Surgical News

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

The College of Surgeons of Australia and New Zealand

Friendly Meeting

Traditional Maori welcome marked a successful Annual Scientific Congress in Auckland

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.

Management of Acute Neurotrauma
10 July, Melbourne

You can gain skills to deal with cases of acute neurotrauma in a rural setting, where the urgency of a case or difficulties in transporting a patient demand rapid surgically-applied relief of pressure on the brain. Importantly, you can learn these skills using equipment typically available in smaller hospitals, including the Hudson Brace.

Writing Medicolegal Reports
15 July, Sydney; 28 October, Melbourne

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

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.

Keeping Trainees on Track (KToT)
31 July, Brisbane

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)
13 August, Sydney

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.

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.

Preparation for Practice
24 - 25 August, Melbourne

This two day workshop is a great opportunity to learn about all the essentials for setting up private practice. The focus is on practicality and experiences provided by fellow surgeons and consultant speakers. Participants will also have the chance to speak to Fellows who have experience in starting up private practice and get tips and advice. This activity is proudly supported by The Bongiorno National Network and mlcoa.

Non-Technical Skills for Surgeons (NOTSS)
20 September, Hobart; 29 October, Gold Coast

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.

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

NSW
15 July, Sydney
Writing Medicolegal Reports

13 August, Sydney
Supervisors and Trainers for SET (SAT SET)

22-24 November, Sydney
Process Communications Model

QLD
31 July, Brisbane
Keeping Trainees on Track (KToT)

SA
12 September, Adelaide
Polishing Presentation Skills

TAS
20 September, Hobart
Non-Technical Skills for Surgeons (NOTSS)

VIC
10 July, Melbourne
Management of Acute Neurotrauma

19 July, Melbourne
Finance for Surgeons

24 - 25 August,Melbourne
Preparation for Practice

18 September, Melbourne
Keeping Trainees on Track (KToT)

WA
24 - 26 October, Perth
Surgical Teachers Course

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

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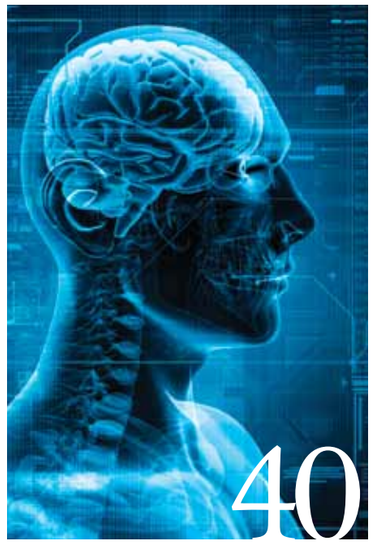

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Correspondence to Surgical News should be sent to:
surgical.news@surgeons.org

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

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ON THE COVER:
Maori welcome at the Annual Scientific Congress in Auckland. Photo by John Aloysius Henderson.

President's Perspective

An innovating Congress

Auckland hosted another successful congress, with sustainability the key

The Annual Scientific Congress (ASC) in Auckland was a great success. It was probably the most friendly ASC I have attended. The theme was Sustainable Surgery. The plenary sessions were excellent with some exceptional speakers highlighting New Zealand and in particular its innovation in many areas. There was also a course on negotiation. Amazing how useful these skills can be! Congratulations to the Organising Committee with John Windsor as the ASC Convener and Andrew Hill as the Scientific Convenor as well as the team of College staff led by Roger Wale and Lindy Moffat.

As noted in the introduction, one of the ongoing themes of the ASC was innovation and I was particularly struck by the presentations by Sir Ray Avery. There is no doubt New Zealand 'punches above its weight' in the world of innovation, but his personal story was inspirational.

Now described as a pharmaceutical scientist, inventor and social entrepreneur, he spent his childhood in English orphanages and foster homes. His lifetime interest in science grew from when he escaped the cold of living on the streets of London by finding warmth in public libraries.

Sir Ray went on to have an outstanding career within the pharmaceutical industry, and then became the Technical Director of the Fred Hollows Foundation where he designed and commissioned intraocular lens manufacturing facilities in Nepal and Eritrea. Sir Ray's innovations led to a massive reduction in the cost of lens production.

Sir Ray gifted the technology to the Hollows Foundation ensuring cost competitive lens production in the world's poorest nations. With a focus of taking the products or concepts found within wealthy countries to the people of the poorest, he has also redesigned incubators for infants with a low cost, long life model requiring minimal maintenance, and cheap peptide supplements for malnutrition. An interesting addendum is that a commercially viable energy drink for athletes is now in production. A truly inspiring story and one where innovation is a constant message.

Over the past 10 years, innovation has been an ongoing theme at the ASC. Ansell sponsored the "Virtual Congress". Ten years ago, it was a brave ASC committee that mandated the use of PowerPoint presentations and did not support the ubiquitous 'slides'. This ASC saw the availability of the RACS ASC 'App' which combined an electronic program where customisation is fully achieved plus integration into the Virtual Congress. The Virtual Congress is now almost 'real time' and certainly same-day. Technology was also embraced to ensure that questions can now be asked through 'Twitter' rather than the more traditional standing and queuing in auditoriums.

Equally the support from industry is moving from static displays to active simulation of devices that provides even more support for surgeons in adapting innovation and bringing new technology to their surgical practice. To the hundreds who took the opportunity of updating their practice profile on the College website, understood the possibilities of our now annual CPD system or started entering data in the new MALT system (Morbidity and Audit Logbook Tool), the innovation that was ever-present was much appreciated.

Our International Visitors continue to highlight how outstanding this event is, in comparison to what is available in other parts of the world. Plans are already well advanced to see how the 2014 Singapore meeting running in parallel with the College of Anaesthetics will progress innovation even further.

Again, congratulations to the 2013 Convenors and to Auckland for being a wonderful host city.

Mike Hollands
President

President's Lecture
Ray Avery

AUCKLAND ASC

2013 Definitive Surgical Trauma Care (DSTC) and Definitive Perioperative Trauma Nursing Care Courses

DSTC Australasia in association with IATSIC (International Association for Trauma Surgery and Intensive Care) brings you courses for 2013

2013 COURSES:
Sydney (Military Module): 23 July
Sydney: 24 – 25 July
Auckland: 29 – 31 July
Perth: 7 – 8 November
Melbourne: 11-12 or 22-23 Nov (to be confirmed)

The DSTC course is an exhilarating educational opportunity focusing on

- surgical decision-making in complex scenarios
- operative technique in critically ill trauma patients
- hands-on practical experience with experienced instructors (national and international)
- insight into difficult trauma situations with learned techniques of haemorrhage control and the ability to handle major thoracic, cardiac and abdominal injuries

The DSTC course is recommended by the Royal Australasian College of Surgeons for all consultant surgeons and final year Trainees who participate in care of the injured. It is considered essential for surgeons involved in the management of major trauma and those working in remote, regional and rural areas.

The Definitive Perioperative Nurses Trauma Care Course (DPNTC) is held in conjunction with many DSTC courses. It is aimed at registered nurses with experience in perioperative nursing and allows them to develop these skills in a similar setting.

The Military Module is an optional third day for interested surgeons and Australian Defence Force personnel (this course is only offered in Sydney).

DSTC is recommended by The Royal Australasian College of Surgeons for all Consultant Surgeons and final year trainees.

Please register early to ensure a place!

Contact Sonia Gagliardi on 161 2 8738 3928
or email: Sonia.Gagliardi@sswahs.nsw.gov.au

Your Foundation

Make a difference through pledging your procedure

As a surgeon I knew a little about the Foundation for Surgery, the College's philanthropic arm. As Vice President, I get to know a lot more sitting on the management Board of the Foundation and keeping Council informed of the Foundation's activities. I have to tell you that I have an overwhelming sense of pride that surgeons have proven to be great philanthropists and have achieved so much for Indigenous communities, for developing countries less fortunate than our own and for surgical research. I am proud to be part of a professional organisation that is mature enough to have a view that extends beyond our immediate self-interest.

Surgeons have established the Foundation and financially supported its continuing activities. Perhaps this is as it should be. It is difficult to inspire the general public that a surgeon's charity should be favoured over so many other worthwhile and deserving charities.

And surgeons have supported the Foundation establishing a significant corpus of funds that has been invested wisely thanks to the highly qualified and talented College's financial advisers who freely give of their expertise, knowledge and time.

Through the work of the Foundation, surgeons have demonstrated a professional willingness to assist colleagues working in very difficult conditions in countries where access to surgical care is at best precarious. Health projects, training and research across all surgical fields have been supported in Australia, New Zealand, across the Asia Pacific region and beyond. Through these activities, surgeons have demonstrated that improved patient care is something that transcends national boundaries. Donations have previously supported programs such as the annual trauma and fracture management course in Fiji. These courses, conducted by volunteer Fellows, successfully build surgical capacity by training local surgeons in complex orthopaedic surgical procedures and in the advanced management of all levels of trauma.

Donations have also enabled the College to assist in the development of emergency medicine in Myanmar and to deliver a Diploma of Emergency Medicine at the University of Medicine in the country's capital, Yangon. These programs train health specialists to implement emergency care systems in a country where previously there had been little or no primary trauma care. Pleasingly, the skills of course participants have improved noticeably and their patients are now receiving better quality care.

Donations also enabled more than 14 specialists from South East Asia, the Pacific Island countries and Papua New Guinea to participate in practical training attachments in Australian, New Zealand and Singapore teaching hospitals. These attachments are crucial in building surgical capacity in developing countries and enable talented health specialists to broaden their understanding and skills in the latest surgical techniques, technologies and treatments.

Through our support, the Foundation provided ENT equipment to the Tharawal Aboriginal Medical Service in NSW which is enabling them to conduct regular outreach clinics and school screening services to more than 3,800, primarily Indigenous, active patients. The Cherbourg Health Clinic, which services Queensland's third largest Aboriginal community, has also been provided with ENT equipment to help them gain a more accurate diagnosis of ear disease and to better monitor and treat the condition.

The conferment of scholarships and grants is vital for the expansion of surgical research and the provision of advanced study opportunities for Fellows and Trainees. Our donations enabled the Foundation to award more than 40 scholarships and grants last year to surgeons who are now undertaking research across a wide range of surgical specialities and to young surgeons who have embarked on further study in Australia, New Zealand and overseas.

It is not possible to list all of the activities of the Foundation, but it is worth recording that the Foundation is planning to continue the provision of surgical training and quality patient care in many of our neighbouring developing countries, including Papua New Guinea, Timor Leste, the Pacific Island countries and Myanmar. It will also support research across all surgical specialties and sub-specialties, and provide assistance to young surgeons of promise through the conferment of scholarships and grants to enable new research, advanced study and surgical related travel opportunities. Our College, through the activities of the Foundation, is the major supporter of surgical research in our two countries.

The Foundation has become an integral part of the College, but its continued activity is reliant on support from surgeons. To help fund these initiatives, the Foundation for Surgery is again conducting its annual fundraising campaign 'Pledge a Procedure'. I would particularly appeal to you to consider donating the proceeds of just one of your most common major operations during the month of June. Such a donation is tax deductible in Australia and New Zealand and will make a tangible difference.

Having now become closely involved with the Foundation, your Foundation, I can testify that the funds raised are entirely devoted to altruistic endeavours and not swallowed by administrative costs. Please consider the Foundation as a worthwhile means of making a difference in so many ways.

Michael Grigg
Vice President

Ban the quad bike push

The College has joined forces with the Royal Children's Hospital, Ambulance Victoria, Kidsafe and the Australian Medical Association to call for a ban on children riding quad bikes. Doctors are calling on the State Government to stop children from riding the bikes in the hope it will prevent more horrific injuries and save lives.
An editorial in the *Herald Sun* backed the call.
"There can be no question in anyone's mind, least of all in the minds of Victoria's legislators, that they must move quickly to stop this terrible toll of young lives and injuries that are sometimes responsible for lifetime disabilities."
***Herald Sun*, May 22**

Not Hollywood

Angelie Jolie's brave revelation of her double mastectomy has been praised by the Cancer Council, though the support and research group says that women should be aware of all the issues surrounding the surgery.
A 2011 study led by WA Fellow Christobel Saunders found that many woman underestimated the impact of the surgery on their lives, after initial happiness gives way to effects such as early menopause and low libido.
"I think it's good that we have a public conversation about managing cancer in women who have a high risk, but (following mastectomies) they can have a lot of grief reaction down the line and that is our experience," Professor Saunders said.
***Sunday Age*, May 19**

Road Trauma Submission

Road safety campaigns should be re-evaluated a state parliamentary inquiry into serious injury has been told.
In its submission, The Royal Australasian College of Surgeons said that although safety campaigns had understandably been directed at reducing fatalities, "this might have been at the expense of preventing serious injuries."
***Herald Sun*, May 21**

More than just money

College President Michael Hollands has written to the Australian Financial Review in response to the coverage of the Australia 2.0 healthcare round table.

