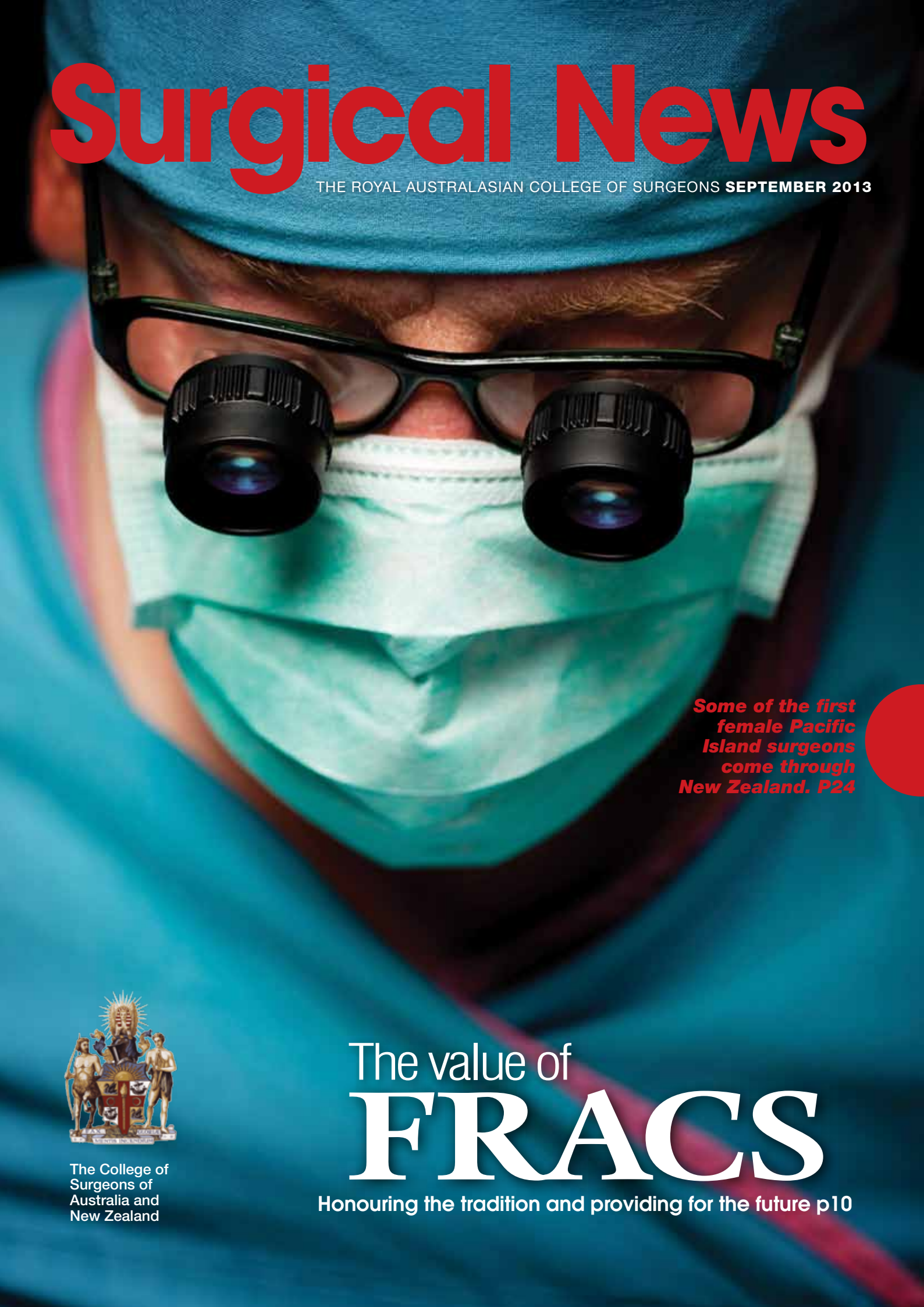
Surgical News

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



Some of the first female Pacific Island surgeons come through New Zealand. P24

The College of Surgeons of Australia and New Zealand

The value of FRACS

Honouring the tradition and providing for the future p10

contents

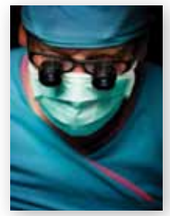
Correspondence to Surgical News should be sent to:
surgical.news@surgeons.org

Letters to the Editor should be sent to: letters.editor@surgeons.org
Or The Editor, Surgical News, Royal Australasian College of Surgeons,
College of Surgeons Gardens. 250-290 Spring Street, East Melbourne, Victoria 3002

T: +61 3 9249 1200 **F:** +61 9249 1219 **W:** www.surgeons.org
ISSN1443-9603 (Print) ISSN 1443-9565 (Online)

Certified System
Quality
ISO 9001
SAI GLOBAL

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



ON THE COVER:
The Value of FRACS.
P10

President's Perspective

Addressing bullying head-on

Just how many Trainees are being bullied? And is it just Trainees?

There was a lively discussion at June Council. The Trainees' Association had undertaken a survey of Trainees about the hospital posts. There was the expected range of 'outstanding experience and supervisors' to 'perhaps this post should not be a training position – they are not interested'. What was more disturbing and referred to on a number of occasions was that more than 20 per cent of the Trainees had felt they were being bullied repeatedly during the term.

I might add that bullying was not just a surgeon to Trainee interaction. Some Trainees felt they were bullied when, for example, the emergency department were struggling to cope with the four-hour rule, Trainees bullied Trainees etc. Debates seemed to spontaneously generate as to whether it had been over-reported or whether people were confusing instructions to 'do the job' with being bullied.

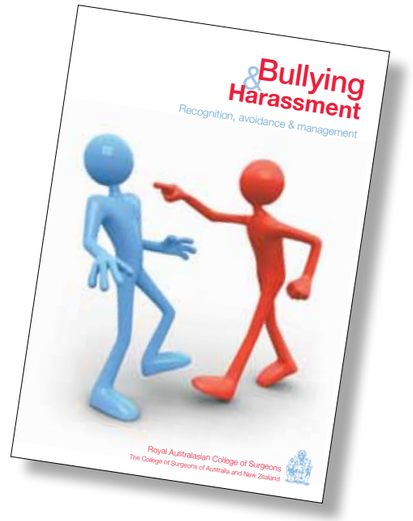
We all have anecdotes, most, fortunately, decades old, where surgeons 'threw things', be they instruments or tantrums. Almost universally this is now regarded as totally inappropriate behaviour. Surgeons do not support it and clinical leaders as well as management now appear to step in to ensure it is corrected.

However, as one Councillor remarked – we work in these bizarre matrix organisational structures where no-one seems to report to anyone. Finding someone responsible to change or improve things is really difficult. To get what you require, you need to either seduce your co-workers or if that does not work then bully them. There is also a culture of denial in some healthcare professions. As surgeons, this is something we must avoid.

The discussion rapidly moved beyond Trainees to individual surgeons being bullied by management. The other medical specialties as well as the nursing profession are no better off. There seemed to be an endless cycle of health professionals having a go at other health professionals.

We finished Council week with a conviction that bullying is endemic within the health sector. Whatever the rate is, it is too high. There is no doubt about the evidence that bullying contributes to worse teamwork and worse outcomes for the individual patient. Whether we like it or not, surgeons are part of it. We are subjected to it. We also contribute to it.

> *"Some Trainees felt they were bullied when, for example, the emergency department were struggling to cope with the four-hour rule"*



Since then bullying continues to be profiled, both within and outside our College and the health sector. It is a worrying trend in our society and other industries are trying to understand how to bring this under control and both regulators and the courts are starting to 'weigh in'.

Over the past two to three years, and in response to Geoffrey Davies' call for us to be more professional, Council has been identifying areas where we need to "be more professional". These include enforcing CPD, the College Code of Conduct and a position on surgical fees. Bullying is part of this push.

We have developed a booklet on Bullying and Harrassment, and we are keen to do more. The College needs to work collaboratively with other groups in the healthcare sector to see these issues identified, addressed and improved. There is much we can do in this area. The College Council and Executive will strive to show our College is a professional organisation leading the drive to address what is an endemic issue in the healthcare workforce.

Mike Hollands
President

Changes ahead

Successful advocacy and a change in command is ahead

Self-Education Expenses Cap

Over the past few weeks I have received innumerable communications from surgeons and Trainees dismayed by the decision announced in the May Federal Budget to cap tax deductibility for self-education at $2000 effective from July 1, 2014. The College has been very vocal on this issue. This has included writing to ministers, their shadow counterparts and the independent members of parliament. In addition, the College chose to join the 'Scrap the Cap' alliance of professional bodies and has been active within this group.

Our advocacy efforts have been rewarded particularly in respect of making this an issue. The Federal Government's August Economic Statement announced that the $2000 cap on self-education expenses would be deferred until July 1, 2015 to, "allow for further consultation on how best to target excessive claims while ensuring the impact on university enrolments and genuine continuing professional development is minimised."

This is a great outcome for your College's advocacy on this issue. Deferring the cap is a welcome reprieve and the accompanying statement could have been extracted from our position statement. We have also been thus far successful in severing the link made by the previous treasurer of the cap to the Gonski education reforms.

We will not, however, rest on our laurels. At the moment the cap is only deferred. Regardless of the outcome of the election, the College will continue to advocate for the abolition of this regressive and misguided idea and we will do this for the benefit of our patients.

Changes at the Skills Education Centre

The College's Skills & Education Centre in Melbourne has had a changing of the guard recently with the departure of urologist Mr Donald Murphy from the role of Medical Director of the Centre. We wish Donald well in his retirement from the College after nine years of significant contributions in the position.

A member of the Skills Laboratory Planning Committee from 2001, Donald was appointed as the inaugural Medical Director when the Skills Lab was opened three years later. The facility was set-up to provide practical surgical and related training in all disciplines and at all levels as part of our commitment to the ongoing training and development of surgeons.

Since the establishment of the Centre in 2004, thousands of Trainees, surgeons, other medical practitioners and medical students have benefited from world-class teaching across a wide array of skills.

Donald was presented with an Award for Outstanding Service at the recent President's Dinner. In his acceptance address Donald reflected on major achievements at the Skills Lab including achieving recognition of the Skill Laboratory as a School of Anatomy by the Department of Health and the development of 'bioreality' models in which the vascular circulation is reconstituted in selected animal organ models for advanced Trainee workshops. He developed a comprehensive portfolio of workshops for the urology Trainee program and spearheaded the development of the extremely successful Minor Surgery for Remote & Rural General Practitioners workshops. In 2008, he successfully completed his MD thesis encompassing the bioreality work and laparoscopic knot-tying techniques.

The College will not lose Donald's expertise altogether as he will continue to conduct his long-running laparoscopic knot-tying workshops and has promised to contribute as an instructor on other courses.

Donald has been succeeded as Medical Director of the Skills & Education Centre by Associate Professor Bruce Waxman, another distinguished Fellow of the College who comes with great credentials for the role. As well as having served as a Councillor for seven years, he was chair of the highly successful SATSET working party.

Bruce is highly motivated and keen to engage with all the Surgical Specialties and encourage them to make use of this great resource that we have at our disposal. Working alongside the Oversight Committee and Skills Lab Management, he plans to build on the first nine years achievements and establish the Centre as the first choice training facility for Fellows and Trainees.

There is an aim to identify 'champions' from each specialty and investigate how the Centre can be of more service. In addition, Bruce and the committee will be providing guidance and assistance in the development of courses and workshops for the nine Specialties in alignment with their curricula.

A good example of the Skills Lab work is the recent Acute Neurotrama workshop conducted by Councillor Associate Professor Marianne Vonau and Dr Teresa Withers for rural practitioners. There are occasions in the rural setting when surgeons need to perform emergency burr hole procedures. Importantly, these skills were taught using relatively inexpensive equipment typically available in smaller hospitals, such as the Hudson Brace.

Participants learned to accurately

evaluate whether immediate treatment is needed and how to proceed after contact with a neurosurgeon. Adequate time was spent operating on cadavers until participants were comfortable with performing the procedures.

If you would like to visit the lab or discuss possibilities for future workshops, don't hesitate to contact Bruce Waxman or Skills & Education Centre Manager David Lawrence on +61 3 9276 7455.

Council Elections

By now you will have received an email with a link to the ballot paper for the elections to Council. Those Fellows without an email address will receive notification via the surface mail as to how to log-on and vote. Council has determined that the introduction of electronic voting was timely, given the level of interactions we all have in the online world. (It is also cost effective being less than 20 per cent of the cost of a paper ballot!) It is also hoped that the ease and simplicity will encourage surgeons to vote.

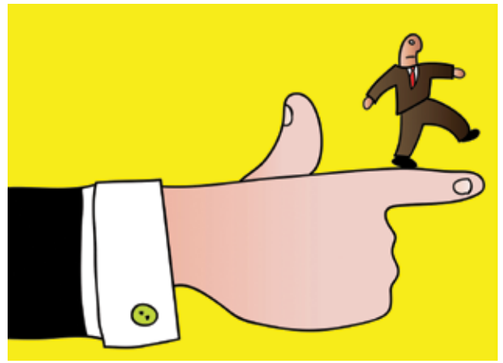
The election this year is a little earlier than normal. This will allow Council to elect the President in October, rather than in February thus affording the incoming President more time to organise their professional and personal affairs for what is an arduous and time consuming position.

It is important to vote. It allows you to have a say in how your professional organisation conducts itself. Voting closes at 5pm on Friday, October 11. Your ballot must be lodged by this time.

Michael Grigg
Vice President

Smart Knife

A revolutionary new tool has been developed to 'sniff' out cancer. The 'iknife' currently being tested in UK hospitals can distinguish between healthy and cancerous tissue.
The knife has the potential to revolutionise cancer surgery by letting off a smoke which is used to detect the cancerous tissue.
Inventor Dr Zoltan Takats has said it "could be a real game changer for resection surgery."
Cairns Post, July 19



Guide for Practitioners

The Australian Health Practitioner Regulation Agency (AHPRA) has released a guide to help doctors understand what happens when it receives a notification from the Medical Board of Australia.
Developed with various national boards, the guide includes a series of information sheets on time limits and process of notifications, an event that AHPRA CEO Martin Fletcher acknowledges can be confronting for practitioners. The guide can be found on the AHPRA website under Notifications.
Australian Medicine, July 29

Surgeon Street name

A developer on the Gold Coast has named a street after his surgeon after relieving him from debilitating back pain.
Norm Rix was headed for a wheelchair before he met Matthew Scott-Young and received the life-changing surgery.
"I was in the operating theatre within a week … he gave me my life back," Mr Rix said.
Gold Coast Bulletin, July 23

Surgery amnesia

A study into the effects of surgery and anaesthetic is underway at Melbourne's St Vincent's Hospital. It follows research that revealed forgetfulness and impaired decision making can affect one in seven older patients up to a year after surgery.
The research will look into whether alternatives of anaesthetics or surgery should be considered, and also whether there is any impact on dementia or Alzheimer's disease.
The research team is currently recruiting 250 patients to measure their cognitive ability before and two years following surgery.
Herald Sun, August 7

> *Fellowship of the Royal Australasian College of Surgeons gives me the privilege of interacting with brilliant, articulate men and women from my own and other craft groups all over Australia and New Zealand and to shape the future of surgery in this region*
>
> Cathy Ferguson FRACS

The value in FRACS

Honouring the tradition and providing for the future

Fellows of the Royal Australasian College of Surgeons carry the suffix FRACS throughout their career and beyond. These five letters represent not only a qualification of great standing, but also a brand of prestige amongst the medical profession and in the communities in which we live and work.

