Surgical News

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS **OCTOBER 2013**

INCLUDES Call for Abstracts for 2014 ASC in Singapore! *p 42*

The College of Surgeons of Australia and New Zealand

How to survive as a consultant surgeon

What you need to know **p32**

Royal Australasian College of Surgeons

2013 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.

Preparation for Practice

25 - 26 October 2013, Brisbane

This two-day workshop is a great opportunity to learn about all the essentials for setting-up private practice. The focus is on practicality and experiences provided by fellow surgeons and consultant speakers. Participants will also have the chance to speak to Fellows who have experience in starting up private practice and get tips and advice. This activity is proudly supported by The Bongiorno National Network, mlcoa and MDA National.

Writing Medicolegal Reports

28 October 2013, Melbourne

This 3-hour evening workshop helps you to gain greater insight into the issues relating to providing expert opinion and translates the understanding into the preparation of high quality reports. It also explores the lawyer/expert relationship and the role of an advocate. You can learn how to produce objective, well-structured and comprehensive reports that communicate effectively to the reader. This ability is one of the most important roles of an expert adviser. This activity is proudly supported by Avant and mlcoa.

Keeping Trainees on Track (KToT)

12 November 2013, Sydney

This 3-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.

Building Towards Retirement

16 November 2013, Melbourne and via video link in Sydney

Surgeons from all specialties who are considering retirement from operative or other types of surgical practice will benefit from attending this day-long workshop. Fellows from a variety of disciplines and their partners join with colleagues and corporate speakers in an interactive discussion format that focuses on three sessions on preparing for retirement, options after retirement and resources to realise options.

Non-Technical Skills for Surgeons (NOTSS)

28 to 29 November 2013, Auckland, New Zealand (Faculty Training)

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 that of your colleagues.

AMA Impairment Guidelines 5th Edition: Difficult Cases

27 November, Melbourne

The American Medical Association (AMA) Impairment Guidelines inform practitioners as to the level of impairment suffered by patients and assist with decisions about a patient's return-to-work. While the guidelines are extensive, they sometimes do not account for unusual or difficult cases that arise from time to time. This evening workshop (3 hours) provides surgeons with a forum to review difficult cases, the problems encountered and the steps that can be applied to resolve the issues. This activity is proudly supported by Avant and mlcoa.

NSW

12 November, Sydney
Keeping Trainees on Track (KToT)

NZ

28 - 29 November, Auckland
Non-Technical Skills for Surgeons (NOTSS) Faculty Training, Auckland

QLD

26 - 27 October, Brisbane
Preparation for Practice

VIC

28 October, Melbourne
Writing Medicolegal Reports

16 November, Melbourne
Building Towards Retirement

27 November, Melbourne
AMA Impairment Guidelines

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

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ISSN1443-9603 (Print) ISSN 1443-9565 (Online)

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

ON THE COVER: Nick Markham talks about things you need to know, **p 32.**

President's Perspective

Fifty Years On…

Working to make a difference

In the midst of all the politically generated hype that has occupied our media and sometimes our thoughts over the past few months, there has been one event that has penetrated through this, the significance of which has faded with time. I was reminded of it recently when, after attending a surgical leaders forum hosted by the American College, I decided to spend Saturday morning, while awaiting my flight, walking from Capitol Hill to the Lincoln Memorial.

On the way I passed the almost-complete Martin Luther King Memorial. Americans recently celebrated the 50th anniversary of the speech by Martin Luther King Jr. that has become famous as the 'I have a dream' speech. Based on the self-evident truth that all men are created equal, his words not only defined the moment for the 250,000 civil rights supporters present that day in Washington, but continued a revolution that eventually saw President Obama commemorate the 50th anniversary.

It brought me to thinking about Australia's own 50th anniversary. It is 50 years since the Yolngu bark petitions were sent to the Australian Federal Parliament by 13 clan leaders of the Yolngu region of the Northern Territory. They are now exhibited in Parliament House, in a ceremonial hall that also houses the Magna Carta and the Australian Constitution.

Rightly, they are considered founding documents of our democracy and were a catalyst for a long and ongoing process of legislative and constitutional reform to recognise the rights of Indigenous Australians. They were an essential part of the process towards the 1967 Referendum and the ongoing recognition of the Aboriginal people.

Australia has for so long been so far behind

New Zealand and the USA in issues of appropriate recognition. Indeed Australia only graduated its first Aboriginal medical graduate 30 years ago – 100 years later than comparable countries like New Zealand.

Internationally I am asked about the health profile of Australia's Aboriginal and Torres Strait Islander people. It is hard to say that Australia has a world-class health system when gaps in health outcomes between the indigenous and non-indigenous Australians are so large.

Despite generous funding and well intentioned commitment by politicians, it remains an area of great concern. Hopefully ongoing commitment promised by the newly elected government will finally see the gap in health outcomes start to close more quickly.

"It is hard to say that Australia has a world-class health system when gaps in health outcomes between the indigenous and non-indigenous Australians are so large"

The College Foundation has created a corpus to enable funding of appropriate initiatives, particularly to highlight surgical careers to Aboriginal and Torres Strait medical graduates. The Committee of Presidents of Medical Colleges (CPMC) and the Australian Indigenous Doctors' Association (AIDA) hope that their recently signed collaboration agreement will see an increase in trained medical specialists and also a profile and engagement in possessing the knowledge and skills to work competently with indigenous populations.

The national health plan for the Aboriginal and Torres Strait Islanders highlights health equality and a human rights approach as well as community control and engagement. Only by continuing to prioritise and improve issues of accessibility, appropriateness and impact for the indigenous population within a health system that is itself free of racism and inequality, will the goals that we all share be achieved. Obviously the same objectives apply to indigenous New Zealanders.

An interest in things historical often provides the nudge we need to focus our thoughts on issues that might otherwise slip past. I am very keen for our College to make a major contribution to Indigenous health in both countries. Hopefully we can partner with others on these issues to produce even better results.

Mike Hollands
President

The College role among peers

We must consider how our healthcare peers see us

Recently I received a very interesting submission from Nigel Willis, Chair of the New Zealand National Board and Justine Peterson, the New Zealand Regional Manager. Although it has a NZ 'flavour', the parallels and potential ramifications resonate in the Australian context. I reprint their submission and encourage you to read it. I would also be grateful for any feedback.

The College constitution clearly states our purposes in regard to surgical education and research, determining and maintaining professional standards, promoting and supporting the Fellowship and providing authoritative advice and information to governments, other organisations and the public.

Other organisations have similar goals – perhaps not specifically for surgery, but certainly under the heading of 'healthcare'. So how do the College's stated purposes sit alongside the expectations of governments and their agencies, in particular those that also have stated purposes related to professionalism and standards within healthcare?

The Council of Medical Colleges in New Zealand (CMC) held a forum recently that explored how key statutory agencies viewed the roles and responsibilities of medical Colleges. The agencies were specific to New Zealand, but there are counterparts in Australia with similar statutory roles.

For instance, the Medical Council of New Zealand is the statutory regulatory authority, as is the Australian Health Practitioner Regulation Agency. New Zealand's Ministry of Health and District Health Boards (DHBs) would, together, have similar responsibilities to Australia's Federal and State Departments of Health and Health Service networks.

Equally there are Commissioners in Australia with responsibilities for patients' rights, similar to those of New Zealand's Health & Disability Commissioner.

Australia does not have an exact equivalent to PHARMAC, although the Therapeutic Goods Administration or Pharmaceutical Benefits Scheme may have some similarities. PHARMAC (Pharmaceuticals Management Agency) was established in the 1990s to get better value for government-funded medicines through more competitive pricing. PHARMAC also decides the medicines and related products that are subsidised for use in the community and, in some cases, funded in public hospitals; and, from 2015, it will have the same responsibility for publicly-funded therapeutic medical devices.

All of these groups have a role in setting expectations and in monitoring the performance of medical practitioners, including surgeons, and all have a view on where the medical Colleges fit into their scheme.

No agency at the Forum challenged the purpose of medical Colleges in education, training and research for their particular branches of medicine. However, it was noted that there are other potential providers who may, at some stage, also seek to have involvement in this area.

The medical Colleges' role in providing advice to government agencies on broad issues was also accepted; with the qualifier that the Colleges might be just one of many groups submitting information and comment.

The decision on whose advice to accept rested with the relevant agency and, depending on the issue, Colleges' comments may not hold sway.

There is no doubt that all agencies participating in the CMC forum look to the medical Colleges for advice on identifying practitioners who are respected by their peers and are considered suitable to be advising those agencies on specific instances where there may be concerns about the clinical standards of a practitioner.

The agencies might then apply their own criteria, but they start their process

> ***"So how do the College's stated purposes sit alongside the expectations of governments and their agencies?"***

with those identified by the medical Colleges. The support that could be provided to an individual clinician by members of his/her College was also acknowledged.

All agencies perceived value in utilising the collegial links within medical Colleges to monitor professional and clinical standards and, at given 'trigger points' that varied among the agencies, to have the Colleges intervene and encourage changes to clinical practice at both an individual and a group level.

Overall there was remarkable congruence between how the Colleges and the agencies perceived the purpose of medical Colleges. However, as with many things, the devil may be in the detail.

A lawyer specialising in health services sounded a note of warning to Colleges that they be wary of taking-on tasks that they had no statutory ability to enforce, and that could be challenged in Court. The costs from any Court challenge, regardless of whether or not a College 'wins', will always be high in dollars and possibly also in public perception.

The 'Phipps vs Royal Australasian College of Surgeons' case, where a clinical review conducted by the College under a contract to a public health service was challenged through several New Zealand courts and as far as the Privy Council, was presented as a warning note to all.

Even without concern for potential legal action, some of the expectations of agencies could well impinge on medical Colleges' purses.

For example, the Chair of the MCNZ recently floated suggestions related to approval of individual annual CPD plans, and of automatic, five-yearly College reviews of groups of 'at risk' practitioners and one-off reviews of practitioners who meet risk factors identified by the MCNZ.

An example of 'at risk' practitioners might be all those working in geographical isolation or in numerically small departments, or all those beyond a certain age. Practitioners meeting 'identified risk factors' might be where three or more complaints are received by the Health & Disability Commissioner within a five-year period (irrespective of whether the complaints were found to have substance).

While there might be conceptual agreement on risk factors, it would be important that processes and mechanisms used to review and ameliorate the risks were designed by the relevant medical College and that this not be a cost-shifting exercise on the part of a regulatory authority.

When clinician time and health funds are stretched, it is important that both are used wisely to achieve the best benefit for patients. Clearly there will need to be more discussions on the MCNZ Chair's 'suggestion'. The New Zealand National Board will be following this up with him and ensuring the wider College is kept advised.

Michael Grigg
Vice President

Help for our neighbours

A team of medical professionals from the Royal Australasian College of Surgeons have provided medical assistance to local doctors in life-saving treatment for children in Fiji.

Led by Auckland paediatric surgeon Philip Morreau, the team treated 18 children in the program along with Suva-based paediatric surgeon Dr Josese Turagava.

Dr Morreau said the trip was a way to help local surgeons develop skills and knowledge in treating children.

"It has been good to see some of the developments already taking place and we need to keep giving assistance so that these surgeons learn more," Dr Morreau said.

***Fiji Times*, September 9**

Drug trial for trauma victims

A drug used in surgical procedures to prevent blood clots from breaking down will be administered by paramedics in an attempt to stop trauma victims bleeding to death.

The trial will be run by the National Trauma Research Institute, headed by Alfred Hospital (Melbourne) trauma surgeon Professor Russell Gruen.

The trial is under ethics approval, though is hoped it will measure not just patient survival, but also level of disability after the accident or incidents of stroke and heart attack.

***The Mercury*, September 2**

SA health cuts

Health cuts in South Australia have drawn the ire of a range of health organisations, including the Royal Australasian College of Surgeons. Groups say that the cuts are based simply on savings and not on providing the best clinical care.

The College's South Australian Chair Peter Subramaniam has been vocal on the cuts.

"The planned changes are based on length of stay and cost, not clinical outcomes. We need evidence that clinical outcomes will not be adversely affected by these changes," Mr Subramaniam said.

***Adelaide Advertiser*, July 29**

College in NZ on the move

The New Zealand National Board of the College have reluctantly vacated their historic premises at Elliott House after being assessed as 'Quake Prone' by the Wellington City Council.

The historic building is 100-years-old and has a long history of connection to the College. It was the head office for the board. Board Chair, Nigel Willis said there are a number of issues to consider about the building's long-term viability.

"For the safety of our staff, as well as College Fellows and Trainees who use or visit the building, we opted to move in the short-term."

***The Dominion Post*, September 12**

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SYDNEY COLORECTAL SURGICAL MEETING

Royal Australasian College of Surgeons

16 November 2013
Hilton Sydney Hotel
488 George Street, Sydney, NSW

To receive a copy of the program or to register please contact:

CONFERENCE ORGANISER
RACS Conferences & Events Management
Royal Australasian College of Surgeons
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Photo credit: Steve Back, Destination NSW

Royal Australasian College of Surgeons Trainees Association

Surgical Training Conference: Induction for New Trainees

30 November 2013

Save the Date!

This **Conference** is designed to facilitate new Trainees' entry into the training program to optimise their training experience by providing guidelines and practical support in the following critical areas:

- Examination Preparation
- Skills Preparation (Basic Surgical Skills)
- Professionalism
- Career Planning

Program Outline:

- The educational objectives of the College and the expectations of Supervisors and Trainees
- Examination preparation
- SET 1 experiences of a Surgical Trainee
- Practical workshop sessions
- A practical guide to surgical research
- Surgical competencies workshop session
- Practical pointers on how to be a good registrar

Further Information

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T: +61 3 9249 1158
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Across the desert

State representatives are seeing first-hand the help needed in rural and regional areas

The Western Australian Committee of the College has embarked on a program of regional visits to hear directly from local surgeons, hospital staff and GPs about the challenges they face in providing the most effective, efficient surgical services across Australia's largest state.

From the vast emptiness of the Pilbara, to the thriving Goldfields, to the beautiful but isolated Kimberley, to the more urbanised Southern regions, the variability and sheer size of Western Australia often poses challenges to health care that are unique in Australia.

According to the former chairman of the WA Committee, Mr Rob Love, the program grew from an initial request to visit the Kimberley region to discuss the possibilities of, and limitations confronting, local surgeons and GPs accessing tele-health support.

In April, Mr Love and the current chairman Mr Tom Bowles travelled to Broome and Kununurra where they had meetings with local staff as well as tele-conferences with surgeons, anaesthetists and obstetrics staff from Fitzroy Crossing and Derby Hospitals.

"The visit to the Kimberley initially came up for discussion through the Committee via the request to discuss tele-health but has since grown into a larger program," Mr Love said.

"Firstly, we wanted to go there so that we could report back to the committee on ways in which we could further support the use of tele-health in more remote regions because of the size of Western Australia and the transport and logistics involved in treating patients across such distances.

"However, we also wanted to show support to our colleagues, in particular the two surgeons up there who service the enormous area of the Kimberley.

"We wanted to meet face-to- face, to understand the details of their working lives and find out if there was anything the College could do as an organisation of advocacy that could result in improvements."

Since that meeting, Mr Love and Mr Bowles have co-signed a letter of recommended improvements to the WA Department of Country Health Service and held meetings with the Director General of the WA Health Department, retired neurosurgeon and Fellow Professor Bryant Stokes.

In particular, the Committee has asked for:

- The better utilisation of the second theatre in the Broome Hospital which is currently unstaffed but which could be used for emergency lists or a general list when visiting specialists arrive and need the main theatre;
- A full-time anaesthetic position to be considered for the Kimberley that could provide support for more complex cases rather than transferring patients across vast distances and that could also help provide cover, ensure standards and provide ongoing education;
- Increased anaesthetic support in the management of the current Nurse Specials area at the Broome Hospital to allow it to function as a High Dependency Unit thereby decreasing the need for transfers and allowing more complex cases to be managed locally;
- The consideration of a third surgeon for a region that experiences a doubling of the normal population during the dry season;
- An increase in the on-call roster of the surgical Trainee position at Broome Hospital to ensure the Trainees are exposed to surgical emergencies, an adequate number of procedures and also learn decision-making skills in a unique geographical setting;
- Greater co-ordination of the tele-health process between GPs, specialists and surgeons across the region.

Mr Love, a plastic and reconstructive surgeon who has a public practice out of the Sir Charles Gairdner Hospital and a private practice, said that despite some early misunderstandings on the part of the Health Department, he believed most of the issues raised were now under active consideration.

"Once we got up to Broome it became obvious that there were more issues that needed to be addressed than simply those relating to tele-health," he said.

"We found that while the region is serviced very well by a group of highly dedicated surgeons, medical and para-medical staff, they faced unique challenges such as the doubling of the population during the winter months.

"It was also greatly re-assuring to discuss these issues with Professor Bryant Stokes who confirmed that he had made similar recommendations two years previously, before becoming the Director General of Health, so we now remain cautiously optimistic."

Mr Bowles, a general surgeon from Albany with an interest in colorectal surgery, became Chair of the state committee in August; the first regional surgeon ever to hold the position.

"We also wanted to show support to our colleagues, in particular the two surgeons up there who service the enormous area of the Kimberley"

He said he thought it of great importance for Committee members to undertake such regional visits to support Fellows across the state and said he planned to undertake a similar visit to the Pilbara region in October.

He said the Committee had worked hard in recent years to lobby for an increase in training positions at regional hospitals to provide young surgeons with exposure to country life in WA in an effort to overcome workforce gaps and shortages.

