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ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

DR RUTH MITCHELL

Neurosurgery Trainee becomes co-winner of Nobel Peace Prize

DR BEN DIXON

ENT surgeon conducts world-first robotic surgery

INTERNATIONAL WOMEN'S DAY

Celebrating our Women in Surgery

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Above: The social media storm on International Women's Day 2018.

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The Spring Street redevelopment

The home of the Royal Australasian College of Surgeons (RACS) on Spring Street in Melbourne has become progressively less fit for purpose over the last few decades, particularly the west wing. The original building at the front (south wing) was built in the mid-1930s and the west wing followed in the 1960s, with an expected functional life span of 50 years. The east wing, complete with the Victorian Skills Centre, was developed in the early 2000s. The older buildings no longer meet contemporary work, health and safety standards. As RACS considers the potential redevelopment of the site, we need to consider the broader RACS community, our Fellows, and what they feel is appropriate, now and for the next 50 years we also need to ensure, that the redevelopment reflects the values, needs and vision of that community both in Melbourne and across Australia and New Zealand.

A recent workshop convened at the RACS Spring Street office, which involved Victorian Fellows, staff and Council members, investigated several aspects of a future restructure. It was generally felt that the current Spring Street site projects an image of RACS that is generally unwelcoming, an imposing but traditional organisation that is something of 'an old boy's club', with the site seen as impractical and difficult to navigate and generally dated. Other descriptors used included cold, austere, masculine and intimidating. All workshop attendees however, highly valued the proud tradition the building represents.

It was felt the key purpose of a redevelopment is to provide a place for meeting and socialising for the surgical community, for education and training of surgeons, for recognising and showcasing the surgical profession, for engagement with the public and for projecting the RACS core values, both internally and to the public

When considering the future and what image the site should project, it was felt the site should project a more progressive, forward looking image of RACS as an organisation that is welcoming, diverse, inclusive, socially responsible, and modern while still being proud of its past. Of note is the well-known fact that the front of the building is heritage protected and so this presents some challenges and restrictions on the redevelopment that needs consideration. These challenges relate mainly to retention of the front building and height and style limits on the adjacent buildings.

It was felt the key purpose of a redevelopment is to provide a place for meeting and socialising for the surgical community, for education and training of surgeons, for recognising and showcasing the surgical profession, for engagement with the public and for projecting the RACS core values, both internally and to the public. This could be achieved by a plan that has a wide range of meeting rooms that is multi-purpose and flexible in its design, with smart IT connectivity throughout the building and video conferencing facilities, dedicated space for socialising (e.g. lounge, bar, restaurant or cafe) and flexible, modern education, skills and simulation areas.

A more welcoming entrance on the Spring Street side is an attractive proposition, featuring open plan and naturally bright spaces, with fewer barriers. The aim is for the new building(s) to be architecturally impressive/ award winning, environmentally friendly, sustainable, and inclusive and reflective of our diverse society.

The new design would need to be complementary to the heritage of the historic façade, incorporating a blend of the old and the new. It should include a modern library, a museum, showers and change room facilities, bike storage facilities, and spaces to rent to external parties (meetings, functions etc.) as a potential revenue source, including underground parking. These are all aspects felt to be important for a modern building.

The key stakeholders of the future redevelopment of the west wing are the RACS Fellowship. We would like you all to be involved in this redevelopment, what form it should take and how it reflects our purpose and values.

I encourage you to have your say.

Mr John Batten
President

2016/2017 NZ National Board Annual Photo

Not one nation

He waka eke noa - we are all in this together

The catch phrase of all the New Zealanders around the council table in Melbourne is '*and New Zealand*', as Fellows frequently forget that we are a bi-national College. This was recognised at the last Council meeting in February where a significant part of the meeting was devoted to an update and detailed discussion on the issues faced by Fellows in New Zealand.

It is with pleasure therefore that this month we update you on some of the recent activities of those working diligently on RACS' behalf in New Zealand.

Māori Health Action Plan

This is led by our Māori Health Advisory Group and continues to work towards achieving equitable outcomes from surgical treatments for Māori, equitable representation in surgery and improved cultural competence for all.

New Zealand specific advocacy

Our New Zealand office regularly responds to Government and industry consultations on issues related to ensuring quality surgical care and the health of New Zealanders. Recently, this has included addressing funding for postgraduate surgical training which is currently under threat with a proposed investment funding approach, as well as responding to the Health Select Committee on the Misuse of Drugs (Medicinal Cannabis) Amendment Bill and the New Zealand Transport Agency (NZTA) proposal to raise the speed limit to 110km/h on certain roads.

Other advocacy work continues with regards to prioritization for initial consultations and elective surgery in public hospitals and cancer treatment outcomes. We are very pleased that RACS has adopted a position statement on the Environmental Impact of Surgical Practice, and that the ORA Taiao Call to Action on Climate Change is endorsed by RACS.

International Medical Graduates

The NZ office is also hard at work processing International Medical Graduate applications. Over the past year the number of these applications received has doubled, causing a considerable lift in workload. As some 15 per cent of all surgeons in New Zealand are IMGs, it is a matter of keen interest to New Zealand National Board members that the processes for New Zealand vocationally registered IMGs wishing to attain FRACS are streamlined and simplified.

Building Respect initiatives

The Foundation Skills for Surgical Educators (FSSE) and Operating with Respect (OWR) courses continue to be held in New Zealand, increasingly organisations are seeking to partner with RACS in managing and sharing complaints, and RACS is an active participant in other New Zealand initiatives such as the Professional Behaviours Taskforce and Sexual Harassment Register.

Representation

We are also active in representing RACS to a large number of external stakeholders. This includes the Council of Medical Colleges, the Ministry of Health and our new Health Minister, and to industry groups such as the Prioritisation Working Group, ACC Infection Advisory Group, Resuscitation Council, and HQSC Safe Surgery Programme, among many others.

So remember - not one nation, but *He waka eke noa* - we are all in this together.

Dr Cathy Ferguson
Vice President

"A psychologically healthy workplace fosters employee health and wellbeing while enhancing organizational performance and productivity,"

Sodexo 2017 Global Workplace Trends

Melbourne Trainee becomes co-winner of Nobel Peace prize

In early October last year, Dr Ruth Mitchell, a Neurosurgery Trainee and founding member of the International Campaign to Abolish Nuclear Weapons (ICAN), took some time off after a busy European neurosurgery conference.

As she sat in a café in Florence, she sipped a coffee while keeping an eye on the news tape spooling at the bottom of a nearby TV.

Although she doesn't speak Italian, she clearly understood one news item.

ICAN, which began its life through a series of dinner table conversations in Melbourne in 2006 and 2007, had been awarded the Nobel Peace Prize.

She couldn't believe what she was seeing.

She began to shake. A waiter (for better or worse) brought her another coffee.

Two months later she travelled to Oslo with fellow ICAN campaigners to receive the award at the Oslo City Hall

which had been decorated, to honour their work, with 1000 red and blue paper cranes made by children in Hiroshima.

"It was such a surreal experience to learn about the Prize so far from home," Dr Mitchell said.

"We had a very special time in Oslo and it was great to meet up with old friends who had worked on this from the beginning and the new campaigners, but it was particularly wonderful to feel part of something so much bigger than me or my career."

A former Deputy Chair of the International Physicians for the Prevention of Nuclear War (IPPNW), which was also awarded a Nobel Peace Prize in 1985, Dr Mitchell is the immediate past Chair of the RACS Trainees Association (RACSTA).

She said that she had only returned to working with ICAN in the past year after having devoted herself to her training, PhD research and College work, wanting to contribute the wisdom and skills she had gained through her time on the RACS Council and committees to global peace initiatives.

The Nobel Peace Prize was awarded to ICAN not only for its work to draw attention to the catastrophic impact of nuclear weapons but also for the pivotal role it played in last year's historic UN treaty prohibiting nuclear weapons, a treaty that was signed in July by a vote of 122 countries to one.

"That was the great achievement because we can now say these weapons are illegal and we can begin to exert pressure not only on the countries who own them but also on those institutions and investors who profit from their sale or development," Dr Mitchell said.

"We need the treaty to be ratified by 50 countries and we are now working to get middle powers involved and I think we can expect to see leadership on this from New Zealand.

"The process of stigmatising, outlawing and removing these weapons which prop up the existing world order is not going to happen overnight, but most people know that we either get rid of nuclear weapons or they'll get rid of us."

Dr Mitchell said she was not overawed at the scale of the task because as a former Chair of RACSTA she knows that cultural change is possible.

In 2016 she became the inaugural AMA Doctor-in-Training of the Year, an honour bestowed largely for her work in addressing bullying and sexual harassment in the medical profession.

Dr Mitchell said the results of the six monthly survey of Trainees made it clear to her as Chair of RACSTA that the surgical profession had a problem and she was driven to do all she could to fix it.

She said the 40 per cent response rate to the survey provided RACS with invaluable longitudinal data, the only data set of its kind collated anywhere in the world.

Dr Ruth Mitchell and medical student Lilly May Blackshell, AIDA 2017.

"That data showed we had a problem, that it is gendered, it is not uniform and that it was impacting the ability of some surgical Trainees to care for their patients," she said.

"We could prove and describe the issue confronting the profession and then we had the chance to work with the Expert Advisory Group and RACS Council to overcome it."

Dr Mitchell said significant changes had made a difference including mandatory training around bullying and sexual harassment, the introduction of a surgical educator's course and a complaint mechanism that was becoming increasingly robust and respected.

"As a board, we ensured that Trainees were involved in every step of the process because they were disproportionately affected by these issues but silenced through fear for their future careers," she said.

"We are now seeing change and there have even been some training units that have lost their accreditation to have a Trainee.

"This measure not only reminds everyone that having a Trainee is a privilege, but that losing accreditation comes with a reputational hit which can hurt."

Dr Mitchell is also a passionate advocate for diversity within surgery and last year attended the Australian Indigenous Doctors Association Conference at which she helped run workshops aimed at attracting junior doctors into surgery.

She said of the 25 participants, 23 were young Indigenous women.

"I was in heaven," she laughed.

"It was amazing to see the wonder in their eyes as they worked at the table suturing, but it was even better to be in the position to not just transfer knowledge but experience the thrill of what we do as surgeons in being able to treat and heal the sick and injured.

"The future of surgery is Aboriginal women and I am determined to help because I don't believe we can best serve the broader Australian community until we reflect our community's diversity within the profession.

Whether it's nuclear disarmament or increasing diversity in our profession, I firmly believe the best thing we can ever do is to dismantle the obstacles faced by others because we rise together, not over each other.

"Whether it's nuclear disarmament or increasing diversity in our profession, I firmly believe the best thing we can ever do is to dismantle the obstacles faced by others because we rise together, not over each other.

"No one can change other people's opinions overnight, but if we keep persisting, persuading, listening and connecting I believe great change is possible."

Dr Mitchell is a Neurosurgery Registrar at the Royal Children's Hospital in Melbourne and this year hopes to complete her PhD thesis investigating the role of the epidermal growth factor receptor (EGFR) in the development of glioblastoma multiforme (GBM).

Karen Murphy
Surgical News Journalist

ENT surgeon conducts world first robotic surgery

Left:
Dr Ben Dixon (left) and Dr Matthew Magarey (right) during the case.

Victorian Head and Neck Surgeon Dr Ben Dixon has conducted what is believed to be the world's first paediatric resection of a retropharyngeal tumour using Trans-Oral Robotic Surgery (TORS).

Dr Dixon conducted the procedure at the Epworth Hospital in Melbourne to remove a rare sarcoma that scores of surgeons from around the world had decided was too difficult or dangerous to reach.

The six year old child had a rare retropharyngeal clear-cell sarcoma, along with other tumours around the head and neck region, located between her throat and her carotid artery behind the palate.

Dr Dixon designed a surgical plan in collaboration with paediatric surgeons from the Royal Children's Hospital Melbourne and paediatric oncologists from the Sydney Children's Hospital and operated on Freyja Christiansen in early March.

He said that while the tumour was in a difficult position, he believed the da Vinci robotic system would allow him to work well in the constricted space.

Working alongside fellow ENT surgeon Dr Matthew Magarey, Dr Dixon reached the tumour through Freyja's mouth via an incision between the palate and jaw, and inserted 3D cameras and instruments through the side of the throat and in behind the hard palate.

The surgery, which took only an hour, proved a success and was followed a week later by another procedure to remove tumours in the neck.

Dr Dixon is the Chair of the Epworth Hospital Head and Neck Multidisciplinary Service and has expertise in head and neck tumour surgery, parotid gland and parapharyngeal tumour surgery, thyroid and sinus surgery.

He established the TORS program for throat cancer at the Peter MacCallum Centre and is one of Australia's most experienced TORS surgeons.

> We first had to weigh up the risks and benefits of conducting the procedure, but we knew that if we were going to try and remove the tumour, it was best done via robotic surgery because you simply can't manoeuvre well enough by hand with traditional instruments and a head light in that area.

"We first had to weigh up the risks and benefits of conducting the procedure, but we knew that if we were going to try and remove the tumour, it was best done via robotic surgery because you simply can't manoeuvre well enough by hand with traditional instruments and a head light in that area.

"The other alternative was open surgery requiring splitting the jaw and lip which would have caused much greater morbidity, but I felt reasonably comfortable we could manage her well using TORS.

From left: A vertical action shot of an operating room featuring the *da Vinci* Si Surgical System; Dr Ben Dixon and Freyja.

"A more radical resection may have necessitated a tracheostomy and free flap reconstruction- something I really wanted to avoid."

Freyja was diagnosed with the aggressive cancer in 2016 after specialists found tumours positioned precariously close to the main artery at the base of her skull.

Yet, while she has the misfortune to be one of the youngest patients diagnosed with the rare disease, she is also one of the youngest to receive immunotherapy.

It was her strong response to such therapy in the months leading up to the surgeries that convinced Dr Dixon to proceed given that he knew he could not offer a cure with surgery alone.

"Freyja became the first person with this condition treated with an immunotherapy regime which reduced the metabolic activity of the tumours as seen on PET scans," Dr Dixon said.

"The cancer wasn't completely dead, but the tumours had reduced in size and we believed that surgery could help her by reducing the burden of disease.

"She continues to have a very poor long-term prognosis, but we believe the surgery will give her an increased chance of survival by giving her time to undergo further immune therapy along with radiotherapy. At this stage, we really don't know what options might be around the corner."

Dr Dixon said his main concern related to how Freyja would respond to the initial surgery, particularly the risk of swelling around her airway and voice box in the hours following.

"The Epworth does not have a dedicated paediatric ICU, so we invited Paediatric ENT Surgeon Dr Sarah Morrison to come over from the Royal Children's Hospital.

"We were worried that we may have to leave the breathing tube in or do a tracheotomy and if so, we would have transferred her, but she did very well.

"We then waited for her throat to heal before we went in again and conducted a neck dissection and parotidectomy to remove the remaining neck disease.

"We took all the tumours we could see but multiple lymph nodes are involved along with some tumour cells in the maxilla leaving microscopic disease which we hope can be tackled through adjuvant therapies.

"More radical surgery is unlikely to provide her with any survival benefit but would certainly massively increase her side effects."

At the time of the operation, Freyja's mother Lizzie told media outlets that 37 surgeons from around the world had told her the tumour near the carotid artery was inoperable until a phone call to Boston Children's Hospital gave her the name of Melbourne head and neck surgeon Dr Ben Dixon.

She was quoted as saying: "We were willing to fly anywhere in the world but the fact that we had the skills and the technology in Melbourne was amazing."

Since conducting the procedure, Dr Dixon has had a chance to review the literature and believes the case to be a novel one.

