SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS; VOL 15 NO 9; **OCTOBER 2014**

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

ASC 2015 Call for Abstracts inside

MICHAEL WONG'S RECOVERY
Melbourne neurosurgeon makes a remarkable recovery after frenzied knife attack. P10

LIFE-CHANGING EFFORT
Filipino boy's new chance at life after Interplast and Monash join forces. P34

Effective communication is the key

2014

PROFESSIONAL DEVELOPMENT

WORKSHOPS & ACTIVITIES

Royal Australasian College of Surgeons

Keeping Trainees on Track (KTOT)

18 October, Newcastle; 22 October, Wellington

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.

Supervisors and Trainers for SET

18 October, Newcastle; 21 October, Wellington; 20 November, Melbourne.

The Supervisors and Trainers for Surgical Education and Training (SAT SET) course assists supervisors and trainers to effectively fulfil the responsibilities of their very important roles. You can learn to use workplace assessment tools such as the Mini Clinical Examination (Mini CEX) and Directly Observed Procedural Skills (DOPS) that have been introduced as part of SET. You can also explore strategies to help you to support Trainees at the mid-term meeting. It is an excellent opportunity to gain insight into legal issues. This workshop is also available as an eLearning activity by logging into the RACS website.

Non-Technical Skills for Surgeons (NOTSS)

24 October, Launceston; 28 October 2014 - Gold Coast, QLD; 21 November 2014 - Melbourne, VIC

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, which can help you improve performance in the operating theatre in relation to situational awareness, communication, decision making and leadership/ teamwork. Each of these categories is broken down into behavioural markers that can be used to assess your own performance as well as your colleagues. This activity is proudly supported by Avant.

Training Standards: Interpretation and Application (TSIA)

24 October, Melbourne; 29 October, Brisbane

Training Standards: Interpretation and Application (TSIA) is a new course offering. This three-hour workshop expands on the in concepts outlined in the Becoming a competent and proficient surgeon booklet developed by the College in 2012. The course aims to provide a baseline standard for College educators in Competency Based Education, ensure that College educators know the required standards for Competent and Proficient performance across the nine RACS competencies and increase awareness of Training Standards in the workplace, including the ability to interpret standards and use them to assess your own performance and the performance of others.

Clinical Decision Making (CDM)

24 October, Melbourne; 29 October, Brisbane

Clinical Decision Making (CDM) is a three hour workshop designed to enhance participants understanding of their decision making process and that of their Trainees and colleagues. The workshop provides a roadmap, or algorithm, of how the surgeon forms a decision. This algorithm illustrates the attributes of expert clinical decision making and was developed as a means to address poor clinical decision making processes, particularly as a guide for the supervisor dealing with a struggling Trainee or as a self-improvement exercise.

National Simulation Health Educator training program (NHET SIM)

24 October, Melbourne

NHET Sim is for educators who currently use or intend to use simulation as an educational tool to support the education and training of others. The program is being tailored for a surgical educator audience and will involve 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 focussed simulations'. All participants that complete the program will be acknowledged as a NHET SIM graduate.

National Simulation Health Educator training program (NHET SIM) *Advanced Course*

1 October, Melbourne; 9 October, Sydney

The Academy of Surgical Educators is running a one day advanced NHET Sim program - modules on Debriefing in simulation & Developing scenarios. A/Prof Paige, Assistant Professor of Clinical Surgery and Surgical Director at Louisiana State University will co-facilitate the workshops with Professor Debra Nestel.

Preparation for Practice

25 to 26 October, 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 proudly supported by the Bongiorno National Network, mlcoa, Rooms With Style and MDA National.

Academy of Surgical Educators Forum

13 November, Adelaide

The Academy of Surgical Educators will host the annual Academy Forum on Thursday 13 November at the Stamford Grand, Glenelg, Adelaide from 7.00 – 10.00pm. Our keynote speakers are Associate Professor Alison Jones on 'Developing Professionalism in Trainees' and Associate Professor David Hillis on 'Surgeons are role models for professionalism'. The evening will be convened by Associate Professor Stephen Tobin, Dean of Education and Professor Julian Smith, Chair, Academy of Surgical Educators.

Building Towards Retirement

15 November, Sydney

Work is an important part of life so when you stop full time surgery or are approaching retirement, you need to take time to plan for the next stage. It's crucial that as much thinking and planning are undertaken for life after surgery as was given to building your career in the first place. Surgeons who attend can expect to receive information about retirement and motivation to plan for retirement, share the experience of retired Fellows to stimulate interest in alternative careers and lifestyles and gain financial and legal management information and resources. This activity is proudly supported by proudly supported by the Bongiorno National Network and mlcoa.

workshop

October-November

NSW

9 October, Sydney
NHET Sim Advanced
18 October, Newcastle
Keeping Trainees on Track (KTOT)
18 October, Newcastle
Supervisors and Trainers for SET (SAT SET)
23-25 October, Sydney
Surgical Teachers Course
15 November, Sydney
Building Towards Retirement

NZ

21 October, Wellington
Supervisors and Trainers for SET (SAT SET)
22 October, Wellington
Keeping Trainees on Track (KTOT)

QLD

25 to 26 October, Brisbane
Preparation for Practice
28 October, Gold Coast
Non-Technical Skills for Surgeons (NOTSS)
29 October, Brisbane
Clinical Decision Making (CDM)
29 October, Brisbane
Training Standards: Interpretation and Application
9 November, Gold Coast
Supervisors and Trainers for SET (SAT SET)

SA

13 November
Academy of Surgical Educators Forum

TAS

24 October, Launceston
Non-Technical Skills for Surgeons (NOTSS)

VIC

1 October, Melbourne
NHET Sim Advanced
17 October
Academy Educators Studio Session - Workplace-based assessment
24 October, Melbourne
NHET Sim
24 October, Melbourne
Clinical Decision Making (CDM)
24 October, Melbourne
Training Standards: Interpretation and Application
15 November, Melbourne
Communication Skills for Cancer Clinicians
20 November Melbourne
Supervisors and Trainers for SET (SAT SET)
21 November, Melbourne
Non-Technical Skills for Surgeons (NOTSS)

WA

15 November, Perth
Building Towards Retirement (via weblink)

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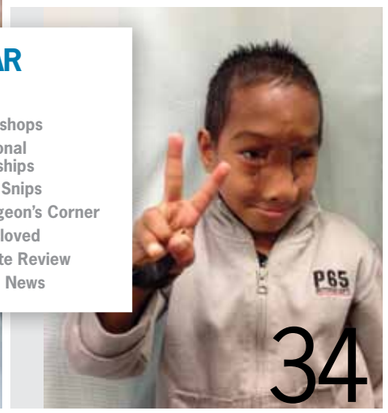

REGULAR PAGES

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ON THE COVER:
IMG Richard Hummel and Fellows Markus Trochsler and Guy Maddern down to business. Photographer: Simon Stanbury.

MICHAEL GRIGG
PRESIDENT

HOW TO BE ALERT LIKE THE AIRLINE INDUSTRY?

How do you know what you need to know?

For at least the past 20 years, I have listened to the ongoing analogies between health – particularly surgery – and the airline industry. At times I have resented the implication that they are more safety conscious than us and been jealous that many of their solutions are related to equipment design.

Nevertheless, we can and are learning from them. The growth of the health simulation industry is one example and the introduction of checklists another. Initially I was sceptical about checklists until I realised that if I was asked to 'pop down' the street to pick up half a dozen items at the local supermarket, I would never dream of doing so without a checklist. And indeed, the surgical safety checklist does seem to have reduced the incidence of wrong side surgery and it does improve teamwork within the operating theatre.

Recently I had the opportunity of talking to an 'authentic' pilot. I was telling him of my return from a conference concerning DVT prophylaxis. It's something that I have had an interest in throughout my career and about which I continue to lecture – often still surprised at how highly trained practitioners had not rapidly adopted key trends that again save the lives of patients in a reliable manner. Often this is not stubbornness, but stems from lack of being informed. I asked the pilot on how the airline industry alerts its key staff on important issues.

He looked at me a bit puzzled. Apparently all pilots are part of the 'hazard alert' system and it is mandated that they check this regularly – in fact every day. He even gave me an example. A colleague of his and his first officer were flying a new model of one of the larger jet liners with the first officer being responsible for the landing. He had disengaged the auto-pilot and started descent, but as he was correcting the trim, he accidentally and unknowingly pressed the autopilot button again. The button was immediately adjacent to another button that is meant to be pressed for landing approaches. The autopilot re-engaged and the manual controls 'froze'.

Both the pilot and the auto-pilot struggled with speed and altitude until they realised that the auto-pilot had been re-engaged. The problem was rapidly corrected. They also realised that the positioning of the buttons was potentially very dangerous. They documented the incident, which rapidly went from the airline to the manufacturer and within 24 hours an industry-wide alert had been issued to all pilots credentialed to fly these planes. Thus all pilots became aware of the danger within a very short time frame and they would know what was wrong if the same thing happened to them before the modification of the control panel had been implemented.

In healthcare, more and more we are analysing near misses and adverse events. In-depth case reviews, root cause analyses and the like have become part of the lexicon. And the people doing these reviews are learning, but how can we communicate the lessons?

If there is an important lesson, could we not have an industry-wide alert so that everyone would know! Could we make adapt this for surgical practice so that information important to surgeons could be made rapidly available? Could it be a focused SMS system or specific emails? The College does receive information that key people like the Chief Medical Officer regard as important and time critical. We do distribute them, but how do we ensure these have the profile, the impact to ensure that patient's safety is improved, that we do not 'lose' a life because we did not know?

Should the College pursue this and, if so, how? We are living in an era of 'urgent information' and it may need to be part of our broader communication strategy. How do you think we should address it?

LIKES, TWEETS, POSTS – YOU'VE GOT MAIL!

DAVID WATTERS
VICE PRESIDENT

The College moves into a new era of communications

Communication is one of the nine College competencies. Every week in our hospitals we manage misperceptions or feelings of unjust treatment due to breakdowns in communication. When what was intended to be said is misunderstood, patients, team members, peers and managers flounder, feel sidelined or grow irritated. Even Colleges struggle with communication, including ours.

Communication – much talked about, though often imperfect – remains fundamental to the success of any organisation. Of particular concern for our College is how to nurture and maintain effective communication between our stakeholders, but who are they? For starters they include Fellows, Trainees, IMGs, junior doctors hoping to become Trainees, medical students and also College staff, Specialist Societies, governments and statutory bodies.

The 21st century has seen some seismic shifts in the way we communicate. Most of us started using email in the '90s and the World Wide Web debuted as a publicly available service on the internet on 6 August, 1991. Since the turn of the century we've seen the development and growth of Facebook, Twitter, Linked-In, ResearchGate and many other digital platforms. We now tend to send large files by Dropbox instead of courier. Although we still teleconference, some committees convene using Go-to-Meeting. We still send letters, but the past few years has seen written communication shrink to near obscurity, much to the chagrin of Australian and New Zealand postal services.

Council has determined that it is time for the College to catch up, particularly in regard to social media. Over the next few months you will see a concerted effort to utilise social media platforms like Twitter and Facebook to better engage with stakeholders. Our goal is to become more interactive, to move from a one-way highway to a two-way information superhighway where we can encourage debate and discussion on topical issues. Social media has the potential to amplify our advocacy efforts through delivering opinion and perspective, generating awareness and exposure, and promoting the College's activities.

The College can for example, use social media to expand the delivery of its media statements and announce the release of significant policies or position papers. The Library is currently piloting an electronic table of contents (eTOC) alert service that will enable an email to go to Fellows or Trainees who sign up for the service as soon as the articles are published online.

Your participation is the key to adding and receiving value from these initiatives! With almost 7,000 members, including retired Fellows, we have fewer than 250 followers on Twitter. So I challenge you today to sign up for Twitter if you don't already have an account and to 'follow' the College @RACSurgeons. You can engage with the College on any particular topic that we tweet. Watch out for the next ASC where we are already planning to step up our social media engagement. Your digital comments can enhance the sharing of knowledge, opinions and ideas.

However, we recognise social media is not for everyone and some of you may prefer to communicate with the College via email, mail and telephone. In the last issue, the President indicated he had received dozens (almost universally supportive) emails from Fellows regarding excessive fees. The President's office also receives many letters from Fellows, government and various healthcare organisations. Last calendar year almost 350 were received, and, for 2014, by early September there have been 250. We try to review and respond promptly, typically within seven days.

I haven't mentioned www.surgeons.org yet. The website is a work in progress. It's an enormous challenge to set up a website that needs to work for so many stakeholders. Some of you will have set up your own websites for relatively small user groups – these can quite quickly be highly successful as well as attractive. With regard to www.surgeons.org we are also consulting with key groups such as RACSTA and our Younger Fellows.

Feedback welcomed

We believe we are getting there despite some early hiccups, but we need your feedback because our aim is to have a friendly and functional website. We are not quite ready to introduce interactive blogging – so for now, 'Surgical News' and Twitter will have to suffice.

A preferred method of communication for many Fellows is to pick up the phone and call the College. The past 12 months has seen a retraining of staff to improve customer service. Rest assured, the staff your College employs have high expectations that they will provide an excellent service on the telephone. Changes to protocol have been made to avoid Fellows being transferred multiple times and all enquiries will be dealt with in a timely manner. If you experience outstanding customer service from an employee, please let me or my office know.

Currently the primary method of communication from the College is to your registered email box, something that 94 per cent of Fellows, all Trainees and IMGs possess. In order to minimise the number of emails you receive, we send a weekly e-newsletter. College e-newsletter Fax Mentis (Torch of the Mind) was created in order to consolidate news and events and provide a forum for Speciality Societies and organisations to reach members.

We have engaged new communications staff in Australia and New Zealand who will help improve our ability to communicate, using both social and traditional media. We hope to raise the College's profile with the public, in the media and with governments. Effective communication is the key. Please email me **college.vicepresident@surgeons.org** or tweet **@RACSurgeons** to communicate about communications.

Planning with heart

In an effort to improve planning and surgery times, 3D hearts are being printed to aid surgeons in their work at Sydney hospitals. Patients are having hearts scanned so that specialists can prepare themselves for any unexpected problems. Cardiothoracic and transplant surgeon Kumud Dhital has said that some surgeries can be very hard to predict.

"The heart can be back to front, the chambers can be connected the wrong way. [3D hearts will make it] far easier to plan your operative procedure," Mr Dhital said.

***Sydney Morning Herald*, September 8**

Simulation for the masses

The College played a special part in inspiring people of all ages at a recent expo held in Adelaide called Science Alive. Offering the opportunity for hands-on interaction, the College lent out a Simulation Box Trainer for the public to try their hand at.

Facility Manager Kathryn Hudson at the Basil Hetzel Institute for Translational Health Research said that, "Everyone was dazzled by the 48 second target, so the population of Adelaide now has a deeper respect for surgeons!"

The event was attended by more than 20,000 people.

Remembering them

The first in a series of lectures commemorating the ANZAC Centenary was held recently at the Launceston General Hospital recently. Speaker Dan Huon said it was important to understand the the advancements in medicine due to the unprecedented wounds received by soldiers in the war. Contributing lecturers included Professor Bernie Einoder. The College will also be commemorating the anniversary with a special exhibition named 'Surgeons of Gallipoli', along with a book.

***Launceston Examiner*, September 22.**

Fish out of water, for surgery

An Australian vet has been inundated with calls and new bookings after the story of his surgery on a goldfish went viral.

Dr Tristan Rich from the Lort Smith Animal Hospital performed delicate brain surgery on a tumour for George the Goldfish. The surgery was successful and George is now recovering well.

Dr Rich even received enquiries from a human clinic in the US asking about what type of surgery had been done.

"They said one of their patients was complaining saying why couldn't they fix them if someone could fix a tumour on a goldfish."

***Brisbane Times*, September 18**

WORKING TOWARDS A FULL RECOVERY

A sure and steady pathway has helped Neurosurgeon Michael Wong return to work

PIC CREDIT: Herald-Sun, David Caird

Neurosurgeon Dr Michael Wong with Western Hospital staff nurse Joanne McIntyre, Dr Rebecca Biron and technician Vinay Dass

The Victorian Neurosurgeon critically injured in a frenzied knife attack as he entered the Western Hospital one quiet morning in February, is now back in full-time practice and is working to promote increased hospital security to protect the health care workforce.

Mr Michael Wong, then head of Neurosurgery at the hospital, suffered 14 stab wounds to his back, arms, hands, chest, abdomen and forehead as he walked through the entrance lobby of the hospital before horrified staff and patients ran to his assistance.

Raced into theatre, Mr Wong was treated by a team of surgeons – including two Plastic and Reconstructive surgeons who worked solely on his hands – operating for 10 hours to both save his life and his surgical career.

Bleeding profusely, particularly from a deep wound to his back, which pierced a lung, Mr Wong lost his entire blood supply during the course of the surgery and required the partial removal of the injured lung to stem the bleeding.