"One of the unique issues we face is the lack of private hospitals and therefore private surgical positions in WA because only Perth and Bunbury have private facilities," Mr Bowles said.

"This can lead some Trainees to believe they will have less control over their professional lives than they may have in the Eastern states or other urban centres so we have to work hard to attract them here and support them when they become Fellows, particularly if they are working in remote areas.

"That is the underlying thinking behind these regional visits and even I, who work in a WA region, found the trip to Broome an eye-opening experience in terms of the logistics behind providing surgical services across such a vast region."

Unique challenges

Mr Bowles said that two of the most pressing issues were the position of a third surgeon during tourist season and raising the responsibility level of the Trainee position.

He said he believed that if funding was provided, the position could suit a surgeon approaching retirement or one who wished only to work part of the year.

"We are also very keen to increase the responsibilities and exposure of the Trainee position in Broome which I believe is now being addressed," he said.

"This is now a SET2 position and we believe a 1-in-3 on-call roster would help increase not only the Trainee's surgical skills but their decision-making and logistics skills.

"For instance, if the Broome Hospital gets a call from Kununurra, the surgeon needs to understand the transport distances involved, how the patient might be moved, where best to move them to and whether the plane needs to stop en-route to Perth to pick-up blood if the patient is bleeding.

"In the Kimberley, there is only one set of ophthalmological and ENT instruments so the theatre managers need to ensure they are at the right hospital at the right time while surgeons need to develop an understanding of logistics behind the scenes when they book lists.

"All these matters are unique to the Kimberley while there are others that are specific to different areas of WA and I am proud that the WA Committee is taking on this program of visits because it is often very difficult for surgeons in remote areas to get their voices heard."

With Karen Murphy

Music for the masses

Do you have to?

There is one thing that really annoys me and that is music – well not all music, but some music. All parents will have been annoyed by their teenagers' awful migraine music, but that is a passing fad. Eventually they get over it and learn to like ABBA and The Beatles. One of the things that really gets up the nose of we curmudgeons is having things forced on us. It seems that music is one such thing that is pushed onto the unwilling by the music vandals.

I phoned an office the other day and was put on hold. What was the music? – Triple J! If I was calling about a rock concert or wanted to enquire about having a tattoo, I could understand it, but I was calling about car insurance. By the way how does the government justify giving money to that station. They say it is "our ABC". Well, that part of the ABC is certainly not my ABC.

At the other extreme is the banal vanilla music of "Muzak" – that mindless synthetic music that drones on and on – usually in shopping centres, elevators and some offices. You can't get away from it as you are trapped in a confined space. I understand that in February, 2009, Muzak filed for bankruptcy. Unfortunately about a year later they emerged from bankruptcy.

Another sort of music that we curmudgeons object to is tradesmen's music. Why is it that tradesmen arrive to do a job, turn on their ute radios (usually pre-tuned to Triple J or worse), turn up the volume, open the doors of the ute and then go inside the house to work? Surely the glue on the tiles will set without "thump, thump, thump". Don't they know about portable radios that they can have next to them? Do they really think that the whole neighbourhood is enamoured with their taste in music?

As for unwanted music in businesses – well that is another thing. Restaurants are the worst offenders. Many lovely meals are ruined by hideous music from a CD or iPod that reflects the musical taste of those serving, not the diners. Do diners at the Hilton want to hear the raucous beats of the "Stones"? My local bank branch is also bad. They have an mp3 player attached to a sound system that plays the tastes of the teenage teller staff – it is definitely not music. How can you think about term deposits to the strains of the Sex Pistols or Black Sabbath?

As for that guy in the park next to me – do I really need his music at a painful decibel level? I have a revenge however. My one-year-old grandson who is with me can out shout the Stones, drown out Led Zeppelin and make Marilyn Manson seem mild. As for KISS and AC/DC, well young Oliver – go for it!

In Memoriam

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

Alwyn J. Seeley,
New Zealand Fellow

Jack L. Swann,
Victorian Fellow

Frederick Binns,
Tasmanian 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

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NSW: Allan.Chapman@surgeons.org
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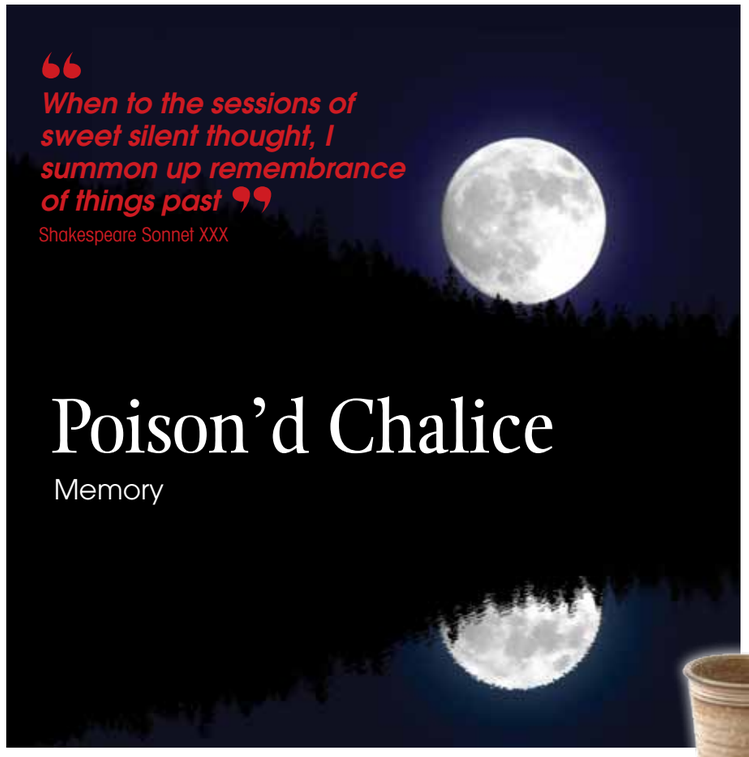


Poison'd Chalice

Memory

It was midnight; the day had been a long one. Indeed I was still in the Operating Theatre, awaiting the 'OK' from my Registrar that the open approach to the urgent repair was now successfully closed. That is the problem with so many procedural issues – only the 'old guys' can remember how to do them without a laparoscopic device and a TV screen.

I looked out the window at the end of the corridor, as the moonlight streamed in, with me totally alone. Like the song, I smiled at the old days. The thought of the old days conjured up the battles of my 'day job'. It was happening again, a change in the political wind had seen a clean sweep through the Board of the Hospital and Senior Management.

As the senior and (sometimes) respected clinician, I had survived the night of the long knives, but we were re-building again. How many farewells of senior managers had I spoken at? I was becoming the corporate memory as I had outlasted six Board Chairs, five Chief Executives and at least eight Medical Directors.

Memory can be a curse, but an enormous advantage. I well recall the words of Mark Twain, "When I was younger, I could remember anything, whether it had happened or not." That was the sort of corporate memory I tried to provide in these times. Be the source 'of the truth', steer the ship with a direction far more suitable for surgical services...

Of course, this balanced those great lines from the Shakespeare Sonnet XXX,

"When to the sessions of sweet silent thought,
I summon up remembrance of things past,
I sigh the lack of many a thing I sought,
And with old woes new wail my dear time's waste."

That may be closer to the truth, but one could never let an opportunity go by as the pendulum of change swung again.

But why a pendulum? Surely change, is 'onwards and upwards'. No, I caution you, my reader – it is a pendulum. There were times when I thought the change inside the hospital was a constructive dynamic, at other times a totally reactive response to random events. But I am now convinced it is a pendulum, retracing a previous path.

The advantage of corporate memory is that you can recognise this. One moment the stress of bed closures, redundancies, reduction of services and then, wait for it, the pendulum swings to more work, more money for more beds and more services.

The advantage as the pendulum reaches the most extreme point of its swing and almost hangs in mid-air, is that you can get a moment's rest just before the direction is suddenly reversed. It does seem kind of unfair. After a moment's rest, far away from where you began; you start the incredible journey back to where you started. The joy of being a Surgical Director.

So I looked at the moonlight streaming through the window and it spoke to me (again), "a new day has begun". It was William Ellery Channing – a famous Unitarian preacher from America who said, "A man might pass for insane who should see things as they are." Was I going mad, was I reaching that part of the spectrum of insanity, where it was really just the insight of a brilliant mind? I quite liked Aristotle's claim (attributed by Seneca in the Moral Essays), "No great genius has ever existed without some touch of madness."

I chuckled to myself. The Registrar stared at me as she tried to give me a 'thumbs-up' through the door. What a great surgeon in the making. The sheer joy of being a Clinical Director. As Polonius said in Hamlet, "Though this be madness, yet there is method in't."

The pendulum may be swinging faster, but the stress of change is but a gentle breeze compared to the howling gales earlier in my career. It was indeed another day, another CEO to brief, a Medical Director to 'side-step' and a surgical department and surgical careers to champion again.

Professor U.R. Kidding

CASE STUDY

Multiple systems

…multiple obstructions to best patient care?

Log in to the College website to join the discussion:
http://www.surgeons.org/182380.aspx

A middle-aged person had a mitral valve replacement and coronary artery bypass surgery. The patient was discharged to the ward within 24 hours and pacing wires were removed nearly a week post-operation. Immediately following this, the patient became hypotensive and was re-admitted to the Intensive Care Unit (ICU). Echocardiogram showed significant pericardial clot and the patient was returned to the operating room, re-opened, and the tamponade drained. A small hole in the right atrium was found and a small bleeding vessel located and dealt with.

The patient developed multi-organ failure and required inotropes and subsequent tracheostomy with positive pressure ventilation. The patient developed a pleural effusion, acute on chronic renal failure requiring dialysis, ischaemic hepatopathy, enterocolitis, critical illness polyneuropathy and sepsis.

It was decided to transfer the patient to an ICU bed in a second hospital closer to the patient's home, and this was undertaken despite a raised white cell count (WCC) being noted. Soon after arrival at the 'new' ICU, the patient again became haemodynamically unstable and inotropes were once again needed. Multiple sources of sepsis were noted and the left empyema seemed to be the most significant. This was aspirated and the local surgeon consulted. The surgeon suggested a chest drain and antibiotics. The patient did improve.

However, despite the drain being removed, the patient remained septic. This surgeon suggested a possible video assisted thoracoscopy, but felt that the primary surgeon should have a significant 'say' in the decision making process. The primary surgeon felt that the patient was too weak for one-lung ventilation and asked for CT-guided chest drainage. Unfortunately, this was not available at that hospital for nearly a week. Transfer to a third hospital was then arranged and the patient underwent thoracotomy and de-cortication of the empyema nearly three months post-operation, but continued to deteriorate. The patient died almost a month later as consequence of sepsis.

Comment

Be careful when transferring a patient who appears to have any impending complications. This patient was not stable and haematology supported a possible serious sepsis. Transfer of 'patient ownership' may not be as easy as transfer to another hospital, and it may be potentially life-threatening.

Be aware of the potential complications during post-operative care. Pacing wire removal in this case may have been a precursor to the empyema? Should this 'removal' process be reviewed?

It appears the CT facilities at the second hospital were not reliable. This did prejudice the outcome of this patient. Always ensure the accepting hospital can manage the patient appropriately. It was clear that the second surgeon was not completely comfortable dealing with the problems that arose after the primary surgeon's operation developed complications. The need to transfer to a third hospital for surgery seems inappropriate, but necessary.

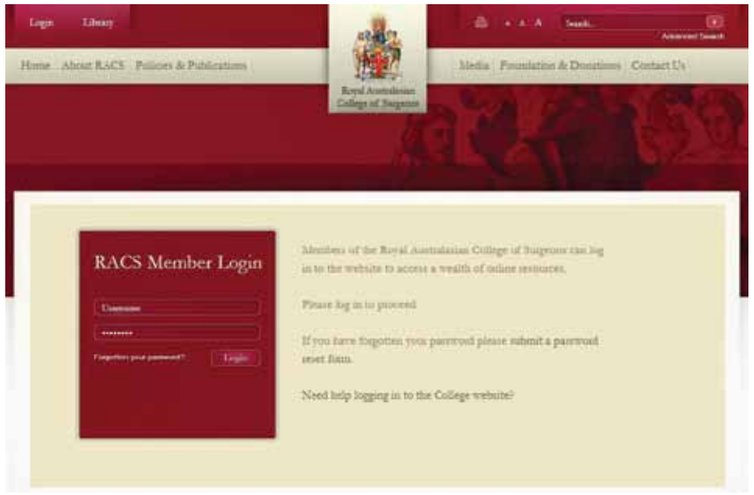
If the patient had stayed at the first hospital, then perhaps better diagnosis and treatment outcomes would have been more likely. In this case, multiple systems broke down, and in retrospect, all of these failures are easily seen.

If this patient was to survive the surgery and the superimposed complications, clinical capability frameworks for each hospital should have been considered much more carefully.

Guy Maddern
Chair, ANZASM

Improved web self-service

What does the College's web access enhancement mean for you?



You might be aware that enhanced access measures are being introduced to the College website to provide greater protection and ease of access for all College online information and applications – including your personal information.

To make it easier for you to access the website in the future, the College will soon be asking everyone to take just a few minutes to set-up a new 'My Security Profile'.

You will be informed by email when the update period starts – expected to be mid-October – and the process is quick and easy. All you need to do is login to the College website and follow the instructions regarding generating a new username and password, and identifying three simple security questions and answers.

The Benefits

A recent Fellowship survey revealed that 76 per cent of both active and retired Fellows were 'satisfied' or 'very satisfied' with the website. However, some Fellows expressed frustration with remembering their username and password and also requested improved 'remember my password' capability.

The enhancement work currently being carried-out on the website specifically addresses these issues. With your new 'My Security Profile' you will have personal control for easy password and username retrieval and the future benefits will ensure improved access and increased online functionality for all.

'My Security Profile'

When we start the upgrade process, you will be asked to set up a new 'My Security Profile' through the College website.

This new security profile will allow you to set an email address as your username which will be easier to remember and you might have to change your password to adhere to the new security requirements. You will be asked to nominate and provide answers for three 'familiar' questions as an increased measure of security. The whole process should only take a few minutes.

Everything else about your access to the College website and associated applications will remain unchanged.

Additional help

The College will provide a range of help information on the website, including an online video tutorial to help guide you through the process of creating your new 'My Security Profile'. Visit the College website for further information or contact the Help Desk via email at **help.desk@surgeons.org** or call +61 3 9276 7417.

Launch

The launch of 'My Security Profile' and associated self-service capability will take place in October.

You will receive an email when the process begins and it is important to the overall security of the College website that we all update our information promptly.

Marianne Vonau
Treasurer

"Wonderful" work

Life changing surgery made possible with determination and a little help

Melbourne Urologist Philip McCahy recently joined a urology clinical service team in a trip to the Kingdom of Tonga specifically designed to provide minimally invasive endoscopic upper urinary tract stone surgery. The trip was made under the auspice of the Pacific Islands Program (PIP), a program funded by the Commonwealth of Australia and being managed by the Royal Australasian College of Surgeons on behalf of the Australian Agency for International Development (AusAID).

The visit to Tonga was designed to broaden the range of procedures provided to the people of small island nations that often cannot afford the expensive equipment or provide the highly specialised support required for such surgery.

Until this trip in June 2013, percutaneous nephrolithotomy (PCNL) had not previously been offered as part of PIP visits because of the need for a working image intensifier in country, lack of specialised equipment and concerns about post-operative management.

However, these issues were resolved through the efforts by team members and College staff to source needed equipment, the enthusiasm of staff at the Vaiola Hospital in Tonga and the generosity of donors.

Mr McCahy said the success of the visit depended on equipment and expertise and took more than a year to organise through the determination of team leader Mr Alex Cato from the Alfred Hospital in Melbourne.

"The College already had a basic cystoscopy set for simple bladder work and resectoscopes for Trans Urethral Resection of Prostate (TURP) and bladder tumour work and the Vaiola Hospital had good quality light sources, a camera and monitor set and a working image intensifier," he said.

"However, PCNL also requires dedicated nephroscopes, other specialised instrumentation, some sort of lithotripter plus a host of disposables.

"Ultimately, the generous donation of a nephroscope set by the Storz Foundation was the catalyst that allowed the trip to go ahead.

"The success of this trip, not only in terms of patient outcomes, but also the complex logistical organisation required, should be considered a tribute to Alex Cato who has wanted to do this for years.

"This was the first time we had the surgeons, the equipment and support all coming together at the same time."

The first of many trips

Mr McCahy works at Casey Hospital in Berwick (part of Monash Health), Victoria, and was specifically asked to participate in the visit to Tonga because of the complex cohort of patients selected for surgery and his expertise in providing minimally-invasive stone urology surgery to obese patients.

He said that while obese patients were increasingly encountered in all surgical practices, they presented special problems during PCNL, but he and his colleagues had developed a new way of positioning such patients to limit complications.

"Traditionally, the operation starts in the lithotomy position and then the patient is transferred to the prone position to allow a posterior renal puncture," he said.

"However, with increasing BMI, that transfer becomes more difficult and requires additional space, equipment and staff. The prone position also has a number of downsides.

"Problems are significantly reduced by utilising a modified supine position and a vacuum bean bag to support the patient with an approximately 20-degree tilt of the torso and we were pleased to receive the donation of an Olympic Vac-Pac to take with us for this trip."

The team arrived in Tonga in early June 2013 and spent the first two days assessing selected patients and preparing the local team and theatres for the procedures.

A total of 25 operations were conducted during the visit including those patients selected for PCNL with another 20 undergoing a range of operations including an open nephrectomy for a massive kidney tumour, open prostatectomies, TURPs, optical urethrotomies, bilateral orchedectomy and a reconstructive penile procedure.

