ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 17 NO 10 NOV/DEC 2016

Global health & access to surgery

RACS continues to contribute internationally

Finances & Budget 2017

The full report inside

RACS LET'S OPERATE WITH RESPECT

The College of Surgeons of Australia and New Zealand

Developing a Career and Skills in Academic Surgery Course

Adelaide Convention Centre, South Australia, Australia

Monday 8 May 2017, 7:00am - 4:00pm

Keynote Speaker:

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

Who should attend?

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

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

2016 comments:

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

"Brilliant opportunity to gain insight into academic surgery"

Association for Academic Surgery and international invited speakers:

Karl Bilimoria
Northwestern University, Illinois, USA

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

Amir Ghaferi
University of Michigan, Michigan, USA

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

Rebecca Sippel
University of Wisconsin, Wisconsin, USA

Tracy Wang
Medical College of Wisconsin, Wisconsin, USA

Australasian Faculty includes:

Marc Gladman, New South Wales
Richard Hanney, New South Wales
Andrew Hill, Auckland, NZ
Julie Howle, New South Wales
Christine Lai, South Australia
James Lee, Victoria
Guy Maddern, South Australia
Julian Smith, Victoria
Mark Smithers, Queensland
David Watson, South Australia
John Windsor, Auckland, NZ

Provisional Program

6:45am	Registration Desk Opens
7:15am – 7:30am	Welcome and Introduction
7:30am – 9:30am	**Session 1: A Career in Academic Surgery** • Why every surgeon can and should be an academic surgeon • The research cycle • Clinical research • Education / simulation research • Translational Research
9:30am – 10:00am	Morning Tea
10:00am – 10:30am	**Hot Topic in Academic Surgery:** **Challenges of Optimising Surgical Training – The FIRST Trial**
10:30am – 11:30am	**Session 2: Ensuring Academic Output** • Writing an abstract • Writing and submitting a manuscript • Presenting at a scientific meeting
11:30am – 12:05pm	**Keynote Presentation: Turning "Failure" into Success**
12:05pm – 1:00pm	Lunch
1:00pm – 2:40pm	**Session 3: Concurrent Academic Workshops**

Workshop 1:
Career Development
What can I do as a:
- Medical Student
- Junior Doctor
- SET Trainee
- Fellow
- Consultant

Workshop 2:
Higher Degrees – Which One?
- The doctorate the ultimate higher degree?
- Masters by coursework
- Masters by research
- Overseas experience – when, what and why

Workshop 3:
Practicalities of Research
- Building a career pathway: opportunities, obstacles and getting past them
- Assembling the team and establishing collaborations
- Randomised clinical trials
- Funding opportunities

2:40pm – 3:00pm	Afternoon Tea
3:00pm – 4:00pm	**Session 4: Sustainability in Academic Surgery** • Academic surgery in private practice • Finding and being a mentor • Standing on the shoulders of giants

DCAS course participation

Cost: $220.00 per person incl. GST

Register online: www.tinyurl.com/DCAS2017

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

Further information:

Conferences and Events Management
Royal Australasian College of Surgeons

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

Presented by:

AAS Association for Academic Surgery

Royal Australasian College of Surgeons
Section of Academic Surgery

Proudly sponsored by:

Johnson & Johnson
MEDICAL DEVICES COMPANIES

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

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

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

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

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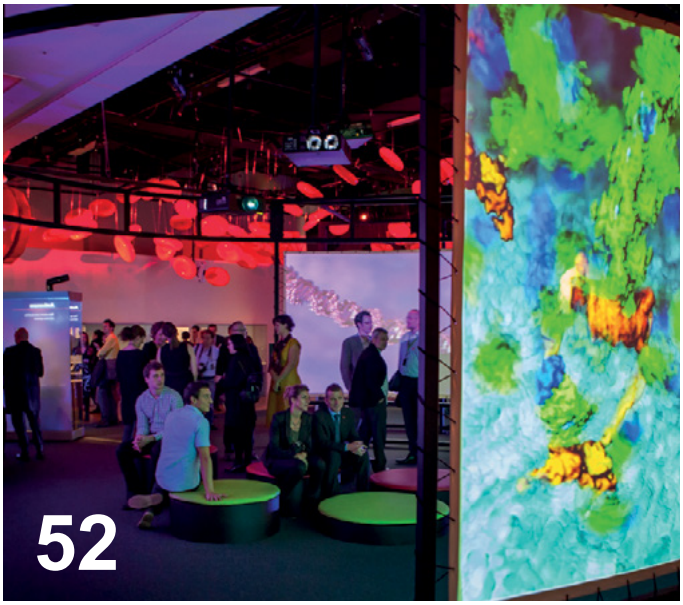

FRONT COVER
The East Timor Eye Program at work.
Photographer: Ellen Smith

REGULAR PAGES

Correspondence and Letters to the Editor to *Surgical News* should be sent to: surgical.news@surgeons.org
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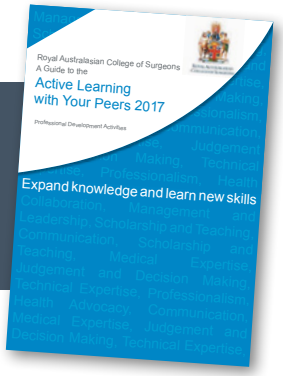
PROFESSIONAL DEVELOPMENT

Workshops & Activities



Online registration form is available now (login required).
Inside 'Active Learning with Your Peers 2017' booklet are professional development activities enabling you to acquire new skills and knowledge and reflect on how to apply them in today's dynamic world.

Foundation Skills for Surgical Educators Course

Monday, 6 February 2017, Melbourne, VIC
Monday, 13 February 2017, Bunbury, WA
Thursday, 16 February 2017, Christchurch, NZ
Monday, 20 February 2017, Melbourne, VIC
Thursday, 23 February 2017, Canberra, ACT
Friday, 24 February 2017, Hastings, NZ
Saturday, 4 March 2017 , Wangaratta, VIC
Saturday, 11 March 2017, Newcastle, NSW
Saturday, 18 March 2017, Brisbane, QLD
Tuesday, 21 March 2017, Adelaide, SA
Friday, 31 March 2017, Port Macquarie, NSW

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

Foundation Skills for Surgical Educators Faculty Training Day

Sunday, 19 February 2017, Melbourne, VIC
Sunday, 4 June 2017, Sydney, NSW

Keeping Trainees on Track (KToT)

Saturday, 18 February 2017, Melbourne, VIC

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 RACS 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.

Supervisors and Trainers for SET (SAT SET)

Saturday, 18 February 2017, 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 that 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).

Responding to Emotions in Cancer

Saturday, 25 February 2017, Melbourne, VIC

Effectively responding to a patient's emotional cues in cancer is an essential clinical skill for acknowledging the patient experience and building rapport. This evidence-based experiential course will provide health professionals with the skills and learning opportunities for responding to emotional cues by using a defined series of skills and framework to enhance communication with patients and families. This educational program is proudly supported by Cancer Council Victoria.

International Medical Symposium

Friday, 10 March 2017, Melbourne, VIC

The Royal Australasian College of Physicians (RACP), the Royal College of Physicians and Surgeons of Canada (RCPSC), the Royal Australian & New Zealand College of Psychiatrists (RANZCP), the Australian & New Zealand College of Anaesthetists (ANZCA) and the Royal Australasian College of Surgeons (RACS) are pleased to host the 2017 International Medical Symposium: Leading Change.

Comcare: Difficult Cases

Tuesday, 21 March 2017, Sydney, NSW

The Comcare Guide to the Assessment of the Degree of Impairment informs medico legal practitioners as to the level of impairment suffered by patients. This assists with determining their patients' suitability to return to work. While the guidelines are

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extensive, they sometimes do not account for unusual or difficult cases. This evening workshop provides surgeons involved in the management of medico legal cases with a forum to discuss their difficult cases, the problems they encountered and the strategies employed to solve them. Cases will be circulated beforehand. This workshop complements the accredited Comcare Guideline Training Courses. Please note: Each attendee needs to bring with them a copy of the Comcare Guide 2nd Edition. This educational program is proudly supported by eReports.

Non-Technical Skills for Surgeons (NOTSS)

Friday, 24 March 2017, Melbourne, VIC

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

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

Friday, 31 March 2017, Melbourne, VIC

The NHET-Sim Program is a nationwide training program for healthcare professionals aimed at improving clinical training capacity. NHET-Sim offers a training program for healthcare educators and clinicians from all health professions. The curriculum has been developed and reviewed by leaders in the simulation field across Australia and internationally.

Surgical Teachers Course

Thursday 16 – Saturday 18 March 2017 , Hunter Valley, NSW

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

PROFESSIONAL DEVELOPMENT WORKSHOP DATES

February – March 2017

ACT
23 February 2017
Foundation Skills for Surgical Educators, Canberra

NSW
21 March 2017
Comcare: Difficult Cases, Sydney
11 March 2017
Foundation Skills for Surgical Educators, Newcastle
16-18 March 2017
Surgical Teachers Course, Hunter Valley
31 March 2017
Foundation Skills for Surgical Educators, Port Macquarie

NZ
16 February 2017
Foundation Skills for Surgical Educators, Christchurch
24 February 2017
Foundation Skills for Surgical Educators, Hastings

QLD
18 March 2017
Foundation Skills for Surgical Educators, Brisbane

SA
21 March 2017
Foundation Skills for Surgical Educators, Adelaide

VIC
6 February 2017
Foundation Skills for Surgical Educators, Melbourne
13 February 2017
Foundation Skills for Surgical Educators, Bunbury
18 February 2017
Keeping Trainees on Track, Melbourne
18 February 2017
SAT SET Course, Melbourne
19 February 2017
Foundation Skills for Surgical Educators Faculty Training Day, Melbourne
25 February 2017
Responding to Emotions in Cancer, Melbourne
4 March 2017
Foundation Skills for Surgical Educators, Wangaratta
10 March 2017
International Medical Symposium, Melbourne
24 March 2017
Non-Technical Skills for Surgeons, Melbourne
31 March 2017
NHET-Sim, Melbourne

WA
13 February 2017
Foundation Skills for Surgical Educators, Bunbury

Contact the Professional Development Department

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

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

Building International Surgical Capacity

Continuing the focus on Global Health and Access to Surgery

PHILIP TRUSKETT AM
President

As President I have been fortunate in attending international forums where access to surgery in a developing country has been a major focus of discussion. RACS and a number of our surgeons have been major contributors to this discussion over the past five years but also RACS has been at the forefront of building surgical capacity in many countries for over 25 years. This was reinforced to me on two key occasions recently. The first was the memorial service for Emeritus Professor Gordon Clunie, a prominent academic surgeon and a major contributor to our College activities. I was well aware of his academic achievements but admit that I was quite ignorant of his major contribution to developing world surgery. From his eulogies I learnt that he spent his childhood based in Fiji. As a result he was committed to the Pacific Island Project and was a major force in the development of the Fiji Medical School in the 1990s and their Master of Surgery program. These initiatives continue to deliver enormous value and support in the Pacific region to this day. The second was a the most recent meeting of the American College of Surgeons, where surgical leaders from around the world discussed the ongoing work needed in implementing the findings of the Lancet Commission.

The Lancet Commission recommendations, published in 2015, highlighted the critical need to develop safe, essential, affordable lifesaving surgical and anaesthesia care when needed. The Lancet Commission report informed the passing of the World Health Assembly Resolution 68 / 15. For the first time the provision of safe, affordable, timely surgery has been recognised as an essential need for people in developing nations. It is difficult to believe that this has not happened earlier but this can be partly explained by the lack of specificity of emergency surgery. It does not appear as measureable as things like HIV/AIDS, TB and Malaria, but according to WHO data, 5 million people die as a result of injury per year; almost twice as many as die from these infectious diseases. This figure does not include those who die because of an inability to access emergency laparotomy or urgent obstetric care. A focus to strengthen universal surgical care and the ongoing requirements to monitor the parameters of success were a key focus of our International Forum at our 2016 ASC in Brisbane. Interestingly at this forum, the 25th anniversary lecture of the Rowan Nicks Scholarship was presented by Professor Godfrey Muguti, Professor of Surgery from Harare, Zimbabwe, who was the first Rowan Nicks Scholar. This Forum reinforced repeatedly the core indicators for monitoring universal access to safe, affordable surgical and anaesthesia care when needed.

The parameters as defined by the Lancet Commission are:

- Access to timely essential surgery, which is defined as where the population can access within 2 hours a facility that can do caesarean sections, laparotomies and treatment of open fractures. The goal by 2030 is a minimum of 80 per cent coverage of essential surgical and anaesthesia per country.

- Specialist surgical workforce density, where the goal by 2030 is that 100 per cent of countries have at least 20 surgical, anaesthetic and obstetric physicians per 100,000 population.
- Surgical volume where the goal by 2020 is that 80 per cent of countries have a minimum of 5000 procedures per 100,000 population and that this is 100 per cent of countries by 2030.
- Perioperative mortality where 80 per cent of countries by 2020 and 100 per cent of countries by 2030 track perioperative mortality and assess global data to set national targets of less than 5 deaths per thousand operations.

Costs are critical and the perception of surgery being unaffordable and too complicated for public health strategies is still of concern in many low and middle income countries. However, as we know, the treatment of most surgical conditions does not necessarily require complex surgical skills or equipment. However the perception of expense is substantial and there were two goals included in the Lancet Commission report:

- Protection against impoverishing expenditure being caused by direct out-of-pocket payments for surgical and anaesthesia care. The goal by 2030 is that there is 100 per cent protection against impoverishment.
- In addition to this there needs to be protection against catastrophic expenditure when this is defined as greater than 40 per cent of household income not including subsistence needs.

RACS Global Health has worked very closely with a number of countries in the South East Asia and Pacific areas to be able to capture these measures. The diversity of outcomes demonstrates the requirements within countries like Laos and Myanmar but also the established systems within many others. However, the most important issue is that we now have a benchmark on which to measure and progress these really important discussions about capacity building.

When practising in Australia and New Zealand, you can become 'blind' to the absolute need across the world. At this time a staggering 5 billion people do not have access to safe, affordable surgical and anaesthesia care with 143 million additional surgical procedures needed annually in low and middle income countries to save lives and prevent disability. What is becoming much more obvious and known is that investing in surgical services is affordable, saves lives and will certainly promote the individual country's economic growth. We can be duly proud that RACS has been involved and recognised internationally as a significant contributor for so many years and that our ability to collaborate with governments and project donors in this space is both prized and praised by many.

Looking back on 2016 – what have we achieved?

PROFESSOR SPENCER BEASLEY
Vice President

In 2016, our College set itself the task of improving surgical culture for the better. Not that it ever expected to achieve that goal in a year – it was always going to be an ambitious task that would take considerably longer than that.

2016 was the year when the implications of the very public scrutiny of (at times inappropriate) surgical behaviour became readily apparent to all Fellows. It was also the year when our College set about in earnest to implement the recommendations of the Expert Advisory Group to change the culture of surgery, and to "operate with respect". One driver of that was to ensure our Trainees were in a safe learning environment, free of discrimination, harassment and bullying.

> *"We have come a long way this year and I believe that RACS, through the action of its Fellows, has a lot to be proud of in 2016 in terms of advocacy and Respect.."*

Our longstanding collective commitment to surgical education, training and assessment, and our willingness to look critically at our performance in these areas, is quite reasonably something of which we should all be proud. RACS has always been dedicated to making sure that everyone who practises surgery in our countries can provide safe, high quality care to patients. Even though addressing the recent issues has made some surgeons feel uncomfortable, no-one could argue that we haven't taken the matter seriously: not only have we been quick to take ownership of the problem but also we are doing something about it.

Our 2015 Action Plan outlined the steps we are now taking to create a healthier culture in surgery, strengthen surgical education and improve complaints management. This includes providing additional training to help our surgeons become better educators and supervisors and to have the skills they need to work in the stressful environment of the health sector. The relationship between respectful and professional behaviour and better patient outcomes has now been well established.

Senior representatives of our College have met with health ministers, health departments and Director Generals. We have run workshops and designed specific courses to give surgical supervisors and surgeons who have SET Trainees the tools they require to perform their work to the highest standards.

Early on we realised that this could not be achieved by RACS alone, so much effort has been devoted to gaining support across the health sector. RACS has now signed Memoranda of Understanding (MoUs) and letters of agreement with multiple prominent health organisations, universities and hospitals across both Australia and New Zealand, committing them to the same goals and standards, and sharing our information and resources.

The next steps require greater involvement by us as surgeons in each of our hospitals. We are the ones who must lead that cultural change at a local level. Supported by our College we seek Fellows to work with their hospital administrators to implement their own local cultural change programs. RACS can provide the support and some expertise to facilitate this, but in 2017 the "hard yards" will need to be done by Fellows at a local level. Other Colleges are coming on board and seem keen for us to share with them our resources and experiences. Our "Let's operate with respect" campaign is now well underway.

This year's annual scientific congress (ASC) in Brisbane was a huge success in terms of media coverage and social media activity. We put out a total of 23 media releases over the week of the conference and picked up more than 120 newspaper articles, more than 50 radio interviews and six television interviews, not to mention achieving more than 11 million impressions for the #RACS16 hashtag and 6500 tweets. Over 1000 participants were dipping their collective toes into the social media pool over the course of the Congress. This contributed to the total impact of the Congress being much greater than in previous years.

RACS has been active in its advocacy as well. For example,

we lent our support at the start of the year to the call to action to reduce alcohol related harm and alcohol trading hours in Queensland, ultimately to applaud the Queensland government's passing of the Tackling Alcohol Fuelled Violence Legislation Amendment Bill 2015. In the wake of that government's decision we urged the Northern Territory government to adopt similar legislation.

Also early this year RACS developed its Māori Health Action Plan (MAP) following consultations with Māori medical organisations including Te Ohu Rata o Aotearoa. One of the core aims of the Action Plan was to develop a more culturally appropriate surgical workforce for Māori. This includes redressing the under-representation of Māori surgeons and Trainees, and recognising the value of cultural diversity and cultural competence during the selection of all Trainees into surgery.

Following that highly successful launch was the launch of the RACS Reflect Reconciliation Action Plan on 1st June, which also garnered strong media support. The Plan focused on building relationships and raising awareness of where there was unmet need or paucity of representation in surgery. I will help staff, Fellows, Trainees and International Medical Graduates (IMGs) to work with Aboriginal and Torres Strait Islander (ATS) peoples and the Australian community towards reconciliation, greater ATS involvement in the provision of surgical care, and greater opportunities for ATS in entering surgical training.

In another significant advocacy success for RACS, our College joined forces with the Royal Australasian College of Physicians (RACP) and the Australasian College for Emergency Medicine (ACEM) to lobby for an end to unrestricted speed zones in the Northern Territory. We produced a powerful video highlighting the dangers that the existing policy posed to the lives of Territorians and visitors due to excessive speed. The campaign was extremely effective and resulted in the Territory Labor Party putting the brakes on Australia's fastest stretch of road following its landslide election victory on August 30 when it confirmed the 130 km/h signs would soon be returning to the area.

This is just a small snapshot of some of our advocacy work this year. Of course, the College has been active in many other areas as well, and the content of the monthly Surgical News provide evidence of that.

We have come a long way this year and I believe that RACS, through the action of its Fellows, has a lot to be proud of in 2016 in terms of advocacy and Respect. I thank you all for your participation in the various activities and campaigns that made up 2016, and I look forward to your continued and energetic participation as we enter the next stage of our ongoing advocacy and associated campaigns.

National Eye Health Survey

Blindness and vision impairment appear to be on the decline in Australia according to the findings of the first ever National Eye Health Survey, released on World Sight Day 2016. Rates of vision impairment were also found to be lower in Australia when compared to other high income countries. However, the importance of regular eye tests was underlined with more than 50 per cent of the 4,836 participants found to have an eye condition being unaware they had that condition prior to taking part in the survey, and over 30 per cent of all participants being onward referred to an eye health professional. The National Eye Health Survey, led by Vision 2020 Australia and the Centre for Eye Research Australia, is the first comprehensive national survey of the prevalence of vision loss in both Indigenous and non-Indigenous Australians and provides a benchmark against which to measure national progression in eye health and vision care.

British Surgeon live-streams operation in Virtual Reality (VR)

In mid-April, a British surgeon allowed anyone with a VR headset to watch colon tumour surgery in near-real-time at the Royal London Hospital. The idea, he said, was to improve the quality of medical training. According to the surgeon VR will provide Trainees with a more detailed, first-hand view of a procedure – something that can't be achieved from simply reading a book or peering over a surgeon's shoulder – and it will open it up to the rest of the world.

New minimally invasive surgery may soon be viable alternative to treat liver cancer

For patients who may benefit from a major liver operation to treat cancer, an open abdominal procedure is often the only option. However, a minimally invasive approach that avoids the large open incision may soon be a viable alternative, according to results from a multicentre study presented at the 2016 Clinical Congress of the American College of Surgeons (ACS). The researchers evaluated 1,015 major liver resections (hepatectomies) performed in 2014 at 65 hospitals. Of those procedures, 13 percent, or 132, were performed using minimally invasive surgery (MIS), the rest were performed using open operations. This research is the largest multicentre study to date evaluating outcomes after MIS major liver resection.

The 2017 RACS Diary has arrived!

RACS has responded to your feedback and produced a select number of 2017 pocketbook diaries for Fellows on request.

Please ensure that you get in early to secure yours!

If you would like a Diary, please email Reception.Desk@surgeons.org with your RACS ID number and mailing address details. The 2017 RACS Diary will then be mailed to you.

Please note that 2017 Diary numbers are limited

If you have any further queries, please call +61 3 9249 1200

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Court of Examiners for the Fellowship Examination

Applications Open

Applications from eligible Fellows willing to serve on the Court should be forwarded to the Department of Examinations of the College no later than **Friday, 27 January 2017** for appointment in 2017.

Fellows are asked to note the following vacancies on the Court, in the specialties of:

- Cardiothoracic Surgery
- General Surgery
- Orthopaedic Surgery
- Otolaryngology Head and Neck Surgery
- Paediatric Surgery
- Plastic and Reconstructive Surgery
- Urology
- Vascular Surgery

Should you wish to apply to be a member of the Court of Examiners, please forward your completed application form with a copy of your curriculum vitae to:

Court.Examiners@surgeons.org or post to
Department of Examinations
Royal Australasian College of Surgeons
250 - 290 Spring Street
EAST MELBOURNE VIC 3002

Application forms are available to download on the College website.

- Prospective applicants are advised to read the Appointments to the Court of Examiners and Conduct of the Fellowship Examination policies, which can be found on the College website.
- For inquiries, please email Court.Examiners@surgeons.org or call 03 9276 7471.

Shrimp on the BBQ

Life is a lottery

THE BARONESS

I was following the recipe prescriptively. Having borrowed it from Neil Perry I was not sure if my attempt was going to fit into a QANTAS takeaway or a serious contender at a Rockpool restaurant derivative. Certainly it was going to be the highlight of the year for the regular contingent that gathers for our 'shrimp on the BBQ'. The recipe demanded green prawns, peeled and deveined although with the tails still on. Combined with scallops and enhanced with garlic, spring onions and snow peas, it was the combination of the Shaoxing cooking wine, chicken stock and soy sauce that would be critical. And then of course the sauce that had that special red chilli heat.

My mouth watered, I sampled my latest find from Margaret River. A chardonnay that was exquisite with the majority naturally fermented in oak barrels but also in tank. The label said complex, freshness and bright fruit aromatics. I tended to agree that the Dragonfly was ideal and just the thing to go with the spicy stir-fried prawns. My ex University friends gathered around – you know the regular group that had accompanied me through life following my legal training. They had gone different ways. Law, business, religion and even surgery. They had done some incredible things. We regularly gathered to share those ups and downs that made that rich tapestry called life.

We had all been promised a party to celebrate the winnings of our inveterate gambler. Not always successful, I knew that his gambling instincts had punctured the practising of his profession on one occasion and had also left fractured relationships in his wake. Some of them unpleasant and with court based resolutions. Not a great portrayal of life's happiness. But there was a reason to celebrate, he had said. At long last he was ahead. The lottery had sailed into town and he had become a major beneficiary of its largesse. Well, that had been the message. We were looking forward to the great celebration.

