised clinical trials Outcomes research Sugical education and research	Multiple faculty ***Attendees to bring along their own current or past research challenges for a masterclass***	Writing an abstract Writing a paper Presenting a paper The ANZ Journal of Surgery - What the Editor wants and where the Journal is going

Afternoon Tea	
Session 4	**A Career in Academic Surgery**
	Choosing and Being a Mentor Work-Life Balance On the Shoulders of Giants

This inspirational course is designed for surgical trainees, research Fellows and early career academics.

DCAS 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.

If you have been to a DCAS course before, the program is designed to provide previous attendees with something new and of interest each year.

Association for Academic Surgery Invited Speakers will include:

Caprice Greenberg, University of Wisconsin, Madison, Wisconsin, USA
Niraj Gusani, Pennsylvania State University, Pennsylvania, USA
Julie Margenthaler, Washington University School of Medicine, St Louis, Missouri, USA
Timothy Pawlik, Johns Hopkins Hospital, Baltimore, Maryland, USA
Timothy Pritts, University of Cincinnati, Cincinnati, Ohio, USA
Julie Ann Sosa, Duke University Medical Center, Durham, North Carolina, USA
Sandra Wong, University of Michigan Medical School, Ann Arbor, Michigan, USA
Wei Zhou, Stanford University, Palo Alto, California, USA

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

2013 Comments

"Excellent talks and inspiring international faculty. Great opportunities to network. I will definitely attend again."

"Reminded me why I challenged myself with research in the beginning."

Further information

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

Registration **Cost: A$255.00 per person**

Register on the ASC registration form or online at www.racsanzca2014.com

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

As per Regulation 4.9.1a for the SET Program in General Surgery, Trainees who attend the RACS Developing a Career in Academic Surgery course may, upon proof of attendance, count this course towards one of the four compulsory GSA Trainees' Days.

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 2014 will be required to marshal at 3.30pm for the Convocation Ceremony.

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

Information correct at time of printing, subject to change without notice.

More than $1.5 million awarded!

2014 Scholarship and Grant Recipients

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

There is a considerable amount of time and energy spent to properly evaluate the extensive number of applications that we receive. The Chair would like to thank all those involved, and in particular, A/Professor Phillip Carson (immediate past Chair), Professor Julian Smith, Dr Romi das Gupta, Professor Paul Norman and A/Professor David Walker, who all put in extra work towards this result.

Research scholarship and Fellowship recipients

John Mitchell Crouch Fellowship

Professor Andrew Hill – New Zealand
Specialty: General
Fellowship Value – $150,000
Andrew Hill is the Head of Medical Education at South Auckland Clinical School research group at the University of Auckland. He is an academic general surgeon with a colorectal subspecialty interest. His research interests are improving perioperative care of the abdominal surgical patient and medical education. It is interesting to note that Andrew's father, Graham Lancelot Hill, also received the John Mitchell Crouch award in 1984, and that together they are the first father and son to have both received this award.

Surgeon Scientist Scholarship

Dr Lawrence Lau - Vic
Speciality: General
Scholarship Value: $70,000
Topic: 18F-FDG PET, Diffusion-weighted MRI & circulating tumour cells: Predictive biomarkers to assess biology and tailor treatment in colorectal liver metastases
Supervisor: A/Prof Vijayaragavan Muralidharan

Raelene Boyle Scholarship – Sponsored by Sporting Chance Cancer Foundation*

Dr Penelope De Lacavalerie - NSW
Specialty: General
Scholarship Value: $60,000
Topic: Chemoradiotherapy responsiveness in rectal cancer patients
Supervisor: A/Prof Maija Kohonen Corish

Sir Roy McCaughey Surgical Research Fellowship*

Dr Anthony Glover - NSW
Specialty: General
Fellowship Value: $60,000
Topic: The pathogenesis of non-coding RNAs and microRNA therapy as a novel personalised treatment for advanced adrenal cortical carcinoma
Supervisor: Prof Stan Sidhu

Paul Mackay Bolton Scholarship for Cancer Research*

Dr Andrew Gogos – Tas
Specialty: Neurosurgery
Fellowship Value: $60,000
Topic: The role of the Hippo-YAP pathway in glioma stem cells
Supervisor: Mr Andrew Morokoff

