Surgical News

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS **SEPTEMBER 2012**

Surgical Education and Training: new agreements developed

The College of Surgeons of Australia and New Zealand

Making a difference

Innovative approach helps treat urgent cases

contents

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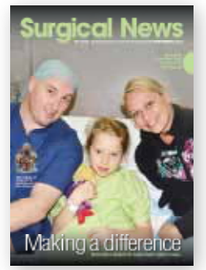

ON THE COVER:
Dr David McIntosh takes a different pathway

President's Perspective

Partnering Agreements

"The process leading to the new agreements has been an instructive one, with several clear and consistent messages emerging"

After two years of dialogue with the Fellowship (as shareholders and owners of the College) and the Specialty Societies (the key stakeholders), new Partnering Agreements have been developed. Promising substantially upgraded relationships with the 13 Specialty Societies, these agreements have been presented to their Presidents for consideration. I hope they reflect the College's respect for the increasing maturity and sophistication of the Specialty Societies.

The process leading to the new agreements has been an instructive one, with several clear and consistent messages emerging:

- Fellows of the College value the FRACS and do not want to see the value of this qualification diminished;
- Fellows want the College and the Council to act in the best interests of the whole of the Fellowship while also having a highly positive relationship with all the Specialty Societies and other key stakeholders in surgery;
- Collectively, the College and the Specialty Societies need to deliver outstanding programs that support lifelong education for Trainees and Fellows; and
- Council and the College need to become more strategic in identifying the key concerns of the Fellowship and become more effective as they advocate for and deliver on these concerns.

As President, I am now very keen to see us start meeting these challenges. Under my direction, substantial changes are being made to the governance of the College to ensure Council can become more effective in developing and delivering on the College's strategic goals.

The management and monitoring of our activities will be delegated to the Executive and senior Boards. Council will continue with its structure of 16 Fellowship Elected and nine Specialty Elected Councillors and will maintain key fiduciary responsibilities.

However, the emphasis of Council's work will be on issues of strategy and advocacy and on closer engagement with Specialty Society and regional committee activities.

As discussions on the nine surgical educational programs have progressed, I have been impressed by several key developments. The Specialty Societies are now far more mature than they were 10 years ago, when the first version of these agreements was implemented (this is now the third version), and some have developed sophisticated educational programs.

With this maturity and sophistication comes a desire to undertake more of the activities involved in Surgical Education and Training, including the opportunity to be involved with the most senior College Boards associated with Education.

Societies want to be more autonomous. They want to have responsibility for both the principle and the detail of their activities, without being micro managed. They wish to provide some of that detail through their own structures and regulations. And they want to have the capacity to bring all this together in a national as well as a specialty context.

With increased autonomy there is the expectation that there will be clarity of purpose, accountability and compliance in delivering the requirements of a high quality educational program, in order for our programs to maintain their AMC/MCNZ accredited status. Fellows, in their capacity as members of the Specialty Societies, expect nothing less.

It is also apparent that most Fellows value a collegiate approach to working through issues of concern, particularly standards and matters relating to training and education.

The College will continue to undertake assessment towards the awarding of the Fellowship. In particular, the Fellowship Examination processes and the Court of Examiners will continue as solely College activities.

There are ongoing concerns about the increasing costs borne by our Trainees and an expectation that our services will be delivered as effectively and efficiently as possible. The new Partnering Agreements identify and address these issues.

THERE ARE NOW THREE CATEGORIES OF PARTNERING AGREEMENT:

Category 1 is where the College manages the program and undertakes day to day administration. This may be most applicable to the smaller Societies (as is now the case) or to a re-constituted Division;

Category 2 is still a collegiate activity, but enables Societies to directly administer the program and undertake a range of educational and administrative activities. In the new agreements these activities are specified in considerable detail. The Training Board continues as a College Committee;

Category 3 is in a distinctly commercial form, with the expectation that the Society will be able to fully deliver across the nine competencies of our curricula. Accountability and responsibility for all issues including legal liability, indemnity, indemnification of the College and handling of Appeals sits with the Society. This arrangement would be under the oversight of a Society Faculty Board.

It is the College's preference that Societies partner with the College through either a Category 1 or 2 arrangement.

The requirements underlying compliance with the agreements are now clearly stated, to ensure that the reports received by the College from the Societies will satisfy the requirements of the Australian Medical Council and the Medical Council of New Zealand. These compliance requirements are comparable to those required of any external provider of education services in the tertiary education sector.

The nine Training Boards relate to the nine specialties, but if a particular specialty wishes to have two national training boards then that can be arranged. It would have to be agreed by both national societies and include a commitment to ensure they continue to have a common curriculum, the same educational outcomes and 'blue printing' to the College Fellowship examination. Any additional costs will be met by the Societies.

In terms of governance the College is committed to the active involvement of the Training/Faculty Board chairs, with all being members of the Board of Surgical Education and Training and having the right of direct attendance at the Education Board. The Education Board is the most senior College committee dealing with education.

The College and the Societies have expended considerable resources over the past two or three years addressing concerns raised by the Societies. We owe it to the Fellowship and to our Trainees to ensure these issues are not revisited in just a few years' time.

Consequently the Societies will be asked to sign agreements with a five year horizon and an undertaking not to withdraw from the agreements for at least two years. This will give all of us, College and Societies, the opportunity to embed the agreements and genuinely assess them.

There is now some urgency to complete this process which, I am convinced, is very soundly based. The reason for the urgency is that the Australian Orthopaedic Association and the Urological Society of Australia and New Zealand have given the College 12 months' notice that they will not support the current arrangements into the future, with this being effective from January 2013.

These discussions need to be finalised to ensure the continuity of all nine training programs and to maintain and build on the value and standing of the FRACS.

Mike Hollands
President

Working side by side

The College and the Specialty Societies have much in common on issues of advocacy

I am sometimes asked about the differences between the Specialty Societies and the College. At these times, I cannot but help think of the similarities – particularly the overwhelming desire of those involved to "do the right thing". Of course there is a lot of overlap between the College and the Specialty Societies, with many Councillors having served, or indeed currently serving, as Presidents of their Societies.

The major difference is that the College Council has to view issues from an "all of surgery" perspective while Societies are able to be much more focused. It is therefore especially pleasing when these responsibilities overlap. This year for example, the College and Specialty Societies have worked in conjunction on two long running issues of importance to Orthopaedic and Plastics Fellows.

In April we wrote to the Western Australian Health Minister, the Hon. Kim Hames, in his capacity as Chair of the Ministerial Standing Council on Health.

We drew the Minister's attention to a submission made by the Australian Orthopaedic Association (AOA) in response to the Podiatry Board of Australia's (PBA) consultation document *Registration standard for specialist registration.*

As the Specialty Society with responsibility for foot and ankle surgery, the AOA is ideally placed to assess the appropriateness of the PBA's proposed registration standard. It was for this reason that the College opted not to make a submission of its own. We reminded the Minister, however, that the College has long taken an interest in the issue of podiatric surgery, raising concerns about its recognition as a specialty and the manner in which this recognition occurred.

We pointed out that the submission made by the AOA in response to the consultation document *Registration standard for specialist registration* reinforced these long held concerns.

The College strongly endorsed the statement made on page two of the AOA's submission:

"AOA feels that the process by which the Podiatry Board of Australia (PBA) has developed and promulgated this standard is inconsistent with undertakings given by the PBA during the process of national registration. It is inconsistent with the processes outlined in the National Registration Legislation and is inconsistent with undertakings given in a letter from the Australian Health Workforce Ministers Council to the Royal Australasian College of Surgeons with respect to podiatric surgery."

Prior to writing to Minister Hames in his capacity as Chair of the Australian Health Workforce Ministers Council (AHWMC) in May 2010, the College had previously raised its concerns with the Medical Board of Australia that the PBA was failing to meet the requirement under Part 3 Clause 9 of the Health Practitioner Regulation National Law 2009 that a National Board consult other National Boards about recommendations to the Ministerial Council that may reasonably be expected to be of interest to those National Boards.

Despite these efforts we understand there was no consultation between the Medical Board of Australia and the Podiatry Board of Australia as to the process by which the Podiatry Board recognised podiatric surgery as a specialty and the implications of this recognition with regard to patient safety.

We reminded the Minister that the College was profoundly concerned that new arrangements for the accreditation of health education courses had failed their first test.

The AOA's latest submission makes it abundantly clear that, regrettably, the PBA remains unwilling to consult in a meaningful way.

The College is profoundly concerned that an undertaking subsequently given by the AHWMC, that accreditation processes relating to podiatric surgery would involve expert input from the Australian Medical Council (AMC), had not in fact been observed.

The AOA states on page 3 of its submission:

"AOA has been in contact with the Australian Medical Council (AMC) and have been advised that the AMC were not involved in any significant meaningful way with the formation of this standard or the investigation and inspection of the institutions offering these Educational Paths. This is a breach of the undertakings offered by the AHWMC."

Given the AMC's record of excellence as an accrediting body, this unwillingness to involve it in the PBA's processes represents a threat to the safety of patients.

We informed the Minister that the College strongly endorses the submission made by the AOA and called on the Standing Council on Health to intervene in the processes by which the PBA effectively examines, endorses and accredits itself and, more importantly, subsections of itself with responsibility for the direct care of patients.

As I write this we are still to receive a reply from the Minister.

On 29 June the College wrote to an organisation called Compliance and Complaints Advisory Services Pty Ltd which has been engaged by the Australasian College of Cosmetic Surgery's Consumer/Patient Code of Practice Administration Committee to undertake a triennial review of the ACCS's Code of Practice.

We wrote that as much as the Royal Australasian College of Surgeons would like to contribute to the review process, it was unable to do so because of the absence of any evidence or data to which to respond.

Rather than being provided with data relating to the application of the ACCS's code over the past three years, the only documentation made available to interested parties was a three year old media release. While this outlined the purpose of the code, there was nothing provided which could inform views on the effectiveness of the code since its introduction.

Similarly, while the code is accessible on the ACCS's website, it appears that data relating to its application is not. It must be said that this does not inspire confidence in the ACCS's commitment to transparency and accountability.

Any meaningful review of the ACCS code of practice must include publically available details of issues presented to the ACCS arising from the application of the code, the way these issues were investigated and resolved, and any penalties applied for proven breaches of the code. A code with no publically available record of action or 'teeth' is no code at all.

We wrote that the Royal Australasian College of Surgeons does not regard the ACCS as a standards body and noted that it is still not accredited by the AMC for training purposes. Fellows might recall that the ACCS applied to the AMC to have cosmetic surgery recognised as a specialty and the College made a submission to the AMC opposing this proposal in June 2009. We are frankly disappointed that, more than three years on, the AMC is still to make a decision on this matter.

The structure of the ACCS's code is not meaningful and appears not to have a scientific basis. Indeed, it is well known that a non-peer review, numbers based approach is not a valid methodology for determining standards.

It is my understanding that the Australian Society of Plastic Surgeons has also made a submission on this matter.

These two issues are still playing out. By working together with the Specialty Societies concerned, we might be able to draw the government's attention to situations which have the potential to put patient safety at risk. And if governments won't listen, our advocacy must be retargeted; we must go straight to the patients themselves. Now, more than ever, the FRACS postnominal is a powerful asset.

Michael Grigg
Vice President

Regional cooperation

More surgery will be performed by ACT surgeons at the Queanbeyan Hospital in a trial to test the success of a cross border surgery agreement between the ACT and NSW.

Local doctors have complained in recent times that the Queanbeyan Hospital is under-utilised having only performed 205 surgeries between January and March.

Chief Minister Katy Gallagher has said that an agreement would be a "small step" towards better services for ACT and NSW patients.

***Canberra Times*, August 18.**

Falls increase off the mainland

Tasmanian surgeons are urging people to be careful after seeing a spike of injuries resulting from falls recently. Falls can be anything from falling from high places or simply stumbling on a step. Neurosurgeon Pauline Waites and General Surgeon Richard Turner have dealt with a number of serious incidents including a death. Serious injuries can result from the falls, including "a fatal brain haemorrhage, a spinal fracture, a depressed skull fracture and multiple spinal fractures requiring major surgery," Dr Waites said. "Not only are these injuries potentially life-threatening, they may also lead to significant long-term disability."

***Hobart Mercury*, August 13.**

Policy failing in NT

Banning drinkers from licensed venues is not working, College spokesman and Fellow Phillip Carson has said. The banned drinkers register (BDR) is not having any effect on reducing numbers with alcohol related cases regularly turning up at Territory emergency departments. The College spokesman has said that the BDR doesn't address the problem drinking with the rest of the community and doesn't tackle the extended consequences of road deaths, violence and personal illness from drinking. "You're really only picking up a small percentage of people right at the end of the spectrum who are a public nuisance." Dr Carson said.

***Northern Territory News*, August 9.**

Micro Microscope

Fellow Christobel Saunders is part of a team that has developed an important new technique for surgery. Led by Professor Robert McLaughlin, the team from University of WA is being lauded with the development of a cancer fighting camera that is the size of a speck of sand.

"Essentially, it's a microscope in a needle which can be used by the surgeon to find where the edge of the cancer is," Professor McLaughlin said.

It is hoped that the microscope will reduce trauma and improve surgery success, also avoiding secondary procedures. They hope to use the microscope on patients within three years. ***West Australian*, August 6.**

Disastrous Wounds

Learning Lessons: Wound care as a part of collaborative response

Dealing with a disaster, either man-made or natural, is to apply knowledge that we know with the resources available. To not recall the lessons of the past[1] runs the risk of repeating the mistakes of the past and to that end the simple management of wounds in a disaster is a topic worthy of serious discussion. Information that goes back to the pre-antibiotic era and indeed modern surgical practice is worthy of consideration.[2]

In World War I before anti-tetanus serum, tetanus immunisation, antibiotics, etc, aggressive wound debridement and delayed primary closure was the norm. In modern times this lesson has been forgotten and anecdotally[3] wounds were sutured after Cyclone Tracey with disastrous consequences. Similar circumstances occurred in Banda Aceh[4] and more recently after the Tsunami in Samoa.[5]

Indeed there were headlines in the South Australian press after the Haiti earthquake indicating that Medical Students and Doctors were "stitching wounds in hotel car parks".[6]

The reality is that in a disaster all the wounds are contaminated and if the wounds are cleaned and not closed this minimises infection and the subsequent risk of losing life and limb. At this point in time this project is being progressed through the Royal Australasian College of Surgeons[7] considering synergies and partnership with the Indonesian College of Surgeons. It may be possible to progress this through the World Health Organisation (WHO). For example, an educational poster, in the appropriate languages, displayed widely in Emergency Departments, Operating Theatres, Out-Patient Departments, or indeed anywhere likely to have a trauma patient surge.

Namely: "In a disaster all the wounds are contaminated. Please do not suture the wounds closed. This will save life and limb."

This may mitigate the enormous pressure to suture as the large numbers of relatively minor trauma patients surge into the available health facilities.

A collaborative application of basic principles has the potential for enormous impact on patient care and build bridges between all involved as often disasters are trans-national requiring rapid collaboration in the immediate response.

The response to the 2009 Tsunami in Samoa[8] included a South Australian Team which travelled via Brisbane, combining with a Queensland Team for the initial deployment. Following this they were augmented by Victorian, New South Wales and New Zealand teams. They arrived, in a staged manner, two days after the initial response and were gradually able to take-over as the first responders fatigued.

The same requirement to take-down the sutured wounds and perform extensive debridement occurred. On occasions, the anaesthetist could identify when the wound was cleared as the pulse dropped significantly – practical evidence of the general toxic effect of a contaminated wound.

Much of the evidence is anecdotal given the nature of the environment in which the surgery occurs; nonetheless the stakes are high enough to encourage doctrinal development at this point in time.

Rob Atkinson
SA Fellow

References

1. John Hunter's teachings on gunshot wounds: H. Ellis, *Journ. of the Royal Society of Medicine*, Vol. 94, Jan 2001.
2. Wound Infection: H Singhal et al, emedicine.medscape.com/article/188988-overview
3. Personal Communication: D. D. Beard Military Surgeon 2010.
4. Personal Experience
5. Personal Experience
6. The South Australian Advertiser: 15 January, 2010.
7. Sudhakar Rao; Chair RACS Disaster Preparedness Committee
8. David Watters: Chair RACS International Committee.