Since its establishment in 1927, the College has championed surgical standards in Australia and New Zealand. It is the result of persistent advocacy and leadership that the FRACS brand is so well respected and the College's opinion is sought on so many issues. Emergency Surgery and Elective Surgery urgency categorisation are two recent examples of this. The Surgical Education and Training Program is popular, highly competitive, excellent in quality and results in the award of Fellowship to more than 200 competent and proficient surgeons every year.

The College is a membership-based organisation, owned by its Fellows and governed by an elected Council of Fellows. Our Council has a responsibility to review current business models to ensure they are sustainable and provide the necessary resources to meet the needs of the Fellowship. The economic model in which the College operates must support the overall College Strategic Plan including the championing of professionalism and standards in surgical practice, enabling surgeons to contribute to their community and in the region.

> *To be a Fellow of the peak professional body for surgeons and to have the opportunity to advance the art and science of surgery through my interaction with Trainees and the Fellowship at large*
>
> Julian Smith FRACS

The annual subscription facilitates a variety of important activities and services, all of which promote the FRACS as the qualification that depicts excellence in surgical practice. Our subscriptions make possible the extensive work of the various College Boards and Committees, the Continuing Professional Development program, a world-class library with increasing online resources, the College website and a suite of highly effective professional development opportunities (including the Annual Scientific Congress).

Our contributions to disadvantaged communities are highly regarded and include humanitarian assistance, international development, indigenous, rural and telehealth initiatives. The College also provides support to Fellows in need through the Executive Directors of Surgical Affairs who are available to assist with up-skilling and re-entry to practice programs for individual Fellows.

A review of annual subscription categories has not been undertaken for some time. Council has revised the categories for 2014 to better reflect changing business models and to safeguard the College's future in terms of finance and the activities it can support.

The majority of Fellows will not be impacted by these changes. However, age-based categories have been replaced by categories designed to reflect the changing nature of the surgical workforce.

As we transition towards retirement, many of us remain in active clinical practice for longer, engaging in different forms of paid work (which may or may not be operative), while continuing to receive the services and benefits available to all Fellows of the College.

The revised categories provide concession to Fellows who have long-standing membership, those working part-time or are on parental leave and those Fellows engaged in a purely educational or voluntary capacity.

> *To share in the rich past and, together with colleagues, help guide and craft our professional future*
>
> John Batten FRACS

Full details of the revised subscription categories are in the table.

Throughout this article you will note some reflections from individual Fellows on what fellowship of the College means to each of them. We welcome your feedback on what fellowship means to you, and the value that you receive from your annual subscription.

If you have any questions or comment regarding the changes to the subscription categories or would like to know more about how these changes will affect your subscription, please contact us at College. Subscriptions@surgeons.org or call the College on +61 3 9276 7439.

Further information on College expenditure and how the annual subscription is allocated can be found in the 2012 College Annual Report, available on the College website www.surgeons.org.

Marianne Vonau
Treasurer
David Watters
Chair, Professional Development and Standards Board

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS COLLEGE SUBSCRIPTIONS AND CONCESSION CATEGORIES 2014

Category	Subscription Category	Subscription
1	Active Fellows engaged in clinical practice* for more than 8 hours per week	100% subscription
2	Active Fellows not engaged in clinical practice* (such as Academics fully involved in Research or Teaching)	50% subscription
3	Active Fellows working 8 hours or less per week	50% subscription
4	Active Fellows who have been a FRACS for less than six months of subscription year	50% subscription
5	Active Fellows who are a FRANZCO or FRANZCOG or are residing overseas	50% subscription
6	Active Fellows with at least 40 years membership	10% subscription
7	Retired Fellows - retiring ON or BEFORE 31 December 2013	0% subscription
8	Retired Fellows - retiring FROM 1 January 2014	10% subscription
9	Active Fellows undertaking a subsequent RACS Fellowship and paying training fees	0% subscription
10	Active Fellows only working in a voluntary capacity or who are on maternity, paternity, sick or compassionate leave	10% subscription
11	Fellows elected to the Court of Honour	0% subscription
12	Special subscription category to accommodate unusual circumstances	To be determined by the Treasurer

** "Clinical Practice" includes operative, consulting, assisting, general practice, medico legal and administrative roles.*

> *Being a Fellow of the RACS is to be recognised as being a member of a highly respected group of Surgeons who have achieved world-class high standards in surgical training and who continue to maintain those standards of surgical practice and professionalism through the ongoing accreditation requirements of membership*
>
> Ian Bennett FRACS

In Memoriam

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

James Robert Smith,
New South Wales Fellow

Peter Adolph Bolliger,
New South Wales Fellow

Kulasingham Ramanathan Sathiah,
New South Wales Fellow

John Sweeney,
South Australian Fellow

John Willams,
Victorian Fellow

Thomas Bruce Smith,
New South Wales Fellow

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

Informing the College

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

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

So many passwords!

How does our mind keep anything useful?

There is one thing that really annoys me and that is passwords. There are so many of them today – passwords for internet banking, for eBay, for ATMs, for frequent flyer programs, for College website access, for share reports, theatre change rooms and so on.

I actually counted mine today and there are 57 that I can find. I am sure that there are more, but until I need to use them I will not have them in my mind. Then I will not be able to remember what they are or where to find them.

One problem is that password requirements are often very different – four numbers, six numbers, eight characters, a mixture of letters and numbers and so on. If there was only one format then we could have one password, but no, they must be different. It seems odd that the highest risk passwords such as ATMs are only four numbers.

Surely that means a maximum of 10,000 combinations (0000 is a possible combination and so it is 10,000 not 9,999). Now my 2-year-old grand-daughter worked out my iPhone code in about five minutes, so watch out NAB.

The other odd thing about passwords is that the most complex ones are often for the websites with the least risk. At one place where I worked, the access to the payroll section was eight characters and had to have a mixture of letters, numbers and symbols. On that website the worst that an intruder could do was to send me on leave for a month. Some days I would have welcomed that.

To make it even more difficult the password expired after 30 days and had to be re-set. As there was no need to access the website more often than every month or so, I was always getting mine reset. This was easily done by phone – the temporary password was always the day and date (e.g. Tuesday14). Now when you re-set it, you could not use any prior password or any three characters in the same order that had been used before. Talk about Fort Knox!

The list of the 25 commonest passwords includes such predictable ones as 1234, password, letmein and iloveyou, but what about ninja, monkey and Ashley? I see that curmudgeon is not on the list, so there's an idea.

Poison'd Chalice

My crown is called content

My career trajectory to being a Surgical Director of a thriving but cash-starved metropolitan public hospital had never been assumed nor dreamed about. Indeed in my earlier days, I had desired to be a thespian, maybe even a Geoffrey Rush. Oh, the drama of a stage.

Indeed, before I had become a Shakespeare fanatic I had done public readings of the poetry of Ralph Waldo Emerson. I had been captured by his involvement in the Transcendentalist movement and quotes like, "Whatever you do, you need courage. Whatever course you decide upon, there is always someone to tell you that you are wrong. There are always difficulties arising that tempt you to believe your critics are right ... but it takes brave men and women to win victories ..."

My career path had been anything but usual; drama, theatre, research, surgical practice, management, health policy guru, sometimes political heavy weight ...

One of the joys of working with enthusiastic Trainees is they all seek advice as to where their career may lead. As Hamlet said, "We know what we are, but know not what we may be ..." (Hamlet Act 4, Scene 5). My current registrar knew that I was susceptible to the occasional flattery and she 'coated' her questions appropriately: "Surely a surgeon of your enormous skill and experience coupled with your caring, personable nature could make a small fortune in private land. So why don't you?"

This was clearly a pivotal moment in my registrar's life. My answer, or rather her assessment of my answer, may well have far reaching consequences. I was glad that my better half was not around – she may have wanted to know the answer as well. She had heard me quote from Othello, Act 3, Scene 3, "poor and content is rich and rich enough" and had always responded that "ambition should be made of sterner stuff" (Julius Caesar; Act 3, Scene 2).

My mind returned to a basement laboratory in a well-known London teaching hospital many years ago. I was sitting on a stool, silently looking at the data – the realisation spreading through the group sitting with me was that we had made a breakthrough that would change the way that we would think in the future.

Even today, in my hospital, I see this discovery applied on a daily basis with nary a thought of where it came from. At times I want to scream that 'it was us.' My mind returned to the evening of that momentous day. I was in the pub – inevitable you might say. My colleague, my partner in research was with me. We should have been jolly. Instead he said somewhat morosely, "Well that is it for me. I am applying for that consultant's job in Gloucester."

This was news. He had embarked on an academic surgical career at a London teaching hospital and was now about to give it all up. I didn't really need to ask the reason why. He had never been interested in money, but he was married and had two small children. His colleagues of the same vintage had been lured to Harley Street and now in comparison he was increasingly unable to provide for his family as well as they were for theirs. Although he had been willing to sacrifice himself for his ideals, he was not so willing to make his family sacrifice. It speaks to "all the world's a stage, and all the men and women merely players: they have their exits and their entrances" (As You Like It, Act 2, Scene 7).

Is a career in academic surgery valued highly enough? Probably not. No, my rewards for doing the job were not financial – they centred around collegiality – peer interaction, teaching and yes, research – exploring something that no-one had done before. And public hospitals were traditionally placed to commit to the words of Timon of Athens (Act 1 Scene 1), "tis not enough to help the feeble up but to support them after ..." Maybe altruism does still exist.

I looked my registrar in the eye. "I like what I do," I said. "And I hope to make a difference. Besides if I was solely in private land, I wouldn't have met you, helped your career develop and ensure that you will be good enough to look after me when I need surgical care!"

I looked at her and through her to the Trainees over the years. Look, I said, I really like this, as Henry VI (Henry VI Part III, Act III, Scene 1) so passionately stated, "My crown is called content, a crown it is that seldom kings enjoy."

Professor U.R. Kidding

CASE STUDY

DVT and PE

Log in to the College website to join the discussion: http://www.surgeons.org/181592.aspx

An elderly patient died from a fatal pulmonary embolus nearly two weeks after a radical cystectomy and right nephroureterectomy with ileal conduit formation. There was always at least a moderate risk of peri operative death as the patient had a pre-existing co-morbidities of ischaemic heart disease and renal impairment (ASA Level 3) as well as being of advanced age.

The patient was at high risk of postoperative deep vein thrombosis/ pulmonary embolism (DVT/PE) and may probably have received more aggressive prophylaxis. A month prior to the operation the patient had undergone a transurethral bladder tumour resection and insertion of ureteric stents in a private hospital. This procedure was covered by subcutaneous (S/C) heparin for around three days. The notes provided are brief, but it would seem the patient had difficulty walking after that operation (unstated reasons) and did not leave hospital between that operation and the cystectomy. It is unclear as to whether the patient received ongoing heparin during that time

On the day before the cystectomy, the resident medical officer's (RMO's) admission notes state the patient had a past history of DVT and PE. This was not recorded at the pre-admission clinic, or by the Consultant Anaesthetist at the same clinic nor on the surgeon's admission/consent form.

The patient received an average dose of s/c heparin the night before the cystectomy, but no heparin at all on the day of surgery. Calf-compressions were used during the operation and for the first 24 hours. Thereafter, the patient wore thrombo embolic deterrent (TED) stockings and received a further average dose of s/c heparin twice daily until death. Post-operatively, the patient had a prolonged ileus requiring total parenteral nutrition (TPN) support. The physiotherapists clearly had considerable problems mobilising the patient, partly due to the clinical condition of the patient.

Comment

This patient was at considerable risk of DVT/PE. Yet, for unstated reasons, did not receive heparin on the day of surgery; these doses arguably being the most important. Consideration could have been given to more aggressive prophylaxis both pre and post operatively, e.g. Clexane 40mg s/c daily or even a higher dose.

Guy Maddern
Chair, ANZASM

Open House Melbourne

Another successful year for Open House at the College

Open House Melbourne began in 2008 and has grown to become one of Melbourne's iconic annual events. This year the event, which is recognised internationally, was held on July 27 and 28.

The College has participated in the event for the last three years and opened its doors from 10am to 4pm on both Saturday and Sunday. It was streamed in an Itinerary called 'Weird Science', which included buildings such as St Vincent's Hospital and the Harry Brookes Allen Museum of Anatomy and Pathology at the University of Melbourne.

This year the tours were arranged in similar manner to 2012 and visitors were given tours of heritage areas and the Skills Centre. The event was very successful with the College receiving 1,056 visitors over the two days. This is about 220 more than last year or an increase of 26 per cent.

Overall this was the most successful Melbourne Open House ever, with more than 126,700 visitors gaining access to 111 sites and properties.

Open House Melbourne remains an excellent opportunity to showcase the College and its works. The College would like to thank the expert room presenters, staff and other volunteers for generously giving their time and sharing their knowledge, thus ensuring the success of the weekend.

I. E. McInnes
Chair, Heritage & Archives Committee

Top left: Campbell Miles welcomes and introduces visitors to the College head office; the line snakes up the driveway for the third year running; John Royle talks about features of the Council Room.

Teaching for change

The second part of the ATLASS program focuses on improving maternal and newborn health

Since 2001, the College has implemented several programs of service delivery and training to treat the people of East Timor and help improve the local health system through funding provided by AusAID.

Now the current ATLASS II program is working to train doctors in specialist skills appropriate to local demand in areas such as surgery, anaesthesia, obstetrics and paediatrics, with a particular focus on maternal and newborn health.

As part of the program, obstetrician Dr Alexis Shub moved to East Timor earlierthis year and now works alongside the College's in-country clinical team at the Hospital Nacional Guido Valadares (HNGV) in Dili.

She works closely with staff in the hospital's Obstetrics Department to help develop the maternal health workforce in East Timor with the ultimate aim of reducing the continuing high rates of maternal and newborn mortality and morbidity and improve access to comprehensive emergency obstetric and neonatal care. She talks to *Surgical News* about the challenges facing the women and babies of East Timor.

Where did you work before taking up the position of Long-Term Obstetrician in East Timor?