Instead, I was being offered a somewhat unsavoury opinion of some of my professional colleagues and the collective called the Family Court. He grilled me on "section 79" of the *Family Law Act 1975*. How could the court have a view about a post separation lottery winning? Section 79 provides property related orders *'with respect to the property of the parties to the marriage or either of them…'* including assets acquired after the parties relationship has ended. It does not define "matrimonial assets".

And so it had happened. His former spouse, having been an unhappy component of this rich tapestry of life believed she was entitled to a portion of these winnings. Indeed there are cases of *Anastatsio and Anastatsio* (1981) FLC 91-093 or *Eufrosin and Eufrosin* (2014) FAMCAFC 191 where arguments were raised that contributions had been made to the "lottery win" from the other party. And where the courts deliberate, they can bring many issues into consideration. Financial and non-financial contributions to marriage, responsibility for children, disparity in the parties' financial circumstances... the list goes on and on.

And with this background, the celebrations were off. How much of this 'windfall' would be left? We all have views. The arguments were clear and well-practised. Cries of 'how could they?' were lost and replaced with 'how to ensure they could not'. And with that, we revisited the importance of finalising all financial matters at the end of a relationship in the next serving of this glorious combination of shrimp and scallop. Mr Perry certainly had the recipe. Maybe with the eventual celebration we could have a true Rockpool experience.

Legal material contributed by Daniel Kaufman, Special Counsel in the Family and Relationship Law Department at Lander & Rogers.

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Dr Brien Hennessy
Avant member

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Sleepy or Sleepless?

DR BB-G-LOVED

Jack and Jill's minds and hearts are racing, their emotions rent. Series 2 Episode 4 has just finished and how can they wait to find out what happens if and when 'they' go up the hill. Or do they download another episode and watch it right now? That might break 'Jack's' crown, as tomorrow will be a busy day. But how do they slow down and go to bed after this episode? "I'll be tumbling in my sleep," fears Jill, so they opt for vinegar [a generous dram] and some nibbles in brown paper. One dram led to another before up they got [home did trot] – and went to bed to mend their heads.

Fast-forward to the middle of the night. Despite feeling so tired, and now somewhat guilty, Jill struggled to fall asleep so lay in silence, for a long time irritated by Jack's snoring – not just by the noise of it, but she also resented his ability to fall asleep. She eventually slept but was later woken by a vivid and terrible dream. Jack was still snoring loudly, almost choking. She tried to tumble him over onto his side, perhaps more for her benefit than his. That provoked a grumble of protest of which there was no memory the next day.

Are you a Jack or a Jill? Are you sleepless, sleepy, or snoring? Is your pattern of sleep causing you injury? Your mental health may be suffering. Your life may even be endangered by excessive daytime sleepiness (EDS), never mind its association with a shorter life-expectancy. Just as concerning should be the increasingly recognised association between sleep disorders, loss of memory, cognitive decline and neurodegeneration.

It may be worth taking Dr Murray Johns' Epworth sleepiness scale that measures your chances of falling asleep in a range of activities from reading a book, watching TV or waiting at traffic lights. You will have your EDS score in less than a minute.

Jill's insomnia shows an inability to fall asleep as well as a pattern of waking up and not being able to get back to sleep. It has many possible causes.

Some are related lifestyle choices to such as caffeine, and nicotine or alcohol. Circadian rhythm asynchrony due to travel or shift work may cause temporary, short-lived disturbance. Chronic pain including osteoarthritis and back pain is often harder to bear through the night but its relief involves certain compromises with hypnotics and analgesics. Insomnia affects persons on antidepressants and those who are depressed [not always the same]. Stress, anxiety about anticipated events, anxiety generally, and anxiety about insomnia may all disturb the ability to fall sleep or remain asleep. Insomnia commonly affects women during their menopausal years, with temperature swings, hot flushes and disturbed sleep. Restless legs syndrome may benefit from iron or magnesium therapy.

Jack has a BMI over 30 and probably has obstructive sleep apnoea (OSA) like some 10 per cent of those who've reached or passed middle age. He needs clinical assessment and sleep studies, particularly if he has EDS, which will impair his quality of life and ability to function. He might benefit from nocturnal CPAP. OSA is associated with hypertension and decreased life-expectancy. It can and should be effectively treated. It also disturbs Jill's sleep.

There may be a sleep disorders or sleep centre near you. They offer overnight assessment of sleep quality, breathing, oxygenation, muscular activity and could be conducted overnight in the lab or at home. You can have EEG, EMG, ECG, Respiration, Oxygen saturation, and video recording of leg and other movements while you sleep (if you can). A sleep study will generate loads of data, but might well be worth the effort. It may help you to face up to tackling the monster you become when you fall asleep.

In case any of my readers think Jack and Jill are too stereotyped, you may reverse their genders. There are many female OSAs and male insomniacs. For a real 'gender bender' you might also want to unravel the story behind the nursery rhyme. Don't be mislead by my misuse of vinegar and brown paper above. In centuries long past those who chimed this rhyme wanted to avoid offending puritans. Later generations forgot its origins and recited it to their children.

Facebook at Work?

Thinking of Facebook at work can conjure images of furtive checks and trying to covertly minimise the bright blue glare of the banner from colleagues and managers.

This may not be the case for too much longer. Facebook is trying to capture the lucrative market for interconnectivity and collaboration with a new business platform. Workplace by Facebook has been released after two long years in beta testing and marks the publicly listed company's first foray into revenue collection through paid subscription. The platform will be sold to businesses on a per-user basis, with each active employee costing up to US$3 per-month.

Workplace is billing itself as an ad free space – completely separate from your personal account. This, at least partially, minimises the risk of accidentally sending that cat video to the CEO instead of your Mum.

"The workplace is about more than just communicating between desks within the walls of an office. Some people spend their entire work day on the go, on their mobile phones. Others spend all day out in the field," Facebook said in a statement.

The Workplace communications enterprise is being primed to wrest market share from the already established Slack as well as Microsoft's own venture Yammer. And in this burgeoning market, more options are set to be released to cater to an increasing demand for collaboration options and network integration. Yet this is the first to mimic an already widely adopted product. Facebook is hoping consumers will have an intuitive understanding of the platform from personal use and this will entice companies who have previously been reluctant to dedicate time to training and maintenance.

The question remains - could we soon be using Facebook at work - for actual work? And will, as Facebook is promising, the tool actually encourage productivity? The jury is currently out.

THE UNIVERSITY OF SYDNEY

Regional Anatomy and Whole Body Dissection Courses 2017

In 2017 you will be able to undertake anatomy dissecting courses whilst working full time. Classes are held on Saturdays (120 hours of face to face teaching in total for a whole body dissection) and is taught by senior surgeons who have years of experience teaching surgical anatomy.
Each region requires approx. 10 hours pre-reading per fortnight before attending the day long practical.
Numbers are strictly limited.

Dates:

- **Upper, Lower Extremity** (4 days) 4 & 18 March, 15 & 29 July 2017
- **Thorax, Back, Spinal Cord** (3 days) 18 February, 1 & 22 April 2017
- **Abdomen, Pelvis, Perineum** (4 days) 6 & 20 May, 3 & 17 June 2017
- **Head & Neck** (4 days) 12 & 26 Aug, 9 & 23 September 2017

These may be completed as: a) Graduate Certificate in Advanced Clinical Skills (Surgical Anatomy) or b) later credited to a Master of Surgery or c) taken as a non award student (may be credited to approved degree within two years of completion if assessments are passed).
Cost: $6,500 per region. **Applications** open now until 31st Jan 2017.
Apply for Graduate Certificate in Advanced Clinical Skills (Surgical Anatomy)
Contact: For further information email Jayne Seward **jayne.seward@sydney.edu.au** or the Discipline of Surgery http://sydney.edu.au/medicine/surgery/postgraduate/coursework/index.php Non Award Students: http://sydney.edu.au/medicine/study/postgraduate/uos.php

THE UNIVERSITY OF SYDNEY

Surgical Anatomy Based on GSSE – Prosection Courses 2017

Courses are taught by senior surgeons who have years of experience teaching surgical anatomy. Numbers are strictly limited.
Description: The aim of the course is to assist students in the preparation of the Anatomy component of GSSE conducted by RACS. Modules comprise: upper limb, lower limb, head and neck, thorax, abdomen, pelvis and perenium. Each module has three components: a) Identification and SCORPIOS of anatomical structures in wet prosections b) Multiple Choice Question (MCQ) exercises c) 'Spot' questions on anatomical prosection photographs. 10 hours pre-reading per fortnight before attending 8 day long practical workshops. The course may be completed as a) part of the Graduate Certificate of Surgical Sciences b) part of a Master of Surgery or c) non non award student (may be credited to an approved degree within two years of completion if assessments are passed).

Dates: Alternate Saturdays from 18/02/17 to 17/06/17 **or** 15/07/17 to 04/11/17.
Cost: $4,000.00
Applications: now open until 31st Jan 2017 from Sydney University website.
Contact: For more information please contact Jayne Seward jayne.seward@sydney.edu.au or visit the Discipline of Surgery, USyd website http://sydney.edu.au/medicine/surgery/postgraduate/coursework/index.php
Non Award applications: http://sydney.edu.au/medicine/study/postgraduate/uos.php

Putting the Brakes on Open Speeds

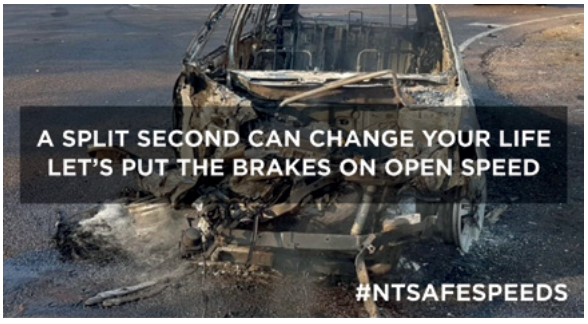
The recent decision by the Northern Territory Government to overturn controversial unrestricted speed zones on sections of the Stuart Highway was a significant milestone. It followed two years of dedicated advocacy by RACS, and was an example of what can be achieved when we adopt principled positions on issues of public health.

MR JOHN TREACY
Chair, NT Regional Committee

The recent decision by the Northern Territory Government to overturn controversial unrestricted speed zones on sections of the Stuart Highway was a significant milestone. It followed two years of dedicated advocacy by RACS, and was an example of what can be achieved when we adopt principled positions on issues of public health.

When it comes to road safety the NT consistently rates as easily the worst performing jurisdiction in Australia. The average yearly road fatality rate in the NT is approximately three times higher than the national average. The isolated and remote nature of much of its geographical area presents added difficulties to emergency response teams when things go wrong, which is why the decision to reintroduce open speed limits in 2014 was unfathomable.

Open speeds were initially introduced as a trial on a 200km stretch of road on the Stuart Highway, north of Alice Springs. The trial area was subsequently extended on numerous occasions. There was never any review published, despite RACS requesting that one be made public, and no end-date was ever identified for the 'trial.' The intention was not to embarrass the Government or to show political favour; however RACS concerns were continually dismissed, which is why it was decided to adopt a much more public approach.



The Government's justification for pursuing unrestricted speeds was to highlight the role of fatigue, alcohol and seatbelts in road accidents, and to promote the need for increased driver awareness. While RACS does not dispute any of these points, there was alarm that the NT government chose to highlight these issues in a manner that downplayed speed as a risk factor.

RACS' consistent message was, and continues to be, that road safety needs to be considered as a package. A vital element of that package is missing when speed is ignored. Regardless of the initial cause of a road crash, there is no question that the risk of serious injury and death are exacerbated when excessive speeds are involved.

The RACS campaign intensified closer to the NT election when a short video was released, in partnership with RACP and ACEM. This was an incredibly important step, as despite the risks posed, a vocal segment of the NT population continued to support unrestricted speeds.

But sometimes governments need to be brave enough to stand behind a platform that protects the health and safety of its citizens, rather than simply engaging in populist politics. There is no doubt that by bringing this issue to the forefront during an election campaign it helped to generate a more mature and balanced discussion, which made it easier for whichever party won government to reintroduce speed limits.

The video proved to be a new and extremely effective form of advocacy for RACS. Despite being produced on a shoestring budget, it received widespread attention in the mainstream media not just in the Northern Territory, but across the county. This allowed RACS to promote the message, without costly advertising.

The overturning of the policy and the return of speed limits in the Northern Territory is a great result for all of those people who demonstrated enormous commitment and perseverance. ACEM and RACP are acknowledged for uniting and working with RACS. There is no question that the voice of three respected Colleges had been more effective than one.

From a RACS perspective, the following need to be congratulated - the Northern Territory Regional Committee, the Trauma Committee, and all the hard working staff who support them. In particular, Mr David Read and Mr Phill Carson need to be acknowledged. This issue is a very personal issue for them both. Phill did a terrific job representing RACS in the video, and David has been a tremendous spokesperson for RACS over the past two years.

There is still much more to do in the Northern Territory and across the rural and remote roads in our country. However, it is also important to take stock, celebrate the milestones as they occur and use this momentum to remind all Fellows, IMGs and Trainees how influential RACS can be when advocating strongly on behalf of our patients and the community.

Riding a dead horse

A farewell to our Professor Grumpy

PROFESSOR GRUMPY

There is one thing that really annoys me and it is dead horses. Now before the equine lovers object let me explain. There is an old Dakota Indian saying that if you discover that you are riding a dead horse the best strategy is to get off. However in our society we ignore dead horses (or ideas, usually from health administrators, that have no future) and press on. Other advanced strategies utilised include:

- Buy a stronger whip
- Change riders
- Appoint a committee to study the dead horse
- Go on a study tour to see how other places use dead horses
- Hire an outside contractor to ride the dead horse
- Redefine the dead horse as living impaired
- Harness several dead horses together to improve the pulling power
- Redefine the standards for all horses - living and dead
- Provide additional funding for training dead horses
- Declare that as dead horses do not need to be fed they are a better economic model.

If all of these measures fail, use the special technique that I am sure is familiar to all surgeons, be they curmudgeons or not; namely promote the dead horse to a supervisory position.

The 'dead horse' idea is not original but was suggested to me by a fellow curmudgeon in WA (he had better remain nameless as he may not realise that he is a curmudgeon and may be offended by the title). On researching this matter further it would seem that the idea is wide spread and no-one seems to know from whence it came, so I hope I have not infringed the 'dead horse' copyright.

On a final matter this is the final Curmudgeon's Corner article. This curmudgeon has flogged his dead horse and is exhausted so is going to use the ultimate 'dead horse' strategy – retire.

Landmark Cancer Australia Statement

Identifies 'what ought to be done' in breast cancer

RACS President Phil Truskett attended the launch and other notable guests included PM Malcolm Turnbull and Prof Helen Zorbas.

While survival for people with breast cancer in Australia is among the highest in the world, there is evidence that not all patients are receiving the most appropriate care. This unwarranted variation has the potential to have an impact on patient outcomes and experience, as well as use of health resources.

To address this variation and support improved and informed practice in breast cancer, Cancer Australia has led the development of a landmark *Statement*. The *Cancer Australia Statement – Influencing best practice in breast cancer* identifies 12 appropriate and inappropriate practices in breast cancer from diagnosis to palliative care, highlighting what 'ought to be done' in breast cancer care to maximise clinical benefit, minimise harm, and deliver patient-centred care.

The release of the *Statement* represents the culmination of a rigorous evidence review and prioritisation process. Cancer Australia brought all key clinical and cancer organisations together with women affected by breast cancer to agree the priority areas of practice. The Royal Australasian College of Surgeons (RACS) contributed to this important body of work, providing feedback to inform the development of the *Statement*.

The *Statement* encourages health professionals to reflect on their clinical practice to ensure it is aligned with the evidence and delivers value to patients and the health system. It also aims to empower people with breast cancer to engage with their health professionals and make informed, evidence-based decisions that deliver the best outcomes for them. All practices should be considered in the context of clinical judgement for an individual patient.

Importantly, the resulting *Statement* is not only underpinned by evidence, but has the support of all key clinical, cancer and consumer organisations. The collaboration and multidisciplinary approach that was central to the development of the *Statement* will continue to play a key role in its implementation.

"There are a number of practices in the Cancer Australia *Statement* that are of particular relevance to our membership," said Mr Philip Truskett, RACS President.

"RACS looks forward to continuing to work with Cancer Australia to identify optimal approaches to promote awareness and drive uptake of the *Statement*."

For more information on the Cancer Australia Statement – Influencing best practice in breast cancer and to access supporting resources, visit canceraustralia.gov.au/statement.

From Left: Dr Bastian Seidel - RACGP President, Mr Phil Truskett - RACS President, The Hon Malcolm Turnbull MP - Prime Minister of Australia, Ms Angela McGarry - Committee of the Presidents of Medical Colleges, Prof Nicholas Talley - Past President RACP, Dr Catherine Yelland - President RACP.

Cancer Australia Statement – Influencing best practice in breast cancer

1. Appropriate to offer genetic counselling to women with a high familial risk, at or around the time that they are diagnosed with breast cancer, with a view to genetic testing to inform decision making about treatment.
2. Appropriate to ensure optimal fixation of breast cancer specimens for accurate pathological examination and biomarker assessment.
3. Appropriate to consider and discuss fertility and family planning with premenopausal women before they undergo breast cancer treatment.
4. Appropriate to offer a choice of either breast-conserving surgery followed by radiotherapy or a mastectomy to patients diagnosed with early breast cancer, because these treatments are equally effective in terms of survival.
5. Appropriate to offer a shorter, more intense course of radiotherapy (hypofractionated radiotherapy) as an alternative to conventional radiotherapy for patients with early breast cancer who:
   - are aged 50 years and over;
   - have a cancer at an early pathological stage (T1-2, N0, M0); and
   - have undergone breast-conserving surgery with clear surgical margins.
6. Appropriate to offer patients with early breast cancer the opportunity for their follow-up care to be shared between a specialist and a primary care physician, to provide more accessible, whole-person care.
7. Appropriate to offer palliative care early in the management of patients with symptomatic, metastatic breast cancer to improve symptom control and quality of life.
8. Appropriate to consider the pre-operative use of chemotherapy or hormonal therapy (systemic, neo-adjuvant therapy) informed by hormone and HER2 receptor status, for all patients where these therapies are clinically indicated.
9. Not appropriate to confirm or exclude a diagnosis of breast cancer without first undertaking the triple test, which involves:
   - taking a patient history and clinical breast examination;
   - imaging tests (mammogram and/or ultrasound); and
   - biopsy to remove tissue or cells for examination.
10. Not appropriate to offer a sentinel node biopsy to patients diagnosed with DCIS (ductal carcinoma in situ) having breast-conserving surgery, unless clinically indicated.
11. Not appropriate to perform a mastectomy without first discussing with the patient the options of immediate or delayed breast reconstruction.
12. Not appropriate to perform intensive testing (full blood count, biochemistry or tumour markers) or imaging (chest X-ray, PET, CT and radionuclide bone scans) as part of standard follow-up of patients who have been treated for early breast cancer and who are not experiencing symptoms.

D'extinguished Surgical Club
Inaugural Meeting

The inaugural meeting of the D'EXTINGUISHED SURGICAL CLUB was held on 23 September 2016 at the Windsor Hotel.

It was organised under the auspices of Mr Cas McInnis who was formerly in charge of the Heritage Section of the RACS.

It is a gathering of the senior Men of Verona with presidential quality, John Royle, to discuss mutual career developments, of times past and present, while enjoying the ambience and familiarity of personalities in a collegiate setting – the Spring Street Brigade.

All schools of thought and open discussion were part of this apolitical gathering and as Cas reminded us we plan to meet two or three times a year with various focal speakers in the gathering.

The Christmas Meeting is planned for 12.30 on the 9th of December 2016 at the RACV Club, 501 Bourke Street, Melbourne.

Invitation to this meeting is extended to all Fellows. Limited places available.

Please confirm attendance via email:
felix@felixbehan.com.au

Meet the Council

Surgical News interviews Dr Claire Campbell who was newly elected to the RACS Council by the Fellowship

A Victorian Vascular Surgeon, and a Queensland academic General Surgeon will soon join the College Council following the elections held in October.

Dr Claire Campbell and Professor Owen Ung have been newly elected to the Council by the Fellowship and will take up their new roles at the Annual General Meeting to be held in Adelaide in May next year. There were four Fellowship Elected Councillor positions that were filled at the recent elections. Sally Langley and Richard Perry, both from New Zealand, we re-elected to Council.

Under the RACS Constitution, 16 Councillors are elected by the Fellowship at large and nine Councillors are elected by Fellows from the nine surgical specialties.

Their role, as the directors responsible for the College's governance, is to decide and monitor strategic direction, policy and budgets with due care and diligence and with a fiduciary duty to all Fellows to act in the best interests of the College.

Dr Campbell and Professor Ung were chosen out of a record number of candidates for the Fellowship Elected vacancies which saw 28 surgeons from around Australia and New Zealand nominate for only two Fellowship Elected council vacancies.

This year, 25.4 per cent of the Fellowship voted in the elections, a result that represents the second highest level of engagement in the past ten years, exceeded only by 27.5 per cent of Fellows who voted in the first electronic elections held in 2013.

Dr Campbell spoke to *Surgical News*.

Dr CLAIRE CAMPBELL

Dr Campbell (pictured, right) is a member of the Australia and New Zealand Society for Vascular Surgery, and other national and international bodies. She is also a member of the RACS Academy of Surgical Educators. Dr Campbell works in private practice based at the Epworth Hospital in Melbourne where her practice is mainly involved in treating venous disease.

The mother of a new baby, Dr Campbell said she will be overseeing her practice, before returning on a part-time basis, which will give her the time to contribute to the College.

She said she nominated for a position on the Council because she wanted to see RACS improve its communication with all stakeholders, provide better support to trainees and play a more prominent role in public health debates to promote disease prevention and reduce pressure on public health budgets.

She said she would also like RACS to re-engage the broader Fellowship which she described as representing an "outstanding talent pool".

"I think it is important that we improve communication with Fellows but particularly with Trainees," she said.

"Because the College has such a complex committee structure, sometimes decisions are not communicated well and while it has come a long way in recent years in terms of transparency, I think it is still sometimes difficult for Trainees to know how best to make the most of the training program.

"Yet despite improvements made in transparency and culture, only 25 per cent of Fellows voted in these elections, which means that 75 per cent appear to be disengaged, which is a great shame given the outstanding talent pool of our Fellowship."

Dr Campbell said engagement could be improved if RACS devised and introduced services that provided practical assistance to improve the professional lives of both Fellows and Trainees.

She said if funds could be found she would like RACS to be able to offer advice on how to run a private practice or assist Trainees with relocation such as assistance in finding a GP, schools or accommodation.

"I think this would create enormous good-will which is crucial if we are to keep Trainees engaged with the College into the future because we need to make them feel valued as our junior colleagues if we want them engaged once they have obtained their Fellowship," she said.

"It has become increasingly clear that we as surgeons need to do more to support our younger colleagues and each other if we are to expect our patients to trust that we can take care of them.

"We need to show we can care for each other."

Dr Campbell said she was also keen for RACS to improve communication not only with Fellows and Trainees but to work to break down the silos that exist between GPs, specialists and allied health professionals.

"Our work as surgeons is much more about managing chronic disease now than it is about treating acute disease and that means we can no longer work in an isolated silo called 'surgery'," Dr Campbell said.

"RACS has a proud history of tackling controversial public health issues like blood alcohol limits, mandatory seat belts and bike helmets and I think we could do the same in terms of nutrition.

"We have the data, we don't have to reinvent the wheel we just have to do something with it and add our voice to the broader campaign because prevention is both possible and vital, particularly in a constrained economy.

> *"It has become increasingly clear that we as surgeons need to do more to support our younger colleagues and each other if we are to expect our patients to trust that we can take care of them."*

"Instead, we need to adopt a holistic approach which includes involving our colleagues in other branches of medicine.

"It seems to me that health organisations like RACS need to start talking about processed food and taking on the major food companies like they once took on tobacco companies because the harm caused by processed food is far higher than that caused by smoking.

"For instance, 90 per cent of cardiovascular disease is entirely preventable and if we addressed that alone we could save the Federal Government $7 billion a year."

An interview with Professor Owen Ung will appear in the next edition of Surgical News.

