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Partnering Agreements

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

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

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

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

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

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

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

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

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

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

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

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

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

There are now three categories of Partnering Agreement:

- **Category 1** is where the College manages the program and undertakes day to day administration. This may be most applicable to the smaller Societies (as is now the case) or to a reconstituted Division;
- **Category 2** is still a collegiate activity, but enables Societies to directly administer the program and undertake a range of educational and administrative activities. In the new agreements these activities are specified in considerable detail. The Training Board continues as a College Committee;
- **Category 3** is in a distinctly commercial form, with the expectation that the Society will be able to fully deliver across the nine competencies of our curricula. Accountability and responsibility for all issues including legal liability, indemnity, indemnification of the College and handling of Appeals sits with the Society. This arrangement would be under the oversight of a Society Faculty Board.

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

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

The nine Training Boards relate to the nine specialties, but if a particular specialty wishes to have two national training boards then that can be arranged. It would have to be agreed by both national societies and include a commitment to ensure they continue to have a common curriculum, the same educational outcomes and by having the right of direct attendance at the College Fellowship examination.

Any additional costs will be met by the Societies.

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

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

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

There is now some urgency to complete this process which, I am convinced, is very soundly based. The reason for the urgency is that the Australian Orthopaedic Association and the Urological Society of Australia and New Zealand have given the College 12 months’ notice that they will not support the current arrangements into the future, with this being effective from January 2033.

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

Mike Hollands
President

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

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

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

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

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

- the College’s correspondence with the Podiatry Board of Australia (PBA) and the Podiatry Board of Western Australia (PBWA) about the process by which the Podiatry Board of Australia (PBA) has recognised podiatric surgery as a specialty.
- the College’s correspondence with the Podiatry Board of Western Australia (PBA) about the College not being involved in the process by which podiatric surgery was recognised as a specialty and the implications of this recognition for the structure, development and accreditation of podiatric surgical training.
- the College’s opposition to the PBA’s process by which podiatric surgery was recognised as a specialty, the implications of the recognition for the College and the professional development of podiatric surgical training.

As the Specialty Society with responsibility for foot and ankle surgery, the College is ideally placed to assess the feasibility of including podiatric surgery as a specialty for the ACCS. The College’s position was that the ACCS has the resources to undertake the work involved in the process and was therefore ideally placed to do so.

The College reminded the Minister that the College had pointed out to the Podiatry Board of Australia that the Podiatry Board of Western Australia had previously raised its concerns with the Medical Board of Australia that the College was failing to meet the requirement under Part 3 Clause 9 of the Health Practitioner Regulation National Law 2009 that a National Board consult other National Boards about recommendations to the Ministerial Council that may reasonably be expected to be of interest to those National Boards.

The College reminded the Minister that the processes outlined in the Australian Registration Legislation and the ACCS’s Code of Practice are intertwined and that the College strongly endorses the submission made by the AOA and called on the Standing Council on Health to intervene in the processes by which the PBA effectively examines, endorses and approves the Code of Practice. We wrote that the ACCS is not an accrediting body, this unwillingness to involve it in the PBA’s processes represents a threat to the safety of patients. The submission indicated that the ACCS’s submission was not in fact been observed.

The College strongly endorses the submission made by the AOA and called on the Standing Council on Health to intervene in the processes by which the PBA effectively examines, endorses and approves the ACCS’s Code of Practice. We wrote that the ACCS is not an accrediting body, this unwillingness to involve it in the PBA’s processes represents a threat to the safety of patients.

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Regional cooperation

More surgery will be performed by ACT surgeons at the Queanbeyan Hospital in a trial to test the success of a cross-border surgery agreement between the ACT and NSW. Local doctors have complained in recent times that the Queanbeyan Hospital is under-utilised having only performed 205 surgeries between January and March.

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

Canberra Times, August 18.

Falls increase off the mainland

Tasmanian surgeons are urging people to be careful after seeing a spike of injuries resulting from falls recently. Falls can be anything from falling from high places or simply stumbling on a step.

Neurosurgeon Pauline Waites and General Surgeon Richard Turner have dealt with a number of cases involving falls, including a man who was hit by a car, a woman who fell down a flight of stairs, and a man who fell from a ladder, all of whom were transported to hospital with severe injuries.

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Hobart Mercury, August 13.

Policy failing in NT

Banning drinkers from licensed venues is not working, College spokesman and Fellow Phillip Carson has said. The banned drinkers register (BDR) is not having any effect on reducing numbers with alcohol related cases regularly turning up at Territory emergency departments.

“The BDR doesn’t address the problem drinking with the rest of the community and doesn’t tackle the extended consequences of road deaths, violence and personal illness from drinking.” Dr Carson said.

Northern Territory News, August 9.

Micro Microscope

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

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

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

West Australian, August 6.

