# SurgicalNews

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ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

**SUPPORTING PRECIOUS LIVES**

Relief for infants 'Born Too Soon' in Timor-Leste

**2019 GRANTS & SCHOLARSHIPS**

Travel and research opportunities announced

**AUSTRALASIAN ROAD TRAUMA**

An escalating epidemic: what is being done?

"We are not a team because we work together. We are a team because we trust, respect and care for each other,"

**Vala Afshar**



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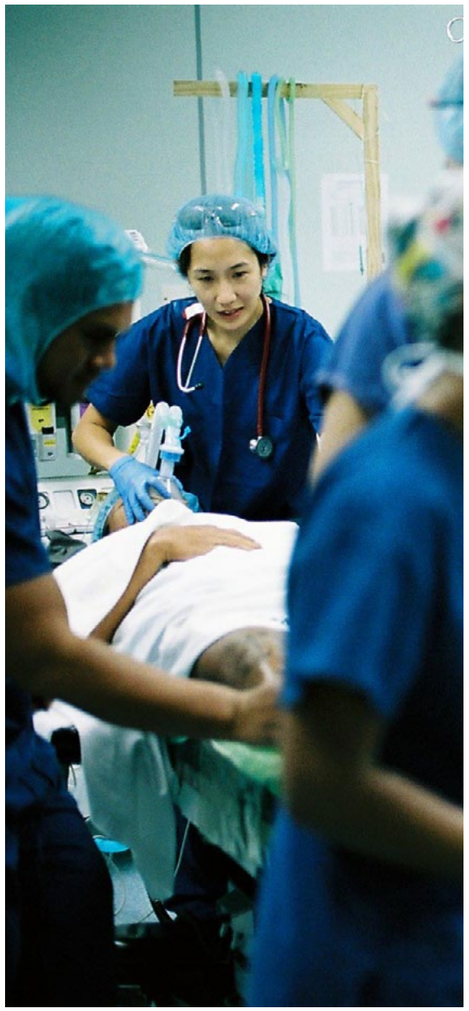

COVER: Mother and child, Timor-Leste. PHOTO: Ellen Smith.

ABOVE: Global Health volunteers: Dr Julie Chan FANZCA, is an anaesthetist and part of the orthopaedic surgical visits to Samoa. PHOTO: Ferraby Ling. Story: page 10.


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# Collaboration is the key to a sustainable future

Together with our new CEO, Mary Harney, we recently spent two weeks on a comprehensive 'road show' visiting all thirteen Specialty Societies, located in Melbourne, Sydney and Wellington. This also included meetings with the New South Wales Regional Office and the New Zealand National Office. I believe this hadn't been done for a considerable time and was well overdue. The invitation was to each of the Speciality Society Presidents, their Training Board Chairs, their Speciality-elected Councillor, CEO and staff. We requested that they determine the agenda and that (where possible) we meet at their offices.

The aim of the meetings was for Mary and I to listen to the issues that are important to each society in partnership with RACS on training, their relationship with RACS, what works well and what causes irritation or frustration. There were issues in common across all specialities. Encouragingly, throughout both countries all wanted RACS to be the advocate and voice for the highest standards in surgery and be responsible for the maintenance of those standards.

The themes that emerged include a desire to improve trust, respect and collaboration between RACS and each society, to work more collaboratively, to coordinate better and more timely communication, reduce bureaucracy, increase agility, flexibility and responsiveness and to improve the value of membership to Fellows. All had some issues with the selection, supervisor support and upskilling, management of Trainees, International Medical Graduate assessment and oversight, speciality-specific audit, data collection and access to College information.

Encouragingly, throughout both countries all wanted RACS to be the advocate and voice for the highest standards in surgery and be responsible for the maintenance of those standards.

All of the issues raised have been accepted as work that will need to be done in collaboration with the societies. We will be tackling these issues head-on as we begin a year of strategic review and reflection to inform the formulation of the 2019-2021 Strategic Plan.

These visits will become an annual event for ongoing dialogue to establish the trust, commitment and communication that is essential for all effective



PRESIDENT'S MESSAGE

relationships and that together, we fulfil our mission as the key peak surgical College and that we meet the needs of our Fellowship and the community.

We are very grateful to our various hosts and sincerely appreciate the time taken to have these important discussions so that we can refocus and make sure we deliver the benefits that are needed by Fellows. We want to reach out to all as much as we can, particularly to those who may feel disenchanted or wonder what RACS can or is doing for them. We would also like to hear from other sectors of the profession that have specific ideas and needs; we are receptive to new ideas and we are changing. We have heard what you are saying and we will respond positively and effectively.

The future of our profession is in our hands – we must rise to the challenge as we face ever increasing government and community scrutiny. If we don't, we will lose a great opportunity. Recent Australian Medical Council accreditation has crystallised this for us and we must take note and act in unison! We have no choice.

RACS has and will continue to work and collaborate with governments on standards on your behalf; this is one of its key strengths. We must continue to review and revitalise our training programs – that is our core business.

We must support our overseas neighbours and continue our important research funding – that is a key responsibility.

We must all work together – **Specialty Societies and RACS together.**

Mr John Batten
President

## RACS Post Op Podcasts

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

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

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

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

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IMAGE: Steve Rodrigues and Mary Theophilus from the Royal Perth Hospital, WA.

# Year two of 'Building Respect'

I am pleased to launch the second annual Progress Report for our Building Respect, Improving Patient Safety Action Plan.

The Report profiles some of the highlights from 2017 in implementing the work detailed in our Action Plan which brings together a wide range of projects across three areas: cultural change and leadership, surgical education and complaints management. During the past year, we have made progress in each of these areas and have built a solid base for our continuing work.

### Cultural change and leadership

Our progress in leading cultural change in 2017 included:

- Signing 15 new memoranda of understanding (MOUs) with hospitals, health services; universities and state governments in Australia and New Zealand – bringing us to 29 MOUs in total;
- Developing and piloting the first *Surgeons as Leaders in Everyday Practice* course;
- Supporting transparency and information sharing about unacceptable behaviour by revising our Privacy Policy and other important documents;
- Producing new videos, banners, posters and digital media content to support the *Let's Operate with Respect* Campaign.

### Diversity and inclusion

Building a diverse and inclusive culture in the surgical profession is a key focus for RACS. In 2017 we began implementing our Diversity & Inclusion Plan. Some of the many activities and achievements during the year included:

- Ensuring our 'public face' — including publications, website and social media — reflect gender and cultural diversity;
- Increasing diversity through the appointment of 12 people who are not surgeons to Specialty Training Boards;
- Initiating research to identify the barriers to women selecting surgery as a career;
- Working with Specialty Training Boards to support their efforts to increase flexible training;
- Advancing the Indigenous selection initiative in surgical training with Specialty Training Boards.

### Strengthening Surgical Education

RACS is committed to providing the best possible surgical education to our Trainees and International Medical Graduates by helping surgeons to be the best and most effective teachers they can be.



RACS LET'S OPERATE WITH RESPECT

RACS is committed to providing the best possible surgical education to our Trainees and International Medical Graduates by helping surgeons to be the best and most effective teachers they can be.

RACS' surgical training and teaching is based on the principles of respect, transparency and professionalism. Our sincere thanks to all who have completed, attended and supported our courses.

In 2017:

- 84 per cent of Fellows, Trainees and IMGs completed the Operating With Respect e-Module;
- A total of 2,009 participants attended 109 Foundation Skills for Surgical Educators courses;
- We delivered 14 face-to-face Operating with Respect courses to build participants' skills in dealing with discrimination, bullying and sexual harassment in the workplace;
- We implemented a multi-source feedback tool for use by Fellows to improve their practices.

### Complaints Management

In 2017, 81 complaint reports recorded on the complaints database related specifically to discrimination, bullying, harassment and sexual harassment (DBSH). Bullying was the prominent concern making up 86 per cent of all complaints received. Seventy (70) of the 81 complaints received throughout 2017 have been closed. The Progress Report provides further information on the sources of complaints and the outcomes.

I wish to thank all Fellows, Trainees, IMGs, Specialty Society partners and our staff for the incredible work that has gone into progressing the Building Respect Action Plan. We know cultural change will take time but with every step taken in the right direction, I have no doubt that it will happen – and sooner than we think.

In 2018 we will continue to deliver against the objectives of the Action Plan, and this includes continuing to upskill our surgical supervisors through the Operating with Respect one-day course and the Foundation Skills for Surgical Educators course.

The Progress Report is available on our website and in hard copy upon request. Please email me at college.vicepresident@surgeons.org for your copy.

Dr Cathy Ferguson
Vice President



# RACS Global Health

RACS manages Global Health programs and projects in various lower and middle income countries across the Asia-Pacific region. Thanks to funding support from the Australian Government, the Foundation for Surgery and generous corporate, community and individual donors, RACS Global Health provides specialist medical education, training, capacity development and medical aid to 18 countries in the Asia-Pacific region.

In 2017, RACS Global Health released its new Strategic Plan 2017 – 2021, which places greater emphasis on workforce development and facilitating regional collaboration. Project activities throughout the year culminated in the delivery of more than 40 specialist clinical visits, 1,989 life-changing procedures performed, 1,063 local health professionals trained, and 22 scholarships and grants awarded.

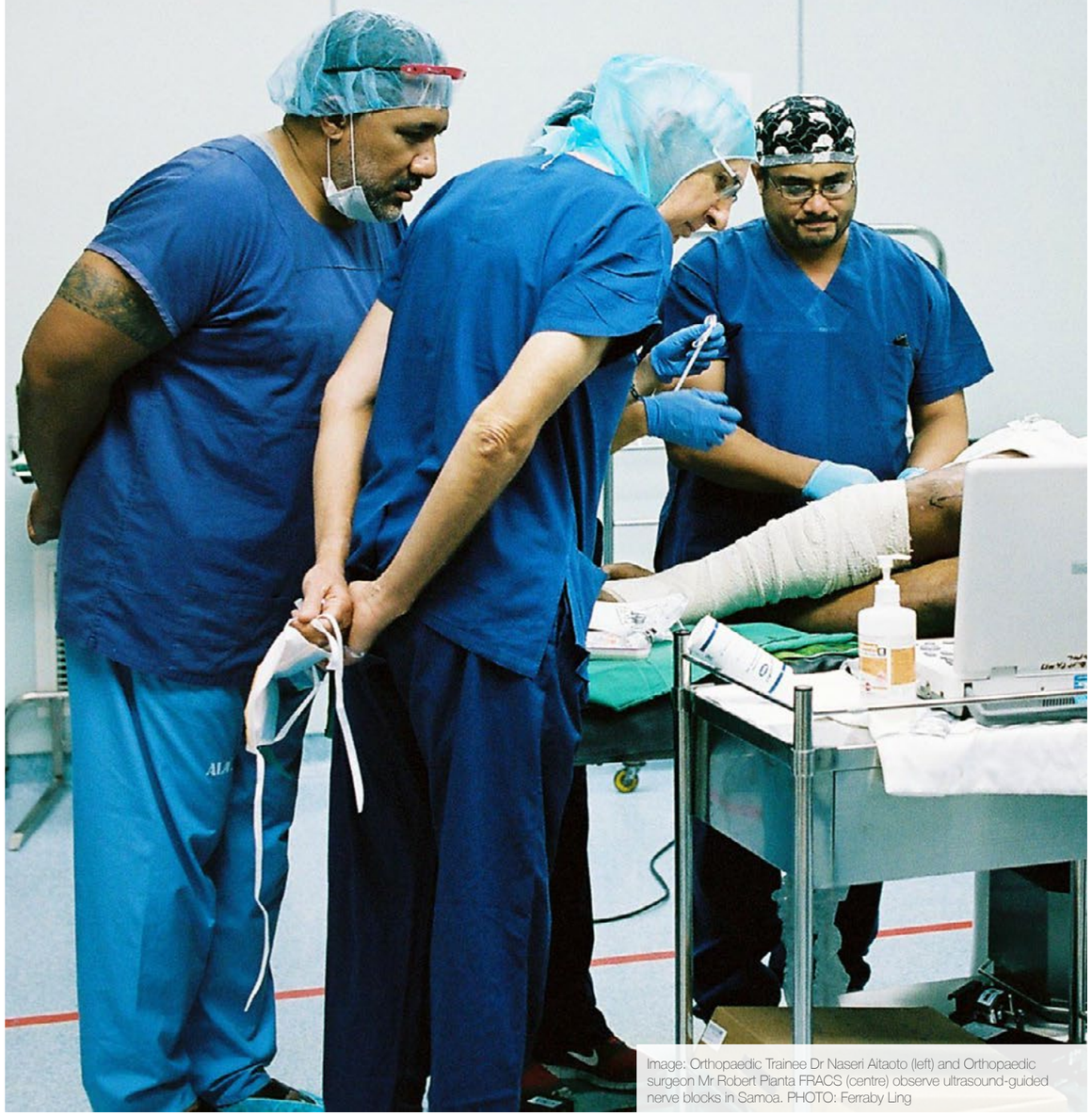


Image: Orthopaedic Trainee Dr Naseri Aitaoto (left) and Orthopaedic surgeon Mr Robert Pianta FRACS (centre) observe ultrasound-guided nerve blocks in Samoa. PHOTO: Ferraby Ling


## MYANMAR

Established in 2009

68 courses delivered

1,250 health professionals trained in trauma, emergency management and surgical skills

3 scholarships awarded

## PAPUA PROGRAM

Established in 2017

7 courses delivered

479 health professionals trained in burns, trauma and pain management

## PACIFIC ISLANDS PROGRAM (PIP)

Established in 1995

11 Pacific Countries
*Nauru, Tuvalu, Cook Islands, Micronesia, Tonga, Kiribati, Samoa, Vanuatu, Solomon Islands, Fiji*

807 clinical visits

93,863 consultations

24,356 operations

341 health professionals trained in trauma, pain management and other skills

## SUMBA EYE PROGRAM

Established in 2007

11 clinical visits

10,031 consultations

1,017 operations

## AUSTRALIAN TIMOR-LESTE PROGRAM OF ASSISTANCE IN SECONDARY SERVICES (ATLASS)

Established in 2001

6 Post Graduate Diplomas in Family Medicine, Surgery, Paediatrics, Anaesthesia, O&G, Internal Medicine; and 1 Masters of Medicine Paediatrics delivered in-country

184 Enrolments

96 Graduates

## EAST TIMOR EYE PROGRAM

Established in 2000

1 Ophthalmologist trained

10 Ophthalmologists in training

100,636 consultations

10,888 operations

## PAPUA NEW GUINEA (PNG)

Established in 1995

158 clinical visits

17,174 consultations

6,777 operations

## SCHOLARSHIPS

Scholars from 34 countries

82 Rowan Nicks scholars

106 Weary Dunlop Boon Pong Thai scholars

72 Surgeons international awardees

# Inspiring a generation of female specialists

## RACS Global Health Volunteers

The adage 'lead by example' could never be more true than with the women leaders and volunteers under the DFAT-funded Pacific Islands Program (PIP) who are inspiring a new generation of female specialists across the Pacific. Men outnumber women in paid employment in the Pacific by approximately two-to-one, and continue to earn 20 to 50 per cent more because they work in jobs attracting higher salaries. Whilst RACS Global Health activities support equal access to clinical health services, surgical workforce representation remains low, where 12 per cent of surgeons in Australia are women[i], and only five per cent are women in the Pacific Islands Program (PIP). RACS Global Health seeks to support female specialist training. A vital role in engaging the interest of women is to have female role models that are successful in their positions, to mentor and guide the next generation of health professionals. The PIP has a number of female volunteers who have built strong mentoring relationships with Pacific counterparts, which has facilitated Pacific women's confidence, courage, and determination to take on specialty training and leadership positions.

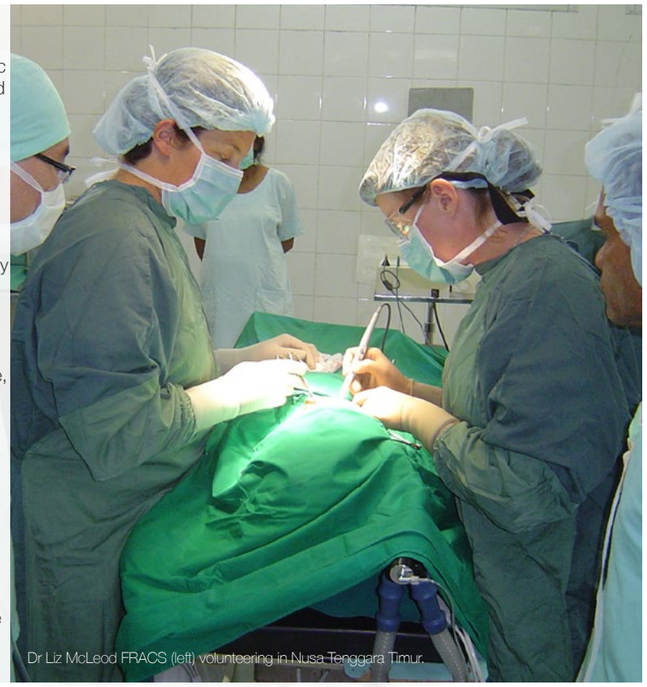
The PIP strives to increase the number of female specialists in Visiting Medical Teams (VMTs) to act as role models for Pacific trainees, interns, and medical students; and will work with interested volunteer candidates to accommodate their personal and family circumstances.

We are far away from achieving a gender balance in surgical specialities, however promisingly, 33 per cent of Pacific medical students who participated in PIP capacity building activities in 2017 were female. There is good momentum that we will need to build upon in the coming years to assist Pacific women shape Pacific development.

i RACS 2016 Annual Activities Reports, published March 2017

### Dr Liz McLeod FRACS

Dr Liz McLeod FRACS, a paediatric surgeon, has been actively involved in RACS Global Health programs in Indonesia and across the Pacific, and is the current Chair of the RACS Global Health Evaluation and Monitoring Committee. From her perspective, childcare is a challenge for women in surgery, and may be one of the reasons why there are only a handful of women participating in Global Health outreach programs. "For the first few years post fellowship, people don't feel well placed to go as they lack experience, which I think is appropriate. Then women are often trying to juggle small children, and the years slip by." Dr McLeod also mentioned that arranging childcare could be a way to encourage more women to be involved. "I would say that child care would be very easy to arrange, particularly in the Pacific, and most of the places we visit are really safe. It would be great to encourage more women to participate, and this may be key."



Dr Liz McLeod FRACS (left) volunteering in Nusa Tenggara Timur.

### Dr Julie Chan FANZCA

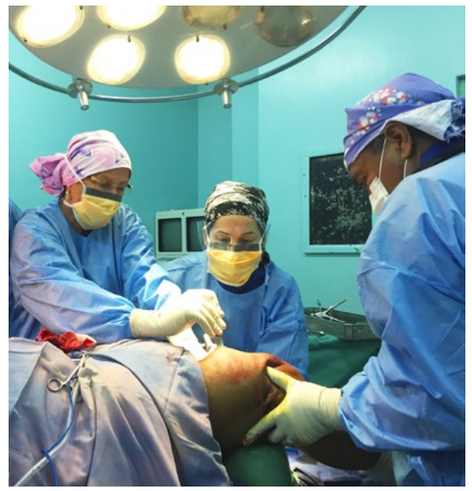
Dr Julie Chan FANZCA, an anaesthetist as part of orthopaedic surgical visits to Samoa, encourages all women to seek global health opportunities. "Put aside the time to do your research. Talk to others who have been involved with similar activities. Believe in yourself. We all have a lot to offer in terms of mentoring and leadership, but we can also learn a lot from the Program."

Dr Julie Chan FANZCA (right) teaching ultrasound guided nerve blocks in Samoa.

### Dr Sheanna Maine FRACS

Dr Sheanna Maine FRACS, an orthopaedic surgeon, has been participating in clinical service and training activities in Kiribati for a number of years. The challenges Dr Maine describes are not necessarily related to gender, but do impact participation in outreach activities. "Working in the Pacific Islands (or any outreach program) presents its own unique set of challenges that take one away from the usual hospital based routine experienced in our health care system. You are often out of your comfort zone from the obvious lack of facilities, to the incredible pathology, the wonderful cultural differences, language barriers, and the need to generate and utilise a different set of rules to apply in clinical judgement."

Dr Sheanna Maine FRACS (centred) on the atoll of Tarawa, Kiribati.



Dr Alex Hockings FRACS (centre) with colleagues in Solomon Islands.

### Dr Alex Hockings FRACS

Dr Alex Hockings FRACS, a urologist, will lead the next urology visit to Solomon Islands planned for June 2018. She is one of the newest additions to the Pacific Islands Program (PIP).

Annette Holian
Chair, External Affairs

*and Natalia Hepp, Project Support Officer, Global Health*

If you are a female specialist, interested in volunteering on a one week outreach team trip, with expenses paid, please contact Natalia Hepp for more information | **Natalia.Hepp@surgeons.org**

Foundation for Surgery
Passion. Skill. Legacy.

# Supporting precious lives

## Relief for infants 'born too soon' in Timor-Leste

Globally, pre-term birth complications are the leading cause of death among children under five years of age, and were responsible for around one million deaths in 2015. Yet three-quarters of these deaths could have been prevented with current and cost-effective interventions.[1]

As a young nation, maternal and infant mortality rates in Timor-Leste (East Timor) remain high. While significant progress has been made in reducing these rates, the United Nations Sustainable Development Goals has outlined a target for 2030, to end preventable deaths of newborns and children under the age of five.

RACS Global Health, through the East Timor Hospital Support Fund established by cardiothoracic surgeon Associate Professor Andrew Cochrane FRACS, has sponsored the urgently needed extension of the Surgical Intensive Care Unit (SICU) within the Neonatal Unit for babies admitted from the emergency department at the National Hospital in Dili; providing palpable relief to the critically overcrowded space.

Assoc. Prof. Cochrane has been involved with the RACS Timor-Leste program since 2003 when he led a visiting paediatric cardiac surgery team. He travelled to Timor-Leste for several years as team leader, undertaking a range of operations without open heart bypass support.

The Neonatal Unit had been bursting at the seams for several years, often having to accommodate far too many babies for the space available.