All operations were successful except for one PCNL procedure that unfortunately had to be abandoned at an early stage.

"This trip was a great success not only because of the enthusiasm and support offered by the local surgeon and hospital staff and the fantastic hospital facilities, but perhaps even more because of the desire by everyone to find solutions to any gaps we encountered in the technology available to the team," Mr McCahy said.

"For instance, the standard stone breakers are either laser, ultrasonic or pneumatic which, as well as being expensive, are bulky pieces of equipment.

"Huge metal boxes with foot pedals, wires and tubes would have been difficult to carry halfway across the Pacific, but fortunately there have been recent developments in intracorporeal lithotripsy and at the last minute Electro Medical Systems came to the rescue and allowed the team to borrow a battery-powered Lithobreaker.

"During the week two PCNL patients with very large stones presented, but the team had no flexible nephroscope to work with.

"However, a fibre-optic bronchoscope was spotted and used for the first flexible nephroscopy ever conducted in the South Pacific.

"It proved to be not quite as flexible as our standard scopes and the suction channel had to be closed off with my thumb to stop fluid leaking, but it worked.

"Another patient was found to have an unexpected 15mm stone in the distal ureter which would normally have been easily dealt with using a ureteroscope the team didn't have."

"It came out with a bit of strong pulling, a large basket, a ureteric meatotomy and a urethral meatotomy and the kidney stone followed a couple of hours later with no unexpected issues."

"This ability of the team to adapt to challenges thrown up by a different environment made for an incredibly successful effort."

Mr McCahy said that now that the first such minimally-invasive surgical visit had been done, logistical challenges could be addressed to make such visits easier to conduct in the future.

Airlines could be approached in advance to waive excess baggage fees or that equipment could be freighted by ship in advance. The team would also continue scavenging for loan equipment and disposables.

The surgeons and anaesthetists involved in the trip are keen to keep returning to help train the local surgeon and Trainees in minimally-invasive procedures.

"There is a philosophical conundrum about providing this type of surgery because while visiting teams bring modern techniques that benefit patients, there is a question as to whether they are also de-skilling the local surgeons who have to deal with the complex issues the majority of the time," he said.

"On the other hand, with repeat visits, visiting teams can teach and reinforce the new skills so that such procedures may be provided locally on a permanent basis.

"A surgeon probably needs to conduct between 50 to 100 endoscopic procedures to become comfortable with the technology. In an ideal world we would train them and find the money to purchase the equipment.

> *"Ultimately, the generous donation of a nephroscope set by the Storz Foundation was the catalyst that allowed the trip to go ahead"*

Clockwise from above: Mr Alex Cato being interview on the PIP; the team: David Daly, Charlie Heldreich, Catherine Grenville, Philip McCahy, Alex Cato, Talosia Vakata, Saia Piukala. Front: Indra Jolayemi, Kathryn Rzetelski-West. Top left: Fellow Mr Richard Grills, College President Michael Hollands, Mr Mike Wedlock, Managing Director from Karl Stortz and Mr Alex Cato after the donations of vital Storz equipment.

> *Ultimately, the generous donation of a nephroscope set by the Storz Foundation was the catalyst that allowed the trip to go ahead*

"In the meantime, visiting teams need to continue such service trips and at least offer Pacific Island surgeons exposure to such procedures and support in their on-going professional development."

Mr McCahy said that although he had done similar aid work in parts of Africa, the Tongan visit had been his first as part of the PIP program and was an experience that he described as "wonderful".

"It is always nice to go somewhere and do good work for people in need without having to deal with the political problems that seem to have become a central part of any developed country's health systems," he said.

"The local staff could not have been more helpful and willing to learn and it was a pleasure to help the lovely patients and see their delight at being able to leave hospital in days rather than a week because of minimally-invasive surgery."

The visiting urology team included Mr Alex Cato, Mr David Daly (Anaesthetist at the Alfred Hospital), Ms Catherine Grenville (Recovery and Ward Nurse), Ms Charlotte Heldreich (Anaesthetist), Ms Indra Jolayemi (Theatre Nurse) and Ms Kathryn Rzetelski-West (Urology Trainee).

Mr McCahy said the trip would not have been possible without the help and support of the PIP team at the College, particularly Priscilla Matters, Dr Saia Piukala, Lord Bill Tangi, Dr Bernard Tu'inukuafe, Sam Cosman, Talosia Vaketa, Mele Lutui and all the staff at Vaiola Hospital, Tongan Ministry of Health, Georgina Cook for Olympus, Angelo Pierobon and Betina Voss for Boston Scientific, Damien Rayner for EMS, Marlin Medical, Justine Moran, Karl Storz Endoscopy, Qantas and Air New Zealand.

With Karen Murphy

All Younger Fellows are invited to nominate for 2014 Younger Fellows Forum.

The Forum focuses on future challenges for surgical practice and the changing face of health care delivery. The core objective is to provide an environment that encourages Younger Fellows to address challenging issues relevant to personal, professional and collegiate life though discussions and debates. It is a great opportunity to share ideas and experiences. In 2014 discussion will focus on supporting underprivileged patients through leadership and health advocacy.

Applications are open from 1 September to 6 December 2013.

Contact the College for the nomination form, and submit your nomination to the attention of the Younger Fellows Forum Coordinator by **Friday 6 December 2013**.

2–4 May 2014,

Younger Fellows Forum

Singapore

- **Post:** Royal Australasian College of Surgeons
  College of Surgeons' Gardens
  250-290 Spring Street
  EAST MELBOURNE VIC 3002
- **Telephone:** +61 3 9249 1122
- **Facsimile:** +61 3 9276 7432
- **Email:** PDactivities@surgeons.org

It's all in the wrists

Some studies may surprise you

> *Motion sickness is easier to prevent than treat once it starts*

A surgical couple, let's call them the Neiguans, consulted me the other day about their 10 year-old child. Every flight they took was upset by motion sickness and the journey was always spoiled by anxiety about vomit, mess, and whether the child will be able to reach for and open a sick bag in time.

Their other children weren't affected, but every journey was a nightmare. When they travelled overseas the poor child would eat and drink nothing – even on a 14-15 hour trip to Europe or the US. They would pack extra sets of spare clothes and plastic bags, and always worry about the reaction from passengers sitting close-by.

Motion sickness is easier to prevent than treat once it starts. This family had already learned to book seats over the wing and avoid the back of the plane, which is the most turbulent place to sit. Children who suffer already know not to read, nor play computer games on their lap; many feel worse looking out of the window, but generally are most comfortable looking straight ahead. It's usually too late to take anything once you feel sick. The gastric stasis induced by the neural centres that invoke nausea and vomiting, means that any medication taken after the onset of symptoms is likely not going to be absorbed.

Back in 1860, an article in the Lancet proposed 'tincture of belladonna' for motion sickness. The leaf has antimuscarinic properties related to its atropine content, which though anti-secretory also lowers the gastro-oesophageal sphincter pressure. As belladonna alkaloids are potentially toxic, I wasn't going to recommend this. The cholinergic basis of motion sickness was only elucidated in over the past 50 years, which is why scopolamine (hyoscine) is one option which has proven effective in some clinical trials in adults though there may be other anti-cholinergic side-effects.

Antihistamines, including various promethazine preparations taken 30 minutes before travel, are the popular pharmacological option for children's motion sickness. Yet anti-histamines are not completely safe, for in younger children, particularly those aged under two, they cause drowsiness – potentially not a bad thing for take-off, but most undesirable when landing.

The Neiguans said they'd rather avoid the side-effects of anticholinergics or antihistamines. Didn't I have anything else to offer? Ginger (Zingiber officinal) has been used for centuries as an anti-emetic and even been shown to have some action in experimental studies (the revolving chair) of motion sickness. But as the evidence is scant, and it can cause gastrointestinal upsets in its own right, I said, "I wouldn't recommend ginger or prism glasses, but why not try acupressure?"

They were incredulous! "We can't stick needles into the poor child on a long flight," they exclaimed. "No," I reassured them, "not acupuncture, acupressure." It employs a similar principle in that the child wears bands on both wrists and presses over the P6 [P for Percardial meridian] acupoint.

Randomised controlled trials lend support for the use of acupressure bands. They are effective in reducing radiation therapy-induced nausea, though they didn't work for chemotherapy induced nausea in women with breast cancer. A 2011 Cochrane review confirmed the efficacy of P6 acupoint stimulation in preventing postoperative nausea and vomiting [PONV] with minimal side-effects (irritation at the site).

A study published in the British Journal of Anaesthesia also reported benefit in preventing PONV. There was no difference in the response between adults and children and the improvement obtained was similar to that achieved by anti-emetic drugs. Not every trial on motion sickness has shown their efficacy, but when there has been an effect it is positive.

The effects of acupressure are subliminal and subcortical, so stimulation at P6 in neuroscientific studies induces activity in the left superior frontal gyrus, anterior cingulate gyrus and dorsomedial nucleus of thalamus. The cerebellar vestibular neuromatrix may also be involved. The Neiguans went off deciding to give the acupressure bands a go, as well as a script for antihistamines – just in case.

A week or so ago I received a very pleasing text message.

"Bought the wrist bands, used them, first flight for years with no vomiting, great idea, it made such a difference to the family holiday, thanks for the info, having a great time."

One swallow does not make a summer, but that's the sort of feedback that brings warmth and sunshine to my otherwise rather dark and tedious day in the wintery Southern Hemisphere, managing expectations about antibiotics and explaining their inability to obtund the common cold or this year's variant of flu.

Dr BB G-loved

Rebuilding the Academy of Surgical Educators

The Academy has been proactive in the past months rebuilding its role

The Academy of Surgical Educators (ASE) was established to support, enhance and recognise surgical educators within the College. The past year has seen the Academy evolve into an active community of practice; next year and beyond will see it build on this further and recognise the contribution of the surgical educators that comprise it.

The first half of this year has seen a number of Academy representatives consulting with our members at major events, discussing future directions for the Academy and asking members how the Academy can assist them better. Presentations have been incorporated into the Victorian, Queensland and Northern Territory/South Australia/ Western Australia regional Annual Scientific Meetings; the specialist society meetings of The Australian and New Zealand Society of Cardiac and Thoracic Surgeons and General Surgeons Australia; Provincial Surgeons of Australia and the Paediatric and Urological Surgical Boards.

As a result of an effective advertising and engagement program, the ASE now boasts a membership base of 461 individuals, comprised of a myriad of surgical and medical educators. This is an increase from 120 at the same time last year.

Thus far the Academy has delivered a comprehensive suite of educational activities for its members. These include: six 'Supervisors and Trainers for SET (SAT SET)' courses to 193 participants, six 'Keeping Trainees on Track (KTOT)' courses to 113, four 'Non-Technical Skills for Surgeons (NOTSS)' courses to 69, three 'Surgical Teachers' courses to 54, 'SAT SET' online to 33, 'SET Selection Interviewer Training (SET SIT)' online to 113, three 'Educator Studio' sessions to 128 and three 'National Health Education Simulation' programs to 64. This is a total of 27 educational programs that have been delivered to 767 of our surgical educators, up until the end of September.

November is hotting up as a big month for the Academy with the inaugural Academy Forum to be held on Wednesday, November 13, from 5.30-9.30pm at the Adelaide Pavilion. This event will immediately precede the Section of Academic Surgery Meeting and the Surgical Research Society Meeting which starts the next day.

Tickets are $90 for members and $110 for non-members and will include a three course dinner, drinks and a fascinating line up of speakers. Guest speakers will cover topics such as e-innovations in medical education, communities of practice and development of progressive independence in Trainees. Attendees will workshop questions at their tables and then engage in a Q and A session with the panel of experts. Remote attendance will be possible via Gotowebinar.

The following week on Tuesday, November 19, during Surgeons Month in NSW, the Academy will host the fourth of its popular Educator Studio Sessions at the College's Sydney office and simultaneously broadcast to its members via a web conferencing platform. Associate Professor Tim Shaw will present on 'Using targeted online learning methodologies to impact on clinician behaviour'. The recordings of this year's four Educator Studio Sessions will be available on the Learning Management System for Academy member access.

The final NHET Sim, Australia's first National Simulation Health Educator training program, funded by Health Workforce Australia is scheduled for delivery in Brisbane on Wednesday, October 30. Educators who currently use or intend to use simulation as an educational tool to support the education and training of others are encouraged to attend.

The program is tailored to a surgical educator audience and involves two online core components – 'Simulation based education: contemporary issues for the health professionals' and 'Being a simulation educator'; and a one day workshop on 'Simulated patient methodology' and 'Patient focused simulations'.

One of the key functions of the Academy this year is to develop a generic foundation surgical educator program which all faculty members and surgical educators can participate in irrespective of what educational role they occupy in the College. A recent gap analysis and surgical educator curriculum report by Assoc Prof Robert O'Brien will inform this. This foundation course will be developed and piloted during the 2014 period.

The fourth Royal Australasian College of Surgeons, Royal Australasian College of Physicians and Royal College of Physicians and Surgeons of Canada Conjoint Medical Education Seminar is to be held on Friday, March 14, at the Hilton on the Park, Melbourne next year. The theme is 'Revalidation', and will involve presenters from the three host Colleges.

The joint Graduate Programs in Surgical Education offered by the University of Melbourne in partnership with the College currently have 32 surgeons in the program. This suite of programs addresses the specialised needs of teaching and learning in a modern surgical environment.

The program is a modular one, with graduates exiting with a Graduate Certificate, Graduate Diploma or Masters of Surgical Education. These graduating Fellows will be integral to enhancing the knowledge and educational leadership of the Academy.

Membership of the Academy is open to all Fellows and Trainees committed to the role of Teacher/Scholar. External members who have strong educational interests and expertise are also welcome to join. For more information on getting involved in Academy activities or how to become a member, please go to the ASE page at http://www.surgeons.org/for-health-professionals/academy-of-surgical-educators/ or contact Kyleigh Smith on +61 3 9249 1212 or ase@surgeons.org

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

TheAlfred

General Surgery Meeting

'Practical Updates for General Surgeons' is the major theme of this biennial meeting


Meeting dinner venue ZINC.

The Department of General Surgery at The Alfred Hospital Melbourne is once again holding The Alfred General Surgery Meeting, November 1 and 2, 2013, at the Grand Hyatt Melbourne, Collins Street, Melbourne.

The meeting is convened by Jonathon Serpell, Professor/Director of General Surgery, Alfred Hospital.

'Practical Updates for General Surgeons' is the major theme of this biennial meeting, that targets General Surgeons and Trainees with a wide range of surgical interests. This meeting highlights 'How I Do It' sessions and updates on controversial, important and common areas.

Keynote speakers are Mr Nick Maynard, Consultant Upper Gastrointestinal Surgeon and Director of Surgery at Oxford University Hospitals; Dr Les Nathanson, Consultant General Surgeon with an interest in minimal access surgery, Wesley and Royal Brisbane Hospitals; and Dr Neil Wetzig, Senior Visiting General Surgeon, with interests in breast and endocrine surgery, Princess Alexandra Hospital Brisbane. The keynote speakers complement an extensive local faculty who will address common and important problems in everyday general surgery practice.

'Practical Updates for General Surgeons' has been scheduled to enable attendance at the meeting, followed by a long weekend in Melbourne, with the option to take in both The Derby and The Melbourne Cup.

There are five scientific sessions including 'Operative Techniques' which covers topics such as laparostomy, laparoscopic common bile duct exploration, varieties and indications for gastrectomy, and addressing whether sentinel node biopsy has replaced axillary dissection in breast cancer.

The second session on 'Emergency Surgery' will cover haemorrhage control in the coagulopathic patient, management of lap bands in elective and emergency surgery, management of retroperitoneal vascular injuries, and the septic patient following laparoscopic cholecystectomy.

The session 'Updates on Common Problems' includes biliary symptoms and gall bladder polyps, pseudo-obstruction of the colon, anal fistulae – to plug, excise, flap, open or refer, laparoscopic inguinal hernia repair, and when to re-operate following abdominal surgery including postoperative bowel obstruction.

The 'Difficult Problems in General Surgery' session will cover Barrett's Oesophagus, idiopathic acute pancreatitis, parastomal hernia, indications for haemorrhoidectomy and current management of ruptured spleen and liver.

A final session on 'Updates in Cancer in General Surgery' will include consideration of gastric cancer, papillary thyroid cancer, recent advances in neo-adjuvant therapy of rectal cancer, melanoma, oncoplastic breast surgery and demonstration of the UK Oesophogogastric Audit.

The meeting dinner will be a social highlight of the weekend held on the Friday evening. The venue, ZINC at Federation Square overlooking the Yarra, is sure to be a superb venue during spring. Be sure to bring your dancing shoes, as plenty of entertainment will be provided by popular Melbourne cover band 'Popcorn'.

This General Surgery Meeting on Practical Updates should appeal to all General Surgeons in all areas and in all subspecialties.

We look forward to seeing you at the meeting.

Jonathan Serpell
Professor/Director of General Surgery, Alfred Hospital

REGISTER ONLINE NOW:
http://tinyurl.com/alfred2013
For more information contact:
RACS Conferences & Events Management
250-290 Spring Street
EAST MELBOURNE VIC 3002
T: +61 3 9249 1139
E: alfred@surgeons.org

spring *Lifestyle*

post op

10 page lifestyle section

Racing to *Win*

General Surgeon Brian Kirkby indulges his need for speed

post op appears in *Surgical News* each season

The speedy surgeon

> *Even though it's small and light it doesn't feel dangerous, so I just go out and try and beat all the other buggers out there on the track*

Hospital director operates a sports car at 200 kilometres an hour

Five years ago, General Surgeon Brian Kirkby moved from the mainland regional hub of Wagga Wagga in NSW to Launceston in Tasmania at the urging of a surgical colleague.

