ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 18 NO 3 APRIL 2017

Ready, SET, go!

Surgical training selection is underway

Operating with Respect

Hitting the mark

Vice President Elect profiled

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ASC 2017

Your guide to being well-connected

RACS LET'S OPERATE WITH RESPECT

The College of Surgeons of Australia and New Zealand

SURGICAL NEWS April 2017 Vol 18 No 3

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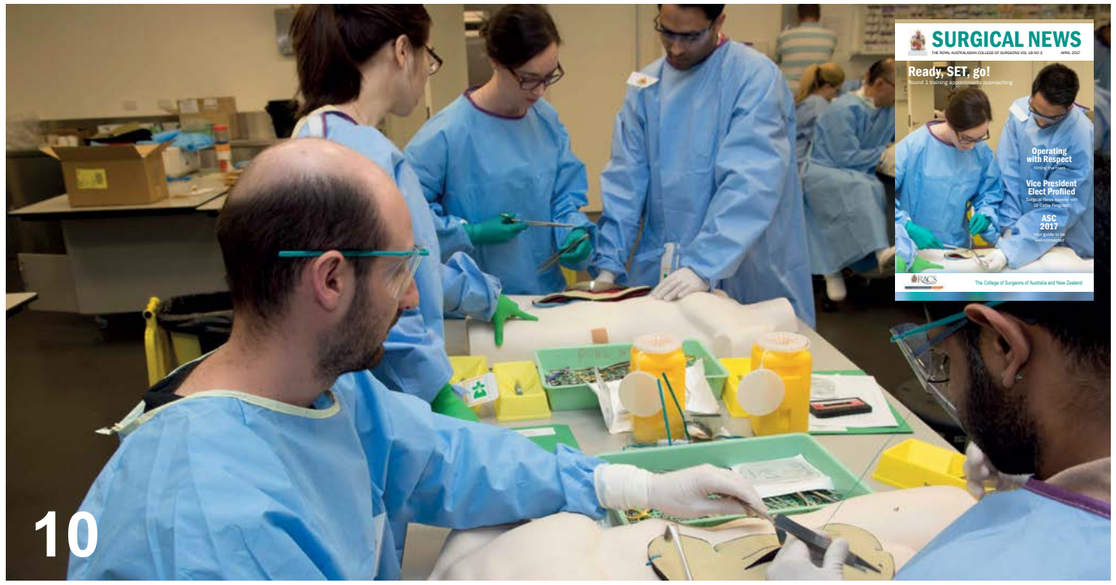

FEATURE: Ready, SET, go! Surgical training selection is underway

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Meet Dr. Cathy Ferguson
RACS' new Vice President-Elect

ASC 2017
How to be well-connected

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Surgical News Editor: David Hillis

A Time for Reflection

PHILIP TRUSKETT AM
President

I have just realised that this is my final President's Perspective, which has triggered me to reflect on the past year. Firstly, I would like to express the true privilege that it has been, representing you as College President. The respect shown to the office of RACS President, both nationally and international, demonstrates the high status afforded to our College by the surgical community. I can tell you quite sincerely that it is not forced. When overseas I have been asked for guidance on all sorts of matters ranging from how we educate our Trainees to how we so successfully engage in global surgical outreach. Our success in so many areas is internationally recognised.

A particular exciting component of my time has been the interaction with our surgical societies. I have attempted to attend every annual society meeting that I could of the 13 specialty societies. It is wonderful to see the extraordinary commitment to professionalism and specialty development shown by these societies. The educational quality of these meetings is outstanding. Although some have a shorter history than others, they are the peak body for their specialty and quite clearly should be considered so. The autonomy of specialty societies is also respected and essential. Although most societies comprise solely of RACS Fellows, they do not wish or need to be part of the College. The concept of RACS being an overarching, controlling body over societies would be both oppressive and counterproductive. RACS does have service agreements with the 13 specialty societies to partner in education of Trainees to the level of Fellowship. This partnership has been a wonderful and appropriate interaction with societies so that the blend of curriculum and syllabus is appropriate in order to train surgeons in our nine specialties - Surgeons who are fit for purpose in Australia and New Zealand.

Still on this theme, I also accept that not all surgeons in a specialty are obliged to join a specialty society; and some choose not to. For some time now Council has comprised of 16 generally elected and nine specialty elected Councillors. The specialty elected councillors are elected by all surgeons in their specialty and not just the society. As Councillors they clearly bring their specialty perspective to Council but they have full fiduciary responsibility, which means the decisions they make must be in the best interest of RACS and not specialty specific. These Councillors are also intended to be a conduit for the specialty societies. In a recent survey of specialty elected Councillors, it is apparent that the degree of interaction varies for a myriad of reasons. I believe that this is an issue that will need to be addressed as our specialty society relationships mature.

> *The respect shown to the office of RACS President, both nationally and international, demonstrates the high status afforded to our College by the surgical community.*

I can also reflect on nine years on Council. Almost a decade. Our engagement with specialty societies has been a major change but there is so much more. Our appetite and role in advocacy has grown dramatically under the direction of Council and spearheaded by the office of Vice-President. There was a time that RACS made little comment, professing to be only concerned with standards. The tide slowly turned with our engagement in road safety ably lead by Gordon Trinca OBE AO. We are now making proactive comment on a range of issues including alcohol related harm, acute surgical care, diversity, Indigenous health in Australia and New Zealand and Global health to name a few. We are leading the way in changing the culture against discrimination, bullying and sexual harassment in the work place. We are careful to advocate for issues that relate to surgery; our area of expertise. Some may find this limitation difficult but it has a lot to do with sustaining our credibility. We promote the brand of FRACS to represent a qualification displayed by a surgeon who demonstrates robust continual professional development - a surgeon fit for purpose.

None of these achievements would be possible without the platform on which we stand; the RACS staff. The more engaged I have become the more that I realise the extraordinary depth and breadth of skill and commitment of RACS staff. I could mention many names here but there is one above all others who I must recognise. A/Prof David Hillis, our CEO, is the architect and maintenance engineer of our infrastructure. David has been with us for more than 13 years. I first met him soon after his appointment. At that time I was on the Board of GSA and EMST. I recall David attending for the entirety of 2 weekend meetings to get the feel of what these committees were about. I am sure he did the same with many other groups. He then put together a RACS governance structure that, with minor modification with growth, is still in place. The structure was not imposed; it was designed skilfully to reflect who we are and what we do. David has promoted the concept of RACS professionalism and sound corporate practice. We are not a series of silos; everything intersects and makes up part of the whole. Our CEO is a strong advocate, is always happy to speak his mind, but by the same token, is entirely committed to putting into practice the strategic direction of Council. We would not be where we are today without David Hillis.

Lastly but certainly not least, I would like to thank Council and all the shoulders on which I have stood. I have always enjoyed the interaction of this group of quite committed and at times passionate people, on matters that form and sustain our profession. I will miss you all. I would also like to thank Prof Spencer Beasley, Vice President. Spencer has spearheaded the Building Respect, Improving Patient Safety program and has been a valued and most gracious advisor who has done a lot of the heavy lifting.

I wish John Batten, President-elect, and his incoming Executive and Council, all the best for the future. I am confident that RACS is in good hands.

May the *wisdom* of Council continue.

Key insights from the 2016 Surgical Workforce Census

PROFESSOR SPENCER BEASLEY
Vice President

May I thank all those of you who participated in the 2016 Surgical Workforce Census. Overall, about 40 percent of the Australian and New Zealand Fellows completed the census; this is somewhat lower than in previous years, which is disappointing. But at least the system did not collapse, unlike another census in Australia that was conducted at about the same time! Despite this, our census has provided us with valuable data that we have started to analyse around various topics and issues that affect the future of surgery; already, the information is being used to inform RACS in its workforce planning and advocacy initiatives.

The 2016 Census was conducted entirely online, with communications from RACS largely relying on email invitations sent out to all Fellows and SMS reminders. We would be interested to gain feedback as to whether this format suited you; or if not, why not? This method of email contact relies on your email address that RACS holds being up to date and correct, so it is a timely reminder to you to ensure your contact details with RACS remain current and accurate.

Some of the key insights from the early findings of the 2016 Surgical Workforce Census are worth highlighting.

In general, the work patterns revealed by participants of the 2016 Census are similar to those of 2014. Full time Fellows worked an average of 51 hours per week, although they indicated they would have preferred to work about four hours less a week. Part-time Fellows worked an average of 22 hours per week, and locums averaged 36 hours per week, and both groups would have preferred to work slightly more hours. This aspect will need further analysis to determine the circumstances around their level of employment. The surgical workforce remains one of the hardest working specialties within the medical profession and health sector.

The trend for older surgeons to be increasingly inclined to remain in the workforce continues: 81% of Fellows aged 65 years or older in 2016 reporting that they intended to continue in paid employment (clinical or other) compared with 76% in 2014.

Around one third of Fellows reported they practiced in rural regional areas, including those practicing in both metropolitan and rural/regional areas, or where a metropolitan surgeon provides regular clinics or operating to rural hospitals. The proportion of Fellows reporting that they worked solely in rural or regional locations was 16% of Australian and 22% of New Zealand respondents, two thirds of whom were working on a full time basis in those rural/regional locations.

Not surprisingly, a much lower proportion of Fellows working only in rural/regional areas was evident for Neurosurgery (1%), Paediatric (6%), Plastic and Reconstructive (6%) and Vascular (7%) surgery. It should be noted that the rural/regional location question was worded differently in the 2016 Census to allow the selection of both metro and rural/regional areas, whereas the combination of metro/rural/regional was not available in 2014. Therefore, it is difficult to make direct comparisons with past Census results.

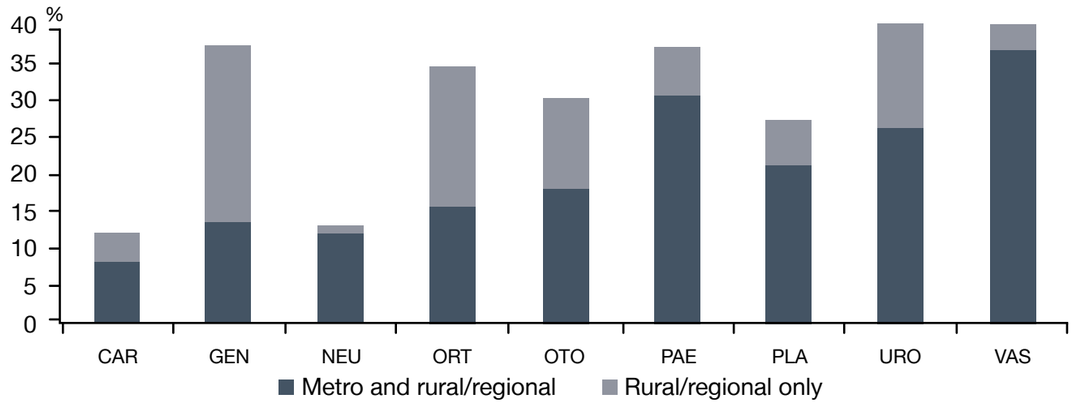


Figure 1: Percentage of Fellows practicing in a rural/regional area by specialty
Note: data exclude Fellows not currently living in Australia or New Zealand; retired Fellows; missing work location responses.

It is particularly encouraging to see that so many of the Fellows who responded to the 2016 Census are involved with voluntary and training activities. Around one in three Fellows participated in volunteer or pro-bono work in 2016, and one quarter of Fellows reported they were involved in RACS activities, which is double that reported in 2014. Two thirds of Fellows were involved in SET training in 2016.

While surgeons work hard to look after others, we are certainly not the best at looking after our own health and wellbeing (Physician, first heal thyself!). Nearly 30% of surgeons reported it had been more than two years since their last general health check. Only 36% reported seeing their general practitioner for a health check in the last two years, and 26% saw their doctor to monitor existing conditions as required. This is one aspect that RACS is particularly keen to address through its soon to commence *Do you have a GP?* campaign.

In terms of stress or other mental health issues, just over half of the respondents reported they had not experienced any in the last two years. However, approximately 8% of Fellowship respondents reported seeking professional assistance to deal with stress or other mental health issues in the last two years, and a further 35% reported they had not sought professional assistance, perhaps a warning sign to the profession as a whole of the stress inherent in surgery.

One third of female respondents who reported taking parental leave returned to work within six weeks of taking their parental leave and this response rate has increased from the previous survey. It is noted that this cohort of female respondents is small so this result should be interpreted with some caution. Nonetheless, this trend may be of concern, given the needs of both mother and child during this critical period of childhood development.

We need to understand this issue in greater detail to ensure we adequately support and advocate for our female Fellows, who now make up around 12 per cent of the active surgical workforce. While we recognise the high demands of surgical training and work, and that surgeons are dedicated to working long hours, RACS is committed to finding ways to ensure the surgical profession caters for an appropriate work life balance, of which this is a good example.

Our Surgical Workforce Census will continue to be conducted every two years. If all Fellows contributed to the 2018 census, RACS should be able to get quality data that will better inform its activities on our behalf.

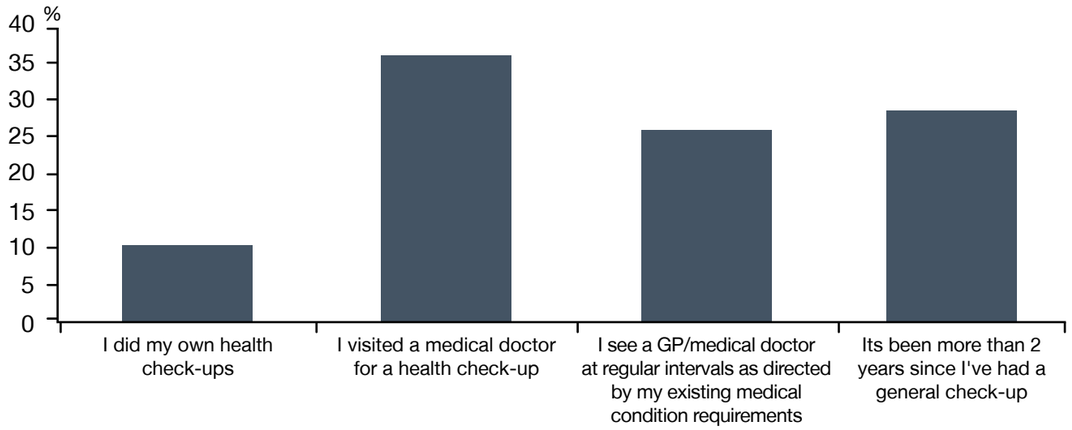


Figure 2: How Fellows monitored their general health in the last two years
Note: excludes Fellows not currently living in Australia or New Zealand; retired Fellows; missing responses to general health monitoring question.

Protein Punch at Lunch

DR BB-G-LOVED

Last week I was visiting the hospital for a GP liaison meeting about communications with surgical outpatients, so decided to lunch in the 'caf'. I was shocked at what people chose to eat! Despite an increasing number of healthy choices, most trays were carbo-loaded, even those belonging to doctors. Those carbs ensure a mid-afternoon surge in blood glucose, with added drowsiness leading to increased insulin secretion causing post prandial (around 2 hours) reactionary hypoglycaemia, and a feeling of unease and hunger. The hypoglycaemia also induces catecholamine release, tachycardia, and an unwelcome but unmonitored rise in blood pressure.

Those of you with a resolution to lose weight and burn fat should minimise or reduce carbohydrates at lunchtime. Carbs will, over weeks, months and years, expand your waistline, adipose your belly, and thicken your buttocks and thighs. Many of the apparent 'healthy choices' on offer are laced with sugar or fructose though marketed as 'low-fat'. Similarly fattening are the many sugar-filled nutty muesli bars. Please don't just count the calories - count the sugars. According to WHO you should keep total daily sugar to less than 32-40mg per day (8-10 tsps). Even sponsored lunches for medical and surgical staff are often carbo-loaded with only sugary soft-drinks for the thirsty!

What your body needs at lunchtime is protein with some salad. The protein will be better for your mood, help build/repair muscle, particularly in response to exercise, and beneficial to your bones and immune system. Both the New Zealand and Australian Dietary Guidelines recommend 63g daily protein for a 75kg male and 48g for a 64kg female (0.84g/kg for men and 0.75g/kg for women). A higher protein intake is needed for healthy ageing so those of you over 70 should increase your protein intake to 1g/kg. Protein is more slowly digested than carbohydrates and therefore results in a more even, and thus safer, blood glucose response over a longer period. It is also best to consume protein in three fairly equal amounts of 15-30g throughout the day rather than consuming the largest protein load at dinner when your body least needs it and may need to excrete the excess.

Higher protein intakes are for body builders, endurance runners and elite athletes in training and who should follow professional advice but may be able to consume up to 2.0g protein per kg. However many amateur body builders go to greater extremes that are potentially dangerous.

Some good sources of protein are shown in the table. Aim for a lunch of 300-400 calories. To miss lunch might seem virtuous to those who are trying to reduce weight but it is ill advised. The fasting invites hypoglycaemia with resultant catecholamine release to mobilise glycogen stores, break down muscle for energy that will drive your cardiovascular system towards a faster pulse and higher 'tension'. You need lunch and you need protein. You are more likely to become slimmer and trimmer by eating the right lunch than going without.

Protein and salads will provide what your metabolism needs. Over time your excess adiposity will metabolise but don't expect to see any immediate effects. As I wrote last month, the changes in your body composition will only be noticeable after weeks and months. I am not recommending a diet (which inevitably fail) but a change in eating pattern. There can be days when you eat what you like. Healthy eating needs to become a habit, not an obsession.

Table: Common dietary protein sources for lunch

Protein source	Serving size	Protein (g)	Calories	Protein source	Serving size	Protein (g)	Calories
Turkey	85g (3oz)	18.5g	100	Cooked Beans	Half a cup	6-9g	160
Chicken breast	1 half breast (3-4oz)	24-30g	160-190	Chick peas	Half a cup	6-9g	135
Tuna	85 g (3oz)	20g	90	Red Lentils	Half a cup	9g	110
Salmon	113g (4oz cooked)	28g	200	Quinoa	Half a cup	4g	110
Beef (sandwich steak)	100g	20	312	Milk	1 cup (240ml)	7.8g	146
Egg	1 hard-boiled	6g	70	Greek Yoghurt	113g (4oz)	15-16g	110
Tofu	85g	8g	70	Soy Milk	1 cup (240ml)	11g	127
Mozzarella cheese	2 slices (56g)	15g	170	Goat's Cheese	25g	5.8g	90

The Flying Eye Hospital

The Orbis, a one-of-a-kind flying eye hospital that serves as a teaching facility, briefly touched down in March, providing a rare opportunity to explore the innards of this unique service. Approximately 90 per cent of people suffering visual impairment live in developing nations. The Flying Eye Hospital flies among 81 countries in Africa, Asia and Latin America, treating cataracts and glaucoma, the top causes of blindness and visual impairment.

As well as learning surgical methods for eye disorders, doctors aboard the Orbis perform operations in the plane's operating theatre, which sits over the wing – apparently the safest and most stable place as it has reinforced floors. The plane is kitted out with cutting edge surgery equipment, a wide screen TV to watch operations taking place in the wing, two-way microphones for cross-communication between the surgeon and the student, a pre and post-operative care room and sterilization area.

Visit: https://www.cnet.com/au/news/inside-orbis-the-flying-hospital-that-battles-blindness/

Australian Synchrotron helps shed light on Parkinson's, stomach cancer, melanoma

The Australian Synchrotron in Melbourne was used by researchers from the University of Otago, in collaboration with Australian scientists, with the results published in a leading international journal.

A protein that controls how a cell responds to cell damage, and is responsible for progressing the damaged cell towards a process of death, has been further analysed in the research of diseases such as Parkinson's, stomach cancer and melanoma, according to Proceedings of the National Academy of Sciences (PNAS) journal. The study was supported by a Royal Society of New Zealand Rutherford Discovery Fellowship and grants from the University of Otago, the Victorian State Government and the National Health and Medical Research Council.

SET Selection Referee Reports

Every year the Royal Australasian College of Surgeons (RACS) selects a new intake of Trainees to its Surgical Education and Training (SET) program. This process, where approximately 800 applicants compete to be ranked sufficiently high to be awarded one of the 200-250 places available, commences in January with the opening of the registration period.

MR NEIL VALLANCE
Chair, Surgical Education and Training

By July applicants will have seen their applications progress through a number of stages and will be anticipating the announcement of the first round of appointments to the program. For many it will not be the first time that they have endured the process that is critical to their career planning.

Selection is a major activity across Australia and New Zealand for the RACS Specialty Training Boards, and the Federal Training Committee of the Australian Orthopaedic Association (AOA). The objective of each board is to identify and select the applicants with the greatest potential for training as a surgeon. Those selected will become our future surgical colleagues, delivering surgical care to the healthcare consumers of Australia and New Zealand.

Selection is governed by RACS policies; the Registration for Selection to SET policy and the SET Selection policy. The SET Selection policy is a principles-based policy that incorporates the Brennan Principles (from the 1998 Trainee Selection in Australian Medical Colleges Report) and meets our obligations resulting from accreditation by the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ).

Each specialty training board determines its own selection process that complies with RACS policies, and are contained in published regulations. Administrative support for the selection process is provided by either RACS or specialty society staff (see Table 1). Due to both the unique nature of each country's health systems and the various Service/Partnering/Collaboration Agreements with the specialty societies, some specialties have separate selection processes in Australia and New Zealand.

The past five years has seen a steady broadening of the criteria that each specialty requires an applicant to meet. With a specialty-centric approach, there is no longer a one-size-fits-all approach to CV requirements and interview structure. Each specialty determines how much weight they give to each selection tool, and to the focus within them. For example, the total points available for publications in one specialty will be different to another. The way interviews are structured may also be different.

Specialty	Selection administered by	2016 Referee reports collected by
Cardiothoracic Surgery	RACS	RACS
General Surgery Australia	GSA	RACS
General Surgery New Zealand	NZAGS	NZAGS
Neurosurgery	NSA	NSA
Orthopaedic Surgery Australia	AOA	AOA
Orthopaedic Surgery New Zealand	NZOA	NZOA
Otolaryngology, Head and Neck Surgery Australia	RACS	RACS
Otolaryngology, Head and Neck Surgery New Zealand	RACS	RACS
Paediatric Surgery	RACS	RACS
Plastic and Reconstructive Surgery Australia	ASPS	RACS
Plastic and Reconstructive Surgery New Zealand	RACS	RACS
Urology	USANZ	RACS
Vascular Surgery	ANZSVS	RACS

Table 1: Responsibility for selection administration and referee report collections

The tool that is common to all specialties however, is referee reports.

The referee report collection period is from late-April until late-May. Most specialties have been using the same online collection service administered by the RACS Surgical Training Department. In 2016, four of the 13 selection processes used a separate system (see Table 1). There were 582 applications requiring 5305 referee reports to be collected by RACS. This equates to over 2000 Fellows participating in the referee process.

Referee reports are the most significant opportunity for individual Fellows who are not otherwise involved in education (e.g. as a member of a board) to influence the quality of surgical training and the future of the workforce. The referee report is aligned to eight of the nine RACS competencies; Collaboration and Teamwork, Communication, Technical Expertise, Judgement - clinical decision making, Medical Expertise, Management and Leadership, Professionalism and Ethics, and Scholarship and Teaching. The reports have between 16 and 20 questions and offer a range of attributes to differentiate between candidates. (See example of a communication question below). As you can see, there is no score, but a range of descriptors of qualities and behaviours.

COMMUNICATION	
❑	Communication with colleagues and team members Fails to keep team members up to date in a timely manner; Poor / inadequate written communication; Poor / inadequate verbal communication; Has poor relationships with peers; Fails to provide clear directions and descriptions of situations to team members; Is defensive or uncompromising when questioned by other staff;
❑	Generally keeps all team members up to date without prompting; Satisfactory written communication
❑	Keeps all team members up to date without prompting; Effective and timely written communication; Effective verbal communication; Has good relationships with peers;
❑	Effective and timely written communication; Effective verbal communication; Keeps all team members up to date without prompting; Has excellent relationship with peers; Always provides clear directions and descriptions of situations; Remains flexible and open when questioned by other staff;

Why is the referee report important and why should it be persevered within the selection process?