The overcrowding meant that conditions were challenging for both families and staff, and the Hospital were unable to care for babies using the World Health Organisation (WHO) recommended 'Kangaroo Mother Care' (KMC) system, a method of care for pre-term infants. Adapted to local conditions, reclining chairs are required as part of KMC but prior to the extension there was simply no space for these. The cramped conditions meant that oxygen cylinders and necessary equipment created a hazardous environment for staff, patients and parents. It also meant an increased risk of nosocomial infection.

Assoc. Professor Andrew Cochrane FRACS

The SICU extension has eliminated poor ventilation and Occupational Health & Safety hazards while addressing space concerns. The refurbishment has provided better quality electrical and plumbing fittings and created critical isolation wards for infectious babies.

Specialists working at the Hospital such as Australian paediatrician, Dr Ingrid Bucens, are confident that they will see further improvement in survival rates after the refurbishment. It has been reported that the number of babies who are discharged alive from the Unit has increased significantly. Dr Bucens shares that "although survival has improved overall; the gains made in survival of the smallest (including the most pre-term) babies have been the biggest".

> "...the gains made in survival of the smallest babies have been the biggest"

In Timor-Leste, World Prematurity Day (17 November), a day where awareness is raised on the global problem of premature birth, was acknowledged through the official launch of the extension. The improvement in outcomes has been significant and Dr Bucens explains that "hospital staff and donors should all feel very proud of this achievement".

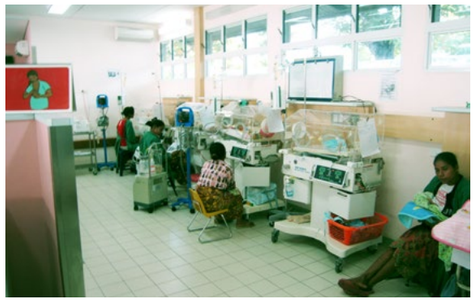


IMAGE: Neonatal ward, before and after the refurbishment.

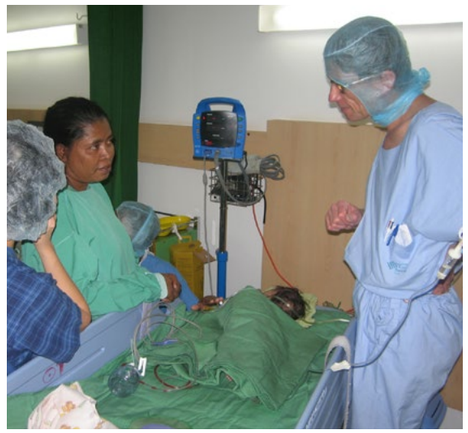
In less than half a year, the East Timor Hospital Fund has assisted to deliver real reprieve for the families and precious lives housed within the Neonatology Unit. Now that the space has been expanded, new techniques of care can be explored within the area. The improvement comes at the right time with admission numbers to the National Hospital, and particularly in the SICU, steadily increasing every month.

The critical injection of funds for the renovation was raised by Assoc. Prof. Cochrane, through the annual *"Dollars for Dili"* concert, donations from community networks and the East Timor Hospital Support Fund. The extension followed the generous donation of a new ultrasound machine in late 2016 for the Obstetrics & Gynaecology (O&G) Department.

The previous 20 year old ultrasound machine lacked key functionalities such as accurate measurements and high resolution images. With the Hospital's O&G Department performing close to 300 ultrasound examinations per month, the brand new ultrasound machine was a vast improvement, allowing for more precise and timely diagnosis of patients. The capacity to manage high risk O&G cases, reduce complications and provide a more streamlined approach to patient care has provided safer and more economical outpatient management alternatives.

*Assoc. Prof. Cochrane FRACS travelled to Timor-Leste early March, supported by RACS Global Health.*

1 http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)31593-8.pdf



Annette Holian
Chair, External Affairs

*and Gwyn Low, Global Health*

# Applications for the 2019 Rowan Nicks Scholarships and Fellowships are open

The Royal Australasian College of Surgeons invites suitable applicants for the 2019 Rowan Nicks Scholarships and Fellowships.

### Rowan Nicks International and Pacific Islands Scholarships

The Rowan Nicks International and Pacific Islands Scholarships provide training opportunities to promising surgical leaders who will contribute to the development of the long-term surgical capacity in their country. Scholars develop their clinical, leadership and research skills through clinical attachments in selected hospitals in Australia, New Zealand and South-East Asia.

The Rowan Nicks Australia and New Zealand Fellowship and Rowan Nicks United Kingdom and Republic of Ireland Fellowship are designed to promote international surgical exchange at the levels of practice and research and advance the profile of surgery.

### Rowan Nicks Australia and New Zealand Fellowship

The Australia and New Zealand Fellowship provides funding to assist a New Zealander to work in an Australian unit, considered by RACS to be of national excellence for a period of up to one year, or an Australian to work in a New Zealand unit by the same principles.

### Rowan Nicks United Kingdom and Republic of Ireland Fellowship

The United Kingdom and Republic of Ireland Fellowship provides funding to assist a surgeon from the UK or the Republic of Ireland to take up the Fellowship in Australia or New Zealand.

### Applicant Information

Fellowships and Scholarships are designed to cover a return economy airfare, provisional living allowance and if applicable, the RACS Annual Scientific Congress (ASC) attendance.

The application form with full eligibility details is available on the RACS Global Health Scholarships website: https://www.surgeons.org/for-the-public/global-health-scholarships/rowan-nicks-fellowships-and-scholarships/

### Applications close on 1 June 2018

Contact: international.scholarships@surgeons.org

# Accreditation of the Australian Medical Council post RACS re-accreditation

As most Fellows, Trainees and IMG's on the pathway to Fellowship would be aware, RACS recently underwent formal re-accreditation until 2022 by the Australian Medical Council (AMC).

This process commenced in the second half of 2016 enabling development of a comprehensive submission by RACS staff with contributions from all specialty training boards and societies. Finally submitted in December 2016, RACS and representative members, boards, societies, and training hospitals were all then reviewed by the AMC accreditation team. The review team also attended a Foundation Skills for Surgical Educators (FSSE) course, the International Conference on Surgical Education & Training (ICOSET) days prior to the Annual Scientific Congress (ASC) and the ASC itself. They also observed some of the Fellowship examinations. The draft report was then received at RACS in September 2017. We judged the draft report to be quite reasonable and some small changes were suggested and accepted by the AMC. The AMC then went through their processes, the accreditation report being approved by the Medical Board of Australia in December 2017. The completed document is now published on the RACS website.

### What is accreditation?

Accreditation is about making sure the standards of post-graduate surgical education are met and to also enable peer review, to stimulate self-analysis within RACS and to assist RACS in achieving its objectives, in a collegiate fashion. Clearly, excellence in surgical education is the major RACS aspiration and activity. The 10 AMC standards provide RACS with plenty of opportunity to develop its own approach, within the overall framework. Being made to report and consider our activities enables reflection and helps plan the way forward. Being challenged from 'outside' means that we have to be able to lucidly state where we are up to, and where we are going.

### The Australian Medical Council

The Australian Medical Council is an organisation with delegated authority from the Medical Board of Australia to develop standards for, and monitor, medical education and training across the medical education continuum. Initially, this was an optional review process but became part of National Law in Australia in 2010. So the AMC accredits all university medical schools in Australia and New Zealand, is responsible for standards relating to internship and also reviews post-graduate medical colleges, not just about specialty education per se but about their continuing professional development programs and supervision of overseas trained specialists. The Medical Council of New Zealand, by way of formal agreement with the AMC, notes this outcome.

Recently the role of the AMC was commented upon within the draft report by the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for the health professions* (Professor Michael Woods, commissioned by COAG Health Council, Australian Health Ministers' Advisory Council, September 2017). An alternative to the AMC was proposed as 'Option C', being a Health Education Accreditation Board. RACS submitted that it was difficult to see benefit from such an option, given the current rigorous approach. From RACS' perspective, engagement with the AMC has been a productive experience: we need to demonstrate suitable outcomes over the next three years. Increasing collaboration with specialty training boards and related specialty societies, and an all-of-College response is now required.

### International Accreditation of the Australian Medical Council

Importantly, the Australian Medical Council itself has also recently been accredited by the World Federation for Medical Education (WFME). Significantly noting the recent review of RACS, Australia's system of accreditation of medical school and post-graduate medical training programs by the AMC was found to meet 'International best practice' and be of rigorous standard.

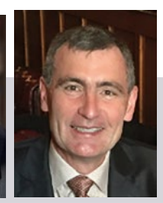
WFME is a senior International medical education body and the AMC is only the eighth accreditation authority in the world to have completed this review process. Satisfactory accreditation with WFME follows three other International reviews by other bodies in the last five years. Coincidently, the WFME review occurred at the same time as the completely separate review of the national Accreditation Standards system referred to above.

### Building on the recent AMC re-accreditation

Our recent review by AMC identified many of the concerns that we have had around surgical education and the comprehensive set of 35 conditions remain to be responded to over the next three years. RACS has considered all of these conditions and mapped the approach to all of this surgical education work, into a series of projects which also include issues and plans that we had noted, presented and developed prior to the official accreditation in relation to surgical education.

This recent comprehensive RACS review, discussed through the Board of Surgical Education & Training and Education Board, has enabled fashioning of a comprehensive and coherent program of work associated with surgical education. This takes into account recent RACS initiatives including the Building Respect, Improving Patient Safety Action Plan, includes data from our own monitoring of the surgical education training program especially about attrition and lack of success at the Fellowship examinations for some. The AMC conditions are woven into this program of work with projects around selection, expanded professional skills curriculum, improved work-based assessment, Fellowship examination feedback processes, all linked towards certified new surgeons: the 'outcomes' of surgical education. Outcomes of surgical training, recently presented by President Batten at ICOSET, include the competent performance of new Fellows as well as the need to meet community expectations including reasonable workforce expectations. As with the Building Respect, Improving Patient Safety Action Plan, being a surgeon is about the surgical patient.

Ultimately, just as AMC personnel engaged with RACS for the purposes of re-accreditation of the College, improved relationships across RACS, its Boards, the surgical societies, supervisors, surgeons who teach and train Trainees, Trainees, and overseas trained (IMGs-on-pathway) surgeons, will deliver the excellence we're aiming for. Relationships are about our people, too.



Mr John Batten
President

Assoc. Professor Stephen Tobin
Dean of Education

# What's in store at the 2018 ASC

The 2018 Annual Scientific Congress will be held from 7-11 May at the International Convention Centre, Darling Harbour in Sydney

Following on from a successful joint meeting in Singapore in 2014, RACS and the Australian and New Zealand College of Anaesthetists (ANZCA) are again collaborating to develop a program, which should be of great interest to Fellows of both colleges. The plenary sessions on the first and final days of the Congress will be jointly presented by RACS and ANZCA, and there will be a number of combined sessions throughout the event.

One such session will discuss the concepts of equality and equity with respect to indigenous health and the challenges faced in measuring, researching and implementing indigenous health programs.

Another session, Trauma and Paediatrics on the management of mass casualty events will be presented by ANZCA. In this session, the current level of risk of terrorist events will be outlined, and the audience will have the opportunity to learn lessons from a variety of international speakers who have experienced first hand the challenges involved in the medical response to recent events in Paris, Manchester and Las Vegas.

A third joint session aims to demystify Enhanced Recovery After Surgery (ERAS) and asks what works, whether the ERAS package reflects more than just good care and what we should be measuring. This session is not aimed at any specific specialty, but rather the concepts that may be used for all perioperative care.

RACS ASC section conveners, Assoc. Professor Navin Niles (Endocrine Surgery) and Dr Farid Meybodi (Breast Surgery), have developed stimulating programs that should appeal to both subspecialty and general surgeons.

The breast program will cover a wide range of topics ranging from oncology to oncoplastic surgery and breast reconstruction. There will be one dedicated session on 'what really matters in breast surgery', focusing on data collection and making our practice responsive to it.

Professor Elisabeth Mittendorf is one of our distinguished speakers from the USA. Moving from MD Anderson to Boston, she is currently the Chair of Surgical Oncology at Brigham and Women's Hospital and director of Surgical Research at Dana-Farber/Brigham and the Women's Cancer Center Breast Program. Her presentation will include the management of breast and axilla in the setting of neoadjuvant systemic therapy. As a surgical immunologist she will also present a keynote lecture titled *'An update on the role of immunotherapy in breast cancer'*.

We are also very excited to have Dr Stephen McCulley as an invited international speaker from Nottingham UK. He has vast experience in all aspects of Oncology, Oncoplastic Reconstructive and Cosmetic breast surgery and will be presenting his perforator flaps technique in the masterclass.

Many international leading surgeons will also contribute to the two combined 'State of the Art Breast Reconstruction' sessions. This includes Professor Peter Neligan from the UW Medical Center in Seattle, USA; Professor David Chang from the University of Chicago; Professor Rodney Rohrich from the University of Texas and many other leading Australasian breast surgeons.

One major focus of the program will be on the discussion of challenging and difficult day-to-day scenarios faced by oncoplastic breast surgeons. This will be conducted in the form of a case discussion and will likely trigger a constructive debate that will not only explore national and international practices but will also be educational.

Endocrine Surgery has a comprehensive program for the Congress this year with three world-renowned international speakers.

Professor Dimitrio Linos has published extensively and authored several chapters in different textbooks. He is the Editor of the Springer's textbooks on *The Adrenals* and *Minimally Invasive Thyroidectomy.* He has organised several international courses in Endocrine Surgery in Greece and has participated as a Faculty member in several courses and meetings internationally. Prof. Linos was the past President of the International Association of Endocrine Surgeons. He currently serves as the Governor of the American College of Surgeons in Greece and as a member of several International Societies as well as the International Advisory Board of JAMA Surgery. He is currently Professor and Chairman of the University's 5th Surgical Clinic.

Dr Cord Sturgeon is the Director of Endocrine Surgery at Northwestern University in Chicago, Illinois. Dr Sturgeon is an expert on outcomes research, primarily through decision analysis, economic analysis and survey studies on quality of life. He has published numerous articles and book chapters spanning all aspects of endocrine surgery in addition to editing the textbook *Endocrine Neoplasia.* Dr Sturgeon is a member of the National Comprehensive Cancer Network Thyroid Cancer Guidelines Committee, was a co-author of the *2009 International Workshop Guidelines on Asymptomatic Primary Hyperparathyroidism* and of the *2016 American Association of Endocrine Surgeons (AAES) Guidelines on the Definitive Management of Hyperparathyroidism*. He has been involved in the governance of the American College of Surgeons (ACS) and the AAES. Dr Sturgeon is the immediate past Recorder of the AAES and is on the editorial board of four journals.

Police Major Dr Angkoon Anuwong, MD, FRCST, FACS serves as laparoscopic surgeon and Program Director of the Minimally Invasive Surgery Division, Department of Surgery, Police General Hospital, Bangkok, Thailand. He is one of the pioneers in transoral endoscopic thyroidectomy (TOETVA) and parathyroidectomy (TOETPVA). He has the world's largest series of transoral endoscopic thyroidectomy, now more than 800 cases to date. Dr Anuwong's clinical research has focused on minimally invasive surgery, with a particular interest in Normal Orifice Thyroid Endoscopic Surgery (NOTES), thyroid and parathyroid surgery.

This eminent invited international faculty is also joined by renowned international speakers Professor Rachel Kelz and Dr Lawrence 'Drew' Shirley.

The Endocrine Surgery program will kick off with a cadaveric dissection course on Monday 7 May 2018. The course is targeted to young Endocrine surgeons, lower volume Endocrine surgeons and Endocrine surgery Fellows. This cadaveric workshop will focus on challenging thyroid surgical techniques mentored by international and local leaders in Endocrine Surgery. The day will conclude with Pol.Maj. Dr Angkoon Anuwong demonstrating the trans oral approach to thyroid surgery.

Masterclasses on the Wednesday and Thursday breakfast sessions will focus on difficult thyroid cases and interesting thyroid cancer cases.

There are many interesting events planned throughout the week including debates between international and local leaders on current controversies in Endocrine Surgery. The joint dinner will be held at Luke Mangan Glass Brasserie at the Hilton, with sweeping views of the internationally acclaimed Sydney Harbour.

The organising committee invites you to take the opportunity to attend what will be an educational and thought provoking ASC, with the added benefit of joining our colleagues from the Australian and New Zealand College of Anaesthetists. We encourage you to register before 18 March in order to take advantage of early bird registration rates.

We look forward to seeing you in Sydney in May.

Julie Howle, Farid Meybodi, Navin Niles, Ben Olesnicky
ASC Convenors

# Supporting surgeons as leaders

## Join the Surgical Directors Section

The Surgical Directors Section provides a network of peers, professional development and resources to support surgeons who aspire to or hold a leadership position. The section is seeking new members and is open to all Fellows, Trainees and International Medical Graduates.

Leadership is a key RACS competency. All surgeons, whether or not they have a formal leadership role, are expected to demonstrate leadership skills. With an increasing emphasis on effective teamwork and ensuring safe environments for staff and patients, surgeons play a central role in influencing the culture of our healthcare teams and the wider organisations in which we work.


The section has established a Surgical Directors Program at this year's Annual Scientific Congress which is open to all members and surgical specialties. Evaluation results show the program has rated highly by participants for its educational value. The 2018 Surgical Directors Program is combined with the Quality and Safety Program, co-convened by Professor Gary Morgan and Professor Michael Cox. The program will focus on themes including quality improvement, the role of surgical leaders in health system transformation, challenges in leadership and taking on the role of director. International Visitors include Professor David Flum, USA (Director, Surgical Outcomes Research Centre - SORCE) and Dr Oscar Guillamondegui, USA (Vice Chair for Quality, Patient Safety and Professionalism for Vanderbilt University's Section of Surgical Science). The inaugural Surgical Directors Section Dinner (combined with Surgical Education) will be held at the Shangri-La Hotel and should not be missed.

The Section also offers an annual day long Surgical Leadership Forum, which is a fantastic networking opportunity for surgical leaders and aspirational leaders to come together from across the jurisdictions. The forum addresses leadership topics nominated directly by section members such as building and engaging clinical teams, managing disruptive behaviour, clinical governance, futile surgery and profiling successful quality improvement programs.

The Section strongly supports the Building Respect and Improving Patient Safety initiative. Surgeons in leadership positions are well placed to promote conversations about the standards expected of all surgeons as we focus on respectful workplaces. As part of this initiative, the Section is actively promoting two newly developed RACS courses: Surgeons as Leaders in Everyday Practice and the Operating with Respect face-to-face skills course. These courses aim to equip surgeons to address disruptive behaviour and to assist with the development of leadership capabilities for individuals and clinical teams.

To find out more about these courses or to become a member of the Surgical Directors Section visit www.surgeons.org/SurgicalDirectors or email surgical.directors@surgeons.org.

Professor David Fletcher
Chair, Surgical Directors Section

*with Kylie Mahoney, Senior Project Officer.*





# Trauma Verification Symposium

## 'From little things big things grow'

Trauma verification is a multi-disciplinary inter-collegiate process which assists hospitals in analysing their system of care. Trauma verification covers all phases of acute care from pre-hospital through to discharge, and identifies the strengths and weaknesses of a hospital's trauma service. It helps save lives, reduce waiting times and lower costs. Today, the RACS Trauma Verification multi-disciplinary program is the leading mechanism for quality improvement and accreditation in trauma in Australia and New Zealand. Key benefits include a critical evaluation of the structure, staffing and resources within a hospital; benchmarking trauma services against international standards and a multidisciplinary approach to assessment of trauma care – including partnerships with the College of Intensive Care Medicine, the Australian and New Zealand College of Anaesthetists, the Australasian College of Emergency Medicine and the Australasian Trauma Society.

IMAGE: Garry Grossbard, pictured with the Road Trauma Advisory Subcommittee. Mr Grossbard was awarded an 'outstanding service certificate' during RACS 2017 'Trauma Week' as recognition of his long term commitment and dedication to the College through Committee membership and his wonderful advocacy work surrounding road trauma.

The focus on Trauma Verification at this year's 'trauma week symposium' served as a timely opportunity to highlight the benefits of Trauma Verification, to assess its journey and to explore future paths. Assoc. Prof. Arthas Flabouris convened the symposium which was opened by RACS President John Batten. Arthas brought a wealth of experience of trauma care and the trauma verification program which provided a sound perspective to review the journey.

Guest speakers included the Hon. David Gillespie, Assistant Minister for Health, Ms Fionnagh Dougan, CEO Lady Cilento Children's Hospital, Ms Deborah Anselm, Manager NZ Health System Design and Prof David Greenfield. Director Australian Institute of Health Service Management. CSL Behring Biotherapies for Life was a major sponsor of the event.

A lively program delivered much interest and interaction with the 70 participants interested in Trauma. The 'on the couch' session with broadcaster, Ross Campbell and Trauma Directors, Associate Professors Rodney Judson (RMH) and Martin Wullschleger (Gold Coast) provided an excellent insight into the real benefits that a Trauma Director gains from a Verification review – as well as the hurdles and challenges they need to overcome to ensure the exercise is worthwhile and the recommendations implemented.

Ms Deborah Anselm, Manager Health System Design, ACC NZ (Accident Compensation Corporation) highlighted how the insurance industry can influence effective trauma care. She spoke of the industry's ability to collect extensive data and to analyse the costs of trauma care and its impact on society and government. Participants were informed about the results of quantitative analysis and its role in providing accurate information of the cost of a specific injury over a life time. Ms Anselm stressed the importance of a patient receiving optimal trauma care at an early stage to lessen the life-time impact that the injuries have on a patient, their family and the financial implications to the community.

### Hughes Room Trauma posters


During the morning the Federal Assistant Minister for Health launched the Hughes Room trauma posters. The posters acknowledge the acclaimed surgeon and former President of the College, Sir Edward Hughes, and his involvement and influence in the road trauma prevention campaigns of the 1970s which helped to bring about legislation for mandatory seat belts, drink driving limits (.05) and mandatory bicycle helmets.

### A 'Trauma Week' Fundraising Dinner

A silent auction was held that evening to raise funds for the Damian McMahon Trauma Research Travel Grant for Trainees. The target of $20,000 has nearly been reached. Congratulations and thanks to all involved especially the Foundation for Surgery for its support, the donors and supporters of the auction. To donate, please contact foundation@surgeons.org.

