Surgical News

MARCH 2013 THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

More than $1.2 million worth of scholarships inside!

The College of Surgeons of Australia and New Zealand

Medical images

Ensure there is patient consent

2013
Workshops & Activities

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

Keeping Trainees on Track (KToT)
9 April, 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)
16 April, Melbourne

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

Non-Technical Skills for Surgeons (NOTSS)
19 April, Melbourne

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

AMA Impairment Guidelines 5th Edition: Difficult Cases
29 May, Brisbane

The American Medical Association (AMA) Impairment Guidelines inform medico-legal practitioners as to the level of impairment suffered by patients and assist with their decision as to the suitability of a patient's return to work. While the guidelines are extensive, they sometimes do not account for unusual or difficult cases that arise from time to time. This 3 hour evening seminar compliments the accredited AMA Guideline training courses. The program uses presentations, case studies and panel discussions to provide surgeons involved in the management of medico-legal cases with a forum to reflect upon their difficult cases, the problems they encountered, and the steps they applied to satisfactorily resolve the issues faced. *Please note: Fellows will still need to attend AMA training to be accredited to use AMA guidelines.*

Writing Medicolegal Reports
15 July, Sydney

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

Finance for Surgeons
19 July, Melbourne

This whole day course establishes a basic understanding of how to assess a company's performance using a range of analytical methods and financial and non-financial indicators. It reviews the three key parts of a financial statement; balance sheet, income (profit and loss) and cash flow. Participants learn how these statements are used to monitor financial performance.

Polishing Presentation Skills
12 September, Adelaide

The full-day curriculum demonstrates a step-by-step approach to planning a presentation and tips for delivering your message effectively in a range of settings, from information and teaching sessions in hospitals, to conferences and meetings.

NSW
9 April, Sydney
Keeping Trainees on Track (KToT)

NZ
6 May, Auckland – ASC
Keeping Trainees on Track (KToT)

6 May, Auckland – ASC
Supervisors and Trainers for SET (SAT SET)

6 May, Auckland – ASC
Non-Technical Skills for Surgeons (NOTSS)

QLD
29 May, Brisbane
AMA Impairment Guidelines 5th Edition: Difficult Cases

VIC
19 March, Melbourne
Keeping Trainees on Track (KToT)

11-13 April, Melbourne
Surgical Teachers Course

16 April, Melbourne
Supervisors and Trainers for SET (SAT SET)

19 April, Melbourne
Non-Technical Skills for Surgeons (NOTSS)

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

contents

REGULAR PAGES

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

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

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

Surgical News Editor: David Hillis / © 2013 Royal Australasian College of Surgeons / All copyright is reserved.
The editor reserves the rights to change material submitted / The College privacy policy and disclaimer apply – **www.surgeons.org**
The College and the publisher are not responsible for errors or consequences from reliance on information in this publication. Statements represent the views of the author and not necessarily the College. Information is not intended to be advice or relied on in any particular circumstance. Advertisements and products advertised are not endorsed by the College. The advertiser takes all responsibility for representations and claims.
Published for the Royal Australasian College of Surgeons by RL Media Pty Ltd. ACN 081 735 891, ABN 44081 735 891of 129 Bouverie St, Carlton. Vic 3053.

ON THE COVER:
Medico-Legal
Know your limits on patient images. P27

President's Perspective

Clinical Leadership

I do not recall the county of Staffordshire well, despite my five years training in United Kingdom. Famous for its potteries, it is a midlands county with the green rolling hills that England does so well, combined with a dedicated industrial base.

Like much of England, it has suffered in the post-Thatcher era without the benefits of the buzz of the 'financial hub' of London. That is my recollection and although I was aware of the 'Stafford Hospital crisis', I was still not expecting the devastating report from the 'Francis Inquiry' that has just been released.

It is a sobering read, for many reasons. I have a lingering fondness of the NHS; I completed my surgical training in its hospitals. It was an important part of the formation of my surgical career. It provided free healthcare to a population of over 50 million. For all its faults, I had always felt that the NHS had its 'heart in the right place'.

However, reading the lengthy report with its 290 recommendations, it makes you wonder whether those thoughts were justified. Maybe that is what compelled the then Secretary of State for Health, the Rt Hon Alan Johnson MP to say to the House of Commons:

> "I apologise on behalf of the government and the NHS for the pain and anguish caused to so many patients and their families by the appalling standards of care at Stafford Hospital, and for the failures highlighted in the report."

UK report has analogies here

Perhaps more sobering is the conclusions are potentially applicable here in Australia and also New Zealand.
I need to highlight some of these for you in an abbreviated form, 'lack of basic care across a number of wards and departments', 'culture was not conducive to providing good care for patients or providing a supportive working environment', 'a high priority was placed on the achievement of targets', 'the consultant body largely dissociated itself from management', 'there was low morale amongst staff', 'there was a lack of openness and an acceptance of poor standards'.

What particularly took my eye were two further comments, 'Statistics and reports were preferred to patient

experience data, with a focus on systems, not outcomes' and 'staff treated patients and those close to them with what appeared to be callous indifference' (Page 13 of report).

You would think that a health system, that has had inquiries with the impact of 'Bristol' and 'Shipman', to the extent that these are now internationally and instantaneously recognised, would have focused the minds of clinicians and management, as well as the organisational scrutiny of regulators. It was not to be and indeed it is the ongoing world of organisational reviews and changes that have compounded, not simplified, these concerns.

The report has major sections on 'negative culture', 'professional disengagement', 'poor governance', 'lack of focus on standards of service', 'inadequate risk assessment of staff reduction', 'nursing standards and performance', 'wrong priorities'. It laments the disconnect between the NHS and the community, general practitioners, trusts, authorities, regulators and professional bodies. It highlights that the chaotic reorganisations of the NHS over the past 10 years compounded by financial imposts, comes at a substantial cost.

However, the dilemma is not to change yet again, but make work what we have. In his letter to the Secretary of State for Health (page 5), the Inquiry Chairman highlighted:

> "The extent of the failure of the systems shown in this report suggests that a fundamental change is needed. This does not require a root and branch reorganisation – the system has had many of those – but it requires changes which can largely be implemented within the system..."

We make same mistakes

Making work what we have – not throwing 'the baby out with the bath-water' is always the challenge. The dilemma for Australia and New Zealand is that our Governments and Departments of Health have this lemming-like attachment to follow the United Kingdom's approach and policies some three to five years later. Perhaps our 'leaders' can short-circuit the process and read section 1.123 of the report (page 67) in the section of 'common values: putting the patient first':

> "The overarching value and principle of the NHS Constitution should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos"

What a novel thought slipped into my mind, as I read this. Over the two months of this year, the health related press has been 'captured' by funding cuts, bed closures, government brawling and the 'blame game'. It would be nice for our 'leaders' to focus on this simple heading – putting the patient first.

I suspect that the risk of a similar report in Australia and New Zealand is compounded by the multiplicity of stakeholders all trying to play a role in healthcare, and all trying to ensure they remain relevant and influential. The conflict between the Federal and State Governments over funding and the 'blame game' recently witnessed in Victoria is one aspect of this.

Welcome to 2013. Advocacy with a focus on the quality of care provided for patients will remain a core component of our activities over the ensuing 12 months

Mike Hollands
President

AUSTRALIA & WAITANGI DAY HONOURS

NEW ZEALAND NEW YEAR HONOURS

Dame Companion of the NZ Order of Merit (DNZM)

Dame Judith Potter (Expert Community Advisor on NZ National Board)

Officer of the NZ Order of Merit (ONZM)
Associate Professor Ian David Campbell

AUSTRALIA DAY HONOURS

Member of the Order of Australia (AM)

– Associate Professor Andrew Donald Cochrane

– Dr Brian Leslie Cornish

– Dr Mark Francis Ellis

Medal of the Order of Australia (OAM)

– Dr Malcolm Baxter

– Dr Geoffrey Vernon Mutton

– Dr John Cracroft Rice

– Associate Professor Michael John Weidmann

Issues that affect you

Vote and stake your claim

Australians have embarked upon what is effectively the longest election campaign in the nation's history (but still eclipsed by the 10 month long New Zealand election campaign in 2011).

Of course, I am not talking about the forthcoming College Council elections – the College's democratic process is fortunately a more streamlined affair.

Nevertheless, the Council election is an important process. The Council largely determines the direction of our College. For surgeons the College is our peak professional body and, with increasing strain on health care systems, there are predictably going to be stresses on our professionalism.

Not the least of these is the dilemma of how to marry our social responsibility to help achieve healthcare cost reduction with our professional responsibility to do the best we can for our individual patients. And healthcare costs are becoming an important issue, already exceeding 9.5 per cent of GDP in Australia.

The healthcare industry has now become the largest employer in Australia – one in nine employed people works in healthcare. Can we point to productivity increases to justify this increased expenditure?

So with difficult times on the horizon for healthcare it will be important to have a strong and supported Council. Taking the time to assess the candidates and casting a vote is one way of demonstrating support.

Together with the ballot papers sent to each surgeon is a CV booklet in which the candidates outline why they wish to be a member of Council and the issues they seek to pursue. Please cast your vote wisely.

Nominations have now closed. I can report that there are 13 candidates for 10 positions as general elected councillors. Ten current councillors are submitting themselves for re-election.

The new College Council will take office on Thursday, May 9.

If you have not received ballot papers by now, please notify Margaret Rode at the College (margaret.rode@surgeons.org). The deadline for the return of ballot papers is Thursday, April 4.

Unfortunately a significant number of ballot papers each year arrive after the deadline and are therefore invalid, so please post your completed ballot paper to the College sooner rather than later.

The manifestation of the strains being placed on our hospital systems right across both our countries are particularly apparent in my state of Victoria. The situation was cruelly exacerbated by the recent withdrawal of a considerable amount of federal funding, some of it taking effect retrospectively. The situation was toxic, with both levels of government blaming the other for a situation that saw many Category 2 patients have their waiting time for elective surgery doubled. If ever proof was needed that the so-called blame game has survived recent reforms to health system funding, this is it. As we go to print, the Federal Government has just announced it will reinstate the withdrawn funding for this year, but uncertainty remains around funding over the next four years.

The Victorian Regional Chair, Robert Stunden, is to be congratulated for the measured and informed manner in which he represented the College during this dispute. He has been quoted several times at length in the Melbourne *Age* and is now a first point of contact for journalists covering the issue. At all times he refrained from taking sides in the dispute, calling instead for the politicians to get together and solve the dispute in the interests of patient care.

Of course, Victoria is not alone. Across all jurisdictions, we are being asked to do more with less. The severity of the situation is felt first and foremost by those waiting for non-urgent elective surgery, but those working in public hospitals are inevitably subject to heightened stress and frustration levels.

Goodbye and good luck

I have had the privilege of being a member of Council for a number of years. During that time I have had the honour of associating with many remarkable members of our profession – of observing first hand the dedication, the sacrifice, the simple desire to do the best that they can.

Make no mistake, being a member of Council for the maximum allowed time of nine years equates to a donation of more than one year of one's professional life. There is little reward for this contribution other than perhaps the knowledge that an effort has been made to make a difference and to support what we believe is a worthwhile and necessary institution.

February Council saw the retirement of two surgeons – Spencer Beasley and Bruce Twaddle. I have had the pleasure of associating closely with both of them. Both were immensely intelligent Councillors, possessed of inordinate common sense. Neither shirked an issue or a task. I know them to be individuals of the highest integrity. They will be missed.

Michael Grigg
Vice President

2013 Training in Professional Skills (TIPS) courses

The TIPS course is a new program delivered by RACS that offers Trainees and International Medical Graduates (IMGs) the opportunity to:

- understand the importance of professional skills in surgical practice
- recognise what constitutes professional skills
- develop skills relating to professional competencies by practicing in a safe environment.

Seven of the nine defined surgical competencies are related to professional skills. As is the case for technical skills, competence in professional skills requires deliberate and repeated practice for expertise to develop – TIPS provides the setting and structure for that practice.

Learn techniques for working with patients and colleagues that can be applied to clinical practice. Participants have the opportunity to practice communication skills and teamwork in real-life scenarios and receive feedback and guidance from experienced instructors.

The TIPS course is recommended for all SET2+ Trainees and IMGs. Places are available on the following courses in 2013:

22-23 March, Melbourne
15-16 August, Sydney
28-29 May, Brisbane
23-24 September, Melbourne
25-26 July, Adelaide
22-23 November, Auckland

FEES

AUSTRALIA

Trainees: $1,320 (inc GST) **Non-Trainees:** $2,735 (inc GST)

NEW ZEALAND:

Trainees: $1,795 (inc GST) **Non-Trainees:** $3,710 (inc GST)

Registration on the waiting list is free and can be completed either via the online TIPS registration form (www.surgeons.org), emailing tips@surgeons.org or by calling Oana Cochrane on +61 (0)3 9276 7419. Confirmation will then be sent to eligible applicants.

TIPS
Training in Professional Skills

Separation success

The Tasmanian Regional Chairman of the College Brian Kirkby has applauded health analyst Martyn Goddard's call for the separation of elective and emergency surgery. Within the letters section of the *Launceston Examiner,* Kirkby said that the urgent need for greater health funding should not preclude the implementation of proven efficiencies.
"In 2011, the College wrote to all health ministers in Australia and New Zealand, enclosing a comprehensive report that demonstrates beyond any doubt that the separation of elective and emergency surgical streams leads to greater efficiency and, most importantly, better patient outcomes."
***Launceston Examiner*, February 7.**

Federal backflip

The crisis in Victorian Healthcare has received a last minute reprieve after the Federal Government announced that it would reverse the decision to cut hospital budgets.
However, the government has pointed out that the money will go directly to hospital administrators and not state accounts.
The reprieve will only count for the financial year. Federal Health Minister Tanya Plibersek blasted the "incompetent" State Government, saying: "For two years Premier Baillieu's blatant disregard for the welfare of Victorian patients has seen … standards of care decline."
***Herald Sun*, February 21.**

Continued health cover for ex-personnel

Diggers returning from service in war ravaged countries will have to prove their conditions were the result of trauma in the field. This can cause secondary trauma, retired Colonel Susan Neuhaus has said. She said recent veterans should have access to the Department of Veteran's Affairs 'Gold Card' which allows all of their medical costs to be covered by the government. "You decrease all of the secondary trauma that goes with people who are sick and trying to put in claims years after the event, who have this enormous burden," she said. ***The Australian*, February 12.**

e-Health lagging

The national e-health system rolled out late last year has been compared to the Federal Government's failed roof insulation system, recording dismal uptake numbers. Dr Mukesh Haikerwal has admitted there have been problems, with the system crashing as he attempted to promote the program for the National E-Health Transition Authority.
"The potential is great but all the snags around the country need to be addressed," Dr Haikerwal said.
The Coalition's eHealth spokesman Andrew Southcott has called the failed system "Pink batts on steroids".
***Sun Herald*, February 17.**

Collaboration with Cuba

Health workers from Cuba are assisting in emergency situations around the world

Cuba's post-revolution focus on delivering free, accessible health care by providing widespread, subsidised medical training has resulted not only in dramatic improvements in all national health indices, but also the world's highest ratio of doctors to population, according to the Cuban Ambassador to Australia, Mr Pedro Monzon.

Mr Monzon said that with 11.8 per cent of GDP assigned to health, Cuba now had first world health standards that included an infant mortality rate of 4.5 per 1000 live births, an average life expectancy of 79 years and the eradication of common tropical diseases with free vaccination programs.

He said that Cuba now had around 79,000 doctors for a population of 11.3 million – a ratio of one doctor per 143 inhabitants – working in 267 hospitals and more than 400 neighbourhood clinics across the country.

Australia, in contrast, has an approximate ratio of one practicing physician per 330 people.

Mr Monzon was a guest speaker at the International Medical Development Symposium held in September last year at the College Headquarters in Melbourne.

He was invited to speak by Symposium organiser and the Chair of the College's International Committee Professor David Watters who felt it important that Fellows understood the Cuban health and international aid systems, given how often Australasian and Cuban surgical teams now meet in Pacific Island countries and Timor Leste.

Addressing the theme of the Global Burden of Surgical Disease, Mr Monzon explained to the conference the central focus placed on international medical aid by Cuba that now sees Cuban surgeons and medical teams working in areas of need around the world.

He said Cuban International Collaboration programs were based on the delivery of Cuban doctors to improve health outcomes where needed along with the provision of free medical scholarships in Cuba.

Cuban oral-maxillo-facial surgeon Dr Ivan removing an arrow embedded in the parotid gland. Assisted by Australian surgeon and Timorese scrub-nurse.

"Since 1963, Cuba has conducted collaborative programs in 108 countries involving more than 120,000 Cuban health workers within 'medical brigades'."

"This is implemented through an international mission of two years for every Cuban doctor and the design of a financial system in which Cuba shares the most important burden," he told the conference.

"Since 1963, Cuba has conducted collaborative programs in 108 countries involving more than 120,000 Cuban health workers within 'medical brigades' that rotate every two years.

"At present, Cuban brigades are working in 66 countries, involving around 39,000 health workers, 17,000 of whom are specialists, many of them working in very difficult environments in (complex) places in Latin America, the Caribbean, Africa, North Africa, the Middle East, Asia and the Pacific.

"We have also begun cooperation with Kiribati, Tuvalu, Vanuatu, Nauru, Solomon Islands, Fiji, Palau and Tonga."

Mr Monzon said Cuba was particularly pleased to have provided medical aid and education to Timor Leste following its Independence.

He said the co-operation began in 2004 and involved approximately 350 Cuban doctors working in-country.

"Cuban doctors now represented 80 per cent of the workforce at the National Hospital, 100 per cent of the workforce at the five district hospitals and 100 per cent of the workforce at the remote clinics," he told the Symposium.

"Also 1000 scholarships have been given to study medicine in Cuba, and in 2013 the country will have around 1000 graduated doctors, a few of whom finished their studies in Timor Leste in a school founded by Cuba."

Mr Monzon said the medical education component of Cuba's international aid programs was supported by the Latin American Medical School (ELAM) which provides six years of free educational scholarships to students from developing countries.

How it began

He said ELAM was founded in 1999 with the entry of 1,933 students from 18 countries, but that it now hosted 18,891 students from 90 countries.

"ELAM offers a Bachelor program consisting in an introductory year of Spanish language training for foreign students followed by first and second years of pre-clinical training, third to fifth years of studies in different medical universities and the sixth year as an internship to train in hospitals and neighbourhood clinics under specialist supervision," he said.

"Almost all doctors then go on to complete an 18-month specialisation in Integrated General Medicine or 'family doctor' training.

"This is completed at hospitals and neighbourhood clinics (in a system that) could be considered the largest medical school in the world with 32 campuses across Cuba.