I had been working as a maternal foetal medicine subspecialist at the Mercy Hospital for Women in Melbourne, caring primarily for women with high risk pregnancies due to their underlying medical conditions, complicated obstetric history or foetal anomalies. I was also a senior lecturer at the University of Melbourne.

What appealed to you about the position and when did you arrive there?

The position appealed because of the strong emphasis on teaching and capacity building, not just service provision. Service provision is very satisfying in the short term, but I also like the aim of making my position obsolete. East Timor was also appealing as a suitable location to bring my young children for an extended period with a stable political situation, schools and great beaches. I arrived in January this year.

What are the main issues affecting pregnant women and babies and driving the high rates of maternal and newborn mortality and morbidity?

The high rates of maternal and infant mortality are multifactorial. Home birth is extremely common here, such that across the country up to 70 per cent of women deliver at home, almost all with only family members for assistance. Many obstetric complications develop and become life threatening within hours and the combination of high risk births, poor health education and difficult travel conditions makes it virtually impossible for these women to be cared for safely.

Many women, especially in the wet season when travel conditions are even more difficult, may face a long walk, and then hours of driving to access skilled health care. Limited antenatal care also contributes to the high rates with around 15 per cent of women having no antenatal care at all, and only 55 per cent having the WHO-recommended four visits. This means that important diagnoses including twins, placenta praevia and preeclampsia are often made very late or while in labour.

Residents at the Hospital Nacional Guido Valadares, Dr Elisa da Silva Belo and Dr Zélia Elisa Soares Vitorino Ximenes, with Dr Alexis Shub.

Malnutrition and anaemia are also common so women are less able to tolerate complications such as postpartum haemorrhage or eclampsia. Grand multiparity is another important contributor because women in East Timor have the highest average parity in the world, with 5.7 children for each woman. These women are more likely to deliver at home and are also more likely to have complications such as postpartum haemorrhage and abnormal presentations.

What has been the central focus of your training endeavours since your arrival?

The main focus of the program has been on teaching junior doctors in the postgraduate diploma of obstetrics. This is a new program, which started with only two candidates, and now has one. Although the numbers are small, the current candidate has made enormous progress in obstetric knowledge while also making some significant advances in medical thinking and professionalism.

Hopefully, with solid background training, she will be able to go overseas and complete specialist training successfully. My other focus has been on trying to support simple structural change in the Obstetrics Department such as encouraging the use of medication charts, whiteboards to track patients and maintaining regular documentation in the patient notes.

What are some of the difficult or life saving procedures you have conducted since your arrival?

Women in the HNGV are regularly seen with life threatening conditions. In comparison to my usual job in a tertiary hospital in Melbourne, I have seen much more eclampsia, which is rarely seen in Australia due to good antenatal care. In the best conditions, the maternal mortality from eclampsia is less than five per cent but here it is closer to 50 per cent.

I have been fortunate to be able to deliver both twins and breeches vaginally, which are much less common in obstetric practice in Australia due to the high caesarean rate and low tolerance of foetal risk. I have also been able to see the benefits of transfusion of fresh whole blood in immediately reversing DIC in a woman with a large abruption and foetal death.

I was also able to make an antenatal diagnosis of foetal duodenal atresia on ultrasound which enabled the woman to be transferred to Australia with the support of the charity ROMAC and for her baby to undergo early neonatal surgery and survive. Before the College inclusion of obstetrics in the program, this level of ultrasound and antenatal diagnosis was not possible and ROMAC had not undertaken antenatal transfer before.

Still, although such work is rewarding, the most satisfying is the introduction of simple clinical procedures, such as detecting oligohydramnios on ultrasound in a woman in spurious labour, organising an induction and knowing that a foetal death has probably been ▶

Royal Australasian College of Surgeons

Nominations invited for the

SURGEONS INTERNATIONAL AWARD

The Surgeons International Award provides for doctors, nurses or other health professionals from developing communities to undertake short term visits to one or more Australian or New Zealand hospitals to acquire the knowledge, skills and contacts needed for the promotion of improved health services in the recipient's country.

The Award may cover a return economy class airfare, necessary accommodation costs and living expenses for the recipient. The value of the award varies up to a total amount of AU $12,000, depending on the requirements of the candidate's program.

Fellows participating in the RACS International Development Program or international outreach work are encouraged to nominate worthy individuals they have identified while undertaking outreach work.

Fellows who nominate worthy individuals with whom they have had contact must be willing to accept the responsibility for arranging a suitable program and acting as a personal host to the award recipient.

NOMINATIONS MUST INCLUDE

- Personal and professional information concerning the nominee;
- Objectives of the proposed visit;
- Anticipated benefits to the nominee and their home country;
- Names of the International Development Program team members responsible for organising the visit (including accommodation, training program and travel within Australia);
- An outline of the proposed training program and activities; and
- Letters of recommendation from the nominee's hospital and/or Health Department with an indication of the local importance of any upskilling resulting from the Award.

Dr Malemo Luc Kalisya from the Democratic Republic of Congo was supported to participate at the RACS ASC 2013 in Auckland, and undertook a four week hospital attachment at Princess Alexandra Hospital under the mentorship of Dr Neil Wetzig. Dr Wetzig has been working with Dr Luc and his colleagues during annual visits to the D.R. Congo for over 10 years.

CONTACT INFORMATION

For further information or to submit an application

International Scholarships Officer
Royal Australasian College of Surgeons
College of Surgeons' Gardens
250 – 290 Spring St, East Melbourne VIC 3002, Australia

Or by fax or email to:

Telephone: +61 3 9249 1211 Fax: +61 3 9276 7431
Email: international.scholarships@surgeons.org

Dr Shub provides vital services while training in-house staff

prevented. If these processes continue beyond my time here, then that to me is more rewarding than the occasionally dramatic clinical events.

What does it mean to you personally to help the women of East Timor safely deliver their babies?

Although there are many frustrations in working here, I am endlessly inspired by the women themselves. They face pain and suffering with bravery and dignity and even when outcomes are poor, they are always polite and grateful for the help they have received. In East Timor, I regularly feel that I have made a real difference to women and their families in a way that is an unusual event in Australia.

Are there any firm expectations of how low mortality or morbidity rates could go with an adequately trained workforce and is there a time frame of when this could be achieved?

Other similar countries have halved maternal mortality rates in as little as six years. This cannot be achieved without huge changes in practice, the most significant of which would be reducing the rates of home birth. While women deliver at home, maternal and neonatal mortality will continue to be high.

The other important issue is that most births and deaths are not registered and so all data which is quoted has an element of uncertainty. Better data collection will make it possible to institute and monitor change.

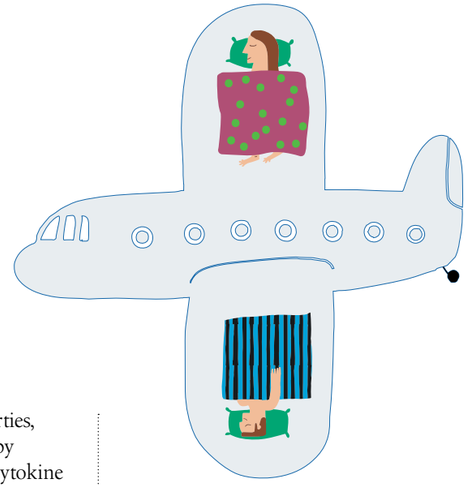
Have you felt supported by the College and the ATLASS II program?

The College and ATLASS have provided excellent support, both during the mobilisation phase and during our time in Dili. The staff in International Projects, especially Kate Moss and Kate Groves, have been endlessly helpful with all the logistics of moving a family to another country.

With Karen Murphy

Jet-lagged in want of chronobiotics

Try to adjust your body the natural way



Surgeons seem to think nothing of flying across the world through multiple time zones, playing havoc with their circadian rhythms suffering sleep deprivation with masochistic bravado. Yes, they get sick, pick up dreadful respiratory infections on planes, but it never deters them from aspiring to be a millionaire in frequent flyer points and flash [in airports] their heavy metal FF loyalty status.

The other day *Professor GL Obe Trotta* came to ask for a prescription for melatonin, a chronobiotic recommended by esteemed colleagues citing its efficacy in clinical trials.

I was hesitant. I have never taken it myself. That's not to say *Prof GL Obe Trotta* can't have it, but first I gave some contrary advice. Dr BB G-loved is no shrinking violet, not even when faced with workaholic professors bent on performance enhancing hormone supplements to advance their international renown and influence.

Melatonin (N1-acetyl-5-methoxytryptamine) is a neurohormone, synthesised from tryptophan via serotonin and secreted by the pineal under control of the suprachiasmic nucleus of the hypothalamus; secretion is inhibited by light [blue light 460-480nm] and permitted by darkness.

It has numerous physiological effects including those on blood pressure, neural, gastrointestinal, immune and endocrine, including gonadal function. Melatonin is also produced in enterochromaffin cells of the gastrointestinal tract and in the gonads. It is also present in plants (Feverfew and St John's Wort), rice, cereals, olive oil, tomatoes, and fruit – especially cherries.

It is a powerful antioxidant, counteracting the generation of oxidative stress, thus reducing mitochondrial and nuclear DNA damage. It has potent anti-inflammatory properties, modulating immune responses by regulation of T helper cells and cytokine production. Its free radical scavenging properties are being investigated in animal models of recovery from stroke. In vivo models of autoimmune disease have been established to study its efficacy for multiple sclerosis, lupus and inflammatory bowel disease.

Further clinical trials are awaited, but one has already shown efficacy in maintaining remission in ulcerative colitis. It is beneficial for the cardiovascular system, ameliorating vascular endothelial damage. Lower melatonin levels are associated with type II diabetes.

Melatonin supplementation protects neuronal cells from ageing by anti-oxidant and anti-amyloid activity, and slows down the progression of cognitive impairment in patients with Alzheimer's disease, probably by reducing tau hyperphosphorylation. Melatonin affects mental health – low levels being associated with both depression and schizophrenia.

It was approved as a pharmaceutical agent (Circadin) in Australia in 2009 and New Zealand in 2011 [2mg prolonged release] as a short-term prescription [up to three weeks] for insomnia or poor quality of sleep in patients over the age of 55. These approvals followed that of the European Medicines Agency in 2007. The FDA regards it as a dietary supplement, not as a drug, so it is obtained without prescription in the US.

It is clinically indicated for those with sleep disorders, and can be considered in those with deranged circadian rhythms due to shift work or mental illness. Surgeons crossing lines of longitude stretches my imagination, but maybe there's a parallel.

I had to admit a Cochrane Review lends support for its use in jetlag at doses of 0.5-5mg, though not the 2mg slow release tablet available on prescription. Yet it must be taken close to target bedtime, having crossed five or more time zones in an easterly direction [i.e. not for the Magi visiting Bethlehem].

But there are simpler alternatives to manage jetlag: sleep as much as you can on the plane, arrive during the morning, stay up until the early evening, no matter how hard that is [no point in taking melatonin unless you can stay up till 10pm], get out in the sun (for some natural circadian re-setting), exercise [preferably outdoors during daylight] and eat regularly.

Natural adjustment occurs at about one hour per day and whenever possible travel back in time (westwards). Back to the Future (eastwards) is harder. If you wake up at 1am, don't get up; lie in bed, breathe deeply and slowly, unburden your mind (almost impossible for professors) and don't dare start working before 5am, and then the next night you'll sleep longer.

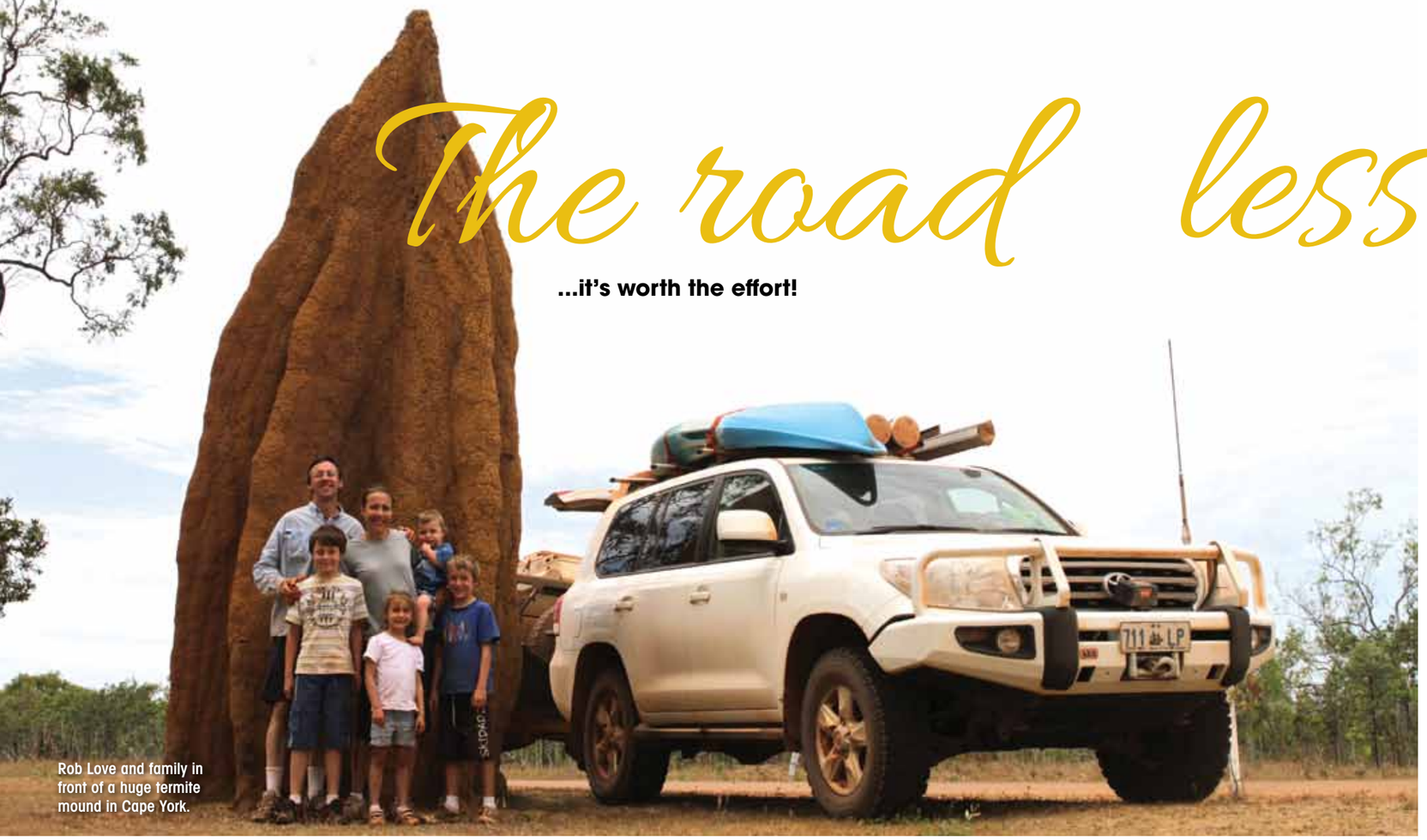
But for those who are determined to take this multi-system neurohormone and free radical scavenger, you will be pleased to hear that no deleterious effects from its administration in humans have yet been reported in the short term.