The President noted his disappointment at the lack of clinician involvement in the discussion, with AMA President Steve Hambleton the only practising clinician quoted.
"Doctors who care for the real stakeholders in this debate, our patients, are ideally placed to identify problems in healthcare delivery and to propose solutions."
***Australian Financial Review*, May 20**

In Memoriam

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

Alan Innes-Brown, New South Wales Fellow

George Owe-Young, Victorian Fellow

William (Bill) Swaney, Victorian Fellow

Caleb Tucker, New Zealand Fellow

John H Cloke, Victorian Fellow

John Hogg, New South Wales Fellow

Richard Taunton Southwood, South Australian Fellow

Kenneth Bruce Cornwell, Victorian Fellow

Marx Wald, West Australian Fellow

Philomena McGrath, New South Wales Fellow

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

Looks good, but practical?

Why must we sacrifice logic for good looks?

There is one thing that really annoys me and that is design – not all design, but things that are said to be "arty" design. This little annoyance came to a peak on a recent trip to Melbourne. The RACS building in Melbourne is an interesting old style building. I have never been sure if I like it or loathe it. It probably depends on what argument I am having with the College at the time.

The external style is 1930's neo-classical at a guess. However, I am happy to bow to an expert in architecture if I am wrong. In any event I am sure that it is not modern. In one of the corridors I noted a smell of fresh paint. Around the corner came an assault on the eyes – an orange red "feature" wall. Feature of what? Poor taste? Colour blindness? It is not in keeping with the building as a whole. I hoped that it was an undercoat – but no.

I stayed at The Hotel Windsor. Now there is a place of taste and refinement, style and design – perhaps from another era, but style that fits in. Muted colours, lovely pictures on the wall, lovely chandeliers, ornate ceilings. However, the door man wears a purple waist coat. I can perhaps forgive that as it is a royal purple.

In the bathroom is an assault on the eyes, but in the opposite direction. When I was in the bath (yes, we curmudgeons have baths, not showers) I noted that I could not read the labels on the little bottles as the print was in a small font and it was pale blue on a pale grey background – it looked beautiful and very "arty" design, but quite unreadable.

And yes, I did wash my hair in body lotion.

Dear Sir,

In the March issue of *Surgical News* (Vol 14, No 3), Dr BB G-loved's article on 'Hidden Benefits' fails to note that magnesium is the prosthetic element of chlorophyll – just as iron is of haemoglobin.

The diet of Dr BB's patient with regard to the consumption of green vegetables was not apparently inquired into. Surely advice regarding diet should precede the prescription of pills.

Incidentally, if the leaves of citrus trees begin to yellow, a spray of magnesium sulphate solution, with some copper sulphate added for good measure, will usually "green them up" again. The trees absorb these elements better through their leaves than through their roots.

Yours faithfully

B. N. Catchpole

DR BB G-LOVED'S REPLY:

Mag up those Mitochondria

Dr Catchpole is quite correct that Magnesium is the central molecule of chlorophyll and that without magnesium there is no photosynthesis. It is considered a secondary nutrient of plants together with calcium and sulphur.

We do get dietary magnesium from green leaves, pumpkin seed, wheatbran and nuts. Acid rain, magnesium deficient fertilisers, and overuse of soil all contribute to magnesium deficiency in plants and the underlying cause as to why Ms Ng Magna was deficient – like so many other patients.

I must confess to not being enough of a Neville Longbottom at school and university – I just didn't pay enough attention in Herbology. However, once one is deficient, supplements are needed, not just dietary adjustment. That's why herbologists (horticulturalists) – as Dr Catchpole rightly points out – spray their plants with magnesium sulphate.

Thank you for reminding us that green leaves and spinach is good for us. I am sure that Popeye's 'mag'd up' mitochondria and well balanced nerves were the secret behind his ability to beat Bluto and win the heart of Olive Oyl. Now Olive Oil – that's something else that is good for us which I must write about another time!

Dr BB G-loved

Cultural and language problem

I read with interest your article headed "Culture eats strategy for breakfast" from *Surgical News* (April edition, Vol 14, No 3). As a general rural surgeon I find the attitude of many of my city colleagues very difficult to understand and it makes it very difficult to work with them.

Former Trainees of mine who have learnt their bread and butter operating skills on cholecystectomies turn into breast surgeons or colorectal surgeons who are incapable of removing a gallbladder on a public hospital on call roster in Melbourne.

A small but significant number of people are fairly derogative about country surgery in general and this is not helpful for patient management and it is certainly not helpful for ongoing workforce training and commitment.

Certainly in Western Victoria we also have a major cultural and language problem with many of our referring general practitioners. It can be difficult to form a satisfactory working relationship with someone who rarely stays more then the immigration requirements of two years in a country town, never comes to any of the post graduate education we offer at the Base Hospital and certainly has difficulty with spoken English on the telephone.

There is no easy answer to any of these problems, but at least you and the College Council are aware of them.

Mr Ian Campbell

General Surgeon

Anastomotic leak following stoma

This case study can be found on the blog discussion at: /my-page/racs-knowledge/blogs/all-blogs/anzasm-case-note-reviews/2013/anzasm-case-note-review-june-2013/

A frail, elderly patient with known respiratory and cardiac problems presented with small bowel obstruction. Anaesthetic risk assessment confirmed a high risk for surgery. After some time a decision to proceed to surgery was made. During the surgeon's discussion with patient and family regarding the need for surgery, the patient made it clear they did not want to be resuscitated in the event of cardiorespiratory arrest.

Just prior to administration of anaesthesia, the registrar informed the surgeon that the patient had indicated they did not, under any circumstances, want a stoma. This refusal of a stoma had not been conveyed to the surgeon during the earlier discussion with patient and family. A decision to proceed with the surgery was made.

At laparotomy, a torted ascending colon with a patch of necrosis and extensive small bowel adhesions were found. Extensive adhesiolysis was necessary to mobilise the ascending colon for a right hemicolectomy, resulting in several serosal tears which were oversewn. A sinus tachycardia and hypotension occurred during the procedure. Because of the patient's refusal of a stoma, the simpler and safer option of then removing the ascending colon and simply 'bringing out the ends' was not available. A right hemicolectomy with side-to-side anastomosis was performed.

The patient required inotropes and ventilatory support postoperatively, but made good progress for the first few days. Patient was weaned off inotropes and extubated, but then began to deteriorate. At this point faeculent fluid from the midline incision was noted, consistent with anastomotic leak or leakage from damaged small bowel. Treatment was withdrawn at request of patient and family and the patient died.

Overall, the management of this case appears to have adhered to a reasonable care pathway. There appear to be no grounds for concern about the initial conservative management, the decision to operate and its timing, the quality and skill of the surgery or the postoperative management.

Reviewer's comments

An adverse event in the form of an anastomotic leak has occurred. The risk of leakage, either from the surgical anastomosis or from damaged small bowel, in a frail, elderly patient with significant comorbidities undergoing this sort of surgery after nearly a week of obstruction, with necrotic bowel present, is very substantial. Once such leakage occurs, a fatal outcome is probably inevitable, even if the family had not ultimately refused further active treatment.

It is reasonable, therefore, to suggest this case is one where the outcome was not preventable. The case does, however, raise one interesting area for consideration in relation to informed consent, or in this case informed limitation of consent – that is, the patient's refusal to allow a stoma 'under any circumstances'. This is a very serious limitation of the surgeon's options. Simple exteriorisation of the bowel ends might have led to a different outcome.

The patient has an absolute right to refuse any aspect of treatment, or all treatment, but as surgeons we have a responsibility to ensure that this is a fully informed decision. We do not know the seniority of the registrar in this case, nor the mental capacity of the patient, or when and under what circumstances the consent was revised. Nobody wants a stoma, but in many patients the fear of such is quite uninformed. Most patients will accept the necessity, if the nature and management of stomas, and, in many cases, their temporary nature, is fully explained. We do not know if this was done, or if the registrar had sufficient experience to do so and to realise what a serious limitation this constituted.

The patient's decision should have been conveyed to the consultant well before surgery commenced, so the consultant could have the opportunity to discuss that specific limitation again with the patient and family and could be satisfied that it was an informed, reasonable and final decision. There appears to have been a significant failure of communication in this instance.

Guy Maddern
Chair, ANZASM

> *When we are afloat on a full sea, we must take the current when it serves*
>
> Julius Caesar (Act 4, Scene 3)

'The Vision Thing'

Poison'd Chalice

Perhaps I have been around too long – past Trainees of mine are now assuming leadership roles around the country. And each year I seem to need an increasingly powerful pair of reading glasses – after all I need to be able to see! This is good and bad. Good in that I have a very attractive Optometrist who it is a pleasure to see each year, and who is clearly attracted to me since she always insists that I have the very best frames notwithstanding that they are always the most expensive in the store. Bad in that she is my wife's best friend!

A more practical manifestation of my approaching obsolescence is the request for me to deliver lectures on 'leadership' rather than surgical technique – the two, of course, are diametrically opposed. The latter requires focus, the former, among other things requires vision. And by vision, I do not mean breadth of observation, but rather the ability to see how things might be in the future – something beyond horizon scanning – the ability to position in order to create. Of course the danger is that 'vision' is the first casualty of the constant buffeting of increasingly urgent demands – the constant requirement for immediate solutions to problems that today are of paramount importance, but by tomorrow are forgotten, or simply replaced by a new set of issues. Herein lies the essential difference between effective management and leadership.

Management courses refer to the phenomenon of constant 'white water' – a term familiar to those who choose to use their leisure time negotiating rapids. It simply means that one is too busy trying to keep afloat rather than remembering where it is it that they actually want to go.

Shakespeare also chose a water analogy in Julius Caesar (Act 4, Scene 3), where he makes comments about the tide in the affairs of men: "When we are afloat on a full sea, we must take the current when it serves." I like to think that Shakespeare is reminding us to maintain a 'vision' about where we want to get to, being alert to opportunities rather than be reduced to flotsam ending up where happenstance determines.

In many ways, the ability to have and develop a vision is the most difficult aspect of leadership, but running a close second is the ability to 'sell' the vision, getting others on board. Without this component, vision becomes an 'agenda' – is there a more effective derogatory label in hospital politics? (If you want to undermine an 'opponent' on the Executive, just spread the word that he or she is running their own agenda – and if you really want to stick the boots in, simply add the word secret!)

Having raised the issue of Hospital Executives, I feel compelled to emphasise the distinction between politically correct, aspirational "vision statements" and true vision – one is noble, notable and noteworthy, while the other is not. Alas there is an exception to the rule. There is one vision statement that caught my attention during my travels. It is "curanda vita" – Latin, translated – "life is to be cared for". Could there be a better vision statement for a hospital?

However, back to my lecture on leadership, focusing on vision. I opened with one of the best quotes that Shakespeare has given us. From A Midsummer Night's Dream (Act 4, Scene1): "I have had a most rare vision. I have had a dream, past the wit of man to say what dream it was."

I reached inside my pocket for my expensive glasses to consult my notes before continuing. Blast! They are not there, where did I leave them – again? I suddenly realised that I was in a bad place – lecturing about vision without vision!

Professor U.R. Kidding

"this year's Annual Scientific Congress (ASC) of the College addressed the theme of sustainable surgery with presentations, not only on the future of sustainable surgical training, research and innovation, but scientific papers describing the use of limited health resources."

The friendly *meeting*

This year's Annual Scientific Congress (ASC) of the College held in Auckland, New Zealand, addressed the theme of sustainable surgery.

In a global climate of fiscal restraint and economic adjustment, this year's Annual Scientific Congress (ASC) of the College addressed the theme of sustainable surgery with presentations, not only on the future of sustainable surgical training, research and innovation, but scientific papers describing the optimal use of limited health resources.

Delegates to the 82nd ASC, held in Auckland last month, were given presentations on the efficiencies derived from having dedicated consultant-led acute care surgical centres in tertiary hospitals and separating elective and acute surgical streams in smaller hospitals.

Other papers described the appropriate selection of patients for day surgery, questioned the need for treating children with appendicitis at dedicated paediatric centres and outlined the results of complex cancer surgery undertaken at a low-volume tertiary centre.

Dr Rose Shakerian, a General Surgeon at the Royal Melbourne Hospital, presented research on the effects of the establishment of an Emergency General Surgery (EGS) Service at the hospital in 2011 in response to an increase in acute general surgical and trauma cases.

She said data gathered from February 2011 to January 2012 showed that the EGS service managed 4523 patients during the study period.

"Hospital length of stay was reduced from 5 to 4.1 days and a 20 per cent improvement was noted in the proportion of patients admitted from the Emergency Department within eight hours," she said.

"The percentage of surgical cases conducted within hours was found to be 50 per cent."

Dr Shakerian concluded from the data that early and increased consultant input reduced length of stay and time spent in the Emergency Department despite a 73 per cent increase in acute admissions during the operation of the new service.

In 2011, the RACS wrote to all health ministers and senior health department officials in Australia and New Zealand, enclosing a comprehensive report which demonstrated that the establishment of dedicated acute care surgical units leads to greater efficiency and better patient outcomes.

While the separation of elective and acute surgical streams is increasingly common in large city hospitals, the viability of such a model of care in smaller provincial hospitals has only recently been tested.

Dr Tracey Barnes, a Surgical Registrar at Invercargill's Southland Hospital told the Congress that Consultant Surgeons and hospital management had structured a model where the on-call surgeon had no elective responsibilities while covering call for the week with the on-call surgeon's usual elective sessions used by other General Surgeon Colleagues.