"In conclusion we could safely say that by far Cuba has the biggest health cooperation program in the world and that Cuba, with its relatively small population, territory and GNP has saved more lives in the developing countries than all the G-8 countries together.

"And all these efforts have been done despite 54 years of economic, commercial and financial blockade that includes everything from food to medicine." ▶

"In conclusion we could safely say that by far Cuba has the biggest health cooperation program in the world..."

Cuban doctors in a field hospital performing surgery on a victim of the earthquake which killed 90,000 people

Last year's International Medical Development Symposium was the third held by the College, but the first to be jointly convened and badged with the Australian Society of Anaesthetists, the Alliance for Surgery and Anaesthesia Presence, the Harvard-based Humanitarian Surgery Initiative and the International Society of Surgery.

Specialists and leaders in global surgery and anaesthesia attended from North America, Europe, Asia and the Pacific who delivered addresses on topics such as the measuring of unmet surgical need, the safety of surgery in low and middle income countries, essential surgical care and the role of organisations in training, support, advocacy and research.

Professor Watters said the address by the Cuban Ambassador was particularly helpful in allowing Australasian surgeons to understand the role and training of Cuban surgeons working across the Pacific and within Timor Leste

"Asking the Ambassador to speak at the Symposium was about increasing cooperation, collaboration and respect between Australasian and Cuban surgeons," he said.

"Australasian surgical teams often work very closely with Cuban surgeons across the spectrum of our international aid program and the more we understand each other the better that cooperation can be.

"The Cuban international medical aid program is very large and there are some very fine surgeons doing very fine work which must be acknowledged.

"At the same time, however, there is always the challenge for doctors returning from Cuba who have been trained in a different medical language and different medical system who may need time to adjust and in some cases more training in order to provide the best possible care in their home environments."

Wide recognition

The Project Director of the College's Australia-Timor Leste Program of Assistance for Secondary Services (ATLASS II), Mr Glenn Guest, applauded Cuba's medical aid program to Timor Leste both in the provision of surgeons and medical training for local students.

"This year will see the return of 600 medical graduates coming back to Timor Leste from training in Cuba and these numbers will result in a dramatic increase in the local medical workforce that will shape the country well into the future," Mr Guest said.

"The challenge now is to integrate those newly graduated doctors who have been trained in a different language, different medical system and different culture back into the Timor Leste health system.

"Now, Cuba and the College in collaboration with the Ministry of Health are all working to select the best and brightest of those graduates to receive specialist training so as to provide the best possible secondary and tertiary health care to the people of Timor Leste."

With Karen Murphy

Hidden benefits

Missing an essential element?

One of my favourite patients attended the other day – a normally convivial, middle-aged surgeon, *Ms Ng Magna*, with the usual health issues of many busy professionals at the same stage of life.

Embracing a slight tendency to be overweight, hypertension, hyperlipidaemia, and approaching type 2 diabetes, my patient could have been in better shape, but was at least making time for exercise and taking some holidays. She was tired, not sleeping well, and not quite the usual bouncy self.

The consultation was timed to discuss the latest results. I had done all the usual annual review tests, but also had included magnesium and red cell magnesium levels, something I've been checking more and more in recent years.

Though the serum magnesium was in the lower range of normal (0.72mmol/l), the red cell magnesium was low at 1.5mmol/l (normal range 1.70-2.90mmol/l). As only 1 per cent of the body's magnesium is in the blood, with 40 per cent in the cells, it is a better reflection of magnesium status to work on the red cell magnesium.

Many diets are deficient in magnesium, particularly where ready-made meals, refined and junk food or snacks comprise a significant part of the diet. There's less magnesium in today's food, particularly as, unless organic, it is normally grown in magnesium deficient soil.

Magnesium advocates also warn of an association between fluorination of water and deficiency, which is the result of insoluble magnesium fluoride deposits in bone and cartilage.

I advised *Ms Ng Magna* to try magnesium supplements promising her no ill effects other than the tendency of some magnesium salts to cause diarrhoea.

Ms Ng Magna was not sleeping well because she was suffering from night cramps. She blamed too busy a practice combined with the demands of and worries about teenage children causing too many topics of disturbance. But I can tell you once her night cramps were relieved by magnesium supplements, she started to sleep better and her hypertension improved.

The results

The improvement in her hypertension was the result of magnesium being a natural calcium channel blocker. Both minerals are important in smooth muscle function and must be in balance.

Each is a co-enzyme of many of the body's reactions (think back to your days of biochemistry), some important for glucose homeostasis. A number of patients respond to magnesium alone in regard to their tendency to be hypertensive.

In the medical mind, magnesium has not gained the clinical limelight that its brother mineral calcium has, despite both being essential for neurological and muscular function. Magnesium [sulphate] is now recognised to reduce the likelihood of cardiac arrhythmias, pregnancy induced convulsions, and probably reduces the likelihood of cerebral vasculature to spasm.

However, given how dim and distant our biochemistry, we overlook that it is an essential co-enzyme for efficient glucose handling, and together with B vitamins helps activate enzymes for digestion, absorption and the utilisation of proteins, fat and carbohydrate. Magnesium may not be a wonder drug, but it is a missing element that plays a role in many common conditions.

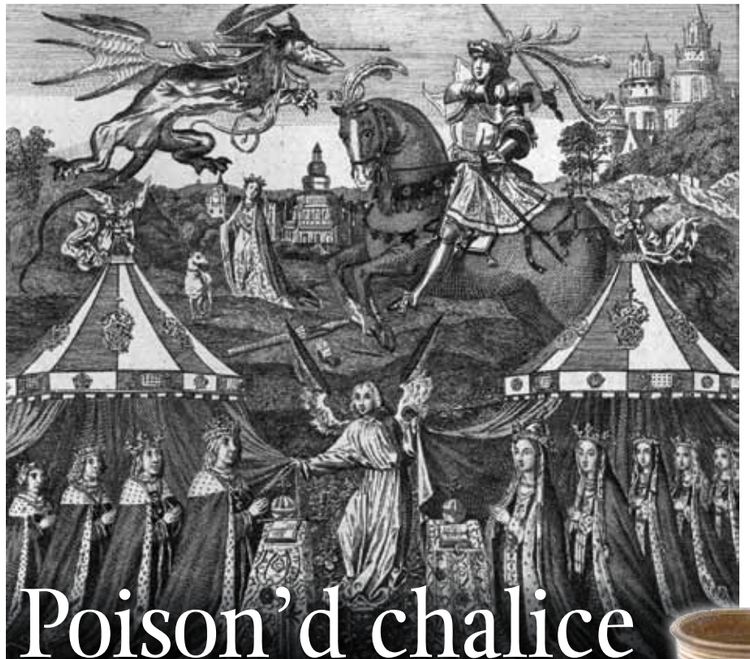
The bibliography of peer reviewed evidence in high impact journals is impressive. There is a link between magnesium deficiency, hyperinsulinaemia and the laying down of body fat, particularly abdominal adipose tissue. My comment at the start about 'approaching type 2 diabetes' alluded to the years of hyperinsulinaemia during middle-age, the generation of adipose deposits, visible to many of us each morning as our struggle with weight gain despite reasonable discipline in diet, and worry about the eventual onset of diabetes in later life.

Magnesium is critical to cholesterol balance, dampening down the HMG-CoA reductase involved in its synthesis. It is used in reactions by enzymes that lower LDL (bad), raise HDL (good) and convert Omega 3's and 6's to prostaglandins. The magnesium deficiency could be contributing to *Ms Ng Magna*'s hyperlipidaemia. The evidence suggests LDL is lowered 10-18 per cent and HDL raised by 4-11 per cent.

Magnesium may be all *Ms Ng Magna* will need. Time will tell. But it's safe and without terrible side-effects. She started on 150mg elemental magnesium (there are various salts and preparations) and, once certain she was not suffering from its laxative effect, increased in stages to 400mg.

When I next saw her she was smiling, she was sleeping well, her night cramps had gone, her blood pressure had dropped, mood bright and she felt generally better. Her teenagers hadn't stopped worrying her but then when does that happen? Maybe they should take magnesium too? But that's another story.

Dr BB G-Loved



Poison'd chalice

"From this day to the ending of the world; But we in it shall be remembered; We few, we happy few, we band of brothers; For he to-day that sheds his blood with me; Shall be my brother"

Henry V (Act 4, Scene 3)

It is my usual practice to do a ward round before theatre. The hospital atmosphere is subdued. You do not need to be clairvoyant to realise that all is not well. Even, the theatre start is delayed. It is clear to me that morale is low.

Alexander Leighton was an American sociologist and psychiatrist. In 1949 he defined morale as the capacity of a group of people to pull together persistently and consistently in pursuit of a common purpose.

As a surgical director in a busy hospital, I am very aware of morale – nebulous and abstract it might be, but there can be no denying its 'realness'. Henry V's speech before the Battle of Agincourt is a lesson in morale building – against overwhelming odds, the English prevailed.

I see it as one of my leadership responsibilities to maintain and enhance morale. If the 'morale meter' is in the positive, efficiency and achievement are enhanced. Alas the opposite also holds true.

I particularly like Leighton's analysis since it identifies morale as a characteristic of a group not an individual. In my experience a fall in morale is just as likely to be triggered by perception as reality.

Alas, of recent times, it is reality that is having a detrimental effect on morale. And although abstract, morale can be measured – directly by absentee and sick leave rates, by resignations, by the number of applicants for positions etc. and indirectly by efficiency, even late theatre starts and "extra curricula" participation.

People would read the words of Hamlet, "Or to take arms against a sea of troubles, And by opposing, end them" (Act 3, Scene 1), and say – not me.

Of course, my group is not only surgeons, but also junior staff, nursing staff and yes, even administrative staff. The trigger for our current crisis of morale is the relentless budgetary pressure – the need for cost savings in the face of increasing demand for our services.

Morale in hospitals is possibly different from other organisations. For example, I suspect that if I were one of the employees in a private company that was losing money, our morale would be low because we recognised that the company could go belly-up and we would lose our jobs.

For doctors and nurses, there is not the same employment focus, not the same threat of unemployment. So why is morale affected in hospitals? The answer is not so simple.

With respect to hospitals, I have come to recognise two things. Firstly, hospitals are either getting better, bigger, improving or they are declining. Treading water, as it were, in a short period of time, is decline. Secondly, public hospitals in particular are staffed by ambitious, high achieving individuals who are working in that environment with at least a little sense of altruism. The altruism may be directed at creating a bigger, better service or educating Trainees or whatever.

Failing to allow and even celebrate such altruism is seen as a slap in the face, felt as frustration and manifests as a fall in morale. Threats and challenges are not a problem but frustration, for whatever reason, is the major impediment to high morale in the hospital setting.

Frustration wears down the individual prepared to see the glass half full and eventually the glass appears half empty and declining morale is a malignant process – it spreads insidiously and sometimes rapidly.

So as a clinical leader, what tactics do I have at my disposal to rebuild morale? Well I don't know of any new ones – I have seen and experienced them all before, but that is not to say that they are ineffective.

The best one, of course, would be to provide certainty – it would appeal to surgeons the most. But in the healthcare environment of today and indeed tomorrow, uncertainty is inevitable. It is one of the reasons why change, reorganisations are so attractive to healthcare managers. The mere process of change provides the possibility of achievement in and of itself – at least for a time.

The second tactic is to celebrate achievements and successes. Too often we focus on our failures and deficiencies. The third tactic is to identify an enemy – real or imagined does not matter (so long as it is not the Director of Surgery).

For hospitals, the usual target is administration – "they are growing at an exponential rate, consuming our funding"; "they don't care about patients, just the bottom line"; "they are the source of our frustrations". Alas, it is not a solution for me. Sure they may be inept at times, frustrating, but by and large they are well meaning people, more at risk of unemployment than clinical staff. Their "growth" is not of their own making, but more a manifestation of society's demand for increased accountability.

So what will I do in the face of falling morale? The two things that I plan to do are provide as much information and education that I can and promote as much understanding of the environment that I can. And provide a forum for discussion and communication and continue to encourage advocacy on behalf of our patients. And secondly, to focus our efficiency drive upon removing any source of frustration, however small.

Professor U.R. Kidding

CASE STUDY

Delayed Diagnosis of Perforated Ischaemic Intestine

Follow the link to join this discussion on the College website
http://www.surgeons.org/my-page/racs-knowledge/blogs/all-blogs/anzasm-case-note-reviews/2013/anzasm-case-note-review-mar-2013/

Case Summary

An elderly patient was admitted to a major metropolitan hospital with a short history of being unwell with abdominal distension and vomiting. The patient had significant comorbidities including dementia and was unable to give a history. The patient had recently been treated in the same hospital under a different unit for small bowel obstruction which was successfully managed conservatively.

The patient was noted by the registrar to have abdominal distension with right sided tenderness and guarding. Abdominal X-ray showed multiple fluid levels. The registrar diagnosed recurrent adhesional small bowel obstruction and admitted the patient for idiopathic ventricular tachycardia (IVT) and nasogastric suction. The following day the patient was reviewed by the consultant of the original treating unit, who assessed the patient as being moribund due to an acute abdomen.

At operation there were extensive adhesions with a perforated ischaemic terminal ileum and gross peritonitis. A bowel resection without anastomosis was performed, leaving the abdomen open, and the patient was managed in ICU.

Several days later at a second laparotomy, the small bowel was anastomosed. The patient then underwent a third laparotomy shortly thereafter so that the abdomen could be closed. The treating surgeon expressed serious concern about the patient's nutritional state and requested parenteral nutrition.

Several days later, due to concerns about wound infection, ICU staff were asked to remove skin staples. It appeared that the sheath suture also was cut, leading to abdominal dehiscence. The patient was returned to theatre for the fourth time to resuture the abdomen.

Subsequent progress was poor with progressive development of multiorgan failure. Consultation with the family resulted in a decision to withdraw active treatment and the patient died nearly a month after admission.

Assessor's Comment:

Clearly this patient's prognosis was poor from the outset (elderly demented patient with other comorbidities and ischaemic gut/gross peritonitis). However, a number of management issues arise.

From reading of the case notes, the gravity of the patient's condition and significant overnight deterioration was not appreciated by the junior staff. When consultant review took place the following day, immediate surgery was scheduled.

Elderly patients with ischaemic gut may appear deceptively well; however, a high index of suspicion is needed. Localised tenderness and guarding in a patient with small bowel obstruction should ring an alarm bell. A CT scan might well have helped in diagnosis. The delayed diagnosis of ischaemic gut is a recurring theme in mortality reviews and needs to be emphasised to junior surgical staff.

Clearly this patient was going to have a prolonged postoperative ileus, and parenteral nutrition should have been commenced much earlier rather than at a week postoperatively after repeated requests by the surgeon.

It appears that a serious error occurred in ICU when nursing staff, requested to remove skin staples, also cut the sheath suture which led to abdominal dehiscence and the need for another operation.

There may have been miscommunication between medical and nursing teams here, and in a busy ICU communications need to be clear and well documented.

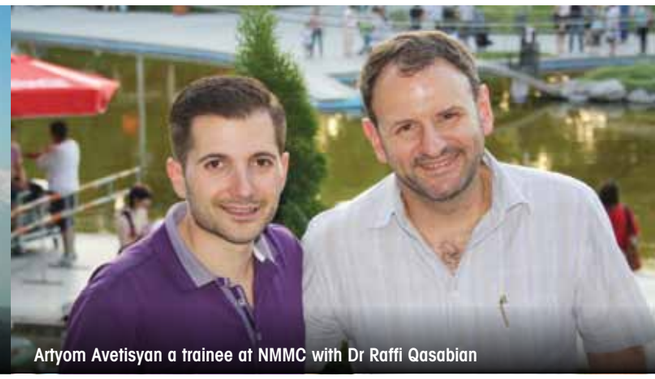
As noted previously in these reviews, in this case enormous hospital resources were expended on an elderly patient who clearly had a poor prognosis from the first operative procedure. Given the subsequent cascade of postoperative problems, consultation with family and withdrawal of active treatment at a much earlier stage might have been appropriate.

Guy Maddern
Chair, ANZASM


Performing the country's first thoracic endovascular aneurysm repair


Dr Raffi Qasabian, Gurgen Balasanyan (Cardiothoracic surgeon), Salpi Mkhitaryan (cardiologist), Karen Zohrapyan (paediatric interventional cardiologist)


Mount Ararat – ancient symbol of Armenia for the Armenians


Artyom Avetisyan a trainee at NMMC with Dr Raffi Qasabian

Drawn to a homeland

The grandson of Armenian refugees and a first-generation Australian, Vascular Surgeon Dr Raffi Qasabian long felt drawn to the land of his ancestors

After an initial visit to Armenia in 2004 which he described as a life-changing experience, Dr Qasabian now tries to get there twice a year to help teach and train local surgeons in the virtually nonexistent specialty of vascular surgery.

In between, he conducts internet consultations with cardiac surgeons, raises money for equipment and is in the process of seeking financial support to bring an Armenian surgeon to Australia for specialist training.

A consultant vascular surgeon at the Royal Prince Alfred Hospital with a private practice in Sydney and an outreach service to Tamworth, Mr Qasabian tells *Surgical News* about Armenia and his efforts to help raise surgical skills in a struggling country.

What made you decide to go to Armenia the first time and what were your impressions?

The first time I visited Armenia was in 2004 while I was a vascular surgical Trainee. It had newly emerged from the Soviet Union collapse as an independent republic, trying to find its own voice, its own feet, in a very hostile neighbourhood.

The republic of Armenia is a tiny, landlocked, mountainous country, less than half the size of Tasmania, in the South Caucasus region of Eurasia. It is bordered to the west by Turkey, the north by Georgia, the south by Iran and the east by Azerbaijan.

It has a population of just over 3 million and when I first went it was still suffering the effects of a major earthquake in 1988 and had recently been to war with Azerbaijan. It was a very poor place. Nevertheless it was a pivotal, life-changing experience for me as I sought to trace my roots and it was then that I first dreamt of one day coming to Armenia to work as a surgeon.

When did you next return and how did you go about providing assistance?

On completing my training and establishing myself as a clinician in Sydney, I had an ongoing nagging sensation to return to Armenia so I did in 2009. On that occasion, I set up meetings with a couple of vascular surgeons at different hospitals, but it was not hugely successful given that I was an unknown entity.

It then became clear to me that I needed to have some backing for the sake of credibility and support. I therefore approached Medtronic, a large US based multinational company, and asked whether they would support me with an educational grant so that I could start teaching surgeons there the newest techniques in vascular surgery. We set up a meeting. As it happened, another staff member at Medtronic, an Armenian by the name of Linette Shahinian heard about my proposal and came along to the meeting also. It was through her help that Operation Armenia was born.

