ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 18 NO 7 AUGUST 2017

From Angkor to Monash

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Surgery & motherhood

Dr Amiria Lynch shows us that parenting is possible in any environment

Improvements to MALT

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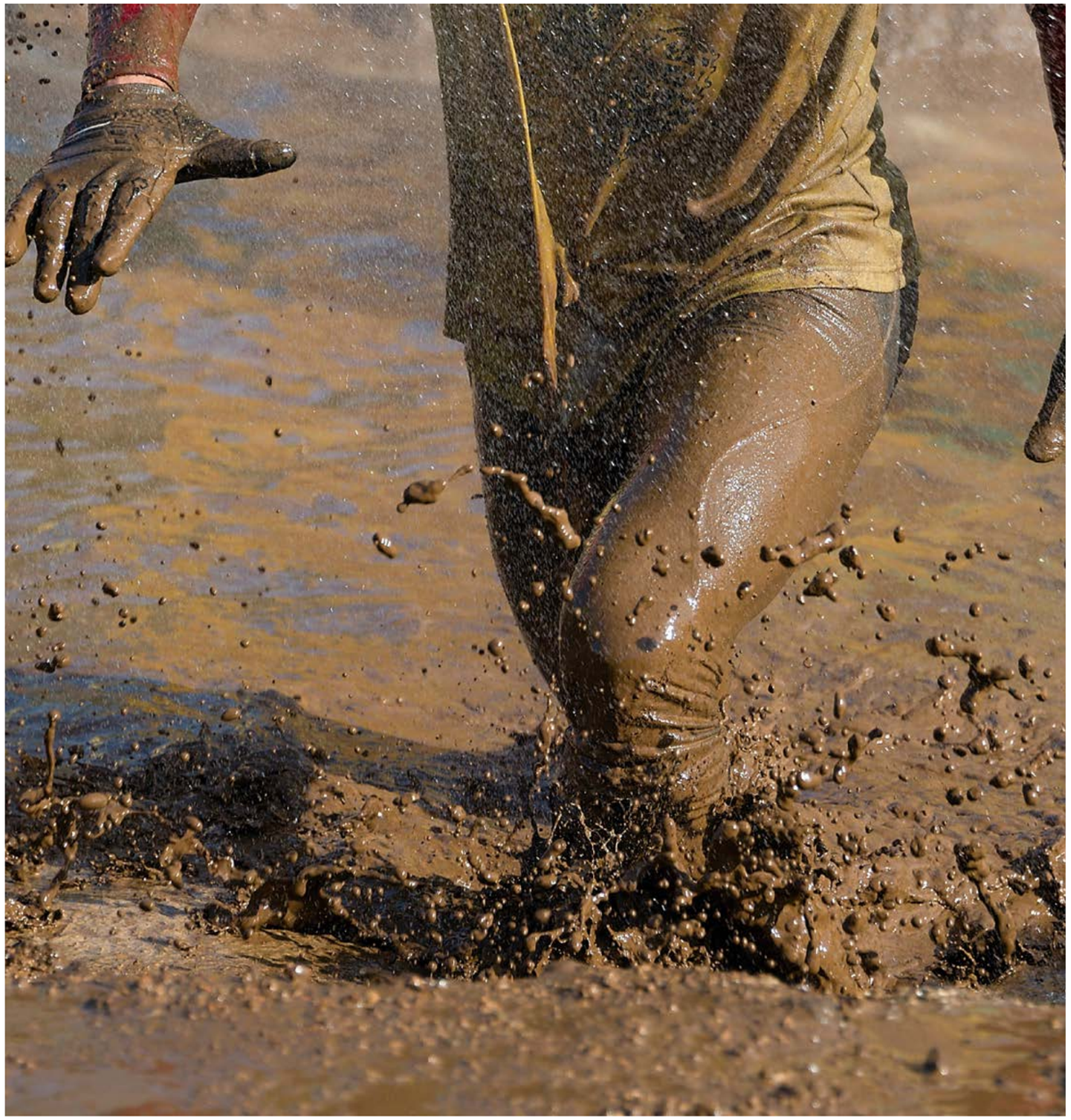
RACS LET'S OPERATE WITH RESPECT

The College of Surgeons of Australia and New Zealand



The best way out is always through.

Robert Frost

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Surgical News Editor: RACS CEO

Achieving Aboriginal, Torres Strait Islander and Māori recognition

JOHN BATTEN
President

This autumn has seen landmark action across Australia, calling for evidence of progress in achieving recognition and equity for our Aboriginal and Torres Strait Islander peoples.

As we mark the ten year anniversary of the "The Intervention" and its divisive legacy, we also now look to the recent Uluru statement, asking how we as a country can navigate and reconcile our colonial past, and move to embrace a new future.

RACS has a rich history of activity in this important area.

Associate Professor Kelvin Kong (pictured, left), an Otolaryngology, Head and Neck surgeon, championed the cause within the Fellowship to address the iniquitous disadvantage within our First Nations peoples, raising awareness of Indigenous health needs, particularly in ear disease, education and training in both New Zealand and Australia.

Kelvin brought together a RACS Indigenous Health Working Group in 2005, culminating in the formation of the Indigenous Health Committee in 2009, of which he was the inaugural Chair. The committee has a broad cross-section of Aboriginal and Torres Strait Islanders, Māori and non-Indigenous Fellows and Trainees from Australia and New Zealand. Several e module resources, available on the RACS website, have been developed by the committee to assist Fellows, Trainees and IMG's to be culturally aware and progressively culturally competent.This will assist with managing patients of Indigenous decent, their beliefs, relationships with the land and the past, and how this influences their relationship and understanding of health related issues.

The committee is responsible for the RACS portfolio of Indigenous Health in Australia and New Zealand, for developing and implementing RACS policy and position papers and for developing programs that benefit Indigenous Health. A major priority is building stakeholder relationships with Indigenous communities and key representative groups such as Te ORA, the Māori Medical Practitioners Association, the Australian Indigenous Doctors' Association (AIDA), the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Leaders in Indigenous Medical Education (LIME) Network. The culmination of this committee's activity was the RACS Aboriginal and Torres Strait Islander Health Action Plan and the RACS Māori Health Action Plan, which were launched in 2015 and 2016, respectively. The Indigenous Health Committee coordinates the implementation and evaluation of the Health Action Plans and oversees RACS commitment to improve cultural competency of the surgical workforce and increase the number of Indigenous medical specialists, including Surgeons.

One of the key activities of the Aboriginal and Torres Strait Islander Health Action Plan was the development of the Reconciliation Action Plan, which was undertaken in collaboration with Reconciliation Australia. This enables RACS fellowship to contribute to the national reconciliation effort by the establishment, through the Foundation for Surgery, of 6 RACS scholarships awarded to Aboriginal, Torres Strait Islander and Māori medical students and junior doctors to attend the ASC, and 2 Indigenous SET Trainee scholarships. The award and scholarship recipients were presented at the Indigenous Health breakfast at the ASC in Adelaide.

The Foundation for Surgery, the philanthropic arm of RACS, this year identified Indigenous health as a priority and supports projects aimed at promoting the health and wellbeing of disadvantaged communities.

The current Chair of the Indigenous Health Committee, Dr David Murray (pictured, right), is a Darug man from the Sydney area. David, an upper GI surgeon practising in Launceston, organised an exceptional Indigenous Health program at the recent ASC in Adelaide. David and his colleagues presented evidence of trends and challenges in recruitment and retention of Indigenous students and aspiring Indigenous surgeons. RACS is also pleased to announce that our immediate past president, Phil Truskett, has been appointed as a Patron of Australian Indigenous Doctors' Association.

An important element of the Aboriginal and Torres Strait Islander Health Action Plan is the Surgical Education and Training Selection Initiative, which enables applicants to SET of Aboriginal and Torres Strait Islander decent, who meet the minimum requirements for training to be selected into the SET program. This has been taken up by several training boards and many others are considering the initiative but need to define the minimum standards. RACS also welcomes Professor Martin Nakata as Education Advisor to RACS on Indigenous matters. Martin is Pro Vice Chancellor of Indigenous Education and Strategy and Head of Australian and Torres Strait Islander Centre at James Cook University, Townsville. Professor Nakata has worked in areas of Indigenous education for 36 years, and in the higher education sector for the last 20 years. His research focus has been on higher education curriculum development and the academic preparation of Indigenous students. His guidance and wise counsel will be invaluable as we move to realise our Reconciliation Action Plan and together guide our Trainees and Fellowship in achieving cultural safety in their professional activities.

"Partnering for good health and wellbeing for Indigenous Australians" is a collaboration between the Australian Government, the Council of Presidents of Medical Colleges (CPMC), AIDA and NACCHO to Closing the Gap in health outcomes between Indigenous and Non-Indigenous Australians. As a member of CPMC, RACS has signed up to work in partnership to deliver the Governments National Aboriginal and Torres Strait Islander Health plan 2013-2023, and to be an active party in the current revision of the Implementation Plan.

Finally, June 30 saw the launch of the Aboriginal and Torres Strait Islander Network, a key initiative highlighted as part of the RACS Reconciliation Action Plan. The Network provides a forum to promote, connect, and support members of the RACS community who share interest and commitment towards improving Aboriginal and Torres Strait Islander health outcomes. The network aims to link interested Fellows, Trainees and IMGs, encouraging the exchange of knowledge skills and experience, fostering collegiate support for engagement through outreach, research and advocacy work. Our New Zealand colleagues envisage a Māori health network in the near future. To join the network please email indigenoushealth@surgeons.org

We as Fellows and the Fellowship must embrace the opportunities that these programs and initiatives as will allow our first nations peoples to achieve health and social equity.

Find out more

RACS Reconciliation Action Plan
https://www.surgeons.org/media/24170346/2016-05-24_RACS_RAP-2016.pdf
Māori Health Action Plan
https://www.surgeons.org/media/22617045/maori-health-action-plan-2016-18_final_29-february.pdf

The Aboriginal and Torres Strait Islander motif

The motif design was created to symbolise RACS commitment to help Close the Gap in Aboriginal and Torres Strait Islander disadvantage across Australia. With dual concepts in mind, it features two snakes winding around the winged staff symbolising medicine, and can also be seen as Rainbow Serpents entwined together carving out the land, creating our rivers and mountains. The white dotted pathways descend from the mountains, flow through the rivers and ascend back to the skies reforming as rainbows, the spirit of the Serpent. Symbolic of medicine, the two snakes winding around the winged staff also symbolise Aboriginal and Torres Strait Islander and non-Indigenous people coming together. The heights of the rainbow also symbolise greater professional equity as well as improved health, social and economic wellbeing for all Aboriginal and Torres Strait Islander people and communities across Australia.

The motif was developed by Marcus Lee. Born and raised in Darwin, he is a descendant of the Karajarri people and is proud of his Aboriginal heritage.

Election to College Council

Influence the future of your College

CATHY FERGUSON
Vice President

Annual elections to Council, the College's governing body, are about to take place. You are invited to consider putting yourself forward to be involved in the governance and leadership of the College.

If you do not wish to do that, you are strongly encouraged to vote, thereby helping decide who will serve those functions on your behalf.

As a membership organisation, it is your College and you have the right to influence how it is run.

What's involved?

Election to Council means becoming a director of a medium sized business with all the duties, responsibilities and rights that entails. You will be well supported. The College funds all new Councillors to undertake the intensive, highly regarded Company Directors graduate course run by the Australian Institute of Company Directors (AICD). Annual governance training is also provided for all Councillors.

Council meets three times a year in the last week of February, June and October with senior boards and committees meeting just prior. Incoming Councillors are invited to observe these meetings in February before taking office at the Annual General Meeting in May. A comprehensive induction is provided and the culture of collegiality within Council ensures a smooth transition into the role of Councillor.

Council sets RACS' strategic direction, its goals, business plans and budgets and monitors their implementation. In doing so, it works closely with the CEO and senior staff. There is enormous scope for Councillors to contribute to all aspects of surgery through the various committees of Council. You will have the opportunity to understand the College's various activities as never before and to influence its direction in SET training, professional standards and development, risk management, advocacy, global health and audits, to name a few.

The position is not salaried, but all expenses are covered.

As RACS embarks on ever more rigorous efforts to safeguard our professionalism and standards into the future, it needs the best talent available.

Image: Council June 2016

I strongly encourage you to consider becoming involved and help lead your College over the next few years. I have found my involvement on Council to be extremely rewarding, both professionally and personally, and it has helped me gain new skills outside the confines of surgical practice.

How and when do I nominate?

College Council is made up of 25 Fellows:

- 16 Councillors are elected by the Fellowship at large.
- 9 Councillors are elected by Fellows in their Specialty.

If you are a Fellow in good standing with no disciplinary sanction placed against you by a regulator or employer you may nominate yourself for election. Your nomination is required to be supported by two other Fellows who are also in good standing.

On Friday 18 August you will receive an email with a link to where you may nominate for election to Council. Nominations are done online and will close on Friday 1 September.

The online CV form enables candidates to submit information and a photograph of themselves. It also enables two supporting Fellows to add brief statements about why they think the candidate would make a good Councillor.

Seeking Diversity

Boards everywhere are being urged to recognise the value of diversity to good decision making. RACS Council is particularly committed to promoting and supporting diversity through its Diversity and Inclusion Action Plan (http://www.surgeons.org/media/24924140/2016_12_20_diversity_and_inclusion_plan.pdf) so age, gender, and ethnicity should not be considered barriers to nomination. We are proud of already achieving almost one third female membership (32%) of Council.

Why Vote?

All Fellows are entitled to vote and all are strongly encouraged to do so. Why?

Firstly, with your vested interest in the continuing success of your College, you can influence its direction and determine who will lead it on your behalf. Secondly, the authority of Council itself is enhanced by having a strong mandate from the Fellowship – which includes you. Councillors who are elected by a good proportion of the Fellowship feel a commensurate obligation to keep faith with their electors and to be held accountable for fulfilling their duty to act in the best interests of the College as a whole. Thirdly, the authority of our College as a professional body is also enhanced by evidence of strong engagement by its membership.

Power of RACS to speak for all surgeons

RACS ensures that surgeons have a respected voice and influence with health policy makers, regulators, funders and other stakeholders. By participating in the elections to Council you exercise your member's right to influence Council's and the College's effectiveness in the many areas of the College's endeavours. This includes advocacy on any issue which affects the ability of members to meet their responsibilities to patients and to the community - one of the founding purposes of the College.

How and when do I vote?

On Friday 8 September you will receive an email with a link to the ballot to elect Fellows to vacancies on the College Council.

Candidates' CVs, photographs and their supporting Fellows' statements are intended to help you decide who to vote for, irrespective of whether you know the candidates or not.

I would like to say again that your participation by voting helps ensure RACS has a wise, diverse and capable Council directing its efforts to safeguard our professionalism and standards into the future.

Voting will close on Monday 25 September. Please take the time to read about each of the candidates and submit your vote. Electronic voting makes the process even quicker and easier.

Here is your chance to influence the future of your College!

– With Margaret Rode,
Manager President's Office and Council

Give us our daily bread – but is it good for you?

DR BB-G-LOVED

The Mediterranean diet has been found to be one of the healthiest, with its staple carbohydrate being bread. The bread is often consumed in generous quantities, soaked in olive oil, the latter rich in Omega 3s, also exhibiting anti-oxidant and anti-inflammatory properties. Populations who consume the traditional Mediterranean or Cretan diet have enjoyed good health and longevity in comparison to some of their Northern European counterparts. It is also conceivable that sunlight, physical work and a simpler life contribute to the statistical associations reported with better health outcomes.

For many, bread is their staple food and much enjoyed. But how healthy is it, which bread should we choose and what has been added to make it more appetizing and profitable? A slice of bread is about 25-33g, though many food constituents are listed in quantities per 100g or about 3-4 slices. Bread flour can be made from a variety of grains, maize, quinoa, chia seeds, rice or nuts. The most common grains are wheat, spelt or rye. We can choose from white, wholemeal, multigrain, brown, sourdough, sprouted, spelt, paleo and gluten-free varieties.

Bread is generally around 75 per cent carbohydrate, 10-12 per cent fat, 11-15 per cent protein and 0.5-2.0g fibre. Before you pop that extra slice in the toaster also consider the 200-300KJ per slice as well as any salt, sugar, preservatives and artificial flavours.

The National Health and Medical Research Council recommends a daily sodium intake of 20–40 mmol (460–920 mg) equivalent to 1.15–2.3g salt. The average slice of bread contains 125-170mg of sodium, between one third and one sixth of one's daily requirement.

Sugar may be added for taste as a sweetener in addition to the sugars that naturally occur in bread. A recent analysis of 15 brown and wholemeal breads from British supermarkets revealed that the manufacturers had added sugar in 10 of the 15 breads, and some contained more sugar than their white bread counterparts, where only 4 of 15 brands had had sugar added. The manufacturers of the so-called healthy breads claimed they needed to add the sugar to mask the bitter taste of the wholemeal flour! Sugar is almost addictive and too much sugar intake is certainly a public health problem. Is your brand of bread surreptitiously upping your sugar intake and along with extra carbs contributing to adiposity where you don't want it?