However, I must warn you to avoid the new agonists that target melatonin receptors [ramelteon, agomelatine, tasimelteon] for which some disturbing side effects are described. As Melatonin is not actually approved to be prescribed for jet lag in ANZ, but only for sleep disorders, I'm pleased to tell you Professor GL Obe Trotta, who has friends on TGA committees, decided to go cold turkey.

Dr BB G-loved

The road less travelled

...it's worth the effort!



Rob Love and family in front of a huge termite mound in Cape York.

The last sign on Highway 1 announced 'Perth 52'. We were nearing the start, or indeed, the finish, depending upon your perspective. Our journey of 21,000 kilometres had happily taken us almost the full circle and we were soon to be arriving home after four months of bitumen, gravel, dust and sand ... and seemingly yet, more dust and sand. My family and I were completing an eagerly anticipated and thoroughly enjoyed trip around much of Australia.

I'd like to say that the holiday was a long time in the preparation and even longer in the planning. This, however, was not the case as an unexpected, but welcomed change in the future schooling of my 10-year-old twin boys precipitated our departure.

Therefore, in the last week of April, 2012, at a casual Practice luncheon, I announced to the staff that my wife and I would be taking our children out of school for the subsequent term "to discover Australia". The logistics of winding down a plastic surgical practice, as well as organising how to transport, accommodate and feed a family of six in remote parts of Australia were yet to be determined!

I was fortunate and humbled to receive a lot of support from hospital theatre administration, my colleagues, including anaesthetic and nursing alike, and my practice staff all of whom I was maintaining.

Eight weeks of new patient consulting were rolled into four, and weekend and additional theatre lists were obtained. My final two weeks of work were dedicated entirely to short and long term patient reviews and accrued leave covered my public hospital appointment.

Our embryonic plan was to head north hugging the WA coast leaving the winter rains behind as quickly as possible. My wife and I had invested in a Trak Shak camper trailer that, with two queen size beds and a 'cubby house' sleeping two, easily accommodated our family of six, the youngest of whom was 18 months. As my wife quite rightly reminded me, however, question marks remained over how best to store clothing, food and equipment for the many possible eventualities.

Solutions came in the form of trailer top aluminium boxes that doubled as solar panel supports, two 12volt, 40 litre fridges run from twin deep cycle batteries, and, among other things, homemade collapsible wardrobes that allowed for clothes to be stored vertically.

The Web became a very important research tool such that by the end of the first couple of weeks of our eight week pre-departure timetable, I had purchased nearly 70 items from eBay and other sites. Indeed, I'd bought so many things that, as they arrived slowly over the subsequent weeks, it felt like Christmas anew each day!

The purchases ranged from low wattage LED lights to handheld UHF transmitters, recovery gear to safety equipment. In fact, it seems having ordered half of the available products from the website of an auto electrical provider, including battery chargers, brake controllers, lengths of cable, fittings and the like, I found myself on first names terms with Luke and was able to pick his brains regularly on the best way to set up a 12volt solar charging system!

On the whole, despite a couple of hiccups testing my limited abilities as a bush mechanic, the trip proceeded nicely and without much of a hitch. Modern technology, including satellite and mobile phones allowed us very regular internet access and to stay in touch.

Indeed, one particularly memorable occasion was while I was participating in a Board of Regional Chairs teleconference by satellite phone for the College. It was made all the more so as from my dune-top vantage point on Ningaloo Station, the scenery included a view westward to the deep blues of the Ningaloo reef and to the east, the beautiful glow the ▸

> ***"Despite the many responsibilities we all shoulder as parents, clinicians, teachers, managers and advocates, it is enlightening to look at the world through the eyes of a child from time-to-time"***

Rob Love gives a talk on medical careers at the Red Hill Community School (Lundja), Halls Creek, WA; The family at the northernmost tip of Australia

setting sun brought to the colours of the magnificent Cape Range National Park (near Exmouth).

Our travels directed us northward along Warlu way, through the spectacular gorge country of the Kimberley region before heading east along the Savannah way to hit the Gulf of Carpentaria at Roper Bar, Northern Territory. There we plied the more remote gravel roads that would take us south past the ancient rock formations of the Southern Lost City (Limmen National Park).

Further south still, the family was immersed in the Aboriginal history and delights of Lawn Hill National Park prior to turning east once more past the Undara Lava Tubes to arrive on the east coast at Cairns.

Naturally, attempting to travel as far from our home city of Perth as possible, and yet still be on the Australian mainland, we then headed north to the tip of Cape York, taking, where possible, the old bush telegraph road. There are so many delights in store for any who are lucky enough to travel this way, and to have your photo taken while standing on 'The Tip' is almost a rite of passage!

Homeward bound thereafter, we explored the Daintree and beautiful Queensland coast, world heritage listed Fraser Island, before heading inland to enjoy the cleansing waters of Moree thermal pools. Our travels took us past the birth place of Banjo Patterson, onto Australia's national capital, through Melbourne and across the vast timeless expanse that is the Nullarbor.

Our experiences were many and I'm happy to report that at the end of the holiday my wife was still talking to me and the kids still laughed at my rather feeble jokes! It is now one year on and we are enjoying reading the children's daily diary of their holiday experiences.

Doing so reminds me that, despite the many responsibilities we all shoulder as parents, clinicians, teachers, managers and advocates, it is enlightening to look at the world through the eyes of a child from time to time.

Over the past two years I have thoroughly enjoyed my role as Chairman of the WA regional committee of the College, learning so much along the way. It is now entering its last month and at the end of my eighth year on the committee I can take a deep breath, but will be sorry to see it go.

I remain indebted to so many at the WA regional office, staff and colleague alike, who have assisted me so ably, not only with regular email communication during my four month trip away, but also over the past many months. They have inspired much change within WA and, I am confident, will continue to do so for the many years to come. I would like to sincerely thank them for their support, contribution and good humour.

Finally, I would like to encourage any who are contemplating a prolonged break from practice that, not only is it possible, but, as many know better than I, it will provide your family with a lifetime of memories and your dinner table with a lifetime of conversation!

Rob Love
Chair, WA Regional Committee

55th Victorian Annual Surgeons Meeting (VIC ASM)

"Surgical Practice and Training - confronting and tackling the regional issues"

FRIDAY 18 - SUNDAY 20 OCTOBER 2013

Novotel Forest Resort, Creswick / Friday 18 October
Welcome Dinner and Show - Sovereign Hill
(Families are encouraged to attend)

Saturday 19 October; Meeting Dinner - Novotel Forest Resort, Creswick

PRIZES

There are prizes for the following categories:

2013 DR Leslie Prize – Best clinical registrar paper
2013 RC Bennett Prize – Best laboratory based research paper presented
DCAS Scholarship – Best presentation appropriate to academic surgery.
Medical Student Prize – Best presentation by a Medical Student
Audio visual instructions will be sent to all successful authors.
Please note that single case reports will not be accepted for presentation or poster

MEETING ORGANISER

Denice Spence, Victorian Regional Manager
Royal Australasian College of Surgeons
College of Surgeons Gardens
250 - 290 Spring Street, East Melbourne VIC 3002 Australia
T: +61 3 9249 1254 **F:** +61 3 9249 1256
E: denice.spence@surgeons.org

Cultural learning

Dr Lupe Taumoepeau in the operating theatre. **Below:** Lupe Taumoepeau and Sherry Tagaloa proudly wearing their College scarves after passing their exams earlier this year.

Two Pacific Island female surgeons will provide a familiar face among the crowd

Two New Zealand surgeons are among the first Pacific Island women ever to join the Fellowship of the Royal Australasian College of Surgeons.

Vascular surgeon Dr Lupe Taumoepeau was born in NZ to Tongan parents and General Surgeon Dr Sherry Tagaloa, of Samoan extraction, was born and raised in Lower Hutt, New Zealand.

Both women speak the language of their parents, have extended family members still living in their Pacific Island homes and both successfully completed their Part II examinations earlier this year – making history in the process.

A pianist and athlete, Dr Taumoepeau said that while she was originally drawn to plastic and reconstructive surgery, she chose vascular for its mix of pathology, reconstructive and fine work and the on-going development of minimally-invasive techniques.

However, she also said it would allow her to help treat Pacific Island patients who face some of the highest rates of diabetes and vascular disease in the world.

"My parents were born and raised in Tonga and came to New Zealand in the 1960s, but they raised us with a strong sense of Tongan culture so I would identify as a Tongan New Zealander," she said.

"Pacific Islander and Maori people are over represented in all the risk factors relating to vascular disease such as heart disease, diabetes, hypertension and high cholesterol yet while they suffer the effects of such conditions earlier, such patients often present late.

"This is partly because many find the hospital and health systems quite daunting so if I can be one brown face that these patients can identify with, perhaps I can make their journey through the health system a little less stressful.

"The Tongan community has a very strong network, particularly in Auckland, with community groups providing both health education and prevention strategies and in the future I would like to become involved in such work."

Dr Taumoepeau said she was originally drawn to a career in surgery through the influence of her grandfather who was an ophthalmologist in Tonga.

"He was my inspiration," she said. "We were very close and I grew up wanting to be like him and to be a surgeon from around the age of five.

"I later found that I enjoy working with my hands and I particularly like that aspect of surgery, particularly vascular surgery, where you get instant gratification from a successful procedure and when you know that your patient will be so much better for it."

Dr Taumoepeau said she had never experienced any racism or sexism throughout her training and described the vascular surgical community as being extremely supportive.

She said that while she married a "Kiwi" a few years ago she decided not to change her name so that Pacific Island and Maori patients would know that she understood aspects of their culture which could be somewhat alien to Western thinking.

"There are certain aspects to Pacific Island culture that surgeons do need to be aware of," she said.

"For instance, it is culturally important in many Pacific Island nations to be buried intact which means that extended family often want tissues or organs returned.

"This is particularly important in vascular surgery where we have to conduct amputations to treat diabetes and we need to understand how important the traditions of death and dying are to people of the Pacific Islands.

"It is also crucial to understand that all decision-making within the health context is a matter for the extended family, not the individual as it may be in Western cultures."

Dr Taumoepeau said that while she was unsure whether she was one of the first Pacific Island women in surgery, she certainly knew she was the first in vascular surgery.

"For some reason vascular surgery is quite a male-dominated specialty, but I certainly did not choose it to become a ground breaker," she laughed.

"To me, it's simply a privilege and a blessing to be in this position, to be able to do a job I love and have always wanted to do and if I can give back to the Tongan community in the process that would be wonderful."

General Surgeon Dr Sherry Tagaloa is currently working at Auckland City Hospital in the Trauma Service, treating patients with injuries from road traffic collisions, sport and workplace accidents.

Dr Tagaloa said she was proud to become one of the first Pacific Island women to become a surgeon.

She said that qualifying as a surgeon had been a great joy to her especially given that Pacific Island and Maori health professionals were currently under-represented in the health sector. ▸

> *If I can be one brown face that these patients can identify with, perhaps I can make their journey through the health system a little less stressful.*

She acknowledged the influence of her parents, who emigrated from rural Samoa, for her success. "They placed a high priority on their children obtaining a quality education which laid the foundations for my career in medicine," she said.

"I understand the social pressures that many Pacific Island students experience, for example caring for younger siblings and the extended family, and am thankful that I was not hindered by these demands during my schooling.

"I have also been fortunate to have had Consultant Surgeons as mentors who view support and guidance for Pacific Island Surgical Trainees as imperative.

"The General Surgeons at Middlemore Hospital and Auckland City Hospital have been particularly influential to me."

Dr Tagaloa said she would like to use her skills and cultural awareness to assist members of the Pacific Island community.

"I am aware of some of the issues that Pacific Islanders face in the health system," she said.

"These include language barriers that may exist and therefore the importance of speaking to Samoan patients in their own language, for example, so that both the patient and the extended family understand clearly the treatment that is taking place as I believe that being fully informed is a basic patient right."

Dr Tagaloa said the next step in her career would be an overseas fellowship which she is currently seeking. She said she aspired to further specialise in the areas of Transplantation and Trauma.

While Dr Tagaloa said she did not see herself as a trail-blazer, she hoped that her example may inspire other Pacific Islanders to pursue a career in medicine so that the New Zealand health sector was more truly representative of New Zealand society.

With Karen Murphy

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

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

Applications are open from 1 September to 6 December 2013.

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

2-4 May 2014,

Younger Fellows Forum

Singapore

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

Royal Australasian College of Surgeons

2013 Workshops & Activities

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

Keeping Trainees on Track (KToT)

18 October 2013 Annual Scientific Meeting Hobart, Tasmania

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.

Non-Technical Skills for Surgeons (NOTSS)

18 October 2013 Annual Scientific Meeting Hobart, Tasmania

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

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.

Surgical Teachers Course

24 - 26 October 2013, Perth

The Surgical Teachers Course builds upon the concepts and skills developed in the SAT SET and KTOT courses. The most substantial of the RACS' suite of faculty education courses, this new course replaces the previous STC course which was developed and delivered over the period 1999-2011. The two-and-a-half day intensive course covers adult learning, teaching skills, feedback and assessment as applicable to the clinical surgical workplace.

Writing Medicolegal Reports

28 October 2013, Melbourne

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

mlcoa Avant

NZ

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

QLD

26-27 October, Brisbane
Preparation for Practice

29 October, Gold Coast
Non-Technical Skills for Surgeons (NOTSS)

TAS

18 October, ASM Hobart
Non-Technical Skills for Surgeons (NOTSS)

18 October, ASM Hobart
Keeping Trainees on Track (KToT)

VIC

9 October, Melbourne
Supervisors and Trainers for SET (SAT SET)

11 October, Melbourne
Strategy and Risk for Surgeons

28 October, Melbourne
Writing Medicolegal Reports

16 November, Melbourne
Building Towards Retirement

27 November, Melbourne
AMA Impairment Guidelines

WA

24 - 26 October, Perth
Surgical Teachers Course

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.

Invaluable research

Work with maggots has lead to remarkable findings for this scholar

New Zealand General Surgery Trainee Dr Lisa Brown is not only undertaking PhD research into novel methods to help treat acute pancreatitis, she is also studying the physics of fluid dynamics at the University of Auckland to help advance that research.

A 2012 recipient of a Foundation for Surgery Scholarship, Dr Brown is comparing the effectiveness of approved enzymes as well as searching for previously unidentified enzymes that could selectively accelerate the break down of necrotic pancreatic tissue while leaving healthy tissue intact.