Once stabilised, he was transferred to the Royal Melbourne Hospital where he spent six days in recovery before returning home to spend six weeks with both arms and hands in splints followed by months of painful physiotherapy rehabilitation exercises to regain the total range of movements in his arms and hands.

> *“Now I want to use the experience to make sure that hospital security is not overlooked in an era of tight health budgets”*

Now Mr Wong, who conducts the full range of neurosurgery with a particular interest in spinal surgery, is back working at the Royal Melbourne, Melbourne Private, Epworth and John Fawkner hospitals.

He said that while the incident was obviously shocking, rather than causing psychological trauma it had engendered a firm resolve to use his unique experience of hospital-based violence to promote the need for greater hospital security to protect all staff, in all hospitals, in all states.

“I remember the attack and I remember trying to get away, but there has been no long-term emotional distress,” he said.

“I have no nightmares, no flashbacks, no PTSD and I think that might be because of the kinds of things we see as surgeons throughout our working lives.

“It is worse for me to see a three-year-old child come in with a malignant brain tumour or young people from serious traffic accidents. That is traumatic to me.

“Of course, I was worried about the damage to my hands and whether I could continue as a surgeon, but the great work done by the surgeons at the Western Hospital – who saved not just my life, but my career – meant that I soon knew I would have full movement although it required long weeks of painful stretching.

“Now I want to use the experience to make sure that hospital security is not overlooked in an era of tight health budgets.”

Mr Wong said that since the attack the Victorian Government had already increased penalties for those committing violence against health care workers with his name being mentioned in Parliament as the legislation was introduced and debated.

He said he specifically wished to see an increased security presence in hospitals to deter violence and increased dialogue between hospital staff and administrators to ensure security measures were not overlooked or under-resourced.

“Hospitals are very open, very public places where anyone can walk in at any time and that has to be kept in mind by management when they are allocating budget resources,” he said.

“At the same time, I think that in the past, hospital staff, health workers and doctors have become somewhat blasé about personal safety in the hospital setting.

“Many of us have done training rotations or worked in Emergency Departments where we see a lot of erratic or violent patients and over time we tend to take that in our stride and consider it part of the job.

“Yet that level of risk should never be accepted and I think that what happened to me gives me a unique perspective on this issue.

“What happened to me was quite unique in that it was extremely violent; I nearly died, but I have fully recovered and now have the opportunity to speak about this issue on behalf of all hospital staff.”

Mr Wong particularly thanked the surgeons who saved his life at the Western Hospital, none of whom he had previously met, and said he had been encouraged throughout his recovery by the support of fellow surgeons.

“All my surgical colleagues have been very generous and supportive and many sent good wishes through letters and emails and I also received a very kind message from the Vice President of the College, Professor David Watters, which greatly encouraged me in my recovery,” he said.

“It feels wonderful to be back and I can’t thank the surgeons who worked on me enough. Now I sometimes run into the plastic surgeons who worked on my hands and they ask if I feel any tightness or pain and I can say that I am fine and that seems to please them as much as it pleases me.”

Helped by many

Since returning to work, Mr Wong has had the chance to meet and thank the patients and staff who ran to his rescue during the attack in February through the efforts of the Sunday Herald Sun.

They included leukaemia sufferer Andrew Di Lollo who was about to begin an eight-hour chemotherapy session when Mr Wong fell to the ground after being stabbed in the back.

Mr Di Lollo tried reasoning with the assailant before throwing his backpack at him to distract him.

Senior nurse Jo McIntyre also tried to intervene and was also threatened while equipment technician Vinay Dass used his military training to distract the man by screaming at him to get his attention and cornering him, which allowed Mr Di Lollo, Ms McIntyre and nurse Rebecca Barbara to drag Mr Wong away and into the emergency department.

In the report that covered the meeting, Mr Wong thanked them all and said: “They were very, very brave people; it’s bravery akin to a war situation... what they did was lifesaving.”

“In many ways it was my patients who gave me the incentive to go through the rehabilitation and drove me toward full recovery,” he said. ▶

"Some patients even waited for me to return and personally requested that I treat them, which was a humbling lesson in loyalty and patience in and of itself."

A 48-year-old man was arrested soon after the attack on Mr Wong and faces a number of charges including attempted murder and intentionally causing serious injury. He is due to face court later this year.

'Surgical News' put a number of questions to Western Health relating to staff security and counselling provided for those caught up in the attack on Mr Wong.

In reply, the Executive Director Operations of Western Health, Mr Russell Harrison said: "The incident at the Western Hospital in which Mr Michael Wong was seriously injured was extraordinary and unforeseeable and occurred in what is a public place within a major hospital.

"Actions taken at the scene by a Western Health patient and staff, and treatment subsequently provided by our surgeons and intensive care teams helped save Mr Wong's life and we are very relieved to know that he has since recovered well.

"A thorough de-briefing with staff and volunteers commenced on the day of the incident, with additional support provided in following days.

"As with all major health services, Western Health security personnel conduct roving patrols throughout the hospital, including publicly accessible areas such as car parks, foyers, entrance and waiting areas as well as wards and emergency departments.

"Western Health Security Services implement a wide range of measures to support a safe environment for staff, patients and families."

With Karen Murphy

FOOTNOTE FROM THE HEALTH MINISTER

The Victorian Government has recently introduced new legislation into Parliament to further protect the Victorian health workforce. Health Minister David Davis says it sends a strong message to the community that violence and aggression against health workers is not acceptable and reinforces the Victorian Government's commitment to ensuring the safety and security of health workers.
The Sentencing Amendment (Emergency Workers) Bill 2014 and the Justice Legislation Amendment (Confiscation and Other Matters) Bill 2014 include amendments to make it an offence to assault a registered health practitioner and provide for increased penalties. Both Bills and their second reading speeches can be read at parliament.vic.au/legislation

RECOGNITION PAID TO FELLOWS

Nominated Fellows all over the regions and New Zealand are being presented with Outstanding Service to the Community Awards from the College, recognising their long-held commitment to the communities in which they live.


NEWS TIPS newsroom@tbw.com.au

IN THE SPOTLIGHT: High-profile Mount Gambier surgeon and community advocate Barney McCusker holds his award as Dr Sonja Latzel, from the Royal Australasian College of Surgeons, looks on. Pictures: SANDRA MORELLO

Surgeon toast of city

Community advocate receives medical recognition

SANDRA MORELLO
sandra@tbw.com.au

PROMINENT Mount Gambier surgeon Barney McCusker is the toast of the city today after being bestowed with a prestigious award that recognises his dedication to the medical fraternity.

The award by the Royal Australasian College of Surgeons also recognises his commitment to the Mount Gambier community as a passionate advocate.

From calling for an indoor aquatic centre to taking up the fight against the loss of specialists and vehemently opposing the sale of the region's state-owned forests, Mr McCusker's voice has given the tyranny of distance for South East patients.

The college's outstanding service to the community award is an honour rarely given across Australia.

Presented at the Mount Gambier Library yesterday, Mr McCusker - who often refers to himself as a local carpenter - said he was humbled and "touched" to receive the award.

Surrounded by family, friends, medical colleagues and theatre staff, the orthopaedic surgeon said he believed it took a village to raise children.

"It is a fantastic village and it is a real privilege to be part of that village," Mr McCusker said.

He said the people in Mount Gambier had "such great resilience".

Mr McCusker said the community had battled various medical service issues

surgeons - said the award was "rarely given" in any state.

"It is an award that is designed to support and recognise outstanding service not normal service to local regional communities," Dr Latzel said.

She said the award recognised not only surgical service, but also advocacy and involvement in cultural and community events.

Meanwhile, Federal Member for Barker Tony Pasin said the wider community has been touched by Mr McCusker.

"I don't think there is a person in this community that hasn't had their lives affected by Barney - directly or indirectly," Mr Pasin said.

"I'm not talking from a professional point of view ... but I am talking about a community point of view."

The Liberal MP said Mr McCusker has

The Award has been designed to recognise Fellows who have given long and dedicated service to their local communities – more often than not unheralded – but without which the standard of surgical care in those communities would have been less than society demands.

Barney McCusker was recently presented with the Award by South Australian Regional Chair Sonja Latzel for his work in the Mt Gambier region. The presentation was covered in the local *Border Watch* paper (top right).

Chris Haw (bottom right) received a similar Award from the Victorian Regional Chair Jason Chuen, while Jeremy Gathercole and Peter Milsom were also recognised with presentations in New Zealand from the National Board Chair Nigel Willis.

Details on the New Zealand presentations can be found at: https://nz.news.yahoo.com/a/-/top-stories/24816634/northland-surgeons-receive-prestigious-australasian-award/#

If you are interested in finding out more about the awards, please contact your Regional Office Manager.

The Henry Windsor Visiting Lecture 11/11/2014

The NSW Regional office of RACS is proud to announce that the Henry Windsor Visiting Lecturer for the New South Wales talk is Mr Ian Civil, past President of the College.

As you will be aware this is an auspicious lecture and places will be limited. If you wish to attend please email Allan Chapman at **allan.chapman@surgeons.org**

IN MEMORIAM

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

Roger Blamey,
UK Honorary Fellow

Wayne Stott,
Victorian Fellow

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

Informing the College

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

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

NANNA NAPS & POPPA PAUSES

Sleep can cause more problems than expected

BY **PROFESSOR GRUMPY**

There is one thing that really annoys me and that is sleep. At my age it is not sleep so much as the lack of sleep that is annoying. I am sure that all my readers know that as the body ages the sleep needs decrease. That concept has been challenged and it is now thought that the hours of sleep required remain the same throughout adult life, but it is the ability to sleep that decreases. Therein lays the curmudgeon's complaint.

The golden rule for a good night's sleep is don't have an afternoon nap – a 'nanna nap' as the non-sleep deprived younger persons so disparagingly call it (Surely in the interests of gender equality it should equally be called a 'poppa pause'). It is obvious that the younger persons who have taken three children to pre-school or school, done the washing and ironing, weeded the garden and worked eight hours in a single day don't need a nap before cooking dinner for a spouse who has spent 14 hours consulting. We curmudgeons on the other hand have a more demanding day. Two hours reading the paper, a two-hour coffee break with a fellow curmudgeon discussing the share market, a look at the lawn and garden and formulating a plan for cutting the lawn and weeding the garden in a few days and then a load of washing is much more demanding.

We curmudgeons also have other issues of sleep. Why do women have poor hearing in the daytime and are not able to hear mutterings about the coffee being too weak or the bacon too crispy? Yet at night the slightest bit of heavyish breathing (no, definitely not snoring) results in a sharp poke in the ribs and a demand to go to the spare bedroom. The author, Anthony Burgess, must have had a woman in his life with this problem when he said, "Laugh and the world laughs with you, snore and you sleep alone."

Another fine curmudgeon, Ernest Hemingway, knew the value of sleep. "I love sleep. My life has the tendency to fall apart when I'm awake, you know?" It is indeed true – when we curmudgeons are asleep we cannot be blamed for the dirty footprints on the floor or the clothes that have mysteriously escaped from the clothes basket. It is in the waking hours that we get blamed for things where no blame should be given.

Even the great theologian, Martin Luther, was aware of this immutable fact – "Whoever drinks beer, he is quick to sleep; whoever sleeps long, does not sin; whoever does not sin, enters Heaven! Thus, let us drink beer!" So there is the choice – beer or sin.

THINK ZINC

Why wouldn't you?

DR BB G-LOVED

We've all managed patients that no matter what we do, they just don't heal. It's easy to blame smoking in smokers, but there are many other possible causes ranging from protein energy malnutrition to vitamin or trace element deficiencies. This month's column is written to encourage you to think zinc. You will sometimes have patients who need it.

Zinc is an essential micronutrient for immune function, intracellular metabolism and DNA. None of us can remember exactly which reactions zinc is essential for as most doctors just don't consider or recognise zinc deficiency in practice, so focus on conditions with which they are more familiar. As a GP, I find it is often innocent questions that unmask my ignorance of a particular topic. For example, should patients with a slow-to-heal wound or ulcer take zinc?

The 70kg adult has a body zinc content of 1.4-2.3g, half of which is in bone and 6 per cent in skin. The highest tissue concentrations (>500ug/g) are found in the prostate, semen, uveal tissue and skin. Zinc cannot be stored in the body and so needs to be continually replenished through the diet (2-3mg/day in infants to 8-12mg/day for adults) to supply the needs of metabolism, growth and repair. It is a co-factor for some 300 enzymes, and needed for 2000 transcription factors. Oysters are the number one zinc containing food, but meat, eggs, fish and beans are good too. Only 20 to 40per cent of ingested zinc is absorbed (upper jejunum), with absorption enhanced by chelating agents and animal proteins, but impaired by phytates, calcium, and phosphate.

Zinc deficiency was first reported in 1961 from the Iranian city of Shiraz. The first cases were young adults with growth retardation and hypogonadism. This year is the 40th anniversary of zinc being declared an essential nutrient by the US Academy of Sciences. Only later was the importance of zinc to immune function understood. Today it is recognised that about a third of the world's population is at risk of deficiency, particularly the developing countries of SE Asia and sub-Saharan Africa. Infants and children are particularly susceptible.

Zinc deficiency is endemic in Iran, Turkey and Egypt where multi-grain breads have a phytate content that renders zinc difficult to absorb. Add protein-calorie malnutrition, enteropathies, or hookworm infestation to the mix and one can appreciate why deficiency is so common. Zinc can be measured in plasma, erythrocytes, hair and urine. Low serum alkaline phosphatase and zinc levels (<50ug%) are diagnostic, but the condition is easily treated with 2-3mg/kg oral zinc per day over a couple of weeks. The various zinc preparations provide 22.5mg (sulphate), 30mg (acetate) or 80mg (oxide) of elemental zinc respectively for every 100mg.

Benefits outweigh risks

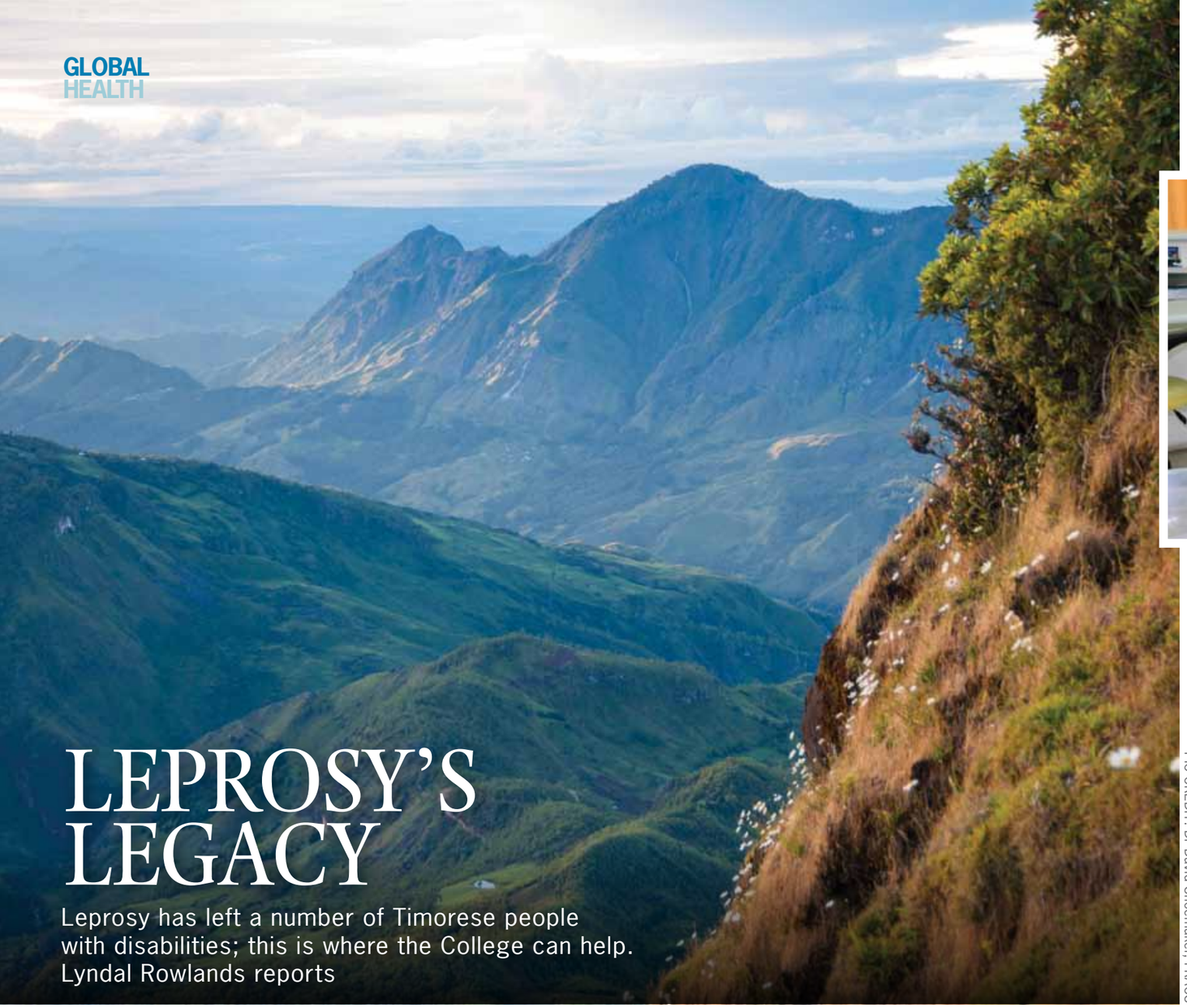
Zinc deficiency contributes to the morbidity and mortality from diarrhoea, pneumonia, and malaria. A recent Cochrane review of zinc supplementation for at risk children in Low and Middle-income countries (LMIC) confirmed the benefits outweigh the risks. Since zinc competes with copper, supplementation may have a negative effect on copper status and overdose with zinc causes nausea and vomiting.