Curmudgeon replies

In regard to Curmudgeon's Corner column in Surgical News and as the first named College Curmudgeon, I am challenged to bring out the latent 'Curmudgeon' in all. I consider that I have a right of reply and would firstly challenge the archaic definition of a "crusty, ill-tempered, churlish old man.[1]"

The modern definition is "anyone who hates hypocrisy and pretence and has the temerity to say so; anyone with the habit of pointing out unpleasant facts in an engaging and humorous manner."

We began a few years ago the first steps to forming the "Ancient Order of Curmudgeons" and the list of characteristics includes:

- ✔ Positive
- ✔ Perceptive
- ✔ Poignant
- ✔ Pithy
- ✔ Peripatetic
- ✔ Persistent
- ✔ Positive
- ✔ Pointed
- ✔ Powerful
- ✔ Pertinent
- ✔ Perspicacious
- ✔ Profound
- ✔ Penetrating
- ✔ Prudent
- ✔ Punchy
- ✔ Pungent
- ✔ Proactive
- ✔ Prepared
- ✔ Planning
- ✔ Pest

This is not sexist or ageist and all can join, capturing wit and wisdom so it is not lost. RACS has an enormous opportunity to advocate for patient care at every level and a great track record has been demonstrated in the Road Safety area with much work to do.

I would challenge to bring out the "latent Curmudgeon" in you, for RACS to unite and pick up the "Curmudgels" and do battle. Conflict is probably the worst thing that we do, but winning is probably better than losing. Curmudgeon-like is in a sense infamous, but I remind you it is much easier to be infamous than famous – so go for it.

I would leave an immediately recognised curmudgeon-like philosophy gained from Sheri Renee Scott at a play in Adelaide recently with her "eternal triangle". Three corners of the triangle are cheap, good and fast. You can only have two. Cheap and fast, but not good. Good and fast, but not cheap. Good and cheap, but not fast. Is the Public Health Sector good and cheap, but not fast?

Food for thought.

I would take you back to a College Council where a group called ASH approached RACS for support for anti-smoking advocacy. We were quite keen on this; however, ASH linked anti-smoking to the immediate presentation of corporate donations to political parties into the public domain.

We debated this and then voted, finding myself and another were the only ones who supported ASH and the attachment. I was unpleasantly surprised and will always remember the lack of "curmudgeonism". I acknowledge another Curmudgeon from Council who can "out" herself if she wishes.

Finally I would indicate that if you are a leader in any form it is the bad news that you really want to hear because that information is likely to be truthful, and therein lay the problems that need to be fixed. Curmudgeons need to be valued.

A final quote by H. L. Mencken: "It is a fine thing to face machine guns for immortality and a medal, but isn't it a fine thing, too, to face calumny, injustice and loneliness for the truth which makes men free?"

Rob Atkinson
SA Fellow

Reference:

1. *The Portable Curmudgeon.* Compiled and edited by Jon Winokur, Oct 1987.

Surgical News
always welcomes letters from readers.

Please write to The Editor,
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Accommodation for Visiting Scholars

Through the RACS **International Scholarships Program** and **Project China,** young surgeons, nurses and other health professionals from developing countries in Asia and the Pacific are provided with training opportunities to visit Australian and New Zealand hospitals. These visits allow the visiting scholars to acquire the knowledge, skills and contacts needed for the promotion of improved health services in their own country, and can range in duration from two weeks to twelve months.

If you would like to be contacted by the College if the need for accommodation in your area arises, please register your details by contacting the International Scholarships Secretariat on the details below. We are currently seeking accommodation in Melbourne (near Royal Melbourne Hospital and The Alfred), Brisbane (near Princess Alexandra Hospital), Sydney (near Westmead Hospital) and Adelaide (near Royal Adelaide Hospital) for visits in 2012. We would love to hear from you.

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T: + 61 3 9249 1211
F: + 61 3 9249 1236
E: international.scholarships@surgeons.org

Repeat success

College drew large crowds for the second year in a row

The College again hosted a successful opening of its Melbourne building as part of the Open House Melbourne weekend at the end of July. More than 800 people toured the building, with many queuing in the cold and wet to find out what lay behind the College's Stripped Classical portico.

Visitors were given a varied tour, learning about the history of the site and the role of the College in the training of surgeons.

Open House Melbourne provided volunteers to work at the front of the building, overseeing queues and counting visitors as well as erecting bright green signage.

The tour was revamped this year, with Heritage and Archives Committee volunteers stationed at particular points of the tour while College staff and volunteer medical students from the University of Melbourne guided the groups of up to 35 around the building. This allowed for a smooth flow of visitors and avoided the congestion that was experienced last year.

Campbell Miles and Cas McInnes welcomed the groups with an introduction to the College in the Hughes Room. Visitors were then led to the Foyer Hall where John Royle shared his knowledge of the courtyard and the Model School which once stood on the site, as well as his experiences as College Treasurer and President.

In the museum, College Curator Geoff Down gave graphic accounts of times past and a particularly compelling overview of the development of plastic and reconstructive surgery after the World Wars. He believes that many visitors were given a renewed appreciation of life in the 21st century.

Fellow Barry King explained the stories behind portraits in the Hailes Room and hallway, while former President Scotty McLeish talked about the Royal seal and the Council Room.

The groups were then led to the Skills Lab where Medical Director Donald Murphy, and on Sunday David Scott, showcased some of the techniques central to modern surgery, with footage to complement. Some visitors with weak stomachs left tours here.

Felix Behan also assisted as a speaker on Saturday.

Many people commented on the rich history of the site and were impressed by the antiques, surgical implements and beautiful artwork that the building revealed.

This is the second year the College has taken part in the Open House Melbourne program, which began in 2008 as an opportunity for people to see buildings of particular architectural or engineering interest not normally open to the public.

Open House Melbourne recognises the popularity of our building and is keen to have the College participate again. The Heritage and Archives Committee will be reviewing the College's involvement and hopes to present on this involvement at the 2013 ASC in Auckland.

The Committee would like to thank all involved for their efforts, including College staff.

From top: Volunteers from Sunday; Curator Geoff Down, John Royle, Scotty McLeish, Barry King, Cas McInnes and David Scott. The Foyer Hall with visitors. Campbell Miles welcoming visitors. Donald Murphy explains the role of the Skills Lab. Cas McInnes on Sunday in the Hughes Room.

Skill up

Or else

There is one thing that really annoys me and that is Continuing Professional Development (CPD) deniers. We all know about that breed of persons who deny that climate change is occurring. We could get into a long discussion about the climate topic, but we curmudgeons aren't big on discussion – we rather favour harangue or diatribe, but that is for another day.

So CPD deniers are surgeons who deny that they need to comply with the College CPD requirements. They are so skilled or clever or educated or whatever that they don't need to learn new things or keep up to date. Curmudgeons don't care about people harming themselves, but we are passionate about people who cause us trouble. If someone wants to smoke or do BASE jumping – ok, go ahead, but don't land on me.

But CPD deniers are a pain, a pest and a pimple on the backside of we ordinary surgeons. Their behaviour says to the clipboard carriers in hospitals and the regulatory bureaucrats, "Come on, take us on. We are too superior to worry about CPD." The regulators will in time decide to take on the whole profession, not just the CPD deniers, and so it will affect me and my fellow curmudgeons and we are damned annoyed about it.

Well, do I have a lesson for you. Do you see that light at the end of the tunnel? Yes it is a train coming at you full speed and, yes I am driving it.

The Telehealth Solution

We explain why it's good for your patients and good for your practice

Telehealth is a consultation between a patient and their specialist via videoconferencing. It allows you to connect and consult with a patient remotely. Telehealth contributes to service availability for patients who otherwise might not access a surgeon. Telehealth helps develop your practice, giving you another way to reach your patients and medical professionals outside your area. By offering video consultations, you can grow your practice by filling in gaps in your list with your new, remote client base.

Financial incentives are part of the Australian Government's Telehealth growth strategy. The Government is funding top-up payments for telehealth items claimed via the Medical Benefits Schedule (MBS), as well as generous incentive payments to cover your start-up costs.

	2012-13		2013-14	
	1st Instalment	2nd Instalment	1st Instalment	2nd Instalment
Telehealth setup incentive payment	$1,600	$3,200	$1,300	$2,600
	$4,800		$3,900	
Telehealth specialist service top-up payment	$48		$139	
Telehealth bulk billing top-up payment	$16		$13	

Surgeon access is the big selling point for those who are eligible to receive this service (patients from remote, rural and outer metropolitan districts, registered age care facilities and Aboriginal medical services). While Telehealth isn't appropriate for every consultation, it does offer many benefits for patients and surgeons alike:

> GP and patient access to a larger potential pool of surgeons
> greater availability of appointments and less waiting time
> less travel time and more engagement time between specialist and patient
> convenience for patients
> more scope for multidisciplinary consults

Setting up is simple, and there are solutions to suit every need. Most clinicians start with Skype, WebEx or something similar. They're easy to find, easy to use and best of all, free. For those seeking greater functionality, there are at least half-a-dozen reputable firms providing a full service from booking to billing. They charge of course, but the rates are competitive and worth investigating.

Consider your needs, and make your decisions accordingly. Are you dipping your toes in the water, or is Telehealth to be a regular occurrence? Are you planning on 'seeing' patients at their GP practice, via the Aboriginal Medical Service, or at home? Whatever you intend, there are a list of things to consider, but most of them are the same as for a face-to-face consult.

Get professional advice, ask your IT support vendor to advise on hardware. It can be as basic as you like and needn't cost the earth. A good webcam can set you back a few hundred dollars, a decent one less. The important thing is to consider your needs and choose appropriately.

The best way to start is just to jump in. There is a host of advice available via the College's Telehealth web page and from other allied bodies. Here you can find links to checklists and 'how to' guides applicable to surgeons and their practice managers, as well as billing advice from the MBS.

Connecting to Telehealth capable GPs is vital to the process and can be achieved in a number of ways. Many established telehealth clinicians say they began by mining their existing networks, and a number say that they first became aware of Telehealth when a referring GP requested it.

Other options include provider directories which list providers and referrers. The free directory managed by the Australian College of Remote and Rural Medicine (ACRRM) is one of the best examples of this approach. Via a simple sign up process, you tell them exactly what you want referrers to see, and ACRRM takes care of the rest.

And look out for the College's Telehealth Support Officer at the upcoming meetings, where we will be on hand to answer your questions:

GSA ..... 21-24 September
NSA ..... 04-06 October
AOA ..... 07-11 October
Tasmanian Regional ASM ..... 13 October
ANZSVS ..... 20-23 October
Victorian Regional ASM ..... 27 October
PSA ..... 01-03 November
ACT Regional ASM ..... 10 November
ANZSCTS ..... 11-14 November

To find out more, contact Matthew Denner, your College Telehealth Support Officer on ***+61 3 9249 1200,*** *email* ***telehealth@surgeons.org****, or check the Telehealth page on the College web site* ***www.surgeons.org***

Cathy Ferguson
Chair, Fellowship Services Committee

Poison'd Chalice

Reflection is good advice

"I can easier teach 20 what were good to be done, than be one of the 20 to follow my own teaching." Merchant of Venice (Act 1, Scene 2)

There are times when there seems to be a tsunami of problems to confront. And just like a wall of water flooding in from every direction, holding one's hands out in front wanting to push back is entirely useless. Probably better to hold one's hands aloft, wave vigorously and yell for help!

At times like this, the operating theatre can prove to be a safe-haven – the problems can be locked out for a while and there is the freedom to concentrate on just one thing. But being a surgeon is not just about operating theatres – it is about an awful lot more, a fact sadly and continually overlooked by my physician colleagues.

Part of surgical training is learning to confront multiple problems, prioritise them and either solve them one at a time or delegate them. My observation of registrars is that they embrace the latter with alacrity – the 'flick-pass' has been developed into an art form! So much so that I am beginning to believe that delegation should be reserved for use by senior clinicians – possibly just for the use of Professors of Surgery!

One thing that I have learned, and learned the hard way, is that delegation is a skill. Delegation does not absolve one of responsibility – it means transferring a task to someone capable of completing the task on your behalf.

Poor delegation means that you are probably just better off doing it yourself. My secretary has learned this. Often she delegates a task to me, but invariably retracts the delegation with words like "forget it; I will do it myself. That way I will know it has been done!" The astute will realise that I am not a poor "delegatee" by accident!

But I digress. Back to problems and safe havens. We were nearing the end of a straightforward operation. My registrar decided it was an opportune time to ask for some advice. I resented the feeling that water was beginning to seep beneath the operating room door.

She was having trouble with the two junior residents attached to the Unit: "How do you achieve a balance between providing support, yet at the same time being really clear about expectations and more importantly, how do you react when they fall short of those expectations without appearing to be a bully?"

I considered drawing on my experience as a resident. An incident detached itself from my memory cells. I remembered scrubbing up at the sink with my consultant at the time and he asked what the patient's haemoglobin was. "It's all right" I replied. "All right, all right," he shouted near apoplectic. "We talk in numbers here!" He went further and enquired whether I had considered doing my prospective future patients and indeed the world at large a favour by taking the lift to the top floor of the hospital and leaping off.

I smiled to myself at the memory, though I most certainly was not smiling at the time. It was a good example of setting expectations, but not one that I could use to help my registrar in the 21st Century. In only 30 years, how the world has changed. Whatever happened to that childhood mantra, "sticks and stones can break my bones, but words will never hurt me!"

Is the training better now, have we progressed? George Bernard Shaw would have been to the point: "What we call education and culture is for the most part nothing but the substitution of reading for experience, of literature for life, of the obsolete fictitious for the contemporary real."

I tend to agree with George. In my day there was a rawness, a vulnerability, a realness associated with training out of which was born experience. Was it mistakes that led to learning? I hope not and I don't think so. Experience without supervision means making the same mistakes over and over, leading to increased confidence, not competence. Or as Oscar Wilde expressed: "Experience is the name so many people give to their mistakes".

"So what should I do?" she prompted.

I prepared myself to embark on a discourse on the challenges faced by modern day educators, of the need to jointly determine expectations.

"Well," I said jolting myself from my thoughts. "I would actually suggest you take some time, get some space and have the same conversation with them that you have just had with me."

Professor U. R. Kidding

Manuel & Glenn -Dili OT

Continuing regional support

Phase II of the Australia Timor-Leste Program of Assistance for Secondary Services program continues support for the Timorese health system

In July 2012, Timor Leste held its third ever parliamentary elections. The ballot was seen as a litmus test for the young democracy, with the UN declaring it would withdraw its 1,300 strong police force if the elections passed peacefully. They did – giving yet another encouraging sign that Asia's newest nation is increasingly ready to stand on its own.

The College began its involvement with Timor Leste in 2001. The AusAID-funded initiative focused on providing essential clinical services and training opportunities in an incredibly challenging post-conflict environment. The health system has improved over the years, and the College program has evolved accordingly. In July of this year, the initiative entered a new phase, a phase reflective of the changing health priorities and capabilities of Timor Leste.

The new program, Australia Timor-Leste Program of Assistance for Secondary Services (ATLASS Phase II) ensures continued, targeted and appropriate support is provided to the Timorese health system. ATLASS II is highly focused on education, capacity building and maternal and child health, rather than general service delivery. While surgical team visits will still take place, they also have a greater training and mentoring focus, with Australian and New Zealand Fellows working alongside Timorese doctors in theatre.

A key component of ATLASS II will be supporting Ministry of Health staff to mentor and supervise more than 500 local doctors, trained in Cuba, who are expected to return home during the next two years. Victorian general surgeon Mr Glenn Guest, who was one of the first Australian surgeons to work in Timor Leste following independence, continues in his role as Project Director of ATLASS.

"Timor Leste is about to undergo a huge change that will see its medical workforce grow from the current level of 60 doctors to more than 500 when those trained in Cuba come home," explained Mr Guest.

The returning doctors enter a two-year internship program at district hospitals across the country. On completion of the internship program, some will go directly to work in the district hospitals, community health centres, and health posts, and others will continue on to develop specialist skills.

