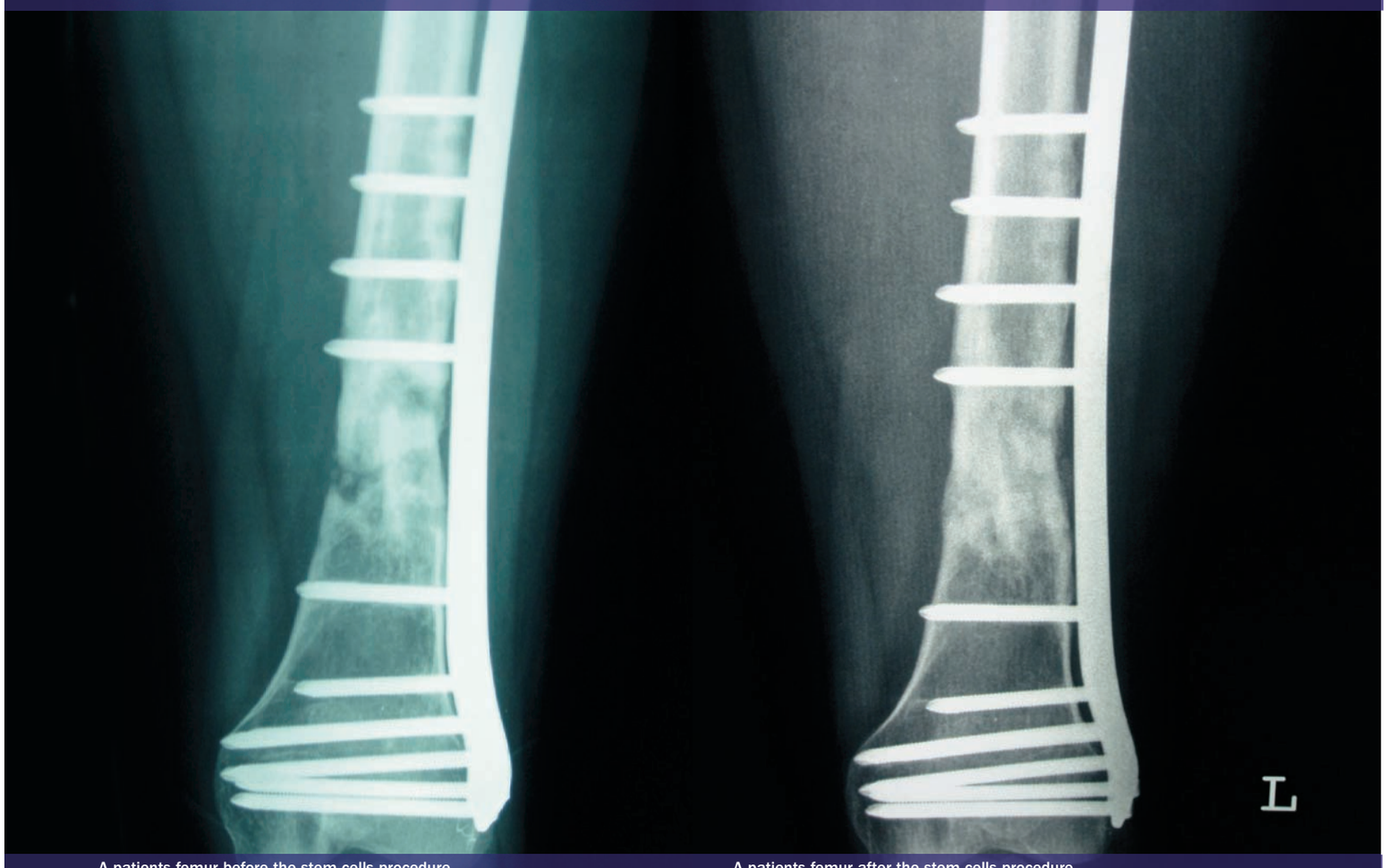
THE ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

SURGICAL NEWS

Vol:9 No:8 September 2008

September Highlights:

Stem cells heal broken bones, page 26



A patients femur before the stem cells procedure

A patients femur after the stem cells procedure

The College of Surgeons of Australia and New Zealand

2008 professional development calendar

WINDING DOWN FROM SURGICAL PRACTICE

Friday 10th October 2008
Radisson Hotel, Darling Harbour Sydney

Are you amongst a growing number of colleagues contemplating or in the process of winding down from surgical practice? A 2005 Surgical Workforce Survey found that almost 1 in 7 Fellows were not participating in the surgical workforce or had reduced participation due to phasing into 'semi retirement'. This workshop helps you plan for the futrue. Sessions include retaining contact within medicine, keeping health after retirement, legal aspects of closing a surgical practice, taxation perspectives and superannuation structuring and investment options. With speakers including retired and current Fellows, lawyers, financial planners and Australian tax office representative, the workshop is a must for any Fellow considering 'winding down'. Partners are welcome to attend and are eligible for member's rates.

Proudly sponsored by Odyssey Financial Management & Tress Cox Lawyers

PRACTICE MANAGEMENT FOR PRACTICE MANAGERS

Friday 10th October 2008
Radisson Hotel, Darling Harbour Sydney

The final Practice Management for Practice Managers workshop for 2008 will be held at the Radisson Hotel, Darling Harbour on 10th October. The workshop covers issues such as practice systems, staff and HR issues, developing a patient centric practice and mitigating medico legal risk. Both experienced practice managers and those just starting out will benefit from this valuable half day learning opportunity. Fellows are also welcome to attend. *Proudly sponsored by the Health Communication Network*

RISK MANAGEMENT – MASTERING INFORMED CONSENT

Saturday 8th November 2008
Royal Australasian College of Surgeons Melbourne

This full day workshop challenges surgeons to listen, reflect and identify techniques to confirm patient understanding of surgical procedures and develops the idea of consent as a two-way conversation between the patient and the surgeon. This workshop will help you to give clear and easily understood information to all your patients and assist in decreasing your risk of litigation.

QLD
26 Sept – SAT SET, Coolum *(GSA Meeting)*

NSW
2 Oct – SAT SET, Wagga Wagga *(PSA Conference)*
10 Oct – Winding Down from Surgical Practice, Sydney
10 Oct – Practice Management for Practice Managers, Sydney
23-25 Oct – Surgical Teachers Course, Sydney

VIC
24 Oct – SAT SET, Traralgon *(Victorian ASM)*
8 Nov – Risk Management Foundation: Informed Consent, Melbourne
15 Nov – Communication Skills for Cancer Clinicians, Melbourne

SA
19 Sept – Practice Management for Practice Managers, Adelaide

TAS
3 Oct – SAT SET, Hobart
14 Oct – SAT SET Hobart (Orthopaedics)

NZ
16 Oct – SAT SET, Palmerston North

**Supervisor and Trainer for SET Courses (SAT SET)

Surgeons as Managers
Friday 3rd, Saturday 4th & Sunday 5th October
Shangri-la Resort Cairns

FURTHER INFORMATION
Contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit the website at www.surgeons.org select the Fellowship and Standards menu, click on Professional Development then 'Workshops and Courses'. Easy online registration is available for all workshops.

President's Perspective

Regional relationships

As the health systems of Thailand and Malaysia mature there will be opportunities for training and service collaborations

Ian Gough, President

Regional relationships

The College is attempting to develop a stronger profile within the surgical communities of Asia and following the Conjoint Annual Scientific Congress in Hong Kong in May, I have had further opportunities to interact with the Colleges in both Thailand and Malaysia.

Our relationship with Thailand has been at a significant level for a number of years with high level involvement at their Annual Scientific Meetings and also in delivery of the Early Management of Severe Trauma (EMST) courses. The Thailand College will substantially support attendance by our Younger Fellows each year to continue to develop these connections and I would encourage this most worthwhile activity. Equally the Academy in Malaysia has established itself at a very credible level with its standards. As the health systems of both of these countries rapidly mature substantial opportunities for training and service collaborations will certainly arise.

Professor Dato Khalid Kadir, Master of the Academy of Medicine of Malaysia & Professor Ian Gough at the awards ceremony

The regulatory world in which we work

It is interesting to reflect on the regulatory environment and the intertwined relationship of academies, colleges, regulatory bodies and legal authorities that exist not only in the Asian countries but the increasing complexity in most countries across the world.

In some countries surgical training is provided by universities or academies as distinct from the College structure that we have in Australia and New Zealand. Regulatory bodies that are statutory such as in Hong Kong or Canada, provide a robust approach to the interpretation of requirements for specialist registration.

The interface with the professional groups that determine the standards can be variable and often in flux. One only needs to look at the dynamic situation between the General Medical Council (GMC), the Postgraduate Medical Training Board (PMETB) and the Colleges in United Kingdom, to see how groups can suddenly be established with enormous confusion being created. At this point the United Kingdom model is still in substantial turmoil and disaster control. Could this happen to Australia and New Zealand?

As practising surgeons there is often a substantial disconnect with the regulatory world. We are all aware of the Medical Boards and their important function. However, we may not be aware of the labyrinthine relationship between all the medical boards, the Australian Medical Council and the New Zealand Medical Council.

Consequently, the College continues to support National Medical Registration in Australia with the strongest links possible between Australia and New Zealand. We certainly require as much commonality in the application of standards and processes as possible. The approach to visas, working conditions and standards is so variable it is creating problems for the community, hospitals and surgical services. Of course we need to be very careful of how these new reforms are implemented. One thing we can learn from overseas is that if the profession has bureaucratic models imposed on it, loses control of standards, or is sidelined, then the situation usually gets worse – a lot worse. So with National Registration in Australia the College remains supportive but must be continue to be involved as the legislation and models are clarified. We encourage all surgeons to be involved in the regional consultative processes so the complex issues of delivering health services are fully understood and not ignored.

Practising surgeons disconnect with the regulatory world continues with issues of International Medical Graduates (IMGs). There is no doubt that the workforce of medical professions including surgeons is now very dependent on attracting practitioners from overseas. This will possibly change over time now that medical graduate numbers from our own universities are increasing. However until 2020 assessing and supporting IMGs will be an important role for all of us – surgeons, Colleges and Specialist Societies. These activities are now tightly described by the Australian Medical Council, the Australian Competition and Consumer Commission, and various Government agencies. →

President's Perspective


President Ian Gough demonstrating work-life balance with a 83cm bonefish at Ningaloo reef, Western Australia. The fish was safely returned to the ocean

We should take time and care to support our newer colleagues who often are practicing in more remote areas with less than adequate hospital support and often dealing with issues in a differing cultural and linguistic frame. Recent media events have highlighted the importance of support, supervision and standards. These will always be our concern and the challenge is to identify more comprehensive ways for these to be delivered.

Regional issues

As I attend Regional Meetings there are constant themes that are being highlighted. These include the challenges of providing high quality training, workforce requirements and the ongoing tensions in the delivery of acute and elective surgery.

The actual definition of a surgical service is being changed and this is applying particularly to the rural areas. On call rosters need to be able to reflect work-life balance, access to continuing professional development, avoiding de-skilling or burnout. A service of four surgeons or ready back up from a metropolitan service may now be required for a surgical service to exist. Consequently, the critical mass of a regional health service and the population to support it are becoming more important. In areas like Western Australia where 26 per cent of the population live in the rural areas but only nine per cent of surgeons practice rurally, this is becoming critical. Combining these issues with social isolation, children's educational challenges and family expectations indicates that there is a substantial question of how rural based surgery is delivered.

Acute surgery

Another model of surgical service delivery that is being challenged relates to acute services. There is an increasing trend to highlight how elective surgery and acute services are best dealt with in separate facilities that are dedicated to that purpose. Many surgeons would say that is the way they have approached their private (more elective) and public (more acute) work for many years. The senior members of the health departments and more experienced health ministers are now starting to clearly articulate these themselves and then combine that with increasing dependence on utilising the private sector for waiting list initiatives and also ensuring that the private sector supports more training. That delineation of service is certainly one component. Another is ensuring acute surgery is respected as having its own particular scope of practice with innovative on call arrangements and adequate remuneration.

Task delegation

Whilst workforce issues remain with us, the increasing use of other health practitioners will be profiled. The College continues to support task delegation within a surgical team lead by a surgeon. The College does not support task substitution. As physician assistants are piloted and possibly broadly introduced it will be important that the surgical team is highlighted. There is no doubt the model has been successful overseas. The challenge will be to ensure that the model is appropriately introduced into Australia and New Zealand. All health professionals must be competent to deliver care within the scope of their designated practice and patient safety is paramount

Beyond the rogue?

There have been a number of cases highlighted in the media over the past few years where medical practitioners have inappropriately carried out clinical activities that have produced outrage in the community and media. In analysis it is more often the hospital system or regulatory mire that has let us down than other issues. If hospital Chief Executives had as much concern about the standards of clinical care in their hospital as they did of balancing their financial ledgers we would work in far better organisations. However the response of governments is always to regulate and legislate. New South Wales has legislation mandating reporting of doctors by doctors due to be introduced in October 1 and Queensland has indicated that it will follow. Is this the answer to hospital management not being responsible for the clinical care that occurs? Will it appropriately reveal people who need support, re-training and only rarely removal of a livelihood? Complaints based systems tend to be too late in identifying problems and patient safety will be better ensured by regular peer-reviewed performance reviews.

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Dramatic changes to Medicare levy

The Government's proposed Medicare levy reconfiguration will further strain an already over-crowded public hospital system

Ian Dickinson, Vice President

As was noted in the June edition of *Surgical News*, the Rudd Government's first budget in May outlined dramatic changes to the Medicare levy surcharge thresholds (MLST) that have the potential to further strain an already overcrowded public hospital system. In response to overwhelming concern from a large and diverse number of organisations, the Senate referred these proposals to the Senate Standing Committee on Economics for review.

Along with other organisations, the College has forwarded a submission to the committee outlining our concerns that the proposed changes to the MLST will result in significant reductions to private health membership which will in turn add to a surge in demand for medical services in the public hospital system.

Below is a summary of the College's submission to the Senate Economics Committee, followed by developments since June. A copy of the entire submission is available on the College website.

Summary of submission to the Senate Estimate's Committee: July 2008

The level of private health insurance (PHI) membership in Australia has a direct effect on the equitable supply of medical services to its citizens. In particular, reductions in PHI result in higher demand for public hospital services as persons with above average weekly earnings compete with lower income earners, aged pensioners and other persons in need for public hospital services. This form of overcrowding in our public health system results in delays in treatment and expansion of waiting lists for surgery that can result in prolonged discomfort and even unnecessary loss of life.

