SurgicalNews

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ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

FOUNDATION FOR SURGERY

Pledge-a-Procedure and support our younger Fellows

SURGICAL SOCIETIES

Plastic surgeons focus on patient safety

RURAL SURGERY

The truth about working in a rural setting

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Cover and above: Dr Pecky De Silva, Vascular Surgeon and Younger Fellow

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Let's talk about surgical fees

Surgical fees are a much talked about issue. The media regularly writes articles about patients complaining about the fees they get charged by surgeons. The word 'excessive' comes up quite frequently and it is an issue that we must address.

So why do people think surgeons charge excessive fees? Is it because we actually do charge high fees? Is it that we don't explain our charges clearly? Is it because we as a profession need to do more to educate the public?

While the vast majority of surgeons do the right thing and charge fair and reasonable fees, we've heard of reports of a small number of surgeons charging extremely high fees for surgical procedures

While the vast majority of surgeons do the right thing and charge fair and reasonable fees, we've heard of reports of a small number of surgeons charging extremely high fees for surgical procedures. We've also heard that some patients have been advised to undergo certain procedures when other surgeons have advised that the proposed treatment may be unlikely to result in patient benefit. It has been suggested that some patients are sometimes placed in a position where they find (often too late) that the recommended procedure will involve very large out-of-pocket expenses. Patients are in a vulnerable position and rely on us, as surgeons, to help them understand what needs to be done and to help them get to a point where they can make a clear, objective and informed decision.

RACS' position on the subject of charging excessive fees has always been unequivocal that charging extortionate fees is exploitative and unethical. Furthermore, such high costs bear little if any relationship to utilisation of skills, time or resources. The RACS Code of Conduct (ref. 8.1) recommends that the surgeon ensures the fee is reasonable and does not exploit a patient's need. It is a breach of the Code to take financial advantage of a patient.

Interestingly, many of the complaints we receive are about non-life threatening procedures where the patient could have sought a second opinion if they felt the fees were high. We also know of many surgeons who will go as far as referring a patient to another clinician when the best procedure for the patient is not within their scope of practice. This level of professionalism is admirable.

We must be open and honest with our patients at all times. Full disclosure and transparency is essential. We are required to seek informed consent regarding the operative procedure and informed financial agreement prior to any surgery. After reviewing a number of excessive fees complaints RACS is working on its position papers on such consent and we recognise that there is work to be done with our Fellows to ensure that this is clearly understood.

The surgeon-patient relationship is critical to the quality of patient care, safety and outcomes. Surgeons must pay attention to all aspects of this relationship and be aware of laws, regulations and guidelines relevant to their field of practice. Patients are entitled to feel that their surgeon listens to them, respects their autonomy and treats them with dignity.

There is another side to this—consumer literacy, and in particular health literacy. RACS can play a role in educating consumers about their rights when it comes to surgery. If we don't do this someone else will. In fact others such as *Choice* and the media have taken on this role. We need to remind patients that they have the right to ask questions and get all the information they need to make an informed decision about their health. We also need to work with consumers to make sure that the information and services we provide are easy to understand, use and act on. We can also support consumers to speak up about information and services that they find difficult to understand.

RACS has developed a number of resources that provide more information to members of the public such as fees for surgery; consumer rights; informed consent; reporting potentially excessive fees, and information about surgical procedures. You can find these on our website.

Mr John Batten
President

Support our younger surgeons and the future of surgical care

One of the great pleasures of my role as Vice President over the last year has been the formal role it has enabled with the Board of the Foundation for Surgery, the philanthropic arm of RACS. I am a long-term supporter of the Foundation for Surgery and am constantly inspired by the positive impacts its activities have had in our communities. Most of all, I am very proud that surgeons have not only achieved so much within their own careers, but have also proven to be great philanthropists in supporting the Foundation for Surgery and its important work.

In today's world, the Foundation for Surgery is needed more than ever to meet the increasing and changing health needs of communities. The Foundation for Surgery is striving to ensure quality surgical care in the areas of global health and Aboriginal, Torres Strait Islander and Māori Health, as well as supporting ground breaking research and training to improve quality surgical care for all.

As many of you know, over the past 37 years the Foundation for Surgery has helped fund some of the most exciting training and research conducted in Australia and New Zealand. Thanks to your support, thousands of people have benefitted from these activities.

There are, however, significant challenges ahead.

Did you know that more than 1,000 active Fellows are approaching retirement? Therefore, we urgently need to support our younger surgeons to be upskilled to fulfil these service delivery gaps.

We need skilled, experienced surgeons to:

- meet the changing health needs and the increasingly complex issues of patients
- strengthen evidence based surgical practice and leadership
- bring critical overseas technological advancements home, so they are available when our patients, communities and families need them most.

Providing travel grant opportunities to exceptional younger Fellows will enable them to go overseas and learn new skills to meet current and emerging surgical needs in our community. Travel grants are a significant stepping stone from being a Trainee to being an experienced surgeon and even an expert in a sub-specialty. This helps ensure we have an agile, educated and efficient Fellowship, meeting tomorrow's health challenges.

Young surgeons are now also graduating with greater pressures and debt than ever before. Working and training overseas incurs even more debt, but at this time in their careers, it is critical that financial constraints do not prevent them from gaining the valuable experience that an overseas fellowship can offer.

Younger Fellows Forum, 2017

Foundation for Surgery
Passion. Skill. Legacy.

YOUR DONATION MATCHED X 2
See pages 8-9

I ask you to work with me to help establish these important travel grants for younger Fellows.
I encourage you to **Pledge-a-Procedure** - that is, make a tax deductible donation of the proceeds from just one of your most common major operations before 30 June 2018. If you are not a practising surgeon, giving a one-off donation will make a tangible difference.

Unlike other charities, 100 per cent of all donations assist in addressing critical surgical need and your support achieves its maximum impact in the community. All costs for administering the Foundation for Surgery are provided for by RACS, so that every dollar of your precious donation can go where it is needed most.

Donating is very simple
Please go to www.surgeons.org/foundation/ to donate and get an immediate tax receipt or complete and return the flysheet form attached to this edition of *Surgical News*. This simple act will have an enormous impact on the future of surgical care and our younger surgeons.

Alternatively, if you would like to make **a more substantial personal contribution or even establish your own scholarship**, please contact Jessica Redwood, Manager, Foundation for Surgery, on +61 3 9249 1110.

Let's work together, support the future of surgical care and support our younger surgeons.

Dr Cathy Ferguson
Vice President

Support younger Fellows

IMAGE: Dr Pecky De Silva, Vascular Surgeon and Younger Fellow

The Foundation for Surgery is this year supporting the career aspirations, development and further specialist training of younger Fellows through its annual Pledge-a-Procedure fundraising campaign.

The philanthropic arm of the College, with your help, this year aims to raise funds to support younger Fellows who wish to travel to further their training, undertake research, develop leadership skills or attend meetings.

Younger Fellows are those who are developing their careers within the first ten years of becoming a surgeon and obtaining their FRACS.

All funds raised will be managed by the Foundation for Surgery, with grants administered by the RACS Younger Fellows Committee.

Currently, the Committee relies on industry funding, support which is not always available and never guaranteed.

The Chair of the Committee, Dr Andrew MacCormick, said the aim of the campaign was to raise a sufficient corpus of funds to allow the Committee to use only the interest earned to fund the grants. He said this could create a continuous funding stream which would allow all younger Fellows to know which grants were available each year while also reducing the need to go 'cap-in-hand' seeking funding every year.

Dr MacCormick is a General, Upper GI and Bariatric Surgeon attached to the University of Auckland and the Middlemore Hospital.

"Many younger Fellows are very keen to develop their surgical careers through on-going education, sub-specialist training, research or the development of leadership skills but they need support to take up such opportunities," he said.

"At the moment, we have to find the money each year to fund only a small grant and sometimes we can't even do that.

"We would love to raise sufficient funds to allow us to provide an ongoing grant, or maybe two, to support more younger Fellows in their career aspirations for the benefit of patients, our specialities and the profession of surgery.

"It is fantastic for younger Fellows to have the support of the Foundation for Surgery and for our career development to be considered a priority through the Pledge-a-Procedure campaign."

Dr MacCormick is well positioned to know the value of such grants. Last year he was awarded the 2017 Younger Fellows RACS Leadership Exchange Scholarship which funded his travel to the Association of Academic Surgeons (AAS)/Society of University Surgeons Conference in the United States.

One of the largest meetings of its kind in the world, Dr MacCormick described the academic conference as having a staggering breadth unmatched by anything available in New Zealand or Australia.

While there he attended plenary sessions which addressed professional leadership, organisational leadership, mentorship and conflict resolution.

"This was an exceptional opportunity to engage with the leadership of the AAS and to be exposed to some high-level thinking about surgical leadership," he said.

"It is my hope that the Foundation for Surgery's fundraising campaign this year might allow us to support more surgeons to attend such meetings not only to learn from leading thinkers and clinicians but to create international networks with other young surgeons."

The Deputy Chair of the Younger Fellows Committee, Dr Pecky De Silva, said that last year 20 Fellows had applied for the two grants on offer which illustrated the gap between demand and funding.

She said the Committee selected funding recipients based on their participation in professional organisations, particularly within RACS, a clear plan of what they hoped to achieve and confirmation of acceptance to training courses or international meetings. She said that because the available funding pool was so small and erratic, recipients were also chosen who hadn't received funding from other sources.

Dr De Silva is a Vascular Surgeon who works out of the Sydney Adventist Hospital, the Dalcross Adventist Hospital and the Hornsby Ku-ring-gai Hospital

During her training she spent a year each at the National University Hospital in Singapore and the Royal Infirmary in Edinburgh.

"There is a public perception that all surgeons are wealthy but that is not true of many younger Fellows who are often paying off their university debt, setting up their own practice and supporting a family," she said.

"This makes it extremely difficult for some younger Fellows to take up opportunities as they arise.

"In Singapore, younger Fellows who wish to expand their skills by working and learning at leading international centres are paid their current salary while they are away, so they can work at the best medical institutions in the world for free.

"They are then able to bring all those skills back to benefit the health system and people of Singapore.

"All we are asking for, is to have enough money to establish a corpus of funds to support the career aspirations of younger Fellows through an going small travel grant, for the benefit of the broader community.

"The Younger Fellows Committee is grateful for the support of the Foundation for Surgery and their acknowledgement that by helping younger Fellows we help the entire surgical profession."

One of Australia's leading cardiothoracic surgeons, Professor Julian Smith, enthusiastically endorsed the Foundation's fund-raising ambitions. Now the head of Monash University's Department of Surgery and the Head of the Cardiothoracic Surgery Department at Monash Health, Professor Smith received two travel scholarships as a younger Fellow.

In 1992 he spent a year and a half at Stanford University in the US on a Cardiothoracic Fellowship in transplantation and in 1994, received funding support to work for a year at the Papworth Hospital in Cambridge, UK, working at the cutting edge of artificial heart technology.

Upon his return to Australia, those experiences and the training provided allowed him to:

- develop and introduce the Heartport system of minimally invasive cardiac surgery;
- participate in the early experience of bridging to cardiac transplantation with a novel left ventricular assist device; and
- pioneer the use of high frequency ultrasound as an energy source for the surgical management of atrial fibrillation in Australia.

Professor Smith urges Fellows to support this fundraising campaign. "These grants allow younger Fellows or Trainees to gain valuable experience in their surgical discipline at international centres of excellence or other centres in Australia and New Zealand, experience that can only benefit broader society," he said.

"The support I received from RACS allowed me to bring new technologies back to Australia and later, my involvement in medical student teaching and cardiothoracic training provided the opportunity to transfer my knowledge to the direct benefit of the medical profession.

"I would encourage all younger Fellows to spend time overseas or interstate yet there can be considerable financial pressure associated with taking up such opportunities which underscores the importance of funding support."

This year a generous Foundation for Surgery supporter, the Bongiorno National Network, has stepped forward and boldly pledged to match every dollar you give to this Pledge-a-Procedure Young Fellows Campaign.

This means your gift will be doubled and will have an even greater impact on young Fellows, like Pecky and Andrew.

Karen Murphy
Surgical News Journalist

YOUR DONATION MATCHED X 2

Foundation for Surgery
Passion. Skill. Legacy.

Every dollar you give before 30 June will be matched by a generous Foundation for Surgery supporter, the Bongiorno National Network,

doubling

your gift's impact.

The Foundation for Surgery and Younger Fellows Committee needs to raise at least $66,000 to ensure an ongoing travel grant, held in perpetuity, that offers the opportunity to outstanding young Fellows each year to go overseas and learn new skills to meet current and emerging surgical needs of our community.

Help a colleague, a younger Fellow like Andrew and Pecky, and be part of the establishment of this critical travel grant.

Please Pledge-a-Procedure—that is, make a tax deductible donation of the proceeds from just one of your most common major operations before 30 June 2018. If you are not a practising surgeon, giving a one-off donation will make a tangible difference.

Donating is very simple: please go to www.surgeons.org/foundation/ to donate and get an immediate tax receipt or complete and return the flysheet form attached to this edition of Surgical News. This simple act will have an enormous impact on the future of surgical care and our younger surgeons.

Let's together, support the future of surgical care and support our younger surgeons.

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Thanks to the Bongiorno National Network for matching gifts up to $66,000 until 30 June 2018

The truth about working in a rural setting

It's not hard to imagine what kinds of challenges those working in surgery in a rural setting are confronted with, especially if you've only ever worked in a metropolitan area. *Surgical News* was interested in finding out more about these challenges, to gain a clear perspective of the rural setting and what it takes to stay. Dr Christina Steffen, Senior Staff Specialist, Vascular & General Surgery, at the Cairns & Hinterland Hospital and Health Service was kind enough to volunteer her thoughts and experiences.

Have you always lived or worked in a rural setting?

No, I was born in Sydney, and lived there till age 38. After finishing surgical training in 1990 I did two and a half post-fellowship years in Sydney, as Senior Registrar at Lidcombe Hospital, and then Senior Registrar in Vascular Surgery at Concord Hospital. This was followed by 18 months overseas at Derriford Hospital in Plymouth UK, which is where I was inspired to pursue more rural/regional opportunities. Derriford was very busy. I gained excellent experience and worked with some very good consultant surgeons and enthusiastic junior staff. The hospital was situated in beautiful countryside and offered an outreach program to local hospitals. I really enjoyed the experience of working for smaller communities and being so close to nature. My last six months there were as a locum consultant surgeon in vascular surgery. I was very much encouraged to stay on, but returned to Australia as there were no opportunities for a career for my husband.