How did you go about providing surgical training and assistance?

Linette had many influential contacts in Armenia, who were able to put us into contact with some of the top surgeons in the country. I visited several hospitals, including the hospital attached to the medical school and I was also introduced to the Dean of the Medical School.

I was invited to speak at a State Hospital called Nork Marash Medical Centre (NMMC), a paediatric and adult cardiology and cardiothoracic surgical hospital which not only has the country's best cardiac intensive care unit, cardiac operating theatres and anaesthetic support, but also has an excellent group of interventional cardiologists and a radiology suite.

After I delivered that talk to the staff and Trainees of the hospital, I was invited to use the hospital facilities to commence vascular surgical services. This was the moment I had been waiting all those years for. Suddenly I could realise my dream of operating in Armenia.

How developed is vascular surgery as a specialty in Armenia?

I had a vision of waltzing in and teaching the vascular surgeons of the country the newest techniques in vascular surgery. It became clear very quickly, however, that there was no real vascular surgical service to speak of in the country.

While there were vascular surgeons, there was no real vascular surgical faculty, no real co-ordinated training, and there was very little experience with even basic vascular services, especially arterial.

Many of the current surgeons had trained in the old Soviet system, one which was foreign to me and not in keeping with the standards of the system in which I had been trained in the West. I decided that I would need to come to Armenia at least twice a year, every six months, to establish some form of serious "service" and also to provide a follow-up and surveillance service.

What does that surgical service involve?

One of the cardiac surgeons there began acting as a go-between for me. He would be sent the vascular cases by the cardiologists, and would then discuss the history with me via the internet and send me copies of any pertinent imaging.

I would then make a decision about the need for surgery, what type of surgery, with a view to operating on the patient (or just seeing the patient in consultation). And so, patients started being referred to me by the local cardiologists.

I started operating on patients-performing open infrarenal abdominal aortic aneurysm repairs, bypasses for peripheral vascular disease, carotid endarterectomies (I gifted a carotid endarterectomy set to the hospital as they did not have the necessary equipment) and a host of other vascular operations.

On my last visit in January this year, I operated on a man with a ruptured aneurysm. I later found out there was no-one else in the country at that time who could have or would have performed this operation. The patient survived and was so grateful that he promised me he would offer a sacrificial lamb to thank God for his good fortune!

What is the Armenian health system like?

While we are used to Medicare and the expectation that our medical treatment needs will be met, in Armenia only the paediatric population's medical care is subsidised by the government, so people have to pay for their own medical treatment. While I do not receive any money for the work I perform there, patients still have to pay for their hospital stay and for any grafts or other equipment that I'd require for the operation. The average monthly wage in Armenia is $200, so you can imagine that any medical treatment is going to be unaffordable for most of the population. I had to negotiate with the hospital administrators to minimise the cost to the patients as much as possible.

Are you planning to bring an Armenian doctor to Australia for training and if so why?

I realised very early on that by going to Armenia twice a year for two to three weeks at a time, I am not going to make any real, long-lasting, significant difference. I feel it is necessary to train some young, local Armenian surgeons in the West with the hope that on their return they can continue the work that I have started by forging a vascular faculty or school.

During my last visit I was approached by a young vascular surgeon who wants to continue his training, preferably somewhere in the West, and I am trying hard to make that happen.

Why are you so passionate about helping the people of your cultural homeland?

I suppose I feel I live a life of great privilege and I am very lucky to have been born in this amazing country and luckier still to have received a high standard of education. In a way I wanted to give something back and being of Armenian descent, with my family being uprooted the way they were, it seemed natural to "return" to complete a cycle that started back in 1915.

Armenia is a struggling little country with many large hurdles before it, yet there are many people like me from all over the world contributing in many different fields and I would like to think that in some way, I too will make a small difference to Armenia.

With Karen Murphy

Online registration and program updates: **asc.surgeons.org**
Sky City Conference Centre, Auckland, 6 – 10 May, 2013

Auckland, winner of the latest most liveable city in the world competition, has a lot to offer visitors and is a gateway to one of the most popular tourist destinations in the world. It is not too soon to get the dates into your diary, and to decide how many of the family members will be travelling to Auckland with you.

The Annual Scientific Congress in Auckland promises to be truly outstanding, and some evidence of this comes from the following:

- The 32 international visitors on faculty, to learn from the world's best.
- The 4 plenary programs covering highly relevant issues related to sustainable surgery.
- The 23 scientific programs are educationally outstanding.
- There will be 28 master classes covering a wide range of topics, across all specialties
- The record number of over 400 abstracts submitted thus far.

There is a renewed plan to involve surgical Trainees by providing a dedicated educational program.

Convocation and Welcome Reception – Monday, May 6

Attendance at the Convocation and the Welcome Reception is included at no additional cost when you register for the meeting. Eighteen senior members of the profession will be acknowledged for their contributions to surgery and to the College. Two prominent figures will be honoured with Honorary Fellowships.

President's Lecture

This year the President's Lecture will be delivered by Sir Ray Avery, founding member of the University of Auckland School of Medicine, scientist, inventor and entrepreneur. Sir Ray developed low cost intra-ocular lens manufacturing technologies which he gifted to the Fred Hollows Foundation.

The title of his lecture will be "Improvements in Global Healthcare through disruptive Science and Technology."

Trauma Surgery

The Trauma program is convened by James Hamill. The trauma surgery program of the 2013 Annual Scientific Congress aims to address issues facing all surgeons dealing with trauma including Management of Burns for non-burns surgeons, Transport and resuscitation, Complex upper abdominal trauma and the management issues associated with mass casualties.

The Masterclasses on Penetrating Injuries, Paediatric Trauma, and Distance, Delay and the Deteriorating Patient are of particular significance, being relevant to many surgical specialties.

Cardiac & Thoracic Surgery

Section Convenor, Indran Ramanathan has invited an outstanding faculty of presenters to the cardiothoracic program in Auckland. Indran has indicated that the themes are an exciting shift in focus.

The meeting will focus on Coronary Artery Surgery, Minimally invasive Thoracic Surgery, and Aortic Valve replacement. The visitors include Professor Freidrich Wilhelm Mohr from Leipzig, Professor David Taggart from Oxford and Professor Robert McKenna for Los Angeles.

There will be a Masterclass on Mitral Valve Repair and a keynote lecture on Trans-catheter therapies for surgeons. The international visitors and local contributors bring a wealth of experience and a strong evidence based approach.

General Surgery

Patrick Alley will convene the General Surgery program which will feature outstanding national and international speakers. Masterclasses covering 'Preserving your Sanity' and 'When to Say No' are issues relevant to all surgeons in their daily practice when managing life work balance and end of life issues.

There are combined sessions with Surgical Oncology and Upper gastrointestinal surgery discussing gastrointestinal neuroendocrine tumours, and Bariatric Surgery covering the complications of Bariatric surgery. A keynote lecture by Professor David Watters regarding preparation for regional and remote practice will be of interest to many.

Professor John Windsor
– Congress Convener
Professor Andrew Hill
– Scientific Convener

What day is it?

Too many days to remember

There is one thing that really annoys me and that is unwanted named days. You may well ask what do you mean by that – I mean Secretaries' Day, Valentine's Day, Halloween etc. It is not that we curmudgeons don't like efficient secretaries – we do but after all we pay them – what more do they expect?

It is all this marketing stuff that tries to get us to buy things such as flowers and perfume, usually unwanted, for secretaries on this special day. When is the day, you may ask? The official (US) day is Friday of the last full week in April so that makes it April 26 in 2013, unless you live in Brisbane where it is on Friday May 3, 2013.

Don't ask me why, but as we all know things are always a bit different in Queensland. I should also add that the politically correct term is now 'Administrative Assistant's Day'.

Look at Halloween. This was a minor non-official religious day, but has been hijacked by the retailers and pesky little kids who want sweets when they knock on your door dressed as goblins and ghosts and fairies. Not at my door they don't.

Last year I scared them witless by opening the door dressed in a sheet with the skull from anatomy studies sticking out the top where my head was carefully covered. Boy, did they scream and run. They won't be back in 2013.

And as for Valentine's Day – what a waste of time and money. It is just retailers trying to sell red roses and silk things and chocolates. In any event, no self-respecting curmudgeon would be seen dead in the ladies' intimate apparel section.

If you look at all the named days, there are more in some months than there are days in the month. On April 1, 2013 we have Easter Monday, April Fools' Day (that is one worth keeping) and César Chávez Day – I bet you don't know that one. Unfortunately I don't have time to tell you who the good César was as today my secretary has quit in a huff and my good lady says I can sleep in the shed which I can't do as some little blighters burnt it down last night.

In Memoriam

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

George Jerzy Schweitzer,
South African Fellow

Sydney Nade,
NSW Fellow

James Broadfoot,
NSW Fellow

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

Informing the College

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

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

Travel and research scholarship opportunities for 2014

The Board of Surgical Research invites Fellows, Trainees and other eligible applicants to apply for the following Scholarships, Fellowships and Grants for 2014.

PLEASE NOTE:
- The availability of the advertised scholarships and fellowships is subject to funding.
- Successful applicants will be required to procure 25% of the value of the scholarship from their research department for applicable research scholarships and fellowships (see website for details).
- These advertised opportunities are to be used as an initial guide only. Please consult the College website from 1 March 2013 for detailed information, including relevant application forms, award conditions and important general information.
- Applications for scholarships and fellowships below must be received by midnight CST 29 April 2013
- Where applications are open to all SET Trainees, then applicants to surgical training are also eligible to apply in anticipation of their acceptance into the SET Program. They must be accepted into the SET Program by 1 August in the year prior to the commencement of the scholarship in order to take up the award.
- The values of these scholarships are all in $AUD, unless otherwise stated.

Research Scholarships and Fellowships - Foundation for Surgery Funded

Surgeon Scientist Scholarship
Open to Fellows and SET Trainees enrolled in or intending to enrol in a PhD. Gross value **$70,000** comprising **$60,000** stipend plus **$10,000** departmental maintenance. Tenure is for up to 3.5 years.

Foundation for Surgery New Zealand Research Scholarship
Open to Fellows and SET Trainees enrolled in, or intending to enrol in, a higher degree. Applicants must be a New Zealand citizen currently residing in New Zealand. Gross value **$60,000,** comprising **$55,000** stipend plus **$5,000** departmental maintenance with a 12 month tenure.

Foundation for Surgery John Loewenthal Research Scholarship
Foundation for Surgery Research Scholarship
Foundation for Surgery Catherine Marie Enright Kelly Scholarship
Foundation for Surgery Reg Worcester Research Scholarship
Foundation for Surgery ANZ Journal of Surgery Research Scholarship
Open to Fellows and SET Trainees enrolled in, or intending to enrol in, a higher degree. Gross value **$60,000,** comprising **$55,000** stipend plus **$5,000** departmental maintenance with a 12 month tenure.

Foundation for Surgery Peter King Research Scholarship
Open to Fellows and SET Trainees enrolled in, or intending to enrol in, a higher degree with the topic relevant to the practice of surgery outside of metropolitan areas. Gross value **$60,000,** comprising **$55,000** stipend plus **$5,000** departmental maintenance with a 12 month tenure.

Foundation for Surgery Research Scholarship in Surgical Ethics
Open to Fellows, SET Trainees and members of the public with a special interest in ethical issues of modern surgery. Lay applicants must be sponsored by a Fellow of the College. Applicants must be enrolled in or intending to enrol in a higher degree with a topic relevant to ethical problems confronting surgery. Gross value **$60,000,** comprising **$55,000** stipend plus **$5,000** departmental maintenance with a 12 month tenure.

Foundation for Surgery Louis Waller Medico-Legal Scholarship
Open to Fellows, SET Trainees and Law Graduates. Applicants must be undertaking, or intending to undertake, doctoral research on the topic of medico-legal risks and the law in this area. Lay applicants must be sponsored by a Fellow of the College. Gross value **$60,000** per annum, comprising **$55,000** stipend plus **$5,000** departmental maintenance. Tenure is for up to 3.5 years.

Fellowship in Surgical Education
The Royal Australasian College of Surgeons and the Southeastern Ontario Academic Medical Organization, Queen's University, Kingston, Ontario, Canada, are offering a joint Fellowship to fund Fellows and SET Trainees wishing to undertake a Masters in Surgical Education at the Faculty of Health Sciences, Queen's University, Canada. The successful applicant will only pursue the educational activities involved in the Masters program. The Fellowship is for a period of up to two years subject to satisfactory performance. It is valued at AU**$70,000** stipend per annum with the Queen's University providing funding for tuition.

Research Scholarships and Fellowships - Bequest, Donation and Sponsor Funded

John Mitchell Crouch Fellowship
The John Mitchell Crouch Fellowship of **$150,000** is awarded to an individual, who in the opinion of the Council, is making an outstanding contribution to the advancement of surgery, or to fundamental scientific research in this area.
The Fellowship commemorates the memory of John Mitchell Crouch, a Fellow of the College who died in 1977 at the age of 36. The Council of the Royal Australasian College of Surgeons invites applications or nominations for the above Fellowship.

Applicants must meet the following criteria:
- The applicant must be working actively in his/her field.
- The award must be used to assist continuation of this work.
- The applicant must be a Fellow of the Royal Australasian College of Surgeons who is a resident of Australia or New Zealand.
- Applicants must have obtained their College Fellowship or comparable overseas qualification within the past 15 years (1998 or later)
- The successful applicant is expected to attend the convocation ceremony at the 2014 Annual Scientific Congress (ASC) of the College for a formal presentation. The Fellowship recipient must be prepared to make a 20-25 minute oral presentation at the ASC on their research work including the contribution arising from the award.
- The successful applicant is to produce a report in the format required at the end of their Fellowship for inclusion in the John Mitchell Crouch book, which is published approximately every five years.

There is no formal application form. A new application must be made for each year of application. Applications must include the following:
- A brief statement about current research work and future plans.
- Detailed curriculum vitae, including a list of publications. Included must be a list of what they consider to be their five most important publications as well as the five most important national or international lectures they have been invited to deliver.
- Important publications must also state impact factors and the impact range for their sub-speciality.

Paul Mackay Bolton Scholarship for Cancer Research
This scholarship was established by Harry Bolton in memory of his late son, Paul. Professor Paul Bolton was a distinguished surgeon, teacher and researcher who died from colorectal cancer in 1978, aged 39. It is designed to support applicants who wish to take time away from clinical positions to undertake a full time research project under the supervision of an experienced investigator in the prevention, causes, effects, treatment and/or care of cancer. Preference may be given to applicants who are enrolled in or intend to enrol in a higher degree. Gross value **$60,000**, comprising **$55,000** stipend plus **$5,000** departmental maintenance with a 12 month tenure.

Sir Roy McCaughey Surgical Research Scholarship
This fellowship was established as a result of a bequest to the College from the late Sir Roy McCaughey. Open to Fellows and SET Trainees enrolled in or intending to enrol in a PhD. The research must be conducted in NSW. Gross value **$60,000,** comprising **$55,000** stipend plus **$5,000** departmental maintenance. Tenure is for up to 3.5 years.

Research Scholarship in Military Surgery *TBC
Open to Fellows and SET Trainees with an interest in Combat Casualty Care Resuscitation Research. This scholarship is to be undertaken in Maryland, USA and offers a stipend of $US40,000 with a 12 month tenure.
*Please note that this scholarship is still to be confirmed – please contact scholarships@surgeons.org for more information.

Foundation for Surgery Richard Jepson Research Scholarship
Open to Fellows and SET Trainees enrolled in, or intending to enrol in, a higher degree. The gross value will be **$60,000,** comprising **$55,000** stipend plus **$5,000** departmental maintenance, with a tenure for up to 3.5 years.

For further information, please contact the Scholarship Program Coordinator, Mrs Sue Pleass, Royal Australasian College of Surgeons, 199 Ward Street, North Adelaide SA 5006.
Tel: +61 8 8219 0900;
Fax: +61 8 8219 0999;
Email: scholarships@surgeons.org .
Applications close midnight CST Monday 29 April 2013.

More than $1.2 million on offer!

Raelene Boyle Scholarship Proudly sponsored by The Sporting Chance Cancer Foundation

The Sporting Chance Cancer Foundation established the Raelene Boyle Research Scholarship in 1997 in honour of Raelene Boyle, an Australian national treasure and champion athlete.

Applicants must be working within either a university or hospital research unit and involved in cancer research that is expected to make a notable impact. Preference will be given to research projects with a focus on prostate cancer.

This Scholarship is open to Fellows and SET Trainees enrolled in or intending to enrol in a higher degree. SET applicants are also eligible to apply in anticipation of their acceptance in the SET Program.

CONROD-RACS Trauma Scholarship

A grant from the Motor Accident Insurance Commission matched by Foundation for Surgery funds has enabled the College to offer annual research funding for research into trauma to the amount of **$50,000.**

This 12 month Scholarship is open to Fellows and SET Trainees. Proposed research may be in any of the following areas: epidemiology, prevention, protection, rehabilitation or immediate or definitive management in trauma. A single Scholarship of up to **$50,000** will normally be awarded but more than one Scholarship may be made to a total of **$50,000** in any one year. The Scholarship may be used for either or both salaries and expenses. It is not a requirement that the research be conducted in Queensland but it must be shown that the potential benefits flowing from the research will assist the people of Queensland.

Travel Scholarships, Fellowships and Grants – Bequest and Donation Funded

Murray and Unity Pheils Travel Scholarship
The Murray and Unity Pheils Travel Scholarship was established following a generous donation made by the late Professor Murray Pheils. It has a value of **$10,000** and is awarded to a SET Trainee or recent Fellow of the College to assist him/her to travel overseas to obtain further training and experience in the field of colorectal surgery. Similarly, overseas graduates wishing to obtain further training and experience in a specialist colorectal unit in Australia or New Zealand are also eligible to apply. Applicants must not have commenced their travels prior to the closing date for applications. The Scholarship is for up to 12 months.

Hugh Johnston Travel Grant
The Hugh Johnston Travel Grant arose from a bequest of the late Eugenie Johnston in memory of her late husband, Hugh Johnston. This Grant for **$10,000** is designed to assist needy and deserving Fellows and Trainees of the College to gain specialist training overseas. Applicants must not have commenced their travels prior to the closing date for applications.

Hugh Johnston ANZ ACS Travelling Fellowship
The Hugh Johnston ANZ Chapter American College of Surgeons Travelling Fellowship has been established to support an Australian or New Zealand Fellow of the College to attend the annual American College of Surgeons (ACS) Clinical Congress in October 2013, which is to be held in Washington DC, USA. It forms part of a bi-lateral exchange with the ACS and is open to Fellows who have gained their College Fellowship in the past 10 years (2003 or later). Applicants are expected to have a major interest and accomplishment in basic or clinical sciences related to surgery and would preferably hold an academic appointment in Australia or New Zealand. The applicant must spend a minimum of three weeks in the United States of America. While there, they must:

> Attend and participate in the American College of Surgeons Annual Clinical Congress in 2013
> Participate in the formal convocation ceremony of that congress
> Visit at least two medical centres in North America before or after the Annual Clinical Congress to lecture and to share clinical and scientific expertise with the local surgeons.