- With Karen Murphy

Elections to Council

Fellowship elected Councillors

There were FOUR Fellowship Elected Councillor positions to be filled.

The successful candidates in alphabetical order are:

Re-elected to Council
Sally Langley (PRS, NZ)
Richard Perry (GEN, NZ)

Newly elected to Council
Claire Campbell (VAS, VIC)
Owen Ung (GEN, QLD)

Specialty elected Councillors

Neurosurgery Specialty Elected Councillor
Re-elected to Council
Bruce Hall (QLD)

Plastic & Reconstructive Surgery Specialty Elected Councillor
Newly elected to Council (previously appointed to fill casual vacancy)
Geoff Lyons (NSW)

Urology Specialty Elected Councillor
Newly elected to Council
Mark Frydenberg (VIC)

The pro bono contribution of Fellows has been, and continues to be the College's most valuable asset and resource. We are grateful for their commitment. We are also grateful to the voting Fellows (25.4%) who demonstrated their engagement with the governance of the College.

The results will be tabled at the Annual General Meeting in Adelaide on Thursday 11 May 2017 when newly elected Councillors take office.

The poll results are verified by Mr Ralph McKay of BigPulse.

Congratulations to the successful candidates and sincere thanks to all candidates who nominated.

Is spinal cord injury due to the effects of ageing reversible?

Surgical decompression not only improves function in patients suffering from cervical spondylotic myleopathy (CSM) through relieving pressure on the spinal cord but could also help patients recover by allowing for the growth of new nerve fibres (axons), according to Neurosurgery Trainee Dr Rana Dhillon.

Dr Dhillon spent 2014 conducting research into the pathophysiology of CSM at the prestigious Anne McLaren Laboratory for Regenerative Medicine at the University of Cambridge, England, working under the supervision of Dr Mark Kotter from the Department of Clinical Neurosciences.

CSM is a neurological condition that arises when the spinal cord becomes compressed due mainly to the effects of aging and is believed to be the most common spinal disorder in patients over 55 years of age.

Typically, CSM develops over years causing gait changes, numbness and weakness in the upper limbs and impairment to bladder and bowel function.

However, Dr Dhillon said that although CSM was a relatively common disease, it had not been widely studied.

"We don't fully understand the pathology driving CSM or the results following surgery so I set out to find out what was happening on the cellular level after decompression," Dr Dhillon said.

Working alongside other scientists, Dr Dhillon created a pre-clinical model of CSM by using an expandable polymer in the dorsal cervical epidural space, which simulated graduated spinal cord compression.

Animals underwent neurobehavioural and electrophysiological testing, followed by sacrifice and immunohistochemical analysis over a period of 15 weeks.

"We found that compression impairs function and causes axonal injury and that decompression improves function and promotes serotonergic sprouting," he said.

"In the model we worked on, no evidence was found for other candidate mechanisms for recovery which suggests that as axonal injury is central to the pathology of CSM, part of this injury may be reversible.

"Surgical decompression increases spinal cord blood flow and results in changes in the metabolic milieu, changes which may result in immediate improvements of cellular and axonal function.

"However, we know from experience that decompressed CSM patients can take months after the operation to demonstrate functional recovery."

Dr Dhillon said the most common treatment for CSM was surgical decompression with or without fusion through an anterior or posterior approach.

However, he said a sub-set of patients with poor functional status pre-operatively often did not show significant improvement following surgery and that surgeons needed a better understanding of the mechanisms underpinning functional recovery.

"This disease occurs when degenerative cascade affecting the vertebral column leads to narrowing and hypermobility, which ultimately damages the spinal cord as it runs through the vertebral column," he said.

"Many people present late because they mistake the disease as part of the ageing process.

"Yet, we know that those patients who experience better outcomes from cervical spine surgery are those who have had a shorter duration of symptoms, are younger and have single, rather than multiple, areas of spinal cord involvement.

"This means that timely intervention is required to maximise benefits which suggests that we may need to raise awareness that the neurological deficits caused by CSM are not simply functions of aging but a disease that can be treated well if treated in time."

Dr Dhillon said it was exciting to find that a degree of plasticity does occur post operatively.

He said this could enable scientists to begin to investigate novel therapies to promote axonal sprouting.

"Our aim in the future would be to take those patients who do not do well after surgery and treat them with therapies which enhance plasticity such as Rho Kinase Inhibitors which we believe could enhance the mechanism of repair that already happens after surgery," he said.

"This research will take time but it is important because CSM is a common and debilitating disease that affects a large number of people and while the economic burden of the disease has not been calculated, it is likely to be large.

"With continued ageing of the populations in the industrial world, the incidence and prevalence of CSM is expected to increase so that concentrated efforts are therefore required to develop therapeutic options for promoting functional recovery following decompression surgery."

Dr Dhillon's research, for which he was awarded a Master of Philosophy in Clinical Neuroscience, was supported by RACS via a Foundation for Surgery Reg Worcester Research Fellowship.

Now in his final year of training and working at the Monash Medical Centre in Melbourne, he said he hoped to receive his FRACS within the next few months and he thanked the College for the support that allowed him to take up the research Fellowship at the University of Cambridge.

"It was a fantastic experience and very humbling to work alongside such talented and hardworking scientists and researchers," he said.

"It was wonderful to have the opportunity to gain exposure to the work done in major laboratories and to see how rigorous the scientists and researchers are in producing their data and the integrity they bring to their work."

The Scholarship provided to Dr Dhillon was funded from a gift by the late Alan Worcester, FRACS, to memorialise his brother Reg, a great educator, doctor and humanitarian. It is open to both Fellows and Trainees enrolled in, or intending to enrol in, a higher degree which incorporates research of relevance to the surgical care of patients.

- With Karen Murphy

CAREER HIGHLIGHTS

- Master of Philosophy, Clinical Neuroscience, University of Cambridge
- 2013: RACS Foundation for Surgery Reg Worcester Research Fellowship
- 2013: Neurosurgical Society of Australasia Research Scholarship
- 2010: RACS Research Prize for Trainees

Professional Standards

Year in Review

DR LAWRIE MALISANO
Chair, Professional Standards

The Professional Standards portfolio has been working on a number of strategic priorities that contribute to promoting the highest standards in surgical care. In 2016 this has included updating the RACS Code of Conduct, revising the Continuing Professional Development (CPD) program and participating in a number of consultations including the Medicare Benefits Schedule (MBS) Taskforce Review, the Medical Board of Australia (MBA) consultation on revalidation and the Medical Council of New Zealand (MCNZ) stakeholder forums.

CPD Review

After broad consultation with the Fellowship, the review of the RACS CPD program has been completed, with the Professional Standards Committee working to ensure that any changes to the program are kept to a minimum. The changes to the program reflect the recommendations from the Building Respect, Improving Patient Safety Action Plan[1] and ensure that the program remains aligned with the MBA and the MCNZ standards. The most notable change is the introduction of a 'reflective practice' category which encourages Fellows to participate in education that promotes self-reflection and champions respectful behaviour.

To better support Fellows completing their CPD, we have been working on a number of resources and tools including an online Learning Plan, which will assist Fellows to plan and reflect on their activities each year. RACS has also been working with education providers throughout the year to develop a process that automatically populates attendance at RACS CPD approved activities into CPD Online. From 2016 Fellows can expect their attendance at activities approved by RACS to be populated in CPD Online within two weeks of attendance. Activities that have been automatically uploaded will also be automatically verified on a Fellow's behalf, if they are selected for verification.

The revised 2017 CPD program and associated changes to CPD Online are effective as of 1 January 2017 and I encourage you to go online to ensure you are familiar with the program requirements.

Revalidation

The MBA has established an Expert Advisory Group (EAG) to explore options for revalidation in Australia, releasing an interim report in August 2016. With the President and key Councillors, we have actively participated in the consultation phase and prepared a submission that will be available on the RACS website.

The MBA has identified two distinct elements as underpinning an approach to revalidation in Australia:

- Maintaining and enhancing the performance of all doctors practising in Australia through efficient, effective, contemporary, evidence-based continuing professional development (CPD) relevant to their scope of practice ('strengthened CPD') and;
- Proactively identifying doctors at risk of poor performance and those who are already performing poorly, assessing their performance and when appropriate supporting the remediation of their practice".[2]

RACS is broadly supportive of the direction being taken by the MBA, including the need for a system-wide approach to improve oversight and remediation of underperforming practitioners. We have taken the position that the onus is on the specialist medical colleges to assume the responsibility of self-regulation. Through active involvement in the early stages of consultation, we are better able to shape and influence the impact of revalidation on our Fellows.

Code of Conduct

In early 2016 the Code of Conduct Working Party met to evaluate all aspects of the RACS Code of Conduct. The objective of the review was to ensure that the content of the Code effectively addressed the contemporary issues and challenges faced by surgeons in their practice, reflecting the values of our Fellowship. During the review the structure of the Code was simplified to improve clarity and address operative practice issues that have arisen since the previous revision. The updated Code clearly expresses that bullying, discrimination or sexual harassment are unacceptable behaviours and that all Fellows have a responsibility to work towards a workplace culture that is supportive and respectful. The Code provides Fellows with an opportunity to reflect on their current practice and make adjustments in areas where they feel they can improve their operational or business practices.

Position Papers

The Professional Standards Committee has continued to progress the development and revision of position papers that address key issues in our surgical practice.

The End of Life Position Paper highlights the impact medical intervention has on life expectancy as patients' options for care in the latter years of life have increased. The value and risk associated with interventions for patients with terminal conditions is a dilemma with which surgeons are familiar, however, this does not make these conversations any less challenging. The RACS paper seeks to affirm the importance of patients' early consideration to end of life options, the role of palliative care and the importance of realistic expectations regarding procedures.

The Briefing and Debriefing Position Paper promotes the importance of surgeons initiating conversations before and after operating lists/procedures to ensure all members of the team understand the plan for the operation and that any issues are promptly addressed following the surgery. This paper acknowledges that surgeons will adapt this practice to suit their context, but that briefing/debriefing practice together with the surgical safety checklist, are key parts of ensuring excellence in patient care and safety.

Medicare Benefits Schedule (MBS) Review Taskforce

The MBS Review Taskforce has been steadily progressing with the second tranche of clinical committees, finalising their recommendations and opening for public review. RACS Fellows have been actively involved in the clinical committees, with RACS assisting to coordinate the distribution of these reports and developing responses in regards to areas of concern. RACS will continue to carefully monitor the recommendations put forward by the Clinical Committees and ensure that, whenever necessary, the perspectives of Fellows are brought to the attention of the Taskforce.

Submissions

Professional Standards has continued to take the lead in a range of key submissions and consultations on medical and regulatory standards. We have responded to requests to ensure that the voice of surgeons is clearly articulated on issues including: the NHMRC 'Better informed health care through better clinical guidelines discussion papers', the 'Cardiovascular' Therapeutic Guidelines, the NSW Health 'Cosmetic Surgery and Private Health Facilities', the ACCC 'Private Health Insurance Senate Report', the 'Use of Chlorohexidine guidelines'. If you are interested in the College's response to these issues, please visit the RACS website for further information.

Sustainability in Healthcare

The Sustainability in Healthcare committee has continued to give consideration to the challenges facing our healthcare system, including an ageing population, increase in preventable disease and the financial cost associated with the rise of new technology. Together with General Surgeons Australia, RACS has been involved in the development of a list of five 'think twice' procedures for submission to the Choosing Wisely Initiative. The goal of the Choosing Wisely Australia initiative is to spark conversations between patients and clinicians about what care/tests are truly necessary for specific conditions. The Committee also sought input from all specialties and recognises contributions from Australian Society of Otolaryngology Head and Neck Surgery. We encourage all specialties to provide initiatives for this important aspect of healthcare sustainability, as with time it will be the healthcare team which will drive efficiencies and improved outcomes. International experience is of trainees providing the major impetus for implementation of choosing wisely initiatives.

Members of the committee were also heavily involved in the collaboration with Medibank Private to develop a number of clinical variation reports[3], an initiative that seeks to improve and progress understanding about variations in surgical practice. Variations in cost, length of stay in hospital and readmissions are highlighted in the reports that are designed to encourage specialist conversation about the best ways to improve private hospital clinical outcomes and patient care.

Year Ahead

RACS will continue to engage with the Medical Board regarding revalidation and we will ensure we lead the conversation and will prepare to embrace any potential future changes in this area. The College will also commence accreditation by the Australian Medical Council (AMC) early in the year. AMC accreditation enables RACS to deliver specialist medical education and training and the Continuing Professional Development program.

The Professional Standards Committee will be involved in the development of a number of position papers impacting our Fellows including use of patient data, standards for day surgery and medical tourism. If you are interested in the College's work in these areas or would like RACS to advocate on other issues of importance, please contact the department at Professional.Standards@surgeons.org.

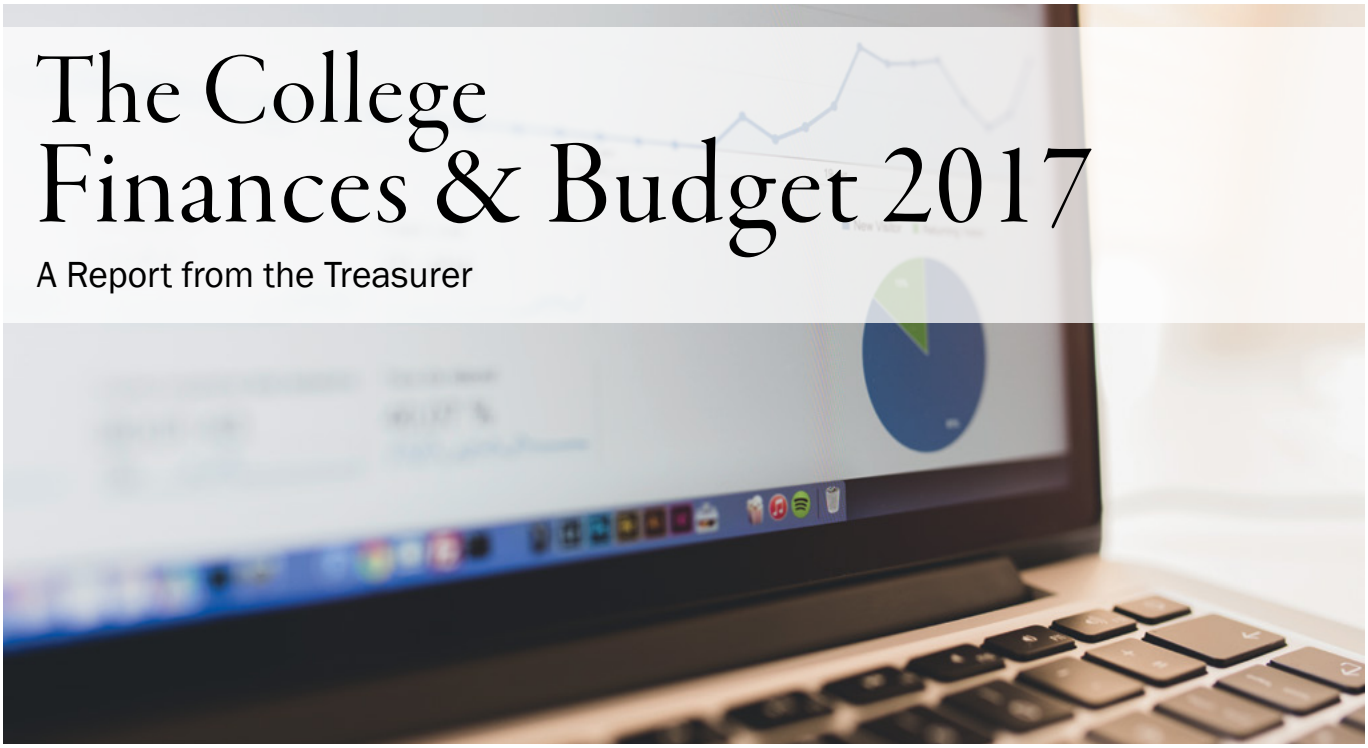
To maintain the standards of CPD, a working party has commenced a review of the Surgical Audit & Peer Review Guide. The aim of the review is to progress the surgical audit guide to be at the forefront of international standards. We will provide an update as to the progress of this review; the updated guide will be available in early 2017. To achieve CPD compliance in 2017, all Fellows as well as Trainees and International Medical Graduates must complete the mandatory 'Operating with Respect' eLearning module. The module, developed by Fellows, will assist to ensure we uphold the standards and responsibilities of our profession.

I would like to take this opportunity to thank all Fellows for the ongoing participation in the RACS CPD Program, which is recognised as one of the leading medical programs in the world.

1. https://www.surgeons.org/media/22260415/RACS-Action-Plan_Bullying-Harassment_F-Low-Res_FINAL.pdf
2. http://www.medicalboard.gov.au/Registration/Revalidation.aspx
3. http://www.surgeons.org/policies-publications/publications/surgical-variance-reports/

The College Finances & Budget 2017

A Report from the Treasurer



JULIE MUNDY
CollegeTreasurer

In contrast to recent times, Budget 2017 has been one of the more challenging budgets to develop. With the Council's support we have focused on funding the strategic imperatives and delivering a balanced financial result. RACS needs prudent fiscal management to ensure that our services are planned and delivered in a financially sustainable and efficient manner.

OVERALL FINANCIAL POSITION

Figure 1 shows RACS is in a sound financial position. The net worth has grown overtime from modest operational surpluses, positive investment returns and significant one-off contributions from generous benefactors. We remain committed to funding the research scholarships and grants program.

COLLEGE CATEGORIES

Figure 2 shows the three categories of revenue and expenses that we use to manage the business. Council has long held a view that Category 1, the core business, needs to generate a small surplus to provide allowance for ongoing investment in areas of strategic priority. Category 2 is for projects delivered under various funding agreements including the multi-year Specialist Training Program (STP) and is very much subject to funding variability in

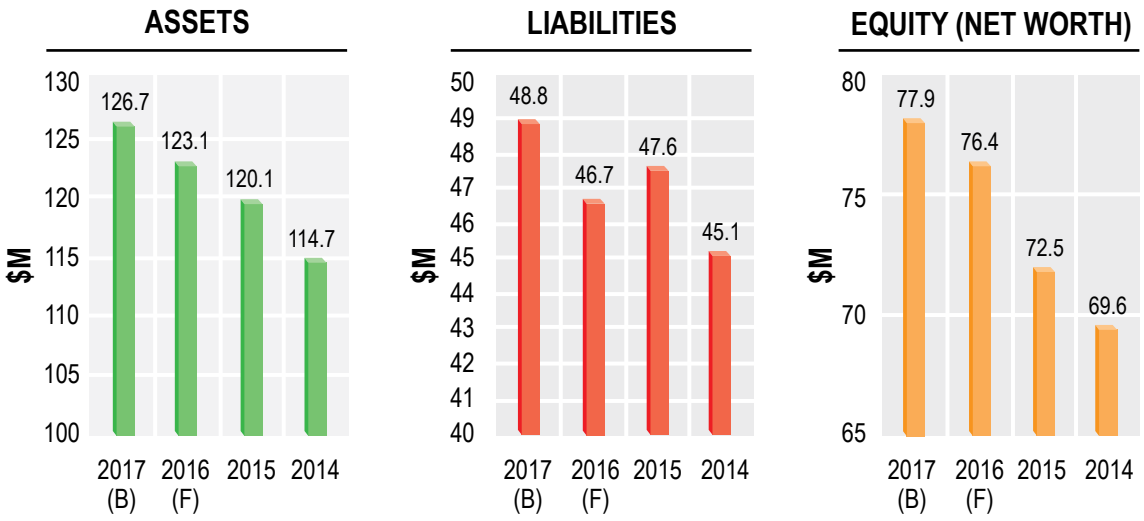


Figure 1: RACS Assets, Liabilities and Equity (Net Worth)

accordance with project deliverables and funding terms. Category 3 is the Foundation, whereby revenues are mostly generated from investments and donations and are committed to fund our scholarships and charitable work.

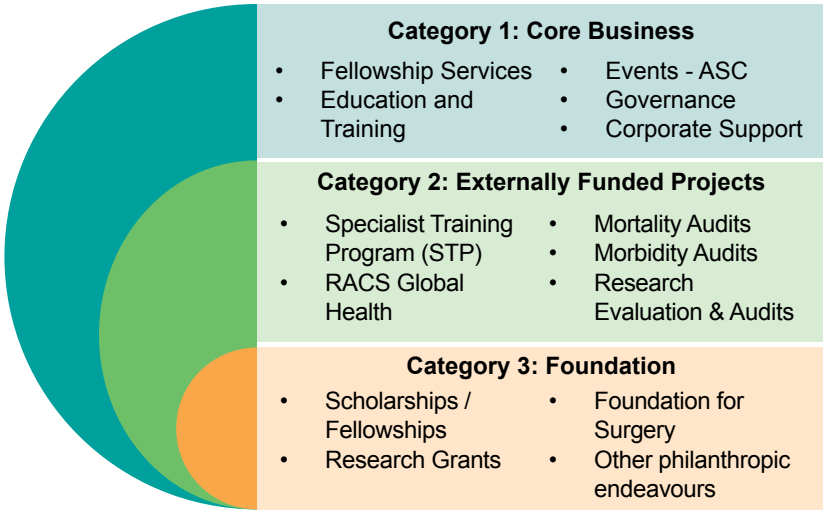


Figure 2: College Categories

BUDGET 2017 MAJOR DRIVERS

There have been five key drivers for Budget 2017:

- Building Respect and Improvement Patient Safety (BRIPS)
- Prevocational sector and examinations
- Investments
- Operating surplus
- Subscriptions and fee increases

BRIPS

Council remains committed to implementing the recommendations of the Expert Advisory Group (EAG) to remove Discrimination, Bullying and Sexual Harassment (DBSH) from the clinical workplace. Our BRIPS campaign is moving into a critical education phase, where Budget 2017 must fund 80 mandatory Foundation Skills for Surgical Educators (FSSE) courses across the two countries as well as the development and implementation of courses in advanced training in preventing DBSH for specialty Boards and supervisors. A key outcome will be establishing a common framework amongst the Fellowship for identifying DBSH issues in the workplace and providing the tools to address these issues as they arise. Attendance at these courses is free and we are keen to run these courses in cooperation with hospitals to minimise cost and offer convenience to attendees.

DBSH Action Plan (Opens PDF)

Prevocational sector and examination registrations

We have seen 400 Junior Doctors (J-Docs) subscribe to the J-Docs Framework and pleasingly many are looking to take the opportunity in 2017 to complete the Generic Surgical Sciences Examination. Thanks to our previous initiatives to make all examinations online, we have the capability to meet this demand.

Investment returns – The Foundation

Five years ago, Council made the decision to lock away permanent capital into Corpora to fund the Foundation scholarships predominantly from investment returns. Budget 2017 factors in an estimated return of 5%, which in turn will dictate the available funding for the 2018 scholarship program. The 2018 scholarship program is intentionally approved by Council 12 month in advance to allow applications to open by early March 2017. The Investment Committee has intentionally set a lower projected rate of return as compared with the 2017 scholarship budget due to the considerable volatility and ongoing uncertainty in the capital markets. As a result we have prioritised the scholarships we will fund in 2018 totalling $1.2M. This funding commitment for 2018 excludes the RACS International Development Program which will be finalised as part of the next annual budget cycle.

The 2017 scholarship budget predominantly approved by Council back in 2015 and inclusive of the RACS International Development Program provides significant funding of $2M. This includes taking the necessary steps of using some capital to fund highly valued commitments, like improving Indigenous and Maori Health on both sides of the Tasman.

Operating Surplus

Council supports that each budget should aim for a modest surplus. Across all categories the goal is to achieve a surplus of $1.5M representing a 2% surplus return on overall revenues of $72.3M. At the end of each year, this surplus is then allocated to fund future new key initiatives (NKIs) or added to the Corpora. ▶

Category	Revenue ($M)			Expenses ($M)		
	2017 (B)	2016 (F)	% Change	2017 (B)	2016 (F)	% Change
Category 1 "Core"	$47.8	$43.9	+9%	$47.3	$43.2	+9%
Category 2 "Externally Funded Projects"	$19.4	$19.3	+1%	$19.8	$19.7	+1%
Category 3 "Foundation"	$5.1	$6.0	(15%)	$3.7	$3.9	(4%)
Overall	**$72.3**	**$69.2**	**+5%**	**$70.8**	**$66.8**	**+6%**
Legend: (B) = Budget (F) = Forecast						

Table 1: Summary Financials by Category

Subscriptions and Fees

The continuing commitment to the BRIPS action plans and aligned activities, like supporting the planned 80 FSSE courses, has driven the decision by Council to increase the annual subscription fee by 4% above the 2% CPI. The funding RACS receives from its Fellows 2017 annual subscription underpins its funding of core services and enables delivery of the comprehensive BRIPS action plans. (refer Table 2).

