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INFLUENTIAL SURGEONS

Eugene Doyen 1859-1916

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Eugene Doyen (1859-1916)

WORKSHOPS & ACTIVITIES

Online registration form is available now (login required).

Inside 'Active Learning with Your Peers 2016' booklet are professional development activities enabling you to acquire new skills and knowledge and reflect on how to apply them in today's dynamic world.



Foundation Skills for Surgical Educators Course

23 May 2016 - Lismore, NSW, Australia
2 June 2016 - Auckland, New Zealand
4 June 2016 - Bendigo, VIC, Australia
9 June 2016 - Wellington, New Zealand
11 June 2016 - Melbourne, VIC, Australia
17 June 2016 - Dunkeld, VIC, Australia
9 July 2016 - Canberra, ACT, Australia
15 July 2016 - Melbourne, VIC, Australia
3 August 2016 - Queenstown, New Zealand

The new Foundations Skills for Surgical Educators is an introductory course aimed at expanding knowledge and skills in surgical teaching and education. The aim of the course is to establish the basic standards expected of our surgical educators within the College.

This free one day course will provide an opportunity for participants to reflect on their own personal strengths and weaknesses as an educator and explore how they are likely to influence their learners and the learning environment. The course will further knowledge in teaching and learning concepts and look at how these principles can be applied into participants own teaching context.

Keeping Trainees on Track (KTOT)

4 June 2016 - Sydney, NSW, Australia

KTOT has been revised and completely redesigned to provide new content in early detection of Trainee difficulty, performance management and holding difficult but necessary conversations.

This FREE 3 hour course is aimed at College Fellows who provide supervision and training SET Trainees. During the course, participants will have the opportunity to explore how to set up effective start of term meetings, diagnosing and supporting Trainees in four different areas of Trainee difficulty, effective principles of delivering negative feedback and how to overcome barriers when holding difficult but necessary conversations.

Clinical Decision Making

4 June 2016 - Sydney, NSW, Australia

This four hour workshop is designed to enhance a participant's understanding of their decision making process and that of their trainees and colleagues. The workshop will provide a roadmap, or algorithm, of how the surgeon forms a decision. This algorithm illustrates the attributes of expert clinical decision making and was developed as a means to address poor clinical decision making processes, particularly as a guide for the supervisor dealing with a struggling trainee or as a self improvement exercise.

Supervisors and Trainers for SET (SAT SET)

28 June 2016 - Perth, WA, Australia

The Supervisors and Trainers for Surgical Education and Training (SAT SET) course aims to enable supervisors and trainers to effectively fulfil the responsibilities of their important roles, under the new Surgical Education and Training (SET) program. This free 3 hour workshop assists Supervisors and Trainers to understand their roles and responsibilities, including legal issues around assessment. It explores strategies which focus on the performance improvement of trainees, introducing the concept of work-based training and two work based assessment tools; the Mini-Clinical Evaluation Exercise (Mini CEX) and Directly Observed Procedural Skills (DOPS).

Surgical Teachers Course

21 to 23 July 2016 - Adelaide Hills, SA, Australia

The Surgical Teachers course builds upon the concepts and skills developed in the SAT SET and KTOT courses. The most substantial of the RACS' suite of faculty education courses, this new course replaces the previous STC course which was developed and delivered over the period 1999-2011. The course is given over 2+ days and covers adult learning, teaching skills, feedback and assessment as applicable to the clinical surgical workplace.



workshop



Non-Technical Skills for Surgeons (NOTSS)

22 July 2016 - Perth, WA, Australia

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. This educational program is proudly supported by Avant Mutual Group.

Process Communication (PCM) Part 2

29 to 31 July 2016 - Melbourne, VIC, Australia

The advanced three day program allows you to build on and deepen your knowledge while practicing the skills you learned during PCM Part I. You will learn more about understanding your own reactions under distress, recognising distress in others, understanding your own behaviour and making communication happen. PCM enables you to listen to what has been said, while at the same time being aware of how it has been said. At times we are preoccupied with concentrating on what is said, formulating our own reply and focussing solely on the contents of the conversation. To communicate effectively, we need to focus on the communication channels others are using and to recognise when they are under distress.



May 2016 - July 2016

ACT

9 July 2016
 Process Communication Model: Seminar 1, Sydney
 Foundation Skills for Surgical Educators, Canberra

NSW

23 May 2016
 Foundation Skills for Surgical Educators, Lismore
4 June 2016
 Clinical Decision Making, Sydney
 Keeping Trainees on Track, Sydney

NZ

2 June 2016
 Foundation Skills for Surgical Educators, Auckland
9 June 2016
 Foundation Skills for Surgical Educators, Wellington

SA

12 July 2016
 SAT SET Course, Adelaide
20 July 2016
 Keeping Trainees on Track, Adelaide
21 - 23 July 2016
 Surgical Teachers Course, Adelaide Hills

QLD

29 April - 1 May 2016
 Younger Fellows Forum (YFF), Canungra
2 May 2016
 Foundation Skills for Surgical Educators, Brisbane
 Keeping Trainees on Track, Brisbane
 Non-Technical Skills for Surgeons, Brisbane
 SAT SET Course, Brisbane

VIC

4 June 2016
 Communication Skills for Cancer Clinicians
 Transitioning to Palliative Care, Melbourne
 Foundation Skills for Surgical Educators, Bendigo
11 June 2016
 Foundation Skills for Surgical Educators, Melbourne
15 July 2016
 Foundation Skills for Surgical Educators, Melbourne
29 -31 July 2016
 Process Communication Model: Seminar 2, Melbourne

WA

28 June 2016
 SAT SET Course, Perth
21 July 2016
 Clinical Decision Making, Perth
22 July 2016
 Non-Technical Skills for Surgeons, Perth

A SHARED VISION

As Surgeons we are measured by our ethical decision making



PHILIP TRUSKETT
President

It is an enormous honour to have been elected the RACS President. This Perspective is being prepared prior to the Annual Scientific Congress and the formal handover, but I do wish to acknowledge the enormous energy, commitment and high standing that David Watters brought to the position over the past 12 months. So many issues had to be forthrightly addressed yet diplomatically handled. All Council members have been in awe of the breadth of activities that have been progressed.

Both Professor Watters and his predecessor Professor Michael Grigg placed RACS at the centre of the discussion about sustainable health care with high levels of engagement on key policy issues of private health insurance, futile surgery, clinical variation and excessive fees.

In debates that are frequently political and sometimes acrimonious it has been our endeavour to be reasoned and thoughtful in standing up for the things that are important for the community as well as the surgical profession. Both Presidents have been towers of strength in these discussions.

I know that we have all been challenged by the concerns around discrimination, bullying and sexual harassment. The Expert Advisory Group was formed under the oversight of Professor Grigg and the Chair of the EAG, Hon Rob Knowles delivered his report to Professor Watters. The Action Plan was completed and distributed in November 2015. It is now starting to emerge in significant programs.

The Foundation course for Surgical Educators is now mandatory for all surgeons involved with our educational activities. It will be available in multiple areas across Australia and New Zealand in the coming months. The additional course specifically looking at Discrimination, Bullying and Sexual Harassment will be finalised in stages.

The eModule will be finalised through the month of May and the Face to Face course later in this year. Again the eModule or a comparable course will be compulsory for CPD purposes. The Face to Face course will be for all

surgeons involved with educational committee activity. All of this is a big ask on RACS resources and a big ask on the time commitment of Fellows, Trainees and International Medical Graduates. However, it is essential it is done.

I am keen that over the next twelve months RACS continues to have a central position in the debate around the sustainability of the health sector and in particular, surgical services. At a political level there has been an essential debate around funding, dollars and the governmental structures. As a surgeon in active clinical practice I am very focused on what is appropriate surgery and where the interface to futile surgery, inappropriate surgery or unnecessary surgery occurs. This goes to two issues that I hold dear. The first is the College motto of *Fax mentis incendium gloriae* of which there is a detailed explanation on the website:

www.surgeons.org The take-home message is that one of the main reasons for the formation of our College was to ensure the promulgation of knowledge (the torch of the mind) – the knowledge that would destroy the false pride of the ignorant. The technical skill of surgery is vitally important but it is only the entry point of our profession. As a profession, we are measured by our ethical clinical decision making. Any management we offer our patients must be solely for their benefit and no other purpose. The wisdom of surgery is not how to operate but when it should be offered.

So it is with particular interest that I have recently read an

“I am keen that over the next twelve months RACS continues to have a central position in the debate around the sustainability of the health sector and in particular, surgical services.”

outstanding book titled ‘*Surgery, The Ultimate Placebo*’ and written by Professor Ian Harris AM, a Fellow of our College.

To some the book may be confronting because it challenges us to understand our craft, our clinical decision making and understand far better both the risks and rewards of undertaking surgery on our patients. As a central theme in his book he analyses the history of bloodletting over thousands of years; how it was discounted and disproved in the 19th century as ineffective and dangerous and yet it took almost one hundred years to disappear from practice.

Bloodletting was based on the notion of purging the body of bad humours. You will recall the initial ‘barber poles’ of blood-soaked bandages as a dramatic image. However it existed for thousands of years due to what Professor Harris described as the placebo effect, where the perceived or measured effect went far beyond that of the specific effect of the treatment.

The placebo effect may be magnified when the procedures are painful, costly, invasive and time-consuming and provided in an environment filled with authority figures and technology. This certainly sounds like surgery in the modern hospital environment.

On this principle the book goes on to suggest that the benefits of many procedures may be overstated and their risks understated. Useful, although undoubtedly contentious examples are discussed and these include coronary stenting, knee arthroscopy, caesarean sections, appendicectomy and back fusion surgery.

It is a book that will certainly challenge us in our clinical decision making. When does this patient who is seeking my opinion and advice, really need an operation? It challenges us in our approach to knowledge – what is our evidence of the effectiveness of this procedure?

This speaks to the very core of sustainable health care, of futile surgery and inappropriate surgery. It is a really significant topic, but one where we as surgeons, must lead and not be intimidated or frightened.

No doubt the word of mouth around the book and the themes will provide fodder for discussion at the ASC in Brisbane in the first week of May. The ASC program has a strong focus on Technology and Communication and looks incredibly promising. At this stage I am looking forward to meeting with many of you in Brisbane and also providing further feedback in future editions of *Surgical News*.

RACS Support Program

The College recognises that Trainees, Fellows and International Medical Graduates may face stressful situations on a daily basis. Coping with the demands of a busy profession, maintaining skills and knowledge and balancing family and personal commitments can be difficult.

The College has partnered with Converge International to provide confidential support to Surgeons. This can be for any personal or work related matter. Converge counsellors are experienced in working with individuals in the medical profession.

- Support is confidential and private
- Four sessions per calendar year are offered (funded by the College)
- Assistance can be provided face to face, via telephone or online
- Services are available throughout Australia and New Zealand

How to contact Converge International:

- Telephone 1300 687 327 in Australia or 0800 666 367 in New Zealand
- Email eap@convergeintl.com.au
- Identify yourself as a Fellow, Trainee or IMG of RACS
- Appointments are available from 8.30am to 6.00pm Monday to Friday (excluding public holidays)
- 24/7 Emergency telephone counselling is available.



FOUNDATION FOR SURGERY

Giving to make a difference

As I take on the role of Vice President of our College, I reflect on the many and varied College activities in which I have been involved over several decades. Of these, one of my greatest sources of satisfaction has been my contribution to the Pacific Islands Project (PIP) managed by RACS Global Health. As a paediatric surgeon, I have long recognised the huge disadvantage suffered by children from several of our neighbouring countries when it comes to access to quality surgical care. In many of these countries there is currently a large unmet need for expert surgical services and limited local capacity to provide it. I take great pleasure in seeing how generous so many of our Fellows have been in helping to increase local capacity and capability in these countries, including training and supporting local surgeons in attaining the skills required to develop a sustainable service. No doubt many of the readers of this column have also had the pleasure of being involved in various projects in the Asia Pacific region.

RACS has now become a key player in delivering much needed surgical care in the Asia Pacific region. Much of this has only been possible through the Foundation for Surgery.

As Vice President, I have an enormous sense of pride that surgeons have not only achieved so much within their own careers but also have proven to be great philanthropists in supporting the activities of the Foundation for Surgery. It is through your support, as Fellows of our College, that the Foundation can do its work.

As many of you know, the Foundation for Surgery is a unique charity that provides surgical support, training and research to those places where it is needed most. The Foundation for Surgery enables us to help provide quality services to communities less privileged than our own. With your support, the Foundation for Surgery is well positioned to address critical and immediate needs in these disadvantaged communities and regions.

Over the past 35 years, thousands of people have benefitted from these activities facilitated by RACS, with quality surgical care at the forefront of all our work. For example, over the past five years the Foundation for Surgery has supported several worthy projects in the areas of global health, indigenous health and surgical research. Its activities have included:

- The provision of over 13,424 critical procedures in these Asia-Pacific countries,
- Support for 184 doctors in Timor-Leste and Myanmar to undertake post-graduate specialist training programs in-country,
- Enabling 14 Indigenous medical students and doctors from Australia and New Zealand to undertake specialised educational workshops,



SPENCER BEASLEY
Vice President

- Providing financial support for ground-breaking research into the early detection and treatment of cancer; ear, nose and throat disorders; heart and lung disease; joint health; brain and spinal cord function, reconstructive surgery as well as many other areas that have significantly improved quality of life.

One of the many successes for the Foundation for Surgery has been in Myanmar. The Myanmar program has provided capacity building and training to the national health workforce, particularly in the areas of trauma, emergency care and cardiac surgery. Over 1,800 local health professionals have undergone trauma and emergency care training to meet the critical needs of this fledgling nation. Returned Rowan Nicks Scholars opened the first open heart surgery unit in Yangon and are conducting coronary bypass and heart valve surgery there.

Yet there is still so much to be done to support the local health system. There are only four senior paediatric surgeons in Myanmar and the health system needs to be configured to provide timely and essential operations for children. In addition, ongoing support is needed to further enhance the capacity of national doctors to respond to their enormous trauma load.

As we approach the end of the financial year I would encourage you to Pledge-a-Procedure – that is, make a tax-deductible donation of the proceeds from just one of your most common major operations during our Pledge-a-Procedure campaign in May and June.

Proceeds of donations assist in addressing critical surgical needs in disadvantaged communities. All costs for administering the Foundation for Surgery are provided for by the Royal Australasian College of Surgeons so that every dollar of your donation can go where it is needed most.

Donating is very simple: please go to <https://www.surgeons.org/foundation/> to donate and gain an immediate tax receipt or complete and return the form that will be mailed to you this month. This simple act will have an enormous impact on the work of our Foundation, including activities such as the Myanmar program. Please, act now and ensure that children, families and communities can access the vital assistance they need, when they need it most.



The best way out is always through.

Robert Frost

Speak to a RACS Support Program consultant to debrief and process some of the challenges, stressors and concerns that are faced by Surgeons, Surgical Trainees and International Medical Graduates.

Australia 1300 our eap (1300 687 327) New Zealand 0800 666 367
convergeinternational.com.au

SURGICAL SNIPS



Collaborating data

In a new partnership, RACS will work with Medibank Private on improving outcomes for patients with access to new data.

Medibank have agreed to provide RACS with de-identified datasets that will include information on length of stay and re-admission following procedure. This information will be compiled in a report to be made available to surgeons.

"These reports align with our purpose to provide continual education and information to our Fellows, and we look forward to further work with Medibank, and also collaborating with other organisations that hold similar data sets," President David Watters said.

Listen to the interview on the Health Report. <http://www.abc.net.au/radionational/programs/healthreport/surgeons-collaborate-with-medibank/7316476>, 12 April

www.surgeons.org, 18 February



Fruity business

Pomegranates are the new superfood, a South Australian surgeon can attest. Orthopaedic surgeon Michael Sandow produces the fruits on his 200 acre property in Wakefield Valley.

Laboratory tests apparently show health benefits including antiviral, antibacterial and antioxidant properties, including the potential to treat conditions such as high blood pressure and high cholesterol.

"Few foods can present a similar array of apparent health benefits, and while it is important not to claim unreasonable medicinal properties, if an agreeable addition to a person's diet can provide potential health benefits, then how good is that?" Mr Sandow said.

inDaily, 14 April



Butt out, outside

Smokefree dining laws due to be introduced in Victoria next year will confuse patrons and only increase alcohol intake, a coalition of organisations have said.

Fifteen groups led by Cancer Council Victoria (CCV) and including RACS have called for the Victorian Government to insure outdoor drinking areas are covered by the new smokefree laws.

CCV Chief Executive Todd Harper said that the coalition would like to see the implementation of laws similar to Queensland, where outdoor dining and drinking areas are smokefree.

"We don't want to see Victoria take the flawed NSW approach of smokefree dining only, which has caused widespread confusion and enforcement difficulties. Smoke free protection should not depend on whether food is being served," Mr Harper said.

The Age, 4 April



Transforming support

Surgeons in South Australia are disputing the Government's claim of support from clinicians for the Transforming Health policy currently rolling out across the state.

In a short survey of its members, the South Australian Regional Committee found that more than 80 per cent of responders had "major concerns" about the policy and more than 70 per cent were concerned about patient safety.

South Australian Regional Chair Sonja Latzel said the survey was not to embarrass, rather to find out the true feeling of clinicians in the field.

"[The Government] have been categorising doctors who speak out as having a vested interest and a minority view which wasn't our perception at all," Dr Latzel said.

