ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 18 NO 10 NOV/DEC 2017

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RACS LET'S OPERATE WITH RESPECT

The College of Surgeons of Australia and New Zealand

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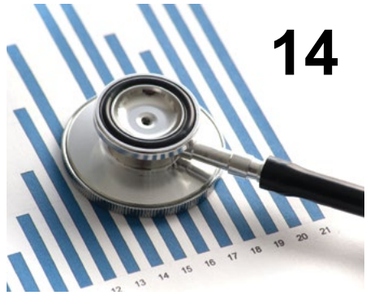

COVER: President Mr John Batten providing suturing advice with Dr Natasha Martin and Dr Natalie Pink.

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Surgical News Editor: RACS CEO

College and Societies - Together

JOHN BATTEN
President

Each October Council week there is a Surgical Leaders Forum (SLF) where Councillors, College staff, Chairs of the specialty training boards and the CEOs and Presidents of the 13 societies come together to discuss a relevant surgical training topic. This October the program centred around the commentary and recommendations of the Australian Medical Council (AMC) and the Medical Council of New Zealand in their draft final report, following the recent review of the RACS accredited training programs administered and delivered by our speciality society partners.

An enormous amount of collaborative work from all specialty groups and RACS staff was required to produce the RACS submission for the accreditation team. This report addressed all the criteria under each of the ten AMC standards outlining the RACS and Society activities, policies and procedures related to these standards, as well as the challenges that RACS and the societies perceived in meeting the criteria under each of the standards.

I would like to acknowledge the directors and staff of the Education Portfolio, Kathleen Hickey, Glenn Petrusch, Zaita Oldfield and the Dean of Education, Stephen Tobin, for the quantum task, over the last two years in the collection and collation of the RACS and speciality input and the presentation of the submission. There were logistics for the accreditation team's visits and interviews as well. It was acknowledged as being an extremely comprehensive submission by the accreditation team.

I would also like to thank all members and staff of Societies for their input during the creation of the submission and for the time volunteered to manage the face-to-face components as the accreditation team worked through the complexities of our devolved training model. This was from many angles whilst they sought a clear understanding of our collaborative surgical education and training program.

The draft report was discussed with the assessment team Chair, Prof Chris Baggoley, on 11 October, for the final review. The report has now been submitted to the AMC Specialist Education Accreditation Committee (SEAC) and will progress to a final report with conditions, recommendations and timelines and the period of accreditation given. This final report is expected in late November.

There is little doubt we train world-class expert technical surgeons but a surgeon must be much more than a medical and technical expert. A complete professional surgeon needs to be an expert in the other seven competencies of communicator, collaborator, leader, scholar, health advocate, clinical decision maker and professional. These non-technical or foundation competencies are common to all surgeons no matter what speciality they train in and are essential competencies throughout a surgical career. They are complex skills and behaviours that are expected by today's patients and the broader community. Medical regulators note these areas are the most common source of complaints or notification, representing 80 per cent of notifications.

How and when we teach and train in these complex skills, who should be responsible for this and how do we assess competency in these areas over the life of a training program is the challenge. Given the complexity of these skills, how we determine which assessment methods, how often they are assessed, and which are the most valid and reliable to confirm competency remains an area to be carefully explored.

Surgery has been regarded as a technical discipline, but it now needs to be a much more humanistic discipline to enable our social contract, thus aligning our surgical education and training to community needs and expectations.

It is this aspect of the training that grows the complete professional surgeon identity that the SLF came together to discuss. RACS and the societies, through their training boards must work together, to deliver and assess these broader competencies uniformly across the training spectrum. This would clearly need to be tailored to each set of training board requirements and there is significant cross over, so a common generic curriculum could be constructed collaboratively that would be of value to all training boards.

The SLF reviewed the common themes identified by the accreditation team. As equal partners and with common purpose, RACS and the societies must consider, across all specialities, non-technical skills, inter-professional learning, communication and behaviour, cultural competency, peri-operative management, quality and safety in healthcare, and healthcare systems.

Each of these topics was explored in group discussion with feedback under the broad headings of

- what we should teach and at what stage,
- who should have the teaching responsibility, and
- how do we assess competent performance in these themes.

It was generally agreed to work together on these common issues.