The World Health Organisation (WHO) sugar report in 2015 recommended that for adults and children less than 10 per cent [and preferably only 5 per cent] of energy intake should be consumed in the form of free sugars. This is the equivalent of less than 10 tsp per day (40g). One slice of some breads may contain up to 1g of sugar, though the traditional Mediterranean diet white bread in Southern Europe and olive oil is a healthy staple without added sugar. Spelt flour breads and many sourdoughs also have little added sugar. Be careful about how much sugar is added to gluten free breads, particularly as coeliacs are prone to type 2 diabetes.

Some countries add Vitamins such as Folic Acid, Niacin, Thiamin, and Vitamin E), but also Iron, or iodised salt, all with the best intentions for public health. Preservatives are often added to prevent mould but there can be a whole variety of other ingredients slipped into your loaf including artificial flavours, emulsifiers and various other chemicals for taste, appearance or a longer shelf life. 'Healthy' brown and wholemeal breads may not be what they appear!

Should you go against the grain? There is probably little need to avoid bread unless you are suffering from unexplained abdominal pain and bloating or non-specific symptoms that are difficult to diagnose. Then it may be worth a trial off wheat to see how you respond. Spelt flour may be an alternative if you are not gluten sensitive. Another time to avoid bread may be when deliberately reducing carbohydrates in the diet in favour of protein to build muscle and burn fat. But otherwise go ahead and enjoy that slice of hot buttered toast!

#Hashtags

The sheer volume of information being fed into social media is overwhelming. Every second, approximately 6,000 tweets are posted on Twitter; Instagram users share an average of 95 million photos and videos per day. Hashtags are the most effective way to cut through the noise to find relevant content.

Hashtags are an easy way to contribute to a particular conversation, and makes it easier for others to find your posts. By simply putting a pound or hash symbol (#) before a word, you can easily search for related posts and tweets.

Hashtags first appeared on Twitter as a way to group tweets by a theme, but have become pivotal in other platforms such as Instagram. The use of hashtags took off after they were widely used in tweets during the 2007 San Diego forest fires in Southern California. Hashtags are now most often used for live-tweeting events, updating or contributing to a news story, during a disaster situation (such as the recent Manchester terror incident), gathering support for an advocacy campaign or collating user-generated content during marketing stunts. With social media becoming the fastest source of news, hashtags serve as the tool to channel.

Although you may think social media is a short-lived phase, this ever-evolving landscape is invading our vernacular. 'Hashtag' was added to the *Oxford English Dictionary* in June 2014, along with 'unfriend', 'emoji', and more recent 'clicktivism' (a pejorative word for armchair activists on social media). If you need further assistance in getting your social media presence and vocabulary up-to-date, please contact RACS' Digital Media Coordinator at fax. mentis@surgeons.org.

A picture paints a thousand words

In May this year, the new purpose-built Monash Children's Hospital (MCH) in Melbourne officially opened its Paediatric Surgical Simulation and Tele-health Centre, the first dedicated paediatric facility of its kind in the Southern Hemisphere.

Politicians, donors, administrators, supporters and staff all arrived to mark the proud achievement but there was one doctor in attendance who was particularly pleased to be there to witness the moment.

Paediatric surgeon Dr Amiria Lynch had spent the previous twelve months not only helping develop plans for the centre but also completing a Graduate Certificate in Clinical Simulation at Monash University to equip her with the skills to teach at the centre alongside her colleague, Director of the Surgical Simulation Unit Dr Ram Nataraja.

Only three months before the opening, Dr Lynch had given birth to her third child, was away on maternity leave and breast feeding.

However, as she told *Surgical News*, there was nothing that would have kept her away on that special day. With baby Nikolaos so small, she decided to bring him with her in a sling whereupon he was welcomed as the newest member of the MCH Paediatric surgical team.

A photograph of Dr Lynch with baby taken on that day when she was demonstrating a simulation training task for laparoscopic surgery has since been seen and warmly received by thousands of people through such online forums as Medical Mums and the Journal of Paediatric and Child Health.

She said that while she was initially taken aback by the enthusiastic reception the photograph received, she had since come to realise that it sends a powerful message about women in medicine.

"I think the message behind the power of the image is that it shouldn't be such a powerful image," Dr Lynch said.

"The response from junior doctors and medical students has been particularly encouraging because in some ways their enthusiastic response shows just how many medical students, in particular, really believe that choosing a career in surgery automatically means that other life options are limited.

"Many still believe that having children and being a mother represent a huge barrier to a career in surgery. It is a real concern to me that at work while heavily pregnant with Nikolaos, or when chatting about my other children, young doctors and students expressed amazement that I was a surgeon too.

"I was therefore happy to have this photo taken and published widely because I believe it helps normalise and promote the reality of women, motherhood and a career as a surgeon."

Dr Lynch was born in New Zealand and completed her undergraduate studies at the University of Otago and began her surgical training in Auckland and Christchurch before arriving in Australia in 2009 to complete her specialist paediatric surgical training at the Royal Children's Hospital in Melbourne.

With a particular interest in paediatric colorectal surgery, in 2011 and 2012 Dr Lynch completed an Observership at the Colorectal Centre for Children at the Cincinnati Children's Hospital in the US and spent a year as a Paediatric Colorectal Fellow at the Leeds General Infirmary in the UK.

With three children aged under five, Dr Lynch said she believed the profession and RACS had come a long way in recent years in providing more flexibility for women surgeons, but that there was still some way to go in providing flexible training options for young doctors.

She said that while taking a child into theatre was not compatible with sterility or safety, she believed babies could and should be accommodated in a training setting or learning environment.

"I would love to see a time when all training, conferences, skills courses and meetings are more accessible to mothers in surgery," she said.

"RACS is doing some good work in this area by providing a parenting space at the last Annual Scientific Congress for example, yet completing CPD requirements still require complex logistics for new mothers who cannot simply pack up and go away for days at a time to attend meetings.

"Potential solutions could include providing more webinars, on-line modules and holding courses or meetings in regional centres rather than capital cities which would require less time away from home."

Having been accepted into a Masters Program in Surgical Education through RACS and the University of Melbourne, Dr Lynch hopes to take a lead in providing child-friendly training options for surgeons who are parents at the new simulation centre.

Upon her return from maternity leave in August, she will be working beside Dr Nataraja to provide training at the centre which features a purpose-built operating theatre, paediatric and neonatal ward and procedures room.

She said that Dr Nataraja would lead on skills training while she would provide training in communication, situational awareness, decision-making and teamwork.

> *"I think the message behind the power of the image is that it shouldn't be such a powerful image."*

"When it was announced that MCH would get this amazing new centre, I did the Graduate Certificate because I was very eager to expand my teaching skills based on the principles of adult learning and it has helped enormously in providing skills to provide really effective teaching. I am looking forward to continuing my learning with the Masters course." Dr Lynch said.

"As a Consultant in a public hospital I have spent years teaching registrars, medical students and nurses and surgical education has, over time, become a particular passion and interest of mine.

"I see no reason why babies could not be accommodated in a simulated learning centre and my long-term goal is to create a dedicated course for surgeons and surgeons in training who are returning to clinical work after time away.

"There is a course such as this run for Anaesthetists and it is very popular with people returning from maternity leave, or those who have spent time away completing a PhD or other research, or through illness.

"Dr Nataraja has set up a network called the Monash Academy of Simulation and we hope that within the next few years we will be able to offer such a course across all surgical subspecialties led by a member of the Academy.

"When you have mastered your surgical psychomotor skills it doesn't take long to regain confidence in your technical abilities but I believe that it takes somewhat longer to regain confidence in decision-making skills after time away from clinical work.

"I believe such courses should be widely available and Dr Nataraja and I are hoping to use MCH's new centre to provide training which incorporates non-technical skills such as communication, team work and decision-making into a technical training environment which we believe would be of great benefit to surgeons across all specialties."

– With Karen Murphy

Image (above): Attending the Victorian Trauma Committee meeting in the President's Meeting room at RACS.

Laparoscopic surgery takes off in the Solomon Islands

Image: Surgical Registrar Dr Clay Siosi and other surgical registrars practicing laparoscopic surgery on the Applied® simulator at the National Referral Hospital (NRH) Laparoscopic Workshop in Honiara, January 2017.

DR SEPEHR LAJEVARDI
Doctors Assisting In Solomon Islands (DAISI)

The National Referral Hospital (NRH), the main referral hospital for the Solomon Islands, located in the country's capital city Honiara, performed its first laparoscopic (key-hole) surgery in January 2017.

Although more than fifty years since laparoscopic surgery first began worldwide, surgeons in the Solomon Islands have made up for lost time, rapidly acquiring these skills thanks to a team of volunteer surgeons and anaesthetists under the umbrella charity "DAISI" (Doctors Assisting In Solomon Islands), with a second and third DAISI laparoscopic workshop at NRH conducted in April and June 2017. These three workshops involved 25 volunteer specialist surgeons and an anaesthetist from Australia, four registrars and six nurses, all paying their own way.

Dr Scott Siota, a general surgeon from NRH, and his team of registrars are now doing diagnostic laparoscopy and laparoscopic appendicectomy independently.

"We are so excited to be able to offer something to our people that for many years just was not available due to a lack of resources" said local Honiara surgeon Dr Scott Siota.

The acquisition of laparoscopic equipment was due to the generosity of a number of hospitals, MedEarth and Olympus, and was shipped over to the Solomon Islands thanks to the support of Rotary and DAISI.

NRH is the only tertiary hospital in the country, located in the capital city Honiara. It receives transfers and admissions from almost one thousand islands across the nine provinces that make up the Solomon Islands. With no CT scanner in the country, diagnostic laparoscopy, now available at NRH, makes sorting out the "undifferentiated abdominal pain" much easier, allowing quicker diagnosis and treatment, and discharge from what is already an overly burdened hospital.

In the West, laparoscopic surgery typically involves the use of disposable single-use equipment. This reliance on disposables is however problematic for the Solomon Islands, being expensive, and ugly with these disposables often ending up as land-fill. Therefore the introduction of new technology and procedures needs to be culturally appropriate, and one of the main objectives of DAISI, is to promote sustainability and provide re-usable instruments to avoid a reliance on disposables.

Laparoscopic surgery has a difficult learning curve. A systematic approach is required for teaching safe laparoscopic surgical skills, with ongoing teaching sessions scheduled to occur on a regular basis, organised totally by volunteers. Teaching also needs to include dedicated nursing staff, to ensure the necessary equipment is sterilised and cared for and stored appropriately.

Fortunately, due to the incredible generosity of so many individuals and organisations, DAISI has been able to send three shipping containers in the past two years with much needed medical equipment.

This year alone over 83 specialists have volunteered in the Solomon Islands with DAISI. "It never ceases to amaze me how much generosity there is amongst my surgical and anaesthetic colleagues. The trick is tapping into and directing this generosity" says Dr Gary McKay, founder of DAISI.

Image: DAISI volunteer and colorectal surgeon Dr Gary McKay and Honiara surgeon Dr Douglas Pikacha perform the first laparoscopic cholecystectomy at the National Referral Hospital (NRH) in January 2017.

With only five local surgeons serving the entire population of 580,000 in the Solomon Islands, the surgical caseload is often overwhelming. This represents a one hundred fold difference to Australia. The per capita income is also one hundredth that of Australia.

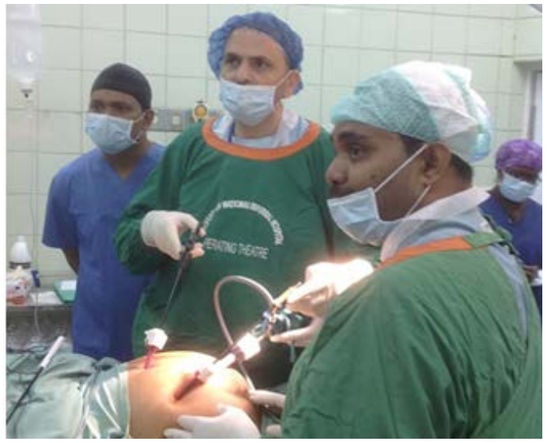


Image: DAISI volunteer hepatobiliary surgeon A/Prof Charbel Sandroussi and local surgeon Dr Scott Siota doing laparoscopic cholecystectomy at the National Referral Hospital (NRH) in April 2017.

The Solomon Islands is currently facing a turning point in its history, with the recent departure of the Regional Assistance Mission to the Solomon Islands (RAMSI). The Solomon Islands drive for self-determination must include a commitment to improving the medical workforce. Overseas training of surgeons and anaesthetists is expensive and fraught with failure. Unfortunately the "brain drain" often results in overseas trained doctors never returning to the Solomon Islands. With a huge number of recent medical graduates just returning to the Solomon Islands from medical training in Cuba, the need is now greater than ever to provide post-graduate specialist training within the Solomon Islands. DAISI is very excited to be involved in this process.

For more information about DAISI visit www.daisi.com.au.

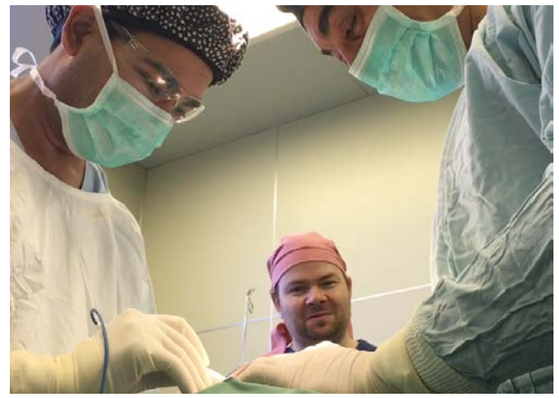


Image: DAISI volunteer and hepatobiliary surgeon Dr Anubhav Mittal and colorectal surgeon Dr Daniel Kozman performing laparoscopic cholecystectomy while anaesthetist Dr Adam Hill watches on during the most recent visit to Solomon Islands in June 2017.

COLLEGE
CORRESPONDENCE

The Editor
Surgical News
Re: "Lets Talk Teamwork" *Surgical News* (May 2017)
The original article can be found here: *https://www.surgeons.org/flipbook3d/Digital/SurgicalNewsMay20172/index.html*

The article in *Surgical News* May 2017 spoke of work from Western Australia with regard to communication. The concept of the "Multi-Professional Team Briefings" aids communication at all levels in theatres.

This Multi-Professional Team Briefing has become the "Huddle" in our theatre and has been the corner-stone of the improvements in our rural hospital theatre.

Shoalhaven Hospital is in rural New South Wales with 6633 elective and 1400 emergency operative procedures per year.

Over the last eighteen months the statistics regarding Shoalhaven Hospital's theatre efficiency have deteriorated dramatically. Problem areas were the first case on time, cancellations of patients on the day of operating, poor communications at all levels of care and between all stakeholders (medical, nursing and ancillary staff with patients and relatives).

A project was established under the umbrella of the Agency for Clinical Innovation (ACI) and four members of the nursing/administration staff combined with the head of division of surgery (HOD) to review the three concerns above and develop ways to overcome all of the problems.

A combination of manual and online questionnaires, focused meetings and many sheets of butchers paper were drawn on to determine the problems. Finally, a number of combined meetings (with food and drink as bribes) to establish a way to deal with each of the agreed problem areas.

The resultant outcomes were importantly linked to 'champions' who had individual intensive training in their areas of involvement. They were available to their colleagues from the start of the rollout of the improvements, as face-to-face or by easy access short films on the hospital web page.

What has been established into the culture and activities of the operating theatres are the following:

The "Huddle"

This has been the most important result of the project and has enabled many other successes, as a platform within the theatre groups.

1. **Theatre nurse huddle:** At 7am all theatre nurses to discuss the days lists and extraneous influences on the progression of the day.

2. **Whole team huddle:** At 7.30am in each operating theatre review each patient on the list. This involves everyone involved in each of the theatres who all have input into how the day is going to run, including patient requirements, clashes with equipment and equipment needed.

Data Dashboard and Executive Rounding

Each of the theatres report to the OT NUM who places a tick and gold star on a large board at the entrance to the theatre (and the tea-room) next to each surgeon's name if the team huddle is done and the patient enters the theatre by 0800 hours (time designated as 'start time' as per NSW Ministry of Health).

Establishment of a "Forecast Meeting"

This brings the OT Manager, on-call anaesthetic registrar, admissions clerk and patient flow manager together at 12.30pm in the theatre office. They review each of the lists the next day so that there are no concerns with the first patient. The notes are reviewed to ensure that all medical, nursing, admission and transport components of these patients are assessed to ensure a seamless progression into the start of each theatre.

Bowel preparation for colonoscopy

One of the areas of confusion for all involved in the patient preparation for colonoscopy was the requirements of each of the five surgeons and two gastroenterologists for the bowel preparation regimen for their patients. So that all the patients received only one set of directions, all the practitioners were bought together to work out one formula for the bowel preparation so that every patient received the same information regarding this often difficult area. This was an important success for the project and the teamwork and leadership shown by the seven practitioners was a mirror of what occurred over the entire process.