John Crozier
Chair, Bi-National Trauma Committee

*with Lyn Journeaux, Executive Officer Trauma Committee.*

# Professor Jonathan Serpell

"It is crucial that surgeons continue to manage surgical education, because we have proven over many years that we do an extraordinarily good job in training surgeons and maintaining skills to ensure best practice"

Professor Jonathan Serpell joined RACS Council as a Fellowship elected Councillor in 2015.

Professor/Director of General Surgery at Monash University, Alfred Hospital, and Director of the Breast, Endocrine and General Surgery Unit, Alfred Hospital, he is also Head of the Breast, Endocrine Surgery and Surgical Oncology Unit, Frankston Hospital.

Over the last 25 years, Professor Serpell has given his time to RACS, serving on the Clinical Committee and subsequently as its Chair, the Court of Examiners, becoming Senior Examiner in General Surgery, and as Chair of the Endocrine Section.

Following election to Council in 2015, he became Chair of the Prevocational and Skills Education Committee (PSEC) in 2016, the Deputy Chair of the Professional Standards Committee and a member of the Education Board.

With a particular interest in Endocrine Surgery, Professor Serpell has been in the forefront of research in the preservation of the recurrent laryngeal nerve in thyroid surgery and has published more than 130 peer-reviewed research papers.

Recently he established and became the clinical lead of the Australian and New Zealand Thyroid Cancer Registry to help drive best-practice surgical care, while he also established the Monash University Endocrine Surgery Unit and helped form the Monash Partners Comprehensive Cancer Consortium.

In the wake of RACS's Operating with Respect campaign, he also introduced the Building Respect Improving Patient Safety (BRIPS) program into the Alfred Hospital.

Last year he was awarded a Fellowship Ad Hominem of the Royal College of Surgeons of Edinburgh in recognition of his contributions to surgery which he described as a great honour.

Reflecting on his time on Council, Professor Serpell said that while RACS faced several challenges, it was well placed to meet them.

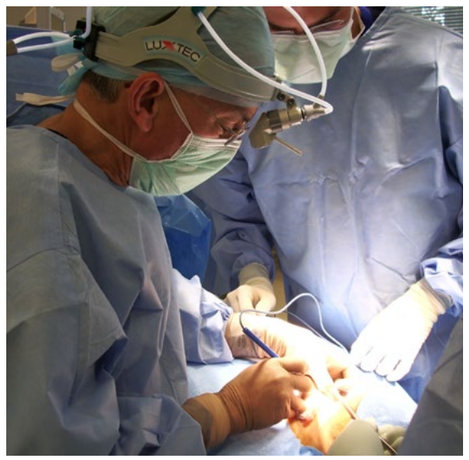
"RACS is one of the great surgical Colleges in the world and the envy of many," he said.

"We not only provide world class training, we support world-leading research, we contribute to Global Health initiatives and we advocate for public health and safety. "It is crucial that surgeons continue to manage surgical education, even though universities would like to take it on, because we have proven over many years that we do an extraordinarily good job in training surgeons and maintaining skills to ensure best practice and a world-class safety record."

Professor Serpell said he believed the most significant challenge facing the College was in enhancing communication between RACS and the broad Fellowship.

"We must become more visible, relevant, approachable, timely in our responses, and engaged with all Fellows," he said.

"We also need to work as partners with specialist societies and to break down some of the silos that have developed over time and I believe the will and the leadership is in place to allow this to happen."




Professor Serpell is married to Tricia Terrill, a plastic surgeon at Frankston Hospital, is a father of two, a marathon runner and the author of a book about his family history.

He said he had gladly served on the Council and various RACS committees to contribute to the development of the profession.

"We should all feel proud of the contribution we make as a profession, not only through our skills but through the research we support," he said.



"I am fortunate to have an enjoyable and satisfying career and RACS has supported me in the early years of my surgical career, so it has been a pleasure and privilege to give back."

While Chair of PSEC he steered through significant changes designed to attract and support a new generation of junior doctors who wish to become surgeons.

Since his time on the committee, the PSEC established the successful JDocs program designed to prepare young doctors for a career in surgery, developed new on-line learning modules, exposed medical students to the RACS Skills and Education Centre and overseen revised and updated skills courses.

Professor Serpell said the courses were being updated to increase the focus on communication, decrease didactic lecture-based learning and to incorporate more scenario-based and e-learning options.

The programs involved include the Australian and New Zealand Surgical Skills Education and Training (ASSET) course, the Critical Literature Evaluation and Research (CLEAR) course, Care of the Critically Ill Surgical Patient (CCrISP) course, the Early Management of Severe Trauma (EMST) course and Training in Professional Skills (TIPS) course.

Professor Serpell, who completed a Master of Education in 2011, said the changes reflect RACS' desire to work more closely with junior doctors and surgical trainees to pro-actively support them in the early years of their careers.

Speaking to *Surgical News*, he said he was optimistic that the changes would enhance the training of junior doctors and encourage more to pursue a career in surgery.

"More than 1000 junior doctors have registered with the JDocs program since 2015 and we continue to increase on-line opportunities to help prepare them for surgical training," Professor Serpell said.

"Some of the new modules, for example, include key clinical tasks such as leading a ward round, managing sick surgical patients, and planning an operating list.

"The EMST course is run in 70 countries now, but the course in Australia and New Zealand is regarded very highly because of the time provided for teachers and mentors to spend with participants and we have built on that strength.

"We are also working to introduce human factor education in the TIPS course such as personal well-being, situational awareness, team building and interpersonal communication.

"I feel very fortunate to have had the opportunity to work in this area on behalf of Fellows and Trainees and it's impossible not to feel enthusiastic and excited about the changes being made.

"I've particularly enjoyed working to meet the training needs of junior doctors, to give them the skills and confidence to pursue a career in surgery and I believe the future looks bright both for the profession and for RACS."

Karen Murphy
Surgical News Journalist

# RACS Surgeon honours service in recent conflict

Group Captain Annette Holian, FRACS, Orthopaedic Surgeon and specialist in trauma and disaster response spoke at the launch of the Redeveloped Recent Conflicts Gallery at the Shrine Auditorium on Friday 23 February. Group Captain Holian who is also a RACS Councillor detailed her experiences on the frontline and the value in broadening our understanding of the Australian Defence Force and the realities of modern conflict.

Formally launched by the Hon. Linda Dessau AC Administrator of the Government of the Commonwealth of Australia, the Redeveloped Recent Conflicts Gallery prominently relates the real-life stories of courage and sacrifice from those who served in conflict.

In her speech, Group Captain Holian said she was pleased the community can visit the exhibition and gain a new understanding about those who serve.

Group Captain Annette Holian spoke about some of the places she served in.

"I have stood in the dust of Oruzgan-and in frozen mud at Tarin Kot and endured the dust storms and blistering heat in Kandahar. I've lived in tents and shelters. Some rocket proof, others not so much. I've given my all for my patients. My teams have gone above and beyond to bring our people home to loved ones and the safety of Australian soil...

"...Medicine affords us the ability to examine our patients, and to experience human connection. To console. To support. To say goodbye. To pray for the strength to face the next challenge and be all we need to be for the next person, for the next day, and the next and the next."

# Australasian road trauma

## An escalating epidemic: what is being done?

The repeated tragedy of preventable death and serious injury which played out on Australian roads last Christmas and over the festive season heightens the call for effective and immediate action if we are to achieve the 30 per cent reduction in death and serious injury on our roads – a conservative target we had set ourselves for the decade ending 2020. In New South Wales alone 28 people died in car crashes over the 2017-18 Christmas/festive season, twice that of the same period a year ago. Dr John Crozier, Chair RACS Bi-national Trauma Committee, was quoted in *The Age* on Friday 5 January 2018, "44,000 people are hospitalised after a vehicle crash each year in Australia. We seem to accept that as the price to travel on our road system. It's got to stop."

He lamented federal government complacency on road safety and the disappointing decision, in 1999, to abolish the Federal Office of Road Safety (FORS) which was an independent body of experts providing, without fear or favour, advice to the federal government on all matters regarding road safety.

In response to the alarming number of road deaths and injuries over the past two years, the Hon. Darren Chester, former Minister for Infrastructure and Transport, last year launched an Inquiry into road trauma to review the progress of the National Road Safety Strategy (NRSS) 2011-2020. The NRSS was signed by all Australian governments in 2011 – its aim to reduce road deaths and injuries by at least 30 per cent by 2020. Tragically, not only is this aim not being met but road fatalities have risen over the past two years. Mr Chester expressed concern that Australians are too accepting of the fact that 1,300 Australians die on our roads and tens of thousands are injured each year.

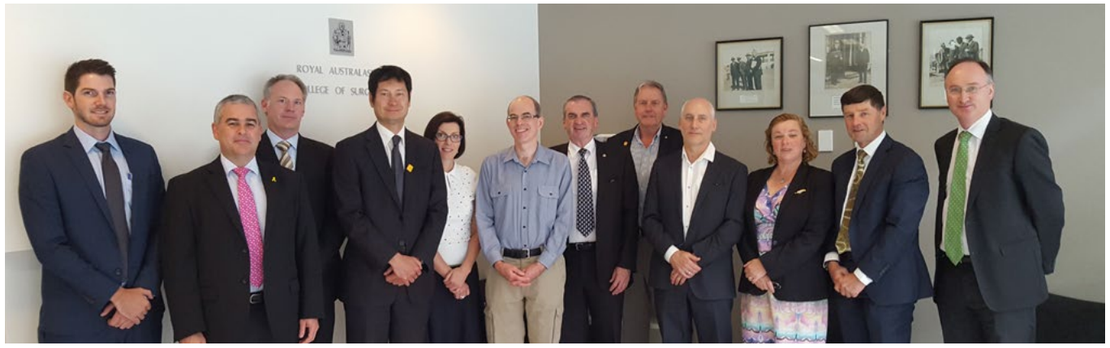
Dr Crozier was appointed co-chair of the Inquiry alongside Professor Jeremy Woolley, Academic and Engineer at the Centre for Automotive Safety Research (CASR) with panel members, Lachlan Macintosh (President Australasian College of Road Safety (ACRS) and Rob McInerney (CEO International Road Assessment Programme (iRAP). This expert panel will address key priorities – making roads safer, assessing actions, and helping to establish new avenues to reduce road fatalities and serious injury.

Road trauma costs the Australian economy almost $30 billion annually. Prof. Woolley recently stated that in the next 15 years 'half a million Australians will be killed or injured on the road – a totally unacceptable burden for something that is mostly preventable'.

With around 100 Australians killed in road crashes each month and approximately 800 per week experiencing serious and life-changing injury, Dr Crozier stresses that the task of making our roads safer both in Australia and New Zealand is an urgent one.

New Zealand is faring no better as its escalating road trauma statistics reflect. There were 379 road trauma deaths in New Zealand last year (2017) compared with 327 deaths in 2016, and 319 in 2015. The 2017 statistics are the worst since 2009 [NZ Ministry of Transport figures]. The NZ Transport Authority recently commissioned RACS to coordinate a 'whole of country' review of the Trauma system in New Zealand to investigate ways to improve the management and delivery of trauma care around the country. Ian Civil, National Clinical Lead, Major Trauma National Clinical Network and his team in New Zealand are to be commended for their work and commitment in this area – see New Zealand Major Trauma Registry and National Clinical Network Annual Report 2016-2017: http://www.majortrauma.co.nz/. An article on the National Clinical Network will feature in next month's *Surgical News*.

RACS has a long involvement and strong advocacy position against preventable road trauma.



Key stakeholders meeting - Inquiry into the National Road Safety Strategy at the RACS ACT offices February 2018. From left: Jason Smith, ANCAP (Australasian New Car Assessment Program); Craig Newland, AAA (Australian Automobile Association); Mark Terrell, ANCAP; Jeremy Wooley, CASR (Centre for Automotive Safety Research); Ailene Fitzgerald, FRACS; Ben Maguire, ATA (Australian Trucking Association); Eric Chalmers, ACRS (Australasian College of Road Safety); Lauchlan McIntosh, ACRS; Simon Tatz, AMA (Australian Medical Association); Laurelle Crawley; John Crozier, FRACS; Tony Weber, FCAI (Federal Chamber of Automotive Industries); not in photo - Malcolm Baalman, PHAA (Public Health Association of Australia).

New Zealand is faring no better as its escalating road trauma statistics reflect. There were 379 road trauma deaths in New Zealand last year (2017) compared with 327 deaths in 2016 and 319 in 2015. The 2017 statistics are the worst since 2009.

RACS, a constituent member of the Australasian College of Road Safety (ACRS), acknowledges that the most important overarching action is to accept that the causes and consequences of road trauma are spread across many portfolios, not just the Ministry for Transport and Infrastructure which currently has the sole responsibility for road trauma. The establishment of infrastructure helps build the economy, but preventable death and preventable serious injury on this infrastructure should not continue to be part of the price we pay – at a cost of $30 billion every year.

Safety features should be an integral feature of all newly built infrastructure.

Agencies responsible for road safety should be able to demonstrate benefits of any implemented policy measure in terms of a reduced number of crashes, fatalities and serious injury, with reliable data available in real time.

A corporate board accepting a $30 billion annual cost to treat 44,000 injured workers annually, acting on data four years old, would be required to show cause why it should not be stood down with immediate effect. This is analogous to our attitude with respect to Australian road safety to date.

Australia receives 1.2 million new vehicles annually. Current ANCAP five-star rated light vehicles are approximately 20 per cent cheaper than five years ago, and by design, inherently safer than five years ago.

Mandatory autonomous emergency braking, and electronic stability control as a regulated requirement of all newly arriving vehicles is anticipated to produce dramatic reductions in rear end collisions, fatalities and serious injury getting us back on track to meet our 2020 National Road Safety goal. South Korea implemented such a policy last year... why can't we, as a nation, be as agile?

Distraction, speed, alcohol and drug use contribute significantly to the burden of preventable crashes.

RACS commends governments of the last decade for prioritising road safety by producing the National Road Safety Strategy 2011-2020, however, it will strongly urge all levels of government to join in a united effort to make a permanent and significant reduction in road trauma a number one priority across all portfolios.

The barriers of federalism, siloism between agencies, passive verbs incorporated in road safety action policies, absence of nominated authorities responsible for action, and a lack of calibration tools embedded in policy should not be allowed to continue. If they do, so too will the current carnage on our roads.

John Crozier
Chair, Bi-National Trauma Committee

*with Lyn Journeaux,*
*Executive Officer Trauma Committee.*

# Inaugural Indigenous SET Scholar gets a French start

Ear Nose and Throat Trainee (ENT) Dr Andrew Martin (pictured) last year attended the renowned G. Portmann Institute in France to complete a week-long course in temporal bone and middle ear dissection.

Dr Martin was an inaugural recipient of the RACS Aboriginal and Torres Strait Islander SET Trainee One Year Scholarship, designed to encourage more Indigenous doctors to pursue a career in surgery and supported by Johnson & Johnson Medical.

Dr Martin, a mid-level specialist Trainee in ENT at the Wellington Hospital and Hutt Valley Hospital in New Zealand, completed the course in June.

He said the course attracted ENT trainees and consultants from around the world and involved both simulation and live surgery at the Pellegrin University Hospital and the St. Augustine Clinic.

With an interest in Otology, Dr Martin listed the clinical highlights of the trip as conducting:

- Ossiculoplasty, a procedure to repair, reconstruct and improve the movement of the bones crucial to hearing in the middle ear, often damaged or immobilised due to infection or diseases such as otitis media or traumatic head injury;
- Stapedectomy surgery conducted to treat hearing loss caused by otosclerosis which causes conductive hearing loss through a build-up of bone around the stapes;
- Cochlear Implantation.

The G. Portmann Institute is one of the oldest schools of Otorhinolaryngology in Europe. For decades, it has conducted courses in English to teach post-graduate trainees from around the world new surgical techniques.

Dr Martin said it was the mix of practical skills-based learning and having the opportunity to mix with ENT trainees and specialists from a variety of countries that made the week such a valuable experience.

“It was a wonderful educational experience, not only in terms of skills acquisition but I also enjoyed learning about new developments in ENT and seeing different ways of tackling the same problem,” he said.

“After chatting to other international trainees it was also great to realise that our training in New Zealand and Australia is world class. I was surprised to learn that many surgical trainees at the same level of training as I myself, are often able to do much less.”

Dr Martin completed a degree in Pharmacy at Monash University with post-graduate research in medicinal chemistry before completing his medical degree and going on to work in several hospitals in the south-east suburbs of Melbourne.

He moved to New Zealand in late 2014 to take up a training position in Otolaryngology, starting in Whangarei, Northland and has subsequently spent time training in Auckland, Palmerston North and now Wellington.

He has conducted several research projects and in 2016 presented his work on the *Clinical Characteristics of Long Standing Aspirated Paediatric Foreign Bodies* at the New Zealand Society of Otolaryngology, Head-and-Neck Surgery Annual Meeting.

He has served as a trainee representative on RACS’ Indigenous Health Committee, is a member of the Australian Indigenous Doctors’ Association (AIDA) and has volunteered his time to be a part of the Australian Indigenous Mentoring Experience.

“RACS has shown a real commitment to improving Indigenous health and encouraging more Indigenous people, both Māori and Aboriginal medical students, to pursue a career in surgery,” he said.

“The Indigenous Health Committee continues to work hard to tackle such issues as the disease burden caused by chronic ear disease, Indigenous cancer rates and access to specialist care but it also supports individual Fellows who are doing wonderful work within the Indigenous community both in New Zealand and Australia.

“In New Zealand, ear disease within the Māori community was tackled earlier than it was in Australia, beginning in the 1970s with the introduction of the Earbus program and now we have specialist ear nurses who work with communities in both New Zealand and Australia.

“So, while we have made headway in both countries, there is still a long way to go but we should be encouraged by the dedication of Fellows who give up their time to work with these communities.

“Learning of their work is one of the best aspects of serving on the committee because it provides me with on-going inspiration about how I might be able to contribute once I’ve completed my ENT training.”

Dr Martin said he hoped to spend a month each year treating patients with ENT problems within the Pacific after he has finished his specialist training.

Participating in the week-long course in Bordeaux last year was Dr Martin’s first trip to Europe.

As a self-described obsessive bird watcher, he took the opportunity to take another week of holidays afterwards to drive across Northern Spain in search of birds that he would never see in the southern hemisphere.

And he was in luck. During the journey he spotted a Spanish Imperial Eagle and a Lammergeier, an old-world vulture that lives on carrion and bones and which is particularly known for its habit of smashing large bones to access the marrow inside by carrying them high into the air before dropping them on rocks below.

“It was an incredible experience being up in the Pyrenees watching these amazing birds that I have longed to see for a number of years,” Dr Martin said.

He thanked RACS and Johnson & Johnson Medical for the funding support.

Dr Martin completed a number of ENT courses. These include:

- The G. Portmann Institute Temporal Bones Dissection Course 2017
- The Auckland Septorhinoplasty Course 2017
- Adelaide Head and Neck Course (Royal Adelaide Hospital) 2016
- The Auckland Temporal Bones Course 2016
- Cochlear Implant Course (Advanced Bionics, Greenlane Hospital) 2016

Karen Murphy
Surgical News Journalist

# NSW Regional update

It was an amazing 2017 for RACS in NSW, with many achievements. We were involved in many projects and activities, and met with some great Fellows, Trainees, IMGs, stakeholders and new colleagues.

Here is a snapshot of what we have been doing:

### Enhancing the Surgeon

The theme of my two-year chairmanship has been 'Enhancing the Surgeon', focusing on educating surgeons on issues other than surgery, and sharing information between Fellows, the NSW State Committee's key stakeholders, and RACS as a whole.

The NSW State Committee members meet regularly throughout the year and members' combined experience, knowledge, and dedication has played a vital role in enabling me to realise the goal of my chairmanship.

Various members of the Committee represent Fellows and other stakeholders on various governmental and external Committees and I am very grateful for their hard work and input. Discussion has largely been based around how we can promote best practice, both in surgery and in the workplace by creating opportunities for development and addressing weaknesses to provide better and safe services.

### Surgeons' Month

We have also spent a lot of time interacting with Fellows, IMGs and Trainees. To do this we provided relevant opportunities for sharing and networking, such as hosting Surgeons' Month where we held some excellent events and were privileged to collaborate with colleagues who we had not met before. In the final event of Surgeons' Month, the Surgeons' Evening, we recognised some of the great work that our colleagues are undertaking. Professor David Little gave an excellent Graham Coupland lecture titled *'Attacking the most challenging Paediatric Orthopaedic conditions through research'*. In conjunction with this Mr Paul Stalley, Professor Henry Pleass and Professor Raymond Sacks received the NSW State Committee Merit Award, Professor Philip Crowe received the Certificate of Outstanding Service and Benjamin Griffiths won the Annual Medical Student Award.

Other highlights of Surgeons' Month included the Women in Medicine event where Kelly Rothwell (Head of School, Women & Leadership Australia) and Carrie Marr (Chief Executive, Clinical Excellence Commission) provided informative and lively presentations and were joined by Associate Professor Theresa Jacques and Dr Sharon Tivey to discuss leadership opportunities.

Our initial event was the Academic Surgery Evening, titled *'Barriers to Surgical Innovation'*, organised by Associate Professor Payal Mukherjee. The panel included Minister for Health Mr Brad Hazzard, Professor Paul Bannon, Associate Professor Cherry Koh, Mr Ben Wright, Professor John Harris and Professor Gordon Wallace AO. This was an exciting night bringing together key stakeholders within the academic world that affects surgery.

We also held an inaugural Preparation for SET course, aimed at a prevocational group, and the Younger Fellows Preparation for Practice Course, convened by Pecky De Silva, for Younger Fellows.

Surgeons' Month has proven to be a terrific medium through which to engage with Fellows and continues to improve in popularity from year to year.

### Representation

We continue to represent you on a number of issues including support of theatre time in hospitals, public places for Younger Fellows, addressing the role of private health insurers, and looking at such important topics as succession planning. The Collaborate Hospitals Audit of Surgical Mortality (CHASM) will go online this year. It is a truly amazing collaboration between RACS and the NSW State Department of Health, with the NSW State Committee often working across the two groups.