Zinc is also widely used for photoprotection (sun screens) and in soothing creams or lotions (calamine). An evidence-based review suggested topical zinc sulphate is effective for warts, genital herpes, visceral leishmaniasis and various dermatological conditions such as acne vulgaris, rosacea, pityriasis versicolor, hidradenitis suppurativa and melasma. Topical zinc oxide paste speeds healing of vascular and leprotic ulcers, though oral zinc sulphate did not show any benefit. Zinc tape has been shown to reduce developing keloids while, for those of you feeling your age, 0.1% copper-zinc malonate cream applied twice daily for eight weeks reduces wrinkles!

Of importance to the world's 250,000 new cases of leprosy per year is that oral zinc is useful for managing lepra reactions to multi-drug treatments, including erythema nodosum. These effects are modulated through its stimulation of IL-2 and by reducing serum levels of TNF. Zinc pyrithione is effective for seborrhoeic dermatitis and is often combined with ketoconazole in anti-dandruff shampoos.

Zinc is not just of importance in LMICs. Bariatric surgery and upper gastrointestinal bypass may result in zinc deficiency by removing the distal duodenum and upper jejunum from the flow of ingested zinc. It is important for the integrity of the macula and can be used to obtund macular degeneration. It is an important neuromodulator, vital for glial function and associated with cognitive impairment. Immune function is essential to neurological health. The increasing role for glial cells in the pathogenesis of Alzheimer's disease suggests zinc may be of importance to all of us who aspire to age well.

So even if you are not a paediatric or vascular surgeon, I suggest, at least sometimes, think zinc.



LEPROSY'S LEGACY

Leprosy has left a number of Timorese people with disabilities; this is where the College can help. Lyndal Rowlands reports

PIC CREDIT: Dr David Shoemaker, FRACS

Joel shows the improved movement in his hands to Julie Hamilton

Joel's story

By the end of 2013, some of the muscles in Joel da Costa's left forearm had pulled his fingers back so far that he could no longer straighten them, leaving his hand in a 'claw'-like shape. Growing up in Timor-Leste during years of civil unrest and poverty, Joel missed out on early intervention for his leprosy. Although he started treatment in 2007, it was only enough to slow his symptoms progressing, not to stop them entirely.

By 2010, the nerves in Joel's hands had become affected. A course of steroid treatment helped, but did not restore nerve function and by 2013, Joel was experiencing weakness, muscle imbalance and a loss of sensation in his hands, as well as the 'claw'-ing of his left hand.

This is when Dr David Hamilton, FRACS and his physiotherapist wife Julie Hamilton, who have worked in Timor-Leste for 10 years, recommended that Joel would be a good candidate for tendon transfer surgery.

Describing the surgery, Joel says, "First Dr David told me that the operation would move the tendon of one of my muscles. When I heard that I was afraid, but now that I have more use of my hand, it is ok."

Joel began to feel more confident about having the operation when he remembered that he had seen two other leprosy patients doing post-operative exercises, and that their hands were no longer clawed.

For Joel, the operation will make a big difference to his everyday life, especially his work as a disability support worker. Joel lives and works in the mountainous district of Aileu. Although Aileu is less than 50 kilometres from the national capital Dili, the mountains rise steeply along the short journey reaching almost 3000 feet. The roads are some of the worst in Timor-Leste and difficult to negotiate at the best of times. It is these roads that Joel needs to navigate on his motorbike every day to get to work and see his clients. Joel received an assistance device in 2010 to help support his hand, but found the device made it more difficult to ride his motorbike. As he began to lose the grip in his left hand, Joel found it increasingly difficult to navigate the roads safely and he ended up coming off his motorbike.

Although Joel was taking his medication and doing hand strengthening exercises, it became clear that surgery was needed to help his hand to recover.

Leprosy in Timor-Leste

The World Health Organisation has had an active leprosy elimination program in Timor-Leste since 2003, providing free multi-drug therapy to help stop the disease from progressing. However, leprosy remains a serious health problem in some parts of Timor-Leste, including in the coastal enclave of Oecusse, which the World Health Organization says is thought to have been a leprosy colony during Portugal's colonisation of Timor-Leste.

The World Health Organization explains that for Timor-Leste, "because of the often long incubation period of leprosy, there remains a significant backlog of hidden cases in the community that have still to be diagnosed, because they are not yet showing any clinical signs of the disease."

Early treatment with multi-drug therapy and, if necessary, steroids, can stop the physical symptoms of leprosy from progressing, however due to the instability of Timor-Leste during years of occupation and unrest, many patients, including Joel, were not able to access this treatment straight away.

David and Julie Hamilton

Dr David Hamilton, FRACS, and his physiotherapist wife Julie Hamilton have had a long term commitment to working in both Papua New Guinea and Timor-Leste. Their work has covered many areas, including the treatment of leprosy.

Julie first became interested in treating leprosy as a physiotherapy student in Dunedin, New Zealand, over 50 years ago; she completed training in India before going to work at the Leprosy Reconstructive Surgical Unit in Madang, Papua New Guinea. Julie introduced David to her interest in leprosy and the two have since spent decades working and volunteering in Papua New Guinea and Timor-Leste. ▶

"In Papua New Guinea when I was based in Madang in the mid-60s, our unit treated 400 hands in two years. Prevalence should be reducing now that they have triple drug therapy."

David explains, "I learned how to do the tendon transfers from Ken Clezy. I did three or four of the tendon operations a year in the '70s and '80s while working in Papua New Guinea.

"Tendon transfer surgery is becoming increasingly rare. It was originally developed to treat polio patients, and with the near eradication of polio in most countries, and effective multi-drug therapy to treat leprosy, there are now fewer surgeons doing this operation."

David and Julie have been coming to Timor-Leste since 2005, with 2014 being their 10th visit.

On their most recent visit, David was invited by the College to teach general surgical Trainees at the national hospital in Dili. His teaching appointment was through the Australian Government funded Australia Timor-Leste Program of Assistance in Secondary Services – Phase II (ATLASS II), a program managed by the College. It employs five specialist doctors as teachers at the national hospital in Surgery, Emergency Medicine, Obstetrics/Gynaecology, Paediatrics and Anaesthesia.

During this visit, David completed four tendon transfer operations. Two surgical Trainees, from the national hospital assisted. "Dr Raimundo scrubbed and did parts of the operations and Dr Gustodio also assisted," David said.

Dr Raimundo is a graduate of the first Post Graduate Diploma in Surgery to be delivered in Timor-Leste while Dr Gustodio is completing the first year of his Master's in Medicine at the University of Papua New Guinea. Neither of these doctors would have been able to complete their training in surgery in their home country without College support.

Joel's Recovery

Joel rests his elbow on the table while Julie applies individual plasters to each of his fingers. She explains that for the first week of post-operative physiotherapy, the plaster cylinders will be changed every second day and for the next two to three weeks they will be removed and reapplied daily to allow for flexion exercises to be practiced.

Joel first met Julie when he was still in high school.

"I contacted the Leprosy Mission to assist with some teaching, and they told me they also had a patient who wanted to see me," Julie said.

Sara, a Timorese physiotherapist, keenly observes and assists Julie as she goes through the rehabilitation exercises with Joel. Julie and Sara have improvised to make equipment to help Joel strengthen his hands, including using a plastic water bottle which Joel grasps and lifts to strengthen his grip.

Julie has been showing Sara how to teach the leprosy patients to use their transferred muscles, and how to apply the plaster cylinders.

Just a few weeks after his operation, Joel is already seeing improvement in his hand. Unlike before his surgery, he now has a good functional grip and his fingers are no longer clawed. He still isn't quite ready to use the motorbike for his hand needs to become stronger, but with further strengthening exercises he should be able to get back to work soon.

CASE NOTE REVIEW

GUY MADDERN
CHAIR, ANZASM

Rupture after endoluminal graft for aortic aneurysm does occur

An elderly patient awoke with abdominal pain. As the pain persisted the patient called an ambulance just after lunchtime, when the patient was transported to the Emergency Department (ED). The patient was assessed by the Triage personnel soon after arriving at the ED, but was not seen by a doctor for more than five hours after calling the ambulance. At that time the patient's history consisted of constant left iliac fossa pain, leg pain, nausea and loose bowel action. Routine blood tests were ordered and an Intravenous (IV) cannula inserted. A surgical referral was made.

The patient was assessed by the surgical registrar. A similar presenting history was obtained, but in addition a past history of a left femoropopliteal bypass and an endoluminal repair of an abdominal aortic aneurysm performed five years prior were obtained. The Blood Pressure (BP) was 100/70. An abdominal Computed Tomography (CT) scan was ordered and performed just after midnight. Shortly afterwards, the radiologist reporting the CT rang the ED doctor to report a ruptured left iliac aneurysm with massive retroperitoneal haemorrhage. The surgical registrar contacted the vascular surgical registrar.

At just before midnight on the day of admission, the patient's BP was recorded as 120/95. The next recorded BP measurement was taken just before the CT scan and measured <80 mmHg. At 1.40 am, the BP was unrecordable. A dose of 500 ml of Gelofusine was administered and this was followed by a further 500 ml at 2.20 am. At 2.25 am, the patient was transferred to the operating theatre. This was more than 13 hours after the patient had sought emergency assistance and 12 hours after arriving in the ED.

On arrival in the operating theatre, the patient was unresponsive, bradycardic with agonal breathing. A decision was made that surgical intervention would be futile, and the patient died.

Reviewer's comments

The case notes are scant, but adequate. However:

This was an avoidable death. Had treatment been undertaken during the period of haemodynamic stability, the patient would likely have survived. The decision not to proceed with the operation when the patient was moribund is not questioned. The delays in the management of this patient presenting to the ED compounded the lack of experience and knowledge of the assessing clinical staff.

There is a lack of understanding apparent in this ED with respect to a patient with an endoluminal aortic repair that is probably common to most EDs. Endoluminal abdominal aortic aneurysm repairs do not cure the aneurysm, they merely control it. Thus a patient with unexplained abdominal and/or back pain should be assumed to have a complication of the endoluminal repair until proven otherwise.

There were unacceptable delays in the management of this patient at every stage – inappropriate triage delayed medical review for hours, the CT scan was not for almost 10 hours and even when the diagnosis was known, transfer to the operating theatre was delayed for more than one hour. These delays directly contributed to the death of the patient. It would be reassuring to know that the institution involved has conducted an internal review of this patient's poor management.

It would be reasonable to consider promulgating the concept that endoluminal repair of an abdominal aortic aneurysm does not cure the aneurysm and that rupture can still occur. Any patient with a history of an endoluminal repair of an abdominal aortic aneurysm who presents with unexplained abdominal or back pain should be considered to possibly have a complication of their endoluminal repair and urgent abdominal CT scan should be arranged.

GATHERING ON A TROPICAL ISLAND

A chance to catch-up with peers at the Younger Fellows Forum 2014

JAMES C. LEE
2014 YOUNGER FELLOWS FORUM CONVENOR

The 2014 Younger Fellows Forum was held at the Hard Rock Hotel on Sentosa Island, Singapore. Gathered on this tropical island were 25 enthusiastic Younger Fellows from the Royal Australasian College of Surgeons (RACS), including colleagues representing the Hong Kong, Singapore, and Edinburgh surgical colleges. The forum was honoured to have the immediate past president of the Academy of Medicine of Singapore, Professor Kok Chai Tan, as their distinguished guest.

Other guests included Associate Professor Christine Jorm and Dr Wayne Morriss from The Australian and New Zealand College of Anaesthetists (ANZCA), Professor Peter Sagar from the Royal College of Surgeons of Edinburgh (RCSEd), and Associate Professor Sandra Wong from the Association for Academic Surgery. Also present from RACS were (former) President – Associate Professor Michael Hollands, Councillors – Professor Julian Smith and Mr Richard Perry, Professor Russell Gruen, Professor Hamish Ewing, and Associate Professor Phillip Antippa.

The forum opened with a welcome from the Younger Fellows Committee Chair, Richard Martin, who enlightened many Younger Fellows of the inner workings of the College. Associate Professor Mike Hollands followed with his presidential address, which set the scene for the forum by reflecting on the College's past, and the challenges it faces moving forward into the future.

Following the opening addresses, a round of "show and tell" quickly broke the ice among the delegates and guests. The group bonding continued into the afternoon with a team-based photo safari challenge, which provided everyone with an opportunity to roam around the island and enjoy the tropical sunshine.

Day two was all about business, and for that, the delegates joined forces with the delegates of the ANZCA New Fellows conference. As the saying goes, the more the merrier. The first theme explored was on International Surgery. General surgeon Professor Ewing and anaesthetist Dr Wayne Morriss shared their joys, trials and tribulations of outreach work, and reflected on the benefits of being involved in aid work.

Patient safety and quality assurance expert Associate Professors Jorm and Professor of Surgery and Public Health Russell Gruen guided us through the minefield of 'Public Disclosure' of surgical performance data. Together, the ANZCA and RACS delegates explored the multiple facets of this intricate issue, and gained some insights into the complexity of this imminent global trend. Fair to say, a productive and exhilarating afternoon of inter-disciplinary dialogues and cross-pollination of ideas was enjoyed by all.

Apart from the two main themes, the discussions and presentations also covered a wide range of other topics including the surgical landscape in Singapore, the world of academic surgery in the US, and the career trajectory of Australasian surgeons. On a lighter note, cardiothoracic surgeon Associate Professor Phillip Antippa shared his personal journey of chasing the surgical dream as a young musician (featured in this issue's Post Op), inspiring all to realise that there can be life outside a surgical career.

For their hard work, the delegates were treated to a pool-side dinner at the Tanjong Beach Club, complete with Mozart's clarinet quintet, displaying the talents of our very own surgeons and anaesthetists.

After a night of socialising, it was back to work on the final morning of the forum. Professor Peter Sagar of the RCSEd kick started the day by sharing his first-hand experience of surgical performance public reporting in the United Kingdom. It was certainly a cautionary tale highlighting the potentially detrimental impact on surgeons if public disclosure is not handled properly by the appropriate agencies.

Upon conclusion of all the invited presentations, it was time for the delegates to formulate the recommendations of this year's Younger Fellows Forum. This was the crux of the forum. All the discussions, debates and presentations had been in preparation for this crucial, final session. Year after year, these recommendations represent the collective voice of the Younger Fellows, and are presented at the October Council meeting for consideration. This year, the recommendations will be presented to Council by the conveners Mr James Lee and Mr Satish Warrier.

There was no doubt that the delegates departed Sentosa Island filled with a sense of accomplishment. Not only did they make a significant contribution to the College, but they had most certainly fostered some long-lasting friendships.

The Younger Fellow's Forum in May 2015 will be held in Bunker Bay in the picturesque Margaret River Region of Western Australia. The program's theme is 'The Healthy, Wealthy and Wise Surgeon'. It will tackle issues related to maintaining career longevity by ensuring a good work life balance, tactics to avoid stress and burn out and how to deal with the injured surgeon and the 'surgeon in crisis'.

The weekend will cover many other topics pertinent to Younger Fellows as suggested by nominated delegates and will provide an opportunity to meet and share insights with peers from different regions and specialties. It promises to be an enjoyable time where delegates can contribute to the voice of the Younger Fellows and be part of the discussion that forms their recommendations to Council.

Forum had great impact

The following is an excerpt of an article published in 'Cutting Edge', Issue. No. 51, June 2014 from one of this year's attendees, Dr Margaret Pohl.

Recently I was fortunate enough to attend the Younger Fellows Forum run annually by the College. Having had little formal College contact, other than participation in skills and teaching courses, and perhaps having a degree of disillusionment with the roles of the College, I must admit I was somewhat dubious about my attendance at this event.

Of any professional development meeting, conference, workshop, or event I have attended, this forum has had the single greatest impact on me. At this busy and challenging time in one's career, life is taken up with the demands and stresses of daily life as a new consultant, often with little time or energy to pause and reflect. Important life-changing decisions about personal development, future direction, opportunities, leadership and a wider involvement and engagement in the surgical community are often overlooked. In this regard, for me, this forum was inspirational and will have an ongoing impact on my career decisions. This event has inspired me to apply for a 12 month Leadership Course run by the Australian School of Applied Management next year.