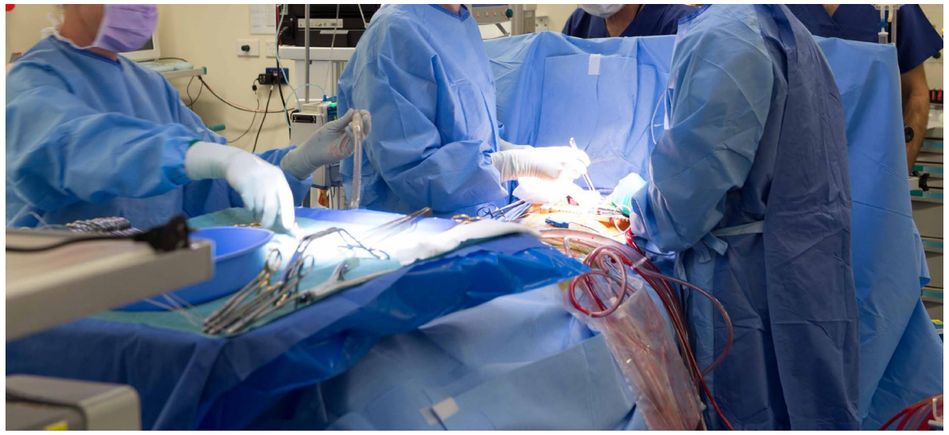
"We believe it is the first paediatric retropharyngeal tumour treated using TORS in the world and the first TORS conducted on a child in Australia," he said.

He is now in the process of writing up the procedure for medical journals and said he believed it could open new pathways of treatment for such rare and inaccessible paediatric head and neck tumours.

"I believe there may well be other tumours in the head and neck region of children that can be safely excised robotically," Dr Dixon said.

"The key will always be, however, selecting patients who are likely to respond well to surgery and having them treated by surgeons who are familiar with a range of techniques including TORS."

Karen Murphy
Surgical News Journalist



Operative experience

Convener Trainee's Section 2018 ASC

I am yet to meet a Surgical Trainee who thinks they are getting enough operative experience. Part of this is probably due to the longstanding generational game of '*when I was a Trainee I was doing...*', But there is a very real perception from Trainees and supervisors that Trainees are getting less operative experience and performing less primary operating than in previous generations.

As a current Trainee it is an issue that is close to home. This year I am convening the Trainee's section at the 2018 Annual Scientific Congress and I have organised an expert panel of local and international speakers to explore the issue of operative experience and its increasing relevance in the modern health care environment.

The reasons underlying this real or perceived change over the decades are no doubt complex. The perception may stem from the anxiety of not yet being a competent surgeon. However, other likely factors include changes: in patient and community expectations; working hours and Trainee numbers; legal liability; hospital administration; and changes to hospital culture.

It is without question that we hold the treatment and safety of our patients as our utmost priority. Fortunately, evidence shows that outcomes are unchanged when Trainees are primary operators[1]. However, the safety of future patients treated by less experienced surgeons is less tangible. Without operative experience we risk deskilling a generation.

The ethics and legalities regarding Trainees as primary operators are continually developing. At the administrative and government level there is growing concern about potential litigation, and a movement towards allowing restrictions on Trainee involvement. This is furthered by a rather tenuous understanding of the Trainee as primary operator by the public, despite the long tradition of its practice. A recent case involving an Ophthalmology Trainee in New Zealand highlighted that a patient can refuse to have a Trainee even observe a procedure[2], the sentiment being that the Trainee plays no other role in the patient's care other than 'practicing' on them.

Trainees are integral members of a team providing a service to the patient, and their role should not be understated. Lessening the role of the Trainee is short sighted and would fundamentally de-skill a health system currently dependent on their service and banking on their leadership in future.

In my experience it has been rare that a patient refuses to have a Trainee involved in their care, but it is not uncommon for a patient to request that the consultant surgeon performs their procedure. I suspect at other times the patient may not know who will perform their procedure, or there may be a 'don't ask, don't tell' position taken, avoiding a difficult conversation.

Of course this concept applies more broadly than to the surgical Trainee. Many junior staff influence patient care. Will there be a refusal to allow a junior radiographer to take an x-ray, or the new graduate nurse take the vital signs? On the surface these tasks may not seem as significant as a surgical procedure, but they still influence a patient's treatment and recovery. It is not hard to find more significant examples: an anaesthetic registrar intubating; the intensive care registrar leading resuscitation; or the newly employed pathology technician sectioning a specimen.

More broadly thinking, it has been popular to contrast surgical safety with the Aviation industry. However, when I fly I don't expect the Captain will land every plane. I expect it is the First Officer with a level of oversight to ensure the landing is performed safely.

The reality is that most if not all industries rely on junior staff, and training them is part of the process of workforce renewal. Surgery and healthcare are no different. A restriction to the work of Trainees in healthcare would cripple the system and have significant implications for future patient care and safety.

Deficiencies in operating experience amongst current Trainees may be real or perceived. In any case it is the right time to start the discussion regarding the roles and responsibilities of the Trainee surgeon as part of a health care team, and maintain the culture of training for our future trainees.

If the subject of operative experience interests you, the panel discussion will be held immediately after the opening plenary on the first day of the 2018 ASC and promises to be an engaging and topical discussion.

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Dr Philip Chia
Trainee Convener, ASC 2018

The Major Trauma National Clinical Network

Improving trauma care in New Zealand

In 2010, New Zealand's National Health Board (since disestablished) was tasked with reviewing the country's trauma services. The Board made several important findings:

- That patient care was highly vulnerable to time-critical clinical response and decision making;
- Mortality and morbidity (around 20 per cent) could be avoided in many circumstances;
- Service quality and patient outcomes varied widely; and,
- Information for health services about how to respond to major trauma was not widely available.

In response to these findings, the Major Trauma National Clinical Network (MTNCN) was established in 2012 with the aim of improving the quality of trauma care in New Zealand and bringing the country's trauma system into line with international best practice. Representing all 20 of New Zealand's District Health Boards (DHBs), the MTNCN is comprised of management and senior clinical leads from across all four of New Zealand's regional trauma networks: the Northern Region, Midland Trauma, Central Region and the South Island.

This national approach to trauma care places the MTNCN in a relatively unique position among its contemporaries rather than focus on trauma systems at an individual region, the MTNCN seeks to institute systems of care and produce results at a national level. In order to achieve this grand task, the MTNCN set three initial priorities upon its creation; establish a formal trauma system, establish a national registry, and develop nationally consistent guidelines.

Over the past five years, the MTNCN has been hard at work establishing a formal trauma system for New Zealand. This formal trauma system is comprised of multi-disciplinary regional trauma networks in each of the four regions, which are brought together under the umbrella of a national trauma network. The network is supported by regular trauma symposiums and educational forums, roadshows to assist with professional development, and a website to act as a repository of information about the network.

The MTNCN has also been working to develop nationally consistent trauma guidelines. This has included the Optimal Trauma Care Guidelines published by RACS, the Spinal Cord Impairment Destination Policy for NZ, and the Major Trauma Triage Policy for Ambulance Officers. Considering how time critical clinical responses and decision making are to optimal outcomes in trauma care, having nationally consistent trauma guidelines are an important element in ensuring that trauma patients have the best possible chance at a positive outcome.

The third and final priority for the MTNCN in its first five years was to establish a national trauma registry. The New Zealand – Major Trauma Registry (NZ-MTR) began collecting data on 1 July 2015. For the 2015/16 and 2016/17 periods respectively, 1301 and 1666 patients were entered into the NZ-MTR, representing a total of 2967 patients in the two years since the registry began. However, the registry has only had full national coverage since the end of 2017; the 2017/18 period will therefore be the first time that New Zealand has had a complete picture of major trauma across the country. It is expected that this will represent around 2000 patients being entered into the registry each year.

In January, the Network published its second Major Trauma Annual Report, providing an insight into the NZ-MTR's key findings for 2016-17.[1] Data from the registry shows that New Zealand, as an entire country, has an incidence of major trauma at around 35.5 cases per 100,000 population – a number which is relatively consistent with the incidence of other similar nations. There is a noticeable degree of regional variation however, with the Central and South Island (which currently only includes full data for Canterbury and South Canterbury) having incidences of 46 and 52 per 100,000 respectively. As the registry collects a more comprehensive data set, analysis in subsequent years should show whether this is a sustained trend.

Within New Zealand's major trauma, 52.5 per cent of cases are categorised as road traffic crashes, a group which includes vehicle occupants, motorcyclists, cyclists and pedestrians. New Zealand has collected data relating to its road toll for decades, but the extent of the true burden of death and serious injury has never really been known as the injury definitions for serious injury have not been as comprehensive as the trauma definitions. As its data grows, the NZ-MTR will provide a much clearer picture of the burden of road crashes on society in general by collecting data on the combination of pre-hospital mortality, hospital mortality, and hospital survival and serious injury.

In summary, five years on from its founding the MTNCN has substantially achieved all three of its initial priorities. 2016-17 was a year for the MTNCN to consolidate on its work so far and create a strong foundation from which to drive quality improvement in trauma across New Zealand. Work has now begun on developing a new strategic direction for the MTNCN where it can build on its past successes and strive towards achieving its ultimate goal of implementing a contemporary trauma system in New Zealand.

Four key priorities have been identified for 2017-18:

1) Improve national consistency across training, audit, review, pathways and quality assurance of data
2) Support a more sustainable funding model for the Network
3) Develop a business case for a national trauma research centre
4) Continue quality improvements across the trauma pathway

The MTNCN has thus far been supported by funding from the Accident Compensation Corporation (ACC) and New Zealand's Ministry of Health. It is hoped that this support will on-going so that the MTNCN can continue to improve the quality of New Zealand's trauma system for the benefit of all New Zealanders.

An article on the verification of the New Zealand trauma system will feature in next month's Surgical News. – Ed.

1 Visit www.majortrauma.nz for a full copy of the 2016-17 Major Trauma Annual Report.

Professor Ian Civil
RACS past President

with Calum Barrett, Policy & Communications Officer

International expertise at this year's ASC

The 87th Annual Scientific Congress (ASC) will be held in Sydney from Monday 7 May 2018 until Friday 11 May 2018 at the International Convention Centre, Darling Harbour. This meeting will be held in conjunction with the Australian and New Zealand College of Anaesthetists (ANZCA) and in partnership with the American College of Surgeons (ACS), which has given us the opportunity to include many distinguished speakers and interesting content.

The 10th Developing a Career and Skills in Academic Surgery course (DCAS) will be held on Monday 7 May 2018. The faculty will consist of a large contingent of dynamic academic surgeons from the USA and Australasia and the course is designed to inspire surgeons and Trainees alike.

The Convocation on Monday night 7 May 2018 will feature the Syme Oration given by Vice Admiral Raquel Bono, a highly decorated surgeon who is a Vice Admiral in the United States Navy. She currently serves as the director of the Defence Health Agency. This year's British Journal of Surgery lecturer will be Associate Professor Rachel Kelz from Philadelphia and the ANZ Journal of Surgery lecturer will be Professor Ian Harris from Sydney.

The Plenary sessions will cover a wide range of topics. The ASC will commence on Tuesday 8 May with a Plenary session titled "*Choosing wisely. Decision making in end of life care- the patient matters*", presented by both RACS and ANZCA. It will be an interactive session that will involve a number of case scenarios. Wednesday's Plenary session, "*Leadership Matters*" will feature the British Journal of Surgery Lecture by Associate Prof. Rachel Kelz, and three other luminaries who will speak about different aspects of surgical leadership. The ACS will present the Plenary session on Thursday 10 May, which will focus on what measures the College has taken in the quality and safety sphere. The final Plenary session of the ASC on Friday 11 May, "*Keeping the passion alive: surviving 21st century practice*", will be presented in conjunction with ANZCA and promises to be a thought-provoking session, exploring issues such as resilience and developing a workplace culture that reduces the incidence of burnout.

Dame Clare Marx, DBE.DL.FRCS Immediate Past President RCSEng, will reflect on Leadership, resilience and the independent review she is leading for the GMC of Gross Negligence Manslaughter and how it is applied to medical practice in the UK.

The session (Chaired by RACS President John Batten and Philip Chia) Thursday afternoon in the Trainees program will include an interactive polling system and will explore how GNM cases are initiated and investigated.

The ASC will again feature a varied range of masterclasses organised by both RACS and ANZCA. Some of these sessions have limited places, so we would encourage you to register early to avoid missing out. The section conveners have constructed a comprehensive program involving both international and local experts, and sessions that are combined with ANZCA.

The International Convention Centre at Darling Harbour will provide a spectacular backdrop of city views for the ASC Banquet, which will be held on Thursday 10 May. We recommend that you register early for the Banquet, as places are likely to sell out quickly.

This year is the first time the ASC will have been held in Sydney for nearly ten years, and a very stimulating and informative program has been developed. We look forward to welcoming you to what will be an outstanding event in Sydney this May.

Arthur Richardson and Julie Howle
ASC – Convenor and Scientific Convenor

Sugar and tax – it's now time for granulation

Dr BB-Gloved told the tale of Sue Sweet and Stu Lumpee in the recent edition of *Surgical News*. We are increasingly familiar with the consequences of diabetes and obesity. We recognise change needs to occur. However, like Sue and Stu, we are not succeeding.

The sugar tax recommended by the World Health Organisation has resulted in a handful of countries initiating the fight against sugar, taking aim at soft drinks. Despite being well intentioned, the marginal price increase in soft drinks will likely only have a modest impact on consumption.

Soft drink manufactures will strongly resist change that will diminish product sales. They will repeatedly demonstrate the 4D's raised by Dr BB Gloved – deflect, deny, discredit, delay. There are many means to alter behaviour, and the price of a product is only one determinant. Socially desirable behaviours are strongly influenced by marketing. Companies invest large amounts of money to promote goods. Advertising works but perhaps it is possible to exploit the tax treatment of the corporate advertising budget in the Australian context to produce a more nuanced impact on soft drink consumption without raising the price of the product to consumers.

An alternative to a 'sugar tax' may be a business incentive for companies to reduce high sugar soft drink promotion, resulting in a secondary change in consumer behaviour. Two changes are proposed to the taxation of the advertising budget of soft drink manufacturers:

Advertising and promotional expenditure is not all tax deductible for manufacturers of soft drinks.

This denial of deductibility would be applied in the same proportion as the revenue the company earns from the sale of high sugar sweetened drinks. The greater proportion of low sugar products sold, the greater the proportion of deductibility. Thus, the policy becomes 'outcomes focussed', providing a strong incentive to the company to achieve a desirable social outcome.

The imposition of a tax equal to the size of the advertising budget for full sugar soft drinks.

This would vary in direct proportion to the value of sugar and non-sugar sweetened products sold. Companies have the potential to reduce this figure to zero in the case of all revenue coming from non-sugar sweetened drinks. Additionally, this tax imposition results in a great cost increase for companies to promote drinks with large amounts of sugar.

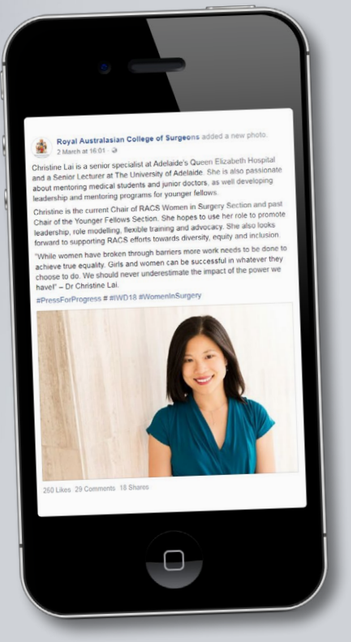
The product mix revenue will be based on sales from the previous financial year. The deduction and potential tax penalty will occur in the current financial year. Consumers should not have to bear the cost of this scheme, as companies may choose how to distribute their promotional budget and could potentially reduce the impact to zero by not earning revenue from sugar containing drinks.

The two-fold effect of the 'sugar tax' would provide a potent incentive for manufacturers to change their conduct of business. They are encouraged and rewarded to produce and promote low sugar alternatives. Obesity and sugar has become a taxing issue, with the risk of Australia becoming a nation of Sue and Stu's.

Professor George Kiroff
Upper Gastrointestinal Surgeon,
Central Adelaide Local Health Network, SA
and Dr Lina Hua, General Surgical Registrar

International Women's Day 2018

Celebrating women in surgery



Started by the suffragettes in the early 1900's, the first International Women's Day (IWD) was celebrated in 1911 and International Women's Day continues to be celebrated by communities all over the world. The theme for IWD 2018 was #PressforProgress, a strong call to motivate and unite friends, colleagues and whole communities to think, act and be gender inclusive. This March, the Royal Australasian College of Surgeons (RACS) conducted a social media campaign to celebrate International Women's Day (IWD) and recognise a number of inspiring female surgeons.