A particularly stark example of this scenario can be found in our recent history with the revamped introduction of Medicare in 1984. Our submission showed that changes in budgetary policy affecting Medicare have resulted in direct effects to the level of PHI, and therefore the availability of medical services to all Australians.

With the budget policy proposal to significantly alter the income thresholds for payment of the Medicare Levy Surcharge, we predict another period of overcrowding to Australia's public hospital system may occur. Our position is supported by widespread expert opinion from a range of respected bodies, including federal treasury economists, who themselves predict that 485,000 people will withdraw from PHI.

Clearly it is not the intention of the Rudd Government to cause strain in our public health system. While the new income thresholds will significantly reduce the current three billion cost from the PHI rebate, this is a false economy in the face of what could be major erosion to our public hospital system.

When taking into account the new increases to income thresholds (100 per cent for singles and 50 per cent for couples) in a period where both Employee Weekly Earnings and the Consumer Price Index (CPI) have shown considerably less growth, the new policy, while well-intentioned, is not in keeping with wage and price movements.

The new thresholds have the following anomalies:

- A disparity between singles and couples in the new income thresholds for payment of the Medicare Levy Surcharge, namely 100 per cent for singles, and 50 per cent for couples, and
- The percentage increases in thresholds for both groups is well in excess of increases to the CPI and Average Weekly Earnings since 2000.

Inquiry into the Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008

Information about the Inquiry

On 18 June 2008, the Senate referred the provisions of the Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008 to the Senate Standing Committee on Economics for report not before 26 August 2008.

This bill increases the Medicare levy surcharge threshold for individuals from $50,000 to $100,000 and for couples from $100,000 to $150,000. The increased thresholds will apply from the 2008–09 year of income and later years of income.

The inquiry will examine:

a. the impact of changes to the thresholds on the number of Australians with private health insurance (PHI), including an examination of how many will abandon their policies as a result and how many will not take up PHI in the future;
b. the modelling underpinning the decision and the veracity of that modelling;
c. the anticipated impact on PHI premiums and PHI products offered;
d. the impact of the change on the cost of living and the consumer price index;
e. including the threshold, PHI rebate and lifetime health cover on increasing PHI membership;
f. the anticipated impact of changes to the threshold on:
   i. the public hospital system including waiting lists and the financial requirements of state governments;
   ii. the ongoing viability of PHI, and
   iii. private hospitals.

Senate Economics Committee, June 2008

Note: Our submission outlined key changes to the health system from 1984 to the late 1990s, showing how policy changes have caused PHI take-up to both fall and rise (this was also outlined in the June Surgical News article). Key issues raised were the following:

- Reduction in PHI from 50 per cent to 30.6 per cent 1984 – 1998 after the introduction of Medicare.
- Introduction of the MLST in 1997 to reduce overcrowding in the public hospital system.
- Establishment of a Lifetime Health Cover (LHC) strategy to increase PHI membership. This included, the introduction in 1999 of the 30 per cent PHI rebate, a surcharge on private health cover for those aged 31 years and over who insured after 2000.

The above policies saw PHI rise to the mid-40s from the late 1990s to the present period.

Without doubt, adjustment of the Income Thresholds was a necessary requirement of this budget in order to take into account reductions in discretionary income which have been largely driven by external shocks to the CPI from extraordinary increases in the cost of oil and the downturn in the US economy.

What has surprised our College, economists, Treasury, and many other respected forecasters, is the breadth of the changes. Not only are the increases excessive, they bear no relationship to actual changes in discretionary income.

There have been numerous predictions from respected forecasters that the new thresholds will result in a new, and more debilitating, episode of overcrowding of the public health system. We concur with economic modelling from sources as diverse as Access Economics, Price Waterhouse Coopers and Treasury, that the proposed changes to the MLST will have a substantial impact on the public hospital system, with longer treatment times for patients, and an explosion of surgical waiting lists.

Conclusion and recommendations

In light of the adverse forecasts that the proposed changes to the income thresholds for the Medicare Levy Surcharge are expected to have on the public hospital system, the College's submission concluded by asking that the policy be modified. We believe a better outcome would include increases to the thresholds cost of living rather than arbitary increases above these levels. Furthermore, the College believes that in future the Medicare Levy Surcharge should be indexed yearly based on changes in the CPI. This will not only ensure a fair and equitable system, but will also put into place a non-partisan process.

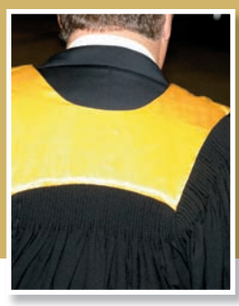
Inconsistencies in the Government's formation of the proposed new Medicare levy thresholds

Since the budget proposals to dramatically lift the MLST were presented to parliament in May, questions to the Senate Community Affairs Committee (4-5 June 2008) and the Senate Standing Committee on Economics (third June 2008) have revealed surprising new details on key outcomes of the changes. These include the following:

- While Treasury has revealed it expects 186,000 singles and 149,000 couples (i.e. 484,000 persons) will move out of private health cover, it has failed to take into account children exiting the private system. Taking into account Private Health Insurance Administration Council (PHIAC) data, inclusion of children would bring the number of people no longer covered by private health insurance to 700,000, not 484,000. This means an additional 216,000 persons requiring services in public hospitals.
- The departure of large numbers of persons from PHI also represents a loss of funding to the overall health system which has not been taken into consideration by Treasury forecasts.
- If MLST rates are adjusted to take into account changes to the CPI they would be $73,000 for singles, not $100,000.

Treasury's estimates of 484,000 persons leaving the private sector have not accounted for the addition of 216,000 children, while costs in lost revenue to the private hospital system have been totally ignored. Added to this is the lack of logic in raising the MLST for singles to an amount that is $27,000 greater than an adjustment for cost of living.

If the Government does not redress its proposed changes to the MLST we will witness further overcrowding to the public hospital system. The College will continue to take up this matter individually with senators.



I.M.A. Newfellow

The ANZ Journal of Surgery

It is not surprising in this electronic age to hear that more journals are heading online

"The orange comic is dead." That is what he said in the hallowed walls of the Council Room (the "he" being Professor John Hall, Editor in Chief of the *ANZ Journal of Surgery*). Now if I had said that I would have been ejected forthwith. The President did chastise him but then Professor Hall explained that there was to be a complete re-design of the journal, from cover to cover – and the covers themselves – and all was forgiven.

Professor Hall also went on to explain the intricacies of the journal and of the medical publishing industry in general. It is not surprising in this electronic age to hear that more journals are becoming online but the extent and speed of the transition is surprising. At the end of 2006, 31 per cent of library subscriptions to the *ANZ Journal of Surgery* were online and by the end of 2007 this number had risen to 45 per cent. This migration is expected to continue in the future.

I was amazed to see that the figures for downloads suggests that there are more FRACS surgeons in Edinburgh and Charlottesville, Virginia than in all of Australia and New Zealand. Each of these places had about 15,000 users. Professor Hall told me that the true explanation was that these places are portals for other centres in Europe and USA (I was glad that I asked the question afterwards and not in the Council Room as I am sure that my fellow councillors would have scoffed at my ignorance).

I was dismayed to learn that fraud exists in the serene world of medical publishing - not just in the world of the so called high net-worth individuals. Apparently some individuals use false addresses to get subscription at the personal rate and then re-sell them to libraries at the higher subscription rate (and at a profit to them). Action against one such agent in Taiwan resulted in 200 "new" subscriptions.

The philanthropic work of the College is even seen in the journal. The publisher allows research access to the journal and others that it publishes by more than 100 of the world's poorest countries.

It is clearly not a journal just for general surgeons. The top article in 2007 was "Cancer Stem Cells: A review" (I even read it). The fourth was "Current Controversies in the Management of Patients with Severe Traumatic Head Injury". I could not help wondering when I read this in the report from Professor Hall whether Mr. Nit Picker had read his own specialty article.

Impact factor! That is the important word in journals. This figure is used to assess the, well, the impact of the journal. As far as my poor mathematical brain comprehends it is a ratio of the number of cites of the articles divided by the total number of articles in the journal. For the ANZ Journal of Surgery in 2007 it was 0.881 but this was a 12 per cent increase on the previous year. Is this good or bad? Well if we look at a similar publication such as the *Annals of the Royal College of Surgeons of England* – their impact factor is 0.774. However if we look at the *Annals of Surgery* it has an impact factor of 7.678 – the highest ranked surgical journal. This figure means that on the average the articles in this journal are each cited about eight times over the next two years. So I suppose the report card for the *ANZ Journal of Surgery* would read "Improving but could do better".

Now what does all this cost? You all know that finance is not my strong point. My simplistic assessment of the balance sheet suggests that the Journal costs Fellows about $65 per year.

It would seem that in view of the increased usage of the electronic format and the redesigned cover "the orange comic" is indeed dead. However knowing the intransigence of some of our Fellows I could not help wondering if some of them may soon be agitating for the death of the blue comic or the rainbow comic or the e-comic. Some Fellows are never satisfied.

Law Commentary

Bullying: a workplace ailment

Australian organisations lose an estimated $21 billion a year due to bullying. And the medical profession is not immune

Michael Gorton & Ross Hodgens
Principals at Russell Kennedy Solicitors

All workplaces have statutory obligations to provide a working environment that is safe and without risks. "Bullying" has been identified as conduct which breaches this obligation and can be summarised as "behaviour that intimidates, offends, degrades, insults or humiliates a person, which includes physical or psychological behaviour". Bullying is usually repeated and unreasonable behaviour, directed towards a person or a group. Occupational Health & Safety legislation places employers under a clear duty to deal with these issues.

The medical Colleges, as workplaces, have an obligation to ensure that bullying does not occur within their own workplace. The Colleges, being responsible for the training and supervision of Trainees, have a clear right and obligation to raise issues of bullying where they are encountered. In the main, they will be matters for the workplace (hospitals), but could raise issues for the Colleges if conducted by their representatives. For example, a supervisor of training who bullied Trainees under his or her supervision, could accrue liability both to the employer (the hospital) and the College which he or she represents.

Bullying is an endemic issue in the Australian workplace. In 2003 the Victorian Government stated:

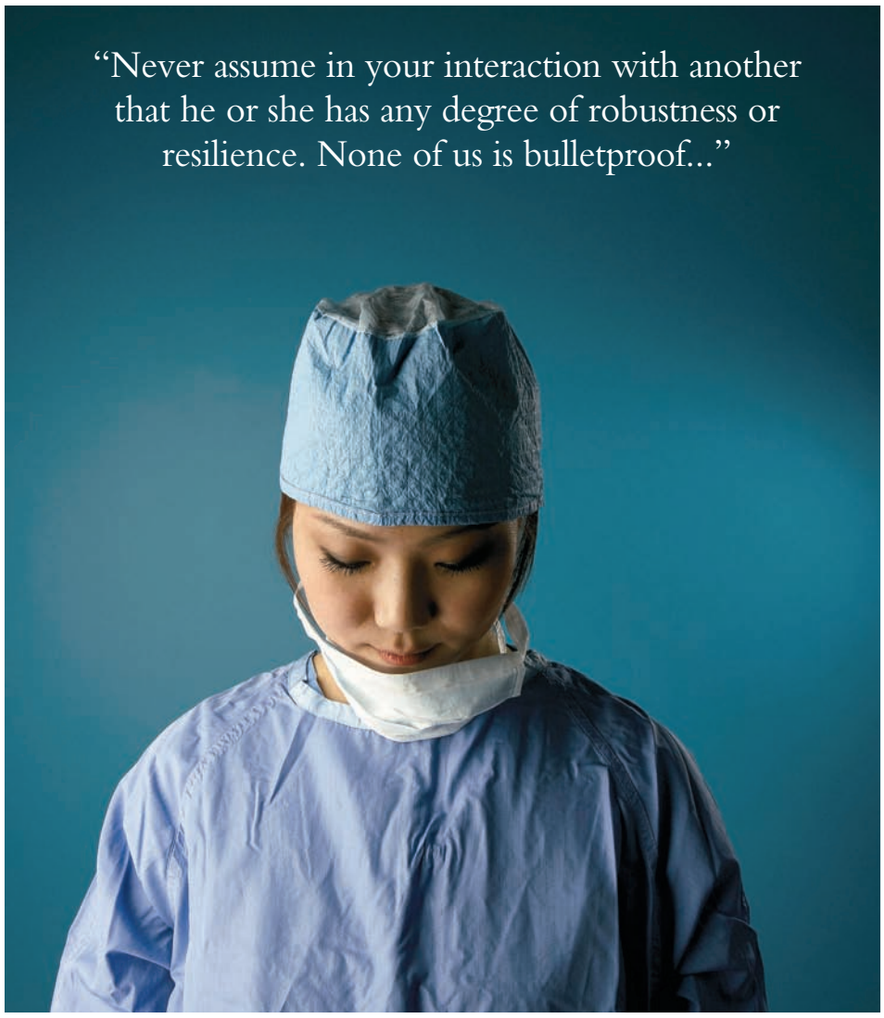
"Workplace bullying claims to the Victorian WorkCover Authority totalled 57,000,000 in 2001-2002. The full cost of workplace bullying and lost productivity in absenteeism is difficult to quantify, but some Australian wide estimates have placed it at a staggering $3 billion per year."

This estimate may be conservative, given a report in The Australian Financial Review in October 2003:

"Bullying is estimated to be costing Australian businesses up to $21 billion per year."

A study by Griffith University, *Safeguarding the Organisation against Violence and Bullying* (McCarthy/Mayhew), estimates that between 350,000 and 1.5 million people are victims of bullying in the Australian workplace. The study sought to quantify the cost of bullying to the Australian economy, and estimated:

- National costs from $6 billion to $13 billion, including that of hidden and lost opportunity costs, rising to between $17 billion and $36 billion per year were calculated.
- Costs to smaller organisations (less than 20 employees) that included direct, hidden and lost opportunity costs, were estimated at between $17,000 - $24,000 per annum. Cost estimates for larger corporations (1,000 employees) ranged from $600,000 to $3.6 million per year.
- The average cost of a bullying case, in lost worker productivity terms, ranged between $17,000 and $24,000.



Many would recognise and criticise the more obvious examples of bullying:

- verbal abuse
- initiation pranks
- displaying written or pictorial material to degrade or offend others.

However, many bullying tactics are not as clear cut, but are clearly intended to have the same effect of offending, degrading or humiliating others, such as:

- sarcasm and belittling one's opinions
- constant criticism or insults
- setting impossible deadlines
- changing work rosters to inconvenience others deliberately
- deliberately delaying or withholding information or resources
- persistent nit-picking and unjustified criticism
- constantly being singled out or targeted for practical jokes or gossip
- deliberately being ostracised, isolated or ignored.