Strong points of the Forum were the interactive nature of the discussions, team building networking, and ability to meet and interact with College Councillors and Chairs.

As far as the role of the College goes, this meeting allows Younger Fellows to gain an understanding of, and take ownership of, their College. This engagement is vital to maintaining a unified College body.

This is an important forum.

I am grateful to have been a part of it.

Margy Pohl

PUSH TO INCREASE ACADEMIC SURGERY AT TERTIARY LEVEL

Sydney Vascular Surgeon and academic Dr Sarah Aitken has been selected to become the inaugural recipient of the College's Senior Lecturer Fellowship to begin next year

An initiative developed by the College Research, Audit and Academic Surgery (RAAS) Board, the Fellowship has been designed and introduced to provide recipients with salary support and in so doing help increase the overall number of Academic Surgery positions in tertiary institutions across Australia and New Zealand.

With monies provided through the Foundation for Surgery, the Fellowship is valued at $132,000 per annum for up to three years with the College providing $66,000 and the recipient's institution expected to provide the equivalent amount.

The Fellowship is open to all Fellows of the College from all specialties, but is particularly aimed at younger surgeons wishing to embark on, or consolidate a career as an Academic Surgeon.

Chair of the RAAS Board, Associate Professor Ian Bennett said the Fellowship initiative had been designed in close collaboration with the College's Section of Academic Surgery and had won warm support from the College Council last year.

He said it was hoped that the seed funding for each Fellowship position would help encourage institutions to provide on-going support for the academic posts.

"The over-all number of funded Academic Surgery positions has been declining in recent years because of the tight budgetary environment affecting educational institutions in Australia and New Zealand and we are trying to turn that around," Professor Bennett said.

"We know that a number of young surgeons would like to pursue a career as an Academic Surgeon, but become disheartened by the difficulty in securing an institutional position with a guaranteed income stream.

"Therefore, we have particularly designed this Fellowship to support surgeons at the beginning of their academic career where future funding is often insecure.

"In recent years the number of academic posts in medicine and surgery has fallen in both Australia and New Zealand because of limited resources and we hope this College funding will act as a catalyst towards redeveloping this vital component of the medical and surgical professions.

"The College supports this Fellowship not only as a way to give back to our Fellows by providing this new career pathway, but also to provide medical undergraduates and post-graduate surgeons with access to highly-experienced and talented teachers."

Dr Aitken has a clinical practice based at the Concord Hospital in Sydney, a teaching position through the University of Sydney at the Concord Clinical School and conducts research through the Concord Centre for Education and Research in Ageing.

She said that while she was initially appointed to her teaching role to boost anatomy education, she was now working with undergraduates, post graduates and hospital residents.

She is also undertaking a PhD into the outcomes and epidemiology of older people having vascular surgery in NSW.

With her part-time vascular practice, Dr Aitken described the three strands of her surgical career as an "exciting mix".

"Each aspect of my working life informs the others and that is a joy," she said.

"While I was initially brought in to teach surgical anatomy, my role soon broadened so now I work with students on problem-based learning and developing clinical and surgical skills.

"We also have a virtual anatomy table – it's like a giant iPad and one of only a few in Australia. The students love it because it helps fill any gaps of knowledge they might have and therefore boosts their confidence.

"Often, it is the students who decide what they want to learn and, while I am no anatomist, I facilitate that learning, act as a mentor and involve other teachers."

Impact on elderly

Dr Aitken is completing her PhD under the supervision of a geriatrician and epidemiologist through the Concord Centre for Education and Research in Ageing and the University of Sydney.

She said she was investigating the outcomes of vascular surgery on older patients because little was known about the longer-term impact of such surgery on the elderly.

As part of her research, she is collecting and analysing the data of all admissions by vascular patients aged over 70 years in all public and private hospitals in NSW, all Emergency Department admissions for the same cohort and collating death statistics through the office of Births, Deaths and Marriages.

"Concord Hospital has a focus on older patients and geriatrics and we see many vascular cases and conduct a number of procedures such as angiograms or vascular by-pass surgery," Dr Aitken said.

"However, not a great deal is known about the impact of such surgical interventions in terms of the possible acceleration of decline or frailty.

"Do these patients become more frail? Do they end up in a nursing home earlier than otherwise? Is age alone the determinant in decline or does the intervention itself have a role to play?

"This analysis of quality of life issues is a very exciting, emerging field of research because while it is complex and statistics-based, it has direct relevance to our patients.

"They want to know what might happen in the future and while we can offer reassurance, that should not be based on conjecture, but solid information.

"The data we collect could even point us toward a new model of shared care where geriatricians and allied health professionals become part of the post-surgery treatment plan."

Dr Aitken was one of 11 applicants for the Senior Lecturer Fellowship and with only a one-year tenure provided for her current teaching position, said she was delighted to have been chosen.

She said she felt both humbled and grateful for the honour of becoming the inaugural recipient.

"A career in Academic Surgery has not been so popular in recent years for younger doctors because it is poorly remunerated, insecure and difficult to find supported positions," she said.

"Yet it is incredibly rewarding not just personally, but in terms of allowing Australian and New Zealand surgeons to contribute to world-wide research and progress.

"Wearing my different hats also creates interactions that are hugely enriching. I learn from my teaching while my research changes the way I think as a vascular surgeon.

"I also appreciate the ability to give back to younger doctors and surgeons the support and mentoring I received as a young doctor.

"I'm also particularly mindful and grateful that the College chose a woman to receive the first Fellowship. It means that I can tell my young female students that they can pursue both a career in surgery and a career as an academic surgeon and there will be the support there for them."

Dr Aitken will take up her Senior Lecturer Fellowship in January next year.

With Karen Murphy

CALL FOR NOMINATIONS

RACS Aboriginal and Torres Strait Islander Health Medal & RACS Māori Māori Health Medal

The Royal Australasian College of Surgeons is proud to announce two new awards to acknowledge significant contributions by Fellows to Indigenous Health advocacy and health outcomes in Australia and New Zealand.
The awards will be made to a Fellow who has demonstrated excellence through leadership, practice, advocacy, community engagement, education or research of significance to either Aboriginal and Torres Strait Islander health or Māori health. The awards acknowledge that surgeons are already engaged in Indigenous Health in urban as well as rural and remote locations, in aspects of improved health care, improved health access, training and education, research and advocacy.

The creation of this reward and recognition program is to:

- Acknowledge and value the tremendous work that has been done by Fellows in both Australia and New Zealand in Indigenous Health care and advocacy
- Acknowledge that Indigenous Health in Australia and New Zealand have common yet distinct needs requiring locally specific responses
- Acknowledge and value an individual's contribution by their peers
- Inspire and encourage new engagement by the Fellowship in efforts to deliver better health outcomes for Indigenous communities in both countries
- Inform and reinforce the College's strong position on and on-going commitment to Indigenous Health
- Promote the College's engagement in Aboriginal and Torres Strait Islander Health and Māori Health and celebrate our achievements thus far

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Nominations are open to all Fellows and the nomination may come from any individual Fellow, surgical society, regional committee, the Indigenous Health Committee, or the Indigenous community in Australia and New Zealand.

Closing date for nominations is
5pm Friday 10 November 2014.

For further information please contact Melanie Thiedeman, Secretariat Indigenous Health Committee
Telephone: (61) 3 99276 7407
Email: Melanie.Thiedeman@surgeons.org

Left: Daryl Wall accepting the award from Len Notaras. Below: RACS Trauma Executive Officer Lyn Journeaux with Daryl Wall.

PIC CREDIT: John Aloysius Henderson

CONGRATULATIONS on your achievements

Associate Professor Daryl Wall AM FRACS

Daryl Wall was presented with a Recognition of Outstanding Service Award in Darwin at the 50th anniversary meeting of the Provincial Surgeons of Australia (PSA) in acknowledgement of his significant contribution to the field of trauma.

Daryl chaired the Queensland Trauma Committee from 2001 to 2009 and took over the reins as Chair of the 'bi-national' Trauma Committee in 2009 from the capable hands of Professor Danny Cass. Daryl is a passionate supporter of the Australasian Trauma Verification Program and played a substantial part in rolling out trauma verification in Queensland. He is a keen advocate for trauma quality improvement, disaster preparedness and trauma prevention and has publicly advocated on behalf of the College on matters concerning quad bike safety, alcohol related violence and road safety. His dedication to trauma education has kept him busy instructing on Early Management of Severe Trauma (EMST) and Definitive Surgical Trauma Care (DSTC) courses.

As Chair of the Trauma Committee, Daryl was integral in ensuring the annual trauma symposium covered topical and concerning issues such as road trauma, disaster preparedness, alcohol related injury and trauma quality improvement.

It was Daryl's leadership and vision that facilitated the joint symposium 'Injury in Indigenous Populations – Learning From Each Other' in Darwin this year. The symposium is a follow up to the highly-regarded 2007 symposium, 'Injury in Indigenous Populations: Towards a Safer Future'.

"I felt honoured to be part of this year's Trauma Committee activities in NT advocating trauma prevention, training and preparation for disaster and partnering with the Northern Territory community in the management of trauma in Indigenous populations"

Dr Len Notaras, Executive Director of the National Critical Care and Trauma Response Centre (NCCTRC) and Chief Executive of Northern Territory Health presented the award to Daryl. Len has been a great supporter of the Trauma Committee over the years and it was a poignant moment to witness the synergy between leaders in the area of trauma, health and disaster preparedness. We were honoured that the NCCTRC along with the Foundation for Surgery sponsored the 'Injury in Indigenous Populations – Learning From Each Other' symposium.

The highly successful Darwin meeting partnered the PSA with College Trauma and Indigenous Health Committees and linked dedicated professionals committed to addressing some of the challenges facing rural and remote surgeons.

The PSA organised an excellent and successful event and the conveners of the tripartite meeting (Dr Mahiban Thomas and Dr Stephanie Weidlich – PSA, Dr David Read – Trauma Committee and Assoc. Prof Kelvin Kong – Indigenous Health Committee) are to be congratulated for creating an innovative and exciting program which brought together international and national speakers from all areas affecting the three groups. The meeting demonstrated the strong collaboration and commitment of the health professionals in the Northern Territory and particularly at the Royal Darwin Hospital. The input and involvement from so many Fellows is recognised, including Phil Carson, Ollapallil Jacob, Annette Holian, John Treacey and Grant Christey, who provided insight into a broad range of topics surrounding rural and remote trauma.

The Trauma Committee will continue to support the key messages from the symposium relating to the link between alcohol and speed to injuries sustained.

As incoming Chair of the Trauma Committee, I would like to thank Daryl for the leadership he has provided over the past five years of this active and important College committee.

Citation provided by Dr John Crozier, Chair, Trauma Committee

spring lifestyle

post op

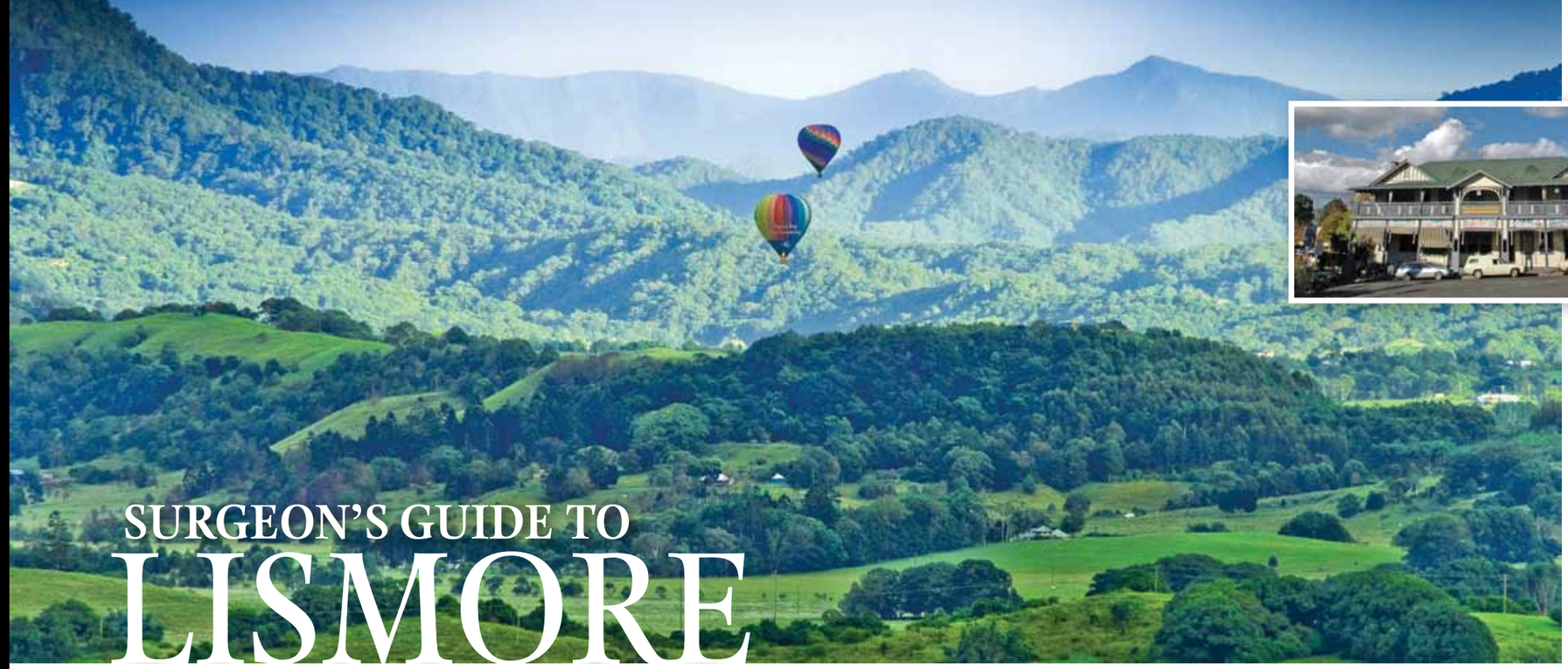
10 page lifestyle section

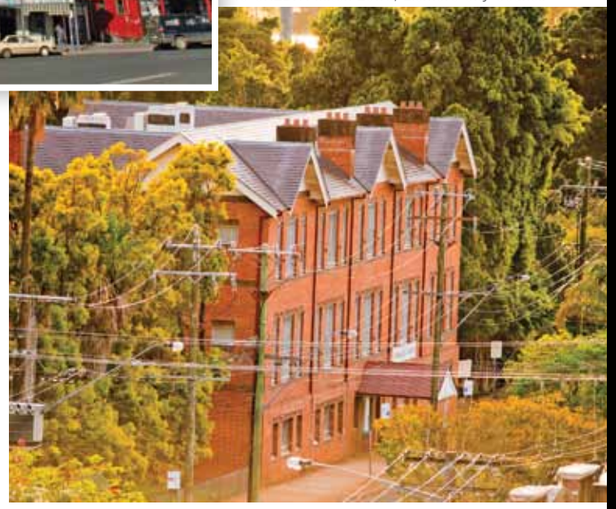
Phillip Antippa addressing the Corpus Medicorum orchestra.

Russian PERFORMANCES

for Melbourne musical medicos

post op appears in *Surgical News* each season





PIC CREDIT: Mitch Lowe, Lismore City Council

SURGEON'S GUIDE TO LISMORE

NSW General Surgeon Dr Sally Butchers moved to the beautiful coastal region of Lismore seven years ago and is now working to encourage other young surgeons to follow her lead.

As Chair of the Rural Section of the College and a member of the Executive of the NSW Regional Committee, Dr Butchers is working closely with colleagues from around the country to look at new training models and job notification systems to help entice surgical Trainees out of the city.

Continuing the work started under her predecessor Mr Tom Bowles, from Albany in WA, Dr Butchers is working with the Rural Section of the College to develop plans to support young surgeons wishing to work in regional or remote areas.

Members of the Section are now looking to establish regional training hubs and to design systems that can notify Trainees of regional positions.

"We know that the best way to attract young surgeons to rural and regional areas is to give them the support and specific training they need along with exposure to both a regional lifestyle and surgical work life," she said.

"Glenn Guest has established a very successful Rural Training Hub based around Geelong in Victoria which addresses all these issues and we are now working to expand that into Northern NSW and other regional areas around Australia.

"It's a wonderful model in that the Trainees are based in the country and sent to the city for specialty rotations which means they get exposure to big, busy city hospitals while remaining attached to a regional hub.

"This gives Trainees a targeted pathway towards a career as a regional surgeon while providing them the skills and confidence they need."

Dr Butchers moved to Lismore, a sub-tropical town in the Northern Rivers region of NSW, in 2008 after having worked there as a Trainee.

Dr Butchers said the landscape of the region, with its forests, villages, mountains, swift clear rivers and beautiful coastline, had also been a strong draw card.