A referee can provide accurate information on a candidate's overall 'fit' for surgical education and training and a ▶

surgical career, by accurately recording the standards of medical practice that they have observed in the candidates on the job performance over a period of time. This type of information cannot be gained from an examination or one-off interview. Those tools are less likely to detect undesirable personal traits or skills deficiencies that can influence whether a candidate has the potential to be successfully trained to minimum standards.

A question asked each year when the Specialty Training Boards are reviewing their selection processes is: 'How meaningful are the referee reports as a selection tool?' There isn't a simple answer or definitive statistics to prove that one tool or set of tools are better than another.

It is evident however, that in the last five years the range of scores from referees has been narrowing. In 2016, a third (33%) of all Referee Reports completed in the RACS on-line referee report system by Medical or Surgical Consultants awarded the applicant a perfect score of 100%.

Such scores can mean two things. Our medical schools could be producing graduates of high and uniform standard, whose performance in the workplace is indistinguishable from their peers, with each deserving of perfect scores. However it is more likely that the scores given are not a true reflection of an applicant's ability. Whether because of pressure from the applicant, an altruistic desire to 'boost' the chances of a favoured colleague getting to interview, or a genuine misapplication of standards of performance, scoring in a tight band at the top end of the range reduces the effectiveness of this tool in selection. It also reduces the ability of the true 'star performer' to stand out.

Predictive Utility of Referee reports

The RACS Education Research and Development Department has found that when used correctly the referee report has predictive utility as a selection tool. There is evidence that those attaining higher referee report scores also achieve higher scores on the Clinical Examination (CE), the Generic Surgical Sciences Examination (GSSE) and the Fellowship Examination (FEX).

What can be done?

It is probable that by now many of you have been approached by aspiring surgical Trainees who have requested your permission to nominate you as a referee. If you have said yes then this is your opportunity to shape the future of the surgical community.

Each Specialty Training Board has a minimum number of referee reports that need to be received for an applicant to ensure validity of the tool. Individual boards will select a set of referees from the list provided by each applicant. For those specialties that use the RACS on-line system you will receive an email request when collection commences on Thursday 27 April, concluding Wednesday 24 May. Reminders will be sent to you until the report is completed. As soon as you complete your report the reminders will cease, with early birds also having the opportunity to go in the draw for an Apple Watch. Towards the last week of the report collection period, referees for applicants without the minimum number of reports required will also receive a phone call from the Surgical Training Department.

If you are asked for a report, carefully consider the questions asked of you. Don't think in terms of the score that will result but about how applicable each statement is to the person you are rating. Resist pressure from others to influence your opinion. All referee reports collected by RACS are confidential; your individual opinions are not shared with applicants, who are advised of their total score only.

There is no doubt that writing a referee report for a prospective trainee is not without its pressures. It does influence the possible career options of young doctors, and can determine who will be your future colleagues. Being a referee is a responsible role, and all that is expected of you is your honest opinion. To those readers called on to perform this role, thank you.

RACS LET'S OPERATE WITH RESPECT

Operating With Respect hitting the mark

ADRIAN ANTHONY
Chair, Education Reference Group

More than 3600 Fellows, trainees and IMGs have now completed the 'Operating with Respect' eLearning module which was launched by the College in July 2016 as part of the RACS Action Plan to tackle bullying, discrimination and sexual harassment[1]. To date, feedback on the module, developed by surgeons for surgeons, indicates it is hitting the mark..

"Congratulations, this is really well produced and worded, good balance between information and video/scenarios and relevant questions to check knowledge".

Developed in consultation with an Education Reference Group, made up Fellows, Trainees, and IMGS, the module includes videos to demonstrate the harmful effects of discrimination, bullying and sexual harassment (DBSH) on team performance.

"The first video was very confronting and brought me to tears as it reminded me of my own traumatic experience as a registrar. I hope no one thinks this is an unrealistic scenario – this was well done!"

"I found it very helpful. I was trained like the trainee (in the video) and it is very easy to revert to the behaviour of your early role models, good and bad".

As part of a wider *Building Respect, Improving Patient Safety* educational program, this module demonstrates what unacceptable behaviour in the workplace looks like and provides practical strategies to help address it.

"This module really takes you into the real world. I felt very anxious watching the real OR enactment."

The module also describes the impact of unacceptable behaviours on individuals, teams and ultimately, patient safety. Having completed the module, participants will be able to identify acceptable standards of professional behaviour in the healthcare setting and identify the principles within legislation relating to discrimination, bullying and sexual harassment.

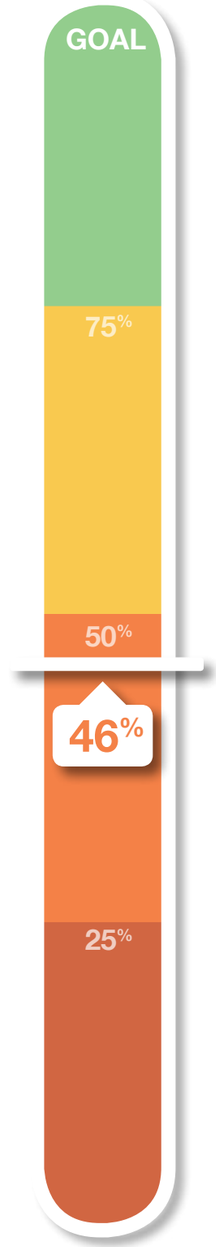
"Excellent guide through ramifications of appropriate and inappropriate behaviour. I would have benefited from this 40 years ago!"

The module encourages surgeons to adopt the 'speaking up' principles based on the Vanderbilt Model (Hickson 2007)[2] and includes a comprehensive database of resources to support participants in addressing unacceptable behaviours in the workplace. To build on this, advanced face-to-face training in preventing and managing discrimination, bullying and sexual harassment, will be available from April 2017.

The bullied and the bully all need wise practical support and empathy.

1 http://www.surgeons.org/media/22086656/EAG-Report-to-RACS-FINAL-28-September-2015-.pdf

2 Hickson GB, Pichert JW, Webb LE, Gabbe SG. A complementary approach to promoting professionalism: identifying, measuring, and addressing professional behaviors. Acad Med. 2007 Nov;82(11):1040-8.



The *Operating with Respect* online module is compulsory for Fellows, Trainees and IMGS and is a mandatory component of CPD for 2017. Completion of the module is automatically recorded. To access the module, login to your RACS portfolio. It will take approximately 45 minutes to complete.

If you need assistance or are experiencing any difficulties, please contact the RACS eLearning team: **eLearning@surgeons.org**

Operating with Respect course DETAILS can be found on page 34

What does leadership mean for the Surgical Trainee?

LEIGH ARCHER
WA Representative, RACSTA

In surgical training, there seems to be a slightly less direct approach to transferring skills related to leadership compared to some other professional groups. We rely upon an interest from surgical supervisors to develop these skills as suggested within the 'in-training assessment forms'. We receive feedback on our professional development at least twice during each term and an aspect of these sessions should be on our leadership activities as demonstrated during clinical duties. So, is this learning through experience the most effective way to master the management and interpersonal skills?

'Leadership and management' is declared as one of the nine core competencies for successful surgeons by the College of Surgeons. A copy of the training Standards[1] framework (2012) is provided to Trainees upon successful application and is intended to guide Trainees and supervisors throughout the process of development of these competencies. Within this framework, each competency is divided into three descriptive 'patterns of behaviour' and descriptions of activities which demonstrate those patterns at five levels of development. Whilst the domain of leadership is described through its own three patterns of behaviour (Setting and maintaining standards, leading and inspiring others and supporting others) it is also clearly represented in other domains.

Effective leadership is cited[2] as being characterised by:

- Clearly defined leadership roles, particularly in critical situations
- Leadership style appropriate to the clinical situation
- Clear direction to the team from the leader
- Continuous seeking of input from team members
- Engaging team members in team-based decision making.

Further afield, the Royal College of Surgeons of England has produced some useful work on the issue of leadership for surgeons. 'The Leadership and Management of Surgical Teams'[3] outlines the importance of training in teamwork and leadership skills for surgeons. It was produced for England in 2007 following on from responses to recommendations from hearings on the Bristol Heart Scandal. Whilst not produced by our college, there are some internationally relevant messages:

- Both technical and non-technical skills are needed for effective leadership
- Human error is inevitable
- Teaching of leadership skills must include teaching of leadership concepts and tools complimented by on the job practice with mentoring

The group recommends that all surgeons should receive leadership and team management training. All clinicians should be taught teamworking skills as a part of foundation training so that effective teamwork evolves as the individual develops professionally.

For RACS, training is conducted through two separate courses. Training in Professional Skills (TIPS) is a two-day course targeted at Trainees in their second or third SET year. It is focussed on communication and team-oriented skills. Non-Technical Skills for Surgeons (NOTSS) is a one day workshop that explores a behaviour rating system developed by the Royal College of Surgeons of Edinburgh which can help a surgeon improve their performance in theatre with situational awareness, communication, decision making and leadership/ teamwork.

The RACSTA board unanimously agreed recently that Trainees desire frequent and supportive but individualised feedback. Many supervisors hesitate in providing frequent feedback due to concern of being thought too critical. When regular feedback is provided it usually relates to a specific task or technical skill, but we regard the non-technical skills as an area that is also best developed through guidance for adjustment with references to the NOTSS behaviour rating system and Standards Framework patterns of behaviour.

Recently I was fortunate to hear some thoughts on leadership from Professor Francis Lannigan when he spoke to incoming Trainees at the 2016 RACSTA Set Induction Conference. This celebrated ENT surgeon has mentored a countless number of Trainees and is an active faculty member for the NOTSS course. He spoke of the importance in maintaining one's own integrity and emanating the practice that we expect our mentees to display. He went on to characterise the importance of effective communication for effective leadership presented with respect for all people. We must recognise the wider team as being essential in patient care and treat them with respect for that input.

The essential non-technical surgical skills are best developed through a combination of conceptual knowledge and experience through implementation. The TIPS course is a valuable course for mid SET Trainees to develop some important aspects and the NOTTS model contains useful measurements of behaviours. I would encourage all young fellows and Trainees to make use of these opportunities and to reflect upon their own leadership practices... somewhere within that busy schedule.

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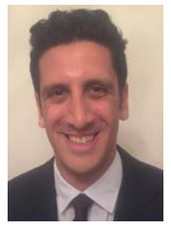
ASC 2017 – Trainees' Association Program



DR ROBERT MCCUSKER & DR GEORGE BALALIS
Co-Convenors of the
Trainees' Association Program

In May of this year, Adelaide will host the Royal Australasian College of Surgeons Annual Scientific Congress. The Trainees Association has an exciting list of activities chosen to pique the interest of training surgeons from all specialties.

On Tuesday morning the Trainee Association session is focused on the non-technical aspects that contribute to becoming a successful surgeon and in particular, what it takes to become a leader in the profession. This is a great topic for Trainees looking to take tips from professionals who have embodied the ideas they are speaking on and have incredible experiences and insights to share. We are very pleased to announce a high quality list of local and international speakers with diverse backgrounds.

On Wednesday morning the Trainee Association is combining with the Surgical Education section to present a session on Competency Training, particularly focusing on future changes in the way surgical training is delivered and assessed. This is sure to be a big ticket item going forward and is applicable not only to Trainees aspiring towards a career in surgical education, but all future fellows of RACS. We will all bear the responsibility of training future surgeons, even if it doesn't come in to effect during our own training.

Finally we have a great social program. Of special note is the combined dinner with the Younger Fellows Association, where we will have a 70s themed night, with prizes for the best costumes and bragging rights for the best dancing.
We can't wait to see you all there.

Diversity in Surgery

DR CATHERINE FERGUSON FRACS
MR RICHARD LANDER FRACS
ASSOC. PROF. JONATHAN KOEA FRACS
ASSOC. PROF. KELVIN KONG FRACS

The concept of diversity encompasses acceptance and respect. It means understanding that each individual is unique, and recognises our individual differences. These differences can be along the dimensions of race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies. These differences should be explored in a safe, positive, and nurturing environment. It is about understanding each other and moving beyond simple tolerance to embracing and celebrating the rich dimensions of diversity contained within each individual[1].

> *As surgeons we are the owners of the legacy of surgery... and we will be responsible for the future of surgery.*

Each and every doctor takes ownership of the environment in which they work. As surgeons we are the owners of the legacy of surgery, we work in today's surgical world and we will be responsible for the future of surgery.

Some say that the legacy of surgery is that of a male dominated, misogynistic community, closed to the outside world. Diversity in the surgical workforce is changing that legacy and today's surgical community is becoming increasing diverse in keeping with modern social trends and demands. There is considerable evidence that diversity improves work culture as well as giving patients greater choice.

The Royal Australasian College of Surgeons (RACS) is actively embracing diversity in surgery by addressing the past inequities of women in surgery, and in Māori, Aboriginal and Torres Strait Islander representation.

Women in Surgery

In 2016, 12% of surgeons across Australian and New Zealand are women; up from 10.6% the year before. This upward trend is likely to continue as 39% of current Trainees are women.

RACS recognises that lifestyle factors are important in choosing a surgical career, but that interventions to improve diversity should be targeted at all Trainees. Factors that have been identified as barriers to women pursuing a career in surgery include; a lack of flexible training opportunities, inaccessibility of leave, a lack of independent and specific support (particularly with regards to family and career responsibilities), and the historically male dominated culture.

In the 2016 'Medicine in Australia: Balancing Employment and Life' (MABEL) research forum held in Melbourne, speakers talked about the hurdles to flexibility in specialist training and found that specialists in training seem to have less flexibility than other doctor types (e.g. general practitioners and hospital medical officers). This issue affects women more, and as a result, this is an extra hurdle in the path to specialisation. Study results have found that women are more likely to temporarily leave clinical practice when they have a newborn or 1-2 year old child. When working they do not reduce their hours as much as other groups and usually remain more than 40 hours per week. It seems that an all or nothing approach to achieving specialist qualifications still occurs. Specialist registrars were found to be more restricted in employment by lack of childcare, as irregular hours do not match with traditional childcare hours of operation.

RACS and its training boards are currently exploring options for less than fulltime training, and are working closely with jurisdictions and employers to facilitate this. It is hoped that by providing greater flexibility during training, the surgical workforce will eventually come to reflect a more equitable gender balance.

Māori in Surgery

According to the Medical Council of New Zealand's most recent medical workforce survey in 2014, only 3.2% of medical practitioners in New Zealand identify as Māori (up from 2.7% in 2013) despite being 15% of the country's population. As the total size of the medical workforce in 2014 was 15,366 this means that there were roughly 490 Māori doctors at the time.

Despite such small representation, the future of Māori in the medical workforce looks promising. In 2014, there were just 34 Māori graduates from New Zealand's medical schools. However, in 2015, 75 out of the 503 new domestic medical students were Māori, making it the first time that Māori were proportionately represented in New Zealand's medical schools - a trend that has since continued. Due to these increasing numbers, it is expected that Māori as a proportion of the medical workforce will continue to grow. The challenge for RACS is now to encourage these Māori students into surgery.

Unfortunately, Māori representation in the surgical workforce at present is relatively low. RACS' last Fellowship Survey has the number of active Fellows who identify as Māori listed as 11, with a further 9 in Surgical Education and Training.

> *There is considerable evidence that diversity improves work culture as well as giving patients greater choice.*

To address these low numbers, RACS has committed to developing the surgical workforce to be representative of Māori in New Zealand[2]. As the number of Māori medical students is now higher than ever, it is hoped that by providing greater access to resources and support, from medical student through to surgical trainee, more Māori will be encouraged and enabled to pursue a career in surgery. RACS is also working with Te Ohu Rata Aotearoa, (the Māori Medical Practitioners Association) to recruit Māori into surgical careers by presenting at medical student gatherings, offering a variety of career enhancement scholarships and supporting events such as the Pacific Region Indigenous Doctors Conference (PRIDoC).

Aboriginal and Torres Strait Islanders in Surgery

Aboriginal and Torres Strait Islanders comprise approximately three percent of the Australian population. In 2012, the admission of Aboriginal and Torres Strait Islanders to medical studies reached parity to the population statistics, that is just under 3% of medical students admitted to medical school were of Aboriginal and Torres Strait Islander descent! This was an exciting moment in Australian history and a representation of the strong future ahead. Unfortunately on graduation from medical school, Aboriginal and Torres Strait Islanders do not pursue a career in surgery in the same proportions as the non-Indigenous population, despite showing a keen interest during medical school.

RACS acknowledges that Aboriginal and Torres Strait Islander membership of the Surgical Education and Training Program and of the Fellowship does not reflect either the demography of Australia or the general uptake of surgery as a career by medical graduates. Of the current Fellowship of over 6000, only two Fellows have identified as Aboriginal. There is a strong sense that the professional inequality should be addressed.

There are positive benefits to all the community in the areas of social advancement and indigenous health, but also the general community benefit from different perspectives, when indigenous peoples are represented in the medical workforce and in surgery in particular.

Based on 2013/14 statistics published by the Medical Board of Australia 5,422 registered medical practitioners had specialty registration in surgery, which is 5.4% of the total registration of 99,379.

The RACS Aboriginal and Torres Strait Islander Surgical Trainee Selection initiative is designed to address the low participation of Aboriginal and Torres Strait Islander doctors in the surgical specialties that RACS trains in. RACS aims to increase the number of Aboriginal and Torres Strait Islander surgeons in the Fellowship[3].

Generational Diversity in Surgery

There is no doubt that there is a generational diversity in medicine as a whole. The selection and training of surgeons and surgical leadership tends to be the responsibility of the older generation of surgeons (baby boomers) and the stellar pool of applicants is from the 'gen X and Y' populations. The older generation tends to have a work related life balance, are motivated by inspirational speeches, have an expectation of leadership roles and have a high work ethic. The younger generations on the other hand have a greater lifestyle focus, lead if necessary and are tech savvy. By not accepting the changing attitudes and motivations of young trainees and medical students, the older generation of surgeons may disenfranchise a high percentage of potential future surgeons[4].

In addressing the current inequity of diversity in the surgical community RACS aims not only to advocate for quality and high standards in surgery but also to produce a diverse and vibrant surgical workforce for the future.

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Adapted from original publication in the New Zealand Medical Students Journal: July 2016

DIVERSITY IN SURGERY

New scholarships to support Indigenous SET Trainees

ENT Trainee Dr Andrew Martin, one of the inaugural recipients of the RACS Aboriginal and Torres Strait Islander SET Program Scholarship, plans to use part of the attached funding to attend the renowned Portmann Institut in France to hone his skills in temporal bone dissection.

The Scholarship is one of three introduced last year with the support of Johnson & Johnson Medical Devices in collaboration with the College, provides a maximum stipend of $20,000 per annum and is designed to encourage more Aboriginal and Torres Strait Islander doctors in Australia to pursue a career in surgery. Speaking about the scholarship, Managing Director of Johnson & Johnson Medical Devices, Gavin Fox-Smith said "Johnson & Johnson Medical Devices is commited to supporting Indigenous health in both Australia and New Zealand. By partnering with RACS we hope to realise an increase in the level of health and wellbeing in Indigenous communities".

Dr Martin completed his medical degree through the University of Queensland after completing an undergraduate degree in Pharmacy at Monash University and is currently in his second year of Otolaryngology, Head and Neck Surgery training at Palmerston North, New Zealand.

The father of two young sons, he has served as a Trainee representative on the College's Indigenous Health Committee, is a member of the Australian Indigenous Doctors' Association (AIDA) and has volunteered his time as part of the Australian Indigenous Mentoring Experience. He speaks to *Surgical News*.

What made you decide on a career in surgery?
I remember wanting to become a doctor when I was quite young. Surgery combines my interests in handiwork and tinkering, a fascination with anatomy and my desire to help people. It can at times be stressful and exhausting but seeing people recover and do well is very rewarding.

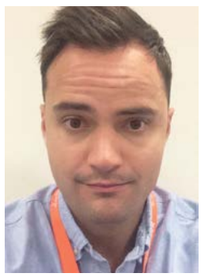
What drew you to Otolaryngology Head and Neck Surgery?
I love my chosen specialty because of its variety, high paediatric emphasis and mixture of complex and straight-forward cases. Ear surgery is of particular interest to me because ear disease significantly affects both people of my own Australian Aboriginal heritage and also the Maori whom I have developed a great respect for during my time in New Zealand.

Was there anyone or anything that steered you toward surgery?
As a medical student and a house officer, surgery was always my goal. My non-medical family have always been very supportive and sacrificial. As a junior non-training registrar at Frankston Hospital in Melbourne there were several key consultants -both in ENT and General Surgery – who were very encouraging in my pursuit of a career in surgery. Here in New Zealand, I have had a very encouraging and supported training experience.

How has the Aboriginal and Torres Strait Islander SET Program Scholarship helped you?
I've used the funds for various things but it has allowed me particularly to attend the Portmann Institut in Bordeaux later this year for a week of supervised temporal bone dissection. I'm very grateful to J&J for making this happen.

Have Indigenous medical associations helped you through you career so far?
I continue to be an active member of the AIDA although living in NZ means I don't get to the meetings so often. More recently, I have signed up for a mentoring program which is important as most Indigenous doctors are relatively junior. I was also able to attend some of the Pacific Region Indigenous Doctors Congress in Auckland last year which was a great event.

Do you think it is important for there to be more Aboriginal surgeons and if so why?
In some of the positions I have held before coming to NZ, I found being Indigenous allowed for great camaraderie with Indigenous patients who would open up a lot more to me which is obviously very helpful in a medical setting. However, there are a great many non-Indigenous surgeons who are doing tremendous work both in Australia and New Zealand in helping to improve the health outcomes of Indigenous people and many of them do not get the recognition they deserve.



The inaugural recipient of the RACS Māori SET Program Scholarship, ENT Trainee Dr James Johnston, plans to use the attached funding to present his PhD research at international conferences in Austin, San Diego and Honolulu this year.

A surgeon scientist, Dr Johnston is currently completing his PhD research into the pathophysiology of adenotonsillar diseases through the University of Auckland while also conducting clinical work at Auckland City Hospital and Middlemore Hospital.

Dr Johnston described the scholarship, funded by Johnson and Johnson Medical Devices in collaboration with RACS, as invaluable in allowing him to advance his research. He speaks to *Surgical News*.

Why did you choose Otolaryngology, Head and Neck Surgery?
I have a particular interest in the special senses and this specialty comprises a unique combination of medical and surgical treatment options. Difficulties in speech, swallowing and breathing are of particular interest to me and I enjoy working with children, many of whom suffer from adenotonsillar disease.

Was there anything or anyone that steered you toward surgery?
I had a pipe dream that I wanted to become a doctor but I thought this was a bit of a joke until my mum told me it was possible and helped me significantly throughout the crazy pre-medical year. I completed my medical school selective in ORL with A/Prof Richard Douglas. He certainly steered me in the ORL direction and now I'm doing a PhD under his supervision. Another incredible mentor I have is Dr Jacqui Allen who is a laryngologist.

Have you met any barriers to becoming a surgical Trainee?
When I started at Auckland University other students used to tell me about the workings of the private schools and how they were ranked in classes of academic ability. They also talked about how they had tutors and had already covered most of the pre-medical curriculum at school. This was certainly intimidating. However, I managed to turn my determination from the sport pitch to the classroom and found the work quite achievable. I think the key is realising that if you want something badly enough you can achieve it, whatever your background.