Foundation for Surgery John Loewenthal Research Scholarship

Dr David Liu - Vic
Specialty: General
Scholarship Value: $60,000
Topic: Targeted molecular therapies and predictive biomarkers in animal models of oesophageal carcinoma
Supervisor: A/Prof Wayne Phillips

Foundation for Surgery Reg Worcester Research Fellowship*

Dr Rana Dhillon - Vic
Specialty: Neurosurgery
Fellowship Value: $60,000
Topic: Assessing the role of remyelination in functional recovery from cervical spondylotic myelopathy in an established pre-clinical mouse model
Supervisor: Dr Mark Kotter

Foundation for Surgery Catherine Marie Enright Kelly Scholarship*

Dr Anannya Chakrabarti - Vic
Specialty: General
Scholarship Value: $60,000
Topic: Targeting disseminated tumour cells in breast cancer - finding a potential therapy and prognostic markers
Supervisor: Dr Ian Street

Foundation for Surgery ANZ Journal of Surgery Scholarship*

Dr Joshua Petterwood - Vic
Specialty: Orthopaedics
Scholarship Value: $60,000
Topic: The kinematics of the arthritic knee before and after total knee replacement surgery - a prospective randomised trial
Supervisor: Prof Peter Choong

Foundation for Surgery Richard Jepson Research Scholarship

Dr Steven Due - SA
Specialty: General
Scholarship Value: $60,000
Topic: Targeting oestrogen receptors for the treatment of oesophageal adenocarcinoma
Supervisor: Prof David Watson

Foundation for Surgery Peter King Research Scholarship*

Dr Naseem Mirbagheri - NSW
Specialty: General
Scholarship Value: $60,000
Topic: Sonographic assessment of postoperative gastric function and its role in the early detection of paralytic ileus
Supervisor: Prof Marc Gladman

Foundation for Surgery Research Scholarship*

Scholarship Value each: $60,000
Dr Regent Lee – NSW
Specialty: Vascular
Topic: Plaque imaging and biomarker study
Supervisor: Prof Keith Channon

Mr James Cheng-Yen Lee – Vic
Specialty: General
Topic: Ceramide-dependent secretion of Exosomal miRNAs by papillary thyroid cancer cells
Supervisor: Prof Stan Sidhu

Dr Julian Ip – NSW
Specialty: General
Topic: Clinical and molecular aspects of adrenal tumorigenesis
Supervisor: Prof Stan Sidhu

Dr Wayne Ng – Vic
Specialty: Neurosurgery
Topic: Utilisation of glioma stem cells to investigate novel therapies for glioblastoma
Supervisor: A/Prof Katharine Drummond

CONROD-RACS Trauma Fellowship

Dr Rajat Mittal - NSW
Specialty: Orthopaedics
Scholarship Value: $50,000
Topic: Combined randomised & observational study of type B ankle fracture treatment (CROSSBAT)
Supervisor: Prof Ian Harris

Travel Scholarship, Fellowship and Grant Recipients

Margorie Hooper Scholarship

Dr Luke Johnson - SA
Specialty: Orthopaedics
Scholarship Value: $65,000

Murray and Unity Pheils Travel Fellowship

Dr Aileen Yen - NSW
Specialty: General
Fellowship Value: $10,000

Morgan Travelling Scholarship

Dr Justine O'Hara - NSW
Specialty: Plastic and Reconstructive
Scholarship Value: $10,000

Hugh Johnston Travel Grant

Dr Sebastian King – Vic
Specialty: Paediatrics
Grant Value: $10,000

Hugh Johnston ANZ Chapter American College of Surgeons Travelling Fellowship

Prof Alexander Heriot - Vic
Specialty: General
Grant Value - $8,000

Ian and Ruth Gough Surgical Scholarship

Mr David Bartle – New Zealand
Specialty: Orthopaedics
Grant Value: $10,000

Dr Sergei Tsakanov - NSW
Specialty: General
Grant Value: $10,000

John Buckingham Travelling Fellowship – 2013

Dr Laura Wang - NSW
Specialty: General
Grant Value: $3,000

James Ramsay Fellowships for Provincial Surgeons – 2013/2014

Dr Shane Anderson - Qld
Specialty: Otolaryngology Head and Neck Surgery
Fellowship Value - $10,000