The Advertiser, 30 March



Neurosurgical Society of Australasia
Annual Scientific Meeting 2016

Hilton Hotel, Sydney Australia
31 August to 2 September 2016

KEY NOTE SPEAKERS

Barth Green, USA
Peter Hutchinson, UK
Ying Mao, China
Jean Regis, France



KEY DATES

Registrations now open
Abstract submissions now open
Abstract submissions close 18 April 2016
Early bird registrations close 31 May 2016

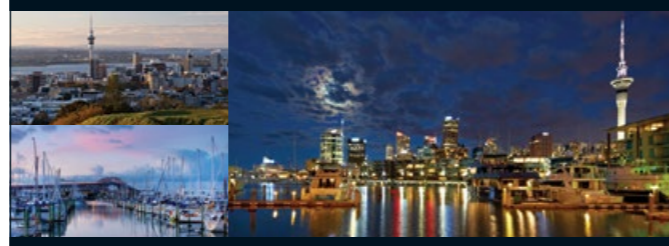
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Australian and New Zealand
Head & Neck Cancer Society
Annual Scientific Meeting

and the

International Federation of
Head and Neck Oncologic Societies
2016 World Tour



25 – 27 October 2016

The Langham Auckland, Auckland, New Zealand

For further information:

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W: www.ifhnosackland2016.org



ANZ SOCIETY FOR VASCULAR SURGERY 16
Vascular Challenges
Call for Abstracts Open

5 – 8 August 2016
Sheraton on the Park, Sydney, Australia

www.vascularconference.com

ANZSVS Australian and New Zealand Society for Vascular Surgery
ANZSVN
ASUM Promoting Ultrasound Excellence

Australian & New Zealand Society of Cardiac & Thoracic Surgeons

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ANNUAL SCIENTIFIC MEETING

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Cairns, Queensland, Australia

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Plastic and reconstructive surgeon,
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SOCIAL MEDIA SURGERY

Podcasts

Podcasting has recently had a revival, with notable podcasts such as the true-crime focused *Serial* making headlines around the world. Medical practitioners are no strangers to this technology, and have created some of the most interesting podcasts on offer, catering to other members of the profession and the general public alike.

What is a podcast?

The term 'podcast', a combination of 'broadcasting' and 'iPod', refers to digital audio files that are made available on the internet for download. Podcasts can be downloaded directly to your computer, as well as portable media players such as smartphones and tablets for listening on the go.

Podcasts are typically available as a series, and listeners can subscribe to a podcast through platforms such as iTunes to receive new instalments automatically.

There are hundreds of podcasts out there, which provide information on medical and non-medical topics. If you're new to the world of podcasting and would like to see what all the fuss is about, here are some surgery and medicine-focused podcasts you might like to try:

Surgical News Extra

A supplement to the *Surgical News* magazine, *Surgical News Extra* features extended interviews on articles in the current issue, plus practical advice that surgeons can implement in their practices, including insights on financial management and wealth creation, legal and tax advice and economic forecasts.

Surgical News Extra is available for download on the RACS website.

The Lancet

The podcast for *The Lancet* medical journal features discussions about journal highlights, including interviews with authors of key articles to provide further context and insight into advancements in medicine and health worldwide.

The Journal of Bone and Joint Surgery

The Journal of Bone & Joint Surgery (JBJS) provides a monthly podcast and vodcast to bring you highlights of the journal's latest print and electronic content. Chosen experts will elaborate on the abstracts that are chosen for discussion. Listeners are encouraged to learn more, with episodes often pointing listeners to additional e-learning resources such as video tutorials on the JBJS website.

Although only two medical journals are listed, many prominent publications such as the *British Journal of Surgery*, the *New England Journal of Medicine*, the *Journal of Trauma*

and *Acute Care Surgery* and the *British Journal of Urology* all provide podcasts that are free to download.

KEY Lime

Key Literature in Medical Education (KeyLIME) is a bi-weekly podcast produced by the Royal College of Physicians and Surgeons of Canada. Articles that are important, innovative, or may impact a surgeon's educational practice are discussed.

Behind the Knife: The Surgery Podcast

Behind the Knife is a general surgery podcast that aims to provide an in-depth look at a broad range of surgery topics, as well as a 'behind the scenes' look at the interesting, humanistic and controversial side of surgery.

Surgery 101

The *Surgery 101* podcast is produced with assistance from the University of Alberta in Edmonton Canada, and provides short reviews of the main topics in general surgery. Although the podcasts are aimed at medical students, they could benefit junior surgical trainees as they cover the essentials of presentation and management of common surgical conditions.

ABC Health Report with Norman Swan

The Health Report, hosted by medically qualified journalist Dr Norman Swan, appeals to both specialist and mainstream audiences by applying a broad definition of health, and seeing health and medicine within social, scientific and political contexts.

TED Talks Health

Although not strictly focused on surgical issues, *TED Talks Health* features interesting speeches on medical issues that affect practitioners across the board, from stress management to addressing ethical issues in the profession.

Do you have a podcast that you love listening to? Tweet us at @RACSurgeons and let us know!



EXCESSIVE FEES

Unchecked charges bring profession under disrepute

Surgeons who charge excessive fees are jeopardising the sustainability of Australia's health system and bringing the surgical profession into disrepute, according to College President Professor David Watters.

In an era of rising health costs and tighter health budgets, surgeons should understand that high gap fees could cause people to drop their private health insurance which in turn would add strain to the public health system, he said.

And he warned that charging booking fees, using double or secret invoices or offering work to an anaesthetist on the proviso of taking a percentage of their earnings were breaches of the Code of Conduct.

Professor Watters made the comments in the wake of recent media reports that some patients were being charged ten times the Medicare fee for particular procedures and more than twice the fee recommended by the AMA.

He said the College was also aware of some surgeons using multiple MBS item numbers that could not be reasonably justified.

"Most surgeons do the right thing but a small percentage of surgeons in all specialties charge fees that are out of proportion to the time, skills and resources required in conducting a procedure," he said.

"Charging excessively just because you think you can exploit the vulnerability of the patient is absolutely unethical.

"No-one in a health system such as ours should have to contact a financial planner, remortgage their home, touch their superannuation or seek crowd funding to access surgical treatment.

"All of us have an interest in maintaining a safe, sustainable, affordable, high-quality public and private health system and surgeons who charge excessive fees put that system at risk and let the rest of us down.

"Urgent, acute or cancer related surgery can be adequately dealt with in the public system and all surgeons have a duty to advise their patients of this."

Professor Watters said the College was currently in the

process of dealing with the entire range of issues relating to health care costs, including excessive fees.

These include:

- The establishment of a Fee Complaints Committee that has the power under the College's Code of Conduct to Reprimand (where a surgeon's behaviour is reported but not their name), Censure (where both name and behaviour is reported), remove the Fellowship, and could even result in reporting the surgeon to the Australian Health Practitioner Regulation Agency (AHPRA) or the Medical Council of NZ (MCNZ).
- The creation last year of the Sustainability in Health Committee, chaired by Lawrie Malisano, which is currently investigating elective surgery prioritisation, private health insurance costs and the identification of low efficacy procedures across surgical specialties;
- The active provision of input and advice to the Medicare Benefits Schedule (MBS) Review Taskforce chaired by Professor Bruce Robinson, Dean of the Sydney Medical School, which is considering how the more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice;
- Collaborating with private health insurers such as Medibank Private to analyse administrative data sets to better understand clinical variation and provide surgeons with a clearer understanding of where their fees sit within the global data-set;
- The establishment of a Clinical Variation Working Party including general surgeons, cardiothoracic surgeons, orthopaedic surgeons, otolaryngologists, urologists and vascular surgeons to review that data and determine how the information can best be used and understood.
- Working with Medicare to identify common patterns in the mis-use of multiple item numbers by surgeons to inflate their fees.

Professor Watters said that while surgeons needed to be actively engaged with the issues surrounding health

"Most surgeons do the right thing but a small percentage of surgeons across specialties charge fees that are out of proportion to the time, skills and resources required in conducting a procedure."

care affordability and sustainability, they were not solely responsible for rising health costs.

He said the Government and private health insurers should take some responsibility for the rise in out-of-pocket costs for their decisions to freeze or reduce rebates while in many specialties, gaps existed because of the rise in the costs of implants and prostheses.

"Some implants and prostheses can cost twice as much when used by a surgeon in the private system as they cost in the public system and that needs to change, possibly by creating cost congruencies through bulk purchases by a government agency," Professor Watters said.

"The government needs to get tougher on manufacturers and through regulation standardise prices across both the public and private health systems."

Professor Watters said rising out-of-pocket expenses were also created by the fees charged by anaesthetists and he also called on General Practitioners to acquaint themselves with

the fees charged by the surgeons and other specialist providers on their referral lists.

"RACS urges all GPs to be aware of the likely range of fees charged by the surgeons on their lists and we sincerely hope they refer their patients to surgeons who do a good job but still charge reasonable and justifiable fees.

"We have had informal discussions about this with the Royal Australian College of General Practitioners (RACGP) because the role of the primary health care provider is essential if we are to provide patients with high quality care at a reasonable cost to them and the health system."

Professor Watters said patients had a right to know any gap fee to be charged before the procedure was done.

He insisted that there was no correlation between the quality of surgery performed and the size of the fee charged.

"There is also no relation between the caseload and the fee as most high volume surgeons do not charge excessively. Surgeons in Australia and New Zealand do good work and we would encourage all private health insurers to show the range of fees charged by providers for various procedures on their websites so that patients can make informed decisions about their surgical care, and whether the fees they are being quoted are reasonable.

"We are also optimistic that the MBS Review will ensure that surgeons using multiple item numbers to inflate their fees will become a thing of the past."

Anyone wishing to make a complaint about excessive fees can contact the RACS at complaints@surgeons.org.

With Karen Murphy

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ENTRUSTABLE PROFESSIONAL ACTIVITIES

Looking at EPAs in the RACS Education and Training Department



SPENCER BEASLEY
Outgoing Chair, Professional Development



STEPHEN TOBIN
Dean of Education

Education at University Medical Centre Utrecht (UMCU). Since 2005 he has led the Center for Research and Development of Education at UMCU. His research interests include vertical integration in the undergraduate medical education, peer teaching and competency-based postgraduate medical education. He has served as President of the Netherlands Association for Medical Education. In 2012 he was also appointed Adjunct Professor of Medicine at the University of California, San Francisco.

He was invited to overview the rationale and role of EPAs, and review the current status of the use of EPAs by RACS. He also provided some guidance around the development of surgical EPAs.

He outlined why EPAs had value in identifying when a specific aspect of Professional practice could be entrusted to a learner to execute unsupervised, once he or she had demonstrated the required competence to a predetermined standard. He highlighted how EPAs needed to be achieved within a time frame, be observable and measurable, and relate to broad tasks that are allocated to individuals and suitable for an entrustment decision.

He described EPAs as:

- Entrustable: acts that require trust – by colleagues, patients, society. It implies that once achieved the trainee is effectively being told that you have now reached this level of performance that we trust you to do this (or these) tasks unsupervised
- Professional: confined to occupations with extraordinary qualifications and Professional privileges, of which surgery is an example, with its associated obligations and responsibilities
- Activities: tasks that must be done (performance rather than knowledge). EPAs ground competencies as they are applied in daily practice

Professor ten Cate talked about the value and limitations of competency-based medical (and surgical) education. Detailed attempts to measure all surgical competencies individually during SET training have proved problematic, and EPAs may provide an additional tool to measure trainee progression. They measure the application of competence to practice, and introduce some flexibility into programs that competency based medical education requires. Entrustment decisions deepen the nature of workplace-based assessment.

We also saw a presentation by Mrs Jacky Heath, Manager, Prevocational and Online Education, RACS who detailed how the RACS has taken on EPAs in JDocs, and Mr Phil Truskett, Censor in Chief presented on how EPAs could potentially be used in SET training. Later, Professor ten Cate spoke about

working with EPAs in workplace-based curricula and how to design EPAs. The meeting broke into three workshops to advance the understanding of the use of this tool in the junior doctor program, SET training and CPD areas. All participants were enthused after a stimulating evening.



College representatives discussing how technology can enable curriculum delivery in the workplace

Erratum for the Provincial Surgeons of Australia Meeting

The March issue of *Surgical News*, page 17 incorrectly stated the dates for the Provincial Surgeons of Australia meeting. The correct details are:

52nd PSA 2016 Annual Scientific Conference
Education of Yourself, Junior Doctors, Students
4-6 August, 2016

Albany Entertainment Centre, Albany, Western Australia

Renowned expert speakers Assoc Prof Mohammed Ballal - Consultant Upper GI Surgeon, Mr Nigel Barwood - Consultant Colorectal Surgeon, and Prof David Watters - Professor of Surgery, Barwon Health, President - Royal Australasian College of Surgeons, along with a cast of leading experts will bring the meeting focus of Education to the forefront.

Dr Lauren Smithson - General Surgeon from St Anthony, Canada, will also join the meeting. Lauren is the Founder and co-President of SYRUS - the Society for Young Rural Surgeons - a society dedicated to promoting Rural Surgery as a career, as well as support and guidance for existing Rural Surgeons.



LET'S OPERATE WITH RESPECT

BUILDING RESPECT, IMPROVING PATIENT SAFETY

Building Respect, Improving Patient Safety Action Plan



GRAEME CAMPBELL
Immediate Past Vice President

about them. Since then, we have received their damning report and launched our Action Plan on Building Respect, Improving Patient Safety.

Many people have reviewed our plan and reflected on the enormity of the task we have set ourselves. As a measure of our commitment to dealing with these problems, our College has dedicated substantial financial and staff resources to supporting the work of the EAG and implementing the Action Plan.

The Action Plan outlines a serious program of work that will touch all Fellows, Trainees and International Medical Graduates. All the work we have planned is underpinned by the twin principles of collaboration and respect. We must work with others – including employers, universities, health departments, governments and regulators – to make sure our approaches are aligned, supported and effective.

The 42 recommendations made by the EAG fall into three areas:

1. Cultural change and leadership – taking a stand and changing how we work
2. Surgical education – with a focus on eliminating DBSH, and
3. Complaints management – ensuring our processes are fair, timely and transparent.

The Action Plan sets eight goals. The work we are doing to achieve them is organised into the projects listed below. There will be an article in Surgical News each month about different components of the work we are doing to build respect and improve patient safety in surgery. For more detail, go to the RACS website and follow the links from the homepage.



SPENCER BEASLEY
Vice President

It is now more than a year since RACS was in the national spotlight because of discrimination, bullying and sexual harassment in surgery. In response, our College appointed the Expert Advisory Group to advise us on the extent of these problems and what we should do

Leasing opportunities - Eastlink Surgical Centre

Eastlink Surgical Centre is a modern fully accredited Day Surgery Centre in Wantirna, Victoria opposite Knox Private Hospital and next to the Eastlink freeway exit.

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Action Plan Goals	Projects
Culture Change & Leadership	
<p>Goal 1 Build a culture of respect and collaboration in surgical practice and education</p> <p>Goal 2 Respecting the rich history of the surgical profession, advancing the culture of surgical practice to the point where there is no place for discrimination, bullying and sexual harassment (DBSH)</p> <p>Goal 3 Build and foster relationships of trust, confidence and cooperation on DBSH issues with employers, governments and agencies in all jurisdictions</p> <p>Goal 4 Embrace diversity and foster gender equity</p> <p>Goal 5 Increase transparency, independent scrutiny and external accountability in College activities</p>	<p>Engagement and collaboration Communications campaign Leadership development Diversity & RACS</p> <p>Updated policies and procedures:</p> <ol style="list-style-type: none"> 1. Code of Conduct 2. Sanctions policy 3. Accreditation of hospital training posts 4. Selection of supervisors 5. IMG oversight 6. Hospital appointments 7. Appointment process for members of specialty training boards
Surgical Education	
<p>Goal 6 Improve the capability of all surgeons involved in surgical education to provide effective surgical education based on the principles of respect, transparency and professionalism</p> <p>Goal 7 Train all Fellows, Trainees and International Medical Graduates to build and consolidate professionalism, including:</p> <ul style="list-style-type: none"> • Fostering respect and good behaviour • Understanding DBSH legal obligations and liabilities • 'calling it out'/not walking past bad behaviour • Resilience in maintaining professional behaviour 	<p><i>Building Respect, Improving Patient Safety</i> Educational Program Foundation course for educators (those involved in Surgical training) Annual survey of hospital training posts Tailored education & support</p> <ul style="list-style-type: none"> • Individual Surgeons • Supervisors and Trainees • IMG support and oversight <p>Assessment tools including multi-source feedback for all Surgeons</p>
Complaint Management	
<p>Goal 8 Revise and strengthen RACS complaints management process, increasing external scrutiny and demonstrating best practice complaints management that is transparent, robust and fair</p>	<p>Complaints & investigation resolution program Privacy legislation review</p>

IMPROVING SURGICAL EDUCATION

The Foundation Skills course for Surgical Educators

One of the cornerstones of RACS' Action Plan on *Building Respect, Improving Patient Safety* is improving surgical education. The Foundation Skills for Surgical Educators course will help us reach this goal. The course will become mandatory for Fellows, Trainees and International Medical Graduates involved in surgical training or other educational endeavours.

The Foundation Skills for Surgical Educators course sets the basic standards that RACS expects of all surgeons involved in surgical teaching. It will help us meet Goal 6 of the Action Plan and more broadly supports our intention to achieve cultural change and leadership.

RACS developed this one day course for senior Trainees, International Medical Graduates and all surgeons who teach Trainees, Residents and Medical Students.

It gives participants an opportunity to identify their strengths and address weaknesses and understand how these influence learners and the learning environment. The course increases knowledge and skills about teaching and learning concepts, and shows how to apply these principles to individual teaching contexts.