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West Australian, August 6.
Disastrous Wounds

A collaborative application of basic principles has the potential for enormous impact on patient care and build bridges between all involved as often disasters are trans-national requiring rapid collaboration in the immediate response. The response to the 2009 Tsunami in Samoa included a South Australian Team which travelled via Brisbane, combining with a Queensland Team for the initial deployment. Following this they were augmented by Victorian, New South Wales and New Zealand teams. They arrived, in a staged manner, two days after the initial response and were gradually able to take over as the first responders fatigued.

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

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

References
4. Personal Experience
5. Personal Experience
7. Sudhakar Rao, Chair RACS Disaster Preparedness Committee
8. David Watters: Chair RACS International Committee.

Curmudgeon replies

In regard to Curmudgeon’s Corner, learning in Surgical News and as the first named College, Curmudgeon, I am challenged to bring out the latent Curmudgeon in all. I consider that I have a right of reply and would fully challenge the archaic definition of a “crusty, ill-tempered, churlish old man.” The modern definition is “anyone who hates hypocrisy and pretence and has the temerity to say so; anyone with the habit of pointing out unpleasant facts in an engaging and humorous manner.”

We began a few years ago the first steps to forming the “Ancient Order of Curmudgeons” and the list of characteristics includes:
- Positive
- Perceptive
- Pithy
- Peripatetic
- Persistent
- Pervious
- Profound
- Pungent
- Pinaute
- Prepared
- Pratetic
- Peat

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

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

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

Food for thought

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

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

Finally I would indicate that if you are a leader in any form it is the bad news that you really want to hear because that information is likely to be truthful, and therein lay the problems that need to be fixed. Curmudgeons need to be valued. A final quote by H. L. Mencken: “It is a fine thing to face machine guns for immortality and a medal, but isn’t it a fine thing, too, to face calumny, injustice and loneliness for the truth which makes men free?”

References
Curmudgeon’s Corner

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

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

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

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

The College again hosted a successful opening of its Melbourne building as part of the Open House Melbourne weekend at the end of July. More than 800 people toured the building, with many queuing in the cold and wet to find out what lay behind the College’s Stripped Classical portico. Visitors were given a varied tour, learning about the history of the site and the role of the College in the training of surgeons.

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

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

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

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

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

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

Felix Behan also assisted as a speaker on Saturday.

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

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

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

The Committee would like to thank all involved for their efforts, including College staff.
The Telehealth Solution
We explain why it’s good for your patients and good for your practice

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

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

Surgeon access is the big selling point for those who are eligible to receive this service (patients from remote, rural and outer metropolitan districts, registered age care facilities and Aboriginal medical services). While Telehealth isn’t appropriate for all patients, it is one of the best examples of this approach. Via a simple sign up process, you tell them exactly what you want referrers to see, and ACRRM takes care of the rest.

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

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<thead>
<tr>
<th>2012-13</th>
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![Image](https://via.placeholder.com/150)

**Poison’d Chalice**
Reflection is good advice

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

**Reflection is good advice**

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

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

Part of surgical training is learning to confront multiple problems, prioritise them and either solve them one at a time or delegate them. My observation of registrars is that they embrace the latter with alacrity – the ‘flick-pass’ has been developed into an art form! So much so that led to learning? I hope not and I don’t think so. Experience is the name so many people use to help my registrar in the 21st century. It was a good example of a decent one less. The important thing is to consider your needs and choose appropriately.

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

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

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

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

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

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<table>
<thead>
<tr>
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<td>AOA</td>
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<td>Tasmanian Regional ASM</td>
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<td>ANZSVS</td>
<td>20-23 October</td>
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<td>Victorian Regional ASM</td>
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<td>ACT Regional ASM</td>
<td>03-03 November</td>
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<tr>
<td>ANZSTS</td>
<td>11-14 November</td>
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To find out more, contact Matthew Donn, your College Telehealth Support Officer on +61 3 9249 1200, email telehealth@surgeons.org, or check the Telehealth page on the College web site www.surgeons.org

Cathy Ferguson
Chair, Fellowship Services Committee

Professor U. R. Kidding
I n July 2012, Timor Leste held its third ever parliamentary elections. The ballot was seen as a litmus test for the young democracy, with the UN declaring it would withdraw its 3,800 strong police force if the elections passed peacefully. They did – giving yet another encouraging sign that Asia’s newest nation is increasingly ready to stand on its own.

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

The new program, the Australia Timor Leste Program of Assistance for Secondary Services program continues support for the Timorese health system.

**Phase II of the Australia Timor Leste Program of Assistance for Secondary Services**

**Continuing regional support**

Secondary Services (ATLASS Phase II) ensures continued, targeted and appropriate support is provided to the Timorese health system. ATLASS II is highly focused on education, capacity building and maternal and child health, rather than general service delivery. While surgical teams visit will still take place, they also have a greater training and mentoring focus, with Australian and New Zealand Fellows working alongside Timorese doctors in theatre.