Now, as Acting Director of Surgery at Launceston General Hospital, he oversees the surgical care of the 100,000 people who call the greater Launceston region home.

Stating plainly that he doesn't much like city living – having completed part of his training in Melbourne and Adelaide – Mr Kirkby and his wife settled easily into life in the historic town; the third oldest city established in Australia.

Yet while he lists one of the downsides of urban life as the time spent travelling to and from work, Mr Kirkby does love to drive.

But not for him are the clogged freeways and choked city streets.

Instead, Mr Kirkby competes in state motor racing championships, hurtling around the track in his bright yellow open-top sports car at up to 200 kmh.

Having acquired the taste for speed from his father who raced cars in his youth, Mr Kirkby now races a Clubman six times-a-year competing in state championships.

A Clubman is a light-weight, open, two-seater roadster designed for both road and track with an emphasis on simplicity, performance and road-holding, the concept was originated by designer Colin Chapman in 1957 as part of the Lotus Super 7 series as a car that could be driven to a meeting, raced and driven home again.

Available as a kit, Mr Kirkby's car was built by his father Phil, a retired business manager, in 2003.

"It's a great little car to drive and a good little racer," he said.

"It only weighs 500 kg with a full tank of fuel and me in it, which means that, while it can't really go much faster than 200 kph down the straight, it has very high cornering speeds which gives us an advantage over the bigger cars we compete against.

"It has a four-cylinder Toyota engine and is very safe, meeting all the requirements of the Confederation of Australian Motor Sport (CAMS) because to race you need to maintain a CAMS logbook and undergo a safety inspection for the roll-cage, the harness and the fire extinguisher.

"Even though it's small and light, it doesn't feel dangerous so I just go out and try and beat all the other buggers out there on the track."

And his results have been impressive.

Having competed at major tracks such as Eastern Creek, Oran Park and Wakefield Park in NSW from 2004 to 2008 during his time in Wagga Wagga, Mr Kirkby has had a number of podium finishes in the New State Motor Racing Championships and was runner-up twice.

Since moving to the Apple Isle, he has competed in the East Coast Targa and Targa West road rallies as well as at Baskerville and Symmons Plains Raceways as part of the Tasmanian Super Series.

Yet while he said he usually comes in second or third in his class, he avoids the champagne celebrations as best he can.

"It's a sweaty, sticky enough business without being covered in champagne," he laughed.

"Perhaps if you had a support team looking after your racing gear it wouldn't be so bad, but without that, if I'm on the podium at the end I try to dodge it as much as possible because it's a most unpleasant feeling."

Mr Kirkby said that while his father often joined him on race day in NSW to work in the pits finessing the mechanics, he now employs a race mechanic to help him on race day.

"As a surgeon, I prefer to keep my hands well away from fast-moving mechanical components," he said.

"My area of interest lies in working out how to get the best performance out of the car after it has been tweaked and tuned, like taking it around the track to determine optimum tyre pressure or the setting of the suspension because both of those elements can cut seconds off your time which is, of course, the aim of the game."

Mr Kirkby, who averages a 60-hour working week with a one-in-five weekend on-call roster, said he enjoyed motor racing for the chance it gave him to immerse himself in a different world and the opportunity to concentrate on just one endeavour within a short space of time.

"There is certainly no money to be won at this level, so all of us just do it for the enjoyment and the bragging rights to the little trophies we sometimes get to take home," he said.

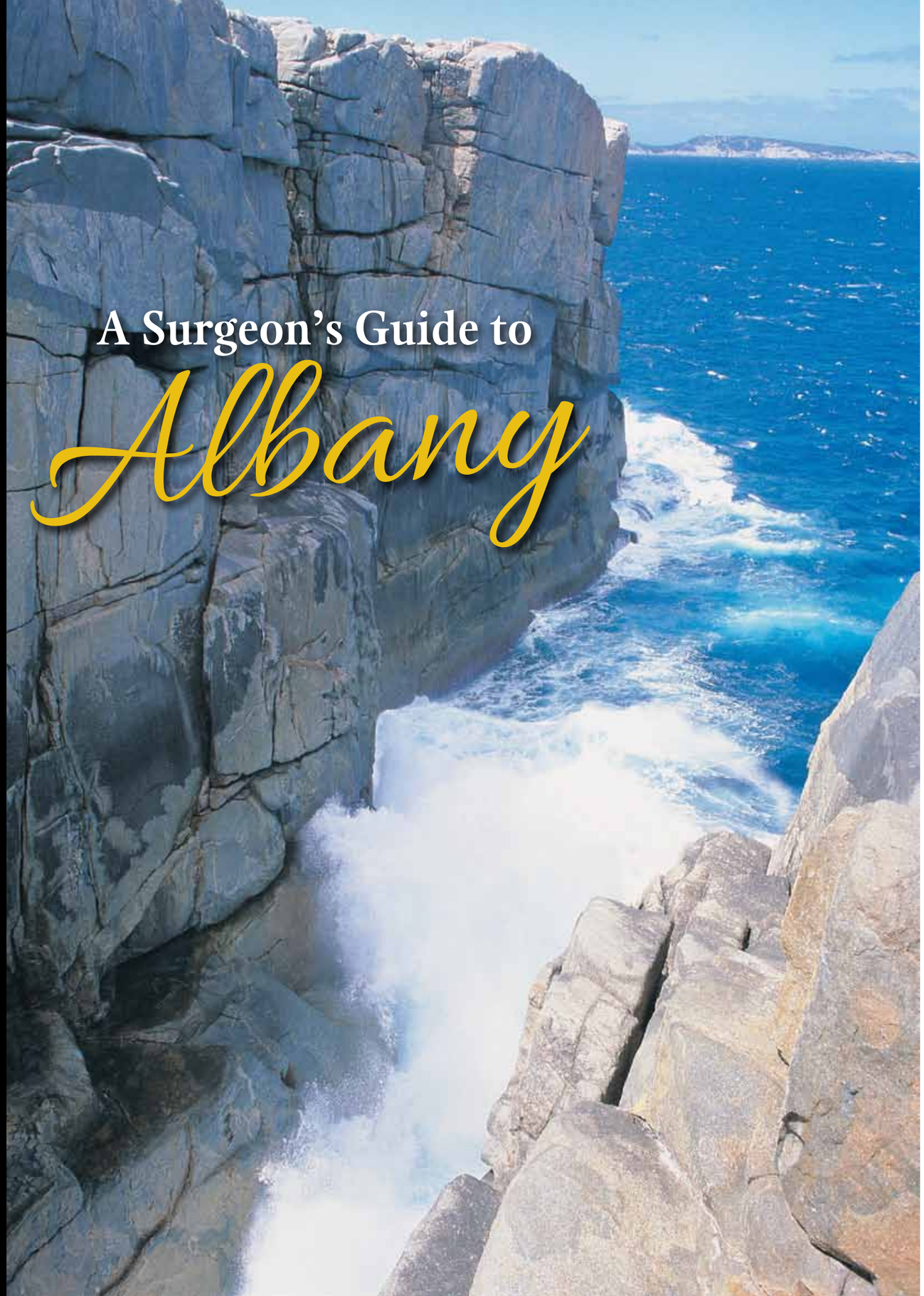
"All I care about is figuring out how to go a bit faster than the next bloke and racing also keeps me fit.

"You've got to be fit to race because it is physically demanding and a test of endurance which many people don't realise.

"You have to have good core body strength to hold yourself up against the gravitational forces; when you hit the brakes you hit them really hard and you sweat a great deal all while you're concentrating like mad on what your car is doing, what the car ahead is doing and what the car behind might be about to do.

"It's great fun, but it is certainly nothing like a casual drive."

With Karen Murphy



A Surgeon's Guide to *Albany*

Drawn to a regional life, Tom Bowles expounds the merits of rural surgery

General Surgeon Mr Tom Bowles, the first regional surgeon to hold the position of chairman of the WA Committee of the College, said he decided early in his training that he wished to work in a regional centre and committed himself to finding the training positions that would give him the skills he knew he would one day need.

Now based in the WA town of Albany, Mr Bowles grew up in country Victoria, completed medical school in Melbourne and began his surgical training on the other side of the country in Fremantle.

Yet he said that while he did all his training rotations in Perth, he and his wife Sarah fell in love with Albany during their frequent visits.

"I'd decided when we first got to Fremantle that I'd either become a procedural GP or a surgeon, but while I was deciding I was renovating a house and thought for the sake of the house I'd better throw myself into surgical training," he laughed.

"Every time Sarah and I visited Albany, I tried to get some time with the local surgeons to understand what skills I needed to work here and how I could best contribute to the array of surgical services offered.

"So I mapped out a plan and travelled back to Victoria to do a Colorectal Fellowship in Geelong with extra endoscopic training, worked as a urology registrar and then did a Trauma Fellowship at the Royal Perth Hospital.

"While there I badgered some consultants to do Plastics training to allow me to do nerve and tendon repair surgery, did some neurosurgery to learn how to do Burr Holes and craniotomies and finally some ENT training.

"As the current Chair of the Rural Surgical Section of the College, I have pushed for some time to have such a tailored model of training available to surgical Trainees who wish to work in rural or remote areas.

"They shouldn't have to organise it all themselves; we as a College should know the skill sets required in various locations and make the necessary training Fellowships and rotations available."

Following his peripatetic training regime, Mr Bowles finally found his place in the pretty seaside town seven years ago, now works out of the Albany Regional Hospital and has a special interest in colorectal surgery.

Servicing a population of 36,000 in the town and 60,000 in the surrounding region, Albany now has three general surgeons, one orthopaedic surgeon, two gynaecologists and a visiting service comprising ENT, Plastic and Reconstruction and Urology surgery with three Trainee positions based at the hospital.

He said the main appeals of becoming a regional surgeon were the breadth of work, the opportunity to teach Trainees and the more relaxed interaction with patients.

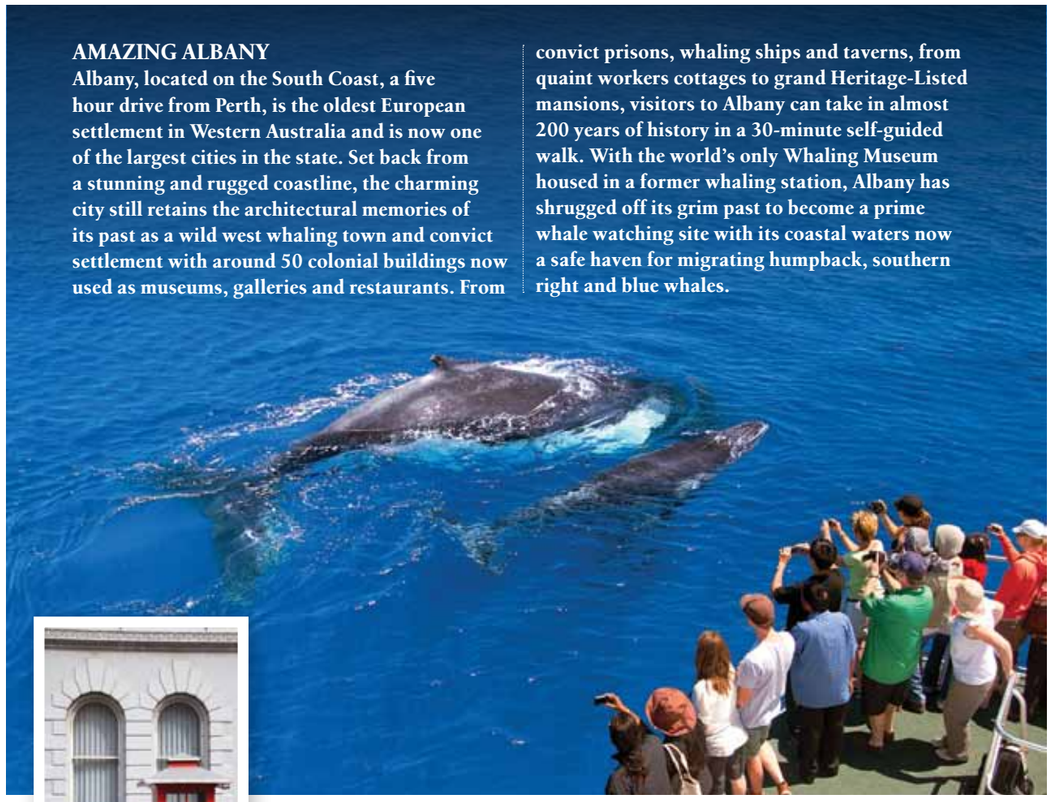
"We have the Rural Medical School in Albany and all the surgeons in the town work closely with the students which I find a professionally enriching experience," Mr Bowles said.

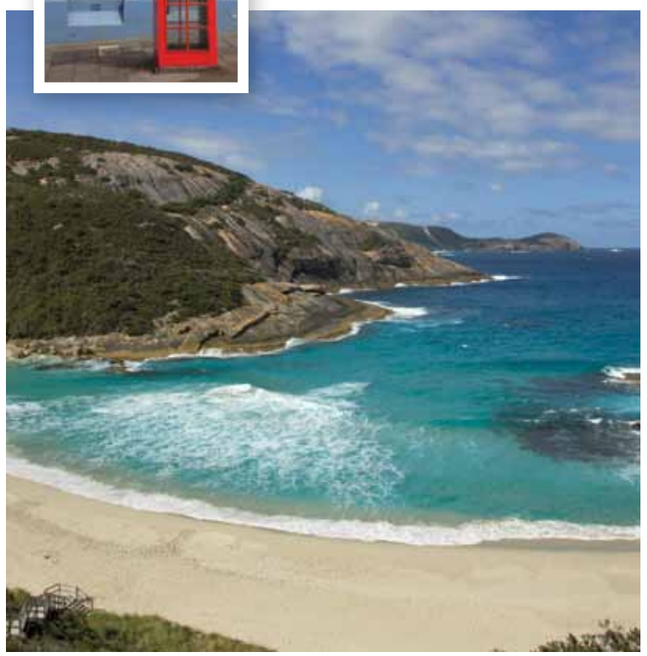
"I also enjoy the follow up you have with patients as a regional surgeon, which is not so much based on consultations, but rather seeing them in town and discussing how they're going after surgery.

"Still, at times that can be a bit strange when you're out having a nice dinner and someone comes up wanting to discuss their haemorrhoid operation, but you just learn to roll with it."

The following attractions lured Mr Bowles to Albany and are among the many reasons why he and his young family are happy to stay.

AMAZING ALBANY
Albany, located on the South Coast, a five hour drive from Perth, is the oldest European settlement in Western Australia and is now one of the largest cities in the state. Set back from a stunning and rugged coastline, the charming city still retains the architectural memories of its past as a wild west whaling town and convict settlement with around 50 colonial buildings now used as museums, galleries and restaurants. From convict prisons, whaling ships and taverns, from quaint workers cottages to grand Heritage-Listed mansions, visitors to Albany can take in almost 200 years of history in a 30-minute self-guided walk. With the world's only Whaling Museum housed in a former whaling station, Albany has shrugged off its grim past to become a prime whale watching site with its coastal waters now a safe haven for migrating humpback, southern right and blue whales.





Salmon Holes Beach

LIFE ON THE WATER

Albany is a nirvana for those who like spending time on the water with surf beaches, fresh water rivers winding into the sea and, of course, King George Sound. The Sound covers an area of 110 square kilometres and is a popular dive location with several fascinating shipwrecks to explore including the former Australian navy warship HMAS Perth. Middleton Beach offers one of Albany's most stunning seascapes with five kilometres of sparkling white sands and views towards the horizon of two picture-postcard granite islands, Michaelmas and Breaksea. Frenchman Bay, a 20-minute drive from the city centre, offers visitors the opportunity to not just swim, surf and snorkel, but the chance to spot whales during the annual migration season which occurs between June and October each year. "The coast, the Sound and the rivers around Albany are truly wonderful," Mr Bowles said. "You can do everything here from surfing to windsurfing, sailing, kayaking and diving to finding a quiet spot by a river to do a bit of fishing."