She also said that the region attracted such a wide variety of people – including artists, chefs, artisan food producers, musicians and, of course, tourists – that there was sufficient expertise and commercial support for restaurants, open-air markets, spas, retreats and art galleries which all added to the cultural sophistication of the area.

"A few of the hospital staff are surfers and it's the coastline that brought them here," she said.

"I loved the beauty of the natural environment, the little villages, the cafes and restaurants."

The following are Dr Butchers' suggestions on how to make the most of a trip to the Rainbow Region.

LOVELY LISMORE

Closer to Brisbane than Sydney, Lismore is tucked away in the far north-eastern corner of NSW and is the hub of the Northern Rivers region widely known for its great natural beauty. The region is nestled along the coast of the Pacific Ocean, with the New England region and the Great Dividing Range forming a rugged boundary to the west. Surrounded by smaller towns, tourism hubs and hamlets, Lismore has a population of around 43,000 and is part of the area known as the Rainbow Region, a Mecca for the flower power generation of years gone by. Small enough to still feel like a laid-back country town, Lismore is large enough to support fine restaurants, bars and art galleries, spas and glamorous getaways while the neighbouring towns of Ballina, Tweed and Byron add to the cosmopolitan atmosphere.

NATURAL WONDERS

Lismore and Nimbin act as the gateway to some of Australia's most significant World Heritage listed reserves with nearby national parks providing walking trails, breathtaking lookouts and access to cascading waterfalls, sparkling rivers and stunning coastlines. The country is the ancestral home of the Widjabul people who carry forward the tradition of the Ngathang Garr, ancestral beings whose movements and history are etched in the landscape and waterways.

Most dramatic of the natural wonders is the ancient Mount Warning volcano which is surrounded by the Border Ranges and Nightcap National Parks as well as the last remnants of a vast rainforest which once covered most of the region. Dr Butchers said: "Mount Warning is stunning. It's a decent hike to get to the top, but the views are fantastic over the national parks and along the coast."

FINE ART BY A FAMOUS LOCAL ARTIST

The Tweed Regional Gallery has rapidly become one of the most popular tourist destinations of the Rainbow Region, particularly since the development of the Margaret Olley Art Centre, created to honour the life and works of one of Australia's most celebrated still life painters. A Lismore native, Olley held more than 90 solo exhibitions during her career before her death in 2011.

Unlike a traditional art gallery, the Tweed centre incorporates a recreation of Olley's beloved Paddington home, a cosy, somewhat eccentric environment known for its eclectic collection of gathered items that the artist used in many works. The home studio installation is on permanent display while rotating exhibitions of Jolly's works are hosted at the attached Art Centre.

A DREAMY DRIVE

Thirty minutes is all it takes tootling along pretty country lanes to see rainforests, beaches, colourful markets, curio shops and quaint villages. Further afield are the picturesque coastal towns of Byron Bay, Bangalow, Lennox Head, Mullumbimby, Murwillumbah and Nimbin. Boasting that the Northern Rivers is home to the largest concentration of practicing artists in regional Australia, the region offers an art trail so that visitors can meet the artists while regular art, craft and farmers markets showcase the area's creative endeavours and gourmet produce.

"There are a number of lovely drives you can take out of Lismore just to potter around and visit villages or find somewhere for a swim and a picnic," Dr Butchers said.

FOOD AND FUN

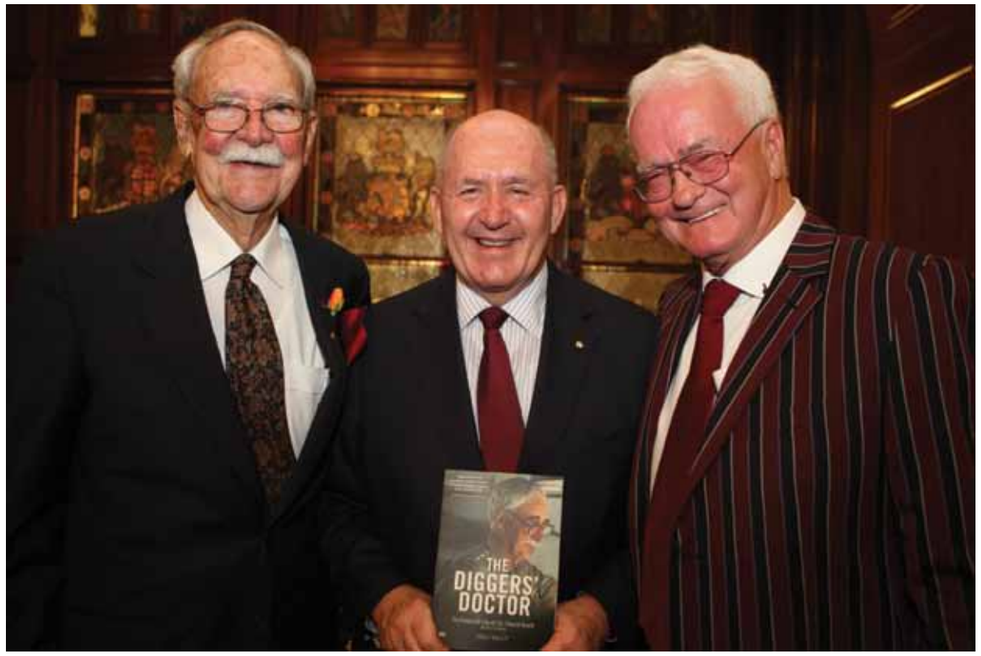
One of Australia's largest coffee growing centres, the Northern Rivers is also fast developing a reputation for fine gourmet, regional cuisine and offers visitors a range of dining options from organic vegetarian to haute cuisine. Dr Butchers listed her favourite cafes and restaurants in Lismore as La Baracca, The Palate and the Loft Restaurants while also listing the Eltham Pantry and Harvest, located in the historic town of Newrybar in the Byron Bay hinterland.

"The little village of Bangalow has great little restaurants and shops, but the fresh produce from around here is so good that you can find good food almost everywhere you go," she said.

With Karen Murphy

spring lifestyle

Donald Beard, General Cosgrove and Ashley Mallett



THE DIGGERS' DOCTOR

War surgeon Donald Beard AM has put his experiences on paper

Donald Beard AM is perhaps the Australian surgeon who most resembles a home-grown version of Hawkeye Pierce of MASH fame except for one big difference – he served in Korea willingly.

As a Captain and medical officer to the Third Battalion Royal Australian Regiment, Mr Beard suffered with his men through bitter sub-zero winters, patched up the wounded in tents and galvanised iron huts and helped develop fast-track triage systems in the new age of helicopter retrieval and transfer of wounded soldiers.

Described by Australia's Governor General Sir Peter Cosgrove as a "strong man of peace and compassion", Mr Beard returned to Australia determined on a career in surgery and travelled to the UK for the requisite training funded by the money he had saved from his military service. Rising through the ranks, Mr Beard became a Colonel in the Reserve Forces, as they were then known, and later became the Consultant Surgeon to the Army Office in Canberra before once again being called to serve, this time in Vietnam.

"It was my job and my duty to go and help wherever and whenever Australia was involved in war, so in January 1968 I went to Vietnam," he said.

"That was a horrible war that caused truly dreadful mine, bomb and burn injuries and was totally different to previous conflicts in that the war was everywhere and nowhere, even underground in Vietnam.

"The soldiers in both Korea and Vietnam were just so brave – even those that didn't want to be there – and they seemed to rise to every occasion which pushed everyone in the medical units to do our very best by them.

"I worked in a field hospital very like a MASH unit where we did much the same work as the US units; in Korea I even spent time in one as a patient.

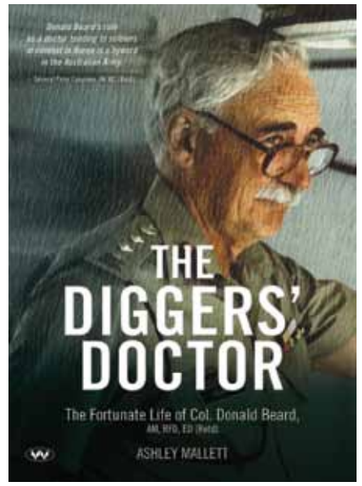
"I'd developed pneumonia in the sub-zero temperatures there and they were going to evacuate me to Japan, but I didn't want to go. Instead, I asked to be transferred to an Indian field ambulance where they treated me with curry and rum and I think that combination could cure anything."

Following the war, Mr Beard returned to Adelaide to take up his general surgery practice based out of the St Andrews, Queen Elizabeth and Royal Adelaide hospitals before being appointed the Head of Surgery at Modbury Hospital in 1973.

Now almost 90, Mr Beard has become the subject of a book called *The Diggers' Doctor* which was launched at Government House in Adelaide by Sir Peter Cosgrove who described his work tending to the wounded in Korea as a "byword" in the Australian Army.

"His invariable good humour, stamina and great professional skill made him a wonderful role model for further generations of medicos in uniform," he said.

Written by former Australian spin bowler Ashley Mallett, the book not only describes his life in the army and as a surgeon, but also his great love of cricket.



A bowler and keen amateur cricketer, Mr Beard became the Surgeon to the SA Cricket Association in the 1950s.

In that role he treated both local players and members of visiting test teams for everything from broken bones and torn ligaments to appendicitis and even a spinal shock sustained in a heavy fall by Clive Lloyd, captain of the visiting West Indies.

Through that involvement, Mr Beard forged a deep friendship with Sir Donald Bradman and it was in Mr Beard's garden – on a pitch made by the legendary curator of the Adelaide Oval Mr Les Burdett – that The Don faced Jeff Thomson and hit his last cricket ball.

"Bradman was truly a marvel and beautiful to watch," he said.

"He came over for a visit one day and my boys were out playing on the pitch and they asked him to put the pads on and show them a thing or two.

"Then Thommo called in and said: 'If Bradman's batting, I'm bowling'. Bradman agreed and was quite cautious to begin with, but then got his eye in and took him on. It was a great afternoon and Thommo still says that he was the last man to bowl to The Don.

"I also became friends with Geoffrey Boycott when he arrived in Adelaide in quite a bit of pain. He'd been vomiting on the plane on the way over and saw a doctor in Singapore who had given him an injection and promptly caught the sciatic nerve.

"By the time I saw him he had severe sciatica and I put him in hospital. Later, when the team had moved on I said he could recover at our home.

"When he was moving better, I arranged for a net and we had a session. He hit me every which way so I knew he was ready to play."

Mr Beard said the book came about after Ashley Mallett approached one of his sons with the suggestion. He agreed and spent weeks recording his memories. The work is the 32nd book written by Mallett.

He said he had enjoyed the experience of looking back on his life, particularly those recollections of the excitement and variety of his working life in an era before the sub-specialisation surgery.

"They really were great years to be a surgeon, particularly in Australia where the development of the profession was just taking off," he said.

"When I decided to become a surgeon I had to go to England to train because we simply didn't have the teachers here and when I look back I'm impressed all over again at how wonderful the English surgeons were to we Australians.

"They gladly gave their time to train us even though there was nothing in it for them because they knew we'd take our skills back home.

"I was always particularly grateful for the support and help given by Sir Gordon Gordon-Taylor and at one stage I wrote to all the surgeons who had dealings with him to raise money to fund a portrait of him for the College in Melbourne.

"We got it done, but not long afterwards he was injured by a taxi outside his beloved Lords and he died a week later so I'm glad we have a lasting memorial to his contribution to Australian surgery."

The good with the bad

Mr Beard said that while he considered his life extraordinarily fortunate, there had been hard times and the sad moments familiar to many surgeons.

"I remember one young girl who had just finished secondary school and was on her way home when she was hit by a bus and terribly injured," he said.

"I spent six hours working on her, but her pulse faded and she died in my hands on Christmas Eve. I went to her home the next day to meet her family and pass on my sympathy and was deeply moved to see all the Christmas presents under the tree that would never be opened.

"But then there were the lovely moments too like when a man and his family walked up my drive one day and though I didn't recognise him, he soon explained that he was a young soldier from Vietnam who'd come all those years later to thank me for saving his life.

"But mostly my life has been blessed by my wonderful wife Margaret and my boys.

"I feel like I have lived a life where I was in the right place for luck to fall over me."

The Diggers' Doctor is published by Wakefield Press. For more information or to purchase a copy visit their website at wakefieldpress.com.au

With Karen Murphy

Phillip Antippa (middle pointing) with the Corpus Medicorum musicians.

Tour OF A LIFETIME

A passion for classical music led to an opportunity for like-minded medicos

The orchestra created by Melbourne cardiothoracic surgeon Mr Phillip Antippa which comprises more than 70 talented musical medicos, was recently granted the honour of representing Melbourne in St Petersburg, Russia, to mark 25 years of the sister-city relationship.

Corpus Medicorum was chosen and supported by the City of Melbourne to mark the occasion and spent 10 days in June rehearsing and performing amidst the splendid architecture, glorious art and rich musical history in one of the world's greatest cities.

When Corpus Medicorum was nominated, the Lord Mayor of Melbourne, Robert Doyle, said he hoped the visit would provide not only a cultural exchange, but also the opportunity to develop relationships between surgeons, doctors and hospitals in each city.

He said: "I can think of no better representative to encapsulate all that is Melbourne than Corpus Medicorum Orchestra."

As official guests of the Governor of St Petersburg, the 73-member full symphonic orchestra performed a charity concert at the State Academic Capella Hall and at a Gala Charity Ball at the Pavlovsk Palace.

Mr Antippa, who plays the viola, described both the honour and the trip as a highlight of the orchestra's history.

"We, as an orchestra and as individuals, felt a great sense of achievement in being asked to perform in St Petersburg," he said.

"It was quite a complex trip to organise and was mostly self-funded so we were grateful for the assistance given to us by intermediaries, interpreters and particularly the Conservatory of Music of St Petersburg who even loaned us some of the bigger instruments that were too bulky to take over.

"It was a wonderful experience where we had the opportunity to play beautiful music in beautiful venues with extremely talented Russian soloists.

"The Capella Concert Hall, which seats around 700 people, is a gorgeous building with phenomenal acoustics while our second concert was in the garden pavilion of a palace with everyone in black tie and evening dress.

"They were both wonderful occasions and I don't think we have ever played better."

Mr Antippa said for the first concert, Corpus Medicorum played the Capriccio Espagnol by Russian composer Rimsky-Korsakov, Dvorak's New World Symphony and premiered a new work by Australian composer Iain Grandage.

They were also joined by Mr Mikhail Gantvarg, a violinist, Rector of the Conservatory of Music and Director of Soloists of St Petersburg Chamber Ensemble to play Tchaikovsky's Violin Concerto.

In the second, more informal performance the orchestra played Strauss Waltzes, Tales from the Vienna Woods and the Capriccio Espagnol.

The money raised at both events went to the Advita Childhood Cancer Charity, a Russian organisation established in 2001 to help cancer patients and their families meet the cost of treatment, travel and accommodation.

"The music and the fund raising are part of our core business in Melbourne, but both are rather unusual in Russia," Mr Antippa said.

"There is no amateur music scene in St Petersburg; you either play as a professional or not at all and the idea of modern philanthropy hasn't really taken off there yet.

"Still there was a degree of curiosity about us and a warmth toward us as representatives of Melbourne so both performances were well attended and appreciated."

Mr Antippa said representatives of Advita also escorted members of the orchestra on visits to four major hospitals where they participated in the creation of a film exploring the benefits of music for children with cancer.

He said that almost all members of the orchestra participated in the hospital visits, keen to meet with their Russian counterparts and compare medical systems.

"The children's hospital in St Petersburg seems to be well resourced, but overall I was disappointed to see how poorly medicine was supported; certainly it would get nowhere near our rate of GDP spending," Mr Antippa said.

"English wasn't widely spoken by the academic staff at most of the hospitals we visited which places a certain limitation on international engagement, particularly given that it is now considered the world wide language of medicine.

"We also noted that there were some marked differences observed in surgical practice with a reliance on major radical surgery instead of the multimodality therapies that are used in most Australian surgical practices.

"I mentioned the Thoracic Surgery Fellowship that we have established at the Royal Melbourne for visiting surgeons which met with strong interest by the younger Trainee surgeons who had very good English, although I sensed a degree of reluctance by the more senior members of the department.

▸

spring lifestyle

The orchestra had the chance to play at some incredible Russian venues.

"However, we did develop some collegial relationships with doctors who attended the concert and we were all glad to have had the opportunity to visit the hospitals because we are doctors first and musicians second and we're proud of that."

Mr Antippa said that so successful was the visit, the City of Melbourne had asked Corpus Medicorum to again represent Melbourne to mark another sister-city anniversary with Osaka, Japan, in 2016.

Corpus Medicorum plays in Melbourne three times each year and has so far raised more than $500,000 since it began in 2000. While in its early days, funding went to provide equipment for the Royal Melbourne Cancer Centre, more now is going toward funding research positions to progress cancer treatment.