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

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

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

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

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

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

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

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

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

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

These teams, including plastic and reconstructive surgery, urology and ENT, are instrumental in providing on-the-job training to the local counterparts. We also plan to offer selected ongoing training or refresher opportunities in Australia and New Zealand while specialists from here will be funded to travel to Timor Leste to deliver courses either at the General Hospital in Dili or through the University of Timor Leste.”

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

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

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

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

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

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

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

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

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

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

**Dr Nilton Tilmaan**

**Dr Glenn Guest**

**RACS General Surgeon on a Ward Round in Dili**

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

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

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

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

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

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

Can’t turn off

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

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

Eventually, as one starts to relax, one sleeps longer and deeper; one even begins to dream—only then are you truly unwinding—and after a few more days any desire to achieve something may even be ignored. Then the holiday really begins—sadly by then there might be only a couple of days left. It probably doesn’t matter whether you climb mountains, lie on a beach, visit museums, trapse barefoot through Buddhist temples, or taste wine in the Bourgogne—just as long as you leave work behind, have fun, relax and spend time with your family.

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

A well-deserved break

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

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

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

Dr BB G-loved
Indigenous health

Leading the help
Dr David McIntosh is making a difference with a different pathway

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In developing the 2013 program, we have sought to tailor requirements that are relevant to their scope of practice and to ensure Fellows participate in activities which Fellows can claim CPD points.

The reduction is intended to better enable Fellows to move between practice types as they transition into different phases of their career. The number of categories has also been reduced to minimise repetitive data entry by Fellows.

**Category 1: Surgical Audit**
This requirement remains unchanged. All surgeons who conduct operative procedures in hospitals, day surgery units or private rooms are required to participate in a surgical audit each year, and to subject the audit to peer review. Many locum surgeons are able to participate in the normal peer reviewed audit that takes place in their hospitals. They should select the practice type ‘operative practice in hospitals or day surgery units’. If locum surgeons cannot meet this requirement they should select the practice type ‘operative practice as a locum only’. They will continue to be able to submit their de-identified audit data, which must include the College’s minimum data set to the Locum Evaluation and Peer Review Committee.

However, from 2013 this committee will only recognise locums who perform an equivalent of 10 weeks full time work. This recognises community concerns about surgeons remaining in operative practice whose case load is very low. The requirement regarding ANZASM participation remains unchanged. Surgeons who have been requested to complete and return a Case Record Form must do so. Any surgeon who believes they were not the treating surgeon must notify their mortality audit.

**Simplification of CPD Categories and Practice Types**

The number of practice types has been reduced to reflect the type of work undertaken by Fellows. The practice types will be:
- Operative practice in hospitals or day surgery units
- Operative procedures in rooms only
- Operative practice as a locum only
- Clinical consulting practice only
- Other practice type (research, administration, academic, teaching, assisting etc.)

Fellows’ participation in CPD may fluctuate and reduces the overall average points requirements from current levels.

**Category 2: Clinical Governance – Quality Improvement, Evaluation of Patient Care and Professional Advocacy**
This requirement remains unchanged. All surgeons who work within hospitals or day surgery units (other than locums) should be involved in ensuring the safe provision of pre-operative, operative and post-operative management of patients and the maintenance of surgical standards.

**Category 3: Performance Review**
This is a new and exciting category. Rather than focusing on learning activities, this category encourages surgeons to seek feedback and analysis of their performance. This is valuable for all surgeons, but is particularly recommended for surgeons at the end of their careers.

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

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

**Category 4: Maintenance of Knowledge and Skills**
From 2013, category four incorporates categories 4-7 from the current program:
- Maintenance of Clinical Knowledge and Skills
- Teaching and Examination
- Research and Publication
- Other Professional Development Activities

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

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

**Streamlining Verification for Fellows**
When requested to verify, the vast majority of Fellows do so successfully. However, we do appreciate that participating in the verification process is a substantial undertaking for Fellows. Currently we verify 35 per cent of Fellows annually. It is likely that the community would regard this as a low percentage. Council has indicated its desire to increase the verification rate.
ASC 2012 Evaluation

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

ASC 2012

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

ASC 2012 Evaluation

> Management of Fistula in Ano: New Research and Progress...very positive comments

The 'Sessions of Interest' including the successful the ASC has become. This year delegate numbers totaled 1942 including 971 Fellows, 167 Trainees, 17 IMGs and 757 other health professionals.

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

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

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

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

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

Most respondents were satisfied with the scientific program indicating that it was balanced and provided a choice of sessions. Some expressed their frustration about program clashes particularly when concurrent sessions targeted the same interest group. Unfortunately, this may be inevitable given the complex ASC program and its four day format.

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

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

There were a number of recommendations for the 2013 ASC in Auckland. Some delegates advocated for more sessions delivered by external 'experts' with a greater emphasis on future-oriented content and innovation. Others suggested multi-disciplinary programs addressing common problems and how I do it presentations which incorporate greater interactivity There were also requests for an increase in topics of interest to Trainees.