The NSW State Committee also submitted a number of submissions to the NSW government , including a number of Clinical Practice reviews, Credentialing and Defining Clinical Privileges for Senior Medical and Dental Practitioners in NSW Health, a review on ante-mortem interventions for organ donation in NSW, Evaluation of The Community Impact Statement Requirement for Liquor Licence applications, a review of the *2012 Health Records and Information Privacy Regulations*, comments on Mandatory Reporting under the *Health Practitioner Regulation National Law*, an Inquiry into the *2015 Alcoholic Beverages Advertising Prohibition Bill* and a consultation of the *2017 Motor Accident Permanent Impairment Guidelines*. I met with Minister Hazzard on several occasions, to discuss current issues important to RACS, including the Building Respect and Improving Patient Safety program and other workforce issues.

IMAGE: RACS NSW Chair, Dr Raffi Qasabian (right) presents Professor Raymond Sacks (left) his NSW State Committee Merit certificate and medal at the NSW Surgeons' Evening 2017. The NSW State Committee Merit Award is for distinguished service to surgery in NSW. Mr Paul Stalley and Professor Henry Pleass also received this Award in 2017.

I represented RACS in a NSW parliamentary inquiry into the provision of health care in NSW.

We have held three Journal Clubs, and have continued our regular Chair's newsletter and introduced a new NSW Prevocational newsletter.

Finally, I would like to pass on my sincere thanks to my Executive and all of the members of the NSW State Committee for their efforts throughout 2017, and on behalf of my Executive and the whole Committee, I would like to pass on sincere thanks to Allan Chapman (NSW State Committee Manager) and his extraordinarily dedicated team without whom none of this work would be possible.

Raffi Qasabian
Chair, NSW Regional Committee



# Election Season

Pollsters around the world will tell you that predicting the outcome of an election is becoming an increasingly fraught activity. While we have seen many examples of this globally, we don't need to look beyond our own backyard to see recent proof.

For the first half of 2017 it looked like New Zealand was heading for one of its most predictable election outcomes in living memory. Fast forward six months and the Ardern Government was elected following a long and protracted negotiating process. Similarly in Queensland, the Palaszcuk Government scraped over the line after the much touted One Nation Party failed to fire.

This year has kicked off in much the same way that 2017 ended. By the end of March there will already have been two more elections in Australia, which both appear to be following a similar trend. In Tasmania the Hare-Clarke system of voting will again make it difficult for either major party to form a majority government, while in South Australia the emergence of Nick Xenophon as a political force has led to a three-party contest that would leave even Nostradamus scratching his head trying to predict.

There will then be a break in the election cycle before Victoria heads to the polls in November, where voters proved last time that they aren't afraid to vote out a first term government. This is the last scheduled state or territory election for 2018. However, there has been speculation that a federal election could be held later this year any time from August.

While not everyone may get as excited about elections as political commentator Antony Green, they are nonetheless an important opportunity for organisations such as RACS to advocate on behalf of their membership. Prior to every state, territory and national election RACS seeks to provide an opportunity for political parties to outline their policy positions on key issues relating to the delivery of surgical services. We then undertake to distribute responses to the membership and indeed the wider community.

There have been many examples where RACS has been able to secure firm commitments from political parties prior to an election. One such example was the most recent Northern Territory election, where RACS secured a written guarantee from the soon to be elected government that they would end the Territory's unrestricted speed policy. Following the election, one of the Gunner Government's first actions was to reintroduce maximum speed limits on the Stuart Highway.

Our election statements balance RACS' core bi-national advocacy priorities with specific local issues of the given state, territory or country. We therefore encourage Fellows to engage with this process, and to contact their local committees or offices should there be any issues they wish to raise prior to their next local election.

Mark Morgan
Policy & Communications Officer

# Travel and research scholarship and grant opportunities for 2019

The Foundation for Surgery Scholarship Programme is now open for funding to assist Fellows, Trainees, and International Medical Graduates (IMGs) in their research, education and other learning aspirations in 2019. This year we have 37 opportunities available, valued at over $1.8m.

The ANZ Scholarship and Grant Committee invites Fellows, Trainees and other eligible applicants to apply for the

**Please note:** These advertised opportunities are to be used as an initial guide only. Please consult the RACS scholarship website (www.surgeons.org/scholarships) from 1 March 2018 for detailed information including application forms and policies

Applications for scholarships and fellowships below must be received by midnight ACST 26 April 2018.

The values of these awards are in Australian dollars unless otherwise stated.

following Scholarships, Fellowships and Grants for 2019.

## RESEARCH SCHOLARSHIPS, FELLOWSHIPS AND GRANTS

### John Mitchell Crouch Fellowship

The John Mitchell Crouch Fellowship valued at **$150,000** is awarded to an individual who is making an outstanding contribution to the advancement of surgery, or to fundamental scientific research in this area. The Fellowship commemorates the memory of John Mitchell Crouch, a RACS Fellow who died in 1977 at the age of 36. Tenure is for one year.

The Council of the Royal Australasian College of Surgeons invites applications for this Fellowship. Applicants must be a Fellow of RACS who is a resident of Australia or New Zealand, with their RACS Fellowship or comparable overseas qualification obtained within the past 15 years (2003 or later). They must currently be working actively in their field and the Fellowship must be used to assist continuation of this work.

The successful applicant is expected to attend the convocation ceremony at the RACS 2019 Annual Scientific Congress (ASC) in May for a formal presentation and be prepared to make a 20-25 minute oral presentation at the ASC on their research work including the contribution arising from the award.

### Tour de Cure Cancer Research Scholarship

Tour de Cure is a pre-eminent health promotion charity that raises funds for cancer research through cycling and other events. Together with the Foundation for Surgery, Tour de Cure has generously offered to fund the prestigious Tour de Cure Cancer Research Scholarship.

Applications are open to Fellows, SET Trainees and IMGs on a pathway to Fellowship who propose to undertake an important cancer research project. Gross value of this Scholarship is **$125,000** comprising $112,500 stipend plus $12,500 departmental maintenance. Recipients are expected to procure $25,000 of this amount from his/her research department, with income from the Tour de Cure corpus supplying the remaining $100,000. Tenure is for one year.

*For information on Tour de Cure, please go to www.tourdecure.com.au*

### James Ramsay Project Grant

Substantial bequests and donations made by Mr James Ramsay and the generosity of Mrs Diana Ramsay brought about the development of this Grant. It recognises James Ramsay's father, Sir John Ramsay, as a co-founder of RACS. Open to individuals or groups wishing to undertake clinical or research projects which will benefit the rural surgical sector. Applicants who are either from SA or who are able to demonstrate a clear benefit to the people of SA will be given preference. Value of the Grant in 2019-2020 is **$78,000** per annum. Tenure is for up to two scholarship years.

*For information on the James and Diana Ramsay Foundation, please go to www.jdrfoundation.com.au*

### Academy of Surgical Educators Surgical Education Research Scholarship

This Scholarship has been established to encourage surgeons to conduct research into the efficacy of existing surgical education or innovation of new surgical education practices. It is governed under the auspices of the RACS Professional Development and Standards Board (PDSB) through the Academy of Surgical Educators (ASE).

Applications for the Scholarship are open to Fellows, Surgical Trainees and IMGs. The value of this Scholarship is **$10,000** and is for a term of one year.

### Brendan Dooley and Gordon Trinca Trauma Research Scholarship

This scholarship was established to honour both the late Mr Gordon Trinca, a trauma surgeon who was instrumental in the introduction of the Early Management of Severe Trauma Program, and retired orthopaedic surgeon Mr Brendan Dooley who contributed greatly to the work of the RACS Road Trauma Committee. Open to RACS Fellows, SET Trainees and Medical Scientists who are conducting a research topic relating to the prevention and treatment of trauma injuries in Australia and New Zealand, this scholarship offers a stipend of **$10,000**. Tenure is for one year.

### Catherine Marie Enright Kelly Scholarship

### Reg Worcester Research Scholarship

The Catherine Marie Enright Kelly Memorial Research Scholarship arose from a bequest of the late T D Kelly, FRACS, of South Australia, and was first awarded in about 1987. The Reg Worcester Research Fellowship was developed after a gift from the late Alan Worcester FRACS, to memorialise his brother, Reg, a great educator, doctor and humanitarian. Both of these scholarships are open to Fellows and SET Trainees enrolled in or intending to enrol in a higher degree. Gross value is **$66,000**, comprising $60,000 stipend plus $6,000 departmental maintenance. Tenure is for one year.

> Research is four things: Brains with which to think, eyes with which to see, machines with which to measure and, fourth, money.
>
> *Albert Szent-Gyorgyi*

### Eric Bishop Research Scholarship

The establishment of the Eric Bishop Research Scholarship was made possible due to a donation from the late Eric Bishop, who was a Queensland pastoralist, and is open to Fellows and SET Trainees enrolled in or intending to enrol in a higher degree. Gross value is **$66,000**, comprising $60,000 stipend plus $6,000 departmental maintenance. Recipients are expected to procure 25% of this amount ($16,500) from their research department, with income from the Eric Bishop Scholarship corpus supplying the remaining $49,500. Tenure is for one year.

### Foundation for Surgery New Zealand Research Scholarship

Open to Fellows and SET Trainees enrolled in or intending to enrol in a higher degree. Applicants must be a New Zealand citizen currently residing in New Zealand. Gross value **$66,000**, comprising $60,000 stipend plus $6,000 departmental maintenance. Recipients are expected to procure 25% of this amount ($16,500) from their research department, with income from the RACS Scholarship corpus supplying the remaining $49,500. Tenure is for one year.

### Foundation for Surgery Research Scholarship

Open to Fellows and SET Trainees enrolled in or intending to enrol in a higher degree. Gross value is **$66,000**, comprising $60,000 stipend plus $6,000 departmental maintenance. Recipients are expected to procure 25% of this amount ($16,500) from their research department, with income from the RACS Scholarship corpus supplying the remaining $49,500. Tenure is for one year.

### Foundation for Surgery Small Project Grant

This Grant is for a SET Trainee or Fellow who wishes to or is already undertaking a small clinical or research project, or requires some funding to purchase equipment to carry out a research project. It is valued at **$10,000**. Tenure is for one year.

### Francis & Phyllis Mary Thornell-Shore Memorial Trust for Medical Research Scholarship

Established in recognition of Mr Francis Thornell-Shore, who left the bulk of his estate for the establishment of a trust to promote medical research, this scholarship is open to Fellows and SET Trainees enrolled in or intending to enrol in a higher degree. Gross value **$66,000**, comprising $60,000 stipend plus $6,000 departmental maintenance. Recipients are expected to procure 25% of this amount ($16,500) from their research department, with income from the Thornell-Shore Scholarship corpus supplying the remaining $49,500. Tenure is for one year.

### Health Technology Assessment Scholarship

This scholarship is intended to support Trainees, Fellows and Junior Doctors who wish to take time away from clinical positions to undertake a systematic review as part of a Health Technology Assessment (HTA) under the supervision of a clinical supervisor and a HTA expert. Potential applicants are asked to contact the Scholarship & Grant Coordinator to assist them in nominating supervisors. Applicants who are enrolled in a Master's program may be preferred. Whilst it is not a requirement to be enrolled in a higher degree, production of a systematic review and of a peer-reviewed publication would be a minimum requirement on completion of the scholarship. Junior Doctors would need to conduct this work in conjunction with the ASERNIP-S program of RACS in Adelaide. This would be conducted as a collaborative research project on a mutually agreed topic. Value of Scholarship is **$66,000**. Tenure is for 12 months duration full-time or 2 years part-time.

### Herbert and Gloria Kees Scholarship

The Herbert and Gloria Kees Scholarship, first offered for 2017, was established from a generous donation from the estate of the late Gloria Joyce Kees in order to support medical research and/or the advancement of surgical technologies, techniques and treatments. Applications are open to SET Trainees, IMGs on a pathway to Fellowship and Fellows who have had their Fellowship for five years or less (since 2013). The value of Scholarship is **$66,000**. Tenure is for one scholarship year.

### MAIC-RACS Trauma Scholarship

This Scholarship was established from a grant from the MAIC (Queensland Motor Accident Insurance Commission) being matched by the Foundation for Surgery to enable RACS to offer annual research funding for research into trauma. RACS Fellows and SET Trainees are invited to apply. The proposed research may be in any of the following areas: Epidemiology, prevention, protection, rehabilitation or immediate or definitive management in trauma. Whilst it is not a requirement of this scholarship that the research be conducted in Queensland it must be shown that the potential benefits flowing from the research will assist the people of Queensland. The value of this scholarship is **$66,000**. Tenure is for one scholarship year.

### Paul Mackay Bolton Scholarship for Cancer Research

This scholarship was established by Harry Bolton in memory of his late son, Paul. Professor Paul Bolton was a distinguished surgeon, teacher and researcher who died from colorectal cancer in 1978, aged 39. The applicant's research topic must focus on the prevention, causes, effects, treatment and/or care of cancer. Preference may be given to those currently working in Queensland or Tasmania. Young researchers, who are relatively early in their careers

and show promise, may be given first choice over more senior established researchers. Projects which are likely to have clinical relevance within a relatively short period of time, as well as to applicants who are enrolled in or intend to enrol in a higher degree will be looked upon favourably. Gross value **$66,000**, comprising $60,000 stipend plus $6,000 departmental maintenance. Recipients are expected to procure 25% of this amount ($16,500) from their research department, with income from the Paul Mackay Bolton Scholarship corpus supplying the remaining $49,500. Tenure is for one year.

### Professor Philip Walker RACS Vascular Surgery Research Scholarship

Professor Philip Walker was a Vascular Surgeon, educated in Sydney, Capetown and USA. He moved to Brisbane in 1992 and was appointed Professor of Clinical Surgery & Head, Academic Discipline of Surgery at the University of Queensland School of Medicine in 2011. He was a distinguished teacher, researcher and clinically active hands-on surgeon who served as an examiner in Vascular Surgery for RACS. He died as a result of illness whilst still very active in all of his areas of interest.

This scholarship is funded by a generous bequest from the late Professor Walker. Applications for the scholarship are open to RACS Surgical Trainees who are undertaking a postgraduate higher degree with research that is in an area related to vascular surgical disease. The value of the scholarship is **$10,000** and it is for a term of one year.

### Richard Jepson Research Scholarship

The late Professor Richard Jepson was the foundation Chair for Surgery at the University of Adelaide. This Scholarship was created in his honour due to a generous donation from his wife, the late Dr Mary Jepson, in order to assist needy and deserving younger researchers. Open to Fellows and SET Trainees enrolled in or intending to enrol in a higher degree, it is valued at **$66,000** per annum comprising $60,000 stipend plus $6,000 departmental maintenance. Recipients are expected to procure 25% of this amount ($16,500) each year from their research department, with income from the RACS Scholarship corpus supplying the remaining $49,500. Tenure is for up to three years.

### Sir Roy McCaughey Surgical Research Scholarship

This scholarship was founded as a result of a bequest to RACS from the late Sir Roy McCaughey. Open to Fellows and SET Trainees enrolled in or intending to enrol in a PhD. The research must be conducted in NSW. Gross value $66,000 per annum comprising $60,000 stipend plus $6,000 departmental maintenance. Recipients are expected to procure 25% of this amount ($16,500) from their research department, with income from the RACS Scholarship corpus supplying the remaining $49,500. Tenure is for up to three years.

### WG Norman Research Scholarship

Open to Fellows and SET Trainees enrolled in or intending to enrol in a higher degree, this South Australian Scholarship arose from a bequest from the late Dr W G Norman of Adelaide in order to fund research with a trauma focus. Applicants must be resident in South Australia, with their research being conducted in South Australia and topics which have a trauma focus will be given preference. Gross value $66,000, comprising $60,000 stipend plus $6,000 departmental maintenance. Tenure is for one year.

## TRAVEL AND EDUCATION SCHOLARSHIPS, FELLOWSHIPS AND GRANTS

### Margorie Hooper Travel Scholarship

The Margorie Hooper Travel Scholarship has been made possible through a bequest from the late Margorie Hooper of South Australia. The Scholarship is open to RACS SET Trainees and Fellows who reside permanently in South Australia. It is designed to enable the recipient to reside temporarily outside the State of SA, either elsewhere in Australia or overseas, in order to undertake postgraduate studies. It is also available for surgeons to travel overseas to learn a new surgical skill for the benefit of the SA surgical community. Preference will be given to the latter.

It is mandatory for the scholarship holder to make a presentation at the SA, NT & WA Annual Scientific Meeting in the year following the conclusion of the scholarship year.

This scholarship is for 12 months. The stipend is **$65,000** and there is provision for accommodation and travel expenses upon application.

### Anwar and Myrtha Girgis IMG Scholarship

Dr Anwar Riad Girgis was an Orthopaedic surgeon in Whyalla and Adelaide after migrating to Australia in 1969. He initially trained in medicine in Egypt, and then undertook postgraduate training in the UK. Dr Girgis appreciated the assistance given to him by generous colleagues in the UK and Australia, and him and his wife Myrtha Girgis later gave the same support to Trainees and IMGs who wished to settle in Australia. Upon his death his children Mona and Peter Girgis pioneered the establishment of this Scholarship with the Foundation for Surgery.

This scholarship is open to doctors who are of refugee or asylum seeker background or who are recent migrants, who are experiencing financial hardship to gain the professional development required to be able to practice surgery in Australia or New Zealand. The value of the scholarship is **$10,000** and is for one year's tenure.

### Hugh Johnston Travel Grant

The Hugh Johnston Travel Grant arose from a bequest of the late Eugenie Johnston in memory of her late husband, Hugh Johnston. This **$10,000** Grant is designed to assist needy and deserving RACS Fellows and SET Trainees to gain specialist training overseas. Applicants must not have commenced their travels prior to the closing date for applications.

### Hugh Johnston ANZ ACS Travelling Fellowship

The Hugh Johnston ANZ Chapter American College of Surgeons Travelling Fellowship is intended to support an Australian or New Zealand RACS Fellow to attend the annual American College of Surgeons (ACS) Clinical Congress in October 2019. It forms part of a bi-lateral exchange with the ACS and is open to those who have gained their RACS Fellowship in the past 10 years (2008 or later). Applicants are expected to have a major interest and accomplishment in basic or clinical sciences related to surgery and would preferably hold an academic appointment in Australia or New Zealand. The applicant must spend a minimum of three weeks in the United States of America in the year of their fellowship. While there, they must:

- Attend and participate in the American College of Surgeons Annual Clinical Congress in 2019.
- Participate in the formal convocation ceremony of that congress.
- Visit at least two medical centres in North America before or after the Annual Clinical Congress to lecture and to share clinical and scientific expertise with the local surgeons.

Applicants must not have commenced their travels prior to the closing date for applications. This Fellowship is valued at **$8,000**.

*More information about the ACS can be found at www.facs.org*

### Ian and Ruth Gough Surgical Education Scholarship

This scholarship, valued at **$10,000**, was established by Ian and Ruth Gough to encourage surgeons to become expert surgical educators. Professor Ian Gough is a former President of RACS. Applicants must be RACS Fellows or SET Trainees, with permanent residency of Australia or New Zealand. Tenure is for one scholarship year.

### John Buckingham Travelling Scholarship

The late John Buckingham was a well-loved specialist breast cancer surgeon who pioneered the sentinel node mapping technique. He contributed significantly to BreastScreen Australia and was also highly regarded in the international arena. This scholarship was established to encourage international exchange of information concerning surgical science, practice and education, as well as to establish professional and academic collaborations and friendships amongst Trainees. It is open to current SET Trainees to enable them to attend the annual American College of Surgeons (ACS) Clinical Congress in 2019. This scholarship is valued at **$4,000**.

*More information about the ACS can be found at www.facs.org*

### Morgan Travelling Fellowship

This Fellowship was formed following a series of donations made by Mr Brian Morgan FRACS in order to fund a RACS Fellow to travel overseas to gain clinical experience or to conduct research. To be eligible, the surgeon must have gained their Fellowship in the past five years (2013 or later) and can be from any specialty. The value of the scholarship is **$10,000** and the duration is for up to 12 months.

### Murray and Unity Pheils Travel Scholarship

Following a generous donation made by the late Professor Murray Pheils this scholarship was created. It has a value of **$10,000** and is awarded to a RACS SET Trainee or recent Fellow to assist them to travel overseas to obtain further training and experience in the field of colorectal surgery. Similarly, overseas graduates planning to obtain further training and experience in a specialist colorectal unit in Australia or New Zealand are also eligible to apply. Applicants must not have commenced their travels prior to the closing date for applications. The tenure is for one year.

### RACS Aboriginal and Torres Strait Islander SET Trainee One Year Scholarship

### RACS Māori SET Trainee One Year Scholarship

These Scholarships which were first offered for 2017 were established by the Indigenous Health Committee to support Trainees who identify either as Aboriginal and/or Torres Strait Islander or Māori. It could be used to cover one or more of, but not limited to, the following:

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

The value of each scholarship is **$20,000** and the tenure is for one year commencing in January 2019.

Applications for the RACS Aboriginal and Torres Strait Islander SET Trainee One Year Scholarship are open to SET Trainees who identify as being Aboriginal or Torres Strait Islander. 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/.

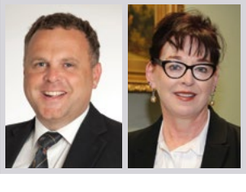
To be eligible for the RACS Māori SET Trainee One Year Scholarship an applicant needs to fulfil the eligibility requirements for membership of Te Ohu Rata o Aotearoa (Te ORA). Details can be found on www.teora.maori.nz/membership.

### Stuart Morson Scholarship in Neurosurgery

This scholarship was established following a generous donation by Mrs Elisabeth Morson in memory of her late husband. It is designed to assist Neurosurgical Trainees or young Neurosurgeons within five years of obtaining their RACS Fellowship (2013 or later) to spend time overseas furthering their neurosurgical skills by undertaking research or further training. It is also open to exceptional young surgeons who are registered to practice neurosurgery in Australia or New Zealand but are not RACS Fellows. Overseas surgeons who plan to spend time in Australia or New Zealand to further their training and/or research in neurosurgery are also eligible to apply. Overseas applicants cannot have commenced travel prior to applying for the scholarship. The value of the Scholarship is **$30,000** and is intended to contribute to the costs of undertaking further training and/or research work in neurosurgery.