The course is designed to enable participants to:

- recognise the importance of educational theory and translate this into daily surgical practice
- provide effective teaching, learning and assessment in different clinical settings
- identify how to plan learning by using suitable teaching, learning and assessment strategies including effective interactive feedback

2016 Foundation Skills for Surgical Educators Courses:

23-May-16	Lismore
02-Jun-16	Auckland NZ
04-Jun-16	Bendigo
09-Jun-16	Wellington NZ
11-Jun-16	Melbourne
17-Jun-17	Dunkeld
09-Jul-16	Canberra
15-Jul-16	Melbourne
03-Aug-16	Queenstown NZ
12-Aug-16	Launceston
25-Aug-16	Adelaide
17-Sept-16	Darwin
23-Sep-16	Brisbane
19-Oct-16	Christchurch NZ
21-Oct-16	Melbourne
29-Oct-16	Adelaide
04-Nov-16	Brisbane
11-Nov-16	Perth
25-Nov-16	Sydney
05-Dec-16	Melbourne

Dates confirmed at time of publication but check the website for updated details. We will publish any revised or new course dates as changes are made

The course was launched in 2015 and evaluation results confirm that it strengthens participants' skills as both supervisors and teachers. It will help improve the quality of the education we provide across the College, by improving the performance of our educators. So far, about 90 per cent of course participants have been extremely satisfied with the course, its resources and content.

RACS has scheduled more than 30 courses for 2016 in Australia and New Zealand, in both urban and rural settings, including RACS regional offices. RACS is also engaging with hospitals and is exploring options to provide courses there, when this is feasible and convenient.

You can register online through the College website www.surgeons.org or contact Chris Gillies, Program Coordinator, Professional Development Department: chris.gillies@surgeons.org or 03 9249 1221.

We welcome enquiries from Fellows who are interested in running the course in their own hospitals or who would like to help train others.

Register online now for the Foundation Skills for Surgical Educators Course. This course will become compulsory for all surgical educators.

LEARNING

- What is learning?
- Understanding learners' learning styles
- Adult learning theory
- Involving learners in the learning process

TEACHING

- Planning learning
- Teaching strategies
- Teaching in different clinical settings
- Roles of the teacher

FEEDBACK

- Effective feedback
- Model for feedback
- Practising feedback
- Summary of lessons learnt

ASSESSMENT

- Purpose of assessment
- Reliability & validity
- Formative vs. summative
- Methods of assessment
- RACS assessment tools
- Responsibilities of a surgical educator

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TRINATIONS ALLIANCE

Trinations Alliance and International Medical Symposium Leadership Workshop, Entrustable Professional Activities workshop and Future Challenges for Medicine



SPENCER BEASLEY

Outgoing Chair, Professional Development



STEPHEN TOBIN

Dean of Education

and New Zealand College of Anaesthetists (ANZCA), Royal Australia and New Zealand College of Psychiatrists (RANZCP) and the Royal Australasian College of Surgeons (RACS).

Dr Kevin Imrie, President of the RCPSC opened the meeting on 8 March, welcoming all participating colleges from the three countries of Australia, New Zealand and Canada. Business matters had been addressed earlier in the day.

Leadership workshop (9 March)

Dr Sarah Dalton, Clinical Director of the Clinical Excellence Commission NSW, set the scene for the day by illustrating a quality improvement project delivered by one of her registrars. This led on to Mr Paul Levy's presentation, Deakin University's 'thinker in residence', on what good healthcare looks like and what organisations need from their medical leaders, on the international stage. Assoc Professor Michael Greco, CEO of Patient Opinion Australia then looked at the healthcare system from the perspective of the patient and why leadership is important to them. Each college then described what they were currently doing or planning on doing, around enhancing leadership. All this vigorous discussion was chaired by Assoc Professor Grant Phelps, who had led the workshop planning.

After lunch, Professor Bruce Dowton, Vice Chancellor and President of Macquarie University Sydney challenged the colleges to develop healthcare leaders now. He explored theoretical frameworks for medical leadership, what future healthcare leaders will look like and how the colleges can produce them.

The 57 delegates then broke into six groups to explore a range of topics:

- Making medical leaders – What are we doing well and what are the gaps at a system level?

- Making medical leaders – Gender differences and how to address inequality
- Making medical leaders – Cultural diversity and cultural competency: what are the big gaps that need to be addressed?
- Leadership in specialist training – Specific curriculum? Or leadership in all things? Models to consider – leadership for all or leadership for the selected few?
- Role of the service provider / organisations in building leaders – What needs to happen? How do the colleges' partner with hospitals and other service providers to build leaders?
- Role of the colleges in building leaders post fellowship – What needs to happen? How? CPD or something more Professoround?

The group then came together to prioritise the recommendations, according to their importance and whether they could be achieved. The draft recommendations that came out of the discussions were:

- A cross-college young leaders program focusing on cultural diversity and cultural competency
- Colleges setting values to support a culture of great medical leadership
- Set up a "one stop shop" for existing leadership resources
- Diversity embedded in medical leadership
- Assessment of leadership competency in trainees

Entrustable Professional Activities workshop (10 March)

This workshop on 'Entrustable Professional Activities (EPAs)' with Professor Olle ten Cate was held at the NSW State Library.

Each of the five Colleges had prepared a vodcast which provided an overview of how competency-based medical education including EPAs was being incorporated into their training programs.

Professor ten Cate then went on to explain the latest research on EPAs. The 58 delegates then broke up into eight groups to explore specific aspects in greater detail. These included:

- Using EPAs across the continuum / curriculum standards and teaching
- Supervisor support / faculty development
- Assessment, decision making and progression using EPAs
- Technology

Professor ten Cate closed the discussion with a critical analysis of the future of competency-based education and how EPAs could be used across the medical practice continuum.

International Medical Symposium (11 March)

The International Medical Symposium, at the Amora Hotel was open to the wider community and was the major day of the program. Just fewer than 200 delegates attended, engaged by a stimulating array of presenters.

'What is a Future Doctor?' chaired by Dr Craig Campbell

Dr Julian Archer addressed the keynote topic of what a future doctor looked like. Dr Craig Campbell reflected on the report from last year's International Medical Symposium, one year later. Then Dr Vlasios (Bill) Brakoulis, Professor Kate Leslie and Dr Nikki Stamp provided their perspectives on '2016 and the Future Challenges for the Medical Profession, Where are we now?'

'How to Enhance Doctors Performance at Work', chaired by Dr Victoria Brazil

Professor Olle ten Cate explored the role of Entrustable Professional Activities, Dr Susan O'Dwyer presented on 'Performance of Doctors in the Public System', Dr Vince Russell on 'How my Private Hospital Assesses Doctors' and Mr Graeme Campbell looked at 'Do Senior Doctors get this?', referring to the RACS Building Respect, Improving Patient Safety Action Plan.

'Diversity in the Profession and in Practice', chaired by Professor Richard Doherty

Assoc Professor Papaarangi Reid and Assoc Professor Gregory Phillips led a provocative discussion of 'Understanding Diversity in the Profession and in Practice through Indigenous Health', challenging established views and urging the colleges to take greater action immediately.

'Effects of Ageing on Physicians and Patients' chaired by Dr Catherine Yelland

Professor David Sinclair looked at 'What is Ageing? And why it happens', through his outstanding work studying the genetics of mice and what makes them age. Assoc Professor Mark Yates looked at the new National Standards for Dementia Care, especially the way in which we treat dementia patients in hospitals and our inability to recognise it in colleagues; and Dr Alison Reid addressed 'Ageing Doctors – how they come to notice'.

The final session of the day chaired by Dr Margaret Aimer

Professor Nick Glasgow, Dr Julian Archer and Professor David Watters gave their interpretations of what the focus of the next 12 months should be.

The three day educational program was beneficial for all attendees. The recording and report from the International Medical Symposium will be made available on the College website.

WAS IT A SHRIMP ON THE BBQ? RU or RU not?



THE BARONESS

The Wisdom of Justice Murphy

One of my priorities in life was to ensure the outdoor area where my five burner BBQ is located was able to accommodate and entertain people in all weather. The outside temperatures of Autumn and Winter may start to dip or even plunge. But nothing will stop our ritual of regular BBQs, great alcohol, fantastic banter and an ongoing experimentation of shrimp (prawn) and their preparation.

Tonight I was going back to one of my favourites. Thai spiced with my own secret combination of lemon juice, soy sauce, Dijon mustard, some garlic and brown sugar plus just the right amount of the secret Indian curry from the local market. And then the challenge was to combine it with the best Riesling possible – that is what the guests needed to bring. What else with Asian food!!

Although many say the best Rieslings are from South Australia, the winner tonight was actually from Germany and the steep slopes of the Rhine. For those who are the connoisseurs think flavours of fresh citrus and granite derived minerals. The additional joy of the BBQs is that although the core group is still that eclectic group of friends from University days, it is often extended to include friends who have strayed or wish to re-join.

After all life should be a series of BBQs and a moving group of life's travellers. We all group and regroup. I had not seen the connoisseur of German Rieslings for many years. As a University student she had always been a bit detached from the union pub scene. She came from being an incredibly talented athlete, then an unbelievably successful commercial lawyer, as well as a bit of a social sophisticate. I had heard she had spent some time in New York. However, she had recently returned to OZ and was 'catching up' with people. No better reason needed to attend a 'shrimp on the BBQ' event.

As sometimes happens, the 'tell us what you have done' had us all spellbound. A bit of Paris, a bit of Belgium and a lot of New York was also accompanied by a statement of 'I have just recently consciously uncoupled... but we were never married and then I discovered that he was'. Perhaps the parlance for people from New York or from Hollywood, but not so frequently in 'the colonies'. There was more than a bit of a pause as this was 'taken in'.



Then the member of our group with an interest in marital things – you remember the one who also did a Theology degree – asked "Does that mean you are or not a couple? What happens to all those legal bits?"

The lawyer in me could not resist.

'Now that is a really challenging question. If you're living together with someone, but they're also together with someone else (even if unknown to you), does that mean you're still in a de facto relationship? And what does that mean for who gets what once the dust has settled?

And then there was another opinion, from another friend. These lawyers are quick you know. Quoting from Justice Murphy in *Jonah and White* [2011] he stated 'exclusivity is not a necessary element of a de facto relationship'.

Indeed a defacto relationship is where 'the parties have so merged their lives that they were, for all practical purposes, 'living together' as a couple on a genuine domestic basis. It is the manifestation of 'coupledom', which involves the merger of two lives.'

My lawyer friend continued. If you end up in court, lots of things will be taken into account like the length of time you were together, whether your relationship was publicly acknowledged, financial dependence and support, property you own together, care and support of children...

Taking a deep breath, he continued like counsel with his closing argument 'We often believe there should be a hard and fast rule or threshold for these factors. But there isn't... The court decides – six months of cohabitation or living together sporadically over 10 years or even if you discover your coupling is with someone who is already married. These could all be considered de facto relationships.

I raised my almost empty glass and in a soft voice advised my theological friend, 'So are you or are you not in a relationship can be a legal quandary. And many hardened lawyers will tell you of 'nuisance' cases that run for days in the Court on this sole question. The number of de facto relationships a person can be in at one time is limited only by their imagination or their ambition'.

The Thai shrimp had been really good. The Riesling outstanding. Suddenly everyone was very contemplative, no doubt their imaginations or perhaps their ambitions now running amok.

Coupling and uncoupling. Consciously or unconsciously. Some knowledge or full knowledge. The interactions of family and commercial law... it was all getting a bit blurred...

Legal material contributed by Daniel Kaufman, Senior Associate in Family and Relationship Law. Lander and Rogers

2016 GSA ASM

INTERNATIONAL SPEAKERS

DR JAMES BITTNER, MD, FAOS
VIRGINIA, USA

MR NICK MAYNARD, MBBS, MS, FROS
OXFORD, UK

MR BRENDAN MORAN, FROS, FORSI
BASINGSTOKE, UK

PLENARY SPEAKER

MR WALEED ALY

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TALES OF THE UNEXPECTED

CONVENORS: MR PAUL OASHIN, FRAOS
MR MATTHEW OROXFORD, FRAOS

ANZSCTS response to Case Note Review Jan/Feb 2016

Minimally invasive mitral valve repair with femoral cannulation resulting in inferior vena cava trauma and exsanguination

The case presented involved eventually fatal injury to the inferior vena cava (IVC) during peripheral cannulation for cardiopulmonary bypass for minimally invasive mitral valve repair. In the comments a number of concerns are raised that are valid.

However, to state that “It (the procedure) could have been carried out without the threat of fatal complications if a standard sternotomy had been used” is simply incorrect. Any case involving cardio-pulmonary bypass and cardioplegic arrest carries a not insignificant risk of mortality and major morbidity. The reviewer seems to conclude that the approach was to blame for the eventual outcome – this is wrong. Multiple studies have demonstrated that a minimally invasive approach via a right minithoracotomy with peripheral bypass for mitral valve surgery is at least as safe as a sternotomy approach (1-3). In almost all studies comparing minimally invasive approaches to sternotomy for mitral valve surgery there was a significant reduction in transfusion requirements.

This has been confirmed in our own institution (4). In addition, there is some evidence that superior visualisation of the mitral valve and its sub-valvular apparatus may in fact improve repair rates. It is acknowledged that peripheral cannulation for cardiopulmonary bypass has potentially severe complications such as vessel injury, leg ischaemia, cardiac perforation and others. However, using transoesophageal echo imaging and appropriate techniques

the frequency of such events is likely no higher than that of major complications during central cannulation. A number of centres in Australia perform a large number of minimally invasive mitral valve procedures with excellent results.

While acknowledging that these are not directly comparable groups - data from the ANZSCTS database from 2010 – 2014 shows that minimally invasive mitral valve replacement and repair have a lower in hospital / 30 day mortality and stroke rates than sternotomy cases (Tables 1 to 4). In addition the data also demonstrates a much higher repair rate for minimally invasive mitral valve surgery (approx. 77% vs 48%).

Table 2: Total case numbers, and in-hospital and 30 day mortality of patients who undergo valve repairs or reconstructions

		MIN n/N (%)	Non MIN n/N (%)	Total n/N (%)
2010	Mortality	0/32 (-)	2/167 (1.2)	2/199 (1.0)
2011	Mortality	0/105 (-)	3/202 (1.5)	3/307 (1.0)
2012	Mortality	0/121 (-)	1/171 (0.6)	1/292 (0.3)
2013	Mortality	1/112 (0.9)	2/185 (1.1)	3/297 (1.0)
2014	Mortality	0/157 (-)	1/192 (0.5)	1/349 (0.3)
Total	Mortality	1/527 (0.2)	9/917 (1.0)	10/1444 (0.7)

Table 3: Total case numbers, and patients who suffered a stroke who underwent mitral valve replacement procedures

		MIN n/N (%)	Non MIN n/N (%)	Total n/N (%)
2010	Stroke	0/24 (-)	9/194 (4.6)	9/218 (4.1)
2011	Stroke	0/29 (-)	6/202 (3.0)	6/231 (2.6)
2012	Stroke	2/41 (4.9)	7/209 (3.3)	9/250 (3.6)
2013	Stroke	1/28 (3.6)	8/218 (3.7)	9/246 (3.7)
2014	Stroke	1/37 (2.7)	9/217 (4.1)	10/254 (3.9)
Total	Stroke	4/159 (2.5)	39/1040 (3.8)	43/1199 (3.6)

Table 1: Total case numbers, and in-hospital and 30 day mortality of patients who have valve replacement procedures

		MIN n/N (%)	Non MIN n/N (%)	Total n/N (%)
2010	Mortality	0/24 (-)	12/194 (6.2)	12/218 (5.5)
2011	Mortality	0/29 (-)	13/202 (6.4)	13/231 (5.6)
2012	Mortality	0/41 (-)	9/209 (4.3)	9/250 (3.6)
2013	Mortality	3/28 (10.7)	8/218 (3.7)	11/246 (4.5)
2014	Mortality	0/37 (-)	8/217 (3.7)	8/254 (3.1)
Total	Mortality	3/159 (1.9)	50/1040 (4.8)	53/1199 (4.4)

MIN – minimally invasive
Non MIN – sternotomy

There is of course a learning curve as with any other procedure and guidelines for the safe introduction of this technique have been published (5). It is important that the specific complications related to this approach and their management are known to the surgical teams embarking on minimally invasive mitral valve surgery and tutoring for the early experience is highly recommended. However, to suggest that a minimally invasive approach is unsafe in general seems to go back to the time of introduction of laparoscopic cholecystectomy.

Cases such as this should be reviewed by surgeons with extensive experience in minimally invasive surgery so as to avoid bias and in fact achieve the aim of case reviews – improvement of outcomes through feedback to the involved surgical teams.

Please note: The response also has the support of the MICS community.

Yours Sincerely,



Paul Bannon
President
ANZSCTS



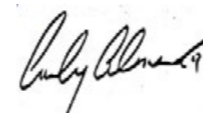
Trevor Fayers
Vice-President
ANZSCTS



Homayoun Jalali
Elected Representative
ANZSCTS



Jurgen Passage
ANZSCTS



Aubrey Almeida



James Edwards

Table 4: Total case numbers, and patients who suffered a stroke who underwent mitral valve reconstructions

		MIN n/N (%)	Non MIN n/N (%)	Total n/N (%)
2010	Stroke	0/32 (-)	2/167 (1.2)	2/199 (1.0)
2011	Stroke	4/105 (3.8)	4/202 (2.0)	8/307 (2.6)
2012	Stroke	1/121 (0.8)	3/171 (1.8)	4/292 (1.4)
2013	Stroke	0/112 (-)	3/185 (1.6)	3/297 (1.0)
2014	Stroke	0/157 (-)	2/192 (1.0)	2/349 (0.6)
Total	Stroke	5/527 (0.9)	14/917 (1.5)	19/1444 (1.3)

Dear Mr Bannon and colleagues,

Thank you for your letter from the 21st of March on behalf of the ANZSCTS in response to the ANZASM Case Note Review from the Jan/Feb edition of Surgical News.

The ANZASM have found that the cardiothoracic assessment reports to be one of the best of all specialties regarding their comprehensive nature. The intention of the audit process is purely one of education and is unique because of the extensive, external independent peer review process. The ANZASM may address systemic issues and also provide heightened scrutiny through the process of the second-line assessment. I would like to stress that all cardiothoracic cases are reviewed by expert assessors from the cardiothoracic specialty.