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

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

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

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

The College is keen to hear your ideas about how to improve this response rate and is willing to 'think outside the square'. Please call +61 3 9276 7491 or contact PDactivites@surgeons.org

Julian Smith
Chair, Professional Development
Roger Wads, ASC Coordinator

Workshops & Activities

Keeping Trainees on Track (KToT)
30 October, Melbourne; 30 November, Sydney
This 3 hour workshop focuses on how to manage trainees by setting clear goals, giving effective feedback and discussing expected levels of performance. You can also find out more about encouraging self-directed learning at the start of term meeting.

Supervisors and Trainers for SET (SAT SET)
26 October, Melbourne (VC: Scientific Meeting - incl dinner)
This course assists supervisors and trainers to effectively fulfill the responsibilities of their very important role. You can learn to use workplace assessment tools such as the Mini Clinical Examination (MCE) and Duly Observed Procedural Skills (DOPS) that have been introduced as part of SET. You can also explore strategies to help you to support trainees at the mid-term meeting. It is an excellent opportunity to gain insight into legal issues. This workshop is also available as an eLearning activity by logging into the RACS website.

The Process Communication Model (PCM)
11 to 13 October 2012 - Wellington, New Zealand (Introductory)
PCM is one tool that you can use to detect early signs of miscommunication and turn ineffective communication into effective communication. This workshop can also help to detect stress in yourself and others, as well as providing you with a means to reconnect with individuals you may be struggling to understand and reach. The PCM theory proposes that each person has motivational needs that must be met if that person is to be successful. These needs are different for each of the 6 different personality types, each person represents a combination of these types, but usually one is dominant.

Surgical Teachers Course
18 to 20 October, Hobart
This revised two-and-a-half day intensive course enhances educational skills of surgeons who are responsible for the teaching and assessment of Trainees. Participants learn the foundation of improved educational skills, which are further developed during the course through practical application. The course is delivered through four main modules, which are integrated to achieve progressive acquisition of knowledge and skills.

Non-Technical Skills for Surgeons (NOTSS)
23 October, Wellington; 30 November, Gold Coast
This workshop is divided into two parts. Part one includes formulating a strategic plan, the strategic planning process, identifying and achieving strategic goals; monitoring performance; and analysis of strategic risk. Part two focuses on the directors' knowledge of risk for the organisation and their monitoring of management's ongoing assessment and treatment of risk.

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

 Dates
OCT-Nov 2012

SA 17 November, Adelaide
Building Towards Retirement

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

NSW 18 to 20 October, Hobart
Surgical Teachers Course

Qld 31 October, Townsville
Keeping Trainees on Track (KToT)

Vic 26 October, Melbourne
Strategy and Risk Management for Surgeons

Not available this year

New South Wales

Strategic Planning and Management for Surgeons

Contact the Professional Development Department on +61 3 9249 1106, by email PDactivites@surgeons.org or visit www.surgeons.org.

- select Fellows then click on 'Professional Development.'
Concerned about their lack of detailed anatomical knowledge and the decline in hands-on anatomy teaching, medical students at the James Cook University (JCU) in Queensland have developed their own program to provide interactive, clinically-oriented, cadaver-based anatomy workshops. With the full support of the JCU Dean, School of Medicine and its discipline of Anatomy and Pathology, the JCU Medical Students’ Association (JCUMSA) launched a new arm in 2011 to drive the extra-curricular teaching called the JCUMSA Anatomy Society.

Since then, two intensive weekend workshops have been held with the voluntary enthusiastic teaching support of a number of local surgeons, with another scheduled for later this year. Supported by the Australian Medical Students’ Association, the program was awarded “Best New Initiative by a Medical Student Society” at the 2011 convention.

The inaugural workshop was attended by 40 students rotated through eight one-hour tutorial stations per day with each station allocated to a particular anatomical region and taught by 14 volunteer surgeons and pathologists who are specialist in that region. So enthusiastic were students to learn and participate, many travelled great distances at their own expense to attend. JCU fifth-year medical student Mr Andrew Hattam, the driving force behind the initiative, said that while some other universities were now offering additional anatomy teaching, he believed the JCU program was the only one established and run by students.

He said that while undergraduate medical degrees, such as that of the JCU, offered the highest average total hours of anatomy education compared to other programs, most anatomy teaching was incorporated as part of the basic science curricula, with no direct anatomy assessment and thus no minimum requirement of anatomical knowledge needed to successfully progress within the course and graduate. “Everyone knows that we don’t know our anatomy and that not only horrifies surgeons, in particular as we progress through our medical teaching, but our lack of knowledge leaves many students feeling lost and uncertain about their capacities,” Mr Hattam said.

“Enthusiasm from local specialists was also so great that we have now developed a waiting list of surgeons and specialists who wish to help us in the future. “The surgeons involved particularly loved it because it is hands-on laboratory-based dissection and their enthusiasm is contagious. “The donation of their time and support of sponsors make these workshops affordable to students.”

The heart valve connects to the…

Medical students are taking control of their anatomical learning.