The campaign – titled *Celebrating Women in Surgery* – launched a week before International Women's Day and continued until 11 March 2018. We took a multichannel approach for this year's campaign, utilising the RACS Twitter, Facebook and LinkedIn platforms in tandem with traditional media activities to spread the message. The individuals profiled in our social media campaign were a diverse group made up of RACS pioneers, leaders, volunteers, trainees and international medical graduates as well as inspiring Indigenous and Maori surgeons.

RACS posts made over 300,000 impressions on social media across the dates of our social media campaign with overall impressions peaking (almost 100,000 combined) over the 7th and 8th of March 2018 – coinciding with the date of International Women's Day. Posts were liked, commented on and shared over 9000 times throughout the campaign, with the highest number of engagements happening on the RACS Facebook page. Engagement peaked on the 8th of March with over 1,500 combined engagements on that day alone.

Some of our most popular posts featured surgeons such as Christine Lai, Maxine Ronald, Ruth Mitchell, Liz McLeod, Jenny Chambers and Claudia Paul among many other inspiring and dedicated female surgeons. The campaign also received many messages of support, with many individuals wishing to nominate other surgeons for their contributions to surgery. While we were not able feature every nomination we received throughout this year's campaign, we were grateful to have been able to share some of the achievements and stories of women in surgery. We would love to keep hearing more inspiring stories, so if you know someone around you that is doing some great work or has an interesting story to tell, please get in touch with the RACS Communications Team and tell us all about it.

Highlights

Christine Lai

Christine Lai is a senior specialist at Adelaide's Queen Elizabeth Hospital and a Senior Lecturer at The University of Adelaide. She is also passionate about mentoring medical students and junior doctors, as well developing leadership and mentoring programs for younger fellows.

Christine is the current Chair of RACS Women in Surgery Section and past Chair of the Younger Fellows Section. She hopes to use her role to promote leadership, role modelling, flexible training and advocacy. She also looks forward to supporting RACS efforts towards diversity, equity and inclusion.

"While women have broken through barriers more work needs to be done to achieve true equality. Girls and women can be successful in whatever they choose to do. We should never underestimate the impact of the power we have!" – Dr Christine Lai. **#PressForProgress #IWD18 #WomenInSurgery**

Rachelle Love

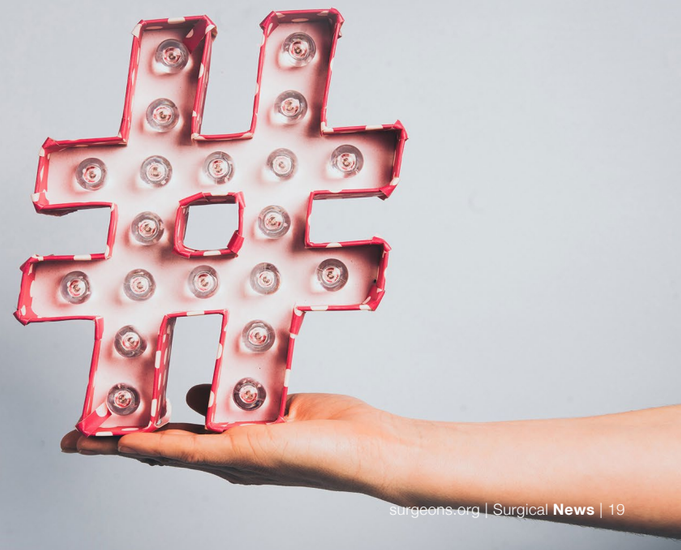
Dr Rachelle Love is RACS' first New Zealand trained Māori female ENT surgeon and was awarded her Fellowship in Otolaryngology Head and Neck surgery in 2017. "There have been times when I have felt alone as there aren't many other Māori women surgeons. I think that is important for people to see themselves in you. The more Māori surgeons you have, the more medical students will come through and see that they can have the kind of life that they want in surgery. "I have been very fortunate with the opportunities that I have had so far; I hope now that I can inspire other Māori women and help them to take their own opportunities," Rachelle says. **#PressforProgress #IWD2018 #WomenInSurgery**

Ruth Mitchell

Ruth Mitchell is a registrar at the Royal Children's Hospital Melbourne and a PhD candidate at the University of Melbourne. She was the inaugural AMA Doctor in Training of the Year in 2016, noted for her work as the Chair of the Royal Australasian College of Surgeons Trainees' Association (RACSTA). She has previously served as Deputy Chair of the Board of the International Physicians for the Prevention of Nuclear War and Vice President of the Medical Association for the Prevention of War.

Ruth Mitchell was part of a campaign that won a Nobel Peace Prize, the International Campaign to Abolish Nuclear Weapons (ICAN). ICAN was awarded the 2017 Nobel Peace Prize "for its work to draw attention to the catastrophic humanitarian consequences of any use of nuclear weapons and for its groundbreaking efforts to achieve a treaty-based prohibition of such weapons". **#PressforProgress #IWD2018 #WomenInSurgery**

Agron Dauti, Digital Media & Internal Communications Coordinator, RACS



Greg Witherow:
a high-flying surgeon

One of RACS' Specialty Elected Council members is a high flyer, quite literally. According to the 2017 *Australian Macquarie Dictionary* a high flyer is 'a person of great ability who achieves career success at a very high level'. According to the same dictionary, a high flyer is also 'someone or something that flies high'. This is also correct, as *Surgical News* found out when talking with Dr Greg Witherow, an Orthopaedic Surgeon and trainee pilot from Western Australia.

high-flyer
noun

1. a person of great ability who achieves career success at a very high level
2. someone or something that flies high

Dr Witherow, who holds a recreational pilot licence, is in training to gain his private licence which will enable him to navigate, fly and land anywhere.

"I've been training at the Royal Aero Club of WA in Jandikot for 18 months. I was inspired to learn how to fly after my student elective in PNG, and hope that one day I can use it for work and pleasure".

When Greg isn't up in the sky, you'll find him running his Orthopaedic practice in West Perth. The practice, which runs out of the Perth Orthopaedic and Sports Medicine Clinic comprises thirteen surgeons, a far cry from when Greg joined Keith Holt in 1992.

"I get great pleasure from benefiting people with what I do. I love the autonomy of being self-employed, and I have a large group of staff and patients who I enjoy working with a lot", he said.

It may not have turned out like this though, as Greg explained. He was all set to be an engineer until someone steered him in a completely different direction.

"Originally I thought I was going to do Engineering at University, but my high school Principal had another idea. Maybe it was my personality, or my nature, but he encouraged me to consider medicine instead.

"I didn't know anyone in medicine at that age. I'd had next to no exposure to it, other than knowing that the man down the street was a GP".

Greg went on to graduate in 1981 from Melbourne University, initially thinking he would be a GP, but by the end of his first year, and as the *Macquarie Dictionary* has confirmed, his drive and enthusiasm led him to greater pursuits – surgery. Then, while on rotation as a trainee he decided on orthopaedics, and was encouraged and supported to do so.

"As a trainee I remember doing cardiothoracic surgery on the weekend. We had to do a redo coronary artery graft, and everything went wrong. Somehow, the right ventricle got cut in half and blood went everywhere. The patient survived, but that experience was enough for me to think more seriously about orthopaedics as a future (alternative) option!

I tried to play golf afterwards, stood on the first tee, and missed the ball entirely. I was still so shaken up by the experience", he said.

On the recommendation from eminent Orthopaedic Surgeon Dr Brendan Dooley, FRACS, Greg packed his bags and took his new wife, Catherine, to Perth to start a new life. Catherine and Greg still reside in Perth despite both being born and growing up in Melbourne. "I actually met my wife on the practice putting green. I was 26 at the time and was well impressed with her swing. We've been golfing together ever since.

"If there's one thing I can say about the key to a lasting relationship, it is to share things, other than your children, with each other, be it travel, leisure or sport… it's very important", he said.

Obtaining his Orthopaedic Fellowship in 1990, Greg then undertook a Fellowship in Sports Medicine and Arthroplasty at the North Sydney Orthopaedic and Sports Medicine Centre. In 1991, he travelled to the UK to complete a Fellowship in Arthroplasty at the National Orthopaedic Hospital in Birmingham.

Returning to Australia in 1992 he joined Keith Holt at the Perth Orthopaedic and Sports Medicine Centre.

When asked what his motivation was to become a part of RACS Council, meaning he would need to travel to Melbourne every three months, Greg reemphasised his need to make a difference.

"Before joining RACS Council I had been involved with the Australian Orthopaedic Association (AOA). I knew that the relationship between the College and the AOA was at times challenging, so I thought that this was definitely something I could make a meaningful contribution to. I'd like to be able to redefine this relationship for the benefit of both," he said.

Greg has been on RACS Council as a Specialist Elected member for three years and will continue his commitment to the group until later this year when annual Council Elections determine membership.

Self-described as 'confident' and 'loud', Greg hopes his attitude and his work with RACS Council will impact on our future Fellows.

"I encourage all Trainees to seize opportunities when they arise, remain optimistic and confident in the skills you have to achieve success, work hard and aim high".

Gabrielle Forman,
Communications and Policy

Images:
(Left) Greg and Catherine Witherow, Tivoli gardens Copenhagen.

(Opposite) Family Xmas diving holiday Wakatobi Eastern Sulawesi 2016.

Dr Ailene Fitzgerald

Patient focussed trauma care in the ACT

The Australian Capital Territory (ACT) is undergoing a decade long redesign of its health services. It is a bit sad that we have to designate 'patient-focused care' as a major priority of the redesign. As clinicians, I am sure we like to think that our work is ultimately patient-focused - be it through the provision of direct patient care, teaching, revising protocols, reviewing literature or attending quality assurance activities.

Surely our consistent aim is patient-focused care. So why the need to 'guide its establishment'? Could it be that our ability to holistically care for patients is impeded by administrative or other processes? Do clinicians, administrators and politicians share the same perception of what patient-focused care looks like? What about the perception and expectation of patients?

Clinicians and administrators must collaborate thoughtfully and respectfully to understand each other's views and determine the best way forward. Clinicians must attempt to understand the political pressures, competing priorities and complex issues that administrators face.

Administrators must truly listen to clinicians and understand the daily challenges they face, where often the quality of patient care able to be provided is heavily influenced by limitations within the system. Often senior clinicians are uniquely placed to provide complex, well-considered, reasonable solutions to challenging issues. Both clinicians and administrators must listen to patients and their families as they often have unique insights of the system's strengths and failings from which we can learn.

Health economics plays a significant role in determining service delivery. Asking clinicians to put forward a business case for improved patient care highlights the tension between sustainability of expenditure and best practice. Often the true economic value of service improvement gets lost in the narrow process of costing a specific resource and comparing it to a proposed potential saving within the restraints of that service's budget.

Yet good fiscal management and best patient outcomes need not be mutually exclusive. Perhaps if we were to focus more on overall quality of care throughout the patient journey, from injury prevention to acute care to rehabilitation and reintegration back into the community and return to work, the true economic burden to society would lessen.

Trauma care is an excellent example. Once perceived to be the domain of general surgeons, present day trauma care is largely comprised of critical care and non-operative management of blunt multi-trauma patients. Surgical intervention when required is predominantly handled by orthopaedic surgeons and other sub-specialties.

That is not to say that general surgeons shouldn't maintain an interest in trauma management, but clearly the model in the ACT where all general surgeons working at a Major Trauma Centre are required to be trauma consultants is outdated and does not deliver best patient outcomes.

Trauma care should be left to those that wish to pursue a sub-specialty interest in this area, and to clinicians who feel comfortable with time critical decision-making in the acute management of multiply-injured patients. Trauma resuscitation in Australian Major Trauma Centres is often led by Critical Care Consultants as team leaders, with surgical decision making the domain of the relevant proceduralist in collaboration with the team leader.

In many of Australia's Major Trauma Centres, a multi-disciplinary trauma consultant roster involving critical care specialists and surgeons has been successfully implemented. Probably the most important factor in the success of these teams is collaboration among different sub-specialties to ensure appropriate and timely management of all injuries.

This model recognises that no one specialist has all the necessary knowledge and skills to provide holistic care to the multiply injured. Implementing such a model requires a great deal of dedication by the clinicians involved and a willingness by administrators to put their faith in the expertise, dedication and knowledge of their senior clinicians. In the ACT, it has been a long journey to persuade general surgeons and administrators of the need to implement a best practice model.

Systems of care which truly support patients and modern day best practice are only possible through careful, considered collaboration between administrators and clinicians. As clinicians we must also be prepared to continually evaluate and adapt to ensure we are truly providing the best care possible.

Read RACS ACT's submission to the Legislative Assembly's inquiry into the future sustainability of health funding in the ACT here: https://www.surgeons.org/college-advocacy/.

Ailene Fitzgerald
ACT Chair

RACS Post Op podcasts

Check out the interviews with some of the most inspiring and forward-thinking industry professionals.

Developed by RACS the Post Op Podcasts feature extended interviews on the latest research across the medical industry as well as practical advice that surgeons can implement in their practices, such as insights on financial management, wealth creation, legal and tax advice and economic forecasts.

You can subscribe to the fortnightly RACS Post Op Podcasts on Apple's iTunes or, for those with other smartphone models, on Stitcher.

Listen on iTunes
https://itunes.apple.com/au/podcast/racs-post-op-podcast/id1125227899?mt=2

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Supporting a new generation of academic surgeons

The inaugural recipient of the Foundation for Surgery Senior Lecturer Fellowship used the funds to establish research collaborations, design surgical education modules, create teaching materials around new technological learning tools and conduct wide-ranging surgical outcomes research.

Dr Sarah Aitken described the Fellowship as one of RACS's great initiatives designed to support and encourage a new generation of academic surgeons who are committed to developing surgical teaching and research across Australia.

She said the funding provided younger academic surgeons like herself with the freedom required not only to pursue their own research interests, but to work with other academic surgeons to improve surgical training, teaching and patient outcomes across all specialties.

Dr Aitken is a Vascular surgeon, PhD Candidate and Senior Lecturer at the University of Sydney, Concord Clinical School. She received the Fellowship in 2015.

During the three years of funding provided, she has:

- Co-established the Concord Institute of Academic Surgery to unite, under one umbrella, the substantial research output produced by the hospital and promote academic surgery;
- Conducted epidemiological, statistical and qualitative PhD research into the outcomes of older patients having vascular surgery in New South Wales;
- Designed a 'Junior Doctors as Teachers' course via video modules to train residents in the mindset and skills needed to teach their colleagues and enhance clinical decision-making skills; and
- Developed anatomical teaching methods based on the 'Anatomage' (virtual cadaver) program now in use at her medical school.

Dr Aitken said that without the Fellowship she would not have had the time to devote to such initiatives, most of which are now an established part of surgical training at Concord or continued in self-sustaining collaborations.

"The 'Junior Doctors as Teachers' course is now mandatory for any young doctors who wish to do tutorials. Since its introduction we have found they are more confident in their teaching while students found a marked increase in the clarity of information provided," she said.

"I was always very keen to enhance anatomy training for our junior doctors because many of them lose that knowledge in their first years out of medical school, and only have the time to learn and refresh their knowledge after-hours or in alternative teaching venues.

"The Anatomage (virtual cadaver) program can fill that gap, but it took considerable research to understand how best to teach this model because it is not the traditional way we teach anatomy, being closer to CT scans.

"This is now available to all junior doctors at Concord and in three years we have had 50 junior doctors go through the eight-week anatomy program. Furthermore, 10 have completed an ultrasound program and 25 junior doctors have completed the teaching course."

Dr Aitken said the Fellowship had allowed her to build her confidence as an academic surgeon and think strategically about surgical research conducted throughout Concord Clinical School.

She said that while Concord Hospital produced a significant volume of research output, it had often not been recognised because each unit and department conducted and published its work separately.