Comparing data from before the introduction of the new system and after, Dr Barnes found that both acute and elective admissions remained similar, with elective surgery throughout remaining similar per consultant.

"Our review led us to the conclusion that in a provincial hospital with just five General Surgeons it is feasible to run an acute surgical service model with a consultant having on-call responsibilities only," she said.

"This can improve acute inpatient care without reducing or compromising elective services."

The mandatory transfer of paediatric patients with appendicitis to dedicated paediatric surgical units does not appear to be justified, according to research conducted by Dr Hasitha Balasuriya.

Dr Balasuriya, a Surgical Resident at Gosford Hospital in NSW, said the cost and possible morbidity associated with mandatory transfer, as well as the inevitable burden on such centres should be formally reviewed against patient outcomes.

Similar outcomes

Dr Jacques Marnewick, who was a Trainee endocrine surgeon in Hamilton, NZ, told the ASC that although it is not standard practice in Australasia, well-selected patients could safely undergo hemi-thyroid surgery as day patients.

Analysing the outcomes of patients who had been operated on by a single high-volume endocrine surgeon, Dr Marnewick said that while 82 partial/hemi-thyroidectomy patients had been treated during the study period, 58 were considered suitable for discharge as ambulatory surgical patients.

"Of all these patients, there was only one re-presentation of surgical complication with an infected seroma," he said.

"Our early experience suggests that in carefully-selected patients, ambulatory partial and hemi-thyroid surgery can be safely achieved and is feasible within an Australasian tertiary hospital setting."

Saving health dollars through improved hospital care could be achieved through the use of a checklist during surgical ward rounds, according to Associate Professor Graeme Thompson.

A General Surgeon at Melbourne's Western Health, Professor Thompson presented a study at the ASC that involved the use of a structured checklist during ward rounds and the recording of key aspects of surgical care.

"Initially, the team was unaware of the nature of the observations or that a formal study was in progress," he said.

"During the second phase team members were informed of the study and told that a designated prompter would alert the team when areas of care had not been considered."

Professor Thompson found significant improvement occurred via the use of the checklist including a notable improvement in communicating with patients and nursing staff, attending to Venous Thromboembolism prophylaxis, fluid balance, catheters and drains, referring to drug charts and discharge planning.

Challenges to overcome

The sustainability of a paediatric surgical service in Vanuatu was the subject of a presentation made by Dr Basil Leodoro, a general surgeon from Vanuatu.

He said that while infant mortality in the country had fallen dramatically in recent decades, mostly due to early diagnosis and treatment of infectious diseases, a specialist paediatric surgical service had only been made available there since 2010 under the Pacific Island Program (PIP) funded by AusAID and co-ordinated by the College.

"From a local perspective, questions must be raised as to how independent Vanuatu can become in sustaining a specialised surgical service, given the local and external challenges that must be overcome," Dr Leodoro told the ASC. ▶

"These include delayed presentation of patients with paediatric surgical disease, a shortage of medical resources and staffing, limited funds for investigation, assessment and management of paediatric surgical cases and a need for specialist paediatric surgical training of surgeons, anaesthetists and nursing staff.

"(Yet) some of the solutions to these problems may not be as remote as one might assume. For example, there are well-established ties with the College, PIP teams, regional consultants and donors who regularly assist local surgeons in both clinical and training capacity.

"These efforts and relationships must be sustained and fostered."

Away from the central theme of sustainability, scientific papers were presented on the dangers of magnet ingestion in children and the growing demand from patients who have had bariatric surgery for follow-up surgery to remove excess skin.

Dr Brooke Rule, a Registrar in the ICU of Royal Perth Hospital, told delegates that when multiple magnets are ingested they can be attracted to each other across the bowel wall which may lead to pressure necrosis, perforation, fistula formation and/or intestinal obstruction.

She called for a campaign to increase public and clinician awareness of the dangers of magnet ingestion along with a review of regulations pertaining to the use of magnets in toys.

Dr Heather Leaver, an Auckland-based surgical Trainee and Mr Jonathan Wheeler, a Plastic and Reconstructive Surgeon, presented a study of New Zealanders who had undergone bariatric surgery which suggested that most would like some form of body contouring surgery after the initial weight loss procedure.

Dr Leaver said 87 per cent of the 115 patients who responded to a questionnaire felt they had excess abdominal skin while 84 per cent said they would be interested in its removal.

She told delegates that it was likely that the study cohort was representative of the increasing number of people undergoing bariatric surgery in New Zealand and that a growing demand for post-operative body contouring surgery could be anticipated.

With Karen Murphy

ASC in pictures


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01: Sir Peter Gluckman
02: Sarita & Brent Eastman, Ian Ritchie & Spencer Beasley
03: Phillip Carson & Colin Summerhays
04: John Woodfield, Sam & Siraj Rajaratnam


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CONVOCATION


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05: Maori women welcome surgeons **06:** Sean Hamilton, Michael Grigg, David Thiele & Ian Bennett
07: Kingsley Faulkner & Ian Civil **08:** John, Deborah, Simon, Amelia Quinn & Marianna Campbell
09: John & Angela Masterton **10:** Luc Malemo Gwen & Neil Wetzig **11:** Mike Hollands
12: Gayl Pollard, Rob Atkinson, Cliff Pollard & Pauline Atkinson


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PRESENTATIONS


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01: Media with Mike Hulme-Moir Bowel screen Launch **02:** John Mitchell Crouch Lecture Russell Gruen
03: Edward Weary Dunlop Lecture Major General Professor Alan Hawley **04:** Dragon makes an appearance through the Exhibitors Hall to promote the ASC in Singapore next year **05:** Michael Wertheimer Lecture Ian Civil **06:** Gordon Trinca Medal Cliff Pollard
7: Rowan Nicks Lecture Eddie McCaig **08:** American College of Surgeons Lecture Nancy Baxter

PLENARY


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EXHIBITORS DRINKS


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09: David Watters & Simon Williams **10:** BJS Lecture Murray Brennan
11: Stephen Tobin **12:** Cathy Ferguson **13:** Alan Merry & Guy Maddern **14:** Michael Gorton
15: Rebecca Hartley, Brian Swain & Wahida Roshan **16:** Camille Furnandiz & Aaron Morgon
17: Chantal Summerton, Hanile Both & Bernice Dobbs **18:** Marcos Serrano & Ben McCluer

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01: Singer Anna Coddington entertains the Congress diners **02:** John Windsor **03:** Campbell Miles & Peter Woodruff **04:** Ian Ritchie, Mike & Jane Hollands **05:** Johnson & Johnson Gavin Fox-Smith **06:** American College of Surgeons President Brent Eastman **07:** Roger & Michelle Wale

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08: Richard Marton, Jason Cheun & Mike Hollands **09:** Holly Keane, Sze Ling Wong & Jacqui Slater **10:** Mary Corboy Richard Hanney Jane Mike Hollands

YOUNGER FELLOWS

Advertising by surgeons

Make sure you know the College Code of Conduct

The College has recently dealt with complaints under the College Code of Conduct against surgeons for inappropriate advertising of their practices and themselves.

The Code highlights professional and legal obligations of privacy and confidentiality owed to patients. The particular use and potential consequences of identifiable information and photos should be carefully considered by surgeons. Whilst consent may be obtained, each surgeon should still consider their professional obligations and the appropriateness of using identifying advertising or promotional material.

The College Code of Conduct requires that surgeons:

1 Provide only clear, factually correct and verifiable information.
2 Not advertise in a manner that could mislead any patient.
3 Not advertise in a manner that promotes the perception that their services are better than their peers.
4 Not use testimonials or "before and after" photographs that create unrealistic expectations of outcomes.
5 Not encourage indiscriminate or unnecessary interventions.
6 Not exploit a patient's vulnerability or fears.
7 Not impugn the reputation of others.

The College has also adopted, and surgeons will otherwise be required to comply with, the Medical Board of Australia "Guidelines for Advertising" and the Medical Council of New Zealand "Statement on Advertising".

The Statement and Guidelines from the MBA and MCNZ reflect some of the requirements of the College Code of Conduct. Additionally, they address issues such as:

a. The MBA Guidelines prevent the use of testimonials or purported testimonials.
b. Failure to disclose health risks associated with a treatment.
c. Containing price information that is inaccurate.
d. Using graphic or visual representations which are inaccurate or unfair, including "before and after" photographs which do not contain similar backgrounds, camera angles, lighting, posture, make up or alteration to make the "after" photograph appear better.

Similarly, the MCNZ Statement suggests the use of photographs should not be unrealistic, and should be typical of what can be expected. Photographs should not be altered in any way, and again contrasts between "before and after" shots should not have used techniques to create unrealistic or unfair representations.

It is also important that the use of photographs or other patient information should only occur with fully informed consent. Use of photographs with children, for example, should be particularly sensitively handled. De-identified children's photographs, appropriate to the clinical situation, may be used with fully informed parental consent.

Surgeons should also consider the appropriateness of multiple images or excessive use of photography in promotional material. Consistent with other forms of medical education, photographs are useful to illustrate a point; but in the context of a website do not need to cover all possibilities. The web is readily and very widely accessible. It should be noted that web images can be easily copied and used inappropriately. The College continues to monitor these issues. Any Fellows may report, and some have reported, breaches of these Guidelines and the Code of Conduct to appropriate authorities and/or the College.

The College will act on complaints.

Michael Gorton,
College Solicitor

Make a difference

The College Foundation's annual fundraiser is upon us, support **Pledge a Procedure** in June

The Foundation for Surgery is the College's philanthropic arm and is the sole charitable entity in Australasia representing the wider surgical fraternity. It supports health projects and research across all surgical fields and supports projects in Australia, New Zealand and across the Asia Pacific region.

I wish to thank Fellows for their generous support of the work of the Foundation. Your willingness to assist colleagues working in disadvantaged communities, and your commitment to surgical training and research is greatly appreciated.

However, there is always more to be done and our sustained support is vital to ensuring the Foundation for Surgery is able to expand and thrive. In doing so, it will continue to facilitate a range of worthwhile and effective health programs that measurably improve the lives of many people in less fortunate circumstances than ourselves.

These programs will continue to address the health inequities in Australia's remote and Indigenous communities, implement Indigenous surgical programs and encourage Indigenous doctors to consider a career in surgery.

They will increase surgical capacity and enable the provision of surgical training and quality patient care in many of our neighbouring developing countries, including Papua New Guinea, Timor Leste, the Pacific Island countries and Myanmar.

They will also support research across all surgical specialties and sub-specialties, and provide assistance to young surgeons of promise through the conferment of scholarships and grants to enable new research, advanced study and surgical related travel opportunities.

The Foundation is an integral part of the College and I encourage all Fellows to help maintain and expand its programs. To help fund these initiatives, the Foundation for Surgery is again conducting its annual fundraising campaign 'Pledge a Procedure' in June.

You will have received a letter from the Foundation asking you to support programs in the area of surgical endeavour that is most important to you by donating the proceeds of just one performance of your most common major operation during the month of June.

I can assure you that 100 per cent of all donations will be used to fund projects within the following areas:

- **Indigenous health:** Indigenous populations in both Australia and New Zealand suffer higher rates of chronic disease and trauma-related injuries than other members of the community, while remote medical centres often lack the surgical equipment needed for treatment. Donated funds are used to upgrade equipment and improve clinical care.
- **International medical programs:** Donations help provide urgently needed specialist medical services and increase surgical capacity in some of the world's poorest regions. Promising young surgeons from such regions have also been funded to train in Australia and New Zealand, with particular support given to those who will go on to train members of their local medical communities upon their return.
- **Research scholarships and grants:** The College is committed to supporting advances in the science of surgery. Donations allocated to scholarships or research grants facilitate scientific work in the Fellows' preferred specialty or sub-specialty by providing opportunities for quality research and advanced research training.

You may be aware that, so far, 'Pledge a Procedure' has helped fund an enormously successful trauma skills program in Myanmar which has a particular focus on training the trainers.

That program involved the provision and delivery of 19 Primary Trauma Care (PTC) courses to local surgeons and doctors who then took ownership of the courses to train others across the nation.

So successful was this initiative that Myanmar health authorities requested the help of the College to develop emergency medicine skills and systems, with training programs now underway.

This aid program to Myanmar has been a great success, not just for the people of that country but also in terms of the international standing of the College. It is a great example of the work we can do with the support of Fellows.

Back at home, we have funded an ENT operating microscope for the Indigenous health clinic at Tharawal in New South Wales, and have donated to the Cherbourg Health Clinic in Queensland surgical equipment for the treatment of chronic suppurative Otitis Media, the leading cause of hearing loss in Indigenous communities.

These projects, funded by the Pledge a Procedure campaign, achieve great things for struggling communities but also say a great deal about the College and its Fellows.

While our core function is to deliver world-class surgical care to our patients in Australia and New Zealand, and to train the next generation of surgeons, we also play an important role in international outreach, we recognise that Indigenous communities in Australia and New Zealand need extra care, and we support the research that underpins our profession.

I urge you all to prove this commitment once again. Donations can be sent to the College and are tax deductible.

Kingsley Faulkner
Chair, Foundation for Surgery

Foundation for Surgery
Passion. Skill. Legacy.