The second half of the forum looked at the difficult nexus of governance, regulation and compliance and how this relates to our training partnerships and the barriers that exist or were perceived to exist in the RACS / Specialty Society / Specialty Training Board relationship.

It was agreed that all relationships required four essential components:

trust, commitment, communication and mutual respect.

If any one of these components fails, then the relationship will struggle or fail.

The forum allowed us to reflect on our relationships in the delivery of training, and our collective and individual responsibilities in the relationship. Hopefully, this will guide us to see how we can do this better together, creating a more fit-for-purpose, well-rounded professional surgeon.

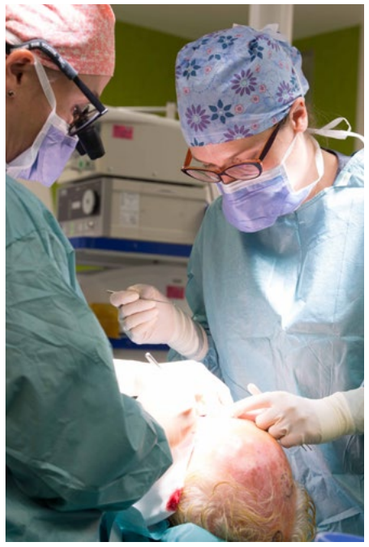
Virtually all Fellows are proud members of their specialty society as well as proud members of RACS.

Societies expect an equal partnership in the training of Fellows, their individual identities respected and valued, and that communication be open, transparent and mutually respectful with a clear delineation of roles and responsibilities. The relationship is one of inter-dependence.

At the end of the SLF there was a feeling of optimism and purpose. There remains much work to be done over the next few years for surgery as a whole, as well as to satisfy the AMC accreditation requirements. This work will need prioritising and careful planning to meet the time lines but will leave us all in a better place together.

The fresh eyes of the external review accreditation process has provided RACS and the Societies with a valuable quality improvement and assurance activity, enabling us to review our strategic approach and how we mutually do business. We can reflect on all components of the training programs, their strengths, challenges and outcomes, aiming to work together.

AMC accreditation is essential – for the community it is quality assurance; we must do this well for those who respect, look up to and hold in high esteem the RACS and FRACS brand. All Fellows must have an interest in this.



Let's Get Up to Dance!

CATHY FERGUSON
Vice President

Tuesday 19th September was **Suffrage Day** in New Zealand, marking 124 years since New Zealand women won the right to vote. Fittingly it came just four days before our general election and it was a great day for New Zealand women to go out and cast an early vote.

September 19 was also the day I attended a New Zealand Global Women seminar called **One Day for Change**. The focus was on Diversity and Inclusion and I would like to share some of the things I learnt and how they apply to our College.

A lot of the focus at the NZ event was about pay parity as well as gender equity. In surgery we do not have such an issue with pay equity, although it was pointed out to me that as soon as you have a part of your workforce doing part-time work, if those workers are female then there is automatically a pay gap.

We heard from the CEO of telecommunications company Spark about his experience of senior women executives leaving because they felt that their organisation was only paying lip service to diversity and inclusion issues. This was an eye opener for him as he had felt that their organisation was doing all the right things. There is a real danger that we will hide behind our policies, believing that we have done enough, but it is apparent that the hearts and minds of the organisation need to be engaged as well. For him the message was that we need to intervene on values and behaviours as well as systems and structures, and that we need to be prepared to listen to feedback, to expect it to hurt and to look carefully for the uncomfortable truths. He summed it up nicely by saying "diversity is about being invited to the party – inclusion is about being invited to dance".

> *"diversity is about being invited to the party – inclusion is about being invited to dance".*

We heard a lot of local data about the dearth of women in leadership roles in New Zealand, particularly in the private sector, yet research tells us that diversity is good for business and so we should be actively promoting women leadership roles. There is no reason why this does not apply in surgery. We talked about unconscious bias – it is just that, and so we need to train people to recognise and avoid it.

Flexibility in the workplace was another focus at this forum. A broad approach to flexibility at all stages of working life is to be encouraged and we must take up the challenge to promote flexible training opportunities.

October 11 was **International Day of the Girl Child**. Along with other College representatives, I attended a breakfast presentation from the **Male Champions of Change STEM breakfast event** in Canberra. STEM professions are those in Science, Technology, Engineering and Maths, and this event was to celebrate the first anniversary of the group's formation and the production of its first report.