In conversation with other students we decided we should do something about our lack of anatomy training instead of sitting around complaining. “When we first alerted other students across the JCU campuses about the first intensive weekend workshop, although preferentially offered to final year students, people from all years of undergraduate medicine came.”

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

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

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

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

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

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

“Enthusiasm from local specialists was also so great that we have now developed a waiting list of surgeons and specialists who wish to help us in the future. “The surgeons involved particularly loved it because it is hands-on laboratory-based dissection and their enthusiasm is contagious. “The donation of their time and support of sponsors make these workshops affordable to students.”

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

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

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

Immediate past-president Dr Christine Pirrone who helped establish the anatomy society as part of the medical students’ association.

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

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

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

“In Australia it has been estimated that human anatomy teaching has decreased to a level of around 20 per cent of that taught previously. “Yet turning around this decline in anatomy teaching is now becoming a ‘move- ment’ within medical education; surgeons are driving it, anatomists are driving it and now students are driving it too.”

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

He said the JCU Medical Students’ Association is driving the introduction of a standardised National Curriculum of Anatomy Education.
Surprising findings

Research continues to interest Urology Trainee Dr Dixon Woon

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

Conducting his research as part of a Doctor of Medical Science (DMedSc) degree through the University of Melbourne, the Urology Department of Austin Health and the Ludwig Institute for Cancer Research, Dr Woon investigated the role that Regulatory T-cells (Treg) and activated cytotoxic T-cells play in prostate cancer tissue. Activated cytotoxic T-cells are responsible for the killing of tumour cells, whilst regulatory T-cells maintain immune homeostasis by inhibiting the activation of the immune system. 

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

Using fresh tissue samples from patients along with matching peripheral blood mononuclear cells (PBMC), Dr Woon’s research looked at the impaired and may not be acting as cytotoxic T-cells and producing “anti-tumour” cytokines to favour cancer growth,” he said.

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

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

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

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

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

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

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

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

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

Dr Woon was the 2012 recipient of the Raedene Boyle Scholarship, awarded by the Surgical Change Cancer Foundation, the scholarship is open to Fellows or Trainees involved in cancer research which is expected to make a notable impact.

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

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

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

With Karen Murphy

Awards

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

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

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

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

For more information visit: http://www.adelaide.edu.au/programfinder/2012/mms_mmininvsur.html

Contact: Professor Guy Maddern
Email: guy.maddern@adelaide.edu.au
Phone: (08) 8222 6756

The University of Adelaide
www.adelaide.edu.au

Looking to specialise in minimally invasive surgery?

Consider the Master of Minimally Invasive Surgery degree at The University of Adelaide

The University of Adelaide invites applications for the Master of Minimally Invasive Surgery for 2013

The program provides a professional qualification for surgeons from a wide range of surgical subspecialties who wish to have minimally invasive surgery as a predominant part of their future surgical practice.

The one year program comprises:

- online tutorials and webinars
- teaching with low and high fidelity laparoscopic training devices
- the completion of a research project and;
- attendance at surgical skills workshops in Adelaide throughout the 12 month program.

Applicants should:

- have completed, or be within 1 year of completing, the FRACS, FRACOG (or equivalent);
- have a surgical fellowship or consultant position with a major interest in minimally invasive surgery and;
- be resident in Australia.

Applications are accepted from international and domestic students.
“A gathering such as this is as much about the future of the College as it is about the past”

College President Michael Hollands in toasting the South Australian Committee, round the College’s current aims to engage younger Fellows and to engage with all sub-specialities to increase and maintain the relevance of the College. The gathering noted that there was still not a woman or an orthopaedic surgeon who had a yet occupied the role in South Australia. Responding to the President’s comments, Tom Wilson (Chair 2000-2002) – a third generation Torchbearer (his father the late Graham Wilson was Chair 1972-1974 and his grandfather a founding fellow of the Australasian College of Surgeons in 1927) paid tribute to the work of many past.

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

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

A rich history

It was recorded that Charles Fagge FRCS released the Mace to the Australian College with the words: “And now, companion of my waking thoughts for many months, farewell. You have watched from earliest hours when, plate of virgin silver, you gave yourself to be fashioned by the craftsman’s skill. Your every spray of watte, every frond of fern have come to life within my ken, and gradually once a thing inanimate, your spirit has entwined itself around mine. “Today we part, but it is my hope that your new friends will ever hold you in their hearts, not only as a kingly emblem richly wrought, but as a spirit of affection... Stay here ever to watch their future, to guide their aims, and to bless their destiny.”

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

Peter Subramaniam
Chair, South Australia Regional Committee

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

Invoking the College motto Pax Mente Incendium Glorae, the current chair explored the origins and meaning of the 17th Century motto which forms a part of the College Coat of Arms.

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

Mr John O’Brien (Chair 1974-1976) was the most senior past chair in attendance while grace was said by Mr RA Rieger (Chair 1984-1986).