"Those going onto further studies are young doctors who have not yet received specialist training, so we will focus on providing basic skills in surgery, obstetrics, anaesthesia, paediatrics and internal medicine.

"This will be delivered through five 18-month diploma courses which are due to begin in August this year.

"For the surgical diploma course we will provide basic surgical skills such as suturing trauma wounds, conducting C Section surgery and skin grafts. Some of the participating doctors may also be eligible to go on to further specialist training overseas.

"Our aim over the next few years is to support the new Timorese doctors and specialists as they embark on their careers with mentoring, training and support so they can provide essential services competently and safely wherever they work."

The second phase of the program will also focus on maternal and neonatal health care and provide continued mentoring and professional development support for existing surgeons and specialists. The in-country specialist team will be expanded to include an obstetrician and paediatrician, to work together with the existing general surgeon, orthopaedic surgeon, anaesthetist and emergency physician. All these positions will have both a clinical and training focus.

"ATLASS Phase II represents a significant step forward in helping Timor Leste develop an effective and self-sufficient health system," Mr Guest said.

"As more Timorese doctors take on more work, visiting teams with a clinical focus will be phased out and replaced with educational teams in consultation with the Ministry of Health and the requirements of the local workforce."

Dr Nilton Tilmaan who is a Timorese doctor currently supported by RACS in training in PNG

Dr Glen Guest RACS General Surgeon on a Ward Round in Dili

These teams, including plastic and reconstructive surgery, urology and ENT, are instrumental in providing on-the-job training to the local counterparts.

"We also plan to offer selected on-going training or refresher opportunities in Australia and New Zealand while specialists from here will be funded to travel to Timor Leste to deliver courses either at the General Hospital in Dili or through the University of Timor Leste."

Since Australia first began providing support in 2001, the College has helped Timor Leste become self-sufficient in basic anaesthesia services, through the training of 21 nurse anaesthetists who are solely responsible for the provision of safe anaesthetics in the districts. The College has also enabled the training of the country's first ophthalmologist, anaesthetist and second general surgeon.

Mr Guest, who works out of the Geelong Hospital in Victoria and who has a special interest in colorectal surgery, took up one of the first long-term positions of Australian Surgeon to Timor Leste in 2002, following the traumatic struggle for independence.

Having long held an interest in providing surgical skills to the people of a developing country, Mr Guest and his wife spent 18 months in Timor Leste and returned for six months in 2004. Mr Guest has since made a dozen more visits to the country.

"When I first arrived in 2002, Dili was a burnt-out wreck," he said.

"The hospital was still standing, but it had no skilled personnel to run it and little if any working equipment.

"When you consider that the country is only ten years old, I think it's fair to say they have achieved more than anyone could have expected and it has always felt a privilege to me to be able to assist them."

Mr Guest said ATLASS Phase II builds on the success of the RACS' involvement in Timor Leste and praised former Project Director Professor David Scott and those Fellows who had gone before him.

"AusAID has been very impressed with the work the RACS has done through ATLASS and the Ministry of Health in Timor Leste made it very clear how enthusiastic they were to have us continue our involvement," he said.

"Although the specialist surgical expertise provided by Fellows has been vital to the program, so too has been the support of the International Development office, particularly Daliah Moss and her team, who have kept the program running smoothly.

"All of us involved in this are working to a long-term plan on the understanding that it will take up to 20 years for Timor Leste to achieve a self-sufficient and effective medical workforce. With AusAID support, ATLASS Phase II is one way to help achieve that."

Depression is more common than many surgeons think. Recently I was consulted by Dr Down-n-dumped. There had been a couple of cases with terrible complications. Probably just those complications that challenge all surgeons, with unplanned returns to theatre, weeks in ICU, open abdomen – all that stuff.

The family of one of the patients was very attentive, but also very demanding. Down-n-dumped had invested a lot of emotional energy and was wrung out. If there was a trigger, that was it.

On further questioning I discovered Down-n-dumped hadn't had a proper holiday for more than a year. The practice was busy, the bills, mortgage and school fees had to be paid, so the distraught surgeon had tended to take only a few days off at a time.

Now the complaint was feeling lethargic, disinterested and also irritated by everyone's demands; could no longer be bothered teaching, resented questions and was ratty at home, even when the children asked to play board games at the weekend. These were all symptoms of impending burn-out.

Dr Down-n-dumped might have been hoping for some pills; I am not sure, but really the first thing to do was to be persuasive about taking time off, ensuring there would be an opportunity to relax and unwind. Sometimes surgeons believe a long weekend after a conference is as good as a holiday – it's not, no matter how enjoyable and refreshing. It's a long weekend and that's all!

By the way, as I am writing this column for Surgical News I must remark that surgeons on holidays are interesting to observe. By interesting, I really mean tragic.

Often the first week of a family holiday is spent struggling to relax, where the surgeon of the family is unable to sit still, hardly able to read a non-medical book. Relaxing on a beach with a copy of a surgical journal looks just ridiculous, even if it's *Surgical News*.

Can't turn off

The temptation to read emails is enormous, even greater now that a smart phone downloads them automatically. Ever thought of handing your partner the phone and agreeing not to look at it for the entire holiday? Could you really let yourself go? Relax your desire for control. Resist that temptation to answer emails and interfere from afar.

Much can be learned from considering one's holiday sleep pattern. In the first few days sleep is often restless, interrupted and one springs out of bed early, ready for action; although such activity includes getting the exercise you should have taken the week before, you can drive the rest of the family bonkers by wanting to achieve things, trying to make the most of the time, meeting self-inflicted targets.

Eventually, as one starts to relax, one sleeps longer and deeper; one even begins to dream – only then are you truly unwinding – and after a few more days any desire to achieve something may even be ignored. Then the holiday really begins – sadly by then there might be only a couple of days left.

It probably doesn't matter whether you climb mountains, lie on a beach, visit museums, traipse barefoot through Buddhist temples, or taste wine in the Bourgogne – just as long as you leave work behind, have fun, relax and spend time with your family.

If you've forgotten how to relax then you need to recognise this as a serious deficiency and make the effort to do much less and learn how to do it! It's good for you, and is essential for well being and work-life balance.

A well-deserved break

Dr Down-n-dumped agreed to take three weeks off – showing more insight than I thought. I was also amazed at the review consultation a month later when I encountered someone tanned and relaxed, with a beaming face sporting a broad grin. A person who had learned that on holiday, colleagues are capable of looking after one's patients; the world does not end, the hospital continues to provide a service, and when you come back everyone feels much better in the presence of such an improved and cheerful boss.

Down-n-dumped is normally intense and driven, so couldn't resist proffering advice in my direction: "Dr BB G-loved, I know I've been giving you a hard time, but you really are looking tired; shouldn't you be thinking of going on holiday?"

You'd think vacations were newly invented. Ah well, humility and gentleness are not Down-n-dumped's forte, but then what does one expect of a surgeon! And I must admit – it is time to use those frequent flyer points.

Dr BB G-loved

Cover Story

Leading the help

Dr David McIntosh is making a difference with a different pathway

The private health sector has both the capacity and the goodwill to provide efficient and effective public health programs if funding was made available to cover basic overheads, according to Queensland ENT surgeon Dr David McIntosh.

Dr McIntosh, from the Sunshine Coast, has been collaborating with a local Indigenous health centre since 2009 to offer free clinics to children supported by Federal Government funding.

However, with no funding for surgical services and no ready access to public operating services, Dr McIntosh earlier this year formed a broader collaboration between local anaesthetists, Ramsay Private Hospital services, Attune Audiology and the Indigenous health clinic to treat 20 of 100 children screened from a total of 400 who were found to be in urgent need of ENT care.

The surgery was funded by money squeezed from the health clinic's budget with theatre space, equipment and consumables provided by the hospital at a significant discount and the services of the audiology centre, surgeon and anaesthetist provided at no cost.

Dr McIntosh said the surgical clinic treated all the children in one day for a range of conditions including Otitis media, cholesteatoma, sinus and tonsillitis for less than $20,000.

"I have been trying to get clinics such as this off the ground for more than six years by writing to State and Federal bureaucrats and politicians and getting absolutely nowhere which has been extremely frustrating," he said.

"There is massive inertia in the public health system and little effort made to ensure sick kids are seen and treated when and where they need to be treated.

"Yet under our model, children were treated within four weeks of their initial consultation.

"So what we have done proves that it can be done – efficiently, effectively and affordably – and that there are highly skilled people and health organisations willing to help if even the most basic financial support was provided."

Dr McIntosh also provides his services to the Queensland public health program Deadly Ears which sends specialist ear teams to remote communities in a bid to reduce the rates of chronic ear disease among Aboriginal and Torres Strait Islander children.

However, he said that the screening program undertaken by the North Coast Aboriginal Corporation for Community Health had revealed high levels of ear disease and hearing loss even in the urbanised population.

Clockwise: Dr David McIntosh with patient Maddy Stephens and her mother Pamela Salon; patient Cecil Sullivan; patient Jada Muggleton and mother Tina Muggleton.

"Of the 400 children screened, 25 per cent were found to be suffering some form of ear disease and some level of hearing loss which was shocking in a mainstream, urban community and that clearly demonstrates that not all kids in need of ENT surgery are to be found in remote areas," he said.

"These are school-aged children whose hearing loss could affect them for the rest of their lives and yet with modest financial support we can instantaneously change their lives and their future prospects."

Dr McIntosh said the collaboration had been particularly successful because of the services and support provided by the staff at the Indigenous health clinic who co-ordinated appointments, provided transport for children where necessary, helped with paperwork and provided parents with moral support in an unfamiliar environment.

"Such an innovative approach as ours is far more efficient than any public health service I know of and significantly contributes to the stated Government desire to close the gap," he said.

"Everything we did was done as a team effort with a single focus of seeing and fixing children quickly, close to home and in a culturally appropriate manner.

"There are a great number of people with good hearts who want to help these children and I think there is both the capacity within the private sector and the goodwill to allow that to happen if it can be done within reasonable cost boundaries."

Dr McIntosh held a follow-up clinic to assess the treated children in August and hopes to hold another surgical clinic later this year.

"When I first approached the local Indigenous health clinic a few years ago and offered my services they were totally bowled over, but I think I am far from alone in wanting to help," he said.

"It's about getting around suffocating bureaucracy, it's about getting people of good will together, it's about sourcing even basic funding to cover basic costs, but it can be done.

"I'd love a mining company to provide some money as a gesture of community support; for instance, if I had sufficient funds I'd drop all my other obligations and help these children because the difference we could make would be enormous."

With Karen Murphy

Develop your skills

Continuing Professional Development in 2013

The Professional Standards Committee has undertaken an extensive review of the College's current Continuing Professional Development (CPD) program and emerging trends in professional development in Australia, New Zealand and overseas. In undertaking this review, the committee has consulted widely with Specialty Societies and key stakeholders to develop a robust and relevant program for Fellows in 2013.

In developing the 2013 program, we have sought to tailor requirements that ensure Fellows participate in activities relevant to their scope of practice and to simplify CPD participation for Fellows.

Transitioning to an annual CPD program

The CPD program will change to an annual program, moving away from the current triennial model. We believe there are a number of advantages to this approach. It is administratively simpler. It will enable refinement of the CPD program to occur on an annual basis, instead of waiting until the end of a triennium. It will better reflect a Fellow's current position with regard to CPD compliance and aligns with the requirements of the Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Council of New Zealand (MCNZ).

The minimum threshold for accruing points has been adjusted in line with an annual program. Fellows in operative practice will be required to accrue 60 points per annum in categories 3 and/or 4 as opposed to an average of 70 points per annum from categories 4-7 within the current triennial model.

The change requires Fellows to participate in CPD consistently on an annual basis, but also recognises that Fellows' participation in CPD may fluctuate and reduces the overall average points requirements from current levels. Attendance at a scientific meeting once every three years will no longer be a requirement.

Simplification of CPD Categories and Practice Types

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

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

The reduction is intended to better enable Fellows to move between practice types as they transition into different phases of their career.

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

Category 1: Surgical Audit

This requirement remains unchanged. All surgeons who conduct operative procedures in hospitals, day surgery units or private rooms are required to participate in a surgical audit each year, and to subject the audit to peer review.

Many locum surgeons are able to participate in the normal peer reviewed audit that takes place in their hospitals. They should select the practice type 'operative practice in hospitals or day surgery units'. If locum surgeons cannot meet this requirement they should select the practice type 'operative practice as a locum only'. They will continue to be able to submit their de-identified audit data, which must include the College's minimum data set to the Locum Evaluation and Peer Review Committee.

However, from 2013 this committee will only recognise locums who perform an equivalent of 10 weeks full time work. This recognises community concerns about surgeons remaining in operative practice whose case load is very low.

The requirement regarding ANZASM participation remains unchanged. Surgeons who have been requested to complete and return a Case Record Form must do so. Any surgeon who believes that they were not the treating surgeon must notify their mortality audit.

Category 2: Clinical Governance – Quality Improvement, Evaluation of Patient Care and Professional Advocacy

This requirement remains unchanged. All surgeons who work within hospitals or day surgery units (other than locums) should be involved in ensuring the safe provision of pre-operative, operative and post-operative management of patients and the maintenance of surgical standards.

Category 3: Performance Review

This is a new and exciting category. Rather than focusing on learning activities, this category encourages surgeons to seek feedback and analysis of their performance. This is valuable for all surgeons, but is particularly recommended for surgeons at the end of their careers.

The principles have already been circulated in the Surgical Competence and Performance Guide. Successful completion of a multisource feedback will accrue 30 points per annum for each of the next three years. Construction of an individual learning plan based on such feedback will also accrue points.

Other possible activities include being involved in a structured practice visit by a peer or undertaking a patient feedback survey. Participation in this category will not be mandatory at this stage.

Category 4: Maintenance of Knowledge and Skills

From 2013, category four incorporates categories 4-7 from the current program:

- Maintenance of Clinical Knowledge and Skills
- Teaching and Examination
- Research and Publication
- Other Professional Development Activities

The breadth and type of activities which Fellows can claim CPD points for remains unchanged. We expect that Fellows will engage in a range of CPD activities that match their scope of practice.

Streamlining Verification for Fellows

When requested to verify, the vast majority of Fellows do so successfully. However, we do appreciate that participating in the verification process is a substantial undertaking for Fellows.

Currently we verify 3.5 per cent of Fellows annually. It is likely that the community would regard this as a low percentage. Council has indicated its desire to increase the verification rate. At the same time we do not wish to overly burden Fellows.

The answer to this problem will be increasing opportunities for Fellows to upload documentation required for verification at the time of data entry into the online CPD diary.

A record of Fellows' attendance at the Annual Scientific Congress and other College courses/workshops will also be automatically entered into the online CPD Diary.

Online CPD is strongly encouraged. It is cost and time effective for Fellows and the College. From 2015 it will become the only method for entering CPD data. Staff in the Professional Standards department are available to assist any Fellows who are experiencing difficulties in this area.

Non-Compliance

Council has mandated Fellows' participation in the CPD Program for all active Fellows. AHPRA and MCNZ also mandate CPD. While we will continue to support Fellows in maintaining their CPD, persistent failure to comply with CPD requirements will be classified as a breach of the College's Code of Conduct.

There is a measured response to breaches of the Code, but all Fellows should be aware that the ultimate penalty for persistent breaches is loss of Fellowship. This could have very significant implications for a surgeon's ability to practice in either Australia or New Zealand

The CPD program aims to meet the needs of Fellows both now and into the future. We would value your feedback with regard to changes to the CPD Program or improvements to the CPD Online Diary.

If you have any comments, please contact the CPD Recertification Officer at cpd.college@surgeons.org or on +61 3 9249 1282.

Graeme Campbell
Chair, Professional Standards

ASC 2012 Evaluation

Congratulations to everyone involved in making the Kuala Lumpur ASC such a success!

The 81st Annual Scientific Congress (ASC) was held in Kuala Lumpur with the theme 'Making a Surgeon'. The ASC is now a major educational activity on the national and international scene and the largest multi-disciplinary surgical meeting held in Australia and New Zealand.