RACS Fees Schedule(Opens RACS Website)

STRATEGIC INVESTMENTS

Over the last three years, we have seen three areas that have justifiable needs for on-going investments in Budget 2017:

1. Supporting and delivering the BRIPS campaign.
2. Investing in IT to improve online services such as the Digital College, exam delivery, online professional development and the internal operations.
3. Increasing resources to support the advocacy work, including a responsive social media capability that is necessary in this digital age to serve the RACS brand.

During the creation of Budget 2017, the Council and management teams have deliberated to ensure we continue to see benefits and capability growth from these areas. We have also committed to a review of major expenditure items, so that Budget 2018 can be placed on an even firmer footing.

Fee description all GST inclusive (unless otherwise indicated*)	AUD$ 2017	NZD$ 2017
Annual subscription	2,975	3,390
Fellowship entrance fee	6,105	6,955
SET annual training fee - RACS	3,405*	4,270
Fellowship examination fee	8,165*	10,235
Pre Vocational – Generic Surgical Science examination fee	4,320	4,925
IMG Specialist assessment fee	9,780	N/A
For summary listing of key 2017 fees refer to RACS website www.surgeons.org		

Table 2 – Sample RACS Fees for 2017

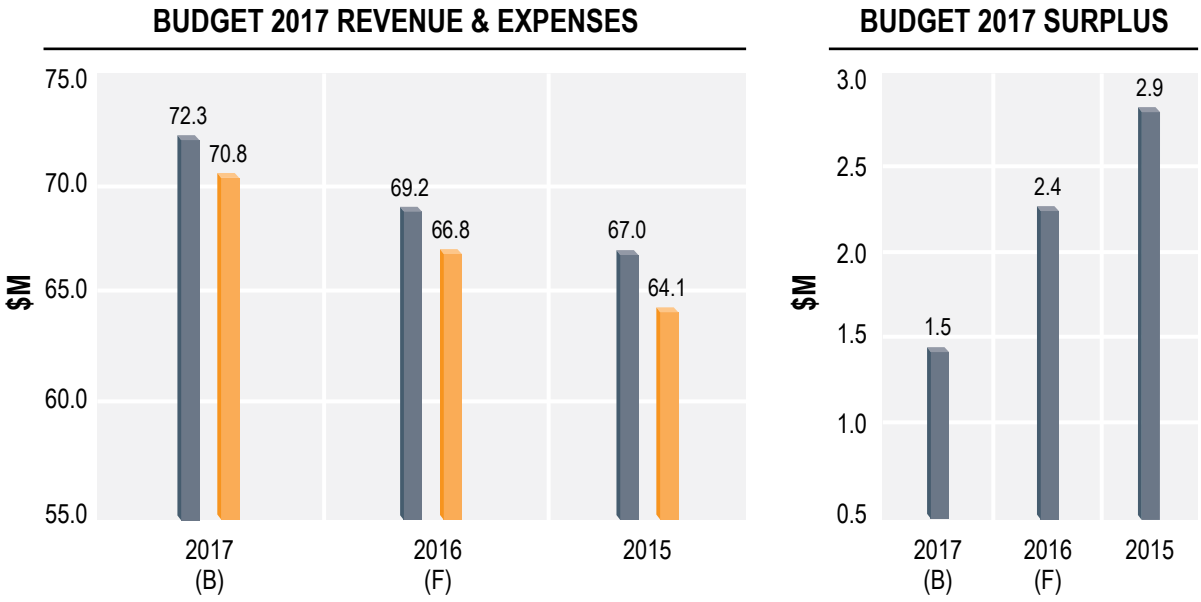


Figure 3: Budget 2017 Summary

NEW KEY INITIATIVES

We have committed to continued funding of the listed multi-year NKI's from 2016 into 2017:

- Tablet marking for the Clinical and Fellowship examinations;
- Two Examiner eLearning modules, one for the Clinical Examiners and a Refresher Module relevant to all Examiners;
- An eLearning module for Surgeons as Leaders in Everyday Practice;
- A new mobile interface with the ability to create MALT cases and update notes in an offline fashion in areas without internet access; and
- The selection of new website technology.

In selecting new initiatives, the focus has been very much on those that will provide strategic imperatives, service, innovation, productivity and quality improvements:

- Staffing and support for delivering the Māori Health Action Plan;
- EMST Faculty retraining, including the move to the use of manikins in courses;
- New question management systems for examinations;
- Upgraded eCommittees; and
- Further technology enhancements to support the Digital College.

All up the continuing work and NKIs for 2017 have a total funding cost of $1.5M.

BUDGET 2017 IN SUMMARY

This budget is a balanced budget and has an operational surplus that may be required to manage any unexpected challenges that may occur. It supports the strategic activities and sees new initiatives that will make a positive difference for Fellows, Trainees and IMG's.

RACS Strategic Plan 2014-2018 (Opens PDF)

The Fellowship should also be assured that Council has a strong desire to keep costs in line with revenue. This means that we may not always be able to put resources into all new ideas or research pieces that surface in 2017, but with supporting business cases and justifications we can set aside resources and funds to tackle anything new in 2018. The Fellowship should rest assured that we are committed to providing good fiscal stewardship for RACS.

WHAT CAN I DO?

The Council appreciates the pro-bono work that many Fellows put into supporting RACS activities. We are also conscious that in 2017 we are looking for Fellows to:

1. Be committed that as a profession we must be leading from the front to address DBSH issues in the workplace.
2. Promote the BRIPS campaign within your hospital and practice; and contact the RACS team who can provide posters, brochures and other resources.
3. Commit to attending an FSSE course and if there is not one scheduled at your hospital contact the RACS staff to organise one.
4. Be aware of the travel policy and please stay within the guidelines, as travel costs remain a significant part of our expenditures.

2016: Onwards and Upwards

ASSOC. PROF. STEPHEN TOBIN
Dean of Education

DR SALLY LANGLEY
Chair, Professional Development

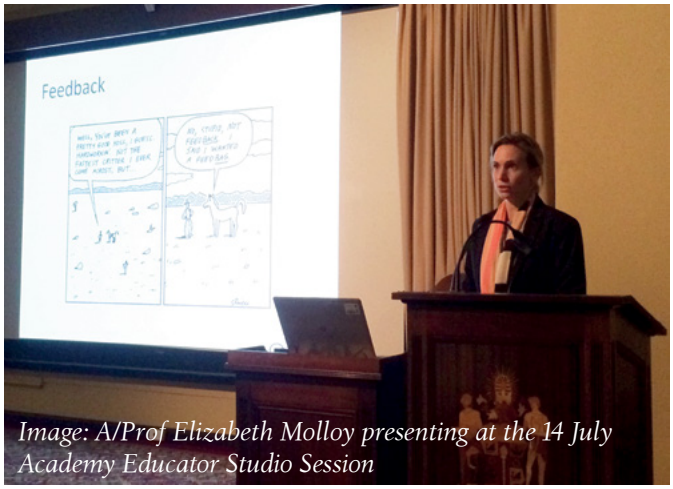


Image: A/Prof Elizabeth Molloy presenting at the 14 July Academy Educator Studio Session

What a great year 2016 has been for the Academy of Surgical Educators (ASE) with the membership base growing, reaching the 700 mark and around 1300 attendees participating in our surgical educator-related activities and courses.

Since the inception of the Academy, it has evolved into an active community of practice and recognises the contribution of surgical educators via the ASE Recognition Awards. The recipients of the Educator of Merit - Supervisor/Clinical Assessor of the Year Awards are Mr Daniel Fletcher of VIC, Dr Mark Muhlmann of NSW, Mr Donald Pitchford of QLD, Dr Marina Yeow of SA, Prof David Fletcher of WA, Mr Tobias Evans of TAS and Ms Jane Strang of NZ. The Educator of Merit Award - Facilitator/ Instructor of the Year Award was won by Mr David Speakman. The Academy Award winners were presented with their awards at the Academy Forum on 10 November in Melbourne.

With the RACS Building Respect, Improving Patient Safety Action Plan in motion, the Academy has been highly involved in the roll-out of 36 Foundation Skills for Surgical Educators (FSSE) courses across Australia and New Zealand in 2016 and around twice that are coming up in 2017. The FSSE course is now mandatory for surgeons who are involved in the training and supervising of RACS SET Trainees.

As part of the Academy's public awareness campaign, the Dean of Education has been presenting about the Academy of Surgical Educators and other RACS activities at the RACS Annual Scientific Congress and the National Prevocational Medical Education Forum. RACS and the Academy were represented at the International Conference on Residency Education (ICRE) 2016 in Niagara Falls by Dr Sally Langley, A/Prof Stephen Tobin and Dr Lawrie Malisano. A well-received interactive workshop was given on the Building Respect, Improving Patient Safety Action Plan. A presentation on 'Leaving Surgical Training' received a lot of interest as well.

The 6th International Medical Symposium (IMS) was hosted by Royal College of Physicians (RACP) in Sydney this year and the theme 'Future Challenges for the Medical Profession' developed from the 2015 IMS theme. As part of the Trinations Alliance annual meetings, workshops on Leadership and Entrustable Professional Activities were part of the program itinerary together with IMS 2016. The workshops and symposium attracted participants from a wide range of colleges, medical schools, health services and regulators. A number of eminent local and international experts presented at the symposium, with the keynote speakers comprising Dr Julian Archer, Prof Olle ten Cate and Prof David Sinclair. The 2017 IMS hosted by Australian & New Zealand College of Anaesthetists (ANZCA) will be held at The Pavilion, Arts Centre in Melbourne on 10 March 2017.

In May, the Annual Scientific Conference (ASC) Surgical Education stream was convened by Dr Rhea Liang. In keeping with the Congress theme of 'Surgery, Technology and Communication', the Surgical Education programme aimed to bring together the broadest possible range of participants. Professor Jonathan Beard, Chair of Surgical Education from Royal College of Surgeons (England) presented a keynote lecture on the 'Role of Endovascular

Simulators in Vascular Surgical Training', and the Hamilton Russell Memorial Lecture on 'A Concise Guide to the Selection, Maintenance and Recycling of Surgeons'. Next year will see an exciting line-up for the 2017 ASC Surgical Education stream as it will follow on from ICOSET2017, to be held at the Adelaide Convention Centre on 7-8 May (immediately before ASC). ICOSET will include many significant overseas surgical educators and an excellent program is being developed. Watch this space!

The Academy hosted two Forums this year with the first one in August, in conjunction with the SA, WA and NT Annual Scientific Meeting (ASM). In line with the ASM theme, the August Forum focused on 'Changes in Health Education: 2016 and Beyond'. Prof Ian Symonds, Dean of Medicine from University of Adelaide presented

Image: Ms Debbie Paltridge facilitating a FSSE course

on 'Transforming Health Education: The Past, Present and Future of Medical Training' and Prof Robert Padbury FRACS Divisional Director of Surgery from Flinders Medical Centre presented on 'Understanding Human Factors - A Key to Leadership'.

Meanwhile, the second Academy Forum with the theme 'What It Takes to Take the Lead' was held in November in conjunction with the Section of Academic Surgery (SAS) and the Surgical Research Society (SRS) meetings in Melbourne. The November Academy Forum saw presentations from A/Prof Victoria Brazil, Director of Clinical Simulation from Bond University on 'Leadership and Healthcare Tribalism' and A/Prof Grant Phelps, Clinical Leadership from Deakin University on 'Why Would Anyone be Led by You?'.

The Educator Studio Sessions are showcase presentations from medical educator thought leaders on topics of interest to members. Eight presentations were delivered in 2016 from Prof Julian Smith, Mr Adrian Anthony, Prof Olle ten Cate, Dr Rhea Liang, A/Prof Stephen Tobin and Dr Kirstie MacGill, A/Prof Elizabeth Molloy and Dr Caroline Ong*.

The Graduate Programs in Surgical Education offered jointly by the University of Melbourne and RACS offer a suite of programs that address the specialised needs of teaching and learning in the modern surgical environment. The program currently has 45 students in its system with a number completing their Masters.

Prof Robert Padbury and A/Prof Stephen Tobin answering queries at a Q&A session during the 25 August Academy Forum

The Academy is supported by an interactive online learning community where members can gather ideas, share interests and research, find resources and keep abreast of upcoming events. The environment is supportive, collaborative and fosters enthusiasm in surgical education. It includes: a newly-revamped database resource that contains searchable items such as articles, e-newsletters, recordings* of webinars together with listings of workshops and courses, pathways to become Trainers and Supervisors and award information. Academy members have responded to requests for faculty training related to delivery of courses such as the FSSE; this is most appreciated.

Membership of the Academy is open to all Fellows, Trainees, IMGs and external medical educators who have strong educational interests and expertise. For more information on getting involved in Academy activities or how to become a member, please contact Grace Chan on +61 3 9249 1111 or ase@surgeons.org

**To access the vodcasts for the above presentations, login to RACS website, go to My Page, eLearning, Academy of Surgical Educators, Database Resources*

Congratulations

The recipients of the Educator of Merit - Supervisor/Clinical Assessor of the Year Awards:

Mr Daniel Fletcher of VIC
Dr Mark Muhlmann of NSW
Mr Donald Pitchford of QLD
Dr Marina Yeow of SA
Prof David Fletcher of WA
Mr Tobias Evans of TAS
Ms Jane Strang of NZ

The Educator of Merit Award - Facilitator/ Instructor of the Year Award:

Mr David Speakman

Harassment – What to say when words fail you

In the October edition of *Surgical News* the spotlight was shone on 'harassment' and the need for those who feel harassed to describe the behaviour of concern, and to articulate the resultant negative impacts.

SUSAN HALLIDAY

Harassment is a form of discrimination. Our equal opportunity and anti-discrimination laws make it clear that it is unlawful to discriminate against a person by treating them less favourably, which could include harassing them on the basis of a protected attribute. Protected attributes can include, but are not limited to, a person's sex, race, pregnancy, parental status, disability, religion, sexual orientation, gender identity, marital status, family responsibilities, and age. As a form of discrimination 'harassment' including 'sexual harassment' is generally defined as unwelcome conduct that causes offense, humiliation or intimidation that a reasonable person in the circumstances at hand, would anticipate as offensive, humiliating or intimidating.

Whether you are the person being harassed, or a witness to the unacceptable behaviour, or being trained in an environment that is permeated by inappropriate banter, tasteless jokes and offensive side comments, there is a need to speak up. There are many ways to speak up or call out the behaviour; and there are many different people to whom you can speak. We all have a responsibility to do so as employees, contractors and consultants – as we are all workplace participants. To do nothing is always the wrong choice. Indeed to fail to raise concerns is to 'allow' and to 'permit' the poor standard of behaviour. In this day and age, a lack of action will equate to condoning the harassment.

It is crucial to understand that a single incident linked to, or based on, one of the legally protected attributes can constitute harassment. Often in cases of harassment based on sex, gender identity, sexual orientation, race, religion, disability and sexual harassment, offended parties (including witnesses) find that they are lost for words. At the time it is important to remember that mood, motive or intent are irrelevant, and that no matter what the circumstances people are entitled to a comfortable, safe, harassment-free environment. It is the impact and the nature of the behaviour that resonates with offended parties, and in turn that is assessed by those tasked with managing generic notifications about repeat offenders, cultural concerns and specific complaints.

The outcomes of cases that surface under our equal opportunity and anti-discrimination laws make it very clear that unacceptable behaviour should be prevented through education and timely comprehensive responses. It is a requirement that unacceptable behaviour is identified for what it is, and eradicated.

However in the heat of the moment, or when unfairly impacted by a respected senior practitioner, or harassed by the person who determines the rosters or which casuals are to be offered shifts, the most intelligent and articulate among us can be lost for words. Calling out unacceptable behaviour can be hard when people have assessed the associated vulnerabilities for themselves and their colleagues. That said the obligation that every workplace participant has to speak up, does not diminish – it may however determine the path taken, or the person with whom the necessary conversation is had.

When addressing the machinations of poor workplace and work-related conduct, the ultimate aim is for people to have a heightened awareness and to be more astute about their own comments and behaviour. The need for people to engage in sound audience analysis, and to take the time to reflect, sensitive to the responses of others, remains.

While keeping our own behaviour in check is important, we do have the opportunity and responsibility to encourage others to do the same. Shocked by a rude side comment, you may respond immediately. Or it may be that grappling with outrage by what was said to your new colleague, requires a different pathway – so calmly drafting a professional email to the offending party given the public humiliation you and others witnessed may be the best way forward.

In response to conduct that could amount to harassment, the following phrases and sentences may be helpful. They can of course be dissected and utilised in relation to any issue of concern, but have been compartmentalised as example types.

Gender:

I have every right to feel comfortable about accessing your help in the same way as my female colleagues, but you make a point of telling people, which you don't do with others. Put yourself in my shoes – how would you feel?

I am writing to ask that you use my correct name in the workplace. The nicknames you have used over recent times are aligned with a female child, and they cause me embarrassment. Both male and female team members have taken your lead and are calling me by the nicknames to rib me. I need this to stop.

Sexual harassment:

You might not be aware of it, but I found your comment offensive and embarrassing. I know some people seem

to enjoy your humour, but I'd be grateful if you could consider all of the women in the room when prior to making judgemental sexual comments.

No one else is willing to tell you, but it's in everyone's best interests to let you know that people are uncomfortable about some of the provocative and sexualised views you express, and that they are often repeated with a level of disdain and upset when colleagues inquire about the morning's activities.

We all know how I became pregnant – but I need to tell you that I'm over the sexual references to my private life. While others laugh, it's not funny for me, and it needs to stop.

Unwanted advances:

You've asked me out previously and I thought I had made my position clear; I want to keep our relationship strictly professional. I hope you can understand the position I am in, and respect my wishes.

I didn't appreciate the texts you sent late last night. I'm not interested and those types of comments will affect our professional relationship.

Sexual orientation and Gender Identity:

I appreciate that you've got firm personal views and you're struggling with the language, but gay and lesbian employees deserve the same respect as everyone else in this environment. As a colleague I'm offended and feel angry that you refer to my peers like that.

I am most concerned by your joke on facebook given your professional standing. My step son is transsexual and I can assure you that it takes courage and integrity to share your real identity with others.

Carer Responsibilities:

Professionally I disagree with your comment that someone who works part-time is less committed to their work. Everyone has different responsibilities. He gets his work done and his commitment to his children is highly regarded. You need to stop making him and his situation the brunt of your jokes – its harassment.

Your comments about needing a good woman to look after me are presumptuous and sexist the way I hear them. Don't assume the way you see the world is what others aspire to.

Racism:

I'm hoping you didn't intend to offend, but either way I'm not happy about that comment. It's unreasonable to stereotype like that. And for the record my niece is married to a school teacher who is …….

Mocking her accent like that wasn't called for. She has a right to disagree with you. Maybe you missed the looks on people's faces – it was seen as a personal attack, even though it was a variance of professional views.

You need to take on board that our workplace and profession should mirror the community. It can be hard to start again and those comments from respected people make me wonder if I made the right decision.

I was uncomfortable with those gestures. For you they are just gestures – for me they are more, and relate to inhumane acts that my community has suffered.

Religious :

I have to be honest with you, I think you expressed that poorly, and misread the room by making light of the situation. People have left feeling uncomfortable and would probably say that you are bias in your decision making. No one was game to raise it at the time – but you need to fix this.

What you've said is cynical and not true. It puts me in a dreadful position and I'm offended. There is no special treatment. We have a responsibility to provide a prayer room, a breastfeeding room, and a disability toilet – we are all different … it's about tolerance and understanding. You are harassing and ostracising me when you say I get special treatment.

Disability:

Her speech impediment is not an issue; why did you bring it up? She was so hurt and embarrassed when you made that comment in the meeting about her not being on the front desk. You owe her an apology; and don't be surprised if she makes a complaint. Like it or not you were in the wrong.

The comments you have made about people with disabilities being a drain are unfair and wrong. I am personally offended and feel vilified. You may not be aware, but I have a disability – you just can't see it. I'm letting you know I'll be making a complaint if this happens again.

Age:

Please stop referencing my age and yelling at me. I have a strong track record in this area. I really feel humiliated and harassed, particularly now that people are repeating your references to my age.

If you have concerns you'd like to raise about my competence, I'd be grateful if you did it in private next time. I may have forgotten to pass that message on, but the comments about dementia were offensive and uncalled for. You crossed the line and I want an apology.

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

SUSAN HALLIDAY – Australian Defence Abuse Response Taskforce 2012-2016 and former Commissioner with the Australian Human Rights Commission.

RACS
LET'S OPERATE WITH RESPECT

If you have any concerns around dealing with discrimination, bullying or sexual harassment, RACS has a formal process via its Complaints Hotline. For further assistance please contact the Manager Complaints Resolution on 1800 892 491 (Australia) or 0800 787 470 (New Zealand).

RACS also recognises that Trainees, Fellows and International Medical Graduates may face stressful situations on a daily basis. The RACS Support Program provides confidential support to surgeons and can be used for any personal or work related matter - further details can be found on the RACS website http://www.surgeons.org/member-services/college-resources/racs-support-program/

RACS
LET'S OPERATE WITH RESPECT

Bah Humbug – it's a work function!

SUSAN HALLIDAY
Australian Defence Abuse Taskforce 2012-2016 and former Commissioner with the Australian Human Rights Commission

It's that time of year again! Whether you call it an End of Year Function or a Christmas Party, two things can be guaranteed. The first is that people are usually very keen to celebrate the fact that they have almost made it to the end of the year. The second is that employees who would normally engage professionally, can act as if "deck the halls with boughs of holly" should be immediately followed by "tis the season to be a wally".

Like it or not, our professional codes of conduct and workplace policies span our behavioural modus operandi 365 days a year, 24 hours a day – depending on where we are and the company we keep. There are no ifs, no buts, and no exceptions .... as partying with workplace colleagues comes with rules. Surprised as some still seem to be by this, it should be clear in this day and age, that dropping your drawers to reveal your gold tinsel G-string is going to end up being more painful in days to come, than actually wearing the G-string on the night.

When socialising with colleagues and people known to us through work, our work-hat needs to be positioned firmly on our heads - albeit under the Santa hat. And irrespective of whether that Santa hat reads Ho-Ho-Ho, or Bah Humbug (given that some employees will complain about the Ebinizer nature of responsible end of year functions) it is always the work-hat that has priority.

To their credit some employers drop subtle hints about appropriate behavior, and sensible dress codes (for the entire evening) before the celebratory event. But rest assured subtle hints won't save the day as festivities loom and people mischievously plan to "don we now our gay apparel" ill informed that "troll the ancient yuletide carol" isn't an invitation to send provocative texts and forward adventurous propositions by email leading up to the big night.

Those tasked with organising activities need to be very clear that anonymous gift giving, sometimes known as Kris Kringle, can have both awkward moments and legal implications under the auspice of sexual harassment as people unwrap questionable and at times highly offensive gifts – be it rude food, pornographic DVDs, black lace thing-a-me-bobs, or the pop-up Kama Sutra book, to share but a few real-life workplace examples. The experiences of those who have gone before should leave no doubt about there being a shortage of happy endings.

Irrespective of the hour or the venue, the work-related gathering is just that, work-related! All the work rules and expectations that align with role modeling professional behavior still apply. Hence over zealous festive season wishes that encroach into one's envelope of personal space and mirror the physical familiarity of a long lost lover, can tend to be problematic, not to mention chatted about in hospital corridors for enduring months, most often accompanied by evidentiary candid Instagram snaps that have an infinite life.