WONDERFUL WINES

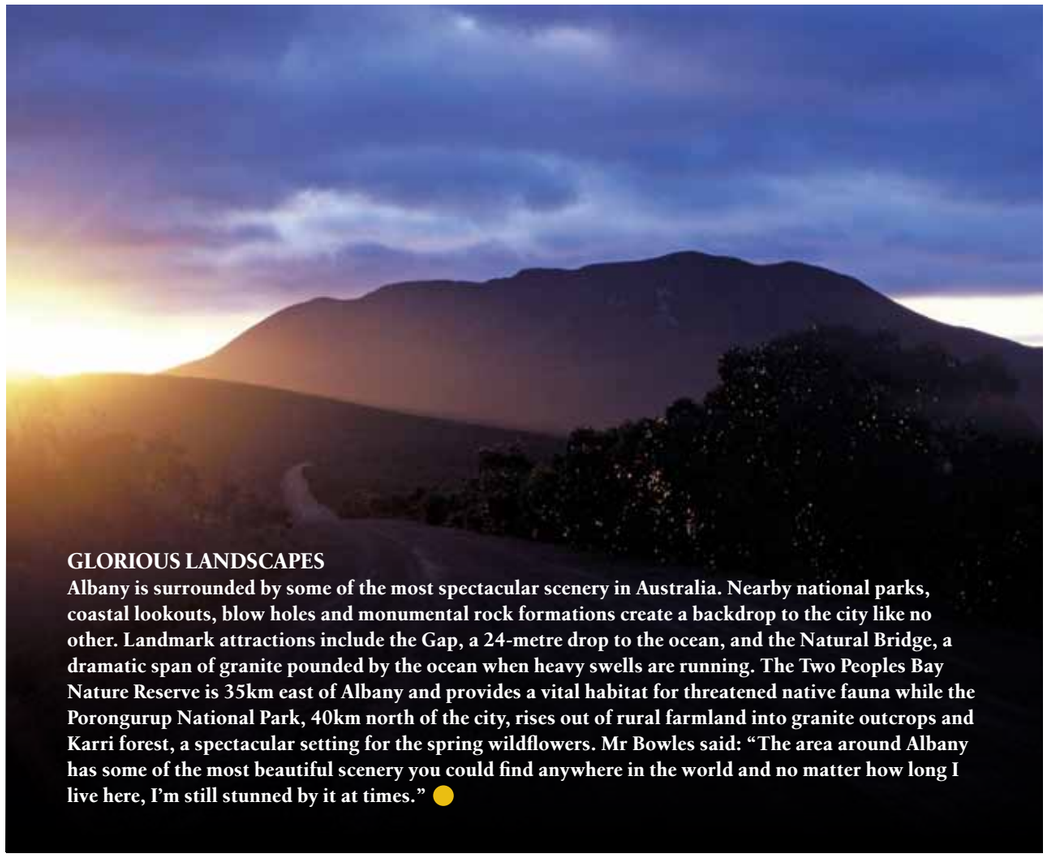
The wine growing area that stretches around Albany is known as the Great Southern Wine region and is the coolest viticultural region in Western Australia. There are around 40 wineries in the district, many with restaurants serving such local delicacies as fresh marron and locally made cheeses. Mr Bowles listed his favourites as West Cape Howe, Plantagenet, Oranje Tractor, Castle Rock Estate and Forest Hill. "The wineries around Albany are sensational," he said. "Often they are located in stunningly beautiful places and the wines themselves are world class. The Boston Brewery is also worth a visit because it's in a lovely spot as well and the beers are great."

AN UNFORGETTABLE WALK

The Bibbulmun Track is a long distance walking trail which runs from Kalamunda, east of Perth, to Albany and is almost 1,000 kilometres long with the final extension through to Albany that opened in 1998. The Track is named after the Indigenous tribe that lived in the region and is a walker-only trail with no wheeled vehicles of any kind permitted. Consisting of 58 sections, the track is marked at regular intervals with signposts that bear the image of the wagyl, a mythical creature from Aboriginal Dreamtime stories. Highlights of the track include the Karri Forests between the Donnelly River and Denmark, springtime wildflower displays and the chance to spot seals, dolphins and whales as you track along the south coast. "I haven't done the entire track yet, but I intend to," Mr Bowles said. "However, I can say that the section from Albany to Denmark is particularly wonderful."

A WILD RIDE

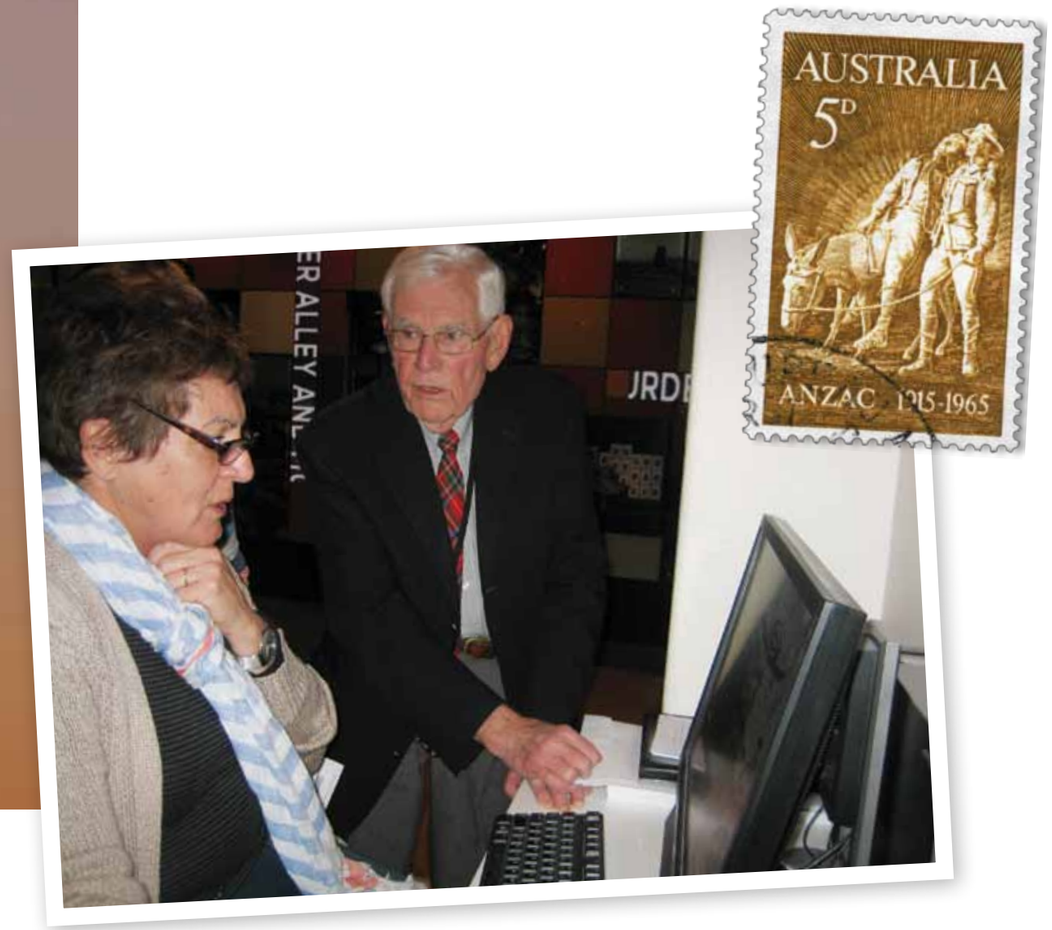
Albany is also the destination of a 1000km cycle track called the Munda Biddi Trail that winds its way through an undeveloped, natural corridor from Perth. Now fast becoming a world-class nature-based, off-road cycling experience, the cycling track meanders through towering eucalyptus forests, ancient bushland and scenic river valleys. The trail has sections suitable for cyclists of all levels and riders can camp in shelters located along the way or organise accommodation in the quiet country towns dotted along the journey. Cyclists who complete the entire trail have come to be known as "trailblazers". Mr Bowles is not one of them.



GLORIOUS LANDSCAPES
Albany is surrounded by some of the most spectacular scenery in Australia. Nearby national parks, coastal lookouts, blow holes and monumental rock formations create a backdrop to the city like no other. Landmark attractions include the Gap, a 24-metre drop to the ocean, and the Natural Bridge, a dramatic span of granite pounded by the ocean when heavy swells are running. The Two Peoples Bay Nature Reserve is 35km east of Albany and provides a vital habitat for threatened native fauna while the Porongurup National Park, 40km north of the city, rises out of rural farmland into granite outcrops and Karri forest, a spectacular setting for the spring wildflowers. Mr Bowles said: "The area around Albany has some of the most beautiful scenery you could find anywhere in the world and no matter how long I live here, I'm still stunned by it at times."

With Karen Murphy

Helping others discover the *past*



Retired Fellow David Nott values the opportunity to help others discover loved-ones' war journeys

It is little wonder that retired thoracic surgeon Mr David Nott developed both a love of medicine and great interest in military service through the inspiration of his father, Lewis Windermere Nott.

Now retired after a professional lifetime of surgical service to the people of the ACT and members of the armed forces, Mr David Nott is now a volunteer at the Australian War Memorial helping members of the public unearth the stories of their loved ones at war.

Both passions flow directly from the influence of his father.

A hero of the First World War, physician, hospital superintendent, mayor and Federal MP, Lewis Nott is described in the Australian Dictionary of Biography as being a man of extroverted, even flamboyant disposition with a strong social conscience and a compassionate concern for the underprivileged.

Having almost completed his medical training in Edinburgh at the outbreak of war and unable to return home, Lewis Nott joined the prestigious Royal Scots Greys, was commissioned and sent to the horrific killing fields of the Western Front where he was wounded and twice mentioned in dispatches.

According to Mr David Nott, when the senior military chiefs heard of his father's medical training they encouraged him to resume his studies and upon completion in 1919, he joined the Royal Army Medical Corps and was appointed resident surgeon at the Pilkington Special (Orthopaedic) Hospital in England.

After returning to Australia, Lewis Nott was appointed medical superintendent of Mackay District Hospital, became mayor of the city in 1924, a Federal MP in 1925 and later, as an Independent, the ACT's first member of the House of Representatives.

"Like most diggers, my father never spoke very much about his war experience, but it was clear that he had a very distinguished military career," Mr Nott said.

"He fought at the Somme and similar terrible places along the Western Front and then spent the end of the war and after at a military hospital where he did his best to help men with dreadful injuries.

"I was always impressed with what he did and about 15 years ago I wrote a book about his experiences during WWI called 'Somewhere in France' because that was all he could say about his location and he put that at the top of all his letters to my mother."

Inspired by both his father's achievements and character, Mr Nott decided as a boy that he wished to be a surgeon.

Over the course of his long and distinguished career, Mr Nott spent time on the ACT Medical Board, the ACT State Committee and a year in Saudi Arabia developing a surgical unit in a new hospital. He served as a surgeon in the RAAF Reserve of Officers, was twice called up for full time duty completing tours in Butterworth, Malaysia, and retired after many years as a Wing Commander in the RAAF Reserve, earning the Reserve Forces Decoration.

"I spent four years overseas after graduating in Medicine, completing my surgical training in England for three years at the London Hospital and further training in Scotland and the US," he said.

"I came back to set up in Canberra at a time when the specialty of cardiothoracic surgery was still rather young and over the years the bulk of my practice became chest trauma, hydatid disease and lung cancer.

"I always found it enormously satisfying to work with people who had surgical problems I could address and specially working with lung cancer patients – treating them, counselling them and seeing them through the bad times – made for a very complete life.

"At that time there were few cardiothoracic surgeons in the bush and all cardiac surgery was done in the major teaching hospitals in capital cities. Many of my colleagues felt that as Canberra was growing so fast, an open-heart surgery unit should be established.

"So throughout the 1980s, I was a member of a group of surgeons, cardiologists, anaesthetists, nursing staff and allied health professionals who worked very hard to establish a heart unit and finally after years of battling the bureaucracy, we were able to recruit a very fine surgeon, Mr Peter Bissaker, to run the unit treating patients at The Canberra Hospital and the National Capital Hospital.

"That unit finally got off the ground in 1994 and since then it has achieved spectacular results.

"I put a great deal of effort into that, particularly towards the end of my career, because I absolutely believed that the people of the ACT deserved such a world-class service and I am proud of my contribution." ▸

Australian War Memorial, Canberra

Yet even upon his retirement 12 years ago, Mr Nott's abiding passions of military history and helping people in need have never wavered.

He said that one aspect of his professional life that he most missed was the special relationship that developed between surgeons and their patients, so upon his retirement he became a volunteer at the Australian War Memorial so that he could continue to help and keep in touch with people.

Having been taken to the opening of the Memorial in 1940, Mr Nott said the dramatic Byzantine-style building had always held a fascination for him so that it felt natural to spend time there when he had the time to give.

"I loved being a surgeon, but the time does come when you have to stop although you are still enjoying the challenge," he said.

"However, the stress of major surgery made me aware that I should retire, but it was hard because I enjoyed it so much. So to help get through the transition I became a volunteer at the War Memorial.

"There are about 50 of us who give our time there working at the Research Centre and the Online Gallery helping members of the public and school kids navigate the maze of archival documents held at the War Memorial, the National Archives and the National Library.

"They are not very easy or intuitive to work your way through and I particularly enjoy helping people who have come in to find out something about a specific person, a grandfather or an uncle, but have no idea where to start.

"It's a very satisfying experience because we can sometimes find many pages of information relating to a single, serving soldier and people are astonished by that and always moved.

"Often these documents were written on the same day as the fighting making them very compelling reading.

"We print out all this information for people and when they take hold of the documents they treat them like they are holding a treasure and sometimes elderly people, in particular, just cry to see the name of their loved one mentioned, honoured and not forgotten.

"In some ways, it is this dynamic, helping someone on a one-to-one basis that is similar to life as a surgeon and I find it a very rewarding way to spend my time."

With Karen Murphy

Cricket

and Younger Fellows of the College

This is an extract of a presentation made at the October Council in 2012

RAISING THE FOCUS on younger Fellows was identified as a priority when Council met in retreat (March 2012). Regional Committees were then encouraged to identify and execute strategies to ensure that Younger Fellows increased their engagement with the College at Regional Committee level. The SA Younger Fellow Voices Program was designed to give younger Fellows in SA a direct opportunity to identify their views of the College, its relevance to them and the future they saw for the College.

When invited to speak at Council lunch in (October, 2012), the SA Regional Chair took the opportunity to report to Council the views expressed at the SA Younger Fellows Voices Program in a talk entitled "The Leg Glance, The Forward Defensive and The Cover Drive; A Younger Fellows College". Some extracts of which are presented here.

The competitive pursuit of excellence required to become very good at cricket requires good technique, good application of this technique and hard work. Equally important is the development of an understanding of success as a cricketer being the result of hard work, mental and intellectual commitment not dissimilar to the requirements of being a success at surgery. Similarly, the preparedness to face a rigorous examination by a probing line of questions by members of the Court of Examiners in the Fellowship exam is akin to facing up to a whizzing new ball on a bouncy wicket as an opening bat.

The key activity of the Younger Fellows Forum, with its inaugural meeting in 1982 after being formally conceptualised by Prof Richard Bennett in 1980, was to provide the younger Fellows with a voice in the College. Yet, that voice is sometimes difficult to hear amidst the din of contemporary surgical life. The reasons for this are myriad and in South Australia, in our Younger Fellows Voices program, we are starting to hear some different elements of the younger Fellows. The challenge, to connect with the younger Fellows, is not new, is not restricted to South Australia and requires creative solutions.

Who is the younger Fellow? What are his or her characteristics? Perhaps the various descriptions of some of the great batsmen in the history of cricket help us understand the various identifiable attributes of our younger Fellows.

The petulant

The behaviour of WG Grace with respect to umpires may similarly remind many gathered here today of the petulant Trainee surgeon. It is said that WG Grace led umpires to lead rather a hard life. Some of them may have been frightened of getting him out, but if he ever intimidated them, it was certainly not malice – it was rather the irrepressible teen boy in him that had never quite grown. That sort of boy thinks the umpire a beast if given out and Doctor WG Grace would appear to be that sort of a boy. That sort of petulance is a challenge for many a surgical supervisor.

The all-rounder

It is said of Sir Garfield Sobers that he was not merely a cricketer from the West Indies; ▶

Batting at the annual SA Surgeons v Physicians match in Adelaide.

rather he was a West Indian cricketer – a calypso spirit with a huge talent. It was said of Sobers that nature indeed had blessed him liberally, with "instincts and suppleness of the panther, exceptional stamina and the constitution of an ox". The all-rounder younger Fellow is a great asset to his unit, to his hospital and to his specialty. The question is whether he or she chooses to be a great asset to his/her College.

The technically brilliant

Sachin Ramesh Tendulkar, the legendary modern batting genius, has trod an inevitable path to greatness. Like Bradman, Tendulkar is a one-stop shop of near perfect technique. It is not merely his technical brilliance, but his strength of character in carrying on his bat the aspiration of a billion adoring Indians that identifies his brilliance as being more than technical.

Sir Rodney Smith at the Mitchiner Memorial lecture presented at the Royal College of Surgeons of England in 1977 makes this point about the difference between wisdom and technical brilliance in surgery when he said "operative technical skill is important, but it must be seen as the servant not the master of knowledge and judgement ..."

The indefatigable

The late cricket writer Peter Roebuck once said, "No cricketer can truly be designated great unless he can save games as well as win them." Steven Waugh, the Australian former captain is well known for a never say die attitude and has saved many games for Australia by his dogged determination and strength of spirit. Sometimes, it requires a certain dogged determination to establish an identity as a younger Fellow within the community of the College.

So what do the delicate and wristy leg glance, the solid and protective defensive shot and confident cover drive have to do with the younger Fellows College? Each of these classic cricket batting techniques reflects the journey of the younger Fellow through a decade of development when a new Fellow journeys through younger Fellowship and comes out the other end.

In selection for surgical training, an aptitude for a life in surgery is noted by the ability to focus and to execute with some degree of flair (albeit raw and untrained) something that will catch the eye of the surgical mentor and lead to selection and training. It is clear to me that all younger Fellows are capable of the leg glance.