Registrations are an indication of how successful the ASC has become. This year delegate numbers totaled 1912 including 971 Fellows, 167 Trainees, 17 IMGs and 757 other health professionals.

The College is very appreciative of the feedback from 335 delegates who took time to complete the ASC evaluation. Jonathon Hong won the Canon Power Shot camera, the lucky draw prize for completing an evaluation.

Feedback is an integral component of the planning and delivery of educational activities such as the ASC. The results influence the development of the ASC's educational content and help to ensure that delegate needs are met. Evaluation also provides an opportunity for self-reflection which can motivate delegates to make refinements to their practice.

Respondents overwhelmingly agreed that the Congress enabled them to improve their knowledge and skills. All 27 scientific programs received a very positive rating in relation to their educational value.

The sessions had an average rating of 4.2 (1 = satisfied, 5 = most satisfied). The Colorectal, General and Breast Surgery sessions were particularly well regarded. The 'Sessions of Interest' including the Masterclasses and Plenary Sessions were also well received. Some Masterclasses generated very positive comments including:

> Prosthetic Breast Reconstruction
> Management of Fistula in Ano: New techniques and how to do it
> Loco-Regional Flaps in Head & Neck Reconstruction
> Damage Control Laparotomy

Most respondents were satisfied with the scientific program indicating that it

was balanced and provided a choice of sessions. Some expressed their frustration about program 'clashes' particularly when concurrent sessions targeted the same interest group. Unfortunately, this may be inevitable given the complex ASC program and its four day format.

Overall delegates appeared satisfied with the time allocated for Congress activities. Every activity was rated close to 'About Right' including case study discussions, workshops, informal discussions/networking and free papers/poster sessions.

This year more than 550 presentations are available on the Virtual Congress (VC) with both presentation slides and sound track. You can also watch the Convocation Ceremony. Remember if you missed a session or would like to hear it again, please check the VC website asc.surgeons.org and follow the links. A presentation is only uploaded if the presenter gives permission.

There were a number of recommendations for the 2013 ASC in Auckland. Some delegates advocated for more sessions delivered by external 'experts' with a greater emphasis on future-oriented content and innovation.

Others suggested multi-disciplinary programs addressing common problems and 'How I do it' presentations which incorporate greater interactivity. There were also requests for an increase in topics of interest to Trainees.

The open format College booth was popular and most found the College staff to be helpful in providing useful information. Some delegates wanted to know how to become involved in College activities and suggested that this could be greater a focus for the future.

The more IT savvy delegates suggested using media technology such as Smart Phone Apps, Facebook and Twitter to increase the speed of access to presentations and enable delegates to communicate about the ASC using social media.

Our thanks go to Philip Truskett (ASC Convenor), Raffi Qasabian (ASC Scientific Convenor) and Campbell Miles (ASC Co-ordinator) and the scientific session chairs for their efforts in promoting the evaluation.

Obtaining feedback from delegates in relation to the ASC is an ongoing challenge. The 2012 evaluation return rate was 18 per cent, similar to the response rate of 20 per cent in 2011.

The College is keen to hear your ideas about how to improve this response rate and is willing to 'think outside the square'. Please call +61 3 9276 7441 or contact PDactivities@surgeons.org .

Julian Smith
Chair, Professional Development
Roger Wale, *ASC Coordinator*

Workshops & Activities

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

Keeping Trainees on Track (KToT)

30 October, Melbourne; 30 November, Sydney

This 3 hour workshop focuses on how to manage trainees by setting clear goals, giving effective feedback and discussing expected levels of performance. You can also find out more about encouraging self-directed learning at the start of term meeting.

Supervisors and Trainers for SET (SAT SET)

26 October, Melbourne

(Vic. Scientific Meeting – incl dinner)

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

Non-Technical Skills for Surgeons (NOTSS)

12 October, Launceston; 23 October, Wellington, NZ; 30 November,Gold Coast, QLD; 7 December, Melbourne

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

The Process Communication Model (PCM)

11 to 13 October 2012 - Wellington, New Zealand (Introductory)

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

Surgical Teachers Course

18 to 20 October, Hobart

This revised two-and-a-half day intensive course enhances educational skills of surgeons who are responsible for the teaching and assessment of Trainees. Participants learn the foundation of improved educational skills, which are further developed during the course through practical application. The course is delivered through four main modules, which are integrated to achieve progressive acquisition of knowledge and skills.

Strategy and Risk Management for Surgeons

26 October, Melbourne

This workshop is divided into two parts.
Part one includes formulating a strategic plan; the strategic planning process; identifying and achieving strategic goals; monitoring performance; and analysis of strategic risk. Part two focuses on the directors' knowledge of risk for the organisation and their monitoring of management's ongoing assessment and treatment of risk.

DATES
OCT-NOV 2012

NSW

19 - 21 October, Sydney
Process Communication Model

18 October, Sydney
Polishing Presentation Skills

NZ

11 - 13 October, Wellington
Process Communication Model

23 October, Wellington
Non-Technical Skills for Surgeons

3 November, Wellington
Keeping Trainees on Track (KToT)

QLD

31 October, Townsville
Management of Acute Neurotrauma

30 NovemberGold Coast
Non-Technical Skills for Surgeons

SA

17 November, Adelaide
Building Towards Retirement

TAS

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

18 to 20 October, Hobart
Surgical Teachers Course

VIC

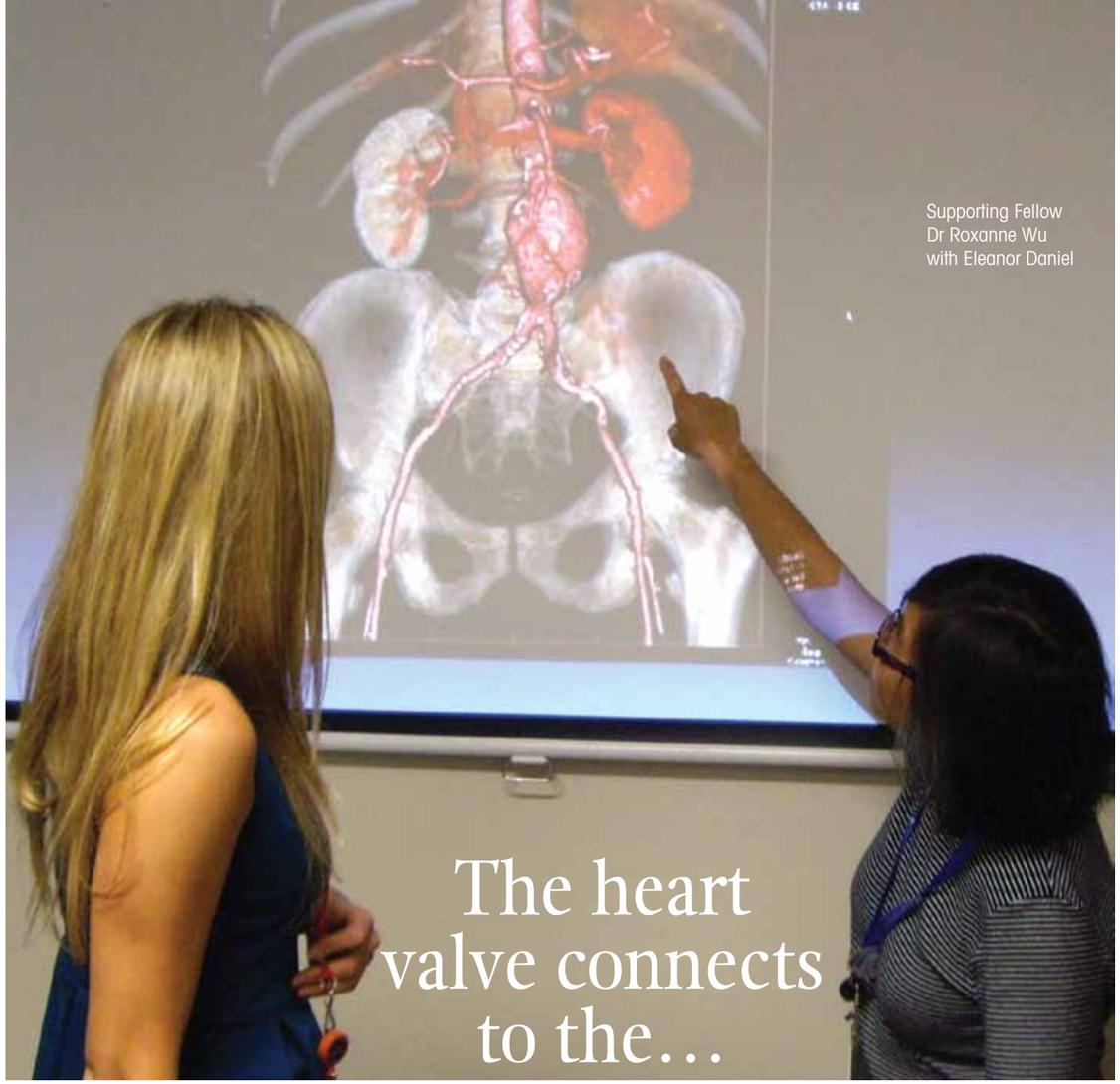
26 October, Melbourne
Strategy and Risk Management for Surgeons

26 October, Melbourne
SAT SET

2 - 4 November, Melbourne
Process Communication Model

23 November, Melbourne
Occupational Medicine

Contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit www.surgeons.org - select Fellows then click on Professional Development.



Supporting Fellow Dr Roxanne Wu with Eleanor Daniel

The heart valve connects to the…

Medical students are taking control of their anatomical learning

Concerned about their lack of detailed anatomical knowledge and the decline in hands-on anatomy teaching, medical students at the James Cook University (JCU) in Queensland have developed their own program to provide interactive, clinically-oriented, cadaver-based anatomy workshops.

With the full support of the JCU Dean, School of Medicine and its discipline of Anatomy and Pathology, the JCU Medical Students' Association (JCUMSA) launched a new arm in 2011 to drive the extra-curricular teaching called the JCUMSA Anatomy Society.

Since then, two intensive weekend workshops have been held with the voluntary, enthusiastic teaching support of a number of local surgeons, with another scheduled for later this year.

Supported by the Australian Medical Students' Association, the program was awarded "Best New Initiative by a Medical Student Society" at the 2011 convention.

The inaugural workshop was attended by 40 students rotated through eight one-hour tutorial stations per day with each station allocated to a particular anatomical region and taught by 14 volunteer surgeons and pathologists who are specialist in that region.

So enthusiastic were students to learn and participate, many travelled great distances at their own expense to attend.

JCU fifth-year medical student Mr Andrew Hattam, the driving force behind the initiative, said that while some other universities were now offering additional anatomy teaching, he believed the JCU program was the only one established and run by students.

He said that while undergraduate medical degrees, such as that of the JCU, offered the highest average total hours of anatomy education compared to other programs, most anatomy teaching was incorporated as part of the basic science curricula, with no direct anatomy assessment and thus no minimum requirement of anatomical knowledge needed to successfully progress within the course and graduate.

"Everyone knows that we don't know our anatomy and that not only horrifies surgeons, in particular as we progress through our medical teaching, but our lack of knowledge leaves many students feeling lost and uncertain about their capacities," Mr Hattam said.

"I have a background in science and had a job tutoring anatomy in Townsville before moving to Cairns and in conversation with other students we decided we should do something about our lack of anatomy training instead of sitting around complaining.

"When we first alerted other students across the JCU campuses about the first intensive weekend workshop, although preferentially offered to final year students, people from all years of undergraduate medicine came.

"We were allowed to use the new world-class, state-of-the-art anatomy teaching facilities at the JCU Cairns Campus and students travelled from Darwin and Mackay and even from rural rotations such as Cooktown and Alice Springs to be there.

"We believe the substantial distances travelled by students, at their own expense, shows how keen they are to boost their anatomical knowledge."

In the first workshop, students were provided a total of 16 hours of anatomy teaching at stations covering such anatomical regions as cranio-facial, meninges and neurovasculature, thoracic radiology, spinal cord and neck.

According to Mr Hattam, the intensive but informal design of the workshop allowed for the exchange of expert knowledge between students and senior colleagues as well as for discussions of issues surrounding the latest developments in the understanding, diagnosis, treatment and prevention of disease.

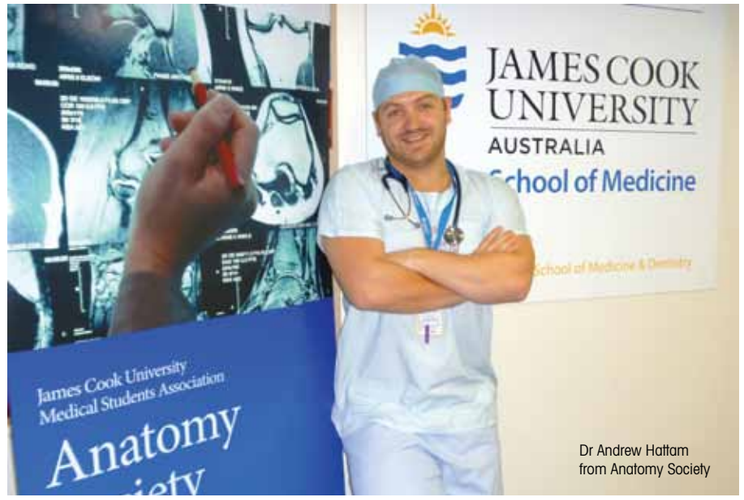
He said a minimal charge of $20 was applied to participants to cover catering costs while industry sponsorship allowed for the incorporation of radiological and plaster casting tutorials.

"Tutors were predominantly surgeons and pathologists from Cairns, however, an anatomist and pathologist from Townsville believed so strongly in the program that they funded their own travel and accommodation to tutor at the workshop," Mr Hattam said.

"Enthusiasm from local specialists was also so great that we have now developed a waiting list of surgeons and specialists who wish to help us in the future.

"The surgeons involved particularly loved it because it is hands-on laboratory-based dissection and their enthusiasm is contagious.

"The donation of their time and support of sponsors make these workshops affordable to students."



Dr Andrew Hattam from Anatomy Society

Mr Hattam particularly noted the great contributions made to the student's endeavour by Associate Professor of Surgery at JCU, Alan de Costa, who has both found surgeons willing to teach and led a workshop himself.

"The teaching of and exposure to anatomy, has declined sharply over the past decade or so. While there is a continuing demand to include other content in medical curricula, anatomy teaching has suffered disproportionately," Associate Professor de Costa said.

"This has occurred in medical schools across Australia and internationally. JCU has been part of this trend, but no more so than many other medical schools. The initiative taken by Andrew Hattam and his friends has been a breath of fresh air."

Fellows lend support

Associate Professor de Costa also said the workshops in Cairns were enthusiastically supported by surgeons, who got a great deal out of the exercise and that the students who attended these classes of course were very enthusiastic. "I would like to think they benefited from these opportunities.

"Unfortunately there is no easy way to learn anatomy, and I have little doubt we will return to some form of small group cadaver based teaching and learning which will be examinable. There is yet a way to go."

Support was also given by the former head of anatomy at JCU, Associate Professor Claudia Diaz, who helped organise the workshop and the JCUMSA immediate past-president Dr Christine Pirrone who helped establish the anatomy society as part of the medical students' association.

Mr Hattam said the decline in anatomy teaching was not related to a lack of cadavers, but was entirely associated with the undergraduate medical curricula.

"It has been said by senior academics that modern medical students now have the soft social skills to sit down and explain that a loved one has died, but be unable to explain why," he laughed.

"Yet it shouldn't be seen as a joke. University education is now doing students a disservice and the public a disservice in not providing the education we need which in turn makes our medical training unnecessarily difficult and will ultimately make us less capable doctors.

"In Australia it has been estimated that human anatomy teaching has decreased to a level of around 20 per cent of that taught previously.

"Yet turning around this decline in anatomy teaching is now becoming a 'movement' within medical education; surgeons are driving it, anatomists are driving it and now students are driving it too."

Mr Hattam has given presentations at conferences on the JCU Medical Students' Association initiative and has written a paper for the MJA which is currently under consideration.

He said the JCU Medical Students Association supports the introduction of a standardised National Curriculum of Anatomy Education.