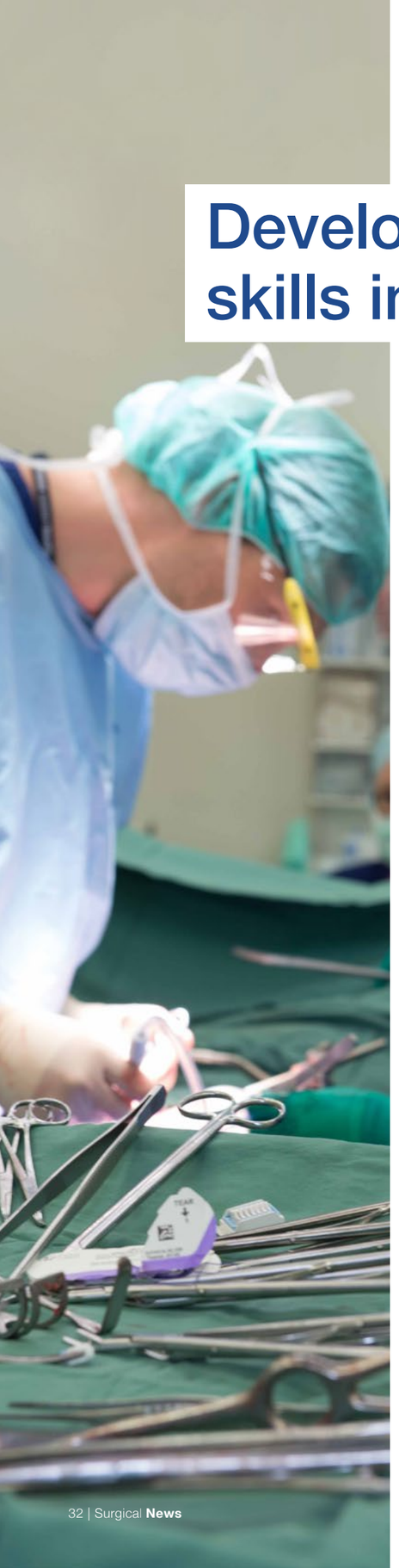
Additional information and links can be found on the RACS website at www.surgeons.org/scholarships. For any other queries, please contact the Australia & New Zealand Scholarship and Grant Coordinator, Mrs Sue Pleass, Royal Australasian College of Surgeons, 199 Ward Street, North Adelaide SA 5006. Tel: +61 8 8219 0900; Fax: +61 8 8219 0999; Email: scholarships@surgeons.org.

**Applications close midnight ACST 26 April 2018**



Andrew Hill
Chair, Research and Academic Surgery Committee

Kerin Fielding
Chair, Australia & New Zealand Scholarship and Grant Committee





# Developing a career and skills in Academic Surgery

This year's 10th anniversary of Developing a Career and Skills in Academic Surgery (DCAS) course promises to be the best and most successful to date. It will be held at the Annual Scientific Congress on Monday 7 May with limited places available. This course continues to excite, inspire and resource attendees who are interested in surgical research and education. To commemorate the anniversary, the course will be delivered by a stellar faculty consisting of Australian, New Zealand and American surgeons aligned with the Association of Academic Surgery (AAS). This special group have been the most highly scored by attendees from previous DCAS courses. Registrants comprise of medical students, along with all tiers of medical officer up to the level of Department Heads (including a senior statesman of Australasian academic surgery who has described attending every year as getting his annual "fix" of inspiration).

The program starts with academic leaders outlining how academic pursuits can be an integral component of a surgeon's career. There will be topics for the aspiring academic surgeon including *'Writing an abstract, writing and submitting a manuscript and presenting your work'*.

Highlights include Kevin Staveley-O'Carroll MD from Missouri addressing the Hot Topic entitled *'Research in personalised medicine'* in the setting of oncology. The Keynote presentation will be given by Mr Gavin Fox-Smith, Managing Director ANZ Medical Johnson & Johnson, who will speak on *'Progress in an evolving professional environment'*.

There will be four workshops; the first on publication advice delivered by the Editors in Chief of the *ANZ Journal of Surgery, JAMA Surgery* and the *Journal of Surgical Research*; all of whom are former DCAS faculty members. The second on early career development – highly relevant for medical students, Junior Medical Officers,SET Trainees and anyone interested in pursuing a research career. Our third workshop outlines common research areas such as clinical trials, health service/outcomes assessments, lab-based and education research. Finally, we have a workshop that focuses on the running of an academic department which is aimed at more senior attendees.

The ever affable faculty members (41 at this course) are highly approachable and welcome any informal discussions over lunch with attendees who have questions relevant to the course.

Attendee feedback is always overwhelmingly positive, with many wishing they had attended the course earlier in their careers. Many attendees have returned and in turn become faculty. There is nothing more satisfying to faculty than seeing the attendees find benefit from what has been presented. For SET Trainees in General Surgery, attendance at this course is counted as equivalent to attending one compulsory Trainees' Day.

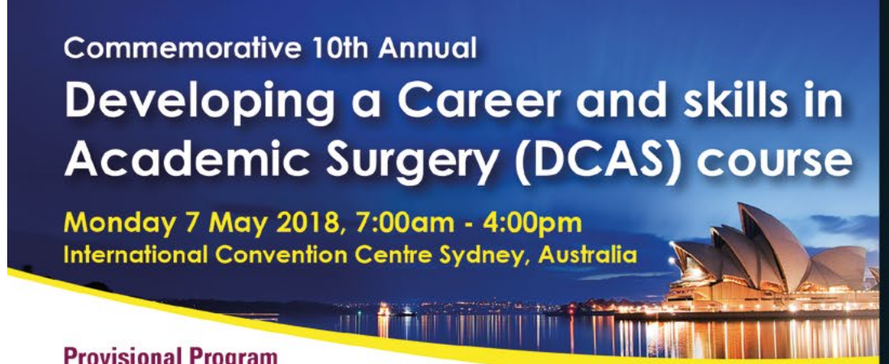
Professor Mary Hawn presenting at DCAS Course 2017.

We invite you to the DCAS course in Sydney in May; you will be impressed and inspired. See for yourself, and tell us what we can do better. Research is about improvement and progress – so come and be part of this course.

Please register at: http://www.tinyurl.com/dcas18reg

Marc Gladman, Mark Smithers, Richard Hanney
RACS Academic Surgery Committee





## Commemorative 10th Annual
# Developing a Career and skills in Academic Surgery (DCAS) course

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

## Provisional Program

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

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

**Proudly sponsored by:**
Johnson & Johnson MEDICAL DEVICES COMPANIES

### Keynote speaker:
**Gavin Fox-Smith**
Johnson and Johnson

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

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

### 2017 comments:
*"I will be recommending attending this to my surgically inclined colleagues"*

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

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

### Association for Academic Surgery invited speakers:
**Amir Ghaferi** - University of Michigan, Michigan, USA
**Adil Haider** - Brigham and Women's Hospital, Massachusetts, USA
**Melina Kibbe** - University of North Carolina, North Carolina, USA
**Kevin Staveley-O'Carroll** - University of Missouri, Missouri, USA
**Tim Pawlik** - Ohio State University, Ohio, USA
**Caprice Greenberg** - University of Wisconsin, Wisconsin, USA
**Jacob Greenberg** - University of Wisconsin, Wisconsin, USA
**Rachel Kelz** - University of Pennsylvania, Pennsylvania, USA
**Lillian Kao** - University of Texas, Texas, USA
**Scott LeMaire** - Baylor College of Medicine, Texas, USA
**Arden Morris** - Stanford University, California, USA
**Rebecca Minter** - University of Texas, Southwestern Medical Center, Texas, USA
**George Yang** - Stanford University, California, USA
**Rebekah White** - University of California San Diego, California, USA
**Sandra Wong** - Dartmouth-Hitchcock Medical Center, New Hampshire, USA

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

### DCAS course participation
Cost: $220.00 per person incl. GST
**Register online: www.tinyurl.com/dcas18reg**
There are fifteen complimentary spaces available for interested medical students. Medical students should register their interest to attend by emailing dcas@surgeons.org

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

NOTE: New RACS Fellows presenting for convocation in 2018 will be required to marshal at 3:45pm for the Convocation Ceremony.

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

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

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


# Courses for every stage of your career

*The Professional Development Department support surgeons in all aspects of their professional life, encouraging professional growth and workplace performance through a range of courses and activities.*

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

## Mandatory courses

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

### By the end of 2018

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

### Foundation Skills for Surgical Educators Course

| | | |
|---|---|---|
| 2 March 2018 | Brisbane | QLD |
| 3 March 2018 | Sydney | NSW |
| 7 March 2018 | Perth | WA |
| 9 March 2018 | Adelaide | SA |
| 9 March 2018 | Melbourne | VIC |
| 16 March 2018 | Wellington | NZ |
| 16 March 2018 | Melbourne | VIC |
| 19 March 2018 | Sydney | NSW |
| 24 March 2018 | Sydney | NSW |
| 7 April 2018 | Sydney | NSW |
| 7 April 2018 | Auckland | NZ |
| 9 April 2018 | Perth | WA |

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

| | | |
|---|---|---|
| 13 April 2018 | Darwin | NT |
| 6 May 2018 | Sydney | NSW |
| 7 May 2018 | Sydney | NSW |
| 28 May 2018 | Perth | WA |

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

### Non-Technical Skills for Surgeons (NOTSS)

| | | |
|---|---|---|
| 17 March 2018 | VIC | Melbourne |

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.

### Clinical Decision Making

| | | |
|---|---|---|
| 24 March 2018 | Canberra | ACT |

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

### Surgeons as Leaders in Everyday Practice

| | | |
|---|---|---|
| 6-7 April 2018 | Christchurch | NZ |

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

### SAT SET Course

| | | |
|---|---|---|
| 26 May 2018 | Melbourne | VIC |

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

### Keeping Trainees On Track

| | | |
|---|---|---|
| 26 May 2018 | Melbourne | VIC |

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

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

### Academy of Surgical Educators Studio Sessions

| | | |
|---|---|---|
| 1 March 2018 | Perth | WA |
| 26 April 2018 | Sydney | NSW |
| 21 May 2018 | Wellington | NZ |

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

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

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

## WORKSHOPS

**PROFESSIONAL DEVELOPMENT WORKSHOP**
**DATES: March – April 2018**

| | | |
|---|---|---|
| ACT | | |
| Clinical Decision Making | 24 March | Canberra |
| NSW | | |
| Foundation Skills for Surgical Educators | 3 March | Sydney |
| Keeping Trainees on Track | 10 March | Sydney |
| SAT SET Course | 10 March | Sydney |
| Foundation Skills for Surgical Educators | 19 March | Sydney |
| Foundation Skills for Surgical Educators | 24 March | Sydney |
| Foundation Skills for Surgical Educators | 7 April | Sydney |
| Academy of Surgical Educators – Studio Sessions | 26 April | Sydney |
| NZ | | |
| Foundation Skills for Surgical Educators | 16 March | Wellington |
| Surgeons as Leaders in Everyday Practice | 6 - 7 April | Christchurch |
| Foundation Skills for Surgical Educators | 7 April | Auckland |
| Academy of Surgical Educators – Studio Sessions | 21 May | Wellington |
| QLD | | |
| Foundation Skills for Surgical Educators | 2 March | Brisbane |
| Process Communication Model Seminar 1 | 16 – 18 March | Brisbane |
| SA | | |
| Foundation Skills for Surgical Educators | 9 March | Adelaide |
| VIC | | |
| Foundation Skills for Surgical Educators | 9 March | Melbourne |
| Foundation Skills for Surgical Educators | 16 March | Melbourne |
| Non-Technical Skills for Surgeons | 17 March | Melbourne |
| WA | | |
| Academy of Surgical Educators Studio Sessions | 1 March | Perth |
| Foundation Skills for Surgical Educators | 7 March | Perth |
| Foundation Skills for Surgical Educators | 9 April | Perth |

## Register online

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

# Skills Training Courses 2018

RACS offers a range of skills training courses to eligible medical graduates that are supported by volunteer faculty across a range of medical disciplines. Eligible candidates are able to enrol online for RACS Skills courses.

### ASSET: Australian and New Zealand Surgical Skills Education and Training

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

### EMST: Early Management of Severe Trauma

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

### CCrISP®: Care of the Critically Ill Surgical Patient

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

### CLEAR: Critical Literature Evaluation and Research

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

### TIPS: Training in Professional Skills

TIPS is a unique course designed to teach surgeons-in-training core skills in patient-centred communication and teamwork, with the aim to improve patient care. Through simulation participants address issues and events that occur in the clinical and operating theatre environment that require skills in communication, teamwork, crisis resource management and leadership.

**SKILLS TRAINING COURSE DATES:**

**APRIL - MAY 2018 | *Available Courses**

| ASSET | |
|---|---|
| Friday, 6 April – Saturday, 7 April | Auckland |
| Thursday, 12 April – Friday, 13 April | Adelaide |
| Thursday, 17 May – Friday, 18 May | Perth |
| Friday, 18 May – Saturday, 19 May | Melbourne |
| **CCrISP** | |
| Friday, 27 April – Saturday, 28 May | Brisbane |
| Thursday, 3 May – Friday, 4 May | Auckland |
| Friday, 25 May – Saturday, 26 May | Sydney |
| **CLEAR** | |
| Friday, 4 May – Saturday, 5 May | Wellington |
| Friday, 25 May – Saturday, 26 May | Sydney |
| **EMST** | |
| Friday, 6 April – Sunday, 8 April | Auckland |
| Friday, 27 April – Sunday, 29 April | Melbourne |
| Friday, 18 May – Sunday, 20 May | Brisbane |
| Friday, 25 May – Sunday, 27 May | Sydney |
| Friday, 25 May – Sunday, 27 May | Melbourne |
| Friday, 25 May – Sunday, 27 May | Auckland |
| Thursday, 31 May – Saturday, 2 June | Darwin |
| **TIPS** | |
| Friday, 27 April – Saturday, 28 April | Brisbane |
| Friday, 25 May – Saturday, 26 May | Adelaide |

**Courses available at the time of publishing*

**Contact the Skills Training Department**

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





# Fruits of Failure

Once upon a time Drs Ms Take and Mr E Roar were more than down in the dumps, they seemed dangerously depressed and in despair. They had been involved in a high profile adverse event, with negative publicity in the local rag. They were wounded down to the core of their beings. The hospital administration had not been as supportive as they should, reacting defensively and evasively, with a cold shower of silence instead of recognising the risks to the mental health of their loyal and hard-working VMO's. Ms Take's and E Roar's self-confidence was shaken, and they doubted they would ever have the courage to again make the bold decisions surgeons sometimes need to make to save lives. I won't share the clinical details – you've all experienced such moments.

Surgeons are accustomed to success. They outperform at school, succeed in entering the career of their choice through University and progress into a profession where annually only 20-30 per cent of applicants are accepted. Once 'in' most flow smoothly from rotation to rotation without much incident, working hard to develop necessary knowledge, skills and behaviours. Those that fail a rotation or take a second go at passing an exam have an early career opportunity to learn positively from failure.

Surgeons are generally unprepared in their early careers for failure which hits them hard. First there is the feeling of shock and guilt, followed by a temptation to explain away and deny the failure. There can be anger at being singled out or criticised, often with some justification as was experienced by Ms Take and E Roar, before they fell into the depths of despair. This all contributed to emotional exhaustion and depression, accelerated by lack of sleep, over-preoccupation with what had happened, and a deep sense of injustice. The despair was magnified by guilt, not easy to completely explain away, for as surgeons they had played a principal role in the patient's outcome.

Failure is normal, it is not wanted, but it is necessary. Not only do patients suffer adverse events through disordered pathophysiology, often revealing a lack of reserve to heal, but their surgeons have made judgements and decisions based on complexity and uncertainty. Sometimes afterwards, they realise they could have made a different or better decision, or taken more time to explain possible outcomes. This is the value of audit and peer review being part of everyday practice.

To become a great surgeon and achieve success involves try, try, trying again until it's right. Everyone must experience and survive failure in their careers. Winston Churchill said, "failure is not fatal; it is the courage to continue that counts". Failure provides an opportunity to be better in the future. It is a motivator to learn and make different choices should a similar event present itself again. Every senior surgeon will tell you about the mistakes they have made and how these have helped them improve.

Ms Take and E Roar needed understanding and support from their colleagues, particularly from their Clinical Director whose role it was to manage the administration. Their concerns for, and the needs of, the unfortunate patient had to be addressed. But I also helped them appreciate that failure is a part of any professional life, provides an opportunity to improve, to be less arrogant, more sympathetic, and more forgiving of others. Today, having tasted the fruits of failure, Ms Take and E Roar are leaders who are respected, eminent and wise.

DR BB-G-LOVED

# Friedrich Trendelenburg

Surgeon and Historian (1844 -1924)

Surgeons today are likely to ask for 'the Trendelenburg position' when they are operating within the abdominal cavity.

In Trendelenburg's time the field of the abdominal surgery was extending rapidly: in 1849 gastrostomy had been introduced by Sédillot and in 1864 the first successful ovariotomy in France was reported by Jules Péan. In 1881, Billroth had described his operation on successfully resecting the pylorus for cancer and Czerny introduced vaginal excision of uterine tumours.

Friedrich Trendelenburg was born on May 24, 1844 in Berlin, the son of the German philosopher and philologist of the same name. He received his early education at home, learning English from his mother, Latin and arithmetic from his father, and grammar from his aunt. After attending a Boys' school in Berlin, despite Berlin's status at the time as a world centre of medical science and teaching, aged 18, he commenced his medical studies at the University of Glasgow in session 1862-63.

Trendelenburg came, at the suggestion of Professor Allen Thomson – an old friend of the family, to study anatomy under him, and surgery under Joseph Lister, who had been appointed Professor of Surgery in 1860. Young Friedrich lived in the Thomson family home during his two-year period in Glasgow, and attended classes in Natural Philosophy, Medicine and Anatomy, under both Lister and Thomson.

He then continued his medical studies at the University of Edinburgh, completing them in Berlin, where at age 22 he received his medical doctorate from the University of Berlin. The following year he took state examinations and wrote his thesis on ancient Indian surgery, (*De veterum Indorum chirurgia*) and was appointed military surgeon at Kiel. At 30 years of age he married, and the couple subsequently had six children.

In 1868 he was appointed assistant to von Langenbeck which was to prove a most important six-year training association: subsequently he held Chairs in Surgery as follows; the University of Rostock 1875-1882, the University of Bonn 1882-1895 and the University of Leipzig (pictured, right), 1895-1911.

He took a leading part in the great advance of surgery during the latter part of the 19th century having become a surgeon at an historically favourable time, following the introduction of both inhalation narcosis and asepsis, two of the major milestones that contributed to the exponential growth of available surgical procedures.

Professor Trendelenburg wrote much exceptional work in the fields of plastic surgery, congenital dislocation of the hip joint and the surgery of blood vessels, besides making an international reputation as a gynaecological surgeon.

He is memorable for his work on stricture of the trachea (tampon-cannula, 1869), his introduction of gastrostomy in oesophageal stricture (1877) and for his high pelvic posture in operating on the viscera (1881).

His name is primarily associated with two clinical tests, one for confirming shortening of a leg due to an ununited fracture of the neck of the femur or congenital dislocation of the hip joint, and the other, for detecting incompetence of the valves of the veins of the lower limb.

Although Trendelenburg has his name associated with this important clinical test for varicose veins it was, in fact, Sir Benjamin Collins Brodie, who had described this test most lucidly in his lectures published in 1846!





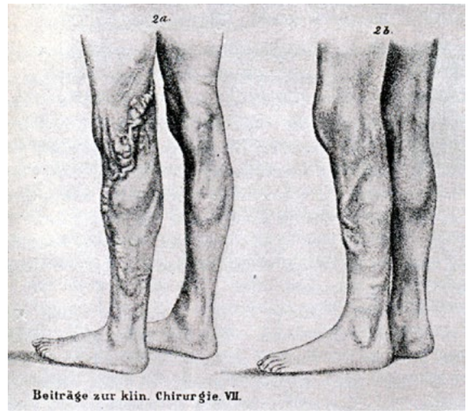
When he was 64 years of age, Trendelenburg devised and carried out an operation for the removal of a blood clot obstructing the pulmonary artery in pulmonary embolism, however he never met with success. On Trendelenburg's 80th birthday, one of his pupils, Kirschner, was able to demonstrate a patient upon whom he, Kirschner, had performed successful pulmonary embolectomy.

Trendelenburg had always acted as a kind of father figure to his collaborators and always encouraged his assistants to publish. It was in this manner that it was Trendelenburg's assistant, Dr Willy Meyer, who in 1885 first described the raised pelvic position, which subsequently and hereafter has been known as 'the Trendelenburg Position'.

Interestingly, in Meyer's article we read that this 45° elevation of the lower limbs of the patient, was originally achieved by allowing the patient's legs to rest on the shoulders of a strong assistant! It was only later that special operating tables were constructed and here we see one such table (pictured, left) as designed by Eugene Doyen in Paris in the late 19th century.

Trendelenburg is eponymously remembered as follows:

***Cannula.*** *The 'Tamponkanüle', the so-called tampon cannula, a drainage tube with an inflatable rubber balloon for preventing patients from swallowing blood into the trachea following tracheotomy. Trendelenburg was a pioneer of endotracheal anaesthesia with tracheotomy (1869).*

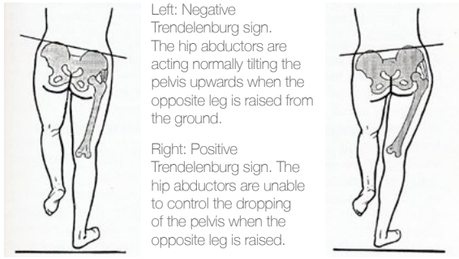



Above: Lower limb varicose veins in a 43 year old male: before and after surgery.

***Operations.***
*A. Excision of varicose veins.*
*B. Ligation of great saphenous vein to prevent reflux into varicose veins.*
*C. Removal of a pulmonary embolus.*
*D. For a slipping patella; the external condyle is raised, and an ivory peg inserted.*

***Position.*** *The head-down position, the patient lying on the back, on a plane inclined to 45°.*

***Sign.*** *When the patient stands on their normal leg and raises the other leg off the ground, the gluteal fold of this side rises slightly with the limb in a normal manner; when the patient stands on the affected leg, the gluteal fold on the sound side, falls, instead of rising.*



Left: Negative Trendelenburg sign. The hip abductors are acting normally tilting the pelvis upwards when the opposite leg is raised from the ground.