Err on the side of caution. Start with a respectable venue with wait staff clad in suitable attire. A function finish time, a dress code, and limited alcohol, with prior warning that Santa has rheumatoid arthritis in his knees so there will be no sitting on them, can all be helpful guidelines for function planners and managers responsible for ensuring a comfortable and safe environment for all attendees, and of course members of the public.

Indeed it is important to encourage all excited pending party participants who have sent an RSVP (be they younger, older, or somewhere in between) to do whatever it takes to ensure they form a healthy quota of "wise men" and "wise women" who are prepared to remind their colleagues that alcohol is never going to be an excuse for conduct unbecoming.

Truth be known, experienced managers will often chorus that the subtle hints can fall on tone-deaf ears, confirming there is a need to do everything possible to head off the risk takers and apprentice comedians at the path. The caroling of bold, blatant repetitive messages prior to the event is an organisation's best bet. This tactic should also help meet the legislative requirement to take all reasonable and precautionary steps to inform party participants about party pitfalls. People must be well informed that unwelcome suggestive behaviour and conduct of a sexual nature that could bring the organisation into disrepute, or cause an individual or by-standers offence, intimidation or humiliation is a No-No-No ... not a Ho-Ho-Ho. And for the record there are no exemptions associated with mistletoe.

Forewarned is forearmed. Take nothing for granted, ever mindful that the workplace party or external work-related function may not result in a "silent night" where "all is calm." Rather a stable of HR staff who "quake at the sight" as people joyfully video the frivolities and post them on Facebook, well prior to last drinks and the arrival of taxis summoned for those about whom it has already been tweeted on twitter - "tis the season to be a wally".

Annual Scientific Congress
Adelaide 8-12 May 2017

PETER SUBRAMANIAM
ASC 2017 Convener

DAVID WALSH
ASC 2017 Scientific Convener

Dear Fellows and Colleagues,

The RACS 2017 Annual Scientific Congress, to be held in Adelaide, is already generating interest amongst the surgical community in light of the current reviews in place looking at the cost effectiveness of surgical care. The Congress will be held at the Adelaide Convention Centre situated alongside the River Torrens from 8 - 12 May 2017.

As well as exceptional conference facilities, the accommodation in Adelaide is in demand at this time of year so go online at http://asc.surgeons.org to reserve your room as soon as you receive the provisional program because it will quickly book out.

The Convocation and Welcome Reception will be on Monday 8 May 2017 at the Adelaide Convention Centre. At this convocation, along with the Syme oration and presentation of our New Fellows, other senior members of our profession will be acknowledged for their outstanding contributions to surgery and the College.

The theme of the Congress is "Safe and Sustainable – the Future of Surgery?"

The planned plenary sessions will explore this theme - locally and internationally - through the areas of sustainability of surgical care, operating within imposed guidelines and understanding how the metric of cost effectiveness is decided by governments, industry and peer group reviews.

Program Review

There is an extensive scientific program arranged for the ASC in Adelaide that can be viewed online at http://asc.surgeons.org and a few are highlighted below. Other section presentations will be highlighted in future editions of Surgical News.

Orthopaedic Surgery

Mark Rickman has developed an excellent integrated program in Orthopaedic Surgery for the ASC in Adelaide to follow on from the successful orthopaedic program that ran in Brisbane this year. The Section Visitor, Professor Justin Cobb, from Imperial College, London, will cover the latest information regarding surgical innovation in 3D planning and 3D printing in orthopaedics and outcomes in orthopaedic surgery.

Global Health

Suren Krishnan has arranged an interesting program with two Section Visitors. Professor Rajat Gyaneshwar from Fiji and Professor Mark Shrime from the USA will focus on sustainable global health and outcomes from the Lancet commission for the Asia Pacific region.

Paediatric Surgery

Day Way Goh has arranged an extensive program in paediatric surgery covering a spectrum of conditions including pectus excavatum, management of paediatric solid tumours, transplantation in children and the controversial area of bariatric surgery in adolescents. These will be addressed by the section visitors Professors Paolo De Coppi, Professor Eugene Kim and Associate Professor Dawn Jaroszewski.

Surgical History

Brian Brophy has arranged for Dr Simon Chaplin to be the visitor to the Surgical History program. Dr Chaplin is from the Wellcome Trust and he will draw on the Wellcome Collection, the world's largest on the history of medicine, to contribute to a wide ranging program. He will elaborate on John Hunter in his Keynote address. Professor David Cherry will deliver the Herbert Moran Lecture titled "Bullecourt". Professor Michael Besser will deliver the Rupert Downes Memorial Lecture and Associate Professor Susan Neuhaus will deliver the "Sir Edward 'Weary' Dunlop Memorial Lecture" entitled "Women, War and the RACS".

In addition to the usual specialist surgery sections above there will be programs covering Quality and Safety (Glenn McCulloch), Senior Surgeons (John North) and Pain Medicine (Andrew Zacest)

We trust you will join us in Adelaide to explore the future of our craft.

Register now through the Congress website asc.surgeons.org

RACS represented in Niagara Falls

Surgery was well represented at a series of recent Conferences and Forums in Canada



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

Assoc Prof Stephen Tobin, Dr Sally Langley and Dr Lawrie Malisano represented RACS at a series of meetings and conferences in Niagara Falls, Canada from 27 September – 1 October 2016. These include the Toronto International Summit on Leadership Education for Physicians (TISLEP), International Medical Education Leaders Forum (IMELF), International Conference on Residency Education (ICRE) and the TriNations Alliance Executive meetings in Niagara Falls, Canada. Surgery in Australia was well-represented with Dr Ian Incoll, Ms Ally Keane and Mr Adrian Cosenza (all AOA) also present.

27 September 2016: TISLEP Summit and TriNations Alliance Executive meetings

The TISLEP Summit is a platform for international thought leaders, educators, patients, learners, faculty and other stakeholders to further the discussion on leadership education for the physician leaders of today and tomorrow. This Summit was hosted by the University of Toronto and the Royal College of Physicians and Surgeons of Canada (RCPSC). The TISLEP Summit 2016 was centred on 'Bringing Leaders to an Everyday Conversation'. Dr Peter Lees (Chief Executive and Medical Director, Faculty of Medical Leadership and Management, UK) led the keynote presentation with an intriguing title 'Everyday Leadership: Why? What? How?' that captured the attention of the audience. Later on, the competency-based leadership curriculum was also launched. This curriculum is mainly focused on L.E.A.D.S. (Lead Self; Engage Others; Achieve Results; Develop Coalitions; Systems Transformations).

The TriNations Alliance Executive meetings were attended by its member colleges: RCPSC, RACS, Royal Australasian College of Physicians (RACP), Australian & New Zealand College of Anaesthetists (ANZCA) and The Royal Australian and New Zealand College of Psychiatrists (RANZCP). The meeting discussed the progress of the TriNations Alliance meetings in March and the upcoming International Medical Symposium (IMS) 2017. Workshops on Indigenous Doctor workforce development and Competency-based Medical Education – both within and after specialty training are planned. ANZCA will be the host for the IMS 2017 on Friday 10 March at The Arts Centre, Melbourne. The program will build on previous symposia and focus on 'Leading Change' in healthcare and the medical profession. More information is available on http://www.anzca.edu.au/events/international-medical-symposium

28 September 2016: IMELF

The IMELF 2016 provided an opportunity for senior leaders such as Presidents, CEOs, Deans and Postgraduate Deans from medical education colleges and institutions around the world to discuss challenges and innovations related to postgraduate medical education and lifelong learning. Prof Roger Strasser (Northern Ontario School of Medicine) spoke on the philosophy of the medical schools and the importance of building community engagement. Dr Jonas Nordquist (Director, Karolinska Institute, Sweden) then presented on 'Social Accountability and Health Care Education' in which he highlighted how the 'body language' of an institution has an impact on the welcoming factor and informal spaces are important. Lastly, Mr Adrian Cosenza (CEO, AOA) presented on 'Inter- and Trans- Professional Education'. His presentation referenced a major Lancet report 'Health professionals for a new century: transforming education to strengthen health systems in an interdependent world' (Frenk et al, 2010). He also recommended collaboration between organisations and groups where there are common goals.

29 September – 1 October 2016: ICRE

This year's ICRE brought together more than 1,600 clinical educators and physicians from around the world to share ideas, challenges, innovations, and advance training. The

Welcome address by Dr Jason R. Frank, Chair ICRE

ICRE 2016 was centred on 'Advancing Quality: Aligning Residency Education and Patient Care' and featured five plenaries, more than 50 workshops and approximately 200 poster and paper presentations. RACS also contributed to ICRE by conducting two workshops, on 'Building Respect, Improving Patient Safety' and the 'JDocs Framework'. The former, presented by all of the three RACS colleagues was done as an interactive workshop presentation, over two hours and was well received.

At ICRE, one of the presentations that resonated with many clinicians was presented by Dr Diane Meshino (Psychiatrist, University of Toronto) on 'Meeting the Needs of the Academic Mission: The How and Why of Faculty Resilience' presentation. She pointed out that faculty resilience contributes to career satisfaction, the academic mission, quality and safety in healthcare. According to Dr Meshino, there are 6 "Cs" that promote resilience. These are: Competence; Confidence; Connection; Character; Caring and being cared for and Contribution.

The Conference Plenary Debate was on 'Longitudinal or Traditional Rotations: Which is Better for Patient Care and Training?'. This generated a lot of discussion from both sides. For those supporting longitudinal rotations, one of their key arguments was that this rotation could provide ongoing care, develop relationships, and obtain feedback when integrated into the institution. The contra argument was about a greater exposure to a greater range of patients, thus experiences of care if Trainees rotated into different units. In addition, the Trainee will be well-supervised which enhances patient care.

The poster session on 'Research in Residency Education' saw many posters on the current topics in this area being presented. The RACS paper presented by the Dean on 'Leaving Surgical Training' referenced the recent Ardnell report* about Australia and New Zealand SET trainees who have resigned. Many of the issues were raised in Canadian papers. These included transition between jobs and roles, disinterested faculty, poor professional behaviours and lack of support.

The Conference Closing Plenary Session featured the Royal College Lecture in Residency Education: 'Graduate Medical Education and Better Value Healthcare Service' by Dr Paul B. Batalden. In his presentation, he touched on including patient perspectives, adjusting health professional education and invoking clinical practice reform. He ended his presentation by mentioning healthcare system needs to include everything from the physical design to best practice and economic use of funding.

Overall, it was a very fruitful visit to Canada. The next ICRE will be held from 17-20 October 2017 in Halifax, Canada.

**RACS will publish this report shortly – it is being submitted for publication*

58th Victorian Annual Surgical Meeting

21, 22 October 2016 | Langham Hotel, Melbourne "Evidence Based Surgery"

Over 100 participants attended professional development workshops on day one. This was followed by an exemplary dinner at the Melbourne Aquarium with delegates and their families delighted by the close encounters with sharks, manta rays and fish.

Following the formal proceedings, Prof Peter Choong opened the scientific program on Saturday, with over 100 in attendance. The symposia looked at the acquisition of evidence and how to best put it into use. Surgeons and non-surgeons informed the conference on a range of issues touching on themes of sustainability in health, use of registries and translational research. Four judges were impressed with the quality of research presentations over four separate sessions.

Professor Ian Harris

The scientific program closed with a debate questioning the role of evidence in best surgical practice. Our team members displayed great knowledge, only surpassed by their good humour and wit. Moderator, Justice Beach judged that Team Affirmative won, by a margin of just 1 point, while acknowledging that a good conspiracy theory has a place in any debate.

Following inspiring presentations from the Foundation for Surgery, and Professor Ian Harris at the Vic ASM dinner, a surprise fireworks display over the Yarra River closed this successful meeting.

Tristan Leech, Convener, 58th Victorian Annual Surgical Meeting.

The 2017 Vic ASM will be held on the Victorian Surf Coast. Date TBA.

Professor Harris explains why there is an over-estimation of the benefits of surgery and an under-estimation of the potential harm on a separate RACS Post Op Podcast session now available for download on iTunes or via the RACS website http://www.surgeons.org/policies-publications/publications/surgical-news-extra/

Royal Australasian College of Surgeons
RACSTA
Your Trainees' Association

A Long Way to Go

DR RUTH MITCHELL
(Chair) RACSTA

Unless you have been hiding under a rock you've probably noticed there have been some changes in the communications coming from the College of Surgeons. Maybe you've seen a letterhead with a groovy orange scalpel emblazoned with the words 'Let's operate with respect,' or perhaps you've heard about new courses, online and face-to-face, which require your attention. And while some members of the surgical profession are wringing their hands asking if we are doing enough to deal with the challenge of disrespectful and unprofessional behaviour, there are others who genuinely believe this is has all gone too far. What's the fuss about anyway?

Bullying affects bystanders and witnesses, not just the person on the receiving end of unwanted unprofessional behaviour

Around the table of the RACSTA (the Royal Australasian College of Surgeons Trainees' Association) Board, there have been many voices, for many years, carrying the stories of Trainees whose lives have been changed and careers ended by bullying, discrimination, and sexual harassment. We are even aware of lives lost to suicide and substance abuse. So it goes without saying that as your Trainees' association, we welcome the leadership that has been taken at the highest levels of our profession, the advocacy of senior surgeons as well as younger fellows, and the clear apology (on YouTube) on behalf of RACS by immediate past president Prof David Watters. But we are becoming aware that this is a long journey, and that in a culture of respect, everyone has responsibilities.

RACSTA runs a survey of Trainees every six months. It's incredibly pleasing to report that a record number of Trainees responded to our most recent survey, giving us a 42 per cent response rate. What's not quite so pleasing is that discrimination, bullying and harassment are clearly still problems faced by a significant number of Trainees. For example, 17.4 per cent of Trainees surveyed had experienced bullying in the past six months, with 23.5 per cent having witnessed it. This is a reminder that bullying affects bystanders and witnesses, not just the person on the receiving end of unwanted unprofessional behaviour. Discrimination was experienced by 7.7 per cent, and 7.5 per cent reported witnessing it.

Even more disappointing than these numbers are the comments made by Trainees. They described bullying in theatre, a lack of consequences for perpetrators of bullying, a fear of speaking up amounting to 'career suicide,' being kicked out of theatre by surgeons, being undermined and marginalised by nursing staff, and sidelined by emergency department doctors, the bullying of unaccredited registrars by SET Trainees, and witnessing female interns being told not to do surgery because they were female. Many of the comments about discrimination touched on gender: a female Trainee asked not to scrub because of concerns around strength, service registrars being told their application for training would not be supported because of being female. These narratives reaffirm the key finding of the Expert Advisory Group: the culture of bullying and harassment is endemic in surgery, and we can't continue the way we are. One Trainee commented "I applaud the College for finally taking steps towards addressing this blight on the profession, but there is a long way to go yet."

There was also a clear message in the comments about feedback. Since the introduction of stronger policies and procedures around bullying and harassment, some consultants have become unsure how to provide feedback and particularly struggle with negative appraisal. The manifestation of this might be not receiving any direct feedback but instead learning later that your performance was sub-par second hand. This concern surrounding how to provide negative feedback appropriately in this new environment, is neatly addressed as a component of the Foundation Course for Surgical Educators. This too will soon be mandatory for all consultant surgeons working with registrars.

We have a long way to go, and we all have responsibilities. Not only do consultants have some learning to do about giving respectful, constructive feedback, but Trainees also must learn to seek out and receive feedback in good faith. And we must all decide that bullying, discrimination and sexual harassment stop with us. We can't treat our juniors and colleagues in the way some of us have been treated, and we must all become better educators. And we must never forget that our efforts will improve not only the wellbeing of Trainees, and surgeons, but the calibre of behaviour in the entire healthcare environment, and the ultimate beneficiaries will be our patients.

Neurosurgery in North America

DR. OMAR K. BANGASH
FRACS

Dr. Omar K. Bangash - Awarded Surgical Research Society Travel Grant, 2015

Award of the Travel Grant at last year's meeting of the Section of Academic Surgery (SAS) and Surgical Research Society (SRS) permitted me the privilege to present our research at the American Association of Neurological Surgeons (AANS) scientific meeting held this year in Chicago. The AANS is regarded by many as the premier stage in neurosurgery, with its origin as the Harvey Cushing Society. This opportunity was particularly special for me as the late Harvey Cushing, surgeon-scientist and father of organized neurosurgery is a hero of mine. Over a century after delivering his address titled '*The Special Field of Neurological Surgery*[1] before the Cleveland Academy of Medicine, there have been many significant advances in neurosurgical treatments. However, progress has been slow in some areas, most notably in the treatment of primary brain tumours. One wonders what Dr. Cushing would have made of what was presented in Chicago.

With my interest in surgical neuromodulation it was inspiring to hear from Professor Alim-Louis Benabid. Many have tipped him to be the next surgical Nobel laureate for his discovery of high frequency stimulation of the subthalamic nucleus leading to the relief of motor symptoms in advanced Parkinson's disease. I learnt of advances in brain-machine-interfaces and their current, albeit limited use in enabling amputees to animate bionic limbs or control electrical devices. I learnt of the possibility of optogenetic control of single neurons in freely moving mammals and its potential application in the treatment of debilitating neurological diseases as well as leading to basic science advances. As part of President Obama's Brain Initiative I learnt of current DARPA efforts to develop closed loop electrical stimulation devices that involve micro-circuitry to both sense and deliver electrical impulses. The device will target multiple neural targets with therapeutic stimulation sequences tailored to alleviate symptoms and perhaps even treat neuropsychiatric or neurological diseases.

Finally I had the privilege to present our work titled '*Electrical Stimulation of the Posterior Subthalamic Area Modulates Eye movements in Humans*' to an audience of experts in the field. I have returned energized and humbled to continue our research efforts and to pursue a career in academic surgery. I would like to thank the SAS, SRS and my mentor Professor Christopher Lind in making this opportunity possible.

References

1. Cushing H. The special field of neurological surgery. Bulletin of the Johns Hopkins Hospital 16:77-87, 1905. Neurosurgery 2005;57(6):1075.

Rural Surgeons Award

Photographer: Dr John Aloysius Henderson

CITATION

Robert North formally retired from General Surgery practice at the end of 2015. During his career he made a significant contribution to the knowledge of General Surgery practice and education, and was a dedicated champion of the interests of rural surgeons and the rural community in general.

His achievements include:

- 47 years of service to the Dubbo community and the field of General Surgery
- the establishment of Breastscreen Assessment Clinics in Dubbo
- the establishment of a Day Surgery in Dubbo
- teaching in the Dubbo Rural Clinical School since 2002
- surgical educator in the RACS dissection and Basic Surgical Skills Course.
- contribution as a presenter to several conferences and scientific meetings including the ASC and PSA.

Robert's commitment to personal and professional excellence, his amicable and gentle nature, and his wealth of rural surgery experience made him a valuable and highly regarded teacher. He will be missed by students, patients, and colleagues alike.

Congratulations Robert.

NEW
RESEARCH

Could the cure for paralysis come from the nose

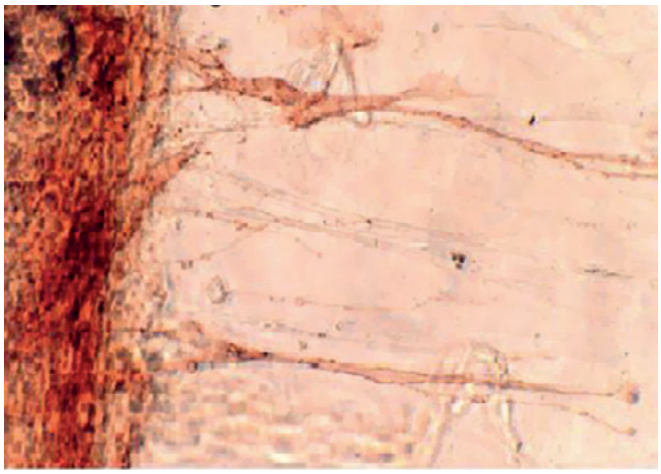
Advances in neuroscience from within our ranks

Two years ago, when news was released that English neuroscientists and Polish neurosurgeons had enabled a man completely paralysed from the waist down to walk again, the international spinal research community was both thrilled and galvanised.

For the first time, scientists had proven that severed nerve fibres could grow and join together if they were provided with a bridge to cross the gap and that olfactory ensheathing cells (OECs) could hold the key to the holy grail of a cure for paralysis.

OECs are unique glial cells which ensheath the olfactory nerve from the olfactory mucosa (in the nose) to the olfactory bulb (in the brain) and play a major role in the ability of olfactory neurons to constantly regenerate throughout life.

In a technique developed by a team at University College London's Institute of Neurology, OECs were harvested from Darek Fidyka's brain, cultured in a laboratory and then injected above and below the site where his spinal cord had been severed in a stabbing attack.



OECs growing out of lamina propria slices (Feron et al., 1999)

These cells allowed the ends of severed nerve fibres (axons) to grow and join together – something that was previously thought to be virtually impossible - and now two years after vision of Mr Fidyka's faltering first steps swept around the world, he can even reportedly ride an adapted bicycle.

Surprisingly, in Australia, one of the leaders in the field of OEC research is not a neurosurgeon but a Queensland ENT surgeon who believes that OECs may also assist in peripheral nerve repair and may even be harvested in the future through a biopsy of the nose, obviating the need for brain surgery.

Dr Brent McMonagle, who works out of the Gold Coast University Hospital and the Pindara Private Hospital, recently completed his PhD thesis on Nasal derived OECs and Stem Cells in Peripheral Nerve Repair and Regeneration through the Eskitis Institute at Griffith University.

Dr McMonagle

Currently the RACS supervisor of training for ENT surgery at Gold Coast University Hospital and a SET1 examiner, Dr McMonagle obtained his FRACS in 2004.

In the years following, he undertook Fellowships at Guy's and St Thomas's Hospitals, the National Hospital for Neurology and Neurosurgery in London and St Vincent's Hospital in Sydney focusing on complex ear, sinus and skull-base surgery.

Upon his return to Queensland, he established a cochlear implant program and introduced image guidance for complex sinus and skull base procedures to the Gold Coast.

Now Dr McMonagle is also the Scientific Committee Director of the Perry Cross Spinal Research Foundation which works to facilitate and initiate the research required to find a cure for paralysis.

The Foundation is named after Perry Cross, a former school friend of Dr McMonagle's, who was left a C2 ventilated quadriplegic at the age of 19 from the injuries caused by a rugby tackle.

The foundation is a not-for-profit charity and has supported four PhD projects through Bond and Griffith Universities investigating spinal cord injuries and regeneration.

Dr McMonagle said that the world first trial of human OEC transplants into injured spinal cord patients took place in Brisbane in 2003 under Professor Alan Mackay-Sim. This was a pilot study to test the safety of the technique and it showed that one out of three patients transplanted displayed modest improvement in neurological function.

Dr McMonagle said that since then, several studies had been performed around the world using similar techniques and the plan now was to bring this cutting-edge research back to Queensland.

He said the first step would be to refine the biopsies and cell culture techniques for the OECs followed by another human spinal cord injury trial using nasal derived OECs seeded to 3D-printed nerve bridges which would be placed around the injured spinal cords.

Dr McMonagle's PhD set out to find alternative methods of repairing peripheral nerve damage which could result in less

morbidity at both the injury site and the harvest site by transplanting OECs into various tubes to bridge gaps created by trauma or tumour surgery.

"Olfactory neurons are the nerves in the nose that are responsible for conveying the sense of smell and because they are directly exposed to the environment, they can be killed easily by noxious chemicals and viruses," he said.

"Fortunately for our sense of smell, they regenerate throughout life, with a completely new set of olfactory neurons created about every eight weeks.

"It is believed to be mainly the OECs which give the olfactory neurons this unique property.

"Interestingly, OECs have been shown to direct neuronal regeneration within the entire olfactory nervous system, from the olfactory mucosa within the nose, through the cribiform plate and along the skullbase to the olfactory cortices of the brain and they can be harvested from anywhere along this path.

"To the best of our knowledge, the olfactory neurons are virtually the only neurons in the body to regenerate and that unique characteristic begs the question: If OECs allow olfactory neurons to regenerate, could they have a similar effect within peripheral nerves, the brain or the spinal cord?"

Dr McMonagle said that while scientists at Institutes around the world were grappling with the same questions, he set out to investigate their use in the repair of peripheral nerve damage.