The Torch that illuminates the Mind is the Fire that consumes Vainglory.
In September a major upgrade to the Web Logbook will be released as the Morbidity Audit and Logbook Tool (MALT). There are many improvements and new functions:

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

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

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

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

Expressing interest in using MALT

<table>
<thead>
<tr>
<th>SET</th>
<th>Fellows sub-specialising</th>
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<tbody>
<tr>
<td>Cardiac Surgery (mandatory)</td>
<td>Gastric and Oesophageal Surgery (ANZGOSA)</td>
</tr>
<tr>
<td>General Surgery (optional)</td>
<td>Hepatic, Pancreatic and Biliary Surgery (ANZHPBA)</td>
</tr>
<tr>
<td>Orthopaedic Surgery (New Zealand) (mandatory for SET1, optional SET2-6)</td>
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To use MALT as an audit tool, users can simply record data against the standard dataset automatically assigned to them, noting that:

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

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

Ian Bennett
Chair, RAAS Board

For more information on the Logbooks application contact Katherine Economides, Manager, Morbidity Audits on katherine.economides@surgeons.org or +61 8 8239 0922.

Younger Fellows FORUM

3 – 5 May 2013, Auckland, New Zealand

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

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

Applications are open from 1 September to 8 December 2012.

Contact the Professional Development Department on +61 3 9249 1106.
A surgical Fellowship in the United States of America can provide world-class training and facilitate rewarding collegiality; however, can be challenging to obtain for Royal Australasian College of Surgeons’ graduates.

When considering a Fellowship in the USA, it is important for surgical Trainees to understand the types of Fellowship available, the preparation required, the necessary examinations, and the overall application timeline. If the requisites are understood and a reasonable amount of effort is undertaken, excellent USA Fellowships are obtainable for New Zealand and Australian surgical Trainees.

Types of Fellowship

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

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

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

Early Preparation

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

> If your College specialty undertakes USA examinations as part of their routine Trainee assessment (such as the Orthopaedic In-Training Examination (OITE)), perform well in these examinations.

> Involvement in additional leadership and support roles within your specialty, within the College, and within the community is encouraged.

> Most importantly, strive to develop positive relationships with your consultants, in order to gain supportive references.

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

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

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

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

The United States Medical Licensing Examination (USMLE) is a multi-part professional exam that is required for RACS Trainees to undertake a USA Fellowship.

The USMLE comprises three “Steps”, with Step 2 divided into two separate examinations.

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

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

Working Visas

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

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

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

Suggested Application Timeline

The application process for a USA surgical Fellowship should begin over three years before the start date of the Fellowship (which usually commence in July or August). With the above points considered, the following timeline provides a step-by-step guide to obtaining a surgical Fellowship in the USA, according to year of RACS Surgical Education and Training (SET):

> SET 3 (January)

> Latest date to begin registration process for USMLE Step 1.

> Allow at least 12 months to complete USMLE Steps 1, 2-CK, 2-CS and 3.

> SET 3

> Determine your preferred sub-specialties.

> Investigate which target USA Fellowship programs accept international medical graduates, and determine their medical licensure requirements.
CONGRATULATIONS on your achievement

Mrs Dianne Cornish

RACS Medal

I
give me great pleasure to present Mrs Dianne Cornish for the award of the RACS Medal.

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

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

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

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

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

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

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

Citation kindly provided by RACS Relationships Director James McAdam.
Kidney Transplantation and Indigenous Australians

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

The EBAPs are action orientated overviews that explain the low rate of transplant among Indigenous Australians, who have lower donation rates than Indigenous populations in America, Canada and New Zealand, there have been no studies to test these theories. Regrettably, the Australian Organ and Tissue Authority does not have a targeted strategy to improve rates of transplant in the Indigenous population.

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

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

Research is required to improve the renal transplant rate in Indigenous Australians. Data needs to be analysed that compares the outcomes of Indigenous long term dialysis patients with Indigenous patients post-transplant. Strategies need to be implemented which will reduce post-transplant complications, namely acute rejection and infection. There needs to be support for the implementation of a national data base and an investigation into which Australian government and non-government initiatives improve Indigenous patient access to transplant.

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

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

Chantel Thornton
Foundation for Surgery Board member
Safe Hours, Safe Patients?

Fatigue: As dangerous as drink?

Staff (Dawson & Read 1997) have claimed 'the effect of sustained wakefulness and moderate alcohol consumption are similar'. Findings from the study, conducted at the University of South Australia, indicate that after 14 hours of wakefulness there is an impairment of motor skills performance equivalent to a blood alcohol level of 0.06%, at which it is illegal to drive! This has obvious implications for medical practitioners. Doctors, who consistently work long hours, with few breaks and little sleep, may suffer a loss of judgement, significantly impairing their performance.

In May 2006, the AMA conducted a survey of over 350 doctors' working hours to evaluate the risks associated with fatigue. Assessing factors such as total weekly hours, amount of night work, length of shifts and on call commitments, the survey revealed that 62 per cent of hospital doctors had worked hours and patterns that posed unsafe risks due to fatigue.