With Karen Murphy

Surprising findings

Research continues to interest Urology Trainee Dr Dixon Woon

With the testing for and treatment of prostate cancer continuing to cause controversy, Urology Trainee Dr Dixon Woon has used the funds attached to a College scholarship to investigate whether the immune-system plays a role in prostate cancer.

Conducting his research as part of a Doctor of Medical Science (DMedSc) degree through the University of Melbourne, the Urology Department of Austin Health and the Ludwig Institute for Cancer Research, Dr Woon investigated the role that Regulatory T-cells (Treg) and activated cytotoxic T cells play in prostate cancer tissue.

Activated cytotoxic T cells are responsible for the killing of tumour cells, whilst regulatory T-cells maintain immune homeostasis by inhibiting the activation of the immune system.

Dr Woon's research aimed to characterise and compare T cell responses in blood and tissue from patients with prostate cancer, benign prostatic hyperplasia and normal prostate.

Using fresh tissue samples from patients along with matching peripheral blood mononuclear cells (PBMC), Dr Woon's research found a much higher expression of activated cytotoxic T cells and regulatory T-Cells in prostate tissues when compared with their matching PBMC.

He said the high level of T-cell activation and proportions of Treg found were unexpected.

"If our local immunosuppression hypothesis is correct, one explanation might be that the activated cytotoxic T cells are impaired and may not be acting as cytotoxic T cells and producing "anti-tumour" cytokines, but instead producing other cytokines to favour cancer growth," he said.

"This finding was very unusual and makes us think that prostate cancer has found a way to get around the immune system.

"Now further work is being done to extend these finding to evaluate the types of cytokines found in prostate cancer, benign prostate hyperplasia and normal prostate tissues."

Dr Woon said the research could possibly lead to a much better understanding of how immunotherapy works.

"There is not much data on how the immune system interacts with prostate cancer, unlike what is known with melanoma and bowel cancer, so it has been rewarding to add to the knowledge in this field," he said.

"It is also an exciting time to be involved in this research because for many years the only treatment we have for castrate resistant prostate cancer was chemotherapy."

"Now, however, just in recent years a whole new field of immune-therapy has emerged for the treatment of prostate cancer."

Dr Woon conducted his research under the supervision of Professor Damien Bolton and Professor Ian Davis. He presented his findings at the American Urological Association Annual Meeting in Washington, DC, last year and at this year's Urology Society of Australia and New Zealand Annual Scientific Meeting in Darwin.

He said one of his main achievements, working alongside scientists at the Ludwig Institute for Cancer Research and colleagues at Austin Health, was designing methods to conduct the research such as creating a prostate cancer tissue sampling/digesting protocol and designing a complex multi-colour flow-cytometric assay for prostate tissue.

"There are a very limited number of research groups in the world looking at Regulatory T Cells at the tissue level," Dr Woon said.

"Most other research organisations use blood which meant that what we are doing had never been described before, so designing new scientific methods to carry out this work was a major achievement in itself."

Dr Woon was the 2011 recipient of the Raelene Boyle Scholarship. Sponsored by the Sporting Chance Cancer Foundation, the scholarship is open to Fellows or Trainees involved in cancer research which is expected to make a notable impact.

Dr Woon said he was honoured and grateful for the College's support as offered through the scholarship and said he hoped to continue to conduct research throughout his career.

"The scholarship was invaluable in that it gave me more time to conduct the research, design experiments and overcome problems while also allowing me to spend more time with my family. I would like to thank the supporters of Sporting Chance Cancer Foundation," he said.

"This financial support is crucial for young surgeons because it allows us to learn how to conduct basic science research, design experiments, present our findings and write papers.

With Karen Murphy

profile

Awards

2011: Awarded the Raelene Boyle Scholarship (Royal Australasian College of Surgeons, and Sporting Chance Cancer Foundation, Australia)

2011: Awarded the Dora Lush Postgraduate Research Scholarship (National Health and Medical Research Council, Australia)

2011: Awarded the ANZUP/ Norvatis Travel Grants 2011 (Australia and New Zealand Urogenital and Prostate cancer trials group)

2010: Awarded the Ronald John Gleghorn, RG & AU Meade Scholarship (University of Melbourne)

A meeting of experience

The Torch that illuminates the Mind is the Fire that consumes Vainglory

With that simple and literal translation of the motto of the College, the "Torchbearers" of the SA College Committee Past Chairmen's dinner were welcomed – an event that was attended by 15 of the 19 surviving Chairmen of the College Committee in SA on 27 July.

Invoking the College motto Fax Mentis Incendium Gloriae, the current chair explored the origins and meaning of the 17th Century motto which forms a part of the College Coat of Arms.

Identifying the torch (fax) providing light, but also the allegorical meaning and connotation of "firebrand" and "inciter", the current chair identified a proactive element which combined with reason and intellectual faculty (mentis) aspiring with an "incendiary passion" (incendium) to glory, honour, fame, renown and praise – all terms that the chairman felt applied to the assembly of past chairs.

Mr John O'Brien (Chair 1974-1976) was the most senior past chair in attendance while grace was said by Mr Donald Beard (Chair 1978-1980), the oldest past chair in attendance. The current chair noted that, "A gathering such as this is as much about the future of the College as it is about the past. For certainly, you have all in leadership of the South Australian College, contrived to better the future of the College and its role in achieving the standards of training and surgical excellence, required not simply by our members, but demanded also by the community we serve in South Australia."

Dinner attendants; Below: Mr RA Rieger (Chair 1984-1986) Mr Peter Subramaniam (current Chair) and Mr Michael Hollands (RACS President).

College President Michael Hollands in toasting the South Australian Committee, noted the College's current aims to engage younger Fellows and to engage with all sub-specialities to increase and maintain the relevance of the College.

The gathering noted that there was still not a woman or an orthopaedic surgeon who had a yet occupied the role in South Australia. Responding to the President's comments, Tom Wilson (Chair 2000-2002) – a third generation Torchbearer (his father the late Graham Wilson was Chair 1972-1974 and his grandfather a founding fellow of the Australasian College of Surgeons in 1927) paid tribute to the work of many past.

"A gathering such as this is as much about the future of the College as it is about the past"

Ken Clezy AM, OBE spoke after dinner on a remarkable career in surgery, originating at the Adelaide High School, the University of Adelaide and a tireless service to humanity in many far flung areas of the world. Although never a chair of the SA Committee, Ken Clezy was easily and unanimously accepted into the Fellowship of South Australian College Torchbearers.

In concluding, the current chair reminded the gathering that the College Mace was accepted by Sir Henry Newland who served as chair of the SA committee between 1939 and 1942 and had succeeded Sir George Syme as President of the College in 1929.

A rich history

It was recorded that Charles Fagge FRCS released the Mace to the Australian College with the words: "And now, companion of my waking thoughts for many months, farewell. You have watched from earliest hours when, plate of virgin silver, you gave yourself to be fashioned by the craftsman's skill. Your every spray of wattle, every frond of fern have come to life within my ken, and gradually, once a thing inanimate, your spirit has entwined itself around mine.

"Today we part, but it is my hope that your new friends will ever hold you in their hearts, not only as a kingly emblem richly wrought, but as a spirit of affection... Stay here ever to watch their future, to guide their aims, and to bless their destiny."

The current South Australian chair believed the words, uttered 80 years ago about an important piece of College history, applied to the Torchbearers of the SA College saying: "... for you were all from your early careers, virgin silver, fashioned by your craftsman mentors into surgical craftsmen yourselves, but beyond being simply surgeons, you became leaders of men and your lives have entwined into the fabric of this, the South Australian committee and in your time, you have watched over its future, guided its aims and by your presence here tonight, you have blest its destiny. And for that, you have its gratitude."

Peter Subramaniam
Chair, South Australia Regional Committee

Morbidity Audit & Logbook Tool

The Logbook, but bigger and better

In September a major upgrade to the Web Logbook will be released as the Morbidity Audit and Logbook Tool (MALT). There are many improvements and new functions:

- > Fast!
- > Modern platform designed for PC's, Mac's and tablets
- > Easier to navigate around the system
- > Records can now be referred to the supervisor in bulk
- > Reports against procedure quotas
- > Rotation Periods lock down after the submission deadline preventing further entries in that time period
- > More easily configurable to specialty-specific requirements
- > Reporting suite (Logbook reports & more)
- > Audit reports (complications, 28 day readmission, length of stay, in-hospital mortality and admission type)
- > Extract data into MS Excel
- > Clinical terms automatically mapped to SNOMED in the background
- > Mobile-rendered website for smartphones coming soon
- > iPhone and Android Apps coming early 2013

Data for existing users of the Web Logbook has been brought over into MALT. All International Medical Graduates will begin using the system for their period of clinical assessment. Fellows will soon be able to use the system as a personal log.

MALT can also be used as an audit tool in many ways, for example to:

- > Self-audit
- > Audit a hospital surgical unit
- > Audit a new procedure, tracking its uptake over time (i.e. by a Specialty Society)
- > Audit a private practice (i.e. several FRACS operating from rooms)

Currently endorsing MALT

SET	Fellows sub-specialising
Cardiothoracic Surgery (mandatory) **General Surgery** (optional) **Neurosurgery** (mandatory) **Orthopaedic Surgery** (New Zealand) (mandatory for SET1, optional SET2-6)	**Gastric and Oesophageal Surgery** (ANZGOSA) **Hepatic, Pancreatic and Biliary Surgery** (ANZHPBA)

Expressing interest in using MALT

Specialty/Sub-specialty	Status
Breast Surgery (BreastSurgANZ)	exploring for potential use in 2013
Otolaryngology Head & Neck Surgery	working towards use in 2013
Paediatric Surgery	working towards potential use in 2013
Plastic and Reconstructive Surgery	working towards a potential migration from their system
Urological Surgery	exploring for potential use in 2013

To use MALT as an audit tool, users can simply record data against the standard dataset automatically assigned to them, noting that:

1. The dataset is that recommended by the College for effective surgical audit (from the Surgical Audit and Peer Review Guide).
2. Additional procedures can be added for Fellows if required.
3. The system provides five basic audit reports and a data extraction tool.
4. To enable aggregate data analyses, users can extract their own data into MS Excel and provide it to the body conducting the audit (i.e. the department of surgery).
5. The College can add a small number of procedure-specific fields on request (i.e. TNM for cancer procedures).

All SET will shortly have access to the system, but are reminded to check with their training board to be sure that the Logbook Summary Reports will be accepted.

Ian Bennett
Chair, RAAS Board

For more information on the Logbooks application contact Katherine Economides, Manager, Morbidity Audits on ***katherine.economides@surgeons.org*** *or +61 8 8219 0912.*

Younger Fellows FORUM

3 – 5 May 2013, Auckland, New Zealand

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

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

Applications are open from 1 September to 8 December 2012.

Contact the Professional Development Department on +61 3 9249 1106

Training in the USA

How to obtain a surgical Fellowship in the United States of America

A surgical Fellowship in the United States of America can provide world-class training and facilitate rewarding collegiality, however, can be challenging to obtain for Royal Australasian College of Surgeons' graduates.

When considering a Fellowship in the USA, it is important for surgical Trainees to understand the types of Fellowship available, the preparation required, the necessary examinations, the appropriate working visas, and the overall application timeline.

If the requisites are understood and a reasonable amount of effort is undertaken, excellent USA Fellowships are obtainable for New Zealand and Australian surgical Trainees.

Types of Fellowship

There are three major classes of USA surgical Fellowships; an observership, a research Fellowship, and a clinical Fellowship. Observerships and research Fellowships typically involve no direct patient contact, and are often unfunded positions. These Fellowships may suit Trainees that are particularly interested in research rather than clinical care, or would prefer to spend a limited amount of time at an institution.

A clinical Fellowship, which typically will be accredited by the American College of Graduate Medical Education (ACGME), will involve full participation in the clinical and surgical care of patients along with a varied amount of academic work. The clinical Fellowship is almost always a 12 month Fellowship and usually provides funding (with an annual salary of approximately $60,000 USD).

While the observerships and research Fellowships may be technically easier to obtain for College Trainees, the clinical Fellowship is considered the gold standard of USA Fellowships. The remainder of this discussion will pertain to the clinical Fellowship.

Early Preparation

Improve your profile. Well before you have selected your target USA Fellowships, the planning and preparation should begin. The best USA Fellowships are highly-competetive, and an impressive curriculum vitae will significantly improve your Fellowship prospects.

> Maintain an interest in research, ideally publishing and presenting studies.
> If your College specialty undertakes USA examinations as part of their routine Trainee assessment (such as the Orthopaedic In-Training Examination (OITE)), perform well in these examinations.
> Involvement in additional leadership and support roles within your specialty, within the College, and within the community is encouraged.
> Most importantly, strive to develop positive relationships with your consultants, in order to gain supportive references.

Assess whether your target Fellowship programs accept foreign medical graduates. The first formal step in obtaining a USA surgical Fellowship is to determine which Fellowship programs in your specialty accept international surgical Trainees. Unfortunately, a number of programs simply will not consider surgical Trainees from countries outside of the USA.

An online review of appealing Fellowship programs, combined with emailing the appropriate program administrators, will quickly determine if the Fellowship programs that you are interested in will consider accepting an overseas-trained Fellow.

Assess the type of State medical licenses that your target Fellowships accept. Although this varies slightly among states in the USA, most College Trainees will not be able to obtain a full State medical license without working in the USA for two to three years.

While some Fellowships have an absolute requirement for a full State medical license (and are therefore typically not available to College Fellows), a large number of Fellowship programs accept training or resident State medical licenses, which can be relatively easily obtained by College Trainees.

The United States Medical Licensing Examination

The United States Medical Licensing Examination (USMLE) is a multi-part professional exam that is required for RACS Trainees to undertake a USA Fellowship. The USMLE comprises three "Steps", with Step 2 divided into two separate examinations.

Although completing Step 1, Step 2-CK, and Step 2-CS will technically result in eligibility for College Trainees to undertake Fellowship training in the USA, an increasing number of Fellowship programs require applicants to have also passed Step 3.

The Educational Commission for Foreign Medical Graduates (www.ecfmg.org) provides the registration support for, and conducts, the USMLE Step 1, Step 2-CK, and Step 2-CS, while Step 3 is conducted by the Federation of State Medical Boards (www.fsmb.org).

Working Visas

Most USA surgical Fellowship programs encourage their international Fellows to obtain a J-1 visa. This is a non-immigrant visa that permits the holder to work in the USA in a specific position for the sponsoring institution, for a duration defined by the institution.

This visa is relatively simple to organise after a Fellowship has been secured, but restricts the holder from remaining as a surgeon in the USA after their Fellowship. Once the term of the J-1 visa has expired, the holder must undertake a mandatory two-year home-country physical presence prior to applying for another USA working visa.

An alternative to the J-1 for Fellowship purposes is the H-1B visa. Like the J-1, the H-1B is a non-immigrant visa. Unlike the J-1, however, the H-1B is a dual-intent visa, meaning that the holder can apply for USA immigration during their stay. The H-1B visa requires significant administration effort and expense on the part of the Fellowship program, and is therefore not actively encouraged.

Suggested Application Timeline

The application process for a USA surgical Fellowship should begin over three years before the start date of the Fellowship (which usually commence in July or August).

With the above points considered, the following timeline provides a step-by-step guide to obtaining a surgical Fellowship in the USA, according to year of RACS Surgical Education and Training (SET):

> SET 3 (January)
> Latest date to begin registration process for USMLE Step 1.
> Allow at least 12 months to complete USMLE Steps 1, 2-CK, 2-CS and 3.
> SET 3
> Determine your preferred sub-specialties.
> Investigate which target USA Fellowship programs accept international medical graduates, and determine their medical licensure requirements.

John Corboy *Medal*

Dr John Corboy (1969-2007) was elected chair of the Royal Australasian College of Surgeons Trainees' Association (RACSTA) in 2007. He was a great leader and a selfless representative of Trainees of the Royal Australasian College of Surgeons. He gave generously to his peers his time and wisdom. His energetic service to the profession and his tenacious passion for surgery despite personal adversity was remarkable. This distinguished award for surgical Trainees commemorates Dr John Corboy's achievements and recognises exceptional service by other Trainees.