She co-established the Concord Institute of Academic Surgery to create a more unified voice.

"We have now enhanced collegiality and enthusiasm by bringing surgical research to the forefront of surgical care and by creating cross-specialty collaborations.

"We have a very active Geriatric department at Concord and so we have also developed collaborations between them, Vascular and Colorectal surgery and Urology and we are looking to broaden that to other specialties.

SUCCESSFUL SCHOLAR

"One of the best aspects of this Fellowship is that it gave me the time to set up and encourage such collaborations which are now self-sustaining and being driven by others."

Dr Aitken's PhD research aims to understand the trends and outcomes of vascular surgery in older patients, identify patient expectations and values and explore the relationship between prognostic factors and surgical outcomes.

To do this, she first had to find out how many people had vascular surgery in NSW because these statistics had not recently been reported.

Trawling through two million coded hospital records, she found that between 2010 and 2012, a total of 95,000 patients had vascular surgery with three quarters of those vascular hospital admissions. The average age of patients was 76 years and the all-cause mortality rate was 15 per cent within three years.

She said that while this indicated the severity of comorbidities in many older vascular patients, it was vital for Vascular Surgeons to understand the implications.

"This high mortality rate means that we should be designing our surgical treatments with this in mind," Dr Aitken said.

"Often there is a perception by surgeons that if we can do a procedure we should do it. But results for older patients can vary dramatically in terms of functional independence and cognition.

"Until now, we haven't had sufficient information to answer certain patient questions and we need to start asking ourselves whether what we're trying to achieve surgically meets patient's expectations."

Dr Aitken also conducted qualitative research as part of her PhD, interviewing vascular patients at Concord Hospital to understand their priorities and concerns.

She said many indicated that they would prefer to avoid major procedures for fear of losing their independence and being forced to enter a nursing home before they wished to.

She said post-operative delirium had been linked to adverse outcomes in older vascular patients. Geriatricians should play a more central role in the care of older vascular surgical patients because if they provide care, in conjunction with targeted rehabilitation therapy, it may improve patient outcomes.

"These issues need to be at the forefront of our thinking because we owe it to patients in an aging society to be able to clearly list the risks and benefits of what we do."

Dr Aitken hopes to have her thesis completed by the end of the year.

She thanked RACS for its support.

This Senior Lecturer Fellowship allowed me to concentrate on academic surgery in the fullest sense; by conducting research, publishing findings, undertaking clinical work, teaching and, most of all, by creating an environment that fosters academic surgery and encourages others to pursue such a career.

"This Senior Lecturer Fellowship allowed me to concentrate on academic surgery in the fullest sense; by conducting research, publishing findings, undertaking clinical work, teaching and, most of all, by creating an environment that fosters academic surgery and encourages others to pursue such a career."

Academic highlights

- 2016: Vascular Foundation Research Grant, Australian and New Zealand Vascular Society
- 2016: Innovations Grant – University of Sydney
- 2015: RACS Senior Lecturer Scholarship (Inaugural)
- 2014: Sydney University Medical Foundation, Chapman Bequest for Cardiovascular Research.

Karen Murphy
Surgical News Journalist

Clifton Beach in Carins, Queensland.

The future of rural and regional surgical training

Thirty eight attendees including representatives from seven specialty training boards and surgical specialty societies came together on 17 March, 2018 to discuss how best to support the future of rural and regional surgery in Australia and the requirements for training a rural surgical workforce.

As part of the accreditation by the Australian and New Zealand Medical Councils, RACS has been asked to define how our educational purpose connects to our community responsibilities. Equipping the surgical workforce to meet the community needs across all of Australia and New Zealand is essential to enact our College vision and lead surgical performance, professionalism and improve patient care.

Professor Richard Murray, Chair of the Medical Deans of Australia and New Zealand presented data highlighting the severity of Australia's maldistribution of healthcare workers. Despite training new doctors at well above the OECD average, these graduates have not gone on to undertake jobs in rural and regional Australia. The "spill-out" strategy has failed with many younger surgeons under employed in metropolitan centres. Australia continues to rely on international medical graduates to address maldistribution despite this growing cohort of doctors practicing in major Australian cities.

Panellists from orthopaedics, general surgery, vascular and ENT surgery discussed the differences between urban and rural practice from their specialty and personal perspectives. Negative stereotypes of rural and regional training and practice were seen as being both pervasive and highly damaging. Participants dispelled these stereotypes and spoke highly of the benefits of rural and regional surgical practice, with an emphasis on the exposure to interesting and varied clinical work.

Delegates worked together to discuss offerings by specialty and region for Fellows desiring to work in rural and remote areas during training, post fellowship opportunities and engaging JDocs with the options for new models of training with a rural focus. The shift towards competency based training across specialties is seen as an enabler for rural training.

The concept of rural training hubs with strong collaborative networks was well received with the focus on regional or rural hospital training linking with metropolitan centres as required. Frustration with a lack of flexibility in many health jurisdictions was acknowledged and this will be on the agenda for RACS to address.

We look forward in the coming months to continue the discussions about rural training amongst the training boards and in the lead up to RACS Council in June. The next steps will see a draft rural surgical training strategy circulated to training boards and specialty societies and RACS engaging formally with the Australian Commonwealth and State Health Departments to ensure that the workforce models across the country facilitate improvements for greater equity in access to surgical services in rural and regional areas.

David Fletcher
Chair Board of Regional Chairs

Adrian Anthony
Chair, Board of Surgical Education and Training

RACS Rural Surgery Section

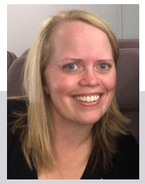
The Rural Surgery Section (RSS) is a long standing interest group in RACS. Initially established by general surgeons it has become a multidisciplinary forum serving the interests of any Fellow, IMG or Trainee in practice or intending to practice in non-metropolitan Australia and New Zealand. In the 2016 Census, 34 per cent of RACS Fellows reported they practice in both metro and rural or regional locations. Recently we have opened section membership to rural based junior doctors and medical students with an interest in surgery recognising they are the future to a sustainable rural workforce.

The section has three primary goals. The first is to connect and support Fellows in rural practice, whether they are resident surgeons, locums or providing outreach services. The second is the promotion of rural surgery as a viable career option and to facilitate the rural surgery pathway pipeline. The third is to guide RACS' development and deliver solutions for today's rural workforce challenges such as recruitment, retention and professional isolation.

Each year the section convenes a multidisciplinary program at the Annual Scientific Congress exploring the craft of rural surgery and issues on the sector's agenda. We are also active participants in the Provincial Surgeons of Australia (PSA) conference, an important networking event for rural specialists. Through the *pro-bono* services of a Clinical Director, we offer the Rural Coach Program that supports trainees interested in a rural surgical career. The program has attracted 84 Trainees since it was established in 2011. The section offers an annual scholarship program to support the upskilling of rural specialists and junior doctors. Since 2015 we have provided 9 travelling fellowships, total value $90,000 to general, OHNS and vascular surgeons, to undertake continuing medical education. Since 2015 we have sponsored National Rural Health Students Association speaker at the PSA conference so we stay in touch with medical students concerns and remain connected to new cohorts of rural medical students.

Every three years, the Section elects from its membership regional representatives to serve on the RSS Committee. They are joined by co-opted representatives from other stakeholder groups including the RACS Trainee Association. The Committee rotates its annual face to face meetings across the regions so that it can engage with local Fellows, better understand the issues on the ground and support the advocacy work of regional committees. Our meeting in Geelong in 2014 for example lent support to the establishment of Australia's first rural surgery training hub. Our meeting in Brisbane in 2015 gave support to the Queensland Regional Committee's advocacy for the creation of rotational fellowships as a means to address surgical workforce shortages in that state. In 2017 we met in Adelaide to visit the new Royal Adelaide Hospital and learn more about impact it was having on the resourcing of South Australia's rural health sector.

We encourage all of you to join the Rural Surgery Section. Membership is free and joining is easy as sending a request to rural@surgeons.org.



Sally Butchers
Chair,
Rural Surgery Section Committee

On behalf of the Rural Coach Program, it is with pleasure that we invite you to register for the

54th PSA 2018 ASC
'The Young Regional Surgeon'

25-27 October, 2018 | Bundaberg, QLD

Rural Coach Program

If you are a surgical Trainee who is considering working in rural Australia in the future, the Rural Coach might be able to assist you.

The Royal Australasian College of Surgeons [RACS] Rural Coach supports surgeons interested in a career in rural surgery or in contributing to the rural workforce in locum or outreach work.

Rural Coaches are experienced rural surgeons who provide 1-1 support, networking, educational or professional opportunities or assistance with attending the Provincial Surgeons of Australia (PSA) Annual Scientific Conference.

Registration grants to attend the PSA are available

General Surgeons Australia (GSA) have again generously offered a RCP-GSA Registration Grant, each valued at up to $770 Inc. GST, to General Surgery Trainees and IMGs to attend the PSA 2018 ASC. For further information on eligibility please contact the Rural Coach Program Officer: ruralcoach@surgeons.org

Sir Charles Bell FRS

Anatomist, Surgeon and Artist

Sir Charles Bell is remembered as an anatomist, physiologist, surgeon, artist and philosopher: he was born in Edinburgh in 1774, the youngest of four sons of William Bell and Margaret Morice. William Bell a clergyman in the Episcopal Church of Scotland, died when Charles was five years of age: Charles' mother had herself been orphaned at an early age. She inherited her great talent for drawing from her grandfather Bishop White, later Primus of Scotland: she was well educated and made every effort to ensure that her children received a full education, despite the family's reduced circumstances; all four sons became eminent in their chosen fields.

Charles noted in his letters "my education was the example set me by my brothers; there was in all the members of the family a reliance on self, a true independence, and by imitation, I obtained it". He attended the Edinburgh High School over the years 1784-8 however he described this time as being, "to me, torture and humiliation".

He later attended the University of Edinburgh for two years before he thought seriously about studying medicine; he then trained under Alexander Monro (*secundus*), who occupied the Chair of Anatomy for half a century.

Charles' older brother, John, wrote, "in Doctor Monro's class, unless there be a fortunate succession of bloody murders, not three subjects are dissected in the year".

Nevertheless, during this time, Charles wrote '*A System of Dissections Explaining the Anatomy of the Human Body*' 1798-1803 and later, '*Engravings of the Arteries, of the Nerves and of the Brain*' 1801-2; all beautifully illustrated by him.

He graduated at age 25 in 1799, becoming a Fellow of the Royal College of Surgeons of Edinburgh: however, dissatisfied, he left Edinburgh for London in 1804: within two days of arriving, exploring possibilities he had called on Matthew Baillie, the nephew of William and John Hunter, and Sir Astley Cooper, *inter alia*.

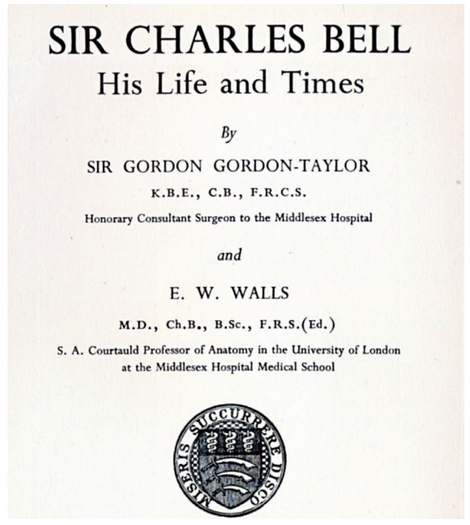
During his first year in London he worked on his manuscript of '*Essays on the Anatomy of Expression in Painting*'; this magnificent quarto volume appeared in 1806 and revealed Bell not only as an expert anatomist but one possessed of the "most exquisite taste and feeling for sculpture and painting": the book was well received in both medical and art circles.

In 1809 he went to Portsmouth to study gunshot injuries in the wounded from the Battle of Corunna; at this stage he was still chiefly interested in anatomy, rather than surgery, producing fine drawings and paintings of cases.

In 1811, aged 37, he married: moving to Soho Square, his wife objected to the presence of anatomy students; Charles noting meanwhile, that there "was an awful pause in regard to patients". He published '*Idea of a New Anatomy of the Brain*', submitted 'for the observations of his friends': Bell was the discoverer of the distinct functions of motor and sensory nerves, the greatest discovery in physiology since William Harvey's demonstration of the circulation of the blood in 1628.

Left:
Sir Charles Bell, aet. 30.

In 1814 he was appointed Surgeon to the Middlesex Hospital and within a short time his private practice increased; he continued to research and write, later that year publishing '*A Dissertation on Gun-shot Wounds*'.


SIR CHARLES BELL
His Life and Times

By

SIR GORDON GORDON-TAYLOR
K.B.E., C.B., F.R.C.S.
Honorary Consultant Surgeon to the Middlesex Hospital

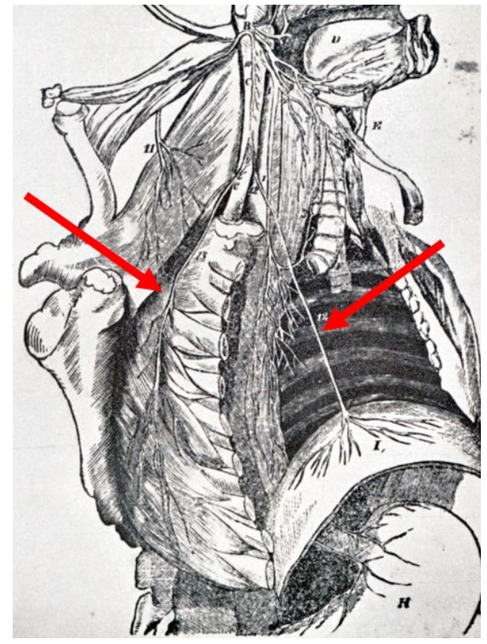
and

E. W. WALLS
M.D., Ch.B., B.Sc., F.R.S.(Ed.)
S. A. Courtauld Professor of Anatomy in the University of London at the Middlesex Hospital Medical School

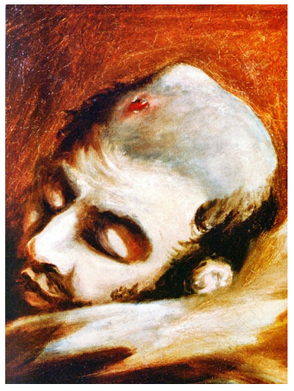
Left:
Life of Bell - Copy.

On 18 June 1815, the Battle of Waterloo was fought and won, and the need for surgeons was immense; Bell and a colleague left for Brussels but found a horrible situation; "while I amputated one man's thigh, there lay at one time thirteen, all beseeching to be taken next": he would operate for 12 to 13 hours without a break until his arms were "powerless with the exertion of using the knife". He depicted numerous examples of the course missiles had taken in anatomico-pathological illustrations that have never been surpassed.

Far right:
The respiratory nerves, internal and external.



Bell's palsy, was described in the Philosophical Transactions of the Royal Society in 1821 and in 1829 he published a more detailed description correcting some mistakes. In 1826 he was elected a Fellow of the Royal Society, being already a Fellow of the Royal Society of Edinburgh.



Above:
Bullet wound of the skull Corunna.
Below:
Bell's dissection of trigeminal nerve.

His best-known works are his Treatises on the nerves of respiration, on the hand, the anatomy of expression and diseases of the urethra: the ninth edition of '*The Hand*' was published more than 30 years after Bell's death.

His versatility and the brilliance of his discoveries in anatomy and physiology were recognised by his contemporaries and he was knighted in 1831, receiving many other honours.

After 30 years in London, Charles Bell was invited to return to Edinburgh in 1835, to occupy the Chair of Surgery: he accepted it, as he considered that "London was a good place to live in but not to die in".

In April 1842, while travelling south to London, he died peacefully in his 68th year; he was buried simply in the local churchyard at Hallow Park, near Worcester.

In spite of exceptional abilities and unceasing application to his profession Charles Bell never attained affluence: partly due to his devotion to research but mainly to his lack of business acumen: as an example, on being elected to the Middlesex Hospital, he disposed of his entire museum to the Royal College of Surgeons of Edinburgh for just £3000: Bell's collection of anatomical dissections, comprising normal and pathologic anatomy, human and comparative, was second only to that of John Hunter.