Communication

Providing information for patients and relatives regarding the admission process, day of surgery mechanisms and follow up have been broken into component parts by focused teams, (including patients). The resultant improvements have been implemented, and include:

A. Patients are asked what method of communication from the hospital is preferred
B. An allocated time is set each day for patients to contact the hospital
C. Patients receive SMS reminders of the day of admission
D. Patients receive an information package
E. Patients are contacted the day before their admission to confirm their ability to attend.

Pre-admission Anaesthetic Clinic

Extensive interaction between the anaesthetic champions, the general practitioners and the nurses checking the Request For Admission forms has resulted in a clear pathway for review of patients pre-operatively for serious illness. It has also empowered the General Practitioners in their pre-operative assessment. They are now providing relevant information rather than a collection of drug and illness data, that is often computer generated.

Results

All the Huddles (Multi-Professional team briefings) are active for seven months after the end of the project. They are the corner stone of the improvement in efficiency and camaraderie seen in the operating theatres of the Shoalhaven Hospital.

First Case on Time:
This is when the patient enters the theatre proper (not the anaesthetic room) at 8am. When the project commenced, the success rate was only 8 per cent but by the end of the project it was 65 per cent. The project length was only 10 months but we have managed to maintain this high level of involvement ever since.

The 'Champion':
The role of the 'Champion' has continued and has worked on so many levels. The most obvious is the continuation of all the Huddles in the day, encouraging the teams to succeed with the first case on time, the use of the Local Health Area's Time-out Sheet, handover information from reception through to theatres to PACU and then onto the ward, and the reinforcement of the duties (inter-professional tasks) that each does to ensure daily efficiency.

Patient's experience with the Surgical Hospital has improved dramatically
Staff have improved elective surgery patient experience at Shoalhaven Hospital by having a better understanding of pre-operative information, and with improvements in coordination and integration of pre-operative care, patient satisfaction increased from 50 per cent to 80 per cent by December 2016.

There has also been a reduction of inpatient-related day of surgery cancellations at Shoalhaven Hospital from 32 per cent to 15 per cent by December 2016.

There has been an improvement in compliance with the Ministry of Health Pre-procedure Preparation Tool-kit Request for Admission Screening Guidelines by:

- increasing the number of Request for Admission forms screened within 2 days of receipt from 0 to 70 per cent;
- reducing the number of patients who are not screened from 22 per cent to 5 per cent;
- increasing the number of patients who are triaged to the appropriate Pre-admission process (as per Illawarra Shoalhaven Local HD Guidelines) from 22 per cent to 70 per cent by December 2016.

The advantage of structured groups (Huddles!) has been seen in this review of the ACI project.

The ongoing success and improvements in all of the problems identified are due to the team building and enthusiasm generated by the huddles and the impact of the champions. Champions are representatives of all the theatre staff. Orthopaedic, gynaecology, general surgeons, anaesthetists, scrub and scout sisters, admission staff and patients all have an ongoing role in maintaining positive outcomes and ongoing success.

This massive project has achieved many changes in less than a year, to the function of the theatres. More importantly it has changed the culture within the theatre and provided a medium for staff to promote further improvements.

I agree with my colleagues from the study discussed in the *Surgical News* - "If you do not practice briefings regularly - give it a go".

Professor Martin Jones,
Honorary Clinical Professor, University of Wollongong
Head of Surgery, Shoalhaven Hospital
Nowra NSW

RACS advocacy

Private Health Insurance out-of-pocket costs

RACS is often asked to give evidence at Australian Parliamentary inquiries. In early July A/CEO John Biviano appeared before the Senate Community Affairs Committee Inquiry into the value and affordability of private health insurance and out-of-pocket medical costs.
Mr Biviano highlighted the College's work on surgical variation with Medibank Private and fielded questions about excessive fees and transparent reporting of surgical outcomes.
Read more about the inquiry at www.aph.gov.au.

Queensland advocacy on regional workforce

The Queensland Committee has been working closely with the state government to develop better approaches to grow the specialist workforce in regional areas. Through this engagement, a more supportive training experience for doctors in regional hospitals, including new investments for rural and remote doctor training and supervision has been announced in the Medical Practitioner Workforce Plan for Queensland and the soon-to-be announced Regional Post-Fellowship Scheme.

Northern Territory focus on road safety and alcohol

Following on from the successful 2016 NT "Let's put the brakes on open speed" campaign, the Northern Territory Committee provided input to the Northern Territory Government's new Road Safety Action Plan.

Key recommendations focused on:
- Reducing the availability of alcohol and its role in road trauma
- Better education programs
- Safe speeds and point to point speed enforcement
- Seatbelts
- The use of new technologies
- Drug testing
- Deterring the use of mobile phones while driving
- Investments in road infrastructure
- Driver licensing and mandatory first aid training
- Mandatory helmet legislation for cyclists

The Committee has also provided input to the NT Government's review of its alcohol policies and legislation. The NT has the highest pure alcohol consumption rate per capita in Australia, at 11.85 litres per person, and roughly 9,000 alcohol-related presentations to NT Emergency Departments each year.
Read the full submission at www.surgeons.org.

ACT Trauma Service model of care set to improve

After nearly two years of advocacy, a new model of care for the ACT's Trauma Service involving an eight-week consultant led roster will soon be implemented. This will mean better quality care for seriously injured patients 24 hours a day, seven days a week, and ultimately cost-savings related to reduced length of stay and better patient outcomes.

Many thanks to Dr Ailene Fitzgerald (pictured below, right) for her dedication and commitment to improving care for the most seriously injured in the ACT.

Violence against health professionals

Following the tragic death of cardiothoracic surgeon Dr Patrick Pritzwald-Stegmann who passed away following an assault by a visitor to the Box Hill Hospital, RACS wrote to the Victorian Premier urging action to prevent violence against frontline medical and hospital staff.

RACS believes that violence is unacceptable in any workplace and that no employee should be expected to accept any form of physical or verbal violence or abuse as part of their work environment.

The recent attack highlights the real and serious risks that health care workers face, even in locations that should be places of safety. RACS acknowledges the strong, bi-partisan approach taken towards the issue of violence against health care workers over the past few years in Victoria with a number of strategies implemented since 2014 but more needs to be done.
For more information about the Victorian Government's "It's never ok" campaign, visit www.worksafe.vic.gov.au.

Electronic cigarettes

Last month RACS provided a submission to the Australian Parliamentary inquiry into the use and marketing of electronic cigarettes and personal vaporisers in Australia. The evidence regarding the efficacy of e-cigarettes as a means for smoking cessation, their health effects, and impact on surgery is inconclusive. RACS therefore does not endorse their use in any way, either for therapeutic or recreational purposes, and believes e-cigarettes should be treated with the same level of caution as tobacco products.

Rheumatic Heart Disease

RACS has written to Queensland Health in support of making Rheumatic Heart Disease (RHD) a clinically notifiable condition. RHD is a clear marker of social disadvantage and poverty and RACS supports all efforts to better identify patients suffering from this condition.

Competencies and standards for Podiatric Surgeons

RACS provided feedback to the Australian and New Zealand Podiatry Accreditation Council (ANZPAC) on the Draft National Competency Framework and Standards for Podiatric Surgeons. RACS supports the position and submission of the Australian Orthopaedic Association, and believes the draft standards do not demonstrate the same stringent training requirements as the surgical profession.

Trauma course turns 21

Highlighting the Definitive Surgical Trauma Care (DSTC) course in Australia and New Zealand

DR JOHN CROZIER
Chair, Trauma Committee
PROF. STEPHEN DEANE
FRACS
ASSOC. PROF. PETER DANNE
FRACS
PROF. MICHAEL SUGRUE
FRACS

1996	First DSTC course in Australia – Liverpool Hospital
1999	Second DSTC course – Royal Melbourne Hospital
2000	Military Module incorporated in Melbourne
2003	DSTC manual published
2003	DSTC course introduced in Auckland, New Zealand
2003	DSTC course introduced in Portugal
2004	First DPNTC (Definitive Perioperative Nursing Trauma Care) course - Sydney
2009	DSTC course introduced in Brisbane
2012	DSTC course introduced in Perth
2017	DATC (Definitive Anaesthetic Trauma Care) course incorporated into DSTC courses in Australasia

The American College of Surgeons (ACS) Advanced Trauma Life Support (ATLS™) course [Early Management of Severe Trauma (EMST) course in Australia and New Zealand] was successfully promulgated internationally in the late 1980s, with clear beneficial impact on the early care of injured patients in communities in many countries. Through the early 1990s, it became apparent to a number of surgeons, familiar with trauma management around the world, that there was a need for training of surgeons in surgical decision-making, operative strategies and technical aspects, essential to the operative and non-operative care of injured patients. Following preliminary discussion in 1993 at the International Society of Surgery (ISS-SIC) in Hong Kong, five trauma surgeons met during the Annual Congress of the ACS in October 1993 and laid the foundations for the development of the DSTC (Definitive Surgical Trauma Care) course. Those surgeons were Drs Howard Champion (USA), Don Trunkey (USA), David Mulder (Canada), Abe Fingerhut (France), and Stephen Deane (Australia).

While the ATLS™ course addressed patient care and survival in the "First Hour" of trauma care in hospitals, the DSTC course would equip surgeons to care for the patient through the "Second Hour" while maintaining priority patient physiology and cellular survival. The course was conducted under the auspices of the International Association for Trauma Surgery and Intensive Care (IATSIC) and designed for early career surgeons and senior trainees. Developed to support flexible and affordable international implementation, it was anticipated that the course would be of particular relevance for developing countries and for rapid mobilisation medical units in areas of conflict.

After pilots in Paris (Fingerhut 1994-5), Baltimore (Champion 1994) and Sweden (Lennquist 1994), the first DSTC course was conducted in Sydney in May 1996 by the Division of Surgery and Trauma Department of Liverpool Hospital, in partnership with the University of NSW, and Prince of Wales/Prince Henry Hospitals, who provided the venues and technical support. The inaugural faculty members were Drs Don Trunkey (USA), Howard Champion (USA), Abe Fingerhut (France), Chris Kaufmann (USA); Stephen Deane (Aust), Michael Sugrue (Aust), Peter Danne (Aust) and Phil Crowe (Aust). The 24 participants included trainees, rural and metropolitan general, orthopaedic, neurosurgery and paediatric surgeons. The 2.5 day course included lecture presentations (physiology and organ support, strategic thinking and decision making, surgical techniques), case discussions, and surgical skills demonstration and practice.


DSTC 2003 course faculty

Case discussion has increased and become the most effective context in which to recognise and integrate rapidly changing physiology data and injury and outcome probabilities into rapid decision-making and appropriate interventions. Physiology was increasingly integrated into all course components, emphasising cellular survival and minimisation of multiple organ failure. The surgical skills practical sessions


DSTC 2004 faculty and participants - RACS

have retained their original structure and importance as consistently reported by course participants, while the curriculum has developed new strategies, techniques and products (resuscitation, haemostatic agents).

The second course in Australia was conducted from the Royal Melbourne Hospital Trauma Department in late July 1999, under the leadership of Assoc. Prof. Peter Danne, and has run annually ever since.

At the ISS-SIC congress in Vienna in 1999, a core DSTC course curriculum was approved by the IATSIC membership. A manual was developed in 2001, and published in 2003, edited by Prof. Kenneth Boffard of South Africa. Videos of surgical anatomy, procedures, and skills related to the DSTC course were produced in Melbourne in 2002.

A military module, that addressed definitive surgical trauma care unique to military and austere environments, was developed and implemented in Melbourne in 2000 and in Sydney in 2001.

DSTC began in New Zealand in August 2003 under the leadership of Prof. Ian Civil which ran alongside the Annual Injury Conference in Auckland. The faculty of the first course (29 participants) included Drs Damian McMahon (ACT), Scott D'Amours (NSW), Michael Muller (QLD) and John Crozier (NSW). The course is held annually with 1-2 international faculty and 16 participants.

DSTC courses have been conducted in Brisbane every couple of years since 2009, annually in Perth since 2012, and twice in Adelaide.

Operating theatre nurses have assisted with the performance and simulation fidelity of the practical laboratory sessions. For integration and to assist learning of the decision-making and strategies of surgeons, the Definitive Perioperative Nursing Trauma Care (DPNTC) course was born in 2004 in Sydney.

The International spread of the courses was initially led by Prof. Boffard and Prof. Michael Sugrue. The first international course developed in partnership with Liverpool Hospital was in Portugal in 2003. The DPNTC Course has also been running in Portugal.

The conduct of DSTC courses in ANZ continues to depend upon the high commitment and voluntary efforts of surgeons and operating room nurses, involved in trauma care. It is run by surgeons, for surgeons, and with the agility to modernise, revise and innovate in response to evidence, new technology and best educational practice. External career educators have added significantly to the continuing improvement of the course.

In 21 years, there have been 47 DSTC courses in Australia and 14 in New Zealand, accounting for over 1400 ANZ surgeons. The attendance of international course participants has created opportunities and enabled partnerships, which have led to the course being delivered in other countries. With more than 80 approved DSTC course instructors in ANZ, the inclusion of instructors from ANZ Major Trauma Services and multiple surgical specialties (General, Thoracic, Orthopaedic, Vascular, Neurosurgery) has enriched both the learning of course participants and the refreshment and enhanced knowledge of faculty members. Over 80 IATSIC approved international trauma surgery experts have contributed as teaching faculty in almost all DSTC courses in ANZ, further enhancing the international quality maintenance and curriculum progress as trauma care continues to evolve, based on new research and experience in both civilian and military settings.

In recent years, there have been initiatives aimed at increasing small group discussion and reflection and using Sim-Lab scenarios to enable operating room teamwork and communication.

There has been growing interest in finding ways to include ▶


Celebrating 21 years

Image: Decision-making with Ken Mattox and Michael Sugrue

colleagues from Anaesthesia and ICU giving rise to the recent development of the Definitive Anaesthetic Trauma Care (DATC) course being incorporated into courses in Australasia this year.

The DSTC course continues to be further developed and monitored by the International DSTC committee of IATSIC, which has always included strong ANZ leadership contributions. RACS provides important support to the Australasian DSTC course committee (a subcommittee of the Trauma Committee) and closely liaises with the ANZ Association for the Surgery of Trauma (ANZAST) to oversee the development of DSTC courses in Australasia.

In the 21 years up to May 14 2017, 439 courses have been conducted in 27 countries:

Argentina 3	France 9	Philippines 5
Australia 47	Germany 12	Portugal 18
Austria 20	Greece 16	Saudi Arabia 1
Brazil 32	Israel 8	Singapore 19
Canada 19	Italy 4	South Africa 48
China 5	Japan 6	Spain 52
Cyprus 1	Netherlands 15	Sweden 33
Denmark 13	New Zealand 14	Thailand 7
Finland 2	Norway 27	Switzerland 3

The international ATLS™ (EMST) course program has been extraordinarily successful and effective because of its educational integrity, protocol-based approach and quality control, as well as the need for guidance by many participants, the commitment of its instructors, and the professional authority (ACS, RACS) conveyed to participants to act in practice as they have learned in that course. The DSTC course structure, content, leadership and professional authority (IATSIC, RACS, ANZAST) are influenced by similar intentions, while ensuring enough flexibility for the program to be adaptable for achieving the maximum benefit for communities served by the participants in any course location.

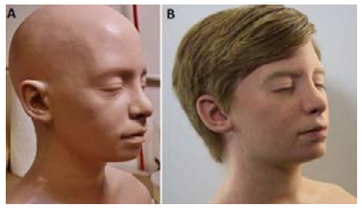
Newcastle entrepreneurs create app to shake up working lives of health professionals

Covering your shift just got a whole lot easier with the development of a Smartphone app that allows you to swap or pick up shifts between your colleagues. *CoverMe Medical*, a subscriber based app is the second to be developed by start-up company Mobito located in the Hunter Valley. Colleagues can advertise their shifts, users receive a notification and can accept if they are available of willing to work it. Perfect! The app is currently being trialled with select groups before it is released on the market.

Visit: http://www.theherald.com.au/story/4632754/shift-swap-theres-an-app-for-that/

When Hollywood met brain surgery

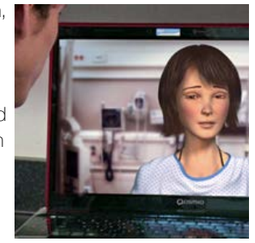
A 3D simulator that guides trainees through an endoscopic third ventriculostomy (ETV), has recently been trialled successfully, marking what could be the future for 3D surgical simulation training. Engineers and neurosurgeons worked with the assistance of Hollywood special effects experts to create a life-like, anatomically correct full-size head and brain with the touch and feel of a human skull and brain tissue. Special features of the simulator include an electric pump to reproduce flowing cerebrospinal fluid and brain pulsations as well as facial features, eye brows and hair.



Visit: http://knowridge.com/2017/04/when-hollywood-met-brain-surgery/

Virtual humans help aspiring doctors learn empathy

A cyber communication tool that allows the learner to talk with computer-based, fully emotive Virtual Humans has been developed in the US, providing detailed feedback about his or her non-verbal communication during the interaction, what was done well and what could be done better. The application, MPathic-VR, could help aspiring doctors better prepare for difficult and emotionally charged discussions with patients and their families according to a study conducted this year by researchers from the University of Michigan.