55th Victorian Annual Surgeons Meeting (VIC ASM)

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

FRIDAY 18 - SUNDAY 20 OCTOBER 2013

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

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

CALL FOR ABSTRACTS

Submissions Are Now Open

Please indicate that your abstract is for VIC ASM 2013 and which area you wish your topic to be submitted under. All successful abstracts will be printed in the Final Program & online.

Submissions must include:

- A title
- An abstract of 250 words or less
- A short presenter bio (50 words) to facilitate the Chairperson's introduction
- Authors (Presenter in CAPS and UNDERLINED, i.e. J.L.M Peterson, A.K.MATTHEWS, A. Thomas, N. Bravo)
- Address and Contact Details
- Conflict of Interest Declaration

Email abstract submissions by **Friday 16 August** to: simone.watt@surgeons.org

PRIZES

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

MEETING ORGANISER

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

"The College is keen to promote the publications and research of our Fellows"

Discover your new Library

Have you seen the new look Library yet?

The Library has been redesigned to provide improved access to an increased range of resources. The redesign has given us the space and opportunity to group the Library resources in a way that is more intuitive for Fellows, Trainees and IMGs.

The Library home page now features a current news service drawn from journals including the ANZJS, BJS, Annals of Surgery, The Lancet, NEJM, Medical Journal of Australia and Medical Journal of New Zealand. The aim of the news service is to help keep Fellows informed of the latest research and news published in the bigger multi-disciplinary journals.

The College is keen to promote the publications and research of our Fellows so if you are aware of any new or forthcoming articles of interest to the surgical community, please email the Library so these can be highlighted.

New pages

The redesign has created a new page for resources relevant to all specialties (top right hand column) and a separate page for Trainee resources (half way down the right hand column). Both these pages are complemented by the Specialty pages.

A-Z listing

If you are looking for a specific resource and can't find it on the library pages, you can always use the A-Z listing (top left hand corner of the Library home page). There are literally thousands more resources included in the A-Z listing that haven't been listed separately on the Library pages.

Specialty hubs

Specialty hubs provide current news from key specialty journals, with links to the full text articles. Each hub brings together all the specialty related information from across the web site, along with prominent access to the related Societies.

Specialty hubs can be accessed from My Page after you log in to the College web site. There are also links from each of the Library specialty pages to the relevant specialty hub. (Top left hand corner).

General Surgery sub-specialty approach

General Surgery is the largest specialty and the sub-specialties are very well developed. The Library has moved towards reflecting this approach by replacing the long list of general surgery journals and books with Library resources organised under sub-specialty headings. The categories of sub-specialty are based on recommendations from General Surgery Fellows consulted at the recent ASC in Auckland.

The Library plans to extend the sub-specialty approach to Orthopaedic Surgery in the near future.

Clinical Key

The acquisition of Clinical Key has brought a vast new range of books, journals and multimedia to the Library. It can take a while to become familiar with the approach and scope of this new resource. The Library has a user guide and link to a mini-tutorial that new users may find helpful. One of the commonly reported problems is that Clinical Key does not work well with Internet Explorer 8 or 9. If you find you are not getting directly through to specific full resources, or if images are not displaying, the easiest solution is try a different browser. Firefox, Safari and Internet Explorer 10 are all good alternatives. Please don't hesitate to contact the Library if you have any questions.

Image Library

Clinical Key has millions of images in its database. Fellows and Trainees can use these for your own personal, non-commercial, informational or scholarly use, provided that you keep intact all copyright and other proprietary notices.

Please note, the licence does not allow the reproduction of Clinical Key images for other publications, including the internet.

Register for Clinical Key to access more features

Clinical Key has some useful tools available if you register for an individual account. These tools include Saved Searches where you can formulate searches and rerun them regularly to get the latest updates on your topic.

Reading lists allow you to create a personal list of specific Clinical Key resources for easy reference.

You can use the Presentation Maker to export text and images to PowerPoint. The Presentation Maker will automatically insert citations. The Library home page includes a mini tutorial video on using the Presentation Maker that you may find helpful.

If you want to download book chapter PDFs rather than reading them as web pages, you need to register.

The Library staff welcome your feedback and suggestions. You can contact the Library by email College.Library@surgeons.org or phone +61 3 9249 1272.

Registering for an individual account is as easy as entering your email address and there is no cost incurred. The link to Register is in right hand corner of the blue bar at the top of the Clinical Key home page.

We hope you enjoy your new Library.

Cathy Ferguson
Chair, Fellowship Services Committee

PICS BY JOHN ALOYSIUS HENDERSON


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CONVOCATION

01: Mike Hollands **02:** Lee Brewster & Glenn Guest
03: Brian Morgan & Phil Truskett
04: Russell Gruen, David Watters & Ikau Kevau

CONGRESS DINNER

05: Pam & John Henderson **06:** Cliff & Elizabeth Hughes and Beverley & Bruce Barraclough **07:** Stephen & Anne Deane
08: Campbell & Vivienne Miles, John & Angela Masterton
09: Michael and Jane Hollands

THANK-YOU TO ALL WHO ATTENDED THE 2013 ANNUAL SCIENTIFIC CONFERENCE IN AUCKLAND ...
'TIL NEXT YEAR!

Cytokines sing the blues

Even surgeons can get depressed

Surgeons receive a great deal of positive feedback during the course of their work. Despite those terrible complications that a small percentage of your cases suffer, patients generally opine their surgeon is 'the best' and few of you show any enthusiasm to dispel this absurd belief in your adoring public.

However, I recognise that much of the positive feedback surgeons receive is well deserved, as the majority of cases do fare well and the procedures you perform [or the advice you give not to undergo a procedure] represent major milestones in an individual's life.

As a result surgeons don't usually get depressed though they can burn out through overwork and lack of play. They are also particularly vulnerable when their domestic life suffers major setbacks, through broken relationships, illness or challenging behaviour in children.

I've always thought it would be nice to be able to prescribe a magic bullet that would fix the blues without significant side effects or a wait of a few days for improvement. So many of those on whom I consult are depressed, though among my surgical patients it is extremely rare.

Some three months ago, a normally gregarious, confident surgeon slouched slowly into my consulting room, having requested a lunchtime appointment between operating list and rooms.

Ms Erabel had lost interest in her work, felt she was trapped by others' expectations, complained about being constantly under pressure to perform, was irritable and stressed. She had been feeling like this for two or three months. I asked whether she could think of any precipitating events, giving her an opportunity to unload. She'd operated on a young patient, thought she'd done a great procedure, but a week or so later there was a major complication.

In the past month or two recognising that her confidence was shattered, she'd been putting off some of the more challenging procedures whenever possible. She'd referred a couple of more urgent, but difficult cases to a colleague and was really frightened she was losing her nerve. She had a disrupted and disturbed sleep pattern and though her family relationships still seemed sound, no one was finding her mood easy and she admitted to having withdrawn from most social commitments. She felt constantly tired and when prompted, admitted to having little libido.

Even a surgeon would be able to diagnose she was suffering from depression, but Ms Erabel seemed to be a little surprised. Surgeons shouldn't be depressed should they, she grunted. It's almost that depression is a form of failure, not a condition that needs treatment. Don't I just need to pull myself together, she asked?

I explained that depression is actually a pathophysiological disorder. It is driven by cytokines, those inflammatory markers that activate microglia in our brain, which are themselves acutely responsive to stress and inflammatory signalling. Oxidative and nitrosative stress, mediated through free radicals, potentiates the process, resulting in damage to proteins, fatty acids and nucleic acid epitopes often with resultant autoimmune reaction. One can measure the cytokines (IL2, IL6 and TNF), and inflammatory markers (including CRP) both in laboratory animals and in humans. The evidence is strong, but it has only been accumulated in the past 20 years, well after Ms Erabel graduated from medical school. The microglial activity affects neurotransmitter pathways. Her CRP was raised, her bloods showed a high LDL to HDL ratio. We didn't measure the cytokines.

Antioxidants such as Vitamin E, Zinc, CQ 10, can modulate these processes by resisting the effects of free radicals. They also enhance the function of our mitochondria. Omega 3 PUFAs (fish oil) reduces inflammation and so protects against inflammation mediated damage to proteins, fatty acids and DNA within our brains. We need to protect our neurotransmitter pathways, particularly the serotonin ones and avoid rogue damage to the molecules within our brains.

I wasn't sure whether Ms Erabel would respond sufficiently to antioxidants and Omega 3s alone so recommended she take also anti-depressants and that she should exercise every other day. Being a surgeon she went away and read it all up, came back and thanked me profusely. Within a month she felt positive, re-engaged with life and confidence was restored. I was able to withdraw the antidepressants without relapse some months later.

She chose to stay on the fish oil and the antioxidants. Cytokines may sing the blues, but I chorus it is time to anti-oxidise, mop up those free radicals, and strum to a different rhythm. Our microglia and mitochondria couldn't agree more.

Dr BB G-Loved

New services for Myanmar

Experience for a Rowan Nicks Scholar has led to a new cardiac unit in Yangon Children's Hospital

Win Win Kyaw operating with Bruce French assisting;

A Rowan Nicks International Scholar from Myanmar who received training and mentoring in Australia in 2010 has recently led the development and opening of a desperately-needed new cardiac surgery unit in Yangon.

Dr Win Win Kyaw was a consultant cardiovascular surgeon at the Yangon General Hospital at the time of her arrival in Australia and spent her time here on attachment to the Cardiothoracic Surgery Unit at the Liverpool Hospital in Sydney under the mentorship of cardiothoracic surgeon Associate Professor Bruce French.

The main objective of her three-month visit was to improve her skills in surgical leadership. Dr Kyaw attended administrative and management meetings at Liverpool hospital, theatre staff debriefings and team consultations and was a participant of the 2010 "Surgeons as Teachers Course" held in Adelaide. She was introduced to surgical audit and was assisted in constructing a database relevant to the needs in her Yangon surgical unit. Dr Kyaw also had the opportunity to assist in open heart surgery cases and to attend related clinical meetings.

On her return to Myanmar, Dr Kyaw resumed her position as second in charge of the cardiovascular unit at Yangon General Hospital until she was asked to set up a new adult cardiac unit at the Yangon Children's Hospital.

Dr Kyaw spent six months planning the design and operation of the unit, built a team, trained operating theatre, intensive care and ward staff and designed computerised patient data records.

Myanmar is the largest country in South-East Asia with a population of almost 60 million people, but is so under-resourced that only hundreds of cardiac surgeries are carried out each year, despite an enormous need because of rheumatic fever, congenital heart disease and acquired cardiac disease.

Professor French, who mentored Dr Kyaw after first meeting her during an Operation Open Heart* visit to the country in 2006, said the opening of her new unit will have a tremendous impact on the quality and availability of surgical treatment for people with cardiac disease.

Archive photo of Win Win Kyaw and Supervisor Bruce French with Rowan Nicks.

"Yangon and Sydney have similar populations, yet Sydney has eight or nine cardiac units which conduct around 4000 surgeries per year while Yangon has two hospitals conducting only around 300 procedures," he said.

"That shows the need just in one part of the country. In Mandalay, Myanmar's second city, and other centres the need is even greater.

"Such is that need that health authorities asked Dr Kyaw to establish a new cardiac unit where she could treat adults within the children's hospital and she has done an amazing job building a team, training staff and setting up systems to monitor patient outcomes which is still not common in Myanmar."

Professor French, who has a particular interest in surgical training and skills transfer, is attached to the University of Western Sydney and the University of New England and has been a member of the Rowan Nicks Scholarship Committee for the past two years.

So far he has made 12 visits to Myanmar since his first in 2006, using each one to facilitate safe practices in coronary by-pass surgery and teach new skills and techniques to local surgeons.

"I see my role as a facilitator in the development of new techniques rather than the primary surgeon on these visits because the key is to enable the surgeons to safely undertake procedures when visiting teams are not there," he said.

"There is such need in Myanmar that the impact of an Operation Open Heart visit in terms of patient numbers is negligible while the up-skilling, mentorship and support of local surgeons is, in my opinion, invaluable."

Leadership qualities

Professor French said Dr Kyaw was a junior cardiovascular surgeon when he first met her during a team visit to Yangon General Hospital and over the following years found her to be a committed and careful surgeon with leadership qualities recognised by local health authorities who sent her to Mandalay to help establish an open-heart surgical unit.

He believed she demonstrated those qualities envisioned by the late Rowan Nicks when he established the scholarship to support surgical leaders in developing countries and the committee agreed.

As the then Clinical Director of the Cardiovascular Clinical Stream of South West Sydney, Professor French agreed to be her mentor during her stay in the country.

"The key to me was providing Dr Kyaw with ideas during her time here rather than technical skills," he said.

"Therefore we discussed ideas around leadership, communication, dealing with stress, surgeons as team leaders and team dynamics.

"She attended meetings with me to see the administrative and management interaction as well as patient interactions via consultations in my rooms.

"I was also keen to offer her exposure to the multi-disciplinary team element of cardiac surgery where surgeons, perfusionists, anaesthetists and theatre staff all work very closely to ensure the best possible outcome for our patients.

"We also often debrief after stressful situations in theatre and Dr Kyaw attended one of those after we lost a patient in theatre who had come to us in very severe distress.