Eponyms associated with Charles Bell are as follows:

1. ***Law.*** Anterior roots of spinal nerves are motor; posterior, sensory.
2. ***Nerve.*** The external respiratory nerve (illustrated above). There are two nerves spoken of as Bell's nerve, the internal and external respiratory nerves. The internal (phrenic) nerve had been fully described before Bell, however, he described the external or long thoracic nerve passing down the chest wall on the outer surface of the serratus anterior muscle; if this nerve is paralysed for any reason the condition of 'winged' scapula results.
3. ***Palsy.*** Facial paralysis.
4. ***Phenomenon.*** An upward rolling of the eyeball on an attempt to close the eye, occurring on the affected side in peripheral facial palsy.
5. ***Sign.*** See phenomenon.

Mr Peter F. Burke
FRACS

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Case note review

Infant with intra-cranial dural venous sinus thrombosis

An infant presented to the emergency department (ED) of a regional hospital with a two-day history of pus discharging from the left ear and a three-hour history of irritability and vomiting. There was a history of recurrent otitis media. On admission, the infant was diagnosed with otitis media and was prescribed amoxycillin and ibuprofen. The infant was then discharged for follow-up with the family's general practitioner, along with a recommendation for ear, nose and throat referral.

The following day, the infant had 'not woken properly' and was brought back to ED and admitted. The infant had a temperature of 38 degrees Celsius and a Glasgow Coma Scale (GCS) of 8/15. The left pupil was fixed and dilated. Within one hour of this admission, a computed tomography (CT) head scan was performed. This CT was reported as demonstrating thrombosis of the left transverse sinus extending to the left sigmoid sinus to proximal left internal jugular vein. Haemorrhagic venous infarction involving the left temporal and parietal lobes was noted. There was mass effect with midline shift to the right. There was no evidence of intracranial abscess.

The infant was intubated and ventilated, and admitted to the intensive care unit (ICU). Intravenous vancomycin, ceftriaxone, dexamethasone and phenytoin were commenced. On the evening of this admission, the infant underwent a left-sided decompressive craniectomy.

A CT scan performed on day one post-operation demonstrated substantial reduction in mass effect and midline shift. The CT scan on day three post-operation demonstrated extension of venous sinus thrombosis involving the sagittal sinus. Further haemorrhagic venous infarction involving both frontal lobes was noted and there was worse midline shift to the right. At this point, anticoagulation was commenced.

Subsequently, the infant demonstrated eye opening, purposeful movements on the left side and a right-sided weakness. The left pupil remained dilated. The ICU medical staff felt the infant was becoming too complex to manage in the ICU of the regional hospital, and arranged transfer to a specialist paediatric ICU in a larger hospital. When the paediatric ICU retrieval team arrived on day 5 post-operation, there was a marked deterioration in the infant's condition. The GCS was 3/15 and, on transfer to the retrieval bed, the infant became bradycardic and developed bilateral fixed and dilated pupils. At this point, it was felt that there was no chance of survival. Therefore, the transfer did not proceed and the infant died the following day.

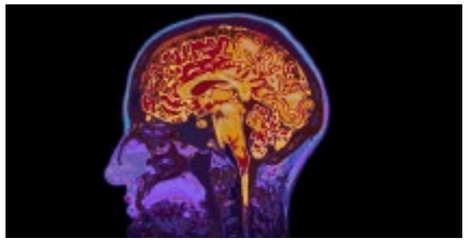
Comment:

This case of suppurative otitis media in an infant rapidly led to progressive septic intracranial venous sinus thrombosis. Progressive haemorrhagic venous infarction of the brain followed, resulting in the infant's death. The intracranial septic process was aggressive and fulminant, and the review considered it unlikely that any other treatment would have resulted in a different outcome.

It may have been an option to initially treat the infant with anticoagulation and non-surgical therapy for raised intracranial pressure, given that following intracranial surgery, anticoagulants could not be commenced for a period of time. Consideration of the potential management options was documented comprehensively in the medical record.

Concerns that the infant was too unstable to transfer were justified, given that the infant essentially became brain dead at the commencement of transfer. Whether or not the infant was transferred had no bearing on the outcome. All involved did well to participate in amicable discussions and agree on criteria for transfer to a specialist paediatric ICU when, and if, appropriate.

Professor Guy Maddern
Surgical Director of Research and Evaluation incorporating ASERNIP-s

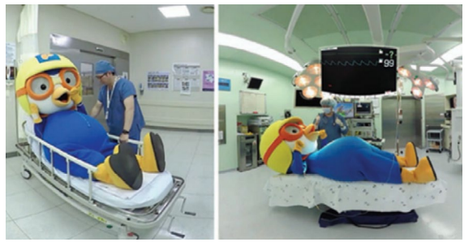


Credit: SpeedKingz/Shutterstock.com

Surgeons describe smartphone assisted neuroendoscopy as a success

It seems that the more functions a smart-phone allows us, the more expensive the device, but the University of São Paulo Medical School has given the smart-phone a new function, with no cost to the consumer at all. According to an article published in the *Journal of Neurosurgery,* the University has been attaching the smart-phone to the front of a neuroendoscope, allowing excellent visualisation of the surgical site, simultaneous sharing of images with other surgical team members and real time manipulation of images. The authors say that the smart-phone endoscope device could provide an alternative neuroendoscopy technique and that the relatively low cost of a smart phone and adapter could be beneficial in underserved countries and where medical infrastructure cannot support expensive equipment.

https://www.news-medical.net/news/20180313/Surgeons-describe-smartphone-assisted-neuroendoscopy-as-a-success.aspx



Virtual reality tour of operating room helps reduce preoperative anxiety in children

An operating theatre can be a daunting place for anyone, let alone a small child, so to make the experience that bit more bearable, trials conducted by the Seoul National University College of Medicine have begun to assess the effectiveness of virtual reality and video on children about to undergo surgery. According to the BJS (*British Journal of Surgery*) the trials use a 4-minute virtual reality tour of the operating room prior to anaesthesia, featuring Pororo the little penguin who explains the anaesthesia, and the operating room in a friendly, simple manner. More studies into the use of virtual reality in medicine is expected in line with current trends.

https://haptic.al/virtual-reality-may-help-ease-pre-surgical-anxiety-in-children-7b397301f94c

Men experience most cervical fractures due to cycling, study shows

It's important we wear a helmet, adhere to road rules and watch out for potential danger zones when riding a bicycle whether it be off or on the road, but according to recent research conducted in Rhode Island, United States, we may need to investigate additional safety measures. The research, presented at the American Academy of Orthopaedic Surgeons (AAOS) Annual Meeting, suggests that sporting-related cervical fractures have increased by 35 per cent since 2000 mainly due to a large increase in cycling-related injuries. The National Cycling Participation Survey conducted by the Australian Bicycle Council, indicated that in 2017 the proportion of people who had cycled in the past month declined from 27 per cent in 2011 to 22 per cent in 2017, however while cycling participation overall may have declined, there may be an increase in the overall time spent riding, or the number of cyclists riding on the road, compared to on bicycle paths.

http://aaos-annualmeeting-presskit.org/2018/research-news/spine_depasse/

http://www.bicyclecouncil.com.au/publication/national-cycling-participation-survey-2017

Commemorative 10th Annual

Developing a Career and skills in Academic Surgery (DCAS) course

Monday 7 May 2018, 7:00am - 4:00pm
International Convention Centre Sydney, Australia

Provisional Program

6:45am	Registration opens
7:15am - 7:30am	Welcome and Introduction ..... John Batten / Marc Gladman / Amir Ghaferi
7:30am - 9:10am	**Session 1: Academic Surgery: The Quadruple Threat ..... Chairs: Stephen Tobin / Lilian Kao**
7:30am - 7:50am	Why I chose to become an academic surgeon ..... Melina Kibbe
7:50am - 8:10am	Competing priorities: How I find time to research ..... John Windsor
8:10am - 8:30am	Competing priorities: How I find time to teach ..... Christobel Saunders
8:30am - 8:50am	Competing priorities: How I find time to provide leadership ..... Scott LeMaire
8:50am - 9:10am	Panel discussion
9:10am - 9:40am	Morning Tea
9:40am - 10:05am	**Hot Topic in Academic Surgery: ..... Chairs: Mark Smithers / Rebekah White**
	Precision Medicine ..... Kevin Staveley-O'Carroll
10:05am - 11:40am	**Session 2: Presenting and Publishing Your Work**
10:05am - 10:30am	Writing an abstract ..... Amir Ghaferi
10:30am - 10:55am	Writing and submitting a manuscript ..... Marc Gladman
10:55am - 11:20am	Communicating your research: presentation and promotion ..... Jacob Greenberg
11:20am - 11:40am	Panel discussion
11:40am - 11:45am	Introduction ..... Caprice Greenberg
11:45am - 12:15pm	**Keynote Presentation: Progress in an Evolving Professional Environment ..... Gavin Fox-Smith**
12:15pm - 1:10pm	Lunch
1:10pm - 2:40pm	**Session 3: Concurrent Academic Workshops**
1:10pm - 2:40pm	**Concurrent Workshop 1: Early Career Development – What Should I Be Doing? ..... Chairs: Christine Lai / Arden Morris**
	Medical Ethics – top tips for successful navigation ..... Tim Pawlik
	What can I do as a Medical Student ..... Michelle Locke
	What can I do as a Junior Doctor / SET Trainee ..... Sebastian King
	Full-time research: Is it worth it? ..... Greg O'Grady
	Winning awards / fellowships ..... Claudia Di Bella
1:10pm - 2:40pm	**Concurrent Workshop 2: Types of Research ..... Chairs: James Lee / Colin Martin**
	Clinical Trials ..... Andrew Hill
	Health Services / Outcomes Research ..... Adil Haider
	Lab-based Research ..... Alexander Heriot
	Education Research ..... Rachel Kelz
1:10pm - 2:40pm	**Concurrent Workshop 3: Establishing and Running an Academic Department ..... Chairs: Julian Smith / Rebecca Minter**
	Assembling the team and establishing collaborations ..... Leigh Delbridge
	Promoting diversity in the Department ..... George Yang
	Funding opportunities ..... Guy Maddern
	Running the Department: budget, staff and barriers ..... Sandra Wong
1:10pm - 2:40pm	**Concurrent Workshop 4: Getting Published – What do the Journal Editors Want? ..... Chairs: Ian Bissett / Andrea Hayes-Jordan**
	JAMA Surgery ..... Melina Kibbe
	ANZ Journal of Surgery ..... John Harris
	Journal of Surgical Research ..... Scott LeMaire
	Panel Q & A
2:40pm - 3:00pm	Afternoon Tea
3:00pm - 4:00pm	**Session 4: Sustainability in Academic Surgery ..... Chairs: John Harris / Amir Ghaferi**
	Finding and being a mentor ..... Mark Smithers
	Work-life balance ..... Fiona Wood
	DCAS: the first 10 years ..... Richard Hanney
4:00pm - 4:05pm	Closing Remarks ..... Marc Gladman / Amir Ghaferi

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

AAS Association for Academic Surgery

Royal Australasian College of Surgeons – Section of Academic Surgery

Proudly sponsored by:

Johnson & Johnson MEDICAL DEVICES COMPANIES

Keynote speaker:

Gavin Fox-Smith
Johnson and Johnson

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.

2017 comments:

"I will be recommending attending this to my surgically inclined colleagues"

"Excellent diverse range of topics. Nice introduction to academic surgery. Gave an insight to future developments"

"Engaging/interesting speakers who showed true passion for their topics"

Association for Academic Surgery invited speakers:

Amir Ghaferi - University of Michigan, Michigan, USA

Adil Haider - Brigham and Women's Hospital, Massachusetts, USA

Melina Kibbe - University of North Carolina, North Carolina, USA

Kevin Staveley-O'Carroll - University of Missouri, Missouri, USA

Tim Pawlik - Ohio State University, Ohio, USA

Caprice Greenberg - University of Wisconsin, Wisconsin, USA

Jacob Greenberg - University of Wisconsin, Wisconsin, USA

Rachel Kelz - University of Pennsylvania, Pennsylvania, USA

Lillian Kao - University of Texas, Texas, USA

Scott LeMaire - Baylor College of Medicine, Texas, USA

Arden Morris - Stanford University, California, USA

Rebecca Minter - University of Texas, Southwestern Medical Center, Texas, USA

George Yang - Stanford University, California, USA

Rebekah White - University of California San Diego, California, USA

Sandra Wong - Dartmouth-Hitchcock Medical Center, New Hampshire, USA

Australasian Faculty:

For the list of Australasian faculty, please visit **www.tinyurl.com/dcas18reg**

DCAS course participation

Cost: $220.00 per person incl. GST

Register online: www.tinyurl.com/dcas18reg

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:

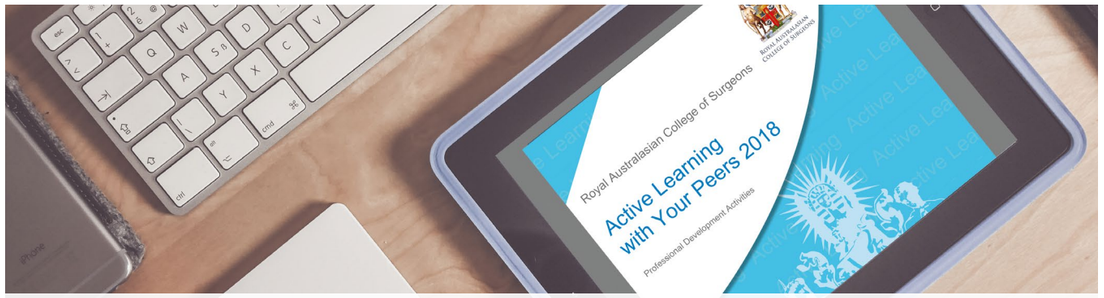
Conferences and Events Management
Royal Australasian College of Surgeons
T: +61 3 9249 1260
F: +61 3 9276 7431
E: dcas@surgeons.org

NOTE: New RACS Fellows presenting for convocation in 2018 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.



Courses for every stage of your career

Inside 'Active Learning with Your Peers 2018' 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.

All activities are CPD accredited and reflect the College guidelines for surgical competence and performance. Book your courses online at https://www.surgeons.org/for-health-professionals/register-courses-events/ (RACS login required)

Mandatory courses

With the release of the RACS Action Plan: Building Respect and Improving Patient Safety, the following courses are mandated for Fellows in the following groups:

By the end of 2018

Operating with Respect one-day course: Mandatory for SET Supervisors, IMG Clinical Assessors and major RACS Committees

Foundation Skills for Surgical Educators Course

21 April 2018	Melbourne	VIC
29 April 2018	Sydney	NSW
6 May 2018	Sydney	NSW
7 May 2018	Sydney	NSW
12 May 2018	Adelaide	SA
12 May 2018	Melbourne	VIC
19 May 2018	Sydney	NSW
19 May 2018	Melbourne	VIC
19 May 2018	Perth	WA
25 May 2018	Adelaide	SA
1 June 2018	Sydney	NSW
1 June 2018	Canberra	ACT
8 June 2018	Adelaide	SA
1 June 2018	Sydney	NSW
1 June 2018	Canberra	ACT
2 June 2018	Brisbane	QLD
2 June 2018	Melbourne	VIC
8 June 2018	Adelaide	SA
15 June 2018	Auckland	NZ
15 June 2018	Brisbane	QLD
16 June 2018	Sydney	NSW
16 June 2018	Perth	WA
25 June 2018	Sydney	NSW
25 June 2018	Auckland	NZ
30 June 2018	Brisbane	QLD
30 June 2018	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.

Operating with Respect course

6 May 2018	Sydney	NSW
7 May 2018	Sydney	NSW
28 May 2018	Perth	WA

The Operating with Respect course provides advanced training in recognising, managing and preventing discrimination, bullying and sexual harassment. The aim of this course is to equip surgeons with the ability to self-regulate behaviour in the workplace and to moderate the behaviour of colleagues, in order to build respect and strengthen patient safety.