Applicants must not have commenced their travels prior to the closing date for applications. This Fellowship is valued at AU**$8,000.**
More information about the ACS can be found at www.facs.org

John Buckingham Travelling Scholarship
This scholarship has been established to encourage international exchange of information concerning surgical science, practice and education, as well as to establish professional and academic collaborations and friendships amongst Trainees. It is open to current SET Trainees to enable them to attend the annual American College of Surgeons (ACS) Clinical Congress being held in Washington DC, USA, in October 2013. This scholarship is valued at **$3,000.**

Margorie Hooper Travel Scholarship
The Margorie Hooper Travel Scholarship has been made possible through a bequest from the late Margorie Hooper of South Australia. The Scholarship is for SET Trainees or Fellows of the Royal Australasian College of Surgeons who reside in South Australia. The Scholarship is designed to enable the recipient to undertake postgraduate studies outside the State of South Australia, either elsewhere in Australia or overseas. It is also available for surgeons to travel overseas to learn a new surgical skill for the benefit of the surgical community of South Australia. Preference will be given to the latter. This scholarship is for 12 months. The stipend is **$65,000** and there is provision for accommodation and travel expenses upon application.

Morgan Travelling Fellowship
The Morgan Travelling Scholarship was established to fund a Fellow of the College to travel overseas to gain clinical experience or to conduct research for a period of approximately one year. To be eligible, the surgeon must have gained his/her Fellowship in the past five years (2008 or later). The scholarship is open to a Fellow from any specialty. The scholarship must be the only College funding secured by the Fellow but the candidate is permitted to obtain alternative external funding concurrent with the Morgan Travelling Scholarship. The duration of the scholarship is 12 months. The value of the scholarship is **$10,000.** Applicants must not have commenced travels prior to closing date for applications.

James Ramsay Fellowship for Provincial Surgeons
The James Ramsay Fellowship was established through a bequest following donations made in 1986 and 1993 by Mr James Ramsay, AO, and subsequently through the generosity of Mrs Diana Ramsay, AO. This Fellowship is only available to provincial surgeons in Australia or New Zealand and is designed to enable Fellows of the College to spend time developing their existing skills or acquiring new skills away from their provincial practice.
These Fellowships are open for travel in 2013 or 2014 and can be taken for a period of eight weeks (value **$20,000**); a period of four weeks (valued at **$10,000**); a period of two weeks (valued at **$5,000**); a period of one week (valued at **$2,500**); or a combination of these.

The Fellowship grant is intended to contribute substantially to:

> Return airfare to city (cities) of choice;
> Daily living allowance (travel, meals, accommodation, ongoing practice costs)

No additional amounts are payable for travel or accommodation for family, locum costs, insurance, or any other unspecified costs.

The Fellow must spend a major part of each week at the appropriate institution and give a guarantee to continue in practice in his local area on completion of the Fellowship. There is no application form. A letter of application should be forwarded to the Scholarship Program Coordinator, including the following details:

> The intended Fellowship duration;
> An outline of the experience or skills you aim to gain through the Fellowship and how this will benefit your current practice/hospital;
> The locations to be visited in order to achieve your aim;
> A written confirmation from the institution/s where you are to gain your skill or experience.
> A brief outline of the costs associated with acquiring the skills and experience.
> wo written supporting references.

Ian and Ruth Gough Surgical Education Scholarship
The Ian and Ruth Gough Surgical Education Scholarship, valued at **$10,000**, was established by Ian and Ruth Gough to encourage surgeons to become expert surgical educators. Applicants must be Fellows or Trainees of the College, with permanent residency of Australia or New Zealand. Tenure is for one year. Please read the important general information and the scholarship conditions prior to submitting your application.

For further information, please contact the Scholarship Program Coordinator, Mrs Sue Pleass, Royal Australasian College of Surgeons, 199 Ward Street, North Adelaide SA 5006. Tel: +61 8 8219 0900; Fax: +61 8 8219 0999; Email: scholarships@surgeons.org . Applications close midnight CST Monday 29 April 2013.

the teachers

Taking teaching to the extreme

Versatility, flexibility and adaptability are all skills associated with good teachers. Last year the College took these principles to the extremes! In October 2012, the College's Surgical Teachers Course was delivered simultaneously in two of the most diverse environments imaginable; Hobart, Tasmania and Dili, Timor Leste.

The southernmost and the northernmost courses ever run differed not only in geography, but also in the diversity of environments of climate, culture and language.

However, even though these courses were worlds apart, they both emphasised the same underpinning principle: the imperative to teach is implicit in the work of surgeons, and teaching is a skill that needs to be learnt, just like the technical aspects of surgery.

For many years in Australia and New Zealand, surgeons were expected to teach, but had never been trained or given any guidance in the skills of teaching. Most surgeons picked up teaching skills in an ad hoc manner from their own personal experience of being a student.

It is now recognised that for surgeons to be effective teachers, education about the principles of adult learning is needed. The College's Surgical Teachers course was developed in recognition of this need and has run successfully throughout Australia and New Zealand since 1999.

Recently, the ATLASS program (The College Humanitarian Aid Program to Timor Leste funded by AusAID, the Australian Government's overseas aid program) achieved a substantial milestone by helping set up the first in-country medical training program under the auspices of the University of Timor Leste. Consequently the opportunity arose to support these diploma courses with a faculty development initiative.

While Timor Leste and Australia share many of the same challenges in the delivery of surgical education, there are also many differences in the context of education.

The Timorese postgraduate diploma courses commenced in July 2012 with five streams: surgery, obstetrics and gynaecology, paediatrics, anaesthesia and internal medicine. The courses will be taught by a faculty of young, recently graduated Timorese specialists.

Dr Joao Pedro Xavier, a recently graduated East Timorese general surgeon has been appointed the director of the new diploma courses and will be assisted by international specialists spending time in Dili.

Dr Joao Pedro's eclectic teaching staff come from diverse backgrounds including Australia, Cuba, China, Nepal and the Philippines and have training in diverse medical systems which all have their own paradigm of health and teaching.

Not only is the teaching faculty diverse, the Trainees whom they teach also have similarly diverse backgrounds as even though they call themselves East Timorese, they may have been trained in Indonesia, Fiji or Cuba for their basic medical degree.

In what was a great challenge for the College, we promised to deliver the Surgical Teachers Course to this diverse faculty and make it culturally specific and relevant for Timor Leste. Coincidentally, and in contrast to this, the updated Surgical Teachers Course was delivered on the same two days in Hobart to Australian surgeons.

Alan Scott, Don Moss and Glenn Guest (the Dili faculty) took on the challenge of making the course culturally specific and relevant to Timor Leste and were assisted by Jenepher Martin and Stephen Tobin.

Jenepher Martin led the original development of the College's Surgical Teachers course and was a member of the foundation faculty for the new Surgical Teachers Course in Hobart, demonstrating her own versatility, flexibility and adaptability as a good educator.

At the same time as the Dili faculty were off to Timor Leste to deliver the course, David Birks, Trish Davidson, Meron Pitcher and Jenepher Martin were heading down south to Hobart to launch the new Surgical Teachers Course.

In delivering these courses, both groups of faculty crossed a relatively narrow body of water off mainland Australia to arrive at their destination and both had course dinners featuring seafood; however, this is where the similarity ended.

As one group enjoyed fresh seafood under the stars on the beach washed down with Tiger beer slapping away malaria and dengue mozzies, the other indulged in delicious food with the heater substituting for the warm tropical breeze.

In Dili, the course was delivered in English (albeit sometimes with a Scottish accent thanks to Alan Scott) to an enthusiastic audience, but the discussions often included a generous smattering of Tetun, Bahasa, Spanish and Portuguese. Despite this tower of Babel, the course was well received.

Registrations are now open for the *NEW* Surgical Teachers Course

Melbourne	11-13 April, 2013
Adelaide	29-31 August, 2013
Perth	24-26 October, 2013

To register please email PDactivities@surgeons.org

Clockwise: Faculty and participants of the 2012 Dili course; Joao Pedro, participating in the course; Eric Vreede with medical student.

To make this course relevant to Timor Leste, there were many adaptations made to the original Surgical Teachers Course. For instance one of the key teaching methods in the course is referred to as the 'snowball' principle. However 'snowball' is not a term that readily translates to a country that is continually bathed in tropical sunshine and hasn't seen snow since the last Ice Age!

Similarly, the sporting analogies involving golf and Aussie Rules football seemed unlikely to strike a chord in a nation where no golf courses exist and the round ball form of football is dominant. In Hobart no such difficulties were encountered and there was even a possibility that the snowball analogy could be demonstrated for real!

Fortunately, despite cultural and language barriers, the course provided appropriate examples across all medical specialties to highlight the principles of education which do cross the cultural divide of two diverse countries as Timor Leste and Australia.

Finally, the question should be asked: are we making a difference in surgical teacher education? These strikingly different venues underline the problem of evaluating what effects the Surgical Teachers Course has on one's teaching practice.

Both courses received overwhelming positive feedback. In Tasmania, the course was noted as a good learning opportunity which provided a framework for teaching, feedback and skills training. In Dili, as a result the fledgling teaching, faculty now feel much better prepared to tackle the responsibility of delivering Timor Leste's first Diploma courses.

The real success of this course can only be measured over years and decades as the attendees use their new found skills to teach and influence the next generation of students and Trainees under their guidance.

But, in a very encouraging and early sign, Dr Joao called a meeting of all Trainees the week following the course and by all accounts applied every principle of teaching and feedback that had been delivered during the course.

It would be hard to find a better example of how a course such as this can influence behaviour. With the Diploma training program in the formative stages, this seems to have been delivered timely and effectively and will hopefully have an influence for many years to come.

Footnote: Many thanks to all the members of the faculty, the participants and the College's Dili staff who organised things so well. Special thanks to Eliza Muir for her behind the scenes work with this course while on her student elective!

Glenn Guest and Jenepher A. Martin

Baby Quentin's Story

An excerpt from the recent College publication, *My Timor Heart*

Of all the patients who have been helped by the College's Timor Leste program, few are as famous as the adorable baby Quentin. The little girl's mother gave birth at an Australian-funded birthing centre north of Dili in December 2008, just an hour before a planned visit from Australian Governor-General Quentin Bryce.

She was born with a cleft lip. When Ms Bryce arrived to tour the facility, she picked the newborn up and cradled her, forming an immediate bond with parents Virginia Ingrazia and Vencisolao Pereira, who decided to name their precious baby after Australia's Governor-General.

In March 2009, when baby Quentin was only a few months old, Dr Mark Moore, a Plastic and Reconstructive surgeon based in Adelaide, operated on her and repaired her cleft lip. "Baby Quentin was seen by the Governor-General on her first overseas visit to Timor Leste," Dr Moore said. "She was keen on arranging for the lip repair and her staff became aware of our team visiting and I was contacted by the Embassy and AusAID who arranged for her to attend our next clinic."

Baby Quentin is now a healthy, beautiful four-year-old, and met up with her namesake again when the Governor-General returned to Timor Leste for independence celebrations last year. Dr Moore said Ms Bryce had also generously made the time to call in on him while she was in Adelaide to pass on her personal thanks.

The College's Plastic and Reconstructive Surgery program has been operating in Timor Leste since Dr Moore made his first trip in early 2000. He took over from Dr John Hargrave, the legendary Plastic and Reconstructive surgeon who had been making visits to West Timor and East Timor since 1990.

Some things have changed in that time. There appear to be less people presenting with traumatic injuries caused by violence and civil unrest. Now, most of the work of the program involves repairing cleft lips and palates in babies and children.

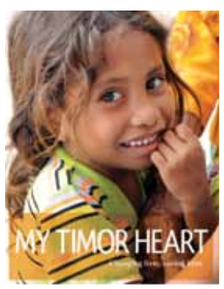
In adults, it's repairing scarring and disfigurement, and Dr Moore sees hundreds of patients suffering from dreadful burns, which have healed in ways that have fused their limbs, faces, or fingers and toes. There are also some adults who have struggled for years with cleft lips or palates.

"Clefts are twice as common in Asian populations as they are in Caucasian populations," Dr Moore said. "In Australia, cleft palates and lips are repaired when children are very young, but in Timor Leste, with no specialists available locally, many people go into adulthood without any surgical intervention.

"On a trip to Oecussi in March 2011, we saw seven patients over the age of 35 with cleft palates and lips. Two were grandfathers. Neither had been to school."

Dr Moore said there had been improvements since the early days, when he used to buy pigs trotters from the markets to train nurses and community health workers how to insert sutures. He paid tribute to Dr Joao Pedro Xavier, whom he first met as a medical student in 2000, and who is now a qualified surgeon.

"Dr Joao Pedro is symbolic of the steps forward. Also to have a Timorese surgeon now doing excellent cleft and burn surgery – Dr Joao Ximenes – is what we have worked towards, and will continue to support," he said.



All proceeds from the purchase of My Timor Heart go directly to the College's Foundation for Surgery to fund the Timor Leste program. An order form can be found on page 46.

To order a copy please contact Emily.salt@surgeons.org or call +61 3 9249 1230.

Photographs, X-rays, medical images and privacy

Ensure there is patient consent when documenting your work

In our current digital era, we have increasing access to instant, easy recording of images through mobile phones, as well as other digital media. The medical field is no exception. It is therefore important to recognise that there is no general right for medical practitioners to use patient photographs, x-rays or other visual images, whether for education, research or otherwise.

Current privacy legislation introduces a set of 10 National Privacy Principles, which establish the minimum standards for handling of personal information. Clinicians may be liable for fines of up to $100,000 if they store or distribute clinical photos incorrectly.

A medical practitioner can only use or disclose health information for the purpose for which it was collected, unless the individual's consent has been obtained – and not doing so may have serious consequences. (Recent research undertaken at a Melbourne hospital* found that only a quarter of doctors surveyed had obtained appropriate patient permission to obtain clinical images.)

Use of clinical images for other purposes, such as education, without consent from a patient not only works against a sense of confidentiality for the patient, but may also have severe legal ramifications. Several recent cases illustrate this:

- An investigation has been carried out in Western Australia in relation to breach of patient confidentiality, after a newspaper published a photograph, obtained from a hospital's internal website, of a patient being treated at that hospital.
- A chief resident of general surgery at a US hospital faces disciplinary proceedings after taking photos of a patient's tattoo, using his mobile phone.
- An apocryphal story tells the tale of a surgeon who objected when a colleague included during a PowerPoint presentation at an educational conference, used x-rays of the first surgeon without his consent. The surgeon giving the presentation was the treating surgeon.

Property of medical imagery is different to that of normal documents – the right of ownership of these images is also accompanied by a duty of confidence. Taking or recording an image does not necessarily mean ownership of the image either – in the public sector these photographs may become both the property and responsibility of the hospital.

These obligations are not necessarily new. Doctors have always had an obligation to maintain confidentiality in relation to patients and patient information. A breach of privacy or confidentiality can also lead to a complaint of professional misconduct, and potential disciplinary proceedings before medical boards and authorities.

Photographs and other medical imagery can be used for many useful purposes, and are included in patient records as an addition to clinical care – and may be displayed to colleagues, Trainees and others for treatment purposes.

However, any use beyond the treatment of the patient runs the risk of a breach of privacy. A breach of privacy or confidentiality can lead to a complaint of professional misconduct, and potential disciplinary proceedings before medical boards and authorities.

As technology improves into the future, clinical photography will also increase. It is important to be aware of the ramifications and consequences of using this imagery – and mobile apps such as the recently released PicSafe aim to guide medical practitioners in the safe usage and storage of such files.

It is also crucial to remember to gain the patient's consent before the images are used. The patient's consent should be recorded, and what the images will be used or potentially used for should be discussed with the patient.

It is also acceptable under privacy legislation for a medical practitioner to have a Privacy Statement or privacy consent document (either signed by or given to the patient) which indicates that images may be used for research, training and education purposes – and allowing the patient to 'opt out' from this by indicating that such permission is not given.

Practitioners operating in hospital environments should check their hospital's Privacy Statement or consent document to determine the extent of consent encompassed within these documents.

(*Research conducted by Dr David Hunter-Smith in the Department of Surgery at Peninsula Health found that only a quarter of doctors surveyed had obtained appropriate patient consent to take clinical images.)

With Isla Tobin

Michael Gorton,
College Solicitor

Surgical simulation-based training

Skills transfer to the clinical setting

Twenty-three recent research studies have strengthened the evidence that surgical skills acquired through simulation-based training can transfer to the clinical setting. In 2012, the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S) looked at research published since the 2006 systematic review (ASERNIP-S report no. 61) to determine whether surgical skills gained through simulation-based training improve the performance of surgical Trainees in clinical settings.

The following information is a brief summary of the full systematic review update (ASERNIP-S report no. 80) which is available at www.surgeons.org/asernip-s.

Main messages

ASERNIP-S looked at the evidence available since 2006 on whether skills acquired through surgical simulation-based training can transfer to the operating room and noted that:

- No solid conclusions could be drawn from the evidence due to differences in simulation-based methods and the variable quality of studies included.
- The evidence was rated as average although the trend was to higher quality studies e.g.
- twenty of the included studies were randomised controlled trials (highest quality);
- more studies required participants to pass (at a predetermined competency level) in simulation-based training prior to assessment in the operating room.
- More studies used standardised assessment based on objective validated global rating scales for patient-based operative performance.
- Simulation-based training was being used in more specialties for surgical Trainees to gain basic technical skills. This increased the variety of equipment, training methods and assessment methods used in studies and made comparison between studies more difficult.
- Simulation-based training was being used to introduce novices to operating room behaviour and communication (using virtual world or simulated operating room) i.e. non-technical skills.
- Further well-designed studies could explore the way that simulation-based technical skills environments might be used to train and assess non-technical skills, such as decision-making.

What is surgical simulation-based training?

Traditionally, surgical Trainees gain practical experience by watching experienced surgeons perform operations on patients and providing assistance. However, the opportunities to train in this way are limited. Thus it is beneficial that surgical Trainees are required to practise their skills in artificial surgical environments before entering the operating room.

While simulation-based training programs were initially used as 'add-ons' to traditional surgical training, simulation is increasingly being incorporated into curricula or even mandated by registration bodies, such as the American Board of Surgery which has required the Fundamentals of Laparoscopic Surgery (FLS) certification since 2009.