"The cardiac surgical environment can be a very stressful one and those stressors need to be addressed and managed, particularly for those surgeons asked to take on leadership roles.

"Cardiac surgeons are not the emotionless god-like figures of yesterday and I wanted Dr Kyaw to see not only how we addressed these issues, but that we did address them before she returned home and was asked to take on more responsibility."

Professor French said he had also given Dr Kyaw basic software, modelled on a data-base used at Liverpool Hospital, to help her monitor patient numbers, outcomes and mortality rates given that such systems are not widely used in Myanmar.

Having last visited her in February this year, during a week-long visit at the new cardiac unit at the Children's Hospital, Professor French said he was extremely impressed with her progress.

"Dr Kyaw is now leading a team conducting coronary by-pass surgery and heart valve surgery and her technical skills are more advanced in this new environment while her leadership and management skills are very good.

Win Win Kyaw with cardiologists on the surgical ward.

"She is now the lead surgeon with two junior surgeons working with her and they are tracking patient results which is a useful exercise in rigour while providing the information needed to demonstrate that they are doing useful work.

"She is also looking to learn paediatric heart surgery because of the high number of children born with congenital heart disease and I am hopeful she will be supported in this so that her skills can continue to expand given the enormous need for them in Myanmar."

Professor French described Dr Kyaw's achievement as of great value to the country and said she epitomised the type of surgeons Mr Rowan Nicks was hoping to assist when he set up his scholarships.

He said he remained in close contact with her via email and had found the experience as mentor to an international scholar an extremely rewarding one.

"I found this an invaluable experience as a surgeon interested in skills transfer and teaching while it also added meaning to my life on a personal level and I would thoroughly recommend taking on such a role to any surgeon wanting to help build a surgical service in a less fortunate country or even here at home," he said.

Operation Open Heart is an arm of the Sydney Adventist Hospital's Healthcare Outreach Programme and the Myanmar component was developed in 2003 by Professor Alan Gale.

Professor Gale, an Australian cardiothoracic surgeon currently in Queensland, mentored the first Rowan Nicks scholar from Myanmar, Dr Khin Maung Lwin, at the Prince Charles Hospital in 2005. Dr Lwin is now the head of cardiovascular surgery at the Yangon General Hospital.

Professor Gale has been awarded the College's International Medal in recognition of his humanitarian and mentoring work in the South Pacific and in Asia.

With Karen Murphy

Aside from the ASC

A number of new initiatives are being introduced in New Zealand

It was New Zealand's pleasure to be the host country for the 2013 Annual Scientific Congress. The scientific program was of a very high standard and it is just a pity that the same can't be said for the weather! I would like to take this opportunity to publicly thank all of the New Zealand surgeons (and the Trainees) who gave so much of their time to develop the programs and help to make this a successful event.

There are a number of initiatives under way in New Zealand with the intention of improving patient care and medical training and education. Just a few of these have been highlighted below.

Medical Council of New Zealand – proposed changes for PGY1 & PGY2

In the second round of consultation with the profession on training in prevocational years one and two (PGY1, PGY2), the Medical Council of New Zealand (MCNZ) has indicated its preference to continue with three-month runs enabling registration in general scope at the end of the first year. It is envisaged that all runs (including relief runs) will have components which will contribute appropriately to the new graduates ongoing training and education.

These doctors will be required to have a Professional Development Plan throughout these years and the move to general scope registration will be contingent upon a Plan having been developed for PGY2. MCNZ's objective is to ensure all doctors have a broad basic training, including some exposure to community medical practice, and to enable progression into subsequent postgraduate programs.

While the proposed changes have the potential to offer improved experience and training for interns this is dependent upon District Health Boards (DHBs) recognising the importance of training as well as service commitments whereby the quality of each attachment can be improved. There is an associated expectation that senior medical staff, as key participants in this process, will make a more significant contribution to both training and regular assessment of the intern working with them. This increased expectation will come at the cost of some decreased productivity; and that can be expected to have a significant impact upon those DHBs that are already struggling to meet Ministry of Health targets.

Shared health record

Work is progressing remarkably efficiently as New Zealand moves towards a goal of a shared, widely accessible patient health record by the end of 2014. Numerous separate items contributing to patient care have been developed and refined and are already in increasing clinical use. This includes medicines reconciliation, electronic prescriptions, maternity record, electronic referral and discharge communication, electronic transfer of patient's records between practices, needs care analysis of the elderly (InterRAI) and widespread access to laboratory and radiological investigation. A new patient and provider health index database is replacing the existing 30-year-old system which has had a 10 per cent duplication rate.

All these components will be linked through a single portal through which the patient and their health care providers will have a variable level of access to the information available. There are four hubs nationally (three in the North Island and one in the South Island), each with regional populations of approximately 1,000,000, where this information will be shared through a central repository. The four hubs will be linked nationally so that healthcare providers will, depending upon their authorisation, have access to some/all electronic information in respect to the care of each of their patients.

Considerable work has been undertaken in the development of a shared care plan, which will be available on the patient portal and capable of constant updating by all health care providers and the patient. It is anticipated that shared care plans will be developed for patients who, because of the complexity of their illness or disability, require repeated interaction with a range of health care providers.

Consumers/patients have been widely involved in the development of this IT work and are extremely supportive while emphasising the need for patient confidentiality and security of information. This aspect has been carefully considered at each stage of the development and there has been good assurance (although obviously never absolute) that this can be ensured. The potential power and utility of this IT support is becoming increasingly evident as clinicians access a diverse range of information in respect to their patients. The full integration in the near future represents an exciting prospect.

This initiative has been developed from bottom-up, and been driven by clinicians (including the EDSA, NZ, Allan Panting) working alongside IT vendors and consumers. The costs, when compared with those of some other international health systems, have been comparatively modest.

Surgical site infection

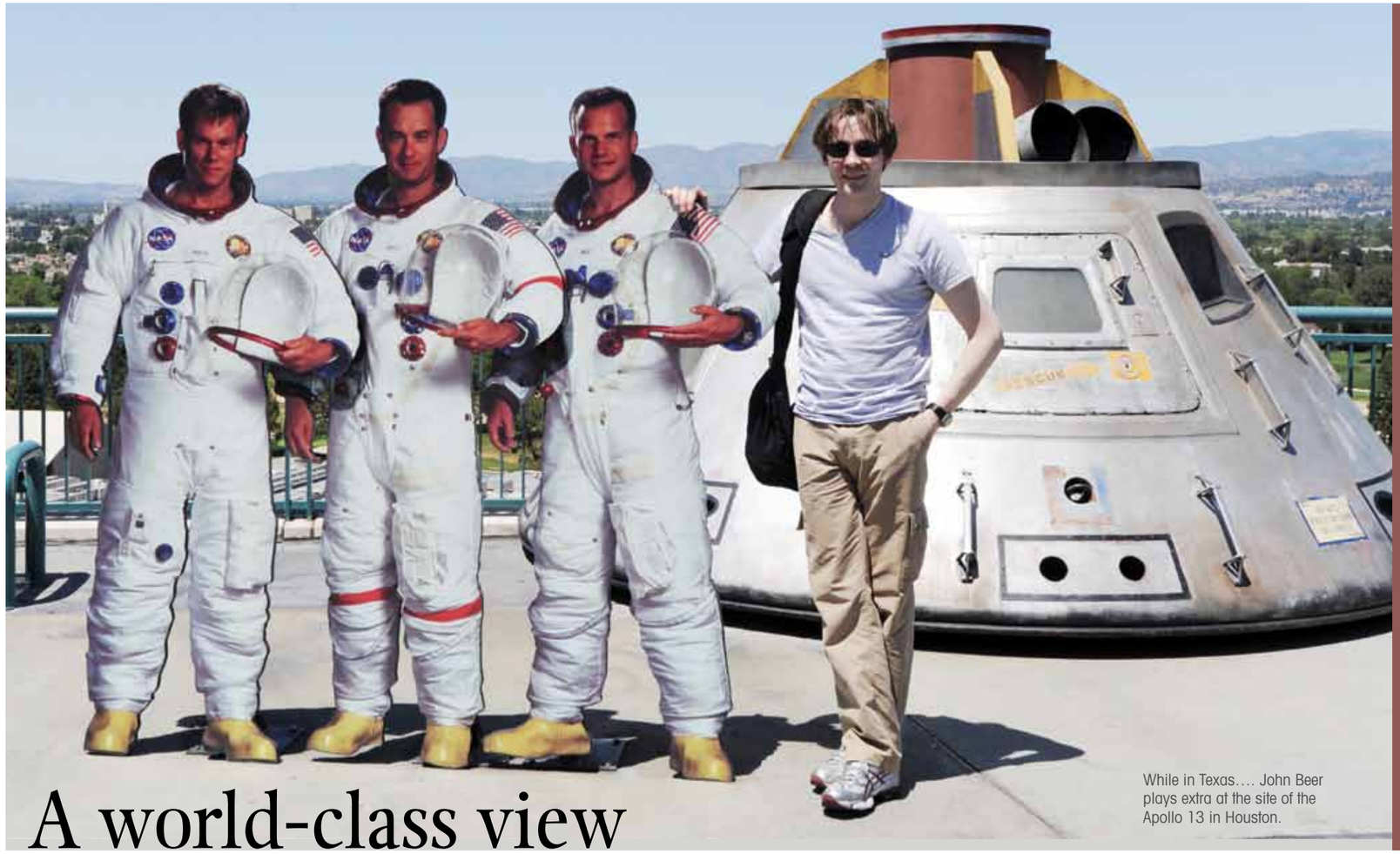
It is recognised that surgical site infection accounts for approximately 20 per cent of all hospital acquired infections. On average patients spend an additional seven days in hospital at an average cost of $1000 per day and with significant additional costs following their discharge from hospital. Deep infection following hip and knee replacement surgery frequently results in repeat surgery on one or more occasions and, not infrequently, complex revision surgery. In these instances, the total costs are frequently several times the cost of the primary arthroplasty (approximately $20,000). Therefore, a reduction in the incidence of surgical site infection has the potential to permit additional funding to be directed to primary surgery and the treatment of more patients.

"The (ASC) scientific program was of a very high standard and it is just a pity that the same can't be said for the weather!"

At the end of March, under the auspices of our Health Quality and Safety Commission (HQSC), prospective data collection in respect to deep infection following hip and knee arthroplasty commenced in eight of New Zealand's 20 DHBs. After identifying and removing any difficulties with data collection it is anticipated that the remaining 12 DHBs will be participating also from the beginning of July. The consistent collection of this data will permit the accurate determination of the incidence of serious deep infection following major joint arthroplasty. The recognition of any variance across the country will result in closer scrutiny to identify any differences in the perioperative care which may be contributory factors; and hopefully result in changes in practice that can lead to a reduction in the rate of infection.

This initiative is the first in a series to collect accurate data in respect to surgical site infection following elective procedures across New Zealand. Allan Panting (EDSA, NZ)) represents the College on the HQSC group developing this program. Once it has been introduced successfully for these arthroplasty procedures, consideration will be given to auditing cardiac surgery and caesarean sections in a similar manner. Further surgical procedures with sufficient volume, whereby the data can achieve statistical significance, will be included subsequently. While initially data collection will be a mixture of web-based and hardcopy, it is anticipated that this will move quickly to electronic entry at all sites once the IT support has been further developed.

Scott Stevenson
Chair, New Zealand National Board



While in Texas…. John Beer plays extra at the site of the Apollo 13 in Houston.

A world-class view

Travel made for invaluable experience for this plastic and reconstructive scholar

Plastic and Reconstructive surgeon Mr John Beer was last year given privileged access to some of the largest and most prestigious medical centres in the US with the support provided by the College's Hugh Johnson ANZ Chapter American College of Surgeons Travelling Fellowship.

In America, Mr Beer spent time at the MD Anderson Cancer Centre in Houston, Texas, the Paces Plastic Surgery Centre in Atlanta, Georgia, the Memorial Sloan Kettering and Lennox Hill Eye and Ear Hospital in New York and the Massachusetts General Hospital in Boston.

He said that having recently completed his training, he was grateful for the College support to allow him to see the advances being made in plastic and reconstructive surgery, to learn from leaders in the field and to compare different medical and education systems.

Mr Beer's time in America became part of what turned into an 18-month global research odyssey which also took him to Europe, Japan and East Asia to observe leaders in the field of plastic and reconstructive surgery such as Professor Isao Koshima at Tokyo University Hospital, a leader in the field of super-microsurgery, Professor Hung-Chi Chen in Taiwan, a pioneer in novel approaches to head and neck reconstructive surgery, and Mr Barry Jones in London, a recognised international figure in facial aesthetic and reconstructive surgery.

He said he had returned home with new skills and new approaches to complex cases, a desire to build consultative surgical networks to discuss difficult reconstructive cases and also with a greater understanding of the world-class standard of Australian surgical training.

Now back working at the Austin Hospital, the Skin and Cancer Foundation in Carlton, Monash Health and with a private practice based in Melbourne's eastern suburbs, Mr Beer said he was unprepared for the sheer scale of the MD Anderson Cancer Centre which covers a geographical area similar in size to the Melbourne CBD.