This meeting was all about creating workplaces that are fit for the future, creating workplaces that are attractive to work in, and have an inclusive culture. It is important that young women believe and see that there is a future for them in the STEM professions.

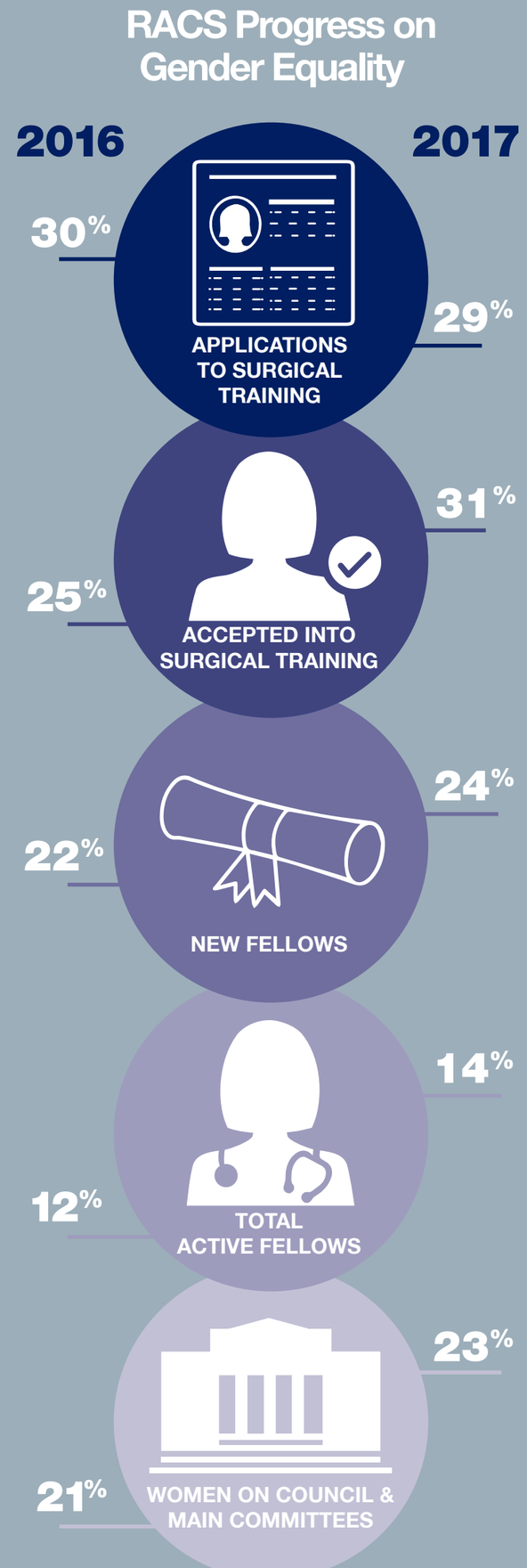
The title 'Male Champions of Change' is one that I, and other women I have met, struggle with. This is one instance where women cannot fix the problem themselves. Men dominate culture in the workplace, and men in leadership roles are at the heart of the issue and the problem, so they need to step up and take a leading role here. Without the support of men in these endeavours, driving change from the top down, the culture and the workplace is unlikely to change. To enable cultural change to occur rapidly, there needs to be a disruptive voice in this space, and supportive male champions can be that voice. I think this is appropriate in the business world, although here in our College we are promoting Champions of Diversity and Inclusion amongst the entire fellowship.

The overarching theme was that this is not just a campaign but that this is a business imperative. Many of the speakers reiterated the statements that gender equity is not an issue for women alone but both an economic and social issue. We must address the problem of inertia in confronting this and accept that diversity makes all organisation better. Currently we are at risk of being seen as predominantly 'male, pale and stale', so we have to be more forward looking and proactive. We need to believe in what we are doing and demonstrate by our actions that we are serious. As one speaker put it 'you can't lead a charge if you look funny on a horse'.

We learnt that, as with Spark in New Zealand, there is often a disconnect between the policies and the culture of an organisation. Change must be embedded in the DNA of an organisation. Flexible working should be just that – truly flexible, and there is not a 'one size fits all approach' to this. We need to engage our Younger Fellows and Trainees as they are closer to the issues than someone like me.