Without exploring the various forms of bullying, which appear to be only limited by human ingenuity, it is useful to make some general observations.

1. Bullies, in general, are often not aware of the nature of their conduct. When confronted with an adverse finding arising from an investigation into their behaviour they cannot appreciate or accept the judgment of the investigator. Quite often they will assert that the investigation process constituted bullying of them and they may well leave the workplace under a stress claim.

Lesson: The intention of the bully in his or her behaviour is irrelevant to whether or not bullying has occurred. Bullies are often motivated by the best of intentions, with the worst of delivery.

2. Bullying is all about abuse of power. Those who bully do so because they can. While there are cases of upward bullying, generally bullies pick on those who lack power.

Lesson: Never underestimate the effect of your behaviour on those who have little power. A whisper from you at the top of the tree is heard as a shout by the powerless.

3. Never assume in your interaction with another that he or she has any degree of robustness or resilience. None of us is bulletproof, and your behaviour may be the straw that broke the camel's back.

Lesson: The unintended consequences of your behaviour will live with you for the rest of your life.

4. Many industries in Australia are low margin enterprises. The profit on a widget may be, and usually is, very small. The difference between success and failure in a competitive marketplace is the quality of your employees.

Lesson: Contented employees are more productive and less likely to change jobs. The bonus is that competitive edge which sees off the opposition.

5. The Federal Government is moving towards a national occupational health and safety regime. It will be an amalgam of the existing state and territory legislation, drawing, one expects, from the strictest aspects of each. The Occupational Health & Safety Act 2004 (Victoria) has significantly increased the personal exposure of officers (directors, board members, senior managers) and employees to fines and imprisonment for breaches of occupational health and safety laws – including bullying.

Lesson: You have personal liability.

What you can do:

The medical Colleges need to ensure that they have appropriate anti-bullying policies in place, both in relation to their own workplace, and in relation to the specialist training programs they conduct.

Colleges need to ensure that all staff and training supervisors undertake appropriate education and training programs based on those policies.

Supervisors of Trainees and International Medical Graduates need to be aware of their individual and collective obligations in relation to bullying issues, and the potential liability they create for themselves and for the College.

Colleges need to react to episodes of bullying where they are encountered. Action should be prompt and effective.

College Boards and Councils should ensure that individual members are also aware of their personal obligations, both to College staff and others, in the way that they conduct and perform their roles.

Regional News NZ

Jean-Claude Theis, Chair, New Zealand National Board

An inexact science

A more diligent approach to workforce planning is crucial if we are to keep pace with mounting surgical needs

As a College of Surgeons, we are responsible for training the right number and mix of surgeons to cater for the surgical needs of our communities now and in the future.

Currently we are seeing an increasing number of smaller provincial and some metropolitan hospitals who are struggling to appoint locally trained surgeons which has resulted in a locum epidemic and an influx of surgeons trained outside New Zealand and Australia. If there is a problem now what about the future?

Surgical workforce planning is an essential function of the College but might not have the priority it deserves. You might say it is not an exact science and we always get it wrong. However workforce planning is crucial just as succession planning in our surgical departments but at a national level. The aim should be that the supply of surgeons will be self sufficient so that we don't have to rely so heavily on non-locally trained surgeons. Currently 40 per cent of the New Zealand medical workforce is made up of International Medical Graduates.

In order to get it right, it has to take into account many variables some of which are difficult to control. Population growth and ageing, change in work practice and unmet need in some areas are some of the main drivers. When talking about surgical workforce, it is not simply about surgeons, but it clearly includes other members of the surgical team like anaesthetists, nurses and support staff. As a College we need to make sure that there is a coordinated planning process at a national level which takes a global view of surgical services delivery in the future.

Recently a surgical needs analysis was carried out by the New Zealand National Board with the aim of predicting the number of surgeons required by 2026. The volume of work was calculated by taking into account the present age specific surgical rates, population growth and an estimate of the current unmet need. The New Zealand population is predicted to grow by an average of 22 per cent which would mean that an increase of surgical volumes of around 39 per cent will be required. When weighted hospital discharges were used in the calculation the increase in workload was even higher at 54 per cent.

Across specialities the increase was variable from 19 per cent to 89 per cent with cardiothoracic and vascular surgery at the high end, ear nose and throat the low end and orthopaedics and general surgery closer to the average. Unmet need in this analysis was estimated at 26 per cent of the current surgical volume. When taking into account the population related increase the number of surgeons needs to grow from 616 to 820 but if unmet need is included the number needs to rise to 1055 in 2026. Similar findings have been reported in Australia and the US.

It is clear from this analysis that surgical capacity in New Zealand has to double in the next 20 years if the future surgical needs are to be met and if the current surgical standards are to be maintained. The challenge for the College is to convince the Government and Ministry of Health that an urgent national surgical workforce strategy and framework be developed in order to cater for the surgical needs of the future. The College on the other hand will have to look carefully how it can double its education and training capacity without compromising quality.

References: A. Raymont and J. Simpson. "Projections of Surgical Need in New Zealand: Estimates of the need for surgery and surgeons to 2026". *New Zealand Medical Journal* 6 June 2008, vol 121 number 1275: 11-18

College Conferences and Events Management

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I.A.A.S.

8th International Congress on Ambulatory Surgery
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MEETING ANNOUNCEMENT

PROVINCIAL SURGEONS OF AUSTRALIA

PSA 2008
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2 – 5 OCTOBER 2008

THEME: Updating General Surgery

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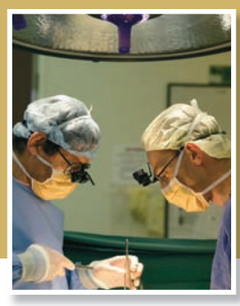
Clinical Practice



I went to work with a "cold"…

Consider staying at home with your cold – because you never know, it just might kill someone

Dawn E DeWitt

I went to work with a cold. My nasty sore throat woke me early, so I spent the time emailing our incoming clinical students: Get your influenza vaccinations before you start your clinical rotations - influenza kills people, vaccinating health care workers decreases mortality in nursing homes, and vaccination reduces other viral infections and days off work or school, and meets duty of care for oneself and others![1,2]

Sincerely, your (vaccinated) Clinical Dean

Sneezing and miserable, I considered staying home, abandoning the 20 complex, high-admission risk (general medicine) patients scheduled at the Aboriginal Health Centre and the hospital, many of whom had waited two-three months for an appointment. I thought of my mother - "Go to school, you're not dying, you only have a cold!" Memories of my only previous sick day resurfaced: as an on-call intensive care unit senior registrar - feverish, achy, sneezing, nose running like a faucet, I had decided this wasn't good for anyone. Caving at the prospect of working all night sick, I settled for guiltily calling in a fellow registrar. My "chief" had then rung - "How are you?" - Oh no, they think I'm skiving off! Peer pressure is strong stuff. So, this time, with patients waiting and my past lurking, I took some paracetamol, packed some tissues, and went to work.

My first patient, recovering from a lung resection for bronchiectasis after last winter's viruses almost killed him, is now surviving his first postoperative virus — not a drama. After warning him to stay far away and not shake my hand, I got through the rest of the day constantly apologising to my patients and colleagues, suppressing sneezes, washing my hands, and touching as few things as possible.

After clinic, an email explained the coincidental absence of my medical students - "Sick with cough, unable to attend". A colleague's voice from the doorway wryly observed, "You're sending the students mixed messages about getting vaccinated and duty of care while working with a cold yourself, potentially infecting everyone in sight". I responded blithely, "I'm more dedicated to my work than the students are (different generation), and besides, a cold never killed anyone"… but then, a moment of evidence-based-medicine horror hit me - That's true, right? Although my work-despite-a-cold ethic hasn't done me any harm (misery aside), I salved my skiving-off guilt with my greater desire to "do no harm", collected kilos of paperwork and my laptop, and retreated home for a day in isolation.

"You're sending the students mixed messages about getting vaccinated and duty of care while working with a cold yourself"

A hasty MEDLINE search for "common cold AND mortality" from 1997 to 2007 revealed 68 papers. Of these, the 13 highly relevant papers (gulp) fell into three categories: chronic obstructive pulmonary disease (COPD) or asthma complications (eight); childhood morbidity and deaths, largely related to cold medications (four); and HIV-related deaths (one).

I quickly discovered that over 50 per cent of COPD exacerbations are attributed to respiratory viruses - no big surprise.[3] More concerningly, rhinoviruses are now well established culprits causing significant morbidity and even mortality.[4-6] Indeed, only miniscule amounts of rhinovirus are needed to infect patients who then develop lung function changes typical of COPD exacerbations.[7] If COPD causes four per cent of all deaths per year in the United States (Australia should be similar) [8] and viruses cause half of COPD exacerbations, then about two per cent of mortality is potentially attributable to respiratory viruses. I began to worry about my patient with bronchiectasis.

On the other hand, at least I hadn't done any harm by prescribing overthe- counter cold medications with worrying potential for harm for any of my adult patients, let alone any children.[9] Hmm… non-steroidal anti-inflammatory medications seem to have evidence for relief (as long as I don't have hypertension, stomach ulcer, heart failure, or kidney disease),[6] so I think I'll take some.

What about vaccination? Reassuringly, at least for my reputation among my students and staff, several reviews supported influenza vaccination,[10,11] especially since influenza viruses account for up to 10 per cent of "common colds".[6] Distressingly, however, vaccination rates among health care workers are less than optimal - 82 per cent of doctors and 40 per cent of nurses had been vaccinated in one emergency department study (the best rates I could find).11

One dilemma remains. I, like 80 per cent of doctors, worked with an illness for which I would have "sick-listed" my patients,[12] but given that I care for under-served patients in a rural area with a shortage of doctors, is it worse to stay home and reschedule patients for appointments weeks to months later or to risk exposing them to my virus-laden self? Mortality rates for residents of rural and regional areas in Australia are 10 per cent higher than for city-dwellers[13] - largely due to health care access issues. My personal vaccination campaign should decrease the frequency of my own (and my students' and staffs') "colds" and, if I'm sick less often, this should increase access to me, thus decreasing my patients' morbidity and mortality. Sadly, the evidence suggests that if I were working in an intensive care unit or a medical ward with high-risk COPD patients, I could justify staying home, but in my general medicine role and doctor-shortage situation, the mortality trade-offs suggest that I should probably go to work with a cold next time too (sigh). But as for you, dear health care providers: first, do what I say and what I do (get vaccinated against influenza); and second, do what I say and not what I did, and consider staying home with your own cold-because, you never know, it just might kill someone …

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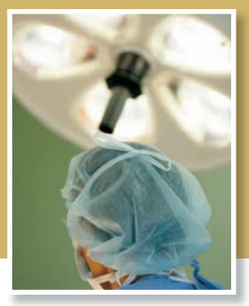
"DeWitt, Dawn. I went to work with a "cold"…. MJA 2008; 189: 91-92. ©Copyright

Research & Audit



Leaping into the CHASM

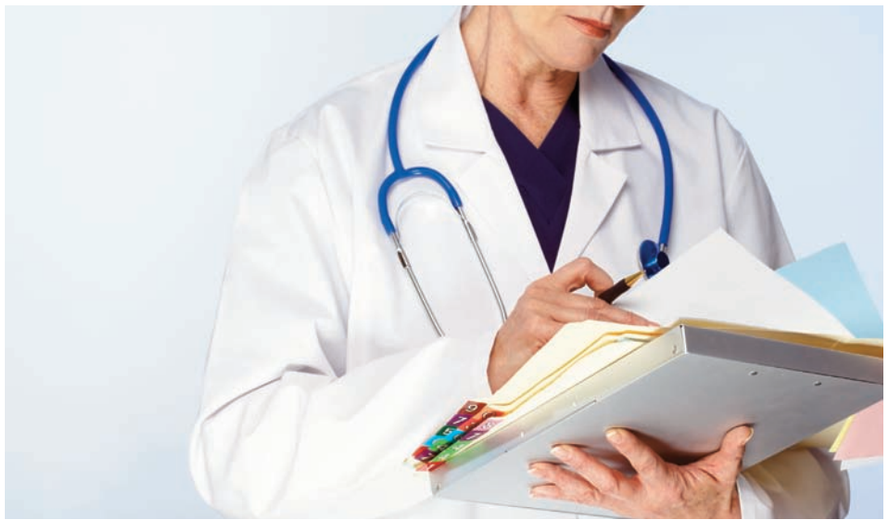
Collaborating Hospitals Audit of Surgical Mortality (CHASM) aims to be an indispensable information-sharing tool

Michael Fearnside,
Chair, CHASM Project
Clinical Excellence Commission

Following a pilot study in the latter part of 2007 in two Area Health Services (AHSs), Sydney West and Hunter New England, the NSW Audit of Surgical Mortality has commenced data collection from 1 January 2008. Throughout 2008 there will be a progressive enrolment of surgeons in the audit throughout New South Wales.

CHASM is a joint project of the New South Wales State Committee of the College, the Clinical Excellence Commission and New South Wales Health. The audit is overseen by a committee of members appointed by the Minister for Health. Associate Professor Michael Fearnside has been appointed Chair and the Deputy Chair of the committee is, ex officio, the Chair of the New South Wales State Committee of the College. The committee consists of 20 members including surgeons who are representative of the specialties and recommended in the main by the New South Wales State Committee, anaesthesia, clinical governance and forensic pathology. Two lay members have been appointed, Professor Belinda Bennett, Professor of Health Law at Sydney University and Dr Graeme Beaumont, an expert in air industry safety systems.

The audit is first and foremost a service for the Fellows. Each year the participating surgeon will receive timely, and, if appropriate, detailed feedback with constructive comment about individual deaths under his or her care whether an operation was performed or not. Secondly, each surgeon will receive an individual summary of deaths, first and second line assessment and categories of the areas of consideration, concern or adverse events and other demographic and comparative data. Thirdly, a booklet will be published of interesting or instructive de-identified case reports for general distribution. Participation in CHASM provides CPD points at one point per hour for the College triennial recertification process.



During 2008, Michael Fearnside, Chair of CHASM and Cliff Hughes, CEO of the Clinical Excellence Commission will be visiting all the Area Health Services to discuss the audit with surgeons and provide documentation and information. We have already completed visits to six of the AHSs and are available to speak at facilities if requested.

The CHASM project has statutory privilege under Section 23 of the NSW Health Administration Act 1982. It is an offence to release or disclose any information associated with the audit. This extends to all work of the committee and includes all data submitted to the project and the activities of anyone who undertakes work as a part of the audit.

CHASM is a voluntary, "opt in" process but we are hoping that all surgeons will embrace the concept. Similar audits are well under way in the other states and we anticipate the state audits will become part of a bi-national audit of surgical mortality across Australia and New Zealand.