Dr Roxanne Wu, also from Sydney and who had set up practice in Cairns, had approached me prior to my stint overseas, regarding working in Cairns (one day), so when I was due to come back I explored more regional posts and was lucky that a number of positions were advertised in Australia, including in New South Wales and in Cairns, Queensland, the latter being the one I accepted. I started working at Cairns Base Hospital as Staff Surgeon in 1994, and then as Director of Surgery from 1999-2009. I've been working as Senior Staff Specialist, Vascular & General Surgery since 2010.

Is there any advice you can provide to an aspiring young female surgeon, or a surgeon working in a rural setting?

For any surgeon contemplating a regional or rural practice I recommend spending a few years in post-fellowship posts where you can gain more broad-based experience as well as expertise in a specific area, prior to commencing practice in a rural setting. Having several years of solid post-fellowship experience in senior registrar positions consolidates experience and skills and optimises confidence.

A combination of specific post-fellowship training in a tertiary centre, plus a post-fellowship year in a regional hospital, in Australia or overseas, is ideal. Keep up these connections to other surgical units and visit them from time to time to update skills, learn new ones, and experience other surgeons' practices.

IMAGE: Outreach operating at Innisfail Hospital, laparoscopic cholecystectomy ready to go.

Having a network of peers and senior colleagues with whom one can discuss and compare approaches to clinical problems, or any other issue affecting one's practice is very important as rural/regional practice can be isolating. I am very grateful for the support I have received over the years from many of my senior colleagues.

Coming into rural practice with this kind of background is a lot less stressful as you bring with you fresh expertise, greatly appreciated by colleagues (usually). Having said this, a newcomer coming into an established regional set-up can experience problems of small-town parochialism. How to avoid this? Working as a registrar or locum in the centre beforehand is very helpful, and enlisting the support of more senior established colleagues is critical. Even with the best intentions there will always be some unpleasant incidents and issues to overcome, because of the stressful nature of the job, however diplomacy, tact, and maintaining the focus on your reason for being there i.e. the welfare of your patients will (eventually) overcome most problems of this kind.

For all surgeons of any gender, moving to a rural setting involves the family so it is crucial that partners and children are likewise motivated. In my case, my husband was able to make the move as he had effectively ended his career as an engineer, and even though we left behind our house in Sydney that we had just completed, he wanted me to make the most of my career. As it turns out, he went on to carve out a very successful new career in Cairns for himself as a builder in industrial real estate.

My last piece of advice for female surgeons – if you would like to have children, don't put it off for fear of missing out in your career. There is always a way to manage both!

What have been your greatest struggles as a woman in surgery?

Firstly, there is a struggle to create a persona of a competent female surgeon. I was by nature rather introverted, not particularly assertive and a follower or bystander wherever possible. I tend to procrastinate, as well. In fact I chose surgery so as to address these aspects of my character which I saw as shortcomings. I am pleased to say that during surgical training and the career that followed I did become much more assertive, pro-active and a leader, and procrastination became prioritisation.

There are struggles related to gender bias – for example, concerns were raised by male surgeons at the effect my being a trainee might have on my marriage. I ignored them and got on with the job. The best way to overcome doubts is to perform the job well.

There are also struggles on a personal relationship level – managing two careers, planning for the future, being separated for long periods of training. I was fortunate to have a partner who has always been absolutely steadfast in his support and encouragement. Word of advice - choose your partner well!

The most difficult struggles have been professional ones - being passed over for deserved promotions, and having to fight for them, standing up for colleagues who have been bullied and "mobbed", and as a result, boycotted by a number of anaesthetists in the hospital. I could not operate there for twelve months until the matter was resolved by the Industrial Commission. These kinds of struggles I would not wish on anyone.

If they do occur, be prepared - make sure you have legal support, peer support and a network of supportive family and friends.

I have been involved in many struggles. I have had to stand my ground against considerable opposition in the name of fairness and natural justice, and I am proud of this.

Did you always aspire to being a surgeon when you went to university – were there any obstacles to your pathway to surgery?

I originally started Medicine at Sydney University in 1972. I did one year, passed quite well and then left to do an Arts degree, majoring in French and English, graduating in 1977 with 1st Class Honours in French. I was intending to continue along this career path but I also regretted not having continued my medical degree and was somewhat torn between the two until finally, with encouragement from my future husband Werner Steffen, whom I met at this time, I decided to return to medicine and resumed medical studies in 1977. I had a lot of exemptions so added German 1B, giving me a good grounding in this language, a great benefit when we spend time in Germany.

IMAGE: Winter cane harvest season at Babinda, south of Cairns.

I did not consider surgery as a career when at University, although it was my favourite clinical subject. Actually, I didn't even think about what career path to follow after graduation, nor did I feel any need to decide. I remember one fellow student whose avowed aspiration throughout university was to be a cardio-thoracic surgeon. He ended up excelling as a geriatrician.

My first six months as an intern consisted of three months in Orthopaedics and three months in Professorial Surgery. By the time I had my interview for my second year all I had done was surgery, which I had enjoyed, so I applied for more of it. I realised that I had aptitude for surgery both intellectually and in terms of manual dexterity. There were no real obstacles. I did my primary exam at the end of my second year, then two years as a non-accredited registrar, eventually moving to Concord Hospital as there were more vacant training positions coming up there for the following year. I was well supported by my referees and became an advanced trainee in 1986. For no particularly reason I was convinced I'd failed the Part 2 FRACS exam, so much so that I'd successfully convinced my husband. We were both so happy when I passed that he came and enjoyed the sherry as well.

What do you enjoy the most about working in a rural setting?

There are so many great things about working in a rural setting. There are opportunities to make real improvements in outcomes through introducing new techniques, clinical management pathways and to create multidisciplinary teams. For example, in 1996 my colleague Sharon O'Rourke, a public health physician, and I established the High Risk Foot Service for the management of diabetic foot disease. This is a major health issue in our population, with over representation of those of indigenous background, and this initiative has certainly helped improve the outcomes in this group. ▶

Clinical work is extremely interesting with varied and often involves very unusual pathology. I am working in a tropical area, seeing unusual infections such as Mycobacterium ulcerans, melioidosis, tuberculosis, necrotising fasciitis, and even the occasional case of leprosy; challenging trauma such as bull goring, horse-kick trauma and crocodile bites, not to mention extreme cases of gall bladder disease, neglected skin cancers and diabetic feet.

In a rural setting having expertise in many different areas of surgery adds greatly to one's usefulness and effectiveness as well as job satisfaction. There are also plenty of opportunities to teach, do clinical research (although a research officer attached to the surgical department would certainly be a plus!) and to be a mentor.

In a rural setting having expertise in many different areas of surgery adds greatly to one's usefulness and effectiveness as well as job satisfaction. There are also plenty of opportunities to teach, do clinical research (although a research officer attached to the surgical department would certainly be a plus!) and to be a mentor.

There is a greater sense of community in a smaller centre, and a connection to the land that is absent in the city. There is much less traffic and no overcrowding. I drive each day to work 22km past the cane fields against the backdrop of the Atherton tableland – it is glorious.

It has been a great place to bring up my son who is now 22. He received an excellent primary and secondary school education here in Cairns, and has just completed his degree in Aeronautical Engineering at the University of Sydney, in minimum time.

When I arrived in Cairns in 1994 I expanded an existing limited Outreach program to one servicing the whole drainage area of Cape York, the Torres Strait and the region around Cairns south to Cardwell. Surgeons now visit to do clinics and operate in Thursday Island, Cooktown, Weipa, Atherton, Mareeba, Innisfail and Mossman. The ability to visit small centres and connect with local communities and hospitals is certainly a highlight.

Having these opportunities in this setting have been pivotal in the recognition I have received in the latter part of my career, the University of Sydney Alumni Award in 2013 and Member, Order of Australia in 2015 for the surgical outreach program and my clinical research on mycobacterium ulcerans infections and diabetic foot disease.

How do you feel about the RACS Bullying and Respect and Improving Patient Safety (BRIPS) initiative?

I see it as a very positive move and step forward that these issues are recognised, brought into the foreground and formal steps are being taken to address them. Making the courses mandatory has been a very good decision. I think there is a lack of self-awareness on the part of many surgeons (male and female) as to the effect their behaviour has on other people. The program holds up the mirror and hopefully will lead to behaviour modifications which benefit everyone in the workplace. Providing support to those who speak out and managing complaints with impartiality is essential.

Ensuring our focus is on doing our work to a high standard, which includes behaving appropriately in the workplace is the best way to achieve a high standard of patient safety.

What could the Government do to improve surgery and health services in a rural setting?

There is a maldistribution of the surgical workforce between the large metropolitan centres and the country, particularly noticeable in the subspecialties. What can the government do?

- Determine what surgical workforce is needed in regional and rural (and remote) areas, taking into account demographic factors, burden of disease, and economic and geographical factors, in consultation with local health providers;
- Ensure that additional funded training positions are established in the subspecialty units that do exist in regional centres.
- Post-fellowship positions in regional centres for new Fellows considering working in a rural setting; and
- Consider further incentives for relocation, and possibly disincentives to remaining in marginally viable metropolitan practices.

Looking back, is there anything you would have done differently?

I would have loved to have had more children. I have one son and a step-son. I was 42 when I had my son, and my husband was 60, so somewhat of a risk, which however in retrospect, we both would have taken on. But we have been very fortunate.

Apart from that, there are plenty of parallel universes in which I have presumably followed a different course from the one taken, but in the end this is the universe I'm in.

Dr Christina Steffen
FRACS

Interviewed by Gabrielle Forman, Communications and Policy Officer, RACS.

What's it really like being an IMG?

Surgical News posed this question to the Chair of the Tasmanian Regional Committee, Dr Girish Pande who began his career in Australia as an International Medical Graduate (IMG) in 2005

Where (country and institution) did you graduate overseas?

I got my MBBS from the Jawaharlal Institute of Post Graduate Medical Education and Research (JIPMER), Pondicherry, India. Later I got my Post Graduate Degree in Surgery from the All India Institute of Medical Sciences (AIIMS) New Delhi, India.

What was your motivation for studying and working in Australia?

I attended a lecture by world renowned transplant surgeon Professor Russell Strong when he visited AIIMS in India. On interacting with him I was quite impressed with his knowledge and skill as well as his personality. Liver surgery and liver transplantation were emerging surgeries at that time and I asked him if I could be trained under him. He kindly agreed and helped me get a fellowship in Advanced Hepatobiliary Surgery and Liver Transplantation at the Princess Alexandra Hospital in Brisbane. It changed my life, but I did not have my family with me at that time. I went back to India and started doing liver surgery and liver transplantation there. About 10 years later there was an opportunity to work in Tasmania. I thought my children who were in school at the time might benefit from spending some time in Australia and this would widen their horizons. I therefore moved to Tasmania with a plan to stay for only two or three years.

Did you bring family with you to Australia? If yes, how did your family manage the transition from your home country to Australia?

Yes, when we moved to Tasmania my wife and two sons joined me. The children were very well accepted into the Scotch Oakburn School in Launceston. My biggest worry was that they may not be able to transition well into the new curriculum and school. But the school was very proactive in helping them settle and they soon made good friends and settled in. So much so, that the children were not keen to go back. Later I found out that the main motivation for them to stay here was that there were no exams till Grade 10, while in India they had exams every week!

My wife found it very cold and spent the first year in front of the lounge room heater. She was an ophthalmologist by profession in India. However she had to re-do her training in Australia. She went through the Australian Medical Association pathway and finally graduated in Psychiatry after 10 more years of study.

Why did you choose to settle in Tasmania?

We moved to Tasmania because the first job offer was in Launceston. With time I found that Tasmania is one of the most beautiful places in the world without the hustle and bustle of big cities. Having lived in Delhi for more than twenty years I felt it was time to have some peace and quiet.

What did you find were your greatest challenges as an International Medical Graduate, and how did you overcome those challenges?

The greatest challenge when I moved to Australia was getting used to its systems and developing a rapport with colleagues and patients. When I moved to Launceston the saga of Dr. Patel in Queensland was at its peak and having a surname starting with P didn't help. I overcame this problem by being patient and developing a good rapport with my patients and colleagues. I made a point of spending a lot of time explaining to my patients what I was going to do and discussing the pros and cons of surgery, so that they could develop confidence in me. Similarly I presented my results to my colleagues and informed them of my results. I also sought their advice when I was in doubt. But most of all I kept my cool and listened more than I spoke. One of the challenges I have not been able to overcome is my accent. Sometimes when I call patients they think I am a telemarketer from India. I am still working on this problem.

When did you receive your FRACS? What is your speciality and why?

I received my FRACS in 2007. My speciality is Hepatobiliary and Upper GI Surgery. I was trained in HPB surgery in Brisbane and also had an interest in Upper GI Surgery, so I persisted with both.

Did you receive support, guidance and mentoring throughout your studies with the College?

RACS provides many opportunities to receive help and guidance. I attended all possible courses and also offered to teach some of them. I attended all of the annual conferences, spoke to the leaders in the field and always asked for help. I was never refused help. Through these meetings I was able to observe other surgeons operate and learn new techniques. RACS is very active in promoting a culture of learning and I found that very helpful.

Have you ever regretted your decision to move to Australia?

No, but having seen other parts of the world I realise that people here are very lucky. Sometimes I wish they could see how difficult things are for people in many other countries. I have decided that after retirement I will spend my time and skills helping people in developing countries like many other surgeons in Australia do regularly. RACS also promotes interaction with other countries so I would like to take that further.

If you could pass on some words of advice to our current IMGs what would you say?

The most important word is 'persevere'. There will be occasions when you feel challenged. To overcome these stresses it is important to have a few good friends and mentors. RACS has a mentoring programme where you can also get help. Most importantly, try to develop a good rapport with people who are kind, sympathetic and have a positive attitude to life at your place of work - they will be your support when you feel down.

Where do you currently work, and what is your title?

You will find me at the Launceston General Hospital working as a senior staff specialist.

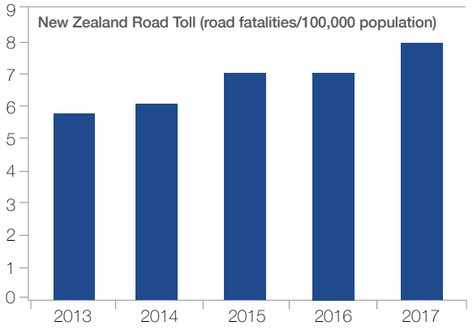
Outside of work and your role as Chair of the TAS Regional Committee, what do you enjoy doing? (hobbies, pets, travel?)

I love gardening and travel, although I am actually still yet to see many other places in Tasmania!

Interviewed by Gabrielle Forman, Communications and Policy Officer, RACS.