Visit: https://medicine.umich.edu/medschool/news/michigan-health-lab-virtual-humans-help-aspiring-doctors-learn-empathy

From Angkor to Monash

In 2015, RACS and Monash Children's Hospital welcomed Surgeons International Award recipient, Dr Sophy Khan from Angkor Hospital for Children (AHC) in Siem Reap, Cambodia.

MS ANNETTE HOLIAN
Chair, External Affairs

Growing up in rural Cambodia during the years of the brutal Khmer Rouge regime, young Sophy Khan contracted a nasal infection which became increasingly severe as his parents battled to seek medical treatment. The regime's persecution of intellectuals, educated professionals and individuals, meant that few educated Cambodian doctors remained in the country. Sophy's infection was left untreated for more than 3 years, causing him and his family great distress; this was until a doctor from the International Red Cross removed the foreign body from his nose.

From this marked childhood experience, becoming a surgeon was a natural progression for Sophy. He was strongly motivated to attend medical school and after successful completion of his studies in 1998, Dr Khan began his medical training at Sihanoukville Referral Hospital, 242km south-west of Phnom Penh.

Dr Khan quips that at the time, Sihanoukville Hospital was a '500 star' hospital, not because of any official rating. However, due to the fact that the hospital lacked roofing over particular areas, he explains, *"one could see 1, 2, 3, 4, 5...500 stars!"* Dr Khan also reminisces that the hospital and patients received many interesting visitors, including cows that would come to visit the wards, seeking shelter during the rainy season.

Dr Khan visited the Monash Children's Hospital in February – April 2015 and received training in paediatric urology under the supervision of paediatric surgeon A/Prof Chris Kimber FRACS. He has now applied the skills and knowledge acquired throughout his time at MCH directly to his own work in Cambodia. Dr Khan believes that the training has resulted in overall better practice in handling urological cases including, VCUG management, hypospadias and pre- and post-op.

Dr Khan has worked at the Angkor Hospital for Children (AHC) for over 10 years and is passionate about helping disadvantaged children and families in the region. The vision of Dr Khan's hospital, the non-profit paediatric AHC, is to provide *'high-quality, compassionate care to Cambodia's children, wherever they live and whatever their ability to pay'*, with some of Cambodia's most vulnerable children falling under their wing.

For Dr Khan, improving access to safe and affordable care is key for children in Cambodia.

He also believes that the greatest challenges facing paediatric healthcare in Cambodia is improving the quality of care with the need for more training. In the long term, he wishes to achieve greater finesse in his skills and looks forward to teaching the new generation of Cambodian surgeons. His sage advice to future Surgeon International Awardees is to focus on improving their knowledge through intensive training, to provide the best quality of care in their home communities. We wish Dr Khan all the best in his future endeavours!

The Surgeons International Award was established in 1989 in order to provide access to further training opportunities for surgeons from lower to middle income countries. The objective of the award is to help recipients acquire the knowledge, skills and contacts needed for the promotion of improved health services in their home country. The Surgeons International Award has since enabled 67 health professionals from different backgrounds to undertake short-term visits to Australian and New Zealand hospitals. RACS Global Health warmly invites nominations of worthy individuals for a Surgeons International Award.

RACS Global Health warmly invites nominations of worthy individuals for a Surgeons International Award.

– With Gwyn Low, Global Health, RACS.

RACS Aboriginal and Torres Strait Islander Network

DAVID MURRAY
Chair, Indigenous Health Committee

On 30 June at the College Council meeting RACS President John Batten launched the RACS Aboriginal and Torres Strait Islander Network. As a key initiative of the Reconciliation Action Plan the network has been formed to act as a forum to promote, support and encourage Fellowship engagement in Aboriginal and Torres Strait Islander health. Membership of the network is free and open to all Fellows, Trainees and IMGs currently working in or with an interest in Indigenous health in Australia and New Zealand.

RACS acknowledges that improvement to Indigenous health outcomes is a social responsibility requiring collective and individual action by the college community in Australia and New Zealand, working in co-operation and partnership with the Indigenous communities we serve. Many of our Fellows have been working with Aboriginal and Torres Strait Islander peoples and organisations for many years, participating in clinics, outreach work and service delivery conversations across Australian regions. Sharing and learning from these experiences is a powerful way in which we can build the capacity of our members to deliver culturally safe patient care.

As RACS goal is to increase the numbers of Aboriginal and Torres Strait Islander surgeons the network will also provide members with opportunity to contribute to the development of initiatives and policies that will drive engagement with our young Indigenous doctors. If you have experience and skills and/or an interest to develop your knowledge and ability to practise in Indigenous health I strongly encourage you to consider becoming a part of the network. The membership benefits include (but not limited to!):

- Exclusive identifiable Network pin (based on the ATSI motif)
- Develop relationships with colleagues working in the field, sharing expertise, research and experiences
- Opportunity to make a valuable contribution to RACS reconciliation initiatives
- Invitations to participate in projects, events and activities at a regional and national level
- Access to a safe forum for open and frank dialogue and discussion of issues
- Support Fellows in their cultural competency journey to deliver appropriate healthcare
- Opportunities to work with Indigenous Trainees, junior doctors and medical students
- Quarterly e-Newsletter with updates on news, programs, events and opportunities

How do I join the Network?

- **Online:** Send an email to the generic address Indigenoushealth@surgeons.org expressing their interest in joining the Network providing full name and RACS ID number.
- **Telephone:** Call the IHC Secretariat on 03 9276 7407

Professor Martin Nakata

During July council week RACS welcomed our new Education Advisor Professor Martin Nakata to the College. Professor Nakata is the Pro Vice-Chancellor (Indigenous Education & Strategy) and Head of the Australian Aboriginal and Torres Strait Islander Centre at James Cook University in Townsville. Professor Nakata is internationally recognised with an extensive research portfolio. His current research focuses on higher education curriculum areas, the academic preparation of Indigenous students, and Indigenous knowledge. He was the first Torres Strait Islander to receive a PhD in Australia. His mother is a Torres Strait Islander, and his father was born in Kushimoto-cho, Japan. Professor Nakata's role with RACS will be to provide strategic insight and encouragement, from his many years of experience, to RACS Indigenous health educational initiatives.

James Ramsay Research Grant

Research project examines program for improving access to surgical simulation training, particularly in outer metropolitan and rural locations

Research designed and directed by Professor Guy Maddern on behalf of the RACS has demonstrated that supervised, regulated simulation training allows junior doctors to develop consistent laparoscopic surgical skills more quickly than those undertaking self-directed learning.

The research project – funded through a James Ramsay Project Grant – examined the optimum program for improving access to surgical simulation training, particularly in outer metropolitan and rural locations, and successfully implemented a new program and format for the delivery of laparoscopic skills training.

Conducted over 2015 and 2016, the Laparoscopic Simulation Skills Program provided a Mobile Simulation Unit - a large van (pictured above) equipped with four Surgical Simulators - to 17 regional and metropolitan hospitals across South Australia and Victoria.

The study attracted 207 participants, including medical students, junior doctors and surgical and gynaecology trainees.

While the College always examines the effectiveness of course delivery, this research represents the first time that different models of learning were compared as to the consistency and speed of skills acquisition.

Designed to determine the best format for delivering a simulated laparoscopic short course, participants were randomised at each hospital into two cohorts with Cohort 1 performing self-directed learning (SDL) and Cohort 2 conducting training in the Mobile Simulation Unit (MSU) under supervision over one week followed by SDL.

All participants were trained and assessed on the acquisition of the psychomotor skills required to conduct peg transfer, pattern cutting and knot tying with both groups assessed at baseline and at the end of their SDL period; participants in Cohort 2 were also assessed at the end of their training in the MSU

The research found that:

- Participants in the MSU and SDL group (Cohort 2) improved more and with less variability than participants in SDL only group (Cohort1) with improvements achieved over a shorter timeframe;
- Simulation-based education (SBE) should be delivered at the site of employment, individually centred, include a structured training and feedback process and be mandatory;
- The greatest barrier to SBE is the ability of junior doctors to access time in which they can undertake training;
- The junior doctors involved found that the program met their needs and that it was beneficial to their learning, with the vast majority (96.1%) noting that the course improved confidence in their skills and that they would continue to train if the simulators remained available;
- Both SDL and training in a MSU were effective methods of delivering laparoscopic skills training.

Image: Basic laparoscopic skills simulator set-up for self-directed learning

Professor Maddern is the RP Jepson Professor of Surgery, University of Adelaide, the Director of the Division of Surgery at the Queen Elizabeth Hospital and the Director of Research and Evaluation, incorporating ASERNIP-S.

He said the research was conducted to explore the best way to train junior doctors in basic laparoscopic surgical techniques particularly in rural and regional centres.

He said the findings indicated that given that time constraints appeared to be the greatest barrier to skills development, junior doctors should be provided with rostered time to undertake simulation training.

"This research has demonstrated that supervised, regulated simulation training provides the best outcomes for participants," Professor Maddern said.

"Self-directed training alone does not provide the best outcomes and skills achieved are not as reliable as those gained through mentored applications.

"In non-metro areas, simulation training is non-existent so more training options need to be provided on-site where the junior doctors are working.

"The need to educate surgeons in rural venues is a high priority for the College so this research gave us an opportunity not only to provide that evidence-based surgical training but to explore the options available and to measure the outcomes of different approaches.

"The findings also strongly suggest that junior doctors require support to undertake simulation training either within rostered time or outside for these programs to be effective."

The MSU visited 17 hospitals over the two years of the study including Port Augusta Hospital, Mount Gambier Hospital, Mildura Base Hospital, Royal Adelaide Hospital, Ballarat Hospital, Bendigo Hospital, Flinders Medical Centre and Warrnambool Hospital.

The mobile unit stayed on-site at each hospital for five working days, allowing junior doctors to access training when time permitted during the week under the supervision of a Masters of Surgery student and an International Medical Graduate who had been trained in simulation training delivery.

After the supervised training week, those doctors had another two weeks to conduct SDL before final assessment, while the other cohort had the full three weeks to conduct their own SDL simulation skills training.

The findings indicate access to the MSU was of clear benefit in improving laparoscopic surgical skills.

The researchers also asked the junior doctors a range of questions to better understand the findings including their level of training, their specialty interest, how much time they had spent in theatre and their interest in a career as a surgeon to determine if a greater interest in surgery affected the amount of SDL they had undertaken.

They were also asked which form of surgical simulation training would best meet their needs. In response, the majority of participants said:

- they would be more likely to attend simulation training when it was held at the site of their employment;
- that they preferred structured teaching and feedback when learning new technical skills;
- that weekly/fortnightly mandatory sessions would be useful as part of employment and training;
- that simulation sessions should be protected time; and
- that simulated laparoscopic training should be a mandatory component of the surgical curriculum;

Professor Maddern thanked RACS and the James Ramsay Foundation for supporting the research.

"Without the support of the James Ramsay Project Grant this research would have been impossible," he said.

"Studies such as this are complex, expensive and time-consuming however, poorly designed programs can waste large sums of money.

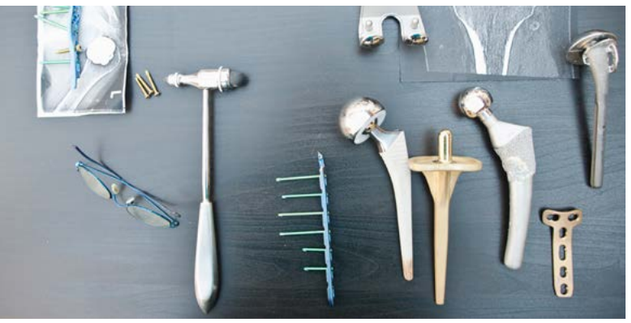
"This research provides evidence of optimum training delivery systems which the College can build on to provide simulation skills training, particularly to junior doctors outside the major cities."

– With Karen Murphy

Optimising rehabilitation after hip and knee arthroplasty

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

Last year, the Royal Australasian College of Surgeons (RACS) collaborated with Medibank on a series of reports which looked into surgical variation in Australian clinical practice. As a result of these reports, RACS and Medibank undertook a joint review of hernia-repair, the results of which were reported in the May edition of *Surgical News*. The review indicated that 70-80 per cent of hernia repair patients can be safely treated as day-cases, compared to the current rate of 19 per cent in private hospitals.



As part of our ongoing review of surgical variation, the next topic that has been chosen is rehabilitation after hip and knee arthroplasty.

Hip and knee replacements carry the highest cost to the Australian healthcare system of all medical procedures.[1] Their cost has gradually increased over the past decade, primarily due to an increase in the number of procedures performed.[2] This demand continues to grow; by 2046, knee replacements are estimated to rise by up to 26 per cent, and hip by 66 per cent, accounting for changes to population demographics and past surgical trends.[3]

In Australia, 77 per cent of surgeons refer private patients to inpatient rehabilitation following hip replacement, and 74 per cent following knee replacement;[4] however, the choice of setting for rehabilitation differs considerably between the public and private sectors. It has been estimated that 20 per cent of public patients receive hospital in-patient rehabilitation after hip and knee arthroplasty,[5] compared to 40 per cent of private patients (variation 0-100%).[4]

Given the large and increasing cost of hip and knee replacement to the Australian health system, potential efficiencies in rehabilitation pathways are a matter of policy interest. It is currently unknown if hospital or home-based models for rehabilitation lead to differences in patient outcomes. As such, the objective of our next project is to demonstrate and promote current best practice for referral to rehabilitation following hip and knee arthroplasty.

To ensure that our results are contextually relevant, the review will be informed by a working group of representatives from RACS Fellows, and Medibank. The results and recommendations will be published on the RACS website, and disseminated through Surgical News and other platforms.

The review will be completed in October, so stay tuned for the results in the November-December edition of *Surgical News*.

For further information please visit:

http://www.surgeons.org/policies-publications/publications/surgical-variance-reports/, www.surgeons.org/HTA or contact college.asernip@surgeons.org

References:

1. Australian Commission for Safety and Quality in Healthcare. Prioritised list of clinical domains for clinical quality registry development: Final report. Sydney, New South Wales: ACSQHC, 2016.
2. Australian Orthopaedic Association. National Joint Replacement Registry Annual Report. Adelaide, South Australia: AOA, 2016.
3. Inacio MCS, Graves SE, Pratt NL, Roughead EE, Nemes S. Increase in Total Joint Arthroplasty Projected from 2014 to 2046 in Australia: A Conservative Local Model With International Implications. *Clinical Orthopaedics and Related Research* 2017: 1-8.
4. Royal Australasian College of Surgeons and Medibank. Surgical Variance Report - Orthopaedic Surgery. Melbourne, Australia: RACS, 2016.
5. Arthroplasty Clinical Outcomes Registry National. Annual Report. Liverpool, New South Wales: ACORN, 2015.

The RACSTA Induction Conference

DR RUTH MITCHELL & DR STEWART MORRISON
RACSTA

There are many things I wish I had known earlier.

At the beginning of surgical training there is so much to learn. So much to understand. Not just about surgery per se, but about life as a registrar, and then life as a surgeon. Around the RACSTA Board table there is an increasingly diverse group of trainees, from different backgrounds, who have come to surgical training with a range of expectations. Even though some of us have been training for what seems like forever, we still remember the trepidation and awe of the very beginning. RACSTA is committed to improving surgical training, and that starts with our newest inductees.

At the time of writing, prospective Trainees are feverishly waiting for the results of their SET interviews. By the time this goes to press, most results will be known. For those who have been successful in the application process, excitement will be mixed with huge relief. For those not successful, it will be a difficult time. Both authors have been in both situations, and are unsure which is more overwhelming.

For this and many other reasons, the flagship event for RACSTA is the Induction Conference for new Trainees. This year it will be held on Saturday 11 November, at the RACS building in Melbourne.

Most successful applicants have worked as unaccredited or service registrars, however appreciate there is 'just something' so intangibly different about the expectations, aura, and competing pressures on registrars in training. What forces contribute to this difference, and how does it translate to one's practice in the clinic, the ward, and the operating theatre? Furthermore, how do new Trainees contribute to this collegiate and fortunately increasingly diverse surgical community, while managing the expectations of the College, their family, and themselves? This is the role of the Induction Conference.

Recognising the changing nature of both surgical training and the environment in which we practice, we will have sessions on social media and surgery, giving and receiving feedback, and a section on getting the most out of your team. Responding to the challenges and adventures that we ourselves have faced as Trainees, we will discuss pregnancy in training, and parental leave, and think about approaches to take if a Trainee is in trouble.

The Induction Conference allows us to consider what happens after training, including careers in academic surgery, fellowships, both in New Zealand and Australia, and overseas, and learn about which scholarships are available to help with achieving these goals.

In order to make the Induction Conference a success, it is important for new Trainees to have the support of the departments they are currently working in. We would like to ask for the support and encouragement of Heads of Department in facilitating the attendance of newly selected Trainees. The timing of the conference is chosen so as not to conflict with term changeover or surgical examinations. We also ask for the assistance of Trainees, both junior and senior, in making sure your newly admitted junior registrar is able to attend this event. May we bring to your attention your weeks of exam or conference leave that these registrars may have covered for you, in the preceding months.