How has the Māori SET Program Scholarship been of assistance to you?
I cannot emphasise enough how helpful this scholarship has been and will continue to be this year. The only way that you can present and share your research around the world is to attend conferences. However most large surgical conferences are based in the USA or Europe and the expense associated with travelling to these locations from New Zealand often makes it impossible to attend. The funding provided by J&J Medical will allow me to present and publish my work on adenotonsillar disease and its relationship to Māori health and I hope that the feedback and ideas generated by the world experts who attend these conferences may help us to improve the health of our people in Aotearoa, New Zealand.

Do you think it is important for there to be more Māori surgeons and if so why?
Of course I do. In a perfect world the percentage of Māori surgeons would reflect the Māori population in New Zealand. This is important as Māori people have a completely different model of health to non-Māori. However, the number of Māori surgeons can only increase at the rate in which the incredibly high training standards of RACS can be upheld. It is obvious that Māori are over-represented in our national sports teams and creative industries, but under-represented in surgery. I am not sure what the answer is but the fact that RACS is identifying and focusing on the importance of Indigenous health is a very positive move in the right direction.

- With Karen Murphy

Celebrating International Women's Day

What better way to celebrate International Women's Day than with guest speaker, Australian-East Timorese activist and founder of the Alola Foundation, Kirsty Sword Gusmão.

On Wednesday 8 March, men and women across the globe celebrated International Women's Day and Melbourne was no exception. RACS Global Health hosted a morning tea where colleagues and guests were invited to show their support on this important day. Distinguished guest speaker, Kirsty Sword Gusmão, Founder of the Alola Foundation, First Lady of Timor-Leste from 2002-2007 and Community Advisor to the RACS Global Health Committee was invited to share a few words.

Kirsty with the Global Health team at RACS

Kirsty delivered a bold and inspirational speech in line with this year's International Women's Day campaign theme *Be Bold For Change*. She honoured the late Dr Katherine Edyvane FRACS for her remarkable contribution to health care in developing countries, particularly in Timor-Leste. Kirsty also spoke of the work of the Alola Foundation, supporting women and children of Timor-Leste to build a stronger future through education, economic empowerment, health and community leadership.

In Timor-Leste, maternal and child health outcomes are particularly dire, one in 12 children dies before the age of five from poor neonatal health and preventable diseases, and one woman dies during childbirth per 180 live births[1] this is largely due to limited maternal health care resources. Through Alola's Maternal and Child Health Program, women are encouraged to give birth with appropriate medical support with community-based health support networks.

The RACS managed, *Australia Timor-Leste Program of Assistance in Secondary Services (ATLASS)* also directly supports improved maternal and child health outcomes through various programs including, Post Graduate Diplomas in Paediatrics, Family Medicine and O&G, and the Master of Medicine (Paediatrics). With the maternal health outcomes for women in Timor-Leste being amongst the poorest in the world, certainly in the Asia Pacific Region this postgraduate training has never been more vital.

In her role as Community Advisor, Kirsty has played a key part in the Global Health Committee since 2015. The Committee advises RACS Council on matters concerning global health activities of the College. In her acceptance letter, Kirsty noted: *"I have been privileged to have connections with a number of RACS doctors and projects over the past fifteen years or so, and I have great admiration for the work you do"*.

The RACS New South Wales Regional Office also organised a special event Gender Does Matter through the Women in Medicine Network for Fellows and Trainees. Keynote speaker Fiona Cameron from Screen Australia facilitated the discussions and Associate Prof Charlotte Hespe, Dr Michelle Atkinson FRACS and medical student Leonara Long were panel members.

International Women's Day serves as a reminder for how much more work there is to be done until we achieve gender parity and equality. RACS is committed to Women in Surgery by expanding the number of women in surgical training and ensuring that training programs do not disadvantage them. The development of the Women in Surgery Section and mentoring programs for Trainees reflect that commitment.

The RACS Post Op Podcast 'Changing lives and opportunities for the women of Timor-Leste' with Kirsty Sword Gusmão is now available on iTunes at https://itunes.apple.com/au/podcast/racs-post-op-podcast/id1125227899?mt=2. To find out more about the Alola Foundation visit: www.alola.org.au

1 Department of Foreign Affairs and Trade. Australia Timor-Leste Partnership for Human Development: Investment Design Document

Kirsty Sword Gusmão

Kirsty Sword Gusmão - born in Melbourne, Australia, in 1966.

- Educated at University of Melbourne and Monash University | Bachelor of Arts, majoring in Indonesian and Italian | Diploma of Education
- pre-1991 – Administrative Secretary with Overseas Service Bureau
- 1991 – Assistant to the Development Coordinator, Oxford University Refugee Studies Program
- 1991 – Researcher/Interpreter for the Yorkshire Television political documentary In Cold Blood: The Massacre of East Timor
- 1992-1996 – Teacher and human rights campaigner, Jakarta, Indonesia
- 2002-2007 – First Lady of Timor-Leste
- 2001 – Founded the Alola Foundation
- 2003 – Autobiography: A Woman of Independence: *A story of love and the birth of a new nation* released
- 2007 – Goodwill Ambassador for Education of Timor-Leste
- 2015 – Officer of the Order of Australia
- 2015-Present – Community Advisor RACS Global Health Committee
- 2016-Present – Community Engagement and Development Coordinator at Asylum Seeker Resource Centre

Dr Catherine Ferguson – FRACS

Vice President elect RACS Council

RACS has just announced its very next Council Vice President Dr Cathy Ferguson. Dr Ferguson is an Otolaryngology Head and Neck Surgeon based in New Zealand.

Dr Ferguson will officially assume her new duties along-side Orthopaedic Surgeon Dr John Batten (President elect) on Thursday 11 May at the RACS Annual General Meeting, to be held this year in Adelaide, South Australia, as part of the RACS 86th Annual Scientific Congress.

Dr Ferguson spoke to us about her election and what she was looking forward to in the coming term.

"I am very honoured and humbled to be elected as Vice President and will put my heart and soul into the role," she said.

When asked what she would like to achieve while in this role, and what she thought the appointment meant for future female members, Dr Ferguson said: "The most important part of the role will be to support the President, but in addition I will have special roles in terms of our College governance structure and the advocacy role of RACS.

"There is a need to overhaul the current appointment processes within RACS Council, and look at the whole nomination process to ensure that the Council has the best possible people to represent the needs of its members.

"The relationships we have with our Specialty Societies are vitally important. We need to find ways to improve our interaction at all levels including committees and boards as well as at Council and with Society Presidents.

"We already have a powerful advocacy voice but I see RACS as playing a more important role in the future to advocate for the needs of the community and our patients as well as for all Fellows, Trainees and IMGs.

"Finally, I would like to continue the excellent work of my two predecessors in the promotion of our Operate with Respect Campaign, and continue to work to build relationships with health jurisdictions and hospitals in both countries to increase collaboration and cooperation in promoting safe respectful working environments for all health professionals.

"There are now a large number of female councillors at RACS who are leading by example. RACS has had a female Treasurer for the past five years, previous female President and previous female CiC, as well as a number of female chairs of regional committees. I am simply following an increasing tradition of female leadership within RACS, which I am confident will continue into the future," Dr Ferguson said.

Biography

Born in the United Kingdom, but raised in New Zealand, Cathy's parents were both doctors. Her mother was a General Practitioner and her father was an Urologist and examiner for the Royal Australasian College of Surgeons.

Cathy has been a Fellow, and involved with the College since 1991, initially as Regional Training Supervisor and then Secretary of the New Zealand ORL Training Committee.

She was co-opted to the New Zealand National Board of RACS in the late 1990s as Honorary Secretary, and then formally elected to the Board in 2000. She became Hon. Treasurer, then Deputy Chair and then New Zealand Board Chair of that committee for two years.

Cathy was the first woman to be elected as New Zealand Board Chair.

After finishing her term in that role, Cathy was successfully appointed as New Zealand Censor for RACS in 2009, a role which she continued for eight years. Cathy served on the Education Board and the Board of SET for that time.

She was first elected to RACS Council in 2010, and became Chair of Fellowship Services in 2011, as well as Chair of PFET in 2012. She became Chair of Professional Standards in 2015, Chair of PDSB in 2016, and now Vice President elect.

Cathy was elected as President of the New Zealand Society of Otolaryngology, Head and Neck Surgeons in 2012 – the first woman President of the Society.

She is trained in general otolaryngology and has a special interest in head and neck surgery, in particular thyroid and parotid surgery, as well as head and neck cancer.

Currently, Cathy is employed as an Otolaryngologist, Head and Neck Surgeon at Healthpoint Private Hospital in Wellington, New Zealand, working full time with a 50/50 mix of private and public practice.

Image: Dr Bill Glasson examines patients in Oecussi

Support in sight for East Timor Eye Program

The coastal and isolated community of Oecussi, Timor-Leste will receive further eye health and First Aid support from both RACS and St John Ambulance Australia (SJAA), as a result of an extension of partnership for a further three years just signed between both parties.

The agreement, in support of the East Timor Eye Program (ETEP), will ensure that Oecussi's residents continue to receive annual consultations and surgical care from visiting Australian eye teams. Timor-Leste has a large rural population, with 72 per cent of the population residing in remote areas. Many people suffering from avoidable eye conditions such as cataracts reside in rural communities and it is not uncommon for family members to travel for hours by foot to access medical services.

In a collaboration lasting more than eight years, the visiting teams have provided over 1,964 eye consultations, 521 operations and prescribed more than 904 spectacles. SJAA volunteers have assisted the visiting ophthalmology and optometry team with screening patients and performing visual acuity tests, providing First Aid Supplies and delivering essential First Aid Training to ambulance officers and nursing staff at the Oecussi District Referral Hospital.

Currently, there is only one eye care nurse and one eye care technician based at the Oecussi District Referral Hospital. The partnership and annual visits help contribute to the upskilling of the national health personnel and leads to significantly improved health outcomes for Timorese patients based in Oecussi.

Mr Kevin Vandeleur FRACS and Dr Bill Glasson are long term ETEP volunteer ophthalmologists and make the annual trip to Oecussi. Dr Glasson, who has volunteered his skills and visited Oecussi for over a decade, explains the progress of the health system in the region, particularly since the SJAA and ETEP collaboration began:

"…there has been a major transition in terms of infrastructure in the form of a new hospital, operating theatre and outpatients. This has made a tremendous difference in delivering the services that we do there on an annual basis".

Oecussi, a landlocked Timorese district, is a coastal enclave; therefore access to this district can be a challenging journey. Thanks to the support of the Mission Aviation Fellowship (MAF) General Charter, visiting personnel from Australia are able to provide medical support and supplies.

The East Timor Eye Program continues to have a strong capacity building focus with the training and upskilling of Timorese registrars and Post Graduate Diploma of Ophthalmology (PGDO) trainees. Dr Bill Glasson said that the standards now offered by the Timorese in terms of the eye health care workers, the optometrists and the nurses can only be described as exceptional.

For more information about the East Timor Eye Program visit: etep.org.au

Meet the next generation of Timorese Ophthalmologists

Photographer: Nikki-Davis Jones

Dr Bernadete Pereira

Senior Ophthalmology Registrar
National Eye Centre, Dili, Timor-Leste

Dr Bernadete Pereira, is originally from Liquica, Timor-Leste. After travelling to Portugal for six months and North Ireland for one month in 2002 she applied for a scholarship to study in Cuba.

Her successful application saw her study medicine in Cuba for the next 6 years from 2003 to 2009.

After completing her medicine degree Dr Pereira worked in Liquica as a General Practitioner for six months.

"It was the first time working as a doctor so it was very fascinating," she said. "In six months' time I received a letter from Foreign Affairs to come to the main hospital. We were the first graduates from Cuba and they placed us all in small villages where I worked initially in general surgery which I enjoyed very much, for three months.

I like surgery, but we changed departments every three months, finishing with paediatric, which I did for another six months."

In 2012 Dr Pereira decided to focus on ophthalmology.

"My boss was an ophthalmologist and every time he did cataract surgery I came in to watch. I thought it was different because I need to use my hand, my mind and my eyes. From that time I thought 'Okay maybe I will go for eye surgery'."

Dr Pereira completed her Post-Graduate Diploma of Ophthalmology in 2015.

Dr Julia Magno

Senior Ophthalmology Registrar
National Eye Centre, Dili, Timor-Leste

Dr Julia Magno, studied medicine in Indonesia, finishing in 2007 and worked in the Suai district for three years before moving to Dili.

"Since I was a child, since elementary school I wanted to be a doctor," she said.

Dr Magno was offered an opportunity to do her Master's degree in Indonesia having worked for 3 years in internal medicine. However, with three small children she decided to decline the offer and stay in Dili.

"When I knew the eye clinic was offering Diplomas I asked to do my clinical attachment here for a few months," Dr Magno said. "During the 18 month Diploma we went to Nepal for three months to learn small incision cataract surgery."

Dr Magno passed her Post Graduate Diploma in Ophthalmology in 2015. She said she now has the confidence to perform cataract surgery independently.

Last year Dr Magno went to Hobart in May for two weeks for clinical observation at the Hobart Eye Surgeons and Royal Hobart Hospital.

"It's very different, much more advanced," Dr Magno said of surgery in Australia.

"When I was there I learnt how to correct refractive error. It was good to see how the staff work together and the way they talk to patients. They treat them like a friend."

Dr Susani Sarmento

Post Graduate Diploma of Ophthalmology Trainee

Dr Susani Sarmento, won a scholarship to study medicine in Cuba. She finished her four year degree in 2012 and worked as a GP in Manatuto soon afterwards.

"I want to save people, help people. That's a very good feeling," she said of her decision to become a doctor.

Dr Sarmento started her Post Graduate Diploma in Ophthalmology in 2016 and, like the other trainees, spent two months in Nepal performing small incision cataract surgery (SICS).

"I performed 56 SICS" she said. "At first I had a lot of problems because my hands were shaking a lot but I am learning now."

Dr Sarmento loves the challenge of eye surgery.

"Ophthalmology is different. It combines the eyes, mind and hands," she said. "When a patient comes back after being treated and they're smiling it warms your heart."

Surgery in the Territory is music to his ears

Outside of the operating theatre Phill Carson tinkles the ivories and blows a mean sax

When Associate Professor Phill Carson first moved to the Northern Territory as a young Resident Medical Officer, it became obvious to him that there was a need for additional outreach services across the Territory, as well as localised services in Darwin.

Since that time he has developed a reputation as a gifted and dedicated surgeon who is well-liked and highly regarded by colleagues and patients alike. While Phill thrives on the everyday challenges of general surgery, outside of his work he loves nothing more than spending time with his family, and working on his burgeoning music career.

We sat down for a chat with Phill to find out a little bit more about what motivates him as a surgeon, and what he likes to do in his (limited) spare time.

What led you to becoming a surgeon?
It was a combination of wanting to help people, and then realising that surgery can lead to dramatic outcomes and improvements in people lives. I guess I also had a leaning towards a more mechanical field of study. Originally I was going to be a procedural GP doing surgery and obstetrics in the country and then I was inspired by some surgeons in Alice Springs and Darwin, which led me to embark on a specialist surgical career.

What do you enjoy most about being a surgeon?
Mainly the variety of the work. There is that face to face contact and interaction with people, then there is the intellectual and academic side of things with training and ongoing learning, and finally there is all the theatre work. It makes for a varied workload which I find very interesting, and I enjoy being able to tie that in with the initial theme of being able to help people.

What is your strongest theatre memory?
My strongest memories are usually those when something has gone dramatically wrong. So for example when a patient is losing a lot of blood and all systems are go, those circumstances tend to generate a heightened sense of alertness but also a necessary state of calm. Those cases always leave an imprint in your memory, but probably more so when the result is an adverse outcome.

What do you feel most proud of?
Being able to deliver a wide range of high quality surgery to a population that is a long way from a major centre. That's what we set out to do, and I think for the most part we can say we are able to achieve it.

What do you hope to achieve?
I guess I would ideally like to leave a legacy of well-trained and well-motivated surgeons serving in remote and rural areas. That has been a life long quest I suppose, but that is what I would like to achieve in my remaining years.

How do you spend your free time outside of surgery.. hobbies, etc?
I like jazz music, and I play the piano and the saxophone. I have been playing the piano since I was a kid, whereas the saxophone has been something I have gotten in to in more recent years. I also like to ride the bike when I get the chance, and I enjoy a lot of family time as well.

What was your most embarrassing moment?
My lack of being able to remember people's names has always been a great source of embarrassment over the years. I am also hopeless with birthdays and dates, and in that vein probably my most embarrassing moment was on my wedding day. I presented my wife with a birthstone gift, which had the wrong month inscribed. At least it signalled early on just how bad I am with dates.

How would your friends and family describe you?
(Phil's wife chipped in at this point). "He is a highly focussed, highly committed person and probably pretty visionary in his own way. You couldn't describe Phil as light-hearted he is quite intense and serious, and always thinking big picture, but at the same time he is a very kind and compassionate person who is always thinking about how he can make a difference in a positive way.

What skill would you like to learn and why?
I'd like to perfect the saxophone so that I can retire in to a jazz band… At the very least I'd like to be able to keep in time when I play!

What does a perfect day look like to you?
It would start with a ride along the coastal track in the morning, followed by a nice stimulating discussion at our surgical meeting. Then there would be a few challenging operations that go right, and I would like to end the day with a nice home-cooked meal on the veranda in the evening with my family.

What career would you have chosen if you hadn't become a surgeon?
Engineering was probably my other big interest when I was young, particularly civil or mechanical.

Quad bikes and kids don't mix

PROF. DANIEL CASS, FRACS
JOHN CROZIER, FRACS
MICHAEL EE, FRACS
JOHN GRAHAM, FRACS
ASSOC. PROF. RICHARD LEWANDOWSKI, FRACS
S SOUNDAPPAN, FRACS
ASSOC. PROF. WARWICK TEAGUE, FRACS

A spate of recent fatal incidents involving children and quad bikes has reinforced the Royal Australasian College of Surgeons position on the use of the vehicles. *Quad bikes and kids don't mix*.

From 2001, *SafeWork Australia* documented 232 deaths associated with quad bike incidents, 43 (15%) involving children less than 16 years of age.

RACS is urging state and territory governments to ban the use of quad bikes by children under 16.

Since 2008, the Accident Compensation Corporation has paid $29 million on 11,084 claims for injuries, and 26 claims for deaths, involving quad bikes. These claims included 260 for children aged 4 or under, 472 for children aged between 5 and 9, and 733 claims for children aged 10 and over.

In 2017 alone, we have already seen 6 fatalities, 4 from NSW, 2 of whom were children under the age of 8.

Depending on the make of the vehicle, the average weight of an adult quad bike is over 180 kilograms. The average weight of a 10 year old child is 40 kilograms.

Quad bikes are widely used in the agricultural and building industries, as well as by military forces, for their manoeuvrability, and off-road capability. But they are also a popular recreational vehicle with very few restrictions in place to prevent injury or fatalities.

Quad bikes appear, to be a more stable vehicle than a two wheeled vehicle. However, they have inherent engineering factors, including a high centre of mass and a small track and wheelbase, which contribute to significant instability, even at low speed, and a repeated propensity to flip and entrap the rider or passenger. Crush entrapment in quad bike rollover is a common factor in over 50 per cent of the quad bike related deaths in Australia.

A **side-by-side vehicle,** which has a slightly wider track and longer wheelbase, integral rollover protection, and seat belts, is an inherently safer vehicle. They frequently meet all of the task requirements of a quad bike. RACS encourage consideration of these in preference to quad bikes.

Off roads, a rider does not need a licence to ride a quad bike. Despite manufacturer 'guidelines', the advice to wear protective clothing and/or a helmet is often not complied with. Legislation around quad bikes per jurisdiction varies. In fact, there is still no national safety rating system for quad bikes, no mandatory training for riders, and no age limit prohibiting those under 16 years of age from riding quad bikes.

Effective controls are essential to prevent the tragedy of child death or serious injury by quad bike.

These deaths can be prevented if controls are put in place that reflect the danger that these machines pose to young riders.

This is not the first time that there have been calls for children to be banned from quad bikes, with the Royal Children's Hospital, Ambulance Victoria, KidSafe and the Australian Medical Association joining RACS in lobbying the Victorian Government in 2013 over the issue.

Last month, the Queensland Government made the use of helmets in farm workplaces mandatory and banned children under the age of 8 from riding quad bikes, but there have been no moves to create similar laws in New South Wales and Victoria.

Quad bikes are not toys. They leave little room for rider error - the penalty for lack of knowledge, lack of judgement, lack or skill, or lack of mass, should not be death or serious injury.

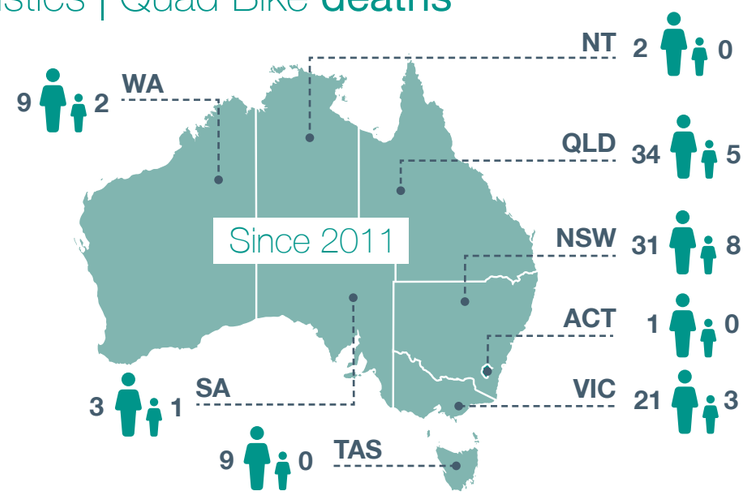
RACS is urging state and territory governments to **ban** children 16 years of age or younger, as riders or passengers on quad bikes.

Statistics | Quad Bike **deaths**

Total from 2001

The number of people who have died in quad bike accidents since 2001 is 232.

Of that figure, 43 deaths involved children aged less than 16 years of age.



2017 Continuing Professional Development Guide

RACS Continuing Professional Development (CPD) program has been refined for 2017 to ensure Fellows remain at the forefront of lifelong learning. Following extensive consultation last year with speciality societies, regions and sections and with consideration to the standards of the regulatory authorities in both Australia and New Zealand, the new CPD program was launched this year.

DR LAWRIE MALISANO
Chair, Professional Standards

RACS Portfolio has been updated to reflect the program changes. The new CPD guide has now been posted to all Fellows in Australia and New Zealand and is available online.

In recent years, Fellows have demonstrated their commitment to on-going professional development through their high compliance rates.

While the program changes have been kept to a minimum, there are key updates implemented from 1 January 2017:

- Category 4: Reflective Practice is new to the framework and is mandated across all practice types, with the completion of one activity from this category annually.
- Practice Types 1, 2, 3 and 4 are required to accrue a minimum of 50 points under Category 3: Maintenance of Knowledge and Skills (previously Category 4) on a yearly basis. Surgical Assisting or other Non-Consulting Practice (Practice Type 5) is unchanged at 30 points.
- Fellows in Clinical Consulting Practice will be required to complete an annual peer reviewed audit of practice.
- Automatic population and point allocation for the completion of Surgical Case Forms, First and Second Line assessments.
- Capturing the RACS competencies against your activities to show how they map to your learning.

The requirements for Surgical and Peer Review (category 1) and Clinical Governance & Quality Improvement (category 2) remain unchanged.