A review of the trauma system in New Zealand

Long term trends in road fatalities indicate that road travel has become safer over the last 30 years. Specifically, in New Zealand, the road toll fell from 747 fatalities in 1985 to 319 in 2015.[1] This follows international trends and improvements in road safety and trauma care delivery in the second half of the 20th century. However, as the graph below illustrates, the trend in the reduction in road trauma fatalities in our nations has declined and appears to be reversing. For New Zealand the number of road fatalities has increased annually, between 2013 to 2017 and so far the road toll in 2018 looks set to be even higher.[2]



New Zealand has committed to the United Nations Decade of Road Safety Action 2010-2020 Strategy, which outlines five pillars of road safety strategy. To date, New Zealand's road safety strategy has mostly focused on the first four pillars. In recognition of the fifth pillar (post-impact care), the New Zealand Transport Authority, in partnership with New Zealand's Major Trauma National Clinical Network (featured in April *Surgical News*), invited RACS to coordinate a project through the Australasian Trauma Verification Program, to review and provide recommendations for the New Zealand trauma system. The review encompassed the entire trauma patient journey from injury to rehabilitation and all levels and aspects of care provided by the trauma system.

The RACS Australasian Trauma Verification Program is a benchmarking process that assists hospitals to improve their standard of care for trauma patients. A multi-disciplinary team incorporating surgeons, intensivists, emergency physicians, anaesthetists and specialist trauma nurses reviews a trauma service against Australian and New Zealand standards. A comprehensive report is produced identifying strengths and weaknesses of the trauma service, and provides recommendations for potential further improvement. Studies conducted in the United States have shown trauma verification driven changes can reduce trauma mortality, length of hospital stay and expenditure.[3,4]

Under the direction of the RACS Australasian Trauma Verification Subcommittee, 39 hospitals across Australia and New Zealand have been reviewed and 58 consultations or formal site visits have been conducted since the program started in 2000.

However, verifying trauma centres in general can only go so far towards improving trauma patient outcomes. By reviewing entire trauma systems, inadequacies in the network of health facilities, ranging from the designated major trauma hospital to the smaller regional hospitals, pre-hospital care providers, inter-hospital transfer arrangements and outreach education programs can be identified and targeted for improvement. Professor Zsolt J Balogh has been a supporter of shifting the focus of the verification program from individual trauma centres to trauma systems since 2011 and is now leading a RACS subcommittee to continue the evolution in this direction.[5]

Although regional reviews of trauma systems are common in the US, few trauma system reviews have been performed outside the US. The Australasian Trauma Verification Program undertook a review of the Northern Territory trauma system in 2004 and the New Zealand Midland Region in 2017. The review of the New Zealand Trauma System is the first time a whole country has been put under the trauma verification microscope. Not only is it a first for RACS, but it is believed to be the first trauma verification review of a country to be undertaken worldwide.

Professor Ian Civil, Clinical Leader of the Major Trauma National Clinical Network, welcomed the review noting that independent, evidence-based assessments of provision of clinical care had the potential to deliver step-change improvements. He noted that the willingness of trauma prevention and injury care agencies in New Zealand to contribute to this review is a sign that New Zealand is ready to step up and address issues where it has been identified that it can do better.

RACS Trauma Verification
BENCHMARKING TRAUMA CARE

Over many months, the Trauma Verification Committee worked closely with key representatives from the New Zealand Transport Authority and Major Trauma National Clinical Network to prepare for this review. Selected team members (see below) were charged with reviewing key aspects of the New Zealand trauma system within the context of the overall national strategy.

Anyone involved with the management and care of patients injured in New Zealand was invited to make a submission to the review. Under the leadership of Associate Professor Arthas Flabouris, trauma experts spent a week in November 2017 reviewing the journey of injured patients from injury scene to recovery and the governance of the trauma system that served them. They met with senior staff from the New Zealand Ministry of Health, the Accident Compensation Corporation, the New Zealand Transport Agency, clinicians from acute adult and paediatric hospitals, pre-hospital care providers, rehabilitation specialists and patients who had sustained major trauma. They visited representatives of all services relevant to optimal trauma care at Wellington Hospital, Auckland City, Starship Children's Hospital, Christchurch and Dunedin Hospitals, ambulance centres, and aeromedical bases.

Site Review Team

- A/Prof Arthas Flabouris, FCICM, FANZCA, Intensivist, Royal Adelaide Hospital, School of Medicine, University of Adelaide (Team Leader)
- Ms Maxine Burrell, RN, State Trauma Programme Manager, Royal Perth Hospital
- A/Prof Mark Elcock, PSM, FACEM, FRCEM, Executive Director, Aeromedical Retrieval and Disaster Management Branch, Queensland Department of Health, College of Public Health, Medical and Vet Sciences, James Cook University
- Dr Ailene Fitzgerald – FRACS, Director of Trauma, Canberra Hospital
- Prof Mark Fitzgerald - FACEM, AFRACMA, Director of Trauma, Alfred Hospital, Director, National Trauma Research Institute
- Dr Anthony Joseph, FACEM, Director of Trauma, Royal North Shore Hospital
- Ms Rosalind Wendt – Royal Australasian College of Surgeons Trauma Verification Program Coordinator

A comprehensive report was prepared for the New Zealand Transport Authority and recommendations made to assist key trauma system agencies and trauma clinical leads to build upon, and enhance, their existing achievements with respect to the future care of trauma patients throughout New Zealand. Ideally, if implemented, the changes to trauma management will further optimise the care of the injured in New Zealand and may address some aspects of the alarming figures on road traffic fatalities.

The Australasian Trauma Verification Program would encourage leading trauma clinicians and trauma stakeholders from other regions, to follow New Zealand's example and consider the potential benefits of a whole of trauma system review.

The Trauma Verification Program is inviting surgeons interested in trauma, emergency physicians, intensivists and anaesthetists to join verification teams. The reviews encourage an exchange of ideas and appreciation for solutions to shared challenges. A hospital review involves two days on site, and contributing to the drafting of the final report. Benefits to the reviewer include the opportunity to see how another hospital manages trauma patients, participation in a bi-national trauma quality improvement process and working with trauma clinicians from a range of other disciplines. Surgeons are eligible for 14 CPD points and recognised professional development by other colleges will be supported. To get involved, or for further information, contact Karen Coates, RACS Trauma Verification Project Officer (trauma.verification@surgeons.org).

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Professor Zsolt Balogh
Chair, Trauma Verification Sub-committee

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
AUSTRALIA AND NEW ZEALAND · THE COLLEGE OF INTENSIVE CARE MEDICINE OF
AUSTRALASIAN TRAUMA SOCIETY (inc)
AUSTRALASIAN COLLEGE FOR EMERGENCY MEDICINE
ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Senior surgeons section

With 1,614 members, the Senior Surgeons Section is the largest of the RACS Sections. Established in 2008 (as the Senior Surgeons Group) to represent the interests of older surgeons, it has evolved over subsequent years to position itself more centrally in relation to all RACS activities. The Section aims to assist all surgeons to navigate the territory of ageing and retirement, and offer the knowledge and experience of senior surgeons in areas such as education, mentoring, policy, governance and more.

The Section is pleased to promote its recently revised Position Paper: Senior Surgeons in Active Practice, intended to provide guidance and advice to surgeons in their last ten years of practice. The paper discusses the effects that ageing may have on surgical performance and how surgeons can manage these to ensure continued patient safety. All surgeons are encouraged to take care of their own health via regular check-ups and to seek appropriate support for workplace, emotional and personal matters, issues which become more critical with age. The paper also looks at CPD and locums in the context of ageing, and at the reduction of and eventual withdrawal from active practice. We hope that all surgeons will make use of this resource.

The Senior Surgeons Section convenes a multidisciplinary program every year at the Annual Scientific Congress, in collaboration with other Sections. Its 2018 visitors are Mr Fred Leditschke, former Deputy Chair of the Section, and Dr Leona Wilson, Executive Director of Professional Affairs and former President of the Australia New Zealand College of Anaesthetists (ANZCA). They will be 'Reflecting on what really matters' in Australian and New Zealand contexts respectively. The program will focus on drivers for the best professional, personal and patient centred practice in surgery.

The Section has previously run "Building Towards Retirement" workshops which aim to equip surgeons with the personal, financial and legal know-how to plan for retirement. Workshops are now run on an as-needs basis, and surgeons should contact their Regional Committee if they would like a workshop held in their state. Resources on retirement are also being progressively added to the Surgical Career Transitions project on the RACS website.

Section membership is open to all RACS Fellows, Trainees and IMGs – you don't have to be a senior to benefit from the accumulated wisdom of this group. Membership was formerly automatic upon reaching the age of 60; however it is now by application. New members are very welcome. For more information or if you would like to join email snr.surgeons@surgeons.org.

Professor Rob Pearce
Chair, Senior Surgeons Section

with Janet Devlin, Administrative Officer, Fellowship Services

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

Vala Afshar

Ryan Mathew, a neurosurgeon, is helping to develop the virtual reality goggles. Pic: ANDREW MCCAREN/THE TIMES

‘Warm-up’ using VR goggles to help you work faster

Surgeons could soon have the ability to ‘warm up’ prior to surgery using pre-op simulation, thanks to virtual reality goggles that transmit holograms of a patient’s body that can be overlaid on top of the real thing in theatre. Doctors could therefore perform life-saving surgeries faster and cut operating times by six per cent. The technology has been developed by a team of researchers in the UK that found that surgeons progressively 'warm-up' as they repeat a specific procedure on their operating list throughout the day, and that medical professionals get progressively faster carrying out common procedures, which were repeated several times during a day. The team hopes that this will help the surgical team to plan and visualise the processes involved in the procedure they are about to carry out well before the first incision.

https://www.thetimes.co.uk/article/warm-up-using-vr-goggles-to-help-surgeons-work-faster-t9w62llxs

Image: C/- Star2.com

Study shows link between low vitamin D levels and severity of forearm fractures in children

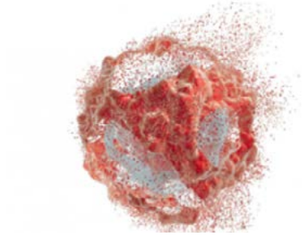
Children are fearless, they run and jump without a care for whether they’ll fall – until a break occurs, and according to a new study presented at the 2018 Annual Meeting of the American Academy of Orthopaedic Surgeons (AAOS), that break is most likely to be the forearm. The study, the first of its kind to show the link between low vitamin D levels and fractures in children caused by falling off a bike or falling while running, suggests that the forearm is the most common site of injury, accounting for approximately 25 per cent of all paediatric fractures in the U.S, with some estimates as high as 50 per cent of boys and 40 per cent of girls having at least one fracture by age 18. Researchers reported that children who are vitamin D deficient have a greater risk of having more severe forearm fractures requiring surgical treatment, and that 49 per cent of those analysed in the study had vitamin D insufficiency.

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

Synaptiv Modus V

The same robotic arm technology used by NASA to deploy, capture and repair satellites in space is being used by neurosurgeons to perform brain surgery in the US. The Brain Tumor Centre at Northwell Health’s Neuroscience Institute, NY says that the Modus V, a fully-automated, robotic digital microscope enables neurosurgeons to perform delicate brain surgery with much more precision, potentially allowing for less-invasive procedures that lead to quicker recovery times and reduced complications. With increased surgical efficiency through hands-free control, better ergonomics during brain surgery and greater versatility for a wide variety of neurosurgical procedures, including brain tumours, cerebrovascular conditions and disorders of the spine, this technology has the potential to make brain surgery as safe and as effective as possible.

https://www.medgadget.com/2017/10/modus-v-high-powered-robotic-neurosurgical-microscope-unveiled-synaptive.html



Cancer: How a novel gel could halt its return

A gel that not only helps to prevent tumour recurrence at the primary site, but also eliminates secondary tumours in the lungs, is being trialled by the Dana-Farber Cancer Institute, US. The biodegradable gel was originally created to deliver immunotherapy directly to the area from which a cancerous tumour has been surgically removed, but was found to have additional and more long lasting benefits. For cancer that forms as solid tumours — such as breast cancer and lung cancer — surgical removal of the tumour is often the primary treatment option. The introduction of this gel however could revolutionise the way cancer is treated and have a great impact on patient confidence.

https://www.medicalnewstoday.com/articles/321307.php

Dr John Corboy A Trainee legend

From the operating room to the communities we live in, surgeons have to possess excellent leadership skills. It is a key attribute required to deliver quality health care for the patients that we serve. Mental fortitude, altruism and integrity are all characteristic features underpinning excellent leadership. No one epitomized these qualities better then John Corboy.

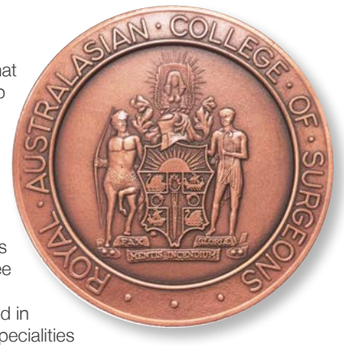
John Corboy was someone who cherished humility, modesty and selflessness. He led by example and his values were inspirational.

John Corboy was an accomplished man. Brought up on a farm in Te Awamutu, New Zealand, John completed his schooling at Sacred Heart College, Auckland and attended Medical School at the University of Otago. In 1998, four years after graduating from Medical School, John was diagnosed with leukemia. Despite this he fought through all adversity to become a Fellow of the Royal New Zealand College of General Practitioners. He gained a Diploma in Aviation Medicine and one of his many significant achievements was his work on laser tattoo removal in South Auckland.

Although battling ill health he continued to pursue his dream of becoming a surgeon. In 2006 he became an advanced Trainee in Surgery. John Corboy was popular with Trainees and was elected to be the RACSTA Trainee representative the same year. Sadly however, his health deteriorated again and it was confirmed he had myelodysplasia. He developed graft vs host disease following a bone marrow transplant and passed away in December 2007, just before his son’s first birthday.

John Corboy was admired for his humility and determination. He is remembered by his peers for his kindness, his unique sense of humour and passion for surgery.

One of his legacies includes the John Corboy Medal. This distinguished award for surgical Trainees commemorates Dr John Corboy’s achievements and recognises exceptional service by Trainees. The John Corboy Medal may be awarded annually to a Trainee who demonstrates the characteristics for which John was admired. These include outstanding leadership, tenacity and selfless service to Trainees of RACS. Nominees must be Trainees of RACS and a Fellow or Trainee may nominate a candidate for the award. As this is a unique award that recognises RACS Trainees, the presentation is made at the Annual Scientific Congress (ASC).



I strongly believe that although leadership comes in many different forms - all Trainees can aspire to perform to the standards set by John. Strong leadership is required at a Trainee level and it is a key component required in order for surgical specialities to thrive at the forefront of medicine and importantly maintain autonomy in the delivery of health care.