Dr Nicola Hill – New Zealand
Specialty: Otolaryngology Head and Neck Surgery
Fellowship Value: $5,000

Dr Servaise de Kock – Vic
Specialty: General
Fellowship Value: $3,200

Dr Arumugam Elamurugan – Qld
Specialty: Plastic and Reconstructive
Fellowship Value: $2,000

Dr Clifton Washaya – NSW
Specialty: General
Fellowship Value: $1,800

Other Scholarships

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

NSA Research Scholarship - sponsored by Macquarie Neurosurgery

Dr Hari Priya Bandi – ACT
Specialty: Neurosurgery
Award Value: $50,000
Topic: Testing ligand-directed thrombotic agents in an animal model of Arteriovenous Malformation AVM)

NSA Research Scholarship - sponsored by DePuy Synthes

Dr Rana Dhillon – Vic
Specialty: Neurosurgery
Award Value: $15,000
Topic: The effect of promoters of oligodendrocyte precursor cell differentiation on remyelination and recovery in a rat model of cervical spondylotic myelopathy

Dr Sasha Rogers – NSW
Specialty: Neurosurgery
Award Value: $20,000
Topic: A new biopsy method to sample brain tumours in novel brain tumour mouse models

NSA Research Scholarship

Dr Andrew Gogos – Tas
Specialty: Neurosurgery
Award Value: $35,000
Topic: The role of the Hippo-YAP pathway in glioma stem cells

Dr Wayne Ng – Vic
Specialty: Neurosurgery
Award Value: $35,000
Topic: Utilisation of glioma stem cells to investigate novel therapies for glioblastoma

Avant Doctors in Training Research Scholarship - $50,000

ANZSCTS Research Scholarship - $20,000

Dr Andrew Cheng – Vic
Specialty: Cardiothoracic
Topic: Prevent atrial fibrillation
Supervisor: Dr Cheng-Hon Yap

Garnett Passe and Rodney Williams Memorial Foundation – OHNS Scholarship

Dr Nathan Creber – Vic
Specialty: Otolaryngology Head and Neck Surgery
Award Value: $210,000
3 year Research Scholarship

Dr Timothy Marr – WA
Specialty: Otolaryngology Head and Neck Surgery
Award Value: $140,000
2 year Research Scholarship

Sam Mellick Travel Fellowship Awarded by ANZSVS

Dr Domenic Robinson – Vic
Specialty: Vascular
Award Value: $5,000

Preliminary Notice: Applications for 2015 scholarships will open in March 2014

Adrian Nowitzke
Chair, Board of Surgical Research

The College finances and budget 2014

A report from the Treasurer

The College Budget for 2014 was approved at the October meeting of Council. This was after an extensive review by the governing committees and boards of the College. Fellows' subscriptions and Trainees' fees fund a variety of important activities and services and therefore I thought it would be beneficial to summarise next year's operations demonstrating our business plans continue to be financially sustainable.

The College activities are divided into three separate "businesses". Firstly there are activities related to your College's core purpose – namely education and training, professional development and standards, as well as regional and national advocacy. These resources such as our world-class library are funded from your subscription and training fees. Secondly, the College administers a growing program of research, aid and audit projects that are externally funded predominantly by government agencies such as Department of Health and Ageing and AusAID. These projects provide multiple health programs from specialist training, Indigenous health, audit and international humanitarian assistance. The third business activity centres mainly on the Foundation which provides scholarships for research, Indigenous health and funds for international aid. These activities are funded through donations to the Foundation and bequests.

The Budget process started in June with the assessment of key budget parameters and strategic initiatives for 2014. Within this guiding framework, the budget is formulated and presented to Council for review and approval. The College continues to maintain a strong financial position and has budgeted for a modest surplus of $800k or 2 per cent

surplus return on projected revenue from its core business activities. The 2014 Budget underpins investment in Fellows' and Trainees' services and educational activities while maintaining the financial capability to fund the overall business structure and resources appropriate for your professional College.