Mr Antippa said he had never lost enthusiasm for the orchestra, despite the time it requires in organisation and administration and said the trip to Russia and the invitation to Japan made all the effort worthwhile.

A former member of the Australian Youth Orchestra, Mr Antippa was asked to tour as a student, but chose instead to concentrate on his medical studies and therefore described the Russian trip as the "tour I never did".

"It is a shame that recent geopolitical issues have put a strain on relations with Russia because it is a fascinating country and every single member of the orchestra came away from the trip with a deeper understanding of the place and the people," he said.

"We also greatly enjoyed the chance to bring quality amateur music to a city that doesn't have that as part of its cultural fabric even though we felt a bit daunted at times performing in the country of such musical giants as Russia.

"But really, establishing and playing in the orchestra is quite selfish for me because it gives me a chance to play the music that I love at a level I enjoy; an opportunity that isn't readily available for amateur musicians."

Corpus Medicorum will next play on December 14 at the Melbourne Recital Centre where it will be performing music by Elgar and Brahms' 4th Symphony.

With Karen Murphy

NOT JUST A ROCK

Former College president, Professor Ian Gough believes Australia's ancient rock art deserves better appreciation

The images range from the elegant to the eerie, from the playful to the informative, from the beautiful to brutal and they are among the oldest art works ever created, anywhere in the world.

They can be found carved into the rocks on the shores of Sydney Harbour or painted on the walls of rock shelters sprinkled predominantly across the Top End of Australia and each of them tells a story of an ancient people in an ancient land.

Some resemble the Cubist art or abstract art of the 20th Century, yet many were created up to 30,000 years ago.

They are a passion of former College president, Professor Ian Gough, who describes Aboriginal rock art as one of Australia's greatest – but most neglected – cultural treasures.

"My wife Ruth and I appreciate these works as both artistically and historically important," he said.

"They have provided a major focus of our travels.

"The parallels between Australian rock art and similar rock art elsewhere in the world such as in the Anasazi culture of North America or the Bushmen of the Kalahari are fascinating and seem to suggest a similarity of thought and human consciousness across time and space."

Professor Gough said there were thousands of Aboriginal rock art sites across Australia with the four major regions of greatest interest being the Kimberley, Pilbara, Arnhem Land and Cape York Peninsula. He said that while some people may have seen the impressive rock art at Kakadu National Park, they represented only a small part of a very large number of sites in the Northern Territory.

"Most rock art sites are located in shelters such as shallow caves or on the walls of rock overhangs near sources of food and water," he said.

"There are a range of distinct styles of artistic expression across the regions and many of the works were created for specific cultural functions.

"Some rock art depicts hunting, animals, birds, fish and gathering of plants and tubers and are clearly educational, painted by the elders to teach younger people about food resources.

"Others are clearly spiritual and depict stories of the Dreaming including the pervasive rainbow serpent."

Professor Gough said there were a number of distinct artistic styles and traditions of rock art found around Australia such as the petroglyphs (rock carvings) found in the Kuringai Chase National Park close to Sydney and the Climbing Man images found in the Pilbara, thought to be around 20,000 years old.

Others include the Gwion /Bradshaw paintings of the Kimberley and the Quinkan images of Cape York.

"There are number of time-related styles of Gwion/Bradshaw art in the Kimberley all showing a range of graceful human figures," he said.

"A Brisbane man, Graeme Walsh, spent many years dedicated to cataloguing and promoting awareness of this great art tradition believed to be up to 30,000 years old, so old the pigment has been incorporated permanently into the rock.

"Other fascinating art works in the Kimberley depict the more recent Wandjina cultural tradition of the past 3,000 years to the present.

"The Wandjina spirit figures are often very large, painted with haloes around the head, a pendant on the chest, and without mouths. They are associated with the changing seasons, especially the coming of the wet season each year. We have been told that if they had mouths so much rain would fall that the land would be flooded."

Professor Gough said the Quinkan figures of Cape York bore some artistic resemblance to the Wandjina, but were much older – in the 20,000 to 30,000 year range – and often depicted images of extinct megafauna.

"Some of these petroglyphs, paintings and sites do have a spiritual power," he said.

"When you visit them you can feel a sense of the people who came before and the indigenous people feel this presence very strongly.

"There is no doubt that these are truly extraordinary cultural treasures yet they remain seriously under-

Clockwise: Wandjina male figure WA, Bradshaw Gwion Gwion WA, Petroglyphs Kuringai Chase NSW, Quinkans Cape York QLD

appreciated and little known to most Australians.

"The Palaeolithic cave paintings in Europe like those in the Lascaux and Chauvet Caves in France and Altamira and Tito Bustillo in Spain are very famous, cherished and protected by World Heritage status. However, much of the rock art in Australia is even older and depending on your eye and awareness, even better."

Professor Gough said Australians had a duty to protect and preserve the works and said such protection would only come with government recognition of their cultural value, World Heritage status and wider public appreciation of their historic, artistic and cultural importance.

He and Ruth support the Kimberly Foundation Australia which was established to promote scientific research into the rock art of the Kimberley and to ensure sites are preserved and recognised for their national and international significance.

The Foundation has established the Kimberley Foundation Ian Potter Chair in Rock Art at the University of Western Australia, a world first.

The Foundation also provides scholarships for members of WA's indigenous communities to support them in their traditional roles as custodians of the art, stories and history of their ancestors.

"This, to me, indicates a growing awareness of the importance of these works – not only to Australia, but to the world – because they tell ageless stories of human life on earth."

With Karen Murphy

ROUNDTABLE

The Mental Health of Doctors and Medical Students

STEWART MORRISON
COMMUNICATIONS PORTFOLIO CHAIR, RACSTA

In June, Royal Australasian College of Surgeons Trainees Association (RACSTA) participated in 'The Mental Health of Doctors and Medical Students', a roundtable discussion co-chaired by Beyond Blue and the Australian Medical Association. Represented were specialist colleges, doctors-in-training, medical schools, as well as medical administrators, regulatory bodies and doctor's health advisory services.

The roundtable was convened in the context of the findings of the Beyond Blue National Mental Health Survey of Doctors and Medical Students, published in 2013.

The findings were interesting: While doctors are no more depressed than other professions, they think about suicide more often. Trainee years were the most stressful stage of a career. It was clear too that while doctors' work is considered 'stressful', the rewards seen by those in clinical roles often compensate – the more severe stressors acknowledged were those arising from study and family issues, long working hours, and the fear of making mistakes.

After initial briefing, streamed sessions covered (i) personal awareness and skills regarding mental health issues, (ii) the concept of the 'mentally healthy workplace', and (iii) the regulatory and cultural environments that are required to support mental health and wellbeing.

The dramatic oversubscription to the third stream highlights the changes to the healthcare regulatory landscape in recent years, and while national practitioner registration under AHPRA is now well established, the framework for addressing issues of doctors' health, mental or otherwise, is still in a state of transition. The future of existing state-based doctors' health advisory services has been uncertain.

The Medical Board's announcement in April of funding for a nationally consistent set of services for doctors' health to be administered "at arms length" from the Board still needs to be backed by significant ground work to establish how these will be administered. The right model is critically important; legislation and regulatory frameworks for supporting practitioners can also act as barriers to care. This is exemplified by the concerns dogging the mandatory notification: Regardless of one's stance on these requirements under National Law, the ambiguity and misinformation surrounding their rollout has had clear potential to impact on doctors' willingness and ability to access health services.

Though APHRA's primary consideration is 'to protect the public' via the regulation of medical practitioners, one would hope this predicates a vested interest in fostering good mental health practices and supporting a structured and appropriate doctors' health advisory service, thereby also preventing some of those issues which may have otherwise escalated to a regulatory or disciplinary level.

Initiatives, however, must traverse beyond those established by regulatory bodies. We must transition from paying lip-service to education and awareness to a clear prioritisation of doctors' health and wellbeing. Health Advocacy, as one of the RACS nine surgical competencies, is explained on the College website as including the need that one "promotes health maintenance of colleagues" and "looks after [one's own] health"; however, the RACS Surgical Competence and Performance Guide (2011) and Training Standards Framework (2012) do not elaborate further on these concepts.

Surgeons and Trainees need be equipped with a 'mental health toolkit' that empowers them to look after themselves and their colleagues. The success of workshops such as NOTSS demonstrate the ability of the College to deliver non-technical skills based curricula as succinct, definable entities, and perhaps this format would be useful in the future for teaching improved resilience, coping and colleague assistance strategies. The discussion highlighted the need for medical school and junior doctor level strategies that could build on well-established models in this area developed within other professional groups.

While the College's role is not one of direct workforce provision, influence can be exerted via the production of policy and guidelines that affirm the concept of the 'mentally healthy workplace'. The group tabled 'mental health in all policies' as a baseline expectation: The concept that any new policy be examined specifically from a mental health and wellbeing perspective.

This could be particularly pertinent for the College when it comes to selection processes, training program design and safe working hours. The College takes the wellbeing of Trainees very seriously as evidenced by work including the Bullying and Harassment guide; however, more can always be done to engender a culture of wellbeing, proactive support, and recognition of issues – in surgeons, surgical units, and health care institutions.

RACTSA eagerly awaits the 'Mental Health Action Plan' being developed following the roundtable discussion and commits to taking a leading role in advancing these initiatives within the College.

Declaration: Stewart Morrison is RACSTA Communications Officer as well as a director of the Victorian Doctors Health Program (VDHP).

THE DOS AND DON'TS OF introducing new technology

Building a new hospital from scratch has its challenges, but a positive new community is being formed

TOM BOWLES
WA REGIONAL COMMITTEE CHAIR

Western Australia's south-west coast is a beautiful place to visit. Beaches, wineries, great food and golf courses if you are so inclined. Holding the combined Northern Territory, South Australian and Western Australian scientific meeting in such an iconic location was potentially going to create some attendance problems. Throw in competition from two perfect sunny winter days and whales breaching in the background, the large turnout was a credit to convener Richard Martin and the staff at the WA state office.

Themed as 'The introduction of new technology in surgical techniques – the dos and don'ts!' the meeting provided surgeons of all disciplines a chance to reflect upon how they dealt with new technology. From completely new innovations that are potentially career making (or ending) to introducing new skills from afar, the meeting was insightful and thought provoking.

Michael Lawrence Brown and Fiona Wood walked us through the journey of their academic careers. The commonality being the highs and lows that require a firm self-belief set the tone for the meeting. The successful introduction of endovascular Aortic Aneurysm Repair alongside of some of Michael's less successful endeavours was thoroughly entertaining. To persist while being forewarned of the multiple deaths that will be on your hands from international experts around the globe, I'm sure would have lead to a few sleepless nights.

Other topics included the introduction of laparoscopic nephrectomies to Western Australia, updates in ENT advances from South Australia and Jacob Jacob from Alice Springs again showed us why he is the world expert on alcoholic pancreatitis. Sunday included the registrar papers and some innovations for the office.

Perhaps the biggest introduction of new technology facing Western Australia and soon to be facing South Australia is that of a new health facility. Fiona Stanley Hospital (FSH) will open its doors in October of this year. The completed but as yet unused flagship of WA health has been five years in construction, cost more than two billion dollars and is the single largest project undertaken by the state.

The new facility has seen a complete overhaul of the health service delivery for South Metro Health with some services from Fremantle Hospital and Royal Perth Hospital moving to the new facility. As such, the case mix, operative numbers and surgical FTE requirements for the three facilities is unknown. A large amount of work has been undertaken by many heads of departments to plan for the move and estimate workloads for which they should be commended.

> *"Throw in competition from two perfect sunny winter days and whales breaching in the background, the large turnout was a credit to convener Richard Martin and the staff at the WA state office"*

The WA state committee has been actively engaging the FSH executive to ensure our Trainees are not disadvantaged. Acknowledgement should be given to the workforce team at FSH who have been transparent in their delivery of facts and deficiencies to the committee. A degree of compromise has been required with some positions required to be shared across two sites, but temporary accreditation for all positions has been reached. It will be interesting in two years time to see how close the modelling has been.

However, a number of those who have given their time at a consultant level have been left frustrated by the political nature in which decisions have been made with often scant regard for process or best practice. Oncology services have been removed and then returned to some facilities at the Minister's whim. Theatre instruments selected for integration as a whole have been ignored.

To date the delay has been blamed on information technology and despite an investment of more than $100 million to create a paperless hospital, there is little to show for it. With numerous hospitals around the world operating in such a manner to attempt a 'build from new' has highlighted how dangerous this approach this can be. Desk space and chairs to now write paper notes (let alone storage for records) will be at a premium while this is rectified.

This aside it will be an exciting time as the new facility opens and finds its feet. To be involved in it, establishing its reputation and providing a focus for health care in Western Australia will be a highlight for many younger surgeons who have yet to form an alliance with one of our tertiary facilities. The building after all is only that; it will be the friendships and shared experiences of those who take up the challenge of working there that will develop its reputation going forward.

DO SURGEONS NEED A WEBSITE?

What would you put on it?

ANDREW RENAUT
COLORECTAL SURGEON

It's a fact of modern day living – we all go to the Internet to check out a service or product before we leap, and a medical practice is no different. If you don't have an internet presence, your patients won't necessarily seek to replace you with someone who is web savvy, but they will certainly form an opinion and may question which century you are living in.

Many specialists don't want to be any busier. They will make the assumption that a website exists only as a marketing tool and is therefore surplus to their requirements. It can serve many other important roles, however.

Information about you and your practice

A patient's concern about their putative diagnosis is eased by having prior knowledge of their specialist. A well designed website will display, hopefully, a friendly face and convivial front desk staff and office. It will also allow you to show-case your hard earned training and expertise. This is particularly important if you do a procedure that is relatively new or unique within your specialty.

It's also helpful to add details about your location – including parking, public transport and access for patients confined to a wheelchair. You can also include enquiry forms and new patient registration forms (both online) and information about the billing process. Software systems now exist that integrate your website seamlessly with the practice management software, allowing patients to book appointments online. All of this will reduce the workload of the administration staff – so much so that in a multi-specialist practice, the staff numbers (the biggest expense in any business) can be cut.

Patient information and risk management

Probably of more importance is the information provided about the more common conditions, the services provided and the procedures performed. This does not replace what you tell patients in the office, but it can save you and your staff having to repeat details. It has been well documented that patients only take in a small percentage of what you tell them. If they want more information, staff can point them to the relevant page on the website.

The information you make available online can also have an impact when it comes to risk management. Its availability does not absolve you of the duty to tell patients about the risk of certain procedures, but if it is accessible publicly it goes some way to reducing your exposure in the event of a dispute about what was actually said. You'll also have an electronic record in the form of an email, if this has been sent to the patient with documents attached, or a link through to the relevant section of the website.

Become the oracle with multimedia formats

The format of your information can vary. Documents are standard, but an increasingly popular and personalised medium is streaming video and online PowerPoint presentations – a picture tells a thousand words. Your practice website can very quickly become a valuable resource where patients automatically go to find the latest news on their condition. And it's not always necessary to reinvent the wheel; often a simple link through to an authoritative source will suffice. Those who want to go one step further can supply registered patients with the latest news items and updates via RSS-fed newsletters or social-media networks, such as Facebook and Twitter.

Smart marketing

All businesses, however big or small, need to spend time and money marketing their services or products, and in this respect a medical practice is no different. This is certainly true if you've completed your training and are just starting out, but also applies when circumstances change and you are restarting after a break or changing locations. It would be good to think that medicine is recession-proof, but for some of us this is simply not the case. Businesses can employ a whole range of media for the purposes of marketing, but the one that stands out head and shoulders above the rest is word of mouth; what your patients and their friends and relatives say about you is invaluable. A web presence comes a close second and a well-designed and search-engine optimised website can fulfil all of your additional marketing requirements, and is considerably cheaper in the long run compared to other methods.

Serving rural needs

Online CPD resources via www.ruralspecialist.org.au

It is well known in the medical community that Continuing Professional Development (CPD) is more difficult to complete in the country. Most workshops are run in cities; there is little or no locum support and there are fewer practitioners around to review your practice or to provide feedback.

In 2010, the Commonwealth merged a number of rural training programs to form the Rural Health Continuing Education (RHCE) Program – a single vehicle to support and help rural health workers complete CPD. Four years on, RHCE Stream One can boast to having helped over 2,000 specialists meet their training needs.

As part of the ongoing commitment to supporting medical specialists working in rural Australia, the RHCE website has recently undergone major redevelopment. It is now a dynamic learning environment where specialists can access RHCE-funded resources and undertake online modules for CPD points.

Developed by participating Specialist Medical Colleges, these resources and modules are applicable across specialisations and are available to all registered health professionals. Current courses include:

- Intercultural Learning
- Indigenous Health
- Management Essentials
- Peer Review and Audit.

Podcasts and resources for workshop facilitators are also available.

A simple login process, requiring an AHPRA registration number, will allow access to the courses and modules. Medical students or health workers in rural areas who do not have an AHPRA number can contact the RHCE Program Management Unit (PMU) admin@ruralspecialist.org.au to ask for access on a case by case basis.