I would like to take the opportunity to express my congratulations to Dr Kim Aikins, Paediatric Surgery Trainee, on being awarded this prestigious medal in 2018.

Nominations for the 2019 John Corboy Medal close 31 August 2018. Contact the RACSTA Executive Officer racsta@surgeons.org for more information.

2018 – Kimberly Aikins
2017 – Genevieve Gibbons
2016 – Grant Fraser-Kirk
2014 – Gregory O'Grady
2013 – Ruth Blackham
2011 – Brandon Adams
2010 – Matthew Peters

RACSTA
Your Trainees' Association

Dr Suheelan Kulasegaran
General Surgery (NZ)
Trainee Representative

“Back pain surgery” doesn’t exist, but do not refuse to fuse

Never before has back pain been so widely discussed, and its management so hotly contested. Social media platforms like Twitter, Facebook, Instagram, and commercial television programs lately are all buzzing about the ‘boring’ topic of Chronic Low Back Pain. Even the Pain Medicine Faculty of the Australian and New Zealand College of Anaesthetists (ANZCA) “advised doctors not to refer patients with mechanical or axial low back pain for spinal surgery”, as quoted in the *Australian* newspaper (14 Febuary 2018).

I read with interest the article on page 48 of March 2018 *Surgical News*, about stem cell research and how the 9.4 Tesla MRI can demonstrate blood vessels and nerve fibres growing in degenerate and compromised lumbar discs… and how this may be the cause of chronic low back pain. The article made no link between the obvious disconnect between imaging features of degeneration and the manifestation of back pain symptoms.

Also, of interest was *The Lancet* Back Pain series in March 2018, publishing a more than doubling of DALYs (Disability-Adjusted Life Years) from Low Back Pain between 1990 and 2015, which followed on from the World Health Organisation’s Musculoskeletal Fact Sheet (February 2018), announcing that Low Back Pain is the single leading cause of disability globally and is not a condition restricted to old age.

Therefore, I wish to express a basic concept widely understood in every other field of medicine but poorly applied in the specialty of musculoskeletal pain and particularly spine region pain. The ubiquitous use of the term “Low Back Pain” and “Low Back Pain Surgery” is itself a problem and reflects a lack of understanding into the cause of back pain symptoms. News Flash: “Low Back Pain” is not a disease, it is a symptom.

Any article that I read that describes the management of “Low Back Pain” and uses this term interchangeably as a disease is indicative of significant misinterpretation of the true problem and reflective of the global prevalence of back pain symptoms.

To any spinal surgeon who might think they can cure low back pain symptoms with spinal stabilisation surgery (fusion or disc replacement), think again. Don’t stop reading here in disgust because, contrary to mainstream media’s objection to spine surgery for low back pain symptoms I know that many surgeries for back pain symptoms are deemed successful by patients and surgeons alike – otherwise we would not offer them to our patients.

But what if our “successful” surgery is merely an association and not causation of the favourable outcome. Have you wondered why just as many “back pain” surgeries also fail?

If we conceptualise ‘disease’ versus ‘symptoms’ we can apply a unifying theory that unravels the complexity of low back pain management, to assure success from our associated spinal fusion surgery “all the time” after all how can low back pain symptoms be effectively cured without first assigning causation to this condition. Imagine trying to treat headache, fever and rigor symptoms in Papua New Guinea without understanding the most common and prevalent cause being Malaria. Like wise we need a “malaria” diagnosis for “back pain”. Surely a disease of ultimate prevalence and disability as the World Health Organisation states, is not a result of multiple etiologies. Occam’s Principle teaches us this along side common sense and logic.

What if the disease causing back pain symptoms is Movement Dysfunction? It could drive spondylosis into spondylitis and pain free disc degeneration into painful discitis, and normal facet arthropathy into stenosing facet arthritis. Movement Dysfunction could drive central sensitisation, and maladaptive behaviours, further entrenching pain cycling, disability and compromising mental health.

Surgery is frequently considered to treat the structural break down in spinal integrity which theoretically is a consequence of Movement Dysfunction. Our researchers postulate that in the future, stem cells may be implanted to reduce the anguish associated with surgery, but even this new, exciting likely expensive technology will fail us and our back pain suffering patients if we continue to address only the symptomatic disc degeneration and ignore the causation - knowing full well that many discs are structural “train wrecks” with zero pain symptoms.

Physical therapists are the first to admit the failings of their expertise to effectively address back pain symptoms. Mostly for the same, but still unrecognised reasons. Improving someone’s core strength, administering gym based exercise or months of Pilates does nothing to improve a patient's movement quality, even if they are following the prescription to move more. Patients just become stronger at moving poorly and continue on with their back pain symptoms, leaving physiotherapists and GP’s mystified with nothing else to offer but to recommend seeing the spinal surgeon.

As spinal orthopaedic and neurosurgeons, we need to protect and defend the imperative skilful art and huge association benefits of spinal stabilisation surgery which is currently under unjustified threat by numerous misguided commentaries.

First, we all must agree that our surgery does not cure back pain symptoms. No more so than oxygen curing pneumonia. It does not cure “back pain” because “back pain” is not a disease. When surgery “works” for back pain symptoms the thing that cured our patients was the fact that we gave them the opportunity to effectively address the root cause disease of Movement Dysfunction and once again move proficiently.

Patients with low back pain, whether they have surgery or not, require specific and distinctive movement therapy to reverse the disease that unifies the simple, but perceived complex puzzling symptoms of low back pain.

Movement Proficiency Enabling Surgery should be on our business cards and office windows if we are surgeons working with patients suffering back pain symptoms because although “back pain” surgery does not exist, Movement Proficiency Enabling Surgery is very real and works tremendously in conjunction with distinctive Functional Movement Therapy.

Don’t leave it to chance that your patients incorrectly get labelled after your perfect stabilisation surgery with Failed “Back Pain” Surgery Syndrome because if we agree that “Back Pain” surgery doesn’t exist – that label can’t possibly be correct. It is actually Failed Rehabilitation Syndrome, ignorance of addressing root causation and the omission of unique Functional Movement Therapy that failed. Not the non existent “Back Pain” Surgery.

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Dr David Johnson
FRACS (Neurosurgery)

Foundation for Surgery
Passion. Skill. Legacy.

RACS supports world-first burns research by WA Plastics Trainee

The Foundation for Surgery is supporting world-first research into the links between Non-Severe Burn Injury (NSBI) and cardiovascular disease now being conducted by Perth based Plastic and Reconstructive Surgery trainee Dr Emily Ryan.

Dr Ryan's unique research aims to understand the drivers behind the connection between NSBI and high rates of ischaemic heart disease, heart failure and cerebrovascular disease.

She has based her PhD research on the findings of an epidemiological study of Western Australian hospital records over 30 years which showed that patients with NSBI have increased hospital use for cardiovascular disease (CVD).

NSBI is defined as a burn that covers less that 15 per cent of total body surface area and less than eight per cent full thickness. Such injuries account for 80 per cent of the clinical case load in developed countries.

Dr Ryan said WA research had shown that patients who suffer burn injuries, including non-severe, have increased hospital use for cardiovascular disease for up to 30 years post injury with children being at higher risk of morbidity and mortality.

Dr Ryan said that while burns injuries elicited a multifactorial response, with acute inflammation necessary to drive healing, that same process could also cause immune dysfunction and metabolic changes which could both be possible causes for the increase in CVD.

She is now investigating the relationship between CVD and abnormalities observed in NSBI patients relating to endothelial function, platelet activation and the gut microbiome.

She began her research using murine models and has now begun clinical studies of both adults and paediatric patients who have suffered NSBI injuries.

"I set out to investigate the underlying mechanisms and mediators that increase the risk of CVD post NSBI to facilitate improved patient care to reduce long-term risks, save lives and reduce healthcare costs," she said.

"My study of NSBI showed significant hypertrophy of the interventricular septum and an increase in the left ventricular end diameter, similar to changes seen in heart failure," Dr Ryan said.

"We recruited 24 adults following NSBI for serial echocardiography and observed a significant increase in left ventricular diameter at three months post-injury compared to baseline.

"Platelet activation, seen in acute coronary syndrome, appears also to be a factor. Results of platelet flow cytometry in murine plasma showed significant activation of platelets in the NSBI group via the Collagen Receptor Pathway compared to controls.

"We know there are also links between the gut microbiome and CVD and in a paediatric cohort of 42 NSBI children and 42 controls, I found that plasma level of Proprionate, a short chain fatty acid involved in gut health and inflammation, was significantly higher in the NSBI group.

"We have known for some time that the gut microbiome is significantly altered in severe burns patients but now we know that those who have suffered from NSBI are also effected."

Dr Ryan said the link between NSBI and long-term cardiovascular morbidity was currently being further explored through randomised control trials in WA treating NSBI patients with probiotics and celecoxib, a selective COX-2 inhibitor.

She said the term 'non-severe burn injury' should be erased.

"The severity of burn injury is multi-factorial and should be decided on a case-by-case basis because the effects of such injuries can impact patients for decades," she said.

"We now believe it is likely that NSBI patients require modulation of the inflammatory/sympathetic nervous system response during the acute phase of burn injury to prevent long term systemic effects on distant organs.

"We now believe it is likely that NSBI patients require modulation of the inflammatory/sympathetic nervous system response during the acute phase of burn injury to prevent long term systemic effects on distant organs."

"The use of probiotics for these patients may also become routine while careful long-term monitoring of cardiovascular health by GPs may be recommended."

Dr Ryan is conducting her research at the Burn Injury Research Unit, University of Western Australia, the State Children's Burns Unit at the Princess Margaret Hospital, the Royal Perth and Fiona Stanley Hospitals and the Centre for Microscopy, Characterisation and Analysis also at the UWA.

She is working under the supervision of renowned burns surgeons Professor Fiona Wood and Professor Suzanne Rea, and Associate Professor Mark Fear.

Dr Ryan left Ireland in 2011 to take up a research Fellowship with Professor Wood to build on their work which had already established profound systemic effects upon bone composition, bone marrow mobilization and cutaneous innervation in animals and humans.

"Since burn patients do not present for many years after injury with CVD, it is only through analysing the WA population-linked datasets that the increased incidence of CVD could be observed," she said.

"This is an invaluable resource which has helped us to understand the long-term impact of burns injuries which in turn will help us devise and adapt treatment regimes to lower the risk of patients developing secondary pathologies."

Dr Ryan became a Plastic and Reconstructive Surgery Trainee in 2015 and received the MAIC-RACS Trauma Scholarship in 2017.

She said she believed herself to be the first WA Plastics and Reconstructive Surgery Trainee to be awarded a research scholarship by RACS.

"Receiving this scholarship was a defining moment for me because the peer review process validated my research and gave me the courage to defer my surgical training," she said.

"As the first plastics Trainee in WA to receive such a scholarship, I hope this will inspire others to engage in full time research."

The MAIC-RACS Trauma Scholarship was established via a grant from the Queensland Motor Accident Insurance Commission (MAIC) and matched by the Foundation for Surgery to fund research into trauma.

Proposed research funded through the scholarship may be in epidemiology, prevention, protection, rehabilitation or immediate or definitive management in trauma and while the research can be conducted anywhere in Australia, it must be shown that potential benefits will assist the people of Queensland.

Academic highlights

- 2018 - Emmett Prize for Scientific Research, awarded by the Australian and New Zealand Society of Plastic Surgeons
- 2017 – MAIC-RACS Trauma Scholarship
- 2011 – Ian Potter Research Scholarship, awarded by the Burn Injury Research Unit, UWA

Karen Murphy
Surgical News Journalist

Plastic surgeons focus on patient safety

Plastic surgeons in Australia and New Zealand have been working hard to promote patient safety on a number of fronts that range from highlighting the dangers of medical tourism to creating awareness about the importance of using qualified surgeons.

In recent years, two Australians have died following cosmetic procedures conducted by an untrained beautician and an overseas surgeon who offered little post-operative care.

The Australian Society of Plastic Surgeons (ASPS) recently met with Australian Federal Health Minister Greg Hunt, to advocate for national legislation to stop unqualified practitioners moving from one state jurisdiction to another to escape sanctions and to develop consistent laws to control standards of day procedure facilities.

State jurisdictional leaders and Professor Brendan Murphy, the Chief Medical Officer for the Australian Government, have all expressed support for the proposed legislation.

Also, of concern is the rise in medical tourism. Public advocacy will build on efforts to provide more information to prospective patients to allow them to make more informed decisions.

Such is the growing problem of people returning to Australia and New Zealand with complications from overseas surgery, that the New Zealand Association of Plastic Surgeons (NZAPS) is in the process of setting up a registry to track such patients referred for treatment to public plastic surgery units.

Plastic surgery leaders in both Australia and New Zealand are particularly determined to highlight the risks of patients developing deep vein thrombosis (DVT) during the flight home following overseas surgery.

President of the ASPS, Professor Mark Ashton (pictured left) is the Director of the newly-established Professorial Plastic Surgery Unit at the Epworth Freemasons Hospital and a Professor in the Department of Surgery, University of Melbourne.

He said that while the skills, standing and role of all FRACS was clearly understood within medical and government circles, the public was often left confused by those who misused the term ‘surgeon’.

“The public doesn’t fully understand who we are as FRACS in terms of our skills, our stringent training, our commitment to the highest ethical values, professionalism and care for our patients,” Professor Ashton said.

“This is particularly evident in the field of cosmetic procedures wherein people use the term ‘cosmetic surgeon’ to overstate their skills and training.

“Cosmetic and aesthetic surgery is a $1 billion industry in Australia now and the growing demand by patients for procedures encourages unethical behaviour that is putting their lives at risk.

“It is critical that the public understands that to become a qualified specialist Plastic Surgeon and Fellow of the College requires five years specialist training and then passing an exit exam which is one of the most difficult and rigorous in the world.

“We are aiming to create a campaign to educate the public about the training and skills of all surgeons in all specialties, so they are less likely to put their trust and their health into the hands of unethical or unqualified practitioners.

“Australasian surgeons are among the best trained surgeons in the world and we need to get that message out into the community,” he said.

He also wants a system established that would allow such patients to find out if the facility where the procedure is to be done is appropriately licenced and meets standards for infection control, sterilisation of equipment and drug integrity.

He said there was widespread knowledge within the specialty that many cosmetic procedures were being performed by overseas medical graduates without appropriate training or supervision, by GPs with limited surgical skills training and by beauticians.

> “It is mind-blowing what’s going on out there now. There are procedures being done without adequate sterilisation, there is sedation being given without the skills or supervision of an anaesthetist, there are patients being operated on in hotel rooms and sent home in taxis with no follow-up.

“It is mind-blowing what’s going on out there now,” Professor Ashton said.