As part of that search, Dr Brown is investigating the effects of enzymes excreted by particular species of maggot using a unique bank of necrotic tissue samples collected through an international collaborative research program between surgeons in Auckland, Christchurch and Indianapolis in the US.

Dr Brown said that acute pancreatitis causes necrosis of the pancreas in up to 30 per cent of patients. The severity of acute pancreatitis is determined by both infection of pancreatic necrosis and multiple organ failure.

The treatment of infected pancreatic necrosis has been an open surgical intervention until recently, yet this is a major physiological insult, increasing the risk and severity of organ failure, as well as requiring patients to undergo repeated, extensive high-risk operations that are associated with an appreciable mortality.

"The pancreas gland is difficult to access with a number of important structures nearby and open surgery itself presents a further risk to patient outcomes," Dr Brown said.

"There has been a recent significant trend away from open surgical management towards minimally invasive necrosectomy with evidence of improved outcome while another notable trend has been away from using percutaneous drainage as a secondary treatment, to using it as the first and sometimes sole treatment.

"Previous research has indicated that while only one-third of patients with infected pancreatic necrosis were successfully treated using only percutaneous drainage, they ultimately did much better than the two-thirds who needed further treatment, which indicates that if we can improve drainage we could improve patient outcomes.

"However, despite the shift in treatment to drainage as first line, there are still many problem areas with this approach. The inefficient and often ineffective passive approach to drainage often results in drain blockage by solid material.

"The goal is to improve the treatment of infected pancreatic necrosis by increasing the effectiveness of percutaneous drainage. This will involve determining a way to break down necrotic tissue in situ through the use of enzymatic irrigation solutions to accelerate liquefaction. If this can be achieved, it will result in further improvements in patient outcome."

Dr Brown said that while various enzymes had been used to treat loculated collections in other tissue locations and with some success (such as streptokinase and urokinase in the treatment of empyema), there may be more effective and selective enzymes to be found in nature.

"Some types of maggots, such as Lucilia sericata, have the remarkable ability to selectively debride necrotic tissue while preserving viable tissue, kill bacteria and promote wound healing," she said.

"This is not accomplished by the mechanical effects of chewing, but due to the maggot excretion altering the pH of the microenvironment to allow activation of enzymes within the maggot secretion.

"Using our bank of stored human necrotic tissue samples, we are now testing a range of commercially available enzymes on their ability to liquefy pancreatic necrosum while we are also investigating the digestive components in maggot secretions which have not yet been identified, using proteomics techniques, and comparing them to known enzyme combinations in their ability to degrade human pancreatic necrosum."

Dr Brown is undertaking her PhD as a member of the Pancreas Research Group at the Department of Surgery at the University of Auckland and is working under the supervision of Dr Anthony Phillips, Professor John Windsor, Mr Richard Flint and Dr Max Petrov.

> ***"One of the reasons she became drawn to the research was that Maori women had one of the highest rates of acute pancreatitis in the world"***

She said one of the reasons she became drawn to the research was that Maori women had one of the highest rates of acute pancreatitis in the world, with incidence rates of 46 per 100,000 compared to the European population of 19 per 100,000.

She said they were often some of the sickest patients presenting at hospitals in NZ with many developing severe complications such as multiple organ failure.

Dr Brown has so far studied six enzymes, all of which act on collagen, the most prevalent constituent of pancreatic necrosis.

She said that while she had to overcome an initial distaste for working with maggots, she was now becoming something of an expert.

"Obviously, for scientific research purposes we have to grow and cultivate them in the most sterile environment possible and while I did find that difficult at the start, I am used to them now and even think they are quite remarkable," she said.

"The ultimate aim of this work is to find the enzyme that works the best and then ▶


Time out from research

ACADEMIC ACHIEVEMENTS

- Awarded New Zealand Health Research Council Scholarship for 2013/2014
- Awarded AMRF Project Grant for PhD Project 2013/2014
- Awarded Royal Australasian College of Surgeons Research Fellowship 2012
- Oral presentation at Asia-Pacific Hepatopancreaticobiliary Conference 2013, Shanghai, China. A systematic review of the extra-pancreatic infectious complications in acute pancreatitis.
- Poster presentations Royal Australasian College of Surgeons Annual Scientific Congress, 2013, Auckland, New Zealand. A systematic review of the extrapancreatic infectious complications in acute pancreatitis and accelerating liquefaction of pancreatic necrosis through enzymes.
- Commendation Prize 2008 CDHB Quality & Innovation Awards.

change current practices in which drainage lines are flushed with a saline solution, to flushing them with the enzyme solution.

"This is where the Physics course, which has a component on fluid dynamics, has been invaluable."

Dr Brown said that once she had identified the enzyme that was most effective, animal trials would be conducted to study the effects of it upon surrounding healthy tissue with human trials some years away.

"A recent review found that patients with necrotising pancreatitis require two to 14 catheter changes per hospital stay while 35 per cent of patients required additional surgical necrosectomy with a mortality rate of 15.4 per cent," she said.

"Yet it has been reported that a successful first line treatment by percutaneous drainage would reduce annual costs of pancreatitis treatment in the USA by $185 million.

"This project could also offer innovative advances relevant to the ever increasing range of minimally invasive drainage procedures being targeted by radiologists, including all other deeply sited collections such as in the pelvis or thorax."

Now with on-going funding from the NZ Health Research Council, Dr Brown hopes to finish her PhD in 2014 at which time she will return to her surgical training program with the eventual aim of becoming a Hepatobiliary surgeon.

She said she particularly enjoyed both scientific research and her teaching role as a Research Fellow at the University of Auckland and hoped to develop a career as an academic surgeon.

"I have greatly enjoyed the opportunity to add to the knowledge behind evidence-based medicine and the support of the College from the outset was wonderful, not only in providing the financial means to allow me to concentrate on this work, but also because of the belief in the research that such support signifies," Dr Brown said.

"I have seen a number of patients who have been extremely sick with acute pancreatitis and others who have died from the disease which I found difficult to deal with.

"This is a particularly difficult disease to treat, not just physiologically, but emotionally because it doesn't just affect the patients, but also their families and communities and I would be thrilled if I could find a way to improve the treatment of it and reduce the risks and suffering such patients now face."

With Karen Murphy

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

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

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

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

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

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

After these workshops you are invited to attend the

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

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

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

PRELIMINARY NOTICE – **SURGICAL RESEARCH SOCIETY ANNUAL MEETING**

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

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

JEPSON LECTURER:
Professor Guy Maddern

Dept Surgery, Queen Elizabeth Hospital, Woodville, South Australia
"50 years of the Surgical Research Society"

ASSOCIATION FOR ACADEMIC SURGERY GUEST SPEAKER:
Dr Chris Breuer

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

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

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

CALL FOR ABSTRACTS:
The call for abstracts will be open on Monday 29 July 2013 and must be submitted no later Monday 23 September 2013. Abstract forms will be available from the email address below.

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

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

CONVENOR:
Professor Guy Maddern

CHAIR, SRS
Professor Leigh Delbridge

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

No duty to refer for bariatric surgery

CASE NOTE: *Varipatis v Almario* – (2013) NSWCA 76

The New South Wales Court of Appeal has recently upheld an appeal brought by general practitioner, Dr Varipatis ("GP"), who was initially held to be negligent for failing to refer his morbidly obese patient, Mr Almario ("Patient"), for bariatric surgery.

Facts

The Patient was treated by the GP between August 1997 and February 2011. The Patient worked at the former Union Carbide site, and initially sought treatment from the GP because he had particular knowledge and expertise in the area of disease arising from toxic exposure.

The Patient was morbidly obese and suffered from a range of health problems. As a result of failing to lose weight, the Patient developed cirrhosis in June 2001 and subsequently liver cancer, which would likely be terminal.

Procedural background

At trial the Patient argued that the GP failed to take the steps that a reasonable general practitioner would have taken to treat his morbid obesity, and thus prevent his liver cancer.

The GP was found to have breached his duty of care to the Patient in the following three ways:

1. By failing to refer the Patient to a bariatric surgeon by 30 July, 1998;
2. Alternatively, by failing to refer the Patient to an obesity clinic or endocrinologist; and
3. By failing to refer the Patient to a hepatologist by the end of September, 2000.

The trial judge found that only the first breach was causally effective insofar that the GP's failure to refer his patient to a bariatric surgeon in 1998 had materially contributed to the Patient's state of ill health. This finding was made despite the real possibility that the Patient may not have been an eligible candidate for surgery, may not have complied with the post-operative lifestyle changes, and may not have been able to afford the procedure to begin with.

Court of Appeal decision

In overturning the Trial decision, and setting aside an award of damages for $364,372.48, the Court of Appeal considered the following issues:

1. Whether the GP breached his duty to the Patient by failing to refer him to an obesity clinic or endocrinologist;
2. Whether referral to a bariatric surgeon was necessary in the exercise of a general practitioner's duty of care in 1997–1998;
3. Whether the Patient would have lost the necessary weight had the GP properly advised him about the cause of his liver disease and other health problems; and
4. Whether the Patient would have lost sufficient weight had he been referred to an obesity clinic or hepatologist.

> *"At trial the Patient argued that the GP failed to take the steps that a reasonable general practitioner would have taken to treat his morbid obesity"*

With regard to these issues, the Court of Appeal made the following findings:

1. Despite being counselled by the GP to do so, the Patient failed to act on a referral of a specialist to attend an obesity clinic. Therefore, even if the GP referred the Patient to an obesity clinic or endocrinologist, there was insufficient evidence to suggest that the Patient would have acted on the referral or lost weight.
   A general practitioner's duty of reasonable care may extend to advising a patient that weight loss is necessary to protect his or her health, to discuss the means by which that may be achieved, and to offer appropriate referrals. However, a general practitioner is not required to do more than that. In light of the Patient's refusal to attend the obesity clinic, the GP was not under a duty to 're-refer' the Patient;
2. The expert evidence given by general practitioners did not support the conclusion that a reasonable practitioner would have referred a patient (in similar circumstances) to a bariatric surgeon in 1998. In fact, the expert evidence of various endocrinologists suggested that it would be reasonable for an endocrinologist in 1998 not to refer a morbidly obese person to a bariatric surgeon;
3. There was no causal link between the Patient's belief that his ill-health was due to his exposure to toxic chemicals and his failure to lose weight. There was overwhelming evidence to suggest that he had been advised by the GP, and numerous other practitioners that he needed to lose weight to improve his health; and
4. Having failed to act on previous referrals to an obesity clinic, the Patient failed to establish that he would have accepted a 're-referral', or achieved the resulting benefits of weight loss. The Patient also failed to establish that weight loss would have followed from a timely referral to a hepatologist.
   As the link between obesity and liver disease was not properly understood until 2002, the hepatologists suggested that in 1998 they would not have taken specific steps to deal with weight loss.

What this means for other Doctors?

This decision is significant as it clearly emphasis the extent of a medical practitioner's duty of care.

It was held that a medical practitioner has a duty to provide advice to a patient and to offer appropriate referrals. However, this duty stops short of requiring an exercise in futility. As a result, a patient will be unable to blame his or her doctor for any complications that arise as a result of the patient's own failure to follow medical advice.

Doctors nonetheless need to properly explain their diagnosis, its implications and likely effects; alternative treatments; and consequences if not followed.

In determining whether a medical practitioner has satisfied this duty, the critical question becomes: What would a reasonable medical practitioner have done in the circumstances, at the relevant time, given the state of medical knowledge? Not what would a reasonable practitioner do today?

Michael Gorton,
College Solicitor

Lending an ear

Professor Stephen O'Leary's work with Indigenous children can have life changing effects

Renowned ENT surgeon Professor Stephen O'Leary, a former recipient of the College's most prestigious award, the John Mitchell Crouch Fellowship, was asked in July to give a public lecture as part of celebrations marking the 150th anniversary of the founding of the Royal Victorian Eye and Ear Hospital.

And although he is known for his research into developing new techniques to protect hearing from damage during surgery to the inner ear and the design of virtual technology to increase the skills of Trainees, he chose to speak about the work being done by researchers and clinicians at the Eye and Ear Hospital to eradicate preventable hearing loss among Indigenous Australians.

Indigenous children in Australia have the highest prevalence of Chronic Suppurative Otitis Media in the world, a condition that can lead to significant hearing loss which in turn directly contributes to the cycle of disadvantage by diminishing opportunities for education, employment and social engagement.

Professor O'Leary said the high rates of Otitis Media in the Indigenous population were not simply a matter of hygiene, nutrition and access to clean water, but also biological determinants.

"Indigenous children have a greater bacterial load in the adenoidal space which is also more pathogenic than that found in other populations, but we don't know why," he said.

"That means they often get these infections earlier and more severely than other children, and they tend to last longer. The fluid behind the ears causes a hearing loss, and the condition may persist throughout childhood.

"Then, of course, if it is not treated and the infection is severe enough, the pressure can blow a hole in the eardrum causing significant and persistent hearing loss."

Professor O'Leary said he originally became involved in the work with Indigenous children through a commitment by the hospital and the Department of Otolaryngology at the University of Melbourne to make a dedicated contribution to improving Indigenous ear health.

"Most people involved in this area of medicine were very keen to help because kids in particular have this window where treatment can influence language acquisition, education and social skills," he said.

"While children are not often able to articulate how they feel when they can't hear properly, you can see in their social behaviour that they are deeply affected.

"In some ways it is even harder on teenagers who have such a strong need to fit in with their peers so there were many of us in the hospital – surgeons, audiologists and nurses – who felt very committed to helping these young people."

"Most people involved in this area of medicine were very keen to help because kids in particular have this window where treatment can influence language acquisition, education and social skills."

Professor O'Leary said the program linking Eye and Ear Hospital specialists directly with the children in need began in 2008 through the efforts and enthusiasm of Indigenous Surgeon Mr Kelvin Kong, Chair of the College's Indigenous Health Committee.

He told ENT surgeons that the Alice Springs Hospital needed help, with long waiting lists of Indigenous children needing treatment.

Teams of surgeons, audiologists and specialist nurses from the Eye and Ear Hospital began visiting that same year.

Professor O'Leary has now done 10 visits to the Northern Territory.

"A particularly note-worth aspect of this program was that it was not about surgeons and specialists going up there as volunteers, but rather it was a formal agreement between the Alice Springs Hospital and the Eye and Ear Hospital," he said.

"This to me was important because it meant that we weren't just there to help out when we felt like it; we were there as part of a vision and commitment by our hospital to help members of Alice Springs and surrounding communities.

"Now, fortunately, more resources have been put into ENT care in the Northern Territory with more infrastructure provided, due to government recognition of the breadth of the problem, and now the Alice Springs Hospital has its own ENT surgeon and service."

Professor O'Leary said that at the same time as the NT program was underway, the Eye and Ear Hospital also decided to focus on the needs of the local Victorian Indigenous community.

He said a hospital-based audiologist, Brooke Paisley, set out to establish rates of ear disease within the community through visits to Indigenous pre-schools and a secondary college in Healesville.