Right: Positive Trendelenburg sign. The hip abductors are unable to control the dropping of the pelvis when the opposite leg is raised.

***Symptom.*** *A waddling gait due to paralysis of the gluteal muscles.*

***Test.*** *For insufficiency of the valves in lower limb varicose veins involving the saphenous system.*

The closing years of his life were spent at Nikolasee, near Berlin, where Trendelenburg died in his 81st year, as the consequence of a mandibular sarcoma.

In 1872, aged 28, he founded the German Society of Surgeons, with which he was associated all his life; serving as president, and, finally, as its historian: he a left a charming autobiography for posterity, *'Aus heiteren Jugentagen'*, *'On happy childhood days'*, Berlin, J.Springer, 1924.

The advance and progress of living medical history was a topic that fascinated him over the period of his long and fruitful life.

Peter F. Burke
FRACS

# Emeritus Professor Bill Gibson AO

## A great surgical mentor

At 73, Emeritus Professor Bill Gibson AO is not ready to retire and continues to see patients at the Sydney Cochlear Implant Centre and speak at international conferences. Throughout his career as an ear, nose and throat (ENT) surgeon, Prof. Bill Gibson has gone above and beyond in his role of mentoring other surgeons from both Australia and the UK where he was born and trained as a medical professional. *Surgical News* spoke to his biographer, Tina Allen, as well as his colleagues about this inspiring surgeon and teacher.

Prof. Bill Gibson was born in Devon in June 1944 and is the fourth generation of doctors in his family. Bill knew by age five that he wanted to be a doctor. He was inspired by his father, a medical officer during WWII, and the general practice he ran from the family home. In 1962, Prof. Gibson was awarded a full scholarship to the Middlesex Hospital Medical School in London.

Despite enjoying his rotation through orthopaedics, he was drawn to ENT because of exciting new microsurgical procedures, such as the tympanoplasty and stapedectomy. He is proud that his specialty was the first to use the operating microscope.

He progressed up the ladder quickly and was a FRCS by age 27. As an MD at Guy's Hospital he developed a hearing test for babies, based on the Post Auricular Myogenic Response. He also undertook a 'mini gap year' at the Institut Georges Portmann in Bordeaux which led to a life-time interest in electrophysiology and finding a cure for Menière's disease. While working as a consultant at the Royal National Hospital for Nervous Diseases in London, he became interested in the possibility of electrical stimulation of the ear to restore hearing and joined a research group called 'Project Ear'.

In 1983, Prof. Gibson and his family left the UK for Australia to take up the inaugural Chair of Otolaryngology at the University of Sydney, and become head of ENT at its co-located teaching hospital, Royal Prince Alfred. Before leaving London, he met the pioneer of the multi-channel 'bionic ear', Professor Graeme Clark from Melbourne who said, 'I hope you'll work with me on the cochlear implant program in Australia'. In August 1984, Prof. Gibson operated on two young women who were among the first people in the world to receive the bionic ear, manufactured today by Cochlear Limited.

After implanting a series of 20 profoundly deaf adults, Prof. Gibson took the brave step in 1987 of operating on a four-year-old, who became the first child to receive the commercialised bionic ear, and a five-year-old who was the youngest congenitally deaf child in the world to receive the device. He then progressively lowered the age of congenitally deaf recipients to around nine months because he believed their brains would be more receptive to speech and language development.

Prof. Bill Gibson and Assoc. Prof. Cathy Birman viewing MRI scans of the brain and middle ear.

In 1998, Prof. Gibson was joined by his former registrar and Fellow, Associate Professor Cathy Birman who became the second surgeon at the Sydney Cochlear Implant Centre (SCIC); the not-for-profit cochlear implant program which he founded.

Assoc. Prof. Birman, who took over as medical director in August 2014, says that the SCIC continues to work to fulfill Prof. Gibson's vision to ensure cochlear implant hearing care for all patients.

Assoc. Prof. Birman considers 'Prof', as she calls him, to be 'a world leader in cochlear implant surgery and inner ear physiology. He is also a wonderful teacher clinician who is always focused on the best outcomes for his patients.'

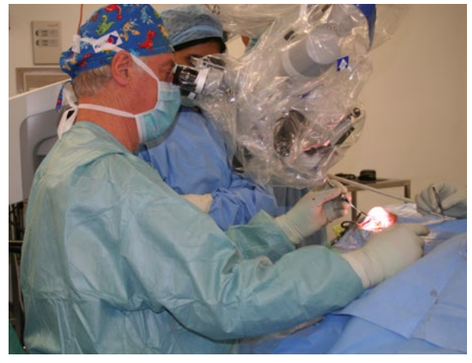
'Most current ENT surgeons in NSW can thank Professor Gibson for sharing his experience, teaching, research and patiently supervising them as registrars. He is a clear surgical teacher, never flustered, entrusting the registrar or surgical Fellow with the crux of the procedure, while carefully supervising over their shoulder. He has also been a great supporter of colleagues undertaking higher degrees, including my own PhD.

'Prof is indeed a visionary, and a remarkable man who has shaped cochlear implant surgery in NSW, nationally and internationally, through the training of Australian and overseas Fellows over several decades.'

Prof. Gibson initially accepted Fellows for six-to-twelve months from countries including New Zealand, South Africa, France and the US. Following the untimely death of the president of the British Cochlear Implant Group, Graham Fraser in 1994, a memorial Foundation was established, and Prof. Gibson agreed to accept a UK Fellow each year for the following twelve years.

In doing so he provided unique surgical opportunities to the current and future generations of consultant otologists in the UK including two professors of ENT from Leicester: Peter Rea and Henry Pau.

In the November/December issue of UK medical journal, *ENT & Audiology News*, Prof. Rea described Prof. Gibson as: 'A generous, patient and hugely sought-after teacher; the benefit of his knowledge is spread around the globe'.



Prof. Bill Gibson's farewell surgery at the Mater Hospital, North Sydney in November 2013 with illuminated surgical site.

In the same journal feature, Prof. Pau fondly commented: 'Prof Gibson is the complete package of a true academic surgeon: an intellectual powerhouse in research, an excellent diagnostician and the most gifted technical surgeon. He has taught me most of the things I know in otology and vestibular medicine.'

Prof. Gibson is now a world expert in the diagnosis and management of Menière's disease. Through various training schemes, he has passed on skills including electrocochleography (ECochG), endolymphatic sac surgery and the Gibson Score, which comprises ten diagnostic questions.

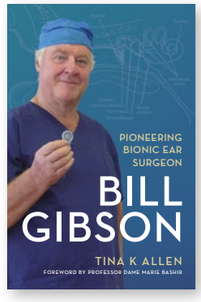
Assoc. Prof. Payal Mukherjee feels honoured to have served with Prof. Gibson on the Menière's Research Fund committee and to have been mentored by him. Prof Gibson supervised her Master's degree on cochlear implants and she comments that he 'always inspired me to think laterally and explore each variable when applying myself to research. He is a surgeon scientist and curiosity and innovation are still very much alive in him'.

'Prof is indeed a visionary, and a remarkable man who has shaped cochlear implant surgery in NSW, nationally and internationally, through the training of Australian and overseas Fellows over several decades.'

Prof. Gibson showed an 'active scientific mind and was very hands on' when Assoc. Prof. Mukherjee recently demonstrated some 3D printing applications in ear surgery to him.

'His ability to rapidly absorb new information and put discoveries in context of his tremendous experience are some of the reasons why I believe that he continues to inspire others and be invited to speak at conferences.'

Assoc. Prof. Mukherjee observed one of Prof. Gibson's last cochlear implant operations before he retired at age seventy from surgery in June 2014. At the time he had clocked up 2200 cochlear implant surgeries, making him one of the most prolific surgeons in his field.




While many people have heard of Professor Graeme Clark, Prof. Gibson's name was virtually unknown outside of hearing circles until the publication of his biography, *Bill Gibson: pioneering bionic ear surgeon* by Tina K. Allen (NewSouth Books) in March 2017. The biography was commissioned by a group of Prof. Gibson's patients, so his inspirational story would not be forgotten. Copies can be purchased from bookshops, on-line booksellers and to borrow from the RACS library.

*Surgical News* acknowledges the assistance of Assoc. Professors Cathy Birman and Payal Mukherjee with the preparation of this article.

Tina Allen, BAppSci, MA (Journalism)
Author & Medical Writer

# It is sexist - not sexual....

As situations of concern surface in professional organisations, medical workplaces, government departments, religious entities, parliaments and the media, there are repeated occasions where people blend, incorrectly name, or blatantly mix up conduct that amounts to sexism, and conduct that is of a sexual nature that amounts to sexual harassment.

When thinking about sexism *in this century* people need to be inclusive of discrimination and harassment against a person on the basis of their sex, gender identity and transgender or intersex status.

Yet despite the existence of legislative frameworks and decades of workplace education people who should know better can still be heard to refer to Australia's *Sex Discrimination Act*, as the 'Sexual' Discrimination Act.

After taking a minute to think through the stereotypical connotations and implications of that *faux pas*, it is worth reflecting upon the fact that people also repeatedly confusing and misinforming others when they talk about race discrimination and the issue of concern relating to religion.

Language is critical and the onus rests with those who speak about such matters, to get it right… to fail to do so seems to equate to calling a kidney a liver and expecting the patient to be happy with the diagnosis!

Sexism is about prejudice, less favourable treatment and stereotypical judgement. It manifests as an attitude or an approach that limits people. By way of references to gender roles and beliefs, it labels and categorises. The most common beliefs include that one sex is intrinsically better than, or superior to another.

In practice sexism tracks hand in hand with the history of civilised mankind (or should that be human beings) evidencing peaks and troughs of discriminatory treatment most often suffered by womankind.

Thousands of years ago the status of women in ancient Egypt depended on their fathers or husbands, but they had property rights and were allowed to attend court, including as accusers. Things did not necessarily move forward in a systematic way as hundreds of years later women in certain societies found themselves in far less advantageous positions, with fewer rights than ancient Egyptian women.

Until recently sexism has prevented women from participating in political processes and following certain vocations. To this day, there are those who ensure male and female children are taught that females should obey a father in childhood, a husband in marriage, and a son in widowhood – sexism that piggy-backs from generation to generation.

It was gender difference that underpinned the hunts and trials of witches that sullied the past of our distant foremothers and forefathers. Thankfully times have changed. Being burnt at the stake is now off the agenda; but alas sexism persists. Dare it be said that being burnt at the stake could be a lot quicker than the amount of time spent enduring unsolicited 'advice' about what is best for women in medicine. There are those with firm views on appropriate career paths for women, particularly given *women have children and want lots of time off*. You have to love an eternal stereotype that features repeatedly in advice deemed to be worthy of female medical students.

Sexism can take many forms; comments, nick names, gestures, unfair treatment, providing prejudicial advice and denying opportunities to reach full potential based on individual merit.

Sexism can take many forms; comments, nick names, gestures, unfair treatment, providing prejudicial advice and denying opportunities to reach full potential based on individual merit.

The 1970s saw the movement towards gender-neutral language take a foothold despite being viewed as heresy by some. It has since served society well and has provided insights into a diversity of career role models for children. It is helpful that English, unlike other languages, is not inherently sexist in its linguistic systemisation. Rather, and disappointingly, it is the way people use the language that invokes inequity, offence and distain.

Sexist language can often cause conflict and tension. In professional environments it can be used to devalue and disenfranchise as well as promote superiority and profile inferiority. While not always overt, sexist language can impact expectation, affect consciousness, disempower and undermine professional opportunities.

The use of generic masculine terms to reference a mixed group can be problematic. Another everyday community example is that some are addressed as Mr (male with no nominated marital status) and others are regularly quizzed – are you Miss or Mrs? (female with disclosure of marital status). This is sexist. Some women opt for Ms as it presents as equivalent to Mr in that only a sex is identified. The fact that a different process is imposed in 2018 to buy a ticket or to fill in a form is outrageous, particularly given there are times when Ms is unavailable. If marital status is genuinely relevant simply ask Mr Smith and Ms Jones the same question.

Defaulting to he, his, him or Dear Sir to refer to a person of unknown sex or gender identity should be avoided - but it persists and blaming the computer program is not a reasonable get out of jail card. The use of unnecessary gender markers is also something that impacts people; for example *female bank manager* and *male nurse* imply that a 'bank manager and a 'nurse' by default have a different regular gender.

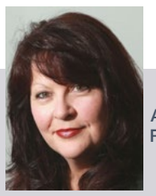
There are a wealth of gender specific terms that amount to unacceptable sexism. Often ignored, accepted as the norm or considered reasonable colloquial language, such terms have no place in a professional environment.

When in the presence of someone referring to a female colleague as a *girl* rather than a *woman* encourage them to think about how language implies that the person is inferior, subordinate or less mature. Ensure others understand that language such as *tranny*, *she-male* or *he-she* offends transgender people, and can amount to unlawful sexism.

Take a stand and explain the difference when someone fails to differentiate between conduct that is sexist and sexual. Be clear that some unacceptable sexual conduct could also amount to sexism if it is sexually offensive in nature, *and* simultaneously devalues a person on the basis of sex, gender identity or marital status. Sexual harassment is not by default sexist conduct.

**NOTE**

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



Susan Halliday
**Australian Government Defence Abuse Response Taskforce (DART) 2012-2016 and former Commissioner with the Australian Human Rights Commission**

# Supporting specialist pathways for Aboriginal and Torres Strait Islander doctors

Professor Martin Nakata (pictured, right) joined RACS as an Educational Advisor during June 2017. Professor Nakata is the Pro Vice-Chancellor for Indigenous Health and Strategy and Head of the Australian Aboriginal and Torres Strait Islander Centre at James Cook University in Townsville. Professor Nakata is providing strategic advice to the College on supporting specialist pathways for Aboriginal and Torres Strait Islander doctors.

It was my pleasure to introduce Professor Nakata to present to the RACS Board of Surgical Education and Training (BSET) on 9 February 2018. The presentation demonstrated the increasing numbers of Aboriginal and Torres Strait Islander medical school enrolments and graduations over the past ten years and insight into the enrolments of Aboriginal and Torres Strait Islander doctors across the specialties.

Professor Nakata noted the challenges faced by RACS with tracking self-reported data around Aboriginal, Torres Strait Islander and Māori identification and suggested some opportunities to improve and make use of this data for developing future support initiatives. In the short term the Indigenous Health Committee and Professor Nakata are discussing opportunities to survey past and present applicants.

It was noted that the recent accreditation by the Australian Medical Council and Medical Council of New Zealand includes a number of recommendations and conditions relevant to improving cultural safety, Indigenous health curricula and increasing the Aboriginal, Torres Strait Islander and Māori surgical workforce.

Professor Nakata noted that RACS was already training across the breadth of the nine surgical competencies, committed to building respect across the profession and medical workforce and training in patient centred and team oriented non-technical skills. This is a strong foundation for further integrating understanding of cultural safety and Aboriginal, Torres Strait Islander and Māori health.

Mr Pat Alley, Chair of the Māori Health Advisory Group and I offered our support to the Specialty Training Boards during the meeting to assist with integrating cultural competence training, Indigenous health education and supporting Aboriginal, Torres Strait Islander and Māori applicants interested in surgical training.

Professor Martin Nakata

It is encouraging to see the support and work done to date in support of the Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative. In particular, the commitment to implement the initiative by the training boards in Otolaryngology Head-and-Neck Surgery, Cardiothoracic Surgery and General Surgery.

The initiative was developed by BSET in June 2016, and is designed to address the low participation of Aboriginal and Torres Strait Islander doctors in the surgical specialties. Its aim is to increase the number of Aboriginal and Torres Strait Islander surgeons in the Fellowship to a minimum of five per cent of registered Aboriginal and Torres Strait Islander medical practitioners.

Dr David Murray
Chair, Indigenous Health Committee



Delivering Bad News role playing scenarios (non-clinical component of our Surgical Skills Workshops)

# Leading surgical education in the ACT

The year 2017 was an exciting year to be a Surgical Trainee in Australia's newest network in the Nation's capital and as the ACT Trainee representative I am very proud of where I think is one of the best places to train in Australia. Whilst it's no secret to NSW Trainees who rotate here that the operative exposure is outstanding with the full range of surgical sub-specialties catered for, I think it's worth reflecting on surgical education activities in the ACT and how it continues to grow as a surgical training hub.

Safely performing a hand sewn bowel anastomosis (Supervising hand sewn bowel anastomosis)

We saw our bi-annual JDocs endorsed surgical skills workshops evolve based on participant feedback and again hugely popular with requests now coming in from JMOs outside the state keen to participate. The sponsored workshops cater to JMOs and advanced trainees with beginner and advanced modules delivered in an interactive setting supervised by surgeons. Participants learn skills such as knot tying, simple excisions and the principles of diathermy through to advanced laparoscopic skills, vascular and bowel anastomoses on porcine tissues. This day would not be freely available without the huge contributions from Applied Medical, Medtronic, Johnson & Johnson, ACT Health and RACS ACT, or the 12 consultants who give up their free time on a Saturday.

The program evolved in 2017 to include two Friday evening sessions at RACS ACT aimed at JMOs prior to the skills session. Both were fully subscribed with globally positive feedback. The first, supported by Avant, focused on informed consent with pre-reading surrounding relevant precedents and medical ethics. Colorectal Surgeon Dr David Rangiah gave his insights and approach to consent before senior solicitor Harry McCay explored common medico-legal issues in his experience. Participants then practised different consenting scenarios in groups with feedback.

The second session focused on delivering bad news and was convened by A/Prof Siva Gananadha with the assistance of myself and included insights from the clinical perspectives of psychiatrist Dr Anna Burger, intensivist Dr Simon Robertson and medical oncologist Dr Nicole Goddard. Similarly, participants practised breaking bad news in groups with feedback. These sessions were constructed around the JDocs model and provided an opportunity for those JMOs interested in surgery to gain competencies but also feel welcomed and supported by RACS ACT. There is particular focus on participant feedback from these sessions as we are always aiming to improve.

We will see these opportunities continue in 2018 as well as regular registrar-led, consultant supervised teaching sessions and a monthly journal club. RACS ACT are committed to surgical education and offering a pathway to gain new skills in accordance with JDocs for JMOs interested in surgery. Whilst the opportunities for hands-on technical experience abound in Canberra so do those for the non-technical competencies and in my opinion surgery is leading the way in fostering relationships that inspire and secure our best and brightest junior doctors in the ACT. Canberra is a great place to live, but it's an even better place to train in surgery.

Dr Rudyard Wake
ACT Representative, RACSTA

# JDocs: Preparing for the Registrar role

## Where are we now?

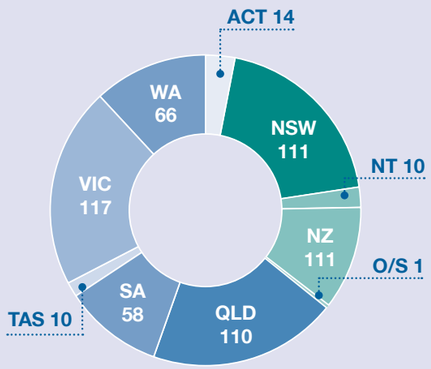
Since launch of JDocs in February 2016, over 1,000 doctors have subscribed to JDocs and just over 30 per cent of subscribers have logged nearly 28,000 procedures in the JDocs MALT log book. With time, this will provide an indication of involvement in surgical procedures and operations prior to specialty applications.


Above: JDocs core competencies

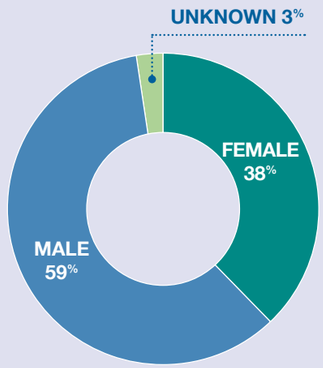
### JDocs Developing Surgical Career Workshops

With the support of the Victorian Regional Office, three JDocs workshops are scheduled at the RACS Skills and Education Centre this year and are open to junior doctors across Australia and New Zealand. The first workshop was held on 3 February thanks to the generous support of Fellows and Trainees who delivered a number of presentations and facilitated a surgical skills session. Feedback from participants was extremely positive with comments that the topics covered were relevant and informative with some doctors stating that the workshop had reinforced their decision to pursue a career in surgery. Further workshops will be held on 30 June and 6 October.

In February 2018, 554 doctors across Australia and New Zealand were subscribed to JDocs.



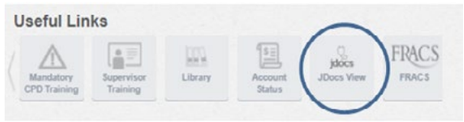

There has also been a steady increase in the number of female subscribers.





### Launch of the Essential Surgical Skills Kit

The Essential Surgical Skills kit is now available for purchase from the JDocs website (jdocs.surgeons.org), for surgical aspriants to practise the basic surgical skills demonstrated in the open access surgical skills videos also available from the JDocs website.



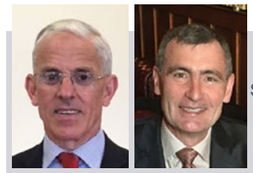

### JDocs View

JDocs View can be accessed from the Useful Links area of the RACS Portfolio.

* Individual JDocs ePortfolios cannot be viewed.

jdocs Best Practice, Better Practitioners

If you would like any further information about JDocs, or you're interested in championing JDocs in your hospital and/or supporting a JDocs event, please contact Jacky Heath, Manager Prevocational and Online Education, jacky.heath@surgeons.org or +61 3 9276 7423.



Professor Jonathan Serpell
Chair, Prevocational and Skills Education Committee

Assoc. Professor Stephen Tobin
Dean of Education

*with Jacky Heath, Manager, Prevocational and Online Education*

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Royal Australasian College of Surgeons

Academy of Surgical Educators
Royal Australasian College of Surgeons

*The Academy of Surgical Educators presents,*

## 2018 Educator Studio Sessions

A series of 1 hour workshops that explore the changing surgical education landscape, one theme at a time.