The John Corboy Medal may be awarded annually to a Trainee who demonstrates the characteristics for which John was admired. As this is a unique award that recognises Trainees of the College the presentation is made at the Annual Scientific Congress (ASC).

The award is made to a candidate who shows some or all of the following qualities in the performance of his/her duties, in service to the surgical community, in the manner and approach to the fulfilment of their surgical training or by their commitment to and involvement with the community of surgical Trainees:

- **Outstanding leadership**
- **Selfless service**
- **Tenacity**
- **Service to Trainees of the College**

Nominations for 2012 are now open. To obtain a nomination form, or for any queries, please contact Ms. Fiona Bull, Manager, Surgical Training, at fiona.bull@surgeons.org. Nominations will close 5 p.m. on Friday 28 September 2012.

> SET 2-4
> Attend and possibly present research at USA conferences and educational meetings.
> Identify speakers that are associated with your programs of interest; approach them and introduce yourself. Most USA surgeons are very interested in, and happy to talk to, enthusiastic surgical Trainees from New Zealand and Australia. Follow up these discussions by email.
> Identify a New Zealand or Australian surgeon with USA connections and have them email relevant programs on your behalf.
> SET 3-4
> Visit your target USA Fellowship programs and spend a few days introducing yourself to local faculty, speaking with current Fellows, reviewing the Fellowship facilities.
> Once the program coordinator and surgeons see that you are an interesting, well-educated surgical Trainee from a developed country, who has complete command of the English language, the rest of the Fellowship organisation becomes much easier.
> SET 4 (April-June)
> Latest suggested date to complete USMLE Step 3.
> SET 4 (September)
> Register for Fellowship match and submit application materials.
> Most Fellowship programs now participate in computer-based "match" processes, which require verification of medical school transcripts, referee reports, and qualifications. After the registration is complete you will receive interview offers from the Fellowship programs you listed that are interested in you.
> SET 5 (January-February)
> Interview for Fellowships (either at the Fellowship institutions or coordinated with a USA surgical conference).
> SET 5 (April)
> Match Day – contacted by Fellowship if successful
> Once interviews are complete, you rank the programs you interviewed with. The programs also rank all of the candidates they interview. On "Match Day", there is a computer match program which aligns these rank lists, and you will be informed by email if you have successfully matched to a program.
> SET 5-6 (December-February)
> Apply for working visa.
> SET 6 (July-August)
> Commence Fellowship.

Matthew Boyle
New Zealand Orthopaedic Surgery Representative, RACS Trainees Association (RACSTA)

CONGRATULATIONS on your achievement

Mrs Dianne Cornish RACS Medal

It gives me great pleasure to present Mrs Dianne Cornish for the award of the RACS Medal.

Di commenced at the College as a casual staff member on 1 November, 1981, after six years working with the Tasmanian branch of the AMA. When this momentous achievement – almost 31 years – was mentioned at a recent gathering of Relationships staff, one of my younger team members muttered, "I wasn't even born then!"

I mention this not merely for the anecdote, but to indicate that this really has been a lifetime's commitment, dedication and contribution to the Royal Australasian College of Surgeons.

The College was a different workplace in the 1980s. Di's youngest son James was born during this time and when she returned to work when James was 10-days-old, he sat in a carry basket on the window ledge while Di got on with the business of the College. During school holidays, the AMA Council room (where RACS shares offices) was used as a crèche by Di and other staff with young children.

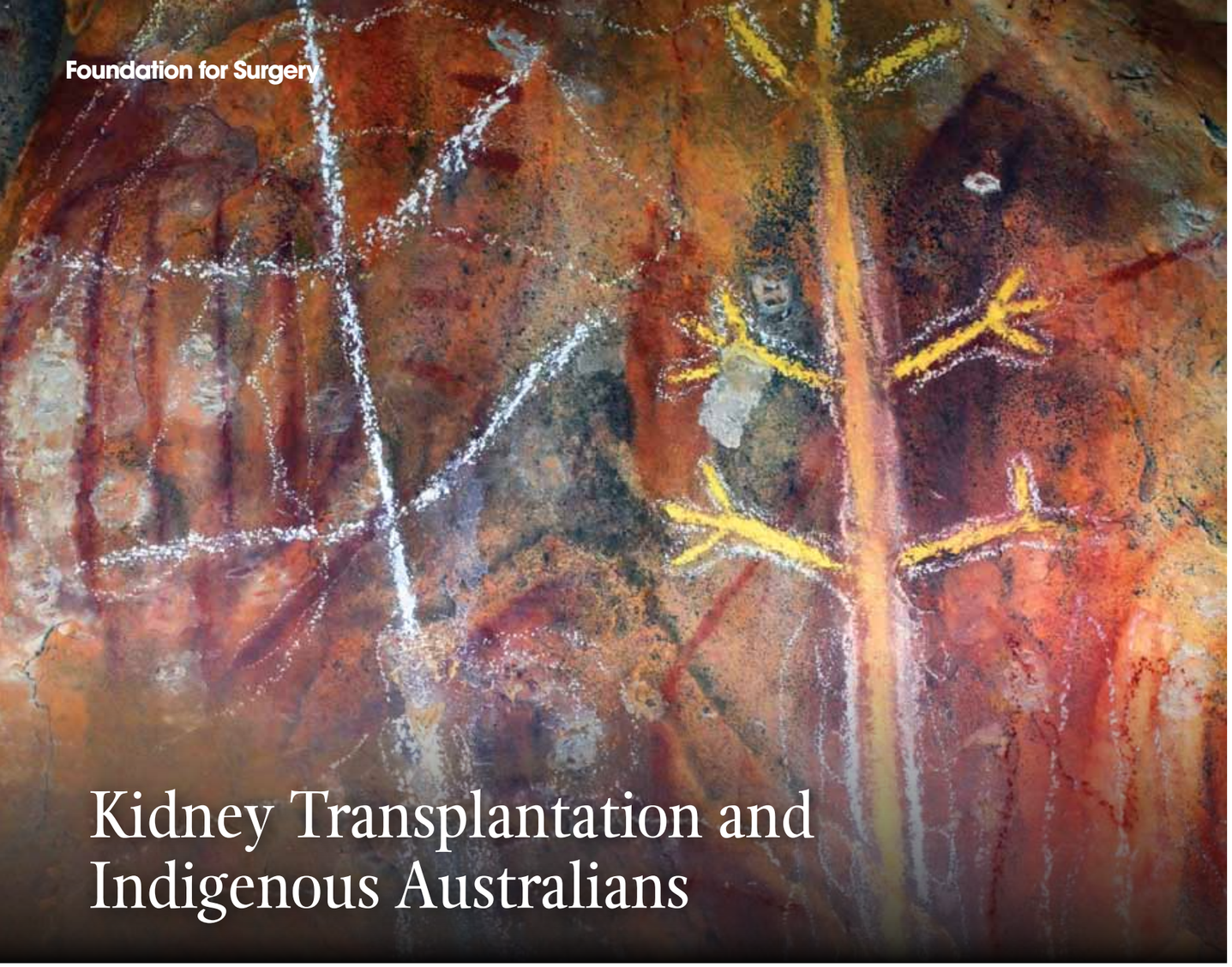
On 1 July 1994, in recognition of increased responsibility and workload, Council approved an increase to Di's hours and made her a permanent part-time employee; however, it was only earlier this year that her full 30 years of employment was formally recognised.

Di has given long and dedicated service to the Tasmanian Regional Committee. She is well known amongst the Tasmanian Fellowship and has won the respect and admiration of Fellows and Trainees alike for the contribution she makes and the dedication she shows to her role. She has an extensive knowledge of the history of the Tasmanian Regional Committee and has been instrumental in the organisation of a large number of Tasmanian Annual Scientific Meetings, many held jointly with the College of Physicians.

Di has worked with the College through changing times and has adapted to the new working environment. She is a well liked and respected member of the staff, especially among her regional manager peers. On a personal note, I have enjoyed working with Di immensely.

Mr President, as you are aware, the sole criterion for presentation of the RACS Medal shall be, "distinguished service to the affairs of the College". There can be no more fitting recipient than Mrs Di Cornish.

Citation kindly provided by RACS Relationships Director James McAdam.



Kidney Transplantation and Indigenous Australians

Another initiative of the Foundation for Surgery

This is the third in a series of four articles based on the findings of the Evidence Based Actions Plans (EBAPs), commissioned by the Foundation for Surgery as part of its commitment to addressing the health challenges in Australia's Indigenous communities.

The EBAPs are action orientated overviews that identify how improvements in the delivery of surgical services to Aboriginal and Torres Strait Islander peoples can contribute to better health outcomes in their communities.

The research was led by Professor Russell Gruen at Monash University and Alfred Health and Associate Professor Kelvin Kong, Chair of the College Indigenous Health Committee, in collaboration with research, clinical and policy experts from across Australia.

In this article, Foundation for Surgery Board member, Dr Chantel Thornton discusses end stage kidney disease among Aboriginal and Torres Strait Islander people.

End Stage Kidney Disease (ESKD) is the final stage of chronic Kidney Disease (CKD). The rate of ESKD among Indigenous Australians is 15 times that of non-Indigenous Australians

The treatment options for ESKD are dialysis and transplantation from either a living donor or a deceased donor. Non–Indigenous Australians have a high rate of success with renal transplant, and experience improvements in both quality of life and life expectancy post transplant. This is more marked with living related donor transplant. Approximately 39 per cent of Australian transplant recipients receive kidneys from live donors and they experience very few post-operative complications.

Transplantation is the most effective treatment for patients of all ages with ESKD. It lowers the risk of long-term mortality by 80 per cent and is more cost effective then long term dialysis. Despite the high rate of ESKD in our Indigenous population, transplant rates among Indigenous Australians are low – approximately one quarter the rate of non-Indigenous Australians – and are associated with a poorer outcome, both for the recipient and the donor.

In Australia's non-Indigenous population 90 per cent of patients are alive and 80 per cent of kidneys are functioning following deceased renal transplant. The figures are even better with live donors – 95 per cent alive and 85 per cent functioning at five years. In contrast, only 80 per cent of Indigenous Australian transplant recipients are alive at three years.

Transplanted kidneys in Indigenous Australians fail three times faster than in the non–Indigenous population. And more than 50 per cent of renal transplants in Indigenous Australians have failed by five years. This is mainly due to an increased rate of severe post-operative infection, acute rejection, Human Leucocyte Antigen (LCA) mismatching and fewer live donor transplants.

Indigenous donors have a much higher risk of death, cardiovascular disease, progressive kidney disease and ESKD compared with Indigenous persons who do not donate. Pre-emptive transplantation for patients with ESKD reduces health care costs, loss of employment and dialysis related morbidity.

Barriers to organ donation exist for both the Indigenous and non-Indigenous populations. The demand for renal transplants heavily outweighs the supply from both living and deceased donors. And while there has been a significant increase in the number of living donor transplants in recent years among non–Indigenous Australians, unfortunately this is not the case for the Indigenous population.

While several cultural factors have been suggested to explain the low rate of transplant among Indigenous Australians, who have lower donation rates than Indigenous populations in America, Canada and New Zealand, there have been no studies to test these theories. Regrettably, the Australian Organ and Tissue Authority does not have a targeted strategy to improve rates of transplant in the Indigenous population.

Unique barriers to renal donation exist in the Indigenous population. These include:

- **Geographic isolation –** while most Indigenous Australians live in Northern Australia, there are no acute renal transplant services located in that part of the country.
- **Waiting lists –** Indigenous Australians have reduced access to hospital waiting lists and late referral to specialist renal services compared with non-Indigenous Australians.
- **Poor communication –** Indigenous patients report confusion and lack of knowledge of their disease and have a poor understanding of ESKD and treatments offered.
- **Human Leucocyte Antigen (HLA) mismatch and sensitisation –** Indigenous patients are more likely to receive a HLA mismatched organ and are more likely to have pre-formed antibodies to the donor kidney, thus increasing the risk of rejection.
- **Cultural concerns of health care workers –** for unknown reasons hospital staff are less likely to ask the families of deceased Indigenous families if they would consider consenting to organ donation.

A variety of strategies have been suggested to improve access to renal transplants in the Indigenous population. These include:

- Developing a co-ordinated approach of targeting the patient and the donor.
- Utilising culturally competent Indigenous health workers and liaison officers to facilitate programs to assist in preventing and delaying progression from CKD to ESK.
- Identifying Indigenous patients that are most suitable for transplant and supporting them through their transplant journey.
- Identifying and addressing barriers to transplant in our Indigenous communities.
- Providing culturally appropriate education to donors and recipients.

Research is required to improve the renal transplant rate in Indigenous Australians. Data needs to be analysed that compares the outcomes of Indigenous long term dialysis patients with Indigenous patients post-transplant. Strategies need to be implemented which will reduce post-transplant complications, namely acute rejection and infection.

There needs to be support for the implementation of a national data base and an investigation into which Australian government and non-government initiatives improve Indigenous patient access to transplant.

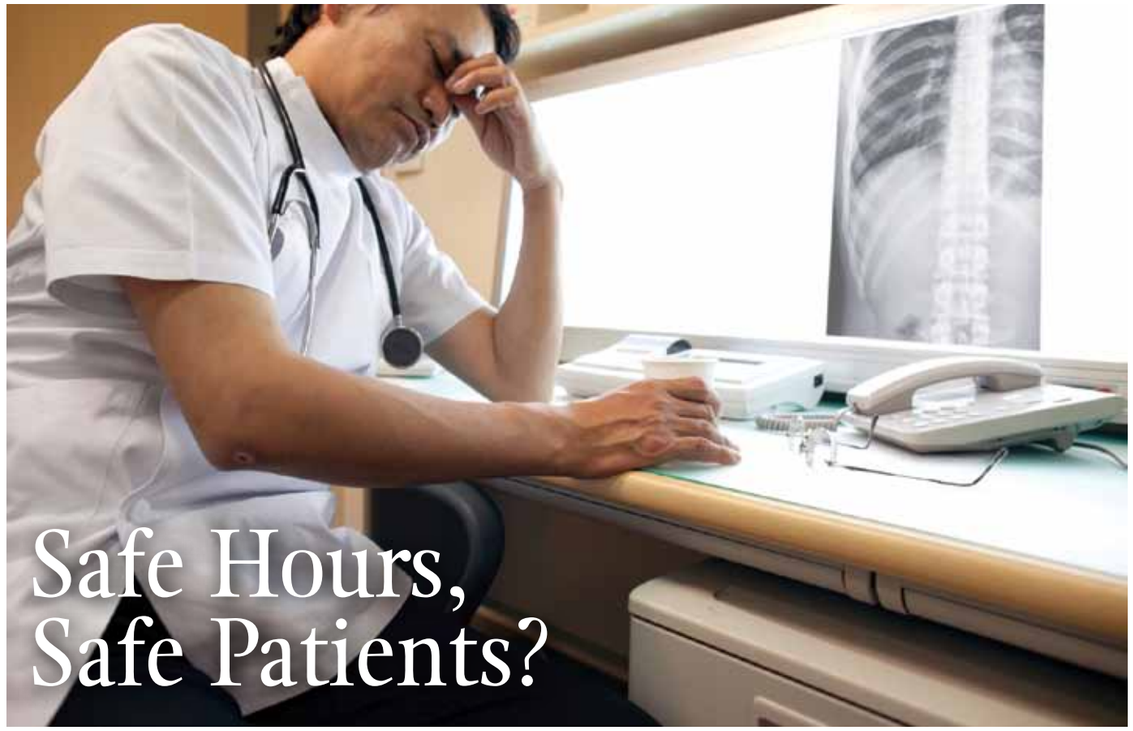
It is disappointing that Indigenous Australians have such a very high rate of ESKD and such a very low rate of successful renal transplant. Much work is required to address the barriers to transplantation in the Indigenous population and to improve both their quality of life and life expectancy.

The final article based on the findings of the EBAPs will be on 'Trauma in Australia's Indigenous Population'. Previous articles published in Surgical News addressed Otitis Media and Cataracts.

Chantel Thornton
Foundation for Surgery Board member

For those who want to support our work in Indigenous health you can do so by donating to the Foundation for Surgery. A donation form will be included in the next issue of *Surgical News*.