An artificial surgical scenario may be set up with:

- physical simulators
- human cadavers
- animals
- virtual reality simulators with computer-generated tools and tissues
- hybrid simulators combining physical and virtual reality simulators.

What is the evidence?

Studies comprised a range of laparoscopic, endoscopic and several other surgical procedures. In most studies simulation-based training programs were an 'add-on' to traditional surgical training. Only two included studies directly comparing simulation-based training to patient-based training.

Simulation-based training added on to normal surgical (patient-based) training.

For 15 different surgical procedures, participants who received simulation-based training prior to patient-based assessments performed better (higher global assessment score and/or shorter time to complete task) than participants who did not have this training. Only one of the 20 studies did not produce any evidence to support this conclusion. In addition, for the laparoscopic procedures, simulator-trained groups generally made fewer errors than control groups in subsequent patient-based assessment.

Simulation-based training versus patient-based training

For colonoscopy (one study) and camera navigation (one study), participants who had trained exclusively on a simulator performed at an equivalent standard on the in-surgery assessment procedure to those who had received patient-based training only.

Clinical & research recommendations

ASERNIP-S recommends that further research be conducted into the transfer of skills acquired through simulation-based training to the patient setting, to strengthen the evidence base. Areas still requiring further study include:

- the nature and duration of training required to deliver the greatest transfer effect;
- the stage of training at which Trainees receive maximum skill transfer benefits from different forms of simulation;
- the effect of different levels of mentoring during the training period on transfer rates;
- changes in staff productivity as a result of simulation-based training (Sturm et al 2007).

Guy Maddern
Chair, ANZASM

Further information
Professor Guy Maddern
ASERNIP-S Surgical Director
199 Ward Street
North Adelaide, SA 5006
AUSTRALIA
P: 61-8-8219 0900
F: 61-8-8219 0999

Communicate well

Improve your career and personal life

Anthony Dilley is a paediatric surgeon who became a certified trainer in Process Communication Model (PCM) last year. He goes through what PCM is and how this model has benefited him both professionally and personally. He has found this model invaluable and thinks his surgical training would have been easier had he participated in it then.

What is Process Communication Model?

The Process Communication Model is largely the result of lessons learnt from a lifetime of observation, data collection and synthesis performed by Taibi Kahler. It started from a simple observation and unfolded as the next question was posed and answered.

Kahler observed that there are six personality types, each associated with a communication style, that occur in all of us to a greater or lesser extent. Our base type is that which is fixed in infancy, and the order of strength of the other five types appears locked in by age seven. With practice we can strengthen our communication skills in these other five types.

PCM is a model that allows us to identify in others their preferred communication style, and should we wish to optimise our interactions we can then choose to communicate with that person in the way that is most suitable.

By identifying the communication style, it is possible to anticipate the manner in which an individual will demonstrate that they are stressed, allowing us to respond appropriately utilising the model.

The model is derived from data generated through the analysis of tens of thousands questionnaires. With practice, similar information can be gleaned by the PCM practitioner through a few minutes of conversation and observation.

How the model is learnt

The Part One PCM course provides the participant with an understanding of the model and an understanding of what the data generated from their pre-course questionnaire actually means. It introduces the ways that different personality types demonstrate distress and how this can worsen or be relieved.

The Part Two PCM course revises the Part One course and concentrates on how the model can be used for those showing signs of distress. The exercises are interactive and a lot of fun. A PCM provider course is available for those who would be interested in teaching.

The professional and personal benefits

PCM has had most benefit for me in providing a new way of perceiving how those close to me, family and friends, prefer to communicate with me. Being time poor like most surgeons, it has been valuable to understand how to make the use of time spent with loved ones more fulfilling.

I am forever grateful my wife agreed to do the Part One course with me! PCM has also provided me with some new insights as to how to make encounters between colleagues, clinicians and administrators alike, less distressing and more productive.

On occasion, my encounters with patients and their families have more quickly steered to stable ground. While I have found the model invaluable at my stage of life, I feel I would have had an easier time during my training had I participated in PCM then.

I think I would have been better at meeting the needs of myself, family and the hospital than I actually did during that period of my life. I know most surgeons would come away from the course with plenty to reflect on!

Anthony Dilley
NSW Fellow

WANT TO SEE WHAT PCM CAN DO FOR YOU?
Call or email the Professional Development Department on PdActivities@surgeons.org or 03 9249 1106.

The two PCM courses scheduled for Thursday 18 to Saturday 20 April in Melbourne and Thursday 13 to Saturday 15 June in Sydney are fully booked. An additional course has been scheduled for Friday 2 to Sunday 4 August in Melbourne.

Growing knowledge

Professor Marcus Stoodley was awarded the John Mitchell Crouch Fellowship in 2012

The premier research award of the College, the John Mitchell Crouch Fellowship, was last year awarded to New South Wales neurosurgeon Professor Marcus Stoodley for his ground-breaking research to develop new treatments for brain arteriovenous malformations (AVMs) and advance understanding of the pathophysiology of syringomyelia.

First awarded in 1979, the Fellowship is given annually to a surgeon who, in the opinion of the College Council, is making an outstanding contribution to surgical advancements and research.

Professor Stoodley is Professor of Neurosurgery at Macquarie University, conducts his research through the university's Australian School of Advanced Medicine and has a clinical practice at the Macquarie University Hospital.

He said AVMs occurred when arteries in the brain connect directly to nearby veins without the normal capillaries between them. He said that while they usually formed before birth, symptoms may occur at any age with catastrophic haemorrhages occurring most frequently in children and young adults.

Syringomyelia is damage to the spinal cord caused by a fluid-filled cyst that forms in the cord due to either congenital abnormalities, spinal cord trauma or tumours.

Professor Stoodley said that while the conditions were comparatively rare, both had catastrophic effects.

"AVMs affect between one in 1000 and one in 10,000, which is about as common as Multiple Sclerosis (MS) and just like MS, the condition mostly affects young people," he said.

profile

HIGHLIGHTS

Professor Marcus Stoodley

2012 John Mitchell Crouch Fellowship – RACS

2012 Eccles Lectureship in Neuroscience - Neurosurgical Society of Australasia and Australian Neuroscience Society

2000 Viertel Clinical Investigatorship – Sylvia and Charles Viertel Charitable Foundation

1997 Stuart Morson Fellowship – RACS

1995 Medical Postgraduate Research Scholarship – National Health and Medical Research Council

"Yet even though the rupture of an AVM can affect people suddenly and catastrophically – causing either instant death or severe disablement – there is nowhere near the same advocacy or funding for research as there is for MS.

"Similarly, syringomyelia can have devastating consequences such as causing a patient who has already suffered a severe spinal injury to lose even more mobility and function and is believed to affect about one-quarter of all spinal cord injury patients."

Far left: Professor Stoodley at work; Left: With his extended team.

Professor Stoodley said the central goal of AVM research was to prevent rupture by either removing the AVM or interrupting blood flow, but that many were surgically inaccessible while other treatments such as injecting glue into blood vessels or using radiation to block them off were not always effective.

Instead, he and his neurosurgery research team have been working to design a new invivo molecular imaging technique which could identify AVM proteins that could be manipulated to encourage clotting to seal off the vulnerable blood vessels.

"Our overall goal in this project is to develop a new treatment for high grade brain AVMs that are untreatable using current methods," Professor Stoodley said.

"In the first step, stereotactic radiosurgery is used to stimulate molecular changes on the surface of endothelial cells in the AVM vessels.

"The second step is to target those molecules with antibodies attached to molecules that stimulate intravascular thrombosis such as tissue factor.

"If proteins in an AVM were unique we could target them directly, but the cells are fairly normal so the idea is to use radiation to stimulate protein expression that makes the AVM cells different to normal cells. Identifying exactly which proteins change after radiation and by how much they change is quite difficult.

"However, last year we worked to develop an invivo molecular imaging technique to allow us to study aspects of radiation-induced endothelial molecular changes.

"First we used endothelial tissue cultures treated with radiation to show that we could image live cells with fluorescent-labelled antibodies to certain molecules and then applied these techniques to the rodent model of AVM.

"This technology had not previously been applied to study endothelial molecular changes after radiation, but we were able to demonstrate that this technique does provide quantitative information about molecular changes."

Professor Stoodley said that the research, funded via the JMC Fellowship stipend, had proved so promising that his team had been awarded a $670,000 three-year NHMRC grant to continue the work.

He said that the team had now identified highly prospective molecules for pro-thrombotic therapy and that the technology and methods used could have a significant impact on other areas of medical research.

"It could be useful in the treatment of particular brain tumours, for example, because sometimes it is very difficult to design effective delivery systems for chemotherapy to the brain, but if we could treat tumours by blocking the blood supply to them that would be amazing," he said.

"And now that we have received the NHMRC funding we can accelerate this work."

Professor Stoodley said his team of ten research scientists and PhD students were now using the technique to also help advance their understanding of syringomyelia given that the cause of it, and the movement of fluids within the spinal cord, remained a mystery.

He said the team, using the invivo molecular imaging technique, could now image the entire spine with molecular tracers showing not only the movement of fluid, but also measuring the quantity of fluid.

"Syringomyelia is one of the most enigmatic neurological conditions because the origin of the fluid that forms the cyst and the mechanism behind cyst formation have remained obscure," he said.

"It has been assumed that the fluid is cerebrospinal fluid (CSF), but that has not been proven.

"Building on the techniques developed in the AVM project, we developed techniques for studying CSF movement which will allow quantitative assessment of fluid flow in the subarachnoid space and the spinal cord.

"The technique will also enable quantification of fluid flow out of the spinal cord, allowing us for the first time to study the balance between CSF flow into and out of the cord.

"Our goal is to understand how syringomyelia forms so that we could perhaps prevent it, but this research could also be useful in other areas of medical research such as in the treatment of hydrocephalus, Alzheimer's disease or any conditions that require the delivery of drug therapy into the central nervous system."

Professor Stoodley, who divides his time evenly between his research and clinical commitments, described receiving the JMC Fellowship as a great honour and said while the acknowledgement of professional colleagues and peers was rewarding in itself, the Fellowship held such prestige it also helped attract wider support.

"Receiving this Fellowship has made it easier when communicating with funding bodies because they know I have the support of the College," he said.

"Sometimes it is difficult to get across the importance of some research projects, particularly as a surgeon with a busy clinical practice because we obviously don't have the same time as pure scientists to devote to writing papers and addressing conferences which can sometimes make the difference in winning funding.

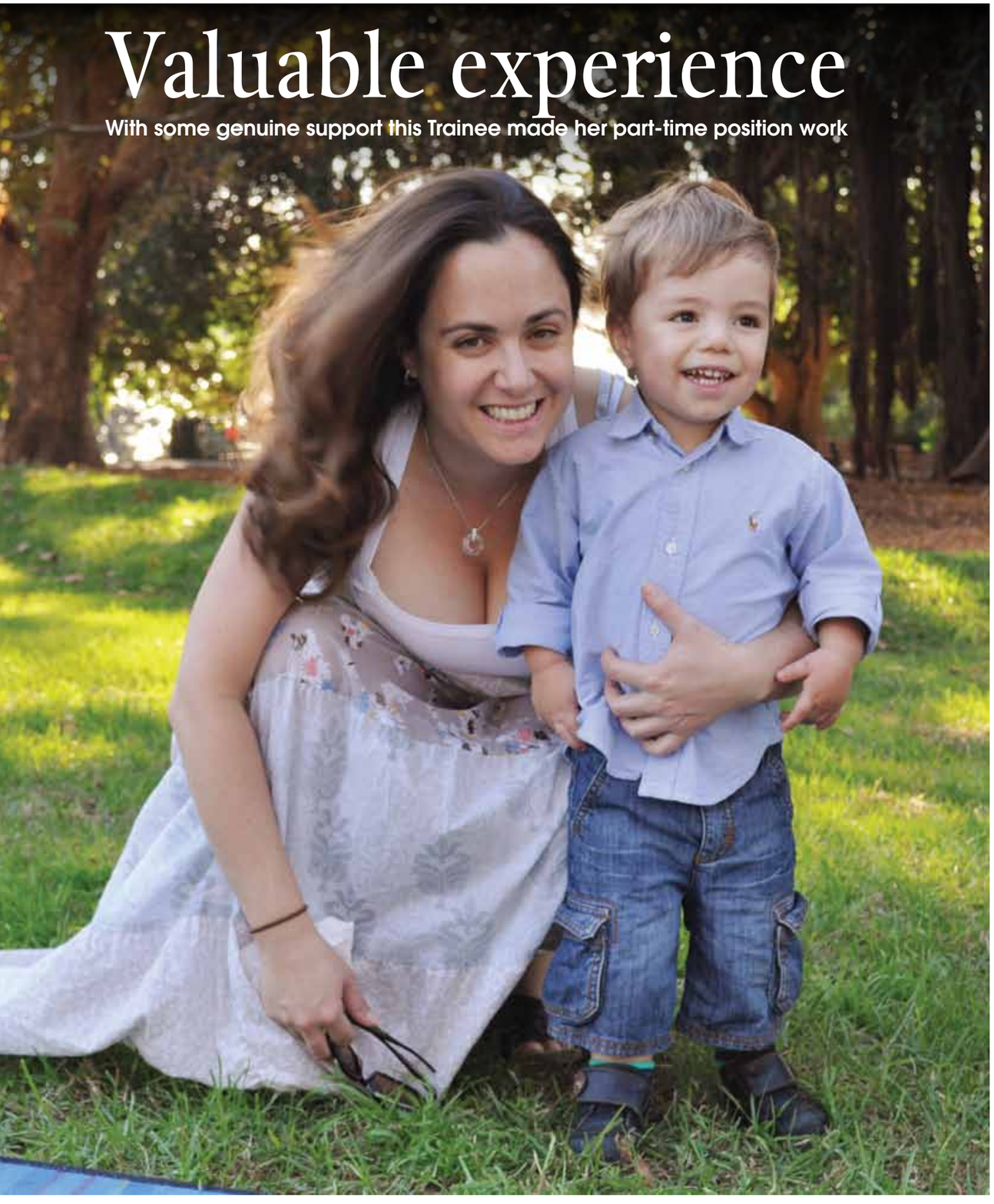
"But I absolutely believe in the importance of surgeons as scientists because we know the clinical problems, we know the conditions and diseases that are the most difficult to treat.

"Only a surgeon, for example, would understand the catastrophic consequences of AVMs and syringomyelia and then be in a position to drive research and attract support."

With Karen Murphyy

Valuable experience

With some genuine support this Trainee made her part-time position work



The College should follow Britain's lead and establish a dedicated contact position, design a standardised application process, transparent guidelines and pathways, and allow for anonymous applications if the goal of flexible training is to be realised, according to Post-Graduate Fellow in Colon and Rectal Surgery Dr Penelope De Lacavalerie.

Dr De Lacavalerie, who passed her General Surgery Fellowship exam in 2012, is currently a Research Fellow in Colorectal Surgery at Bankstown Hospital as part of her training through the Colorectal Surgical Society of Australia and New Zealand. She undertook the last year of her General Surgery training over two years in a job-share position at Bankstown-Lidcombe and Liverpool Hospitals in Sydney.

Dr De Lacavalerie said she pursued the option of flexible training following the birth of her first child, Emilio, and her return to work after maternity leave.

"When I applied he was only ten months old, but within two months of returning to full-time training I realised that my expectations of myself as both a first-time mother and full-time Trainee were not working," she said.

"I wanted to be part of his life, not just see him occasionally, so I applied and was very lucky to have very good, supportive mentors.

"I wrote to the NSW Chairman of General Surgery at the time and fully explained my reasons for requesting flexible training and was very lucky to gain the support of the SET Supervisor and other surgeons at Bankstown-Lidcombe Hospital. In the letter I included details of the South Australian experience with part-time training which is the only stand-alone, part-time training position available in Australia to my knowledge

"I was informed by the Board that the only way forward to make it work was to find another Trainee to do a job-sharing arrangement. Following this, the College put out an email to all Trainees in NSW and after an interview process a fellow Trainee was selected to share the position.

"Unfortunately, after four months of starting the post she decided not to continue with surgical training so I ended up with a de facto stand alone part-time position which was kindly supported by my mentors and Senior Registrar at the time. On completion of the first year, another email went out to Trainees offering the job sharing position.

"It was decided by the Board to rotate me to Liverpool Hospital to undertake Head and Neck Surgery training where I shared the position with Dr Gowrinanthanan Panchacharavel."

Now a PhD student researching the molecular genetics of rectal cancer at the Garvan Institute of Medical Research and The Kinghorn Cancer Centre, Dr De Lacavalerie received her medical degree in her home country of Venezuela and did her Basic Surgical Training in London before moving to NSW with her Australian husband and entering the SET training program.

Make it easy

She said that despite the support she had received which allowed her to undertake part-time training, there were still significant barriers and a stigma attached to flexible training which dissuaded some Trainees from pursuing the option.

"During those two years and even now, I received many calls from other Trainees whom I had never met asking me how I went about finding a job-share training position because they did not know, given that it is still so uncommon in Australia," she said.

"All of them wanted to know how it was working out because one of the central issues seems to be the myths that still exist from both the perspective of Trainees and supervisors.

"Trainees fear that they will only be given the boring easy work and discouraged from taking on more complex surgeries because they are not around all the time. Some supervisors and employers seem to think that Trainees working part-time are less committed, less capable or less professional.

"Yet these are all myths.

"I worked 100 per cent every day, and because of the support I received I was able to conduct more surgeries, not less, and at a high level. I had the highest number of major surgeries as primary operator in all my training during the part-time training year at Bankstown-Lidcombe Hospital which puts paid to that myth.

"At Liverpool Hospital it became more challenging to maintain a reasonable work-life balance. That hospital has the largest Trauma Centre in NSW, very busy Head and Neck and Emergency Departments and the usual staffing shortages. While there I still ended up working 50 to 60 hours per week which is not really a part-time arrangement.

"Often I would be asked to work on or change hours which posed major problems in trying to organise last minute child-care arrangements.

"Still, despite this I believe it is much better to have part-time training as an option rather than see dedicated surgical Trainees leave the profession, but much work still needs to be done to make it better."

Dr De Lacavalerie said that another central challenge confronting Trainees who wish to take up part-time training was that there was no clear pathway or dedicated officer at the College to work with to ensure that everyone's expectations were met.

She said in the absence of clear guidelines as to how such positions should work, both Trainees and supervisors were being asked to make up the arrangements as they went along.

"In the UK, you apply through the Postgraduate Deanery in charge of the region; you have clear provisions that must be met and the process is very transparent because it is a right not a favour," she said.

"In Australia you have to be quite assertive, you have to do the legwork to find a position, you have to design your own business plan or working model and you have to find and win your own support which can be a difficult and draining experience.