**Venue:** RACS Sydney Office, Suite 1, Level 26, 201 Kent Street, Sydney
**Date:** Thursday, 26th April
**Time:** 6:30pm – 7:30pm
Registration is free
Light refreshments provided
*Sessions are also simulcast via webinar*


*Further information about the Academy and the series can be found here: https://www.surgeons.org/studiosessions/*

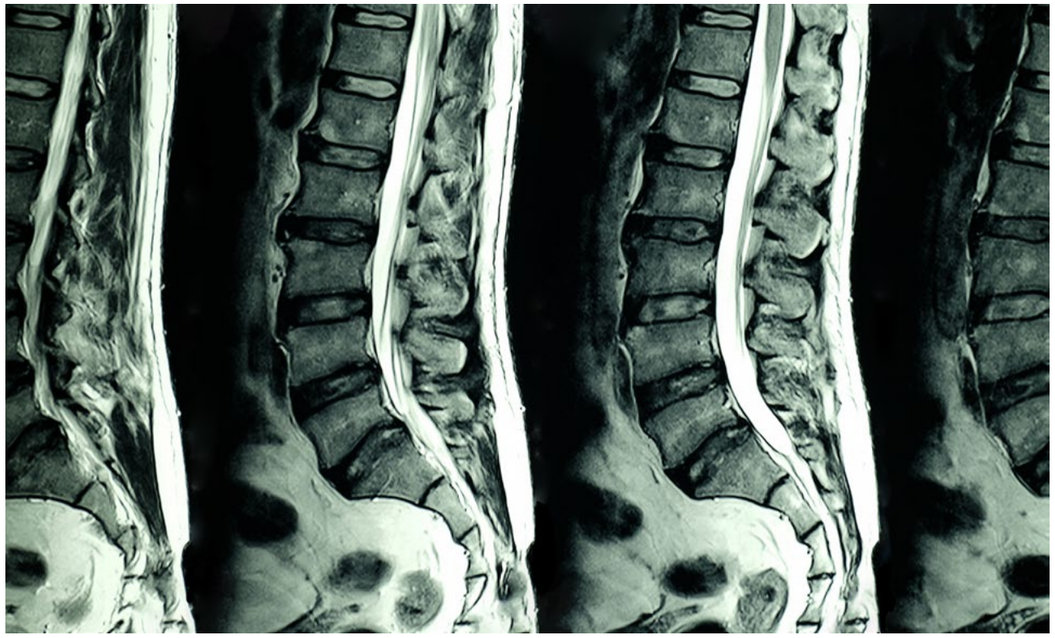


IMAGE: Spine MRI

# Major international science prize for Neurosurgery Trainee

Victorian Neurosurgery Trainee Dr Idrees Sher has become one of the few surgeons outside the United States to win the Best Basic Science Paper at the prestigious North American Spine Society (NASS) annual meeting.

Dr Sher won the award for the presentation of his research into the use of mesenchymal precursor stem cells (MPCs) as an alternative to surgery for disc degeneration and the management of discogenic lower back pain.

His work not only caused excitement at the meeting by explaining the workings and impact of MPCs within the first weeks following injection but also because his use of new technology provided super high-resolution images of the disc never previously captured.

In his research, Dr Sher conducted a range of investigations – including histology, immunohistochemistry, polarised microscopy and Magnetic Resonance Imaging (MRI) - to demonstrate that MPCs provide a direct beneficial effect in the rate of repair and reconstitution in the degenerate and nutritionally-compromised intervertebral discs during the first four weeks of application.

As a central component of this work, Dr Sher used MRI equipment set at 9.4T to capture images of the MPCs behaviour in damaged discs in animal models.

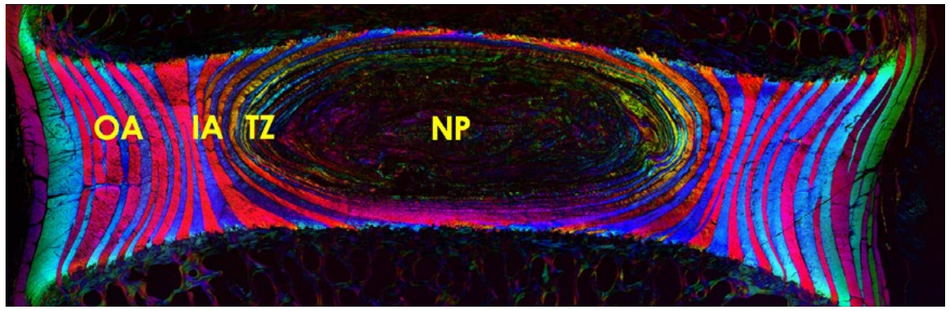
He used both live and dead MPCs which were tagged with a ferric oxide nanoparticle. These were then injected into the contralateral nucleus pulposus (NP) of injured intervertebral discs with results studied at two, four and eight weeks after injection.

He found that live MPCs not only helped restore damage during their lifetime (four weeks) but appeared to activate endogenous disc cells to up-regulate the production of anti-inflammatory cytokines and suppress catabolic activities.

His work supports larger international research being conducted by his supervisor, Neurosurgeon Associate Professor Tony Goldschlager, on stem cell regeneration of the intervertebral disc and was published by the influential *The Spine Journal* last year.

Speaking to *Surgical News*, Dr Sher said that while some smaller studies had shown that MPCs reduced pain for up to six months while also promoting disc healing, no-one fully understood the biology and biomechanics involved.

He said while other researchers were investigating outcomes at six months and 12 months, he wanted to understand the initial reparative processes occurring in the first few weeks following application.




Abrio birefringence image of the intervertebral disc. Key: NP = nucleus pulpous, TZ = transitional zone, IA = inner annulus fibrosus, OA = outer annulus fibrosus.

"Our findings provide novel insights in the actions of MPCs and support their use in degenerative disc disease, further paving the way for human trials," he said.

"We focused on the transitional zone between the nucleus pulposus and the annulus fibrosus. We were able to identify specific biomechanics in that region as well as demonstrate that it is here where the first signs of disc degeneration appear within the intervertebral disc.

"Until now, no-one has been able to specifically demonstrate that disc repair is caused by the action of MPCs but this is what we were able to show.

"We could demonstrate that the live stem cells migrate to the site of disc injury, that they replicate the role of, or up-regulate the production of, fibroblast to heal the disc and that they have an active life of about four weeks.

"Using histological techniques, we could see notochordal cell nests within the uninjured disc, and smaller MPC nests in the injured disc, so we think these cells break up to migrate to the site of disc injury.

"That action was not seen in the action of dead MPCs."

Dr Sher's research was conducted at the Monash Health Translation Precinct (MHTP), a collaboration of Monash University Departments of Surgery, Neurosurgery, Monash Imaging and Monash Biomedical Imaging and the Hudson Institute.

Dr Sher said his work represented the first time such super high-resolution MRI technology had been used to investigate the intervertebral disc.

"MRI images obtained using 9.4T have been used to study the brain and the heart but never used to study lumbar discs (and) it allowed us to study the disc in micro-anatomical detail which was amazing."

"MRI images obtained using 9.4T have been used to study the brain and the heart but never used to study lumbar discs," he said.

"It allowed us to study the disc in micro-anatomical detail which was amazing.

"We could even see blood vessels and nerve fibres growing in degenerated and compromised discs which has never been seen before.

"We theorise that as the disc degenerates, blood vessels and nerves invade the intermediate zone and may be the cause of the chronic low back pain associated with disc injury."

Held in Florida in October last year, the NASS annual meeting is the largest spinal meeting in the world.

Dr Sher said he had been pleased that his paper had been accepted for presentation and thrilled to win the Best Basic Science Prize.

"Most researchers never contemplate moments like that when we're busy getting the science right but while it was greatly rewarding, the real thrill is contributing to advances in this area," he said.

"Degenerative disc disease is the leading cause of chronic pain in the world and costs billions of dollars in health care and lost productivity, so if we can make advances in this area we could not only improve the quality of life for millions of people, we could take significant pressure off health budgets."

Dr Sher said his research was conducted as a Master of Medicine Degree but that he planned to extend his work as a PhD after he completed his neurosurgery training next year.

His research supervisor and the Research Group Leader at the MHTP, Assoc. Prof. Tony Goldschlager, has been a leading researcher into the use of stem cells to treat degenerative disc disease for the past decade.

He is now leading a Phase 3 clinical trial through Monash University, Monash Health and Mesoblast, to measure both pain relief and improved function following a single injection of MPCs.

He described Dr Sher's achievement as remarkable.

"For an Australian to win this prize is extraordinary and it speaks to the quality of work being done here," Assoc. Prof. Goldschlager said.

"While quite a bit of research has indicated that MPCs have the potential to reverse, halt or slow disease progression, no-one really understood the driving mechanisms behind this until Dr Sher used the super high-resolution MRI technology to study the cells in the first few weeks of application.

"His work has produced some of the world's first high quality images of the disc in exquisite detail, work which has been justly rewarded."

Karen Murphy
Surgical News Journalist

# Eye surgeon sets his sights on fine art

Retired ophthalmologist Dr Henry Lew (pictured, right) , FRACS, FRANZCO is using his deep understanding of the workings of the eye to fundamentally change public understanding of how we see and appreciate works of art.

An art collector and connoisseur, author and world authority on early modernist Australian painters Horace Brodzky and Derwent Lees, Dr Lew has written and published a book that connects the science of vision to human perception.

Called *Imaging the World*, the book is based on a well-received presentation he gave at the Royal Australian and New Zealand College of Ophthalmologists (RANZCO) Annual General Conference in 2016, a lecture that is now under consideration by the American Academy of Ophthalmology for presentation at this year's Annual Scientific Congress.

Dr Lew's theory is that the eye is designed to "see" lines which the brain then connects to form patterns and images.

He believes the right lines, in the right colours, in the right tones and in the right places create a life-like image that we respond to, and that some of the Old and Modern Masters may have instinctively known this.

He uses the works of Frans Hals, Edouard Manet and Alfred Munnings to explain how their use of undisguised brushstrokes (lines) creates such vibrancy in the eye of the beholder that many of their works came to be considered masterpieces. At the same time, he provides a scientific explanation as to why the French Impression movement started.

Dr Lew believes this is because while we continuously look at a painting, the brain responds to a series of different sets of lines sent by the retina, and therefore perceives a series of slightly different images, creating a constantly changing visual engagement with the artwork.

He hopes that this understanding of the neurophysiological engineering of human vision could also aid in the identification of possible sleepers, those paintings by significant artists which remain unrecognised by connoisseurs, art dealers and academics.

Speaking to *Surgical News*, Dr Lew said the aim of the book was to amalgamate a knowledge of art history and artistic techniques with an appreciation of the engineering behind human vision.

"The retina responds to lines, which then send the basics of image-forming visual information through the retinal receptors and the bipolar and ganglion cells via the thalamus to the cerebral hemispheres," he said.

"The brain then creates the images we see. Therefore, the more lines involved in any given image, the more vibrant and life-like we perceive that image to be.

"The lines can be vertical, horizontal or oblique, fat or thin but these lines all need to fit into the retina's visual field for the brain to create an image, hence those artworks that make no visual sense up close but burst into life when you stand back."

Dr Lew trained at the Royal Victorian Eye and Ear Hospital, did Retinal and Paediatric Fellowships overseas, and then spent most of his career working from his private practice in Caulfield and as a Visiting Senior Surgeon at the Repatriation Hospital in Heidelberg.

And just as he's doing in retirement, he used revolutionary thinking throughout his working life.

He was one of the first surgeons in Melbourne to implant posterior chamber intraocular lenses, modifying the Crock vitrectomy machine into an infusion/aspiration cataract machine, which made the later transition to phacoemulsification surgery effortless.

He was the first ophthalmologist in Victoria to perform manual small-incision cataract surgery, which has become perhaps the most widely performed procedure in developing countries.

However, he regards his greatest contributions to his specialty to be in the management of glaucoma, particularly his combined trabeculectomy/cyclodialysis procedure which showed that profound pressure lowering glaucoma surgery could be associated with an improvement in the visual field.

"In 1984, I published the first case of an extremely rare ocular tumour that we cured by immunotherapy in Australia," he said.

"It was a fascinating case and remains, I believe, the only ocular tumour ever cured in this way in this country."

Dr Lew said the Repatriation Hospital, provided an opportunity to maintain a generalist practice at a time when sub-specialisation was on the rise.

"It was a very exciting time to be a surgeon and Ophthalmologist from the 1970s until 2000 because incredible advances were made," he said.

"I particularly enjoyed working at the Repat because we were driven to do the absolute best we could for the returned soldiers which meant, at times, lateral thinking and the latitude to come up with novel solutions," he said.

"I also felt very comfortable with these patients because in many ways they reminded me of my parents at a time before we fully understood Post Traumatic Stress Disorder and its life-long consequences if left untreated."

Dr Lew's parents lived in Bialystok, Poland which was wiped out by the Nazis and they lost most of their family members to the barbarity of the Holocaust.

Arriving as refugees in Melbourne in the late 1940s with money sent to them from a family they had helped to protect, the Lew's moved into an apartment owned by an antique dealer, stillfilled with her belongings.

Thus, when young Henry arrived, he arrived into a household filled with art.

"As a first-year medical student I received a book called *Great Pictures by Great Painters* and I absolutely loved it," Dr Lew said.

"As soon as I began earning money I began collecting, not for investment but for enjoyment and that sparked my interest in art history."

Since then, Dr Lew has gone on to write four works connected with the arts.

They are:

- *Horace Brodzky* (1987) – which introduced one of Australia's earliest significant modernist painters back into Australia's cultural awareness;
- *In Search of Derwent Lees* (1996) – a book which not only described the life and works of an artist who suffered from schizophrenia, but which helped launch an exhibition that raised funds and awareness for Sane Australia;
- *The Five Walking Sticks* (2000) – the story of Australia's first great investigative journalist, Maurice Brodzky;
- *Smitten by Catherine* (2016) – which covers the life of Catherine Rachel Mendes da Costa (1678-1756), the first female Jewish painter in recorded history.

Dr Lew has also honoured his parent's courage, dignity and memory by co-ordinating the translation into English (at his father's request) of a Holocaust memoir called *The Stories Our Parents Found Too Painful to Tell* (2008) and writing the quasi-sequel *Lion Hearts* (2012).

Those books, which detail the experiences of the Jews in Poland during World War II, are now found in most Holocaust museums around the world.

Karen Murphy
Surgical News Journalist

# WAASM 2017 Report Highlights

The Western Australia Audit of Surgical Mortality (WAASM) is an external, independent, peer-reviewed audit of the process of care associated with surgically-related deaths in Western Australia. The data analysed for the 2017 Report covers cases from **1 January 2012 – 31 December 2016**. There has been an overall relative decrease of **7.5%** in the rate of deaths under a surgeon per 100,000 population.

Mr James Aitken
Clinical Director WAASM

*with Dr Franca Itotoh – WAASM Project Manager*

## PARTICIPATION

**100%** Surgeons

**100%** Hospitals

## ANALYSIS & AUDIT NUMBERS

**2,897**
Reported cases meeting WAASM criteria

**80.5%**
Completed cases
(2,332/2,897)

**8.0%**
Excluded terminal care cases
(231/2,897)

### Admission Type

**14.3%** Elective
(342/2,397)

**85.7%**
Emergency
(2,055/2,397)

### Hospital Status

**83.5%**
Public
(1,980/2,370)

**4.6%**
Co-location
(110/2,370)

**11.8%**
Private
(280/2,370)

## RISK PROFILE

**Ages**
Overall median age **77**
(range 1day to 104 years)

**56:44**
Male (1,608/2,897)
Female (1,289/2,897)

**89.6%**
Comorbidities
(2,018/2,253)

**5.2%**
Fluid balance issues
(113/2,182)

**79.7%**
DVT prophylaxis use (1,775/2,226)

**60.1%**
CCU use
(1,327/2,209)

## PATIENT TRANSFERS

**28.8%**
Patients transferred
(632/2,191)

## INFECTION

**31.9%**
Patients with clinically significant infection
(584/1,829)

▶ **40.2%**
Pneumonia
(233/580)

## OPERATIONS

**65.7%**
Patients that had surgery
(1,596/2,428)

▶ **5.4%**
Operations abandoned on finding a terminal situation
(104/1,920)

## PEER REVIEW OUTCOMES

**14.3%**
Cases referred to SLA (341/2,377)

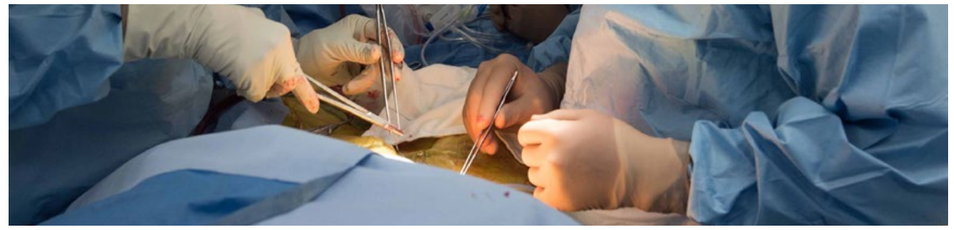
▶ **25.2%**
Clinical management issues (588/2,332)

▶ **13.1%**
Adverse events
(77/588)

*Note: DVT (deep vein thrombosis) and CCU (critical care unit)*







# Case Note Review

## Pancreatic malignancy with biliary and duodenal obstruction; communication issues

### Clinical details

A 67 year old patient presented to Hospital A's emergency department with a three-day history of abdominal pain and dark urine. A computed tomography (CT) scan had shown an irregular mass in the region of his pancreatic head, with obstruction of the biliary system and narrowing of the third part of the duodenum. The proximal duodenum was dilated and there were enlarged lymph nodes in the vicinity of the coeliac axis which were thought to be pathological in nature. The patient had undergone a curative subtotal gastrectomy with Roux-en-Y anastomosis three years earlier for a poorly-differentiated adenocarcinoma.

Having been diagnosed with obstructive jaundice due to a carcinoma of the pancreas, the patient was transferred to a tertiary hospital in the same health facility as Hospital B under the care of the gastroenterology unit. By this time the patient was septic and unwell and transferred to ICU.

An endoscopic retrograde cholangiography cholangiopancreatography (ERCP) was attempted the day after admission, and although the biliopancreatic ampulla was cannulated successfully, the bile duct could not be reached. The biliary tree was then decompressed via a percutaneous trans-hepatic cholangiography. A period of clinical improvement followed briefly with bilirubin falling. The patient's sepsis did not completely settle and his condition deteriorated, requiring circulatory support. Another CT scan a week later showed a large collection in the right upper quadrant. Two days later 600mL of haemopurulent fluid was aspirated. While the initial gram stain was negative, subsequent culture showed Vancomycin-resistant *Enterococcus faecium*.

The day after the CT scan, the patient further deteriorated with septic shock associated with a tender distended abdomen. The patient was diagnosed with peritonitis and an immediate laparotomy was organised. Bile stained free fluid was found in all quadrants, with an infected haematoma in the right upper quadrant associated with a blown duodenal stump. The transverse colon was dusky, with a hard mass at the base of the mesocolon. A biopsy was taken, the perforation closed and a wash-out performed. The patient worsened rapidly, the procedure terminated and the patient was treated palliatively but died the next day. The intraoperative biopsy showed metastatic carcinoma.

### Assessor's comments

It is concerning that the patient was not referred to a surgeon on day one, rather than on day 10 when in a pre-terminal state. The case notes were on the whole satisfactory, except for the absence of an ERCP report. There was no explanation of why the bile duct could not be accessed, and one wonders if the duodenoscope was not able to negotiate the third part of the duodenum, strictured by metastatic carcinoma. The surgeon who performed the gastrectomy would have been aware of the anatomy of the Roux-en-Y reconstruction and the feasibility of performing an ERCP. In retrospect, the duodenal stump blow-out was due to the introduction of air into the proximal duodenal loop, already obstructed by the malignant stricture of the third part of the duodenum.

Surgical consultation at admission would have been helpful in discussing other management options. Palliative surgical bypass of both duodenum and bile duct could have been considered at an earlier time in a fitter patient[1].

By the time surgeons were involved the patient was pre-terminal and could not have been saved. The dusky transverse colon was most likely due to malignant involvement of vessels at the base of the mesocolon, and resectability is doubtful. Surgeons should have had earlier discussions as to whether the tumour was a primary of the pancreas or metastatic gastric carcinoma. If it was the latter, the patient should have been admitted under the surgical unit.

### Reference

1 Pu L, Singh R, Loong C, de Moura E. Malignant Biliary Obstruction: Evidence for Best Practice. Gastroenterol Res Pract [serial on the Internet]. 2016 11 May 2016]: Available from: http://www.hindawi.com/journals/grp/2016/3296801/.

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

# Work after retirement: A surgeon's experience in Iraq

At age 68 and having just retired from active General Surgical clinical practice in Australia, I found myself somewhat at a loose end. I had always wanted to do overseas/humanitarian work so I set about finding a way to fulfil that ambition. Médecins Sans Frontières (MSF), (also known as Doctors Without Borders) proved to be a good fit from my perspective.

I have now just returned from my first assignment (seven weeks). I worked in Iraq providing emergency medical care to a population of approximately 300,000 made up of 'permanent' residents of the town and a large 'displaced' population in various camps. The hospital was basically equipped, had approximately 30 inpatient beds (medical, surgical and paediatric), an operating theatre and an emergency room but very limited investigation facilities (plain X-ray and haemoglobin only). The surgical staff consisted of national anaesthetists and surgeons, and myself and a colleague as international anaesthetist and surgeon. We managed all admissions, burns accounted for over 50 per cent of the work load, but we also managed the general run of surgical emergencies and trauma in its various guises. Of note was a run of Typhoid Fever perforations. Typhoid Fever (Enteric Fever) is something that we learn about in medical school in Australia but are unlikely to come across in our clinical practice. Over a six week period we had six cases of bowel perforation. I'd like to share that experience.

Typhoid Fever (Enteric Fever) is something that we learn about in medical school in Australia but are unlikely to come across in our clinical practice. Over a 6 week period we had 6 cases of bowel perforation. I'd like to share that experience.