He said that while the current gold standard method was the nerve graft, the results from this method were often disappointing and could cause numbness in the region from where the nerve was taken and painful neuromas.

"Much is known of the complex processes involved in axonal regeneration following peripheral nerve injury yet despite improvements in surgical instruments, materials, techniques and equipment, results from peripheral nerve repair remain only moderately successful and inconsistent," he said.

"I set out to determine if OECs had the potential to direct regenerating axons toward appropriate endoneurial tubes and promote extension towards peripheral end-organ sites. This research has shown a trend which suggests OECs within a vein graft are as successful as nerve grafts in repairing peripheral nerve injuries caused by a gap in the nerve."

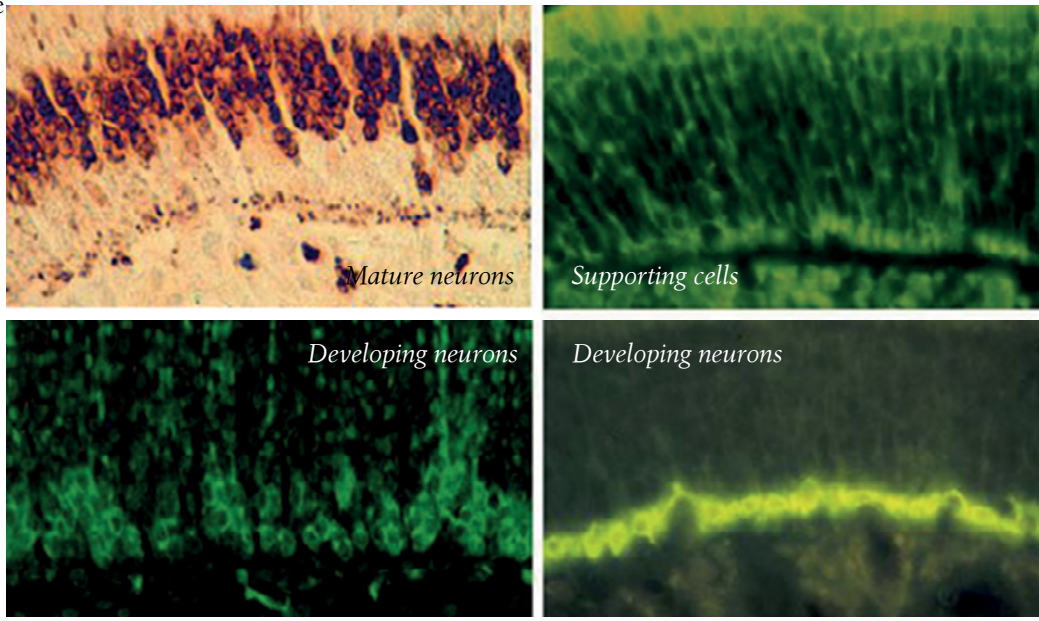


Figure 1.10: Olfactory mucosa (Feron, 1999)

Working under the supervision of Professor Alan Mackay-Sim at the Eskitis Institute for Drug Discovery, he refined his research using a rat sciatic nerve model with gap lengths from 10-17mm using various conduits to bridge the gap - silicone tubes, nerve grafts, biodegradable tubes, and vein and artery segments - with and without OECs.

"We tried several different approaches to this and eventually developed a method of peripheral nerve repair using these unique olfactory ensheathing cells suspended in an extracellular matrix gel within a vein," Mr McMonagle said.

"This alternative method gave results which were comparable to the traditional nerve graft overall and in some respects potentially better.

"Now we believe this technology may be useful in neurological diseases, stem cell regeneration therapies and human spinal cord injury trials which is extremely exciting."

Dr McMonagle said that OECs had many of the attributes of stem cells without the problems such as the ethical issues associated with embryonic stem cells, the chance of the recipient rejecting donated cells and the risk of transferring viral or prion infections.

He said the work being done through Griffith University's Eskitis Institute under Dr James St John was now leading the world in the use of nasal-derived OECs.

"Most other research laboratories around the world working on this are deriving the OECs from the brain via a craniotomy," he said.

"We have unique expertise by using nasal olfactory ensheathing cells which are much easier to harvest, with much less risk and morbidity.

"This is wonderful science because it could mean that a patient who has suffered a nerve injury could have a tiny 2mm x 2mm biopsy of the nose performed by an ENT surgeon under local anaesthetic to harvest olfactory mucosa from which OECs could be extracted, purified, cultured and then suspended in a gel to be transplanted back into the injury site.

"The lead British neuroscientist behind the treatment of Darek Fidyka, Professor Jeffrey Raisman, has since then treated another paraplegic patient who can now also stand and walk with a frame.

"He described Mr Fidyka's first faltering steps as representing a greater leap forward for humanity than the steps taken by Neil Armstrong on the moon and I absolutely agree with him."

- With Karen Murphy

Feron, F., Perry, C., McGrath, J.J., Mackay-Sim, A. (1998). New techniques for biopsy and culture of human olfactory epithelial neurons. Arch Otolaryngol Head Neck Surg 124(8): 861-6.

Case Note Review

Clot retention can lead to death

PROFESSOR GUY MADDERN
Surgical Director of Research and Evaluation

Case summary:

An elderly male underwent an elective transurethral resection of the prostate. The procedure was delayed for some weeks to gain admission to a hospital with an appropriate level of care for the known cardiac risk factors. The operation report and the preoperative haemoglobin level were not available to the reviewer. The case notes, consisting of entries by resident medical and nursing staff, were adequate to establish the course of events. The preoperative assessments by resident medical and the anaesthetic staff provided an adequate appraisal of the patient's status.

The patient was diagnosed with clot retention shortly after returning from the operating room. The urology resident attempted to wash out the clots but realised this was incomplete. The size and type of catheter used were not recorded. Nursing notes indicated ongoing pain consistent with clot retention well into the next day. There appeared to be an idea that catheter traction alone would solve the problem. The patient was then transferred to another ward and hypertension, possibly indicative of persisting pain, was recorded, as were frequent catheter blockages.

In the days following the operation, the patient developed chest pain along with a fall in blood pressure and oxygen saturations. A rise in cardiac enzymes was consistent with a myocardial infarction. A fatal asystolic cardiac arrest occurred that evening.

Clinical lessons:

Postoperative blood loss is difficult to assess without knowing the admission haemoglobin level. Painful clot retention may hold a litre of blood. The management of the chest pain had been timely and appropriate with the involvement of the cardiology registrar. The use of aspirin in this circumstance may have had associated risks, but in view of the proven benefit of aspirin in survival from acute myocardial infarction it should probably have been administered. This would mean that any ongoing prostatic bleeding would have needed to be controlled.

The major area of concern is the failure to resolve the persisting clot retention. Clot retention is dangerous as well as very distressing to patients. Evacuation of all of the clots within the bladder is required to stop ongoing prostatic bleeding and the formation of more clots. This may be done by return to the operating theatre and evacuation of the clots by cystoscopy under direct vision. An alternative method is to do a manual bladder washout (vigorous) in the bed. For this to be successful a large bore (22-24 French Gauge (FG)) open-ended (whistle-tip) catheter is required. A 22 FG Foley-type catheter that is usually inserted post-TURP does not allow adequate extraction of the clots. Therefore, a change of catheter may be needed and probably should be done with an introducer to ensure accurate placement; hence a urology registrar needs to be involved.

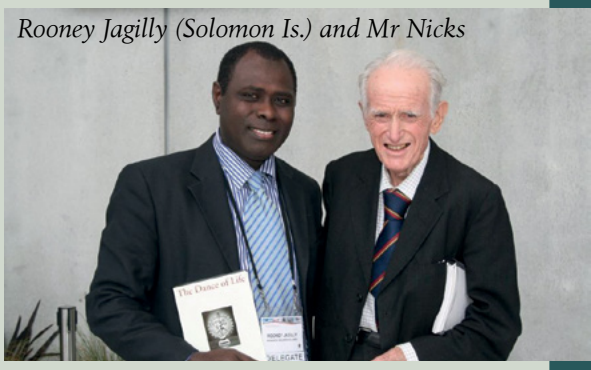
The procedure may take upwards of 40 minutes with the irrigation of several litres of fluid to be sure of removal of all clots. It is probably not a procedure to be delegated to a junior medical staff member without appropriate training and supervision. Once the bladder is free of clots and the return in the syringe is clear, another Foley-type catheter can be inserted and then traction applied to isolate and tamponade bleeding distal to the catheter balloon.

The postmortem report made no comment about the presence of clots within the bladder at the time of death. The definitive management of this patient's postoperative clot retention may have reduced the likelihood of the myocardial infarction. Complete clearance of the bladder clots may have allowed the use of aspirin with more confidence without worsening the prostatic bleeding.

GLOBAL HEALTH

2018 Rowan Nicks **AWARDS**

Dr Vuthy Chhoeurn (Cambodia) with patient



Rooney Jagilly (Solomon Is.) and Mr Nicks

Win Win Kyaw (Myanmar) operating

- **2018 Rowan Nicks Pacific Islands Scholarship**
- **2018 Rowan Nicks International Scholarship**
- **2018 Rowan Nicks Australia and New Zealand Exchange Fellowship**

The Royal Australasian College of Surgeons invites suitable applicants for the 2018 Rowan Nicks Scholarships and Fellowships. These are the most prestigious of the College's International Awards and are directed at qualified surgeons who are destined to become leaders in their home countries.

Rowan Nicks International and Pacific Islands Scholarships

The Rowan Nicks International and Pacific Islands Scholarships provide opportunities for surgeons to develop their management, leadership, teaching, research and clinical skills through clinical attachments in selected hospitals in Australia, New Zealand and South-East Asia.

The goal of these Scholarships is to improve the health outcomes for disadvantaged communities in the region, by providing training opportunities to promising individuals who will contribute to the development of the long-term surgical capacity in their country.

Applications for the International Scholarship are open to citizens of Bangladesh, Bhutan, Cambodia, Indonesia, Laos, Mongolia, Myanmar, Nepal and Vietnam.

Applications for the Pacific Islands Scholarship are open to citizens of the Cook Islands, Fiji, Kiribati, Federated States of Micronesia, Marshall Islands, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu or Vanuatu.

Selection will primarily be based on merit, with applicants providing an essential service in remote areas, without opportunities for institutional support or educational facilities, being given earnest consideration.

Rowan Nicks Australia and New Zealand Fellowship

The Rowan Nicks Australia and New Zealand Fellowship is intended to promote international surgical interchange at the levels of practice and research, raise and maintain the profile of surgery in Australia and New Zealand and increase interaction between Australian and New Zealand surgical communities.

The Fellowship provides funding to assist a New Zealander to work in an Australian unit judged by the College to be of national excellence for a period of up to one year, or an Australian to work in a New Zealand unit using the same criteria.

Value

The value of the Scholarships and Fellowships is up to AU$50,000 for a 12 month attachment, depending on the funding situation of the candidate and provided sufficient funds are available, including support to attend the Annual Scientific Congress of the College, if the Scholar is in country at the time of the Congress.

Further Information

Application forms with the full criteria and submission instructions will be available from the RACS website from December 2016: www.surgeons.org

Closing date: Monday 5 June, 2017. Applicants will be notified of the outcome of their application by 31 October 2017.

Please contact:

Secretariat, International Scholarships Committee
Royal Australasian College of Surgeons
250 - 290 Spring Street, East Melbourne VIC 3002
Email: international.scholarships@surgeons.org
Phone: +61 3 9249 1211 Fax: +61 3 9276 7431

2017 Scholarship and Grant Recipients

Foundation for Surgery
Passion. Skill. Legacy.

The Board of Surgical Research thanks all applicants and congratulates the following successful recipients

ASSOC. PROF. KERIN FIELDING
Chair,
Board of Surgical Research

RACS wishes to acknowledge and thank our benefactors and sponsors for their generosity in funding many of the following scholarships and grants.

Where indicated * scholarship recipients must procure 25 per cent of their scholarship from either their research department or by external award or donation.

There is a considerable amount of time and energy spent to properly evaluate the extensive number of applications that we receive. The Chair would like to thank all those involved, and in particular, Professor Marcus Stoodley, Dr Niall Corcoran, Professor Wendy Brown and Professor Robert Fitridge, who all put in extra work towards this result.

Research Scholarship, Fellowship and Grant Recipients

John Mitchell Crouch Fellowship
Valued at $150,000pa
Associate Professor Andrew Barbour - Qld
Specialty: General Surgeon specialising in Upper GI, Melanoma and Soft Tissue
Associate Professor Andrew Barbour is based at the School of Medicine, Discipline of Surgery, Translational Research Institute at the Princess Alexandra Hospital, Brisbane. In 2017 he will continue to expand his work, particularly within the area of genomics of oesophageal disease. The Fellowship will fund the direct research costs, in the form of whole genome sequencing, for his research plan "Precision Medicine for Oesophageal Adenocarcinoma: Understanding the Importance of Tumour Heterogeneity and Treatment Response"

Foundation for Surgery Senior Lecturer Fellowship
Value: $132,000pa, with 50% of this procured through the research department.
Mr James Lee - Vic
Specialty: General Surgery
Mr Lee will use this Fellowship to focus on studying the microRNA biomarkers in thyroid cancer. He will also establish a research short course for Trainees along with ongoing work for the SAS workshops and DCAS.
Head of Department: Professor Wendy Brown

Foundation for Surgery John Loewenthal Project Grant
Value: $100,000pa
Ms Claudia Di Bella - Vic
Specialty: Orthopaedic Surgery
Topic: Next generation of bioprinting for cartilage regeneration
Supervisor: Professor Peter Choong

Foundation for Surgery Tour de Cure Cancer Research Scholarship
Value: $125,000pa, with $25,000 procured externally.
Dr Glen Guerra - VIC
Specialty: General Surgery
Topic: Exploring the immune landscape of anal squamous cell carcinoma and its utility as a therapeutic avenue
Supervisor: Professor Alexander Heriot

James Ramsay Project Grant
Value: $95,000pa
Dr Gregory O'Grady – New Zealand
Specialty: General Surgery
Topic: Defining the pathophysiology of post-operative colonic ileus and pseudo-obstruction using fibre-optic high-resolution colonic manometry

Surgeon Scientist Scholarship
*Value: $77,000pa**
Mr Krish Chaudhuri - New Zealand
Speciality: Cardiothoracic Surgery
Topic: The "COMCAB" Study
Supervisor: Mr Indran Ramanathan

Eric Bishop Research Scholarship
*Value: $66,000pa**
Dr Steven Due - SA
Specialty: General Surgery
Topic: Targeting oestrogen receptors for the treatment of oesophageal adenocarcinoma
Supervisor: Dr Damian Hussey

Foundation for Surgery Catherine Marie Enright Kelly Scholarship
*Value: $66,000pa**
Dr Su Kah Goh - Vic
Specialty: General Surgery
Topic: Donor-specific cell-free DNA as a non-invasive marker for the surveillance of organ rejection after liver transplantation: A pilot study
Supervisor: Professor Chris Christophi

Foundation for Surgery Health Technology Assessment Scholarship
Value: $66,000pa
Dr Niranjan Sathianathen – Vic
Specialty: Urology
Topic: The role of MRI fusion biopsy in prostate cancer diagnosis
Supervisor: Associate Professor Nathan Lawrentschuk

Foundation for Surgery Herbert and Gloria Kees Scholarship
*Value: $66,000pa**
Dr Christopher Nahm - NSW
Specialty: General Surgery
Topic: The prognostic role of biomarkers in pancreatic ductal adenocarcinoma
Supervisor: Dr Anubhav Mittal

Foundation for Surgery New Zealand Research Scholarship
*Value: $66,000pa**
Dr Alistair Escott – New Zealand
Specialty: General Surgery
Topic: Towards the treatment of toxic thoracic duct lymph in critical illness
Supervisor: Dr Anthony Phillips

Foundation for Surgery Reg Worcester Research Fellowship
*Value: $66,000pa**
Dr Geraldine Ooi - Vic
Specialty: General Surgery
Topic: Non-alcoholic fatty liver disease in the obese and the effects of bariatric surgery
Supervisor: Professor Wendy Brown

Foundation for Surgery Research Scholarship in Surgical Ethics
*Value: $66,000pa**
Dr Joseph Smith – SA
Specialty: N/A
Topic: Surgery and climate change: The scientific, ethical and public policy implications
Supervisor: Professor Guy Maddern

Francis & Phyllis Thornell Shore Memorial Trust for Medical Research Scholarship

*Value: $66,000pa**

Dr Timothy Chittleborough - Vic

Specialty: General Surgery

Topic: Profiling desmoids tumours in familial adenomatous polyposis patients & exploring strategies to prevent & treat desmoids tumours using novel mouse model

Supervisor: Professor Alexander Heriot

MAIC-RACS Trauma Fellowship

Value: $66,000pa

Dr Emily Ryan – WA

Specialty: Plastic and Reconstructive Surgery

Topic: Investigating the effects of non-severe burn injury on the cardiovascular system

Supervisor: Associate Professor Mark Fear

Paul Mackay Bolton Scholarship for Cancer Research

Value: $66,000pa each*

Dr Penelope De Lacavalerie - NSW

Specialty: General Surgery

Topic: Molecular basis of chemoradiotherapy responsiveness in rectal cancer patients

Supervisor: Associate Professor Maija Kohonen-Corish

Dr Joseph Kong - Vic

Specialty: General Surgery

Topic: Immune markers to predict response and developing methods to enhance immunotherapy in the neoadjuvant treatment of locally advanced rectal cancer

Supervisor: Professor Alexander Heriot

Sir Roy McCaughey Surgical Research Scholarship

Value: $66,000pa each*

Dr Juyong Cheong - NSW

Specialty: General Surgery

Topic: Quantifying the peritoneal damage and inflammation due to ambient air during laparotomy and effect of humidified, warmed CO^2 in mitigating the peritoneal injury

Supervisor: Professor Anil Keshava

Dr Ahmer Hameed - NSW

Specialty: General Surgery

Topic: Modifying donor organ retrieval and preservation to enhance transplant outcomes

Supervisor: Associate Professor Wayne Hawthorne

WG Norman Research Scholarship

*Value: $66,000pa**

Dr David Smolilo – SA

Specialty: General Surgery

Topic: Enteric neural circuits underlying propulsion of content in the large intestine of mammals, including human, in health and disease

Supervisor: Professor Nick Spencer

Foundation for Surgery Small Project Grants

Valued at $10,000pa each

Chief Investigator: Dr John Bingley – Qld

Specialty: Vascular Surgery

Project: Opening the discourse for open disclosure: A simulated education program to enable surgeons to have effective open disclosure conversations

Chief Investigator: Dr Vignesh Narasimhan – Vic

Specialty: General Surgery

Project: Peritoneal malignancy: Advancing the understanding of pseudomyxoma peritoneii and colorectal cancer in the context of peritoneal carcinomatosis

Chief Investigator: Dr Maryam Nesvaderani – NSW

Specialty: General Surgery

Project: Gene-expression profiling to identify biomarkers in severe pancreatitis

Chief Investigator: Dr Assad Zahid – NSW

Specialty: General Surgery

Project: Surgical Education

Foundation for Surgery Brendan Dooley/ Gordon Trinca Trauma Research Scholarship

Value: $10,000pa

Dr Ben Beck – Vic

Specialty: N/A

Topic: Trauma deaths in Victoria, Australia - epidemiology and preventability

Supervisor: Professor Peter Cameron

Travel and Education Scholarship, Fellowship and Grant Recipients

Margorie Hooper Travel Scholarship

Value: $75,000pa

Dr Saleem Hussenbocus - SA

Specialty: Orthopaedic Surgery

Stuart Morson Scholarship in Neurosurgery

Value: $30,000pa

Dr Hamish Alexander - Qld

Specialty: Neurosurgery

Foundation for Surgery Ian and Ruth Gough Surgical Education Scholarship

Value: $10,000pa

Dr Adam Watson – Vic

Specialty: Orthopaedic Surgery

Hugh Johnston ANZ Chapter American College of Surgeons Travelling Fellowship

Value: $8,000pa

Dr Jane Mills - Vic

Specialty: General Surgery

Hugh Johnston Travel Grants

Valued at $10,000pa each

Dr Joseph Dusseldorp - NSW

Specialty: Plastic and Reconstructive Surgery

Dr Dylan Wanaguru - NSW

Specialty: Paediatric Surgery

Morgan Travelling Scholarship

Value: $10,000pa

Mr James Toh - NSW

Specialty: General Surgery

Morgan-Opie Travelling Scholarship

Value: $10,000pa

Mr Rowan Valentine – SA

Specialty: Otolaryngology, Head and Neck Surgery

Murray and Unity Pheils Travel Fellowship

Value: $10,000pa

Mr Vladimir Bolshinsky - Vic

Specialty: General Surgery

John Buckingham Travelling Scholarship

Value: $4,000pa

Dr Shin Sakata - Qld

Specialty: General Surgery

Inaugural Aboriginal, Torres Strait Islander and Maori Scholarship Recipients

RACS Aboriginal and Torres Strait Islander SET Trainee One Year Scholarship

Value $20,000pa each

Dr Andrew Martin – New Zealand

Specialty: Otolaryngology, Head and Neck Surgery

Dr Anthony Murray – NSW

Specialty: Orthopaedic Surgery

RACS Māori SET Trainee One Year Scholarship

Value $20,000pa

Dr James Johnston – New Zealand

Specialty: Otolaryngology, Head and Neck Surgery

Johnson & Johnson MEDICAL DEVICES COMPANIES

Other Scholarships

The following lists external awards that Fellows and Trainees of RACS have been successful in attracting from other organisations.

Sam Mellick Travel Fellowship

Value: $5,000

Dr Andrew Bullen

Specialty: Vascular Surgery

Academic Surgeon-Scientist Research Scholarship 2016 by the Garnett Passe and Rodney Williams Memorial Foundation

Value: $75,000

Dr James Johnston

Specialty: Otolaryngology, Head and Neck Surgery

Topic: Determination and manipulation of the microbiome in adenotonsillar hyperplasia

Preliminary Notice: Applications for 2018 scholarships will open in March 2017

Attendees at the opening of the 2016 Pacific Islands Surgeons Meeting

11th Pacific Islands Surgeons Meeting

MR RANDALL MORTON
Chair, New Zealand National Board

Every two years, the Pacific Islands' Surgeons Association (PISA) holds its Pacific Islands' Surgeons Meeting, the location of which rotates across the islands. Overcoming the limitations imposed by the expanse of the Pacific, these gatherings provide an invaluable opportunity for the surgeons in the region to come together to present local research, review standards and best practices, discuss improvements in surgical training, and maintain the supportive and collegial Pacific Islands' surgical community.

The 11th Pacific Islands' Surgeons Meeting was held in the stunning surroundings of Apia, Samoa from 5 to 8 September. Much has changed since the inaugural Meeting that was held in 1994 in the Cook Islands and featured surgeons from just two Pacific Island countries – Cook Islands and Samoa – alongside surgeons from New Zealand. Now, 22 years later, the Meeting included surgeons, surgical Trainees and registrars hailing from 11 Pacific Island countries, including American Samoa, Cook Islands, Fiji, Kiribati, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu, as well as from New Zealand, Australia and Myanmar / Hong Kong.

The 2016 Meeting was officially opened by the Samoan Minister of Health, the Honourable Tuitama Leao Dr Talalelei Tuitama, with Her Excellency Jackie Frizelle, New Zealand High Commissioner to Samoa, also present to welcome the attendees. Over the four days, delegates had the opportunity to attend workshops and courses, and present on subjects including surgical responses to non-communicable diseases, disaster preparedness and response, and workforce issues in the region. As in previous years, the majority of presentations were given by the Pacific Island surgeons and surgical Trainees and reflected the realities of surgical practice within their home countries.

Cancers and the complications of diabetes are key conditions requiring surgical services throughout Pacific Island countries. Both have considerable detrimental impacts on individual patients, their families and communities, and present a significant strain on health systems across the Pacific. Research from Tonga showed that over a recent two year period 50 to 60 per cent of the surgical beds at Vaiola Hospital in the capital, Nuku'alofa were filled by patients with diabetic sepsis. In Lautoka Hospital, Fiji, 67 per cent of the workload of the orthopaedic department (which has the major role there in the surgical treatment of diabetes) is focused on diabetic foot sepsis. Pacific Islands' surgeons are actively involved in, and committed to, the ongoing processes of gathering information, evaluating options and educating themselves and other clinicians on treating these conditions; and in educating communities to present earlier for treatment.