It was clear, he said, that a far higher number of local Indigenous children had Otitis Media compared to children in the general population.

"There was clearly a local need for treating children identified during screening. When we began this outreach program we would bring the children to the hospital for further testing and treatment, but we always wanted to do as much of this work as possible in a more culturally appropriate setting.

"For the past two years, however, we have run a monthly clinic at the Victorian Aboriginal Health Service in Fitzroy which is a really fabulous development because it allows us to see the children where they are comfortable, with those needing surgery brought into the hospital by Indigenous health workers."

So successful has the outreach program been, that it was one of three Aboriginal ear health clinics to receive a state-of-the-art voroscope from a donation by the Wilbur-Ellis Connell Bros Company of Australasia through the College's Indigenous Health Committee.

Professor O'Leary said the voroscope, a head-mounted microscope that provides a clear view of the inner ear and ear drum, would be invaluable not only for diagnosis, but for training.

"This piece of equipment was invented by the Australian ENT surgeon Dr John Vorrath," he said.

"This will help us at the clinic to not only treat the children in need, but also to train Indigenous health workers and doctors in understanding and diagnosing ear disease.

"We want to transfer as much of our knowledge as possible so that Aboriginal health workers and doctors can share in the care of their patients."

Starting out as the vision of one man and with only five pounds of funding and one bed, the Royal Victorian Eye and Ear Hospital now treats more than 250,000 patients and is the only specialist ENT hospital in the country.

Far left: Professor Stephen O'Leary with patient and parents at the Eye and Ear Hospital.
Top: The donated equipment.
Above: Reg Thorpe - VAHS Senior Policy & Project Officer, Susan Hedges - VAHS Manager, Women's & Children's Services, Professor Stephen O'Leary, and Katie Edney - Health Worker.

Professor O'Leary said this gave it a unique ability to take on programs and research of national significance.

"The Eye and Ear Hospital is a great facilitator of this kind of work and its potential is enhanced because the Department of Otolaryngology of the University of Melbourne is located on site," he said.

"It acts as a focal point for not just outreach services, but also in the development of major research projects and we are now running a national trial to determine the best treatment options for Indigenous children with Otitis Media funded by the NHMRC.

"The Eye and Ear Hospital brings together surgeons, scientists and other health professionals which creates the kind of synergy that allows major research projects to get over the line and off the ground and it is a venerable institution that all Australians should be proud of."

With Karen Murphy

‘The Spark of Life’

Australian Resuscitation Council

Clockwise from top left: Douglas Leslie; Peter Braithwaite. Foundation members of the ARC, 1976.

In November 1974, the College’s Faculty of Anaesthetists “convened a meeting of 95 representatives – medical advisors and lay educators from 40 organisations actively involved in the teaching of Cardiopulmonary Resuscitation”. The meeting aimed to discuss the standardisation of the teaching and technique of Cardiopulmonary Resuscitation in Australia and New Zealand. It was the genesis of what was to become the Australian Resuscitation Council (ARC).

The aim of organisation envisioned by anaesthetists such as Tess Brophy and strongly supported by the College Council, was to “correlate and disseminate information about resuscitation equipment and techniques”. It was to be established in Australia and New Zealand and include “representatives of professional groups – medical, paramedical and legal – voluntary community-based organisations, industry and commerce, the Standards Association and industrial and health authorities”.

In October 1975, Ken Jamieson, a neurosurgeon who was Council representative on the Faculty of Anaesthetists, issued a report concerning the formation of the Australian Resuscitation Council. Jamieson, who was active on the College’s Trauma Committee, was interested in head injuries, particularly those caused by motor accidents. Noticeably, a few months later he published ‘The Ambulance Survey’ which “emphasised patient care at the scene of the accident and during transit”. In his report to Council, Jamieson proposed that the ARC’s Memorandum of Association and Constitution be adopted and recommended that the College be a major sponsor of the organisation. He also suggested that four representatives from the College (three from the Faculty) – Ken Jamieson, Tess Brophy, Maurice Sando and David Crankshaw join the newly formed organisation.

Jamieson’s recommendations were endorsed by Council and the ARC was formally launched on February 7, 1976. Unfortunately, Ken Jamieson died 10 days after the launch and his place was filled by Peter Braithwaite who became the first Chairman of the ARC. Other foundation members of the ARC included the Red Cross, Heart Foundation, the Defence Medical Services, ambulance services and organisations involved in lifesaving and nursing.

The Australian Resuscitation Council currently has seven state branches which are integral to the vision for the organisation. In 1975, prior to the formation of the ARC, a seminar on ‘Accident Prevention and Community First Aid’ had been held in NSW. And in the Council minutes of February 1976, Wyn Beasley reported on the working party that had been set up to form a New Zealand Resuscitation Council. Modelled on the Australian organisation, the New Zealand body was not established until 1996.

“ The aim of the organisation … was to ‘correlate and disseminate information about resuscitation equipment and techniques. ”

ARC 1985, Chairman Doug Leslie.

Seminal aims of the ARC were to “promote uniformity and standardisation of resuscitation techniques’ and to ‘foster and co-ordinate the teaching of resuscitation”. The President’s Newsletter of 1978 includes the ‘Proceedings of the ARC’ and makes reference to the inconsistencies in the teaching of the ‘coma position’. It emerged that the Red Cross and St John Ambulance taught a different version of the position to their members. With a view to standardising techniques and teaching methods, the ARC instigated a review of the teaching methods of organisations in each state.

Although sponsored by the College the early ARC did not have a permanent home or any funding. ARC Executive Officer Carol Carey remembers Tess Brophy (later Professor Tess Cramond) used her own secretary for ARC meetings and transported papers from Brisbane to Melbourne in a suitcase. In 1985 a seeding grant from the Department of Health enabled the ARC to set up in an office donated by the College. When the Anaesthetists formed their own College in 1992, sponsorship of the ARC was shared by RACS and ANZCA.

In 1993, the ARC established the ‘Spark of Life’ resuscitation conferences – these were held triennially and included speakers from Australia and abroad. Since that time, the ARC has increased its activities – producing publications and through initiatives such as ‘easy access to defibrillation for sudden cardiorespiratory arrest’, constantly improving and promoting the importance of resuscitation techniques.

The principal task of the ARC is to satisfy its objectives by preparing guidelines that govern the way resuscitation is taught and practised in Australia. Although some representatives can be funded by member organisations, the ARC is a voluntary organisation and with a history spanning 37 years, it is internationally renowned. Up to three members attend meetings of the ‘International Liaison Committee on Resuscitation (ILCOR)’, representing the ‘Australian New Zealand Council on Resuscitation (ANZCOR)’. In April 2013, the ARC hosted the ILCOR meeting in Melbourne.

Written by Elizabeth Milford, College Archivist.

Opus XXVIII

Felix Behan
Victorian Fellow

Gillies, McIndoe

and their New Zealand link

A tapestry woven in silk portraying two eminent Plastic Surgeons.

Recently Mike Klaassen invited me to participate in his plastic surgical course on Loco-Regional Flaps (including the Keystone) at the University of Auckland. There I met Earle Brown, now retired from Middlemore Hospital, where the late Bill Manchester was the doyen of Plastic Surgery. Earle told me of an early experience when offering Bill some advice. He responded by saying, "Son, if anyone comes here and wants their child's cleft lip done, they want the best. Go and practice your talents on the bedsores in the paraplegic ward for the time being."

Stories about Gillies and McIndoe (related by marriage) kept surfacing. Both came from Dunedin. Gillies grew up in a two-storey house in Park Street where he sustained a supracondylar fracture when sliding down the banister – presumably not affecting his future surgical nor fish-casting skills. Earle even managed to persuade Gillies' daughter to donate a portrait of the Master to Middlemore, now in the archives.

The inventive Gillies had a mind for design – even fashioning a golf tee of varying heights for varying wind conditions. He made his own trout lures using colour, texture, fabric and surface to entice (even lure) unsuspecting trout in the freezing waters of Scotland. The Gillies' needleholder design had its origins in the south of Spain, as the late Ian Wilson told me in London. There, oyster fishermen used a plier-like device to prise open the shell, scooping the contents out with the other arm. Gillies' needleholder and the Fosters refinement should be re-fashioned with a ratchet for needle-point protection – a registrar's opportunity?

On my arrival in London in the 1970's, I was invited to the Savage Club by Gordon Hamilton-Fairley, a family friend from Melbourne of the late Bill Dargie, the Queen's portraitist. For security reasons, the Hamilton-Fairleys stored at their flat the back-up portrait of the Queen (in a green gown), which was only recently sold at Sotheby's. The Savage Club (for aesthetes) off Piccadilly, shared premises with the Constitutional Club upstairs, the latter being another gentlemen's club for the establishment. Prime Minister Ted Heath was even a member. Mounted over the entrance to the Savage Club was a 6kg stuffed trout caught by Gillies.

The following day I returned to retrieve my raincoat, and began a conversation with the receptionist upstairs, as the Savage Club was closed. In the idle chit-chat and persiflage that followed, she suggested I become a member of the Constitutional Club. Somewhat astonished, I asked, "Whom shall I use as a referee?" Her response was simple: "Your address is sufficient". I was living at the Royal College of Surgeons (Nuffield residence) in ▶

1904 Darracq – 'Genevieve' from the 1953 film *Genevieve*
This is the type of vehicle that Earle Brown saw in London on the occasion of the annual Royal Automobile Club London to Brighton Veteran Car Run when he was living in Chelsea. This event still takes place every year in November (www.veterancarrun.com)

> *How the hell did you – a colonial – get in here?*

Lincoln's Inn Fields. My first hospital appointment in London was close by, at St George's Hyde Park Corner (Hunter's old domain). On offering the club's hospitality to my English associates, I could read their minds as they wondered, *sotto voce* or otherwise, "How the hell did you – a colonial – get in here?"

Archie McIndoe came to London from the Mayo Clinic at the behest of Baron Moynihan (whose baronetcy later became a DNA legal issue between the scions by multiple marriages). During the war, Gillies sent McIndoe down to East Grinstead, establishing a unit outside London as a precaution against German invasion. Gillies showed his chagrin after McIndoe modified his forceps into a non-toothed variety. Benny Rank taught us all how to use these for tying knots under tension.

Archie was a fine surgeon with a speed of execution which matched his surgical skills. He had an enduring attachment to his RAF "boys" as he called them (having treated over 600), and they called him the "Maestro". His outstanding success in burns management was based on his astute observation that those who ditched in the English Channel, into cold salty water, ended up with a lesser severity of burns than those who landed on *terra firma* – the basis for McIndoe's cold saline baths for severe burn injuries – 'evidence based medicine' from observational findings.

On the subject of speed, please note that it was Lawrence of Arabia's speed boat design with its shallow draught and outboard motor that rescued many of these RAF personnel. This speed addict (famous for his work in the Palestinian campaign of 1916) died in 1935 following a motorcycle accident (when avoiding two schoolchildren).

Earle Brown recounted how, when George VI visited East Grinstead he asked, "How did you manage to do all this wonderful work?" Archie raised his hands in a gesture of supplication and said, "With these two hands, Your Majesty." After starting practice in Harley Street, someone asked, "How are things in Civvie Street, Sir?" and he responded, "I have just paid my first £10,000 in income tax." Incidentally on a fiduciary line, a prominent surgeon once confided to me one night at the Melbourne Club, "Felix, I'm into my second million in income tax." He had one of the largest private practices in Australia thanks to the Gorton $5 scheme of the 1970s – in spite of his Murray Greys.

With his American links, Archie was consulted regarding Ava Gardner, who cracked her cheek in a horse-riding accident in 1957. MGM sent her to a surgeon in Los Angeles, who wanted to operate. Archie advised conservative management. In the text, *Reconstruction of Warriors*, Ava said of Archie, "I knew that in comparison to those badly burned pilots, my injury was of almost no consequence. But Archie was a man of enormous compassion and understanding."

After divorcing Frank Sinatra she became the *femme fatale* on the London scene. Archie invited the world press to photograph her unblemished face following his advice without a surgical scar. I can recall Benny saying, "Son, when giving negative advice, double the fee – the patient will respect it more, and might even pay."

On another film star, Archie had earlier operated on Kaye Kendall. Her rhinoplasty resulted in an elegant physiognomy and she went on to star in the 1953 film *Genevieve* about the London to Brighton rally, featuring the antique 1904 Darracq car (see illustration). Her famous trumpet solo playing Larry Adler's 'Genevieve Waltz' (originally for harmonica) is quite memorable. This composer got royalties for life amounting to a six-figure sum, while Kenneth More, the lead actor, only received £3,500. The car was displayed in the Giltrap car museums in Australia, where I saw it, before going to New Zealand and then back to Europe.

Archie would invite these film star celebrities to his Guinea Pig club outings for his boys in the English country pubs. He understood the psychological disintegration they experienced following their horrific injuries, helping them back into society. John Hueston was Archie's protégé at East Grinstead and his own earlier Korean War experience would have bonded this relationship. John had earlier experience in Melbourne with Edgar King investigating Dupuytren's pathology. This became a stepping stone to his world prominence in this field (as Don Marshall reminded me). When I speak in Paris on Dupuytrens, John's publications are always quoted (but rarely locally). John always recalled the Maestro's style and elegance in surgery, mirroring Gillies' edict, "Style will get you anywhere and open many doors." Another pearl in the list of McIndoe's aphorisms is his often-quoted statement, "Unless you do good aesthetic surgery, you don't do good plastic surgery," which John emulated. John often told me the story that McIndoe died of a broken heart in April, 1960, having missed out on the Presidency of the English College of Surgeons.

In December, 2012, while in London to speak at the Plastic Surgical Meeting, I phoned Bob Marchant (thanks to Roger Adlard, our Fellow in Plastic Surgery at Western Hospital from East Grinstead). Bob was an assistant to the late Cyril Jones, Archie McIndoe's chief theatre technician. Mike Klaassen had told me that Bob Marchant, now honorary barman at East Grinstead's surgeon's mess, was drinking with McIndoe at the 'Saints & Sinners' club in London in 1960 on the evening of his death. He had just lost the Presidency. His theatre sister Jill Mullins found his body the next morning and he was cremated within 24 hours.

Back to New Zealand; Michael and I attended the dinner at the Auckland Medical Historical Society meeting where I met Professor Graeme Woodfield. He has written Lord Porritt's definitive biography and two interesting facts emerged. Firstly, it was Porritt who won a Bronze Medal in the 100 metres in the 1924 Olympics. His story featured in the film *Chariots of Fire*, but he always regretted that the pseudonym Watson was used. Porritt eventually became Governor General of New Zealand.