Between 1 January 2008 and 31 July 2008, there were 458 deaths reported to CHASM and surgical case forms sent out to the surgeons. Of the surgeons who had a death under their care, 48 per cent are at present participating in CHASM – and we have yet to hear from 50 per cent. Only two surgeons have declined to participate. It is gratifying that the vast majority of participating surgeons have agreed to act as First Line Assessors and many as Second Line Assessors.

CHASM is well supported by a secretariat based at the Clinical Excellence Commission in Sydney. The secretariat consists of Ms Paula Cheng, Ms Barbara Herden and Ms Adeline Nguyen.

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Academic Surgery

Encouraging students to consider a career in surgery

Andre van Rij, Chair, Section of Academic Surgery

Student interest in surgery and surgical anatomy is of great importance to the future of New Zealand's surgical workforce. As students, we felt that surgical education was not given sufficient emphasis in the undergraduate medical curriculum in comparison with the other specialities. Hence, we took it upon ourselves to provide a service to the student body which would lift the profile of surgery and encourage it as a career option. This has been named the University of Auckland Surgical Interest Society (USAIS). Although a similar development has occurred in overseas medical schools, this student led initiative is believed to be the first in New Zealand and possibly Australia.

Aims of the Society

The aims of the UASIS were carefully considered by a group of interested students. These were:

Develop medical students' interest in a surgical career

Internationally, the proportion of medical graduates pursuing surgical training has fallen over recent years.[1] Students are increasingly showing a preference towards "lifestyle" specialties over surgery.[2] New Zealand has an aging population and cannot risk an understaffed surgical workforce in the future. The best way to ensure a healthy interest in surgical training in the future is by fostering surgically oriented students today. This has been done overseas through mentoring, surgical interest societies and research opportunities.[3,4,5] Our society aimed to promote women in surgery. Interest from female medical students has been shown to be lower when compared with their male counterparts[6]. Given that there is a higher proportion of females entering medical school, the workforce will require more of these students to enter surgery to maintain a sustainable service.

Promote and support excellence in surgical anatomy

Anatomy forms the foundation of surgery. Through modern medical education reforms, the emphasis placed on anatomy has decreased.[7] As a general consensus, senior doctors have noted a decline in student knowledge of anatomy.[8] Only a third of fourth and fifth year students feel confident that their knowledge of anatomy is adequate for safe medical practice.[9] Eighty seven per cent of students would like to revise anatomy during the clinical phase of their education.[9]

Allow greater exposure to the full extent of surgical fields

In New Zealand, surgical education, for very good reasons, is mainly focused in general surgery. Rotations in the other surgical specialties are very short or non-existent (cardiac, plastic and pediatric surgery). The surgical club planned to provide students exposure to the smaller specialties.

Support and guidance for student involvement and leadership in surgical research

Ongoing excellence in surgical research and academic surgery is imperative for the future of surgical education, training and advancement of the profession[10]. It is believed that an early introduction to academic surgery will help promote this as a career option

Create and maintain professional, academic and personal relationships between students and surgeons

Students are more likely to pursue surgical careers if they are supported by positive role-models from the specialty.[3] By creating such a connection at an early stage, students are able to utilise such mentors for academic and career advice.

Our Experience

The UASIS was formed in 2005 by the authors. The first year was quiet given our limited funds. The following year, we approached a number of medical affiliated companies to provide sponsorship. We were fortunate enough to secure sponsorship from KiwiSTAT locum agency, Medical Assurance Society, New Zealand Medical Association, Sanofi-Aventis, Cardinal Healthcare and Medipak NZ. These sponsors helped us provide refreshments for the events and a small gift for our speakers.

Organising events was helped by advice from Dr Andrew Wood, one of the founding members of the Oxford Surgical Interest Society, who is currently surgical registrar in New Zealand. It has also been very helpful to have the support of senior surgeons, such as Professor John Windsor, our society patron, who suggested possible speakers who supported us enthusiastically.

The speakers and topics to date have included the following:

- Mr Ian Civil (SET training scheme)
- Prof John Windsor (Surgical research and a career in academic surgery)
- Ms Anne Kolbe (Women in Surgery)
- Mr Murray Beagley (Plastic and Reconstructive Surgery)
- Mr Bruce Twaddle (Orthopaedic Surgery)
- Assoc. Prof. Andrew Hill (General Surgery)

The meetings were held at the University of Auckland School of Medicine buildings on weekday evenings. This enabled clinical students to attend after their commitments at the hospital. Attendance averaged 20 to 30 people. The most successful event was the Women in Surgery evening where attendance exceeded seating capacity. Feedback was positive from all the events. The success of UASIS is evidenced by the increasing membership and positive verbal feedback.

In addition the UASIS organised a session on suturing skills for students in the well supervised environment at the Advanced Surgical Skills Centre, which is part of the School of Medicine on the Mercy Hospital campus.

"The best way to ensure a healthy interest in surgical training in the future is by fostering surgically oriented students today."

The success and interest of our surgical club even spread around the country. Based on our club format and direction, a group of students at the Wellington School of Medicine have started a similar society.

International Experience

Surgical interest societies are relatively common at medical schools in the United States, such as Brown, Yale, Stanford, UCLA and Georgetown. These groups are strongly supported by the American College of Surgeons. Similarly, most universities in the UK have college affiliated surgical societies. Furthermore the Royal College of Surgeons of England provides an excellent forum for students to liaise with the college through the Medical Student Liaison Committee (MSLC).

During the final year of medical training all medical students are given the opportunity to travel and work overseas. One of the authors, while in England, made contact with committee members from Cambridge University Surgical Society and Barts & The London Student Surgical Society, the Pott's Barbers. This was very informative as it provided me with event ideas and invaluable tips on running such a society. An interesting event organised in Cambridge was the annual surgical specialities "debate" where surgeons from each speciality would proclaim why their specialty better the rest. The students were very positive about the club and the MSLC.

The Future

UASIS has provided students with a forum for career advice, surgical information, mentoring research links and practical experience. In the future, we intend to provide a platform for ongoing education in surgical anatomy. We also hope to form direct links with the College in a similar fashion to the MSLC in England. By working together with students and the UASIS, surgeons and the College will help to promote a strong, competent and sustainable surgical workforce.

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Without borders

On its 25th anniversary, Interplast Australia and New Zealand reflects on its aims and methods

One of Australia's most highly-regarded international non-profit medical programs – Interplast Australia and New Zealand – is this year celebrating its 25th anniversary. Set up by the College & Rotary District 980 in 1983, Interplast sends voluntary medical teams to carry out plastic and reconstructive surgery in developing countries.

Still supported by Rotary clubs across the two nations and with assistance provided by the College, Interplast Australia grew out of an initial aid project provided by American plastic surgeon Dr Don Laub. Asked to treat a child with a cleft lip while on holiday in Mexico, Dr Laub was spurred to action when he realised how many children there were with similar conditions and no plastic surgeons to treat them. In reaction, he gathered a group of surgeons to undertake the work on a voluntary basis.

Over the years, Australian plastic surgeons became involved the programs and began working with Rotary Clubs to set up a similar service here.

Professor Marshall, Chair of the Plastic and Reconstructive Division of the College at the time, helped found Interplast Australia and New Zealand as a partnership between the College and Rotary District 980 with the first team sent to Samoa that year.

Since then, the organisation has grown from a two person co-ordinating team to one that now employs eight staff. In its first ten years of operation, Interplast undertook an average of 14 programs a year to an average of eight countries. Now it runs almost 30 outreach surgical programs to an average 15 countries and facilitates the training of doctors both in the countries visited and in Australia.

President since 1996, Professor Marshall said he was both proud of the organisation's outstanding achievements as well as the system of governance that made the Australian organisation different from its counterparts in other countries.

"I think the key issue– outside the wonderful work done by Australian and New Zealand plastic surgeons – is that all of us who worked to establish Interplast here believed it should not be in the hands of one individual. I believed then, as I do now, that it should sit within the College with the involvement of the whole of the plastic surgical profession," he said.

"We are the only one set up this way, as a limited liability company with three College appointees, three Rotary appointees and one appointee chosen by the others to sit on the Board. This system of Governance has always meant that we have been in a position to seek and receive government assistance, to operate independently within the countries to which we are invited and to make the best decisions as to where we go and what we do within the funding available.

"We now have an office within the College staffed by a team who have great expertise, we have Non Government Organisation status and we comply with external audit requirements. We are the only body that operates this way and I am very proud of its success as an inclusive professional organisation.

"The Board is not just run by surgeons, but includes representatives from other professions such as lawyers, academics, business people and anaesthetists which I think is a very good model of governance. Sometimes surgeons can feel the need to run off and solve a problem but wiser heads prevail which makes for strong decision making."

While Interplast Australia and New Zealand began, like its US counterpart, undertaking mainly cleft lip and palate repair surgery, it has now broadened its scope to include reconstructive surgery particularly for burns scar contractures. More than 70 per cent of patients are children, many born with congenital abnormalities that can be repaired through relatively simple operations if such expertise is available.

> "Here plastic and reconstructive surgeons do a cross-section of work from trauma to cosmetic procedures and I think many of these surgeons feel that it is rewarding to get back to basic reconstructive surgery,"

Unlike some other service organisations, Interplast teams only visit a country upon invitation and work within each country's health system and in collaboration with local partners to conduct the surgeries and boost training.

Each country is assessed on the basis of need. Those with a small population that could never support a dedicated plastic surgeon are offered the services of visiting volunteer Australasian surgeons while larger countries are also assessed for their training needs.

During the 25 years of its history, Interplast Australia and New Zealand has trained hundreds of overseas surgeons, anaesthetists and nurses, sponsoring more than 60 to receive some of their studies in Australia, and has sent over 600 volunteers to 23 countries on more than 400 programs. Those volunteers have provided 28,000 consultations and performed more than 17,000 operations.

More recent achievements include:

- The development of a Laos Cleft Team from Mahosot General Hospital which now offers repair surgery in provincial centres;
- Assistance in the establishment of Burma's first post-graduate programme in Plastic and Reconstructive surgery scheduled to commence 2007; and

Interplast Country Co-ordinator for Sri Lanka Randall Sach with Interplast Vice-President David Inglis

Interplast President Donald Marshall, KCI Managing Director Peter Hickey, Interplast General Manager Marion Wright, Parliamentary Secretary for Foreign Affairs the Hon Bob McMullan & Interplast Ambassador Wendy Harmer

Naveen Somia, Interplast Vice-President Michael McGlynn & Rowan Gillies

Interplast Director the Honorable Dr Kay Patterson & the Honorable Alexander Downer

Timothy Edwards, Donald Marshall & Jim Katsaros

- The successful delivery of microsurgery training in Nepal in 2007 with Nepalese surgeons successfully performing a forearm flap procedure.

Some of the many countries visited by Interplast Australia and New Zealand volunteers include Papua New Guinea, Bangladesh, Kiribati, Vietnam and Sri Lanka.

During the past 15 years, Interplast has also played a significant role in the development of plastic and reconstructive surgery in Indonesia by being involved in their plastic surgical training program and also providing training in Australia.

Professor Marshall said the organisation continued to grow and develop with negotiations now underway between Interplast and the Australian & New Zealand Burns Association (ANZBA) who may wish to tap into the knowledge and infrastructure built up by Interplast Australia and New Zealand to conduct its own off-shore aid programmes.

A number of celebratory functions supported by KCI Medical, are to be held around Australia and New Zealand to celebrate the 25-year milestone with receptions already held in Adelaide and Sydney.

Professor Marshall said that more than half of the 300 plastic and reconstructive surgeons from Australia and New Zealand had now been involved in an international Interplast aid program.

"I think that is quite amazing and says something very positive about the profession in Australasia. Here plastic and reconstructive surgeons do a cross-section of work from trauma to cosmetic procedures and I think many of these surgeons feel that it is rewarding to get back to basic reconstructive surgery," he said.

"It is a great challenge and quite often the surgery is life changing, but more than anything, I think it shows that many surgeons, are willing to give their time and expertise if the opportunity is presented to them."

However, Professor Marshall saved his greatest praise for the members of Rotary for their continued financial support and the local health care workers who supported each team. He said that Interplast spent $1.5 million each year, with one-third of that provided by the Federal Government with the remainder raised by Rotary and through corporate private donations.

"The Rotary clubs that have supported the program have been marvellous and their efforts should be acknowledged and applauded. The nurses from each country are also amazing and are the mainstay of the various communities," he said.

"We couldn't work if they didn't put in an enormous effort behind the scenes. I am a great believer in the post modern idea of the bottom-up aid model, of helping at the grassroots, and the continued success of Interplast supports this approach. I reckon it's the model for foreign medical aid, built up over 25 years, fully supported by the profession and with the backing of the College and the Government."

Professor Marshall also particularly thanked Marion Wright, who heads up the office within the College, who had been working alongside him since the programs began so many years ago.

Successful Scholar

Pictured: Martin Wood

Stuart Morson Scholarship

The Scholarship has enabled Dr Martin Wood to learn new techniques in some of the busiest paediatric neurosurgical clinics in the world

Dr Martin Wood, a recent recipient of the Stuart Morson Scholarship in Neurosurgery, used the funding to spend time at one of the largest paediatric neurosurgery units in the world. In 2007, Dr Wood travelled to Paris to spend three months at the Hopital Necker Enfants Malade as part of his Post Fellowship Clinical Fellowship in Paediatric Neurosurgery. He said he spent much of that time watching the work of world leaders Professor Christian Sainte-Rose and Professor Michael Zerah.

"The basis of the trip was to learn new techniques and to watch world-class neurosurgeons working in probably the biggest and busiest paediatric neurosurgical clinic in the world. In particular, the unit treats a significant volume of complex brain tumours so that in terms of exposure, I saw there in three months the variety of cases it would take three years to see in Australia."

Mr Wood spent his time observing and assisting and is now back in Australia working out of the Royal Children's and Mater Children's Hospitals, in addition to having an adult neurosurgical practice at the Princess Alexandra and Mater Private Hospitals.

While his particular interest is in paediatric neurosurgery he also treats adult patients because of the limited number of paediatric cases.

"Most paediatric neurosurgeons in Australia also have to do adult neurosurgery to maintain an adequate caseload, so the experience of watching and learning from dedicated paediatric surgeons in Paris was extremely valuable. While there I studied different surgical techniques including novel aspects of microsurgery and the endoscopic surgical management of various diseases and conditions," he said.