With a special interest in reconstructive microsurgery particularly as it applies to the head and neck region, Mr Beer was given access to operating theatres, clinics and clinical meetings and worked alongside Dr Peirong Yu, an internationally-regarded figure in Microvascular Head and Neck Reconstructive surgery.

"Dr Yu has authored many papers on refinements and the anatomical basis to the anterolateral thigh flap and his technique is the one that most young plastic surgeons in Melbourne are trained to do," Mr Beer said.

"I attended several cases with him which allowed me to see the approach and the philosophies which he applies to head and neck reconstruction.

"I also had the pleasure to meet Dr Hiroo Suami, the director of the microsurgical research laboratory at MD Anderson.

"His particular area of interest is in the lymphatic system and through him I was able to learn more about some of the recent advances in lymphatic surgery that are taking place in several places around the world.

"Later in my travelling Fellowship I was able to visit three centres in Japan due to introductions provided to me by Dr Suami."

Mr Beer said that while the type of procedures performed at MD Anderson was similar to those conducted here, the enormous resources available and the large caseloads led to markedly different systems.

"There, surgeons are divided into teams to assist in particular reconstructions with each surgeon often assigned to multiple cases through the day and because all the surgeons are on staff, they are often available for cases at fairly short notice, an approach which is different to what we tend to have in Australia.

"The enormous resources at centres like this, where patients fly in from overseas just for an out-patient appointment, are great to experience, but impossible to replicate in a country the size of Australia.

"Yet while the on-staff team approach has its advantages in that it fosters group interaction and expertise and allows surgeons dedicated research time, it can limit skills by limiting exposure to the wide variety of cases that we are asked to treat as plastic surgeons in Australia."

Mr Beer, who travelled with his wife Dr Alicia Au, an ophthalmologist and oculoplastic surgeon, next visited the Paces Plastic Surgery Centre, the private practice of Dr Foad Nahai, author of plastic and reconstruction surgery texts used by most Australian Trainees. ▸

PAPERS PRESENTED

Ultrasound Assessment of DIEP Perforators
Annual Scientific Congress of The Royal Australasian College of Surgeons
May 2008 Hong Kong
Contributing Author: D McCombe

Radial Artery Anomalies for Cardiac Surgeons
Annual Scientific Congress of The Royal Australasian College of Surgeons
May 2006 Sydney
Contributing Author: M Yii

Inguinal Canal Soft Tissue Sarcomas
Annual Scientific Congress of The Royal Australasian College of Surgeons
May 2005 Perth
Contributing Author: M Henderson

Subcutaneous Neurovascular Advancement Flap with Full Thickness Skin Graft in Finger Tip Amputations
Annual Scientific Congress of The Royal Australasian College of Surgeons
May 2003 Brisbane
Contributing Author: WA Morrison

Simultaneous Avulsion of Two Adjacent Flexor Digitorum Profundus Tendons
Annual Victorian Hand Surgery Society Meeting
November 2007 Melbourne
Contributing Author: J Burt

The 2012 American College of Surgeons International Scholarship & Fellowship recipients with Stephen Deane, chairman of the International Relations Committee.

He said that of the many cases of aesthetic and reconstructive surgery that he saw there the greatest point of difference was in the use of acellular dermal matrix in breast reconstruction which is used to control the inframammary fold, to assist in pocket control, help cover the inferior half of a breast implant and in some cases to minimise the effects of rippling or contour problems.

After a month in New York, Mr Beer visited the Massachusetts General Hospital at the invitation of the hospital chief, Dr William Austen, who had mentored Mr Beer for the Fellowship and co-ordinated his travels through the US.

"One area that I had no previous experience with was migraine surgery of which Dr Austen is a pioneer," he said.

"From our brow lift experience it has been noted that some patients receive dramatic improvements in the symptoms of migraine which has led to the development of surgical procedures in selected patients.

"We know that it works, but the real key is choosing the right patient and I believe over the next decade it will become much clearer where surgery fits into the treatment of migraine."

A warm welcome with Professor Yoshihiro Kimata - Okayama Japan.

The final stop in the US for Mr Beer, before he headed to the UK to work for three months at King Edward VII hospital in London under Mr Barry Jones, was attending the Annual Scientific Congress of the American College of Surgeons held in Chicago.

There he participated in many formal aspects of the ASC as part of the commitments attached to the Travelling Fellowship, attended many of the scientific sessions and, along with other international scholars, delivered a presentation.

New career focus

Looking back, Mr Beer described his time overseas as an extraordinary opportunity and one which he felt had helped shape his career, not just in terms of his technical skills and knowledge, but also in relation to consultative problem-solving and professional cross-pollination.

"As an individual surgeon in Australia, I think we have more experience than our counterparts in the US despite their enormous resources, not only because we have a broader case mix, but also because all of us here have to constantly take into account the limitations of our resources and ensure we put them to the best possible use," he said.

"At the same time, in Australia an average patient at every major hospital gets world-class treatment whereas in the US, a patient is not guaranteed that level of care outside major centres and I think we should be very proud of that.

"We may lack the same resources, but not the skills or expertise or commitment and I grew in confidence during this visit knowing Australian surgeons and Australian surgical training are up there with the best."

With Karen Murphy

Review of ANZASM

An overwhelming majority of surgeons felt that the Surgical Mortality Audit was useful

Key Points

The Australian and New Zealand Audit of Surgical Mortality (ANZASM) is an external peer-review audit by surgeons of deaths that occur under their surgical care.

- 92 (10 per cent) of invited surgeons responded to the survey
- 83 per cent of respondents indicated that they completed the surgical case form (SCF)
- 54 per cent of participants completed the SCF online via the Fellows Interface
- 80 per cent of Fellows found the feedback from second-line assessments useful
- 79 per cent of respondents felt that the annual report publications and case note review booklets were informative
- 73 per cent of participating surgeons felt that the ANZASM process could influence and improve patient outcomes
- 48 per cent of participants felt that the audit made them risk averse in surgery
- 82 per cent of surgeons agreed that they felt comfortable with the audit process, reporting and assessor's feedback.

The aim of the survey was:

- To ascertain if the audit was useful to surgeons.
- To establish whether it had improved or influenced their practice.
- To enquire about the surgeon's attitude towards the audit.
- To elicit information that would improve the audit and address any dissatisfaction surgeons might have.

Demographics

- 83 per cent of participating surgeons completed the surgical case form themselves.
- 54 per cent of participants used the online web-based Fellows Interface to complete the surgical case form. Processing and turnaround time is significantly reduced when forms are submitted online.

Audit Process and Feedback

- Nearly half of respondents (48 per cent) were unaware that they could appeal against the findings of an assessor's feedback. In circumstances where the treating surgeons did not agree with the assessment, they are within their rights to request another assessment to be conducted.
- 80 per cent of participating surgeons felt that the feedback they received from a second-line assessment was useful to their practice. Feedback was considered not useful by 9 per cent of respondents.

Comments and feedback from surgeons on the ANZASM assessment process:

Receipt of two successive assessments that were critical of processes (internal subspecialty referrals causing delays), gave me the courage to take on some more complex cases in emergency situations, with good results so far.

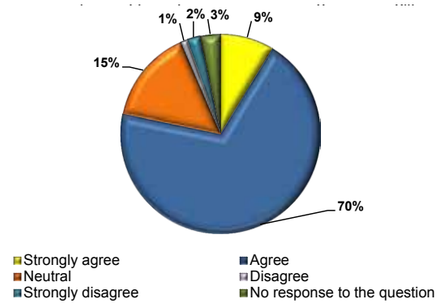
Being aware that our work will be reviewed, there has been improvement in outcomes in the regions with the institution of the audit. This has previously been seen in institutions and overseas, so there must be some changes!

We should be auditing PROCESS as well as outcomes. Outcomes are not as powerful an assessment tool, nor do they provide a solid template for protocol change and process evaluation.

All comments are most valuable. Whether they lead to change will depend on the individual circumstances and whether modifications are needed, required or appropriate. All input is valuable.

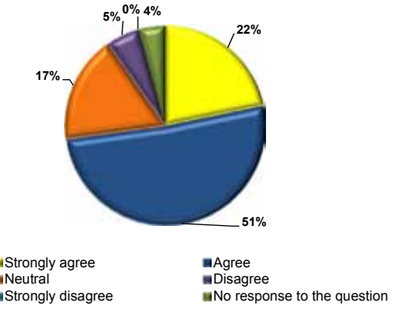
Audit Value

Figure 1: Annual reports and case note booklets are informative



- 79 per cent of participants agreed that they found the annual reports and case note booklets they received as informative.
- 3 per cent of participants disagreed however that the reports and booklets were informative.

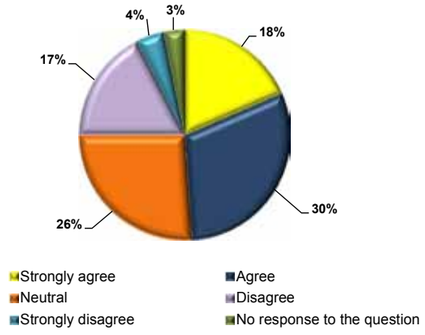
Figure2: ANZASM can influence and improve patient outcomes



- 73 per cent of participants agreed that they felt that the ANZASM process could influence and improve patient outcomes.
- 5 per cent of participants disagreed however that the process could not influence patient outcomes.

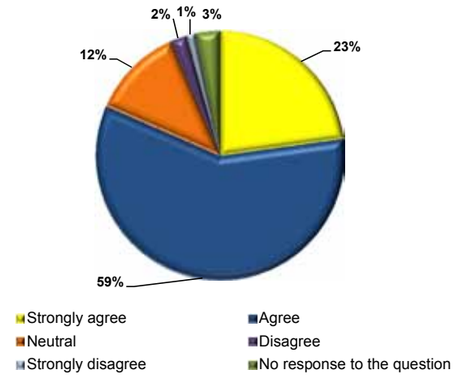
A survey was conducted in January 2013 to seek feedback from participants about the mortality audits. Two reminder emails were sent over the break period and survey feedback was anonymous.

Figure 3: The audit is likely to make surgeons averse to risk taking in surgery



- Conversely, surgeons felt in 48 per cent of cases that the audit made them averse to risk taking in surgery.
- 21 per cent of surgeons felt that they disagreed that the audit made them feel averse to risk taking in surgery.

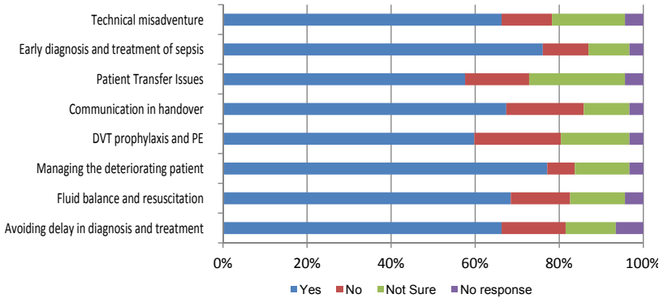
Figure 4: I feel comfortable, within the audit process, reporting & comments on areas of concern & adverse events relating to patient management



- 82 per cent of surgeons felt that they were comfortable with the overall audit process, especially when it came to feedback on areas of concern and adverse events.
- 3 per cent of participants disagreed however that they were comfortable with the feedback they received from the audit process.

WORKSHOPS & SEMINARS

Figure 5: ANZASM has identified the following topics for further workshops – are these relevant?



- Workshops on the subject of the deteriorating patient and early diagnosis and treatment of sepsis continue to be popular educative topics. Future workshops could include topics such as fluid balance and communication in handover issues.

Comments from surgeons on how the process can be improved:

If the death is expected as the patient is elderly, then we shouldn't have to fill out the whole form. I can see the value in the audit for people who have preventable deaths or management issues and the audit generally is an excellent way of an external body reviewing patients care. In those circumstances, I am sure the audit would help the surgeon involved and hopefully lead to improved patient care. It is a good idea to continue to ensure that we don't have surgeons out there with excessive deaths. Otherwise who will monitor that? College would be required to intervene if a surgeon was clearly unsafe in practice with poor judgement and decision making.

It is difficult to ascertain whether the results of the POM (Perioperative Mortality) data are actually causal in any reduction in mortality or improvement in outcomes. It has happened in some areas, contemporaneously, but probably as a general improvement in preoperative and perioperative care, case selection and involvement by senior staff in more complex emergency cases and decision making. This is most likely parallel to the introduction of POM data gathering. There is now enough data published to show:

1. Widespread variation in supervision of cases for emergency and complex care
2. Variation in DVT prophylaxis
3. Variation in access to and utilisation of high level care

These issues should be identified, and advice given to centres whose data show a systematic variation from the norm.

Open workshops where actual cases from previous audits could be presented and discussed particularly controversial cases would be of great benefit.

It is an excellent peer reviewed activity.

There needs to be a mechanism for more than one surgeon to be officially involved in a patient's report (maybe by producing multiple, duplicate forms for each patient). It would be useful in these cases if the feedback went to all the consultants who had been involved. In some cases; nearly all of the forms are completed by registrars, without the consultant even seeing the request. These have to be done on paper because the registrars can't access the on-line forms. The registrars rarely get feedback, even when they have effectively been the treating doctor. When the assessments were passed back to the registrars involved, they were astounded, because they had no idea the forms led to feedback.