Key attributes incorporated in the budget strategy review and the budget processes were to:

- achieve a modest surplus return from core operations
- fees from Trainees, International Medical Graduates and Fellows need to support the costs of the infrastructure and governance of the College
- subscription fees to be increased by CPI to ensure all Fellow related activities are fully funded from fees charged
- training, education and international medical graduate fees to be increased by Education Price Index to ensure all training and educational expenditure is fully funded from fees charged
- review of all NZD denominated fees to be charged at AUD equivalent to maintain equity in fee structure between the jurisdictions
- project related activity should be fully funded
- new key initiatives proposed will be assessed on the basis of adding value to Fellows and Trainees.

Category 1

In 2014 revenue from operational activities is budgeted to increase by 9 per cent to $39,521k (2013 - $36,292k) while expenditure is budgeted to increase by 9 per cent to $38,721k (2013 - $35,589k).

Specific items of expenditure in category 1 activities include:

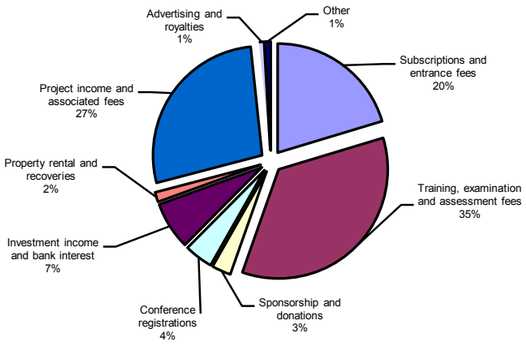
- personnel costs – increased by 8 per cent to $14,148k (2013 - $13,121k) and provides for salary increases in line with the general market and new staffing resources to support the delivery of new initiatives and growing business needs.
- consultants' fees – clinical - $197k (2013 - $332k) – activities for clinical/ medical support and assessments, usually provided by Fellows of the College.
- printing and general office supplies - $1,408k (2013 - $1,304k) primarily related to the production of the ANZ Journal of Surgery, Surgical News and prospectus for the Annual Scientific Congress.
- travel and accommodation - $4,046k (2013 - $3,906k) – predominately relates to governance activities, travel co-ordination for examinations and skills courses.
- property costs - $1,844k (2013 - $1,861k) predominantly related to the leasing of office premises in NSW, QLD, WA and New Zealand and scheduled property maintenance and service programs.
- specialty society funding - approximately $5,000k provided for from Surgical Education Training (SET) fees in accordance with the training partnership agreement (fees still being confirmed by specialty societies at time of printing).

In addition to the delivery of core Fellowship services, training and education programs, Council also approved an additional $609k funding from the Category 1 surplus of $800k in 2014, to enhance our priorities including:

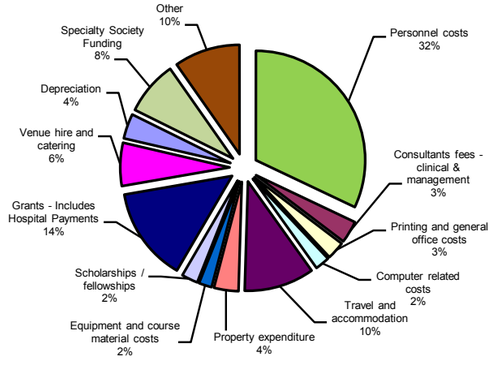
- continue to promote the FRACS brand as a quality mark standing for excellence in surgical care
- ongoing development of new and innovative online and Information Technology based resources to support Fellows, Supervisors and Trainees including developing mobile device compatible CPD systems.
- further expansion of library resources to promote lifelong learning including acquisition of Embase, a key medical database and Springer eBook package

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

Budget 2014
Sources of Revenue



Budget 2014
Sources of Expenditure



Total College Budget – All Business Activities – 2014

	Budget 2014 $000s	Budget 2013 $000s	Increase / (Decrease) %
Revenue	61,276	56,310	9% ↑
Expenditure	57,750	55,222	5% ↑
Total Surplus	3,526	1,088	224% ↑

to complement the College's existing eBook collection
- all examinations will progressively move to an improved IT platform that will provide greater efficiencies in the development and delivery of the Fellowship and other examinations
- active advocacy initiatives with high level stakeholder representations including funding to appoint a policy and communications staff member to proactively initiate advocacy initiatives in New Zealand

Category 2

In 2014 revenue for College project activities has decreased by 1 per cent to $16,897k (2013 - $17,073k) while expenditure is forecasted to be $16,852k (2013 - $16,917k). The overall result is a projected surplus of $45k which provides a modest return to the College's consolidated earnings after accounting for all direct and indirect costs.