For those who want to give their time, we are more than happy to get them involved in some capacity and they are encouraged to contact the Indigenous Health Committee by telephone on (03) 9276 7407 or by emailing indigenoushealth@surgeons.org



Safe Hours, Safe Patients?

Fatigue: As dangerous as drink?

Studies (Dawson & Read 1997) have claimed 'the effect of sustained wakefulness and moderate alcohol consumption are similar'. Findings from the study, conducted at the University of South Australia, indicate that after 14 hours of wakefulness there is an impairment of motor skills performance equivalent to a blood alcohol level of 0.056, a level at which it is illegal to drive.[1]

This has obvious implications for medical practitioners. Doctors, who consistently work long hours, with few breaks and little sleep, may suffer a loss of judgement, significantly impairing their performance.

In May 2006, the AMA conducted a survey of over 550 doctors' working hours to evaluate the risks associated with fatigue. Assessing factors such as total weekly hours, amount of night work, length of shifts and on call commitments, the survey revealed that 62 per cent of hospital doctors had working hours and patterns that posed unsafe risks due to fatigue.[2]

Many hospitals have claimed to have taken measures to review working arrangements, but it is clear that many doctors continue to work long hours; which can have dangerous consequences for both patients and staff.

The AMA's Safe Hours = Safe Patients' campaign has identified a National Code of Practice for fatigue management for all members of the medical workforce:

> Avoid working in sessions for more than 10 hours.
> Take breaks that allow for a minimum of six hours continuous sleep.
> Avoid working more than four consecutive nights.
> Allow for short breaks within work sessions.[3]

The AMA's National Code, however, is far less comprehensive than the professional codes that regulate a number of other 'risky' industries, most notably the Australian Marine Pilots Association. That organisation's guidelines dealing with the moving of commercial ships in and out of Australia's harbours, is far more comprehensive, regulated and widely implemented than the equivalent guidelines laid down for doctors.

What is 'negligence'?

Where clinical incidents occur because of fatigue, a claim of 'negligence' may arise. Negligence is simply defined as the failure to possess or exercise the required degree of skill and knowledge in caring for a patient.[4]

A case noted in the ASMOF/AMA Queensland – Safe Hours Report 2005, is a clear illustration of the ways in which liability may arise from the practice of unsafe working hours. In this case, a 12-year-old boy developed glucose intolerance after open heart surgery for a congenital condition; subsequently developing brain damage. It was clear, however, that the surgery and its devastating consequences could have been avoided had the downward trend in his blood sugar levels been properly recorded.

This neglect prohibited the preventative action which could have been taken prior to injury. The hospital was ordered to pay $2.79 million in damages, with the Court concluding that the long shifts the staff worked, combined with an overwhelming workload had contributed to the oversight.

It is evident that the practice of unsafe working hours has severe implications for the proper practice of medical care.

How far are doctors protected?

Some protection of medical practitioners against the consequences of fatigue may be affected by the provision of indemnity insurance.

For example Queensland Health have stated: 'Legal assistance, representation and indemnity are to be provided by Queensland Health at the request of the practitioners, when the incident subject to the claim would not have, on the balance of probabilities occurred but for the fatigue'.[5] Other clinicians may be covered by private insurance or public hospital indemnity.

However, there is a possibility that a doctor may become excluded from coverage when:

> The medical practitioner's conduct has been proven to constitute 'wilful neglect'.
> The practitioner has been convicted of a criminal offence arising from the conduct that is the subject of the claim.
> The unsafe hours were not sanctioned by the hospital or employer.

When does fatigue become 'wilful neglect'?

The question, therefore, is what constitutes 'wilful neglect'. 'Wilful neglect' might be classified as an individual's failure to abide by rules and regulations relating to the mitigation of fatigue rest. The limitations of such provision are most apparent when we observe that Queensland Health references 811 pages of documents pertaining to workplace fatigue, and that a violation of any one of these regulations could form a case for 'wilful neglect'.[6]

Indeed, the Medical Insurance Group Australia (MIGA) clearly state that 'fatigue is no defence for negligence by a doctor in an action by a patient'.[7] MIGA argues that it is the responsibility of the individual doctor to ensure they manage their workloads effectively so they do not compromise patient care or their own general health. MIGA perceives this to be an 'essential risk management strategy for practising medicine in today's climate'.

How then can practitioners reduce risks associated with fatigue?

The AMA has identified three levels of risk: low, significant and high. They identify that doctors are operating at 'low risk' when they:

> Work no more than 50 hours a week.
> Work no more than 10 consecutive hours in any one period.
> Have a schedule shift for hours worked.
> Take three more short breaks during the shift.
> Work little or no overtime.
> Work no night shifts or extended hours into night shifts.
> Are rostered for on-call less than three in seven days. [8]

Of course, very few doctors operate under such optimum conditions. The campaign for safe hours and safe patients goes on.

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Michael Gorton, *College Solicitor*
With Sarah Walker, *Law Clerk*

Complications from umbilical hernia repair

Another important review

Sepsis following laparoscopic repair of an umbilical hernia

An elderly hypertensive patient had a laparoscopic intraperitoneal mesh repair of an umbilical hernia with a 3cm diameter defect. The patient did not progress well post-operatively and was thought to have a respiratory problem and was transferred to a second hospital on day four. CT pulmonary angiogram was negative and abdominal pain and distension and fever continued.

A CT of the abdomen revealed multiple fluid and gas containing collections and a "difficult laparoscopic removal of infected mesh and washout" was performed. The patient made slow progress, but continued to be septic and several weeks later a CT scan suggested pulmonary emboli and the patient was treated with Clexane.

Just over a month later the patient suddenly collapsed with a drop in haemoglobin to 4gms/dl and laparotomy was performed. Purulent fluid was drained deep to the umbilicus and a large volume of dark blood was found. The patient died on the operating table in spite of intensive efforts at resuscitation.

Comment

1. Repair of a primary umbilical hernia with a 3cm defect by the laparoscopic route is not recommended. It is only indicated for a very large ventral hernia with loss of domain of the abdomen. When a complication of a laparoscopic procedure occurs the question arises whether a repeat laparoscopic procedure or an open laparotomy should be performed.
2. The use of low molecular weight heparin which can't be monitored by pathological testing in the presence of intra-abdominal inflammation has to be questioned. The alternative therapy would have been Heparin infusion. The post-mortem did not reveal evidence of pulmonary embolism The last two issues are secondary, however, to the initial operation and to the delay in recognising the complication of it.

Guy Maddern
Chair, ANZASM

You can listen to this lecture through our ASC Virtual Congress, http://asc.surgeons.org/

Unity in a multi-ethnic *society*

The following is the second half of the President's Lecture delivered at this year's ASC, by Professor Chandra Muzaffar from the Universiti Sains Malaysia.

Friends, the second challenge that I talked about; justice. Here, again, you find that in many multi-ethnic societies how one distributes wealth and power is really the nub of the matter. How do you do this? There's hardly any society I know which has been able to overcome this challenge completely. But, nonetheless, you have societies that have attempted to address this challenge in different ways.

One of the lessons we can draw from the different experiences is this: that if your challenge is ethnic, in the sense that there is disparity in wealth which expresses itself in ethnic terms, a disparity in political power that expresses itself in ethnic terms, you will have to be conscious of that challenge. But you should not attempt to overcome that challenge by pursuing an ethnic approach. Because the moment you do that, you aggravate the problem. In other words, recognise the underlying ethnic currents pertaining to the distribution of wealth and power, but in trying to forge a solution, in trying to formulate policies and programs, adopt a non-ethnic approach.

For example, if a lot of people of a particular community are poor, you know that this is your challenge. But you try to overcome this by addressing that challenge on the basis of needs, not on the basis of ethnicity. In other words, help those who need help.

So you help those who are poor from that community and they may be the majority. But you also help others from other communities who are poor; simply put a user/needs approach. Now this is something which one has to think about as far as justice is concerned in relation to wealth and opportunities.

When it comes to power, political power, here again, one's concern has to be with expanding the space and scope for participation regardless of ethnicity. In other words, by adopting a non-ethnic approach you try to overcome what may be an ethnic problem, a problem of disparity in political power but you expand the opportunities for participation.

What this means is that we should try to strengthen the foundations of democracy in our society, the foundations for popular participation and the other institutions that strengthen democracy. Accountability is a very important institution. So is good governance. These institutions become very important in strengthening democracy.

The third challenge of empathy which is in some ways the most difficult. How do you create empathy? Perhaps through education, awareness; you make people aware of the differences that exist and you celebrate those differences. But, at the same time, you show them that there are similarities between people. You create situations which allow people to express feelings for the other and you set good examples. That's very important. Examples must come from the top in your society and people would begin to see that it is important to reach out to the other.

Friends, that brings me to the second part of this presentation and this will be the briefer part; looking at it globally. If you look at the situation globally, it is amazing how barriers have broken down, friends, in the last 40 or 50 years across the globe. For a variety of reasons, you'll find that people have become more aware that they are in a situation where there is the other. The other was always there, but becoming aware of the other globally is, in some ways, a new phenomenon. As a result of a number of factors and among the factors, great human tragedies have made us more aware of the presence of the other.

If you go back to the last 70 or 80 years; the Holocaust, the Second World War and after the Second World War if you look at the great environmental crisis that confronts all of us; they have made us aware of the other, that we are together, that there is a certain inter-connectedness that you cannot deny.

The economic crisis, the financial crisis, the energy crisis, the water crisis, the food crisis – all these crises have enhanced our awareness of our inter-connectedness. I know that crisis is a word that we social scientists use very loosely. It is a word that owes its origin to medicine. Of course, we have misused the term. But to return to the main point, all the crises that confront us, the great tragedies that have been part of our recent history and also tsunamis and cyclones and typhoons, these have somehow made us aware that there is a connection. There is a certain bond that holds humanity together.

But nonetheless, friends, even though we are aware of this vaguely, there are a lot of barriers. They're formidable barriers. Some would even argue that these are insurmountable. What are these barriers? The concentration of wealth and power and knowledge in the hands of a few at the global level is one of the big barriers. Because as long as wealth is concentrated in the hands of a few, you will find that a lot of people will feel disenfranchised. It could be a few in the north and a few in the south; not just in the north mind you, in the global north, but also a few in the global south who are rich and powerful and knowledgeable and a lot of others who have been left out. So you don't really create a united family. You don't really establish unity in that sort of circumstance. So this is a very big challenge; the challenge of disparities in wealth, power and knowledge at the global level.

There's another formidable challenge, friends. We have not been able to overcome prejudices, stereotypes, negative feelings about the other. In spite of our education, there doesn't seem to be a correlation unfortunately between our level of education and our attitude towards the other. Well educated people are sometimes very, very prejudiced. They're full of hate towards the other. It's very difficult to explain this, but this has been the sad story of humankind. Now, we have to overcome this.

Overcoming

Albert Einstein once said that it is harder to crack a prejudice than an atom. I think it is absolutely true. So this is the other challenge that we face. As the world becomes borderless, as we become more conscious of our common humanity and of our togetherness, we have to overcome challenges of this sort; disparities in wealth, power and knowledge and our prejudices which are very, very deep. That is something we have to overcome through education, awareness building, through exposure. One hopes that we will be able to overcome this particular challenge of prejudice and stereotypes.

In terms of overcoming the challenge of distribution of wealth and power and knowledge, it's going to be much more difficult in one sense because here you need institutional changes, major structural changes. But, here again, attempts are being made. I'm glad, for instance, to give you a very small example of this, that the G8 has become the G20. That's significant. It's not just a numerical change; it is a change that recognises the shifting pattern of global economic power. That, I think, is something that is good. It's positive.

Likewise, I'm glad that there are attempts to reform international institutions. Whether it is the IMF or the World Bank or the United Nations, attempts are being made in that direction. One hopes that through dialogue, not through war, through dialogue, we'll be able to bring about these changes.

As long as we can move along that path, friends – and this is the note on which I want to conclude – as long as we can address our challenges without going to war, without resorting to violence, there is hope for humankind. We must remain hopeful about the future because this is a moment in our history when a lot of good people can become very desperate and frustrated.

But moments like this also challenge us to look ahead with hope and with courage and that's what we need to do today.

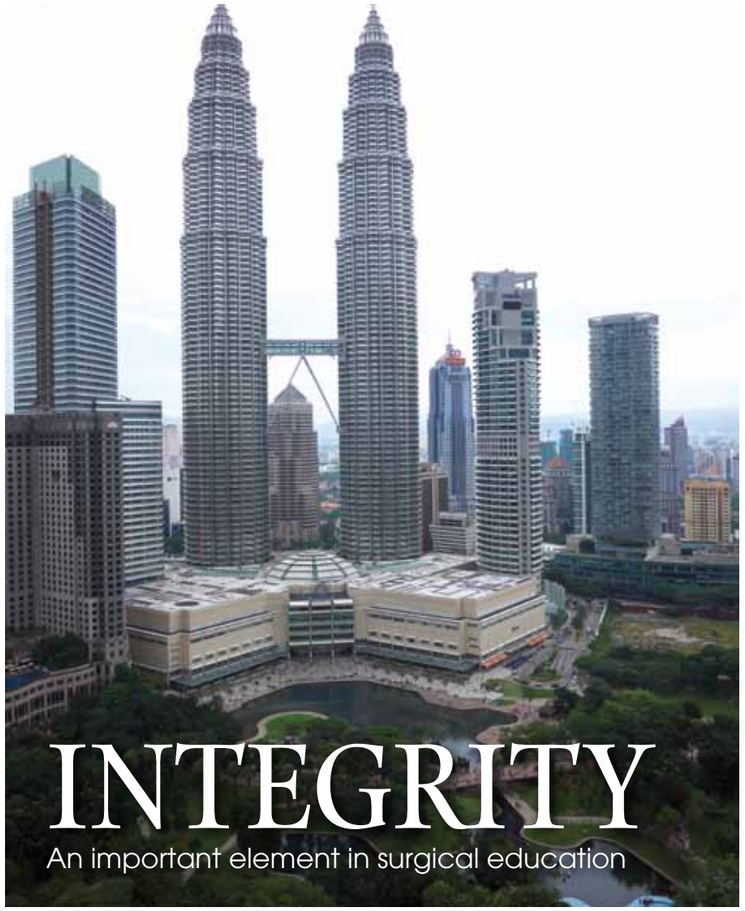
Thank you very much.

Thanks from immediate past President Ian Civil:

Professor Chandra, I'd like to thank you very much for coming and speaking with us today. What you said had much resonance for us as surgeons, when you talk about things like empathy and for us, as citizens of countries and members of the global population, talking about power and prejudice.

What you've said was inspiring and I think a challenge to all of us to reflect on our activities in our own lives and in our professional lives and I want to thank you again.

I would like to give you this medal to recognise this presidential lecture and a certificate that goes with it. Thank you very much.



Senior Surgeons and Surgical Specialists in all the states of Australia have noticed, with much concern, a growing disregard by younger practitioners of recognised ethics in Surgical Practice, combined with a spirit of commercialism tending to degrade the high traditions of the surgical profession.

Extract from the foundation letter of the Royal Australasian College of Surgeons, signed by Sir Graeme Syme, Hamilton Russell and H.B.Devine 1925

The theme of the RACS 81st Annual Scientific Congress in Kuala Lumpur in May 2012 was 'The Making of a Surgeon' and addressed the establishment of integrity in the surgical mind. To become a surgeon, you have to learn. Even Berlioz humorously once remarked that time is a great teacher, but inevitably kills its students.

The process of surgical teaching to produce a complete and rounded professional goes through many phases before the virtuoso emerges, and some of us take longer.

To operate one must be adept. To be successful one strives to become the "compleat" surgeon. Even to reconstruct one must embrace a further dimension – a touch of artistry, better said by Shama le Fleur whimsically years ago, "to dance you have to be an athlete, but to be a dancer you have to be an artist".

Kuala Lumpur

Kuala Lumpur (or KL) was founded as an enterprise settlement in the middle of the 19th century, its wealth based on the operations of the tin mine owned by the Selangor Royal family and renowned for producing everything from pewter goblets to wine decanters, to name a few.