I would like to point out that the second-line assessment reports are subjective by nature. By this I mean that the assessor makes a judgement based on the information that he/she has to hand at that time i.e. the surgical case form and the medical case notes and forms an opinion based on these documents.

I hope that you find the case notes informative and I would like to thank your society for your valuable contributions to the ANZASM.

Regards,

Professor Guy Maddern
Chair, ANZASM

THE RACS PLEDGE

A short history

MICHAEL GRIGG

Immediate Past President, RACS

DAVID WATTERS

Outgoing President

It was October 2008 when President Ian Gough reported to Council on his attendance at the American College meeting and spoke of being impressed by the Pledge of the American College of Surgeons. He asked Michael Grigg, then Chair of Professional Standards, and David Watters, then Chair of External Affairs, to draft a RACS Pledge to be presented to Council by February 2009.

We discussed the task at hand and set ourselves the challenge of stating what it is to be a surgeon, and the values that, as a profession, we prize. And we wanted to do this in around 100 words. The content of the American College of Surgeons Pledge was admirable but it was too long at 234 words. Furthermore, we wanted to create a Pledge that not only read well but also stirred emotion when spoken aloud. Whether we achieved this or not is for others to determine but we urge you to read the Pledge, and then take the trouble to say it out loud.

The first drafts were shorter than the American Pledge but still too long. Every word was scrutinised and had to "earn its place". There were frequent and interesting email discussions and debates over the wording. For example, should 'the Royal Australasian College of Surgeons' be in the first or last line of the Pledge or both. There was competition between the words 'honour and privilege' and 'challenge' in the final statement on accepting responsibility. In the end 'honour and privilege', both in an original draft, lost out to 'challenge'. There was also some interesting correspondence as to whether it is grammatically correct to split an infinitive with an adverb by pledging 'to always act' or 'to act always' as in the early drafts.

We have Guy Maddern, Keith Mutimer, Hugh Martin and Julian Smith to thank for further edits and suggestions before the version that was approved at February Council in 2009. Since then there has only been one revision, and this involved adding the word "trainee" to the 3rd statement regarding lifelong learning and teaching for the benefit of patients and the community.



College Pledge

I pledge to always act in the best interests of my patients, respecting their autonomy and rights.

I undertake to improve my knowledge and skills, evaluate, and reflect on my performance. I agree to continue learning and teaching for the benefit of my patients, my trainees and my community.

I will be respectful of my colleagues, and readily offer them my assistance and support.

I will abide by the Code of Conduct of this College, and will never allow considerations of financial reward, career advancement, or reputation to compromise my judgement or the care I provide.

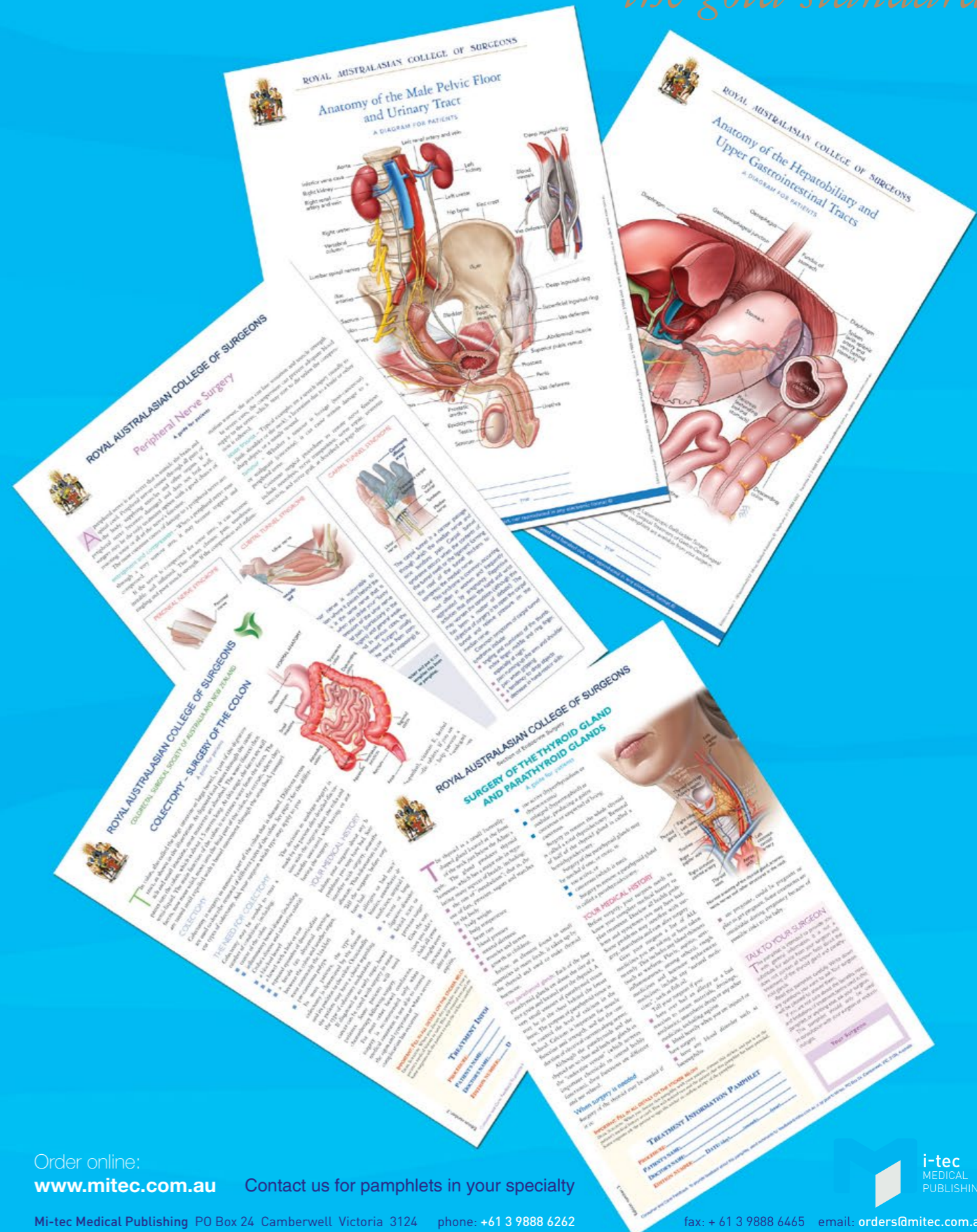
I accept the responsibility and challenge of being a surgeon and a Fellow of the Royal Australasian College of Surgeons.

Today the College Pledge is taken by all newly convocating fellows present at the RACS Annual Scientific Congress. In 2014 the tradition began that all existing fellows are also invited to stand, on stage and throughout the auditorium, so as to restate the Pledge in solidarity and in support of their new colleagues. It is, for us in particular, an emotional moment.

RACS

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TONSILS AND ADENOIDS

Cystoscopy without resection

DAVID WATTERS
Chair, Clinical Variation Working Party

As highlighted in the last edition of Surgical News understanding clinical variation is becoming increasingly important both locally and internationally. Fifty years ago medical interventions were limited, more straight forward and carried a much lower cost impact on the community. Today medical and surgical interventions have become incredibly complex, involving multidisciplinary decision making by sophisticated teams, and chronic disease must be managed for decades at substantial expense both to the individual patient, private health insurance and government funders.

Consequently it is a strategic priority for the College to work with health funders and other groups that 'own' big data sets, so we can understand the approach they use in interpreting them, and ensure that relevant and meaningful information is made available to all surgeons. The College needs to be actively involved in the discussions about how health care can be affordable whilst ensuring good surgical practice. An outcome that will certainly benefit our patients, as well as the profession.

The College and Medibank have established a collaboration to progress the analysis of the administrative data sets that Medibank has available from over one million surgical interventions per year. By focusing on high volume procedures, we are developing an approach in reporting that can be applied across most areas of surgical practice and enable a careful review of clinical practice.

The data is published in the report on a global basis as well as a regional basis, where appropriate. We are looking into

making the data available at a hospital level without identifying any individual surgeon. The College and Medibank are currently exploring a way to provide information to individual surgeons who wish to know where they are within the global data-set. This process will take several months to develop and will be via a direct enquiry between the surgeon and Medibank with consent being given for the data to be extracted.

The College will never have individual surgeon performance data made available to it.

The role of the College is to ensure a meaningful approach is established and that education can be provided across the entire Fellowship as to what variation exists. We are very fortunate that Medibank has engaged so productively with the College in this endeavour. We are hopeful of progressively replicating this process with other funders and their data sets.

We are presenting these initial reports

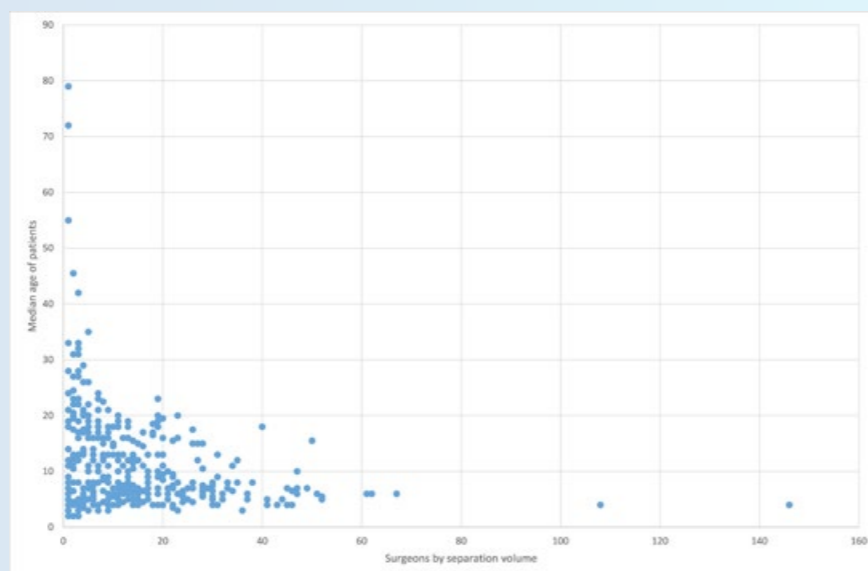
through Surgical News as the first part of a broader communication strategy. There are two procedures within this report. Tonsils and Adenoids and then Cystoscopy without resection.

Tonsils and Adenoids

In 2014 Medibank funded a total of 5,455 operations in private hospitals for which tonsils and adenoids surgery was recorded as the principal procedure (highest value MBS fee from the medical claim) for the hospital admission. The analysis is limited to those 5,455 procedures. 380 surgeons (identified through the stem of their Medicare provider number) billed Medibank for those procedures. 276 (73%) of these surgeons undertook 5 or more procedures.

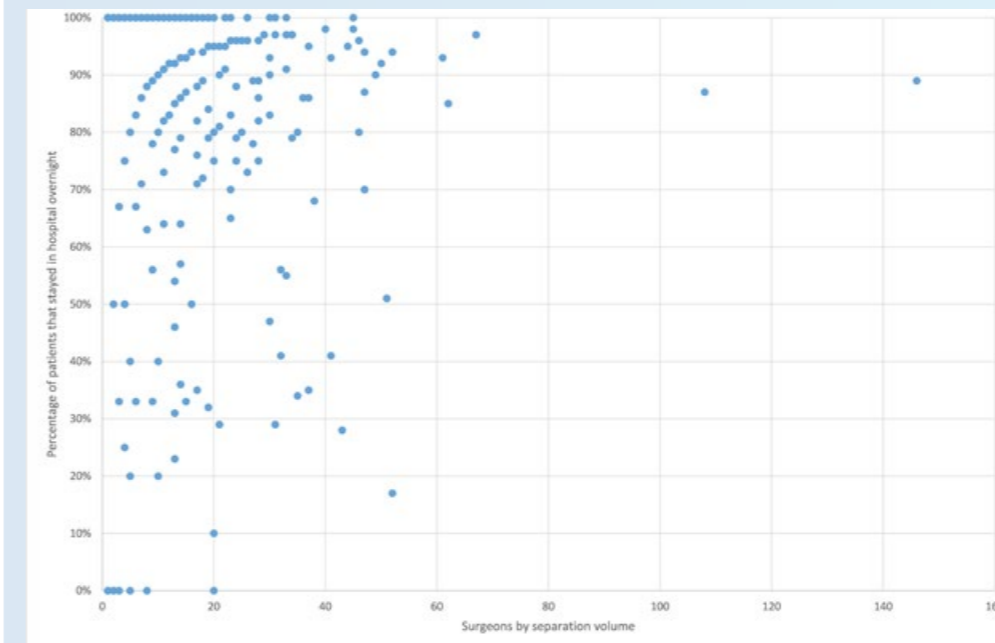
Of course the surgeons could also be doing many more of these procedures in the public sector or on patients with other private health insurers. The Medibank dataset does not have this

Figure 1: The Median patient age for tonsils and adenoids



For the 276 surgeons who performed at least 5 procedures, the median patient age was 7.5 years

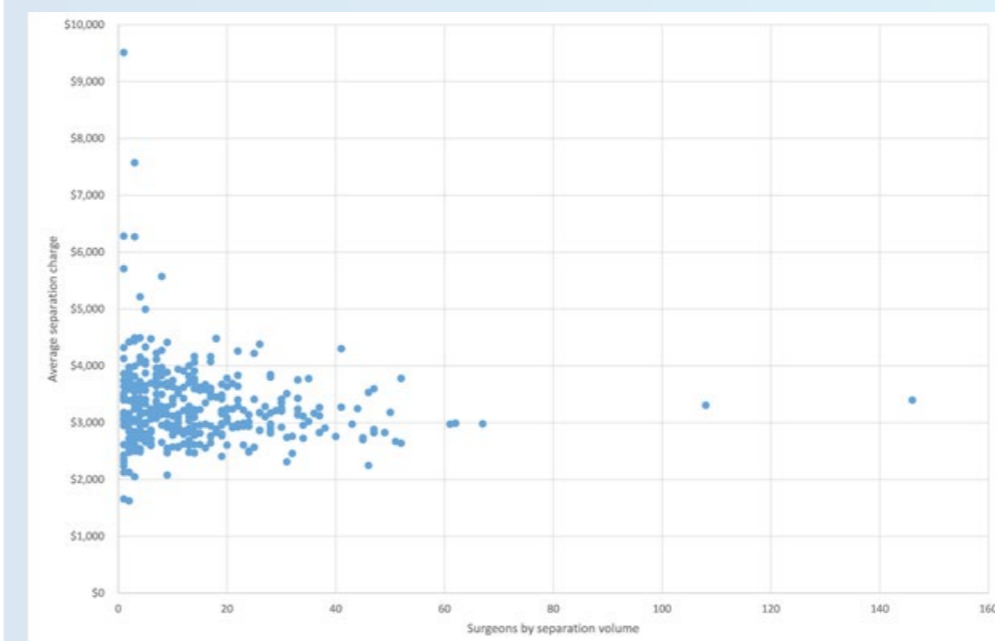
Figure 2: The percentage of patients who stayed in hospital overnight for Tonsils and Adenoids



83% of patients stayed in hospital for at least one night following their procedure. For the 276 surgeons who performed at least 5 procedures:

- For 86 (31%) all of their patients stayed in hospital overnight
- For 3 (1%) all of their patients were discharged on the same day of admission
- 187 (68%) had a mix of patients that either stayed in hospital overnight or were admitted and discharged on the same day

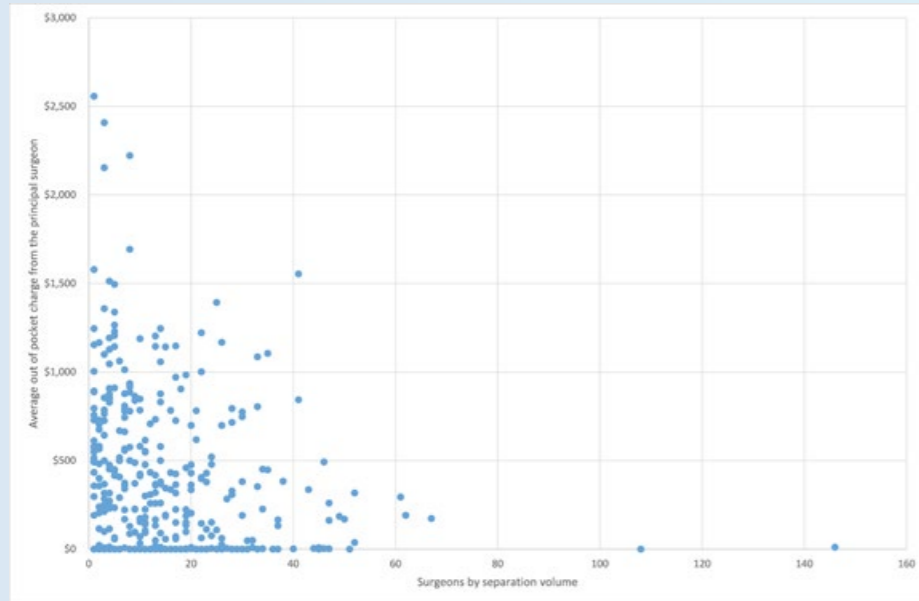
Figure 3: The Average Separation Cost for Tonsils and Adenoids



The separation cost includes the total charges that Medibank sees including payments made by Medibank, Medicare and the patient. Costs include hospital, prosthesis, surgeon(s) and diagnostic services. For the 5,455 separations, the average separation cost was \$3,192.