All externally funded projects are levied with a College overhead charge which is budgeted to generate funding of $748k (2013 - $836k) to provide coverage of costs associated with the oversight governance and corporate support of project related activities.

The total contract value of currently operating projects is approximately $76 million and demonstrates continuing significant Commonwealth investment in specialist training programs, research, international aid and surgical audit.

Specific items of expenditure in category 2 activities include:
- personnel costs - $4,292k (2013 - $3,663k) represents ongoing level of staffing need
- consultants' fees – $1,102k (2013 - $1,839k) – relates to professional services from external consultants for clinical / medical support and assessments provided to the College projects with increase in costs generally due to full year operation under the funding contract for the Timor Leste Program II
- grants - $7,160k (2013 - $6,974k) predominately related to specialist training posts and rural loading hospital payments under the Specialist Training Program contract.

Category 3

Revenue for all activities relating to the Foundation and Investments is budgeted to increase 65 per cent to $4,858k in 2014 (2013 - $2,945k) and mainly relates to setting a projected 8 per cent rate of return on investments compared to 5 per cent for 2013. Expenditure is budgeted to be $2,176k (2013 - $2,716k) resulting in a forecasted surplus of $2,682k (2013 - $229k) which provides ongoing funding of scholarships, fellowships and research grants and other philanthropic endeavours.

The Investment Committee provides direct oversight of the investment activities, the Board of Surgical Research the oversight of the significant research scholarships and grants program and the International Committee the oversight of the international scholarships and other surgical aid initiatives.

Balance Sheet

As at 31 December 2014, it is estimated that the College net assets will be $65,569k (2013 forecast - $62,043k).

College Properties

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

The College sold the Brisbane property earlier this year and has relocated to leased premises. Furthermore the New Zealand office has also relocated into new leased premises due to OH&S issues relating to current assessment of seismic strengthening requirements of the New Zealand property, Elliott House.

Maintenance and repair of these properties has decreased to $224k compared to $262k in 2013 and relates to routine scheduled maintenance.

In Closing

As the year draws to a close, the College continues to make significant progress regarding the key activities outlined in the Strategic Plan. The proposed initiatives, and challenges, for 2014, which I have outlined in my report, will ensure that the College continues to meet these challenges and progress in 2014.

I would like to thank my Deputy Treasurer, Mr Andrew Brooks, for his continued support during 2013 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 OAM, Mr Michael Randall, Mr Anthony Lewis, Mr Stuart Gooley, Mr Reg Hobbs, Mr John Craven, Mr Chesley Taylor and Mr Peter Wetherall for their ongoing advice and support. Also the advice, excellent service and support from Mr Graeme 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 has been set to continue to invest 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 continues on a solid base and is in sound shape for the year ahead.

Marianne Vonau
Treasurer
November 2013

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SUMMARY OF SUBSCRIPTIONS AND OTHER FEES FOR 2014

	2014 AUST Fees AUD (Inc. GST)	2014 NZ Fees NZD (Inc. GST)
SUBSCRIPTIONS & ENTRANCE FEES		
Annual Subscription - 2014 payable on 1 January 2014	#* $2,570	$3,410
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)	$330	$457
Selection Processing Fee - (Note 6)	$715	$950
Selection Registration Fee	$485	$640
SET Training Fee - College Component - 2014	#* $3,000	$4,370
Examinations		
Clinical Examination Fee	* $1,985	$2,900
Fellowship Examination Fee	* $7,190	$10,500
Generic Surgical Science Examination Fee	* $3,460	$5,050
Orthopaedic Principles & Basic Science Examination Fee	* $2,600	$3,795
Paediatric Anatomy and Embryology Examination Fee	* $3,280	N/A
Paediatric Pathophysiology Examination Fee	* $1,300	$1,900
Plastic and Reconstructive Surgical Science & Principles Examination Fee	* $2,600	$3,795
Cardiothoracic Surgical Sciences and Principles Examination Fee	* $3,280	N/A
Specialty Surgical Science Examination Fee	* $1,730	$2,525
OTHER FEES		
Appeals Lodgement Fee	$6,795	N/A
International Medical Graduates		
Paper Based Assessment Fee	$5,455	N/A
Paper Based Assessment & Interview	$8,220	N/A
Supervision / Oversight Fee- onsite	$6,655	N/A
Supervision / Oversight Fee - remote	$19,015	N/A
Document Assessment Fee - AoN subsequent to specialist assessment	$1,305	N/A
Document Assessment Fee - College endorsement for AoN (Area of Need)	$1,305	N/A
Assessment Fee - Reconsideration for Exceptional Performance	$2,610	N/A
Short Term Specified Training Position Application Fee	$1,045	N/A
MOPS - Maintenance of Professional Standards		
Australia & New Zealand	$2,850	$3,785