Audit

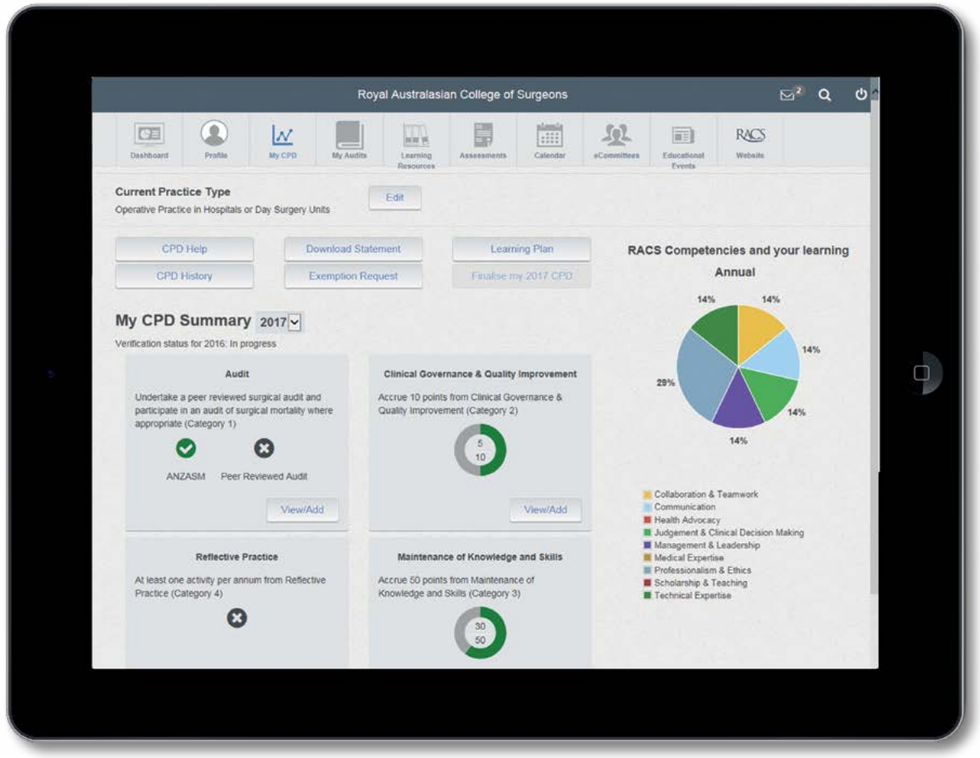
All Fellows who have contact with patients are required to participate in an audit of surgical practice, to improve the quality of care they provide to their patients. Those in Clinical Consulting Practice (including medico-legal work) are now included in the requirement and must undertake an annual peer review audit of practice. Fellows who are concerned that they may not have the relevant peers to complete the peer review component of their surgical audit can contact RACS Professional Standards Department to facilitate this process.

Operate with Respect

Following RACS 2015 consultation with Fellows, Trainees and International Medical Graduates (IMGs) into bullying, discrimination and sexual harassment there was an identifiable gap in the need to reflect and improve how we engage with our peers.

A key pillar in RACS response was a commitment to increasing education and training, and to improve the support offered to colleagues in need. To set the standards for valuing diversity and addressing inclusion in surgery, the 'Operating with Respect' eLearning module is now compulsory for all Fellows, Trainees and IMGs.

This module is designed to help surgeons identify discrimination, bullying and sexual harassment and give them the knowledge and skills to deal with it effectively.



Completion of the activity is mandatory to achieve 2017 CPD compliance, meeting the Reflective Practice requirement. The new Reflective Practice, category 4, has been incorporated into the CPD framework to promote the process of self-reflection and champions respectful behaviour.

RACS Competencies

Another change to the program is the inclusion of the RACS Competencies when populating activities in CPD online. The competencies refer to the abilities required of a surgeon to practice effectively within a defined scope and context. For your personal reference, the RACS Portfolio will provide an overview on how your CPD activities map to the competencies.

RACS has identified nine competencies of a surgeon:

- Collaboration and Teamwork
- Communication
- Health Advocacy
- Judgement-Clinical Decision Making
- Management and Leadership
- Medical Expertise
- Professionalism and Ethics
- Scholarship and Teaching
- Technical Expertise

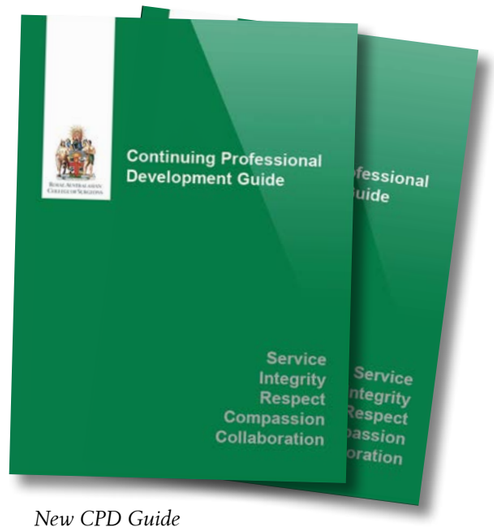
RACS online Learning Plan

RACS has developed an online learning plan to further support achieving CPD requirements, identifying and planning your learning needs. The learning plan is developed around the competencies framework and integrates directly into your CPD record.

Automatic Population in CPD

RACS has further expanded the automatic population of CPD activities into your Portfolio, including the Operating with Respect eLearning module, RACS Supervising and Examining and all RACS approved activities. Expanding on the population of the surgical Case forms, first and second line assessment are also now included. All auto populated activities are automatically verified.

If you require any assistance with your CPD or would like to provide any feedback on the program please contact the RACS Professional Standards Department on +61 3 9249 1292 or Professional.Standards@surgeons.org.



New CPD Guide

Workshops 2017

Online registration form is available now (login required)

Inside 'Active Learning with Your Peers 2017' 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

21/04/2017	Melbourne	VIC
28/04/2017	Melbourne	VIC
29/04/2017	Geelong	VIC
8/05/2017	Adelaide	SA
8/05/2017	Adelaide	SA
13/05/2017	Melbourne	VIC
19/05/2017	Wollongong	NSW
20/05/2017	Sydney	NSW
22/05/2017	Sydney	NSW
26/05/2017	Brisbane	QLD
27/05/2017	New Plymouth	NZ
27/05/2017	Brisbane	QLD
31/05/2017	Gold Coast	QLD
2/06/2017	Melbourne	VIC
16/06/2017	Traralgon	VIC
17/06/2017	Brisbane	QLD
23/06/2017	Sydney	NSW
24/06/2017	Christchurch	NZ
27/06/2017	Wellington	NZ
30/06/2017	Melbourne	VIC

The Foundation Skills for Surgical Educators is an introductory course to expand knowledge and skills in surgical teaching and education. The aim of the course is to establish a basic standard expected of RACS surgical educators and will further knowledge in teaching and learning concepts. Participants will look at how these concepts can be applied into their own teaching context and will have the opportunity to reflect on their own personal strengths and weaknesses as an educator. With the release of the RACS Action Plan: Building Respect and Improving Patient Safety, the Foundation Skills for Surgical Educators course is now **mandatory** for Surgeons who are involved in the training and assessment of RACS SET Trainees.

Breaking Bad News

3/06/2017	Melbourne	VIC

Delivering distressing news can be challenging for all involved; patients, family and clinicians alike. 'Breaking Bad News' is a four hour evidence-based workshop in which facilitators will guide you through 'real-life' scenarios with a trained actor. You'll learn effective communication techniques and be able to practise them in a safe environment.

SAT SET Course

27/05/2017	Brisbane	QLD
3/06/2017	Sydney	NSW

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).

ICOSET

7-8/05/2017	Adelaide	SA

The Biennial International Conference on Surgical Education and Training (ICOSET), will be held in Adelaide, Australia from Sunday 7 May to Monday 8 May 2017 at the Adelaide Convention Centre.The mandate of the ICOSET is dedicated to sharing global developments and innovative approaches in surgical education through interactive sessions and debates. The conference provides a special opportunity to meet and network with surgeons, leaders in surgical education and policy makers from different jurisdictions. The topics for discussion are:

- Outcomes of Surgical Training
- Selection for Surgical Training
- Preparation for Surgical Training
- In-training Assessments
- Learning about Teams & Teamwork
- Learning Good Professional Behaviours

To register and for more information, please visit the ICOSET 2017 website.

Keeping Trainees on Track

27/05/2017	Brisbane	QLD
3/06/2017	Sydney	NSW

Keeping Trainees on Track (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.

National Health Education and Training in Simulation (NHET-Sim)

2/06/2017	Melbourne	VIC

The NHET-Sim Program is a nationwide training program for healthcare professionals aimed at improving clinical training capacity and consists of e learning modules on simulation-based education. NHET-Sim is funded by the Australian Government. The project, being undertaken in partnership with Monash University, offers a training program for healthcare educators and clinicians from all health professions. The curriculum has been developed and reviewed by leaders in the simulation field across Australia and internationally.

The e-learning component of the NHET-Sim Program takes approximately 12 hours to complete. Registrations are already open for the 2017 NHET-Sim courses. (log in required).

Clinical Decision Making

23/06/2017	Christchurch	NZ

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.

PROFESSIONAL DEVELOPMENT WORKSHOP DATES

April – June 2017

NSW		
Foundation Skills for Surgical Educators	19/05/2017	Wollongong
Foundation Skills for Surgical Educators	20/05/2017	Sydney
Foundation Skills for Surgical Educators	22/05/2017	Sydney
Keeping Trainees on Track	3/06/2017	Sydney
SAT SET Course	3/06/2017	Sydney
Foundation Skills for Surgical Educators Faculty Training Day	4/06/2017	Sydney
Foundation Skills for Surgical Educators	23/06/2017	Sydney
NZ		
Foundation Skills for Surgical Educators	27/05/2017	New Plymouth
Clinical Decision Making	23/06/2017	Christchurch
Foundation Skills for Surgical Educators	24/06/2017	Christchurch
Foundation Skills for Surgical Educators	27/06/2017	Wellington
QLD		
Foundation Skills for Surgical Educators Faculty Development day	24/04/2017	Brisbane
Foundation Skills for Surgical Educators	26/05/2017	Brisbane
Foundation Skills for Surgical Educators	27/05/2017	Brisbane
Keeping Trainees on Track	27/05/2017	Brisbane
SAT SET Course	27/05/2017	Brisbane
Foundation Skills for Surgical Educators	31/05/2017	Gold Coast
Foundation Skills for Surgical Educators	17/06/2017	Brisbane
SA		
Foundation Skills for Surgical Educators	8/05/2017	Adelaide
Foundation Skills for Surgical Educators	8/05/2017	Adelaide
Younger Fellows Forum (YFF)	5-7/05/2017	Adelaide
ICOSET	7-8/05/2017	Adelaide
VIC		
Foundation Skills for Surgical Educators	21/04/2017	Melbourne
Foundation Skills for Surgical Educators	29/04/2017	Geelong
Foundation Skills for Surgical Educators	21/04/2017	Melbourne
Foundation Skills for Surgical Educators	28/04/2017	Melbourne
Foundation Skills for Surgical Educators	29/04/2017	Geelong
Process Communication Model: Seminar 1	28-30/04/2017	Melbourne
Foundation Skills for Surgical Educators	13/05/2017	Melbourne
Foundation Skills for Surgical Educators	2/06/2017	Melbourne
National Simulation Health Ed Training Program (NHET Sim)S5, S6 modules	2/06/2017	Melbourne
Breaking Bad News	3/06/2017	Melbourne
Foundation Skills for Surgical Educators	16/06/2017	Traralgon
Facilitator Skills for Surgeons	24/06/2017	Melbourne
Foundation Skills for Surgical Educators	30/06/2017	Melbourne

Contact the Professional Development Department

Phone on +61 3 9249 1106 | email **PDactivities@surgeons.org** | visit **www.surgeons.org**

Please contact the Professional Development Department on +61 3 9249 1106, PDactivities@surgeons.org or visit the website at www.surgeons.org and follow the links from the Homepage to Activities.

WORKSHOPS • ACTIVITIES • EVENTS

Developing a Career and Skills in Academic Surgery Course

Adelaide Convention Centre, South Australia, Australia
Monday 8 May 2017, 7:00am - 4:00pm

Keynote Speaker:

Professor Mary Hawn
Chair, Department of Surgery,
Stanford University, Palo Alto, California, USA

Who should attend?

Surgical Trainees, research Fellows, early career academics and any surgeon who has ever considered involvement with publication or presentation of any academic work.

If you have been to a DCAS course before, the program is designed to provide previous attendees with something new and of interest each year.

2016 comments:

"Equally as good as previous years. Very well structured"

"Brilliant opportunity to gain insight into academic surgery"

Association for Academic Surgery and international invited speakers:

Karl Bilimoria
Northwestern University, Illinois, USA

Ankush Gosain
Children's Foundation Research Institute, Tennessee, USA

Amir Ghaferi
University of Michigan, Michigan, USA

Eugene Kim
Children's Hospital Los Angeles, California, USA

Rebecca Sippel
University of Wisconsin, Wisconsin, USA

Tracy Wang
Medical College of Wisconsin, Wisconsin, USA

Australasian Faculty:

For the list of Australasian faculty, please visit www.tinyurl.com/DCAS2017

DCAS course participation

Cost: $220.00 per person incl. GST

Register online: www.tinyurl.com/DCAS2017

There are fifteen complimentary spaces available for interested medical students. Medical students should register their interest to attend by emailing dcas@surgeons.org.

Further information:

Conferences and Events Management
Royal Australasian College of Surgeons

T: +61 3 9249 1260
F: +61 3 9276 7431
E: dcas@surgeons.org

NOTE: New RACS Fellows presenting for convocation in 2017 will be required to marshal at 3:45pm for the Convocation Ceremony.

CPD Points will be awarded for attendance at the course with point allocation to be advised at a later date.

Information correct at time of printing, subject to change without notice.

General Surgery Trainees who attend the RACS Developing a Career and Skills in Academic Surgery course may, upon proof of attendance submitted to: board@generalsurgeons.com.au, count this course towards one of the four compulsory GSA Trainees' Days.

Provisional Program

6:45am	Registration Desk Open	
7:15am	Welcome	
7:20am	Introduction	Marc Gladman / Amir Ghaferi
7:30am - 9:30am	**Session 1: A Career in Academic Surgery**	**Chairs: Richard Hanney / Amir Ghaferi**
7:30am	What is an academic and why every surgeon can and should be one	John Windsor
7:50am	The research cycle	Marc Gladman
8:10am	Clinical research	Guy Maddern
8:30am	Education / simulation research	Rebecca Sippel
8:50am	Translational Research	Klaus-Martin Schulte
9:10am	Discussion	
9:30am	**Morning Tea**	
10:00am - 10:20am	**Hot Topic In Academic Surgery**	
10:00am	Introduction	Marc Gladman
10:02am	Challenges of Optimizing Surgical Training – The FIRST Trial	Karl Bilimoria
10:20am - 11:30am	**Session 2: Ensuring Academic Output**	**Chairs: Marc Gladman / Mary Hawn**
10:20am	Writing an abstract	Amir Ghaferi
10:40am	Writing and submitting a manuscript	Tracy Wang
11:00am	Presenting at a scientific meeting	Eugene Kim
11:20am	Discussion	
11:30am - 12:15pm	**Keynote**	
11:30am	Introduction	Amir Ghaferi
11:35am	The Art of Success: Learning from Failure	Mary Hawn
12:15pm	**Lunch**	
1:10pm - 2:40pm	**Session 3: Concurrent Academic Workshops**	
1:10pm - 2:40pm	**Workshop 1: Early Career Development**	**Chairs: Eugene Kim / Yishay Orr**
	What can I do as a:	
	Medical Student	Andrew MacCormick
	Junior Doctor	Peter Pockney
	SET Trainee	Julie Howle
	Fellow	Jonathan Karpelowsky
	Consultant	Sebastian King
1:10pm - 2:40pm	**Workshop 2: Higher degrees – which one?**	**Chairs: Karl Bilimoria / Christine Lai**
	The doctorate the ultimate higher degree?	Greg O Grady
	Masters by coursework	Cherry Koh
	Masters by research	Ian Bissett
	Overseas experience – when, what and why	Alexander Heriot
1:10pm - 2:40pm	**Workshop 3: Practicalities of Research**	**Chairs: Susan Neuhaus / Tracy Wang**
	Building a career pathway: opportunites, obstacles and getting past them	Ankush Gosain
	Assembling the team and establishing collaborations	Julian Smith
	Randomised clinical trials	Andrew Hill
	Funding opportunities	David Watson
2:40pm	**Afternoon Tea**	
3:00pm - 4:00pm	**Session 4: Sustainability in Academic Surgery**	**Chairs: James Lee / Rebecca Sippel**
3:00pm	Academic surgery in private practice	Henry Woo
3:20pm	Trainee-led multi-centre clinical trials: the benefits for ANZ	Dion Morton
3:40pm	Standing on the shoulders of giants	Glyn Jamieson
4:00pm	Discussion and close	Marc Gladman / Amir Ghaferi

Presented by: AAS Association for Academic Surgery; Royal Australasian College of Surgeons Section of Academic Surgery

Proudly sponsored by: Johnson & Johnson MEDICAL DEVICES COMPANIES

Skills Training Courses 2017

The College offers a range of skills training courses to eligible medical graduates that are supported by volunteer faculty across a range of medical disciplines.

Eligible candidates are able to enrol online for RACS Skills courses.

ASSET: Australian and New Zealand Surgical Skills Education and Training

ASSET teaches an educational package of generic surgical skills with an emphasis on small group teaching, intensive hands-on practice of basic skills, individual tuition, personal feedback to participants and the performance of practical procedures.

EMST: Early Management of Severe Trauma

EMST teaches the management of injury victims in the first hour or two following injury, emphasising a systematic clinical approach. It has been tailored from the Advanced Trauma Life Support (ATLS®) course of the American College of Surgeons. The course is designed for all doctors who are involved in the early treatment of serious injuries in urban or rural areas, whether or not sophisticated emergency facilities are available.

CCrISP®: Care of the Critically Ill Surgical Patient

The CCrISP® course assists doctors in developing simple, useful skills for managing critically ill patients, and promotes the coordination of multidisciplinary care where appropriate. The course encourages trainees to adopt a system of assessment to avoid errors and omissions, and uses relevant clinical scenarios to reinforce the objectives.

CLEAR: Critical Literature Evaluation and Research

CLEAR is designed to provide surgeons with the tools to undertake critical appraisal of surgical literature and to assist surgeons in the conduct of clinical trials. Topics covered include: Guide to clinical epidemiology, Framing clinical questions, Randomised controlled trial, Non-randomised and uncontrolled studies, evidence based surgery, diagnostic and screening tests, statistical significance, searching the medical literature and decision analysis and cost effectiveness studies

TIPS: Training in Professional Skills

TIPS teaches patient-centred communication and team-oriented non-technical skills in a clinical context. Through simulation participants address issues and events that occur in the clinical and operating theatre environment that require skills in communication, teamwork, crisis resource management and leadership.

AVAILABLE SKILLS TRAINING WORKSHOP DATES*

May – June 2017

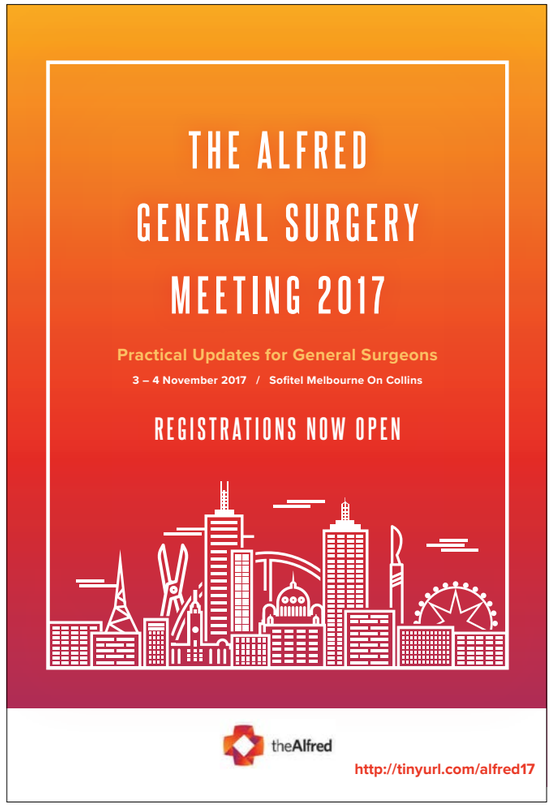
ASSET	
Friday, 23 June 2017 – Saturday, 24 June 2017	Wellington
CCrISP	
Friday, 26 May 2017 – Sunday, 28 May 2017	Sydney
Thursday, 8 June 2017 – Saturday, 10 June 2017	Auckland
Friday, 16 June 2017 – Sunday, 18 June 2017	Sydney
Friday, 23 June 2017 – Sunday, 25 June 2017	Bendigo
CLEAR	
Friday, 19 May 2017 – Saturday, 20 May 2017	Brisbane
Friday, 30 June 2017 – Saturday, 1 July 2017	Sydney
EMST	
Friday, 19 May 2017 – Sunday, 21 May 2017	Brisbane
Friday, 19 May 2017 – Sunday, 21 May 2017	Melbourne
Friday, 19 May 2017 – Sunday, 21 May 2017	Auckland
Thursday, 25 May 2017 – Saturday, 27 May 2017	Perth
Friday, 26 May 2017 – Sunday, 28 May 2017	Sydney
Friday, 26 May 2017 – Sunday, 28 May 2017	Adelaide
Friday, 2 June 2017 – Sunday, 4 June 2017	Sydney
Friday, 2 June 2017 – Sunday, 4 June 2017	Brisbane
Friday, 16 June 2017 – Sunday, 18 June 2017	Sydney
Friday, 16 June 2017 – Sunday, 17 June 2017	Auckland
Friday, 23 June 2017 – Sunday, 25 June 2017	Sydney
Friday, 23 June 2017 – Sunday, 25 June 2017	Melbourne
Friday, 30 June 2017 – Sunday, 2 July 2017	Hobart
Friday, 30 June 2017 – Sunday, 2 July 2017	Auckland
TIPS	
Friday, 19 May 2017 – Saturday, 20 May 2017	Melbourne
Friday, 16 June 2017 – Saturday, 17 June 2017	Auckland

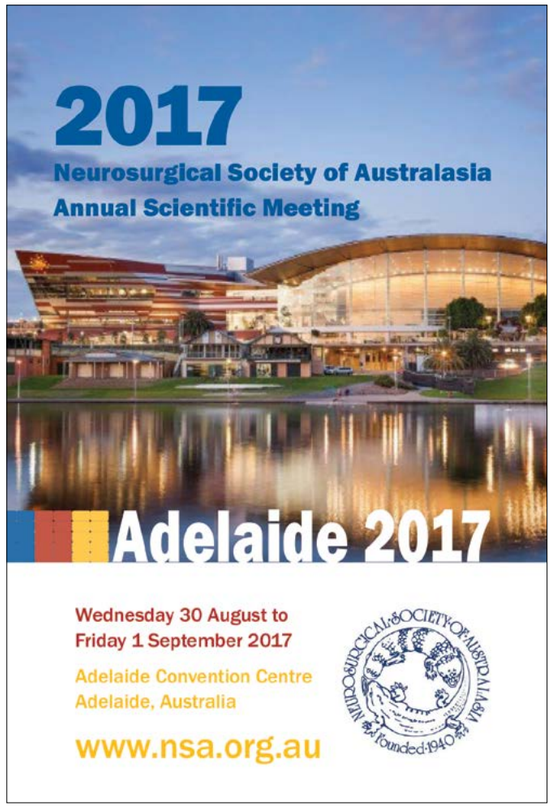
Contact the Skills Training Department

Email: skills.courses@surgeons.org • Visit: www.surgeons.org click on Education and Training then select Skills Training courses.
ASSET: +61 3 9249 1227 asset@surgeons.org • **CCrISP:** +61 3 9276 7421 ccrisp@surgeons.org • **CLEAR:** +61 3 9276 7450 clear@surgeons.org
EMST: +61 3 9249 1145 emst@surgeons.org • **TIPS:** +61 3 9276 7419 tips@surgeons.org • **OWR:** +61 3 9276 7486 owr@surgeons.org

**Course dates were available at the time of publishing*

WORKSHOPS • ACTIVITIES • EVENTS





Australian and New Zealand Post Fellowship Training Program in Colon and Rectal Surgery 2018

Applications are invited for the two year Post Fellowship Colorectal Training Program, conducted by the Australia and New Zealand Training Board in Colon and Rectal Surgery (ANZTBCRS). The ANZTBCRS is a Conjoint Committee representing the Colon & Rectal Surgery Section, RACS, and the Colorectal Surgical Society of Australia and New Zealand (CSSANZ). The program is administered through the CSSANZ office.