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President of the New Zealand Association of Plastic Surgeons (NZAPS), Dr John Kenealy (pictured right), said that the New Zealand specialty group is looking to establish a registry to track the number of patients requiring treatment following overseas cosmetic surgery at the four public plastic units across the country.

“This has become such a common problem we have decided we need a better understanding of what is actually going on,” Mr Kenealy said.

“Our concerns are mainly for those patients who come to us with serious complications such as major wound necrosis and serious infections.

“This adds another strain on the public health system, yet we know that our registry will only capture details of patients receiving the care of Plastic and Reconstructive surgeons working in the public system.

“Many might get treated by general surgeons or surgeons working in private practice so the information we gather will be an underestimation of what we know to be a significant problem.”

Dr Kenealy said the public needs to understand not only the risks posed by having cosmetic procedures done by unqualified practitioners, they also need to understand the law.

“The public think that if a service is provided it is well regulated and that the system will protect them, but the law in New Zealand largely takes the position of buyer beware,” he said.

Karen Murphy
Surgical News Journalist

LET'S OPERATE WITH RESPECT

No bias here!

Individually each of us can be viewed as a *package*. Within the *package* resides your very own collection of social views, personal values, beliefs, life experiences, likes, dislikes, attributes, qualities, talents, knowledge and skills. In every *package* a pocket of *conscious bias* and a pocket of *unconscious bias* can be found - that's life.

Our professional obligations are twofold. Firstly, it is incumbent upon each of us to identify and eradicate our *conscious bias* in relation to any situation where it may unfairly impact or compromise the rights of others with whom we work or engage due to training responsibilities. Secondly, we should take the time to understand the often invisible nature of *unconscious bias* and the way in which it infiltrates our daily activities and decision making at work and in training environments. Ultimately resulting in tangible fallout, *unconscious bias* can influence judgements and shape behaviour.

Unconscious bias can also subtlety weave a web of disadvantage, courtesy of established policies, procedures and everyday practices on the ground. Be it language, indirect discrimination or cultural disadvantage, policies, procedures and everyday practices can fail organisations and the people they exist to support and ensure equivalency of opportunity.

Conscious bias

The following two real-life examples of *conscious bias* are explicit and overt:

1: "A proper marriage takes place in a church" [workplace comment made in 2017 by a supervisor about an employee; it was raised by the employee as part of a bullying complaint].

2: "Her accent makes her a less capable job candidate for the accounting role" [workplace comment made during a recruitment and selection process; it was raised with HR by a concerned recruitment panel member who deemed the position unfair and biased in 2018].

Both examples reflect personal views, preferences and beliefs. In reality a legal marriage can be performed anywhere; it's about the process and the qualified third party tasked with altering the domestic status of the betrothed, not the venue. As for the accent, it has no direct bearing on accounting skill and intellect. Comprehensive assessment of qualifications, experience and aptitude were the criterion necessary to determine merit based selection.

When examined in a forensic manner, personal biases (some of which we hold dear) can amount to a lack of impartiality, individual preferences, prejudice, preconceptions, predispositions, preconceived notions, pre-judgement, favouritism and bigotry. Often the result of a personal experience that's applied generically, individual likes/dislikes and comfort zones, stereotypical assumptions or behavioural conditioning, we have a clear responsibility to keep *conscious bias* in check in all professional situations.

Unconscious bias

Just like conscious bias, our unconscious bias can relate to age, gender, sexuality, ethnicity, marital or domestic status, family background, education, suburb of residence, medical history, criminal history, physical features, social origin and a range of other variables.

Unconscious bias is a process that unfairly favours one aspect above another. It is automatic in its flawed comparison resulting in negative consequences for some, and a leg-up for others.

Professionally and in our work and training environments, the way we identify with, organise, categorise and label situations and people, can feed our unconscious bias.

Say each of the following out loud. Consciously and honestly take stock of where your brain takes you and the images it summons … golfer, regional high school graduate, Holden driver, rugby union player, single mother, vegan, AFL player, Volvo driver, resident of government subsidised housing, prison officer, functioning alcoholic, owner of a holiday house in the south of France, father of seven children, person employed to do psychic readings, Rolex wearer, western suburbs resident, feminist, rower, greyhound breeder, chiropractor, vintage car collector, hotel chef, barrister…

It is important to recognise that unconscious bias can be incompatible with the conscious values and behaviours of a professional. Time pressure, decisions driven by organisational policy and procedures, or an expectation to act on inherent trust can trigger the unconscious bias of a credible well-seasoned professional deemed to be impartial and fair.

One particular example of *unconscious bias* that surfaces continually throughout our personal and professional lives is inherent trust. While it can provide us with a level of comfort and engenders faith in the human race, it can lead us down a range of garden paths to somewhat muddy swamps. Take the case where a person is from a well-respected family engaged in philanthropic activities and hence is automatically deemed appropriate for a non-executive director position on a not-for-profit board. Given the surname and a decade of profiled commercial experience, a level of inherent trust not extended in the same way to others who may have been interested and qualified, was automatically extended to the individual in question. A level of *conscious bias* then played a support role to the *unconscious bias*, when it was viewed as unreasonable, unnecessary and far from political to undertake any reference checks prior to the person's appointment. This decision lead to a level of regret and reflection on receipt of complaints from young male staff. Nothing like a few sexual harassment complaints to reboot thinking about fairness and equity.

Another example of *unconscious bias* associated with worthiness, importance and influence can be examined by way of comparative treatment. Take the scenario where some who arrive late to a meeting or training session are welcomed and given a brief summary of what has been covered, while others receive a transitory look from the very same chairperson or trainer, conveying a message of reprimand with no welcome or summary offered. The need to be astute to our messaging as professionals is paramount. Also of importance are those messages that we send unwittingly. In this case the chairperson and trainer relayed a range of bias permissions to others who were present.

Our pocket of unconscious bias may well align excellence in maths with ethnicity, and instability with single parenthood. Social status may well be aligned to a school, a car or a residential suburb. Positions on age and retirement, generational differences and gender roles can all impede the neutrality of professional assessment.

When talking about *unconscious bias* it is worth noting that 60 per cent of America's CEOs are said to be over 184 centimetres tall, yet less than 15 per cent of America's menfolk are over that height – do with that what you will, mindful that there are significant research findings more closer to home that evidence the more facially and physically attractive you are, the more likely you are to receive a bigger bonus or pay increase.

It is important to take the time to ask ourselves, and each other, about how we see people and how we perceive reality. It is worth challenging our own attitudes and those of our professional peers with regards to our automatic reactions towards certain people. It's informative to examine our behaviour, and that of colleagues, to monitor how receptive, friendly and caring we are. Reflecting upon which aspects of a person we pay the most attention to can be revealing. Evidence of active listening to what some people say compared to others can be enlightening. The way in which we draw comfort or feel 'at home' with certain people in particular situations can speak volumes.

Let us not forget the age-old primary school riddle - 'A man and his son were in a car accident. The man dies. His injured son arrives at hospital for surgery. The surgeon looks at the boy and says "*I can't operate on him as he is my son.*" Who is the surgeon?'

While some adults remain stumped, for years 'stepfather' has been offered up as an answer by children. The fact that the surgeon could be the boy's mother (or step mother) eventually gathered momentum in classrooms. Today same sex and transgender parents also feature in the offerings from primary schoolers. Indeed children are the future! While we await their entry to the professional world everyone benefits from a regular spring clean of those pockets of *conscious bias* and *unconscious bias.*

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

TECH CORNER

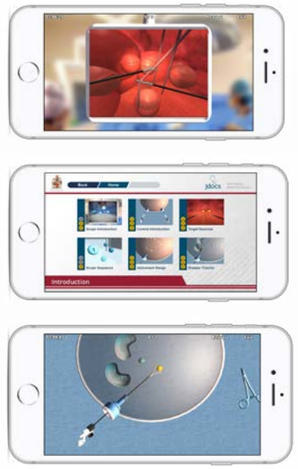
Minimally invasive surgery in the palm of your hand…

The next time you see someone glued to their mobile phone, they might not be texting, they may be extracting a specimen! That's right, with the use of the new RACS SimuSurg app, Trainees and Fellows can experience a virtual operative environment to refine their operating skills, from dissection to cutting and grasping.

The app, created by surgeons for surgeons simulates minimally invasive surgery, and is the only one of its kind in the world. It provides an engaging, fun and interactive way to perform surgical skills in a gaming environment.

Challenge yourself through four levels of surgical scenarios including simple movement exercises designed to familiarise you with the controls, to more complex tasks associated with using the various instruments.

So let's get started! Download the app today.



Survey finds better operating room culture good for patients

The culture and environment in which we work in the operating room is associated with better outcomes for the patients who pass through it, according to a paper referred to by Auckland City Hospital's Dr Ian Civil, FRACS in the latest issue of the Australia and New Zealand Journal of Surgery (ANZJS), RACS' peer-review publication.

Dr Civil says that a survey was adapted in New Zealand across all twenty hospitals and following the implementation of a New Zealand Safe Surgery programme which was rolled out across the country's hospitals and private practices in 2015, improvements have been shown on various levels.

With around 1,000 responders, the survey revealed a 20 per cent increase in team discussion and briefings, a 15 per cent increase in surgical planning and most who participated in the survey said that they would feel safe being treated in their hospital as a patient.

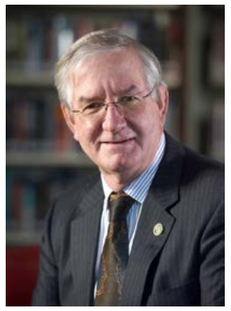
Results of the same survey across 31 hospitals and 1,793 respondents in South Carolina, US, reports that 30-day post-operative death rates were associated with staff perceptions of the safety of surgical practice. It seemed that for every positive statement associated with operating room culture, there was a considerable decrease in mortality.

"It's a good thing that culture has improved. It is a more pleasant environment if you are acknowledged and accepted and you feel you're able to speak openly, notwithstanding the importance of a mutually respectful workplace free from bullying and harassment, in light of RACS' Expert Advisory Group's recent findings on widespread discrimination, bullying and sexual harassment in the workplace, it now appears that the implications extend to patient outcomes," Dr Civil said.

The MORSim (Multidisciplinary Operating Room Simulation), a detailed, immersive, scenario based learning tool has also been implemented across the country's hospitals and private surgical providers. Each member of the team is given a brief about a patient they are about to care for. Each brief is slightly different and may not include vital information that another may find vitally important. Through discussion and investigation, transparency and clarity the team is better able to perform the procedure than without the tool, which clearly demonstrates that failure to share information can have a great effect on the success of a procedure.

"MORSim scenarios teach us that the willingness to cooperate and share information ultimately reflects in positive patient outcomes," Dr Civil said.

An insight into Vanuatu from our President's perspective



Vanuatu has a small population of just over 270,402, dispersed across 83 islands. According to the Ministry of Health's Health Sector Strategy 2017-2020, life expectancy in Vanuatu has increased and now stands at 69.6 and 72.7 years for males and females, respectively (VNSO, National Population and Housing Census, 2009).

People are living longer, but often with the burden of chronic illness and disability, e.g. stroke, amputation, blindness and mental illness.

The World Health Organisation's 2011 Non-Communicable Diseases STEPS Survey for Vanuatu showed that 19 per cent of the adult Ni-Vanuatu population were obese, 51 per cent overweight and obese and around 29 per cent had high blood pressure. High blood sugar levels are also increasingly common, but treatment for diabetes is often delayed until traditional remedies have failed and diabetic related amputations
are required.

Staffing shortages are seen as the major factor limiting the fair distribution of health services. Many public health facilities are understaffed, particularly in rural areas.

Specialist skills are increasingly needed e.g. midwives, nurse practitioners, health educators, foot care nurses, mental health nurses, surgical nurses and critical care nurses. Additionally, many health facilities do not have the right kinds of functional space and equipment needed for staff to provide the services required.

Surgical News spoke to RACS President Mr John Batten to get his perspective on the work RACS is doing in Vanuatu to help strengthen its healthcare system and provide much needed support.

What are the greatest challenges to providing support to Vanuatu?

"The challenges to providing support in Vanuatu are not about the capacity of the surgeons, but about the infantry of equipment available. Low resource settings mean that much of the infantry is non-existent, or donated; screws, plates, and other devices, but these are often incompatible with other equipment used so therefore deemed useless.

"We can provide specialist training, and I am now confident that existing surgeons are now capable of managing most orthopaedic conditions, but the lack of inventory means our capacity will always be limited.

"Our primary goal is to build capacity."

What types of orthopaedic conditions are most common in Vanuatu and why?

"The Clubfoot – Vanuatu has seven times the incidence of clubfoot than Australia."

The condition is an abnormality usually present at birth where the foot is twisted out of shape or position. The tissues connecting the muscles to the bone are shorter than usual. Clubfoot can be mild or severe, and about half of children with clubfoot have it in both feet. If the condition isn't treated early, the child will have difficulty walking.

"I have performed twenty-two operations of club feet while in Vanuatu, 19 children, between the ages of 6 months to five years."

According to the Mayo Clinic, The cause of clubfoot is unknown, but it may be a combination of genetics and environment. If either of the parents or their other children have had clubfoot, the baby is more likely to have it as well.

"We set up a *Ponseti Program*, a method of managing clubfoot that involves stretching and casting as opposed to surgery. It's the most common method of treatment in the world.

Left: RACS President John Batten, treating a child using the Ponseti Method.

"We ran a course for four years to train local doctors and physiotherapists in how to manage clubfoot without surgery. With the success of the treatments, we were able to confidently communicate that the condition was easily treatable, and combat the stigma that if a baby was born with clubfoot that the parents must have done something wrong.

Above: RACS President John Batten, operating

"Other eye openers are multiple septic fractures where the wounds were infected with pus. Over the course of three years we ran a series of workshops to train clinicians in the management of external fractures and eventually we saw a decline in this kind of surgery.

"Unfortunately, we see a delayed presentation of fractures. There are cultural issues in play that prevent patients from seeing anyone other than a traditional healer. There is a fear of western doctors to some degree because clinicians are not commonly available, so locals don't trust surgeons yet. When they finally present, their wounds have become complicated. Traditional healers aren't 'wrong', but it's about exposure, experience, and understanding value."

What changes have you experienced/observed over the years?

"It has been a privilege to see young doctors attached to the unit progressively move up through the program to get their qualifications in surgery and return as junior consultants, over a 10 year period. When we go back this year we'll see a consultant who was a young registrar when we started.

"One problem for the medical system in Vanuatu however is that if you're good you get promoted into the Health Ministry, which means you lose good clinicians to administrative jobs. We need to excite our junior doctors that treating people hands on is the most rewarding thing, but of course lifestyle is also important so they need to weigh up the differences."