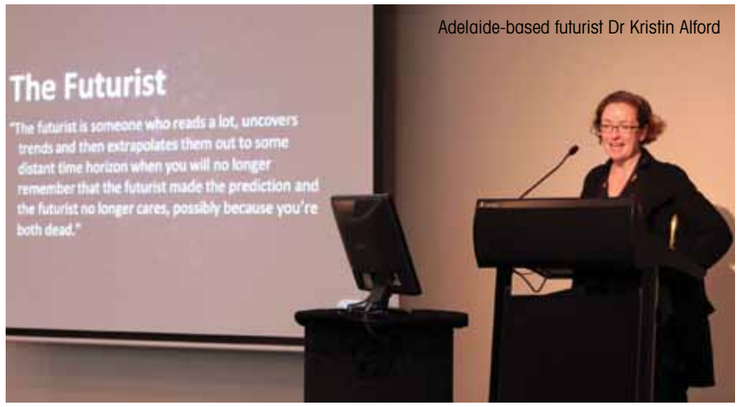
The College, as a training institution, is often perceived by the Trainee and in the memory of the recently graduated Fellow as an uncompromising master during training years. Many do not lose this perception and I suspect this forms the basis of suspicion and cynicism especially if the training years have been difficult. Yet, to survive those training years requires a solid and protective ability to play the forward defensive. In learning the forward footwork, placing the bat in front of the body and protecting the wicket without flinching, the young Fellow survives the slings and arrows of the Fellowship examination.

With the passage of years comes confidence; an ability to see beyond just the need to survive at the crease, but to score runs; and the younger Fellow flourishes – happy to take risks because there is not much that cannot be handled with well founded confidence. The cover drive epitomises this confidence and it is at this stage of their career that the younger Fellow is most likely to recognise his or her position in the context of the wider Fellowship of the College. It perhaps is at this time, the time of well-timed cover drives, run-making square cuts and pull-shots that the younger Fellow is most likely to move from being a Fellow of the College to understanding that the College survives, not on the efforts and achievements of an individual, but on the joint efforts of the 10 other people on the team and it is at that moment that the younger Fellow takes his or her place in the enterprise of leadership.

But yet at the end of the day this is not a younger Fellows College after all. Neither is it an older Fellows College. It is a single College with a single set of unifying values of service and professionalism, of integrity that values respect and compassion to each other and to the community it serves.

I believe that in the progression from the raw aptitude demonstrated by the leg glance, the ability to play a forward defensive during the sometimes difficult training and early years and to step-up and drive 'through covers' when those difficult years are over and the confidence is running high, that the younger Fellows of this College will come to the realisation that this College is theirs.

Peter Subramaniam
Chair, SA Regional Committee



Adelaide-based futurist Dr Kristin Alford

The debate team:
Tim Bright, Mark Edwards, Peter Subramaniam, David Fletcher, John North & Michael Grigg

SA/WA/NT meet in the Barossa

The SA, WA and NT Combined Annual Scientific Meeting was held in the Barossa Valley, South Australia, in August. The meeting, with the theme of 'Future Directions in Surgery' was well attended by WA and SA surgeons, as well as visitors from Darwin.

Attendees were treated to a keynote presentation by Adelaide-based futurist Dr Kristin Alford who talked about ideas we should expect in the coming decades, such as artificial meat and the opportunities in 3D printing.

The program also included a light-hearted debate, ran for the third year around a theme generated by the convenors, this year being the statement 'Surgery does not need to be performed by Surgeons'.

WA Cardiothoracic Surgeon Mark Edwards, SA Chair Peter Subramaniam and SA General Surgeon Tim Bright argued For, while WA General Surgeon David Fletcher, NT Clinical Director John North and Vice President Michael Grigg were Against. The Against team won the favour (not surprisingly!).

The Annual ASM Dinner was held at the atmospheric Vintners Bar and Grill, with local Barossa Fellow and Wine Master John Tomich presenting a detailed Hanrahan Oration on the complexities of wine.

John Tomich

The Western Australian Committee will be hosting the 2014 Combined ASM in the portside town of Fremantle on 8-10 August, and welcomes Fellows to attend.

Being a Dean, being a surgeon and being a *student*

You can be involved in the next generation of surgeons

The privilege of being our College's Dean of Education carries with it many responsibilities. We strive continuously to fulfil the credo of excellence in surgical education and practice, ensuring that our Trainees and surgeons are central to that philosophy.

Currently there are enormous efforts being made to revamp the College's IT systems, which will support the curriculum, learning and development and assessment as well as service functions of the College.

The Academy of Surgical Educators is flying along with members and we are working to provide professional development to our surgical educators with education articles, webinars, an upcoming forum and eventually regular e-newsletters and even a blog – when the Dean has time.

The main initiative for 2013/14 is the Foundation course for surgical educators, which will target senior Trainees or Fellows and is an important New Key Initiative for the first part of next year.

The Post Graduate Years (PGY) suite of resources also depends on new IT, for this is our big project over the next few years. Here we go you say, "BST again". It is not BST. It is a suite of resources carefully mapped from the Australian Curriculum Framework for Junior Doctors (ACFJD), to the novice/intermediate standards covered in the 'Becoming a Competent Surgeon – Training Standards in Assessment'.

We will provide registration and, as a result, access to some College resources, as well as describing pathways to the surgical specialties and access to fee-paying courses. All of this is designed to support the best of the tsunami of medical graduates who aspire to be SET surgical Trainees and eventually FRACS surgeons.

With the tremendous support of College staff and Council, we can make all of this happen. If we get the most able and highly motivated people into surgical training with improved skill-sets on entry, we should find that they have better progress through SET, and come through as competent, and confident, younger Fellows.

Really, if we don't do this, we ignore our professional role, our proud tradition, and we risk the future of surgery in Australasia. Unfortunately, there is no time to experiment as we must invest in a way forward. After all, surgeons make reasonable and considered decisions, day-in and day-out. With the support of my Ballarat colleagues, I continue in clinical practice without compromising clinical standards.

Let's step back. Much of this is about our College and its role for the community, as well as Fellows and Trainees. What underpins this? Is it political? Is it demanded by government? Are we worried about competition?

Medical schools, which generate the young doctors, map their outcomes to the ACFJD. We establish the suite of resources for the PGYs who aspire to surgery. We have SET; we are evaluating some aspects of this. Ultimately, as Fellows, we have our professional responsibility to demonstrate excellence in practice across the nine College competencies.

This is a continuum of lifelong learning. It extends us as surgeons to do better, under the guidance of the nine College competencies. One of these is Scholar and Teacher. This competency is about facilitating learning in the workplace, be those medical students learning about communication or showing specialty colleagues aspects of a new technique.

Between 2000 and 2003 I conducted my Clinical Education studies at the University of NSW, and supplemented this with some postgraduate education subjects including curriculum design at the University of Notre Dame. Nevertheless, the collaborative College Graduate Programs in Surgical Education at the University of Melbourne beckoned, especially for this member of the Advisory Board. I want to share my experience of becoming a student again in the Research Methods on Surgical Education workshop.

The workshop commenced with some pre-workshop tasks including the critique of a self-selected article from the surgical education literature. This included commentary and uploading to the SOLE learning management system. In doing so, we initiated a community of learners (practice) in this subject.

In addition to the critical appraisal skills required – there was also an essay about a research method in educational research, followed by a substantial research proposal, likely to become the thesis of the Masters' program. Maybe all that sounds a little dry.

However, the day was anything but dry. Firstly, sitting in the imposing Council room, mainly in jeans, were 15 Fellows and Trainees from around Australasia. Professor Debra Nestel had assembled some experts in their fields. Dr Gabriel Reedy of Kings College London gave an exciting overview of how to make sense of education research.

Associate Professor Margaret Bearman of Monash University spoke informally while using an excellent lesson plan about qualitative research methods. Professor Nestel used focus groups as an example of qualitative research. After lunch, Associate Professor Pamela Andreatta from the University of Michigan spoke persuasively about quantitative research and contrasted that with qualitative research in order to illustrate the merits of each.

Eventually we started to discuss our research that will follow on from completion of this subject. All of this was actually 'fun'. No, it was not a College employment day – like the others, it was a day away from clinical practice and it was stimulating and enjoyable.

Being a student again, even at this Masters level, is really just a specific example of what all of you do each day. Why not reflect on all of this? Does it resonate? Why not get involved? Have a look at the Academy, comment on our PGY approach as we need your support and would appreciate your input, and facilitate some professional development activities as an educator.

The combined College-University of Melbourne program has been mentioned, but there are many other clinical or health professional education programs around so find the right one for you and get involved!

Please feel free to contact me at the College, my email address is stephen.tobin@surgeons.org.

Stephen Tobin
Dean of Education

Working with Mr Deepal Attanayake in Galle - one of only two neurosurgeons servicing a region of about 4 million.

Dr Arul Bala was able to learn a range of new procedures with the help of the College grant

Building skills across the *sea*

Perth neurosurgeon Dr Arul Bala returned to Australia earlier this year after spending two years expanding his skills in both traditional skull base and endoscopic skull base surgery at a prestigious neurosurgery unit in Manchester, England.

With financial support provided by the College through a Hugh Johnston Travel Grant and a Covidien Travel Grant, Dr Bala spent 2011 and 2012 as a Fellow at the Salford Hospital, which also manages one of the largest type 2 neurofibromatosis clinics in the northern hemisphere.

While there, Dr Bala worked under the supervision of Professor Andrew King and Mr Scott Rutherford and his mentor Mr Kannan Gnanalingham.

During the Fellowship he spent his time treating vestibular schwannomas, meningiomas within the skull base, pituitary tumours, removing intracranial tumours through nasal pathways and in the emergency setting, treating spinal fractures and head trauma.

He said that while the process of winning the Fellowship position was rigorous and competitive, he believed he had been chosen because few neurosurgeons in Perth conduct endoscopic skull base surgery.

"The leading surgeons at the Salford Royal Trust are very keen to train younger Fellows, particularly in new and emerging techniques and particularly from cities and regions who have limited access to endoscopic skull base surgery," Dr Bala said.

"Skull base surgery was the Holy Grail for many preceding generations of neurosurgeons in their attempt to deal with the most inaccessible of pathologies, but endoscopic surgery has now taken that work onto a whole new level.

"This type of surgery really started with pituitary surgery, with the endoscope slowly replacing the microscope and now technology provides us with the most remarkable vision in high definition allowing us to see every bleeding point and miniscule tumour while also allowing us to plot a safe path to the site.

"In the past, we would have had to take a transcranial approach to treat some of these conditions, which is obviously far more invasive with far more risk attached, and in more extreme cases we would have been able to do very little because the risks associated with simply getting to the site outweighed the benefits of what we could do when we got there.

"To work, then, with next generation equipment and learn the skills needed to make the most of it for the good of patients was a wonderful experience."

Dr Bala said that while it had been thrilling to work with leaders in the field, such as the head of the Salford unit Professor Richard Ramsden, a pioneering neuro-olotologist, the sheer size of the case load allowed him to refine his skills in both traditional and endoscopic skull base surgery.

He said he spent the first year working under supervision and independently during the second year.

"Throughout my time there, I averaged two vestibular schwannoma surgeries in the first year and four pituitary tumour procedures per week in the second year – which we would simply never see in Australia," he said.

"I also had a very intensive on-call roster with two on-call shifts per week which allowed me to the see the broadest possible range of neurosurgical cases.

"One of my most memorable experiences was the first time I was given the lead in theatre with endoscope in hand to navigate the nasal cavity to extract an intracranial tumour.

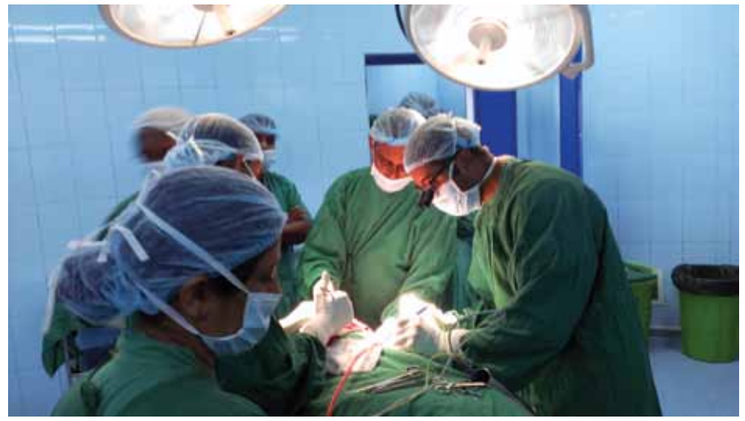
"The vision afforded by the new technology, along with new instruments and broader skills allowed us to see into the most remote parts of the pituitary fossa and cavernous sinus.

"I found this an exhilarating experience and while I progressed cautiously over the first year, by the second year I was independently extracting tumours of the pituitary region unsupervised, a learning curve that all Fellows dream of.

"And on top of that, what used to be a five hour operation in some cases is now down to about half that; the patient wakes with no scar and most can hardly believe they have had neurosurgery at all."

Now back working as a consultant at the Sir Charles Gairdner Hospital in Perth, Dr Bala said he particularly liked the collegiality of his time in England, dining "Harry Potter" style in the halls of Oxford, jaunting off on quiet weekends to European cities and attending meetings of other neurosurgical units spread across the country.

Dr Bala was born in Sir Lanka, came to Australia as a small child and decided to visit the town of Galle on his trip home to Australia.



"To work, then, with next generation equipment and learn the skills needed to make the most of it for the good of patients was a wonderful experience"

There, he spent three weeks working alongside a neurosurgeon friend treating skull base tumours, pituitary tumours, spinal fractures and paediatric brain tumours.

"I had long wanted to work in my home country and see how things had changed since the Boxing Day tsunami in 2006 and the end of the civil war in 2009 and was disappointed, but not surprised, to find that while there has been economic growth, little financial support has made its way into the health system yet," Dr Bala said.

"It was a bit confronting to find myself working without a high-speed drill or a neuro-navigation unit in the second largest neurosurgical centre in the island, but that shows what we take for granted in first world countries.

"But despite these limitations, I actually found it a valuable learning experience because with less equipment, few staff and fewer specialists to call on, you have to be more skilful and more adaptable and focussed.

"It was rewarding, but it was also stressful because what we would consider low-risk operations can quickly become high risk without all the equipment we take for granted."

Dr Bala said he was now discussing with a number of colleagues both in Australia and Sri Lanka the possibility of starting a Fellowship that would allow Trainees to transfer between both countries to expand their skills and surgical experience.

He said he was enormously grateful to the College for its support and said he hoped to use his new array of skills in both traditional and endoscopic skull base surgery for the good of Western Australian patients.

"I hope to deliver this as an aspect of my surgical service in the future on the basis that the more options a surgeon has the better," he said.

"I work closely with my ENT colleagues and we have the necessary endoscopic equipment that we can use to go further into the brain cavity to treat a number of very serious conditions."

The Hugh Johnston Travel Fellowship is provided through a bequest established to assist Fellows and Trainees to take time away from clinical positions to gain specialist knowledge overseas to the benefit of the Australian community, the Fellow or Trainee and the College.

With Karen Murphy

Practical steps to Good Governance and Risk Management

For us tragic Essendon supporters, good governance is something that cannot be ignored

Governance and risk management go hand-in-hand, and provide a framework to ensure that an organisation meets its legal obligations, manages its risks and ensures appropriate accountability throughout the organisation.

Some practical steps that a Board might consider as part of this framework include:

Board Charter

A Charter can set out the duties, responsibilities and expectations of the Board, the Chief Executive and the executive staff of an organisation. The key roles and responsibilities of each help to clarify respective duties and help prevent a Board overly interfering in management issues, and allow the Chief Executive and other executive staff to recognise the Board's rights to enforce accountability. The Charter can also set out the expectations of all participants in relation to meetings, reporting, provision of information and risk management.

> *"Where delegation of powers is made, there should also be requirements for reporting (monthly/quarterly/annually) on all areas of the organisation's operations"*

Delegation and Reporting

A formal document setting out the delegation of the Board's powers to the Chief Executive and other executive staff helps establish accountability. Where delegation of powers is made, there should also be requirements for reporting (monthly/quarterly/annually) on all areas of the organisation's operations. Delegations will not just be financial, but may reflect contractual rights, communication on behalf of the organisation, and other non-financial areas. Similarly, reporting expectations can be established, so that the Board receives timely information in relation to how delegated powers have been utilised.

Risk Register and Risk Management Framework

Every organisation should have analysed its risks, established clear procedures to minimise and control risks, and set out accountabilities for management of risk. A Risk Register, appropriately and regularly reviewed, sets out the risk, the likelihood of the risk, the controls to minimise the risks and who is responsible for oversight. This should be in the context of a framework which sets out the processes by which risks will be managed, by whom, and when reporting should be made to the Board.

Policies

High level policy documents endorsed by the Board establish the organisation's framework for quality, safety, risk and operations. These should include occupational health and safety policies, now mandated by legislation. However, they can also include appropriate provisions for quality of service, financial processes and other legal risks.

In relation to all policies, the Board should be satisfied that all relevant staff within an organisation have access to appropriate education and training so as to be able to fully understand the policies that have been set, and be equipped to implement those policies as required.

Incident Monitoring and Notice Requirements

One of the clear policies that should be endorsed by a Board can set out processes by which the Board, the Chief Executive or other executive staff are notified of adverse incidents which may occur and affect the organisation. A process of escalation in relation to dealing with those incidents should be clear. In relation to the most serious risks, provision should be made for prompt notification to the Chief Executive and the Board. Boards will recognise that things can go wrong, and will adversely impact on the organisation. It may not be the organisation's fault, but nonetheless the incidents need to be addressed promptly, and the Board will need to be satisfied that there are appropriate policies and processes in place to address these matters.

Compliance Check List and Sign off

Notwithstanding the policies that may be in place, occasionally things go wrong, and notification to the Chief Executive or the Board may not always be prompt. There is always the possibility of parts of an organisation not recognising the severity of a risk or incident, or even actively concealing it. A compliance check list, which requires senior executives to formally "sign off" on a quarterly basis in relation to a range of compliance issues, can be one method to "flush out" any lurking issues. A compliance check list can require an executive to confirm whether they are aware of any particular incident or non-compliance, or any circumstances that may give rise to an incident or non-compliance. These can include breach of legislation and legal obligations, human resources issues, OH&S, product liability, criminal or penalty offence matters, customer claims, breach of contract and other matters which can be tailored or made more specific to the nature of the organisation.