"While we are lucky in Australia to have access to world class surgeons, equipment and health systems, we don't have the population to generate a high volume of uncommon conditions. In general, paediatric neurosurgery is a small part of neurosurgery and in Australia it is smaller again given our small population so you really have no choice but to go overseas to watch and learn at high-volume centres. But that of course is expensive so the assistance provided by the scholarship was extremely important."

The Stuart Morson Scholarship in Neurosurgery was established following a donation by Mrs Elisabeth Morson in memory of her late husband who was a Sydney-based neurosurgeon. The scholarship is designed to assist young neurosurgeons to travel overseas and further their neurosurgical studies by undertaking research or further training. It is awarded annually provided there is a worthy candidate and runs for six months duration. Mr Wood received $20,000 through the scholarship to help cover travel and accommodation costs.

He said he was grateful for the support of the College in allowing him to expand his knowledge.

"It was a fantastic experience and I certainly couldn't have gone there without the scholarship because it was an unpaid position. I went with my family so some level of income was needed and we lived in Montparnasse in the Sixth Arrondissement which was a ten minute walk from the hospital and a great part of Paris to get to know," he said.

Call for Abstracts

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78th Annual Scientific Congress
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Royal Australasian College of Surgeons

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Submission of Abstracts for Research and Invited Papers

Abstract submission will be entirely by electronic means. This is accessed from the College website www.surgeons.org/asc2009 and click on 'Abstract Submission'.

Several points require emphasis:

1. Authors of research papers who wish to have their abstracts considered for inclusion in the scientific programs at the Annual Scientific Congress must submit their abstract electronically via the Congress website having regard to the closing dates in the Call for Abstracts, the Provisional Program and on the Abstract submission site. Abstracts submitted after the closing date will not be considered.
2. The title should be brief and explicit.
3. Research papers should follow the format – Purpose, Methodology, Results, Conclusion.
4. Non-scientific papers, eg. Education, History, Military, Medico-Legal, may understandably depart from the above.
5. Excluding title, authors (full given first name and family name) and institution, the abstract must not exceed 1,750 characters and spaces (approximately 250 words). In MS Word, this count can be determined from the 'Tools 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 in 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 specialties under which their abstract can be considered. Submissions are invited to any of the specialties or special interest groups participating in the program (see page 3).
9. A 50 word CV is required from each presenter to facilitate the Chairman's introduction.
10. The timing, presentation and discussion of all papers is at the discretion of the Convener of each Section. Notification of the timing of presentations will appear in correspondence sent to all successful authors.
11. Tables, diagrams, graphs, etc. CANNOT be accepted in the abstract submission. This is due to the limitations of the computer software program.
12. AUTHORS MUST BE REGISTRANTS AT THE MEETING FOR THEIR ABSTRACT TO APPEAR IN THE PUBLICATIONS.

Important Note

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 an email confirmation 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 (binh.nguyen@surgeons.org) to determine why an email confirmation has not been received.

Scientific E-Posters

All posters will be presented electronically during the Congress and will be available for viewing on computer screens at the venue. The poster will also be placed on the Virtual Congress in addition to the abstract.

Research Prizes

Please ensure that you indicate on the Abstract Submission site whether you wish to be considered for the Mark Killingback Prize (best scientific paper in Colon & Rectal Surgery given by a surgical trainee or Younger Fellow). Other prizes to be awarded during the meeting are – the Tom Reeve Prize in Endocrine Surgery (best research paper from a trainee); the Surgical Education prize (for best research paper) or the C.R. Bard Prize (best research paper by a trainee related to hernia management, including incisional, hiatal and parastomal hernias in the General Surgery program). Other prizes to be awarded during the meeting will be indicated on the Abstract Submission site.

Important Information

The closing date for scientific paper abstract submission is **19 January 2009**.

The closing date for abstract submission by speakers invited by Conveners is **9 March 2009**.

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, Project Officer, for assistance on +61 3 9249 1279 or email binh.nguyen@surgeons.org

Important Dates

Abstract submission opens	2 October 2008
Closure of abstracts	19 January 2009
Closure of early registration	16 March 2009



78th Annual Scientific Congress
6 - 9 May 2009

Brisbane Asc 2009 Overview

	Tuesday 5 May	Wednesday 6 May	Thursday 7 May	Friday 8 May	Saturday 9 May
Breakfast session 7.00am - 8.20am		Masterclasses	Masterclasses	Masterclasses	Masterclasses
Session 1 8.30am - 10.00am	Workshop Program	PLENARY	Scientific Session	Scientific Session	Scientific Session
10.00am-10.30am		Morning Tea	Morning Tea	Morning Tea	Morning Tea
Session 2 10.30am - 12noon		Scientific Session 2	PLENARY	PLENARY	Scientific Session 2
12noon - 12.30pm		Pre-lunch Keynote lectures	President's Lecture	Pre-lunch Keynote lectures	Pre-lunch Keynote lectures
12.30pm - 1.30pm		Lunch	Lunch	Lunch	Lunch
1.30pm - 2.00pm		Post-lunch Keynote lectures	John Mitchell Crouch Lecture Keynote lectures	American College of Surgeons Lecture Keynote lectures	Post-lunch Keynote lectures
Session 3 2.00pm - 3.30pm		Scientific Session 3	Scientific Session 3	Scientific Session 3	Scientific Session 3
3.30pm - 4.00pm		Afternoon Tea	Afternoon Tea	Afternoon Tea	Afternoon Tea (ASC concludes)
Session 4 4.00pm - 5.30pm	4.30pm Convocation	Scientific Session 4	Scientific Session 4	Scientific Session 4	
				RACS AGM	
7.00pm - 11.00pm	6.00pm Welcome Cocktail Reception	Sectional Dinners and Younger Fellows & Trainees Dinner	Sectional Dinners	Congress Dinner	

Research Paper Specialties

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

Bariatric Surgery
Breast Surgery
Burns
Colon & Rectal Surgery
Endocrine Surgery
General Surgery
Hand Surgery
Head & Neck Surgery
Hepatopancreaticobiliary Surgery
International aid delivery (International Forum)
Medico-Legal aspects of surgery
Neurosurgery
Paediatric Surgery
Pain Medicine
Plastic Surgery: Reconstructive and Cosmetic Surgery
Rural Surgery
Surgical Education
Surgical History
Surgical Oncology
Thoracic Surgery
Transplantation Surgery
Trauma Surgery
Upper GI Surgery
Vascular Surgery
Women in Surgery




Surgeons and the Community

Brisbane 2009 Executive

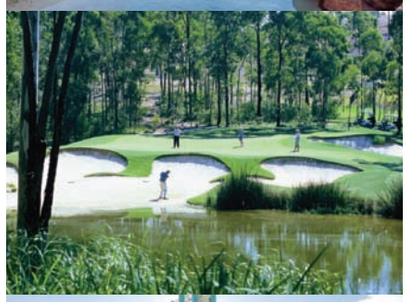
Convener	Assoc Prof Mark Smithers	
Scientific Convener	Dr Andrew Stevenson	
Committee Member	Dr Julie Mundy	
Committee Member	Dr Nicholas O'Rourke	
ASC Co-ordinator	Mr Campbell Miles	campbell.miles@surgeons.org
ASC Manager	Ms Lindy Moffat	lindy.moffat@surgeons.org
Queensland Regional Manager	Mr David Watson	david.watson@surgeons.org
ASC Secretariat	Ms Jennifer Hannan	jennifer.hannan@surgeons.org or telephone +61 3 9249 1248

Scientific Conveners

ANZBA (Burns)	Dr Michael Rudd
Bariatric Surgery	Dr George Hopkins
Breast Surgery	Dr Daniel de Viana
Cardiothoracic Surgery	Dr Morgan Windsor
Colon & Rectal Surgery	Dr Mark Doudle
Endocrine Surgery	Dr Teresa Nano
General Surgery	Dr Michael Donovan
Hand Surgery	Dr Shireen Senewiratne and Dr Daniel Rowe
Head & Neck Surgery	Dr Maurice Stevens
Hepatobiliary & Upper GI Surgery	Dr Robert Finch
International Forum	Dr Richard Lewandowski
Medico-Legal	Dr Terence Coyne
Military Surgery	Dr Peter Sharwood
Neurosurgery	Dr Martin Wood
Orthopaedic Surgery	Dr David Morgan
Paediatric Surgery	Assoc Prof Deborah Bailey
Pain Medicine	Assoc Prof Leigh Atkinson
Plastic & Reconstructive Surgery	Dr Gerard Bayley
Rural Surgery	Assoc Prof Richard Turner and Dr Roxanne Wu
Senior Surgeons	Dr Glen Merry
Surgical Education	Dr Julie Mundy
Surgical History	Dr Reg Magee
Surgical Oncology	Dr Andrew Barbour
Transplantation Surgery	Dr Jonathan Fawcett
Trauma Surgery	Professor Michael Schuetz
Vascular Surgery	Dr Douglas Cavaye
Women in Surgery	Dr Marianne Vonau

Racs Visitors & Industry Sponsored Visitors

Bariatric Surgery	Dr Gerhard Prager	Austria
	Dr George Fielding	USA
	Dr Christine Ren Fielding	USA
Breast Surgery	Professor Emiel Rutgers	Netherlands
Colon & Rectal Surgery	Professor John Monson	USA
	Professor Cameron Platell	Australia
Endocrine Surgery	Mr Peter Malycha	Australia
	Professor William Inabnet	USA
General Surgery	Mr Timothy John	UK
	Mr Mervyn McCallum	Australia
Hand Surgery	Dr S. Raja Sabapathy	India
Head & Neck Surgery	Dr Randal S. Weber	USA
Hepatobiliary & Upper GI Surgery	Professor Irvin Modlin	USA
Medico-Legal		
Military Surgery	Brigadier Jeffrey Rosenfeld	Australia
Neurosurgery	Professor Guilherme C. Ribas	Brazil
Pain Medicine	Professor Andrew Rice	UK
Plastic & Reconstructive Surgery	Dr Peter Neligan	USA
Rural Surgery	Dr Ollapallil Jacob	Australia
Surgical Education	Professor John Collins	Australia
	Professor Alastair Scotland	UK
Surgical History	Sir Barry Jackson	UK
Surgical Oncology	Professor John Thompson	Australia
Transplantation Surgery	Mr Giles Toogood	UK
	Dr Robert Montgomery	USA
Trauma Surgery	Professor Timothy Pohlemann	Germany
	Professor C. William Schwab	USA
Vascular Surgery	Dr Timothy Chuter	USA



Photos: Brisbane Marketing & Tourism Queensland

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W: **www.surgeons.org**

2008 Younger Fellows Forum, Hong Kong

Patrick Moore, Younger Fellows Forum Convenor 2008

The Younger Fellows Forum is an annual College event, traditionally held in May on the three days immediately preceding the Annual Scientific Congress (ASC). The inaugural Forum was held in NZ in 1982 with the aim to acknowledge and encourage the contribution of Younger Fellows.

The value of the Younger Fellows Forum has been proven time and again. Many past Forum attendees have succeeded in contributing to the College in various capacities. However the Forum is more than a breeding ground for College 'devotees'. It offers a unique opportunity for a diverse and representative group of Fellows to share ideas and experiences and debate issues that they believe affect their professional or personal lives. This can kindle the will to make changes that count in personal and professional development. It also provides Fellows with an insight into the workings of the College and an opportunity to develop a generous sense of Fellowship and friendship across surgical disciplines. Above all, the forum empowers Fellows to influence the College, either as individuals or collectively, in the way the College serves its Fellowship and the community.

This year the Forum was held in Hong Kong. Two College Councillors and eighteen Younger Fellows attended, as well as three invited guests: two Hong Kong Younger Fellows and one from the United States.

The Forum offered a packed programme designed to inform and promote discussion about issues that affect Younger Fellows. Mr Andrew Sutherland, College President, opened the Forum with an excellent presentation about the College.

Issues relating to auditing and credentialing were facilitated by Professor Guy Maddern (a College Councillor), Dr Carol-Anne Moulton and A/Professor Steven Gallinger. We were also fortunate to have the Global Medical Director of Bupa, Dr. Andrew Vallance-Owen, available to provide an international perspective of both hospitals and the medical insurance industry in relation to credentialing. These presentations stimulated significant discussion about how new surgical procedures are learnt and whether there needed to be a process whereby Fellows, particularly Younger Fellows, could become credentialed in new surgical procedures.

Photos: Brisbane Marketing & Tourism Queensland

Associate Professor Julian Rait, Vice President of MDA National, spoke about the impact of burnout on physical and mental health. This provoked speculation about how we will manage our surgical workforce in the future. Mr Daryl Harkness, Treasurer of the Medical Technology Association of Australia (MIAA) and General Manager of Johnson and Johnson Medical, presented 'Interactions with Industry'. He raised issues in relation to ethical behaviour on the part of industry and medical professionals, which were hotly debated.

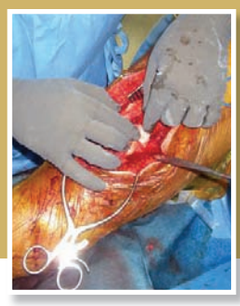
It is not often that Fellows are able provide direct feedback to the College. However, when Professor Ian Gough presented 'The Good, The Bad, and The Ugly' in regard to the Surgical Education and Training program (SET) and Professor Spencer Beasley, Chair of the Board of SET, and Dr Ian Dickinson, Chair of the Professional Development and Standards Board, spoke about problems relating to underperforming Trainees and surgeons, we were able to 'tell it like it is' and discuss solutions to the issues we encounter at the 'coal face'.

We were also given insight into how American surgeons are dealing with similar issues when A/Professor Scott Le Maire from the Association of Academic Surgeons used US examples to provide some guidance as to what Younger Fellows could achieve as a group.

As well as providing an opportunity for Younger Fellows to discuss issues, the Forum allows Fellows to relax and have fun. This year's programme featured Dragon Boat Racing – a great team building exercise thoroughly enjoyed by all. Sitting two abreast with a coach at the front and a steersman and a drummer at the back, the two teams paddled furiously and raced to reach the finishing line. Despite urgings and rowdy protests, the series was declared a draw.

The Younger Fellows Committee would like to acknowledge the ongoing support of College Council and the generous sponsorship provided by Johnson & Johnson Medical, MDA National and Tyco Healthcare in helping to make this year's Younger Fellows Forum so successful.

Nominations will soon be sought for the 2009 Younger Fellows Forum in Brisbane, 2-4 May. Contact Glenda on +61 3 9249 1122 or email PDactivities@surgeons.org for more information.



Stem cells heal broken bones

We have the potential to save millions of dollars in terms of theatre time, hospital time and the time taken for patients to return to work

Melbourne orthopaedic surgeon Richard de Steiger has led one of the world's first successful clinical trials to use stem cells harvested from the bone marrow of patients to repair the poor union or non-union of fractured bones.