How would you describe the relationship between yourself and national counterparts, and has this relationship changed over the years (i.e. teacher, mentor, peer?)

"Each year our national counterparts show us more and more that they've become our colleagues more than our students, so I have become very confident in their abilities. Unfortunately though, they tend to move clinicians to different islands, some more remote than others.

"It's great seeing them enthused to be treating, to work in our absence, emailing us and asking for advice the more they get used to us. But one of the most important things to remember is not to translate what you do here, to over there, because their needs and expectations are immensely different. If you tackle things that are likely to have a difficult outcome you will likely have a poor result. It's better to accept a degree of deformity than a long period of rehabilitation that has no guarantees.

"They are making decisions on their own now, which shows a great degree of trust. When we plan the next trip we will write to them asking what we should bring with us, like a wish list. For example, – the patient may have a bleed after a brain injury after falling out of a tree, which is quite common, but they have no burr hole equipment, so we have sourced a kit. We always try to find out what's most important and what they need training in. They often ask for inventory but we can't provide that, it would be endless. Access to sustainable inventory is the current challenge."

Where do you see the future of the Pacific Island Program (PIP), and the relationship between RACS Fellows and our colleagues in the Asia-Pacific?

"The Pacific Islands Program has been going for a significant period now, and it's making a difference. Things are improving. Their needs are still substantial, but without it these communities would be at a huge loss.

Interviewed by Gabrielle Forman, Communications and Policy Officer, RACS.

Courses for every stage of your career

Online registration form *is now available (login required).*

Inside 'Active Learning with Your Peers 2018' booklet are professional development activities enabling you to acquire new skills and knowledge and reflect on how to apply them in today's dynamic world.

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:

Foundation Skills for Surgical Educators Course: Mandatory for SET Surgical Supervisors, Surgeons in the clinical environment who teach or train SET trainees, IMG Clinical Assessors, Research supervisors, Education Board members, Board of Surgical Education and Training and Specialty Training Boards members.

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

Foundation Skills for Surgical Educators Course (FSSE)

19 May 2018	Sydney	NSW
19 May 2018	Melbourne	VIC
19 May 2018	Perth	WA
25 May 2018	Adelaide	SA
1 June 2018	Sydney	NSW
1 June 2018	Canberra	ACT
2 June 2018	Brisbane	QLD
2 June 2018	Melbourne	VIC
8 June 2018	Adelaide	SA
15 June 2018	Auckland	NZ
15 June 2018	Brisbane	QLD
16 June 2018	Sydney	NSW
16 June 2018	Perth	WA
25 June 2018	Sydney	NSW
25 June 2018	Auckland	NZ
30 June 2018	Brisbane	QLD
30 June 2018	Melbourne	VIC
8 July 2018	Sydney	NSW
20 July 2018	Brisbane	QLD
20 July 2018	Hobart	TAS
17 August 2018	Christchurch	NZ
25 August 2018	Brisbane	QLD
18 October 2018	Queenstown	NZ

FSSE 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 (OWR)

28 May 2018	Perth	WA

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

Safer Australian Surgical Teamwork (SAST)

2 June 2018	Melbourne	VIC
30 June 2018	Adelaide	SA
21 July 2018	Sydney	NSW
4 August 2018	Brisbane	QLD

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

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

Clinical Decision Making

22 June 2018	Auckland	NZ

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

Surgeons as Leaders in Everyday Practice

8 - 9 June 2018	Gold Coast	QLD
3 - 4 August 2018	Sydney	NSW
10 -11 August 2018	Canberra	ACT

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

SAT SET Course

26 May 2018	Melbourne	Vic

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

Keeping Trainees on Track

26 May 2018	Melbourne	Vic

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

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

Academy of Surgical Educators Studio Sessions

21 May 2018	Wellington	NZ
26 June 2018	Melbourne	VIC
25 July 2018	Brisbane	QLD
10 August 2018	Hobart	TAS

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

PROFESSIONAL DEVELOPMENT WORKSHOP DATES: May - August 2018

ACT		
Foundation Skills for Surgical Educators	1 June	Canberra
Surgeons as Leaders in Everyday Practice	10-11Aug	Canberra
NSW		
Foundation Skills for Surgical Educators	19 May	Sydney
Foundation Skills for Surgical Educators	1 June	Sydney
Foundation Skills for Surgical Educators	16 June	Sydney
Foundation Skills for Surgical Educators	25 June	Sydney
Foundation Skills for Surgical Educators	8 July	Sydney
Safer Australian Surgical Teamwork	21 July	Sydney
Surgeons as Leaders in Everyday Practice	3-4 Aug	Sydney
NZ		
Academy of Surgical Educators – Studio Sessions	21 May	Wellington
Foundation Skills for Surgical Educators	15 June	Auckland
Clinical Decision Making	22 June	Auckland
Foundation Skills for Surgical Educators	25 June	Auckland
Foundation Skills for Surgical Educators	17 Aug	Christchurch
QLD		
Foundation Skills for Surgical Educators	2 June	Brisbane
Surgeons as Leaders in Everyday Practice	8-9 June	Gold Coast
Foundation Skills for Surgical Educators	15 June	Brisbane
Foundation Skills for Surgical Educators	30 June	Brisbane
Foundation Skills for Surgical Educators	20 July	Brisbane
Academy of Surgical Educators – Studio Sessions	25 July	Brisbane
Safer Australian Surgical Teamwork	4 Aug	Brisbane
Foundation Skills for Surgical Educators	25 Aug	Brisbane
SA		
Foundation Skills for Surgical Educators	12 May	Adelaide
Foundation Skills for Surgical Educators	25 May	Adelaide
Foundation Skills for Surgical Educators	8 June	Adelaide
Safer Australian Surgical Teamwork (SAST)	30 June	Adelaide
VIC		
Foundation Skills for Surgical Educators	19 May	Melbourne
SAT SET Course	26 May	Melbourne
Keeping Trainees on Track	26 May	Melbourne
Safer Australian Surgical Teamwork (SAST)	2 June	Melbourne
Foundation Skills for Surgical Educators	2 June	Melbourne
Process Communication Model Seminar 1	22-24 June	Melbourne
Academy of Surgical Educators – Studio Sessions	26 June	Melbourne
Foundation Skills for Surgical Educators	30 June	Melbourne
WA		
Foundation Skills for Surgical Educators	19 May	Perth
Foundation Skills for Surgical Educators	16 June	Perth
TAS		
Foundation Skills for Surgical Educators	20 July	Hobart
Academy of Surgical Educators – Studio Sessions	10 Aug	Hobart

Register online

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

Skills training courses 2018

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

ASSET: Australian and New Zealand Surgical Skills Education and Training

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

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.

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.

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: JUNE - AUGUST 2018 | *Available Courses

ASSET	
Friday, 15 June – Saturday, 16 June	Brisbane
Friday, 15 June – Saturday, 16 June	Melbourne
Thursday, 5 July – Friday, 6 July	Adelaide
Friday, 27 July – Saturday, 28 July	Sydney
Thursday, 9 August – Friday, 10 August	Perth
Friday, 10 August – Saturday, 11 August	Wellington
Friday, 17 August – Saturday, 18 August	Melbourne
Friday, 24 August – Saturday, 25 August	Brisbane
CCrISP	
Friday, 8 June – Sunday, 10 June	Adelaide
Friday, 20 July – Sunday, 22 July	Melbourne
Friday, 27 July – Sunday, 29 July	Brisbane
Friday, 27 July – Sunday, 29 July	Melbourne
Friday, 10 August – Sunday, 12 August	Perth
Thursday, 16 August – Saturday, 18 August	Wellington
Friday, 24 August – Sunday, 26 August	Brisbane
CLEAR	
Friday, 15 June – Saturday, 16 June	Melbourne
Friday, 20 July – Saturday, 21 July	Brisbane
Friday, 24 August – Saturday, 25 August	Sydney
EMST	
Friday, 15 June - Sunday, 17 June	Hobart
Friday, 15 June - Sunday, 17 June	Sydney
Friday, 22 June - Sunday, 14 June	Melbourne
Thursday, 28 June - Saturday, 30 June	Sydney
Friday, 29 June - Sunday, 1 July 2018	Auckland
Friday, 29 June - Sunday, 1 July	Adelaide
Thursday, 19 July - Sunday, 21 July	Perth
Friday, 20 July - Sunday, 22 July	Brisbane
Monday, 23 July - Wednesday, 25 July	Melbourne
Friday, 27 July – Sunday, 29 July	Christchurch
Friday, 27 July – Sunday, 29 July	Adelaide
Saturday, 4 August – Sunday, 5 August	Brisbane
Friday, 10 August – Sunday, 12 August	Sydney
Friday, 24 August – Sunday, 26 August	Dunedin
Friday, 31 August – Sunday, 2 September	Melbourne
Friday, 31 August – Sunday, 2 September	Brisbane
TIPS	
Friday, 27 July – Saturday, 28 July	Adelaide
Friday, 24 August – Sunday, 26 August	Perth

**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

Sit down, let go.

"Sit down, sit down", said Dr Sit Down! But I didn't want to sit down. Dr Sit Down wanted to talk down and so I was told to sit down. I stood up, determined not to be sat down, hoping to be respected and wanting to share decision making. Dr Sit Down was none too pleased to find on turning round from the bedside that I was still standing, refusing to be "put down". The stage for this showdown drama was in an ICU, the patient was my elderly relative, Dee Syst, and the task at hand was to ensure a peaceful and dignified end to life.

Dr Sit Down was keen to address and correct various clinical problems. Renal insufficiency, atelectasis trending to pneumonia, and increasing delirium on top of diabetes, cardiovascular disease and progressive dementia. Dr Sit Down was a skilled, sharp-thinking but time-poor clinician, focused on treating disease. But sometimes one does not see the wood for the trees, and there is too much focus on correcting failing systems, so failing against the bigger picture, in this case to achieve a comfortable journey out of life as we know it. Dee Syst was no longer *compos mentis*, and if a return to home was indeed achievable it would have been with increasing incontinence, immobility and placing impossible demands for the carer, N Syst. I tried to insist, suggesting that this was not the time for medical heroics. Indeed, I was determined to put the case that failing kidneys, pneumonia and confusion are quite kind processes through which to depart.

Dr Sit Down did not want to let Dee Syst down. Dr Sit Down had intravenous fluids, antibiotics and Intensive Care to try to keep Dee Syst alive. Unfortunately Dee Syst had no advanced care plan – I recognised it was silly that we, the family, had not proactively helped arrange this.

Atul Gawande wrote on 'Being Mortal', "the waning days of our lives are given over to treatments that addle our brains and sap our bodies for a sliver's chance of benefit. These days are spent in institutions – nursing homes and intensive care units – where regimented, anonymous routines cut us off from all the things that matter to us in life."

"Letting go, how to plan for a good death" is the title of a recent book by Dr Charlie Corke, current President of the College of Intensive and Critical Care Medicine.[1] It includes a range of end of life stories and conversations, highlighting the choices that determined how the individual concerned died. There is a great benefit in individuals such as my relative, Dee Syst, considering their values, and making personal choices as to what is important and what they would not want for their final hours and days. Particularly when, if specifically asked, the family including N Syst, would have predicted Dee Syst had a high risk of dying within a year. Dr Corke says, "too frequently, we leave it until crisis strikes …. but a crisis is never the best time for careful thought, especially about something difficult." That was the situation confronting the medical enthusiasm of Dr Sit Down.

Decision making can be paternalistic, shared or informed. Paternalistic decision making involves decisions being made by the treating doctors in the light of their perceptions of what a person would want. Informed decision making describes information being provided by the doctors but the patient then makes the decision what option to choose. Shared decision making describes an ideal where a doctor listens to a patient, provides advice, and together they agree.

A few months well lived is worth more than three years of pain, dependence, incontinence and misery. It's usually about quality not quantity. It's about realistic expectations of outcomes and avoiding suffering prolonged by treatment. So I did not sit down for Dr Sit Down, or at least not until we both sat down, listened to each other, and agreed with N Syst to a plan for palliation.

1 Corke C. Letting Go. How to plan for a good death. Scribe 2018, Melbourne.

DR BB-G-LOVED

RACS advocacy

RACS is committed to effecting positive change in health care and the broader community by adopting informed and principled positions on issues of public health. We regularly advocate for these positions across a number of different mediums, including through the media, public campaigns, or by negotiating directly or providing written submissions to Government. Below is a list of some of our recent advocacy work;

2018-2019 Pre-Budget Submission

The Australian Federal Budget will be delivered in May, and as is customary individuals, businesses and community groups were invited to provide their views regarding the priorities for the 2018-19 Budget. RACS was one of more than 260 interested parties that made submissions to the Treasury. Our submission identified the following five key focus areas relevant to the 2018-19 Budget:

1. Maintaining high quality and timely access to healthcare
2. Recognition of the burden of trauma on the healthcare system
3. National leadership to reduce alcohol-related harm
4. Aboriginal and Torres Strait Islander health
5. Surgical training and academic pathways

Misuse of Drugs (Medicinal Cannabis) Amendment Bill New Zealand

The New Zealand Government recently consulted on amendments to legislation which would allow medical cannabis to be more available to people with terminal illness or chronic pain.

RACS also recently considered the legalisation of medicinal cannabis in response to legislation proposed in South Australia in early 2017. At that time we felt there was insufficient evidence to support the medicinal use of cannabis, and we do not believe additional evidence has been forthcoming in the past year. Overall the scientific and clinical evidence to justify legalisation is poor, and consequently RACS has formed the position not to support the pathway for patient access to medicinal cannabis in New Zealand or Australia.

Tasmanian and South Australian Election Statements 2018

Earlier this year RACS provided election statements prior to the Tasmanian and South Australian state elections. Both documents outlined what we believe will be the key issues requiring the attention of both Governments over the next four years.

In Tasmania the Hodman Government was returned to power, with the Hon. Michael Ferguson re-appointed as the state's Health Minister. In South Australia the Marshall Government was elected and replaces the Weatherill Government. The new Health Minister is the Hon. Stephen Wade, who was previously the opposition health spokesperson.

Australian National Alcohol Strategy 2018-2026

As a sub-strategy of the National Drug Strategy 2017-2026, the National Alcohol Strategy is overseen by the Ministerial Drug and Alcohol Forum. The Forum consists of Ministers from across Australia with responsibility for alcohol and other drug policy from the health and justice/law enforcement portfolios from each jurisdiction.

In late 2017, members undertook a public consultation on the draft National Alcohol Strategy. In our response RACS reiterated our longstanding positions on alcohol related harm and highlighted the importance of adopting a system of strong accountability measures to monitor progress, and introducing priority actions with timeframes.