We had an inspiring talk from Francesca Maclean, an engineer with a PhD in Tissue Engineering, who co-founded the Fifty50 student-run gender equity movement in 2015. She threw out the following challenges to us all – 'listen to, protect and utilise your change promoters'; 'don't give me your words-give me your actions'; and 'be brave, be bold and don't look back.'

So for our College – still a male dominated arena – let's invite some more to our party and get them up to dance!



Welcome Mary Harney

Former *Gardiner Dairy Foundation* chief executive Ms Mary Harney joined RACS in October 2017 as its Chief Executive Officer. Ms Harney brings to the College more than 30 years' experience in senior leadership roles inside and outside the health sector, including as Chief Operating Officer of Research, and Director of the Office for Cancer Research, at the Peter MacCallum Cancer Centre.

In the last 15 years, Ms Harney has held executive positions in the public health, commercial, biotechnology, pharmaceutical, and agricultural sectors.

RACS President, Mr John Batten, welcomed Ms Harney saying that the organisation is excited to work with Ms Harney to realise its vision of leading surgical performance, professionalism and improving patient care.

"With Ms Harney's support and the Council's commitment, we will continue our extensive program of work and maintain our focus on building respect and improving patient safety in our profession," Mr Batten said.

A special interview with Ms Harney will be featured in the January/February edition of *Surgical News*.

Results of 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
Phill Carson (GEN, NT)
Andrew Hill (GEN, NZ)

Newly elected to Council
Christine Lai (GEN, SA)
Maxine Ronald (GEN, NZ)

SPECIALTY ELECTED COUNCILLORS

Cardiothoracic Specialty Elected Councillor
There was ONE Specialty Elected Councillor position to be filled. The successful candidate is:
Re-elected to Council
Julie Mundy

General Surgery Specialty Elected Councillor
There was ONE Specialty Elected Councillor position to be filled. The successful candidate is:
Re-elected to Council
David Fletcher

There was ONE position to be filled in each of the following specialties. The successful candidates were unopposed.

Otolaryngology Head & Neck Specialty Elected Councillor 2017
Previously appointed, now elected to Council unopposed
Christopher Perry

Paediatric Specialty Elected Councillor 2017
Re-elected to Council unopposed
Anthony Sparnon

Vascular Specialty Elected Councillor 2017
Re-elected to Council unopposed
John Crozier

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 (23.9%) who demonstrated their engagement with the governance of the College.

The results will be tabled at the Annual General Meeting in Sydney on Thursday 10 May 2018 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.

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS RACS

Court of Examiners for the Fellowship Examination Applications Open

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

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

Applications from eligible Fellows willing to serve on the Court of Examiners should be forwarded to the RACS Examinations Department no later than **Friday, 26 January 2018** for appointment in **2018**.

Email: Court.Examiners@surgeons.org OR

Post: Examinations Department
Royal Australasian College of Surgeons
250 - 290 Spring Street
EAST MELBOURNE VIC 3002

- Application forms are available for 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.
- For further information please email Court.Examiners@surgeons.org or phone 03 9276 7471.

Australian Indigenous Doctors' Association 20th Anniversary

DAVID MURRAY
Chair, Indigenous Health Committee

This year marked the Australian Indigenous Doctors' Association's (AIDA) 20th Anniversary. As part of the opening ceremonies RACS President Mr John Batten presented AIDA President Dr Kali Hayward with a bespoke plaque acknowledging this important milestone and the partnership between the organisations. RACS was a gold sponsor of the program with nine RACS Fellows and trainees participating in a range of program activities.

Surgical Skills Workshop

RACS and the NSW Health Education and Training Institute (HETI) worked together to run an oversubscribed surgical skills workshop, aligned to the JDocs Framework, with a focus on education and engagement in a relaxed atmosphere. The workshop had 24 Aboriginal and Torres Strait Islander medical students and junior doctors participating, including five previous RACS ASC Scholarship Award winners who are progressing with their desire to undertake a career in surgery. RACS Councillor Associate Professor Kerin Fielding and RACS Indigenous Health Committee Chair, Dr David Murray led the workshop encouraging attendees to ask questions and seek advice on surgical skills and careers.