We believe we have an excellent program, and the feedback from previous years' attendees has been extremely positive. While some training programs and states have separate induction processes, we know that what we offer is quite unique.

We are looking forward to meeting the next group of SET Trainees at the Induction Conference in November, and we thank you, Trainees and Fellows of The College, for your support in helping this new cohort optimise their transition into Surgical Education and Training.

Royal Australasian College of Surgeons | RACSTA Your Trainees' Association

ACT Annual Scientific Meeting focuses on systems of care

This year's ACT Annual Scientific Meeting will feature presentations from a range of healthcare experts, trainees and junior doctors which cross the spectrum of issues affecting surgical care, health policy and how efficient and collaborative health systems can improve patient outcomes.

In a society with an ageing population facing chronic and complex health conditions, health systems must continue to adapt to the changing needs and demands required of them.

Scientific Convenor Dr Rebecca Read has invited several guest speakers with expertise in health system efficiencies:

- Dr James Kong from the University of Hong Kong will be discussing the establishment emergency and surgical services in Myanmar and health informatics
- Mr Grant Christey, Director of Trauma, Waikato District Health Board New Zealand will speak about his experience in developing a data visualisation tool and the opportunities this offers to engage policy and decision makers
- RACS President Mr John Batten will provide insights on challenges to surgical education and competency-based learning
- Professor Imogen Mitchell, Dean of Medicine, Australian National University, will speak about translating research to clinical practice.

All specialty groups are encouraged to attend this one day event on Saturday 4 November 2017.

Online registrations are open: www.tinyurl.com/ACTASM17
Submit an abstract online: www.tinyurl.com/actabs17

REGIONAL MEETINGS UPDATE

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

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

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

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

WA, NT & SA Annual Scientific Meeting

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

Trauma: When Disaster Strikes

A foundation course will be offered on the 24 August.

Find out more:
RACS WA Regional Office
T: +61 8 6389 8600 • E: college.wa@surgeons.org
W: www.surgeons.org/about/regions/western-australia
RACS SA Regional Office
T: +61 8 8239 1000 • E: college.sa@surgeons.org
W: www.surgeons.org/about/regions/south-australia

83rd TAS Annual Scientific Meeting

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

Surgery in One State, One Health System, Better Outcomes

A foundation course will be offered on the 22 September.
Find out more:
E: college.tas@surgeons.org
W: www.surgeons.org/about/regions/tasmania

59th Victorian Annual Surgical Meeting

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

Safety in Surgery

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

ACT Annual Scientific Meeting

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

Systems of care: collaboration and innovation

Submit an abstract online www.tinyurl.com/actabs17
Find out more:
T: +61 2 6285 4023 • E: college.act@surgeons.org
W: www.surgeons.org/about/regions/australian-capital-territory

Workshops 2017

Online registration form is available now (login required)

Inside 'Active Learning with Your Peers 2017' booklet are professional development activities enabling you to acquire new skills and knowledge and reflect on how to apply them in today's dynamic world.

Mandatory courses

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

By the end of 2017

Foundation Skills for Surgical Educators course: Mandatory for surgeons involved in the training and assessment of SET Trainees

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

18 August	Palm Cove	QLD
19 August	Melbourne	VIC
19 August	Sydney	NSW
26 August	Gosford	NSW
29 August	Adelaide	SA
02 September	Darwin	NT
02 September	Rockhampton	QLD
15 September	Melbourne	VIC
15 September	Perth	WA
22 September	Hobart	TAS
22 September	Adelaide	SA
28 September	Canberra	ACT
6 October	Melbourne	VIC
6 October	Perth	WA
7 October	Sydney	NSW
13 October	Clayton	VIC
14 October	Auckland	NZ
18 October	Armidale	NSW
20 October	Geelong	VIC
28 October	New Plymouth	NZ

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

24 August	Perth	WA
8 September	Brisbane	QLD
21 October	Melbourne	VIC
6 October	Auckland	NZ
24 November	Sydney	NSW

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.

AMA Impairment Guidelines 4th & 5th Edition: Difficult Cases

2 September	Sydney	NSW

The American Medical Association (AMA) Impairment Guidelines inform medico legal practitioners as to the level of impairment suffered by patients and assist with their decision as to the suitability of a patient's return to work. While the guidelines are extensive, they sometimes do not account for unusual or difficult cases that arise from time to time. This morning workshop provides surgeons involved in the management of medico legal cases with a forum to discuss their difficult cases, the problems they encountered and the steps they applied to satisfactorily resolve the issues faced. This workshop is part of the AOA/RACS/AMLC Combined Meeting (to attend the Combined Meeting, register through AOA http://medico-legal.aoa.org.au/).

Writing Medico Legal Reports

12 September	Brisbane	QLD

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

Non-Technical Skills for Surgeons (NOTSS)

22 September	Brisbane	QLD

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

SAT SET Course

9 September	Melbourne	VIC
23 September	Adelaide	SA

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

9 September	Newcastle	NSW
23 September	Adelaide	SA

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

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

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

22 September	Melbourne	VIC

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

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

Process Communication Model Refresher (PCM)

24 September	Melbourne	VIC

Participants will refresh the skills learnt during an earlier attended Process Communication Model workshop. A needs assessment is done at the beginning and the workshop then addresses any issues of interest. This way the course program will be adapted to each participant's needs. Participants will have the opportunity to practice the parts they consider most relevant to them. Note: In order to participate in PCM Refresher, registrants must have attended and be familiar with the content of PCM Seminar 1.

Surgical Teachers Course

19 – 21 October	Mandurah	WA

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

Process Communication Model Seminar 1 (PCM)

20 – 22 October	Auckland	NZ
17 – 19 November	Sydney	NSW

Patient care is a team effort and a functioning team is based on effective communication. PCM is a tool which can help you to understand, motivate and communicate more effectively with others. It can help you detect early signs of miscommunication and thus avoid errors. PCM can also help to identify stress in yourself and others, providing you with a means to re-connect with those you may be struggling to understand. Partners are encouraged to register.

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

Clinical Consultation Skills Education Retreat

Cancer Council Victoria and Deakin University's Centre for Organisational Change in Person-Centred Healthcare are pleased to present a Clinical Consultation Skills Education Retreat for oncology clinicians, 9-11 October at RACV Torquay Resort. This three day immersive residential education program will offer tailored, small group learning with other oncology clinicians, delivered by expert facilitators in a luxury environment away from workplace demands.

For more information please visit https://www.cancervic.org.au/clinical-consultation-skills-for-oncology-clinicians-three-day-retreat or register your interest education@cancervic.org.au

PROFESSIONAL DEVELOPMENT WORKSHOP DATES

August – October 2017

ACT		
Foundation Skills for Surgical Educators	28/09/2017	Canberra
NSW		
Foundation Skills for Surgical Educators	26/08/2017	Gosford
AMA Impairment Guidelines 4th and 5th Edition: Difficult Cases	2/09/2017	Sydney
Supervisors & Trainers for SET	9/09/2017	Newcastle
Keeping Trainees on Track	9/09/2017	Newcastle
Foundation Skills for Surgical Educators	7/10/2017	Sydney
Foundation Skills for Surgical Educators	18/10/2017	Armidale
NT		
Foundation Skills for Surgical Educators	2/09/2017	Darwin
NZ		
Non-Technical Skills for Surgeons	6/10/2017	Auckland
Foundation Skills for Surgical Educators	14/10/2017	Auckland
Process Communication Model: Seminar 1	20-22/10/2017	Auckland
Foundation Skills for Surgical Educators	28/10/2017	New Plymouth
QLD		
Foundation Skills for Surgical Educators	2/09/2017	Rockhampton
Non-Technical Skills for Surgeons	22/09/2017	Brisbane
Writing Medico Legal Reports	12/09/2017	Brisbane
SA		
Foundation Skills for Surgical Educators	29/08/2017	Adelaide
Foundation Skills for Surgical Educators	22/09/2017	Adelaide
Supervisors & Trainers for SET	23/09/2017	Adelaide
Keeping Trainees on Track	23/09/2017	Adelaide
TAS		
Foundation Skills for Surgical Educators	22/09/2017	Hobart
VIC		
Process Communication Model: Refresher	1/09/2017	Melbourne
Foundation Skills for Surgical Educators	15/09/2017	Melbourne
Effective Cancer Communication for End-of-Life	9/09/2017	Melbourne
Clinical Decision Making	16/09/2017	Melbourne
National Health Education & Training in Simulation	22/09/2017	Melbourne
Foundation Skills for Surgical Educators	13/10/2017	Clayton
Foundation Skills for Surgical Educators	20/10/2017	Geelong
WA		
Foundation Skills for Surgical Educators	24/08/2017	Perth
Operating with Respect (OWR)	24/08/2017	Perth
Foundation Skills for Surgical Educators	15/09/2017	Perth
Foundation Skills for Surgical Educators	6/10/2017	Perth
Surgical Teachers Course	19-21/10/2017	Mandurah

Contact the Professional Development Department

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

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

WORKSHOPS • ACTIVITIES • EVENTS

Annual Scientific Congress Sydney, 7 – 11 May 2018

ASSOC. PROF. ARTHUR RICHARDSON
ASC 2018 Convener

The 2018 Annual Scientific Congress of the Royal Australasian College of Surgeons will be held from 7 – 11 May in the newly built International Convention Centre at Darling Harbour in Sydney.

The theme of the congress will be "Reflecting on what really matters". This will encompass a variety of issues of importance and relevance to practising Australasian surgeons.

The ASC has not been held in Sydney since 2006 and 2018 is shaping up to be an important and pivotal event. It will be co-badged with the American College of Surgeons (ACS) and run in conjunction with the Australian and New Zealand College of Anaesthetists (ANZCA).

With the involvement of the ACS, there is an impressive line-up of speakers from the USA with more than 40 outstanding American academic surgeons participating in the congress. The ACS will also run one of the plenary sessions.

Our intention is to build on the successful collaboration that occurred with ANZCA at the 2014 ASC in Singapore. The scientific program will incorporate sessions combined with ANZCA, and two of our plenary sessions will also be combined.

In addition, there will be the opportunity to enrol in masterclasses, courses and workshops run by both RACS and ANZCA.

Sydney is a vibrant city with much to offer and the committee is planning a range of exciting social tours and activities. It is also home to some of the finest restaurants in Australia. In addition to an outstanding social program, we are also planning post-congress tours to popular destinations such as the Blue Mountains and New Zealand.

We strongly encourage you to save the date in your 2018 diary in order to attend what is shaping up to be a stimulating and enjoyable ASC from May 7-11 in Sydney.

Skills Training Courses 2017

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

AVAILABLE SKILLS TRAINING WORKSHOP DATES*

September – October 2017

ASSET	
Friday, 6 October – Saturday, 7 October	Brisbane
Friday, 27 October – Saturday, 28 October	Auckland
CCrISP	
Friday, 15 September – Sunday, 17 September	Sydney
Thursday, 21 September – Saturday 23 September	Auckland
Friday, 20 October – Sunday, 22 October	Melbourne
Friday, 27 October – Sunday, 29 October	Sydney
Friday, 27 October – Sunday, 29 October	Brisbane
CLEAR	
Friday, 8 September – Saturday, 9 September	Melbourne
Friday, 22 September – Saturday, 23 September	Sydney
Friday, 27 October – Saturday, 28 October	Melbourne
EMST	
Friday, 1 September – Sunday, 3 September	Brisbane
Friday, 8 September – Sunday, 10 September	Melbourne
Thursday, 21 September – Saturday, 23 September	Darwin
Friday, 22 September – Sunday 24 September	Melbourne
Friday, 6 October – Sunday, 8 October	Melbourne
Friday, 13 October – Sunday, 15 October	Sydney
Friday, 13 October – Sunday, 15 October	Brisbane
Friday, 20 October – Sunday, 22 October	Perth
Friday, 27 October – Sunday, 29 October	Adelaide
TIPS	
Friday, 8 September – Saturday, 9 September	Melbourne
Thursday, 6 October – Friday, 7 October	Sydney
Friday, 27 October – Saturday, 28 October	Melbourne

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

**Courses available at the time of publishing*

Medical Tourism Patient Fact Sheet

RACS has updated its Medical Tourism Position Paper highlighting the key issues including Accreditation and Quality Assurance, Adverse Events including the risk of infection; and Insurance and Legal Issues

DR LAWRIE MALISANO
Chair, Professional Standards

The Royal Australasian College of Surgeons (RACS) continues to monitor the growth in the Medical Tourism industry, which is being driven by a range of factors including the cost of surgery overseas and increasing cost of domestic procedures, greater access to information via the internet, dissatisfaction with the local health system inclusive of waiting periods and the low cost of international travel[1]. In association with these factors, there has also been an increase in marketing of travel and surgery 'packages' by travel agents specialising in medical treatment and more recently by some private health insurers[2].

In response, RACS has updated its *Medical Tourism Position Paper* highlighting key issues including Accreditation and Quality Assurance, Adverse Events including the risk of infection; and Insurance and Legal Issues. RACS' position paper offers advice for medical practitioners treating patients seeking medical treatment outside Australia and New Zealand of the potential difficulties they may encounter. To assist consumers to make an informed decision, RACS has developed the *Medical Tourism Patient Fact Sheet*, which is available free of charge on the RACS website (www.surgeons.org). The fact sheet incorporates a comprehensive checklist for consumers to consider when deciding to undertake surgery overseas and highlights key issues they may face when seeking surgery abroad.

Patients may find it difficult to navigate healthcare options overseas, as all countries provide varying standards of medical care, surgical training and credentialing of medical practitioners. This ambiguity may increase the patient's risk and threaten their safety, as they may be exposing themselves to treatment from inadequately qualified or registered medical practitioners, a lack of clear documentation of procedures and identification of implants, as well as the possibility of fragmentation of aftercare and follow up.

The fact sheet emphasises that irrespective of the locality, all surgical interventions involve a degree of risk. Patients considering an international medical intervention must consider the possibility of postoperative complications and appropriate access to post-operative care. Some procedures may limit a patient's fitness to fly commercially during the post-operative period. RACS recommends consideration of this when planning the procedure and the recovery timeframe should be advised by a medical practitioner to decrease any risk. Medical tourism may also increase the risk of acquiring an infection that is more common outside of Australia and New Zealand, which may be resistant to conventional antibiotics.

Insurance and legal issues also need to be factored into a patient's decision making process, as they should obtain specialised health insurance that provides coverage for procedures and post-operative care. In the case of an adverse event or incidence of medical negligence, patients should be aware that there is no standard international complaints system. Moreover, there may be additional complications associated with pursuing legal action within an international context.

Consumers are also reminded that in some circumstances, complications require corrective surgery which is often not covered by medical travel insurance. Unless it is an emergency that requires immediate treatment in a public hospital, the required corrective surgery may be completed privately at the expense of the patient and this also requires consideration within a patient's decision making process. Practitioners should also be aware that they may be involved in the ongoing management of unexpected outcomes where the patient requires support, explanation or further intervention.

RACS encourages surgeons to discuss the range of issues that may be associated with medical tourism and provide the Medical Tourism Fact Sheet to patients who may be considering surgical procedures overseas.

1 Zega, N 2016, Patient Travellers, *University of Otago Magazine*, vol. 42, p. 6-9
2 https://www.nib.com.au/nib-news/media/2014/03/nib-launch-domestic-and-overseas-cosmetic-surgery-offer

Partners signing up to operate with respect

CATHY FERGUSON
Vice President

In a clear signal of success, 24 hospitals, health districts, health departments and other medical colleges have now signed agreements as part of our collaborative efforts under the *Building Respect, Improving Patient Safety Action Plan*.

The Action Plan, released in November 2015 is supported by the *Let's Operate With Respect* (LOWR) campaign which aims to make a visible connection between the projects and activities in the RACS' Action Plan and support long-term behavior change in the surgical profession.

The campaign is focused on surgeons and their profession, raising awareness of discrimination, bullying and sexual harassment in surgical practice and what RACS and its partners are doing to change this behaviour and support cultural change.

By signing a Memorandum of Understanding (MOU) or a letter of intent with RACS, organisations signal their shared determination to deal effectively with discrimination, bullying and sexual harassment in surgery using the Vanderbilt Principles as a foundation.

The agreements cover key areas such as:

- the training environment and accreditation standards
- Ensuring surgical supervisors are adequately trained and equipped
- sharing information about complaints
- sharing educational resources; and
- co-branding on initiatives to promote cultural change.

Agreements have recently been signed with the Auckland District Health Board (DHB), Alfred Health, Barwon Health and the Australasian College of Emergency Medicine.

The number of partners wishing to work with us to change the culture of health care has exceeded our expectations. With an initial goal of 5 partners when the Action Plan was launched, we have been overwhelmed by the recognition of hospitals and health jurisdictions that we must work together to effect change.

Our range of partners is a clear metric of this support. From private hospitals to large health districts, both surgeons and hospital administrators have shown a keen interest in collectively working towards a respectful culture in medicine.

What do our partners have to say?

Auckland DHB CEO Ailsa Claire said Auckland DHB Board and Managers are committed to providing a safe and supportive workplace.