Many hospitals have claimed to have taken measures to review working arrangements, but it is clear that many doctors continue to work long hours, which can have dangerous consequences for both patients and staff. The AMA's Safe Hours = Safe Patients campaign has identified a National Code of Practice for fatigue management for all members of the medical workforce:

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

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

What is 'negligence'?

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

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

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

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

How far are doctors protected?

Some protection of medical practitioners against the consequences of fatigue may be afforded by the provision of indemnity insurance. For example Queensland Health has stated 'Legal assistance, representation and indemnity are to be provided by Queensland Health at the request of the practitioners, when the incident subject to the claim would not have, on the balance of probabilities occurred but for the fatigue'. Other clinicians may be covered by private insurance or public hospital indemnity.

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

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

When does fatigue become 'wilful neglect'?

The question, therefore, is what constitutes 'wilful neglect'. 'Wilful neglect' might be classified as an individual's failure to abide by rules and regulations relating to the mitigation of fatigue risk. The limitations of such provision are most apparent when we observe that Queensland Health references 81 pages of documents pertaining to workplace fatigue, and that a violation of any one of these regulations could form a case for 'wilful neglect'.

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

How then can practitioners reduce risks associated with fatigue?

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

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

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

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4. Dr. Robert Norelli. 'Legal implications of fatigue', OIG Magazine
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Complications from umbilical hernia repair

Another important review

Sepsis following laparoscopic repair of an umbilical hernia

An elderly hypersensitive patient had a laparoscopic intraperitoneal mesh repair of an umbilical hernia with a 5cm diameter defect. The patient did not progress well post-operatively and was thought to have a respiratory problem and was transferred to a second hospital on day four. CT pulmonary angiogram was negative and abdominal pain and distension and fever continued. A CT of the abdomen revealed multiple fluid and gas containing collections and a ‘difficult laparoscopic removal of infected mesh and washout’ was performed. The patient made slow progress, but continued to be septic and several weeks later a CT scan suggested pulmonary emboli and the patient was treated with Cloxane. Just over a month later the patient suddenly collapsed with a drop in haemoglobin to 4gms/ml and laparotomy was performed. Purulent fluid was drained deep to the umbilicus and a large volume of dark blood was found. The patient died on the operating table in spite of intensive efforts at resuscitation.

Comment

1. Repair of a primary umbilical hernia with a 5cm defect by the laparoscopic route is not recommended. It is only indicated for a very large central hernia with loss of domain of the abdomen. When a complication of a laparoscopic procedure occurs the question arises whether a reopen laparoscopic procedure or an open laparotomy should be performed.
2. The use of low molecular weight heparin which can't be monitored by pathological testing in the presence of intra-abdominal inflammation has to be questioned. The alternative therapy would have been Heparin infusion. The post-mortem did not reveal evidence of pulmonary embolism. The two last issues are secondary however, to the initial operation and to the delay in recognising the complication of it.

Michael Gorton, College Solicitor
With Sarah Walcher, Law Clerk

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

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

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

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

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

If you go back to the last 70 or 80 years; the Holocaust, the Second World War and after the Second World War if you look at the great environmental crisis that confronts all of us, they have made us aware of the other, that we are together, that there is a certain inter-connectedness that you cannot deny. The economic crisis, the financial crisis, the energy crisis, the water crisis, the food crisis – all these have enhanced our awareness of our inter-connectedness. I know that crisis is a word that we social scientists use very loosely. It is a word that owes its origin to medicine. Of course, we have misused the term. But to return to the main point, all the crises that confront us, the great tragedies that have been part of our recent history and also tsunamis and cyclones and typhoons, these somehow made us aware that there is a connection. There is a common bond that holds humanity together.

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

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

Overcoming

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

In terms of overcoming the challenge of distribution of wealth and power and knowledge, it’s going to be a little more difficult in one sense because here you need institutional changes, major structural changes. But, here again, attempts are being made. I’m glad, for instance, to give you a very small example of this, that the G8 has become the G20. That’s significant. It’s just a numerical change; it is a change that recognises the shifting pattern of global economic power. That, I think, is something that is good. It’s positive.

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

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

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

Thank you very much.

Thanks from immediate past President Ian Civil:
Professor Chandia, I’d like to thank you very much for coming and speaking with us today. What you said has had much resonance for us as surgeons, when you talk about things like empathy and for us, as citizens of countries and members of the global population, talking about power and prejudice.

What you’ve said was inspiring and I think a challenge to all of us to reflect on our activities in our own lives and in our professional lives and I want to thank you again. I would like to add and say that I’m very pleased to recognise this presidential lecture and a certificate that goes with it. Thank you very much.

Unity in a multi-ethnic society

The following is the second half of the President’s Lecture delivered at this year’s ASC, by Professor Chandra Muzaffar from the Universiti Sains Malaysia.
The theme of the RACS 81st Annual Scientific Congress in Kuala Lumpur in May 2012 was ‘The Making of a Surgeon’ and addressed the establishment of integrity in the surgical mind. To become a surgeon, you have to learn. Even Bertheau humorously once remarked that time is a great teacher, but inevitably kills its students.