Although the paper form can be quicker, I try to complete forms on-line because it is easier for the audit. I still have to do a paper form if I complete it the day the patient dies because I can't generate my own blank electronic form.

One should ask whether there was something in the management of this patient that could have led to more than 12 months of quality survival. There should be a second category of patient. The person, who has committed to a Nursing home or is in a facility requiring assisted living, should be assessed in a separate category. Our biggest dilemma is how and will the ageing patient and the appropriate level of care be given, to an elderly person who has accepted that their life is nearing its end and is ambivalent about intervention.

Sometimes more robust clinical criticism may be necessary, but must remain within craft group of experience. One must avoid being seen as imposing management/clinical 'rules' for an 'ideal world' which can be far from providing in all settings, e.g. rural.

Comments from surgeons on what further information could be collected:

Major complications that do not result in death, but near death. There is a lot to learn from these cases.

External factors influencing care such as the reason for delay – having six fractured neck or femur cases in one day does not realistically allow any hospital sterilisation department and other infrastructure to respond ideally. Everything that is done is a compromise assisting the health system to assist patients.

Closer inspection is needed at the ageing patient. Also look closely at Trauma patients, as this is an area for constant improvement.

Conclusions

As the audit grows and develops, the ability to identify trends across Australia will further add to the ongoing knowledge of the particpants, and potentially lead to better outcomes for all surgical patients.

Guy Maddern
Chair, ANZASM

To support the findings of this survey:

- Peer-reviewed feedback has been provided directly to individual surgeons, via assessors' comments, on individual cases. This is an essential component of the audit as it provides specific targeted information on a case by case basis.
- Workshops and seminars have been facilitated based on regional reports and in-depth investigations of issues identified. These activities have increased the quantity and quality of information disseminated on issues that have greatly affected clinical governance and patient care across the country.
- The audits will continue to encourage the use of the 'Fellows Interface' web-based tool as an important initiative which provides users with a dynamic, user-friendly tool to enter online surgical case and complete first-line assessment forms. This minimises data entry time, the risk of errors in data entry and hastens turnaround time.
- The audit will continue to produce and deliver an annual report and national case note review booklet for distribution to surgeons, Trainees and other clinical staff involved in patient care. These cases in the booklet were identified as offering clinical insights and have been well received by the surgical community.
- Improvements have been made to the surgical case form in order to streamline the data and to collect more detail around a patient mortality with infection.

Opus XXVI

Felix Behan
Victorian Fellow

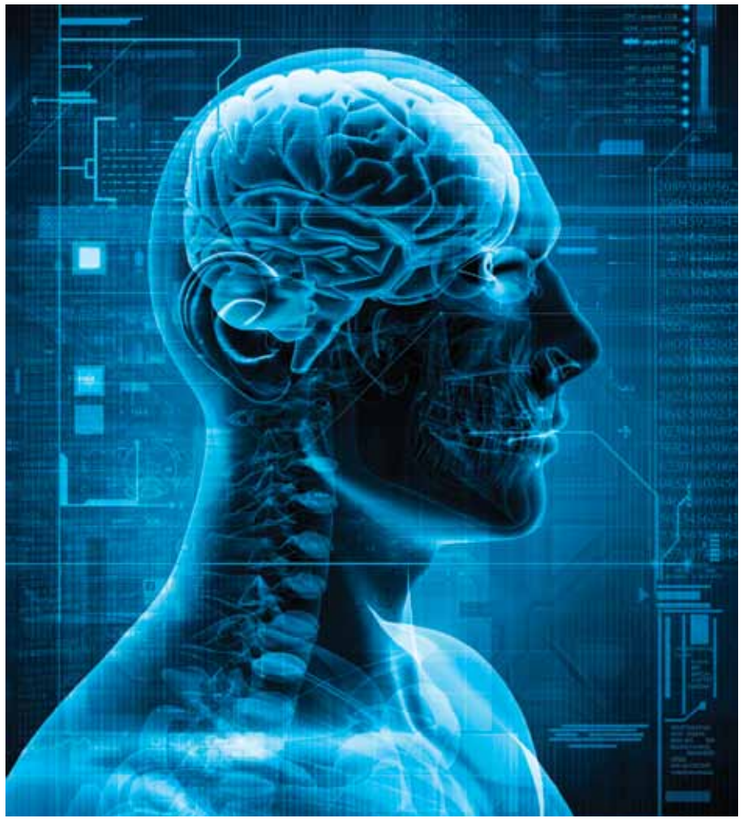
A Clinical Story about *Intuition*

Hunches come from right brain activity and should be trusted more often

In the March 2013 edition of Surgical News, in the section of Audits of Surgical Mortality a case of delayed diagnosis of a perforated ischaemic intestine was reviewed, under the authorship of Guy Maddern.

For those who missed it, this was a case study of an elderly patient with co-morbidities including dementia and an earlier admission for a small bowel obstruction managed conservatively. Subsequently on re-admission he had signs of abdominal distension and vomiting associated with multiple fluid levels on X-ray. He was reviewed by the consultant the following day. The patient was assessed as becoming pre-moribund due to the acute abdomen, and proceeded to laparotomy as a life saving option. A perforated ischaemic terminal ileum was identified, associated with gross peritonitis. A series of open laparotomies followed. Then the premature removal of staples from an infected wound in ICU led to wound dehiscence which accelerated his demise. The patient's condition deteriorated and with the family in consultation the decision was made to withdraw active treatment.

The assessor's comments in Surgical News highlighted certain aspects of the case including an absence of suspicion of the severity of the case before the overnight deterioration. Guarding of the abdomen should ring bells in relation to the urgency of surgical management and with poor parenteral nutrition and subsequently the issue of mistakenly removing sutures prematurely, all these factors contributed to his demise.



This article brought to my mind an experience of my own where intuition worked and "gut feelings" (my own this time) led to a fortunate outcome which was not based on logical deduction. Here is that story.

Some years back a friend of mine in the Art and Antiques trade returned from a buying trip in Paris. He had done this almost yearly throughout his commercial life. His touch of frugality meant he did not waste money on Business Class (like the chairman of IKEA, who had the same philosophy, one often seen in people who recall the frugal days of the Depression).

This tall man, of 74 years, was cramped into his economy class seat for 24 hours; this may have been the aetiological link (or kink). Following a stopover in Singapore, he arrived back in Melbourne with gastro-intestinal symptoms. His local GP diagnosed gastroenteritis from food poisoning and reassured him it would settle. His son phoned me that afternoon and said "you are the only guy my father will listen to – can you speak to him?" Knowing full well that I could do next to nothing over a phone I offered some consolation. I then rang the father. In our conversation he just said "Felix, I don't feel well, I can't breathe and I feel distended". That to me was a key indication of some impending disaster – thinking it may have been a heart problem. I asked the simple question, "Have you had any heart disease in the past?" He told me he had had coronary stents at the Epworth some time back.

I exclaimed dramatically and my tone must have reflected my anxiety – "holy s___!" just came out. I advised him to phone the MICA ambulance immediately in case he was having an impending infarction. His wife even asked "Should I go with him?" I responded "You had better – it might be the last time you hold his hand".

Bowel necrosis

By then the patient was in a pre-deathly state. The ambulance diverted to a regional teaching hospital thinking they would not make it to Melbourne – an hour away in peak hour traffic. Yes on admission, he was able to bypass the wait in the Emergency Department. Pre-operative imaging must have confirmed the bowel necrosis and fluid levels and he was on the table for a laparotomy in a rapid time frame, for this perforated ischaemic intestine. The consultant on call resected the bowel and left the open laparotomy wound for the next stage. The next day one of the academics from a major teaching hospital came to assist and further resection was completed over the ensuing days because of the degree of questionable bowel viability.

After repeat laparotomies, I think the abdominal cavity was eventually closed after the fourth return to theatre which included finally a Hartmann's procedure. Incidentally, Hartmann worked at the Hospital Dieu in Paris, Dupuytren's old haunt and described this procedure in 1921 and he himself died in 1952; I got this pearl from Professor Ellis's notes on Clinical Surgery – a person I met in London in a recent presentation I did at The Royal College of Surgeons. He even bought my textbook for the Kings College Library. He was a sparkling and dynamic wit in his eightieth year and held the audience in his palm, the Michael Parkinson of surgery.

My friend, finally left ICU, but there is a funny twist in this tale. The ICU team asked the family, during this crisis period, to sign a document stating the patient was "not for resuscitation". Some say this is a feature characteristic of ICU staff where they handle death regularly and the management team make decisions about the impending outcome of a person dangerously ill.

Once more the son phoned me on that Saturday morning, 10 days after the acute admission, to ask me whether or not they should sign as it was still touch and go regarding recovery. My response was simply "under no circumstances do you sign that document, as without it, the onus remains on the ICU team to carry on active treatment." Yes, the patient recovered. He went back to the ward alive with all his mental faculties and eventually went home with a colostomy after a 3-4 week stint in hospital, one of the minority (I think 5 per cent) to survive ischaemic bowel necrosis.

Hunch was right

An interesting valete comment came from one of the senior ICU staff, when all was done. After the chocolates and champagne had been passed around, his son was asked, "Has someone been tutoring you in the background throughout this crisis?" Interesting. This brings me to the background of thinking about intuition and the gut feelings or heuristic "rules of thumb" which apply in clinical medicine.

My clinical diagnosis in this instance was absolutely wrong, but my hunch was that his condition was life threatening. His restricted breathing was not of cardiac origin, but the result of abdominal distension restricting respiratory and diaphragmatic movement. However the MICA ambulance team expeditiously transported him to the closest hospital. They short circuited any delay through the Emergency Department. The pre-operative imaging with aneurysmal speed would have been completed in transit to theatre. A surgical team was available that evening and subsequently with the series of laparotomies to assess bowel viability in a combined consultative manner.

This resulted in a successful outcome against all the odds; thanks to this team and the public hospital system, the outcome was favourable (if you are really sick go to a public hospital). From my general surgical days, we always learnt a soft abdomen is a soft option, but when there is guarding, this must galvanise activity – it sounds like something Bertie Coates may have said, and perhaps he did.

So I publicly thank all involved (the surgeons involved will recognise the story) from the ambulance team to the nursing staff and other surgical personnel. My friend is still alive and well and still buying art on the international art scene in Paris on a regular basis. He is now a little wary of international travel and I am sure he might even upgrade his future travel arrangements.

On another tack I read recently Ross Gittins's recent in The Age quoting the German psychologist Gigerenzer of the Planck Institute from his recent book "On Gut Feelings". He goes on to say that since The Age of Enlightenment, universities have taught students to think logically, analysing problems to arrive at a definitive conclusion. But often better results are achieved by employing the subconscious.

A photograph of the musical instrument, made by Naderman who was the harp maker to Marie Antoinette. In the label inside the instrument it reads Luthier Facteur de Harpe ordinaire de service de la Reine – Harp maker in the service of the Queen. In 1797 the word Reine is crossed out which is a subtle reference to the be-heading of Marie Antionette in 1792. Simply the maker was divorcing himself from any Royal connections to save his own head. The harp was purchased in Paris by my friend after his recovery and is now housed in an important art collection in Melbourne. This may never have occurred if he had not been one of the lucky 5 per cent.

1: The instrument in the antique "restorer's cave" (or the "dealer's den" – I know not which) with a single action paddle mechanism with crochettes craved and glided with Chinoiserie decoration and a painted sound board.

2: The maker's mark for this 18th century musical instrument dated 1784. Three years before the French Revolution.

3: This is external signature important verification for authenticity - The harp maker to Marie Antoinette

Daniel Kahneman in his book 'Thinking Fast and Slow', for which he won the Nobel Prize for economics, demonstrated the value of such decisions which we make spontaneously and instinctively. He goes on to state that deliberation takes away any intuitive influence. In conclusion, he states that cognitive limitations exist when too much information confuses and misleads.

Instinctive behaviour

These instinctive mental shortcuts are what psychologists sometime describe as "heuristic" and may seem quite illogical to the academically trained mind. Any fast and frugal decisions are likely to work. An instinctive behaviour produces a successful result without relying on any logical sequence. It is the intelligence and the subconscious awareness, without thinking, which produces a beneficial outcome.

According to the renowned neuropsychologist Roger Spery, intuition is a right brain activity, while factual and mathematical analysis are left brain activities. Intuition can also be noted in writings which might have a spiritual flavour. As Thomas Merton discusses in his essays, is it a transition between the common touch of the earthly knowledge and the spiritual inclination beyond, which appear as flashes of illumination.

To cap it all, even Einstein gets into the act when he said that "the intuitive mind is a sacred gift and the rational mind is a servant forever."

Yes I had a little bit of luck in this case/story, I suspected something ominous. Fortunately, the public hospital system was available, experts were on hand, time was of the essence and what a fortunate outcome – all over the phone.

CONGRATULATIONS on your achievements

John Corboy Medal 2012 Recipient: Dr Ruth Blackham

Dr Ruth Blackham has demonstrated and continues to demonstrate all the qualities the John Corboy medal recognises and celebrates.

A General Surgical Trainee based in Perth, Western Australia, she is a competent and compassionate surgeon, who regularly makes time to supervise, educate and encourage surgical Trainees to expand their surgical abilities.