> *By signing an agreement, organisations signal their shared determination to deal effectively with discrimination, bullying and sexual harassment in surgery*

"Auckland DHB people are known and valued for our high quality work and the care we give to our patients. Over the past few years we have been on a journey together to improve our culture. This includes the way we respond to bullying and unacceptable behaviour and as importantly to celebrate and appreciate our staff," she said.

Alfred Health CEO, Prof Andrew Way (pictured with Mr John Batten, RACS President), said the Alfred Health Board, hospital administration and staff are committed to providing a safe and supportive workplace. "We're pleased to partner with the Royal Australasian College of Surgeons on this important issue."

Murrumbidgee Local Health District Board Chair Gayle Murphy says "Under the agreement, we will further explore methods to mutually support each other in activities that promote respect and counter discrimination, bullying and sexual harassment in the practice of surgery, to improve patient safety."

For more information about the *Building Respect, Improving Patient Safety* Action Plan including how you can get involved and complete compulsory training, visit surgeons.org/about-respect

– With Deborah Jenkins, Director, Relationships & Advocacy Division

More than most think

Disability Rights and Responsibilities

SUSAN HALLIDAY

Many have a narrow understanding of the extent to which individual rights associated with disability and impairment are protected. Too often assumptions are made in circumstances where disability and impairment surface; indeed it is proven on a repeated basis that the careful consideration needed in areas of employment, the provision of goods, services and facilities, as well as education, is not always party to the decision making and behaviour of others.

The onus rests with employers, those providing goods, services and facilities, and educators (be it university, other Colleges or on-the-job training) to ensure the rights of those with disabilities and impairments are not compromised. With the aim of challenging the breadth and depth of current understanding, and past decisions that may need revisiting, essential points have been referenced.

While New Zealand and Australian states and territories have relevant statutes, the federal Disability Discrimination Act 1992 (DDA) is often viewed as a lighthouse piece of legislation.

In the DDA the definition of disability includes physical, intellectual, psychiatric, sensory, neurological and learning disabilities. It also includes physical disfigurement and the presence in the body of disease-causing organisms.

Hence its requirements and the protection it extends underpin this article, mindful that its major objectives are to eliminate discrimination against people with disabilities, promote community acceptance of the principle that people with disabilities have the same fundamental rights as all members of the community, and to ensure as far as practicable that people with disabilities have the same rights to equality as others in the community.

In the DDA the definition of *disability* includes physical, intellectual, psychiatric, sensory, neurological and learning disabilities. It also includes physical disfigurement and the presence in the body of disease-causing organisms.

It is a surprise to many that the DDA covers disability broadly. A quarter of a century on it also seems that people are often taken aback that the legislation spans across people who currently have a disability, or have had one in the past, and covers those who may have a disability in the future (for example when family medical history is known) and additionally covers a person with an imputed disability.

The DDA extends protection to people with a disability who are discriminated against personally, or because they are accompanied by an assistant, interpreter or a reader. It also protects people who are discriminated against because they are accompanied by a trained assistant animal. Further it covers people if they are discriminated against because they use disability related equipment or aids. Finally the DDA protects people who have some form of personal connection with a person with a disability including friends, carers, relatives and co-workers, if they are discriminated against because of that relationship.

Disability discrimination can be direct or indirect, and it happens when people are treated less fairly than people without a disability. Direct disability discrimination is less favourable treatment compared to that of a person without that disability in the same or similar circumstances.

Indirect disability discrimination occurs when there is an unreasonable rule, practice, policy or procedure (written or unwritten) that appears to be the same for everyone or a blanket decision, but has an unfair effect on people who share a particular disability.

Given the DDA seeks to ensure people receive equivalent opportunities irrespective of disability, it means there are times where alternative pathways are required to achieve this outcome. It is clear that in some circumstances treating someone differently because of their disability is not against the law, rather the way to ensure the objectives of the law. Accordingly the DDA requires that reasonable adjustments be made to ensure equivalence of opportunity, education and access to goods, services and facilities. An adjustment is reasonable if it does not impose an *unjustifiable hardship*. It should be noted that there is a need to demonstrate that the hardship is unjustifiable as opposed to a *personal view* or reverting to *that's how things have always been done around here.* The onus to prove this rests with the employer, educator or provider of goods, services and facilities.

Of interest is the fact that in the areas of education and access to public premises, in certain circumstances a temporary exemption may still be granted under the DDA if demonstrated that the adjustment required to accommodate the disability is unreasonable and would impose an unjustifiable hardship.

As many know, harassment is a form of discrimination and the DDA prohibits such behaviour. In this context the harassment is conduct that offends, humiliates or intimidates based on a disability or impairment. Be it inappropriate insults or humiliating jokes, inappropriate images or social media engagement, mimicking or mocking a person, a single incident can amount to disability based harassment. Motive and intent are irrelevant; it will be the nature of the conduct and its impact that will be assessed.

Real life examples usually help cement legislative concepts and requirements. So it is worth noting in conclusion that the following two examples are likely to be unlawful discrimination under the DDA. The first relates to a parent who was refused a training position because it was assumed the parent would need time off to look after a child with a disability.

The second relates to a person with a physical disability being mimicked in front of colleagues, after the person had exited a meeting room. Sadly the person turned and saw the conduct through a glass door. Be clear that if the conduct had not been observed but rather the person with the disability was informed by a concerned colleague who was present, action in relation to disability harassment could still be progressed.

NOTE – This article is not legal advice. If legal advice about age discrimination, bullying or defamation is required, an employment law or defamation law specialist should be consulted with reference to the specific circumstances.

SUSAN HALLIDAY – Australian Government's Defence Abuse Response Taskforce (DART) 2012-16 and former Commissioner with the Australian Human Rights Commission.

Regional Report - Tasmania

GIRISH PANDE
Chair, Tasmanian State Committee

Practicing surgery in rural and remote areas comes with many challenges. In Tasmania two hospitals are located rurally, and this combined with a small widely dispersed population makes the job even more challenging. It is difficult to attract and retain specialists who often have to work alone. It's no surprise that the only spine surgeon and neurologist in the north of the state left for Melbourne!

This year has been an interesting year for surgery in Tasmania. Dr John Batten has taken over as President of RACS, being the first Tasmanian to be elected to this office. Having worked in a rural area he is quite familiar with the challenges it brings.

rather than by committees based locally at each hospital. This has required that surgeons provide personal data about themselves and their family to a private data network which in-turn will be provided to the credentialing committee. With past incidences of cyber hacking of data within the health system, most surgeons are reluctant to provide this information and have tried to raise these concerns with the government with little effect.

Trauma care was the focus of the well-attended Trauma Tasmania Conference in Hobart on 25 March. Judging from the response and the interest shown by all surgeons in the state, the 2018 Tasmanian Annual Scientific Meeting in Hobart will focus on trauma care and will be jointly hosted by the Tasmanian Regional Committee and the National Trauma Committee on 9-10 November 2018.

State elections are due next year and health care has been the focus of major political parties. The Labor party has communicated its manifesto and promised a lot of changes and improvements, including $50 million for initiatives to reduce bed block; access during evening hours and weekends to services including radiology, medical imaging and pharmacy services; community nursing to extend services seven days a week and the implementation of Medi-hotels based on models used in other states. Another initiative includes the re-introduction of local leadership

Image: Inaugural Trauma Tasmania 2017 symposium lecture-room.

The state government has been trying to overcome this problem of maldistribution of specialists by trying to create a single statewide health system which would see all patients receiving equal access to health care. Patients have been provided with special travel buses to commute from the North West to Launceston. Additional surgeons have joined the work force in Upper GI and HPB surgery both in Hobart and Launceston, and Urological services have received a boost with the addition of two more surgeons in the north of the state.

The theme of the RACS Tasmania Annual Conference this year is '*One State, One Health System, Better Outcomes*'. What we have been able to achieve so far will be a matter for discussion.

The government has decided to centralise the credentialing of surgeons through a central committee at each of the state's four public hospitals to ensure that operational decision-making is at a regional level, rather than centralised in the Tasmanian Health Service.

The capital works program at the Royal Hobart Hospital is ongoing with bed shortages being discussed frequently on the evening news. To overcome the backlog of surgery, patients are being transferred to private hospitals resulting in RACS trainees finding it difficult to meet their surgical numbers.

More federal funds have been made available to the North West of the state for development of services. The state is trying to develop uniform criteria for bariatric surgery to be followed throughout the state.

With these ongoing changes in the health system we will have to wait and see what the voters decide in the next election.

Failure to make a mandatory report

MICHAEL GORTON AM
Principal,
Russell Kennedy Lawyers

Requirements for health practitioners to make mandatory reports under the Health Practitioner Regulation National Law have been in place since 2010. It requires health practitioners to make a mandatory report in relation to the conduct of the health practitioners. Conduct that must be reported includes:-

- Practice affected by drugs and alcohol
- Sexual misconduct in practice
- Practitioners impairment that imposes a risk to the public (include physical or mental health)
- A practitioner who places the public at risk of harm in a way that constitutes a significant departure from acceptable professional standards

A recent legal case highlights the consequences for a doctor who fails to make a mandatory report.

In a case before the New South Wales Civil and Administrative Tribunal, a senior neurosurgeon was suspended for three months for, amongst other things, failure to report a registrar who died in connection with a drug overdose. The neurosurgeon who was a mentor of the registrar, and was involved in a relationship with the registrar, failed to report the use of drugs. The neurosurgeon went so far as to prescribe Pregabalin to assist the registrar's withdrawal from the drug GHB. In 2013, the registrar died of an overdose. The circumstances both of the neurosurgeon drug use, and failure to report the drug use of the registrar came to light.

The failure to report carried serious implications. By reporting a colleague's drug use, it may enable the colleague to seek help and assistance. It also enables the regulator to put in place relevant conditions, to ensure that the public and patients are protected. In this case, it was argued that the failure to report by the neurosurgeon may have contributed to the death of a colleague.

Whilst there is understandable reluctance to "dob in" a colleague, the obligations of mandatory reporting are fixed by law, and can carry consequences for those who breach these obligations.

Doctors will also be aware of the current debate in relation to the mandatory reporting provisions in relation to impairments, which may create a reluctance for doctors, who have any impairment, from seeking the assistance of medical colleagues and clinical help. This issue is a live debate at present, with New South Wales indicating that it may reverse the position in relation to mandatory reporting for impairment. Western Australia has, since 2010, not required mandatory reporting in relation to an impairment by a treating doctor. Western Australia has differed from the provisions in other States.

In the case of the neurosurgeon, following suspension there will be a number of conditions on the practice of the neurosurgeon. It serves as a reminder that mandatory reporting is an obligation on all health practitioners.

– With Laura Haffenden, Law Student

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

IN MEMORIAM

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

Mark Sharam Byrne (QLD)
Samuel Lindsay Cooke (WA)
Peter Gustav Bryan Nelson (VIC)
Edward Pockley (NSW)
Ngoh Tan (Singapore)
George Alexander Wilson (NZ)

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

Informing the College

If you wish to notify the College of the death of a Fellow, please contact the manager in your regional office:

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

Adelaide team conduct cutting edge endoscopic endonasal skull base surgery

A team of surgeons in Adelaide successfully removed a large neuroendocrine tumour that had extended intracranially, and repaired the defect without the need for a craniotomy. The patient was an 80 year old man who made an excellent recovery and was discharged home to his farm within a few days of the surgery.

The surgical team – which comprised of ENT surgeon Dr Harshita Pant, Neurosurgeon Dr Marguerite Harding and anaesthetist Dr Jessica Staker - performed the surgery at the Calvary Wakefield Hospital in Adelaide earlier this year.

Their patient was diagnosed with a rare type of sinonasal tumour, a neuroendocrine cancer that is known for its aggressive behaviour.

"The nasal cavity is home to a wide variety of malignant tumour types with diverse biological behaviour and prognosis," Dr Pant said.

The first Australian ENT surgeon to complete a Fellowship at the world-leading Cranial Base Centre in Pittsburgh, Dr Pant is now a leader in the use of endoscopic endonasal surgery (EES) for the treatment of sinus and skull base pathologies.

tissues in the nose and sinuses along with adjacent lamina papyracea, nasal septum, cribriform plate, intracranial tumour and adjacent dura."

Combined therapy including chemoradiotherapy followed by surgical resection is usually recommended for advanced neuroendocrine cancers.

"Surgical options included a traditional craniotomy or the less invasive EES which reduces morbidity, speeds up recovery and which offers improved quality of life and equivalent oncological results as that achieved through an open procedure," she said.

"Endoscopic surgical techniques have transformed many areas of surgery, and skull base surgery is no exception. In pituitary tumour surgery, EES (an endoscopic trans-sphenoidal approach) has reduced the operative complication rates. For example, it allows us to reduce visual complications by identifying and preserving the minute vessels to the optic chiasm that arise from the superior hypophyseal arteries."

Dr Pant said that while EES offered superior visualisation of the tissues, vessels and neural structures and faster recovery times, the ultimate success of such procedures depended on novel reconstruction techniques designed to reduce the risk of a cerebrospinal fluid (CSF) leak.

> *"Performing these complex surgeries and pushing the boundaries is challenging and working alongside another surgeon means you have another domain of knowledge, skill set and pair of hands and eyes focused on the task which reduces stress, minimises intraoperative risks, facilitates surgical innovation and ultimately achieves better patient outcomes."*

A consultant at the Queen Elizabeth Hospital and an academic at the University of Adelaide, Dr Pant and her team performed EES, specifically an endoscopic anterior cranial base resection, to remove a sinonasal neuroendocrine tumour that extended intracranially and showed radiological features of brain invasion.

Dr Pant said the three main components of the surgery included resection of the intranasal tumour and exposure of the skull base, resection of the anterior skull base and intracranial tumour and reconstruction of the defect.

"The goal of the surgery was to remove all of the macroscopic tumour with resection of all the involved soft

She said that it was in Pittsburgh that the nasoseptal flap, introduced by Hadad and Bassagasteguy, was applied to the reconstruction of skull base defects.

"Its application drastically reduced the incidence of postoperative CSF leaks and allowed surgeons to push the boundaries of EES further," she said.

"In the year prior to my Fellowship, the Pittsburgh team developed the technique of the extracranial pericranial flap to better manage such patients where the nasoseptal flap could not be used due to tumour involvement."

Image: Dr Jess Staker (Anaesthetist), Dr Harshita Pant (ENT Surgeon), Dr Marguerite Harding (Neurosurgeon).

Dr Pant, who has a PhD in rhinology and immunology, spent a year at the University of Pittsburgh Medical Centre as a fellow and clinical instructor in minimally invasive skull base surgery, rhinology and allergy after receiving her FRACS.

She said that the cranial base centre was the first of its kind in North America and that it had been at the forefront of developing both open and endoscopic skull base surgical techniques.

During her time there, the unit treated more than 400 patients with a variety of skull base pathologies which she described as a vastly enriching experience.

"This Fellowship was uniquely established to train ENT surgeons from two main subspecialty backgrounds – rhinology and head and neck surgery – as well as neurosurgeons," Dr Pant said.

"The Pittsburgh centre has a dedicated laboratory set up to allow surgeons to master the anatomical relationships of the internal carotid artery, how these relationships apply to EES, the surgical skills required to work in this area and the protocols used to assess at-risk patients and manage vascular complications."

However, she said that EES was not feasible for every skull base tumour.

"There are limitations to this approach depending on the nature and location of the tumour, proximity of major vessels and nerves to the tumour or whether these vital structures are in the path of the endonasal corridor and tumour," Dr Pant said.

"It is essential, therefore, that the skull base surgical team is trained in both traditional open approaches and in endonasal approaches to best manage their patient's pathology."

"Some of the major challenges presented by endoscopic skull base surgery include haemostasis, avoiding injury to the internal carotid artery and reconstruction of skull base defects."

Dr Pant said a key component in the success of EES and complex skull base surgery was multidisciplinary collaboration throughout all stages of patient care - before the patient reaches the operating room and well after the patient leaves the hospital.

She said such surgery was not possible without a dedicated team of surgeons, anaesthetists, nursing staff, intensive care specialists, interventional radiologists and resources including suitable operating room facilities and technological support such as image guidance systems and specifically designed instruments.

For patients with tumours, a tumour board multidisciplinary team (MDT) is essential and includes radiation and medical oncologists who play a vital role in patient management. The MDT pools expertise and knowledge of tumour biology, treatment outcomes, advances in surgical and non-surgical treatment modalities, thus offering best treatment options tailored to the patient and their wishes. In patients with pituitary tumours, their endocrinologist also plays a key role in their care, throughout medical and surgical treatment.

"The role of a radiologist and pathologist dedicated to the diagnosis of skull base pathologies cannot be emphasized enough," Dr Pant said.

"These tumours have features that can make diagnosis a challenge, and ultimately the treatment is dependant not only on tumour stage but also its biology."

"Among the many things I learned during my Fellowship, one of the most valuable lessons was the importance of comradery and teamwork. Traditional "tag team" approaches where resection is performed by one surgeon and reconstruction by another is less applicable to skull base surgery. With EES, it is the same team working together from the beginning to end.