Pacific Island countries are always vulnerable to a range of natural disasters and Cyclone Winston's devastating

impact on Fiji earlier this year was yet another example of that vulnerability. There is no doubt that fast access to well organised, responsive surgical services reduces both the number of deaths and the potentially lifelong consequences of injuries and related infections following a disaster. The Meeting included presentations on other disasters in Samoa, Vanuatu, Haiti and Nepal, and the first hand surgical lessons that could be learnt from these. Crucially, the sharing of such information enables Pacific Island surgeons to learn from each other and to improve their own preparedness and response plans.

While the majority of medical students in the Pacific Islands are female, there are exceedingly few female surgeons. This Meeting included personal reflections by female surgical Trainees from Papua New Guinea, Fiji and Tonga on their journey into a surgical career. The influence of female role models in their career choice was mentioned by all.

The Ava Ceremony, held to welcome the attendees

PISA is a signatory to the 2015 Bangkok Declaration for Global Surgery that calls on the health community worldwide to promote the implementation of the WHO Assembly's resolution to strengthen access to emergency and essential surgical care and anaesthesia as part of universal health coverage. The resolution includes adopting the indicators identified in the Lancet Commission on Global Surgery. Eight Pacific Island countries are already gathering data on all four indicators (timeliness, surgical capability, surgical capacity and safety (utilising perioperative mortality data)) and another has data on one. Their initial data was presented at the Meeting and other countries were encouraged to begin collecting information.

The Meeting provided the opportunity for PISA to hold its General Meeting and to elect its office bearers. Lord Viliami Tangi (Tonga) has been re-elected President, Ifereimi Waqainabete (Fiji) Vice President and Basil Leodoro (Vanuatu) Secretary Treasurer. Other Executive members are Navy Collins (Samoa), Micky Olangi (Solomon Islands), Rajeev Patel (Fiji), Ponifasio Ponifasio (Samoa) and Deacon Teapa (Cook Islands). The Past President, Eddie McCaig (Fiji) is a co-opted member; and the Trainees Representatives are Elizabeth Alok for the Western Pacific (a cardiothoracic trainee in PNG) and Ronal Kumar for the Eastern Pacific (an MMED trainee in Fiji).

This Meeting could not have been such a success without the generous sponsorship of the RACS, NZ Aid Programme, Strengthening Specialised Clinical Services in the Pacific and, of course Samoa's Ministry of Health, National Health Service and the Samoan Medical Association. We all look forward to the next meeting in Fiji in 2018.

Maitare Leiha, a 5th year medical student in Samoa is pleased to gain access the ANZ Journal of Surgery.

Thank you

Asia-Pacific surgeons gain support for essential CME from RACS Fellows

Thank you to all of the Fellows who have responded to RACS Global Health's Journal Appeal to support Continuing Medical Education for the Asia-Pacific surgical community.

For many people in Asia-Pacific countries, the subscription fees for the ANZ Journal of Surgery and other medical journals are unaffordable. Thanks to your generosity, the first shipment of journals was delivered to Tupua Tamasese Memorial Hospital in Samoa in September. Twelve other institutions across the Pacific Islands, Papua New Guinea and Myanmar are also being supported with regular donations of the ANZ Journal of Surgery, ensuring the local doctors are kept up to date with the current literature. The journals are being donated to hospital libraries so that all surgical staff and Trainees can access these valuable educational resources.

If you would like to participate, please contact global.health@surgeons.org

With thanks to the following sponsors

Mr Peter Carne
Dr Susan Taylor
Dr Ruth Mitchell
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Mr Robert Allbrook
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Dr Philip Lockie
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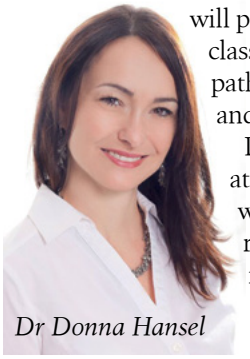
USANZ Announcement

Urological Society of Australia and New Zealand (USANZ) ASM, 24 – 27 February 2017, Canberra

MICHAEL NUGARA
CEO, USANZ

Internationally recognised leader in genitourinary pathology, Dr Donna Hansel, will be a keynote presenter at the Urological Society of Australia and New Zealand (USANZ) ASM in February 2017 in Canberra. She will present a number of talks including Re-classification in prostate & kidney cancer pathology; Transitional Cell Carcinoma review; and Renal Cell Carcinoma - biopsy pitfalls.


Dr Donna Hansel

Dr Hansel received her MD and PhD degrees at the Johns Hopkins School of Medicine, where she subsequently completed her residency and genitourinary pathology fellowship in the Department of Pathology. Dr Hansel was Assistant and Associate Professor at the Cleveland Clinic from 2006-2013, where she developed her clinical and translational program in bladder cancer research. She was recruited to the University of California at San Diego in 2013 as Full Professor and Chief of the Division of Anatomic Pathology.

Dr Hansel's laboratory research focuses on identifying high-yield, targetable pathways in advanced bladder cancer, with a strong emphasis on mTOR signalling and novel downstream targets that are involved in cell motility and invasion. Overall, her research results have been presented in the USA and internationally and have culminated in over 80 peer-reviewed publications. In addition, Dr Hansel has clinical expertise in bladder, prostate, kidney and testicular cancer. She is currently on the Editorial Board for Advances in Anatomic Pathology and is a section editor for urologic oncology in Archives of Pathology and Laboratory Medicine and has mentored over 20 residents, graduate students and postdoctoral fellows. Dr Hansel has recently been awarded the Ramzi S. Cotran Young Investigator Award by the United States and Canadian Academy of Pathology.

ASOHNS Announcement

Renowned international specialist in complex ear diseases will present at ASOHNS 2017 ASM

LORNA WATSON
CEO, ASOHNS


Prof. Jackler

Internationally renowned otologist-neurotologist, Professor Robert Jackler, from the Stanford School of Medicine, Stanford, USA, will be presenting at the Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) 2017 Annual Scientific Meeting in March in Adelaide.

Sponsored by the Royal Australasian College of Surgeons, Professor Jackler will join other prominent international guest speakers and Australia's own experts in a program that will explore the latest otolaryngology head and neck surgery subspecialty knowledge. Information in the fields of Rhinology, Facial Plastics, Sleep, Otology/Neurotology and Head and Neck Surgery will be presented with particular relevance to the general otolaryngologist.

Professor Jackler specialises in complex ear diseases. He has a particular interest in tumors of the lateral and posterior cranial base and has written numerous analytical papers derived from his microsurgical series.

During the ASOHNS ASM, he will present session topics including "E-Cigarettes – A Primer for the Otolaryngologist", "Practical Suggestions on Managing Cholesteatoma" and "Contemporary Trends in Skull Base Surgery".

Professor Jackler is currently the Edward C and Amy H Sewall Professor in Otorhinolaryngology and Professor By Courtesy, of Neurosurgery and Surgery at the Stanford School of Medicine.

He leads the Stanford Initiative to Cure Hearing Loss, whose mission is to create biological cures for major forms of inner ear hearing loss through a research effort that is sustained, large-scale, multidisciplinary, focused, goal-oriented and transformational.

For more than 25 years, Professor Jackler has directed a fellowship program in neurotology and skull base surgery, which has trained a number of academic leaders in the field.

He has authored more than 160 peer reviewed papers, more than 40 textbook chapters, numerous editorials and has published three books: *Neurotology* (1994, 2004), *Atlas of Neurotology & Skull Base Surgery* (1996, 2008) and *Tumors of the Ear and Temporal Bone* (2000).

The ASOHNS ASM 2017 theme is Ingenuity at Work and the main program will be held from 23-26 March, 2017 at the Adelaide Convention Centre.

For more information and to register, go to:
http://asm.asohns.org.au/

Nearing Completion: The Laparoscopic Simulation Skills Program

PROFESSOR GUY MADDERN
Surgical Director of Research and Evaluation

The Laparoscopic Simulation Skills Program is a research project designed to help determine the optimum format for improving access to surgical simulation training, particularly in outer metropolitan and rural locations. The project commenced in February 2015 and is funded by a James Ramsay Project Grant.

Since the first site visit in June 2015 research staff have driven the Mobile Simulation Unit (MSU) almost 20,000km; successfully conducting 17 hospital visits in South Australia and rural Victoria. Researchers have enrolled junior doctors, SET and RANZCOG Trainees as well as medical students, to examine differing approaches to laparoscopic skills training. The MSU remained at each hospital for one week to enrol participants into the two arms of the study. One group was provided guided training in the MSU followed by a three week period of self-directed learning, while the other group just received the self-directed learning. After that period, the MSU returned for final assessment of participants' skills. These training periods and a series of timed participant assessments have been collated to form the project data-set.

This multi-state, multi-site project is one of the largest for simulation-based education. Its successful implementation is a testament to the joint effort between researchers and local hospital authorities, administration officers, surgical departments, medical schools and local research governance officers. Due to the outstanding support of those who saw in the project a unique learning opportunity for student and Trainees, more than 200 participants enrolled in the project.

Feedback from project participants has been extremely positive. Comments included: "Thought it was very useful, particularly for someone young like myself to get a chance to get used to the instruments in my own time. I am sure it will be useful when I get to theatre."

Meanwhile a junior doctor stated: "I found the course and [self-directed learning] enjoyable..... I think it will add to my manual dexterity and overall skill."

Many participants also expressed their willingness to continue practising on a regular basis if there were simulators available at their workplaces.

The finalised data set is still being analysed and interpreted however the research project continues to remains on schedule and will provide its final report in early 2017. It is hoped the information gained from this project will enable program directors to develop simulation-based training activities that are effective and accessible for all Trainees, regardless of training location

Response to the Toast to the Court

Professor Richard Turner has stepped down from his role on the RACS Court of Examiners and gave an outstanding speech at their recent dinner event

Richard Turner is a prominent surgeon – a Professor of Surgery at the University of Tasmania School of Medicine, Director of the Hobart Clinical School and Consultant General Surgeon at Royal Hobart Hospital, and until recently, an examiner appointed by the RACS Council to its Court of Examiners, whose purpose is to conduct the Fellowship Examination. The Court's role is to assess the knowledge, clinical skills, judgement and decision making and professional competencies of candidates, in order to ensure that they are safe and competent to practise as surgeons.

Richard did not initially put himself forward as a Fellowship examiner. A couple of worthy colleagues where he was working in Cairns presented him with a pre-completed nomination form – all he had to do was attach his CV.

"After all, I had done my bit, often being the last to step backwards when it came to being a training supervisor or sitting on various committees; I enjoyed a modicum of respect in the workplace. So when I learned that my application had been successful, I was pleased but not hugely surprised.

"It was not until I attended my first examiner workshop the following year, that I discovered how humbled (in a different way) I should have been. Selecting new examiners was to some extent based on surgical prowess and academic achievement, but when it came down to final decision, one had to be a 'good' person, someone who could work with others, be sensible, and be a worthy gatekeeper for the future culture of our profession.

"Looking back through the haze to my own Fellowship examination, it was a generally positive experience. When I wasn't waxing lyrical in vivas, I was talking to the mirror in my room at the Travelodge Wynyard. The examiners were (mostly) quite benign, if somewhat hard to read at times; but I cannot recall being interrogated by anyone except middle-aged white men. I guess this was the *boys' club*.

> *A lifestyle based on same-sex attraction should not in this day and age need to be accepted, just as playing golf should not need to be accepted.*

His question at the time was whether he was worthy of being one of these people who, in the not too distant past, he had variably seen as being on an unattainable pedestal - or as part of a notorious *boys' club* that deep-down he wanted to subvert.

His decision to nominate, according to his resignation speech at the recent Court of Examiners Annual Dinner was made with a view to subverting it from within. This was his speech.

"I submitted my application to the so-called Court of Examiners, in the Specialty Court of General Surgery," he said.

"In 2008, the specialty court that I entered, full of good people as it was, did not appear to be an accurate reflection of the current Fellowship nor of the Fellowship about to come. Out of what was even then a multitude of examiners, there were barely two or

three women, a couple of non-Anglo, and a visiting examiner or two from the soon-to-be-obsolete Hong Kong fellowship exam.

"When I examined for the first time, I was told that it was difficult to recall anonymised candidates three days hence when they were being discussed as part of the moderation process. It was therefore useful to use some sort of coded notation on the marking sheets as an aide-memoire. One of the examiners was adept at drawing caricatures of the nuances of candidates' distinguishing features – I was no such artist. I cannot remember what sort of symbolic scribbles I used, but after the fifth 'East Asian male, glasses', I gave up.

"The conveyor belt of candidates was indeed a diverse and interesting place. So-called IMGs typically comprised a significant part of the workload, both in the vivas and in the specialty court moderation meetings. Many of these people had come to our countries with an established career in their own, but now had to face renewed judgement.

"It is gratifying to see the various initiatives that have been made to support IMGs in the Fellowship examination process. And without overtly coining the fraught term of affirmative action, my specialty court has certainly made considerable progress in redressing its own cultural and gender imbalance with respect to the body of candidates. This is no doubt of great reassurance to the many trainees we examine each year.

"Many other reforms of the examination process have taken place. So-called vivas are much more structured than I recalled them. Exam setting is certainly a lot more efficient than it once was, thanks to expert delegation and blueprinting, of which I will expound the virtues on another occasion. And most importantly, the specialty court meetings on Sunday afternoons are a lot quicker than they used to be, which allows enough time for a well-deserved pre-dinner drink or two.

"It is hard to know where these last 8 years have gone. Things have also happened on a personal level: I did the unthinkable and relocated from Queensland to Tasmania; I experienced the sadness of losing parents; but I also experienced the life-affirming joy of getting married as much as I possibly could in this country at this point in time.

"Getting back to why I thought I might not be a rightful member of this lofty body of people, I would need to look back even further beyond my Fellowship examination. I graduated from medical school in 1985. Ah the 80s… Because of an initial interest I expressed, I more or less got streamed into a variety of surgically oriented jobs from my intern year onwards. I also started to stream myself in another way. If people can recall what it was like to practice medicine in the 80s – we barely knew what caused AIDS or even exactly how you caught it, but we certainly knew who you could catch it from. This was a time when some doctors were refusing to touch patients because they were HIV-positive. Judgement was rife. I personally witnessed secret blood tests done on men who were slightly effeminate, or an operation was refused until the test was taken. So at this time, to declare oneself as a gay man aspiring to invade the body cavities of innocent people seemed awfully like career suicide. In the case of my timorous self, it was a case of "don't ask don't tell" for the next 15 years.

General Surgery examiners (Sydney 2016), Richard Turner is 4th from the right

"My time with the Court of Examiners has been an extremely fulfilling experience, professionally and socially. Once again, I was not terribly confident about the latter, despite numerous indications that the dark clouds had probably lifted. At my first exam, also here in Sydney, I realized that the 'partners' – mostly a series of redoubtable extraordinary women – were a major part of the intense four-day experience. I remember being pulled up at the lifts after the Court dinner by a fellow General Surgery Examiner, the equally redoubtable Amanda Robertson, who asked me 'Richard, why didn't you bring *your* partner?' And so from then on I did – and all I can say is 'you asked for it'. For the last eight years, and well before that, Dr Michael Beresford has been my staunch supporter and defender, and at events such as this, all I need to do is sit back and bask in his reflected charisma.

"As I said earlier, I entered the *boys' club* thinking I might subvert it in my own modest way, not realising that in some ways it might be beating me to it. In my training, I have known occasional bullying, indeed homophobic bullying that did not quite speak its name. Yet when those recent infamous revelations made it into the media, rather than feeling angry or vindicated, I actually felt defensive and then proud of an organisation that tackled the issue head-on and with a much broader brief than the original allegations.

"There are indeed residual pockets of prejudice in some dark corners of our fellowship, but the driving force that dictates the culture of the organisation is one of inclusion and acceptance. That last word, 'acceptance', is *slightly* problematic. It implies that one is doing something that might otherwise offend the sensibility of others. A lifestyle based on same-sex attraction should not in this day and age need to be accepted, just as playing golf should not need to be *accepted*. Of course marriage equality would also be able to spell this out in capital letters – we would not need to rely on the awkward beneficence of others to be received as equal. We are equal because the law and society as a whole say we are.

"The diversity of our College, in all its forms, is a fact. We must recognise it and grow with it. I would like to acknowledge all those in the Court of Examiners who are part of this same journey."

Beauty more than skin deep

Melbourne Museum is hosting *Biomedical Breakthroughs: A New View of You*

A unique fusion of art, animation, medical history and biological science has resulted in a new exhibition that allows visitors to see microscopic biological processes occurring in real time on giant projectors while also telling the story of Australia's pivotal role in improving global health.

The exhibition, called *Biomedical Breakthroughs: A New View of You*, explores the extraordinary research breakthroughs pioneered by scientists at the Walter and Eliza Hall Institute (WEHI) of Medical Research and CSL over the past 100 years.

From the discovery of anti-venom in the 1920s to the clinical trials now taking place into the use of BH3-mimetics to induce cancer cells to undergo programmed apoptosis, the exhibition takes a modern look at a century of scientific achievement while educating the public about human biology.

Ranging across topics such as the Immune System, Blood, Antivenoms, Infection and Antibiotics, Autoimmune Disease and cutting-edge Cancer therapies, the exhibition explores how Australian scientists have saved the lives of millions of people around the world.

The first such exhibition of its kind to be held in Australia, it uses both historical objects and animated recreations of biologically correct real-time cellular activity as well as high-definition projections of magnified DNA to explain those advances.

The exhibition also includes an interactive cancer molecule spinner and a 'space-invaders' game that allows audiences to target viruses in the immune system.

Historical and biological artefacts on display include the taipan that provided the first venom for scientists to use to create an anti-venom, tiny infant pneumonia jackets used during the 1918/1919 Spanish Flu pandemic and the vessels used to culture the world's first mass produced penicillin.

Johanna Simkin, senior curator of human biology and medicine at the museum and a former biomedical researcher with a PhD investigating stem cells, put the exhibition together over 18 months in collaboration with staff from WEHI and CSL.

She said she trawled through the archives of WEHI and CSL and spoke to current scientists to find the stories that described both the beauty of biology as well as the role of Melbourne scientists in improving global health.

"Once you see how incredibly intricate and dynamic biology is, you can't help but be captivated by the beauty of the processes going on inside us every second of every day," Ms Simkin said.

"To see DNA replicating in real time is just incredible and many people have asked us how we came up with the idea of trying to make biological processes beautiful but you just have to see them to be struck with the wonder of it.

> *"Once you see how incredibly intricate and dynamic biology is, you can't help but be captivated by the beauty of the processes going on inside us every second of every day,"*

"We use the phrase 'chaotically coordinated' because that phrase captures it perfectly and the amazing animations we use allow people to learn how their cells are able to talk to each other and do that with their own specialised roles within the body.

"I've worked in this field for some time and yet to see large-scale projections showing the complexity and beauty of microscopic human biology is utterly awe inspiring."

Ms Simkin said she was particularly enthusiastic about the section, which explores the biology behind cancer and explains how scientists can find the genes that are either over

or under expressed, the proteins that drive the changes and the molecular structures of both cancer cells and treatments.

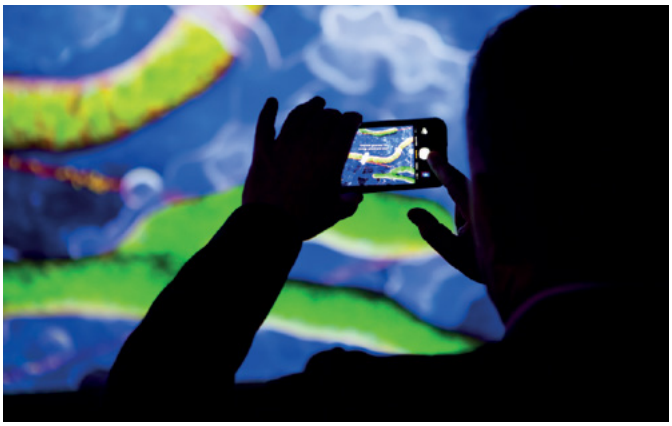
"We explain the workings of a new drug that allows cancer cells to be vulnerable to death again so they stop proliferating and this work is now being done at WEHI and is so new it is still being trialled but is showing great promise.

"I think visitors will be blown away with the exquisite biology bubbling away inside their own bodies while also learning about the significant impact Melbourne's research community has had on the biomedical field."

Ms Simkin also said the exhibition pays as much attention to the people behind the scientific breakthroughs as the breakthroughs themselves and tells the stories of researchers such as Kevin Budden who was bitten as he captured a taipan, one of the most deadly snakes in the world, for scientific study.

"Even when he knew he was dying he insisted the snake be kept unharmed and delivered to CSL in Melbourne so they could obtain the venom needed to produce an anti-venom," she said.

"That is the heroic side of biological science but we also wanted to get across to the public that most scientific advances are not based on a single 'eureka' moment but are the product of years of painstaking effort, collaboration and insight."



The two stars of the show – WEHI and CSL – have an intertwined history that stretches back to WW1 when they shared laboratories in Melbourne and both have gone on to lead the world in scientific advances across a range of biomedical fields.

Founded in 1915, WEHI now employs more than 750 researchers who are currently working to understand, prevent and treat diseases including cancer, immune disorders and infectious diseases including malaria, hepatitis B and HIV while trials are now underway of vaccines to prevent Type 1 diabetes and malaria and a potential new curative treatment for hepatitis B.

Originally named the Commonwealth Serum Laboratories, CSL was established in 1916 by the Federal Government to ensure an isolated nation had reliable access to therapeutic sera, vaccines and other life-saving biological products.

From its humble beginnings as a small branch of the Quarantine Department, CSL is now a $45 billion global speciality biopharmaceutical company that operates in more than 30 countries.

Dr Andrew Cuthbertson, Chief Scientific Officer at CSL said the exhibition was a wonderful way to mark the company's centenary.

"Melbourne has a long and rich history of scientific discovery and commercialisation that has significantly advanced human health in Australia and worldwide," he said.

Professor Doug Hilton, Director of WEHI, said the institute and CSL had shared in many medical research successes over the past century.

"The collaborations between our two organisations' researchers and our shared missions of improving health have enabled lab research to progress through to clinical outcomes," he said.

"In the 1930s this brought the first anti-venoms for Australian snakes while more recently we have seen institute research be advanced through CSL collaborations to potential new treatments for rheumatoid arthritis and cancer.

"This exhibition is a wonderful showcase demonstrating how Melbourne medical research is helping improve Australian, and global, health."

Biomedical Breakthroughs: A New View of You runs until January at the Melbourne Museum.

- With Karen Murphy

Rural Coach Program Provincial Surgeons Association

RICHARD PERRY
Chair, Fellowship Services

Since 2011, the Rural Coach Program (RCP) has identified and supported Trainees interested in a rural surgical career. This may be by way of ongoing networking with a rural surgeon, information regarding educational or professional opportunities and the opportunity to build their rural connections by offering financial assistance to Trainees to attend the Provincial Surgeons of Australia (PSA) annual conference.

General Surgeons Australia (GSA) generously provides a Rural Coach/GSA Registration Grant for Trainees to attend the PSA each year.

The 52nd Provincial Surgeons Australia Annual Scientific Conference held over three days from 6th to the 8th of August 2016.

Attendance at the meeting by Rural Coach participants offered exposure and an opportunity to contribute to the rural and regional surgical community. The Rural Coach Session led by the program's Clinical Director Dr Sally Butchers, brought together program participants from across Australia. Participants were able to connect with their peers and surgical mentors and feedback highlighted participant's motivation to continue their focus on a rural and regional career in surgery.

The Natural Bridge at the Gap - Albany

Rural Coach Session with the Clinical Director Dr Sally Butchers

Provincial Surgeons Association:

'Education of Yourself, Junior Doctors and Students'

RICHARD PERRY
Chair, Fellowship Services

LAURENCE WEBBER
Co-Convener- PSA 2016

I'm not sure what was the greater achievement by the organising team in the end, managing to arrange a hundred odd surgeons, Trainees and students plus invited guests to travel to a tiny coastal town in rural Western Australia, or managing to put on three glorious days of sunshine in the midst of a record cold, long and rainy winter. Regardless the team from GSA of Sally and Sarah did this brilliantly and the 52nd Annual Provincial Surgeons Conference was held.