For details about the Training Program and applications, please see https://cssanz.org/index.php/training/about

A Notaras Scholarship will be awarded in 2018. Further information can be obtained from A/Prof Christopher Young via the email below.

Application Closing Date:
Friday 5 May 2017

Applications:
All applicants must use the ANZTBCRS Application Template (see website link above).

Please email your application to:

A/Prof Andrew Stevenson
Chair, Australia and New Zealand Training Board in Colon & Rectal Surgery

Email: secretariat@cssanz.org

Enquiries: +61 3 9853 8013

ANZTBCRS
Australia and New Zealand Training Board in Colon and Rectal Surgery

REGIONAL MEETINGS UPDATE

Surgery 2017: Future Proofing Surgical Practice

Date: 17 –18 August 2017
Venue: TE PAPA, Wellington, New Zealand
In addition, the NZ Surgical Pioneers session will be held the day before on Wednesday 16 August from 1:00pm-6:30pm.

Find out more:
T: +64 4 385 8247 • E: college.nz@surgeons.org
www.surgeons.org/about/regions/new-zealand

2017 RACS Combined Queensland Annual State Meeting & Surgical Directors Section Leadership Forum

Date: 18 – 20 August 2017
Venue: Pullman Palm Cove Sea Temple Resort & Spa, Palm Cove

Whither the 21st Century Surgeon? The Challenge of Adaptation to Change- Advancing Technologies, Clinical Governance and Leadership, Payment for Outcomes, Role Delegation

For additional information regarding the ASM:
David Watson
T: +61 7 3249 2900 • E: college.qld@surgeons.org
W: surgeons.org/about/regions/queensland/
For enquiries regarding the Surgical Directors Section:
Kylie Mahoney
T: +61 3 9276 7494 • E: surgical.directors@surgeons.org
W: surgeons.org/member-services/interest-groups-sections/surgical-directors/

WA, NT & SA Annual Scientific Meeting

Dates: 25 August 2017
Venue: Pan Pacific Hotel, Perth

Trauma: When Disaster Strikes

A foundation course will be offered on the 24 August.

Find out more:
RACS WA Regional Office
T: +61 8 6389 8600 • E: college.wa@surgeons.org
www.surgeons.org/about/regions/western-australia

RACS SA Regional Office
T: +61 8 8239 1000 • E: college.sa@surgeons.org
www.surgeons.org/about/regions/south-australia

83rd TAS Annual Scientific Meeting

Date: 22 - 23 September 2017
Venue: The Old Woolstore Apartment Hotel, Hobart

Surgery in One State, One Health System, Better Outcomes

A foundation course will be offered on the 22 September.

Find out more:
E: college.tas@surgeons.org
www.surgeons.org/about/regions/tasmania

59th Victorian Annual Surgical Meeting

Dates: 20 - 21 October 2017
Venue: Novotel, Geelong

Safety in Surgery

Find out more:
T: +61 3 9249 1188 • E: college.vic@surgeons.org
www.surgeons.org/about/regions/victoria

ACT Annual Scientific Meeting

Date: 4 November 2017
Venue: Australian National University, Medical School, Canberra

Systems of care: collaboration and innovation

Find out more:
T: +61 2 6285 4023 • E: college.act@surgeons.org
www.surgeons.org/about/regions/australian-capital-territory

WORKSHOPS • ACTIVITIES • EVENTS

Australian Society of Plastic Surgeons

Fifth Biennial Plastic Surgery Congress
31 May – 4 June 2017

RICHARD PERRY
Chair, Fellowship Services

The Australian Society of Plastic Surgeons (ASPS) is delighted to welcome world-renowned hand and cleft surgeon, Dr Mike Ruettermann (pictured, right), as the 2017 RACS Visitor to the fifth biennial Plastic Surgery Congress 2017 (PSC 2017). ASPS will host PSC 2017 on the Gold Coast, Queensland from 31 May to 4 June 2017.

Dr Ruettermann studied medicine in Germany (Universität Münster) and New York (New York University) and was trained as a plastic surgeon in several hospitals in Germany and South Africa. He is an editorial board member of the *Journal of Hand Surgery - European Volume*. As reflected by his publications, his clinical interests include hand and wrist surgery, including peripheral nerve surgery, reconstructive microsurgery and children's plastic surgery, especially cleft lip and palate surgery and congenital hand deformities. On the aesthetic level, he specialises in the functional and aesthetic surgery of the nose and the aesthetic surgery of the hand.

Dr Ruettermann is a member of several national and international associations in the field of plastic surgery, hand surgery, nose surgery and schisis.

PSC 2017 targets fellows from Plastic Surgery, Orthopaedic Surgery, Head and Neck Surgery including the subspecialty surgeons for hands, microsurgery, breast, oncologic and aesthetic surgery. SET Registrars are welcome.

ASPS would like to thank RACS for its support of Dr Ruettermann through the RACS Visitor Grant Program.

RACS
LET'S OPERATE WITH RESPECT

Launching Operating with Respect course

Enrol in the Operating with Respect (OWR) course today.

The key themes of this new one-day workshop are building respect, building resilience and speaking up. This is a valuable follow up to the Operating with Respect e-learning module.

Objectives:

- Appraise why a culture of respect matters
- Evaluate behaviours that support respectful environments
- Recognise the importance of resilience in maintaining respectful interactions
- Practise how to address unacceptable behaviours

The OWR course follows the release of the RACS Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery and is a component of the required education for supervisors, clinical assessors and RACS major committees. The course is also available to Fellows and IMGs. Priority access is given to participants required to complete the course by the end of 2018.

To enrol, visit www.surgeons.org >Education and Training>Skills Training>Operating with Respect

For more information, contact the Skills Training Department at +61 3 9276 7486 or owr@surgeons.org.

2017 COURSE DATES

VIC		
Operating with Respect course	29 April 2017	Melbourne
SA		
Operating with Respect course	7 May 2017	Adelaide
NSW		
Operating with Respect course	16 June 2017	Sydney
NZ		
Operating with Respect course	7 July 2017	Auckland

Program Highlights 2017

Annual Joint Academic Meetings

Thursday 9 - Friday 10 November
Adelaide, South Australia

DAY ONE - SECTION OF ACADEMIC SURGERY MEETING

Presentations

How I approach challenging conversations
How I unlearnt bad academic habits
Self awareness and avoiding burnout
#Ilooklikeanacademicsurgeon

Concurrent Workshops

1. Concept to reality
2. Write like a pro
3. Clinical Trials Network

Short Debates

1. Full-time (HDR) research vs after hours projects (debate between trainees)
2. Independent researcher vs Research Group (debate between department heads)
3. Focussed academia vs academic generalist (debate between Mid-careeer Academics)
4. Academics should embrace social media vs social media has no place in academia

DAY TWO - SURGICAL RESEARCH SOCIETY MEETING

Invited Guest Speakers

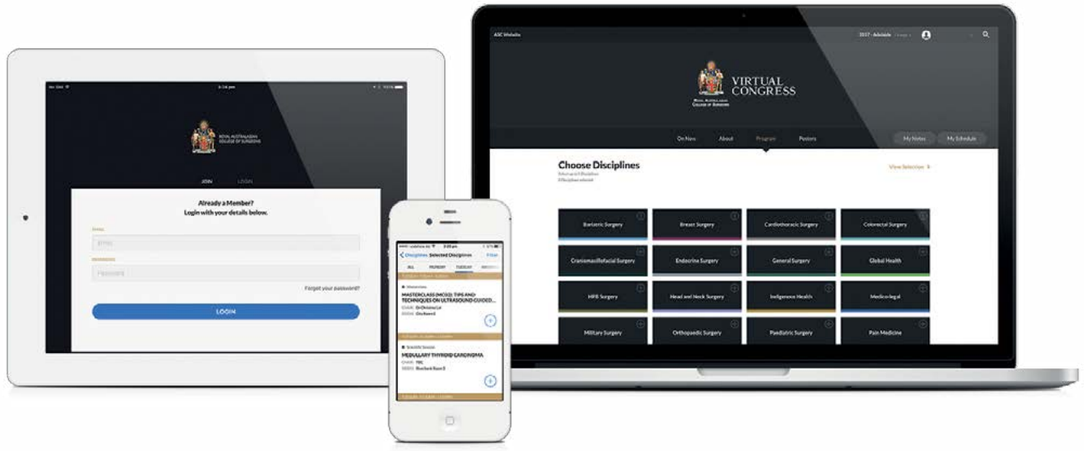
Society of University Surgeons Guest Speaker - Dr Sharon Weber
Association of Academic Surgeons Guest Speaker - Dr Sam Wang
Jepson Lecturer - Professor Robert Fitridge

Presentations of Original Research

Awards for the best presentations;
Young Investigator Award, DCAS Award and Travel Grants

Registration opens in May
Contact Details
E: academic.surgery@surgeons.org
T: +61 8 8219 0900

Royal Australasian College of Surgeons
Section of ACADEMIC SURGERY
SURGICAL RESEARCH Society



Connecting at the ASC

Go to **asc.surgeons.org** for further details on how to obtain the 2017 ASC App

What type of information will I have access to from the app?
The RACS 2017 eProgram will allow you to access various forms of congress information. Users will be provided with event specific information, exhibition hall maps, handy tips, news and updates as well as a full event and program guide.

Will the app let me plan my days while I am attending the congress?
The app will allow users to explore the Annual Scientific Congress (ASC) program guide and manage your schedule. Users can plan their day by adding the sessions and presentations of their choosing to their schedule. Within the app there will be full visibility of session and presentation times and locations. For each presentation Abstracts, Presenter CVs and related media will be available on demand.

Through the app, an 'On Now' feature will allow users to quickly see which sessions and presentations are currently running or are about to start. Delegates can quickly change sessions and presentations as required or attend unplanned events. Ultimately, these features ensure seamless integration with member accounts for easy event schedule management.

What additional benefits will the app have compared to the printed guide?
While the printed program is a great resource, the tablet app provides users with ability to 'Ask a Question' within a session or presentation without interrupting the presenter. Delegates can also take notes via their app while attending a session or presentation.

As an attendee are there any other features I should be made aware of?
The eProgram will also allow you to browse and view all available ePosters submitted for the event. Users will be able to 'favourite' posters for easier reference, as well as access to associated Abstracts and Author CVs. Delegates can also highlight/add presentations to their schedules to view at a later date (dependant on the presentation being given permission to be viewed). Presentations will be available shortly after they've been presented and delegates will have continued access to these presentations long after the ASC is over.

Will the eProgram work on my device?
The eProgram app has been developed to work across Apple and Google mobile devices and will be made available via the Apple App and Google Play stores. The links to download the eProgram app will be provided closer to the date of the Congress.

The Virtual Congress web app will also allow delegates without a tablet device to access online features via their mobile phones and/or laptops. The tablet apps will be linked to the Virtual Congress website, allowing participants to manage their schedules and take notes across various devices.

What is the Virtual Congress?
The Virtual Congress is a responsive website designed to extend and assist your ASC experience. Registered members can view program information, take notes, manage their schedules and ask questions to the session Chair. Primarily used on a desktop, the Virtual Congress is also accessible from mobile devices.

Both the Virtual Congress and the app are secure with new password protection and allows delegates access to data even if they have missed an event. A rich media experience is provided to users in which multimedia features are made available as the event progresses. This includes audio, video and ePosters with playback functionality and gateways to further information. These features ensure the ASC is a global reaching event and caters for those delegates who are unable to attend.

Can you use the app without being connected to the internet/offline?
Once the app is installed and initial content is downloaded, you can view the program offline and add sessions to your schedule. General event information will also be available to delegates without being connected to the Internet.

Will the app keep me informed throughout the Congress?
Yes, the app will keep delegates informed of important announcements that will be made throughout the Congress. Delegates will be kept informed via app notifications and general information updates.

Do I need to register/login to use the app?
To fully utilise all functionality within the app, i.e. create a custom schedule, take notes on specific sessions, ask questions of a presenter or participate in a poll, you must establish an account. This account can be used across both apps as well as the Virtual Congress web app.

Delegates need to know that while being registered to attend the ASC, this does not mean you have registered for the app. The registration process can take place on either the app or Virtual Congress web app and only requires general user profile requirements; there is no additional fee to gain access to these applications. Please see the Mobile App help desk next to the registration desk if you need help during the ASC.

How else can I stay informed and participate?
The greatest way to stay informed and to participate is via the conversation on Twitter. Anyone can join in by using #RACS17 to discuss sessions they've enjoyed, people they've met, interesting knowledge shared and more. You can also follow RACS using @RACSurgeons or mention RACS in relevant posts.

WORKSHOPS • ACTIVITIES • EVENTS

Back by Popular Demand - WA *Surgeons Ball*

Anyone who says that surgeons don't know how to have fun has clearly never been to the Western Australian Surgeons Ball. Granted; there has only been one of them so far, but the success of last year's inaugural ball has already placed this event firmly on the RACS social calendar.

Arabian Nights is the theme of the 2017 ball, which will be held on **Friday 10 November at Crown Towers**. Fittingly, guests can expect a night of mystery and intrigue, with a wide range of entertainment on offer, and a live band to help dance the night away.

The concept of the event dates back to the Past Chairs Dinner we held in 2015, when it was proposed a social function be organised as a way to bring together Fellows from across all of the surgical specialties. There seemed to be few opportunities to engage colleagues outside our own fields in a more informal setting away from the workplace, which is what we sought to rectify through the ball. I think anyone who attended would agree that this objective was well and truly achieved.

As well as being a night of good natured fun, the ball also has a serious side and is an excellent opportunity to raise money for the Foundation for Surgery. Last year's event raised $22,850 which helped support a team of four surgeons to the region of Papua, Indonesia, to provide much needed critical surgical support and training for local practitioners. We hope to do the same this year for another region.

Most importantly the ball provides an outlet for surgeons across all specialties, and their partners, to come together in a relaxed environment and enjoy each other's company. So if you are after a truly enjoyable evening with a few surprises along the way, then I encourage you to join us on 10 November.

Tickets are on sale via the RACS WA website, or you can contact the local office for more information. My only tip is to book in early, as this event is proving to be an extremely popular fixture, and tickets will sell out.

We hope to see you there.
Organising Committee.

Foundation for Surgery
Passion. Skill. Legacy.

Is your patient properly informed about their treatment?

ACT doctors test their skills in obtaining informed consent

SIVA GANANADHA
Chair, ACT Regional Committee

Surgeons know that patients have a right to make their own decisions about treatment. To do so they need information about treatment options including fees, associated risks and expected outcomes.

How well are you covering these issues with your patients, especially if they want to waive any discussion and simply sign the form? How much do biases about a patient's appearance, age, culture or disability impact on the effort you put in to obtaining informed consent? Do you refer your patients to your receptionist if they ask you about fees?

The RACS ACT Committee has recognised that junior doctors don't get much of an opportunity to workshop different approaches to obtaining informed consent, and the law relating to more complicated scenarios.

An informed consent session was included in a September 2016 surgical skills workshop in Canberra, but the Committee decided to run this as a dedicated two-hour session after registrars expressed a lack of confidence in this area.

Dr David Rangiah facilitated the session on 3 March at the RACS ACT office, along with senior solicitor Harry McCay.

Dr Rangiah commented that the consent process, particularly in the acute hospital setting, is of variable quality.

"Often the focus is on obtaining a signed form to get the patient into theatre. The focus should be directed at truly informing the patient about the procedure that is proposed," Dr Rangiah said.

"There is an ethical and clinical need for informed consent, which is why we looked at the issue of bias and coercion of the patient and the clinician's influence as part of the session."

Mr Harry McCay commented that from a legal perspective, the courts want to know if information about a specific risk was provided, and if not, would the patient's decision to have the operation have been different if they had been given the information.

He reiterated the importance of maintaining a focus on appropriate patient care during the consent process, noting that clear documentation is vital.

"When I am talking to a patient about their treatment I ask myself, 'What would I need to know to make a decision about this operation if it were happening to me? What are the material risks to the patient?'" Dr Rangiah said.

RACS ACT Trainee representative Rudyard Wake showed the workshop participants his framework for obtaining informed consent which involves a step-by-step process:

Indications
Pre-Procedure
Procedure
Post procedure
Risks
Ask questions

Dr Wake commented on the difficulties of obtaining consent as a junior doctor, citing time pressures, language and cultural barriers as issues.

"But you also have experienced masters of cross-cultural communication who avoid jargon, draw pictures and persist until they are absolutely certain their patient understands what they are consenting to," Dr Wake said.

The group spent time practising complex scenarios. This included consent in the emergency situation, how to ensure patient care is prioritised when the power of attorney stands to benefit from a patient's death, and consent involving children. Senior solicitor Harry McCay also provided guidance on the extent to which parents and other family members can provide consent for minors or people with a mental impairment.

Feedback from the workshop was excellent, with many participants saying it had provided an interactive learning experience which was directly relevant to people's current practice.

RACS ACT will continue to develop educational opportunities for trainees and registrars to practise their core surgical competencies in a non-critical environment. We thank the consultants who gave up their time to teach on both 3 and 4 March.

Image: Dr David Rangiah (L) and senior solicitor Harry McCay explain the clinical, ethical and legal importance of informed consent.

The Decision to Operate

End of life care & Advance Care Directives

MR GLENN MCCULLOCH
SAAPM Chair

It is not surprising that among the cases audited by the SAAPM, surgeons often report having to deal with challenging end of life issues. These include decisions about whether to continue with active treatments, such as surgery, when the treatment has a high risk of death or the end of life is near. Acute hospitals now provide end of life care to the majority of people who die in Australia[1]. The majority of surgical deaths occur in high-risk patients. For example, in the most recent SAAPM Report the median age was 80 years and 90% of patients had at least one comorbidity that increased the risk of death[2] (although it should be noted that advanced age itself can be identified as a comorbidity).

Since the inception of the audit, the decision to operate has been one of the most common clinical management issues identified by assessors across all specialties. It seems that the treating surgeons themselves often reflect on their decisions. The SAAPM surgical case form asks the question *In retrospect, would you have done anything differently?* When the answer is "*yes*", many question the appropriateness of having operated on elderly, high risk or terminal patients.

Cases in which the patient no longer has decision-making capacity are often the most difficult, and the decision about treatment is seen to be influenced by family members or even other clinicians. For example:

"This patient was clearly not expected to have a good result following operation, the decision to operate was heavily influenced by the patient`s family despite several long conversations which took place and clearly explained the risks of operating."

"The second operation was deemed to be futile in a patient with global ischaemia. It was difficult not to proceed with the family wishing to pursue all avenues."

"Sometimes it is very difficult to resist family and other practitioners' entreaties to operate. In these circumstances, I usually make my views prevail - but that is not always possible and sometimes the compassion has to be that of agreeing to operate."

Most would agree that the patient's wishes should be the primary consideration in approaches to end of life care. However, this relies on the patient being well informed through open discussion about the implications of treatment or nontreatment, and the clinician having a good understanding of the patient's wishes.

Advance Care Directives

Research has shown that advance care planning can have a positive impact on end of life care, with benefits such as improved patient and family satisfaction and reduced stress and anxiety among surviving relatives.[3] In South Australia, *The Advance Care Directives Act 2013 (SA)* and changes to third party consent came into effect on 1 July 2014. The changes promote a rights-based, patient-centred approach to health care and decision making. Under the new Act, the Advance Care Directive (ACD) replaces the existing Enduring Power of Guardianship, Medical Power of Attorney and Anticipatory Directions documents.

An ACD is a legal document that allows people over the age of 18 to:

- write down their wishes, preferences and instructions for future health care, end of life, living arrangements and personal matters and/or
- appoint one or more Substitute Decision-Makers (SDMs) to make these decisions on their behalf when they are unable to do so themselves.[4]

The ACD only comes into effect in the event of impaired decision-making capacity.

Many other regions have legislated ACD forms allowing for documentation of a person's health care wishes, however, variation exists regarding who can be appointed, how they are appointed, the powers that an SDM can be given and the decision-making principles that the SDM needs to follow. It has been argued that uniform laws and documents would assist with awareness and understanding of, and compliance with, ACDs.[5]

Consent to medical treatment

In South Australia, as important as the introduction of the ACD, have been the associated amendments to the *Consent to Medical Treatment and Palliative Care Act 1995* that give greater clarity in regard to the legal basis of end of life decision making and care. The fundamental basis on which others must make decisions for an individual who has lost decision-making capacity is now clear: they must genuinely try to do as the person would have wanted and make the decision "as if in their shoes". There is clarity in regard to the hierarchy of individuals or documents that health practitioners must consult in obtaining consent for treatment: an SDM, followed by relevant instructions on an ACD, followed by a legally defined individual known as 'Person Responsible'.

The legislation supports good end of life care in making it clear that medical practitioners do not have to provide treatment that is of no medical benefit (some call this "futile treatment") to a dying patient, and that they will be protected in the provision of medication that is adequate in maintaining the comfort and dignity of their patient, even if this may have the secondary effect of shortening life.

Resuscitation Plan 7 Step Pathway

To support the changes introduced in the new *Advance Care Directives Act 2013 (SA)*, SA Health has developed the Resuscitation Plan 7 Step Pathway. The pathway aims to improve how resuscitation and end of life care planning decisions are made and documented by doctors. It recognises that while an ACD is important in documenting the wishes of an individual, it may not convey clear enough instructions to be useful if the patient rapidly declines, or suffers a cardiac arrest, and urgent decisions about resuscitation need to be made.

The 7 Step Pathway walks the doctor through seven logical steps in making decisions about resuscitation and end of life care, in alignment with their legal (including ACD and Consent Acts), ethical, and professional responsibilities. The process results in the development of an agreed resuscitation plan. Of paramount importance, the Resuscitation Planning process asks this essential question: "If the patient is not for resuscitation or curative care, what are you going to do to ensure the comfort and dignity of your patient?" The aim of standardisation of use and recognition of a single process and form by all sectors - hospital, ambulance service, general practice, community and aged care - increases the chance that clinical instructions aligning with the person's wishes will actually be carried out.

Increasing the uptake & implementation of Advance Care Directives

The prevalence of ACDs in Australia is low, but increasing rapidly, and when they do exist they are not always applied.[6]

Changes to the administrative processes on admission to public health services in South Australia are underway to enable access to ACDs at the point of care when needed, so that staff will know who to contact for third party consent.

The importance of training for health professionals has also been recognised. In Victoria, a recent trial of a short multimodal education programme proved effective in improving doctors' confidence in advance care planning.[7]

SAAPM seminars

The Decision to Operate – Or Not

To promote a discussion about the experiences of clinicians involved in end of life care, and decision-making tools available, SAAPM held a seminar in 2015 titled 'The Decision to Operate – Or Not'. The seminar was attended by more than 100 health professionals and the feedback was very positive.

End of Life Matters

To inform and promote discussion about end of life issues, the SAAPM held a seminar in October 2016 titled 'End of Life Matters'. The keynote speaker was Dr Chris Moy, a General Practitioner and Chair of the Federal AMA Ethics and Medico-legal Committee, who outlined recent legislative changes and described the important tools available to doctors to improve end of life care.

Other presentations covered surgeons' and other clinicians' perspectives, as well as addressing consumer and ethical aspects. The seminar was very positively received with close to 100 attendees including surgeons, surgical trainees, anaesthetists, nurses, resident medical officers, physicians, and hospital quality and safety staff.