Other site content that is freely available includes:

- Details about current RHCE CPD projects, with the appropriate College contact so you can get involved
- A regularly updated list of upcoming events and CPD activities of particular interest to rural health practitioners
- A Useful Links page, making it easy to navigate to sites that offer locum support, grants and a range of rural and Indigenous health services.

The site will continue to expand, with more resources being added as they are developed. To keep up with developments in the RHCE Stream One Program and for news of future funding rounds, sign up for the quarterly eNewsletter

RHCE is an initiative of the Australian Government, Department of Health and is managed by the Committee of Presidents of Medical Colleges (CPMC).

BIO-REALITY SIMULATION

Meeting surgeons' needs by creating hybrid models for skills acquisition

BRUCE WAXMAN
MEDICAL DIRECTOR, SKILLS AND EDUCATION CENTRE

Whether it be a heart-lung preparation for thoracic surgeons to perform VATS (video assisted thoracoscopic surgery) or a combined buccal mucosa/penile model for urologists to perform urethroplasty, the staff of the Skills Laboratory at the College's Skills and Education Centre in Melbourne can deliver.

The bio-reality simulations constructed by Centre Manager David Lawrence and Technical Officer Arwen Tudor are in response to the needs of surgeons to create a realistic representation of the clinical environment in a simulation, to allow them to hone their surgical skills in a risk-free environment.

The hybrid models are a combination of a synthetic manikin and biological tissue. In the case of the VATS model, a plastic chest wall with supple neoprene inlay to allow the passage of endo-surgery instruments (Figure 1) is combined with the heart-lung preparation of a pig, harvested from the abattoir and specially prepared with air and artificial blood to add to the reality (Figure 2). The VATS Workshop is sponsored by Covidien.

Other simulations available in the Skills Laboratory include: cadaveric simulations using human specimens and the lab's wide range of real operating instruments supplemented by specialised equipment provided by surgical instrument companies to perform procedures such as joint replacement surgery; fresh whole-animal simulations for laparoscopic surgery such as hernia repair on the abdomen (pig); fresh animal organ simulations for example urethroplasty of the penis (deer) combined with a manikin of the pelvis and buccal mucosa (using chicken skin) in a manikin of face and mouth, and manikin simulations: laparoscopic trainers (FLS), endoscopy trainers (colonoscopy/gastroscopy), wound suturing and others ideal for skills courses.

Figure 1: Workshop participants with the manikin chest wall in the VATS model with the heart-lung preparation inside. Fellows Lucas Sanders, Himanshu Desai and Bruce Stewart.

Figure 2: The heart-lung preparation for the VATS model. Situ: Fellow Dong Rong

The relevance and benefits of these facilities for surgeons are:

- A facility for simulation of operations for improving skills, developing new skills and teaching Trainees
- Networking with other surgeons – local and international, Trainees and representatives from surgical instrument manufacturers to improve skills, knowledge and experience
- To be provided with a resource that suits their needs where much of the preparation, planning, pack-up and clean-up is provided by the Skills Laboratory staff in a smooth and seamless manner, at the same time providing an experience that recreates a clinical environment that is realistic and authentic
- Convenience of co-location with other College facilities, meeting rooms and conference facilities and to College administration and library
- Providing a good example of how their College subscription fees are being used in a very practical and tangible manner in which they and their Trainees and medical students can benefit directly.

The Skills Laboratory can be set up with eight to 12 operating stations each with suction, irrigation, laparoscopic stacks, operating microscopes, surgical instruments and audio-visual technology allowing video and data projection of procedures. In addition there are storage areas, change rooms, an amenities block, offices and a break-out area for refreshments and buffet meals. The adjacent lecture theatre can be used for didactic sessions to supplement the hands-on workshop.

The Skills and Education Centre is a vibrant seven-day operation. The Skills Laboratory hosts an increasing number of workshops every year with more than 2200 people attending over 80 College courses and workshops for external groups in 2013. In addition to these workshops, the wider Centre was occupied during 40 weekends for 25 CLEAR, EMST, ASSET and CCrISP courses, as well as 23 other professional development workshops attended by over 460 Fellows.

If you have a need for simulation in surgical skills acquisition, then the Skills Laboratory will have the answer for you. Contact the Centre Manager: David.Lawrence@surgeons.org or +61 3 9276 7455.

BUILDING COMMUNITY THROUGH SURGERY

Changing a life calls for passionate teamwork

A Monash Medical Centre team comprising three Plastic and Reconstructive Surgeons, plastics registrars, a Neurosurgeon, Anaesthetist, theatre technicians and nurses recently gave their time and skills to treat a Filipino boy suffering the rare birth defect frontonasal encephalocele.

The condition occurs when the neural tube fails to close during foetal growth allowing the coverings of the brain and brain matter to protrude through the skull and while occasionally seen in Australian newborns, it is usually picked up in ultra-sound allowing for early corrective surgery.

However, in developing countries such early assessment and treatment is often unavailable, causing the contents to continue to leak through the herniation at the front of the skull to create a sac-like bulge protruding from the face.

When seven-year-old Jhonny Lameon was assessed by a volunteer team from Interplast last year, the encephalocele had grown so large it weighed 1.5 kilograms and had cost him the vision in his left eye through a combination of the pressure of the sac and its location which caused his optic nerve to atrophy.

The team from Interplast took photos of the child and sent them to Associate Professor James Leong, a plastic and reconstructive surgeon and member of Interplast's surgical committee.

Mr Leong immediately contacted the CEO of Monash Health to seek approval to treat Jhonny at no cost and was given the green light while the Children First Foundation agreed to manage the logistics of getting him and his mother Chochi to Melbourne and providing accommodation.

The two arrived early this year and after conducting a range of tests and assessments on the child – including MRI and CT scans – the team successfully conducted the complex seven-hour surgery in March.

Mr Leong said the surgical team comprised Plastic and Reconstructive Surgeons Charlie Baillieu, Anand Ramakrishnan and himself, Neurosurgeon Chris Xenos and Anaesthetist Richard Barnes.

The surgery took place at Monash Medical Centre's main campus on a Saturday so as not to delay or disadvantage local public patients, with a full theatre team of enthusiastic volunteers.

For more than seven hours, they worked to not only remove the mass, but also to rebuild Jhonny's nose using a bone graft from his rib, medialising his orbits which had been pushed apart by the sac and removing the large remaining flaps of unwanted skin.

"The mass was so large by the time we took Jhonny into theatre it took up space from his eyebrows to his upper lip and while his nasal airways were functioning normally, he had to move it out of the way to eat or drink," Mr Leong said.

"He was thus quite a small child so we waited for three months after his arrival in Australia to build up his nutrition to make sure he was strong enough to undergo such a major procedure.

"There were a number of stages required in this surgery and when we had planned it out we originally thought it might take up to nine hours, but in the end we were out in just over seven hours."

Mr Leong said the plastics team began with a bi-coronal incision from the hairline.

"We then dissected the facial skin to allow us to chase the mass all the way down through the frontal nasal bone to find the origin of the herniation and remove the sac.

"Chris Xenos then came in and resected the narrow connection between the herniated sac and the frontal lobe of the brain.

"After that, we closed the hole in his face with calvarial bone graft, absorbable plates, medialised his orbits, reattached both the medial canthal ligaments and harvested a rib to reconstruct his nose.

"We then had the task of dealing with a great deal of excess skin, most of which we cut away to create the most aesthetic result possible."

Professor Leong said Johnny had dealt well with the surgery, spending three days in UCI and four days on the ward without complication before being discharged to spend time recuperating with his mother at a Children First Foundation farm outside Melbourne.

After a number of joyful post-operative consultations, the child was given the all clear and he and his mother have returned to the Philippines.

Professor Leong described the surgery as a great result and said without it, there was a risk that any infection in the sac could have resulted in fatal meningitis.

He said Jhonny would be unlikely to require further surgery as he grew.

"His skeletal facial structure should grow normally and he might even get some catch up growth now that he can eat normally and I don't expect him to require further procedures," he said.

"Jhonny is a very bright and engaging child from a large family and while he had been teased about the deformity it seemed that he had also come to accept it so when it was gone, his reaction was almost understated.

"Yet surgery such as this is not just about the patient. It's also about rebuilding the family and their community and his mother was incredibly happy for him and that was wonderful."

Professor Leong has been a volunteer through Interplast for a number of years and has participated in 14 surgical trips through the Asia Pacific Region including Indonesia, Philippines, Tonga and Samoa.

He thanked all the team members for their assistance and also the hospital administration for supporting the endeavour.

From Left: Charlie Baillieu, Chris Xenos (with Jhonny) and James Leong.

"The administration at Monash Health has a very generous approach to cases like these and allow us to do a major pro bono case at least once a year and they deserve acknowledgement for it in a period of on-going budget pressure," he said.

"It was a great feeling to have the chance to change this little fellow's life, particularly in terms of having the chance to bring together all the expertise across the hospital – from the Plastics team to Neurosurgery, radiography, anaesthesia, ICU and nursing.

"When the word first spread about Jhonny's case and the day was chosen for surgery, volunteers from across the hospital put their hands up, relishing the chance to be of assistance, even though the surgery was likely to take up most of their Saturday.

"Surgery such as this, therefore, is not only very good for the patient, it's also very good for morale and very good for team spirit," Professor Leong said.

"This was the first large frontonasal encephalocele ever treated at Monash Medical Centre and certainly Jhonny was the youngest patient we have seen, so it was a great feeling to be able to change his life so dramatically."

Interplast is a non-profit organisation which conducts volunteer surgical team visits across the Asia Pacific Region and is supported by Rotary, the Australian Society for Plastic Surgeons and the College.

With Karen Murphy

AUSTRALASIAN SURGICAL LEADERSHIP SYMPOSIUM

Young leaders with an enthusiasm for surgery gathered for advice from peers

DOUGLAS BELL
ASLS EXECUTIVE MEMBER

The inaugural Australasian Surgical Leadership Symposium (ASLS) was undoubtedly a resounding success. Held on August 23 and 24 this year, it brought together more than 200 delegates from across Australia and New Zealand. It created a forum where students and junior doctors could listen to presentations from some our nation's foremost surgical leaders.

Speakers came from a vast array of backgrounds including medicine, public health, politics, biotechnology and low-resource medicine. Delegates also participated in a wide variety of surgical workshops and were even provided with a fun and entertaining social evening.

Registrars and consultants were on hand for the emergency skills workshops. It was a great opportunity to learn surgical and critical care skills in a low-pressure environment. In true surgical fashion, the workshop was named Dr Toughlove and the facilitators, most of them surgeons, dealt out nothing less than this to our unsuspecting medical students.

A key focus of the symposium was practicing medicine in the third world. We were most privileged to have our keynote speaker Dr. Barry Hicks speak to students about his work in Ethiopia. This added another dimension to the conference and everyone was most fascinated and impressed to learn of the innovation required to practice medicine and, in particular, surgery in such a setting.

This theme was then extended through the Desert Island workshops where delegates developed solutions to hypothetical scenarios based in low-resource settings. Their thought processes were guided and challenged by a wonderful panel of innovators who have worked extensively in the third world.

Another presentation came from the Executive Director of Surgical Affairs Dr John Quinn who represented the College and expressed support for the gathering of young leaders. Dr Quinn also discussed how to become involved and develop communications with the College.

One of the most popular workshop activities was the parliamentary style debate featuring each of our delegates. Topics included the sale of human organs, introduction of a 'fat tax' and whether recreational drugs should be legalised. There was a government and opposition side for each topic. Each debate was chaired by a panel of former politicians and barristers.

The range of ideas flowing from the students was most impressive and even our experienced panel admitted to learning something from what our delegates had to say. The activity really engaged students; so much so that many walked out now considering a career in law. Alas, perhaps the activity was a little too engaging! But rest assured that the ASLS team promptly reminded delegates that these skills are just as important in a medical career as they are in a legal one.

A unique feature of this symposium was the leadership stream. This was an entirely separate part of the conference designed specifically for the 22 leaders of each surgical student society from around Australia. Again, these students heard from a vast array of inspiring speakers and participated in a multitude of workshops.

However, the focus was more on leadership in medicine and how to run an effective student surgical interest group. It was also a wonderful collaborative effort and a first of its kind. It is only in the past few years that medical schools have begun to develop surgically oriented student groups. This is the first time that the leaders from each society have gathered formally to share their ideas. This establishes links across the nation. It helps to generate interest in surgery and medicine and produces doctors with a broader medical awareness. It was at this forum that the leader of next year's Australian Medical Student Association (AMSA) Surgical Interest Network (SurgIN) was elected by the council of surgical society leaders.

Certainly, exciting times lie ahead for both the future of the ASLS and for student surgical interest groups across the country. It is our hope that this becomes an annual event, which will continue to attract a diverse range of speakers and students. We hope that it continues to solidify the purpose of surgical interest groups and the connections between the groups across the country. We also hope that it continues to be a lot of fun for everyone involved!

Finally, we must thank the National E-Health Transition Authority, our Platinum Partner, as well as Healthscope, Ethicon, and our other generous partners for their support. The event would not have been viable without your faith, so thank you! Also, thank you to the speakers, countless hours of behind the scenes work from the executive and of course the students. You are the motivation and driving force behind the whole concept. Thank you and we hope to see you next year.

THE SURGEON'S DILEMMA

With a touch of Entropy

OPUS XXXV

FELIX BEHAN
VICTORIAN FELLOW

The definitive word in this title – ENTROPY – may confuse some people as it did myself when I had to ask Don Marshall what he meant. He was referring to the Professor Brian Cox television series, 'Wonders of the Solar System – The Arrow of Time', where entropy was used to explain the loss of thermodynamic resilience, resulting in nothingness, Don was referring metaphorically to the present financial state of our health service.

As Ernest Hemingway once said, "When people talk, listen completely as most people never listen" (and I like the other quote from Hemingway the storyteller when he said, "Any story based on truth is a good story and worth recalling"). During our regular entre nous discourses, this word surfaced when we discussed everything from Hippocratic altruism to the patient satisfaction and economic reality.

Many medicos generate higher incomes to support fancy tax deductions. Financial schemes orchestrated by smart accountancy firms (who always win on the way in and usually on the way out even before bankruptcy) range from property development to negative gearing, to aircraft leasing, art and primary producing, even with vineyards and some which end up in the 'bottom of the harbour'. Thus surgical procedures may be tailored by the flavour of higher financial rewards to service such schemes when simpler procedures should obtain.

Recently in the 'ANZ Journal' we see a microvascular procedure (with possibly four people, four hours and $4,000 later) for a digital defect. This prompted Don Marshall to observe, "Haven't they heard of a skin graft?" In my present forensic phase, the range of complaints by the patients for complex microsurgical procedures and scarring are not insignificant. In another IME I surveyed documents of an orthopaedic surgeon requesting insurance permission for a $10,000 wrist arthrodesis (marred by complications). On mentioning this to another surgeon he said, "Felix, I am in the wrong business."

In this field, Don asked me to review George Bernard Shaw's play, 'The Doctor's Dilemma', a story of the medical fraternity in 1906. It recounts a story of a knight of the realm, Sir Colenso Ridgeon, who has a new expensive treatment for tuberculosis, the scourge of the time. This new technique was restricted to 10 patients and when this limit was to be exceeded by two more cases (one an ailing medical colleague and the other the husband of an attractive lady on the London scene, une femme fatale dans la haute société, with whom he had an affair) – quite a quandary – embracing social issues of personal intimacy, financial return and dedication to his profession. This GBS 1906 reference to health care applies today – it should be equitable to all patients under a universal health system, from the cradle to the grave. The National Health Service took 40 years to come to fruition under the Attlee government.

In the national press recently, our current President of the RACS, Michael Grigg, has been quite forthright in his criticism of exorbitant surgical fees. Does that entrenched notion of the highest price equate to the best service? One may question this statement. Here are two commercial stories from my experience worth recounting.

In Venice over 30 years ago I was presenting my experiences of Desmoplastic Melanoma at the International Melanoma in 1983. Yes, in Venice where the spaghetti is "gold plated", the first unforgettable incident occurred when I went to pay a $A7,000 bill for hotel accommodation. The Concierge, when looking at my first card, inferred it was only for having lunch and luckily my backup card saved my bacon. The next snippet is even better. I passed the Gucci leather store behind San Marco – where one could have heard Monteverdi's madrigals of the 1610s. My wife admired the quality of the Gucci leather goods. Starting in Florence in 1921, his signature statement emblazoned in the window read, "THOUGH EXPENSIVE, THESE GOODS REFLECT QUALITY". Quite surprisingly the shop attendant closed the shutters immediatement when I was about to take a photograph. Did I look too sinister? And my mafia-like Fedora hat was in my suitcase.

When this Gucci principle is applied universally in surgery, troubles erupt when the fees do not match the quality. For those with the most experience this may be legitimate, but not those in the process of surgical maturation.