Mark Morgan,
Communications and Policy

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:

Henry Abeyasundara (QLD)
Edwin William Carr (NSW)
Andrew Forsyth (UK)
Terry Mulhearn (QLD)
Toga Tuki Potoi (Western Samoa)
Sarin Wongprasartsuk (VIC)

Informing RACS

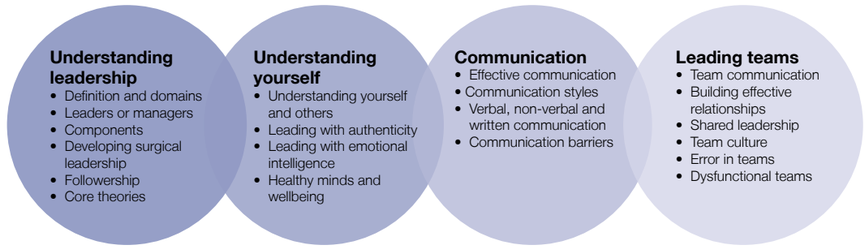
If you wish to notify the College of the death of a Fellow, please contact the manager in your regional office:

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

Enhance your leadership capabilities

Surgeons as Leaders in Everyday Practice

Last November, RACS launched a new leadership course for its Fellows. This year, we are excited to be running four courses in Australia. The first course is titled *Surgeons as Leaders in Everyday Practice*, and is designed to give Fellows a real understanding of the meaning and relevance of leadership as a core surgical competency as defined in the CANMEDS, and RACS surgical competency of Leadership and Management, even to those who are not in official leadership roles.



There is much discourse around the 'big L' - " Leadership in surgery, but there are many courses available to prepare and support surgeons in formal leadership roles. In contrast, there is little educational material or instruction available to teach all surgeons – even those with no leadership aspirations - about 'little l' - leadership, as it applies to surgeons in daily clinical practice.

This course addresses that need. The course helps all surgeons understand the specific leadership skills required to succeed and to provide safe clinical care within the context of their daily surgical practice. Without these leadership skills, they are less likely to become proficient in all domains of surgical competence.

Course Dates:

Gold Coast, 8-9 June 2018

Sydney, 3-4 August 2018

Canberra, 10-11 August 2018

Melbourne, 23-24 November 2018

The course runs for 1 ½ days starting with a Friday evening, followed by a full day of training. Accommodation for the Friday night and all meals are included within the registration fee.

The course includes four sessions on understanding leadership, understanding yourself, communication and leading teams, along with some more contemporary themes such as followership and situational leadership.

Followership is a relatively understudied area derived from the concept that without followers, a leader isn't a leader at all and that the style of leadership will inevitably influence the style of followership, and vice versa. *Surgeons as Leaders in Everyday Practice* unpacks the different styles of leadership and of followership.

The course does cover some aspects of leadership theory, but is mostly very practical and contains many gems that will be valued and helpful to the participants when they return to work.

The course is relevant to all surgeons, but particularly those in the first years of their consultant practice. It is no less relevant to surgical trainees.

Register for any of the upcoming courses at https://www.surgeons.org/for-health-professionals/register-courses-events/professional-development/

Professor Spencer Beasley
Former Vice-President

and Andrew Rose, Education Development Coordinator

An update from Western Australia

I have been Chair of the Western Australian Regional Committee for10 months now, and it has coincided with an interesting period for health policy in our state. Just prior to my commencement as Chair, the Western Australian Government changed hands and the Barnett Government (which held office for almost nine years) was replaced by the McGowan Government.

Throughout my time as Deputy Chair I accompanied our past Chair, Mr Steve Honeybul, to meetings with the Minister and Shadow Minister for Health. This was an excellent opportunity for me to familiarise myself with the representatives from both sides of politics, and it ensured that when the government changed I already had an existing rapport with the new Minister.

I also appreciated the opportunity to meet with members of the Health Department while I have been Chair and Deputy Chair, including the Western Australian Director General of Health (DG). Governments come and go with their differing policy positions, the one remaining constant is the health departments that support them. It is important therefore, that we take the time to develop working relationships and engage with health officials, to ensure that we are effectively able to advocate on behalf of our Fellows, Trainees, IMGs and patients.

While there have been several issues at a local level that have kept us busy over the past year, there are two items in particular that I have decided to concentrate on in this article. Despite the obvious Western Australian flavour, I believe these issues are equally relevant and of interest to surgeons across all jurisdictions.

Ethical sourcing of instruments

The issue of ethical instrument sourcing was brought to my attention last year by Dr Mood Bhutta. Dr Bhutta is the Chair of the Ethical and Fair Trade Committee of the BMJ. He gave a presentation to the WA branch of ASOHNS last year, which was very confronting and eye-opening. He outlined how many instrument and medical goods companies outsource their manufacturing to second and third world countries, often with very poor workplace conditions and wages. The issue of child labour was also raised

Dr Mood's committee has set up guidelines for companies to follow to demonstrate that they have safe work conditions for their workers and are paying them appropriately. It is my hope that we can introduce a similar system to WA in the procurement of instruments and medical equipment. The first step is to engage with the procurement officers in the hospitals and health services and introduce the concept. Hospitals can help by being open to the concept that cheapest is not necessarily best.

This is an issue of particular interest to me and the state committee. We hope to be able to report on the progress that we have made in subsequent updates.

Notifications

The Committee fully supports the principles of transparent reporting arrangements, however, we believe that without intervention the Western Australian model is open to exploitation, and is not delivering the quality and safety benefits that were intended.

As is the case in most jurisdictions, in Western Australia if a patient is readmitted to a public hospital after having undergone a surgical procedure in the public system within the previous month, then a notification of the readmission is provided to the health department, the original treating hospital and the surgeon. This is an important process as it allows complication rates and performance to be continually monitored.

Unfortunately, in our system (and possibly others) a loophole exists whereby private hospitals are excluded from these reporting arrangements. Consequently, if a patient presents to a public hospital emergency department, after having previously undergone surgery in a private hospital, the same formal notification requirements do not exist. This is also a concern when the same circumstance arises between two private hospitals, given that the private sector has been excluded altogether from these reporting arrangements. As a result the original treating hospital is potentially never made aware of the readmission, and therefore their ability to monitor the outcomes of their patients is significantly hindered.

We first wrote to the DG in August outlining our concerns. Since that time private hospitals across the state have been consulted, and they have all agreed on the importance of creating a mechanism that will close this loophole. Each hospital has been asked to nominate a safety and quality representative who will participate in the reporting process.

Although it is still early days, we are heartened by the progress that has been made, and this is another area for which we are hopeful of being able to provide positive updates in the future.

Stephen Rodrigues
WA Chair

CPD updates

In 2017, RACS introduced a Reflective Practice category into the College's CPD Program. The introduction of this category is consistent with the direction the Medical Board of Australia (MBA) is taking in the development of their Professional Performance Framework and also the principles outlined by the Council of Medical Colleges in New Zealand and supported by the Medical Council of New Zealand (MCNZ).

Fellows can choose from a variety of activities to complete their 2018 CPD Reflective Practice requirement.

In 2017, all Fellows were required to complete the Operating with Respect eLearning module to obtain compliance with the reflective practice requirement. From 2018, Fellows can choose from a variety of activities that promote reflection, respectful behaviours and cultural competence including:

- Development of a Structured Learning Plan (including self-reflection)
- Multisource Feedback
- Surgical or Clinical Attachment to a Peer (including clear learning objectives and self-reflection)
- Completion of Cultural Competency Training
- Participation in a Structured Mentoring Program
- Patient Feedback Survey (including Action Plan)
- Recipient of a Structured Practice Visit (including evaluation and action plan)
- Participation in a Practice Visit (as a visitor)

To support Fellows in meeting these requirements, RACS offers access to a number of these activities free of charge to Fellows.

Structured learning plan

Fellows participating in the RACS CPD Program and using CPD Online can access an online Learning Plan tool. The tool is based on the RACS surgical competencies and asks Fellows to identify in which competencies they would like to undertake activities to improve their practice. At the end of the year, Fellows are asked to reflect on the activities they have undertaken during the year and whether this has resulted in improvement to their practice. Once complete, the activity is automatically credited towards a Fellow's reflective practice requirement. For further information, please contact the CPD Team at cpd.college@surgeons.org

Multisource feedback (MSF)

RACS has a limited number of Multisource Feedback (MSF) assessments available to Fellows, including the option of incorporating patient feedback. The assessment is based on the RACS surgical competencies and is administered via an independent external agency that has extensive experience in MSF including working with the General Medical Council (GMC) in the United Kingdom (UK), the Australian Health Practitioner Regulation Agency (AHPRA) and other specialist medical colleges. The assessments are available to all Fellows (including those participating in other approved CPD programs). For more information, please contact the Professional Standards Department at professional.standards@surgeons.org.

Cultural competency training

RACS offers two online learning courses that focus on improving cultural competency and awareness. One course focuses specifically on Aboriginal and Torres Strait Islander Health and the other intercultural competency (five modules). These are available via the RACS website (login required). For further information, please contact the Fellowship Services team at indigenoushealth@surgeons.org.

Dr Lawrie Malisano
Outgoing Chair,
Professional Standards

Fothergill's Disease

The Evolution of Open Surgical Management

When Charles Frazier was appointed Barton Professor of Surgery in Philadelphia in 1922, his two main interests were neurosurgery and surgery of goitre. With William Spiller, a Neurologist, he developed the subtemporal extradural approach for fifth cranial nerve root section in the treatment of Trigeminal Neuralgia.

In a 1928 article on Trigeminal Neuralgia[1], he wrote, "I have nothing to add to that description of Fothergill of the year 1776. We should accept Fothergill's picture as a faithful portrayal of the disease".

John Fothergill (above) was a successful London physician in the mid 18th Century. After two years postgraduate work at St Thomas's Hospital he set up practice in London. In 1774 he obtained his higher qualifications as a physician and was subsequently made a Fellow of The Royal Society.

Fothergill founded The Medical Society in London and it was to this Society that he gave his paper entitled *Of a painful affection of the face* in 1773. Lettsom's volume of the collected works of Fothergill held in the Cowlishaw Collection has been the impetus for this review.

Fothergill believed he was reporting an entirely new or previously undescribed condition. He reported 14 cases and we can easily recognise the condition as Trigeminal Neuralgia. Although Fothergill did not give the condition a name, in many places it became known as Fothergill's disease. Nor did he indicate whether he thought the fifth or seventh nerve was involved. He thought the likely cause was a 'cancerous acrimony' and prescribed Hemlock.

Fothergill was unaware of the work of Andre in Paris, who devoted 25 pages to a condition he named Tic Douloureux in a book published in 1756. Andre had in fact treated his first case in 1732. Of the five cases reported only two were true Trigeminal Neuralgia. Andre's first two cases had been treated by Marechal, surgeon to Louis XIVth, who in the first case, attempted an infraorbital neurectomy but was defeated by bleeding. Andre went on to treat both cases using cauterizing stone and Mercury water, the procedure inspired by Marechal's thinking.

Writing dating back to antiquity suggests that the condition was recognised; clear reports of isolated cases exist. Jorjani [1040-1136] a Persian physician showed remarkable prescience when he wrote " If a patient complains of sudden onset jaw pain and anxiety, know that the pathology is at the nerves….and the cause is the artery moving close to the nerves or in contact with them". Two cases from the mid 17th Century[2] are clear descriptions of single cases.

Fothergill, did not implicate the fifth or seventh nerve and it was not until the work of Charles Bell in 1821 that the unique functions of these nerves were clarified. Following Bell's work the term Trigeminal Neuralgia appeared.

Throughout the 19th Century it was recognised that one to two years relief could be achieved with peripheral neurectomy but long term relief evaded surgeons.

In 1856, Carnochon, a New York surgeon, posited that the 'grey matter' of the Gasserian Ganglion was a generator of 'nervous power' and that this structure had to be removed for sustained relief. His first patient was a French Physician from Maryland.

The operation was performed under chloroform with the patient seated in a solid chair opposite a good light. Carnochon[3] used a V incision over the malar to expose the infraorbital nerve. It is recorded that "with various chisels, elevators and mallets he traversed the maxillary sinus…. removed the maxillary nerve and then excised the Gasserian ganglion". The patient was pain free at 14 months and Carnochon went on to report three cases - all successfully treated.

Victor Horsley, a brilliant and eccentric individual, was the first surgeon appointed to a Neurosurgical post anywhere when he took up his position at Queens Square in London in 1886.

In 1890 he reported an entirely new approach namely a subtemporal intradural approach to Meckel's cave and posterior root section. The patient did not survive and Horsley did not persist with this approach.

Harvey Cushing had just commenced his career when he visited Horsley in 1900. Cushing accompanied Horsley to a private house where Horsley both anaesthetised and operated on a patient's Trigeminal Ganglion all within an hour. Cushing reported he saw nothing but blood and swabs. He wrote, "there was nothing of modern neurosurgery that he could learn from Horsley".

In many treatises on the history of Trigeminal Neuralgia the first ganglionectomy is incorrectly attributed to William Rose, Professor of Surgery at Kings College Hospital. In a Lettsomian Lecture published in The Lancet in 1892 he reported on what he called his trans-pterygoid approach for removal of the Gasserian Ganglion[4]. The description of the operation is a treatise on the dissection of the infratemporal fossa via a lateral transzygomatic approach. It is not surprising that his first patient lost her eye as the exposure necessarily damages the nerve supply to the orbicularis oculi and combined with denervation of the cornea invariably resulted in keratitis.

At around the same time Hartley[5] in New York and Fedor Krause[6] in Berlin described a subtemporal extradural approach for ganglion excision.

Through a small temporal craniectomy the middle fossa dura is elevated to expose the second and third divisions of the fifth nerve and they are divided along with the intervening ganglion.

Cushing adopted a similar approach with minor modification in an attempt to reduce the morbidity associated with hemorrhage from the middle meningeal artery.

In 1900, at a Symposium on the fifth nerve, it was suggested that relief should be as complete with division of the dorsal roots as with excision of the ganglion. Horsley had of course done this 10 years earlier, but there was concern that this limited procedure would be compromised by regeneration.

Spiller and Frazier in Philadelphia undertook a series of experiments on dogs and showed that regeneration did not occur and the Spiller-Frazier procedure of extradural posterior root section became the main procedure in the management of Trigeminal Neuralgia in the early part of the 20th Century. Although Frazier operated using general anaesthesia, many preferred the safer local anaesthesia. Complications of root section included an eight per cent risk of facial palsy.

Walter Dandy, a resident of Cushing's, was an outstanding early neurosurgeon and innovator. In 1925 he proposed root section via a retromastoid or posterior fossa approach[7] which he said was easier and quicker, often only taking 15 to 30 minutes from opening to root section. He went on to report 250 cases with a remarkably low mortality rate at a time when most surgeons regarded such surgery as risky.