"Performing these complex surgeries and pushing the boundaries is challenging and working alongside another surgeon means you have another domain of knowledge, skill set and pair of hands and eyes focused on the task which reduces stress, minimises intraoperative risks, facilitates surgical innovation and ultimately achieves better patient outcomes."

– With Karen Murphy

The evolution of the RACS Audit of Surgical Mortality

MR JAMES AITKEN
Chair, Western Australian Audit of Surgical Mortality (WAASM)

Organisms that do not evolve within a changing environment die. Organisations that do not adapt to new circumstances become obsolete and are replaced. The Australian and New Zealand Audits of Surgical Mortality (ANZASM) had a genesis in the minds of surgeons committed to improved surgical patient outcomes, and, within 10 years propagated throughout the whole of Australia. The constant flow and quality of publications derived from this unique source is a testament to its value.

In establishing the ANZASM, surgeons demonstrated that they were agile, innovative and creative. However, ANZASM cannot afford to stagnate. So how should ANZASM evolve?

A primary goal of ANZASM is to be responsive to the needs of patients, and increasingly patients want to be better informed about the care they are receiving. Our profession needs to recognise that debate around the value of public reporting has moved on. Whatever the evidence, and it is probably supportive, the reality is that people want public reporting. They are our paymasters, as taxpayers or patients (sometimes both), and in that client-provider relationship our profession needs to provide what people want. This can either happen voluntarily or by diktat. Preemptive adaption is preferable.

People want surgeon specific outcomes. Our profession is legitimately concerned that the imprecision or absence of risk adjustment may mean results are not reliable, or even misleading. People argue that they are able to appropriately interpret well presented data. In only a few years they have recognised the limitations of league tables in which, by definition, half of those listed are worse than the average. Statistical control charts, as have been used in industry for almost a century, are being increasingly adopted. There are many examples of funnel plots being used to detect variation in surgical outcomes. Run charts are another example that have the advantage of being continuous and near real time, so small variations are detected early and addressed before larger problems develop.

The ANZASM provides near real time personal education and may be one reason why it has been able to influence the surgical practice (as surgeons have acknowledged in several regional and national surveys). Missing data is still a major factor that degrades any analysis. Participation is a professional responsibility. Surgeons cannot seek self-regulation and then not fully discharge that obligation. Participation that includes all data can be mandated (stick) or missing data imputed assuming the worse outcome (carrot), an approach that has encouraged participation in other studies.

An alternative view is that patients merely want assurance that the surgeons' performance is under constant review and managed as required. When boarding a plane, we do not look for the pilot's simulator record in the seat pocket. We know the pilot has been to the simulator and performed an acceptable level and we know that were that not so, the pilot would not be in the cockpit. Pilots who do not attend their scheduled simulator sessions do not fly. Our patients may think the same is true of mortality reviews. The reality is different. Is it reasonable for patients to demand that surgeons who do not participate in mortality reviews do not operate? When required, an airline Chief Executive Officer (CEO) can almost immediately provide details of a pilot's simulator record. How many hospital CEO's could attest to their surgeon's participation in mortality reviews? The RACS position would be infinitely stronger if it places the same obligation on its Fellows as airlines place on their pilots.

Variation in outcome has become a major focus for the public, profession and government. The Australian Commission on Safety and Quality in Health Care has just released its second Atlas on Healthcare Variation. The RACS and Medibank Private have published a series of reports demonstrating marked inter-surgeon variation in patient outcomes. At best, such variation represents inconsistent care, but often reflects poor care and that is usually expensive. As a penalty for poor surgical outcome, the government has foreshadowed withholding payment for Hospital Acquired Complications (HAC). Exact details are yet to be confirmed. This is important as there is an obvious perverse disincentive to comprehensive reporting of morbidity.

The RACS, through the ANZASM, helps achieve reduction in HAC by externally reviewing surgical deaths, some of which are associated with a HAC. For example, the Western Australian Audit of Surgical Mortality (WAASM) has always peer-reviewed deaths associated with a pulmonary embolus, one of the HAC, and it is surprising, and disappointing, to note how often prophylaxis treatment has been suboptimal, and so the death at least potentially preventable. Cooperation with the desire of government and the wishes of people for a reduction in hospital acquired complications, informed by the processes of ANZASM, is a tangible demonstration of ANZASM's capacity to evolve and remain relevant.

AUDITS OF
SURGICAL MORTALITY

Case Note Review

Palliative approach should be considered for a fractured neck of femur in a patient with terminal metastatic prostatic carcinoma

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

Clinical details:

This case is of an elderly patient with right neck of femur (NOF) fracture (peritrochanteric) who underwent operative fixation the day after admission with long gamma nail and HydroSet bone graft.

The patient was in the terminal stage of prostate cancer with extensive bony metastases. He also had multiple comorbidities including atrial fibrillation (AF), congestive cardiac failure, ischaemic heart disease and coronary artery grafts. Medications were warfarin, digoxin, Lasix, bisoprolol and Endone. The patient was not on any active anticancer treatment.

Prior to the incident the patient was living at home with his wife for palliative care and walked using a four wheel walker. The patient had an unwitnessed fall after getting out of bed and was transferred to hospital by ambulance with no loss of consciousness. The patient was admitted and reviewed by medical, orthopaedic and anaesthetic teams.

The reasoning for the operation was palliative to decrease pain, although the patient was not for resuscitation. The patient's initial international normalised ratio (INR) was 2.5 but after 2 units of fresh frozen plasma (FFP) and vitamin K over 2 days had decreased to 1.6 on the day of the operation.

Under general anaesthesia, the operation started at 20:05 pm and finished by 20:45 pm. He was transferred to the ward 4 hours later. Intravenous (IV) antibiotics and anticoagulant (40 mg Clexane daily) were commenced. Postoperatively the patient had some on/off confusion (Glasgow Coma Scale (GCS) 9-10 to start and eventually GCS 14) but later ambulated to chair. Although oral intake was started, his urine output decreased on the third day and IV fluid was given. He had cold peripheries, his feet were oedematous and the issue of palliative treatment was discussed with the family.

While the patient was waiting for transfer to a nursing home his level of consciousness deteriorated. Respiratory rate increased to 25-20 per minute and urine output was still nil overnight. Major deterioration occurred the morning of day four: the patient was not conscious and developed Cheyne-Stokes breathing. The issue of palliative treatment was again discussed with the family. Eventually respiration ceased with no heartbeat, dilated pupils unreactive to light and at 8:10 pm the patient passed away.

Assessor's comments:

Considering the multiple comorbidities on a background of bony metastatic of prostate cancer and NOF the choice of operation (gamma nail) is only justifiable as palliative care especially when the patient is not for resuscitation. However there are many surgeons who prefer not to perform this operation due to considerable/expected risk of death.

Overall, if we accept the idea of operating as a palliative care for above mentioned patient, the choice of operation, acceptable duration of operation, preoperative evaluation, postoperative review and care were adequate and acceptable. There was a mismatch in some documentation on the surgical case form and history regarding operation type and timing of operation.

The patient, with AF and taking warfarin (initial INR 2.5) who received two packs of FFP and vitamin K on 2 days prior to operation eventually with INR 1.6 when operation was done, was at a major risk of embolisation. The balance between therapeutic level of anticoagulation and bleeding risk remains a matter of clinical judgement by the treating team.

Operative versus nonoperative treatment for NOF patients with end stage disease is another unresolved and challenging problem for medical and surgical teams. A proper guideline, confirmed by senior surgical (orthopaedic) authorities, would be a very helpful tool to assist decision-making in future cases.

Surgical lessons:

Careful thought should be given to decisions about surgery in patients with extensive metastatic disease. Surgery is not indicated if the patient presents in a premorbid stage, but palliative surgery can be worthwhile in patients expected to survive for a prolonged period. However, it should be recognised that this is high-risk surgery, and the outcomes are not always those that are hoped for. In this case the surgeon probably made the correct decisions but the outcome was unsuccessful.

MALT: what's new in 2017

For long-time users of the MALT system, you will have noticed some changes recently. The MALT team was delighted to introduce enhancements to the system that address many suggestions from those of you who use MALT.

MR JOHN TREACY
Chair, Morbidity Audit Committee

Improvements to the Morbidity Audit and Logbook Tool in 2017

Peer Review Audit functionality
The peer review audit functionality in MALT has been designed to help make the process of conducting an audit easier. The functionality was piloted at the Royal Darwin and Mt Gambier Hospitals to assist in this design.

We are now able to offer the feature to any user of MALT who has been migrated to a SNOMED Logbook, to:

- Collect data standardised to RACS guidelines and international terminology
- Use in-built reports to compare outcomes across audit members, regardless of specialty, user type or location
- Opt-in or opt-out of audits at any time.

All you need to do is appoint an Audit Champion, decide on the restrictions you want to put in place (e.g. only audit on specific procedures or at specific locations) and the data you want to collect, and then contact the MALT team at RACS to set you up.

Self-audit BETA release – feedback wanted
A suite of new self-audit reports has been released within the Custom Report tool in MALT. You can view summaries of your own data based on procedure group, postoperative outcomes, or complications. Each report is customisable, which means you can use the tool to drill down for more detail and to filter the results by criteria of your choosing.

The reports that are now available are a BETA release and will be improved upon over time. Feel free to take a look at what is currently available and send your feedback to the MALT team on how you feel it can be improved.

Latest version – user requested improvements
For long-time users of the MALT system, you will have noticed some changes recently. The MALT team was delighted to introduce enhancements to the system that address many suggestions from those of you who use MALT.

- Copy case feature: ability to copy patient information, procedure dates or procedure data into a new case to avoid re-entry of similar data
- Quicker navigation: ability to save and move on to a new case rather than having to go back to the journal screen each time
- Customisable flags that allow you to mark cases so that you can easily locate them later, or to export those specific cases only
- Improved searching: extra filters on the journal screen, with the filter section now collapsible to save screen space
- Quicker review: ability to move through the 'view cases' pop-up to see all cases filtered in the Journal rather than merely the specific case clicked on
- Easier case scanning: pop-up on side of Journal screen which lists specifics of each case if you hover the mouse over it
- Streamline the supervisor dashboard list so that only current Logbooks are shown.

Locum Report now available
It is now mandatory for locum surgeons to use MALT, if they wish to submit their logbooks to the Locum Evaluation and Peer Review Committee to undertake peer review for the audit component of the RACS Continuing Professional Development requirements.

A new report was introduced in MALT for this purpose.

The MALT team is currently working on some specific instructions tailored for locums on how best to navigate the MALT system to produce the report as required. In the meantime, if you have questions, contact the MALT Helpdesk.

Achievements

Successful implementation of SNOMED procedure list
RACS is among the leaders in Australia and New Zealand when it comes to SNOMED implementation. Almost all specialties are now using the SNOMED procedure list.
What does this mean for MALT users?

- higher specificity about procedures performed
- those under training or assessment can keep a complete record of all procedures performed, regardless of whether the procedure is on a list of 'Board Approved' terms
- Logbook Summary Report will only show 'Board Approved' procedures, available for those whose procedure count needs to be reported to a training board
- extra reports available showing 'all procedures' logged, whether 'board approved' or not
- peer review audit capabilities now available and can be set up across specialties
- data can be exported in SNOMED terms for comparison with international datasets and results.

Uptake of MALT
Each year, the MALT user-base grows as more discover the benefits and features. Some quick stats:

- One year after MALT went live, 571 surgeons had tried it. Now, almost five years later, that number has more than quadrupled to 2412.
- One year after MALT went live, 85% of users were SETs. Currently, while SETs remain by far the largest group of users, they make up only 56% - Fellows are growing as a cohort and are now proportionally the second largest group of users.
- Earlier this year Fellows reached the milestone of having collectively logged 100,000 procedures. Usage by Fellows is growing strongly and has doubled over the past 18 months as the SNOMED logbooks have been released
- When MALT went live in 2012 there were 8 types of logbooks. Today, there are 38 separate types!

More coming soon

Two million procedures upcoming milestone
The MALT system will be marking another big milestone in 2017 when we reach two million procedures logged.

MALT offline app
The MALT team is currently working closely with RACSTA on an app for smartphones which will allow MALT users to enter data without needing an internet connection. You will be able to record cases or complications as they occur throughout the day, then upload to the main MALT application once you have internet connectivity.

The first iteration will be available for download on iPhones in late 2017. Be sure to check it out when available and send us through some feedback. We'd love to hear what you think about the app.

In the meantime, you can still log into MALT through the mobile friendly version of the site if you have internet connectivity on your phone.

Contact us

The MALT team appreciate the feedback you provide. Please contact us on malt@surgeons.org, via the feedback form in MALT or by calling +61 8 8219 0939.

– With Katherine Economides, Manager, Morbidity Audits

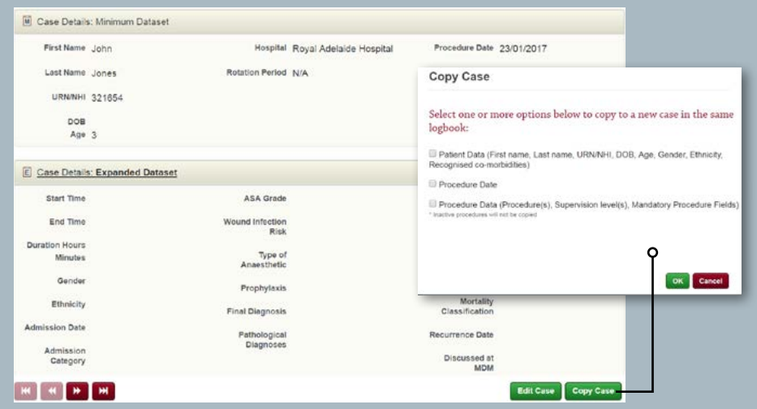


Image 1: An example of a review case screen showing back-forward buttons and copy case button

Image 2: Journal showing new case flags

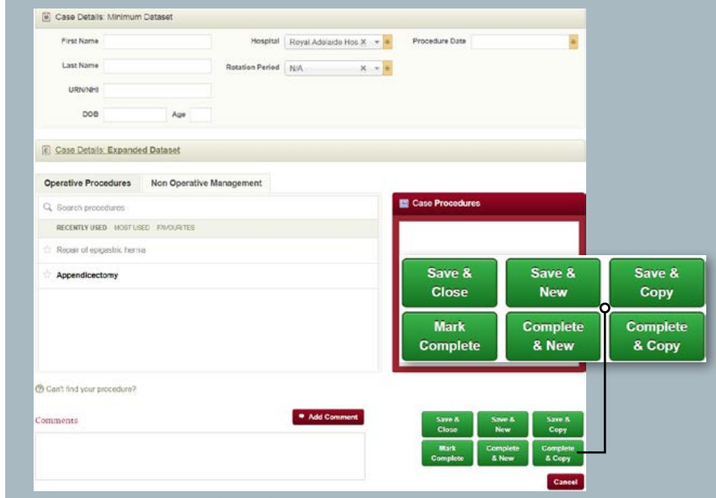


Image 3: Case entry form showing copy case

Your College, Your Council: David Fletcher

Professor David Fletcher certainly has an impressive CV. After becoming a Fellow of the College in the early 1970s he undertook a wide range of surgical roles, including postings overseas and interstate. With such a long list of credentials to his name you get the impression that David could easily be embarking on any number of projects in Australia or across the world.

However, the Fletcher family has always had a strong connection with Perth, and particularly the Fremantle area. His father Harry Fletcher was the local member for the state seat of Fremantle for 19 years, and his mother Esme was the Deputy Mayor of Fremantle and established the Social Work Department at Fremantle Hospital. His brother John too was a Social Worker. It was little wonder therefore, that David decided to return to his origins in 1994.

"I always had two big ambitions. One was to get back and work in Fremantle and the other was to own a yacht. When I moved back in 1994 I managed to do both!" David chuckles.

"I was committed to going back because of my own history (he returned to the same hospital he did his training), my family's history, and also that of my wife Chrissy who helped establish the Cytology department at Fremantle Hospital.

"Before we left, Fremantle was an old port area and a pretty poor environment. I wanted to go back and help bring about change."

As a child David's heroes were Alexander Fleming and Howard Florey, and his ambition was to become a medical researcher. When he was a fourth year medical student, however, he was taught by an IMG Surgeon from Kenya who inspired him to be a surgical researcher.

"This Fellow was a superb technician, clinician and all-round gentleman. I was very impressed by him and thought that I would love to be like that."

"I always enjoyed doing things with my hands like fixing cars and I used to play the violin as well. I guess surgery was always going to be a good fit for me."

David has since enjoyed a long and prosperous career in surgery. He lists one of his proudest achievements as the pioneering role that he played in introducing laparoscopic surgery to Australia and New Zealand.

Through his association with Austin Hospital and his involvement with RACS, David was instrumental in establishing the Guidelines for the introduction of new technologies, which still stand today.

"Looking at the epidemiological data what we found was that laparoscopic surgery was introduced relatively safely in to Australia and New Zealand. This wasn't the case across much of the rest of the world.

David found his early involvement with RACS to be a rewarding experience, and as he has drawn closer the end

of his career, he decided it would be a good time to scale back his professional workload and increase his involvement in the College. His role in Council has offered him many rewarding opportunities, and allowed him to advocate for some of his most passionate causes.