The success of the post-Independence era was further revealed to me when I met David David in the foyer during the meeting. He has been coming to KL for many years as part of his International Cranio-Facial contribution.

He said that until the 1980s, pot-holes peppered the roadways and old colonial buildings were ubiquitous. Now the cityscape is dominated by glass towers, with only some token remnants of colonial architecture surviving.

The Convention Centre where the meeting was held lies in the shadows of the Petronas Towers, until recently the highest in the world (now outdone by Dubai). It is remarkable how the financial success of developing nations becomes quite evident once colonial domination recedes.

I attended the Convocation Ceremony on that Sunday afternoon, a rare event for me, and listened to erudite dissertations from the various college dignitaries, embracing aspects of surgical education including integrity. Merit awards were given to various beneficiaries befitting their surgical, educational and even legal contributions.

As is my usual wont, I was making notes to help pass the time. Perhaps in future a few Bach cantatas would lighten the atmosphere and alleviate the tedious formality of repeated handshakes and the frou-frou of academic gowns.

During the proceedings the person next to me nudged my arm and inquired "are you a reporter?" I did not have the quickness of wit to respond that I was writing for the Surgical News – another example of Diderot's l'esprit d'escalier, i.e. the smart response that one recalls only after the event.

During the meeting one of the plenary sessions was titled "The Making of a Surgeon". Three keynote speakers, David Hillis, Bruce Barraclough and John Quinn, addressed this theme from their pooled experience, including snippets from Aristotle to George Bernard Shaw.

However, one word encapsulates it all – "integrity" – commencing at the surgical training level, progressing to the scientific and acedemic stage, overcoming any political frustrations that emerge while balancing commercial necessities – edicts that remind one of the familiar teachings from the Marshall school of surgical philosophy.

Following my presentation on Head and Neck reconstruction, I appreciated the comment of Mike Klassen (from Auckland) who quoted the JFK adage "conformity is the jailer of freedom and the enemy of growth". Finally my time in Kuala Lumpur was prematurely curtailed and on Wednesday afternoon I left to catch a plane to Sumatra as part of an Interplast commitment. The Oriental express now passes on to Medan.

Ian Carlisle had organised for me to attend the meeting of the Indonesian Association of Plastic and Reconstructive surgeons at Medan at the exotic Hill Hotel and Resort in North Sumatra.

Ian has travelled to Indonesia many times over the past 20 years, teaching, lecturing and demonstrating – a great manifestation of his professional integrity and commitment.

Medan, the fourth largest city in Indonesia, is the capital of North Sumatra. There is an obvious commercial link between the old Dutch colonial city and its modern development.

The Dutch East India Company was one of the most successful colonial enterprises, trading in spices, rubber, cocoa, coffee, tea and tobacco (and even narcotics, one suspects).

It became one of the wealthiest trading entities in the world and let's not forget that the Dutch even introduced tea to Europe in the 16th century.

I arrived in the evening and the colonial airport at Medan was the size of Melbourne's Queen Victoria Market and at least as crowded. I was directed to the entry Visa counter. I then went back to collect my luggage and felt like a fish out of water. No language and no control, something I found daunting – quite lost.

However, a blessing in disguise came my way when an Indonesian plastic surgeon also returning from the KL Congress recognised me and offered me transport to the Hillside Resort for the clinical meeting, a drive of more than two and a half hours.

It was quite an experience meandering through traffic chaos, four lanes deep, with vehicles of all kinds snaking along and mopeds whizzing everywhere.

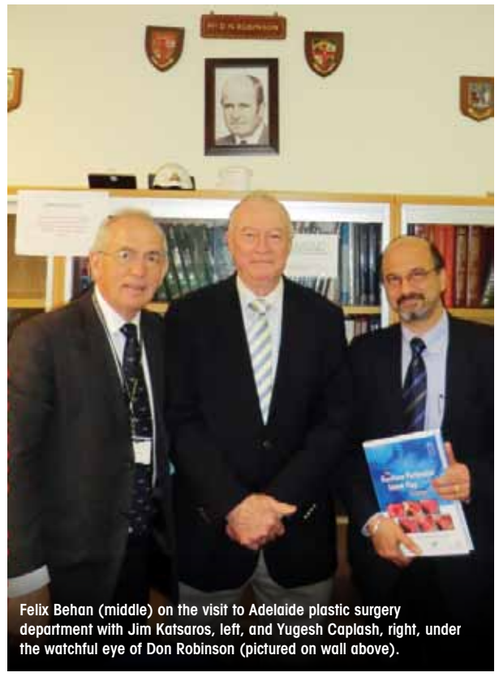
We then began our mountain ascent. We arrived and discovered a modern, exclusive resort development which was so large that we needed a golf cart to get from Reception to our accommodation.

The well-organised meeting displayed an international flavour and I was impressed by the diversity of speakers. Ian Carlisle was given an award for his surgical and academic contribution to Interplast in Indonesia over 20 years.

I was particularly impressed by the poster display, which covered a wide range of reconstructive topics including Millard and Manchester repairs (statistically Sumatra has approximately 4000 cleft lip and cleft palate cases per year, of which only 25 per cent are privileged to have surgery).

The sovereign wealth is there, the expertise is evident and there would have been over 100 plastic surgeons in attendance. Back in the late 1990s in the Asian financial crisis President Suharto signed a bailout agreement for $40 billion from the IMF – now 15 years later Indonesia is now one of the world's major economies. This is reflected everywhere.

With the group of Indonesian Plastic surgery and oncological colleagues


Felix Behan (middle) on the visit to Adelaide plastic surgery department with Jim Katsaros, left, and Yugesh Caplash, right, under the watchful eye of Don Robinson (pictured on wall above).


Trying to find my suitcase at the Medan airport

Opus XXIV
Felix Behan
Victorian Fellow

In Memoriam

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

Damian McMahon,
ACT General surgeon

Matthew Green,
Vic General surgeon

Ratan Edibam,
WA Orthopaedic surgeon

Christopher Elmes,
Qld General surgeon

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

Informing the College

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

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

Surgical Sketches and Sillouhettes

One of Randall Sachs glass sculptures

Adelaide

Back in Australia I was next invited to speak at the Plastic Surgical Department of Royal Adelaide Hospital, the home of the late Don Robinson and now David David, among others.

In the Reception foyer, a landscape by Tony Rieger is displayed on the wall. A bronze bust of Hippocrates lies beneath, together with the 1943 Edelsten translation of the oath, which is really a historical summary of integrity.

It states: "I swear... to hold him who has taught me this art as equal to my parents and to live my life in partnership with him, giving him a share of my money, teaching all who desire to learn all aspects of my craft and share the precepts and oral instructions with the sons of him who instructed me." I had not re-read this since graduating.

Randall Sach, now President of the Australian Hand Surgery Society, also had one of his sculpture pieces on display a composition of intertwined hands in both blue and translucent glass that to me had the Murano touch, but more importantly this sculpture also reminded me of a Rodin piece I saw at the Musee Rodin near Les Invalides in Paris some years ago.

As a parting gesture after my presentation, Jim Katsaros, one of the senior members of the team, gave me some quotes from the late Don Robinson which rounded off my visit. Don was quoted as saying, "thou shalt not commit tension unless you have to" and "If it won't go, force it".

Yes, integrity is the term which encompasses all the qualities inherent in making the accomplished surgeon. It embraces values, actions and methods, while acknowledging the origin of the word from the Latin "integer – wholeness or completeness", which seems to summarise all these facets.

PS: At the College Open Day on Saturday, 28 July, 2012, I enjoyed learning more about the College and its significant history from Scotty McLeish, one of the learned men of surgical science and a patrician of his day. Speaking to the public gathering, he pointed out some historical highlights, particularly the letter signed by Graeme Syme, Hamilton Russell and Hugh Devine in 1925, which became the foundation document for the establishment of the College (see illustration). The thoughts expressed in this letter still have relevance today. One has to ask has our metier really changed. In 2012, we still must adhere to the concept of integrity to provide the foundations of the surgical mind. Such a principle with the conflation of honesty and truthfulness must be always balanced against commercial influence however strong and other pressures which may impede such developments. Let's not forget the opposite of integrity is hypocrisy.

Opus XXIV

Felix Behan
Victorian Fellow

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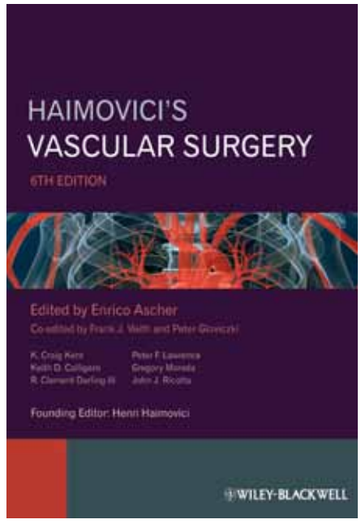

Haimovici's Vascular Surgery, 6th Edition

Enrico Ascher (Editor)
9781444330717 | Hbk | 1344 pages
August 2012

~~AU$445~~ | AU$333.75
Member Price

The role of the vascular surgeon has evolved. Vascular surgeons now perform minimally invasive vascular procedures and provide comprehensive care in addition to open surgery. This edition has been extensively updated to provide readers with expert perspectives on how the vascular surgery field has evolved. It contains concise and practical advice about what these changes and new areas of practice mean to practitioners and trainees in the fields of vascular surgery, interventional cardiology and interventional radiology.

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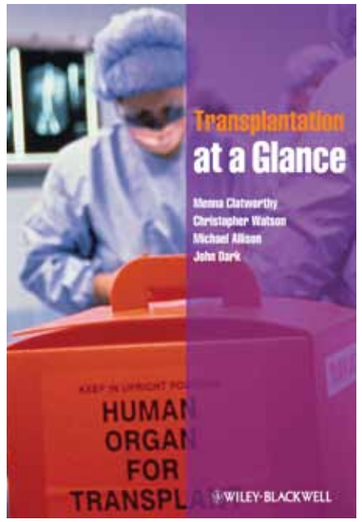

Transplantation at a Glance

Menna Clatworthy, Christopher Watson, Michael Allison, John Dark
9780470658420 | Pbk | 104 pages
August 2012

~~AU$47.95~~ | AU$35.96
Member Price

This brand new title provides a succinct overview of both the scientific and clinical principles of organ transplantation and the types of organ transplant, featuring highly-illustrated information covering core topics in transplantation including:

- Organ donors
- Organ preservation
- Assessment of transplant recipients
- Indications for transplantation
- Immunology of transplantation
- Immunosuppression and its complications
- Overviews of thoracic and abdominal organ transplantation, including the kidneys, liver, heart and lungs

Transplantation at a Glance is the ideal introduction for medical students, junior doctors, surgical trainees, immunology students, pharmacists, and nurses on transplant wards.

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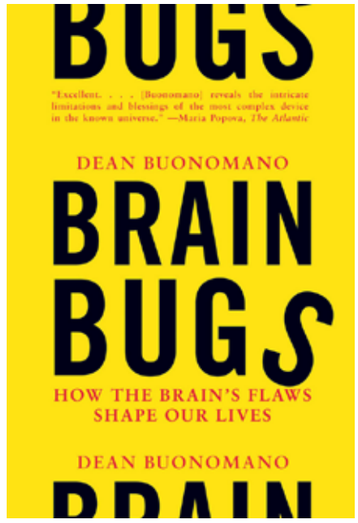


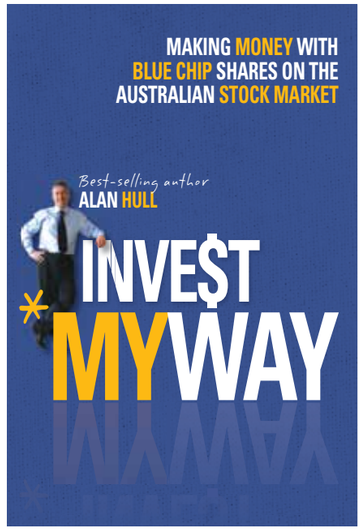
Brain Bugs: How the Brain's Flaws Shape Our Lives

NEW IN PAPERBACK
Dean Buonomano
9780393342222 | Pbk | 320 pages
August 2012

~~AU$22.95~~ | AU$17.21
Member Price

With its trillions of connections, the human brain is more beautiful and complex than anything we could ever build, but it's far from perfect. Our memory is unreliable; we can't multiply large sums in our heads; advertising manipulates our judgment; we tend to distrust people who are different from us; supernatural beliefs and superstitions are hard to shake; we prefer instant gratification to long-term gain; and what we presume to be rational decisions are often anything but. Drawing on striking examples and fascinating studies, neuroscientist Dean Buonomano illuminates the causes and consequences of these 'bugs' in terms of the brain's innermost workings and their evolutionary purposes. He then goes one step further, examining how our brains function — and malfunction — in the digital, predator-free, information-saturated, special effects-addled world that we have built for ourselves.

25% Discount



Invest My Way: The Business of Making Money on the Australian Share Market with Blue Chip Shares

Alan Hull
9781118319314 | Pbk | 272 pages
July 2012

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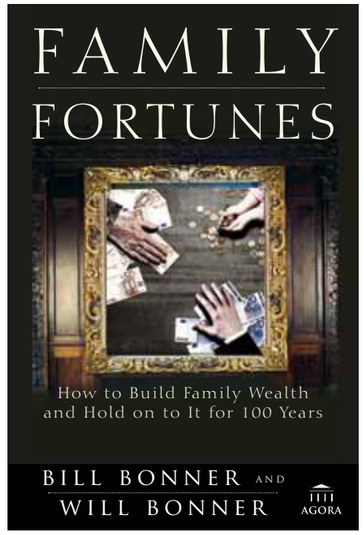

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Bill Bonner with Will Bonner
9781118171417 | Hbk | 324 pages
July 2012

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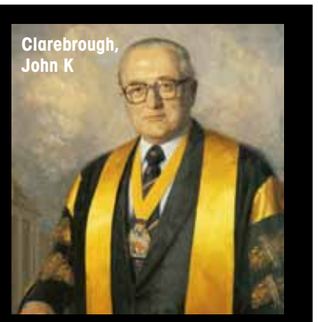

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The region is well serviced with public transport, and the combination of Freeways and Tollways, makes travel time to the city from Frankston less than 45 minutes, and 55 minutes to Melbourne airport. The Frankston bypass will open in early 2013, and further reduce these times. This new bypass will also speed up travel from the southern peninsula to Beleura and Peninsula Private Hospitals.

Exceptional wineries and many world class restaurants are scattered throughout the Peninsula's coastal fringe and the region between the two bays. Farmers markets and craft markets abound throughout the many 'villages' that span the region.

Major developments are nearing completion

A new Intensive Care Unit is part of a major development underway at the Peninsula site at 525 McClelland Drive, Frankston. Stage 1 of a new ward block will add 13 extra surgical beds to the hospitals bed stock. Stage 2 will see a further 11 beds added. An additional operating room is nearing completion and will expand the suite to 6 rooms. The expanded capacity will allow for the introduction of cardiothoracic surgery; this room is located next to the cardiac angiography suite. A cardiac diagnostic and interventional laboratory has been a feature at PPH since 2003. It meets the needs of the local community 24/7 and provides primary angioplasty for patients with acute infarction. There is a plan to replace this lab in the very near future.

At Beleura in Mornington, a fourth Operating room has been commissioned and a new 26 bed surgical ward block is underway. This will increase surgical capacity and support heavy demand for orthopaedic, plastic and reconstructive surgery, urology including green light laser and general and vascular surgery. The redevelopment project will also increase the number of mental health beds for both alcohol rehabilitation and general mental health ward.

Private Practice opportunities are available at both hospitals for specialists wishing to make a lifestyle choice to live and work in a semi rural environment and at the same time enjoy all the benefits the City of Melbourne (one of the world's most liveable cities) has to offer.

Beleura Opportunities

- Oncology
- General surgery
- Psychiatry
- Vascular surgery
- General surgery

Peninsula Opportunities

- Orthopaedic surgery
- Neurosurgery (spinal)
- Endocrine
- General surgery
- Obstetrics and Gynaecology
- Respiratory medicine
- General physicians

Please contact: Greg Hall
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