"I also think that like the UK, the application process should be anonymous because many Trainees are frightened that they will be stigmatised just by making the request and that they will be viewed differently if they seek flexible training.

"I think it is because part-time training just doesn't fit the framework of surgery as it has developed over hundreds of years, but this needs to change if the profession is to retain capable and dedicated Trainees.

"I have now received medical training on three continents and I honestly can say that the quality of training in Australia is of the highest standard. However, it still has some way to go in terms of making flexible training an acceptable, accessible option and not a special request."

With Karen Murphy

Next month, *Surgical News* will talk to Dr Panchacharavel about his experience as a part-time Trainee.

Professor Paul Finan, Anil Koshy, and Professor Peter Sagar. Inset: Anil Koshy, with the surgical secretaries, Mary(sitting), Fiona (middle) and Allyson.

A year abroad

The experience from another country is invaluable

I did my internship, residency, basic and advanced surgical training at Royal Prince Alfred Hospital (RPAH), Sydney. I then did a year of colorectal research and completed my Masters of Surgery (Sydney University). I then completed advanced colorectal fellowship training with Colorectal Surgical Society of Australia & New Zealand (CSSANZ), spending a year at both Fremantle and RPAH.

In order to gain overseas experience in complex pelvic and laparoscopic colorectal surgery, I did a year of fellowship at John Goligher Unit Leeds, United Kingdom with Professor P.M.Sagar and Professor P.J.Finan.

Moving overseas can be a very stressful experience since it involves extensive organisation with relocation, getting medical council recognition, visas and addressing family issues such as schooling for children and so on.

However, this move was an extremely rewarding experience for the whole family. We were able to take the opportunity to explore England and Europe with the children and the cultural exposure was of immense benefit to our kids, who adapted quicker than anyone could imagine.

The John Goligher Unit in Leeds was a major eye-opener into the NHS. Having spent most of my training years at RPAH, reputedly the largest pelvic exenteration centre in Australia-New Zealand, I was particularly keen on going to Leeds to learn advanced complex surgery including pelvic exenterations for colorectal cancer recurrence from Peter Sager.

At the other end of the continuum, I have always been fascinated with minimally invasive laparoscopic and robotic colorectal surgery. I was uniquely privileged to work at a public NHS hospital where not only did they perform the most invasive and radical surgery for colorectal pelvic cancer recurrence, but it was also the one NHS hospital in the UK in which robotic colorectal cancer surgery was being pioneered.

During my time in Leeds I was on the on-call roster, and I enjoyed my time training surgical registrars and Fellows in the unit, taking them through laparotomies and laparoscopic procedures. I regularly attended the outpatient clinics, conjoint IBD clinics with the gastroenterologists and MDTS. I was also involved in research with Professor Sagar during this period.

While I was there, I had the opportunity to attend the European Colorectal Congress meetings in Vienna, ACPGBI meeting in Dublin, and the Frontier's colorectal meeting at St Mark's, London.

I had the opportunity to meet a number of doyens of colorectal surgery including spending a week with Professor Neil Mortensen at Oxford Hospital and then a week at St Mark's Hospital, London.

I'm extremely grateful to my wife Ann, who is herself a successful and busy GP in the Maitland area. Her preparedness to give all this up for one year, and relocate herself and family to support me in my own surgical pursuits made it all possible.

Experience for all

We have two children, Sarah and Alex, who are nine and seven years-of-age and very affectionate. Our biggest fears were for Sarah and Alex, and how they would assimilate, and whether their education would suffer from the move.

Rest assured, kids make friends quicker than adults and seeing their immediate fascination with the UK and ability to adapt, as well as their accelerated maturation from this move has made it clear to me that travel is a great educational experience for children.

What I have gained from a single year of being an overseas Fellow is hard to put into words. My family and I have gained a lot in terms of settling in a new country and meeting different people, and this has been very confidence boosting.

The hospitality shown and the genuine acceptance by my surgical colleagues at Leeds was humbling, and I am motivated to be involved in training of a similar sort while a colorectal surgeon in Newcastle. I feel inspired from my Leeds' experience to utilise this in the best way possible and provide a quality colorectal surgical service to the people of Newcastle.

I am currently awaiting a surgical consultant post in the public hospital system.

I was extremely honoured to be invited to take over Dr Paul Anseline's Practice in Newcastle. In the not too distant future, I would like to be involved in academics and the training of junior members of the surgical profession.

I strongly recommend doing an overseas fellowship year to gain a life-altering experience. You will not be disappointed.

Anil Koshy
NSW Fellow

Sir Alexander MacCormick on board

Sailing Surgeons

ADA COURTESY OF THE ROYAL SYDNEY YACHT SQUADRON (RSYS)

"Ironically, these stolid students were not what they seemed"

Sailing surgeons are part of our history

In 1876 four young men, Robert Scot Skirving, Alexander MacCormick, Thomas Anderson Stuart and Arthur Conan Doyle were studying medicine at the University of Edinburgh. Skirving made notes about his fellow students. He observed that Anderson Stuart, who later founded the Sydney Medical School, was a bright boy with a hook nose that earned him the nickname of 'coracoid' from the Latin corax (crow), but he found MacCormick and Conan Doyle rather dull.

Ironically, these stolid students were not what they seemed – Conan Doyle's literary success is well known and MacCormick became a highly respected surgeon. In another twist of fate, the cultured Robert Skirving who admired Robert Louis Stevenson and the rather gruff Alexander MacCormick, a man with 'no poetry in his soul', were to become close friends who shared a passion for the sea.

Following a visit to Australia during his brief career in the merchant navy, Skirving immigrated to Australia in 1883 and MacCormick arrived the same year. Under Anderson Stuart's patronage, MacCormick became a demonstrator in Anatomy and Physiology at the Sydney Medical School and Skirving was appointed as the Superintendent of the (Royal) Prince Alfred Hospital.

When Skirving and MacCormick arrived in Sydney, sailing was already a popular sport. According to the Sydney Gazette, the 'first Australian Regatta' had been held on Sydney Harbour in 1827. It consisted of three races organised by the officers of the HMS Success (Captain Stirling) and HMS Rainbow (Captain Rous) and two of the races had an alluring prize of 50 Spanish dollars.

By the 1880s, stimulated by reports of the fashionable regattas at Cowes and the formation of the Royal Sydney Yacht Squadron in 1862, sailing regattas were an established feature of Sydney society.

Skirving and MacCormick began their sailing careers on Sydney Harbour in Chinese canoes. They also sailed with Frederick Milford, the first lecturer in surgery at the Sydney Medical School and Honorary Surgeon at St Vincent's and the Prince Alfred Hospital. Skirving was slightly injured when sailing with them in 1889 and Milford distressed by the incident, subsequently helped him to secure the position of Honorary Surgeon at St Vincent's Hospital.

Two of a kind

By this time Skirving was also an Honorary Physician at the Prince Alfred Hospital and he says of the dual appointments:

"I was neither one thing or the other. I therefore rose to eminence in neither. I became a surgeon of sorts with a medical mind, and a physician with a very surgical mind. On the whole I think it made me a better all-round doctor."

MacCormick on the other hand was clearly making his mark as a surgeon. Working at the Prince Alfred Hospital from 1885, MacCormick was an advocate of Lister's antiseptic methods and was present at the Sydney Hospital in 1896 when X-Rays were first used to remove a bullet from a patient's thigh.

Officers of the RSYS 1895-1896, Alexander MacCormick is in the middle row, second from the right. Courtesy of the RSYS.

Skirving says that MacCormick was "one of the best exponents of safe surgery" and notes that his knowledge of anatomy was a factor in his surgical success. He was also a man of "inexhaustible energy", starting at the hospital at 6.30 in the morning, lecturing at the university in the afternoon and returning to the hospital to operate until 8 or 9 at night. Despite this busy schedule, MacCormick did manage to pursue his other love, sailing.

In 1893, MacCormick joined the Royal Sydney Yacht Squadron and purchased the yacht, *Thelma* from JH Hoare. Typical of her class, *Thelma* had a large sail area and a lengthy gaff extending to the head of the mainsail. She was very fast and consistently won races in the 1890s, including the Gascoigne and Carleton Cup.

In 1897 MacCormick was appointed Commodore of the Royal Sydney Yacht Squadron and at the opening of the season, the Sydney Morning Herald commented that "the manoeuvres organised by Dr MacCormick had enabled the spectators to realise in some measure the fascination of the pastime..."

It is interesting to note that the pastime was even more 'fascinating' in the 1880s when racing yachts had to avoid random shots from gunnery practice at St George's Head.

MacCormick relinquished his position as Commodore of the squadron in 1900 and both he and Skirving served as surgeons in the South African War. MacCormick was mentioned in dispatches in 1901 and Skirving wrote a pamphlet on 'Our Army in South Africa' (1901). Skirving also completed his only novel, *Love and Longitude* in 1901 and in the years leading up to World War I, still managed to find time to study navigation and sail.

"the thunder on a western beach, and the windy hills and white crested lochs of the Hebrides"

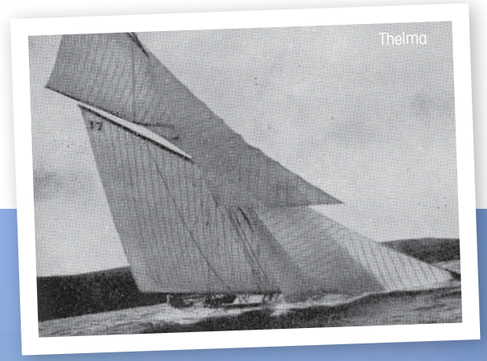


PHOTO: PETER GAWTHROP RPS

Not surprisingly and despite his increasingly successful practice, MacCormick continued his love affair with yachts. He sold *Thelma* in 1906 to Charles Lloyd Jones and commissioned Monson and Sinclair of Longnose Point to build the cutter *Morna*, 'an elegant fast yacht named after his youngest daughter'.

In 1913, he again became Commodore of the Royal Sydney Yacht Squadron, a position he retained until after he returned from his war service with the Australian Army Medical Corps. In 1920 he left the Yacht Squadron to become first Commodore of the newly formed Royal Prince Edward Yacht Squadron.

When the College was formed in 1926, MacCormick was a Founder and its first Vice-President. However, he resigned in 1933 without having attended a Council meeting and was not very involved in the College. It seems that as a sailing surgeon nearing the end of his professional life, he had 'other fish to fry'.

In 1926, he supervised Fyffe's construction of the yacht, *Ada* on the Clyde in Scotland. When the yacht was finished, MacCormick, who was then 71, set off for Australia with a skeleton crew of five. He sailed through the Panama Canal and returned to his mooring in Rose Bay four months later. His surgical practice also remained a dominant feature of his life until in 1931 at the age of 75, he retired to Jersey.

Robert Skirving's later years continued on a quieter course. A Foundation Fellow of the College, he worked at St Vincent's hospital until 1923 and published extensively in journals such as the Medical Journal of Australia.

In 1931 he wrote an authoritative book called *Wire Splicing for Yachtsmen* which used X-Ray photographs to show the interior of ropes. Skirving who sailed until he was in his eighties and insisted on the Hebridean practice of dyeing his sails red, was a distinctive sight on Sydney Harbour.

According to Douglas Miller, MacCormick viewed Skirving's later nautical activities with some amusement saying that:

"...the boat with the deep red sails always had the engine in action and never ventured past the Sow and Pigs." (The 'Sow and Pigs' was the opening of the Heads on the city side.)

Although very different, Alexander MacCormick and Robert Skirving were linked by their heritage, profession and the sea. Skirving dreamed of "the thunder on a western beach, and the windy hills and white crested lochs of the Hebrides" and as Herbert Moran says, MacCormick "now rests in Jersey tied up like a noble old hulk in quiet waters unperturbed awaiting the slow reluctant hand of the breaker".

With Elizabeth Milford, *College Archivist*

ANZSVS
Australian and New Zealand Society for Vascular Surgery

ANZSVS Sam Mellick Travel Fellowship

The Australian and New Zealand Society for Vascular Surgery recently awarded the inaugural Sam Mellick Travel Fellowship at the ANZSVS Meeting held in Melbourne 20 – 23 October, 2012.

This award, supported by industry sponsorship, was awarded to Dr Simon Quinn from St Vincent's Hospital, Melbourne. The award honours and recognises the contribution to Australian and New Zealand Vascular Surgery by Professor Sam Mellick CBE, FRACS, FRCS, FACS.

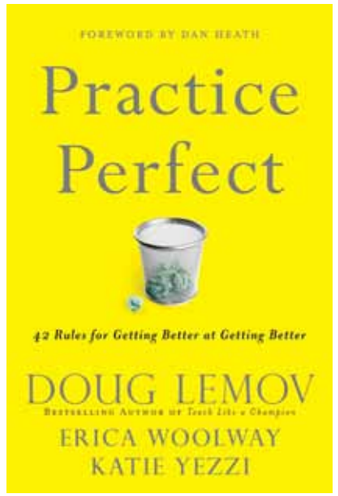
Dr Quinn will use the Fellowship funds to present at the 2013 European Society for Vascular Surgery annual meeting in Budapest, where he will present data relating to outcomes from fenestrated and branched aortic endografts from St Vincent's Hospital Melbourne, and to visit Nuremberg, Germany to gain further experience in the planning and techniques of deployment of such endografts for the management of thoracoabdominal aortic aneurysms.

The ANZSVS will award the next recipient of the Sam Mellick Travel Fellowship at the ANZSVS Meeting being held in Hobart 12 – 15 October, 2013.

Welcome to the Surgeons' Bookclub

ALL BOOKS NOW 25% DISCOUNT

25% Discount



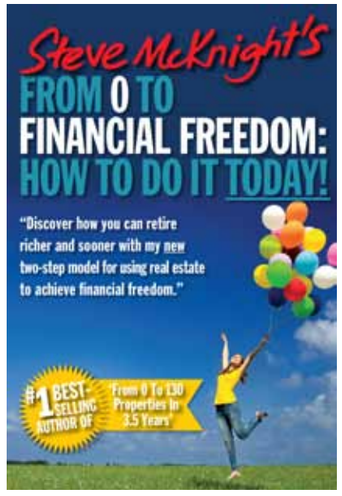
Practice Perfect: 42 Rules for Getting Better at Getting Better
Doug Lemov, Erica Woolway, Katie Yezzi, Dan Heath (Foreword by)
9781118216583 | Hbk | 288 pages
August 2012
~~AU$32.95~~ | **AU$24.71**
Member Price

In this book, the authors engage the dream of better, both in fields and endeavors where participants know they should practice and also in those where many do not yet recognize the transformative power of practice. The clear set of rules presented in *Practice Perfect* will make us better in virtually every performance of life.

- Discover new ways to think about practice. Learn how to design successful practice. Apply practice across a wide range of realms, both personal and professional
- The authors include specific activities to jump-start practice
- Doug Lemov is the best-selling author of Teach Like a Champion

A hands-on resource to practice, the rules within will help to create positive outliers and world-changing reservoirs of talent.

25% Discount



From 0 to Financial Freedom: How To Do It Today!
Steve McKnight
9781118597415 | Pbk | 102 pages
November 2012
~~AU$12.95~~ | **AU$9.71**
Member Price

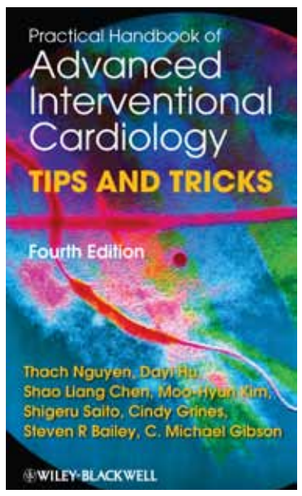
What does financial freedom mean to you? Not having to work? Being able to afford life's luxuries without worrying about the cost? Financial security? Perhaps supporting the needy or disadvantaged? Well, if you believe and follow the conventional approach to investing then forget it!

You need a different approach, and in this book expert property investor Steve McKnight reveals how to start from scratch in today's property market.

Inside you'll discover:

- Steve's exciting new two-part system for retiring richer, and sooner
- Which properties make the best growth and income investments
- What strategies are best for you, and why
- How to buy more properties without working harder in your job
- And much, much more

25% Discount

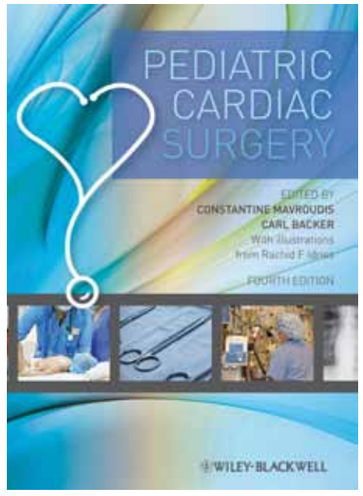


Practical Handbook of Advanced Interventional Cardiology: Tips and Tricks, 4th Edition
Thach Nguyen, Dayi Hu, Shao Liang Chen, Moo-Hyun Kim, Shigeru Saito, Cindy Grines, C. Michael Gibson, Steven R. Bailey
9780470670477 | Pbk | 712 pages
December 2012
~~AU$120.00~~ | **AU$90.00**
Member Price

Written and edited by today's most-recognised inteventional cardiology thought leaders, this popular guide focuses on key procedures and techniques. Each strategic or tactical move is graded by complexity level and described in a simple, step-by-step approach that includes guidance on how to overcome practical difficulties and navigate particularly challenging clinical scenarios and complications.

- "Tips and tricks" gathered from the personal experience of over fifty international experts
- Clear, practical, step-by-step guidance on the latest procedures and techniques, performing challenging interventions, and managing complications

25% Discount



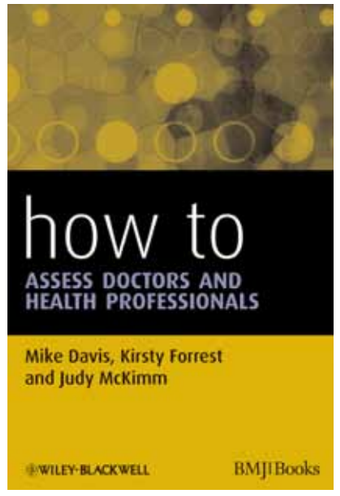
Pediatric Cardiac Surgery, 4th Edition
Constantine Mavroudis (Editor), Carl Backer (Editor), Richid F. Idriss (Illustrator)
9781405196529 | Hbk | 958 pages
~~AU$285.00~~ | **AU$213.75**
Member Price

Pediatric cardiac surgery is a dynamic, fast-moving field. Busy practitioners, like you, need clear and comprehensive guidance you can rely on to ensure optimal patient care.