"I wanted to repay the College for what it has done for me over the years, so that is why I decided to stand for Council. When I stood I always said one of the things I was very keen to do was to improve the support for rural surgery because they seem to function independently of the rest of the system and are quite poorly supported."

"There is often the reverse problem in metropolitan areas, particularly on the east coast of Australia. There can be an excess of newer Fellows who don't have any public appointments, which obviously stands in contrast to the situation in remote areas."

"One of the greatest challenges, and what I am hopeful of achieving in my time on Council, is to continue to work out ways we can negate this problem and improve the outcomes for both groups."

"It is something that is slowly happening, and we have seen some improvements in Queensland but there is still a lot of work to do, particularly here in Western Australia and potentially in New Zealand."

In a professional capacity David has always thrived in being able to help others and believes that Council gives him the ability to do this on a larger scale.

"What I love most about my role in Council is sharing in the progress of surgery with some extremely bright and committed people. When you look around the table at Council and see the talent and commitment that is on display you can't help but feel motivated by it. I think that I have learnt a great deal from it and am very appreciative for my time on Council at it has been a very worthwhile thing from my point of view to have done."

As a person David is renowned for his relaxed and patient manner and for being somewhat of a 'straight shooter.'

"I guess I regard myself as a bit of an open book. I wear my heart on my sleeve and what I think about things is usually pretty obvious. My politics and my philosophy on life are pretty well known to everyone around me."

"It takes a long time to wind me up and get me cross. As a Surgeon I think patience is an important virtue to have, particularly with Trainees. You need to give them a chance to do things for themselves and to learn. You can't always be in a hurry to get through everything quickly and go home."

"People did that for me in my training which I am very grateful for, so I am always prepared to do the same for others."

Despite his busy schedule David finds time to enjoy many hobbies, and thrives on being around other people.

"I'm not sure if you would call it a hobby, but I really enjoy good company and stimulating conversation. In terms of actual hobbies, I am always listening to music especially classical (including in the operating theatre when I can!). Reading and learning are also two of my favourite things to do; I think I'll know it is time to shuffle of this mortal coil when I feel like I can't learn anymore."

"I also enjoy boating and sailing and I like putting my feet up with a wine or beer by a camp fire or doing a bit of fishing. I have done part of the yacht masters course, and I would also have loved to have learnt to fly. Sadly I think that one has passed me by."

But despite all of his successes as a surgeon and his many favourite past-times, David is very much a family man and says that it is the simple but precious moments in his life that bring him the most joy.

"A perfect day for me is one spent with my family. I have a 22 month-old grandson (pictured with David, opposite page) who I am totally besotted with, and I love seeing him grow and learn. I think he is just wonderful and I have another granddaughter due in December which I can't wait for."

"I just love being a granddad. My father was always a terrific grandfather to my son and I really hope I can replicate that."

– With Mark Morgan,
Communications Officer, Communications & Advocacy

Clinical Variation

Promoting transparency to improve surgical outcomes for patients

DR LAWRIE MALISANO
Chair, Professional Standards

Being aware of and understanding variation in clinical practice is becoming increasingly important both locally and internationally. Consequently RACS is working with Medibank to make data available to surgeons in a way that helps with the interpretation of this data, that the data is appropriate and presented in a way that helps improve patient outcomes.

In 2016 RACS and Medibank worked together to analyse and interpret administrative claims data and develop the inaugural Surgical Variance Reports. These reports covered five specialties, including general surgery, urology, otolaryngology, head and neck surgery, vascular surgery and orthopaedic surgery.

In 2017 RACS and Medibank will be publishing updated reports for each of these five surgical specialities. These will include expanded data over two financial years, partner brand AHM data and confidence interval analysis[1].

We are presenting the urology and orthopaedic surgery reports through *Surgical News* as part of the broader communication strategy. Copies of these reports have been included for specialty Fellows. The procedures in profile are:

- Radical prostatectomy (Urology)
- Knee replacement (Orthopaedic surgery)

Radical prostatectomy

In financial years 2015 and 2016 Medibank funded 2,727 operations in private hospitals where radical prostatectomy was recorded as the principal procedure (highest value MBS fee from the medical claim) for the hospital admission. The analysis is limited to those 2,727 procedures. 268 surgeons (identified by their Medicare provider number) billed Medibank for those procedures. 154 (57%) of these surgeons billed Medibank for five or more procedures during financial years 2015 and 2016. Surgeon-level analysis of the indicators considered for this procedure has been limited to those surgeons with five or more patient separations, so that each surgeon has a sufficient sample of separations from which a value (e.g. an average, median or percentage) for an indicator can be reported.

For the 154 surgeons who performed at least five procedures:

- The median number of nights that a surgeon's patient stayed in hospital ranged between 1 night (same day admission and discharge) and 18 nights with a median of 3 nights (see figure 1).

The average number of MBS items billed by a surgeon (the principal surgeon only) was 1.5 per hospital separation (see figure 2).

Of the 154 surgeons who performed five or more procedures, the average number of MBS items billed by a surgeon ranged between 1 and 5.3 with a median of 1.2.

Although most surgeons sit within the 95% confidence interval there are a number of outliers.

Knee replacement procedures

In financial years 2015 and 2016 Medibank funded 13,807 operations in private hospitals where knee replacement was recorded as the principal procedure (highest value MBS fee from the medical claim) for the hospital admission. The analysis is limited to those 13,807 procedures. 729 surgeons (identified by their Medicare provider number) billed Medibank for those procedures. 543 (74%) of these surgeons billed Medibank for five or more procedures during financial years 2015 and 2016. Surgeon-level analysis of the indicators considered for this procedure has been limited to those surgeons with five or more patient separations, so that each surgeon has a sufficient sample of separations from which a value (e.g. an average, median or percentage) for an indicator can be reported.

Across the total sample of 13,807 hospital separations, patients were transferred to inpatient rehabilitation (see figure 3)[2] following 5,913 hospital separations (43%).

For the 543 surgeons who performed at least five procedures:

- 56 (10%) had no patients referred to inpatient rehabilitation
- 462 (85%) surgeons had one or more patients referred to inpatient rehabilitation
- 25 (5%) had all of their patients referred to inpatient rehabilitation
- The percentage of surgeon's patients that were transferred to rehabilitation ranged between 0% and 100% with a median of 39%.

Data shows significant variation between surgeons as to whether they send their patients to inpatient rehabilitation or discharge them home (potentially for home-based, community-based or outpatient rehabilitation). Consequently, a large proportion of surgeons sit outside the 95% confidence interval (both above and below). Therefore we would caution against the use of the 95% confidence interval to identify outliers from normal or indeed best practice.

The average number of MBS items billed by a surgeon (the principal surgeon only) was 1.4 per hospital separation (see figure 4).

Of the 543 surgeons who performed five or more procedures, the average number of MBS items billed by a surgeon ranged between 1 and 4.8 with a median of 1.1.

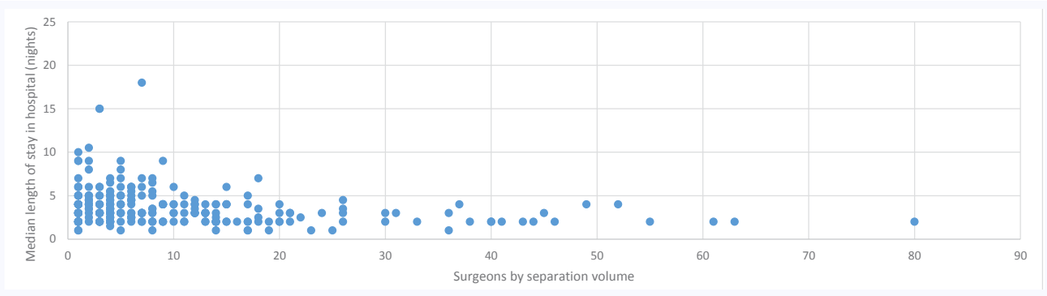


Figure 1: Percentage of patients that stayed in hospital overnight

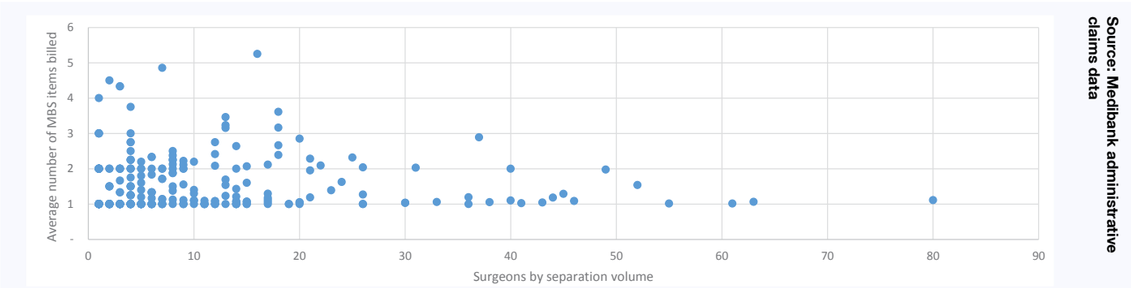


Figure 2: Average number of MBS items billed

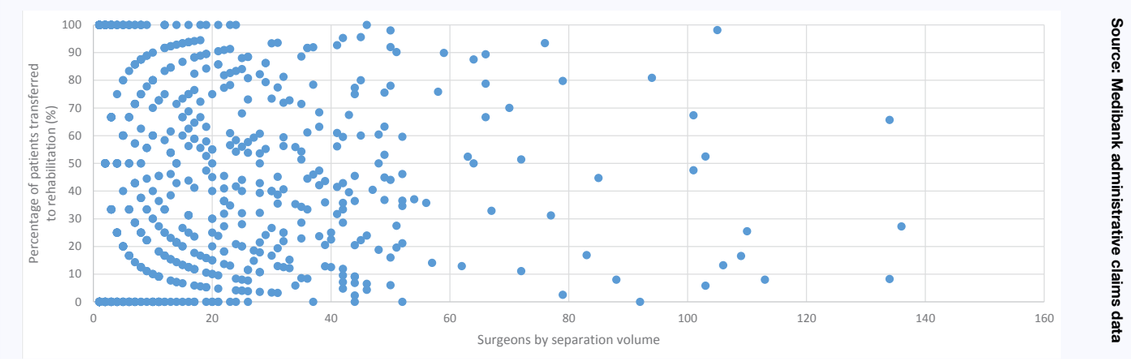


Figure 3: Percentage of patients transferred to inpatient rehabilitation

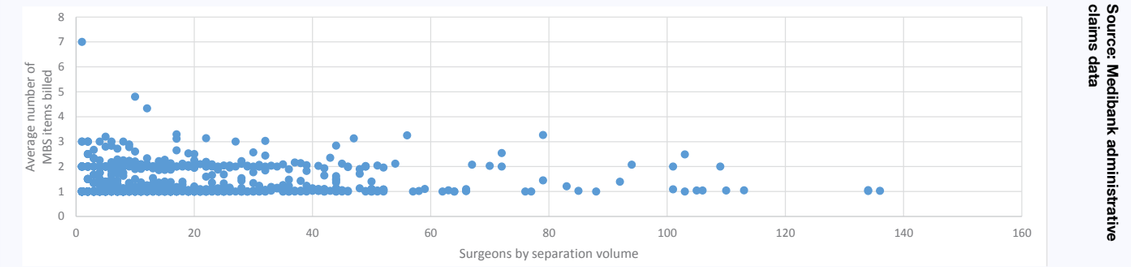


Figure 4: Average number of MBS items billed

1 Confidence intervals are not represented in this article. They are available in the final reports.
2 Administrative claims data indicated that the patient was discharged from acute care and admitted to a rehabilitation facility (or rehabilitation ward within the same hospital) within 24 hours.

2017 Fellowship Survey – Have Your Say

RUTH BOLLARD
Chair, Fellowship Services Committee

All active and retired Fellows will receive an email invitation in October to participate in the 2017 Fellowship Survey.

By participating in the survey, you will help shape the future direction of RACS to identify areas for improvement, strengths and the potential path Fellows wish our College to take in the coming years.

While feedback is being collected, it is timely to look back at the previous Fellowship Survey results and how feedback from Fellows has been addressed. The Fellowship Survey was last conducted in 2015, achieving a response rate of 31 per cent. Importantly, Fellows who participated in the survey were a representative sample of the broader Fellowship in terms of specialty practiced, regions, age and gender.

Advocacy

When evaluating how well RACS has been advocating on key health issues in 2015, trauma had the highest satisfaction level (89%), and excessive fees had the lowest satisfaction level (still significant at 68%). Feedback confirms that RACS is focused on the issues that Fellows wish to see highlighted and that advocacy is viewed by members as a necessary function to better support the patients we serve.

RACS has significantly increased efforts to be a leading advocate in areas such as alcohol-related harm, trauma, indigenous health, global health, sustainable healthcare and discrimination, bulling and sexual harassment. Recent examples include universal access to safe, affordable surgical and anaesthesia care when needed, the Ear Health for Life campaign, the launch of the Reconciliation Action Plan, the RACS Diversity and Inclusion Plan collaborating with key stakeholders on a successful campaign to ensure the Northern Territory government maintains speed limits on the Stuart Highway and funding of the Australian Trauma Registry.

Communication and Publications

The 2015 Fellowship Survey results indicated that Fellows were largely satisfied with RACS' publications and e-newsletters. Fax Mentis (weekly email) and *Surgical News* were the modes of communication Fellows prefer.

RACS has been responsive to Fellow feedback on the types of issues they wish to see addressed in *Surgical News*, with an increase in reporting on workforce issues, monitoring of the RACS Action Plan to address bullying and sexual harassment and more details on professional development opportunities.

Only 27 per cent of Fellows reported in 2015 that they used the RACS Pocket Diary. A review of this product has now taken place. Given the low usage reported in both 2010 and 2015 surveys, the pocket diary is now issued only on request.

Customer Service

Almost 85 per cent of respondents reported that they were 'always' or 'very often' able to easily make contact with the appropriate RACS staff member to assist them. RACS continues to value customer service as a core function to serve our members. All staff have completed formal customer service training and clear standards have been established to ensure all queries are responded to in a timely manner.

Professional Development Opportunities

The professional development topics reported to be of most interest to Fellows in 2015 were surgical education, managing adverse outcomes, clinical governance, business/ practice management, leadership and work/ life balance. Face-to-face workshops continue to be the most preferred delivery method with increasing interest in online learning.

A wide variety of courses and upskilling opportunities are offered each year. Two notable initiatives include the Operating with Respect eLearning module and the Surgeons as Leaders in Everyday Practice workshop, which is in development.

Ongoing Challenges

In 2015 Fellows provided feedback on what they see are the challenges for RACS over the next five years. The most commonly reported issues were:

- meeting community expectations
- maintaining standards and championing professionalism
- changes to eliminate discrimination, bullying and harassment
- advances in surgery and responding to change
- ongoing review of the SET Program
- engaging with stakeholders
- remaining relevant to all specialties.

It is pleasing to see that these issues are aligned with the RACS strategic plan, however the challenges remain and there is much more work to be done.

I urge all Fellows to complete the Fellowship Survey to provide feedback on RACS services and programs and help determine our future priorities.

Look out for your invitation to participate in the 2017 Fellowship Survey in your inbox in October.

Worth $20,000

RACS Aboriginal & Torres Strait Islander

SET Trainee One Year Scholarship

Due to availability in funding, applications for this scholarship have been re-opened. This scholarship was established by the RACS Indigenous Health Committee to support Trainees who identify as Aboriginal and/or Torres Strait Islander, and could be used to cover one or more of the following:

- SET registration fees
- SET course fees
- SET examination fees
- Research projects
- Mentoring Programs
- Travel, accommodation and registration fees to attend conferences
- Other relevant professional development activities

Who can apply

SET Trainees of any year who identify as being Aboriginal or Torres Strait Islander. Scholars are eligible to re-apply observing the advertised application deadlines and formats in competition with all applications.

Conditions

To be eligible for the Scholarship an applicant needs to fulfil the eligibility requirements for membership of the Australian Indigenous Doctors' Association (AIDA). Details can be found on www.aida.org.com.au/membership/eligibility/.
All scholarships are conditional upon the applicant being a permanent resident or citizen of Australia or New Zealand.

For further information and to apply, please go to the RACS scholarship website at www.surgeons.org/scholarships or directly to Research Scholarship web page.

Value

$20,000

Tenure

One scholarship year commencing in January 2018

Closing Date for Applications

Applicants will be notified in December 2017

Sponsored by Johnson & Johnson MEDICAL DEVICES COMPANIES

Contact

Scholarship Program Co-ordinator
Royal Australasian College of Surgeons
199 Ward Street
North Adelaide SA 5006 Australia
Telephone: +61 8 8219 0900
Fax: +61 8 8219 0999
Email: scholarships@surgeons.org

The closing date for applications for this award is 31 August 2017

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Thank you!

A very special thanks to all those who have donated to the

Pledge-a-Procedure campaign in June

The support was overwhelming and we couldn't be more grateful. You have made an incredible difference to aspiring Indigenous surgeons, which will have a profound positive impact on their and all our communities.

Thank you!

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