Six men and four women participated in the trial based at the Royal Melbourne Hospital. All had serious fractures of the tibia and femur that would not heal following surgery, one patient in pain and on crutches for more than three years. Within months, using the stem cell technology, the bones had united.

Mr de Steiger, the principal investigator, said the process involved extracting stem cells from the pelvis of each patient using a needle in a painless day procedure. The cells were then sent to a laboratory based at the Peter MacCallum Cancer Institute to be multiplied using a new technique.

"This technology allows us to use an IgG antibody which identifies mesenchymal precursor cells (MPCs) which are the stem cells that can grow into bone," he said.

"Those cells were then extracted from the sample cultured and multiplied to create up to 225 million autologous MPCs.

"After that process was complete, which takes about four to six weeks, the patients were brought back into theatre and those cells were put into the exposed fracture site.

"All the patients had metal rods and plates inserted previously to help repair the fractures so the MPCs were placed on a sponge and packed around the injury. "The substance is quite viscous, slightly thicker than honey, and the cells remain at the fracture site to form new bone."

Mr de Steiger said that the process could obviate the need for painful bone grafts and could reduce the usual healing time for fractured bones. The trial began in March 2006 and was completed in July this year.

According to Mr de Steiger, the ten patients involved had suffered 11 fractures.

Mr de Steiger adding Stem Cells to the carrier

"The fact that it worked in eight out of ten patients, the fact that it did prevent all these people from having a second operation is exciting."

One man fractured both his tibia and femur with only the tibia healing after the treatment while another patient required further surgery. Eight achieved full bone regrowth.

One patient had fractured his tibia in a motorbike accident in 2005. Despite the placement of a rod in his tibia, the bone failed to heal and he was facing further bone graft surgery before agreeing to participate in the trial. After receiving the stem cells he was able to walk without crutches and is now pain-free and able to play football.

Mr de Steiger said that while the results of the trial were exciting, it was simply the first phase of understanding the full potential of the technology.

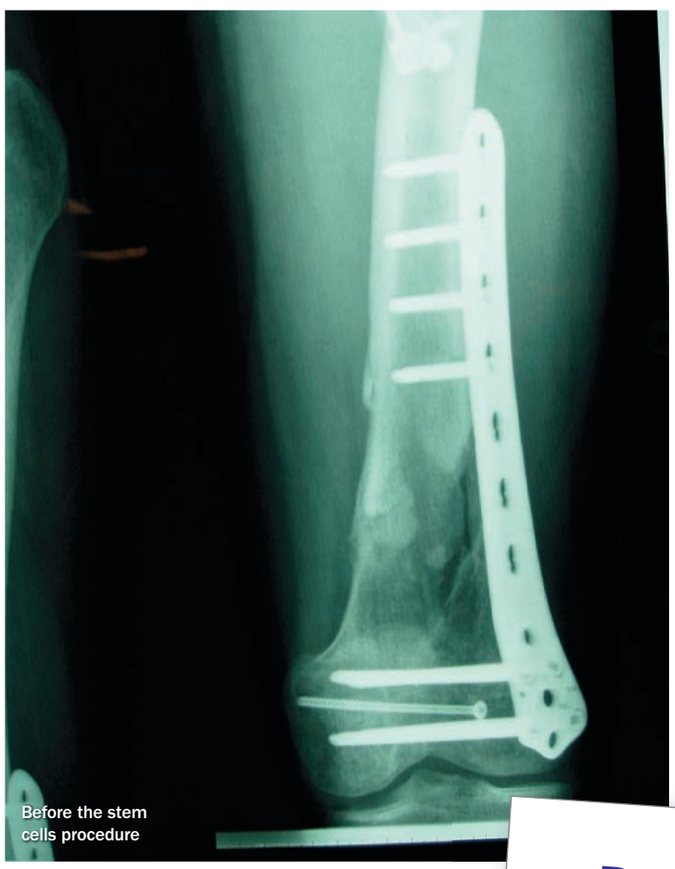
"This was a safety study rather than a study into the effectiveness of the stem cell technology," he said.

"But it is the first of its kind – using this particular method of multiplying the stem cells - in the world.

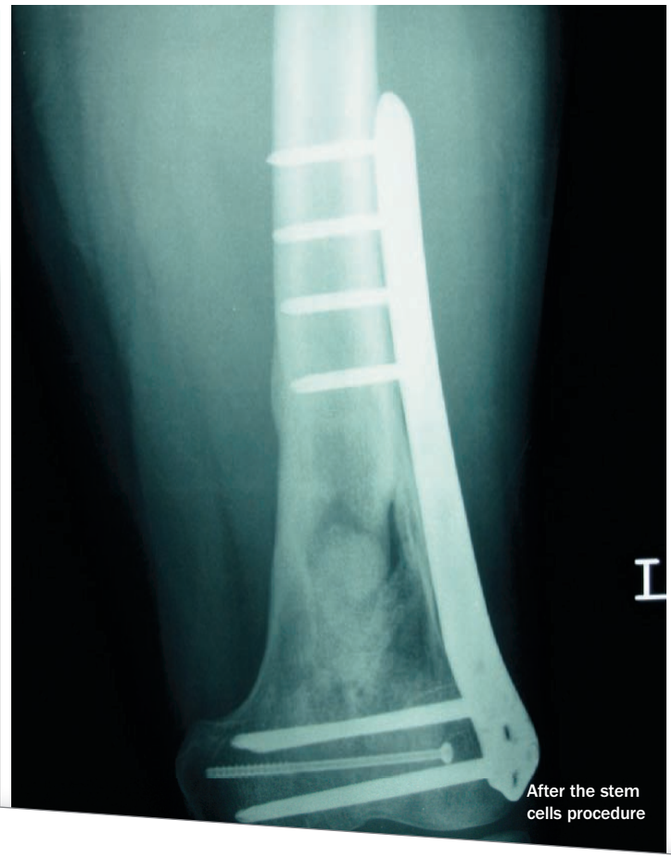
"The fact that it worked in eight out of ten patients, the fact that it did prevent all these people from having a second operation is exciting.

"We can say that it does work, there is no question, but this study was just a stepping stone and now we are using the results of this safety trial to launch a more extensive efficacy study.

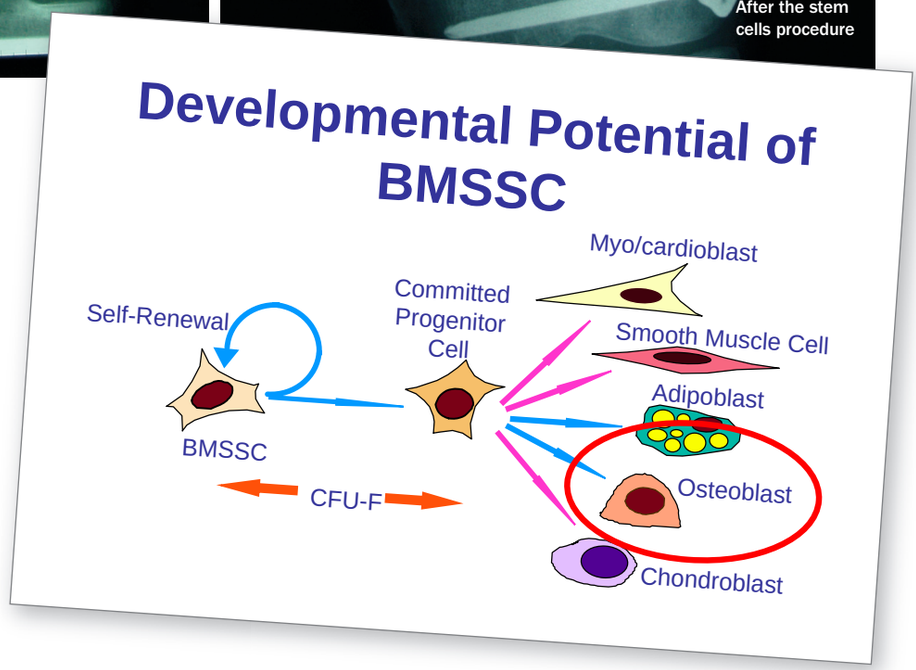
There is strong competition around the world to conduct similar trials but Mr de Steiger felt it was important to continue orthopaedic research in Australia.



Before the stem cells procedure



After the stem cells procedure



He said a conscious decision had been made to avoid any controversy sparked by the use of embryonic stem cells. He said the phase two trial would look at the potential of the stem cell technology to heal fresh fractures and said it could potentially speed up the healing process by half.

He said it would be a multi-centre and multi-national trial involving up to 100 Australian patients which he hoped to begin soon in Melbourne.

"This technology has huge potential not only to reduce pain and suffering but also in terms of economic savings in regard to hospital time and return to work," he said.

However, he said the next challenge was to find if allogenaic cells, those unrelated to the patient, could be mass produced and used to similar effect.

"We need to fully understand the immune response in relation to using such cells but if we can do it we can make this a commonly available clinical treatment because it is the growing of the stem cells that is expensive," Mr de Steiger said.

"If we can grow them from healthy donors, we won't have to wait four to six weeks and they could be applied "off the shelf."

Mr de Steiger said that this first trial had been partly funded by regenerative medicine company Mesoblast which owns the worldwide licence to commercialise the technology which he said was approximately three years away from being used in hospitals.

"This is an exciting point in research because the ability to identify the stem cells and multiply them has implications not just for bone injuries but in growing cardiac muscle and for growing cartilage to treat arthritis which is one of the most chronic diseases in first world countries," he said.

"It could even be used to delay on the onset of arthritis."

Mr de Steiger said his particular research aim was now to find a process to grow bone on metal plates that could be used as an alternative to hip replacement revision surgery.

"Around 28,000 hip replacement operations are done in Australia each year and in up to 12 per cent of cases we have to do revisions," he said.

"These patients have lost their own bone so that if we could fashion a piece of metal with bone growing on it, that metal could fuse with the patients bone and grow where it is needed.

"It would be a sort of customised implant, a more secure form of treatment.

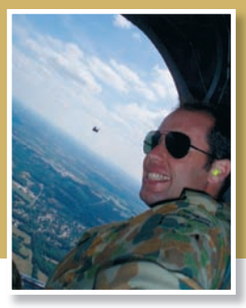
"All of these potential uses also have the potential to save millions of dollars in terms of theatre time, hospital time and the time taken for patients to return to work.

"But also it shouldn't be forgotten that this technology reduces the patient's pain and suffering because sometimes bone grafting surgery can be more painful that the actual injury."

Mr de Steiger said the initial trial was based on more than 12 years research conducted by the Hanson Institute in Adelaide and the University of Adelaide.

He said research participants would now begin the process of sourcing funds for the second phase of research from the National Health and Medical Research Council, the College and private corporations.

Successful Scholars



Medicine and war

Dr Peter Watson was chosen to participate in an international surgical exchange program to study combat casualty resuscitation

Surgical Trainee Dr Peter Watson has such strong views about war and the prevention of war that they could seem somewhat confusing at first blush. A former director of the International Physicians for the Prevention of Nuclear War, he has now been a Flight Lieutenant in the Royal Australian Air Force Reserve for the last three and a half years.

Once a peace activist and a member of the Medical Association for the Prevention of War, he recently spent one year at the Uniformed Services University of the Health Sciences (USUHS) in Maryland in the US. With a passion for military medicine, Dr Watson sees no contradictions in this.

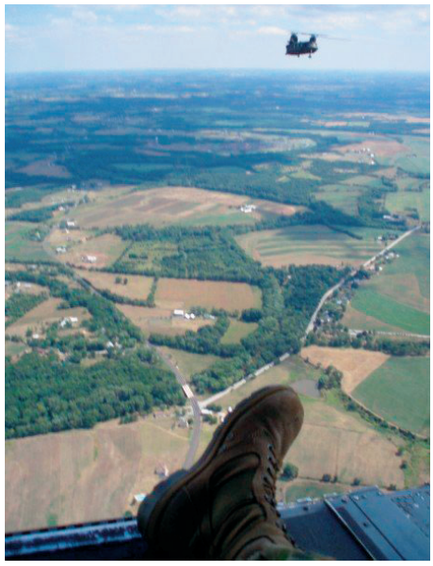
"I don't believe there is a conflict in having both an anti-war stance and treating the victims of war. I came to the conclusion that I could either stand idly on the sidelines or help those affected by war. And that is what I decided to do. I think that that is a relatively easy position to take in Australia," he said.

"Because the Australian Defence Force (ADF) is often used for peacekeeping and humanitarian roles, I saw no conflict in serving my country and pursuing my wish to help those injured in conflict. I do not believe I am blind to the horrors of warfare and daily seeing injured US soldiers and marines last year constantly reminded me that the ADF is still primarily a military force for the defence of our nation at home and abroad."

"The men and women who serve in the ADF are often asked to do a difficult job on behalf of the Australian population. And I believe that they demonstrate great courage, loyalty, teamwork, and honour in carrying out that duty."

"When our soldiers, sailors and airmen willingly undertake dangerous tasks that others aren't prepared to do, clearly then they deserve the best medical care that we, as a nation, can give them."

After being accepted into surgical training, Dr Watson was chosen to participate in an International surgical exchange program to study combat casualty resuscitation, an exchange made possible by the $US40,000 stipend attached to the College's Research Scholarship in Military Surgery awarded to him in late 2006.



"When our soldiers, sailors and airmen willingly undertake dangerous tasks that others aren't prepared to do, clearly then they deserve the best medical care that we, as a nation, can give them."

Working under the supervision of Colonel David Burris (US Army) and Dr Norman Rich (USUHS), and mentored by Brigadier Jeffery Rosenfeld (RAAMC), he conducted a swine model study investigating the epigenetics of Class IV haemorrhagic shock.

Now in the process of writing up his findings as part of his Masters Degree, he said the research aimed to discover possible ways to prevent resultant organ failure as a result of massive blood loss.

"This research was designed to investigate the altered genetic expressions of apoptotic heat shock proteins as a result of shock and hopefully to discover methods to target that expression and thus prevent negative sequale such as acute respiratory distress syndrome and multi-organ failure.

"We hoped to find a way of minimising reperfusion injury to combat casualties in the field and at the aid station or hospital," Dr Watson said.

"The team looked at the role of sodium valproate and other HDAC inhibitors and compared it to normal and hypertonic saline. Obviously this could have great potential uses in the civilian world in terms of motor vehicle accidents or serious injury." Dr Watson went to America in February last year.

"The Uniformed Services University is an amazing facility and obviously, because of our relatively small population, we have nothing like it in Australia. It is attached to the Bethesda Naval Medical Centre and trains doctors and nurses in the three arms of the US services," he said.