1. Australian Commission on Safety and Quality in Health Care. Safety and Quality of End-of-life Care in Acute Hospitals: A Background Paper. Sydney: ACSQHC. 2013.
2. Royal Australasian College of Surgeons. South Australian Audit of Perioperative Mortality report 2015 [internet]. Adelaide: Royal Australasian College of Surgeons. 2016 [cited 2017 Feb 9]. 26 p. Available from: http://www.surgeons.org/media/24428817/2016-07-18_rpt_saapm_ar_2015.pdf.
3. Detering KM, Hancock AD, Reade MC, Silvester W. The impact of advance care planning on end of life care in elderly patients: randomised controlled trial. BMJ. 2010; 340: c1345.
4. Government of South Australia. Advance Care Directives: Your wishes for future care [Internet]. 2016 [cited 2017 Feb 13]. Available from: www.advancecaredirectives.sa.gov.au/about.
5. Carter RZ, Detering KM, Silvester W, Sutton E. Advance care planning in Australia: what does the law say? Australian Health Review. 2016; 40(4): 405-14.
6. Rhee JJ, Zwar NA, Kemp LA. Uptake and implementation of Advance Care Planning in Australia: findings of key informant interviews. Australian Health Review. 2012; 36(1): 98-104.
7. Detering K, Silvester W, Corke C, Milnes S, Fullam R, Lewis V, et al. Teaching general practitioners and doctors-in-training to discuss advance care planning: evaluation of a brief multimodality education programme. BMJ supportive & palliative care. 2014; 4(3): 313-21.

Tools and guidance

A region by region account of the statute laws can be found at: *http://advancecareplanning.org.au/advance-care-planning/for-professionals/the-law-of-advance-care-planning*

To assist both consumers and health professionals, SA Health has produced a range of resources including a do-it-yourself kit. *http://www.advancecaredirectives.sa.gov.au/upload/home/Current_ACD_Guide.pdf*

SA Health provides information, policies and procedures for clinicians about the following topics on its webpages, under the heading 'End of life care for health professionals': *http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/end+of+life+for+health+professionals*

Other regions' Health Departments provide similar resources, e.g.:
New South Wales
http://www.cec.health.nsw.gov.au/quality-improvement/people-and-culture/end-of-life-care
Victoria
https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning
Queensland
https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/end-of-life/guidelines
The Medical Board of Australia published Good medical practice: a code of conduct for doctors in Australia in 2014. This includes section 3.12 End of life care: *http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx*
Further information about SAAPM seminars, including presentations, can be found on the SAAPM webpage: www.surgeons.org/saapm.

Foundation for Surgery
Passion. Skill. Legacy.

RACS – a leader in supporting surgical research

PROFESSOR DAVID SCOTT
Chair, Scholarships Evaluation and Monitoring Committee

The Foundation for Surgery was established in 1981 to generate funds for scholarships through donations from Fellows, contributions from individuals (including bequests), and corporations.

RACS supports surgical research through the provision of up to 41 scholarships annually, with approximately $1.7 million awarded for 2016.

A recent article published in the ANZ Journal of Surgery evaluates the effect of the RACS Scholarship Program on the subsequent careers of scholars three to seven years post scholarship-funded project[1].

Thirty two of the scholarships provide funds to support Trainees and Fellows undertake research activities, while the remainder are travel scholarships. Available scholarships provide between $10,000 and $150,000.

To ensure that the RACS Scholarship Program is an industry leader in the provision of funds to support vital research, a benchmarking exercise was conducted, similar to work conducted by the Royal Australian and New Zealand College of Radiologists[2]. A number of Colleges and Australasian funding bodies were contacted for this benchmarking exercise. Information pertaining to the number and value of scholarships offered, sources of funding, promotion of scholarships and analysis of benefits was requested. This report provides a summary of the information collected on a number of key organisations that offer funding for clinicians performing research.

Australasian Colleges

The Australasian College of Dermatologists offers four scholarships per year with a combined value of up to $77,000 (range of $2,000 to $25,000). The funding duration is one year and assists research projects.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) offered seven scholarships in 2015 with a combined value of $175,000. The values of individual scholarships ranged from $5,000 to $40,000 per annum and are awarded for one or two year's duration. Scholarships are for early career Fellows and Trainees. Some scholarships provide funds to conduct research overseas. Up to 17 grants, scholarships and fellowships were offered for a duration of between 1 to 3 years.

Royal Australasian College of Physicians (RACP) offers a range of scholarships, fellowships and grants each year, with a range of $5,000 to $100,000. Scholarships are available for researchers at different career stages; from postgraduate scholarships to undertake a PhD or equivalent research degree in research development scholarships through to Career Development Fellowships for mid-career researchers (the criteria of which is to be within seven years of completing a higher degree).

Other Australasian Funding bodies

Government funded awards

The National Health and Medical Research Council (NHMRC) is Australia's largest funding body for medical research. In 2015 the NHMRC administered 923 new grants with a total value of $763 million. Scholarships are available for clinicians who wish to undertake a higher research degree with a per annum value of $38,388. A number of grants are available to provide a salary to researchers who have been awarded a PhD. Practitioner Fellowships range in value from $133,000 to $160,000 pro rata and are available for clinicians who wish to undertake part-time research in addition to their clinical work. There are a number of other Fellowships targeted to early and mid-career researchers ranging in value from $74,000 to $170,000 per annum with a duration of four or five years. In addition to providing funding for stipends, the NHMRC also administers Project Grants to fund costs associated with research such as equipment, salary support and direct research costs (including personnel costs, consumables and other reasonable costs required to complete the research). These funds are provided by the Australian Government.

The Health Research Council of New Zealand (HRC) is the primary funding body for health research in New Zealand. In the 2013/14 financial year the HRC awarded 85 new contracts with a combined value of approximately NZ$80 million ($73 million). These contracts included Projects (50 contracts up to $1.1 million each); Programs (4 contracts, up to $4.6 million each); Feasibility Studies (13 contracts, up to $137,000 each); Emerging Researcher First Grants (14 contracts, up to $137,000 each); and Explorer Grants (4 contracts, up to $137,000 each). In addition to these awards, the HRC offers a range of Career Development Awards with a focus on funding postgraduate studies or further research in the areas of Māori and Pacific health research identified as priority areas. In 2013/14 a total of 30 new Career Development Awards with a value of $5.9 million (range $110,000 to $229,000) were made.

It is impressive to note that RACS matches two of the globally leading Surgical Colleges, the ACS and RCS of England, on per capita-based funding

Commercially funded awards

Avant is an Australian indemnity insurance company that offers a range of scholarships and grants for doctors in training, interns or resident medical officers who are an Australian or New Zealand citizen. Avant offers a total of 22 scholarships and grants with an approximate combined value of $350,000 (ranging from $12,500 - $50,000). The awards fund individuals working on a project related to advancement in medicine; at the level of emerging researcher or experienced researcher, or for quality improvement projects in medicine.

International Colleges

The American College of Surgeons (ACS) administers awards for both national and international applicants. The various programs provide funds for a stipend ranging between US$40,000 and US$80,000 pa ($55,500-$111,000) for two to five years. The ACS also offers supplemental funding to researchers who are recipients of a National Institute of Health Mentored Clinical Scientist Development Award.

The Royal College of Surgeons (RCS) of England administers Research Fellowships, which provide a stipend of £60,000 ($128,000) for one year as well as providing funds for research costs (£3,000, $6,400). These Fellowships are available to Trainees who are members of the RCS of England. In addition to these, one-off grants of up to £10,000 ($21,400) are available to fund the purchase of equipment for pilot studies.

The RCS of Edinburgh administers five research fellowships each providing up to £50,000 ($107,000) to cover salary and research costs for 12 months. The RCS of Edinburgh also provides Pump Priming grants of up to £10,000 ($21,400) to fund the purchase of equipment.

Undergraduate bursaries are available for medical students who are affiliated with the College.

RACS offers a total funding pool to members of approximately $1.7 million per annum for a total of 6,219 Fellows and 1,274 Trainees. This is relative to the funding per Fellow/Trainee of the ACS (total estimated value of scheme $2.3 million AUD pa for >80,000 members) and the RCS of England (total estimated value of $5,144,000 AUD pa, for >20,000 members).

It is impressive to note that the RACS matches two of the globally leading Surgical Colleges, the ACS and RCS of England, on per capita-based funding. The RACS can be very proud of the contribution it has made to the advancement of medical research in Australia and New Zealand. As a College, we can be confident that the scholarship program is funding the highest quality research projects whilst retaining its competitive nature.

1. Garrod, T.J., et al., Evaluating the scholarship and Fellowship Programme of the Royal Australasian College of Surgeons. ANZ J Surg, 2016. 86(11): p. 856-857.
2. Roos, D.E., J.K. Kartika, and M.Q. Hu, Radiation Oncology research grants awarded by the Royal Australian and New Zealand College of Radiologists: Value for money? J Med Imaging Radiat Oncol, 2016.

All currency conversions in this document were calculated on 18 November 2015 using data provided by the Reserve Bank of Australia. The exchange rate may have varied since the value of the scholarships was calculated and should be seen as approximate only.

Frederick Treves: Surgeon and Author

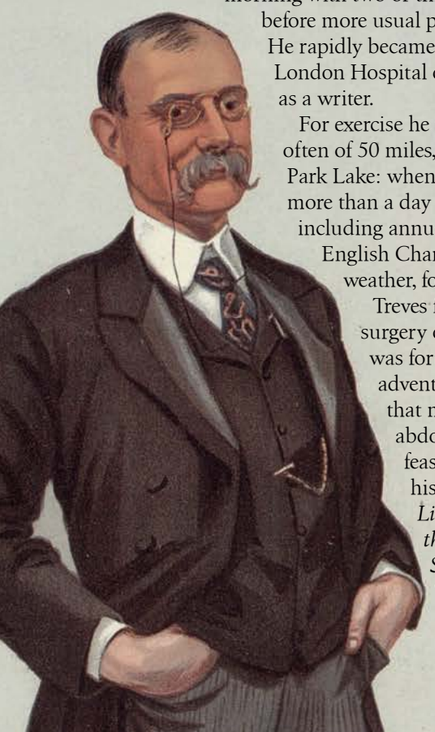
Frederick Treves (1853-1923) C.B., K.C.V.O., Baronet, G.C.V.O., F.R.C.S. (1878), L.S.A. (1874)

PETER F BURKE
FRACS

Frederick Treves, the son of a Cabinet maker, was born in the family home and spent his childhood in Dorchester. Between the ages of seven and nine years he attended a small school run by William Barnes a remarkable polymath who became known as the 'Dorset poet': Treves retained vivid lifelong memories of this benign schoolmaster and his unusual methods of teaching.

In 1919, Treves recalled his early days at the London Hospital, *inter alia*, "I entered the London in 1871, was house surgeon in 1876, and was elected assistant surgeon in 1879. Gin was still regarded as the normal drink of the hospital nurse. The fire was never allowed to go out in the operating theatre since a red hot iron might, at any time, be needed to arrest bleeding. Maggots in a dressing were regarded as the normal fauna of a hospital ward and called for no comment. Operation results were not encouraging and the public knew it".

Whilst on the staff of the London Hospital Treves had tireless energy, showing an immense capacity for work whilst living a Spartan life: his day started at five every morning with two or three hours writing before more usual professional work. He rapidly became known beyond the London Hospital owing to his genius as a writer.

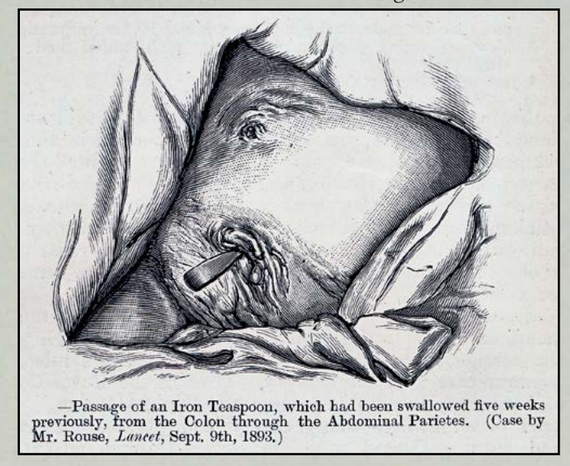


For exercise he took a bicycle ride, often of 50 miles, or rowed on Regents Park Lake: when he did get away for more than a day or two, he sailed, including annually, across the English Channel, whatever the weather, for a Christmas break.

Treves founded his surgery on anatomy and was fortunate with the advent of Lister's teachings that major advances in abdominal surgery were feasible. To quote from his entry in *'Plarr's Lives of the Fellows of the Royal College of Surgeons of England'*: "He was an expert dissector, and operated neatly, quickly and cautiously. He was myopic and generally wore spectacles, but in operating, especially in the days of the spray, he laid aside his spectacles and held his head close to his work. He taught without elaboration".

His very many surgical texts included, *'Surgical Applied Anatomy'*, 1883, his most widely known book with an eighth edition in 1926; *'Intestinal Obstruction'* 1884 and *'A Manual of Operative Surgery'* 1891.

His awards/service to the College included the Jacksonian Prize in 1883 for his dissertation on *"The Pathology, Diagnosis and Treatment of Obstruction of the Intestines in its Various Forms in the Abdominal Cavity"*; Hunterian Professor of Comparative Anatomy and Physiology, and Membership of both the Court of Examiners and College Council.



—Passage of an Iron Teaspoon, which had been swallowed five weeks previously, from the Colon through the Abdominal Parietes. (Case by Mr. Rouse, *Lancet*, Sept. 9th, 1893.)

At the age of 45, in 1898, he caused astonishment when announcing his intention to retire from *'The London'*, after becoming the most successful of London surgeons, continuing only with private practice, and commanding the maximum fee of 100 guineas per consultation.

However, the financial advantages of retirement were offset by liabilities, chief among them that a surgeon needed a hospital appointment in order to remain at the forefront: one biographer observed that Treves as surgeon to the London Hospital was recognised as the leader of English surgery; after his resignation, he gradually ceased to lead.

He was a man of action, who was also deft and cautious. He was athletic and physically powerful, endowed with unusual resources of energy and stamina, which he applied in the same way to his intellectual endeavours. He was a fine teacher and had the gifts of rhetoric. The caption which accompanied his caricature in 'Vanity Fair' in 1900 noted, *'he is a cheery fellow with an alert manner who can tell a story well. He is also a good companion, who is known to his friends as "Freddie"'.*

He served three monarchs, Queen Victoria, King Edward VII and King George V: in the summer of 1902 his national fame, became worldwide, when two days before the date fixed for the Coronation of Edward VII, Treves operated at Buckingham Palace draining Edward's appendiceal abscess: valiantly, the King had insisted that the Coronation proceed, until Treves bluntly advised him, *"Then, Sir, you will go as a corpse."*

In later years Treves became an accomplished travel writer, for many years he had an instinct that literature was his proper pursuit. His wife said that he was never more pleased than when he had a pen in his hand. One critic noted,' *many books have been written by doctors-I mean professional books-and most of them have been rather futile. When therefore I heard that Treves had written a book of travel and it was sent to me for review I groaned. But I'd scarcely looked at a few pages when I realised that I was in the presence of a considerable writer'*.

'The Other Side of the Lantern: an account of a commonplace tour round the world', was published in 1905; the first printing sold out in a week and it was reprinted five times in four months. It stayed in print for 28 years, a remarkable achievement for a book of its kind.

Treves populated the book with his own photographs: he particularly enjoyed Japan; reproduced here his photograph at Kyoto: whilst in Tokyo he was presented to the Emperor of Japan and some weeks later in Washington, met President Roosevelt.

He continued private practice until 1908, after which he devoted himself to public works, travel and writing books. He was one of the founders of the British Red Cross Society and heavily involved in the development of the Radium Institute.

His books encompass a wide range, including accounts of visits to Uganda and the West Indies and Palestine and after moving to live in Switzerland he wrote about the Riviera and the Lake of Geneva. As a travel writer Treves explored remote corners of the world long before tourism existed.

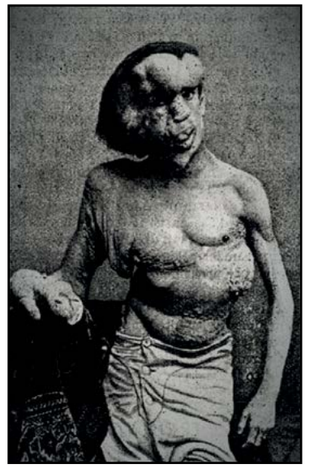
Although Treves greatly appreciated King Edward's loan of Thatched House Lodge in Richmond Park, aged 66 he decided that the English climate no longer suited him and that it was time to retire properly: he would now frequent the more sedate haunts of Rome, the Riviera and the Lake of Geneva.

In the last three years of his life he published three books including '*The Elephant Man and other reminiscences*', 1923, his best-known work.

Treves died at Lausanne, Switzerland, in December 1923, ironically, of peritonitis, of uncertain aetiology. He was cremated and his ashes returned for burial at Dorchester Cemetery, Thomas Hardy being among those present at the funeral.

Perhaps his greatest book was one that never saw the light of day: in 1921 he was encouraged to prepare his autobiography: and following his death in 1923, his delighted long-time publisher received the manuscript and worked on it for a year.

However, Treves had bequeathed all his papers to his wife, with an instruction to destroy his case books and any other papers she saw fit: in 1924 concerned about offending the Court, Lady Treves had destroyed, the manuscript autobiography along with most of his records, stating that her husband's memory should survive in history by the work he did!



Prophetically, perhaps, Treves concluded his account of the South African War, *'The Tale of a Field Hospital'* 1900, with the words, *'Sic transit Gloria mundi!'*

Images (Opposite page l-r): Treves by 'Spy' in Vanity Fair 1900; An illustration from 'Intestinal Obstruction' (1884).
This page (clockwise from left): Treves' photograph Kyoto; Thatched House Lodge Richmond; Joseph Merrick 1889 The 'Elephant Man'.

Tea for Two with Sexual Harassment

SUSAN HALLIDAY

Sexual harassment takes place in our workplaces every day. While often unreported it has a negative impact on those who experience it, impeding workplace interaction and placing limitations on professional trust.

A recent scenario of note involved a woman in her early thirties. She spoke of a planned workplace conversation over a cup of tea that took an abrupt turn. From discussing various developments in her work and the requirement to travel repeatedly given her specialisation, her senior colleague (whom she had only known for a few months) referred obliquely to their employer needing to be across the detail of everyone's travel arrangements. He then leant in towards her and said ... "If we were having an affair, they would know which hotel we were staying in."

Her male colleague went on to ask *'and exactly how old are you?'* The woman thinking the question seemed irrelevant and neutral, responded - albeit unnerved and embarrassed.

Leaning forward again he exclaimed *'amazing'* followed by *'no partner; any children?'*

She shook her head to indicate the answer was no, and her colleague who was some 15 years older offered his opinion about women leaving it far too late to have children, making a series of assumptions about her and her life.

Continuing the story she said "while I was collecting my professional dignity from the floor and wondering how to exit without it coming back to bite me, he took the conversation to another level suggesting maybe more practice was needed. He offered his personal views and advice, completely oblivious to any impact his comments were having on me. I was embarrassed, humiliated and affronted. I did what I could to steer the conversation back to work. Afterwards, as so often happens, I thought of several witty retorts and kicked myself for being rendered mute. When I left all I could think about was avoiding future contact as much as possible."

Concluding her story she said that she realised she had tried to ignore the comments which were invasive and offensive, adding "at the time I found myself minimising their seriousness – not wanting to appear shrill and I certainly didn't want to burn a bridge given his role.... It was the last thing I expected to encounter from such a prominent and influential person over a cup of tea."

> *Sexual harassment is unwanted or unwelcome behaviour of a sexual nature that makes a person feel offended, humiliated or intimidated. It can be obvious, subtle or indirect. It can be physical, written, verbal or a selection of gestures.*

Revisiting the incident the woman stated her stomach turned and her mind catapulted from a planned professional work conversation to a hotel room. Reflecting she added "I had to supress my instinct to run ... but at the time I didn't want to be seen to over react – but what do you say to that, and why should I be put in that position?"

Sexual harassment in employment, education and training, and the provision of goods and services has been prohibited for decades, just like driving under the influence of alcohol. Similarly, in both scenarios people break the law, be it by choice, bad judgement or a failure to think about, or care for others who may be negatively impacted. In both situations the offending party is accountable and potentially liable for their own behaviour. The fact that we have legal frameworks to protect people by prohibiting the behaviour, does not mean that people are physically protected in the first instance from the bad behaviour if someone decides to behave poorly.

Sexual harassment is unwanted or unwelcome behaviour of a sexual nature that makes a person feel offended, humiliated or intimidated. It can be obvious, subtle or indirect. It can be physical, written, verbal or a selection of gestures. As with drink driving, motive and intent are irrelevant, and a single incident is an incident, and it can amount to a breach of a workplace policy and legislation that prohibits the conduct.

It is worth noting that a workplace that is permeated with conduct of a sexual nature can amount to sexual harassment for those required to work in or visit the environment. A sexually hostile workplace culture can also amount to sexual harassment. Sexual orientation and gender are irrelevant; it is the nature of the behaviour and the impact of the behaviour that are assessed when a situation is under review.

The question to ask is given the specific circumstances is it reasonable for the person *experiencing the behaviour to have felt offended, intimidated or humiliated.* If the answer is less than clear, place your partner, good friend, son, daughter, niece or nephew in the same situation ... and ask the question again.

Sexual harassment can take place at work, via a text message, online outside of work hours, as well as in other work related or social situations. It is the *alignment* with work and the associated professional relationship that are key.

When a personal intimate relationship ends, and both parties are in the same work environment, the workplace is not the place to try to rekindle the relationship. Such unwanted attention can amount to sexual harassment. The fact that there was a previous relationship does not lessen the impact or the assessment of the unwanted conduct – in fact there is clarity about there not being a mutual interest.

People often assume that for conduct to amount to sexual harassment that their needs to be a direct interaction or encounter. This is not so. While a person who is harassed needs to be aware, or made aware, of the relevant conduct, it is not necessary that they *receive* such conduct directly. In relevant legislation conduct of a sexual nature is defined as including *making a statement of a sexual nature to a person, or in the presence of a person, whether the statement is made orally or in writing.* So the words do not need to be directed to, or spoken in the presence of the victim to constitute unwelcome conduct of a sexual nature.

Placing a heightened spotlight on gossip, it is important to understand that a person is to be distinguished from the *sexually harassed* person as definitions do not require that the statement be made to *the person being sexually harassed* but contemplates that the statement can be made to a person generally.

So when a colleague out of concern shares with you that sexually offensive things have been said behind your back in front of other colleagues and trainees, it can amount to sexual harassment, and you can make a complaint.

Be it explicit or implicit, sexual harassment can surface in many forms. It is incumbent upon all workplace participants to fully understand and adhere to the boundaries of professional conduct ensuring a good understanding of the line that should not be crossed.

TO BE CONTINUED...

The next edition of Surgical News will house a selection of case examples of conduct that constituted sexual harassment, that people did not identify as sexual harassment.

NOTE

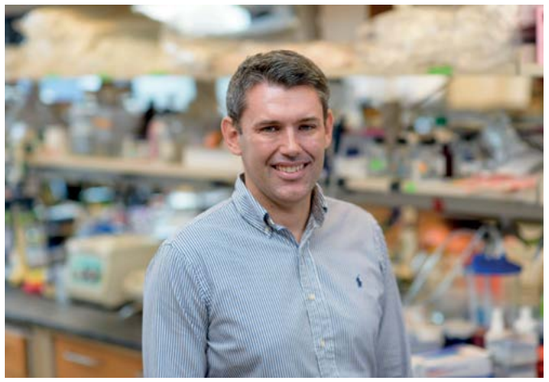
This article is not legal advice. If legal advice concerning sexual harassment is required, an employment law specialist should be consulted with reference to the specific circumstances.

SUSAN HALLIDAY

Australian Government's Defence Abuse Response Taskforce (DART) 2012-2016 and former Commissioner with the Australian Human Rights Commission.