For over 25 years *Pediatric Cardiac Surgery* has been the gold-standard reference for pediatric and adult congenital heart surgeons, pediatric and congenital cardiologists, intensivists, anesthesiologists, residents and nurses.

Now, in this thoroughly revised fourth edition, you again get trusted, complete coverage of the field with timely new features and expert reviews of critical topics including heart transplantation, emerging modalities for diagnosing congenital heart and tracheal defects, the surgical technique of Fontan conversion with arrhythmia surgery, the medical challenges of managing adult CHD patients, and more.

25% Discount



How to Assess Doctors and Health Professionals
Mike Davis, Judy McKimm, Kirsty Forrest
9781444330564 | Pbk | 160 pages
March 2013
~~AU$47.95~~ | **AU$35.96**
Member Price

Newest How To title from BMJ Books. This important book offers an introduction to the theory and the varying types of assessment for health care professionals. The book includes information on such topics as Where have work based assessments come from?; Why do we have different parts to the same exam like MCQs and OSCEs?; How do colleges decide who has passed or not?; Why can people pick their own assessors for their MSF?; The role of formative assessment Portfolios and their value. The book avoids jargon, is clear and succinct, and gives the pros and cons of the different assessment processes.

WILEY-BLACKWELL

To Order

RACS Members can now access the **25% discount*** by following the instructions:

Log on to the RACS website

Go to College Resources then Member benefits – then Wiley-Blackwell

Follow the steps on the website to ensure your **25% discount*** on all Wiley-Blackwell books

Postage is charged on all orders: AU$7.50 within Australia and AU$25.00 to New Zealand

*Excluded from discount are School (Jacaranda) titles.

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

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

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

CONGRATULATIONS on your achievements

Awards presented at last year's Annual Scientific Congress

award winner

Professor David Scott FRACS
International medal

The RACS International Medal is awarded to Fellows who have made lasting contributions of an exceptional nature over a long period of time in the delivery or development of surgery for underprivileged communities overseas.

David Scott has made a significant contribution to surgery both in Australia and Internationally.

After attaining his medical degree through the University of Queensland in 1962 and higher studies resulting in a Masters of Surgery in 1966 (UQ), he gained the FRACS in 1967 and then embarked on a long and distinguished career as a general, vascular and transplant surgeon at the Prince Henry Hospital (1971-1991), Fairfield Hospital (1971-1996), and Monash Medical Centre (1991-2003). He was also a strong contributor to the College and its committees, including becoming Executive Director for Surgical Affairs and, for a brief period, the acting Chief Executive Officer.

Early in his career Professor Scott developed an interest in contributing to surgery outside Australia. He developed strong associations with Malaysia, Hong Kong and Singapore where he visited to teach and examine on many occasions. These links also resulted in training opportunities for surgeons from South East Asia to train in Australia under his guidance. He also represented the College on the Asian Surgical Association (1997-2007), including being its Vice President.

In 2001, Professor Scott travelled to newly independent East Timor to perform a needs analysis with regard to specialist services. This resulted in an Australian government funded, RACS-managed program of surgical and anaesthetic specialist service, for which he became director for the next decade. These were formative years for the young nation of Timor Leste, years that included turmoil and unrest, but despite the challenges, David Scott maintained a steady hand and provided consistent leadership.

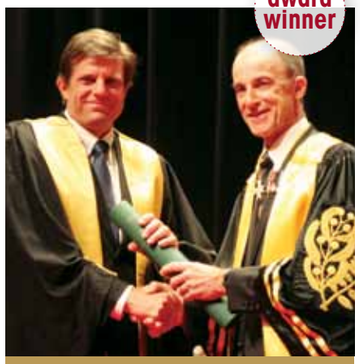
Not only have many patients received care they might never have had, but there have also been significant advances in the training of local staff, including a general surgeon, an ophthalmologist and an anaesthetist. Other Trainees are in the training scheme and today the Timor Leste program is recognised as a model for other assistance programs.

David Scott has been a member of the International Committee since 1997, convening the first International Medical Aid Symposium held at the College in 2006 and he chaired the International Project Management Committee from 2002 to 2007. David has been a mentor and guiding force for other junior surgeons who have also gone on to contribute to the international work in this College.

It is fitting that the International Medal is presented to David Scott at this convocation, being held during the 2012 RACS ASC in Malaysia, the place of his initial contributions to International Surgery.

Citation kindly provided by Professor David Watters FRACS

award winner



Professor Marcus Stoodley
2012 John Mitchell Crouch Fellow

The John Mitchell Crouch Fellowship is the premier research award of the Royal Australasian College of Surgeons. It is separate from Foundation Grants and independently funded. The Fellowship commemorates an outstanding younger Fellow of the College who died in 1977 on the threshold of a highly promising career. John Mitchell Crouch was a young surgeon who showed astute clinical, organisational and research abilities and this award is made to an individual who, in the opinion of Council, is making an outstanding contribution to the advancement of surgery.

Professor Stoodley is a committed surgeon-scientist.

Marcus Stoodley graduated from the University of Queensland with a Bachelor of Medical Science with distinction in 1986 and MB BS (Hons) in 1987. His neurosurgical clinical training was in Perth and Adelaide and he was the first Australian neurosurgeon to complete an intercalated doctorate during his clinical training.

He undertook neurovascular fellowships at the University of Chicago and Stanford University. On his return to Australia in 1999, he established an academic neurosurgery unit at the University of New South Wales and Prince of Wales Hospital. In 2008, Professor Stoodley was appointed the inaugural chair of Neurosurgery at the Australian School of Advanced Medicine (ASAM) at Macquarie University.

Professor Stoodley was awarded a PhD in 1997 for his research on the pathophysiology of syringomyelia. During his neurovascular fellowship training at the University of Chicago, Professor Stoodley developed an interest in endothelial and arteriovenous malformation (AVM) molecular biology.

A further interest of Professor Stoodley is the monitoring of surgical outcomes using information technology. Marcus developed prototype software for this purpose and was awarded patents in the USA to cover the coding and analytical aspects of this work.

Professor Stoodley has published over 100 papers and book chapters. He has supervised four students who have completed their Doctor of Philosophy and he has six PhD students currently under his supervision. This is in addition to supervising three Masters students, three Honours students, and nine undergraduate research projects.

Professor Stoodley served as the neurosurgery representative on the RACS Board of Surgical Research from 2006 to 2011. He is a board member of the Brain Foundation and is on the editorial board of Pædiatric Neurosurgery.

Professor Stoodley worked as a volunteer neurosurgeon in Kathmandu, Nepal as part of a program that led to the development of an independent neurosurgical service there. He participates in the CSIRO 'Scientists in Schools' program, regularly visiting a regional primary school to engage students in an appreciation of science.

Citation kindly provided by Mr Joseph Lizzio FRACS

Surgical News
welcomes letters from readers.

Please write to The Editor, Surgical News, Royal Australasian College of Surgeons, 250-290 Spring St, East Melbourne. Vic 3002
or email: **letters.editor@surgeons.org**

CONGRATULATIONS on your achievements

Awards presented at the NSW End of Year Dinner, held on 14 December, 2012

Graham R. Nunn

It is with great pleasure that I introduce Graham Nunn to the NSW State Committee.

Graham Nunn has had a great influence not only on my own career, but that of many other currently practising cardiothoracic surgeons, both adult and especially paediatric surgeons . Not one to seek the limelight, outside of the cardiothoracic community Graham's achievements are perhaps little known.

I first met Graham in the latter stages of my advanced training. I was one of the fortunate few Trainees who were allocated a rotation to the Cardiac Unit at the RAHC at Camperdown prior to its relocation to the Westmead site. The most striking feature was the absolute attention to detail in all aspects of an operation from the prepping and draping to the application of the dressing at the end of the procedure. This applied no matter whether the procedure was a relatively simple ASD closure or a complex intracardiac structural repair. To this day I strive to achieve an atrial closure suture line that even attempts to resemble a Graham Nunn closure!

Graham is not native to NSW. He grew up in the wilds of Kangaroo Island in South Australia prior to attending the University of Adelaide. His university transcript would make the majority of students blush with shame. His lowest grade appears to have been a credit on a single occasion. Throughout his undergraduate years Graham was awarded no less than seven prizes.

On graduation he went on to the Royal Adelaide Hospital and trained in cardiothoracic surgery under the tutelage of Ian Ross and Darcy Sutherland. On gaining his FRACS in 1979 he undertook further training in both adult and paediatric surgery in London and Boston as well as research work. He worked with Professor Magdi Yacoub, Marcus Deleval, and Aldo Castaneda.

Returning to Australia, Graham was appointed to Westmead Hospital and the Royal Alexandra Hospital for Children as a cardiothoracic surgeon. He subsequently went on to become Head of Department at both these institutions. In 1992 he was also appointed to the Prince of Wales Hospital as a cardiothoracic surgeon. In 1997 he retired from Westmead Hospital to concentrate on paediatric cardiac surgery and subsequently was appointed Consultant Emeritus.

Graham remained at the Children's Hospital at Westmead and the Prince of Wales hospital until 2008 when Queensland Health restructured its paediatric cardiac surgical services and he was approached to lead this service. Graham was appointed Director of Paediatric and Congenital Cardiac Surgery Queensland. He retired from this position in March of last year.

Graham has both a national and international reputation in the paediatric cardiac surgical community, having developed a single patch closure technique for the repair of atrioventricular canal defects. He is visiting professor at the Mafraq Hospital in Abu Dhabi in the United Arab Emirates.

Graham was an examiner for the RACS from 1994 until 2002. In 2006 his contribution to cardiothoracic surgery was recognised by the RACS with the Award and Medal for Excellence in Surgery.

His contributions were recognised by the Commonwealth with awarding of the Member of the Order of Australia in 2004.

Graham has been an avid supporter of the Operation Open Heart Project of the Sydney Adventist Hospital. This project brings cardiac surgical services to developing nations where no such services exist. He has been on at least 20 such trips. This has led to the development of a fledgling cardiac surgical unit in Port Moresby. The PNG Government has recognised this contribution by awarding The Order of Logohu.

Graham Nunn's personal attributes are too numerous to even attempt to describe.

Ladies and gentlemen, Fellows, this Merit Award by the NSW State Committee is but a token of appreciation for the contribution Graham Nunn has made to surgery in NSW.

Citation provided by Robert Costa

Reginald Lord

Professor Reginald Lord AM, MD, FRCS, FRACS, has shown all the qualities of leadership in the academic and clinical aspects of surgery throughout his career to be a worthy recipient of the NSW Merit Award of the RACS.

Professor Lord graduated in Medicine from the University of Sydney in 1960. He trained at St Vincent's Hospital, Sydney 1960-1965 and St Thomas' Hospital, London with vascular leaders Drs Kinmonth, Cockett, and Browse 1966-1967. He trained at UCSF 1967-1969 with Dr Jack Wylie the pioneer of the operation of endarterectomy and completed his training in vascular and renal transplantation surgery in San Francisco.

He returned to Australia and St Vincent's Hospital to join the Professorial Unit with Professor Doug Tracy. Subsequently he became Associate Professor 1972-1985 and Professor of Surgery and Chairman of the Department 1985-2004. He established the Rural School of Medicine in 2004 at Wagga. In 2004 the UNSW conferred Emeritus Professor Status.

The same year he became the first Professor of Surgery at the University of Western Sydney and helped establish the Medical School. He was Director of Surgery at Campbelltown and Camden Hospitals.

His skills in establishing and maintaining standards in surgery have been used in metropolitan and rural areas throughout Australia by health authorities where codes of practice and outcomes had been a concern. Professor Lord has always been a problem solver for the community and an advocate for our profession.

Professor Lord is author of over 250 publications, mostly related to vascular disease including the text book 'Surgery of Occlusive Cerebrovascular Disease' of which he is the sole author.

He is a pioneer of extracranial arterial and thoracoabdominal aortic reconstructions.

He has been a member of the editorial advisory boards of the Journal of Cardiovascular Surgery, Annals of Vascular Surgery, Phlebology and ANZ Journal of Phlebology.

He has been an invited speaker and visiting Professor in every Australian State, NZ, USA, Canada, Portugal, Spain, Brazil, Italy, Monte Carlo, Greece, the Netherlands, England, Scotland, Israel, Singapore, Fiji, China, Japan, Vietnam, Indonesia and India.

He has trained 1-3 Fellows per year from Asia and Australia in vascular and transplant surgery. Many hold chairs in surgery in Australia and overseas including Professors Effeney, Lusby, Jones, Lynch, Gotley, and the late Alex Chao from Singapore.

He has been president of the Australian Chapter and Vice President of the International Society of Cardiovascular Surgery, and Chairman of the Section of Vascular Surgery and Military Surgery RACS.

In 1985 he was invited to serve as Colonel of the Royal Australian Army Corps. He led a St Vincent's team to Vietnam 1971-1972.

Prizes and Honours are numerous and include Member of the Order of Australia 2004.

His scientific contributions include dynamic studies of flow in the thoracic duct, haemodynamics of the vascular steal phenomenon in the cerebral circulation, the mechanism of TIAs via alternate pathways and defining the syndrome of carotid paraganglioma.

Together with Dr Yuri Bobryshev, Professor Lord postulated and then identified dendritic cells in the artery wall and defined their role in inflammatory components of atherogenesis.

Professor Lord has encouraged students and graduates to be actively involved in the learning process. He is recognised as a leading academic researcher, teacher and outstanding vascular surgeon with the equanimity that encourages calmness, care, skill and an endless thirst for knowledge. He is the complete Professor of Surgery and deserves recognition by our College.

Citation provided by Anthony Graham

Alan Kline

It is my honour to present to you Mr Alan Kline. Alan has been a friend, colleague and mentor for over 20 years. He is, even in retirement, the Senior Surgeon of the Shoalhaven Hospital District in Nowra, on the beautiful south coast of NSW.

Alan and his wife Pat have been for many years the ambassadors of Rural Surgery both at home and across the many lands they have travelled. They, initially, as a young couple enjoyed the travel to distant shores, and despite the arrival of Chris then Tom and finally Amy, their times of camping, walking, biking and sailing all over the world have not slowed.

Alan had his surgical training-wheels on in many of the hospitals of the British Isles, where he worked with many fine surgeons of the time. He was very proud of the academic achievements in his studies into vascular disease. He also worked with the legendary Mr Les Ernest Hughes. This excellent grounding in establishment of logic to investigation has held him in good stead.

Alan and I both are grateful to the pioneering spirit of Dr Irwin Hanan, who established the first General surgical practice in Nowra. He worked as a General practitioner to establish himself, and then used his skills learned in New Zealand and the United Kingdom to further the practice of surgery. Alan also wishes to recognise the role played by Drs Pat and Bill Ryan in helping him establish a specialist surgical practice in Nowra in 1978.

Alan had an interest in almost all aspects of surgery. He was truly a General Surgeon. A dab hand at Breast Disease, Biliary disease, and hernia repair, Alan would not be daunted by the occasional fracture and hand injury. Children were very much part of his operative repertoire, and I still remember the intensity of concentration over the tiny sick babies with pyloric stenosis.

It must be remembered that this young upstart had arrived in a town where there was one part time surgeon plying his trade, and the stories go of GP surgeons removing gallbladders with the hospital gardener attending to the ether mask.

Alan was involved in an almost imperceptible change to specialisation amongst the regions' doctors and hospitals. Alan's best man at his wedding had been Col Shepherd, and the Shepherds have spread their influence throughout the practice of surgery in many ways throughout NSW and Australia. Col was Alan's anaesthetist, a lovable larrikin of a GP and part-time anaesthetist. Together they performed the little miracles that defined surgery in country NSW in those times.

Slowly but surely, Alan instigated the protocols to his practice and then the hospital that would be used to establish breast cancer treatment, bowel cancer surgery and trauma treatment. These practices have been refined over the years, but the basis to current practice is easily seen in Alan's work.

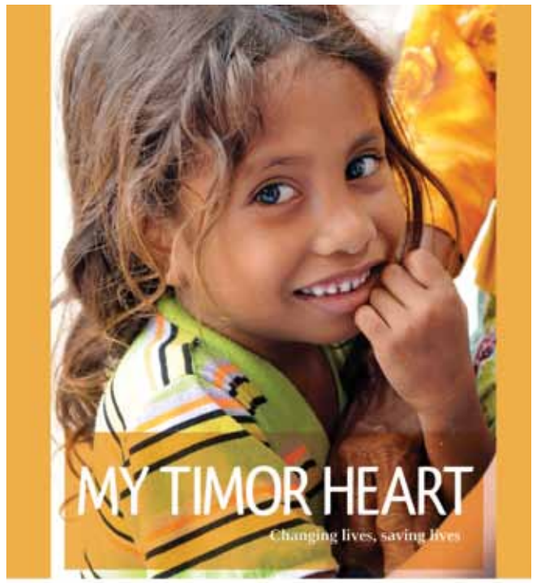
Alan was one of the doctors who watched over the establishment of a private sector in the area, and was heavily involved in the establishing audit. There was the arrival of other specialists and the largest change of all, the arrival of specialist anaesthetists. This transition was not the simplest in this GP driven town; however, with Alan's involvement many of the difficult moments were smoothed over and possible combatants became tennis partners or sailing buddies.

Alan has one major failure; he likes adventure, but he sometimes gets lost or injured. To have Alan as the doctor for the canoeing trip for his son's school class was in theory an excellent choice, but that is theory for you. Alan being involved, as always, set out in the canoe only to see the paddle stick in an underwater rock and his shoulder continue on its merry way to dislocation. There at the head waters of the Shoalhaven, he thankfully had an eperb alert device and was eventually airlifted out of the canyon, following his self administration of IVI pethidine – the other responsible adult had fainted at the sight of the needle.

Alan has retired from active surgical practice and we are hoping that he will continue in a teaching role in the Shoalhaven. His retirement dinner from the hospital was in Kigali in South Africa, the only people there were his family. Alan is, an intensely private man and proud of his Queensland heritage (especially at time of the State of Origin).The people of Country NSW, especially the Shoalhaven, have benefited from his love of surgery, simplicity and his genuine respect of patients, most of whom now count themselves as his friend.

Mr Chairman, I present Mr Alan Kline, for the presentation of the State Committee Merit Award.

Citation provided by Martin Jones



My Timor Heart

Written by Ellen Whinnett and Ellen Smith

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

ORDER FORM

Name: .....

Address: .....

Telephone: .....

Email: .....

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

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

Cheque: ☐ Money Order: ☐

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

Card No: ____ ____ ____ ____

Expiry Date: .....

Signature: .....

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

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

Foundation for Surgery
Passion. Skill. Legacy.