"While there I attended lectures on traumatic brain injury, the treatment of blast injuries, Post Traumatic Stress Disorder, tropical medicine and military medical history.

"I also did the Emergency War Surgery Course run by the US Navy which is offered to military medical personnel before deployment to Iraq or Afghanistan, and it involved receiving training from military doctors who had recently returned from those conflicts."

While there, Dr Watson won the Ben Eiseman International Professorship of Sur-

> "I don't believe there is a conflict in having both an anti-war stance and treating the victims of war. I came to the conclusion that I could either stand idly on the sidelines or help those affected by war."

gery Award for a lecture he presented on the history and developments of body armour in which he patriotically mentioned the pioneering armourer, Ned Kelly.

In addition to this, he sat and passed the final exam for a Diploma in Medical Care in Catastrophes, the second only Australian to have gained this award. He also participated in clinical teaching and military exercises that involved setting up a battlefield clearing station for the wounded in the wooded hills of western Pennsylvania.

"It was a great experience and if there was a similar institution here to the USUHS I would have joined it yesterday. There is nowhere to learn this kind of medicine at this intense level – in that kind of facility – in Australia. We also don't have the same social problems and lack of gun control as the US, thus we don't see as many shootings here as they do there.

As a result many surgeons are, fortunately, not as familiar with the treatment of bullet wounds," he said. Dr Watson, who has particular experience in general and orthopaedic surgery, said he was now undertaking locum work as he finalised his thesis, but that he had made it clear to military authorities that he would happily take up a military deployment if asked.

"As a medical officer you have the opportunity to care for wounded comrades, civilians, and foes alike, although most of my time in the force is spent checking the health and fitness of our personnel."

"This may sound a cliché, but one of the proudest moments in my life was the first time I put on my uniform," he said.

"It made me feel a part of the ANZAC tradition that my great-grandfather and his Great War mates helped create". You feel different somehow, part of a wonderful tradition of service and sacrifice to your country. But most of all, I'm proud to serve with the men and women of the ADF."

The opinions expressed herein are those of the author and interviewee alone and not of any official policy of the Royal Australian Air Force, the Australian Defence Force, the Australian Department of Defence, or the Australian Government.

2008/2009 Rowan Nicks
Australian & New Zealand (ANZ) Scholarship

RACS - The College of Surgeons of Australia and New Zealand invites suitable applicants who are citizens of New Zealand to apply for the 2008/2009 Rowan Nicks ANZ Scholarship. Rowan Nicks Scholarships are the most prestigious of the College's International Awards and are directed at surgeons who have the potential to be leaders in their home country in their chosen surgical speciality area.

The 2008/2009 Rowan Nicks ANZ Scholarship is offered to a surgeon from New Zealand to take up the scholarship in Australia. The scholarship is intended to provide an opportunity for the surgeon to develop skills to enable him/her to manage a department, become competent in the teaching of others, gain experience in clinical research and the applications of modern surgical technology and obtain further advanced exposure to general or specialist surgery. The scholarship is not only a personal award but is planned to 'teach the teacher to teach others' and all scholars must come with a sense of responsibility to the needs of their home base. The scholarship will be awarded for any period up to a maximum of twelve months.

Applicants should be under 45 years of age and have completed the FRACS. As the scholarship is for training within Australia if the applicant has a sponsor in Australia and or wishes to work in a specific centre, this will be considered by the selection committee. Applicants must undertake to return to New Zealand on completion of the scholarship program.

APPLICATIONS MUST INCLUDE THE FOLLOWING:

1. Cover letter that outlines intended program and any sponsor in Australia if such exists (this is not obligatory)
2. CV
3. Copy of basic medical degree and Fellowship

FORWARD APPLICATION TO:
Secretariat, Rowan Nicks Committee
Royal Australasian College of Surgeons
College of Surgeons' Gardens
Spring Street Melbourne VIC 3000 Australia
Email: international.scholarships@surgeons.org
Phone: + 00 11 61 3 9249 1211
Fax: + 00 11 61 3 9276 7431

Information about deceased Fellows

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

John Leonard Connell VIC
Arthur Newton Talbot NZ

We would like to notify readers that it is not the practice of *Surgical News* to publish obituaries. Obituaries when provided are published along with the names of deceased Fellows under In Memoriam on the College website http://www.surgeons.org/Content/NavigationMenu/WhoWeAre/Inmemoriam/default.htm

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	TAS	Dianne.cornish@surgeons.org
NSW	Beverley.lindley@surgeons.org	VIC	Denice.spence@surgeons.org
NZ	Justine.peterson@surgeons.org	WA	Penny.anderson@surgeons.org
QLD	David.watson@surgeons.org	NT	college.nt@surgeons.org
SA	Daniela.giordano@surgeons.org		

East Timor

The broken hearts of East Timor

It was an honour to work with such extraordinary individuals contributing above and beyond to help the children

Zoe Wainer

Associate Professor Andrew Cochrane during formal teaching session

In July of this year I excitedly boarded a small Air North aeroplane in Darwin headed to Dili, East Timor. I was fortunate to be one of the doctors on a volunteer paediatric cardiac surgical team from the College and AusAID. Working in developing countries has always been a driving force for me as a doctor, because, put simply, the potential to do good is so great. So as a cardiothoracic Trainee, when the opportunity arose to be the surgical assistant on the Timor Leste paediatric cardiac surgical team I did not hesitate.

The paediatric cardiac team is one of several surgical specialty teams that make up the Australian Timor Leste program of Assistance for Specialist Services (ATLASS) managed by the College. The aim of the ATLASS program is twofold. Firstly to provide specialist surgical services to the people of East Timor. Secondly to build the health care capacity of the East Timorese doctors and nurses.

Our team was made up of Associate Professor Andrew Cochrane (paediatric cardiac surgeon), Dr David Baines (Paediatric Anaesthetist), Siok Chew (ICU nurse), Cheaw-Shya Lim (Theatre nurse), myself as the surgical assistant, Dr Lance Fong (paediatric cardiologist), Dr Noel Bayley (Cardiologist) and Nic Bayley who provided much needed general support.

The two cardiologists, equipped with their portable echocardiography machines, hit the ground running. Dr Fong and Dr Bayley worked from three main clinics during our stay, the Bairo Pite clinic, The Dili National Hospital outpatients and Bacau hospital. They saw literally hundreds of patients, diagnosing two types. Firstly children with cardiac anomalies amenable to surgery not requiring cardiac bypass, as our team did not have bypass capacity. Secondly patients requiring bypass for whom funding is currently being sought

Dr David Baines teaching

Dr Zoe Wainer, Cheaw-Shya Lim and Associate Professor Andrew Cocohrane

in order to bring them back to Australia for their operation.

We operated on the Monday, Tuesday and Wednesday of our eight day stay. Our patients ranged in age from 11 months to six years old. The operating theatre was relatively well equipped, although oxygen was supplied via bottles, so part of the anaesthetist's job was to ensure the oxygen bottle didn't run out mid procedure. Additionally, suction was via an external machine, which stopped working when the power went off, which was at least one to two times per day. The bullet holes in the theatre walls served as a reminder of the recent troubled history of the youngest nation on earth.

We brought a large amount of equipment, including our own gloves, surgical instruments, endotracheal tubes and anaesthetic monitor, as the ATLASS teams endeavour to be self sufficient. The aim is to leave behind suitable equipment to assist the ongoing surgery. Lots of bags and quite a bit on negotiating with the airlines regarding excess baggage!

The mosquitos were a new experience in the operating setting, insect spray was mandatory. Initially we had not been alert to the requirement of insect spray as a pre operative treatment for the theatre and as a consequence spent much time catching and dodging mosquitos. Then a scene I am fairly sure none of us will forget as a fly flew into the open chest of a patient. We all froze as we couldn't touch the fly as we were sterile (and we were in very short supply of gloves) so we tried gentle persuasion and were grateful it took the hint. This was followed up with an extra dose of antibiotics for the patient (who recovered from the close encounter with no infection).

The medical staff at Dili National Hospital are a multinational collection with doctors from East Timor, Cuba, China and Australia. Part of the College's ongoing commitment to capacity building of the world's youngest nation is the employment of a full time team including a general surgeon, Ms Emma Lang, a very experienced ICU nurse Daniel MacKenzie, Operating Theatre nurse Amanda Jennings, program officer Natalie Stephens and anaesthetist Dr Eric Vreede. All do an outstanding job not only in their commitment to the care of the East Timorese people, but also in ensuring ongoing education for the staff of Dili National Hospital.

It goes without saying that being part of a team that makes such a huge difference to the lives of children and their families was inspirational, and a profound reminder of the privilege working in such a setting, and the privilege of the health care we have in Australia. Then there are the people you meet that you cannot help and the stark contrast to their outcome if they lived in Australia. The 14-year-old girl with rheumatic valvular disease and severe heart failure with the only treatment available being digoxin and lasix. The-18-year old girl with post partum cardiomyopathy and severe ascites, and again only lasix and digoxin. These people will stay with me forever. And in fact one must never forget, for their stories are the powerful reminders of why these teams are so important and why we must continue to support and expand such programs.

During our trip the United States Naval Service Mercy ship was anchored in Dili harbour. The Mercy ship is a 1000 bed floating military hospital, which is deployed on humanitarian missions when not required in conflict zones. We had an extensive tour thanks to Dr Bruce Lister, an Australian doctor serving on the ship. The ship was in East Timor for two weeks to provide humanitarian health care to the East Timorese people. The ship is equipped with 12 operating rooms, 60 ICU beds, a very impressive CT scanner and full lab testing facilities. The resources were quite a contrast to the two operating rooms, intermittent x-ray service and five ICU beds at Dili National hospital.

Providing education to the East Timor health care professionals is an important component of the capacity building aspect of the trip. Assoc Prof Cochrane and Dr Baines undertook both formal and informal education sessions. Both Nurse Siok Chew and Cheaw-Shya Lim worked very closely with local nursing staff. As both nurses spoke Bahasa Indonesia, the education process was smooth and very successful. I was also able to make a contribution to education, in an informal manner. Several of the nurses and doctors approached me with questions about patient care and the surgical procedures. The surgeon and anaesthetist were highly revered and thus local medical staff were hesitant to seek their advice, whereas they appeared to feel more comfortable with me as a Trainee.

I learnt two very important aspects to being a Trainee on such a program. One aim of the Timor Leste program is capacity building. What this means for the Trainee is that should a local doctor or nurse be available to benefit from the role you are playing you must without hesitation step back. For me that meant not scrubbing in when a local doctor was present to do so and not intubating when a local nurse had the opportunity to learn from my senior colleagues.

The second important aspect is to only practice under supervision. I travelled with a senior nursing and medical team who had worked in East Timor previously and understood the local culture and process. So I ensured that I always deferred to their senior medical and local knowledge.

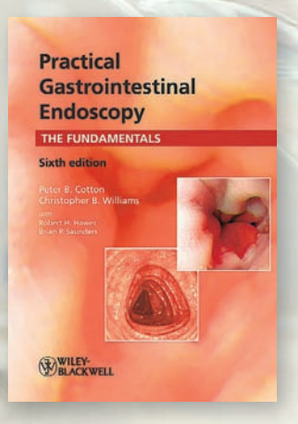
The camaraderie of the trip to East Timor was a spectacular example of team work, leadership and collaboration with each team member being an outstanding leader in their area of expertise. It was an honour to work with and become friends with such extraordinary individuals contributing above and beyond to help the children of the nation of East Timor.

The experience of working in East Timor has been a highlight of my medical career and I unreservedly commend involvement in overseas teams to other Trainees.

The Surgeon's Book Club

Welcome to The Surgeon's Book Club

Highlighted in this months issue are recent and new titles from across the surgical spectrum available from John Wiley & Sons (inc Blackwell Publishing books).



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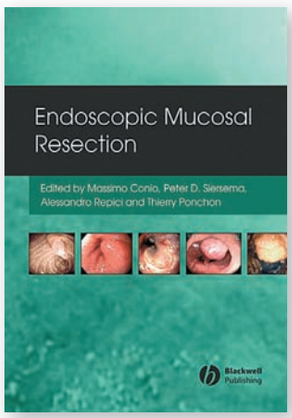
Book of the month 20% discount

Practical Gastrointestinal Endoscopy: The Fundamentals, 6th Edition
Peter B. Cotton, Christopher B. Williams, Rob Hawes, Brian Saunders

Practical Gastrointestinal Endoscopy has become the basic primer for endoscopy around the world. This new edition has been thoroughly revised and updated. Drawing on the vast experience of the authors it provides clear and practical guidance on the fundamentals of standard endoscopy practice. It describes procedures in great depth and addresses improved therapeutic techniques and advances in technology.
The book is well illustrated throughout with colour line drawings and diagrams. It is an indispensable resource for all trainees in gastroenterology and essential read for all practising endoscopists who are interested in improving their techniques.

Endoscopic Mucosal Resection
Massimo Conio,Pieter Siersema,Alessandro Repici,Thierry Ponchon

Endoscopic mucosal resection is a new endotherapy technique that can avoid the need for open surgery in the treatment of many superficial gastrointestinal cancers. In this practical 'how-to' manual, experts in the field provide specific, technical guidance on all aspects of endoscopic mucosal resection relevant to therapeutic endoscopic practice. The book provides an in-depth analysis of the technique, including methods and particularities that are not usually reported in scientific articles. Each chapter includes a comprehensive literature analysis and is supported by detailed illustrations, tables and photographs.



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Surgery - Clinical Cases Uncovered
Harold Ellis and Chris Watson

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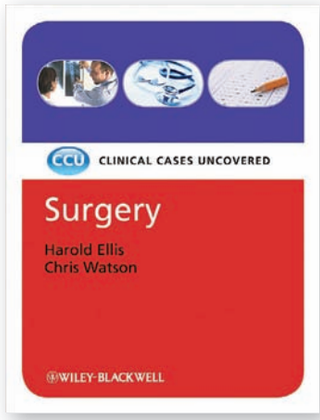

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Surgery: Diagnosis and Management, 4th Edition
Nigel Rawlinson and Derek Alderson

Surgery: Diagnosis and Management is a concise pocketbook designed for the busy junior surgeon and clinical medical student for use in the day-to-day management of surgical patients. This highly respected, very successful on-the-ward reference guide has been fully updated and covers the principles and practice of surgical management, and is particularly valued for its consistent structure and practical information.

Divided into three parts; part one introduces general surgical management and ward care, part two covers the principles of surgical practice, and part three deals with specific surgical conditions and includes concise descriptions of each condition, the steps to reaching a diagnosis and its management.