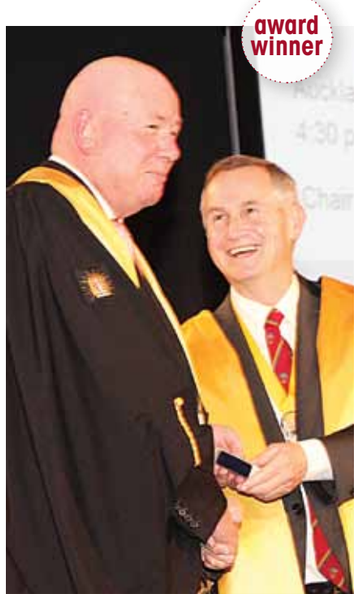
Graeme's second revelation was that the old story about McIndoe "dying of a broken heart" was, to quote him, "absolute bunkum". I was stunned. His book reveals that Porritt told Archie before the election, "As president of the BMA, I cannot be President of the College as well. The job is yours." However, Porritt became President and Archie died in April, 1960. This begs the question and with my Sherlock Holmes' antennae vibrating, and Virgil springing to mind "*latet anguis in herba*" – was there a snake in the grass? We will never know. Perhaps it was simply McIndoe's expressed wish that, following immediate cremation, his ashes go to the Royal Airforce Church of St Clement Danes. La piste etait sans success - the investigation was not successful.

> *Son, when giving negative advice, double the fee – the patient will respect it more, and might even pay.*
>
> - B. K. Rank

Congratulations
on your achievements

Sir Louis Barnett was responsible for the original proposals in 1920, to create a New Zealand and Australian association of surgeons which would be modelled on the American College of Surgeons and bestow a "hallmark" of surgical excellence. The Sir Louis Barnett Medal is awarded for outstanding contributions to education, training and advancement in Surgery.

award winner



PROFESSOR MARK EDWARDS FRACS
Sir Louis Barnett Medal

Mark Edwards graduated from the University of Western Australia (BSc MB BS) in 1973 and has been a Fellow of this College since 1982. He trained as a cardiothoracic surgeon in Perth and Sydney, and is particularly grateful for the inspiration and mentorship of Alan Farnsworth at St Vincent's Hospital. He spent a busy and rewarding 18 month period at the National Heart Hospital in London as SR to Sir Magdi Yacoub and Donald Ross, one of the fathers of modern cardiac surgery. He played a major role in establishment of a cardiac transplantation program in Perth, a service which began in 1995.

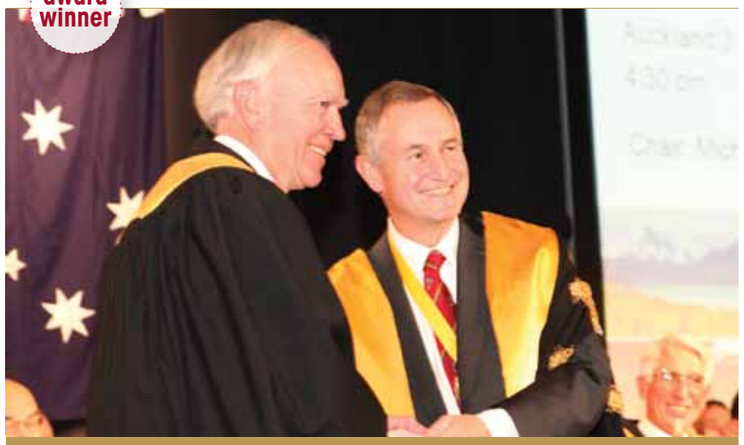
When the time came to work for the surgical profession he joined the WA State Committee in 1992. 1993 saw him elected to the Court of Examiners, so beginning 20 years of service in the assessment, delivery and administration of surgical education and training. He served first as an Examiner until 2003, then was elected as the Cardiothoracic representative on RACS Council, serving the maximum of 9 years from 2004 to 2012, including a term as Chairman of the Court before becoming Censor in Chief. (2010-2012).

On behalf of the Specialty Training program in Cardiothoracic Surgery he made numerous accreditation visits including assisting fledgling departments to meet the exacting requirements for a SET Trainee. His style was generous, friendly, serious and consultative, a natural extension of his prowess as a clinician to the business of standards in Surgical Education. He has lectured, examined and operated in Indonesia, China, India, Egypt and Ireland.
In 2011, he was appointed Clinical Professor of Surgery by the University of Western Australia in recognition of his contributions to surgery and medical education.

He attended Kent Street Senior High School in Perth, played grade cricket, represented the State at baseball and is a sport enthusiast. His other interests outside surgery include climbing mountains, bush walking, photography and the history of World War II. He is married to Cathy, has four adult children, but also a son of 4, and two grandchildren; they are the loves of his life and his inspiration.

Citation kindly provided by David Watters and Simon Williams

award winner



MR GARNET TREGONNING FRACS
Colin McRae Medal

Inaugurated in 1992 the Colin McRae Medal commemorates the life and work of Colin McRae, an outstanding New Zealand surgeon and former President of this College. The award recognises and promotes the art and science of surgery and surgical leadership in New Zealand. It honours those who have made outstanding contributions in this way.

Garnet Tregonning was born in Dunedin and attended Kings High School, where he excelled academically and at sport. He then entered the Otago Medical School completing his MB ChB in 1965. Fellowship of the Royal Australasian College of Surgeons was gained in 1970, this being a general fellowship. Garnet quickly embarked on a career in orthopaedic surgery, spending three years in Toronto and a year in London before returning to Middlemore Hospital in Auckland in 1975, working primarily in trauma and spinal surgery.

Having been exposed to and recognising the considerable value of the AO techniques of fracture fixation, Garnet was instrumental in the rapid dissemination of this knowledge in New Zealand. His fracture management was outstanding, and he set a standard that transformed trauma care with major implications for improved outcomes and radically shortened hospital stays.

His leadership and teaching ensured that techniques that carried some risk when applied inappropriately or without expertise, were safely established in this country. Garnet took a leadership role in the introduction of practical skills workshops and was the course director and organiser of the "Inaugural National Instructional Course for New Zealand Orthopaedic Surgeons on A.O. Techniques of Internal Fixation of Fractures" in 1976. He continued this involvement with many subsequent courses both in New Zealand and internationally over many years,

Garnet has had an exemplary and unwavering commitment to surgical education, both undergraduate and postgraduate. He has always found time during busy clinics and ward rounds to keep students interested and involved. For more than 15 years he organised and ran the undergraduate program at Auckland. His outstanding contributions have been recognised with the University of Auckland Medical School Dennis Pickup Clinical Teaching Award in 1999 and the Students Association's Most Supportive Member of Department Award in 2009.

Garnet served six years as a member of the New Zealand Orthopaedic Education committee – four of those years at its chairman. He was elected to the Court of Examiners in 1998 where he served eight years, the final two as Senior Examiner.

A member of the New Zealand Orthopaedic Association, Garnet has served terms on the Executive Committee and was President during 2000-2001. He has been an adviser to the Health and Disability Commissioner and the Ministry of Health for extended periods and is a long serving trustee of the New Zealand Orthopaedic Association Wishbone Trust.

Garnet Tregonning is an outstanding role model, demonstrating clinical excellence throughout his career, lifelong commitment to education and contributing significantly to leadership in orthopaedic surgery. He is a most worthy recipient of the Colin McRae Medal.

Citation kindly provided by Scott Stevenson

award winner

PROFESSOR DONALD STEPHEN ESMORE, AO
Award for Excellence in Surgery

The award was presented to the Cardiothoracic Unit at the Alfred Hospital.

Top: Julian Smith, Cardiothoracic surgeon Adam Zimmet and College President Mike Hollands with Prof Don Esmore's award. Julian Smith and College President Mike Hollands with Don Esmore's family.

Professor Donald Esmore, AO has made a major contribution to Australasian Cardiothoracic Surgery for over 30 years especially within the field of cardiopulmonary transplantation and mechanical support of the circulation. A highly gifted technical surgeon, he has lead the Heart and Lung Transplant Service at the Alfred Hospital since 1989 and has achieved outstanding outcomes for a very challenging group of patients with end stage heart and lung disease. Under Professor Esmore's leadership, the Service has pioneered many new heart and lung transplant procedures which are now common place today.

He was instrumental in pioneering the Australian made Ventrassist mechanical heart assist device which subsequently achieved worldwide usage. He also introduced to Australia the heterotopic or "piggy back" heart operation in which a second heart is implanted into the patient's chest to boost the native one. Many results of basic science research within the Service have been successfully translated into clinical practice.

The Alfred Heart and Lung Transplant Service has attracted a steady stream of overseas surgeons to train who have subsequently become surgical leaders in their own countries and the Service has an outstanding reputation within the international transplantation community. Professor Esmore has published widely, has been a key note speaker at many international conferences and would be one of the highest profile individuals within the world of cardiopulmonary transplantation and mechanical support of the circulation.

His capacity for hard work is legendary, being able to stand for seemingly unlimited hours at the operating table during complicated transplant and circulatory support procedures. He also has a reputation for tackling cardiac surgical cases that many other surgeons had rejected and usually achieving successful outcomes.

Professor Esmore has already received Federal and State Government recognition for his contribution to Cardiothoracic Surgery, to Thoracic Organ Transplantation and to the community, and it is therefore fitting he be recognised by the Royal Australasian College of Surgeons. He certainly fulfils all the criteria for an Award for Excellence in Surgery.

Citation kindly provided by Julian Smith, FRACS

award winner

PROFESSOR RONALD KAY FRACS
ESR Hughes Medal

Inaugurated in 1998, the ESR Hughes Award is designed to recognise distinguished contributions to surgery by Fellows of the College and others. It was created in recognition of the outstanding contributions to surgery by Professor Sir Edward Hughes. The sole criterion for the Award is distinguished contributions to surgery.

Ron Kay completed his MB ChB at Otago in 1953, became FRCS in 1957 and FRACS in 1963. After spending three years as a Post-Doctoral Research fellow at Harvard Medical School and Peter Bent Brigham Hospital, Boston, Ron returned to Auckland where he was quickly appointed Associate Professor of Surgery at the newly formed Auckland School of Medicine. Tasked with the establishment of an academic surgical unit with a major research section, Ron completed this work with conscientious attention to detail, considerable flair and superb judgement. He was able to secure the cooperation of colleagues in respect to undergraduate and graduate teaching. Ron subsequently developed an innovative program for examination of the program in surgery.

Ron was a pioneer in the use of intravenous nutrition in New Zealand from the late 1960s. His leadership contributed to the saving of numerous lives. His careful research in this area resulted in a number of seminal papers.

Ron has been accorded international recognition for his work with breast cancer. He was the founding chairman of the Auckland Breast Cancer study group in 1976. At an early stage this group, with great foresight, established a detailed breast cancer register; this data influencing beneficial change in the management of breast cancer. Unfortunately the introduction of the Privacy Bill led to its cessation. Approximately 10 years ago, assisted with funding from the New Zealand Breast Cancer Foundation, Ron restarted the Auckland breast cancer register and this is once again an increasingly valuable resource.

Ron Kay has made a unique and sustained contribution to breast cancer research for more than 30 years. He was a member of the first group undertaking clinical trials of breast cancer treatment in New Zealand and a foundation member of the board of the Australia and New Zealand Breast Cancer Trials Group. He was also a foundation member of the International Ludwig Institute Breast Cancer Trials Group, subsequently the world leading International Breast Cancer Study Group. These groups were at the forefront of clinical trials of chemotherapy for breast cancer during the 1980s and Auckland was extensively involved.

Ron devoted much of his practicing career to the improvement of standards in the management of breast cancer, founded upon evidence-based practice. This included promoting breast conserving surgery instead of simple or radical mastectomy. He has remained committed to research and the provision of care for patients suffering from cancer of the breast and, in retirement, continues an advisory role to the New Zealand Breast Cancer Foundation.

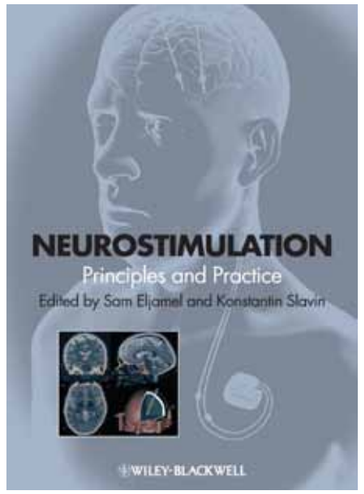
Ron Kay is a surgeon of considerable humility who has set standards of clinical excellence, demonstrating insight, care and respect for his patients. He has been a trusted, respected and valued colleague sought out as a mentor and teacher by many New Zealand surgeons and Trainees. He has been a leader and major contributor to surgical research and education. Professor Ronald Kay is a fitting recipient of the ESR Hughes award

Citation kindly provided by Scott Stevenson

Welcome to the Surgeons' Bookclub

WILEY BOOKS NOW UP TO 35% DISCOUNT

25% Discount



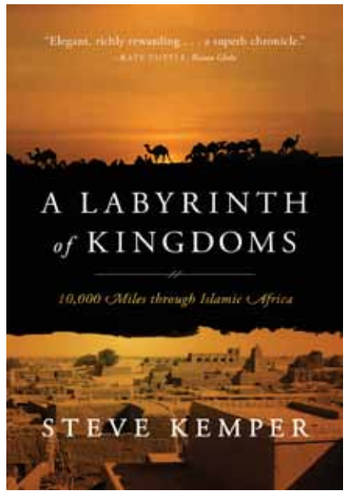
Neurostimulation: Principles and Practice

Sam Eljamel, Konstantin Slavin (Editors)
9781118346358 | Hbk | 248 pages | September 2013

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

Could neurostimulation be a management option for your patients?
Neurostimulation techniques present real management options for patients with a range of neurologic and psychiatric disorders, such as movement disorders, pain and depression. They should be actively considered when conventional medical approaches have failed or are inappropriate. But for many clinicians, these new methods pose many questions. What are the available modalities? How do they work? Which patients might benefit from them? How do I explain the processes to patients? How do I monitor my patient's progress after implantation?
Neurostimulation provides a concise, easy-to-read fusion of the clinical applications of implanted neurostimulators. It demystifies selection and referral criteria, maximizing therapy, programming the implanted neuromodulators, monitoring progress and troubleshooting problems associated with neurostimulation.