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

Royal Australasian College of Surgeons

2014 Rowan Nicks Australian & New Zealand Exchange Fellowship

The Rowan Nicks Australian and New Zealand Exchange Fellowship is intended to promote international surgical interchange at the levels of practice and research, raise and maintain the profile of surgery in Australia and New Zealand and increase interaction between Australian and New Zealand surgical communities.

The Fellowship provides funding to assist a New Zealander to work in an Australian unit, or an Australian to work in a New Zealand unit, judged by the College to be of national excellence for a period of up to one year.

Applicants must have gained Fellowship of the RACS within the previous ten years on the closing date for applications.

Selection Criteria
The Committee will
– consider the potential of the applicant to become a surgical leader and ability to provide a particular service that may be deficient in their chosen surgical discipline.
– assess the applicants in the areas of surgical ability, ethical integrity, scholarship and leadership.

The Fellowship is not available for the purpose of extending a candidate's current position in Australia or New Zealand.

Value: Up to $75,000 pro-rata, depending on the funding situation of the candidate and provided sufficient funds are available, plus one return economy airfare between Australia and New Zealand.

Tenure: 3 - 12 months

Further Information
Application forms and instructions will be available from the College website from December 2012: www.surgeons.org
Closing date: 5pm Monday 6 May, 2013. Applicants will be notified of the outcome of their application by 30 October 2013.

Please contact:
Secretariat, Rowan Nicks Committee
Royal Australasian College of Surgeons
250 - 290 Spring Street, East Melbourne VIC 3002
Email: international.scholarships@surgeons.org
Phone: + 61 3 9249 1211 Fax: + 61 3 9276 7431

The Royal Australasian College of Surgeons
Member Advantage Benefit Program

Member ADVANTAGE®

Take advantage of great savings on a wide range of benefits!

RACS Fellows and Trainees enjoy exclusive savings on accommodation, leisure experiences, airline lounge memberships, package tours, insurance services and more.

These services are free to use at any time and can be accessed by phone or via the Member Advantage website.

For further information, visit:
www.memberadvantage.com.au/racs

VALUE ADDED BENEFITS
☑ Save on travel related expenses
☑ Save on insurance services
☑ Save on financial and wealth services
☑ Save on shopping, leisure experiences and gifts

Accommodation

Magazine Subscriptions

Travel Insurance

Package Tours

International Money Transfers

Car Buying Service

Lifestyle Experiences

Gourmet Hampers

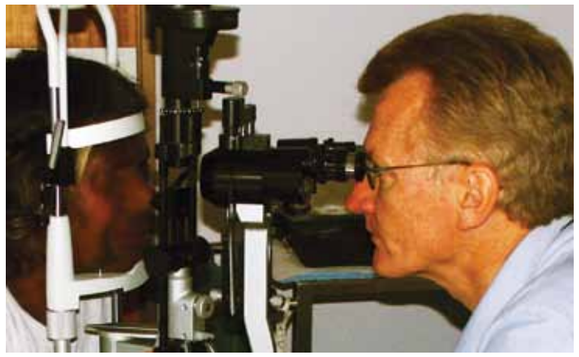
Online Wine Sellers

Car Rental

Airline Lounge Memberships

Home and Car Insurance

For further information on these benefits, please contact Member Advantage:
Call 1300 853 352 or visit www.memberadvantage.com.au/racs
NZ Fellows and Trainees call +61 3 9695 8997



Thank you for your donations

Australia

Mr Robert Aitken
Mr Rodney Allan
Mr Robert Allbrook
Mr Nicholas Anastas
Mr Michael Anderson
Dr Matthias Axt
Prof. Bruce Barraclough AO
Mr Robert Bartlett
Mr Edward Bates AM
Dr Edward Bates AM
Mr John Batten
Dr Neil Berry
Prof. Michael Besser AM
Mr David Birks
Dr Frances Booth AM
Mr Jeffrey Brennan
Mr Russell Brereton
Assoc. Prof. Anthony Buzzard
Assoc. Prof. Richard Cade
Mr Peter Campbell
Mr Peter Cant
Mr Raymond Carroll
Mrs Ann Carter
Mr Vidyasagar Casikar
Mr Anthony Cass
Mr William Castleden
Mr Simon Ceber
Dr Venu Chalasani
Mr James Cheng
Mr Robert Claxton
Mr Peter Clements
Mr Harvey Coates AO
Mr Leon Cohen
Mr John Copeland
Dr Joan Cosgrove
Mr Simon Crowley
Mr Owen Deacon
Mr James Downie
Mr David Elder
Mr David Failes AM
Assoc. Prof. Gregory Falk
Mr Gary Fell
Mr Gerard Fogarty
Mr Harry Frydenberg
Mr Kwai Fung
Dr James Gaffield
Mr John Giles
Dr Leon Gillam
Mr David Golovsky
Mr Antony Graham
Mr Anthony Guiney
Mr Philip Hardcastle
Prof. John Harris AM
Mr Trevor Harris AM
Mr Malcolm Hay OAM
Mr Soon Ho
Prof. Andrew Holland
Mr Raymond Hollings AM
Mr Boon-Hung Hong
Mr Robin Hooper
Prof. Ronald Huckstep CMG
Mr William Huffam
Mr Jeffery Hughes
Assoc. Prof. Thomas Hughes
Mr Stephen Jancewicz
Dr Larry Kalish
Mr Anthony Kane
Mr Bhadu Kavar
Mr Sikander Khan
Dr Japinder Khosa
Dr Lee Kiang
Mr Paul Kierce
Kimberley Foundation
Mr David Lai
Mr Steven Lai
Dr Noel Langley
Mr Robert Leitch
Mr Gregory Leslie
Mr Albert Leung
Dr John Liddell
Mr Andrew Lindsay
Mrs Elizabeth Livingstone
Mr John Lorang
Mr Hugh Lukins
Dr Kirstie MacGill
Prof. Donald MacLellan
Mr Hugh Macneil
Mr William Maling
Mr Victor Mar
Mr Hugh Martin
Mr Frank Martin AM
Dr Michael McAuliffe
Dr Gregory McDermant
Mr Richard McMullin
Mr Hugh Millar
Mr Neville Minnis
Dr Bruce Moore
Estate of the late Dr John Moulton
Mr Adrian Munyard
Mr Donald Murphy
Mr Michael Neale
Mr James Nield
Mr Gregory Nolan
Prof. Paul Norman
Mr John O'Connor
Mr Peter Oatey
Dr Michael O'Sullivan
Dr Damien Petersen
Mr Kenneth Pettit
Mr Marinis Pirpiris
Mr William Poate
Mr Francis Prendergast
Mr Timothy Proudman
Dr Anantha Ramanathan
Dr Lynette Reece
Mr Dominique Robert
Mr William Roberts
Mr Francis Robertson
Mr James Roberts-Thomson
Mr Harry Ross
Prof. John Royle OAM
Mr Nihal Samaraweera
Mr Huat Saw
Dr John Scott
Prof. Ainslie Sheil AO
Mr Robert Sillar OAM
Prof. Julian Smith
Mr Samiul Sorrenti
Mr Dean Southwood AM
Dr Johannes Stofberg
Mr Andrew Tang
Mr Theophilus Taylor
Mr Charles Teo AM
Prof. David Theile AO
Dr Chantel Thornton
Mr Eric Torey
Mr Eric Torey
Dr Peter Treacy
Mr Pleun Verheul
Mr Nicholas Vertzyas
Mr Roland Von Marburg
Dr Petar Vujovic
Mr Roger Wale
Assoc. Prof. Bruce Waxman
Dr Diane Webster
Mr Neil Wetzig
Dr Jennifer Wheatley
Mr Deepak Williams
Dr Roger Wilson
Dr Andrew Wines
Assoc. Prof.
Peter Zelas OAM

Foundation for Surgery
Passion. Skill. Legacy.

New Zealand

Mr David Adams
Mr Philip Allen
Mr Robert Allison
Mr Grant Beban
Mr David Brougham
Assoc. Prof. Ian Campbell
Mr John Chaplin
Mr Simon Chinchanwala
Mr Hugh Cooke
Mr Richard Coutts
Mr David Crabb
Mr Roy Craig
Mr John De Waal
Mr John Dunn
Mr Stephen Dunn
Mr James Fenton
Dr Catherine Ferguson
Mr Adrian Folwell
Mr Anthony Hardy
Dr Peter Heppner
Dr Nicola Hill
Mr Andrew Hill
Mr Christopher Holdaway ED
Dr Gordon Howie
Mr Peter Hunter
Mr Michael Hunter
Mr Grahame Inglis
Mr Robin Jackson
Dr Simon Johnson
Mr John Keating
Dr Erica Kelly
Mr Burton King
Mr Geoffrey Lamb ONZM
Mr Julian Lofts
Mr Simione Lolohea
Mr Stanley Loo
Mr Murali Mahadevan
Mr John McDonald
Dr William McMillan
Mr Stuart McNicoll
Miss Philippa Mercer
Mr Arend Merrie
Mr Philip Morreau
Mr Robert Orec
Dr Zbigniew Poplawski
Mr Christopher Porter
Mr Sudhindra Rao
Dr Helen Rawlinson
Mr Bruce Rhind
Mr John Riordan
Mr Ross Roberts
Dr Alex Rutherford
Mr David Schroeder
Dr Belinda Scott
Dr Peter Shapkov
Mr David Shaw
Mr Paul Silvester
Mr Graeme Skeggs
Mr Hans Stegehuis
Mr Duncan Stevenson
Mr Ian Stewart
Mr Gary Stone
Mr Howard Swan
Mr Dev Tandon
Mr Christopher Taylor
Mr Ian Thomson
Dr Fiona Timms
Mr Etienne Truter
Mr Ravindranath Ullal
Mr Vipul Upadhyay
Mr Stephen Vallance
Mr Julian White
Mr David Whitehead
Mr Michael Woodfield
Mr William Wright
Mr Michael Young

Total: $89,800

Your passion.
Your skill.
Your legacy.

Your Foundation.

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

Foundation for Surgery
Passion. Skill. Legacy.

All donations are tax deductible

Name:

Address: Telephone:

Email: Speciality:

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

Please debit my credit card account for $ ☐☐☐☐.☐☐

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

Credit Card No: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiry ☐☐/☐☐

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

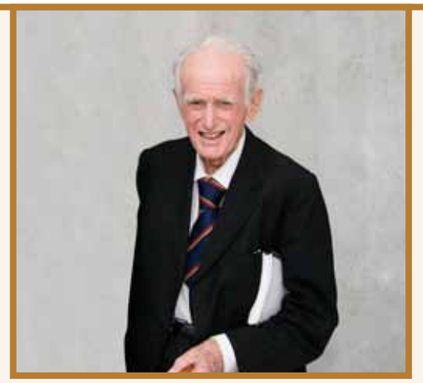
I would like my donation to help support:

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

Please send your donation to:

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

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



Royal Australasian College of Surgeons

2014 Rowan Nicks Pacific Islands Scholarship & 2014 Rowan Nicks International Scholarship

The Royal Australasian College of Surgeons invites suitable applicants for the 2014 Rowan Nicks Scholarships. These are the most prestigious of the College's International Awards and are directed at surgeons who are destined to become leaders in their home countries.

The Scholarships provide opportunities for surgeons to develop their management, leadership, teaching and clinical skills through clinical attachments in selected hospitals in Australia, New Zealand or South-East Asia.

Applicants for the Rowan Nicks International and Pacific Islands Scholarships must:

– commit to return to their home country on completion of their Scholarship;
– meet the English Language Requirement for medical registration in Australia or New Zealand (equivalent to an IELTS score of 7.0 in every category);
– hold a Master of Medicine in Surgery, or his/her country's post-graduate qualification in surgery. However, consideration will be given to applicants who have completed local general post-graduate surgical training, where appropriate to the needs of their home country.
– be under 45 years of age at the closing date for applications.

Applicants for the International Scholarship must be a citizen of one of the nominated countries listed on the College website from December 2012.

Applicants for the Pacific Islands Scholarship must be a citizen of the Cook Islands, Fiji, Kiribati, Federated States of Micronesia, Marshall Islands, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu or Vanuatu;

Selection Criteria

– The Committee will consider the potential of the applicant to become a surgical leader in the country of origin, and/or to supply a much-needed service in a particular surgical discipline.
– The Committee must be convinced that the applicant is of high calibre in surgical ability, ethical integrity and qualities of leadership.
– Selection will primarily be based on merit, with applicants providing an essential service in remote areas, without opportunities for institutional support or educational facilities, being given earnest consideration.

Value: Up to $36,000 pro-rata, plus one return economy airfare from home country

Tenure: 3 - 12 months

Further Information

Application forms and instructions are available from the College website: www.surgeons.org
Closing date: 5pm Monday 6 May, 2013.
Applicants will be notified of the outcome of their application by 30 October 2013.

Please contact:

Secretariat, Rowan Nicks Committee
Royal Australasian College of Surgeons , 250 - 290 Spring Street, East Melbourne VIC 3002
E: international.scholarships@surgeons.org P: + 61 3 9249 1211 F : + 61 3 9276 7431

Developing a Career in Academic Surgery

Monday 6 May 2013, 7.00am – 4.00pm

SKYCITY CONVENTION CENTRE AUCKLAND, NEW ZEALAND

Provisional Program

7:00am Registration and Breakfast
7:15am Welcome
Introduction — *Andrew Hill (Auckland)*

SESSION 1: GENERAL PRINCIPLES

Chairs: Mark Smithers (Brisbane) and Julie Ann Sosa (Durham, USA)

7:30am What is a career in academic surgery? — *John Windsor (Auckland)*
7:50am Research - How to get research started - ideas, grants, ethics and collaboration — *Russell Gruen (Melbourne)*
8:15am Academic surgery - the essentials - teaching, leadership and administration — *Timothy Pawlik (Baltimore, USA)*
8:40am Discussion

9:00am MORNING TEA

SESSION 2: TOOLS OF THE TRADE

Chairs: Eric Kimchi (Hershey, USA) and Richard Hanney (Sydney)

9:15am **HOT TOPIC IN ACADEMIC SURGERY - Stem Cells** — *Julie Ann Sosa (Durham, USA)*
9:35am Bedside to bench to bedside — *Lillian Kao (Houston, USA)*
9:55am Basic science — *Carlton Barnett (Denver, USA)*
10:15am Randomised clinical trials — *Andrew Hill (Auckland)*
10:35am Comparative effectiveness research — *Justin Dimick (Ann Arbor, USA)*
10:55am Surgical education/simulation — *Jeffrey Hamdorf (Perth)*
11:15am Discussion

11:30am LUNCH

12:30pm **KEYNOTE PRESENTATION - An Antipodean academic odyssey - between the siren call and the rocks** *Charles McGhee (Auckland)*

SESSION 3: CONCURRENT ACADEMIC WORKSHOPS:

Workshop 1: Interactive Workshop on Issues in Research

Chairs: Mark Smithers (Brisbane) and Julie Howle (Sydney)

1:00pm Getting the most out of a team — *Justin Dimick (Ann Arbor, USA)*
1:20pm Multiple Faculty — *Justin Dimick (Ann Arbor, USA)*, *Michael Edye (Sydney)*, *Jeffrey Hamdorf (Perth)*, *Timothy Pawlik (Baltimore, USA)*, *Julie Ann Sosa (Durham, USA)*

Workshop 2: Career Development

Chairs: Russell Gruen (Melbourne) and David Watson (Adelaide)

I want to be an academic surgeon. What can I do as a:

1:00pm Medical Student — *Deborah Wright (Auckland)*
1:15pm Intern — *Marc Gladman (Sydney)*
1:30pm SET Trainee — *Gregory O'Grady (Sydney)*
1:45pm Fellow — *Win Meyer-Rochow (Hamilton)*
2:00pm Consultant — *Susan Neuhaus (Adelaide)*
2:20pm Discussion

Workshop 3: Presenting Your Work

Chairs: Lillian Kao (Houston, USA) and Arthur Richardson (Sydney)

1:00pm Writing an abstract — *Eric Kimchi (Hershey, USA)*
1:15pm Writing a paper — *Rebecca Sippel (Madison, USA)*
1:45pm Presenting a talk — *Carlton Barnett (Denver, USA)*
2:00pm Producing a poster — *Eric Kimchi (Hershey, USA)*
2:15pm Discussion

2:40pm AFTERNOON TEA

SESSION 4: A CAREER IN ACADEMIC SURGERY

Chairs: Andrew Hill (Auckland) and Timothy Pawlik (Baltimore, USA)

3:00pm Choosing and being a mentor . . . . . *Mark Smithers (Brisbane)*
3:20pm Work-life balance . . . . . *Julie Howle (Sydney)*
3:40pm On the shoulders of giants - The legacy of the Otago University Department of Surgery . . . . . *Andre van Rij (Dunedin)*

Registrants receive a complimentary copy of Success in Academic Surgery (Part 1) edited by Herbert Chen and Lillian Kao.

Presented by:
Association for Academic Surgery
in partnership with the
RACS Section of Academic Surgery

AAS Association for Academic Surgery

Royal Australasian College of Surgeons, Section of Academic Surgery

Proudly sponsored by:
Johnson & Johnson MEDICAL COMPANIES

Cost: $265.00NZD (inc NZ GST).
Register on the ASC registration form or online at asc.surgeons.org
There are 15 complimentary spaces available for interested medical students.
Medical students should register their interest to attend by emailing dcas@surgeons.org
Further Information: E: dcas@surgeons.org T: +61 3 9249 1273

Program correct at time of printing (Feb 2013), however the Organising Committee reserve the right to change without notice.

"Avant's support of the research careers of junior doctors is a socially responsible step. The scholarships support our careers as well as efforts to improve patient care."

Dr Gulam Khandaker,
2012 Avant Doctor in Training
Research Scholarship recipient

Read his scholarship story
at avant.org.au/Khandaker

Take your career to the next level with Avant.

At Avant, we know how valuable research can shape a career in medicine. In 2013 we are offering 4 Full-time and 4 Part-time Scholarships, totaling $300,000.

Scholarships are open to Interns, RMOs and DiT's.
You can apply online at avant.org.au/scholarships

As well as providing comprehensive indemnity cover, resources and risk advice, Avant is committed to supporting medical research and technological advancements, and providing our members with every opportunity to excel and make a difference.

Applications close 5pm, Wednesday 1 May 2013.

Give your career a boost.
Apply for Avant's 2013 Doctor in Training Research Scholarship Program today.

$300,000

IN SCHOLARSHIPS AVAILABLE IN 2013

Open to Interns, RMOs & DiTs

4x $50,000 Full-time
4x $25,000 Part-time

Apply at
avant.org.au/scholarships

Avant
Australia's Leading MDO

120 YEARS

go to avant.org.au or call 1800 128 268

Terms and conditions apply - see avant.org.au/scholarships

AVA0078-DIT-SN-GUA