A true life-saver for the busy junior surgeon and clinical medical student.

Leisure Reading

Think One Team
Graham Winter

Think One Team has been specifically designed to help readers, and everyone in their organisation to create and sustain the teamwork across boundaries that will enable them to experience the rewards of working as one team.
Beginning with the fable of the big jelly bean team, the readers join one company's engaging, enlightening and at times funny journey from silo-afflicted to one team. From their experiences you will learn the five practices that define the difference between 'think silos' and 'think one team', and see what these practices mean for leaders and employees across an organization.

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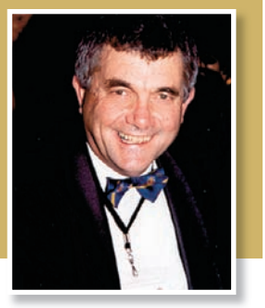
Winding Down



Bruce Waxman

Winding Down from Surgical Practice

A look at the psychological impact of changing roles. When do you do it, and what do you do with yourself?

Winding Down from Surgical Practice (WDfSP) is an euphemism for retirement because it is a more inclusive description of a period of time in one's life when one winds down one's practice and moves from being an operating surgeon to something else.

Because this is a difficult time in the life of a surgeon, the Professional Development Department of the College have conducted seminars on winding down, the first in 2004.

As a consequence, the Senior Surgeons Group was developed, currently chaired by Glen McCulloch, to provide support and advise to surgeons who are contemplating this phase in their lives and a forum for those surgeons who have made the decision to retire and wish to maintain contact with their colleagues.

Be sure to head to the College website (surgeons.org) for further details about the WDfSP workshop and the Senior Surgeons Group.

My contributions to these seminars have been to initiate the concept, coordinate its development and contribute to the program by exploring how we deal with this phase in our life particularly from a psychosocial perspective. This article is a summary of presentations I have given at these seminars and most recently at the May 2008 CASC Meeting in Hong Kong.

What are the psychological implications of winding down and changing roles?

To explore the difficult decisions that surgeons need to make when considering the appropriateness of retiring or winding down from surgical practice, it is useful to ask oneself a series of questions, the answers to which I have provided with some evidence from the literature and surveys of retired or retiring surgeons.

Why will I retire?

The number of one reason should be 'Because I want to!'.

Rovit RL in 2004[1] surveyed neurosurgeons in the United States and found the common reasons for retiring were: reduced personal satisfaction, reduced financial rewards, a desire to pursue other activities, hospital rules mandating age-related retirement, the sense that enough is enough and the strong desire to stop performing – whilst at the top of one's game.

There are of course gender differences and women retire for different reasons than men, such as: the need to care for their aged or unwell husband, demands of dependents, particularly grandchildren and to coincide their retirement when their husband retires[2]. Women also often start their careers later and have more disruptions.

When should I go?

Many feel they should quit while still in top form or others may have sufficient insight to recognise deteriorating cognitive and sensory function or deteriorating personal health or the health of a spouse. Many would hope to retire before they are "pushed" either because of a performance pathway problem or a medical/legal disaster[3,4].

Again age related retirement is sometimes determined by hospital policy and the Royal Australasian College of Surgeons recommends full time public hospital surgeons retire at the age of 65.

Where should I go and live?

Many wish to stay at home or alternatively move into a smaller house or unit. The latter probably best done before the decision is made to retire. Some seek a "sea change" and move out of town and take on a new lifestyle with new activities[3].

Who will I be and will I adjust?

Many fear that psychosocial adjustment will be difficult and question whether they will be satisfied with their new lifestyle and how they will deal with their own concerns and vulnerability and if this if the case should seek professional counselling. Many fear the fact that they would be spending more time with their spouse or that they may not have made adequate pre-retirement preparation.

It is vital to maintain good physical and mental health, partake in a balanced high fibre, low fat diet, have regular exercise and rest and more importantly get a general practitioner.

The importance of the supportive role of the family network and friends is often overlooked.

What will I do with all my spare time?

Withdrawing from the workforce may follow three models as described by Mutcher and Quinn[5,6]: Crisp, Blurred or Holding "Bridging" Jobs approach'.

The Crisp withdrawal is a clean break, not involving oneself in any surgery related work; a Blurred approach is repeated stopping and starting which cannot be recommended.

Probably the most popular model is the Holding "Bridging" Jobs approach which often goes on for 10 years and may include such things as consulting, teaching, adminis-

Pursuing outside interests is crucial

trative work or counselling, having made the initial decision to stop operating.

In Cogbil's analysis of a survey of surgeons in Wisconsin in 2003[4] he found the seven most common activities that retired surgeons involve themselves with were; family activities, travel, playing sport, spectating sport, church, educational courses and service organisations. Volunteerism (22 per cent) was a popular choice in the Wisconsin survey – most involved overseas aid missions, community projects or church sponsored projects.

With whom will I spend all my time?

Needless to say, in most instances it will be one's spouse, but many take the opportunity to spend more time with family, friends and colleagues.

Will I be prepared?

One of the functions of the Winding Down from Surgery Practice seminars has been to give surgeons the opportunity of advice on Pre-retirement financial planning – particularly investment and superannuation. Legal advice is also given, including selling the practice and dealing with medical records. Many surgeons will need to seek professional advice and attend other pre-retirement seminars either provided by other financial organisations.

How can the College help?

The College does provide ample opportunities for surgeons wishing to wind down their practice in addition to WDfSP. The Professional Development Standards Board provides a CPD portfolio for semi-retired surgeons either for assisting or in locum work. Surgeons can be involved in International Projects, the Rural Locum scheme and more information can be obtained by reading *Surgical News* or accessing the College website. The Senior Surgeons Group is another option.

Teaching and instructing is popular with retired surgeons in Australia and New Zealand and the College conducts a wide range of Skills courses and professional development seminars and related education programs where surgeons can act as instructor or facilitator – for example: Early Management of Severe Trauma (EMST), Care of the Critically Ill Surgical Patient (CCrISP), Surgical Education and Training Program (SAT SET) and of course Winding Down from Surgical Practice (WDfSP).

The Nine Rs of winding down

Another way of contemplating the psychosocial aspects of retirement can be summarised by the nine Rs as follows:

1. Retire the word 'retirement'
2. Retain the nine College core competencies
3. Restructure your priorities
4. Renew your zest for education
5. Respond to new opportunities
6. Recharge your system by taking up physical activities
7. Revisit your childhood dreams
8. Be responsible for winding down your practice
9. Remember your wisdom is still with you

(Modified from the seven Rs presented by Gordon Clunie at the first winding down seminar in 2004)

The take home message

One needs three things for a successful retirement

- Enough money
- Outside interests
- Knowing in one's heart that one's self worth is not dependent on being a surgeon

Ritter MA, 1999[7]

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If you are interested in more information, why not attend a winding down workshop. See page two.

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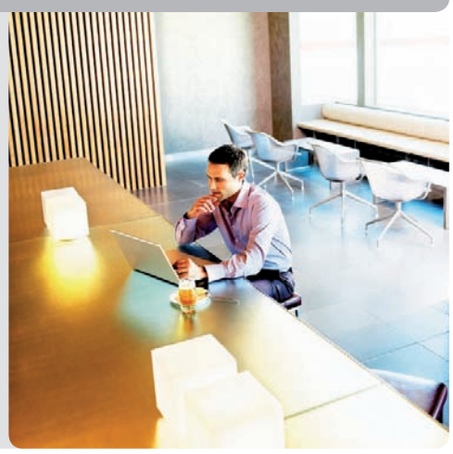

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The Younger Fellows Committee in partnership with Tyco Healthcare, is pleased to offer two Travelling Scholarships to assist Younger Fellows who are travelling overseas in 2009 to further post Fellowship studies and diversify their surgical experiences.

The inaugural Tyco Healthcare Travelling Fellowship Grants were awarded in December 2006.

The applicant must be a Younger Fellow of the College (within ten years of gaining Fellowship) at the time of submitting their application, who is planning to travel overseas within the next 12 months to further post Fellowship studies prior to returning to Australasia to practice.

The Tyco Healthcare Travelling Fellowship Grants are each valued at AUD$7,500.

For further information, please contact the Younger Fellows Secretariat, Glenda Webb, on +61 3 9249 1122 or email glenda.webb@surgeons.org

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Notice to Retired Fellows of the College

The College maintains a small reserve of academic gowns for use by Convocating Fellows and at graduation ceremonies at the College.

If you have an academic gown taking up space in your wardrobe and it is superfluous to your requirements, the College would be pleased to receive it to add to our reserve.

We will acknowledge your donation and place your name on the gown, if you approve. If you would like to donate your gown to the College, please contact Jennifer Hannan on +61 3 9249 1248.

Alternatively, you could mail the gown to Jennifer C/o the Conferences & Events Department, Royal Australasian College of Surgeons, College of Surgeons Gardens, 240 Spring Street, Melbourne 3000.

The College would like to acknowledge Dr Annabel Carney for generously donating her late father's gown, Mr Leonard Pellew

Pacific Surgeons Meeting

The sixth Pacific Islands Surgeons Meeting was held in Suva, Fiji, in July 2008 was a success

Surgeons from around the Pacific began meeting together in 1996 to discuss both clinical and non-clinical issues of relevance to surgery in the Pacific Islands. One outcome of these meetings was the formation in 2003 of the Pacific Islands Surgeons Association (PISA).

Surgeons from the Pacific Island nations of Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu attended the 2008 Meeting. Surgical Trainees from many of those countries who are currently based at the Fiji School of Medicine (FSM) in Suva also attended; as did a number of New Zealand and Australian surgeons.

As at previous Meetings, the first day focused on the Trainees undertaking the Diploma or Masters in Surgery programmes. This included practice written and clinical "examinations", assisted by the surgeons from the Pacific Islands, New Zealand and Australia; plus presentations on examination techniques and research. The Trainees also participated in the rest of the meeting with presentations of case studies and their research.

The other three days of the meeting were focused around the themes of workforce development, acute surgical care and "Oncology – the Pacific way". Workforce problems in New Zealand and Australia pale in comparison to those in Pacific Islands nations. Developing and retaining their workforce are key issues for these countries. The FSM continues to seek assistance from New Zealand and Australia through access to appropriate clinical placements in our countries as a component of the FSM surgical training programmes.

While Fiji and PNG have populations that enable a degree of access to the technology taken for granted in our countries, that technology is not available in many Pacific Island nations. These meetings provide Pacific surgeons with the opportunity to discuss diagnoses and treatments with colleagues who have similar limitations on technological and staffing resources.

Above: Diploma and Masters Trainees, FSM with General Surgery lecturer, Mr Waqainabete (back row, 4th from R)
Left: Jean-Claude Theis (Chair, NZ National Board) assisting Stephen Homasi (Tuvalu) at the orthopaedic workshop, observed by Johnny Hedson (Fed. States of Micronesia)

No comment on a Pacific Surgeons Meeting would be complete without mentioning the amazing hospitality of our hosts. From the barbeque at Professor Eddie McCaig's through the Pacific Night at Mr ifereimi Waqainabete's and on to the beach picnic run by the Trainees all visitors were made to feel very welcome, entertained and exceedingly well fed. The New Zealand and Australian "cultural items" at the Pacific night undoubtedly have a way to go yet to meet the standard of the other Pacific countries - and all could take lessons from the surgical Trainees. New Zealanders and Australians attending future meetings may well have to attend cultural item practice sessions beforehand!!

Thanks are due to NZAid who was once again the primary sponsor for this meeting with some assistance on this occasion from AusAid.

Written by Justine Peterson, New Zealand Manager

College Awards

Congratulations on your achievements

Mr Michael Baldwin – ESR Hughes Medal

Mr Michael Baldwin was awarded the ESR Hughes Medal in 2008 in recognition of his distinguished contributions to surgery.

Michael Baldwin was trained first in general surgery, then plastic and reconstructive surgery. He has focused his skills on reconstructive microsurgery and craniofacial surgery working as a Visiting Medical Officer at both Prince of Wales Hospital and Sydney Children's Hospital for more than 30 years. Michael has become recognised as an Australian and world leader in his plastics and reconstructive surgical speciality.

Michael has played a key role in the development of the multi-disciplinary clinic management of Head & Neck Cancer, Skin Oncology, Soft Tissue tumour and Craniofacial disorders at Prince of Wales Hospital and Sydney Children's Hospital.

He has selflessly offered his time and expertise to help teach Trainees in Plastic & Reconstructive, Orthopaedic, Head & Neck Otolaryngology and General Surgery.

Michael is regarded by all who work with him, or know him professionally, as a man of infinite integrity and honesty. His opinion is often sought by his peers, and is readily given.

His clinical outcomes show a commitment and diligence directed at achieving the best possible results; for example one of the largest personal series of microvascular groin flaps in the world with the lowest reported failure rate.

Finally he displays compassion to patients and staff alike being particularly kind to visiting surgery trainees from underdeveloped countries. His commitment to teamwork is demonstrated by him involvement in multiple multi-disciplinary clinics as well as frequently being involved in multi-team procedures for Head & Neck malignancy.

Mr Robert William Robertson – RACS Medal

Mr Robert Robertson has been awarded the RACS Medal in recognition of his dedicated contributions to the College.

Rob Robertson is a surgeon at Christchurch Hospital and recognised as a highly skilled surgeon who has been acknowledged by his peers by his election as President of the New Zealand Association of General Surgeons.

Rob graduated from the University of Otago in 1975 and after surgical training, which included 2 years at the Norfolk and Norwich Hospital in England, obtained the FRACS in 1983. He was appointed as Consultant General Surgeon at Christchurch Hospital in 1985 and remains in the same post to the present.

Rob did an outstanding job in convening the 2007 Annual Scientific Congress. He put together an exceptional team which worked with him to ensure that the Congress was a success. The feed-back on the various components of the Congress including the scientific programme, the social events and its general organisation has been very positive. Rob must take a good measure of the credit for this result.

He has had a distinguished career both within the Canterbury Board area and also nationally. In Christchurch Rob has served as Clinical Director of General and Vascular Surgery and as Lead Surgeon for BreastScreen South. He has been the Hospital Supervisor of Specialist Trainees in General Surgery and a member of the New Zealand Subcommittee of the Board in General Surgery. On the national stage he was President of the New Zealand Association of General Surgeons from 1999 to 2001 and served an 8 year term as an elected member of the New Zealand National Board of the College. He has been active in the Division of General Surgery, serving as the New Zealand representative on the Division.

Rob has been one of the most active and energetic members of the New Zealand surgical community and is well respected both for his clinical skills and also for his administrative ability. The award of the RACS Medal is a well deserved honour.

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