The stats boggle the mind

It sees more than 137,000 in-patients and accommodates more than 500,000 out-patient visits each year, has a staff of more than 13,000 and conducts one of the largest clinical research programs in the world. It treats more than 400 different subtypes of cancer, operates more than 100 research laboratories and receives many hundred millions of dollars in philanthropic support alone per annum.



It is the Memorial Sloan Kettering Cancer Center in New York City (MSKCC) and the current workplace of Sydney General Surgeon and Endocrine cancer researcher Dr Anthony Glover.

With funding support from the Foundation for Surgery's Tour de Cure Fellowship and the Neil Hamilton Fairley Fellowship provided through the National Health and Medical Research Council (NHMRC), Dr Glover moved to the US last year to work with renowned physician and scientist Jim Fagin, a pioneer in the molecular biology of thyroid cancer.

Having completed PhD research into adrenocortical cancer which contributed to two world-first discoveries, Dr Glover has now turned his attention to understanding the biology of radioactive iodine resistant thyroid cancer.

Speaking from the US, Dr Glover said that while radioactive iodine was the mainstay of treatment for patients with metastatic or unresectable papillary thyroid cancer (PTC), about one fifth of such patients are resistant to radioactive iodine therapy (RAIR), which leads to many deaths associated with thyroid cancer.

He said that work in progress at the James Fagin Laboratory had shown that RAIR thyroid cancers are often associated with a novel gene mutation in RNA splicing proteins and also associated with increased expression of a number of microRNAs.

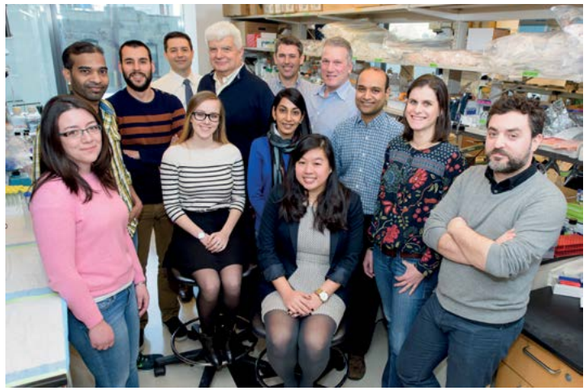
This work has the potential to lead to clinical trials for patients with RAIR and that understanding how RNA splicing proteins and microRNAs regulate thyroid cancer development could lead to effective new therapies to improve the outcomes for patients around the world.

"So far we have established five different cell models of splicing factor modulation with analysis of cell proliferation of these models, showing that loss in the knockdown cells leads to reduced cellular growth" Dr Glover said.

"This is very encouraging and confirms that the splicing factor has a tumour suppressor action in thyroid cancer.

"We have also identified two microRNAs that have been shown to be over-expressed in PTC and we are currently devising a system to knockout the genes for these two microRNAs to see how they effect thyroid cancer progression.

"The splicing factor project is particularly exciting as it was recently found that splicing factor mutations are important in the development of cancers such as leukaemia, but their significance in thyroid cancer is newer still.



"A number of drugs are being developed or currently under trial to target splicing, so if I can show in the mouse models that splicing factor is important in thyroid cancer development, it could lead to clinical trials even within the timeframe of one or two years."

Dr Glover said that although it had been a difficult decision to leave Australia after finishing his PhD research to take up the Fellowship in the US, he hoped that conducting research at the MSKCC would enable him to best develop his career as an independent surgeon-scientist.

"It was a big decision as I had just been given the appointment as a Visiting Medical Officer at Mona Vale Hospital on Sydney's northern beaches where I had started to develop my practice which I then had to close," he said.

"In addition, there is currently a shortage of clinical appointments in Sydney so resigning from a VMO position meant that I had no guarantee of finding another one when I returned to Sydney but while I had to carefully consider this, I thought the chance to work at the MSKCC was worth the risk.

"Dr Andrew Biankin who is also a RACS Fellow and previous recipient of the Neil Hamilton Fairley Fellowship is now a very successful pancreatic cancer surgeon scientist in the UK so I knew that the experience of working overseas at one of the greatest cancer centres in the world had to be embraced."

The decision appears to have paid off.

Since taking up his research position in New York, Dr Glover has been offered an appointment as a Group Leader at the Garvan Institute of Medical Research in Sydney upon his return in 2018, which will allow him to establish his own independent research group into endocrine cancers. He has also been appointed as a Guest Editor for a special edition of the *Journal of Molecular and Cellular Endocrinology*.

"From a collaborative viewpoint, both the sheer scale of the MSKCC and its location creates a cross-pollination of ideas and interaction with other scientists, surgeons and physicians that is both incredibly dynamic and more difficult to find in Australia," he said.

"For instance, part of my project has involved working with the Omar Abdel-Wahab Laboratory, a leukaemia research group at MSKCC as well as working with computational biologists from the Hutch Institute in Seattle.

"The MSKCC also neighbours the Rockefeller University and the Weill-Cornell Medical School and they all share some facilities and open their meetings to staff from the three institutions, which means there are always amazing meetings, discussions and presentations to access.

"Another great difference working here is the availability of routine genomic sequencing for cancer samples which is crucial in advancing our understanding of various cancers such as thyroid cancer."

Dr Glover said he was also greatly enjoying his free time in New York. He said he had swapped his Sydney interests in surfing and surf life saving to sailing and running and that he will be a crew member later this year on the America II yacht. He has also recently won a lottery spot to compete in this year's New York City marathon.

He thanked RACS and its Fellows for the support provided to him.

The Foundation for Surgery Tour de Cure Research Scholarship is funded by the Australian charity *Tour de Cure*. Entirely dedicated to curing and preventing cancer, the charity raises funds through cycling tours and events across Australia.

- With Karen Murphy

CAREER HIGHLIGHTS: GRANTS, AWARDS & SCHOLARSHIPS

2016:
Foundation for Surgery Tour de Cure Research Scholarship for research into *"understanding the role of RAS mutations in advanced thyroid cancer".*

2016:
NHMRC Neil Hamilton Fairley Early Career Fellowship – *granted to persons of outstanding ability who wish to make clinical research a significant component of their career.*

2015:
Kolling Institute Young Investigator Oral Prize.

2014:
American Association for Cancer Research Scholar in Training Award.

2014:
Sydney Cancer Conference Award for Basic Biomedical Cancer Research.

Images (From far-left): Dr Anthony Glover; With the team at the Fagin Laboratory, Memorial Sloan Kettering Cancer Center in the US; Working with Dr Jim Fagin (l).

Churchill Fellowship highlights surgical simulation

While surgical simulation technology is now capable of replicating the entire patient journey from pre-operative work-ups to post-operative care and with programs now being developed which mimic the data capture role of "black box" flight recorders for use in theatre, simulated surgical training is still being used at a fraction of its potential, according to Dr Ruth Blackham.

Dr Blackham is a General Surgeon, Bariatric Fellow and Senior Lecturer at the University of Western Australia and the renowned Clinical Training and Evaluation Centre (CTEC), one of the busiest simulation learning centres in the world to specialise in the teaching of surgical skills.

Recently having travelled abroad to study the work of international leaders in the field, Dr Blackham said simulation training was undergoing a global shift away from a purely supplemental role in training towards a complementary model observing proficiency in a simulated setting prior to working on patients.

She said that while simulation training had not yet been mandated in any surgical program to date, an increasing number of educational institutes now expect simulation to become a necessary adjunct to the surgical curriculum rather than an optional side-arm.

"While Australia has some of the most innovative surgical simulation centres in the world, more could be done to encourage trainees and surgeons to use such facilities to learn or refine new skills away from the competing demands of a busy hospital setting," she said.

Supported by funding provided through a prestigious Churchill Fellowship, Dr Blackham spent time in Canada, England and Ireland last year.

In November, she visited a number of facilities including:

- The Steinberg Centre for Simulation, Montreal, Canada: A world-leading research and teaching institute focused upon patient outcomes and simulating the entire patient journey from preoperative patient work-up, operative simulation to postoperative care;
- The LiKaShing Institute, Toronto, Canada: A world leader in the development of a "black box" in the Operating Room model of training and quality assurance. The data collected from both the patient and theatre staff can be viewed in real time to improve patient safety;
- Imperial College London learning from Professor the Lord Ara Darzi and studying his work in the fields of simulation metrics, validation methodology, surgical training and health policy;
- University College of Cork Application of Science to Simulation based Education and Research (ASSERT): a combined high-fidelity and cadaver based laboratory opened in February 2016 which specialises in the teaching of orthopaedic procedures.

Dr Blackham said that one of the great benefits of the Fellowship was the opportunity it provided to visit such a wide range of simulation centres focusing upon different aspects of surgical teaching and safety and quality assurance programs.

"St Michael's hospital in Toronto is largely mannequin-based which provides a good foundation for non-technical skills, especially surgical crisis scenarios for teams," she said.

"The Steinberg Centre in McGill University in Montreal has a large procedural skills area with dedicated work stations for basic surgical skills where junior doctors can practice laparoscopic suturing and peg transfer whenever they have free time from the hospital.

"Imperial College in London has a phenomenal centre for clinical simulation and education research, developing training curricula and methods of measuring the learning curves of surgical 'novices'.

"Finally, the ASSERT centre in Cork is a world leader in the use of proficiency-based progression, developing surgical metrics and making 'deliberate practice' a reality in surgery."

Dr Blackham said that while simulation in surgical education had undergone a rapid paradigm shift over the last decade to become a common form of surgical education, it was most valuable as a complement to theatre time and operative experience rather than as a replacement.

She said her Fellowship had convinced her not only that Australia has some of the best simulation courses and facilities available, but that all surgical leaders are now grappling with the role it should play in surgical education and assessment.

"Whilst the validity evidence for both low and high-fidelity models is compelling, simulation is being used at a fraction of its potential at all levels from de novo training of a medical student or a trainee, to the up-skilling of a consultant," Dr Blackham said.

"Having visited both the Canadian College of Surgeons in Ottawa and the Royal College of Surgeons in London, I found that we all seem to be saying the same thing – that is, that while ideally simulation would be fully integrated into a comprehensive surgical curriculum, providing trainees with the time for it remains an ongoing challenge.

"It is clear that providing that time requires leadership from Government authorities, hospital management and surgical supervisors and they have already begun to formalise simulation training in England.

"The UK and Canada are both leading in this field. In England, trainees have protected mandatory teaching time where they can access the simulators for laparoscopic surgery and hone their skills while vascular trainees have ready access to a high-fidelity angiogram simulator."

Dr Blackham said that some of the great benefits of simulation surgical training include giving trainees the chance to build confidence and technical expertise along with an opportunity to push themselves in a safe environment. This provides greater standardisation across a range of procedures and a capacity to obtain data and provide feedback.

She said that such data capture technology was being led by Professor Teodor Grantcharov at the Centre for Simulation in Medical Education at the LiKaShing Research Institute in Toronto where he has built a "black box" specifically designed for the operating theatre.

His system, now being used in an operating theatre at St Michael's Hospital, collects real-time data captured via video, audio and metadata including the patient's physiological data such as heart rate, blood pressure and ventilation, as well as external factors such as room temperature, noise and the number of people entering and leaving the room.

"The 'black box in the OR' is a modality which collates data not only from the physiology of the patient garnered through anaesthetic machines and scrubbing sensors but it also picks up biometric data from the surgical team from electromyography placed on the forearm," Dr Blackham said.

"Data analysing fixed factors are also collected such as how many times the door opens and how many people are in the room at any given time while motion tracking sensors can track where they are at any given time.

"This multi-channel data allows analysis of communication and non-technical skills of the team in real time, particularly how they may affect patient outcomes. This represents a ground-breaking and fascinating addition to the field of human factor research."

> *She said her Fellowship had convinced her not only that Australia has some of the best simulation courses and facilities available, but that all surgical leaders are now grappling with the role it should play in surgical education and assessment.*

Dr Blackham presented the key points of her Churchill Fellowship program at the Asia-Pacific Medical Simulation in Healthcare Conference at the National University of Singapore last year.

She particularly thanked Professor Stephen Tobin, Dean of Education at RACS, for his guidance and assistance in creating inter-collegial links and Professor Jeffrey Hamdorf, Director of the CTEC, who helped devise the itinerary and provide contacts with global leaders in the field of simulation surgical education.

– With Karen Murphy

The Winston Churchill Memorial Trust aims to honour the memory of Sir Winston Churchill by providing the opportunity for Australians to travel overseas to conduct research in their chosen field and to continue their pursuit of excellence for the enrichment of Australian society.

Images (Clockwise from far-left): Award Ceremony for the Churchill Medallion with CEO of the Winston Churchill Memorial Trust, Mr Adam Davey; Professor the Lord Ara Darzi and Dr Blackham; The Hamlyn Centre; SimMan in their high fidelity simulator.

Meet the Awardees

ASSOC. PROF. STEPHEN TOBIN Dean of Education
DR SALLY LANGLEY Chair, Professional Development

In November 2016, the Academy of Surgical Educators (ASE) presented the Educator of Merit and Educator of Commitment awards to our surgical educators. These awards acknowledge and recognise the dedication and excellence of our surgical educators. Some of the awardees will be featured over the next few editions of Surgical News. Here's the Part 3 and the final snapshot.

David Fletcher
Educator of Merit: Supervisor/Clinical Assessor of the Year (Western Australia)

David has been a RACS Fellow since 1974, in General Surgery specialty

What is your proudest moment as a surgical educator?
Amazed watching one of my former UGI Fellows performing a laparoscopic assisted pancreatico-duodenectomy (Whipple), picking nodes off the superior mesenteric artery next to the portal vein with aplomb, far better than I ever did open.

Any advice for new surgical educators (supervisors/ clinical assessors)?
Get yourself involved; attend one of the many College Teaching/Education programs. Teaching is so much fun. You light a fire under people and watch them take off, achieve and then go on to motivate others.

How has the Academy of Surgical Educators impacted you as a surgical educator?
The Academy has connected me with like-minded surgeons and educators who help me continue to refine what skills I might have.

How do you feel receiving the ASE Educator of Merit award?
Pleasantly surprised, to me I was just fulfilling my responsibility to the College and its Trainees, Fellows and IMGs

Jeffrey Brennan
Educator of Commitment

Jeffrey has been a RACS Fellow since 1999, in Neurosurgery specialty

Why is surgical education important to you?
Teaching registrars is challenging but rewarding and enjoyable. They are of course our future colleagues and will carry the reputation and standards of our profession going forward. Being involved in their development as surgeons not only allows me to offer some direction of these standards but also helps build professional relationships and a sense of community between individuals and amongst Fellows within the College more broadly.

What is your proudest moment as a surgical educator?
On a personal basis, congratulating the Trainees as they pass the fellowship exam and are introduced to the Court of Examiners is very rewarding, as is the individual "thank you" that you sometimes get from registrars with whom you have worked very closely as they progress. Professionally, receiving the Educator of Commitment Award from the Academy was an unexpected honour and reminds me that positive feedback from leaders is a powerful influence on training and behaviour.

Any advice for new surgical educators (supervisors/ clinical assessors)?
Recognise that this is an honour but also an important responsibility, at least as important as the treatment of your own patients. Lead by example and stay true to the principles of fairness and professional integrity. Remember that positive encouragement is more constructive than reprimand, and that different trainees will mature at different times. Nonetheless, if a Trainee is under performing then stand by the principles set out by the training boards and do not shy away from negative feedback and reports when appropriate.

Images (from left): Prof David Fletcher receiving the Educator of Merit award from Prof Spencer Beasley, Vice-President RACS; Mr Jeffrey Brennan receiving the Educator of Commitment award from Dr Sally Langley, Chair ASE.

ACADEMY OF
SURGICAL EDUCATORS

Appreciating Our Educators

Thank You to all of our SET Supervisors, PD Facilitators, IMG Clinical Assessors who have contributed to surgical education and training in the RACS community. We wish to acknowledge the following educators in achieving these service milestones

(as of 31 December 2016*):

Those who have served for 9 years or more

SET Supervisor

Mr Jacob Goldstein	Mr Simon Knight	Mr Sivendram Seevanayagam	Assoc Prof Rebecca Dignan
Mr Ian Campbell	Mr Moheb Ghaly	Mr Stephen Allison	Mr Midhat Ghali
Mr Bruce Stewart	Mr Pravin Kumar	Mr Murray Pfeifer	Mr David Moss
Mr Grant Broadhurst	Assoc Prof Teresa Withers	Dr William Johnston	Mr Chi-Kee Shaw
Mr Thomas Kertesz	Mr Martin Forer	Mr David Pohl	Prof Stephen O'Leary
Assoc Prof Nigel Biggs	Mr Ian Jacobson	Mr Allan Keast	Mr John Clarkson
Mr Rajendra Kumar	Mr Mark Lovelock	Assoc Prof David McClure	Prof Bibombe Mwipatayi
Mr Brendan Stanley			

PD Facilitator

Assoc Prof Bruce Waxman	Mr David Stoney	Dr Philip Sprott	Assoc Prof Marianne Vonau
Mr David Speakman			

Those who have served for 6 years

SET Supervisor

Mr Christopher Merry	Dr Sumit Yadav	Mr Philip Worley	Mr Stephen Clifforth
Mr Ahmad Hooshyari	Dr Matthew Ryan	Mr Senarath Werapitiya	Dr Robert Spychal
Dr Usha Shan	Dr Simon Bann	Dr Andrew Kam	Mr David McDowell
Mr Eduard Pudel	Mr Michel Neeff	Mr Richard Sackelariou	Mr Winston McEwan
Mr David Hussey	Dr Ravi Huilgol	Dr Lubomyr Lemech	Dr Wendell Neilson
Mr Jeremy Perkins	Assoc Prof Ramon Varcoe		

Those who have served for 3 years

SET Supervisor

Mr Peter Skillington	Mr Manu Mathur	Dr Gregory Rice	Dr Ashutosh Hardikar
Mr Raymond Lancashire	Mr Hugh Lukins	Mr Paul Sitzler	Dr Anthony Chambers
Mr Mark Cullinan	Assoc Prof Vincent Lam	Dr Isabella Mor	Mr Farnoush Noushi
Dr Carina Chow	Dr Ollapallil Jacob	Dr Sarah Martin	Dr Satish Warrier
Dr Quentin Ralph	Dr Usama Majeed	Mr Hong Xia	Dr Nicholas Ngui
Ms Stephanie Weidlich	Dr Francesco Piscioneri	Mr Isaac Cranshaw	Mr Falah El-Haddawi
Dr Linus (Shun-Jen) Wu	Mr Christopher Thien	Prof Christopher Lind	Mr Robert Eisenberg
Dr Michael Chin	Mr Brent Uren	Dr Adnan Safdar	Mr Simon Ellul
Mr Teariki Maoate	Dr Camille Wu	Dr David Stewart	Mr Steven Merten
Mr Shiby Ninan	Mr David Ying	Dr Carmen Munteanu	Mr Terry Wu
Dr Sian Fairbank	Mr David McCombe	Mr Michael Weymouth	Mr Anthony Williams
Miss Sarah Hulme	Mr Niall Corcoran	Mr Rupert Ouyang	Dr Nader Awad
Dr Daniel Spernat	Dr Jon Paul Meyer	Mr Jamie Kearsley	Mr Paul Sved
Mr Philip Dundee	Mr Matthew Claydon	Dr Toby Cohen	Mr Thomas Daly
Mr David Ferrar	Assoc Prof David Lewis		

PD Facilitator

Dr Jai Bagia	Mr Ian Gilfillan	Dr Sylvio Provenzano

IMG Clinical Assessor

Prof David Watters	Mr Donald Laing	Mr Kevin Chambers	Dr Alison Taylor
Mr Andrew Swanston	Mr Bernard Whitfield		

**The Academy of Surgical Educators and the affiliated RACS departments endeavour to publish these lists as accurately as possible. If you know someone whose name is missing from the list, please contact ase@surgeons.org.*

Legal responsibilities regarding volunteers

MICHAEL GORTON AM
Principal, Russell Kennedy Lawyers

Not for Profit organisations, use and rely on the services of volunteers. This article explores the exposure arising from the use of volunteers.

Legal responsibilities regarding volunteers fall into two categories:

- responsibilities to volunteers; and
- responsibilities arising out of the conduct of volunteers.

Occupational Health & Safety Legislation

This legislation will usually impose a statutory responsibility on employers in relation to non-employees such as volunteers.

Duties of employers

Every employer…shall ensure so far as is practicable that persons (other than the employees of the employer…) are not exposed to risks to their health or safety arising from the conduct of the undertaking of the employer…

The section is applicable to volunteers.

The obligation of an employer under this section turns on the meaning of the phrase 'so far as is practicable' and will usually require consideration of the following issues:-

(a) the severity of the hazard or risk in question;
(b) the state of knowledge about that hazard or risk, and any ways of removing or mitigating that hazard or risk;
(c) the availability and suitability of ways to remove or mitigate that hazard or risk; and
(d) the cost of removing or mitigating that hazard or risk.

The Courts have set out some principles for employers to decide the meaning of the word 'practicable'. They are:

- What is practicable must be determined on the facts of the case known at the time of the event which may have been a breach, not at the time of the hearing of the case.
- The higher the seriousness of the potential outcome of the event, the more that it is expected to be done to control the risk, even if the likelihood is low. Further, more is expected to be done to control a risk which has a higher likelihood of happening, even if the outcome is less serious.
- The consideration of knowledge must take into account what someone in the position of the person not only knows, but ought to know.
- It is relevant to consider what may reasonably be expected of others. Employers should take into account the potential for inadvertence or error, or potential failures of others to comply with their obligations. However, the employer does not have to allow for unforeseeable, inexplicable or bizarre behaviour of others. Put simply, the employer should expect inherent failure of systems, but not gross misconduct.
- The ability of the person to control the circumstances and outcomes is a significant factor in determining what is practicable for them to do.
- The Courts are usually unsympathetic to arguments based on cost alone, but the level of effort or cost expended need not be disproportionate to the level of the risk.
- The cost of taking measures to control a risk will rarely, if ever, excuse doing nothing.

The next issue is the definition of the 'workplace'. The workplace is usually defined to include a premises under the control of the employer; including any area of the employer's enterprise in which the employer has any control. The distinction is relevant because volunteers may be injured in an area not under the employer's sole control.

Duties of occupiers of workplaces

An occupier of a workplace shall take such measures as are practicable to ensure that the workplace and the means of access to and egress from the workplace are safe and without risks to health.

Employers are occupiers of the premises at which they conduct any part of their business but the issue is complicated by the possibility of different people having management or control of the same workplace for different purposes (or the possibility of one person having the management and another having control of the workplace). However, the legislation is interpreted to establish that the person will only be an occupier of that part of the workplace over which that person has management or control.

Duties of employees

Legislation usually requires that:-

1 While at work an employee must take reasonable care for...the health and safety of anyone else who may be affected by his or her acts or omissions at the workplace.
2 An employee shall not wilfully place at risk the health or safety of any person at the workplace.

The significance of this obligation is that it imposes, an obligation on employees to be concerned for the health and safety of volunteers. The issue includes behaviour of an employee which is in contravention of safety directions or safety policies.

The impact of this obligation is that, provided an employee is acting within the normal course of his or her employment, although negligently, the employer will generally be vicariously liable for the actions of the employee. At law the employer may be liable vicariously for the breach by an employee of his or her statutory duty.

Liability of Occupiers

Relevant legislation usually provides that:

- An occupier of premises owes a duty to take such care as in all the circumstances of the case is reasonable to see that any person on the premises will not be injured or damaged by reason of the state of the premises or of things done or omitted to be done in relation to the state of the premises.
- In determining whether the duty of care has been discharged consideration can be given to:
  (a) the gravity and likelihood of the probable injury;
  (b) the circumstances of the entry onto the premises;
  (c) the nature of the premises;
  (d) the knowledge which the occupier has or ought to have of the likelihood of persons or property being on the premises;
  (e) the age of the person entering the premises;
  (f) the ability of the person entering the premises to appreciate the danger;
  (g) whether the person entering the premises is intoxicated by alcohol or drugs voluntary consumed and the level of intoxication;
  (h) whether the person entering the premises is engaged in an illegal activity;
  (i) the burden on the occupier of eliminating the danger or protecting the person entering the premises from the danger as compared to the risk of the danger of the person.