Providing advice

RACS Fellows were in high demand as part of a two hour AIDA 'Growing our Fellows' program speaking to medical students and junior doctors with an interest in surgery, about training, careers and life as a surgeon. The conversation was electric and RACS delegates were in high demand for the entirety of the session.

Presentations

RACS President Mr John Batten, Immediate RACS Past President and AIDA Patron Dr Phil Truskett and RACSTA Chair, Dr Ruth Mitchell, presented as part of the conference on the importance of cultural competency and diversity within the surgical workforce.

Awards

Associate Professor Kelvin Kong, FRACS was awarded the 2017 AIDA Indigenous Doctor of the year honour.

Images (clockwise from top-left): Dr David Murray showing off surgical skills kit at RACS Booth; Dr Ruth Mitchell and Mr John Batten providing suturing tips; Past President Phil Truskett AM providing laparoscopic skills advice.

Images (clockwise from top-left): Dr Natalie Pink and Dr Natasha Martin; AIDA President Dr Kali Hayward and RACS' President Mr John Batten with the 20th Anniversary Plaque; Associate Professor Kerin Fielding and Mr Chris Perry providing suturing advice; Mr Phil Truskett AM providing laparoscopic skills advice with group; Dr David Murray and Associate Professor Kelvin Kong at the RACS booth.

Pain after Surgery

ASSOC. PROF. ANDREW ZACEST
Chair, Pain Medicine Section Committee

Pain remains one of the most neglected and poorly understood areas of healthcare. Chronic or persistent pain – constant daily or recurrent pain – is a common condition affecting up to one in five Australians, including children and adolescents and one in three older Australians.[1,2] This prevalence rises to 80 percent of residents in our aged care facilities.[3]

Every year the International Association for the Study of Pain (IASP) selects a different pain-related theme to raise awareness and facilitate better pain management practices across the globe. This year's theme is 'pain after surgery', drawing attention to postsurgical pain management.

In the past, pain after surgery was seen as inevitable because traditional surgical techniques used large incisions and damaged surrounding tissues. Acute pain was poorly treated while pain of recently discharged patients was not adequately addressed and focused on simple pharmacological regimes with frequent side effects. The number of people affected by chronic post-surgical pain was under-estimated and it only emerged as a topic deserving systematic study around 25 years ago.[4]

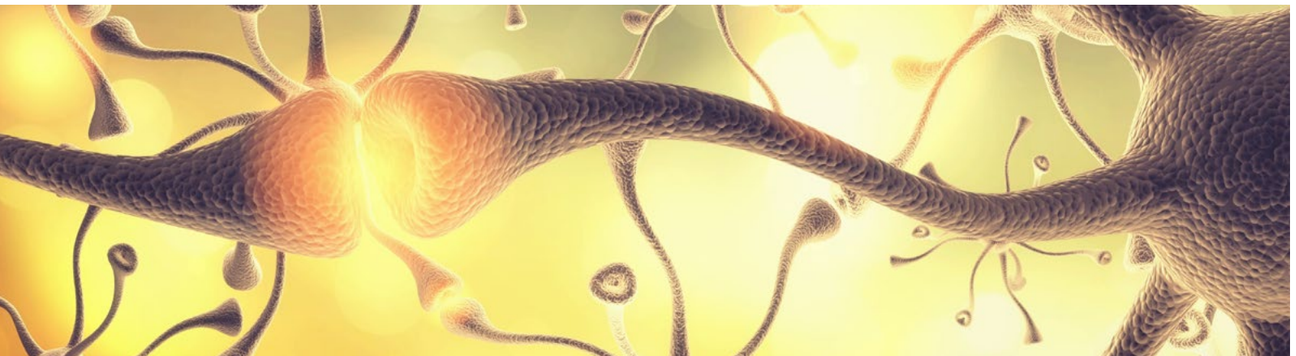
We now know that chronic post-surgical pain – pain lasting beyond three months after surgery – can affect as many as one in five surgical patients. This prevalence depends on the type of surgery, with some high-risk procedures thoracotomy and breast surgery (35 percent), knee arthroplasty (20 percent) and hip arthroplasty (10 percent). In a review of studies of children aged six to 18, the median prevalence of chronic post-surgical pain was 20 percent. Neuropathic pain features in about one in three cases of chronic post-surgical pain.[5,6]

There is a strong link between the severity of pain in the 10 days or so after surgery and the development of chronic post-surgical pain, highlighting the importance of optimal post-surgical pain relief. Despite progress, management of acute pain can still be improved and requires greater use of multimodal approaches. Various studies have shown that the incidence of chronic post-surgical pain can be reduced with specific treatments, such as perioperative ketamine; epidural analgesia following thoracotomy; and paravertebral block after breast cancer surgery.