For the 276 surgeons who performed at least 5 procedures, the average separation cost was between \$2,078 and \$5,571 with a median of \$3,177

Figure 4: Average out of pocket charge from principal Surgeon for Tonsils and Adenoids



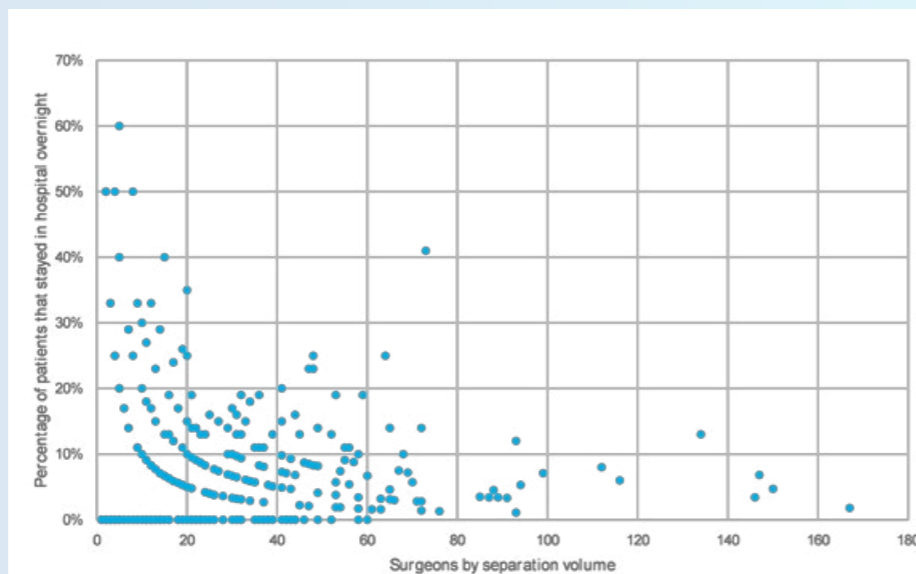
The patient was charged an out of pocket fee by the principal surgeon in 49% of admissions. For the 276 surgeons who performed at least 5 procedures, 71 (26%) did not charge any of their patients an out of pocket for the hospital admission. The average out of pocket charged was between \$0 and \$2,222 with a median of \$198

Cystoscopy without resection procedures

In 2014 Medibank funded a total of 10,431 operations in private hospitals for which cystoscopy without resection was recorded as the principal procedure (highest value MBS fee from the medical claim) for the hospital admission. The analysis is limited to those 10,431 procedures. 418 surgeons (identified through the stem of their Medicare provider number) billed Medibank for those procedures. 318 (74.3%) of these surgeons undertook 5 or more procedures.

Again, of course the surgeons could also be doing many more of these procedures in the public sector or on patients with other private health insurers. The Medibank dataset does not have this information.

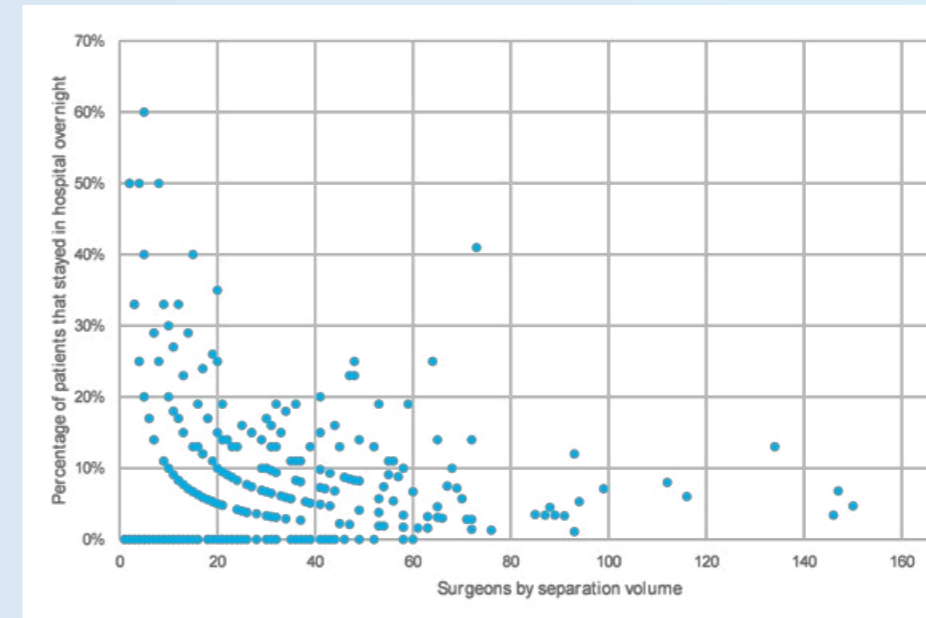
Figure 5: Percentage of patients who stayed in hospital overnight for Cystoscopy without resection



7.9% of patients stayed in hospital for at least one night following their procedure. The median age of patients that stayed in hospital overnight was 76 years, compared with a median age of 69 years for all patients. For the 318 surgeons who performed at least 5 procedures:

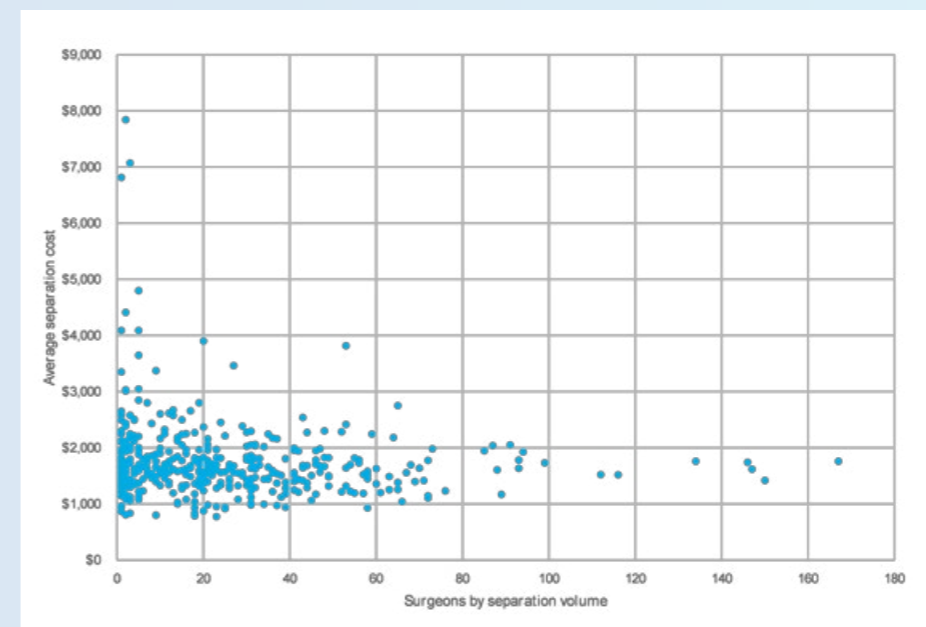
- For 90 (28%) all of their patients were discharged on the same day of admission
- For 228 (72%) one or more of their patients stayed in hospital overnight.

Figure 6: Percentage of patients re-operated on within six months for cystoscopy without resection



Of the 10,431 hospital separations 1,217 separations (12%) was where the patient was re-operated on within six months. The average age of patients re-operated on was 72 years compared with an average age of 69 overall. Of the 318 surgeons who performed 5 or more procedures, 89 (28%) had one or more patients that were re-operated on within six months.

Figure 7: Average separation cost for Cystoscopy without resection procedures



The separation cost includes the total charges that Medibank sees including payments made by Medibank, Medicare and the patient. Costs include hospital, prosthesis, surgeon(s) and diagnostic services. For the 10,431 separations, the average separation cost was \$1,647. For the 318 surgeons who performed at least 5 procedures, the average separation cost was between \$773 and \$4,799 with a median of \$1,616.

OPEN HOUSE MELBOURNE

SATURDAY
& SUNDAY
25-26TH
JULY



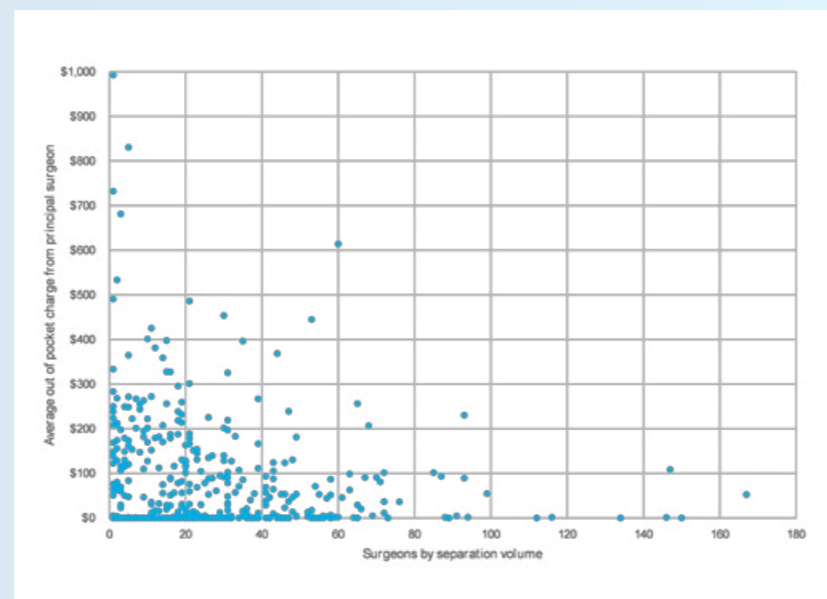
The College is again opening its doors to the general public as part of the Open House Melbourne weekend

A number of buildings not normally open to the public will be participating

If you would like to be involved and volunteer as a room presenter we would like to hear from you

For more information and to register as a volunteer please contact **Megan Sproule**
+61 3 9249 1220
megan.sproule@surgeons.org

Figure 8: Average out of pocket charge from principal surgeon for cystoscopy without resection



The patient was charged an out of pocket fee by the principal surgeon in 32% of admissions.

For the 318 surgeons who performed at least 5 procedures, 89 (28%) did not charge any of their patients an out of pocket for the hospital admission. The average out of pocket charged was between \$0 and \$831 with a median of \$32

Like all reports of administrative data sets there is substantial work in ensuring the data is represented in a meaningful and relevant style. I would like to acknowledge the commitment of Medibank in accessing and representing this data in a way that can be usefully interpreted. I would also like to acknowledge the Clinical Variation Working Party including general surgeons, cardiothoracic surgeons, orthopaedic surgeons, otolaryngologists, urologists and vascular surgeons who are now reviewing the data and its presentation. They are trying to ensure that these reports can be sent to surgeons and that they will be seen as valuable despite their limitations.

The reports will become progressively available over the coming months.

And that is when both the interesting and challenging part starts. As Fellows of the College we need to have an understanding of what drives variation in health care. We are all responsible for the quality of care that our patients receive and the resources that are utilised in providing that care.

I would be delighted in receiving feedback about this process. Also, if you wish to pursue this data with questions to Medibank our key clinical contact is Dr Linda Swan, Chief Medical Officer, Provider Networks and Integrated Care at Linda.Swan@medibank.com.au



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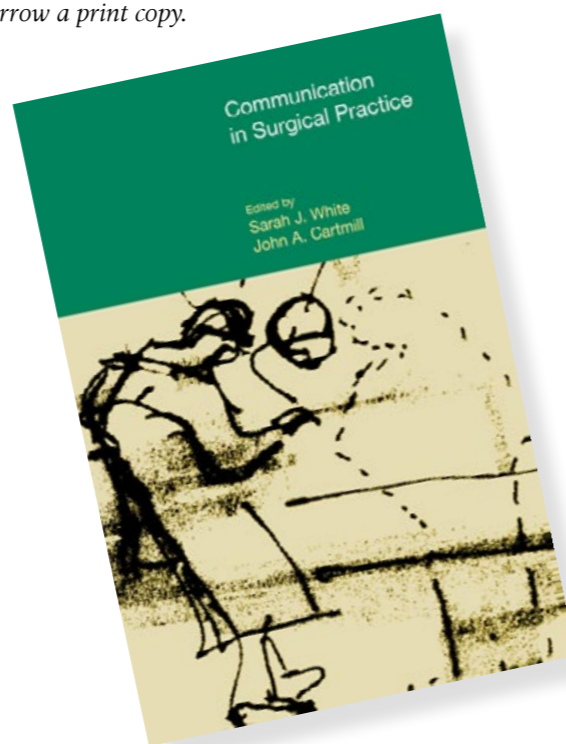


RICHARD PERRY
Chair, Fellowship Services

making, Verbal Acknowledgement in the Operating Theatre, Minor Awake Surgeries, Inter-Professional Clinical Handovers and Open Disclosure in Surgical Practice and Clinical Communication Education for Surgeons.

There is also a quite extensive list of references for further reading at the end of the book.

Copy kindly donated by the authors. Contact Library staff to borrow a print copy.



Communication in Surgical Practice

2016 Edited by Sarah J. White and John A. Cartmill

Both editors work at Macquarie University. John Cartmill, FRACS is a colorectal surgeon, Associate Dean, Clinical and Professor of Surgery at the Faculty of Medicine and Health Sciences while Sarah White is a linguist and qualitative health researcher and senior lecturer at the Faculty of Medicine and Health Sciences.

Surgery is reliant on the highest standards of communication. Communication forms a central part of clinical work for surgeons. However, it has only been in the past several years that the uniqueness and complexity of this aspect of surgeon competence has gained currency in research and education.

This volume brings together new research from key international academics, who contribute a range of linguistic, sociological, and professional views on communication in surgical practice. The primary aim is to provide an insight into the complexity of surgeon communication, covering a variety of communicative activities required in the everyday work of surgeons. Through the selection of authors from a variety of interactive sociolinguistic disciplines as well as the contribution of clinicians, this book is able to encapsulate a broad range of topics in, and methodologies currently used to understand, communication in surgical practice.

The intended audience for this book includes surgeons, surgical colleges, medical educators, communication researchers and educators, linguists, sociologists, and others with an interest in surgical and medical communication.

Chapters include information on Patient-Centred Consultations, Psychological Effects in Surgical Decision-

Reverse Shoulder Arthroplasty Biomechanics, Clinical Techniques, and Current Technologies

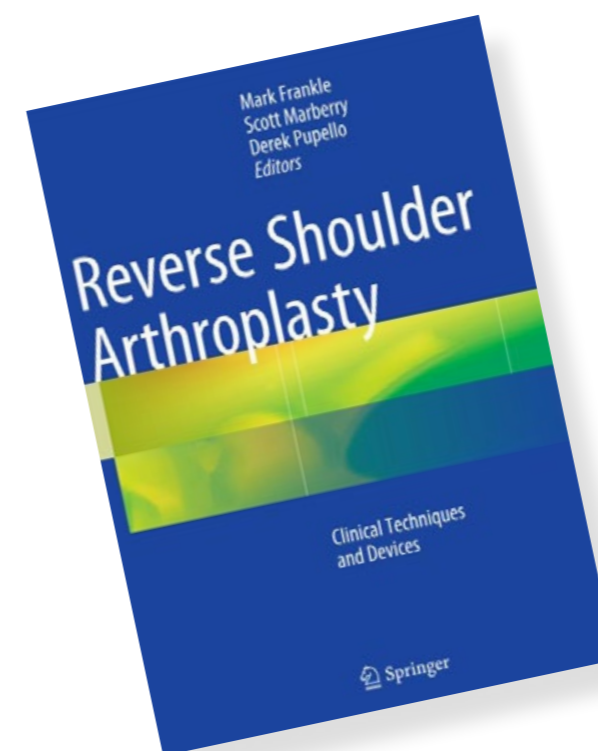
2016, Edited by Mark Frankle, Scott Marberry, Derek Pupello

Nearly four decades ago, reverse shoulder arthroplasty (RSA) was introduced to orthopedic surgeons with the aim of helping reduce shoulder pain and dysfunction in the most severe pathological states. Its contribution to the treatment of advanced shoulder diseases has been significant. Patients who were previously untreatable due to the severity of their pathology are now receiving pain relief and functional improvements. There have been numerous significant contributions made to the development of RSA, the most

notable being the Delta III prosthesis, introduced by Paul Grammont. Following his contribution, there have been many others who have provided substantial information on RSA's mechanics, effectiveness, technical application, potential complications, and value. Each author in this book has been carefully chosen based on their contributions to peer-reviewed literature. As in all fields of scientific endeavour, a variety of viewpoints have been formed and reflected in this textbook.

It is hoped that this diversity of opinion will provide the reader with a better overall understanding of RSA and its potential to treat severe shoulder conditions. After an introduction to the history of the technique, Part II of this textbook is devoted to the biomechanics and kinematics of RSA. Part III describes its clinical use for treating a myriad of shoulder pathologies. Here you will discover surgeons, renowned worldwide for their expertise in RSA, sharing their experiences with relevant technical pearls. Part IV covers commercially available devices from a variety of manufacturers, with the surgical technique and design rationale for each device provided. Finally, in Part V, the economic aspects of this technology are examined from a societal perspective.

Focusing exclusively on reverse shoulder arthroplasty (RSA) techniques and devices, this well illustrated text covers all aspects of this important and innovative treatment for shoulder pain and dysfunction. The book begins with a history of RSA followed by a thorough overview of the basic science and biomechanics of the shoulder. Indications for



and clinical applications of RSA in a number of surgical interventions are then described, including the revision of failed shoulder arthroplasty, setting in cases of glenoid and humeral bone loss and rotator cuff tears. A whole section is then dedicated to various commercial devices with descriptive expert analysis of the design and implementation of each. An examination of the current economic value of RSA, including cost effectiveness and expected cost outcomes, comprises the final section.