Complaint Handling

Depending on the nature of the business of the organisation, the Board should be satisfied that it has appropriate complaint handling processes in place, particularly in relation to customers, but also in relation to suppliers. The complaint handling process can be an early warning system for problems with products or services, or deficiency in operations. A complaint handling process should provide a prompt empathetic response, to preserve the goodwill and reputation of the organisation, and appropriate reporting should be made to those within the organisation who need to understand the nature of complaints and any trends or developing issues.

Audit

Just as an organisation will undertake a financial audit on an annual basis, it can also utilise internal audit processes to review some of these governance processes; to ensure that they are in place, and more particularly that they are operational and effective. An internal audit could be undertaken by those within the organisation to save costs, or could be done by external independent auditors or consultants.

Not all of these practical steps will be possible for any organisation, depending on the resources available. The size of the organisation will depend on how critical some of these particular issues may be. Nonetheless, they are issues that should be considered by Boards as part of the overall governance framework of an organisation.

Michael Gorton,
College Solicitor

Cover Story

How to survive as a consultant surgeon

Things they never tell you

This article originally appeared in the 'Journal of the Association of Surgeons of Great Britain and Ireland' (No. 37, September 2012). The first half is reproduced here with permission. The second half will run in the next issue (Nov/Dec 2013) of Surgical News.

Remember the bygone days when you reported to your chief and he or she was there (or thereabouts) to proffer advice, encouragement and reassurance? When, if there were problems, tricky situations or difficulties, help was, at most, just a phone call away? When the buck stopped up the chain somewhere, and if you got out of your depth, there was the helpful reassuring hand able to rescue you? Comforting, for sure – only trouble is that, now you have attained the dizzy heights of consultancy, it is you with whom that buck rests. So, how to survive? I believe there are some basic tips and rules which are bound to help you (in no particular order, as the saying goes).

> *"Surgeons need to have the courage to make difficult decisions, the humility to know when they need help and the wisdom to know the difference"*

Patients

Have patience with patients – if the reverse is true too, you'll be quids-in. Learn to like your patients and you'll find the whole experience of looking after them infinitely more pleasurable. They can be pretty frustrating, sometimes downright annoying, but at the end of the day, you are their source of comfort and problem resolution, and they depend on you. Becoming cross with them for any of what you see as their perceived inadequacies will achieve nothing.

Apologise when things go wrong (which they will) and be honest about what you think you can do, and what you have actually done. Patients will be amazingly forgiving if you say a genuine sorry when things don't go well, and the more humble and distraught you are in those situations, the more likely you will be pardoned. Most human nature is to be reasonable and understanding, but a sniff of arrogance or shiftiness on your part will very likely result in resentment, anger, and the likelihood of a formal complaint and legal action.

If you do get sued (and very few escape without at least one of these occasions in their careers), try not to take it too personally. It is the fashion now in our society to want to blame someone when things don't go right, and often the motive is money, not necessarily to see you personally dragged through the courts and punished. Remain calm, honest, and seek comfort from those who support you in life (see below).

You will go through many times when there are very hard clinical choices to make. Surgeons need to have the courage to make difficult decisions, the humility to know when they need help and the wisdom to know the difference. Being confident and assured needn't mean arrogance, but be careful that it isn't interpreted that way. Involve your team, the nurses, and other colleagues when the way forward may not be clear.

But when things do go wrong, and you feel alone and bereft, you will need succour of a very special kind. Almost all have been there – the sleepless nights spent worrying about the hows, whys and wherefores, the increased irritability, the feelings of depression and of wanting to throw the towel in – you will not have been the only sufferer.

We are trained to be the ultimate professionals, and it would be strange indeed if there were such little insight as to negate such responses. Having fallen off the bicycle, it is vital to get back in the saddle as soon as you can (although a period of time away from the coalface, hopefully brief, can be useful if necessary), and however alone and upset you may feel, be assured that you are travelling down a well-trodden path.

In these modern days, when patients are looked after by teams rather than being the responsibility of an individual consultant, be sure that you can live with what that means for your relationship with your charges. Ask yourself what you would think as a patient if, having had your major surgery on a Friday, your consultant announces that he or she will see you on Monday and leaves you to the care (or mercy, as you may interpret it) of a series of other doctors whom you have scarce, if ever, met, and whose skills and abilities are an unknown. Some still find the greatest satisfaction in making their patients feel the most special people on the block, and I would urge you to give serious consideration to trying to take as much individual responsibility for each and every person who nestles under your wing as possible – the rewards in terms of personal satisfaction cannot be overestimated.

Colleagues

Your closest colleagues are likely to be fellow surgeons, but you may form close working relationships with, for instance, your anaesthetist, gastroenterologist, or interventional radiologist. Whichever, these people are the bedrock of your working life, so nurture and cherish them. And help them when they need it – they will be far more likely to return the favour when you are the needy one.

Difficult colleagues can be a nightmare. Their motivations for being so can vary from jealousy to sheer bloody mindedness. Whatever the reason, you are going to have to have a strategy for dealing with them. Don't get dragged down to their level by ▸

The NSW Regional Office is running the inaugral 'Surgeons' Month' in November.

'Surgeons' Month is an opportunity to highlight this diversity and celebrate the many facets of this great profession.

A range of events will be held, including:
NSW Younger Fellows' Preparation for Practice Course
Saturday 9 November
College NSW Regional Office, Level 26, 201 Kent Street, Sydney

View the program on the website at http://www.surgeons.org/media/20004741/2013-11-09_frm_yfp4p_program.pdf

For more information on NSW Surgeon's Month, see the brochure on the College website at http://www.surgeons.org/media/20037769/nsw_surgeons__month_brochure.pdf

bad-mouthing them in private (let alone in public), and be dignified at all times. The reasons for their issues may well be problems at home, monetary, or who knows what – you may never find out – but respect them for what they are, as everyone has some redeeming qualities. Don't allow yourself to be bullied; stand up for yourself, but act with dignity at all times.

A bad colleague – one whose performance, in your opinion, is below par – is yet another issue that may tax you, especially if at times they are scheduled to be take care of your patients. Be careful not to judge too harshly – the way out of this dilemma is simply to ensure that you increase the input into your own patients' welfare.

There is a temptation which you may find hard to resist (although it may be something of a subliminal feeling); that of trying to out-do your colleagues. Healthy competition is a good thing, but beware of the unhealthy practice of trying to get one over on someone else in order to make yourself look better. Others will spot the ploy, however subtle you may think you are being, and there is something very unattractive about such activity that will not serve you well in the long run. Empire building only ever works if it is in the ultimate best interests of the institution.

Managers and management

Like it or not, clinicians are managed by a group of people, and these may be people whose redeeming qualities are not immediately apparent. Embark on the pathway of hostility and you are making a rod for your own back. Work with them, understand where they are coming from, and that they are often merely passing on rules and regulations that come from way above them, and your life will be a lot less traumatic. They have a pretty rotten job, and coping with recalcitrant and haughty clinicians who think they are above such things only makes their job even more unpleasant. Besides, you must be prepared to take some executive responsibility in the organisation for which you work, and refusing to get on board will damage it in the end.

You may feel that you have far superior and extensive knowledge about how the practice of surgery should work – and you are probably right. In which case, allow them to benefit from that greater experience, and work with them to achieve the best possible outcome, given the very real constraints to which healthcare is subject. We are in the same boat, with much the same aim, and one cannot function in today's monitored health system without the other, so make the very best of it that you can. Besides, those who are prepared to play ball will get to influence what happens, rather than find that decisions are made for them.

Nick Markham
Director of Informatics, ASGBI

The Section of Academic Surgery Annual Meeting of Academic Departments will be held in Adelaide on Thursday 14 November 2013

This year Day 1 of this meeting will consist of two workshops. We have excellent and interesting speakers who will be presenting during the day, with time to spend on discussion after each session and during the small group workshops which will occur at the end of the day.

- **9.00am – 12.30pm**
  MID-CAREER WORKSHOP FOR SURGICAL LEADERS

  SESSION 1: Being an Academic Surgeon
  SESSION 2: Academic Surgery and the World

- **1.30pm – 5.00pm**
  WORKSHOP: UNIVERSITY HOSPITALS AND SURGICAL SERVICES

  SESSION 1: Models of Care – Academic Strengths and Weaknesses
  SESSION 2: General Workshop on Academic Health Centres

After these workshops you are invited to attend the

- **SURGICAL RESEARCH SOCIETY 50TH ANNIVERSARY DINNER**
  The Adelaide Club
  7.00pm.

- **THE SURGICAL RESEARCH SOCIETY ANNUAL SCIENTIFIC MEETING**
  Friday 15 November 2013
  You are encouraged to stay overnight and attend Day 2 of this meeting which will be held at the same venue in Adelaide. This meeting is open to those involved in or interested in research, including surgeons, surgical or medical trainees, researchers, scientists and medical students.

- **CONTACT**
  For further information, please telephone Sue Pleass on +61 8 8219 0900 or email academic.surgery@surgeons.org .

SURGICAL RESEARCH SOCIETY ANNUAL MEETING

The Surgical Research Society 50th Annual Scientific Meeting will be held in Adelaide on Friday 15 November 2013

This meeting is open to those involved in or interested in research, including surgeons, surgical or medical trainees, researchers, scientists and medical students.

JEPSON LECTURER:
Professor Guy Maddern

Dept Surgery, Queen Elizabeth Hospital, Woodville, South Australia
"Who cares about surgical research?"

ASSOCIATION FOR ACADEMIC SURGERY GUEST SPEAKER:
Dr Chris Breuer

Professor of Surgery and Director of the Tissue Engineering Program Nationwide Children's Hospital, Columbus and Ohio State University
"The development of tissue engineered vascular grafts for use in children"

SOCIETY OF UNIVERSITY SURGEONS GUEST SPEAKER:
Professor David J Hackam, MD, PhD FACS

Professor of Surgery, University of Pittsburgh School of Medicine
Children's Hospital of Pittsburgh of UPMC
"Small cells for small patients: The interaction of the innate immune system with intestinal stem cells in necrotizing enterocolitis"

CALL FOR ABSTRACTS:
The call for abstracts has now closed.

AWARDS AND GRANTS:
The following will be awarded to the best presentations:
- Young Investigator Award
- Developing a Career in Academic Surgery Award
- Three Travel Grants
- Best Poster Award

A dinner commemorating the 50th anniversary of the SRS will be held the evening prior to the SRS Meeting at the Adelaide Club on Thursday evening, 14 November 2013.

CONVENOR:
Professor Guy Maddern

CHAIR, SRS
Professor Leigh Delbridge

FOR FURTHER INFORMATION CONTACT:
Mrs Sue Pleass | Tel: +61 8 8219 0900 | Email: academic.surgery@surgeons.org | Web: www.surgeons.org/academic-surgery

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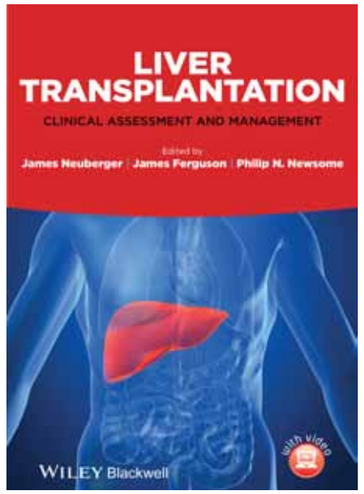

Liver Transplantation: Clinical Assessment and Management

James Neuberger, James Ferguson, Philip N. Newsome (Editors)
9781118277386 | Hbk | 376 pages | October 2013

~~AU$155.00~~ | **AU$100.75**
Member Price

Liver Transplantation: Clinical Assessment and Management is the perfect tool for all gastroenterologists, hepatologists and transplant surgeons managing patients with liver disease awaiting and undergoing transplantation. Led by James Neuberger, world experts in hepatology and transplantation provide a chronological, step-by-step approach to best clinical management and patient care.

Evidence-based throughout and with reference to the very latest practice guidelines from major societies such as EASL and AASLD, the book covers:

- When to refer a patient for liver transplantation
- Selection, assessment & management on the list
- Transplantation for acute liver failure
- Donation and allocation
- Care of the liver transplant recipient

80 high definition videos of transplant surgery allow you to watch the experts in action and provide an outstanding visual / teaching element.

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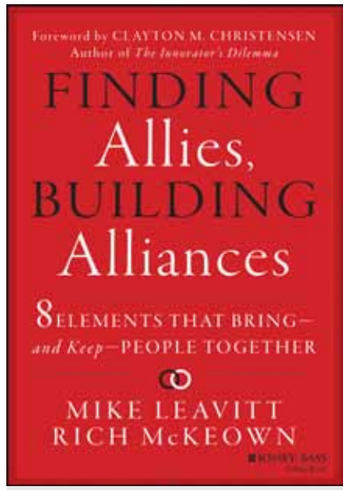

Finding Allies, Building Alliances: 8 Elements that Bring--and Keep--People Together

Mike Leavitt, Rich McKeown
9781118247921 | Hbk | 240 pages | August 2013

~~AU$37.95~~ | **AU$24.67**
Member Price

Your business challenges extend far beyond you and your firm, to the competitors within your industry and the regulators outside it. Finding solutions to larger issues requires cooperation between diverse stakeholders, and in this rapidly changing world, only those able to adapt and network successfully will produce fast, competitive solutions.

How can leaders successfully bridge divides and turn competitors into collaborators? Leavitt and McKeown explain how a well-chosen network can become a powerful alliance. Whether you're launching a new partnership, or rehabilitating one already in progress, Finding Allies, Building Alliances will help you find workable solutions to the most complex problems.

25% Discount

Global Governance at Risk

David Held, Charles Roger
9780745665252 | Pbk | 272 pages | September 2013

~~AU$34.95~~ | **AU$22.72**
Member Price

Since 2007 the world has lurched from one crisis to the next. The rise of new powers, the collapse of our global financial system, the proliferation of nuclear weapons and crisis in the Eurozone have led to a build up of risks that is likely to provoke a more general crisis in our system of global governance if it cannot be made fairer, more effective and accountable.

In this book, nine leading scholars explore the fault lines and mounting challenges that are putting pressure on existing institutions, the ways in which we are currently attempting to manage them – or failing to – and the prospects for global governance in the 21st century. In doing so, the contributors offer a fresh look at one of the most important issues confronting the world today and they suggest strategies for adapting current institutions to better manage our mutual interdependence in the future.

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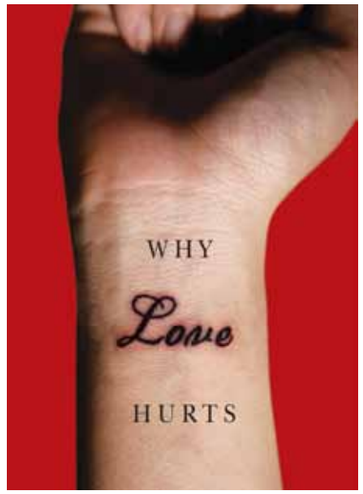


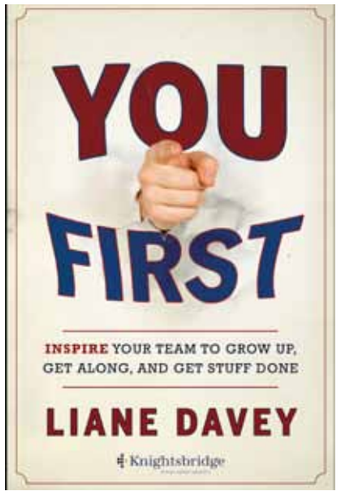
Why Love Hurts: A Sociological Explanation

Eva Illouz
9780745671079 | Pbk | 304 pages | September 2013

~~AU$24.95~~ | **AU$16.22**
Member Price

Few of us have been spared the agonies of intimate relationships. They come in many shapes: loving a man or a woman who will not commit to us, being heartbroken when we're abandoned by a lover, coming back lonely from bars, parties, or blind dates, feeling bored in a relationship that is less than we had envisaged - these are some of the ways in which the search for love is an often painful experience. This book argues that the modern romantic experience is shaped by a transformation in the ecology and architecture of romantic choice. The samples from which men and women choose a partner, the modes of evaluating prospective partners, the very importance of choice and autonomy and what people imagine to be the spectrum of their choices: all these aspects of choice have transformed how we want a partner, the sense of worth bestowed by relationships, and the organization of desire.

25% Discount



You First: Inspire Your Team to Grow Up, Get Along, and Get Stuff Done

Liane Davey
9781118636701 | Hbk | 240 pages | October 2013

~~AU$29.95~~ | **AU$19.47**
Member Price

Five common problems your team is susceptible to—and the one thing you can do to fix all of them. There are so many ways a team can go wrong. Does your team make decisions so slowly that nothing ever gets done, or does it go too fast and miss critical issues that come back to bite you later? Does your team bicker endlessly or smile and nod while avoiding the tough issues? Too often, team dysfunction leads to abysmal productivity and zero innovation for your organization, as well as misery and wasted time for you. Most team members sit and wait, feeling trapped in a team that just isn't working. You First: Inspire Your Team to Grow Up, Get Along, and Get Stuff Done presents a radical new idea: you can change your team. Author Liane Davey shows how you, from any seat at the table, even without support from your colleagues or your team leader, can transform even a toxic team.