1. All fees are payable in either Australian or New Zealand Dollars as invoiced.
2. All New Zealand fees will be subject to GST of 15% unless marked with (**) which are not subject to New Zealand GST.
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, 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.
7. N/A relates to College services not charged in stated currency.

A full list of fees can be found on the College website.

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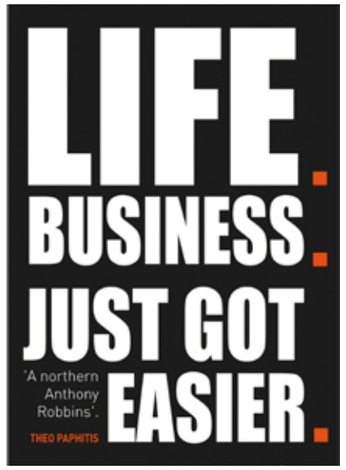

Life. Business: Just Got Easier

Brad Burton
9780857084835 | Pbk | 216 pages | September 2013, Capstone

~~AU$19.95~~ | **AU$12.97**
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A motivational smack in the face! Brad Burton, once a regular in the dole queue, burdened with unbearable levels of debt, is now the MD of a multi-million pound international business. If anyone knows about sorting your life out, it's Brad. But this isn't Brad's story – this is about YOU. Brad is here to share practical, actionable steps – stuff you can actually do – to improve your life, both at home and in business. He's learnt exactly how to motivate yourself, focus on your passion, face setbacks and keep on moving forward – and now Brad wants to share these lessons with as many people as possible. We all have it in us to improve our lives and succeed – we just need a friendly kick in the pants from Brad!

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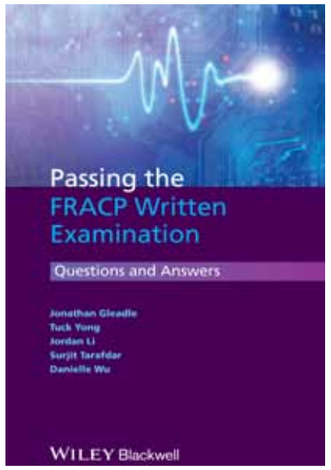

Passing the FRACP Written Examination: Questions and Answers

Jonathan Gleadle, Tuck Yong, Jordan Li, Surjit Tarafdar, Danielle Wu
9781118454954 | Pbk | 472 pages | October 2013

~~AU$105.00~~ | **AU$68.25**
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Passing the FRACP Written Examination is the ideal study aid for candidates of the Fellow of the Royal Australasian College of Physicians (FRACP) examination. Written by a team of physicians based at Flinders Medical Centre, and covering the key components of the FRACP basic training syllabus, this guide presents over 500 multiple-choice questions on all major topics covered in the examination. Questions echo the written examination, including those on both 'Basic Sciences' and 'Clinical Practice'.

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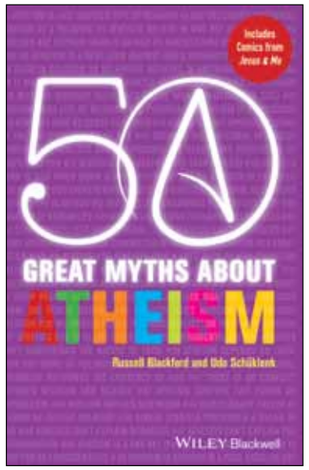

50 Great Myths About Atheism

Russell Blackford & Udo Schüklenk
9780470674055 | Pbk | 288 pages | October 2013

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