Available as a Springer e-book from:
ezproxy.surgeons.org



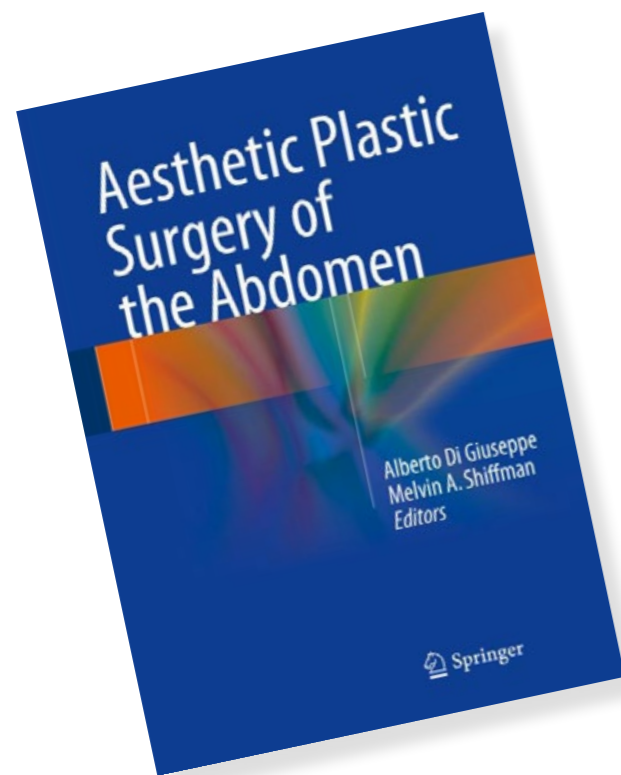
Aesthetic Plastic Surgery of the Abdomen

2016, Edited by Alberto Di Giuseppe and Melvin A. Shiffman

Contouring of the abdomen has reached a high standard of sophistication in the last decade, in aesthetic plastic surgery. New techniques, such as lipoabdominoplasty introduced by Saldanha, based on a study of the vascular anatomy of the abdomen, have led to a less invasive procedure for contouring the abdominal wall.

New technologies such as the third-generation ultrasound energy device (Vaser) has brought a selective approach to liposuction in the deeper fat of the abdominal wall, flanks, and torso, giving the ability to contour and refine the shape and giving more attention to details and improving frame and a defined shape.

New concepts, such as the enhancement of the flanks and superficial lines of contouring to re-create an athletic body by better sculpting the oblique rectus abdominis muscles, and lines of definition (linea alba, linea semilunaris). This has led to a specific approach to more patients looking for an athletic appearance of the abdomen. The younger and older populations are achieving a more athletic body look by eating a healthy diet, by constant proper training, and now by an increasing demand of body contouring—sculpting. This book has the specific target of explaining the new techniques,



Laparoscopic Surgery for Colorectal Cancer

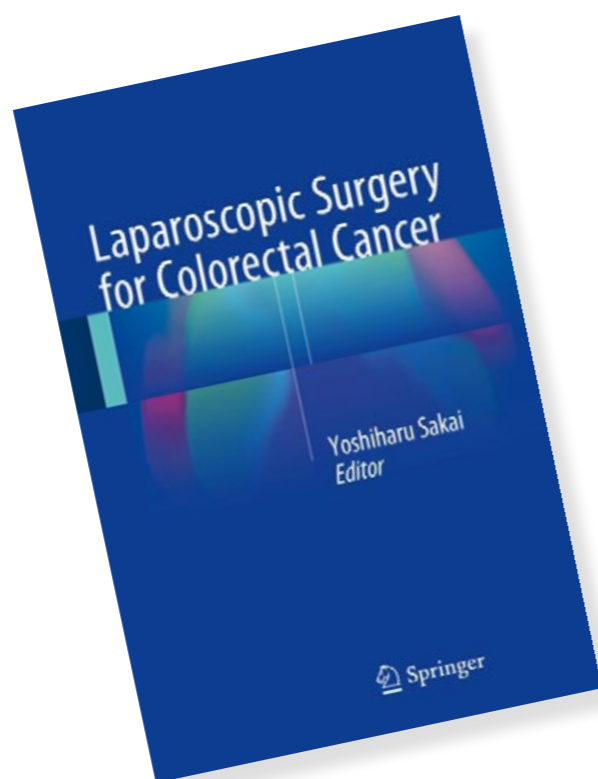
2016, by Sakai, Yoshiharu

This book provides simplified principles of surgical anatomy for colorectal cancers with sophisticated drawings, standard laparoscopic procedures with striking photographs and illustrations, and advanced procedures such as lateral pelvic node dissection and “down to top” or “reverse” total mesorectal excision.

Oncological safety as well as minimum invasiveness of laparoscopic surgery for colorectal cancer has been acknowledged worldwide, based on long-term outcomes of several randomized controlled trials comparing laparoscopic surgery and open surgery. Developments in optical devices have provided us with a magnified clear vision of fine anatomical structures, facilitating our understanding of surgical anatomy and surgical procedures have been refined and improved accordingly.

All these topics are presented in this book—valuable for surgical residents and experts eager to learn more about laparoscopic colorectal surgery—and readers will be enlightened by a new paradigm for “lap-enhanced surgical anatomy”. Therefore this volume will greatly benefit not only colorectal surgeons but also general surgeons as well as gastroenterologists and oncologists.

Available as a Springer e-book from:
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technologies, and procedures for the “state of the art” in abdominal contouring.

This book covers anatomy, recent techniques, postoperative care, possible complications and outcomes in aesthetic surgery of the abdomen. The extensive section on aesthetic procedures includes many important innovations in abdominoplasty. Detailed consideration is also given to the various potential complications, with guidance on their prevention, diagnosis, and management. The book is written by acknowledged experts in the topics on which they write. It will be of value for residents and fellows and more experienced surgeons in the fields of plastic surgery, general surgery, cosmetic surgery and general surgery.

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NEWS FROM TASMANIA

Progress and preparations continue

BRIAN KIRKBY Chair, Tasmanian Regional Committee

Tasmania continues to be busy from a surgical point of view. We are well down the track in preparations for our state ASM, with the theme of Poles Apart. We have been lucky in obtaining a visiting speaker from regional Canada, who was in Australia as the invited speaker for the Provincial Surgeons meeting. To fit in with invited speaker from Canada, Lauren Smithson, the meeting has been moved forward to Friday 12th and Saturday 13 of August. Additionally we have invited speakers from the Antarctic Division and an anaesthetist with extensive experience in aid work particularly in the Middle East.

The reform agenda from the State Liberal Government continues but there has been a significant change in the relationship between RACS and the Minister for Health. This relationship has deteriorated particularly where the Minister has strong opinions about outcomes that he wants delivered and the manner in which they will be delivered. The areas in which differences of opinion have arisen are around waiting lists, delivery of surgical activity and resourcing.

There is a feeling among the fellows of the College that the Minister has a strong desire to deliver immediate results in terms of surgical activity rather than investing in latent capacity that already exists within in public health system and that such immediate results are requiring large investments of resources in a manner which is not cost effective in the medium to long term.

There remains a governance void in the reformed health system. The previous three Tasmanian Health Organisations have been amalgamated into a single Tasmanian Health Service (THS) under a single board. The CEO of the THS was finally appointed at the start of February after eight months under an interim CEO. While an upper level governance structure has now been released but remains to be appointed too, there is essentially no structure between Departmental Heads and the CEO. This has led to a situation of essential paralysis where normal day to day administrative requirements are unable to be achieved.

The reform process has also seen the abolition of the State-wide Surgical Services Committee, which has previously been responsible for coordinating a comprehensive state wide approach to surgical services. This is to be replaced with a Surgical and Peri-operative Clinical Advisory Group which is to be comprised of a representative of each of the surgical craft groups.

Major Capital works programs are either underway or just completed in two of the three major hospitals in Tasmania. The Launceston General Hospital (LGH) has just completed a major capital works program with the previous six theatre suite being refurbished into nine operating theatres incorporating a hybrid theatre. Additionally the LGH has a new sterilising department, a new ICU and Short Stay Surgical Unit and a new Emergency Department. The Royal Hobart Hospital has just commenced a complete rebuild on the existing site which while delivering a new hospital in about five years, will have a significant impact on capacity during the construction period.



TRAVEL FOR BEST PRACTICE

Breast and Endocrine Surgeon Dr Anita Skandarajah visited major cancer centres in the hope to build her knowledge of best models of care

Dr Anita Skandarajah and Dr Kevin Hughes, Breast Surgeon Mass General Hospital

Breast and Endocrine Surgeon Dr Anita Skandarajah visited three major American cancer centres last year to analyse models of cancer care delivery in anticipation of the opening this year of one of Australia's most advanced cancer centres.

The \$1 billion Victorian Comprehensive Cancer Centre (VCCC) is a State and Federally funded facility which brings together the expertise and services of the Peter MacCallum Cancer Centre, the Royal Melbourne and Royal Women's Hospitals and the University of Melbourne and other partners.

Expected to open in June, the VCCC will have a dedicated clinical trials unit, more than 25,000 square metres of specialised research space, 160 overnight inpatient beds, eight operating theatres, eight radiation therapy bunkers and education and training facilities.

An employee of all four organisations, Dr Skandarajah used the funds attached to the Hugh Johnston ANZ Chapter American College of Surgeons (ACS) Travelling Fellowship to attend the annual ACS Clinical Congress and visit the MD Anderson Cancer Centre, the Memorial Sloan Kettering Cancer Centre and the Massachusetts General Hospital (MGH).

Dr Skandarajah, who has research interests in risk reduction and cancer risk assessment, said she had deliberately selected internationally renowned cancer centres along with a tertiary general hospital to allow her to compare models of cancer care delivery.

She said that in the US, as in Australia, there had been a move towards developing treatment models based on strong links between regional services and specialised tertiary care.

"The historical model of cancer care delivery was to centralise specialist services which often caused a great deal of disruption to patients and their families, particularly those who had to travel," she said.

"In recent years, however, there has been a push to develop high quality regional services, particularly to treat patients with relatively common cancers like breast and colon cancers, with strong links to a tertiary centre and much the same has happened in America.

"In Houston I visited both the main campus of the MD Anderson Cancer Centre and a regional centre which bolstered my opinion that cancer patients should not be forced to travel for high quality care, while understanding that some cancers will, of course, require tertiary care in a specialist centre."

Dr Skandarajah said her visit to the MD Anderson Cancer Centre in Houston, Texas, had been a particular highlight of the trip.

"The MD Anderson is extremely well funded so it is an extraordinary place because it can afford to be, it attracts patients from around the world and while it offers world-class care it is also very expensive care," she said.

"It was interesting then to compare this level of care with that offered by the MGH and see how the US system works because I did my Post Fellowship training in Europe which is more closely aligned with the Australian health system.

"The focus on patient care and the patient experience was most impressive."

Dr Skandarajah praised the generosity and support of her

"In recent years, there has been a push to develop high quality regional services, particularly to treat patients with relatively common cancers like breast and colon cancers, with strong links to a tertiary centre."

supervisors at the MD Anderson Cancer Centre - Dr Kelly Hunt, Chief of Breast and Endocrine Surgery, and Endocrine Surgeon Dr Nancy Perrier who allowed her access to patients with rare endocrine conditions which are infrequently seen in Australia.

"The visit with Dr Hughes at MGH was a highlight in learning about how to assess risk of breast and ovarian cancer development in all patients and using risk calculators to enable focused and tailored prevention plans to be designed for each patient," she said.

"Dr Hughes has developed a computer-based risk app which all patients complete upon arrival as they wait for a consultation which not only uses up otherwise empty time but gives treating physicians a great deal of useful information in developing a treatment plan.

"All my hosts and mentors in the US also impressed me with their dedication to fostering and mentoring younger doctors and developing and sustaining surgical teams which is a focus I hope to take forward throughout my career."

While she was in the US, Dr Skandarajah also attended the ACS Clinical Congress in Chicago as an International Fellow along with other surgeons from Europe, Africa and Asia.

She said the group forged strong bonds through a structured program and through the warm welcome they received at the ACS.

"As a group of surgeons in our early to mid careers, we were able to discuss the challenges of balancing our clinical commitments with our research and teaching duties while also striving for a degree of balance outside our working lives," she said.

"Our discussions also brought home to us the differences in the global provision of health care resources.

"I believe these links will be professionally rewarding as was attending the meeting itself.

"It was particularly astounding to be part of the Convocation and to be part of the opening ceremony of the ACS and to be honoured repeatedly throughout the meeting."

Dr Skandarajah said some of the academic highlights of the Congress were discussions surrounding the optimal frequency of breast screening, the introduction of the 2015-revised edition of the American Thyroid Association Guidelines and issues surrounding the management of primary cancers in the setting of metastatic disease.

She said that while she had been impressed by the attention given in the US to patient-centred care, her pre-opening viewings of the VCCC inspired similar excitement.

"I've already had a walk around the VCCC and it is a beautiful place, on a level with some of the facilities I saw in the US in terms of creating lovely spaces for patients and their families," she said.

"The trip last year was wonderful in terms of what I gained in clinical knowledge and leadership skills but overwhelmingly, it made me very proud of the skills, knowledge and facilities that we have in Australia and while I learned a lot, I also learned that it was a very exciting time to be a cancer surgeon in Melbourne."

With Karen Murphy



Dr Skandarajah's research has taken her around the world



NOT JUST A SURGEON

Otolaryngology Surgeon Dr Elizabeth Sigston has applied her skills to environmentally friendly business operations

Perenjori from Cave Rock, Western Australia

Otolaryngology Surgeon Dr Elizabeth Sigston was last year selected as a finalist of the prestigious Telstra Business Woman of the Year Awards for the innovative enterprise she created which combines commercial profit with environmental investment.

A Head and Neck cancer specialist with a public practice at Monash Health in Melbourne, Dr Sigston is also the founder and CEO of SavinGreen which uses the funds earned from the sale and brokerage of telecommunications, LED lighting, gas and electricity services to buy trees to reforest degraded land and act as carbon offsets.

Working with the large scale, specialist environment group Carbon Neutral, SavinGreen has so far funded the planting of almost 60,000 trees since it was established by Dr Sigston in 2010.

Describing her business model as “profit with purpose”, Dr Sigston said she decided to establish the company because she felt compelled to help mitigate the impact of climate change as an issue of public health and personal responsibility.

“We cannot expect to live on an unhealthy planet that cannot provide clean air, water and food and expect for us, our children and grandchildren to have healthy lives,” she said.

“I established SavinGreen to show that by adopting principles of ‘people, planet, profits’, a commercial business model could be created to enable everyone to become involved in contributing to environmental sustainability simply by making a conscious choice about where they obtain every day services.”

Dr Sigston said she was honoured to have been chosen as a Victorian finalist in the Entrepreneur category of last year’s awards yet she is no stranger to enterprise, endeavour or courage.

As a young doctor, she became the first woman with a small baby to be accepted into surgical training and in 2007 she became one of the first women to be appointed as Executive Director of Clinical Services, Training and Research at the Department of Otorhinolaryngology, Head and Neck Surgery at Monash Health.

“I began my surgical training at the Alfred Hospital under the supervision of Chris Christophi and although some people thought it would be impossible to combine surgical training and motherhood, it just felt like a natural step for me,” she said.

“When I was a second year resident, Professor Christophi became the Director of Surgery. He has always been very supportive of women in surgery and without his support I probably would not have become a surgeon.

“At one time there were six women surgical registrars at the Alfred, a number which I don’t think was replicated in any other hospital in Australia at the time.”

While Dr Sigston flirted with the idea of becoming a Plastic and Reconstructive Surgeon, she chose Otolaryngology, Head and Neck surgery. After being awarded her FRACS, Dr Sigston completed a two year Fellowship at the George Pompidou Centre in Paris.

“We cannot expect to live on an unhealthy planet that cannot provide clean air, water and food and expect for us, our children and grandchildren to have healthy lives.”

“That was a wonderful experience and it was exciting to work with people who approached their patients with great care and compassion,” she said.

“I have always believed that the way we treat our patients can have a considerable impact on outcomes and that we have a duty to maximise a patient’s quality of life, no matter how long that might be.”

Dr Sigston is currently completing her PhD thesis investigating biomarkers to assess margins in head and neck cancer, sponsored by a Project Grant from Garnett Passe and Rodney Williams Memorial Foundation and funding from the Department Of Surgery (MMC), Monash University. She has also recently established a collaborative translational research project with the Monash Institute of Medical Engineering into 3D Printing of prosthetic maxilla and mandibles for use in cancer patients, and is a co-investigator for a multicentre research project in conjunction with Flinders Medical Centre into RNA markers.

She is active within the Australian Society for Otolaryngology Head and Neck Surgery (ASOHNS) and is currently the Chair of the Specialty Surgical Sciences Examination Committee for ORL and member of the Training Board.

And in the midst of all this, she suffered and survived breast cancer at the young age of 38.

“I have always believed that health and a healthy environment are absolutely intertwined and at the time I established SavinGreen I had just gone through a divorce, breast cancer and was working as a single mother,” Dr Sigston said.

“Undergoing treatment for breast cancer gave me the time to think about those matters that were important to me and how I wanted to live my life in the future and that experience changed my life absolutely for the better.

“While we as surgeons tend to concentrate on practical interventions, I believe that health is not just dependent on physical wellbeing but the balance



Dr Elizabeth Sigston

and interaction between body, mind, soul, spirit and emotion.

“I see caring for the environment as part of this because connecting with nature can be very healing at many levels. If we don’t work now to save and sustain our environment, we will be doing a grave injustice to our children and grandchildren.

“I enjoy the business because its primary focus is not solely about money but has a broader public purpose while it also allows me, as a surgeon, to separate my income generation from my work treating cancer patients which frees me to really love medicine.”

Dr Sigston said SavinGreen aimed

to provide positive economic, social and environmental outcomes. She had chosen to invest in tree planting because one mature tree can provide enough oxygen for two people over a lifetime.

The trees funded by SavinGreen have been planted as part of a massive project run by Carbon Neutral called the Yarra Yarra Biodiversity Corridor which is now the world’s largest privately-owned biodiverse reforestation carbon sink.

The corridor, which covers 13,135 hectares of previously cleared and degraded land 400km north of Perth, has now been planted with more than 20 million trees comprising 40 native tree and shrub species indigenous to the environment.

WOMEN IN SURGERY

This tree planting project not only removes 1.257 million tonnes of carbon over the 50-year project cycle, it also conserves soil and water, prevents salinity and protects and stabilises ground cover.