25% Discount



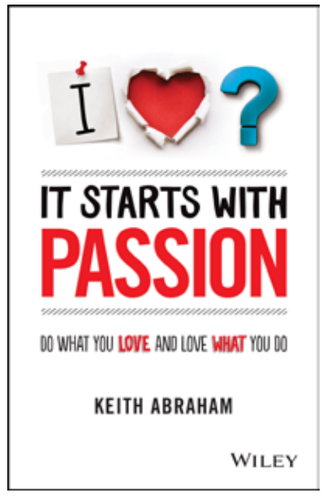
A Labyrinth of Kingdoms: 10,000 Miles Through Islamic Africa

Steve Kemper
9780393346237 | Pbk | 304 pages | August 2013, Norton

~~AU$22.95~~ | **AU$14.92**
Member Price

In 1849 Heinrich Barth joined a small British expedition into unexplored regions of Islamic North and Central Africa. One by one his companions died, but he carried on alone, eventually reaching the fabled city of gold, Timbuktu. His five-and-a-half-year, 10,000-mile adventure ranks among the greatest journeys in the annals of exploration and his discoveries are considered indispensable by modern scholars of Africa. By delivering the first biography on Barth in English, Steve Kemper goes a long way to rescue this fascinating figure from obscurity

25% Discount



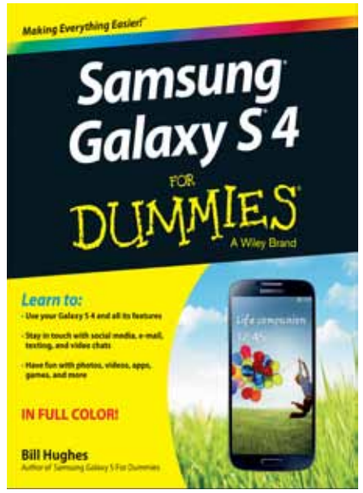
It Starts With Passion: Do What You Love and Love What You Do

Keith Abraham
9781118512708 | Pbk | 240 pages | June 2013

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

How to ignite your passion, live with purpose, and succeed in life and business
No matter what you want to achieve in life, the secret to doing it is passion. For people to be happy, they need to find meaning in what they do and in the roles they play in their lives, careers, and communities. When we identify the personal passions that drive us, the byproduct is focus, satisfaction, and achievement. But it's not always easy to find our passions.
In this book, Keith Abraham shows you how to ignite the passion in your life, as well as in the lives of your colleagues, employees, and associates. He includes in-depth research, easy-to-understand concepts, inspirational stories, and clear visual models to show you how to find out what's meaningful to you and pursue it with passion and energy. In the process, Abraham shows you what you can achieve when you align your purpose, passion, and personal goals.

25% Discount



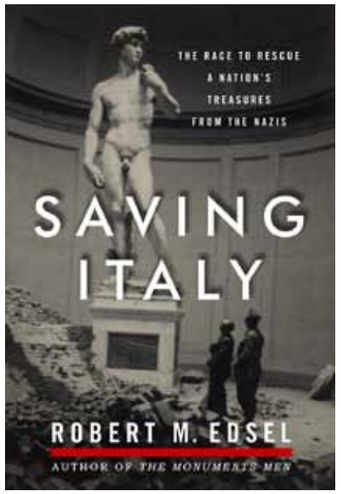
Samsung Galaxy S 4 For Dummies

Bill Hughes
9781118642221 | Pbk | 320 pages | May 2013

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

Explore a world of possibilities with your Samsung Galaxy S 4 smartphone
Everything's more exciting when you've got the Galaxy in your hand. Let For Dummies be your guide to getting the most out of your Galaxy S 4. You'll cruise through the smartphone basics and set up process before moving on to the fun stuff like staying in touch with e-mail and texting, surfing the web, navigating with maps, shooting and sharing photos and video, watching movies, listening to music, and so much more. Whether you're entering the smartphone world for the first time or just moving up to the Galaxy S 4, you'll stay on course with this one-of-a-kind reference.
Provides easy-to-understand advice to help you find your way around your Galaxy S 4 smartphone, get to know all the built-in features, and start making calls
Explains the Galaxy S 4 features using full-color screenshots and images and step-by-step instructions on accessing the Internet, sending and receiving e-mail, texting, taking photos, recording videos, downloading apps, managing your calendar, and organizing your contacts

25% Discount



Saving Italy: The Race to Rescue a Nation's Treasure's from the Nazis

Robert M Edsel
9780393082418 | Hbk | 480 pages | Sept 2013

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

When Hitler's armies occupied Italy in 1943, they also seized control of mankind's greatest cultural treasures, plundering the masterpieces of the Renaissance, the treasures of the Vatican and the antiquities of the Roman Empire. In May 1944, artist Deane Keller and scholar Fred Hartt, embarked on the treasure hunt of a lifetime, to track billions of dollars of missing art, including works by Michelangelo, Donatello, Titian, Caravaggio and Botticelli. An unforgettable story of epic thievery and political intrigue, *Saving Italy* is a testament to heroism on behalf of art, culture and history.

WILEY

To Order

RACS Members now **save up to 35%*** on Wiley books by following the instructions below:

Log on to the RACS website

Go to Member Benefits – then Wiley-Blackwell

Follow the steps as shown on RACS website to ensure your member discount on Wiley books

If you have previously ordered from the RACS\Wiley Books Discount Page, then you can purchase direct from www.wiley.com by selecting the book/s of choice and then logging on.

Place your order – no discount code needed

Postage is charged on all orders:

AU$7.50 within Australia and AU$25.00 to New Zealand

To read more about these titles please go to **www.wiley.com**

*25% on textbooks and excluded is a discount on School (Jacaranda) titles.

Not all books promoted in Surgical News will appear on the RACS/Wiley Landing Page.

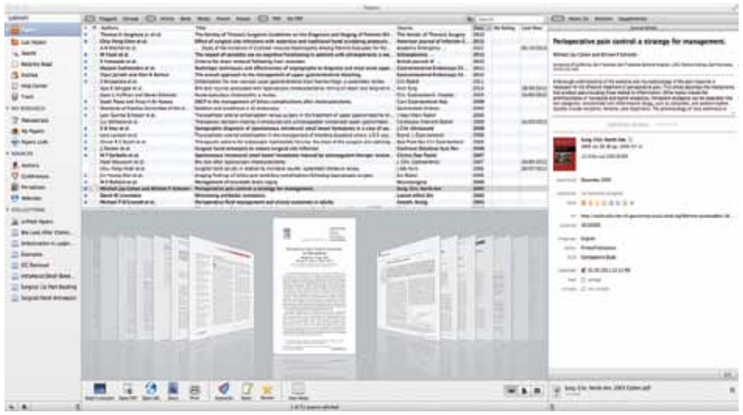
You can still order these, as with any other book, by finding it within **www.wiley.com**

App review: Papers (Mac, iOS)

Got a review? Email it to Surgical.News@surgeons.org

Papers for Mac has been around since 2004. It was originally designed by two Dutch PhD students who were looking for a better way to organise the multitude of journal articles that they collected during the course of their studies at the Netherlands Cancer Institute.

The application has become a hit with researchers around the world, and won three Apple Design Awards for its straightforward design and ease of use.



Mac version

One of the most useful functions of the app is its ability to clean up an article's meta data. If you have a PDF with a random filename you can ask Papers to 'match' it to its corresponding author and journal data. All you have to do is select the paper, hit 'match' and then select the correct article from the search page. Papers will automatically fill in the author and title data so that your library of PDFs is appropriately labelled, enabling you to easily search your own collection.

The desktop version also has a number of integrations with other software: there are plug-ins for Safari, Google Chrome and Firefox allowing you to import PDF articles into your library directly from the web-browser, as well as a citation manager allowing you to input citations directly into Microsoft Word when writing articles. The citation manager even allows you to select the format of the citations based on the journal you are writing for: just select the journal name and your citations and reference lists will automatically be updated with the appropriate format.

There are also some additional interesting features like an automatically updating 'smart folder' of articles that you have written as well as a social networking system called Papers Live which allows you to share your library with other Papers users via the web.

The desktop version was the original iteration of the application and is now in version 2.6.4. It is currently only available on Mac, but a Windows version is available with a pre-release trial available to download from their website.

At its heart the application allows you to search for articles, download the PDFs and add them to your own library. Custom folders and keyword tagging allow you to organise the articles you have imported, and EZProxy support allows you to use library or college subscriptions to obtain full text articles from within the program.

The application is regularly patched and updated and in its current incarnation is very stable. The desktop version was tested using the latest version of Mac OS X (Mountain Lion 10.8.4).

Papers Touch

The iOS version of Papers allows the syncing of the database between iPad, iPhone and desktop, allowing you to carry your library of journal articles with you on the go. It will also keep your highlights and notes in sync, allowing you to make notes on the PDF on your iPad and having those notes and highlights available to you on your computer after a quick sync.

The syncing keeps your user created folders in order: allowing you to make individual collections of articles for quick reference, and is bi-directional, allowing documents you download on the mobile version to be synced back to the desktop and vice versa. The only downside is that the syncing doesn't work over the web. This means that you have to open Papers on both devices while at home to get the libraries to synchronise.

> *"The application has become a hit with researchers around the world"*

Sharing tools allow you to quickly email, print or export articles and a newer feature allows you to quickly 'share' an article with a nearby Papers user. However, while this function sounds great, I haven't found it any quicker than hitting the share button and then email – everyone has email, not everyone has an iOS device with Papers installed. Articles that have been emailed to you can be opened from your iPad or iPhone mail directly into Papers with a couple of quick taps.

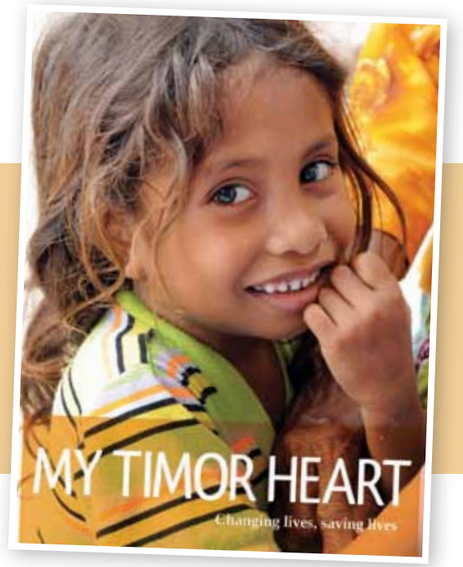
The iOS version has most of the features of the desktop version including 'match', searching, EZProxy support, and custom folders. One quirk that I have noticed in the iOS versions is that making highlights and inline notes is unavailable on the iPhone, but works fine on iPad.

The app is now on version 1.9.17 and is also quite stable. Both iPad and iPhone versions were tested using the most current version of iOS.

The desktop version can be downloaded from http://www.papersapp.com/papers/ for AU$79 with a 30 day free trial available and Papers Touch can be obtained from the app store on your iPhone or iPad for AU$14.99

Suraindra Rajadurai,
Victorian Trainee

The College has produced a book, called *My Timor Heart*, to celebrate our achievements in Timor Leste. *My Timor Heart* will recognise the extraordinary efforts of the medical volunteers in Timor Leste, and the life-changing impact their work has on people living in a country that continues to struggle with the legacy of years of civil war and violence.



My Timor Heart

Written by Ellen Whinnett and Ellen Smith

Using striking photographs and volunteers' stories *My Timor Heart* illustrates the profound positive impact of the College's Timor Leste program. The book was written by Ellen Whinnett, a Walkley award winning journalist and the Head of News at the Herald Sun newspaper. *All proceeds from the sales of My Timor Heart go directly to Foundation for Surgery to fund the Timor Leste Program..*

ORDER FORM

Name: .....

Address: .....

Telephone: .....

Email: .....

Please find enclosed my payment for: $.....

$60 AUD + P&H ($10 AUD in Australia for first copy then AUD $5 for each additional copy) (incl. GST)
*Please contact us for Postage & Handling costs outside Australia.

Cheque: ☐ Money Order: ☐

Credit Card:
Card Type: Mastercard / Visa / American Express

Card No: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Expiry Date: .....

Signature: .....

Please send this form to:
Timor Leste Program
College of Surgeons' Gardens
Royal Australasian College of Surgeons
250-290 Spring Street,
East Melbourne. VIC 3002
AUSTRALIA

Email: emily.salt@surgeons.org
Phone: +61 3 9249 1230
Fax: +61 3 9249 1236

Foundation for Surgery
Passion. Skill. Legacy.

The Royal Australasian College of Surgeons takes the issue of security and privacy seriously. Information contained in this form will not be used for any other purposes

Foundation for Surgery
Passion. Skill. Legacy.

Thank you for donating to the Foundation for Surgery

Victoria
Athenaeum Club
Mr William Huffam
Assoc. Prof. Helen O'Connell
Mr Simon Williams
Estate of the late Dr Lena McEwan

New South Wales
Mr Richard Arnot
Professor Wui Chung
Mr Anthony Emmett
Mr Anthony Goodman
Mr Stanley Koorey
Mr Robert North
Mr Garry Scarf

New Zealand
Mr Majeed Alwan
Dr Wiliam Farrington

Total: $456,800

Your passion.
Your skill.
Your legacy.

Your Foundation.

Yes, I would like to donate to our Foundation for Surgery

Foundation for Surgery
Passion. Skill. Legacy.

All donations are tax deductible

Name:

Address: Telephone:

Email: Speciality:

Enclosed is my cheque or bank draft (payable to Foundation for Surgery) for $ . .

Please debit my credit card account for $ . .

☐ Mastercard ☐ Visa ☐ AMEX ☐ Diners Club ☐ NZ Bankcard

Credit Card No: Expiry /

Card Holder's Name - block letters Card Holder's Signature Date

I would like my donation to help support:

☐ General Foundation Programs ☐ International Development Programs
☐ Scholarship and Fellowship Programs ☐ Indigenous Health Programs
☐ I have a potential contribution to the Cultural Gifts Program
☐ I do not give permission for acknowledgement of my gift in any College publication

Please send your donation to:

AUSTRALIA & OTHER COUNTRIES
Foundation for Surgery
250 - 290 Spring Street
East Melbourne , VIC 3002
Australia

NEW ZEALAND
Foundation for Surgery
PO Box 7451
Newtown, 6242 Wellington
New Zealand

Save on travel this Spring

Find out how:

Save $512[1] on family adventure tours

Save on a family Croatian Coastal Adventure tour for four people booked using the 10% Member Advantage discount, or choose from a variety of trip themes including family, short breaks, food, cycling, marine, self-drive and many more.

Save $355[2] on airline lounge memberships

Enjoy specially negotiated rates on Qantas Club, Virgin Australia and Koru Club airline lounge memberships when you apply through Member Advantage. Discounts available for both new applications and renewals.

Save $186[3] on luxury accommodation

Save up to 10% on accommodation for two at Quarterdecks Retreat, Harvey Bay; just one of hundreds of hotel discounts available through Best Western. Fellows and Trainees can also save up to 15% on accommodation through HotelClub.

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

Call 1300 853 352 or visit www.memberadvantage.com.au/racs

Member ADVANTAGE®

All savings listed 13/08/13 and subject to change. 1) Based on an 8 day Family Croatian Coastal Adventure tour for four people departing 25/05/2014. 2) Based on savings acquired by taking out a new two year Qantas Club airline lounge membership. 3) Saving of $186 based on 10 nights stay at Best Western Quarterdecks Retreat, Harvey Bay QLD for 2 adults from 04/11/13 to 13/11/13.