Safer Australian Surgical Teamwork (SAST)

2 June 2018	Melbourne	VIC
30 June 2018	Adelaide	SA

SAST is a combined workshop for surgeons, anaesthetists and scrub practitioners. The workshop focuses on non-technical skills which can enhance performance and teamwork in the operating theatre thus improving patient safety.

It explores these skills using three frameworks developed by The University of Aberdeen, Royal College of Surgeons of Edinburgh and the National Health Service - Non-Technical Skills for Surgeons (NOTSS), Anaesthetists Non-Technical Skills (ANTS) and Scrub Practitioners' List of Intra-operative Non-Technical Skills (SPLINTS). These frameworks can help participants develop the knowledge and skills to improve their performance in the operating theatre in relation to communication/teamwork, decision making, task management/leadership and situational awareness. The program looks at the relationship between human factors and safer surgical practice and explores team dynamics. Facilitators will lead you through a series of interactive exercises to help you to reflect on your own performance and that of the operative team you work with.

Clinical Decision Making

14 April 2018	Sydney	NSW
22 June 2018	Auckland	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.

Surgeons as Leaders in Everyday Practice

8–9 June 2018	Gold Coast	QLD

Surgeons as leaders in everyday practice is a one and a half day program which looks at the development of both the individual and clinical teams leadership capabilities. It will concentrate on leadership styles, emotional intelligence, values and communication and how they all influence their capacity to lead others to enhance patient outcomes. It will form part of a leadership journey sharing and gaining valuable experiences and tools to implement in their own workplace. All meals, accommodation and educational expenses are included in the registration fee. The evening session will involve an inspirational leadership speaker.

SAT SET Course

26 May 2018	Melbourne	Vic

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).

Keeping Trainees on Track

26 May 2018	Melbourne	Vic

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.

Academy of Surgical Educators Studio Sessions

26 April 2018	Sydney	NSW
21 May 2018	Wellington	NZ
26 June 2018	Melbourne	Vic

Each month, the Academy of Surgical Educators presents a comprehensive schedule of education events curated to support surgical educators.

The Educator Studio Sessions are presented around Australia and New Zealand and deliver topics relevant to the importance of surgical education and help to raise the profile of educators. They provide insight, a platform for discussions and an opportunity to learn from experts.

All sessions are also simulcast via webinar. Register here: www.surgeons.org/studiosessions

WORKSHOPS

PROFESSIONAL DEVELOPMENT WORKSHOP DATES: April - June 2018

ACT		
Foundation Skills for Surgical Educators	1 June	Canberra
NSW		
Academy of Surgical Educators – Studio Sessions	26 April	Sydney
Clinical Decision Making	14 April	Sydney
Foundation Skills for Surgical Educators	6 May	Sydney
Foundation Skills for Surgical Educators	7 May	Sydney
Foundation Skills for Surgical Educators	19 May	Sydney
Foundation Skills for Surgical Educators	1 June	Sydney
Foundation Skills for Surgical Educators	16 June	Sydney
Foundation Skills for Surgical Educators	25 June	Sydney
NZ		
Academy of Surgical Educators – Studio Sessions	21 May	Wellington
Foundation Skills for Surgical Educators	15 June	Auckland
Clinical Decision Making	22 June	Auckland
Foundation Skills for Surgical Educators	25 June	Auckland
QLD		
Foundation Skills for Surgical Educators	2 June	Brisbane
Surgeons as Leaders in Everyday Practice	8 – 9 June	Gold Coast
Foundation Skills for Surgical Educators	15 June	Brisbane
Foundation Skills for Surgical Educators	30 June	Brisbane
SA		
Foundation Skills for Surgical Educators	9 March	Adelaide
VIC		
Foundation Skills for Surgical Educators	21 April	Melbourne
Foundation Skills for Surgical Educators	12 May	Melbourne
Foundation Skills for Surgical Educators	19 May	Melbourne
SAT SET Course	26 May	Melbourne
Keeping Trainees on Track	26 May	Melbourne
Safer Australian Surgical Teamwork (SAST)	2 June	Melbourne
Process Communication Model Seminar 1	22 – 24 June	Melbourne
Foundation Skills for Surgical Educators	2 June	Melbourne
Foundation Skills for Surgical Educators	30 June	Melbourne
WA		
Foundation Skills for Surgical Educators	19 May	Perth
Foundation Skills for Surgical Educators	16 June	Perth
TAS		
Academy of Surgical Educators Studio Sessions	20 July	Hobart

Register online

For future course dates or to register for any of the courses detailed above, please visit https://www.surgeons.org/for-health-professionals/register-courses-events/
Contact the Professional Development Department on +61 3 9249 1122 or email **PDactivities@surgeons.org**

Skills training courses 2018

RACS 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 is a unique course designed to teach surgeons-in-training core skills in patient-centred communication and teamwork, with the aim to improve patient care. 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.

SKILLS TRAINING COURSE DATES:
MAY - JUNE 2018 | *Available Courses

ASSET	
Thursday, 17 May 2018 - Friday ,18 May	Perth
Friday, 18 May 2018 - Saturday, 19 May	Melbourne
Friday, 15 June 2018 - Saturday, 16 June	Brisbane
Friday, 15 June 2018 - Saturday, 16 June	Melbourne
Thursday, 5 July 2018 - Friday, 6 July	Adelaide
Friday, 27 July 2018 - Saturday, 28 July	Sydney
CCrISP	
Thursday, 3 May 2018 - Sunday, 5 May	Auckland
Friday, 8 June 2018 - Sunday, 10 June	Adelaide
Friday, 15 June 2018 - Sunday, 17 June	Sydney
Friday, 20 July 2018 - Sunday, 22 July	Melbourne
Friday, 27 July 2018 - Sunday, 29 July	Brisbane
Friday, 27 July 2018 - Sunday, 29 July	Melbourne
CLEAR	
Friday, 4 May 2018 - Saturday, 5 May	Wellington
Friday, 25 May 2018 - Saturday, 26 May	Sydney
Friday, 15 June 2018 - Saturday, 16 June	Melbourne
Friday, 20 July 2018 - Saturday, 21 July	Brisbane
EMST	
Friday, 18 May 2018 - Sunday, 20 May	Brisbane
Friday, 25 May 2018 - Sunday, 27 May	Sydney
Friday, 25 May 2018 - Sunday, 27 May	Melbourne
Friday, 25 May 2018 - Sunday, 27 May	Auckland
Thursday, 31 May 2018 - Saturday, 2 June	Darwin
Friday, 8 June 2018 - Sunday, 10 June	Brisbane
Friday, 15 June 2018 - Sunday, 17 June	Hobart
Friday, 15 June 2018 - Sunday, 17 June	Sydney
Friday, 22 June 2018 - Sunday, 14 June	Melbourne
Thursday, 28 June 2018 - Saturday, 30 June	Sydney
Friday, 29 June 2018 - Sunday, 1 July	Auckland
Friday, 29 June 2018 - Sunday, 1 July	Adelaide
Thursday, 19 July 2018 - Sunday, 21 July	Perth
Friday, 20 July 2018 - Sunday, 22 July	Brisbane
Monday, 23 July 2018 - Wednesday, 25 July	Melbourne
Friday, 27 July 2018 - Sunday, 29 July	Christchurch
Friday, 27 July 2018 - Sunday, 29 July	Adelaide
TIPS	
Friday, 25 May 2018 - Saturday, 26 May	Adelaide
Friday, 27 July 2018 - Saturday, 28 July	Adelaide

*Courses available at the time of publishing

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

Endocrine disruption

Where has all the plastic gone, long time passing;

Where has all the plastic gone, long time ago;

Where has all the plastic gone - gone to oceans everyone,

When will they ever learn? When will they ever learn?

The world is awash with plastic, and far too much of it is in our oceans. With 6.3 billion tonnes of plastic waste produced since the 1950's, only nine per cent of it has been recycled and 12 per cent incinerated, our world has made a poor job of recycling. The other 79 per cent sits in landfills, floats in the sea or uglifies beaches. It is estimated that some ten million tonnes a year flows to the sea, most of it discarded from South East Asia. Ten rivers, two in Africa, and the rest in Asia discharge 90 per cent of all marine plastic debris. Some 85 per cent of plastic recycling has previously been undertaken in China until their recent decision to stop imports of plastic waste. This decision will have a big impact on how much waste is recycled, including plastics, particularly from Australia and New Zealand.

A recent Lancet Commission on pollution and health hardly mentioned plastic. This was probably because there are other much worse pollutants with evidence for their impact on health, particularly dirty air and water.

Yet there is a great deal of evidence about endocrine disrupting chemicals (EDCs). When plastics are exposed to salt water or ultraviolet light, they can fragment into microplastics, including many endocrine disrupting chemicals that enter the marine food chain, some of which have undoubtedly already attached themselves to our endocrine receptors.

EDCs bind to oestrogen, thyroid and androgen nuclear receptors. They may play a role in the obesity and diabetes epidemics by causing mitochondrial dysfunction, promoting adipogenesis, and interfering with glucose homeostasis. The organotins, tribytylin and Tributylin, increase adipocyte differentiation and adiposity whilst another, triphenyltin, induces hyperglycaemia and hyperinsulinaemia. EDCs are implicated in non-alcoholic fatty liver disease (NAFLD).

EDCs derived from polyvinyl chloride (PVC) release oestrogenic-like compounds and attract absorption of heavy metals, including arsenic. Some EDCs have the potential to evoke neoplastic change, particularly in hormone dependent tumours such as breast and prostate. Bisphenol A (BPA) causes progression of breast and prostate cancer cell lines.

Plastic exposure may be bad for fertility. A number of studies in different countries have shown phthalates are excreted in the urine of pregnant women, indicative of the potential for *in utero* detriment to foetal hormone systems. During reproductive life phthalates have been found to accelerate the loss of the ovarian follicle pool by disrupting folliculogenesis. Dioxins could play a role in male infertility.

Bioassays, still limited in number, are being developed to measure clinical associations and correlations. A cellular AhR ligand activity (CALA) assay reported in a case-controlled study that AhR ligand activities were higher in glucose intolerance or diabetic patients and also associated with components of the metabolic syndrome - hypertension, obesity and hyperlipidaemia. Mitochondrial ATP production in these patients was lower and associated with high AhR ligand activity indicative of the presence and toxicity of dioxin-like chemicals.

With plastic bags, wraps and containers discarded in our seas, it is not just coral reefs and their marine inhabitants that will suffer. It is the human race that risks being obesified, re-metabolised and sterilised. The Science of EDCs, how to measure individual chemicals in human tissue, and establishing cause and effect is still in its infancy despite the 8,942 articles that my *pubmed* search identified. More than five billion tonnes of plastic waste accumulated in the last half century is 'out there' some of which is already disrupting our endocrine systems and that should scare us. We need our mitochondria to be unimpaired, with intact aerobic metabolism that is dependent on the very Krebs cycle we struggled to memorise as medical students. Where has all the plastic gone? Not just to the oceans! Once these EDCs are attached we have, as yet, no idea how to de-attach them! They are fat soluble and persistent. Next time you shop, refuse that plastic bag, and let's hope Australia and New Zealand will soon make a better job of recycling.

DR BB-G-LOVED

SAASM 2015-2016 report highlights

The South Australian Audit of Surgical Mortality (SAASM) is an external, independent, peer-reviewed audit of the process of care associated with surgically-related deaths in South Australia. The 2015-2016 report includes cases reported to the SAASM from 1 January 2015 to 31 December 2016. It is encouraging to note that, since 2013, there has been a consistent downward trend in the number of surgical deaths, from 583 in 2013 to 481 in 2016.

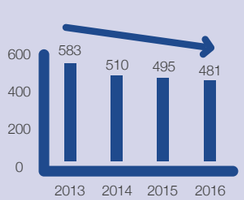
PARTICIPATION

97% Surgeons

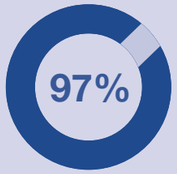
100% Public Hospitals

100% Private Hospitals

ANALYSIS & AUDIT NUMBERS



Surgical deaths*
*non-terminal care

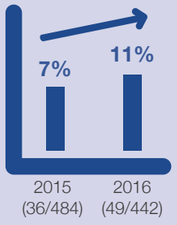


Return of surgical case forms
(1141 of 1182)

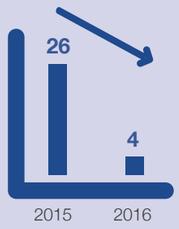
ASSESSMENT

71%
of clinical management issues identified by assessors were attributed (solely or partially) to the surgical team

Cases referred for second line assessment (SLA)

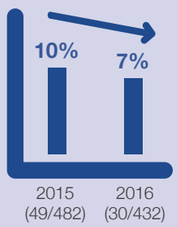


Cases with adverse event (most serious category)



The most common criticisms made by assessors:
1. decision to operate
2. delay to surgery
3. inadequate assessment and/or diagnosis

Cases with serious clinical management issues



It is suggested that surgeons, hospitals and health departments consider the recommended actions below and establish or review their systems or process to improve the outcomes and experiences for their patients.

Patient care

- Surgeons should be expected to undertake comprehensive clinical assessments preoperatively, including clear documentation of risks and patient preference.
- Surgeons and other clinicians should carefully consider whether patients would benefit from admission to a critical care unit.
- The most common postoperative complication identified was 'significant postoperative bleeding'. This requires increased vigilance in the postoperative period to ensure early detection of this complication.
- The high risk of infection among comorbid surgical patients is an ongoing issue. Adherence to protocols and guidelines for best practice is essential, e.g. the Australian Guidelines for the Prevention and Control of Infection in Healthcare.

Improved leadership and communication

- Communication failures have been identified in association with clinical handover and interhospital transfers and between junior and senior clinicians. There should be a continued focus on standardisation and systematisation of communication processes to minimise errors.
- Consultation with senior surgeons is essential when dealing with important decisions and unexpected complications.
- Surgeons are encouraged to share valuable assessor feedback and audit findings and recommendations with surgical colleagues. The findings and recommendations should be discussed at relevant meetings.

Below is a selection of recent and upcoming reports and activities that SAASM undertake to disseminate the valuable findings of the audit.

November 2017
Release of the 12th National Case Note Review Booklet from the ANZASM (including SAASM). The focus of this edition is cases involving insufficient preoperative assessment, misdiagnosis or delays in diagnosis.

April 2018
Seminar – Nobody told me: Poor communication kills. A case series and panel discussion highlighting the importance of effective communication.

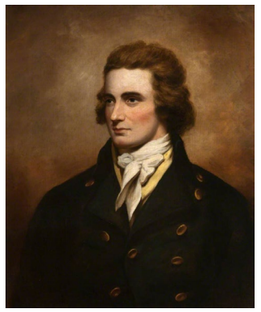
July 2018
Individual surgeons reports to be provided to all participating SA surgeons.

The full report can be viewed on the SAASM webpage: www.surgeons.org/saasm

Glenn McCulloch
Clinical Director SAASM

Mungo Park: surgeon and explorer 1771-1805

This is the story of a Scottish surgeon, the early exploration of sub-Saharan Africa and the quest to determine the course of the Niger River in the late 1700s



Mungo Park was born in Foulshiels, near Selkirk Scotland on the 10 September 1771. Park died near Boussa, Niger in 1805.

It was known that deep in central Africa there were two great golden cities that lay on a trade route well known to the caravans of the Tuaregs and Moors from Northern Africa. These great cities were known for their richness of both intellect and tradable goods. Both Timbuctoo and Djenne were the centre of great African empires both past and present. The city of Timbuctoo lay on the banks of a great river, known by the locals as the Joliba or the Niger.

The Niger arose from the high mountains of West Africa but its termination was not known. If the river terminated in the sea, was this a possible trade route to Timbuctoo? There was considerable debate whether this river flowed east to west or west to east. Did it flow into some great lake in Central Africa or was it a tributary of the Nile or the Congo?

In London "The Association for Promoting the Discovery of the Interior Parts of Africa", (the Africa Association) was formed on 9 June 1788 with the express purpose of sending out young explorers to the dark and unknown continent.