These provisions are primarily designed to render occupiers of premises liable for the state in which they leave the premises. The application of such obligations include situations where persons entering onto premises, even trespassers, are injured (for instance, falls or unsafe machinery or, in the case of children, being attracted to dangerous items attractive to those unfamiliar with their use). Such obligations are applicable to volunteers injured because of the state of the employers premises.

Insurance

Obviously organisations will ensure that they adequately insure for all of these risks - but it should be clear that the insurance specifically covers:

- Liability for injury to **volunteers**;
- Liability for injury to others caused by **volunteers**.

The Editor,
Surgical News

Dear Sir,

I wish to correct a statement made by *Surgical News* Vol. 18 No. 1. page 16 in which was said that the New Zealand Surgical team based in the Binh Dinh province of central Vietnam from 1963 to 1975 'distinguished themselves FROM OTHER INTERNATIONAL MEDICAL UNITS BY THEIR WILLINGNESS TO TREAT EVERYONE IN NEED – INCLUDING SICK AND INJURED CITIZENS AND SOLDIERS ON BOTH SIDES OF THE CONFLICT'.

As a member of the Royal Prince Alfred Hospital medical team to Vung Tau in 1967 I would like to inform you and your readers that our team and the teams at Ben Hoi and Long Xuyen treated civilians and soldiers of both sides with NO discrimination. In fact we had no real way of telling who was 'friend' and who was 'foe'. Not that that mattered.

The *Surgical News* is respected and read widely and this incorrect statement may go down as 'history'.

Please do not try to rewrite that part of the medical help we gave to the Vietnamese. The statement is also a slight on the many members of these teams who are now deceased and cannot tell the true facts.

Yours faithfully,

Colin John Andrews.
MB BS [Syd] FRACS.

It was not our intention to ignore or dismiss the amazing work performed by other international medical units working in Binh Dinh province at this time and Surgical News acknowledges the efforts made by members of these medical teams who dedicated twelve years of their lives to the sick and injured from both sides during the Vietnam war.

Our apologies for any offence caused by the claims in the article.
- Ed.

IMS 2017 stars on Twitter

Friday 10 March was the 2017 International Medical Symposium (IMS) bringing together five medical colleges from Australia, New Zealand and Canada to collaborate, explore, share and advance international best practice in leading cultural change, strengthening indigenous healthcare, enhancing medical education and improving systems and practices across our healthcare systems.

While there were many discussions in-person during the panel Q&A, and break periods, there was plenty of chatter on Twitter, using the conference hashtag #IMSMelb17. In fact, there was so much Twitter discussion that we **trended number two in Australia**, trumping conversations about Game of Thrones and sports (no mean feat on any social media platform).

RACS Associate Professor Stephen Tobin, Associate Professor Grant Phelps, Clinical Leadership at Deakin, RACS Past President Professor David Watters and Dr Kevin Imrie, Past-President of Royal College of Physicians and Surgeons of Canada were some of the main voices in the IMS Twittersphere discussing key topics of the conference panels – driving change in culture of medicine, indigenous healthcare, medical education, and systems and practice.

> *We had 62 retweets, 93 likes and 75 mentions on the day.*

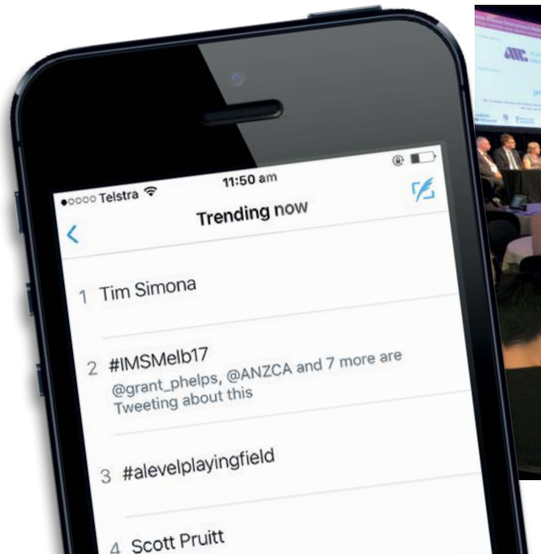
Our Building Respect, Improving Patient Safety program was presented by Professor Spencer Beasley generating much discussion about bullying, harassment and gender issues in medicine as a whole. RACS was applauded for leading change in this arena, and the data we have collected for further understanding this problem in surgery.

Facilitating online discussion around events is easy. If you want to have a successful social media presence, particularly on Twitter around your event, just follow some simple steps.

1. **Create a hashtag (for example #IMSMelb17)**
   Make the tag as short as possible. Twitter only has a limited number of characters, so the shorter the better. Also include the year at the end, to differentiate between next year's event.
2. **Promote your hashtag everywhere**
   Print your hashtag on your program, posters, flyers, and all other collateral. Consider making a separate social media poster for your registration desk to let your delegates know to use it when tweeting about the presentations.
3. **Tweet, post photos and join in the discussion**
   Join in and hear what people are saying about your event online. You can tweet photos of the presenters, pose questions to your Twitter followers, or highlight an interesting slide. You can also see others' reactions to the presentation content, and start a conversation about the topic.
4. **Contact RACS Digital Media Coordinator for training**
   Sarah-Jane Matthews has just joined the RACS office in Melbourne, and would be happy to help you with your social media questions.

About the Tri-nation Alliance

The Tri-nation Alliance includes RACS, along with the Australian and New Zealand College of Anaesthetists, the Royal College of Physicians and Surgeons of Canada, the Royal Australian and New Zealand College of Psychiatrists, and the Royal Australasian College of Physicians.



Case Note Review

Collaboration – a core competency for all surgeons.

PROFESSOR GUY MADDERN
Surgical Director of Research and Evaluation incorporating ASERNIP-S

Clinical details

A patient was brought to the emergency department by ambulance, awake, alert and with no limb movement or sensation below the C6 level. The patient had been discovered unconscious the previous day, following a fall whilst intoxicated. X-rays and a computed tomography (CT) scan of the cervical spine showed an unstable fracture-dislocation at C6/7. A CT head scan showed an area of lowered density within the cerebellum, consistent with infarction. A neurosurgical opinion was obtained regarding this. No specific advice or treatment was suggested, other than the comment that the cerebellar infarction may have been the cause of the fall.

The patient was under the care of the orthopaedic spinal surgeon with intensive care unit (ICU) support and neurosurgical input. The unstable spinal fracture was treated with corpectomy and cervical fusion. The operation was uneventful and the patient was taken to the ICU intubated and ventilated. There were episodes of bradycardia and evidence of cardiovascular instability throughout the following day. Later the following day, both pupils became fixed and dilated.

Emergency CT head scan and CT angiogram confirmed the previous cerebellar infarction with more mass effect and obstructive hydrocephalus. The CT angiogram showed evidence of a vertebral artery dissection. Neurosurgical input was sought once more and the patient was returned to theatre where a ventricular drain was placed and a posterior fossa decompression performed.

The patient recovered some papillary function, but progress was poor and a subsequent CT scan some days later showed extensive posterior fossa and brainstem infarction. The situation was thought to be irretrievable. The patient was extubated and soon died.

Assessor's comment:

This death may have been avoided.

1. The first aid (or lack of it) administered by this patient's peers was clearly inadequate, and may have contributed to the overall outcome.
2. Failure to call for an ambulance immediately and the decision to lift and carry the patient after the fall, may well have worsened injuries.
3. At hospital, a CT head scan identified a probable cerebellar infarction. At that point, management should have changed. If the cerebellar infarction was identified, the cervical surgery probably need not have proceeded without further investigation.
4. At presentation, a CT angiogram of the neck would have been appropriate. If the cerebellar infarction and vertebral artery dissection had been identified, the decision to proceed with the cervical fusion may have been postponed. The risk with the cerebellar infarction was that cerebellar swelling and posterior fossa mass effect may have caused brainstem compression and hydrocephalus.
5. Knowing that a surgical procedure (for the fracture-dislocation) would occur and that surgery may last for some hours, during which time clinical assessment could not be undertaken, it may have been prudent to insert a ventricular drain prior to surgery. Intracranial pressure could then be monitored.
6. Opportunities for closer collaboration between the orthopaedic, intensive care and neurosurgical teams were missed.

In this case, because the neurological condition and the intracranial pressure were not monitored for many hours, when it became obvious that the cerebellar infarction was causing significant problems, it was really too late, and despite subsequent neurosurgical intervention, the damage was already done.

Collaboration is an essential part of the management of the multiply-injured patient and remains a core competency for all surgeons. The lack of close multi-disciplinary collaboration, in retrospect, affected the timing and sequencing of this patient's care and was a factor in the patient's death.

True happiness comes from giving?

DR GARY MCKAY
FRACS & Secretary of DAISI

Volunteers returning from Gizo Hospital from left: Dr Adam Hill (Anaesthetist), Dr Ann Collins (OMF Surgeon), Dr Daniel Kozman (Colorectal Surgeon), Erin Bertolin (Pharmacist), Dr Gary McKay (Colorectal Surgeon & DAISI Secretary) & Roshini McKay (Nurse).

I chose medicine and surgery because I wanted to make a difference. I wanted to help the sick and poor. Well, that's at least how it started.

I'm pretty sure most of us started off with good intentions. Even as a teenager I was fortunate to travel the world and had seen a lot, including some real poverty in the developing countries. I remember walking across the US/Mexican border as a teenager and suffering from culture shock seeing the stark contrast between wealthy San Diego in the north and poverty-stricken Tijuana in the South separated by a barb wire fence. As a dual Australian-Us citizen at the time I felt a sense of shame that one of the richest countries could be right next to one of the poorest.

I was also fortunate to study medicine at a faculty where the Dean of Medicine Prof John Hamilton had himself spent many years working in Ethiopia and was very public in encouraging us as medical students to volunteer in the developing world. I was surrounded by inspiring clinicians who had worked in parts of Africa or India and I was able to do a number of electives in India as a medical student. Pretty soon a group of us at med school started a "Third World Interest Group" known simply as TWIG. We also created an elective database that allowed medical students to communicate their developing world experiences with other medical students.

But then along came the gruelling process of 'surgical training', consisting of one year of internship, at least two years as resident then a minimum of four years doing advanced general surgical training. If you're lucky enough to get through all your exams first go then this whole process takes a minimum of seven years. But just when you think you're finished, the academic treadmill continues and there's another two to four years of subspecialty training before you're considered employable. With four kids in the mix, it would be fair to say that I was not a lot further ahead financially at the end of this process than the start. Upon finishing training there was a real sense of urgency to start working and making up for lost time in building a practice and chipping away at the mortgage, the school fees, and so on. It probably wasn't until six years of doing this that I realised I was in a rut and my dreams of helping the poor in the developing world had been all but snuffed out.

By now my practice was stable enough that I'd stopped worrying about having empty lists and began, instead, to resent too many overbooked lists. Financially I was comfortable,.. in fact I fear I was, as Pink Floyd put it, 'comfortably numb'.

I'd not done anything substantially selfless for over two decades and was well and truly engaged in the rat race of work, indulge, relax sleep and repeat. This blinkered existence was paying the bills but was it good for my soul? I fear I was (as Simon & Garfunkel put it) becoming a rock or an island, not all that much different to the country I live in. And like the country I live in, the surrounding oceans were walls, a fortress deep and mighty that prevented me from seeing the suffering outside or of feeling any pain.

It was during this 'numbed' phase of my life that I was conducting surgical SET interviews for doctors wanting to get into surgical training when I struck up conversation with another examiner who had just returned from a trip to Gizo hospital in the far Western province of the Solomon Islands. He was glowing with enthusiasm and I wanted some of it. He'd been there with his son who as a result was inspired to do medicine. I knew instantly this was exactly what I had to do. I had to get out of my rut. So I made some phone calls between interviewing surgical candidates and before anyone could blink I had locked myself and family into a trip to Gizo hospital in December 2015. My surgical registrar Dr Sepehr Lajevardi also joined me.

Medical students David Maze & DAISI Vice-Chair Gareth Iremonger transporting unconscious patient by water ambulance

When I arrived at Gizo I discovered that the one Australian paid doctor deployed to Gizo Hospital had left urgently after contracting Dengue fever. The only foreign volunteers there where a New Zealander medical student Gareth Iremonger and an Australian medical student David Maze (see photo above). They would attend to ED all day and every day and their selfless act of charity was very inspiring. We bonded instantly and between the four of us we decided to create a charity and after a bit of whisky-cola inspiration came up with the acronym **DAISI** (**D**octors **A**ssisting **I**n **S**olomon **I**slands). We each pledged that we would return to the Solomon Islands and do our best to improve the conditions of the Solomon Islanders.

It was during my revisit to the Solomon Islands that I discovered that the Solomon Islands, like Australia, are part of the Commonwealth. The difference in income is however 100 fold with the GDP per capita in the Solomon Islands being $600 compared with $60,000 in Australia. It seemed wrong that our friendly closest commonwealth neighbours were doing it so tough with the waters that surround Australia apparently just as effective as the barb wife fence that separate the US from Mexico.

Medical student & DAISI Vice-Chair Gareth Iremonger assisting Plastics Registrar and DAISI Treasurer Dr Sepehr Lajevardi with a tendon repair.

But despite the poverty in the Solomon Islands and so much, one would think, to be unhappy about, Solomon Islanders do not appear unhappy, but rather appear to display great happiness and content.

This happiness amazed me as did the sense of happiness I saw in volunteers returning from the Solomon Islands to the West, almost as though the happiness were contagious. During my upbringing I was always taught that 'true happiness comes from giving', but didn't really believe or even understand it at the time. But this happiness effect on volunteers is profound and I've experience it and seen it in others time and time again.

"Relative deprivation" is a state of mind where discontent is felt when surrounded by others who have more than them. And I'm sure the corollary of 'relative content or happiness' is what occurs after any volunteer visits a developing country. One of my colorectal colleagues once said after a visit to the Solomon Islands, 'I just feel so lucky and blessed'. Just like me the trip got him out of his first world rut, with all his problems seeming quite insignificant.

So whether volunteering in the Solomon Islands is a selfish or selfless endeavour or not, the end result appears to be a large dose of happiness.

To find out more about DAISI and their work visit: www.daisi.com.au

To Pakistan and back

ASSOC. PROFESSOR MICHAEL HOLLANDS
Past President RACS

Forty years ago, orthopaedic surgeon Murray Hyde Page and I travelled with a pack on our back from Kolkata to London, much against the advice of our surgical mentors at the time. Part of our journey followed the Grand Trunk Road. The Grand Trunk Road is one of those iconic symbols of civilisation. It runs from Kolkata at the mouth of the Ganges, through the Khyber Pass, to Kabul in Afghanistan.

Just after crossing the border into Pakistan is Lahore. Nowadays Pakistan's second city, it remains the artistic and cultural heart of the country. In recent times, it has been ruled by the Moghuls, the Sikhs and the British before becoming capital of the Punjab in modern Pakistan. It is the fusion of these cultures, not to mention the food and the people, that makes Lahore such an iconic place to visit.

Recently I was invited to return to Pakistan to teach an ATLS Course (EMST) and examine the final Fellowship in Surgery. The College of Physicians and Surgeons of Pakistan (CPSP) was founded in the early 1960s and is responsible for professional standards across the country. Like our College, it is responsible for selection, training and assessment of the nation's specialist medical practitioners. Their College President regularly attends our ASC and their Council is keen to develop closer links with RACS.

The CPSP was the first of the major international colleges to introduce entirely web based assessment of training.

Supervisors and trainees log on with their mobile phones and all assessments are recorded and marked online.

The practical part of the examination was not dissimilar to our own exam. The standard was quite high and the candidates well prepared. The quality of the patients was excellent. The two long cases I examined were a right sided colorectal cancer and a patient with a liver abscess. As in our exam a history was taken and examination performed before discussing the case. The short cases were examined differently with each pair of examiners having one case and the candidate going from case to case. Each candidate saw 10 short cases. The cases were similar to those we would expect in the FRACS general surgical examination. My two short cases were a testicular neoplasm and a thyroid tumour. The candidates also undertook an OSCE type exam where they moved from station and discussed a case one on one with the examiner. This was very challenging! As the examiner, you had a list of questions you had to ask as part of the interview but you had only eight minutes. My case was a bleeding duodenal ulcer. I was very impressed how quickly most candidates proceeded on through failed endoscopic control to surgery and how well they handled the operative questions. Overall the candidates' clinical acumen was very good. The pass rate was similar to the FRACS exam.

No visit to Lahore would be complete without the opportunity to see some of the city's historic sites and taste some of the local street food. I was privileged to take a "behind the scenes tour" of the Shahi Qila or Royal Fort with one of the archaeologists as a guide and the College CEO organised for me to attend the Wagah Border Flag Ceremony. Unfortunately, as in many countries with a history of multiple conquerors, many of the sites have been badly damaged. Currently there is a lot of restoration work being undertaken, usually funded by overseas agencies. This has been an opportunity to rekindle many ancient skills such as intricately carving the local sandstone and inlay work with semi-precious stones.

With the passage of time, travel to Pakistan will once again become feasible. When it does a visit will be rewarding – fabulous history, wonderful food and friendly people.

Images (Clockwise from top-left): Main gate to the old city of Lahore; Mike Hollands with Profs. Khalid Gondal and Mahmood Ayyaz; The Court of Examiners.

Who wants to be a Pioneer?

Find stunning, find character, find welcome – sound like you? Read on

PHIL MORREAU
FRACS

To sit on a mountain bike for seven days, to ride over 545 km along the Southern Alps of New Zealand and to climb a total of 15.5 kilometers in the process may not be everyone's idea of a week away from work, but for seven Kiwis Fellows of the College, this was what they paid to do! At the end of their race, covered in mud scratches and smiles Michael Booth, Mike Mackey, Terri Bidwell, Richard Harman, Andrew Gordon, Tony Beavan, Arend Merrie David Ferrar and Phil Morreau all became Pioneers.

Riding in pairs no more than two minutes apart and tracked by GPS units, such multi day mountain bike stage races are uncommon but becoming more popular. Modeled on the famous Cape Epic in South Africa, the Pioneer is in its second year. 338 participants from 17 nations started the event and whilst long and demanding only a fraction were unable to complete it.

A prologue in the purpose built Christchurch Adventure Park on day one separated the real men and woman from the weekend warriors. But that didn't really matter for those not at the pointy end of the race, as we got to know those riding around us. Small rivalries developed within the race to scratch those with a competitive itch but the dominant mood was one of mutual support, mild anxiety about the days ahead and ultimately, overwhelming satisfaction.

The week was fully supported from beginning to end- great food, entertainment, hot showers, and a personal tent erected and relocated at the end of each day. All personal gear was placed in a large bag and found its way to the tents before we did. Sleep was never a problem. The bikes were variably battered and broken but with at least six mechanics on site potentially working until dawn, the riders could keep going. Out on course aide stations kept us hydrated, fed, patched up and repaired. Obviously the times out on course varied but around 90 mins for the prologue was the shortest day and some of us spent close to 11 hours on course as we talked the Queen's Stage. This fifth leg from Lake Ohau to Lake Hawea was a brute of a day comprising 112 km of riding with 3,500m of climbing. There were plenty of relieved and tired bodies rehydrating in the social zone by dusk but mostly an unspoken and internal quiet sense of achievement at having almost passed the test.

Single track, farm tracks, gravel roads and a bit of tarseal made up the route. At times the incline and the surface combined to make us walk but then there were downhills.- ah the downhills.. it is hard to adequately describe these arm arching and heart stopping moments as we flowed and bounced our ways down the hillsides but it certainly needs to be experienced. So long as your brakes hadn't failed it was always safe and totally exhilarating

I was reminded early on day two of the need to concentrate and not be too distracted by the scenery, when a large rock jumped in front of my front wheel, but luckily only a bit of skin and a slightly larger amount of pride were lost.

A week to remember and savour.

So if you think you might want to be a Pioneer or you just want to have a look at some amazing videos and snaps of the Southern Alps check out the website

www.thepioneer.co.nz

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

IN MEMORIAM

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

Brett Adams (NSW)
William Bruce Conolly (NSW)
James Fenton (NZ)
Robert Nall (NSW)
Brian Shearman (VIC)

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: college.act@surgeons.org
NSW: college.nsw@surgeons.org
NZ: college.nz@surgeons.org
QLD: college.qld@surgeons.org
SA: college.sa@surgeons.org
TAS: college.tas@surgeons.org
VIC: college.vic@surgeons.org
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NT: college.nt@surgeons.org

Congratulations!

Professor Joseph Gruss FRCSC

Honorary Fellowship

The Council of the Royal Australasian College of Surgeons admits from time to time distinguished surgeons, scientists and other persons to Honorary Fellowship of the College in recognition of their contributions to Surgery, Surgeons and the College. The purpose of the award is to recognise significant work of eminent individuals in any field of endeavour.

Professor Joseph Gruss is a plastic and craniofacial surgeon and an eminent and distinguished leader in his speciality. Professor Gruss is currently a Professor in the Department of Surgery at Harbour View Medical Centre, Seattle Children's Hospital, and the University Hospital Medical Centre, Seattle, Washington. Professor Gruss holds the Marlys C. Larson Professor and Chair in Craniofacial surgery at the Seattle Children's Hospital and University of Washington School of Medicine. This position is the first fully endowed chair and professorship in craniofacial surgery in the world. Prior to this appointment Professor Gruss was an Associate Professor in the Department of Surgery University in Toronto, Canada.

Professor Gruss is a world leader in the principles of surgical treatment of complex craniofacial trauma, with numerous awards and prestigious lectureships from all corners of the world. In fact it would be fair to say that Professor Gruss revolutionised the modern management of complex craniofacial trauma.

During his time in Toronto and Seattle, Professor Gruss has taught, lectured and mentored many Australian and New Zealand plastic surgery Fellows in the management of complex craniofacial trauma and these Fellows have brought these skills back to Australia and New Zealand.

Professor Gruss has written or co-authored 33 book chapters, three text books and published 115 papers in peer reviewed journals, largely in the plastic and reconstructive surgery literature but also in speciality groups such as neurosurgery, otolaryngology and dermatology literature.

Professor Gruss was a visiting Professor at the University of Auckland in New Zealand in 1993. Concurrently he was the invited guest at the Australia and New Zealand Association of Plastic Surgery post graduate course in plastic surgery.

In April of 2013, Professor Gruss was an Invited Visiting Lecturer to the conference of the Australian Society of Plastic Surgeons in Melbourne. Professor Gruss was also the guest Lecturer for the Trainee's Program and the demonstrator in Craniofacial Techniques at the Master Course which was run concurrently.

Professor Gruss is also the Australasian Foundation for Plastic Surgery BK Rank Lecturer, Plastic Surgery's most prestigious award, last year's ASC.

Professor Gruss has demonstrated not only that he is an eminent world leader in the area of plastic and reconstructive surgery but he has made significant contributions to this speciality in both Australia and New Zealand, over a 25 year period.

Citation kindly provided by Mr Keith Mutimer FRACS, Mr Howard Webster FRACS and Mr Peter Callan FRACS.

Image: Professor Gruss and Professor Watters, President at the ASC 2016

Thank you for your extraordinary kindness and generous support to the Foundation for Surgery.

Every donation makes an incredible difference to help ensure children, families and communities can access safe and quality surgical care when they need it most. Our sincere thanks to these incredible donors who supported the Foundation for Surgery in **February**:

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To find out more, please join us at www.surgeons.org/foundation

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