The PSA meeting started in Shepparton, Victoria in 1965 and has only visited Western Australia four times prior to 2016. Just getting to a PSA is a challenge for a rural surgeon as it involves organising a locum and lists, a flight or long drive to a major centre, another across or down the country, and finally an infrequent flight or drive to a small peripheral town. Starting from Geelong, getting to Tokyo takes the same time as getting to Albany WA.[i] Yet somehow we drew them down, bringing rural surgeons, Trainees and students together to advocate and plan for the future.

Given the oversupply and underemployment of surgeons in some metropolitan areas, and an ongoing and worsening deficit of well-trained surgeons in the regions it is no surprise that we are being forced to re-examine the model and rhetoric behind city centric surgical education and training. The theme 'Education of Yourself, Junior Doctors and Students' was devised and executed in order to demonstrate how world class education can be supported and delivered in the bush.

Topics ranging from understanding and enhancing adult learning, support for higher degrees, upskilling courses and local models for surgical education excellence were intertwined with original research presentations from all levels of presenter, including rural based, comparative cancer outcomes research as well as poster presentations on rare conditions being dealt with in small centres. Included with these presentations was a healthy dose of the PSA motto and some excellent heckling.[ii]

Our most travelled guest was Lauren Smithson, a General Surgeon from Newfoundland in Canada, which is only 33 flying hours away and almost the antipodes of Albany.[iii] Lauren founded the Society for Young Rural Surgeons (SYRUS)[iv] and gave presentations on the society, on working in remote Canada as a young surgeon, the challenges of medical education in North America and gave a refreshing point of view to our conference.

The immediate past and current RACS Presidents gave views on the present and future of rural medical education and answered questions on behalf of RACS. We were also host to Rebecca Irwin, Chair of the National Rural Health Student Network who presented on the doings and involvement of that group as well as – Prof Ikau Kevau and Dr Ashley Eri Ebos from PNG who made the long trip to a PSA.[v]

Local medical education experts gave views on the evolution of medical education and the setup and running processes of the CTEC facility and courses in Perth and robust argument as to why the bush is the best place to educate doctors.[vi] The only major glitch we experienced occurred when a local Professor managed to book an optimistic flight from Perth that didn't exist. With some impressive work by the IT support he was still able to give his presentation via Facetime with such a good response that perhaps we will be giving more lectures from our living rooms to conferences in the future.

Much was said of the Rural Clinical School which has been running in Albany for 10 years now and it was worth noting that of the 40 odd students and doctors present a high number of these had been through a year of rural medical education prior to graduation.[vii]

i https://www.rome2rio.com/s/Geelong/Tokyo
ii 'Verissimum Non Taurum'
iii http://www.antipodesmap.com
iv http://www.youngruralsurgeons.com
v http://www.nrhsn.org.au
vi http://www.ctec.uwa.edu.au
vii http://www.rcs.uwa.edu.au

In Memoriam

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

Thomas Stevenson
Orthopaedic Surgeon

14 April 1931 - 21 August 2016

Sadly we acknowledge the passing of a truly great man, a gentleman surgeon, Mr Thomas Stevenson who passed away on 21 August 2016 following a battle with pancreatic carcinoma since 2014.

Thomas Stevenson's origins are from Luss, a village near Loch Lomond in Scotland which accounts for his tenacious accent. He received his medical degree from the University of Edinburgh in 1954 and commenced working in that year as a house physician and surgeon at Shoreham, a small town in Sussex, Southern England. During his time in England he married Kathleen (Kathy), a romance that lasted their entire lives.

Samir Nessim Bishara
Neurosurgeon

15 November 1928 – 21 June 2016

Samir Bishara (widely known as Sam for much of his life) was born in Cairo, Egypt, the eldest child of Nessim Bishara (a general surgeon) and Clare Simaika. He had four sisters - Aida, Leila, Sophie and Mary, and grew up in Heliopolis, a suburb of Cairo, and the surrounding provinces.

Strongly influenced by his father's work as a surgeon, Sam embarked on a medical career graduating MB. BCh. in Cairo in December 1950. He then commenced as a trainee in surgery and subsequently assistant surgeon at Cairo's Kasr-El-Eini University Hospital. He was awarded a Diploma in Surgery in 1956 and a Master of Surgery in 1958 (this being presented by President Nasser). Sam emigrated to Britain to enter neurosurgical training and worked as SHO, Registrar and Senior Registrar successively at the Frenchay Hospital in Bristol, Morriston Hospital in Swansea and then in the London Hospital, where while working as Senior Registrar to Mr WDC Northfield, a prominent neurosurgeon, he participated actively in undergraduate and graduate teaching. Sam gained his FRCS in 1962. While working at Morriston Sam met Lois Gravelle, a nurse on the surgical ward, and they married in 1965.

John (Jack) Richard Mackay
Colorectal Surgeon

16 August 1943 – 9 October 2016

After graduating from the University of Melbourne in 1967, Professor Jack Mackay held training positions at St Vincent's Hospital in Melbourne and obtained a Fellowship in General Surgery in 1973. He was appointed as a visiting medical officer at Box Hill Hospital in 1976 and St Vincent's in 1977. He then completed sub-specialist training in colon and rectal surgery, including a Clinical Fellowship in 1979 at the prestigious Cleveland Clinic in Ohio, USA – one of the leading colorectal surgery units in the world. He subsequently became head of colorectal surgery at Peter MacCallum Cancer Centre, St Vincent's Hospital and Box Hill Hospital (Eastern Health). In 2005 he was appointed Associate Professor in the Department of Surgery, University of Melbourne.

Over his career he made extraordinary contributions to the profession. He was instrumental in the formation of the Colorectal Surgical Society of Australia and New Zealand. Of particular note was his service to the Royal Australasian College of Surgeons over two decades, as Chairman of Training Boards and Surgery Sections between 1994 and 2004. He created the Colorectal Training Program of the Society and the RACS Section of Colon and Rectal Surgery.

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:

2016

Samir Bishara, ONZM NZ

Gordon Clunie, VIC

Peter Grayson, NZ

John (Jack) Richard Mackay, VIC

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

Informing the College

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

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

While RACS accepts and reproduces obituaries provided, we cannot ensure the accuracy of the information provided and therefore take no responsibility for any inaccuracies or omissions that may occur.

Abstract Submissions Close: Sunday 29 January 2017

Safe and Sustainable – The Future of Surgery?

RACS ASC 2017

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Royal Australasian College of Surgeons

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OPUS XLIV

Coffee – Le Toast Des Dieux

FELIX BEHAN
Victorian Fellow

Coffee – the toast of the gods – is the basis of this little story put together coincidentally on the International Day of Coffee - October 1st.

Another stimulus for this composition was the coincidental medico-legal consultation I had to do the following day with a Ethiopian client and her son. Yes, my favourite psychotropic stimulus is coffee. As the great Voltaire said "perfection is the enemy of good" after his umpteenth coffee – rumoured to be 30 a day. Victor Hugo of Les Miserables fame went higher in volume with up to 50 a day. Surely they could only have been soupçons otherwise the diuretic effect would have been overwhelming.

As they recounted during the consultation, the origin of coffee dates back to goat herders in the Ethiopian ranges in the 10th or 11th century. These Ethiopian nomadic goat herders (Kaldi) were the first to recognise the stimulating effects of coffee. The patient's son could recount that the goats would retire to a certain place on the mountain escarpment, finally coming down in a somewhat excited state and that is all I will say about that!

The next day, so the traditional story goes, the Kaldi followed the goats and found them eating red berries from a tree and as we know goats will eat anything from shoe leather upwards! He took the berries home and on eating them found them to be tasteless. He threw them into the fire in disgust. The subsequent aroma was more than elevating. We have all experienced this stimulating aroma of roasting coffee beans. Some say the aroma is often more satisfying than the actual taste.

One coffee that blends these two sensual stimuli is from Blue Mountain in Jamaica; the price of which may go as high as $400 a kilogram. At the place I went to in Fitzroy asking about it they can only get this twice a year as 80% is exported back to the owners of the coffee plantation in Japan. I remember entertaining Miki Pohl at the Gallerie Lafayette in Paris with Blue Mountain to entice him back to the antipodes - it worked!

The patient during the consultation had her own pearls of Ethiopian experience. She buys her coffee raw and roasts it in a saucepan. The colour changes to a darkened hue, develops a shiny coat which indicates to her the oils of the Arabica beans are ready for consumption. When these are cool she grinds them and boils them in a ceramic pot similar to the Turkish method, which no doubt was adopted from her home country.

Early manuscripts trace the spread of coffee from *Arabia Felix* – presently Yemen. I have flown many times to Europe crossing over Mocha the principal port of Yemen en route. History recounts that it has been the major marketplace for coffee Arabica since the 15th century. Mocha in the 17th century reached the zenith of its trade and remained a major emporium and coffee exporter until the 19th century.

The word coffee, they say, first entered the English language in the 1580s via the Dutch word *koffie*. Let us not forget the Dutch owned New York and the Dutch East India Company traded around the world no doubt addicting the masses with their coffee exposure. My colleague Mike Klaassen from Auckland had a grandfather importing tobacco leaves from Java as part of the Dutch East India Company and he created cigars *(Hofnar)* for the Dutch and European market. He offered me a cigar recently when I was attending an International Head and Neck Meeting there in October 2016.

Knowing its origins from Ethiopia, a Muslim enclave, it is easy to understand the connection between coffee and its global distribution with this religious group.

Coffee houses were established in Syria especially in the cosmopolitan city of Aleppo. Its popularity then spread to Egypt and then Malta where it eventually became the toast of Maltese High Society. It is interesting to note that coffee was first introduced to Europe via the Turkish Muslim slaves imprisoned, by the Knights of St John.

The first European coffee houses opened in Venice in 1645 (the eventual home of the beloved cappuccino named after the Capuchin monks, brown and white habits) then spreading to France and Germany.

The next pinnacle in this coffee peregrination surfaces in Leipzig. Zimmerman's Coffee House in that town was the social focus every Friday afternoon. Why? It was the venue for the first performance of many of Bach's secular cantatas – one is even called the Coffee Cantata. All and sundry met and communicated whilst listening to the masters of composition showcasing their talents. This introduced educationally the concept of teaching to the younger minds that were willing to learn and listen. Voltaire did the same.

The musical talents of Telemann, godfather to most of Bach's children, could well have featured his important composition: Collegium Musicum. The rent was minor as the sale of the coffee balanced this commercially for Zimmermann. Even then the commercial value of coffee

Above: Café Crème – a French twist of on a cappuccino as bought in Paris.

was starting to surface. They say every morning around the world today up to 6 billion cups of coffee are consumed.

The *illustration* (left) is a detail of an engraving by Schreiber of Cafe Zimmerman. This Baroque building began its life in 1715 and was destroyed during an air raid in December of 1943.

In 1688 the coffee trail moved from Paris to London to Mrs Smith's Teahouse in the East End before it became the site of a coffee house. Here shipping negotiations took place – cargo contracts were signed which needed insurance cover for their valuable coffee cargo and during these business gatherings the importance of coffee became established. The Lloyds Coffee House plaque sits on the site of this historic cafe where Lloyds of London became the corporate headquarters for Lloyd's insurance.

Poland also played an important role in our coffee story. It was a Pole who opened the first coffee house in Vienna. Jerzy Franciszek Kulczycki, a Polish Diplomat, used coffee beans left by the retreating Ottoman Turks. Poland subsequently became the place where milk and sugar were first added to coffee to elevate (or otherwise) the taste.

The Frank Sinatra song "There's an awful lot of coffee in Brazil" indicates the transitional development of coffee growth into the Americas - from Blue Mountain in Jamaica down to Puerto Rico and Guatemala. And the Boston Tea Party of 1773 killed tea for Americans.

The coffee trail did not end there however it eventually arrived at St Helena an important element in this story. When I discussed this article with Don Marshall (my editorial assistant together with Trish) he said "do you understand the significance of St Helena and the Rose Chapel in Greensborough"? It transpired that coffee had been grown St. Helena since the time of Napoleon's imprisonment on the island following the loss at Waterloo. Could he have been a market gardener to help pass the time? The Governor of the Island, Anthony Beale, took over the British East India Company and became involved in coffee transport himself ending up back in the UK before migrating to the antipodes. His wife Katherine Rose died in 1856 at what is now called Greensborough (a Melbourne suburb) and the Rose Chapel was built as a memorial to her. It is now run by the Anglican Church.

The coffee prize goes to Kopi Luwak. This is the coffee from the Civet cat in Indonesia and Vietnam. They eat the red coffee berries which are lubricated with gastric juices descend through the digestive pathways of the duodenum, maturing in the large bowel (colonic storage) before progressing down the colonic descent to the anal ring creating the coffee droppings. Here the coffee-slaves collect and clean (hopefully) these droppings for world consumption with prices as high as $600/lb.

It is intriguing that eventually the coffee seedlings returned to the Africas where now Kenyan coffee and Tanzanian coffee command world respect. A 600 year world voyage, a little slower than Jules Verne 80-days story.

I have a fond memory of greeting many of my Ethiopian theatre sisters at the Western Hospital when I was clinically operating, some of whom I didn't know personally. I would shake their hand and thank them and they would respond inquisitively "why". I would reply "because you bought coffee into our world".

St Katherine's Church, Greensborough, Victoria

An indelible legacy

Dr Anwar Riad Girgis was born in Assiout, Egypt in 1927 and migrated to Australia in 1969. He had suffered many hardships in his native Egypt before settling well into the peace of Whyalla in country South Australia while working extraordinarily hard as an orthopaedic surgeon.

The second oldest son in a family of nine children - Anwar grew up in Cairo and excelled at school, winning two scholarships for national achievement. His memoirs describe a typical boy's childhood in Cairo - he did especially well in maths and science, and in high school was presented with an award from King Farouk.

He chose to study medicine at Cairo University, one of only two medical schools in Egypt at the time and graduated in 1951. After an internship at Cairo University Teaching Hospital, he spent the next two years working in rural Egypt close to the border with Sudan.

From early in his career Anwar had focussed on those most vulnerable and ensured that those under his care were protected and cared for professionally and with compassion. This became one his most respected traits along with his gentle nature and concern.

At the time of the nationalisation of the Suez Canal in 1956 a brief war broke out between Britain and France, and in 1962 the nationalisation of much private property saw Anwar's family stripped of most of their assets.

This was the precursor that saw Anwar travelling to Edinburgh in 1962 where he worked and studied before obtaining his FRCS(Edin) two years later, specialising in orthopaedics. Relocating again to London he met Myrtha Maetzler, a Swiss au pair working for a young British family, and they fell in love.

He returned to Egypt without Myrtha to work in the Ahmed

> *"The scholarship is unlike anything RACS has done before, and aims to support migrant, refugee and asylum seeker doctors who are experiencing financial hardship..."*

This was a turbulent period in Egypt, with the monarchy and King Farouk being overthrown in a revolution in 1952. The next eight years saw Anwar studying surgery in Egypt, obtaining his Diploma of Surgery and practising general surgery in several regional centres. Female circumcision and abortion were illegal in Egypt, but very poorly performed abortions and circumcisions were commonly undertaken by traditional "midwives" and others without skill or training. This was always an area of grave concern to Anwar, and after caring for many women with severe complications from these procedures, he provided assistance wherever possible.

Mahar Teaching Hospital in Cairo as an orthopaedic surgeon with a special interest in bone and joint tuberculosis, in particular, the spine and Potts' Paraplegia. As this hospital was a referral centre for the Middle East, Anwar gained considerable experience and was published on the subject. During this time, the pair continued a long distance romance, and they married in May 1965.

After the seven-day Arab-Israeli War of October 1967, Anwar returned to the UK at the invitation of a lifelong friend Dr Peter Ring.

While in the UK he successfully applied for a job advertised

Foundation for Surgery
Passion. Skill. Legacy.

Images (From opposite page, L-R): Circa 1952, taken during Anwar's Internship at Cairo University Teaching Hospital – Anwar second from right, back row; Visiting Egypt in later years.

in the British Medical Journal as a resident orthopaedic surgeon in Whyalla some 400km north of Adelaide. It was only the second such regional position offered in South Australia. The move in 1969 was a challenge - Whyalla was promoted to Myrtha and Anwar as a beautiful resort town, much like the French Riviera. Myrtha had spent a lot of her childhood in the beautiful region of Geneva, and felt that Whyalla was a place in which she could settle down.

Their first impressions upon arrival in the region were of stunned silence.

Despite the initial shock, Anwar, his young Swiss wife Myrtha and small daughter Mona, took it all in their stride with Anwar diving head first into an extremely busy and comprehensive elective orthopaedic service in the days before sub-specialisation. He was permanently on emergency call, not only for Whyalla but also a huge area of the north and the west coast of South Australia. He was much in demand for the management of industrial injuries from the steelworks and mines, and their subsequent assessment for compensation. In acknowledgement of his home country, the practice that he worked in and his wife managed, was named Karnak House, after one of Egypt's most famous Pharaonic temples on the Nile.

Anwar and Myrtha were very sociable and adapted well to their new lives, involving themselves in the social and artistic life of the steel town and quickly making long term friends through their open manner and generous hospitality. Myrtha was active in the Arts Council of South Australia and hosted many regional arts tours to the region. Anwar developed contacts with orthopaedic colleagues in Adelaide, especially Brian Cornish, for advice and referral where appropriate. He became an Associate Fellow of the Australian Orthopaedic Association in 1970 and a Fellow the following year.

In Whyalla, with lawyer Terry Reilly, Anwar established the first medico-legal conference in Australia. At the time Whyalla was an industrial town with ship building and the BHP steel works. Workplace injury was common. Recognising that medico-legal work was an important sub-specialty, Terry and Anwar hosted several important meetings over the following years. Anwar maintained throughout his career, his concern for the patient affected by workplace injury and their rehabilitation and return to work.

Through this period Anwar gained the great respect of his Adelaide orthopaedic colleagues, was appointed an Honorary Assistant Surgeon to the Department of Orthopaedics and Trauma of Royal Adelaide Hospital, and in 1981 was nominated and elected as a Fellow of Royal Australasian College of Surgeons (RACS). Anwar moved to Adelaide in 1984, was appointed as a Senior Visiting Orthopaedic Surgeon to Modbury Teaching Hospital and conducted a private practice in association with a long-term colleague and friend.

He was liked and respected by his patients, staff and referring doctors. He was courteous and gentlemanly and calm in the most complex of situations. His orthopaedic colleagues liked and admired him and enjoyed his company and hospitality in many encounters as he regularly attended continuing education meetings.

He stopped clinical practice in 1997, continuing medico-legal consulting for the next decade.

Anwar Girgis died in 2015 and is a wonderful example of the brave, hardworking, intelligent and admirable migrant and International Medical Graduate (IMG) from a vastly different culture to our own. He contributed so much to Australia and to surgery.

The Anwar and Myrtha Girgis IMG Scholarship is being established in Anwar and his wife's honour, through a generous donation from the Girgis family. The scholarship is unlike anything RACS has done before, and aims to support migrant, refugee and asylum seeker doctors who are experiencing financial hardship, gain the professional development required to practice surgery in Australia or New Zealand.

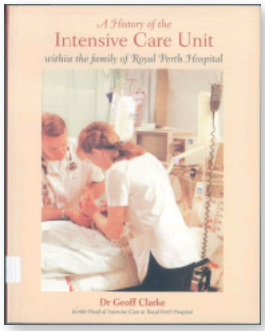
If this story has pricked your interest and perhaps you are an IMG from a refugee, asylum seeker or migrant background, then please take a look at the scholarship section of the RACS website early next year.

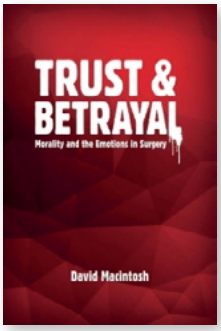
If you would like to find out more about establishing your own scholarship, like the Girgis family, then please contact the Foundation for Surgery on 03 9249 1110.

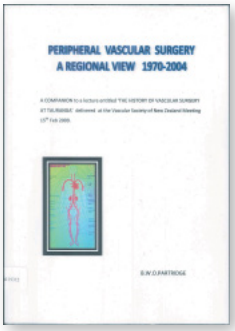
LIBRARY UPDATE

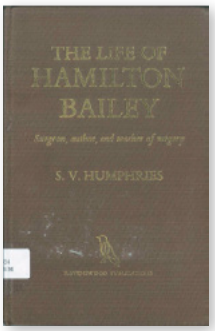
Donations and new items of interest in the library collection

The library is extremely grateful for donations from the authors of the following new books, which are now included in the collection.









A history of the Intensive Care Unit within the family of Royal Perth Hospital 2015 by Geoff Clarke

Dr Geoffrey M Clarke's (AM) book covers the origins and development of the ICU at RPH up until July 2003. Dr Clarke was ICU Head of Department from September 1970 until July 2003 when he retired.

A history of the Intensive Care Unit within the family of Royal Perth Hospital covers a period of RPH's history during a time of rapid advances in medical and information technology, medical training for Intensive Care Specialists, nursing education and career structure and increased research opportunities.

Kindly donated by the author

Trust & Betrayal: Morality and the Emotions in Surgery 2016 by David Macintosh FRACS

'It was always very difficult for me to tell someone they were dying. No course or lecture about how to approach it or what words to use seemed to help. I eventually worked out that the actual words I used did not seem to matter...'

David Macintosh, FRACS is a former surgeon and an ethicist who writes with candour, insight and eloquence about empathy, practical wisdom, rationality and human frailty, factors that bear profoundly upon our understanding of trust. He sees trust as a burden a doctor must accept for all patients. It imposes an obligation that goes to the core of a doctor's character.

Kindly donated by the author

Peripheral Vascular Surgery: a Regional View 1970-2004 2016, by Barry Partridge FRACS

This book covers the introduction, history and development of vascular surgery in the Bay of Plenty, centred in Tauranga Hospital. It details how much vascular surgery has developed from its earliest beginnings to the sophisticated diagnostic and therapeutic procedures that are available today.

Kindly donated by the author

Churchill's Pocketbook of Surgery 2017 (5th Ed) by Michael Wagstaff FRACS.

The Fifth Edition of this highly-praised and bestselling pocketbook continues to deliver a concise and didactic account of the essential features of all common surgical disorders. The book covers fundamental principles as well as providing basic information on aetiology, diagnosis and management, including pre-operative and post-operative care. The text includes an overview of history-taking, relevant physical signs, differential diagnosis, investigations and practical treatment. The book provides comprehensive coverage of general surgery but in addition covers the basic needs of the medical student and those in the early years of postgraduate training as far as the surgical specialities are concerned.

Kindly donated by the author

The life of Hamilton Bailey: Surgeon, author and teacher of surgery 1973 by S. V. Humphries

This is the first book to be written about Hamilton Bailey, the well-known surgeon, who is best remembered for his surgical text books, that won world-wide acclaim from surgeons, doctors, medical students and nurses, and have been translated into many languages.

This biography gives a clear insight not only into the technical skill of Hamilton Bailey, but also bears witness to the humanity which caused him to put the welfare of his patients above every other consideration.

Kindly donated by Dr John Garvey, FRACS

Foundation for Surgery

Passion. Skill. Legacy.

Supporting Global Health, Indigenous Health and Research

Striving for a world where children, families and communities can access safe and quality critical care when they need it most.

The Foundation for Surgery relies on donations and bequests to continue to support people live their healthiest lives. All costs for the Foundation for Surgery are kindly provided for by the Royal Australasian College of Surgeons – ensuring that 100% of your support achieves its maximum impact in the community.

Our most sincere thanks to the donors listed below for their extraordinary kindness and generosity in supporting the Foundation for Surgery during September and October!

GOLD

Anwar and Myrtha Girgis

Special thanks to Anwar and Myrtha Girgis for their extraordinary compassion and generosity to establish the 'Anwar and Myrtha Girgis IMG Scholarship' to support IMGs from migrant, refugee and asylum seeker backgrounds.

Hear more about this scholarship on page 60-61 of this edition of Surgical News.

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