Ruth's service to the surgical community is commendable. She was elected as the General Surgery Representative of the RACS Surgical Trainees Association from 2009–2010 while serving on other committees including AMA Doctors in Training WA Committee (2008-2010) and prior to that in 2006 she was the Chair, Junior Medical Officer Committee, of the Postgraduate Medical Council of Western Australia. More recently, Ruth is a member of the Ethics and Medicolegal Committee, an AMA Federal Council subcommittee, the RACS Surgeons as Educators Committee, the Australian and New Zealand Gastro Oesophageal Surgeons Association, and the AMA Doctors in Training.

Her commitment to the representation of Surgical Trainees has not distracted her from her surgical training. As a SET 5 Trainee at the Royal Perth Hospital, Ruth continues to perform as an outstanding registrar while balancing a multitude of other interests around education and research, including advocating for junior doctor wellbeing and teaching junior medical staff and interdisciplinary health professionals. Ruth has also been active academically and is currently undertaking a Masters in Surgery with a focus on Simulation in Surgical Education. She recently published an article "Surgical Simulators in Training: Are we there yet?" in the ANZ Journal of Surgery. Ruth also has an interest in legal medicine.

Truly a remarkable role model and accomplished clinician, Ruth is a regular guest speaker for both Western Australian Medical School Surgical Societies. She has demonstrated exceptional leadership qualities and continues to inspire post graduate medical students in their pursuit of a surgical career.

Ruth is a worthy recipient of the John Corboy Medal.

Surgical News always welcomes letters from readers.

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

A Letter from Syria

Dr Tamaris Hoffman, a surgeon from Wangaratta, Victoria, recently spent six weeks in Syria on her first field placement with Médecins Sans Frontières. Here she talks about her experiences working as a surgeon in conflict conditions.

I was working in a surgical project in the north of Syria, mostly doing war surgery on people who had injuries due to gunshots. There were two broad categories of injuries – orthopaedic injuries and abdominal injuries. Many orthopaedic injuries were unsalvageable and I performed five amputations, including an amputation of an arm. Gunshot wounds to the abdomen also caused a great deal of damage and I performed nine laparotomies for these injuries alone.

One young man I remember well was a 19-year-old who was hit by rocket fire and unfortunately sustained extensive burns. He wasn't a fighter, just a civilian who happened to be in the wrong place at the wrong time. He had extensive, full thickness burns to his arms and legs. He'd also sustained shrapnel injuries to his pelvis, so I had to remove his entire bowel and give him a permanent stoma. When he woke up and I told him he now had a colostomy bag, at age 19, he was devastated. You begin to wonder whether you've done the right thing by the patient. But there were few other options for this young man. We also had to graft his burns, and he ended up spending four weeks in the hospital. I would often think how terrifying it must have been for him, being hit by a rocket in Aleppo and running down the street with such serious burns. He'll have that in his memory forever.

A brave young boy

As well as the war surgery, another large component of the work was surgery among children who had been accidentally burned as I was in Syria during winter, and families were using fuel for heating. One boy who made a big impact on me was aged 12, with extensive burns from playing with fuel. He had burns on the back and front of his trunk, on his legs, feet, arms, hands and face. I thought he might not make it. He needed anaesthetic every time he had a dressing change, and sometimes he'd wake up from the anaesthetic and think I was his mother, so he'd hold my hand and want to kiss me! We dressed his burns every second day for three weeks, and his wounds healed beautifully. He eventually left hospital without needing any grafting, which shows what a good job nature does on children. When I said goodbye to him I cried... it was awful! He was a lovely little boy and very brave. He put up with those dressing changes without any complaint.

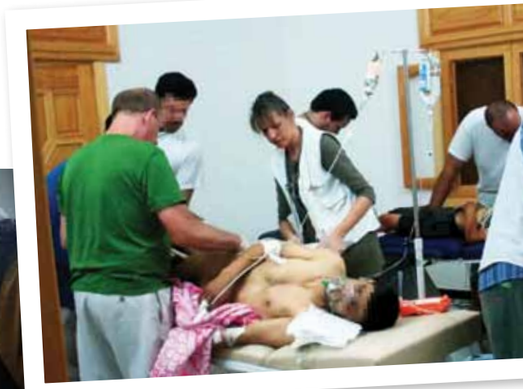
We responded to one mass casualty event when I was there, after fighting around Idlib. There were heavy casualties on both sides, plus a number of prisoners were freed from the local prison. We received about 30 patients in all, including patients from the prison, from the rebels and from the regime. As soon as they walked through the door, they were just patients – there wasn't any problem at all that they were from different sides of the conflict. I don't recall any conflict in the wards whatsoever. We also had a no-weapons policy that was strictly enforced and worked very well.

> *"You begin to wonder whether you've done the right thing by the patient"*

A lost generation

In Syria I operated for 10 to 12 hours a day, for 35 days straight. I kept a log of all my operating and overall I did 219 operations on 80 patients, 75 of whom were men. The average age of the patient was 24. The problem is, you wonder about the future of the country when so many young men have been killed, and many of those who survive will be disabled. There'll be many families without a means of support, and there won't be a fit workforce to rebuild the country.

Part of my role was working with and training Syrian staff. I was impressed with how well trained the Syrian theatre assistants were. We learnt a lot from each other, and chatted about our lives outside the hospital. The Syrian staff had a huge thirst for knowledge of the outside world and wanted to know all about my home and family in Australia.



Limited resources

The hospital was located in a two-storey house in the centre of the village. On the ground floor we had a resuscitation room, an X-ray facility, a sterilising area and the operating theatre. If a patient needed an emergency operation they came through the system very quickly. Upstairs, we had three wards and an office, then an open rooftop with our laundry.

I had to adapt to not having the same resources that I'm used to in Australia, such as a CT scanner, or a mobile X-ray machine. But it didn't make much difference managing patients. We worked on first principles (basic clinical facts and knowledge in the absence of elaborate diagnostic investigations) and I think it made me a better surgeon in some ways. It makes you aware that you can cope with just about anything. It builds your confidence.

I was mostly confined to the hospital and the house. We had a 50 metre walk between the two, so I saw nothing else of Syria. That confinement was difficult to cope with; it drove me mad actually! That was the most challenging aspect of my time in Syria.

The most rewarding thing was realising that people want the same things from life, no matter where they are in the world. In Syria, which has such a different culture to Australia, people want a secure place for their family, they want education for their children and they want to make sure they can provide for their family. You realise that no matter what religion you are or what colour you are or what language you speak, people all want the same basic things.

Tamaris Hoffman
Victorian Fellow

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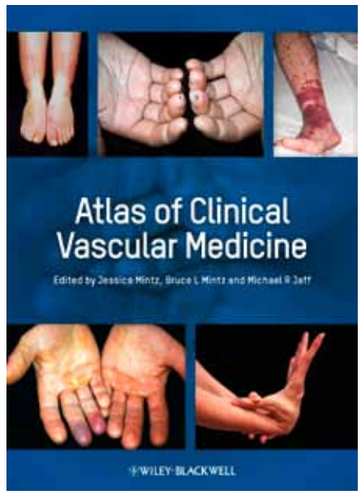

Atlas of Clinical Vascular Medicine

Michael R. Jaff , Bruce L. Mintz, Jessica Mintz (Editors)
9780470658093 | Hbk | 208 pages
April 2013

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This new atlas, featuring over 200 images, focuses on clinically-relevant information to help you identify the myriad manifestations of vascular disease and enhance the care of your patients. The case-based approach, with self-assessment questions at the end of each chapter, helps reinforce key concepts and will aid preparation for board examination or recertification. A companion website features downloadable versions of the book's images in Powerpoint format for easy integration into your own presentations.

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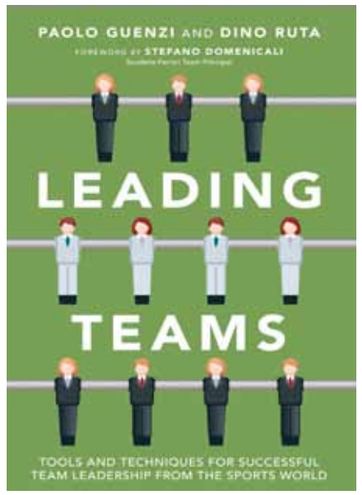

Leading Teams: Tools and Techniques for Successful Team Leadership from the Sports World

Paolo Guenzi, Dino Ruta
9781118392096 | Hbk | 352 pages
April 2013, Jossey-Bass

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How do the sports world's most successful coaches instill their teams with esprit de corps, a collaborative mindset, and an unbeatable desire to win? More importantly, what can business leaders and managers learn from their example? This book answers these and a host of key questions about what it takes to be a successful leader in business or in sports. Drawing upon their unique experiences working with top sports coaches, as well as some of the world's leading corporate executives, authors Dino Ruta and Paolo Guenzi offer important new insights into team leadership and motivation, as well as new tools for optimizing teamwork and inspiring teams to reach for and achieve new heights of glory.

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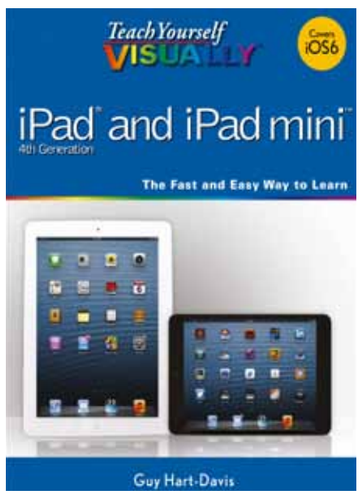

Teach Yourself VISUALLY iPad 4th Generation and iPad mini

Guy Hart-Davis
9781118596326 | Pbk | 352 pages
January 2013

~~AU$37.95~~ | **AU$28.46**
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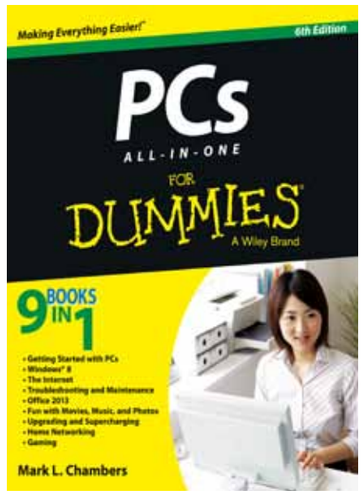

PCs All-in-One For Dummies, 6th Edition

Mark L. Chambers
9781118280355 | Pbk | 720 pages
April 2013

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Whether you use your PC for work or play, there's a lot to learn and a lot of territory to discover, so take along a good guide. This All-in-One guide covers essential PC topics from soup through nuts, including the latest on PC hardware, Windows 8, the Internet, all the tools in Office 2013, digital media, troubleshooting and maintenance, upgrading your PC, home networking, and PC gaming. You'll get to know your PC inside and out and find yourself turning to this terrific resource again and again.

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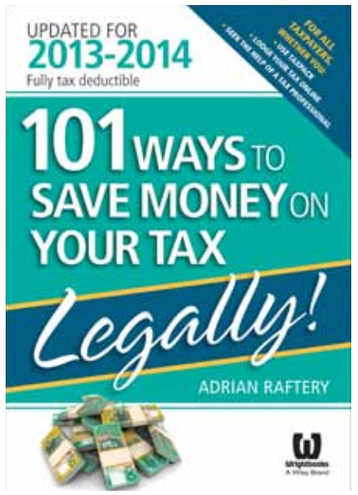

101 Ways to Save Money on Your Tax - Legally! 2013-2014

Adrian Raftery
9781118621769 | Pbk | 340 pages
May 2013, Wrightbooks

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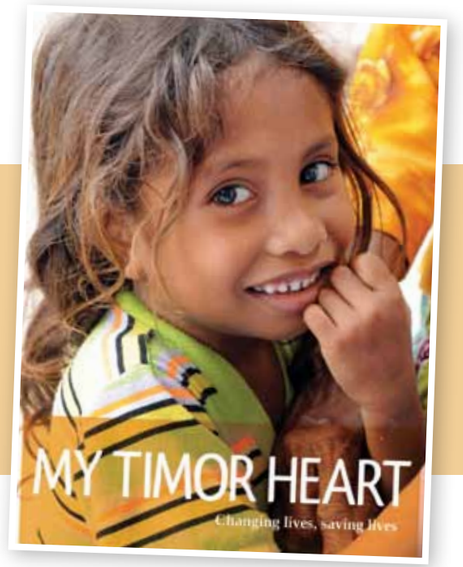
The College has produced a book, called *My Timor Heart*, to celebrate our achievements in Timor Leste. *My Timor Heart* will recognise the extraordinary efforts of the medical volunteers in Timor Leste, and the life-changing impact their work has on people living in a country that continues to struggle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



My Timor Heart

Written by Ellen Whinnett and Ellen Smith

Using striking photographs and volunteers' stories *My Timor Heart* illustrates the profound positive impact of the College's Timor Leste program. 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..*

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

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

NOMINATIONS MUST INCLUDE

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

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

CONTACT INFORMATION

For further information or to submit an application

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The Timor Leste Program currently employs six full-time clinicians at HNGV and coordinates around 16 specialist team visits across Timor Leste per year.

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