The Yarra Yarra Corridor is one of only 35 globally significant biodiversity hotspots. These are regions that have an exceptionally high number of plant and animal species found nowhere else in the world and account for 90 per cent of all species on earth.

Since it was established in 2001, the Corridor has now created a thriving bush landscape that has brought abundant life back to desolate areas that could no longer support viable

farming practices.

Dr Sigston visited the area two years ago.

“It was a very emotional experience to see what we had been part of,” she said.

“When you’re there you can look one way and all you see is dry, red dirt and then look the other way and all you see is green. It has been planted so well, with so much scientific knowledge and care that it doesn’t even require irrigation and it is already changing local rainfall patterns to the delight of nearby farmers.”

With Karen Murphy



Tree plantation in WA with Kent Broad from Carbon Neutral

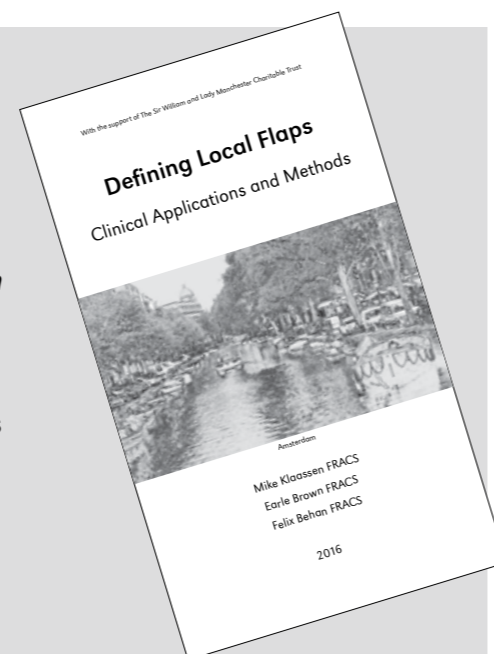
Defining Local Flaps: clinical applications & methods (2016)

By Mike Klaassen, FRACS, Earle Brown FRACS & Felix Behan FRACS

‘This masterpiece underscores how one thinks like a plastic surgeon when faced with varied and often challenging clinical scenarios. The 116 pages cover 131 clinical cases, mostly pertaining to reconstruction of cutaneous defects following excision of skin cancers.’

- Dr Swee Tan ONZM MBBS PhD FRACS, founder & director of the Gillies McIndoe Research Institute, New Zealand

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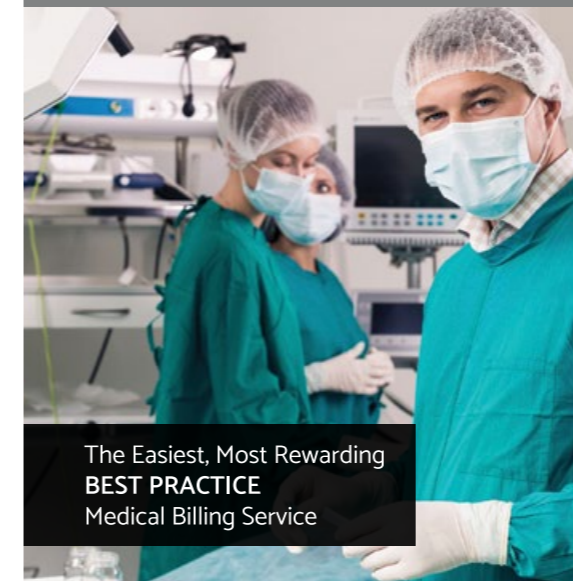
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EUGENE DOYEN

1859-1916

MR PETER F BURKE

Specialty Editor -
Surgical History: ANZ JSurg

Eugene Louis Doyen died in Paris at the comparatively early age of 57: his passage through life has been described as 'the solitary tragedy of a prodigy'. A century after his death it would appear appropriate to briefly review the life and times of an extraordinary surgeon.

The son of the Professor of Anatomy at Rheims, he commenced medical studies there in 1877 and from the outset noted the deficiencies of existing surgical instruments, particularly as he had for years had been in the habit of working with the tools of the cabinet maker.

Doyen observed then at the Hôtel Dieu that the instruments were imperfectly cleaned after the previous operation and were brought forth dusty and rusty and strewn without order on untidy metallic trays. Such was the state of French surgery that Billroth observed that it followed German surgery "with slow and limping footsteps".

From 1880 Doyen attended the extern practice of the Paris hospitals and was received as an intern in 1881 where he was initiated him into the methods of Lister. Then in 1882 Doyen commenced his researches into the bacteria of suppuration and osteomyelitis: such was his skill that in later years Louis Pasteur offered him a position at his famous Institute on the condition that Doyen abandon surgery!

In 1883 he visited the German clinics as gastrointestinal surgery was almost unknown in France. He was greatly impressed by their organisation and worked with Billroth in Vienna, assisting at operations previously unknown to him including resection of the greater curvature of the stomach: he noted that pathological specimens were immediately studied in the laboratory attached to the operating theatre.

Obtaining his degree in 1885 he returned to Rheims with an ambition to combine all that he had learned. Doyen commenced to operate that year and wrote: "from the beginning I had always been impressed with the abuse of forceps and ligature in a field where no considerable vessel existed., I soon convinced myself that the great vascularity of certain solid tumours of the abdomen was almost exclusively venous, and quite beyond proportion to the local arterial development, which had remained almost normal".

"I then practised rapid isolation of these tumours from the anatomical attachments without attending to the venous



Eugene Doyen

channels while limiting the process of haemostasis to the afferent arteries".

"The 'method' was discovered; I had now but to apply it throughout the whole domain of surgery".

Doyen noted that it was in Brussels at the first International Congress of Gynaecology in September 1892 that he made, "my first attack on the abuses of preventive haemostasis".

Doyen protested against the indefinite duration of some operations; in his hands a simple vaginal hysterectomy required only the application of 2 to 4 forceps, and occupied just four or five minutes; difficult cases necessitated 20 to 30 minutes. He could perform eight abdominal hysterectomies in a morning. The methodical precision of German surgery wearied him and he described these operations as long "séances".

Paradoxically his surgical skills limited the acceptance of his surgical techniques in his lifetime: Doyen was endowed with rather exceptional eye-hand coordination that made him not only an excellent surgeon but also a sharp shooter, and he was a formidable fencer.





Use of the *ecraseur* in appendectomy

An obituary later noted: “Doyen’s operative skill was extraordinary, but we can conceive no more dangerous or undesirable an example than a master who sacrifices everything to speed. Competent critics expressed the opinion freely that, while they marvelled at the lightning-like dexterity displayed, they would not trust their own relatives to so daring a surgeon.”

Doyen’s ‘Surgical Therapeutics and Operative Technique’, the English edition of 1917, in three large volumes, written in the first person, reveals the immense scope of his surgical practice.

The first volume is taken up with an historical review of surgery and surgical techniques and then Doyen’s general surgical technique, going into detail on the general treatment of patients before, during and subsequent to surgery: then follows ‘Regional surgery’, including surgery of the head, thorax, the liver, inter alia. Doyen was the first to operate for congenital or acquired valvular disease of the heart.

His surgical life could be divided into

two equal periods; the first one from 1885 to 1896 at Rheims;

The second period from 1896 to the War took place in Paris: He operated the house of champagne that his father left him and his own Institute; in total, Doyen opened some 20 clinics in Paris mainly financed by his personal fortune as was his research: he had soon left the slow road of official promotion.

Doyen’s Institut Chirurgical was unique in its class inasmuch as it included all requisites for general and special surgery, applicable to disease of every kind and patients of all classes; as well as perfectly equipped laboratories for research in the departments of histology, bacteriology, and serotherapy.

The structure opening on the Rue Piccini was set apart for the wealthier class of patients and also contained M. Doyen’s consulting room: that on the Rue Duret was devoted to extern patients and intern treatment of the humbler classes.

Full facility of communication with the several floors was secured by electric

lifts and other modern appliances: the new patients on arrival were examined by the chef de clinique and distributed to the extern department.

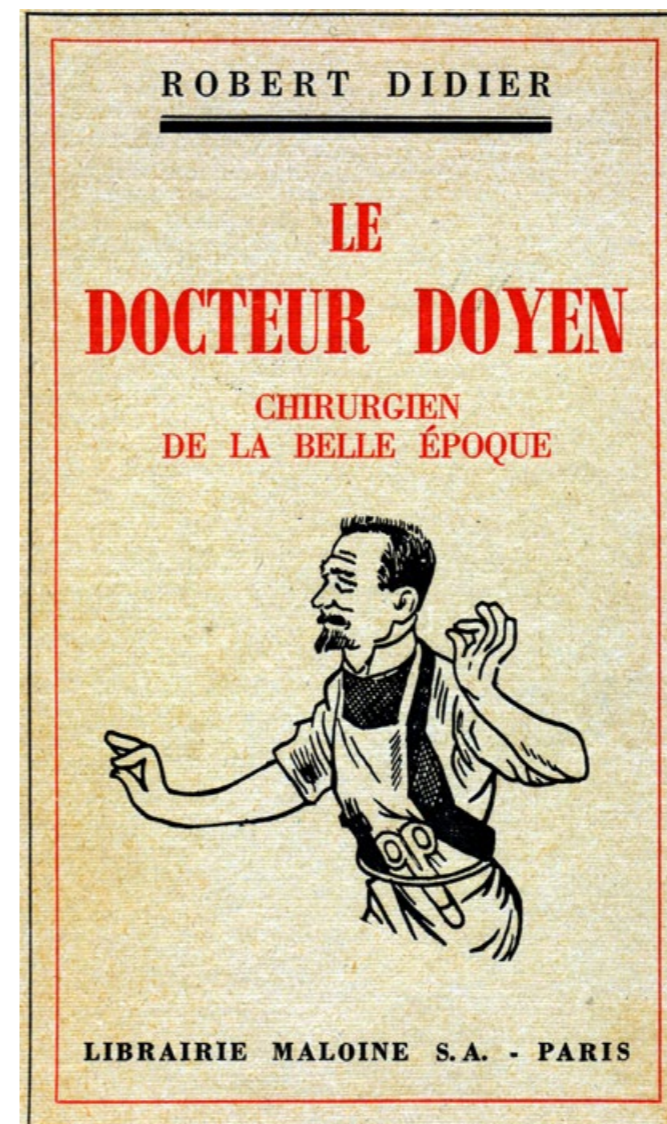
This department included ten special ‘cabinets’, and to this series of consulting rooms were attached the following services, a) orthopaedic and plaster apparatus, b) chemical and bacteriological analyses, c) radiography and photography, d) electricity and phototherapy, e) massage, gymnastics and hydrotherapy, f) serotherapy, g) operations and dressings.

He had the genius of action and many different pictures may be drawn of him; as a surgeon in his operating room, as histologist involved with bacteriology, the laboratory claimed as much of his time as did the operating theatre: as a mechanic, perhaps his greatest contribution to surgery was the perfection of a vast array of instruments.

Doyen was also involved with a variety of imaging media, most prominently cinema, but also micro photography, topographical photography, colour photography and stereoscopic photography. He utilised existing technologies to supplement and record his surgical practice and was also an inventor of optical devices with a particular interest in three domains of technical representation: stereoscopy, the preservation of movement (cinema) and technologies for the representation of colour.

On July 29, 1898 Doyen showed three films to the British Medical Association meeting in Edinburgh including a hemi-craniectomy, which he easily completed in nine minutes with his special instruments: from 1898 to 1906 he made over 60 films.

Dominating his contemporaries and unattached to any large hospital or teaching institution, his views on the aetiology and treatment of cancer attained worldwide publicity. In 1901 he announced the discovery of an organism which he believed produced cancer, *Micrococcus neoformans*; and in



Robert Didier’s biography of Eugene Doyen

the same year began to treat malignant disease by injections of toxins and vaccines prepared from its cultures. He authored works on the treatment of cancer in 1904 and 1909: later clinical reviews in both Paris and London discredited his claims.

Doyen’s manner of announcing his claims exposed him to much criticism by his professional brethren and his position for some years before his death was one of open antagonism to his profession. His book ‘Le malade et le médecin’ published in 1904 is almost a declared defiance of the accepted rules of medical ethics. He gave a public address deploring the want of a 20th century Molière to expose the wrong-doings of doctors, yet when he separated the xiphopagous twins Radica and Doodica he gave a full account of the operation in the ‘Echo de Paris’ of February 10, 1902.

Since Radica and Doodica were part of Barnum & Bailey’s touring cabinet of curiosities, their surgery became the subject of intense media attention. Adding to the aura of impropriety the second camera operator employed by Doyen distributed illicit copies of the operation film and although Doyen was eventually vindicated in court, the damage had been done and the proximity of this film to the world of sideshow exhibitions, crystallised the pre-existing suspicion about cinema held by many members of the medical community.

Doyen’s work was honest and painstaking, although the non-fulfilment of expectations brought him into violent conflicts in civil courts and with members of his profession.

Like many intelligent men his brain was always boiling; his impatience to complete a task had no boundaries. Maybe it was this kind of spirit that forced him to always perform surgery quickly: midway in surgery he would throw his forceps away, take a piece of chalk, draw an instrument on the board and ask that the drawing be copied so that the instrument be made.

During the turbulent course of his brief life, pictures in his young years show a hopeful person with naive eyes, but in his last stage, one sees a man who is tired, disenchanted and with a sad look. What happened to this powerful but so impenetrable mind?

One of his obituaries noted; “Doyen, the Napoleon of modern surgery, was his own worst enemy. Defiant of precedent, impatient of etiquette, contemptuous of convention, he fought for his own hand in a city where officialdom and routine had exceptional strength”.

Married twice, this prodigious talent traversed an essentially lonely odyssey, before, somewhat like the mythical Icarus, having soared, then falling to his premature death.



Doyen’s Institut Chirurgical

TERRIFIC TRAINEES

Do you know an inspirational Trainee?



RUTH MITCHELL
RACSTA Chair

As the Chair of Trainees Association for the College of Surgeons I have the privilege of meeting Trainees from across nine specialties and two countries. Despite the many challenges of surgical training, the depth and character of Trainees shines through. The stereotype of the surgical trainee is the cocky, self-assured, self-absorbed soul.

But in fact, surgical registrars tend to be unfussy, hard-working sorts, with a propensity for self-effacement, self-sacrifice and I daresay, self-flagellation. At great odds with their considerable achievements, surgical Trainees tend to downplay what they have accomplished and focus on the work still to be done. Because there is always more work to be done.

My view is that we should celebrate successes when we discover them. If we wait until everything is perfect before we celebrate, we will never get around to it. The end of a year of training, a new procedure performed, the first time you stop the bleeding by yourself, on your own, without a boss in the theatre. These moments flash by without acknowledgement in the business of the next call from ED, the next septic patient in ICU, the never-ending clinic.

But I'm keen to celebrate the achievements and accomplishments of surgical Trainees. While we continually strive to do better work tomorrow, to operate with more finesse next week than we did this week, to anticipate our patients' needs better and better, we need to pause and notice those around us who are doing fabulous work, and notice our own achievements.

Let me give you some examples of inspirational good work. Iwan Bennett, a neurosurgical trainee, recently contributed to the development of the stentrode device by performing craniotomies on sheep. The stentrode is a matchstick-sized device might one day help paralyzed people move their limbs.

For more information, you can either read the paper¹ or watch US President Barack Obama explain it here: www.sciencechannel.com/tv-shows/science-channel-presents/videos/president-obama-explains-stentrode-devices/

Trainees are doing important research that will shape the future of our work, and improve the lives of our patients in ways we can currently only imagine.

When I was an intern, young(er) and highly impressionable, I remember being particularly inspired by a plastic surgery registrar, Cameron Mackay. He went above and beyond the call of duty in teaching and training his somewhat clueless junior colleague – me. He took so much time to explain things, in theatre, on ward rounds, during hand-over, and his focus on the wellbeing of the entire patient was profound.

At one stage we had a patient who had cut off a number of digits shortly after a weekend trip to Bunnings. His gardening misadventure resulted in a lengthy surgical repair to replant a finger and thumb, and led to a prolonged period of therapy with leeches.

On his way out the door (fittingly enough to teach a CCrISP course), Cam said to me "Everyone else is going to worry about the fingers. You worry about the patient." I never forgot that. A simple statement, but it has come back to me numerous times, like when a patient arrives in ED with brain on view, or a bullet in their spine.

The tendency is to be greatly distracted by the impressive injury, and forget blood pressure, oxygenation, analgesia. In sharing his wisdom Cam modeled the kind of thoughtful, big-picture surgeon I wanted to be. And in treating me like a surgical colleague, he helped me to become one.

So who inspires you? Have you seen a trainee do something amazing? It might be time to tell them. And in particular, if you know a trainee who has provided a service to the surgical community, or notable commitment to and involvement with the community of surgical Trainees, and has demonstrated qualities of outstanding leadership, selfless service, tenacity and service to Trainees of the college, then we need to hear from you! Nominations are open for the John Corboy Medal, which honours John William Corboy, who served as RACSTA chair in 2007, and sadly passed away that year. Nominations for 2016 will close Thursday June 30 and can be submitted to RACSTA.chair@surgeons.org

Looking forward to hearing from you!

¹ Oxley et al. *Minimally invasive endovascular stent-electrode array for high-fidelity, chronic recordings of cortical neural activity. Nature Biotechnology* 34, 320-327 (2016).



SUNLIGHT

Be bright

DR BB G-LOVED

Caucasians, especially pale-skins who blister after sunburn, have been made aware of the risks of skin cancer for decades, and those who are elderly may be accumulating a series of excisions and scars for basal cell carcinomas, as well as monitoring their moles for change in colour or size.

Yet what if a lack of sun exposure was contributing to an increased risk of mortality from other cancers or cardiovascular disease? Could such heresy really be true when we have been so educated in slip, slop, slap that even dark skinned immigrants to our shores are sometimes persuaded to cover their backs in the sun, despite needing longer exposure times than their paler counterparts to synthesise enough Vitamin D. Indeed we, the human race, have evolved to synthesise vitamin D in the skin in response to UVB.