West Africa was known as the 'white man's grave' due to the curses of starvation, infection, tropical disease, and usually violent trauma that commonly plagued the early European explorers. Most never returned.

Mungo Park was the seventh of 13 children. Park's father was a yeoman farmer and relatively well to do in that he was able to employ a tutor at home for his many children before sending them away for their education.

Park was schooled in Selkirk and was destined to study medicine. At 14 he was apprenticed to Thomas Anderson, a Surgeon in Selkirk. Park received his Diploma in Medicine from the University of Edinburgh in 1791, then went to London to practice medicine. His brother-in-law, William Dickson, a botanist, was a great friend of Joseph Banks, chair of the Africa Association.

Park's introduction to Joseph Banks was immediately followed by his appointment as assistant-surgeon during a mission to Sumatra in 1792. Park collected rare plants and fish on this trip and presented these on his return in 1793. That year Park was officially licensed by the Royal College of Surgeons.

In the following year, Banks suggested Park be recruited to follow the failed mission of Irishman Daniel Houghton, sent in 1790 to find the true course of the Niger. Houghton reported that the Niger apparently flowed eastward to the heart of Africa. Although Houghton's reports returned to Britain, Houghton himself perished violently so his claims could not be substantiated.

Park sailed from Portsmouth on 22 May 1795 on the small two masted, square-rigged brig, Endeavour that traded to the Gambia for ivory and beeswax.

Park arrived at Pisania on the Gambia in July 1795. He encamped with a well-known slave trader, Dr John Laidley for five months to learn the Mandingo language and to 'acclimatise', as well as recover from the 'fever' that plagued virtually all early European travellers.

Park set off eventually with a shotgun, a brace of pistols, two natives – one as a guide and the other as a servant, a horse and two donkeys.

Early into his travels Mungo Park and his companions were in trouble. In each region they passed they were relieved of possessions piece by piece by unscrupulous petty monarchs until he was relieved of not only his nice blue coat but also his guns and umbrella. In the Kingdom of Bondou he was seized by horsemen and threatened with death or dismemberment. He eventually escaped but was then ill-treated and robbed of half his remaining possessions in the next town only surviving by the charity offered by a female slave.

When he ventured north into Moorish territory he was again taken prisoner, stripped of all his possessions and held captive for four months. He relied heavily on the native slaves for food and water and came close to dying of starvation.

Eventually he made his escape with his horse, some of his clothes and a compass he had hidden in the sand. He reached the Niger at Segu and was able to confirm that the river flowed towards the East. He wrote:

"And looking forwards, I saw with infinite pleasure the object of my mission – the long-sought-for majestic Niger, glittering in the morning sun, as broad as the Thames at Westminster, and flowing slowly to the eastward. I hastened to the brink, and having drunk the water, lifted up my fervent thanks in prayer to the Great Ruler of all things, for having thus far crowned my endeavours with success."

His return journey to Pisania was fraught with hardship and attacks of fever, so much so that it took over seven months. Dr Laidley had given him up for dead.

On his return to England, Park was somewhat of a celebrity and tales of his exploits in his book "*Travels to the Interior of Africa*" were an instant success.

He returned to Scotland and married Alice, the sister of his good friend David Anderson and eldest daughter of his old medical chief in Selkirk.

Park settled for the first two years at his home in Foulshiels and then took up a medical practice in nearby Peebles.

In 1803 Park was offered £5,000 by the British government to lead another expedition in search of the termination of the Niger accompanied by 30 soldiers from an African regiment commanded by Lieutenant John Martyn, together with a number of builders and sailors. In addition Park was permitted to take two civilians of his choice. Park settled on David Anderson, his brother-in-law and a draftsman, George Scott of Selkirk.

Park, then aged 32, eventually embarked from Portsmouth in 1805 arriving in Pisania on 19 August of that year.

Park obtained the services of a Mandingo priest as interpreter and guide, and they set off for the Niger with supplies and a large contingent of around 50 men.

They crossed the Bafing River and finally reached Bamako by which time their numbers had dwindled to 11 due to disease and attrition. By November of that year only four men were left. David Anderson and George Scott were both dead.

On 17 November he wrote to the Colonial Office in London:

"I have changed a large canoe into a tolerably good schooner, on board of which this day I hoisted the British flag and I set sail to the east with the fixed resolution to discover the termination of the Niger or perish in the attempt. I have heard nothing that I can depend on respecting the remote course of this mighty stream, but I am inclined to think it can end nowhere but in the sea. My dear friends, Mr Anderson and Mr Scott are both dead; but though all Europeans who are with me should die, and though I were myself half dead, I would still persevere; and if I could not succeed in the object of my journey, I will at least die on the Niger."

According to the diary and letters to his family delivered later to the Gambia by Issaco, his guide, Park and Lieutenant Martyn appear to have sailed down the Niger past the fabled Timbuctoo to the town of Boussa, where the river passes through a rocky gorge. Here the natives were hostile and Park had the choice of either resisting them or chancing the rapids.

By this stage he was poorly equipped. He chose the latter option and he and all others drowned except for one slave.

Richard Lander
FRACS, Convenor of the Cowlishaw Symposium

OPUS LI (51)

Some facets of education in a surgical career

There are many aspects in the development of a surgical career linking training, research, publications, personalities—rather like the many facets on a diamond.

I joined the Plastic Surgery establishment as a Trainee with Benny Rank in 1970 at the Victorian Plastic Surgery Unit (VPSU). I had written to him in 1967 from Queensland seeking advice in Plastic Surgical training and his curt response was very simple: "Son, the only place to train in Plastic Surgery is with me so get your Primary Fellowship and come and join us at the VPSU". At the completion of that year, Benny had managed to organise the International Congress of Plastic Surgery in Melbourne in February 1971 where I met every leading plastic surgical entity on the world stage. I then moved to London to be trained in Head & Neck Surgery at the Royal Marsden Hospital and Westminster and St George's (in a rotating Fellowship). I continued this association with the Masters.

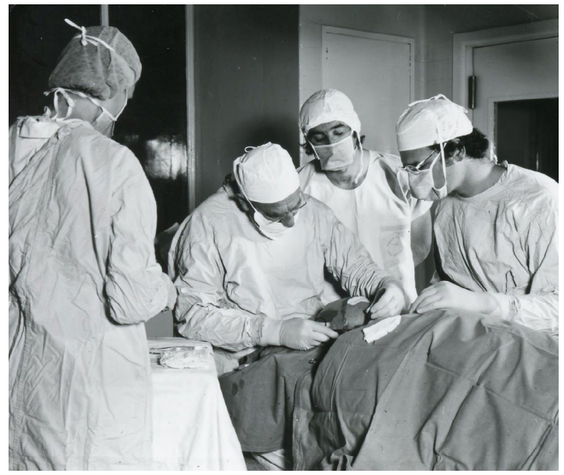
Image: Illustration of St George's Hospital now a five-star hotel – The Lanesborough.

A surgical career has exposure to many important personalities, and often these people give valuable insight into the surgical mind. There is a learning to be had from the personalities of such Masters; the way they conduct their surgical lives and handle complications provide invaluable pearls of wisdom that add value to the surgical experience.

Even some of the interesting personalities relate to patients one meets. I remember a very wealthy American (oil) who would book a West End hotel suite for a month on end for his entourage costing around £1000 per day. I enjoyed his hospitality over breakfast when I was earning £50 a week at the time. I have kept up this breakfast meeting habit on my return to Melbourne and it is a great way of saying 'thank you' to surgical and staff associates. Following his surgery at the Marsden, he gave me one tip when I was expressing my initial anxiety about returning to Melbourne and which I have never forgotten – **there is always room for quality.**

I would also add that things have a way of falling into place. I was reading Ovid, the Roman poet—a contemporary of Virgil and Horace who enjoyed enormous popularity but was banned by Augustus because of his writings in his poem, *Carmen et error* – A Poem and a Mistake - ***"Everything comes gradually and at its appointed hour"***. I make this quote as it has relevance to my return to Melbourne when in conversation with Benny in London, the evening he received his Knighthood at Buckingham Palace, I had arranged accommodation for Lady Rank and him at the New Nuffield College facility superior to the President's suite. I was fortunate enough to be a type of aide de camp during his London visits and when socialising later that day he asked me what my plans were. I listed my current commitments in clinical practice and surgical research with little plans to return to Australia. He said to me "Son, they are using you here and if you don't come back now, you can forget Melbourne". I made a flight booking the following day leaving some unfinished symphonies.

Mentoring is an important adjunct to surgical development and those that have a close association with a Senior Surgeon have a source of wisdom, a well of experience, a confidant in times of problems which can all be rewarding in any career development. We have all had experiences where cases have not done well and issues of questionable surgical technique and/or talent arise. I still remember vividly, Michael Long, taking me through my first block dissection of the neck, not using the usual blunt dissection McIndoe scissor technique but using a sharp dissection method with a 15 blade which appeared fairly adventurous in those early days. Michael had just returned from exposure at the Bikamjian Unit at Roswell Centre of Head and Neck Reconstruction organised by Benny on John Hueston's advice and was regarded as the Senior Head and Neck Surgeon in Melbourne.



Sir Benjamin Rank (Second from left): Operating and teaching, circa 1970 and the VPSU.

Never cease to learn, continue to publish and observe. As Louis Pasteur said "In the field of observation chance favours the prepared mind." The scientific developments and foundations from an observational point of view gravitate to the mind so attuned. I still remember Neil Allan my Trainee of years past at the Western Hospital, implying quiet disbelief when I observed that the hyperaemic phase evident in the Keystone Island Flap bled more at the suture points on the island flap side than around the defect site. I'm sure he mumbled the words "the boss is having another one of his aberrations". Such findings have been the basis of subsequent publications. It was the former Head of Surgery at the RMH, the late Gordon Clunie who said to me years ago when I talked about my new idea in reconstruction – I have never forgotten his words – "if you have something new to say, get off your derriere and get into print". And in twenty years I ended up with the principle of the Keystone Island Flap Reconstruction text books.

Finally, a concluding facet about **surgical income** - never forget the academic environment which are one of the main sources of our surgical training. It is disturbing that their fee structure and income are governed by university statutes. Private practice alternatively may become a distracting force where the Rolex price sometimes does not match the Rolex quality. When the dollar becomes the surgical determinant science fades.

As Givenchy said when designing garments you mould the fabric to fit the form as the College now does with it's Fellowship aspirants.

Assoc. Professor Felix Behan
Victorian Fellow

Foundation for Surgery
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3 pm
Thursday 3 May

Lecture:
Groundbreaking Scottish-Australian Surgical Collaborations in the Great War.

This lecture will be delivered by the international speaker,
Tom Scotland FRCSEd
of Aberdeen, renowned military surgery historian.

Hughes Room,
Royal Australasian College of Surgeons,
250 - 290 Spring Street,
East Melbourne.

Light refreshments will be served after the lecture.

Guests are encouraged.
Please feel free to forward this email to your colleagues, friends and family.

Admission by donation to the Foundation for Surgery.

RSVP
foundation@surgeons.org
by Tuesday 2 May.

Arthroscopy for knee arthritis +/- meniscal tears

It's a lot more complicated than you think!

In 2013 the *New England Journal of Medicine (NEJM)* published three articles claiming to prove that arthroscopy does not help patients with arthritis. This result has been criticised by health experts with differing views. Unfortunately some of them also have varying vested interests in their support for this viewpoint and some show varying levels of understanding and knowledge of the facts.

Like many things in life and especially in medicine 'there are always two sides to the story'.

Let's start with five non-disputed points on the things that help arthritis that all (or most) knee surgeons agree with and use, and then get to the controversial things.

1. Weight loss and activity modification

- Obesity will damage knees and cause arthritis;
- At a BMI of 40 we are 30 times more likely to need a joint replacement than a person with a normal BMI (published American Medicare data);
- Running frequently and long distances often damages knees when people are heavy or have had previous injuries and/or knee surgery;

The problem is getting people to lose weight and quit activities that progress arthritis.

2. Anti-inflammatory medication

- Anti-inflammatory medication helps but has side effects and should be used with caution and won't heal arthritis.

3. Nutraceuticals

- Fish oil, shark cartilage, glucosamine sulphate, glucosamine with chondroitin, etc. Of these, the last one is the only one our Research Fellows could find supportive evidence of its usefulness.

4. Intra-articular injections

a. Steroid: useful for occasional flare-ups. Not recommended for repeated and regular use, because it can worsen the arthritis (chondrolytic) and increase the risk of infection when surgery is eventually performed (published data).

b. PRP (platelet rich plasma): A relatively new technology, PRP helps some knees and can delay major surgery but not is not a long-term cure.

c. Visco-supplements: Very expensive, lasts a short time, and only helps 60 per cent of those using them, but can also delay major surgery.

5. Physiotherapy and Bracing

- Very helpful to most patients but not a cure for progressive arthritis.

6. Stem cells

There is limited evidence to support the concept that these cells can selectively deposit in only the arthritis spots to grow new surfaces. Despite this there are clinics all over Australia and overseas claiming miracle cures and not surprisingly charging very high fees for this dramatic and emotionally appealing but currently 'useless' technology for arthritic knees.

Discussion

If health funds ban arthroscopies for arthritis it is possible many patients will have a knee replacement or an osteotomy, costing many thousands of dollars more. My prediction is that when and if arthroscopy is banned for arthritis we will see a tsunami of premature total knee replacements from the same surgeons who are currently misusing arthroscopic surgery or lacking the skills to do it properly.

Government and academic experts are sometimes 'narrow interest experts' in this arena. They naturally look at the data that suits their argument which they inevitably deliver with conviction. They are possibly the same people who in the past have said we should use cheaper, newer technology (i.e. arthroscopy) instead of more expensive treatments (knee replacements).

Some joint replacement/osteotomy surgeons are inadequately trained in arthroscopy. These are sometimes the same surgeons who publish the articles 'proving' that arthroscopies don't help arthritis and who dismiss arthroscopy as a useless procedure.

Arthroscopic arthritis surgery demands all of the skills of a good arthroscopist and when properly performed is very difficult, time consuming and is true microsurgery. These skills involve the use of many different delicate manual instruments, fine powered shaving instruments and electro surgery (which has replaced laser surgery). These skills are totally different from the skills required to do joint replacements and osteotomies as emphasised by the Arthroscopy Association of North America (AANA) guidelines.

I am often referred second opinion patients who have not had a good result from an arthroscopic early arthritis/meniscus resection combination done elsewhere. MRI will suggest residual meniscal pathology and repeat arthroscopy reveals what I think is a poorly performed previous meniscectomy and debridement. Happily many of these patients respond to the repeat procedure done properly.

'Experts' do admit that some arthritic knees with meniscus tears does benefit from arthroscopy. They suggest that patients with arthritic knees and mechanical symptoms of true locking be allowed to have an arthroscopy. This of course limits the surgery to only those patients with bucket handle tears or very large flap tears.

Those surgeons who do arthroscopic clean-ups of arthritis properly will tell you that many patients come back and have one or two further clean-ups over a 10-20 year period before they need or are willing to have a knee replacement. This is a massive reduction in health care costs and patient risk. In addition it ethically places those patients in a higher prosthesis survival age subgroup when they do have an arthroplasty.

There is a massive difference in cost and much more importantly surgical risk between an arthroscopy and a knee replacement/osteotomy. Most osteotomies will go onto a knee replacement eventually and is a very difficult higher risk procedure.

There are other benefits of arthroscopic evaluation of arthritic knees. Despite the undisputed value of MRI, they are not as accurate in documenting the extent of arthritis as we would like. This is partly because it is simply not possible to use two plane images to fully evaluate a three plane structure.

Very often information obtained at arthroscopy provides the surgeon with more accurate data to guide the patient with activity modification that is accurate and supported by visual images captured at the time of procedure. Many patients find this far more convincing than the many hard to interpret tiny images on an MRI.

Another very useful benefit from the procedure is the ability to more accurately predict whether a patient will need a Partial Knee Replacement or a Total Knee Replacement. This is very important in a young patient with early/moderate arthritis.