You may or may not recall that Typhoid Fever is caused by bacillus *Salmonella Enterica Serovar Typhi* as well as *Salmonella Paratyphi*. It is endemic in developing countries, is associated with poor hygiene and has a seasonal variation. The bacillus typically involves the Payers Patches of the terminal ileum where it is ingested by histiocytes, has a systemic phase, then reinfests the lymphoid tissue of the gut with the potential to cause perforation.

My mission corresponded with the end of summer, a peak time for enteric fever. Diagnosis of necessity was empiric as serological testing (Widal Test) was seldom available and there was no ability to culture the organism. Typically cases present in the second or third week with sudden worsening of abdominal pain, though this was variable. A high index of suspicion was required, a history suggestive of enteric fever (more often than not, they had received antibiotic treatment in the previous week or so, on a presumptive diagnosis), and a careful examination needed to assess the likelihood of perforation. We did not have the luxury of a WCC though did have access to a plain abdominal X-ray (provided it was used in 'office hours'). The latter may or may not demonstrate free gas as the amount of free air might be quite small. The degree of peritonism varied, seldom was it generalised, and more often than not it was somewhat localised to the right or lower abdomen.

At surgery, the contamination varied from gross faeco-purulent peritonitis to more modest contamination. The perforation was usually a single punched out hole on the anti-mesenteric border of the terminal ileum though one case had evidence of 2 micro perforations sealed by omentum (Figure 1 and 2). Treatment of the perforation ranged from simple debridement and primary closure, resection and primary anastomosis and exteriorisation and creation of a loop ileostomy. The literature advice is

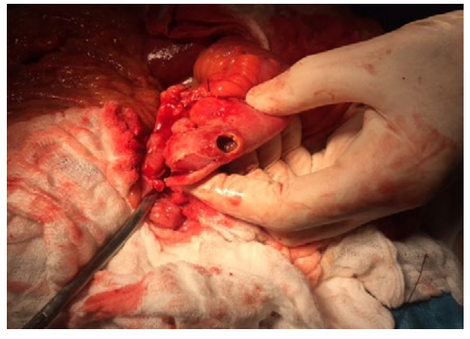


Figure 1

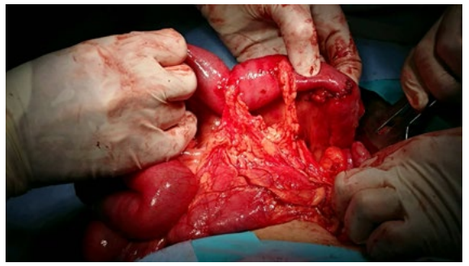


Figure 2

variable as to which is the preferred method. It is difficult to translate to an individual setting as it depends on the context and quality of the local health service. In general, I feel a stoma is best avoided as this can be difficult to manage in a developing country with limited availability to stoma bags, however sometimes the bowel can be so friable that primary closure/anastomosis can be problematic. I'm pleased to report that all six patients made a smooth recovery. The one ileostomy patient had his stoma closed a few days before I left the mission.

I can say I thoroughly enjoyed my mission but can also confess that I felt out of my comfort zone at times. My general surgical training however with RACS stood me in good stead even though at times this meant trawling back through past experiences for inspiration (sometimes going back to junior rotations in training). There was also a reasonable library on site and internet availability was good. I can recommend the experience to anyone who wants to push their boundaries.

Ivan J Thompson
MBBS FRACS

# Sir John Pringle (1707-1782)

Previously presented at the 2016 Cowlishaw Symposium, Campbell Miles highlights the life of Sir John Pringle, the Father of Military Medicine

A lowland Scot, John Pringle attended St Andrew's and Edinburgh Universities before graduating Doctor of Physic from Leiden University then subsequently establishing a practice in Edinburgh. In 1733, he was also appointed Professor of Moral Philosophy at Edinburgh University.

In 1742, he was appointed personal physician to Sir John Dalrymple, Commander of the British forces in the Low Countries, fighting in the War of the Austrian Succession (1742-1748). Within a year, Pringle was appointed Physician-General of the British Army, retiring from active service in 1748.

Before taking up the appointment, Pringle undertook a literature review. However, '…perceiving what little assistance I was to expect from books, I began to note down such observations as they occurred, in the hopes of finding [material] afterwards useful in practice, and having continued this method to the end of the last war, I then put those materials into order and with as much clearness and conciseness as I could, I endeavored [sic] from my own experience to supply in some measure, what I thought so much wanting on this subject.' Pringle realised that interventions he would propose had to be implemented by an administrative structure: 'The chief intention…was to collect materials for tracing the more evident causes of military distempers…so that [depending] upon those in command, and consistent with the service…to suggest proper measures either for preventing or lessening such causes in any future campaign.'

This was at a time, as it had been for centuries before, and would be for many decades to come, when more soldiers died of disease than died of battle injuries.

War wounds were confined to battle; diseases were a constant threat for an army - hence the title of his groundbreaking book – 'Diseases of the Army in Camp and Garrison'.

Pringle maintained a comprehensive register of the diseases he saw and treated with morbidity and mortality numbers, correlating these with the seasons, the weather, geography, ground and atmospheric conditions, and diet. While there was an appreciation that some diseases were contagious, the spread of disease was still thought to be due to fomites, miasmas and putrid air. Hence his admonition '…we may lay it down as a rule, that the more fresh air we let into hospitals, the less danger there is of breeding [malignant hospital fever]'. Malignant hospital fever (typhus) was the military's greatest fear; as Pringle notes '…the most fatal distemper incident to an army'.

Having collated his voluminous records, Pringle posited comprehensive plans to address the enormous burden that diseases made on an army, not only in death rates but also in reducing the number of troops fit for combat. His recommendations made it clear that he was in contact with the soldiers at ground level; one could not charge Pringle with being an armchair theorist. As he states '…the prevention of diseases cannot consist in the use of medicines, nor depend upon anything a soldier shall have in his power to neglect; but upon such orders as shall not appear unreasonable to him, and such as he must necessarily obey.' That said, Pringle is also aware of the deficiencies in medical therapy for 'We must be content to palliate what we cannot avoid.'

Pringle's book contains so many novel preventative and organisational concepts that it is easy to see why it was such a 'best seller', eventually going through eight editions plus various translations. He makes the recommendation that 'the officers and quartermasters should be held responsible for the health of their men'; noting the that troops were using their cloaks as blankets. He recommended that all soldiers should be issued with a blanket. 'The only point to be considered' Pringle added, 'is whether or not the expense and impediment of so much more baggage will over-balance [the] advantage.' Due to Pringle, a blanket became standard issue to the British soldier.

While Pringle took the King's shilling, he could still be trenchant in his criticism of the military, to whit 'Among the chief causes of sickness and death in an army, the Reader will little expect that I should rank the hospitals themselves.' He recommended a complete reorganisation of the military hospital system where soldiers were cared for by the regimental surgeon who would be 'best acquainted with the constitution and disposition of their patients', would enjoy a better staff-patient ratio and better accommodation: he recommends granaries and churches. However it was important that regimental hospitals should not be clustered together to reduce the risk of disease spreading between hospitals.

General hospitals were larger and admitted patients too sick to move. They were under the care of a physician who would also visit the regimental hospitals. He warns, the wards must be as open and airy as possible and 'to admit so few patients into each ward, that a person unacquainted with the danger of bad air, might imagine there was room to take double the number.'

Having noted the high death rate among the wounded being carried to hospitals sited many miles from the battlefield, Pringle proposed to Dalrymple that an agreement be forged with the French commander to declare hospitals on both sides 'non-combat' zones so they could be situated closer to the front line; the Duke of Noilles agreed to the proposal. This advance presaged the Geneva Accords by 200 years. Unfortunately the arrangements collapsed with the change of military leaders and with Pringle's retirement.

John Pringle published the great work upon which his fame rests in 1752. He was physician to George III, received the Royal Society's Copley medal for papers on sepsis and anti-sepsis (Pringle's neologism) and was elected President of the Royal Society (1772).

Sir John Pringle died in London in1782, and such was his fame that he was buried in Westminster Abbey.

*This article is based upon material presented at the 2016 Cowlishaw Symposium and extracts are from the third edition of Pringle's book held in the Cowlishaw Collection.*

*A facsimile copy of the first edition is available online.*

Opposite Image: Sir John Pringle. Oil painting.



Campbell Miles
FRACS




694 Of Monsters and Prodigies. Lib.25.

The figure of the Chameleon.

Africa produceth the Chameleon, yet is it more frequent in India: hee is in shape and greatness like a Lizard, but that his legs are straight and higher, his sides are joined to the belly as in fish, and his back stand's up after the same manner, his nose stand's out not much unlike a swine's, his tail is long, and endeth sharp, and hee fould's it up in a round, like a serpent, his nails are crooked, his pace slow like as the Tortoise, his bodie rough, hee never shut's his eies, neither doth hee look about by the mooving of the apple, but by the turning of the whole eie. The nature of his color is verie wonderful, for hee changeth it now and then in his eies and tail, and whole bodie beside; and hee alwaies assimilate's that which hee is next to, unless it bee red or white. His skin is verie thin, and his bodie clear; therefore the one of these two, either the color of the neighbouring things in so great subtilitie of his clear skin, easily thine's as in a glass; or elf various humors diverly stirred up in him, according to the varietie of his affections, represent divers colors in his skin, as a Turkie-cock doth in those fleshie excrescences under his throat, and upon his head: hee is pale when hee is dead. Mathiolus write's that the right eie taken from a living Chameleon take's away the white spots which are about the thornie coat of the eie; his bodie being beaten, and mixed with Goat's milk, and rubbed upon anie part, fetcheth off hairs; his gall difcuffeth the Cataracts of the eie.

CHAP. XVIII.

*Chameleon*
*The Workes of Ambroise Paré (1649)*

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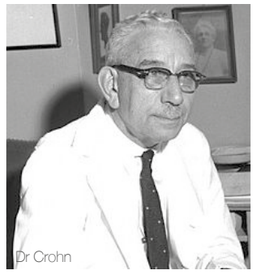
# A Visit with Dr Crohn (1884-1983)


Dr Crohn

In 1962, having recently completed my surgical Fellowship at the Royal Melbourne Hospital, senior colleagues suggested that I approach my Chief, Bill Hughes (later Sir Edward) to help me obtain a registrar post WITH Bryan Brook in Birmingham UK. Brooke at this time was Reader (senior lecturer in surgery). Brooke was regarded in the UK as the developer of the ileostomy for ulcerative colitis (CUC). I later trained with Rupert Turnbull, regarded in the USA as its developer.

Six months after joining Brooke, he was appointed Professor of Surgery at St. Georges Hospital in London. At the time (1963) I obtained a Resident Surgical Officer (RSO) role at St. Marks, where I was invited by the renowned hospital pathologist Basil Morson to undertake studies into the outcome of patients with malignant colonic polyps treated by local excision. After 6 months at St. Marks I re-joined Brooke as a registrar at St. Georges, and was able to continue my research at St. Marks. I then moved to the Cleveland Clinic (CCH) in Ohio USA in early 1964 to work under Rupert Turnbull.

That year at the tripartite meeting of UK, US and Australian colorectal surgeons in Philadelphia USA, I was given leave from CCH to present the paper on malignant colonic polyps. Bryan Broke introduced me to Dr Burrill Crohn who was attending the meeting. On talking with him, I found that he was a keen traveller and hoped to visit Australia with his wife, Rose. He was extremely friendly, suggesting I call on him at his holiday home in New England if I passed that way, as I had been considering a camping trip in that area.

As I finished at CCH, my wife, our two year old daughter and I had time for the camping tour of New England that Autumn. Finding ourselves in New Milford, I remembered his kind offer, and with trepidation I telephoned. Dr Crohn insisted we call in as he and his wife were alone and lonely and would love some company, even from an Australian Trainee and his family. We were greeted most enthusiastically, commanded to pitch our tent on their lawn, and to stay for dinner and breakfast. During this stay plans for a visit to Australia were formulated.

Dr Crohn's wish to visit Australia was enthusiastically endorsed by both Melbourne and Sydney specialists. This led to a combined meeting in 1965 in Canberra, which involved gastroenterologists, surgeons and pathologists. Dr Crohn would make the key note contribution.

He spent a few days prior to the meeting in Melbourne where he was lionised by the Jewish community, later to survive a car ride with us, requesting a visit to a 'sheep ranch' on the way to Canberra.

The meeting was regarded as a great success as it enabled clinicians to more easily differentiate and improve the specificity of treatment of inflammatory bowel disease in Australia. At this time, even before I left St. Marks, I was aware that Basil Morson and Lyn Lockhart Mummery, (who did not attend our local meeting), were working hard at differentiating CUC from Crohn's Disease. The features they defined were just being recognised in Australians, emphasising CUC to affect the colon, and its inflammatory character, led to possible fistula formation within the abdomen. It sometimes caused the formation of severe anal fistulae, in the pathology of which, giant cells were noted by Morson as a diagnostic feature.

Dr Crohn's 80th birthday occurred at the time of the Philadelphia tripartite meeting and therefore his subsequent 85th, 90th and 95th birthdays always occurred close to these meetings which I always attended. There was always an invitation to stay with Dr Crohn and his wife in Upper Manhattan or Connecticut which I was always happy to accept. In 1982, then visiting the USA for the American College of Surgeons meeting, I was travelling with a younger CCH trained Vascular surgeon, Charles Flanc. The Crohns were delighted to accommodate him, and Rose asked us to return the following year to celebrate Dr Crohn's 100th birthday. We were aware at that visit that Dr Crohn was suffering progressive dementia, as he sat all day with a book of Civil war history in his lap, never turning a page. Sadly he passed away soon after we left.

Dr Burrill Crohn was a softly spoken gentleman who had a great friendship with Bryan Brooke. He and his charming wife Rose were wonderful hosts and entertaining company. On one visit Rose took me to the later doomed Trade Centre, and, on a day when the National Art Gallery was closed, she had the Impressionists gallery re-opened for us to visit. She was a Governor of the gallery. Dr Crohn was said to be a painter, though we never saw him in action, but he gave me a water colour which I gave to the Royal Australasian College of Surgeons (pictured, above) along with a painting of Bryan Brooke.

Dr Crohn was quoted as not wishing to have the condition bearing his name, as various stories abound on the basis that his name was used in the 1932 paper as 'first author' on an alphabetical basis. Dr Crohn preferred the term 'Regional Ileitis'. Others, including Lord Moynihan, had described the condition decades earlier, and many were involved at Mount Sinai Hospital in New York, where Crohn did most of his work. The hospital and its location has a large Jewish population and the condition seems to have an increased incidence in the Jewish community. The condition had previously tended to be regarded as a form of tuberculosis (TB) creating an inflammatory mass in the right lower abdomen, but bacteriology and TB therapy had obviously been unsuccessful.

The reaction in some circles could be reflected in a tale current at the time: on traveling and visiting a London operating theatre, an American surgeon was asked to introduce himself. He said "I am Al from New York". The operating surgeon host responded with "Al who?" to which he replied "You've heard of Crohn, Ginzburg and Oppenheimer et al – well I am Al".

Tony Carden
FRACS FRCS FACS

# Donations to the Library Collection

**A Life in Two Lands: The autobiography of a surgeon/forensic pathologist by Timothy David Koelmeyer, FRACS.**

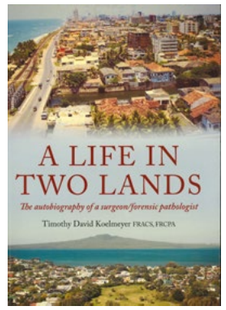
It is a privilege to review the autobiography of retired Associate Professor Timothy Koelmeyer FRACS FRCPA, University of Auckland, a chronicle of interest to contrasting audiences.

In this memoir he documents his unique accomplishment of qualifying as a general surgeon and forensic pathologist, having completed his medical schooling in the former British colony of Ceylon, and subsequently completing his dual specialty training in 1970's New Zealand. Koelmeyer was born into a Ceylonese family of Dutch heritage, and as his story depicts so well, his is a journey marred by ethnic discrimination and the subsequent challenge of having to start life with his wife in the Land of the Long White Cloud as a newly married pioneering couple with only $25 in hand. His anecdotes are colourful and personalities depicted are larger than life.

One gathers Koelmeyer is blessed with intellect, ability, charisma, theatrical style, tempered by the compassionate and humanistic wit of the true teacher.

His philosophy of teaching, which I experienced first hand was based on understanding the normal structure and function of the body and disease as a disorder of this, and not blindly memorising lists. This enabled us to gain an early mastery of our life's work as well as a distinct advantage when preparing for future specialist exams, and remains a scaffolding for conducting our professional lives.

Dyslexia was his gift and gave him a unique perspective into the natural world. His "Holmes"- like deductive powers are demonstrated by the potpourri of forensic vignettes featured and make for an almost fiction-novel-like read.




It is worth noting that his aptly titled "Breakfast club" of interactive teaching in the autopsy theatre (eloquently captured in the book's appendix written by Jonathon Koea), was formed by renegade students, who over the decades, formed a kinship that espoused the virtues of bedside teaching and learning using one's senses and understanding, in a time when didactic teaching and regurgitation for exams and 'superficial learning' was encouraged.

This was balanced with a study of the lives of our medical forefathers, making their morals, character and stories come alive.

He thus lit in us all a passion for history and cultivated in us the right qualities of heart and mind and perspective a prerequisite for a lifetime of fulfilling and successful practice.

His former students constitute the medical fabric of both New Zealand and Australia and remain some of the most highly respected practitioners in their fields.

Not surprisingly, he inspired many leaders in surgery and a former RACS President. We owe him the fulfillment we are privileged to enjoy in our daily careers. Sadly these cannot be given by or purchased from an institution but only learned from a great teacher.

His memoirs chronicled here are familiar to us and flood us with fond memories of a time in the white, cold space of the mortuary, when the great teacher affectionately called us impressionable 'turkey chicks' that have now fledged into his proud 'soaring eagles'.

*Donation and Review by Dinesh Ratnapala FRACS*
*Staff specialist general surgeon*
*Cairns Hospital, Queensland, Australia.*

*This book is now available at the RACS Library.*








Image:
RACS Vice President Cathy Ferguson receiving award from Past President Mr Phil Truskett AM.

# Congratulations!

## Dr Catherine Ferguson: Award of The Sir Louis Barnett Medal

Cathy Ferguson became a Fellow of our College in 1991. She is not just a well-respected surgeon in her specialty, Otolaryngology, Head and Neck Surgery – she was recently the President of the New Zealand Society of Otolaryngology, Head and Neck Surgery – but also is admired across both countries for her contribution to surgery generally. She has held a variety of leadership roles, including NZ Censor, Chair of the NZ National Board and Deputy Chair of the Peri-operative Mortality Review committee. She is now RACS Vice President.

If that was not enough, she was also one of only 2 surgeons on our College's Expert Advisory Group on Discrimination, Bullying and Sexual Harassment. She continues to advocate for cultural change within our College, and serves as an excellent role model for many aspiring surgeons of both genders.

Admired for her diligence, calmness, common sense, commitment and attention to detail, she has made - and continues to make - substantial input into many levels of governance and leadership within our College.

It gives me great personal pleasure to provide this citation for a very well deserving recipient of the Sir Louis Barnett Medal.

*Citation kindly provided by Mr Richard Lander FRACS*

*Sir Louis Barnett was responsible for the original proposals in 1920 to create a New Zealand and Australian association of surgeons which would be modelled on the American College of Surgeons and bestow a "hallmark" of surgical excellence. The Sir Louis Barnett Medal is awarded for outstanding contributions to education, training and advancement in surgery.*

**Academic gown donation**

RACS would like to acknowledge **Associate Professor John Gurry FRACS** for generously donating his academic gown.

RACS maintains a small reserve of academic gowns for use by Convocating Fellows and at graduation ceremonies at the College. If you have an academic gown taking up space in your wardrobe and it is superfluous to your requirements, RACS would be pleased to receive it to add to our reserve. We will acknowledge your donations and place your name on the gown if you approve.

If you would like to donate your gown to RACS, please contact the Conference and Events Department on +61 3 9249 1248. Alternatively you could mail the gown to Ms Ally Chen c/o Conferences and Events Department, Royal Australasian College of Surgeons, 250-290 Spring St, EAST MELBOURNE, VIC 3002

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:

**Peter Kenneth John Gerard (NSW)**

**Chong Yew Khoo (Singapore)**

**Gordon James Ormandy (SA)**

### Informing RACS

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
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# In Memoriam

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

### Rodney Elston Dalziel

**Orthopaedic Surgeon**

1947- 2017

Rodney Elston Dalziel was born in Perth to parents Ken and May Dalziel in 1947. He completed his education as a young man at Strathmore High school in Victoria. At a young age he was clearly a gifted student and athlete.

From 1965 - 1970 Rod attended University of Melbourne Medical School, where he continued his academic brilliance and achieved honours in every subject in every year.

He did his junior resident years at Royal Melbourne hospital and in 1972 where, as the Plastic Surgery resident met his future wife Marie Burger, a 5th year medical student (while they were sewing up a leg in casualty.) They were married in 1977.

He found his way to orthopaedic training were he predictably excelled and subsequently did post fellowship training at Vanderbilt University Medical Centre, Nashville Tennessee in 1979, and The Brigham & Women's Hospital, Boston in 1980. He became superbly trained in the modern arthroscopic treatment of sport injuries and the rapidly evolving field of hip and knee arthroplasty.

### John Stanislaus Roarty OAM

**Orthopaedic Surgeon and Pioneer of hip replacement surgery**

18 April 1924 - 23 August 2017

Dr John Roarty is regarded as one of the pre-eminent orthopaedic surgeons, and a pioneer of hip replacement surgery, in Australia. He devoted his life to his profession, and with a gentle tenacity, in his characteristically unassuming way, rose to the top of his field.

Born on April 18, 1924, to Winifred and Stanislaus Roarty in Bellevue Hill, Sydney, John was the eldest of four children. He completed high school at St Aloysius College in Kirribilli and entered the Faculty of Medicine at Sydney University at the age of 17. He graduated in 1947, joining the staff at Lewisham Hospital as a resident medical officer, initially as an intern and then as the orthopaedic registrar before becoming medical superintendent in 1950.

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