We need Vitamin D not only for skeletal health but also for immune and metabolic health. Low levels may impair the pancreas and are associated with diabetes mellitus. The problem is that Vitamin D, whilst reflective of sun exposure, may not be the vital ingredient. Melatonin may be much more influential for our longevity and general health. Vitamin D and sunlight reduce autoimmunity and release antioxidants. When the skin is stimulated with UVA radiation, nitric oxide is released, stimulating vasodilation and lowering of blood pressure. A diastolic fall in BP of 5mmHg reduces the risk of stroke by 34% and coronary artery disease by 21 per cent. The blood pressure lowering effects persist for 30 mins after sun exposure, and perhaps longer as you are also likely to feel more relaxed and less stressed after being out in the sun.

One mechanism for this mood effect is that UVB stimulates beta-endorphin production in the skin, also boosting the immune system, as well as improving well being and that feeling of being relaxed.

A Swedish study of a cohort with almost 30,000 women has reported on the association between active sun exposure and a lower risk of cardiovascular disease and non-cancer/

non cardiovascular death. The effect was similar to that of smoking in that non-smokers who avoided the sun had the life-expectancy of smokers. Because these women lived longer than their sun-avoiding counterparts their longevity was associated with a greater risk of cancer because of years lived at risk.

Geographical pathology has suggested an association between latitude and cancer for 15 types of cancer, even within the US. Colon and breast being two of the cancers cited.

The reasons that sun exposure is beneficial for longevity may be multifactorial and related to mental health, enhanced antioxidants, cardiovascular effects or even release of melatonin, the least understood of all hormones.

Light signals received through the eye and on the retina result in melatonin synthesis and release. Melatonin is an anti-oxidant and positive immune modulator in its own right, with anti-inflammatory properties and the potential to be beneficially active on multiple systems and organs.

UVB exposure, results in skin thickening in the epidermis, and the deeper melanocyte production of melanin also protects the skin from the damaging effects of UVA to your DNA. Even your skin needs sunlight!

Winter is coming in the Southern Hemisphere. You will need sunlight, and probably more than just for Vitamin D which, when not on supplements, will be a measure of just how much sunlight you are getting. Almost every cell in your body has Vitamin D receptors and it is vital to many of your systems. You need a level of over 50ng/L to avoid raising your parathyroid hormone levels and those unwanted, increased bone turnover, parathormone effects. A level of over 70ng/L is probably far safer if you really aspire to health and well-being. So get outdoors in the sun, sometimes during the middle of the day, and just avoid sunburn. We live in multi-cultural societies, with a rich variation of skin-types, so our health promotion should no longer target only white Caucasians. How long you need to be out there depends on your skin colour. And what of those sunglasses that often form part of our fashion display? They block the sunlight reaching your retina and may be detrimental to better melatonin levels.

WHERE ARE THEY NOW?

Prof Owen Ung visits past Weary Dunlop Boon Pong Travelling Fellowship Recipients

Professor Owen Ung, the head of the Breast and Endocrine Surgery Unit at the Royal Brisbane and Women's Hospital, took the opportunity to visit two former Weary Dunlop Boon Pong (WDBP) Exchange Fellows while he was in Thailand last year to attend the World Congress of Surgery.

Professor Ung visited Dr Jittima Jaroensuk at the Chonburi Hospital and Dr Noppawat Samankatiwat at the Ratchaburi Hospital, located near the border with Myanmar.

Dr Jaroensuk spent four months working under Professor Ung's supervision in 2012 while Dr Samankatiwat spent six months with the Breast and Endocrine Unit in 2011.

Professor Ung covered some travel expenses with the funds attached to the WDBP Travelling Fellowship which is designed to enable Australian mentors of Thai Fellows to visit their protégées in their local hospitals for teaching, training and support.

He said that he had been impressed with the professional progress made by the two surgeons since their time in Australia and said that while oncology services in Thailand were not as highly specialised as in Australia, they were being significantly advanced by the experience WDBP Fellows take back to their institutions.

Professor Ung said that while the breast surgery skills of Thai surgeons were excellent, they were less familiar with breast conservation and reconstruction techniques but that this was changing.

He said a signifier of this advance was that breast conservation rates had increased in both hospitals where the WDBP Fellows worked and that both surgeons had advocated for improved radiotherapy and oncology services to facilitate that increase.



Dr Jaroensuk (right) with her residents

"There is no doubt that the WDBP Fellowships in Australia have had a significant influence on both Dr Jaroensuk and Dr Samankatiwat," he said.

"For both of them, there are challenges due to limited resources, however, they adapt well to the circumstances and work hard to develop their surgical services.

"Women undergoing mastectomy are offered reconstruction in both the Chonburi and Ratchaburi hospitals, but of course the reconstructive rates are quite low by comparison to our health system.

"Nevertheless, women who do want reconstruction are generally offered pedicled TRAM flaps and these are performed skilfully with a high degree of success by both these breast surgeons.

"Implant based reconstruction, while common in our environment, is a less

attractive option in Thailand due to the cost of prostheses."

Following her time working under Professor Ung's supervision, Dr Jaroensuk spent time at the National Cancer Institute in Bangkok and upon her return to Chonburi Hospital, became the lead surgeon for breast cancer surgery while also specialising in pancreatic cancer and trauma surgery.

According to Professor Ung, she is now working to develop breast conservation services, introduce formalised multidisciplinary oncology meetings and broaden surgical audits.

"I believe both surgeons have certainly benefited from the WDBP Fellowship"

While visiting the hospital, Professor Ung presented a breast cancer lecture attended by the entire surgical department and conducted a number of complex procedures.

"I performed a total mastectomy and axillary clearance for a patient who had received neoadjuvant chemotherapy for a locally advanced breast cancer because Dr Jaroensuk was keen for me to demonstrate for her trainees the surgical technique she had observed during at her time at the Royal Brisbane and Women's Hospital," he said.

"While cancer multidisciplinary meetings have not been formalised, Dr Jaroensuk is certainly working towards that and a great collaborative approach has been developed following her observations in Brisbane."

After the World Congress of Surgery, Professor Ung travelled west of Bangkok up to the border of Myanmar to spend time with Dr Samankatiwat at Ratchaburi Hospital, the main service and teaching hospital for the province.

He said that since his return to Thailand, Dr Samankatiwat had become the Head of the hospital's Breast Unit and the Director of the hospital's Cancer Services which gives him responsibility for all cancer services including radiation oncology, medical oncology and imaging.

While there, Professor Ung delivered a series of lectures and participated in the discussions surrounding various case presentations.

"Dr Samankatiwat has been very much influenced by his time at the Royal Brisbane and Women's Hospital and has established multidisciplinary oncology meetings and developed into an astute administrator," Professor Ung said.

"He has been able to obtain services and support for cancer management in his hospital and last year, his unit submitted abstracts to the St Gallen Breast Cancer Conference in Switzerland which dealt with the choices women make between mastectomy and conservation.



Operating room entrance - Chonburi Hospital

"They concluded that the doctor's explanation had the greatest impact upon those choices.

"That has a direct bearing on the experience of the surgeons and thus, if we have the opportunity in Australia to broaden the experience of younger surgeons such as these two, it makes sense that we will see greater use of breast conservation techniques for appropriate tumours."

Professor Ung has been a former Chair of the Breast Section of the RACS, the Breast Group of the Clinical Oncology Society and is the current Chair of the RACS Queensland State Committee. Through his roles at the Breast Cancer Institute at Westmead in Sydney and now at the Royal Brisbane and Women's Hospital he has received many International Fellows from all corners of the world and always finds the exchange rewarding and valuable for both host and visitor.

He said he became involved in the WDBP Exchange Fellowship at the request of former RACS President, Professor Michael Hollands and said he greatly enjoyed the mentoring and mutual learning involved in supervising such skilled and dedicated surgeons.

"I believe both surgeons have certainly benefited from the WDBP Fellowship," he said.

"They have been able to take these experiences back to their respective hospitals and it is clear that this has influenced the development of their departments."

The Weary Dunlop Boon Pong Exchange Fellowship provides opportunities for Thai Surgeons to obtain further exposure in general or specialist surgery, gain experience in clinical research and develop management skills in a multi-disciplinary environment.

The College is seeking expressions of interest from Departments of Surgery or Heads of Surgical units of any specialty who feel they can offer a milieu in which young Thai surgeons can obtain experience.

With Karen Murphy

Please contact the RACS Global Health Department on:
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AUDITS OF SURGICAL MORTALITY

CASE NOTE REVIEW

Relatively well octogenarian with incarcerated hernia



GUY MADDERN
Chair, ANZASM

A patient in their late 80s, with relatively insignificant past medical history, was admitted with a four-day history of abdominal pain, obstipation and abdominal distension. The emergency department doctor diagnosed a small bowel obstruction and obtained an erect abdominal X ray which showed multiple air fluid levels. Intravenous (IV) fluids and nasogastric aspiration were commenced and a surgical review requested. Amiodarone infusion was also started to control newly discovered atrial fibrillation.

The Surgical Registrar diagnosed small bowel obstruction of uncertain causes, given the virginal abdomen. He felt an inguinal mass, but excluded hernia as there was no cough impulse. A computed tomography scan with oral (gastrografin) and IV contrast was requested after discussion with the Consultant. The scan was done 15 hours after admission; ischaemic bowel in the abdomen and the hernial sac identified. The patient was hypotensive, oliguric and dehydrated with persistent fast atrial fibrillation

Laparotomy was performed 21 hours following admission and two large segments of small bowel were resected with appropriately performed stapled anastomoses. Postoperative management was in the intensive care unit where the patient received inotropes, antibiotics, ventilatory support and alimentation. There was

a significant systemic inflammatory response syndrome contribution, with peripheral and pulmonary oedema, resulting in the patient's demise a week after admission.

Clinical lessons

The key concern is the delay in getting the patient to the operating theatre - 21 hours after admission. Several factors contributed to this:-

- The reluctance on the part of the Radiology registrar to perform a CT when requested. Was the surgical registrar assertive enough?
- Resultant delay of over 12 hours to do an investigation that would have changed the management.
- The surgical registrar's inexperience - the registrar spotted the inguinal swelling but thought it inconsequential. In defence, the case was discussed with the Consultant, including the need for CT. Was the inguinal swelling mentioned?
- There is no record of a Consultant Surgeon seeing the patient before surgery. Would the consultant have waited for CT had a diagnosis of incarcerated hernia been made early in the morning?

As a consequence of the delay, the patient was noted preoperatively to be oliguric, hypotensive and dehydrated, probably as a result of inadequate fluid resuscitation or sepsis or both. Once the decision to operate was taken, the management thereafter cannot be faulted. The patient was brought to the hospital, triaged, and reviewed by the surgical registrar without any delays.

An earlier, lesser operation through a herniotomy would have been better tolerated by a relatively well preserved elderly patient and the outcome may well have been different in spite of the advanced age.



IN MEMORIAM

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

Andrew Jenkins	2016
Peter Meffan	2016
Norman W Thompson	2015

RACS is now publishing abridged Obituaries in Surgical News. The full versions of all obituaries can be found on the RACS website at www.surgeons.org/member-services/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:

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

While RACS accepts and reproduces obituaries provided, we cannot ensure the accuracy of the information provided and therefore take no responsibility for any inaccuracies or omissions that may occur.

Program highlights 2016

Annual Joint Academic Meetings

Thursday 10 - Friday 11 November 2016
Royal Australasian College of Surgeons,
250-290 Spring St, Victoria.

DAY ONE – SECTION OF ACADEMIC SURGERY MEETING

Morning session: Mid-Career Course

Leadership: Identifying leadership opportunity

Balance: Balancing academic and clinical practice

Innovation: Innovation and research in practice.

Impact: Developing a broad academic impact

Legacy: The importance of legacy in surgery.

Afternoon session: Principles of research – planning and funding your research

RACS Scholarships

NHMRC / HRCNZ

Translational Research

DAY TWO – SURGICAL RESEARCH SOCIETY MEETING

Invited guest speakers

Society of University Surgeons Guest Speaker – Dr David Hackam

Association of Academic Surgeons Guest Speaker – Dr Daniel Abbott

Jepson Lecturer – Professor Andrew Hill

Presentation of original research by surgeons/trainees/students/scientists

Awards for the best presentations;

Young Investigator Award, DCAS Award and Travel Grants

We would like to acknowledge Medtronic as the Foundation Sponsor for the Section of Academic Surgery

Registration opens in May

Day one - Complimentary

Day two - Only \$100 for SAS members to attend - *no membership joining fee*

Places will be limited at these meetings

Contact Details

E: academic.surgery@surgeons.org T: +61 8 8219 0900



Medtronic

Held
jointly with the
Academy of Surgical
Educators Forum
Evening of Thursday
10 November
2016

In Memoriam



RACS is now publishing abridged Obituaries in *Surgical News*.

We reproduce the first two paragraphs of the obituary. The full versions can be found on the RACS website at:

www.surgeons.org/In-memoriam

Norman Winislow Thompson

Endocrine Surgeon

12 July 1932 – 17 November 2015

Norman Thompson was Emeritus Professor of Surgery of the University of Michigan, where he had been chief of the prestigious Division of Endocrine Surgery from 1979 until his retirement from clinical practice in 2001. His teaching and lecturing activity continued while he remained physically able.

For the full version see webpage: <http://www.surgeons.org/member-services/in-memoriam/norman-winislow-thompson/>

James (Jim) Martin Gray

11 November 1925 – 6 June 2015

Urologist

Jim Gray, a respected Hamilton urologist, passed away in his sleep on June 6 2015 in Auckland. He lived by core Presbyterian beliefs of hard work, community service, fairness and equal respect of all, irrespective of their role in society. Hierarchy, symbolism or power through position never impressed him.

For the full version see webpage: <http://www.surgeons.org/member-services/in-memoriam/geoffrey-j-coldham/>

Anwar Girgis

Orthopaedic Surgeon

1927 – 2015

Anwar Girgis excelled both at school and university, and following graduation completed his internship at the Cairo University Teaching Hospital. Anwar attended the Cairo University Medical School in 1946 and graduated in 1951. He then worked for two years in rural Egypt adjacent to the Sudanese border. Following this he worked as a surgical registrar and received his diploma of surgery.

For the full version see webpage: <http://www.surgeons.org/member-services/in-memoriam/anwar-girgis/>

Caleb Lewis Tucker

General Surgeon

12 May 1919 – 23 November 2012

Caleb Tucker was born in Ashburton, the second of four children, of Edward, a timber and joinery business owner, and Elizabeth Tucker. Both parents were keen musicians, his mother a pianist and his father playing the cornet, and Caleb was encouraged to learn the piano. He was educated at Ashburton High School where at a pre-enrolment meeting the headmaster, Mr E A Cockcroft suggested that Caleb take an academic course including Latin and French rather than pursuing accountancy with the intent of joining the family building firm.

For the full version see webpage: <http://www.surgeons.org/member-services/in-memoriam/caleb-lewis-tucker/>

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Thank you for donating to the



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February and March 2016

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Dr Matthew Richard Leaper, FRACS
Dr Richard Findlay Tapper, FRACS
Dr Rosalind Terry
Dr Yi Chen, FRACS
Friends of Mornington Peninsula Art Gallery
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Mr Colin Stuart Barber, FRACS
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Cutaneous Solution

2% Chlorhexidine Gluconate w/v and 70% Isopropyl Alcohol v/v

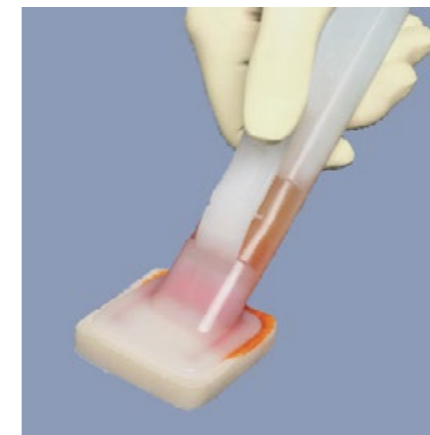
Sterile applicator and solution

Squeeze

Hold the applicator as shown, with the sponge facing downward. Squeeze the applicator once gently:

- 26 mL squeeze the lever on handle
- other products, squeeze the wings.

Saturate the sponge by repeatedly pressing gently against the treatment area.



Skin Preparation for all Surgical Procedures

Apply

Starting at the incision site, gently press the applicator against the skin using a gentle back and forth motion for at least 30 seconds, before working outwards to the periphery.

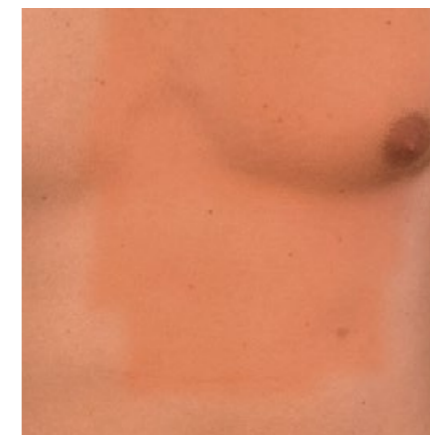


Dry

Leave the area to air dry completely before applying sterile drapes. Do not blot or wipe away. Discard the applicator after a single use.

Important safety point:

Do not drape or use ignition source until the solution has completely dried.



3 mL



Coverage Area:
15 cm x 15 cm
Product Code:
600415
25/Box 100/Case:
UOM Case

10.5 mL



Coverage Area:
25 cm x 30 cm
Product Code:
600715
25/Box 100/Case:
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26 mL



Coverage Area:
50 cm x 50 cm
Product Code:
600815
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Before Using the ChloroPrep™ applicator, read the instructions for use. Use in accordance with the policies and procedures of your hospital.

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2% w/v chlorhexidine gluconate (CHG)
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For more information:

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