Dandy said that other advantages of this approach included identification of pathology likely to be the cause of the problem and a low risk of facial palsy. Dandy noted "in many instances the nerve is grooved or bent by the artery. I believe this is the cause of Tic Doloureux".

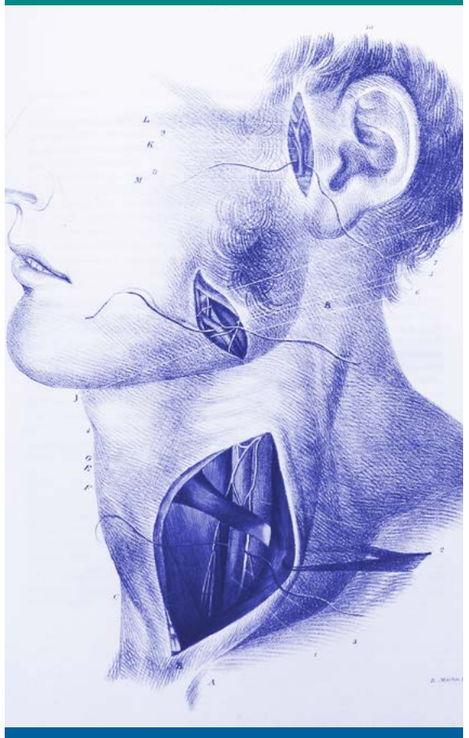
For most surgeons the less demanding middle fossa approach remained the preferred procedure. There were some in the 1930's and 40's who returned to Horsley's intradural procedure in an attempt to reduce the risk of facial palsy but often more serious problems were encountered.

Jannetta has been credited with popularising the procedure known as microvascular decompression based on Dandy's observation. His original report in 1967 [8] was based on a series of five cases operated on via a subtemporal trans-tentorial route. Jannetta was working with Rand at the University of California, Los Angeles (UCLA) at the time; Rand would later dispute Jannetta's claims regarding the procedure which he attributed to Gardner[9].

Most neurosurgeons today accept that Dandy's observations were correct and microvascular decompression is well established as the main open procedure in surgical management of Trigeminal Neuralgia.

1. Charles Frazier. Operation for the radical cure of Trigeminal Neuralgia; Ann. Surg. 88 534-547 1928
2. Stookey B, Ransohoff J; Trigeminal Neuralgia ; Its History and Treatment. Springfield, Il ;Charles C Thomas, 1959
3. Carnochon JM Exsection of the trunk of the 2nd branch of the fifth pair of nerves, beyond the ganglion of Meckel, for severe neuralgia of the face ; with three cases. Am L Sci 69: ART. X11. 1858
4. William Rose Surgical Treatment of Trigeminal Neuralgia The Lancet Feb. 6 1892
5. Hartley F Intracranial neurectomy of the second and third divisions of the fifth nerve; a new method. NY Med J 55 ; 317-319, 1892
6. Krause F ; Resection des Trigeminus innerhalb der Schadeohohle. Arch Klin Chir 44: 821-832, 18
7. Dandy WE; Section of the sensory root of the Trigeminal Nerveat the pons; preliminary report of the operative procedure. Bull Johns Hopkins Hosp 36: 105-106, 1925
8. Peter Jannetta . Arterial Compression of the Trigeminal Nerve at the pons in Patients with Trigeminal Neuralgia. J Neurosurg. Vol 26[1] Suppl 159-162
9. RW Rand The Gardner Neurovascular Decompression Operation for Trigeminal Neuralgia. Acta Neurochirugica 58, 161-166 [1981]

Assoc. Prof. Brian P. Brophy
FRACS



Aneurysm ligation, Manec, 1832.

The Australian and New Zealand Emergency Laparotomy Audit - Quality Improvement

Emergency laparotomies (EL) are a common operation frequently undertaken in an elderly, acutely unwell and high-risk patient. Almost all studies undertaken prior to 2012 were based on retrospective administrative data and reported an overall mortality of 15 per cent, and over 25 per cent in those over 80 years. There were substantial inter-hospital variations in outcome and processes of care. There was no multi-hospital data from Australia or New Zealand.

The United Kingdom (UK) Emergency Laparotomy Network, one of the first prospective multi-hospital studies, confirmed an overall 30-day mortality of 15 per cent and noted wide inter-hospital variation in outcomes and process of care. At the same time a prospective Quality Improvement (QI) study in four hospitals in south-east England reported a reduction in risk adjusted 30-day mortality from 15.6 per cent to 9.6 per cent ($p<0.003$). More recently a QI study from Copenhagen has also reported improved outcomes.

These data prompted the UK government to commission the National Emergency Laparotomy Audit (NELA) in England and Wales. NELA's aim is to collect and publish high quality comparative information in order to drive quality improvement. An important component of the NELA was the prospective documentation of risk and its use to guide escalation in care. The first three annual reports have demonstrated improvements in outcome and care processes. These encouraging results prompted the government to extend funding for a further five years.

In the last 12 months EL data from several multi-hospital Australian studies suggest that while local mortality may be lower than that reported overseas, there appears to be the same inter-hospital variations in care and poor compliance with evidence based standards. From these studies it is already clear Australia is different to overseas, notably the much greater proportion of patients transferred as part of their EL care and the number undertaken in the private sector. However, the quality of this Australian data is in no way comparable to that now available overseas.

The surgical and anaesthetic colleges, supported by their specialised societies and sister colleges, believe there is a compelling case for a prospective Australian and New Zealand Emergency Laparotomy Audit (ANZELA). The value of conducting this as a prospective QI project appears clear and likely to be confirmed when the final results of the Emergency Laparotomy Collaborative are published shortly.

The colleges have agreed to support a 12-month bi-national pilot study, co-led by RACS and ANZCA, and this will be used to support a funding application for a more detailed, multi-year bi-national QI study. Funding for this bi-national pilot is being provided by ANZCA and four specialty societies; General Surgeons Australia (GSA), New Zealand Association of General Surgeons (NZAGS), Australian Society of Anaesthetists (ASA) and the New Zealand Society of Anaesthetists (NZSA). Over the last nine months a working party has agreed on the protocols and framework required. Ethical consent has been obtained in both countries for a database that will facilitate prospective real time data collection and feed comparative outcome and process analysis back to participants promptly. ANZELA-QI has gained greatly from the experience, support and advice willingly provided by colleagues in the UK.

Those wishing to support the pilot study should in the first instance contact Katherine Economides katherine.economides@surgeons.org at the RACS Research, Audit and Academic Surgery Office in Adelaide.

Further information will be available at the RACS stand at the Annual Scientific Conference in Sydney.

Mr James Aitken
FRACS

Annual Joint Academic Meetings 2018

Thursday 8 – Friday 9 November 2018

University of Technology Sydney, Aerial UTS Function Centre, Sydney NSW

Program Highlights

DAY ONE – SECTION OF ACADEMIC SURGERY MEETING

Presentations on topics including "Cognitive errors and biases" by Professor David McGiffin, Head of Cardiothoracic Surgery at Alfred Health.

Professor McGiffin's main areas of research centre around improving outcomes in transplantation, particularly donor organ optimisation and preservation as well as innovations in cardiothoracic surgery, including sutureless valves, bidirectional ECMO cannulae and new generation VADs.

DAY TWO – SURGICAL RESEARCH SOCIETY MEETING

This meeting provides a constructive, friendly forum for Medical Students, JDocs, SET Trainees and Junior Fellows to present their novel surgery-related research and obtain "peer-review" and feedback from leading academics in Australia and New Zealand. In particular, recipients of College research scholarships are encouraged to come along to showcase their work

Awards for the best presentations;

Young Investigator Award, DCAS Award and Travel Grants

International Guest Speakers:

Association of Academic Surgeons Guest Speaker:

Dr Heather Yeo

Heather Yeo, MD, MHS, is Assistant Professor of Surgery and Assistant Professor of Public Health at Weill Cornell Medical College and Assistant Attending Surgeon at New York-Presbyterian/Weill Cornell Medical Center. Dr. Yeo has a Master's in Health Services Research and is focused on surgical outcomes and quality improvement in Gastrointestinal Cancer Surgery.

Dr Yeo will present on: Diversity in academia – beyond gender and race

Society of University Surgeons Guest Speaker:

Dr Rebecca Minter

Rebecca M. Minter, M.D., is the A.R. Curreri Professor and Chair of the Department of Surgery at the University of Wisconsin School of Medicine and Public Health. Dr Minter's clinical practice is in the areas of pancreatobiliary and gastrointestinal surgery. She has a particular interest in the management and treatment of benign and neoplastic diseases of the pancreas.

Registration opens in May

Contact Details

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

Royal Australasian College of Surgeons | Section of Academic Surgery | Surgical Research Society

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The College Standard

The flag, or standard, was designed by Wyn Beasley FRACS at the time of the Presidential visit of (Sir) Benjamin Rank to New Zealand. It was a gift to the College from the New Zealand Fellows, and flew for the first time in 1968, at a meeting of the Heads of the Royal Colleges in Melbourne.

The proportions of the standard are 3:2. This ratio allows it to fly in all kinds of weather, being light enough to catch a soft breeze, but strong enough to withstand a gale. It was made in Wellington by Hutcheson, Wilson & Co.

The design of the standard is taken from the shield at the centre of the RACS coat-of-arms. The division of the shield is quite elaborate. At the top a golden sun rises. Below, the field is subdivided into four sections by a red cross, on which are set a lighted torch and two snakes swallowing their tails. In alternate quarters are a black swan and an ancient ship, known as a lymphad.

The blazon, or heraldic description, of the shield is as follows:

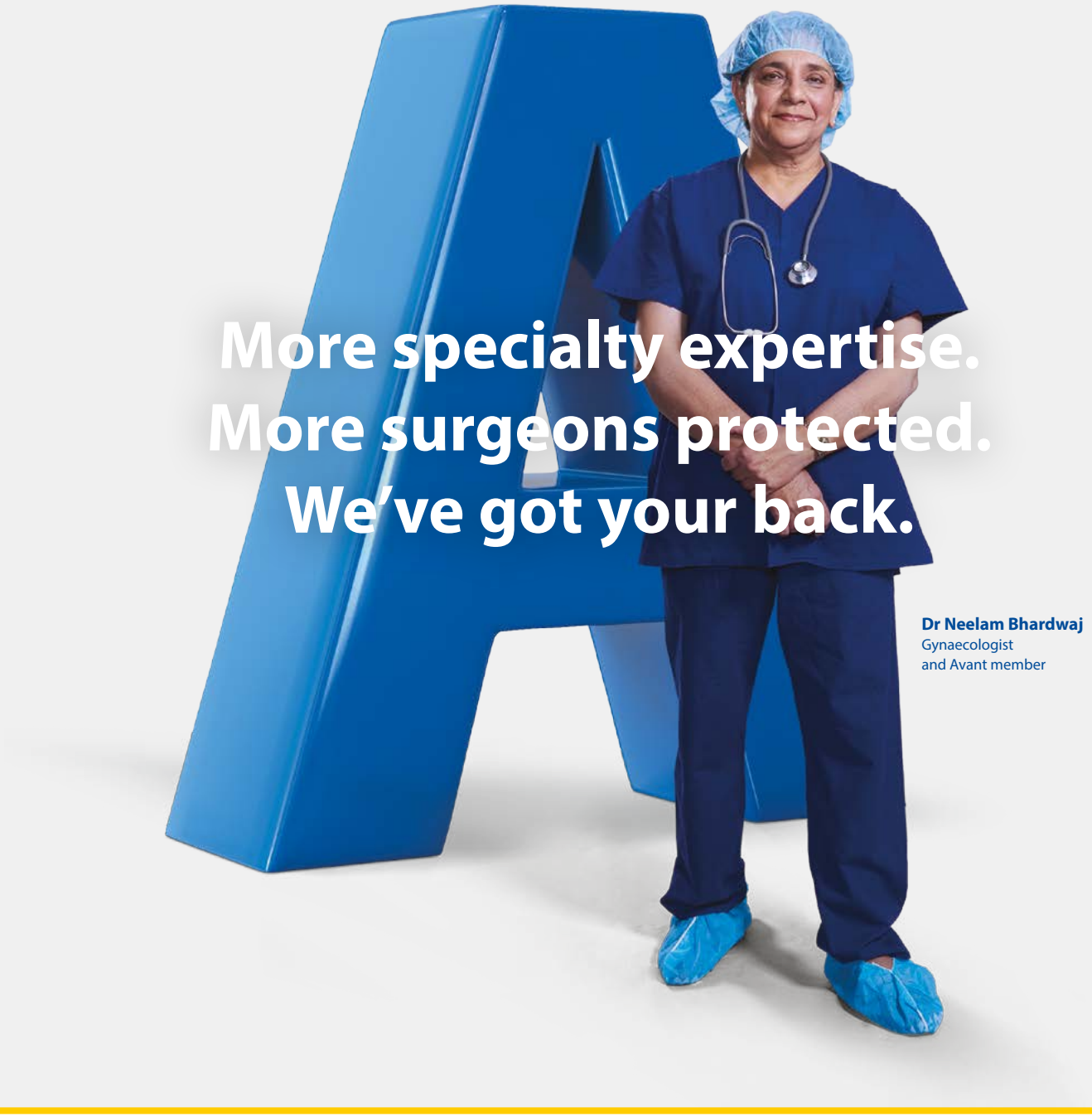
Quarterly Or and Argent on a Cross Gules between, in the first and fourth quarters a Swan Sable naiant on water proper and in the second and third quarters a Lymphad also Sable, a Torch in pale of the first between two Serpents embowed respectant in fess proper, on a chief Azure, a Sun rising Or.

The symbolism of this convoluted arrangement is quite dense. The rising sun may represent the new dawn brought about by the founding of the College, but it may also represent the Royal associations of the College. The red cross dates back to the Crusades, when it was adopted as the sign of the Knights Hospitaller. The black swan on the gold background represents Australia, and the lymphad on the white ground represents New Zealand. The lymphad is taken from the New Zealand coat-of-arms, and symbolizes discovery by sea (appropriate to both Māori and European arrivals). The torch is the *fax mentis* of the RACS motto, and represents knowledge. The coiled snakes swallowing their tails are an ancient and universal symbol for eternity. Brought together, the message of the shield may be interpreted as:

“In the great tradition of western medicine, brought to the Antipodes from across the water, a new dawn has broken for Australasian surgery by the founding of a College dedicated to knowledge, which shall last forever.”

This is the message which the standard proudly proclaims whenever it flies over the College, as it does when Council is in session.

Geoff Down
RACS Curator



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