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Congratulations
on your achievements

award winner

MS LESLEY DUNSTALL
Royal Australasian College of Surgeons Medal for Service

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

Lesley Dunstall has been an ATLS coordinator, CCrISP coordinator and has organised RACS skills courses throughout Australia and through the International Development Programs in Papua New Guinea, Fiji and Myanmar. Everyone who teaches on these courses, both visiting instructors and home-based instructors, appreciate Lesley's humanity, cheerfulness, managerial ability and common sense. She has a habit of getting things done, even in the most challenging of circumstances.

Lesley comes from Adelaide where she worked at Flinders Medical Centre as a Clinical Nurse Educator, also completing a Diploma of Education and Bachelor of Education and was a lecturer in the Faculty of Nursing. She was also seconded to the SA Ambulance Service.

In 1988, Lesley began her long association with the College through her role as Course co-ordinator. In 1994, she was appointed National Co-ordinator (of EMST), at first on an honorary basis until 1998. Since 1989 she has coordinated over 95 EMST and ATLS courses and more than 30 CCrISP courses. In recognition of her status within the ATLS community, she was appointed as the ATLS International Co-ordinator in 2012 and is a member of the ATLS Committee of the American College of Surgeons.

Lesley is also someone who makes the effort to be present at the ASC where, at the College booth, she is a strong advocate for the EMST courses. Her ability to liaise with instructors is one of the reasons why so many here are happy to teach course after course. Many who have trained in surgery and entered the Fellowship over the past 20 years have benefitted from her warmth, dedication and ability to organise. It is indeed fitting that she is awarded the RACS Medal at the ASC

Citation kindly provided by Professor David Watters

award winner

ASSOCIATE PROFESSOR COLIN RUSSELL FRACS
Royal Australasian College of Surgeons Medal for Service

> ***"Colin has constantly and tirelessly worked on issues regarding surgical safety for 30 years and Victorian surgeons have a high level of trust, respect and admiration for him"***

Associate Professor Colin Russell announced his retirement following the release of the 2011 Victorian Audit of Surgical Mortality (VASM) annual report.

Colin Russell was a surgeon at Prince Henry's Hospital and for 16 years was Director of Surgery at Peninsula Health. Since December 1, 2007, Colin has been Clinical Director of VASM, which is part of the Australian and New Zealand Audit of Surgical Mortality (ANZASM), a quality assurance program aimed at the ongoing improvement of surgical care.

The VASM audit process is designed to monitor the surgical system, address process errors and identify significant trends in surgical care. It aims to improve the quality of healthcare in Victoria, and is funded by the Victorian Department of Health and managed by the Royal Australasian College of Surgeons. VASM works closely with the Victorian Surgical Consultative Council (VSCC), which reports to the Health Minister on issues of surgical care.

As the inaugural Clinical Director of VASM, Colin helped to set up the audit team and establish Victoria's place in the national ANZASM program. During Colin's time at VASM, the project has recruited all Victorian public hospitals, 80 per cent of Victoria's private hospitals and 87 per cent of Victorian Fellows, who are now actively participating in the audit.

Colin has constantly and tirelessly worked on issues regarding surgical safety for 30 years and Victorian surgeons have a high level of trust, respect and admiration for him. He has been active in educating and training Victorian surgeons, who have benefited from his experience. He has provided outstanding leadership and made an outstanding contribution to the VASM audit. During his tenure, the audit published four annual reports, three case note review booklets, two national reports, two national case note review booklets, hospital guidelines and assessor guidelines.

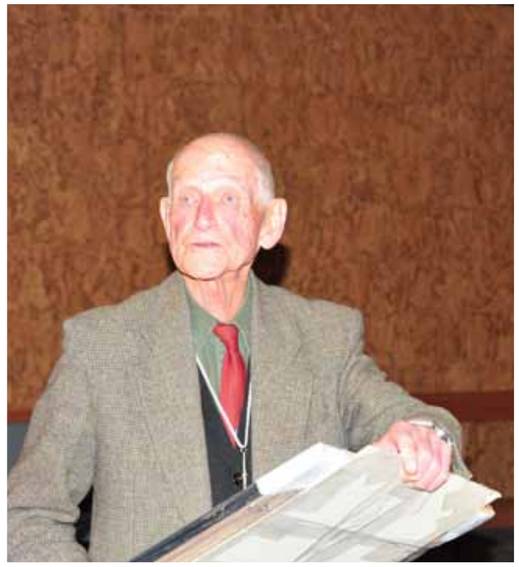
Colin embedded transparency and trust in VASM which enabled Fellows to appreciate the audit process, its confidentiality and its feedback. Treating surgeons and other audit stakeholders have valued the publication of its annual reports and case note review booklets. His collaborative efforts with the VSCC have also led to the publication of improved guidelines to better clinical practice within Victoria.

VASM, ANZASM, VSCC and the College are very grateful to Colin for his strong support and guidance and invaluable contribution.

Citation kindly provided by Professor Guy Maddern

Outstanding Community Service

Acknowledging service to the community



Two more 'Awards for Outstanding Community Service' were presented recently, acknowledging the huge contribution our Fellows provide in the communities in which they live.

Mr Mark Eastman received the award after 33 years of work in the community contributing many aspects of healthcare, including for Goulburn Valley Health and Shepparton Private Hospital as well as playing a crucial role in the University of Melbourne Rural Clinical School, teaching our next generation of doctors.

Mr Eastman has been described as a "complete doctor" and has built his service of mutual respect between patient and doctor, and always taken an active interest in the patient's whole and comprehensive care, as well as their surgical management.

A Tasmanian Fellow also received the award after more than 55 years of service. **Mr Douglas (Robbie) Roberts** was awarded by the Tasmanian Minister for Health, Michelle O'Byrne, at a Morbidity and Mortality Meeting held at the Launceston General Hospital in August.

As an Urologist, Mr Roberts has been tireless in serving the community in both private and public sectors, and is now Emeritus Consultant at the Hospital. Despite retiring in the mid-1990s, Mr Roberts still attends rounds and assists other surgeons, providing experience and insight for those who work with him.

Mr Roberts' service is held in high regard; he is described as "an excellent mentor and supporter... able to provide timely and sage advice on matters of urological practice and all aspects of being a medical professional".

RACS ASC AND ANZCA ASM – May 5-9, 2014

Sands Expo and Convention Center, Marina Bay Sands, Singapore

Working together for our patients

Submission of Abstracts for Research and Invited Papers

Abstract submission will be entirely by electronic means.
This is accessed from the Annual Scientific Congress website 'racsanzca2014.com' and clicking on Abstract Submission.

Several points require emphasis:

1. Authors of research papers who wish to have their abstracts considered for inclusion in the scientific programs at the Annual Scientific Congress must submit their abstract electronically via the Congress website having regard to the closing dates in the Call for Abstracts, the Provisional Program and on the Abstract submission site.

   ABSTRACTS SUBMITTED AFTER THE CLOSING DATE WILL NOT BE CONSIDERED.
2. The title should be brief and explicit.
3. Research papers should follow the format: Purpose, Methodology, Results, Conclusion.
4. Non-scientific papers, eg. Education, History, Military, Medico-Legal, may understandably depart from the above.
5. Excluding title, authors (full given first name and family name) and institution, the abstract must not exceed 1750 characters and spaces (approximately 250 words). In MS Word, this count can be determined from the 'Review' menu. Any references must be included in this allowance. If you exceed this limit, the excess text will NOT appear in the abstract book.
6. Abbreviations should be used only for common terms. For uncommon terms, the abbreviation should be given in brackets after the first full use of the word.
7. Presentations (slide and video) will only have electronic PowerPoint support. Audio visual instructions will be available in the Provisional Program and in correspondence sent to all successful authors.
8. Authors submitting research papers have a choice of two specialities under which their abstract can be considered. Submissions are invited to any of the specialties or special interest groups participating in the program.
9. A 50-word CV is required from each presenter to facilitate their introduction by the Chair.
10. The timing (presentation and discussion) of all papers is at the discretion of the Convener of each Section. Notification of the timing of presentations will appear in correspondence sent to all successful authors.
11. Tables, diagrams, graphs, etc CANNOT be accepted in the abstract submission. This is due to the limitations of the computer software program.
12. AUTHORS MUST BE REGISTRANTS AT THE MEETING.
13. Please ensure that you indicate on the Abstract Submission site whether you wish to be considered for the following:

Section	Prize
Bariatric Surgery *(Trainee)*	$500
Breast Surgery *(Trainee)*	$500
Burn Surgery *(Trainee)*	$500
Cardiothoracic Surgery *(Trainee)*	$500
Colorectal Surgery *(Mark Killingback Prize for Younger Fellows & Trainees)*	$500
Craniomaxillofacial Surgery *(Trainee)*	$500
Endocrine Surgery *(Tom Reeve Prize - Trainee)*	$500
General Surgery *(Trainee)*	$500
Head & Neck Surgery *(Trainee)*	$500
Hepatobiliary Surgery *(Trainee)*	$500
Neurosurgery *(Trainee)*	$500
Paediatric Surgery *(Trainee)*	$500
Plastic & Reconstructive Surgery *(Trainee)*	$500
Quality Assurance & Audit in Surgical Practice	$500
Rural Surgery *(Trainee)*	$500
Surgical Education *(Not exclusively for Trainees)*	$500
Surgical History *(Trainee)*	$500
Surgical Oncology *(Trainee)*	$500
Trauma Surgery *(Trainee)*	$500
Upper GI Surgery *(Trainee)*	$500
Vascular Surgery *(Trainee)*	$500

The submitting author of an abstract will ALWAYS receive email confirmation of receipt of the abstract into the submission site. If you do not receive a confirmation email within 24 hours it may mean the abstract has not been received. In this circumstance, please email Binh Nguyen at the Royal Australasian College of Surgeons to determine why a confirmation email has not been received (binh.nguyen@surgeons.org).

Important Information

TO SUBMIT AN ABSTRACT GO TO 'www.racsanzca2014.com' AND CLICK ON 'ABSTRACT SUBMISSION'.

THE CLOSING DATE FOR ALL SCIENTIFIC PAPER ABSTRACT SUBMISSION IS FRIDAY 7 FEBRUARY 2014.

PLEASE NOTE THAT PAPER OR FACSIMILE COPIES WILL NOT BE ACCEPTED. NOR WILL ABSTRACTS BE SUBMITTED BY COLLEGE STAFF ON BEHALF OF AUTHORS.

If there are any difficulties regarding this process please contact Binh Nguyen, for assistance on +61 3 9249 1279 or email (binh.nguyen@surgeons.org).

Scientific Posters

All posters will be presented electronically during the Congress and will be available for viewing on computer screens at the venue. Posters will be placed on the Virtual Congress.

Important Dates

Abstract Submission opens	October 2013
Closure of Abstracts	7 February 2014
Closure of Early Registration	23 March 2014

RACS ASC 2014 Provisional Program Overview (subject to change)

	Monday 5 May	Tuesday 6 May	Wednesday 7 May	Thursday 8 May	Friday 9 May
Breakfast session 7.00am – 8.20am		Masterclasses	Masterclasses	Masterclasses	Masterclasses
Session 1 8.30am – 10.00am	Pre-Congress Workshop Program	Opening Plenary	Scientific Sessions	Scientific Sessions	Scientific Sessions
10.00am – 10.30am		Morning Tea	Morning Tea	Morning Tea	Morning Tea
Session 2 10.30am – 12 noon		Scientific Sessions	Plenary	Plenary	Plenary
12noon – 12.30pm	Transplantation Surgery Program	Keynote and Named Lectures	Keynote and Named Lectures	President's Lecture	Keynote and Named Lectures
12.30pm – 1.30pm		Lunch	Lunch	Lunch	Lunch
Session 3 1.30pm – 3.00pm		Scientific Sessions	Scientific Sessions	Scientific Sessions	Scientific Sessions
3.00pm – 3.30pm	International Forum Program	Keynote and Named Lectures	Keynote and Named Lectures	Keynote and Named Lectures	Keynote and Named Lectures
3.30pm – 4.00pm		Afternoon Tea	Afternoon Tea	Afternoon Tea	Afternoon Tea
Session 4 4.00pm – 5.30pm		Scientific Sessions	Scientific Sessions	Scientific Sessions	Closing Session
4.30pm - 7.00pm	Convocation Ceremony	HCI Reception			
	Welcome Cocktail Reception				
7.30pm – 10.30pm		Sectional Dinners	Sectional Dinners	Gala Dinner	

Research Paper Specialties

Authors of research papers and posters are invited to submit abstracts for consideration and inclusion in the Scientific Program in the following areas:

Bariatric Surgery
Breast Surgery
Burn Surgery
Cardiothoracic Surgery
Colorectal Surgery
Craniomaxillofacial Surgery
Endocrine Surgery
General Surgery
Hand Surgery
Head & Neck Surgery
Hepatobiliary Surgery
International Forum
Medico-Legal
Military Surgery
Neurosurgery
Paediatric Surgery
Pain Medicine
Plastic & Reconstructive Surgery
Quality Assurance & Audit in Surgical Practice
Rural Surgery
Senior Surgeons Program
Surgical Education
Surgical History
Surgical Oncology
Transplantation Surgery
Trauma Surgery
Upper GI Surgery
Vascular Surgery
Women in Surgery

ASC Executive

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For further information contact:
asc.registration@surgeons.org

RACS ANNUAL SCIENTIFIC CONGRESS AND ANZCA ANNUAL SCIENTIFIC MEETING

May 5-9, 2014 Sands Expo and Convention Center, Marina Bay Sands, Singapore

Scientific Conveners and RACS Visitors

Program	Scientific Convener/s	RACS Visitors	
Bariatric Surgery/ Upper GI Surgery	Associate Professor Wendy Brown Mr Paul Burton	Dr Jaime Ponce Professor Robert Mason Professor Rudolf Weiner	USA UK GERMANY
Breast Surgery	Mr Robert Tasevski Miss Melanie Walker	Professor Monica Morrow Professor Jerome H Pereira	USA UK
Burn Surgery	Mr Andrew Ives Professor Suzanne Rea	Dr Matthias B Donelan	USA
Cardiothoracic Surgery	Mr Naveed Alam	Professor Tom Treasure Dr Douglas Wood	UK USA
Colorectal Surgery	Mr Ian Faragher Mr Satish Warrier Ms Audrey Yeo	Professor Eric J Dozois Professor Cameron Platell Associate Professor Peter Sagar	USA AUSTRALIA UK
Craniomaxillofacial Surgery	Mr Walter Flapper	Dr Irene Mathijssen	NETHERLANDS
Endocrine Surgery	Dr Meei Yeung	Dr Robert Udelsman Associate Professor Jan Zedenius	USA SWEDEN
General Surgery	Mr Ben Thomson	Mr Iain Anderson Professor David Flum Professor Rodney Hicks	UK USA AUSTRALIA
Hand Surgery	Mr David McCombe	Professor Jagdeep Nanchahal	UK
Head & Neck Surgery	Dr Elizabeth Sigston	Associate Professor Stephen Lai Professor Michael Walsh	USA UK
Hepatobiliary Surgery/ Upper GI Surgery	Mr Simon Banting	Professor Stephen Wigmore	UK
International Forum	Associate Professor Glenn Guest		
Medico-Legal	Mr Andrew Tang	Associate Professor Graeme Brazenor Dr Phoebe-Anne Mainland	AUSTRALIA AUSTRALIA
Military Surgery	Mr Ian Young	Colonel James Ficke	USA
Neurosurgery	Associate Professor Peter Hwang Dr Wan Tew Seow	Professor Ivan Ng Professor Wai-Hoe Ng	SINGAPORE SINGAPORE
Orthopaedic Surgery	Mr Richard Lander		
Paediatric Surgery	Mr Michael Nightingale	Associate Professor Anette Jacobsen Professor Mark-David Leclair Professor Krishnan Prabhakaran	SINGAPORE FRANCE SINGAPORE
Pain Medicine	Professor Peter Teddy	Dr Allen Burton Professor Robert Foreman	USA USA
Plastic & Reconstructive Surgery	Mr Mark Hanikeri	Professor Phillip Blondeel Professor Joseph McCarthy Dr Marc Mureau Dr Filip Stillaert	BELGIUM USA NETHERLANDS BELGIUM
Quality Assurance & Audit in Surgical Practice	Mr Graeme Campbell Professor David Watters	Sir Bruce Keogh	UK
Rural Surgery	Associate Professor Francis Miller	Dr Peter Bird Professor Robert Sticca	KENYA USA
Senior Surgeons Program	Associate Professor Bruce Waxman	Associate Professor Carmelle Peisah	AUSTRALIA
Surgical Education	Ms Meron Pitcher	Professor Jonathan Beard Dr Carol-Anne Moulton	UK CANADA
Surgical History	Professor David Watters	Mr David Hamilton	UK
Surgical Oncology	Dr Cuong Duong	Professor Simon Law Associate Professor Grant McArthur Dr Vernon Sondak	HONG KONG AUSTRALIA USA
Trainees Association	Dr Brian Loh		
Transplantation Surgery	Mr Graham Starkey Dr Nancy Suh	Professor Peter Friend	UK
Trauma Surgery	Professor Russell Gruen	Dr Amit Gupta Dr Avery B Nathens Dr Chiu Ming Terk	INDIA CANADA SINGAPORE
Vascular Surgery	Mr Matthew Claydon	Professor Peter Taylor Professor Matt Thompson	UK UK
Women in Surgery Program	Associate Professor Kate Drummond		
Younger Fellows	Mr Jason Chuen	Dr Sandra Wong	USA

Keep abreast of program developments on the Congress website: **www.racsanzca2014.com**

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