Finally let's consider a common practice problem facing an orthopaedic surgeon.

1. The acid question: How do I treat this patient?

A 45 year old female patient with serious worsening and disabling medial knee pain is referred to me. She has been using anti-inflammatory medications and six months of physio, nutraceuticals and a sleeve brace but the pain is getting worse. She refuses ▶

I am not advocating wholesale arthroscopies in severely arthritic knees and support suggestion that this practice should cease. I am however suggesting it is time to recognise there are conflicting vested interests and we should acknowledge and advocate that properly indicated, well performed arthroscopic debridement of early to moderate arthritic knees with associated meniscal tears of all kinds is helpful after failed conservative treatment.

visco-supplements. She has lost 10kg and now has a normal BMI. She does not participate in any kind of sport, and can no longer go for walks with her husband and works at a desk. An X-ray reveals moderate grade two medial joint space narrowing and very early lateral arthritis. The MRI shows moderate to advanced medial arthritis with a few severe patches. There is a large degenerate tear of the medial meniscus. There is early lateral and patella arthritis. Examination also reveals marked medial joint line tenderness and a grade two effusion. Her hip is normal.

This clinical picture (or similar) represents a large proportion of patients presenting with an early to moderate arthritis knee.

Treatment choices:

a. Discuss the pros and cons (including the possibility that it won't work and to take one week off work) of an arthroscopic debridement (cost $3,600) and proceed carefully.

b. Discuss the pros and cons (including the serious potential complications and likelihood of an early limb threatening revision, especially in young patients and two months off work) of a knee replacement (cost $22,000) and proceed. An osteotomy is not indicated in this patient.

c. Tell the patient there is nothing that will help them surgically, and to manage the pain until they are at a more optimal age to have a knee replacement more safely.

Those who oppose arthroscopy will select option 'c', presumably without being influenced by the pain and disability continuation. Many patients given this advice will go elsewhere and get option 'a' or 'b'. Joint replacement surgeons will offer option 'b' and hopefully include the warnings needed. I and many other surgeons experienced in arthroscopic debridement will offer option 'a'.

The experts opposing arthroscopic arthritis debridement will criticise us but I know that I am offering a safe and cost effective procedure which has a good chance (if properly performed) of helping.

Summary

I am not advocating wholesale arthroscopies in severely arthritic knees and support suggestion that this practice should cease. I am however suggesting it is time to recognise there are conflicting vested interests and we should acknowledge and advocate that properly indicated, well performed arthroscopic debridement of early to moderate arthritic knees with associated meniscal tears of all kinds is helpful after failed conservative treatment.

We should also advocate that it is also cost effective and safer than alternative surgeries such as osteotomy and knee replacements and does not prevent those procedures being done later if needed.

Finally we need to understand the current push to ban this procedure will inevitably result in much younger patients having total knee replacements, putting these patients immediately in a much higher risk category with all the associated costs and complication risks that go with revision arthroplasty.

Dr Greg Keene
Knee Surgeon, Adelaide, South Australia

Dr Gue (centre) with the Governor of South Australia, the Hon. Hieu Van Le AC, Dr Gue's wife Anne, Former RACS SA Chair David Walsh and RACS SA Regional Manager Daniela Ciccarello.

Talented Sam showcases his other side

While Dr Sam Gue's reputation as a dedicated and highly gifted surgeon has been well known across Adelaide for almost four decades, it may surprise some of his patients and colleagues to learn that he has developed an equally high profile in the arts community.

On Friday 9 March, family, friends and colleagues of Dr Gue gathered at the RACS SA Regional Office building as the Governor of South Australia, the Honourable Hieu Van Le AC, officially opened Dr Gue's first solo art exhibition.

The exhibition ran for eight days and featured seventy of Dr Gue's paintings, most of which were done in oil with brush and layered with a palette knife to achieve a 3D effect.

Dr Gue first discovered his passion for painting thirty-eight years ago in Broken Hill after operating on the renowned Australian artist, author and adventurer Jack Absalom, also known as the 'Brushman of the Bush'.

"Jack introduced me to the basics of oil painting and we became lifelong friends. At that stage I had just migrated to Broken Hill after completing my higher surgical training in England," Dr Gue said.

"I fell in love with the outback, the red earth and the blue bushes. Unfortunately, my career as a surgeon hasn't allowed me to spend as much time in these beautiful natural surrounds as I would have liked, but by featuring them heavily in my art I feel as if I am still in those peaceful surrounds."

Despite having no formal training in painting, Dr Gue's fine motor skills that have been utilised to perform many delicate and often life-saving surgical procedures are evident in the deft touch and intricate detail demonstrated in his paintings.

"Painting for me has been a great way to relax away from the busy and challenging life of surgery, which as you can imagine can be quite stressful to say the least."

"I feel surgery is art and so is painting. Caring and creating brings me not only joy, but fulfilment and unlimited happiness. For me this is the greatest achievement one can acquire and deliver in life."

Following the exhibition Dr Gue donated one of his large landscape paintings to the College. The painting features the Flinders Rangers and remains on display at the RACS SA Office, 51-54 Palmer Place North Adelaide.

Clinical Trials Network Australia and New Zealand (CTANZ)

Progress update

Significant progress has been made in growing the Clinical Trials Network (CTANZ) since May last year. RACS has provided administrative support, and a clinical director position was recently advertised. In close coordination with RACSTA, Trainee Leads and consultant Surgical Specialty Leads have been appointed in General Surgery, Vascular Surgery, and Paediatric Surgery. Trainee Networks in these three specialties have since gone on to initiate collaborative trials both locally and internationally. Other specialties have expressed interest in joining CTANZ.

In General Surgery, three Trainee Leads (one for Australia and two for New Zealand) have led the charge to join the international IMAGINE Study (Ileus Management International) which brings together trainees and students from Europe and Australasia in a unique international cohort study exploring postoperative ileus after colorectal surgery. Recruitment has now commenced in 19 hospitals in Australia and 15 in New Zealand. Recruitment numbers have been massive (>1000 patients at the first two-week recruitment period, with two more to go). This promises to be the largest published prospective ileus study to date and now includes significant representation from ANZ.

In Paediatric Surgery, a trainee survey was conducted using a value proposition canvas model aimed at understanding trainee needs, experience and potential barriers to undertaking surgical research projects. Following on from this, a trainee-led trial has been selected to assess whether age at operation affects testicular atrophy rates post orchidopexy (ORCHESTRA Trial). A snap-shot audit on a related topic is also planned.

In Vascular Surgery, a research proposal and terms of reference have been established to improve radiation safety, with ethics about to be submitted. Funding is being sought for radiation detection devices.

There will be several CTANZ presentations at the upcoming Annual Scientific Congress in Sydney, and an opportunity for Q&A at a dedicated RACS trade booth. Please forward any questions or comments to CTANZ@surgeons.org.

Associate Professor Tarik Sammour
and Professor John Windsor
On behalf of the CTANZ Working Group

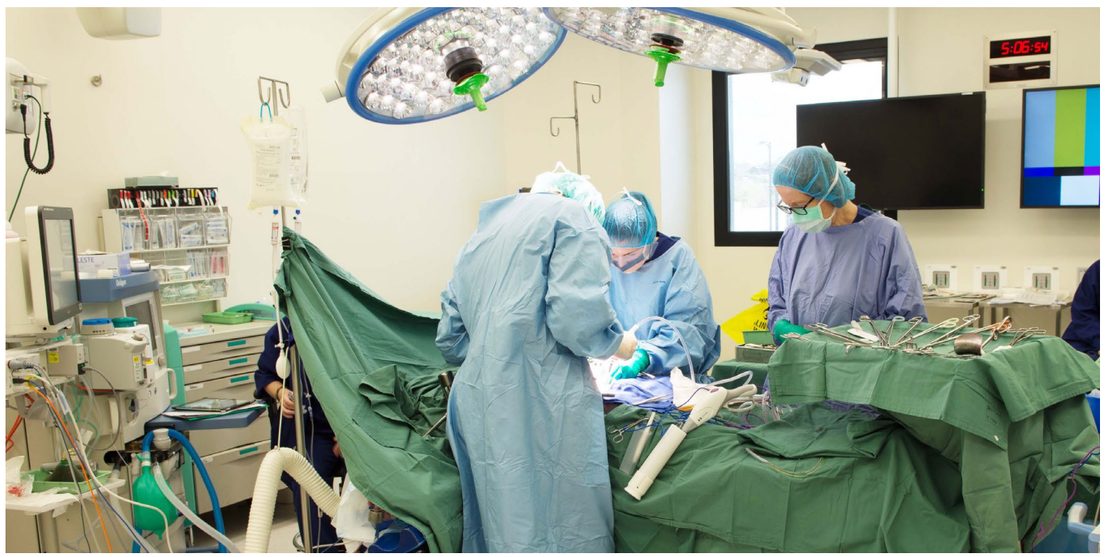

Image:
Mr Sean Hamilton receiving award from Past President Mr Phil Truskett AM.

Congratulations!

Mr Sean Hamilton FRACS: Award of the ESR Hughes Medal

The ESR Hughes award recognises distinguished contributions to surgery, honouring those who stand out by virtue of their commitment to their field. The most recent recipient of this prestigious award, Sean Guy Livingston Hamilton has devoted his life to the promotion of and education in the field of plastic surgery.

Sean Hamilton attended the University of Western Australia and was awarded his Bachelor of Medicine and Bachelor Surgery (MBBS) in 1972, completing his registrar training and gaining his FRACS by 1980 at St Vincent's Hospital, Melbourne. Sean was awarded the Plastic and Reconstructive Surgery Prize, RACS in 1980. He undertook overseas Fellowship in Advanced Plastic Surgery and Reconstructive Microsurgery at the Eastern Virginia Graduate School of Medicine in the United States in 1982 where he won the South Eastern Residents Prize for that year.

On his return to Australia, he became a consultant plastic surgeon at the three WA hospitals: Royal Perth Hospital; Princess Margaret Hospital; and Sir Charles Gairdner Hospital where he served as Head of Department between 1995 and 2001. He also worked at a number of Perth private hospitals, during which time he also served as a member and Deputy Chair of the Mount Hospital Medical Advisory Committee from 1998-2013. Sean held the position of Secretary for the State Committee, RACS from 1984 to 1990. During this time he was appointed organiser and convener for the newly created Head and Neck Group Meeting held at the 1987 RACS meeting in Perth.

Sean Hamilton went on to hold numerous memberships and offices throughout his career including Deputy Director of the Western Australian Melanoma Advisory Service (2000 – 2014), Councillor with the Australasian Society of Aesthetic Plastic Surgeons (2008 – 2014), President, Western Australian Society of Plastic Surgeons (2005 – 2007), Councillor with the Australian Society of Plastic Surgeons (1998-2000) and Councillor and Director of the Royal Australasian College of Surgeons (2012-2014).

In concert with his involvement in multiple areas of plastic surgery, Sean Hamilton has published several articles in prestigious journals, including co-authoring the well cited paper "The Scapular Free Flap" in the British Journal of Plastic Surgery. His interests in reconstructive microsurgery teaching and education have led to him holding numerous positions as examiner, course co-coordinator, organiser of registrar training, conference organising and registrar course convening. He has served ten years as an Examiner in Plastic and Reconstructive Surgery of RACS, including five years as Senior Examiner. During this period he was also involved in a curriculum revision for Fellowship exams. Sean also served as the Coordinator for Plastic Surgery Education for the Western Australian Society of Plastic Surgeons for over ten years and as University of W.A. Department of Surgery Examiner for seven years.

His life time contribution to education, educational institutions and his influence in raising standards is worthy of recognition. He has been an outstanding Councillor and generous supervisor of surgical trainees.

Citation kindly provided by Mr James Savundra FRACS

In memoriam

RACS publishes abridged Obituaries in *Surgical News*.
We reproduce the first two paragraphs of the obituary. The full versions can be found on the RACS website at:
www.surgeons.org/member-services/in-memoriam/

John Samuel Hopkirk

General Surgeon

November 1922 - September 2017

John Samuel Hopkirk was born in Kelburn, Wellington, to Cyril Hopkirk (a veterinarian) and Dorothy (nee Saunders, a ballet dancer and teacher). He had two sisters, Mary and Patricia and a brother, Alan. John's early life was coloured by his father's absence for veterinary studies at Melbourne. Money was tight. At the age of four he had surgery to remove a hydatid cyst from his lung and as a consequence he was educated at home for a year. This gave him a head start at Upper Hutt Primary School where he went directly into Standard One. His secondary schooling was at Wellington College. He enjoyed chess, playing the piano and a variety of sports, but excelled in shooting, representing both the College and Wellington.

At the age of seventeen John entered Knox College to study medicine at Otago University. At Knox College he was a member of the 'Green Hornet Gang' noted for endless academic pranks within the hall. He commented on student life: "*The lifestyle in Knox College in 1940 onwards was fundamentally one of persistent hard work. There was a war on, and we were reminded that we were a privileged group to be allowed to study at such a time and if we failed to perform academically, we too would not continue to have the privilege of study. Knox was a college with strong traditions, closely allied to the Presbyterian Church by which it was governed. Alcohol was not permitted, and women only to a limited degree.*"

Brian Otto

Orthopaedic Surgeon

1938 - 2017

Brian Otto was born in Auckland, the only child of Gwen Fairey (a milliner) and Sandy Otto (Milk Board employee). The family moved to Greenmeadows, near Napier, when he was still a toddler and he grew up there attending Greenmeadows Primary School and later Napier Boys High School, where he was a member of the first fifteen, the Pipe Band and Head Boy.

Brian then entered Otago University and secured a position in Medical School completing his MB ChB in 1962. He spent the next two years as a house surgeon in Auckland. During this time, on a trip back to Hawkes Bay, Brian met Dorothy Cardno (a clerk) and they married a few months later. In 1964 their first son, Chris, was born and their family was completed with the arrival of a second son, Simon, in 1967. On securing a position as surgical registrar at Middlemore Hospital, Brian and his family bought their first family home in Mt. Roskill. In 1968, after three years as a rotating surgical registrar in Auckland, Brian obtained a six month position as orthopaedic registrar at St. Mary's Hospital in London. A further six months was spent at the Royal Surrey Hospital and during that time Brian secured his FRCS(Ed). Following a year as orthopaedic registrar at the Ipswich and East Suffolk Hospital Brian returned to his family in Auckland.

John Stuart Simpson MNZM, FRCS (Eng) FRACS

General Surgeon

28 October 1942 – 15 October 2017

William Shakespeare, in his play 'As You Like It' could well have been describing John Simpson as he wrote-

"All the world's a stage,
And all the men and women merely players:
They have their exits and their entrances;
And one man in his time plays many parts".

- because John did play many parts during his life - and in each role he excelled. There was John the 'sportsman' who defeated the English Schoolboys Boxing Champion, played cricket for the English Schoolboys' team, and senior rugby for St. Mary's Hospital in London. There was John the 'Renaissance man' who graduated from the University of Cambridge with a BA Hons and retained an active interest in the Classics throughout his life, eventually returning to the study of Latin during his retirement. There was John 'the actor' who at Pinewood studios in London played the part of a handsome escort in the film '*It happened to Me*', a guard at Fort Knox in '*Goldfinger*', and an extra in '*Those Magnificent Men in their Flying Machines*', to mention but a few. Of course there was John 'the academic surgeon', author of numerous publications and holder of Visiting Professorships in four different universities. And finally, John 'the servant' to the highest standards of patient care and the College.

John more than fulfilled the description of the early nineteenth-century surgeon - 'A good Fellow, scholar, a gentleman as well as a dignified diagnostician and a sturdy sawbones'. After spending his formative years in England and completing surgical training, in 1977 John moved to Wellington to take up a position as Senior Lecturer in Surgery. He quickly completed his FRACS and forged a career committed to the College and the development of surgery, and in particular breast surgery. Characterised by great energy, unshakeable integrity and an advocacy for the highest standards of professionalism in surgery with complete commitment to patient care, John was a source of wise counsel to many colleagues and organisations. He will be remembered as an innovator, a clear thinker, a first class surgeon and a man of great *mana* and dignity.

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.

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