Even the President was stimulated to go to press recently criticising the trend of excessive surgical charges. In the 'Sunday Herald Sun' of July 20 this year, it talked about the $19,998 prostatectomy when the rebate is $1,935. Only nine per cent of surgeons in 2013 charged similarly. Then we have the $9,270 mastectomy charge when the rebate is $1,040. The President goes on to say that some ethical, well trained surgeons charged modest fees and are kept busy by a steady referral drain while those with less work charge higher in the hope of "fooling patients" into thinking they are delivering a higher quality service.

We must be grateful for those colleagues in the public system who survive on sessional payments. From my years at Peter Mac working with the doyennes of Head and Neck surgery and Radiotherapy, I learnt to enjoy this brotherhood, combining multi-disciplinary support, surgical collaboration to establish evidence based medicine as the foundation of treatment and subsequent publications – with level 4/5 evidence. We would regularly present our findings at the original COSA - Clinical Oncological Society of Australia. This cohesion of specialist minds is most enjoyable in its own right, in spite of the financial impedance of sessional payments. Thus the advancement in surgical science is rewarding while contributing back to the system at the source of their training.

I quote again how American insurance companies are deciding on post-mastectomy reconstructions a $US2,000 maximum per procedure, compared with a $US20,000 microvascular fee some may charge. Hence we have cost accountants determining surgical procedures, which is wrong. In Australia the microvascular breast rebate amount is $A4,000, not six times this amount as I have heard quoted recently. Is this the reverse of the Gucci principle? Time will tell.

Insurance traps

On the ABC program '7.30' recently the insurance company administrators have deleted completely post-mastectomy reconstruction as a rebatable fee and even excluded a 70-year-old gentleman from having a skin graft following excision of a mitotic defect of the leg. Now when clerks and insurance administrators are deciding on clinical management, the system fails.

As Don quoted Benny many years ago, because of the cosmetic elements and their implied exaggerated fees, the bookkeepers possibly are assuming that everything in the plastic and reconstruction section of the Medicare rebate has a cosmetic, therefore non-refundable element in treatment. If this attitude is allowed to persist it is wrong for the specialty, intolerable for the patients and exorbitant from a financial perspective.

The 'Herald Sun' also said that "out of pocket expenses in Australia were the third highest in the OECD." Recently one of the major Workers' Compensation Insurance companies was discussing the option of selling that part of their business to private health funds. Thus the value of a $400 graft of a fingertip compared with a $4,000 microvascular free flap may be called into question. Our hopes for the specialty will survive if charges are not excessive.

The President reflected this very image when he says well trained and well reputed surgeons have their own rewards – the College respect and their colleagues' respect, practising in this collegiate domain. With the patient's admiration, litigation evaporates, but there is nothing like the sting of an exorbitant fee to ignite criticism if anything goes wrong. In 1970 Benny said, "We have the best health service in the world with exposure to the private and public systems." This comment was reflected recently by the Nobel prize winner, Joseph Stiglitz – Professor of Economics at Columbia University on the ABC's 'Q&A' TV program in July 2014: "You have the best health system in the world, why change it?". There are moves afoot.

I conclude with a quote from Umberto Eco's 'The Name of the Rose'. The title is explained in those final paragraphs about the young acolyte and his moment of ecstasy with the village maiden whose name he could not recall, but she was the 'Rose' in the title. Similarly Don uses the word 'entropy' as a warning for our health service when exorbitant costs are not sustainable.

In closing I must say Don's mental sharpness is as crisp as ever; his recollections superb; he is the Patrician. This 'triton amongst the minions' still guides and advises all and sundry in the Plastic Surgical fraternity for the advancement of science.

And Confucius said in the 5th Century BC, "Work, when enjoyable, ceases to be a burden". What a burden when we are operating commercially rather than scientifically.

PS: Umberto Eco – "For every feared thing there is an opposing hope that encourages us." And finally:
Q: In haute couture circles "What did the 0 say to the 8?"
A: "Ma'am, that's a nice Gucci belt you have there."

HERITAGE REPORT

The College has recently received several gifts which will enhance the Rare and Historic Book Collection

MARIANNE VONAU
TREASURER

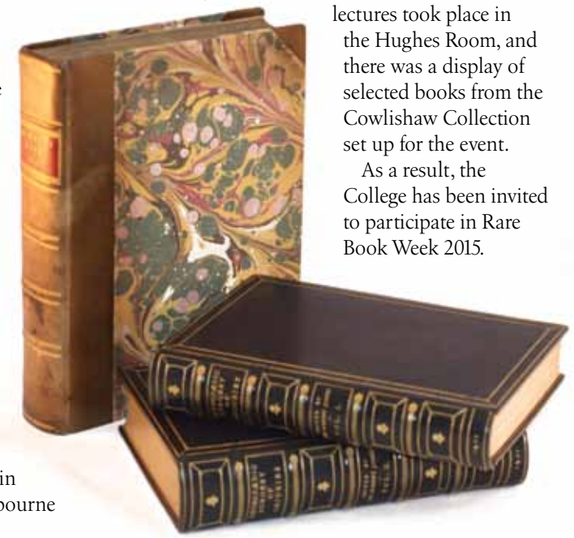
A very significant collection of books on orthopaedics came to the College in June. This collection was assembled over many years by John P. O'Brien FRACS, an orthopaedic surgeon now retired and living in Ireland. For a long time it resided with the Spine Society of Australia at the Adelaide Centre for Spinal Research, Institute of Medical and Veterinary Science. However, redevelopment of the building forced the Spine Society to relocate, and they could no longer house the collection. So the Society approached the College to ask whether the College in Melbourne would be willing to take the O'Brien books into its own collections and over a period of months agreement was reached to do so.

There are several hundred books in the collection, including important texts such as the writings of Hugh Owen Thomas, Percival Pott, (Sir) Robert Jones and (Sir) Arthur Keith. In the back of one book was found pasted a letter from Lord Lister dated 18 March 1908. The Collection is too large to be exhibited in its entirety, but significant items will be displayed in the cedar bookcase in the President's Meeting Room.

Past President Mike Hollands presented the College with a copy of Benjamin Travers' *An Inquiry into the Process of Nature in repairing Injuries of the Intestines* (London, 1812). Travers was a demonstrator in anatomy at Guy's Hospital and surgeon to the Hon. East India Company. The book is dedicated to Astley Cooper.

The family of the late Jim Morley donated, in addition to some instruments, his collection of books on orthopaedics, which included a fine three-volume set of *Bell's Principles of Surgery* (1815) and the 6th edition of Astley Cooper's *Treatise on Fractures and Dislocations* (1829).

Donald Hossack donated a copy of the limited facsimile edition of Matthew Baillie's *Morbid Anatomy of the Human Body* (London, 1799). This facsimile reproduces William Clift's copy of Baillie's work, now in the University of Melbourne Library, with a commentary by Professor Harold Attwood.



The College would like to thank these generous donors, especially John O'Brien, for their contributions to the rare and historic book collections.

Rare Book Week

Rare Book Week, held in July, has become an established event in the Melbourne cultural calendar. This year the College was asked to participate, with a specific request for a talk about the Cowlishaw Collection. In addition, because of the concurrence of the 20th International AIDS Conference, a request was made for a talk on a topic related to AIDS.

As AIDS is not a historic disease it was suggested that a good topic might be syphilis, which in many ways was the 19th century equivalent. Cas McInnes, Chair of the Heritage and Archives Committee, kindly volunteered to present a lecture on the older sexually transmitted diseases, using as his basic text John Hunter's *A Treatise on the Venereal Disease* (London, 1786). This took place on Monday evening and proved to be very interesting.

On Thursday evening Past President John Royle presented a lecture on the Cowlishaw Collection itself, which again proved to be an interesting and informative talk, with special emphasis given to Edward Jenner's *An Enquiry into the Causes and Effects of the variolæ vaccinæ a Disease … known by the Name of the Cow Pox* (London, 1798). Both lectures took place in the Hughes Room, and there was a display of selected books from the Cowlishaw Collection set up for the event.

As a result, the College has been invited to participate in Rare Book Week 2015.

Call for Abstracts

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.

E binh.nguyen@surgeons.org

IMPORTANT INFORMATION

TO SUBMIT AN ABSTRACT GO TO 'asc.surgeons.org' AND CLICK ON 'ABSTRACT SUBMISSION'.

THE CLOSING DATE FOR ALL SCIENTIFIC PAPER ABSTRACT SUBMISSION IS FRIDAY 30 JANUARY 2015.

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.

T +61 3 9249 1279

E binh.nguyen@surgeons.org.

SCIENTIFIC POSTERS

All posters will be presented electronically during the Congress and will be available for viewing on plasma screens in the industry exhibition. Posters will be placed on the Virtual Congress in addition to the abstract.

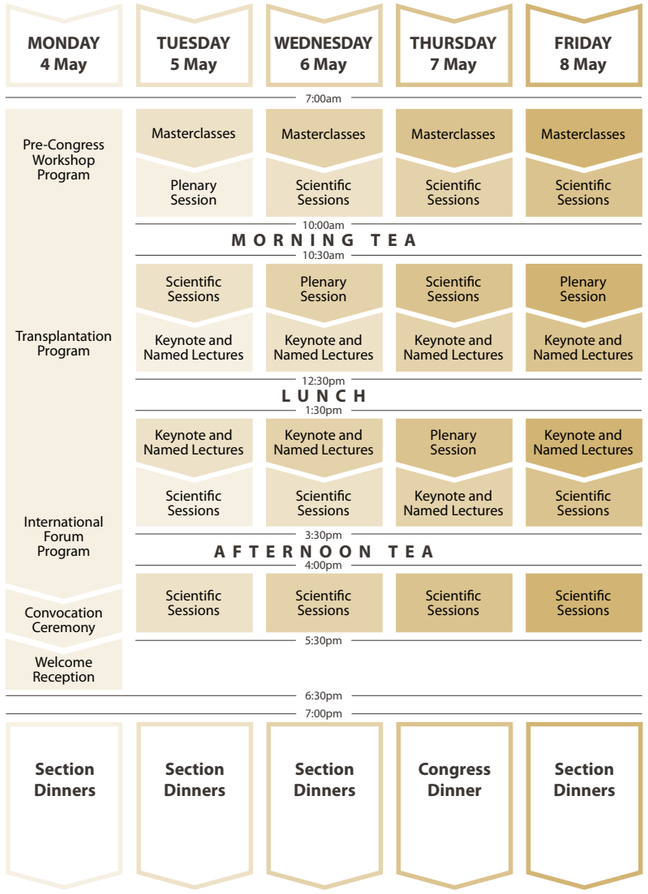
IMPORTANT DATES

Abstract Submission opens
October 2014

Closure of Abstract
30 January 2015

Closure of Early Registration
16 March 2015

RACS 2015 ASC Program Overview



ASC Executive

ASC Convener	**Stephen Honeybul FRACS**
ASC Scientific Convener	**Christobel Saunders FRACS**
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WA Regional Manager	**Angela D'Castro**

ABSTRACT SUBMISSION WILL BE ENTIRELY BY ELECTRONIC MEANS. This is accessed from the Annual Scientific Congress website 'asc.surgeons.org' 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 and Conclusion.
4. Non-scientific papers, e.g. 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 Congress 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 except cross-discipline.
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 each Section Convener. 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 to present and for their abstract to appear in the publications, on the website or the Virtual Congress.
13. Please ensure that you indicate on the Abstract Submission site whether you wish to be considered for:

SECTION	PRIZE
Bariatric Surgery (Trainees)	$500
Breast Surgery (Trainees)	$500
Cardiothoracic Surgery (Trainees, sponsored by MAQUET)	$500
Colorectal Surgery (Mark Killingback Prize for Younger Fellows & Trainees)	$500
Craniomaxillofacial Surgery (Trainees)	$500
Endocrine Surgery (Tom Reeve Prize - Trainees)	$500
General Surgery (Trainees)	$500
Head & Neck Surgery (Trainees)	$500
Hepatobiliary Surgery (Trainees)	$500
Paediatric Surgery (Trainees)	$500
Quality Assurance & Audit in Surgical Practice	$500
Rural Surgery (Trainees)	$500
Surgical Education	$500
Surgical History (Trainees)	$500
Surgical Oncology (Trainees)	$500
Transplantation Surgery (Trainees)	$500
Trauma Surgery (Trainees)	$500
Upper GI Surgery (Trainees)	$500
Vascular Surgery (Trainees sponsored by MAQUET)	$500

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	**Paediatric Surgery**
Breast Surgery	**Quality Assurance & Audit in Surgical Practice**
Cardiothoracic Surgery	**Rural Surgery**
Colorectal Surgery	**Surgical Education**
Craniomaxillofacial Surgery	**Surgical History**
Endocrine Surgery	**Surgical Oncology**
General Surgery	**Transplantation Surgery**
Head & Neck Surgery	**Trauma Surgery**
Hepatobiliary Surgery	**Upper GI Surgery**
Indigenous Health	**Vascular Surgery**
International Forum	

RACS ASC 2015 PERTH *with The Royal College of Surgeons of Edinburgh*

4 - 8 MAY 2015 Perth Convention and Exhibition Centre
Perth, Western Australia

THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH

RACS ASC 2015 Visitors

Bariatric Surgery	Dr Gerhard Prager	AUSTRIA
Breast Surgery	Miss Fiona MacNeill	UK
	Professor Eva Weiler-Mithoff	UK
Cardiothoracic Surgery	Dr Silvana Marasco	AUSTRALIA
	Dr Marc Sakwa	USA
	Dr Jean-Philippe Verhoye	FRANCE
Colorectal Surgery	Dr Tsuyoshi Konishi	JAPAN
	Professor Robin McLeod	CANADA
	Professor Norman Williams	UK
Craniomaxillofacial Surgery	Dr Oleh Antonyshyn	CANADA
Endocrine Surgery	Dr Gary Hammer	USA
	Dr Akira Miyauchi	JAPAN
General Surgery	Professor Zygmunt Krukowski	UK
Head & Neck Surgery	Professor Chris Holsinger	USA
HPB Surgery	Professor Graeme Poston	UK
Indigenous Health	Asscoiate Professor Jacinta Elston	AUSTRALIA
International Forum	Mr Richard Villar	UK
Medicolegal	Dr Christopher Ryan	AUSTRALIA
	Dr Daniel Sokol	UK
Military Surgery	Mr David Read	AUSTRALIA
	Associate Professor Darryl Tong	NEW ZEALAND
Pain Medicine	Professor Ian Harris	AUSTRALIA
Quality Assurance & Audit in Surgical Practice	Professor Justin Dimick	USA
Rural Surgery	Professor Tom Cogbill	USA
Senior Surgeon Program	Emeritus Professor Max Kamien	AUSTRALIA
Surgical Education	Professor Anthony Gallagher	IRELAND
Surgical History	Mr Thomas Scotland	UK
Surgical Oncology	Dr Charlotte Ariyan	USA
Transplantation Surgery	Professor Pranjal Modi	INDIA
Trauma Surgery	Dr Tarek Razek	CANADA
Upper GI Surgery	Mr Shaun Preston	UK
Vascular Surgery	Professeur Stéphan Haulon	FRANCE
Women in Surgery	Ms Annette Holian	AUSTRALIA
	Mr Damon Klotz	AUSTRALIA
	Dr Margaret Sturdy	AUSTRALIA

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Letter to the Editor

A worthwhile, noble profession

I write regarding the article in *Surgical News* (August edition Vol 15 No 8), 'What to expect in a Surgeon'.

Surgery is a noble profession! Patients expect the best from his or her surgeon.

Surgeons should behave and give a service better than anyone else in the community.

There are many requirements from dress, speech, general behaviour in and out of the hospital and consulting rooms to communications and the highest surgical ability.

We should try to give what the patients expect and to be a peer in society.

We should maintain our training so we can use the best methods, the best equipment and always the best of our ability so that we can be looked up to as a pillar of society – not only medical, but in the wider field. It is not easy, but it is worthwhile!

Donald Beard
South Australia

Your RACS member benefits deliver great value with health insurance from HCF

HCF offers RACS Fellows and Trainees great value for money with a range of extra benefits on private health insurance plans.

In fact, HCF has been awarded CANSTAR's national award for Outstanding Value Private Health Insurance for the last five[1] consecutive years, so why not reassess your options today?

Benefits for RACS Fellows and Trainees include:

- 5% discount[2] on Hospital and Extras Products
- No hospital excess payable for accidents or dependent children
- Free health and wellbeing programs with My Health Guardian
- High benefit limits on dental, optical, physiotherapy, chiropractic and osteopathy

For further information on your benefits, please contact Member Advantage:

Call 1300 853 352 (Australia) or 0800 453 244 (New Zealand)
or visit www.memberadvantage.com.au/racs

Member ADVANTAGE®

1) Source: www.canstar.com.au. 2) HCF health insurance products available to Australian residents only. Discount applicable to new and current HCF health policies only. Correct as at 09/08/2014.