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

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

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

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

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

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

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

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

During the proceedings the next day I nudged my arm and inquired “are you a reporter”? I had not have the presence of wit to respond that I was writing for the Surgical News—another example of Diderot’s l’esprit d’esclaire, i.e. the smart response that one recalls only after the event.

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

However, one word encapsulates it all—“integrity”—meaning at the surgical training level, progression to the scientific and academic stage, overcoming any political frustrations that emerge while balancing commercial necessities—editors that remind one of the familiar teachings from the Marshall school of surgical philosophy.

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

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

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

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

The Dutch East India Company was one of the most successful colonial enterprises, trading in spices, rubber, cocoa, coffee, tea and tobacco (and even narcotics, one suspects). It became one of the wealthiest trading entities in the world and let’s not forget that the Dutch even introduced tea to Europe in the 16th century.

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

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

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

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

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

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

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

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

Damon McMahon, ACT General surgeon
Matthew Green, Vic General surgeon
Ratan Edibarn, WA Orthopaedic surgeon
Christopher Elmes, Qld General surgeon

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

Informing the College

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

ACT: Eve.edwards@surgeons.org
NSW: Allan.Chapman@surgeons.org
NZ: Justine.peterson@surgeons.org
QLD: David.watson@surgeons.org
SA: Susan.Burns@surgeons.org
TAS: Dianne.comish@surgeons.org
VIC: Denise.spence@surgeons.org
WA: Angela.D’Oustr@surgeons.org
NT: college.nrl@surgeons.org

Surgical Sketches and Silhouettes

Adelaide

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

In the Reception foyer, a landscape by Tony Reger is displayed on the wall. A bronze bust of Hippocrates lies beneath, together with the 1894 Edelstein translation of the oath, which is really a historical summary of integrity.

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

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

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

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

PS: At the College Open Day on Saturday, 28 July 2012, I enjoyed learning more about the College and its significant history from Scotty McLeish, one of the learned men of surgical science and a patron of his day. Speaking to the public gathering, he pointed out some historical highlights, particularly the letter signed by Graeme Syme, Hamilton Russell and Hugh Devine in 1923, which became the foundation document for the establishment of the College (see illustration). The thoughts expressed in this letter still have relevance today. One has to ask how our meter really changed. In 2012, we still must adhere to the concept of integrity to provide the foundations of the surgical mind. Such a principle with the conflation of honesty and truthfulness must be always balanced against commercial influence however strong and other pressures which may impede such developments. Let’s not forget the opposite of integrity is hypocrisy.

Felix Behan

Victorian Fellow

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The 9th Cowlishaw Symposium is coming

Saturday 27 October 2012
9.30am

SPEAKERS
Mr Gordon Low
Mr Wyn Beasley
Mr Ross Blair
Prof Mike Hollands
Ms Elizabeth Milford
Prof Susan Neuhauß
Prof David Walters
Prof Alan Thurston

Registration will be available closer to the date.

Royal Australasian College of Surgeons, 250-290 Spring St, East Melbourne (Level 2 Training Area)

Fee: $130.00 inc.

GST person covers morning tea, lunch, afternoon tea and cocktail reception
For further information contact geoff.down@surgeons.org +61 3 9276 7447

Presentation: Portraits
Friday 19 October at 12pm
at The Royal Australasian College of Surgeons, 250-290 Spring Street, East Melbourne

$30 inc. GST per person and lunch.

For further information contact geoff.down@surgeons.org or phone: +61 3 9276 7447

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New facilities, new opportunities

Beleura & Peninsula Private Hospitals, Mornington Peninsula VIC

Beleura and Peninsula Private Hospitals are located at Mornington and Frankston respectively and occupy privileged positions at the gateway to the Mornington Peninsula. Both hospitals are ideally situated for easy access to private schools, outstanding housing and a huge range of rural and bay side leisure and sporting activities.

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

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

Major developments are nearing completion

A New Intensive Care Unit is part of a major development underway at the Peninsula site at 525 McClelland Drive, Frankston. Stage 1 of a new ward block will add 13 extra surgical beds to the hospital bed stock. Stage 2 will see a further 11 beds added. An additional operating room is nearing completion and will expand the suite to 6 rooms. The expanded capacity will allow for the introduction of cardiothoracic surgery; this room is located next to the cardiac angiography suite. A cardiac diagnostic and interventional laboratory has been in operation since 1996; it meets the needs of the local community 24/7 and provides primary angioplasty for patients with acute infarction. There is a plan to replace this facility in the very near future.

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

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

Beleura Opportunities

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

Peninsula Opportunities

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

Please contact: Greg Hall
Chief Executive Officer
Beleura & Peninsula Private Hospitals on
m: 0421 615590 or
e: hallgr@ramsayhealth.com.au

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