In other cases, surgery may be entirely ineffective for the pre-existing pain condition such as spinal fusion for non-specific low back pain, and no better than multimodal non-surgical treatments. Rather than cure the pain, major surgery can result in further deterioration of health and wellbeing and increased levels of pain. The onus is on surgeons to make sound and ethical judgements about how to best assist people with a pre-existing pain condition.[7]

Unfortunately while patients are informed of a multitude of risks prior to undergoing surgery, it is uncommon for chronic post-surgical pain to be included. Patients who believe surgery will cure their pain are eager to sign on the dotted line, while those without pre-existing pain who find themselves with chronic post-surgical pain end up confused and without support. They can be dismissed, not believed or simply told that unfortunately in some cases the pain will not go away.

When Painaustralia, a leading national advocacy body working to improve understanding and treatment of acute chronic and cancer pain, reached out to consumers for their stories of chronic post-surgical pain, the response was overwhelming and consistent: patients had not been informed about the risk. When Melbourne mother-of-two Victoria had a skin graft taken from her arm a year ago, she wasn't told about the risk of nerve damage. She now lives with shooting or stabbing pains down her arm and into her hand, altered sensations and numbness. No longer able to drive and working just eight hours per week, her 19 year-old son has become her carer. Brisbane-based Susanne had surgery to remove skin cancer from her forehead, which prolonged her life but left her with devastating ongoing pain. The pain makes her nauseous and unable to work or drive. She says while she was told about the risk of nerve damage, she was never told about ongoing pain. When mother-of-four Rachael had spinal surgery she was told she had a five percent chance of becoming a paraplegic, but there was no discussion about the risk of chronic post-surgical pain. She now lives with burning pain that radiates into her neck and down her arms and fingers.



We can and must do better for people in pain, and it begins with sound education and training. While we cannot remove the risk of ongoing pain entirely, we can do better at prevention and we can begin conversations prior to surgery and provide appropriate chronic post-surgical pain support. Best-practice pain management is based on a multidisciplinary approach. This offers demonstrated ways of reducing pain-related disability, improving function and quality of life. It relies on a team of health professionals managing patients through individual patient-centred plans, with a focus on cognitive behavioural therapy and self-management of pain on a daily basis.[8] Prescription opioids are not recommended for the management of chronic pain as they are ineffective and carry significant risk of harm.[9]

In 1998 RACS was a founding member of the Faculty of Pain Medicine of the Australian and New Zealand College of the Anaesthetists. The Faculty's fellowship and board remains multi-disciplinary and leads the training of specialist pain medicine physicians, setting standards for clinical practice in pain medicine in Australia and New Zealand. RACS' Pain Medicine Section provides advice to the College on matters relating to pain medicine, education and training. The section offers Fellows with an interest in pain an opportunity to engage and coordinates the pain medicine scientific program at the RACS annual scientific congress.

The 'Global Year Against Pain After Surgery' gives us the opportunity to reflect on how we can ensure quality care for every person in pain and adequate supports for people who develop chronic post-surgical pain or other chronic pain conditions. In light of harms associated with overuse of opioids it is critical now more than ever before, to ensure the health of our nation.

More information about the 'Global Year Against Pain After Surgery' is available from https://www.iasp-pain.org/GlobalYear or through contacting the RACS Pain Medicine Section at painmedicine@surgeons.org

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RACS Finances & Budget 2018

A Report from the Treasurer

ASSOC PROF JULIE MUNDY
College Treasurer

This budget will continue to ensure that prudent fiscal management is maintained by setting aside a small surplus to deal with the unexpected, whilst also funding the College's strategic imperatives. There remains a strong commitment to ensuring our profession is respected as the major provider of surgical grants, research scholarships and philanthropic causes in the southern hemisphere. There remains a commitment to ensuring the advancement of the Building Respect and Improving Patient Safety (BRIPS) program, which positions surgeons as leaders in changing to a respectful and inclusive culture in the workplace. We also continue to advance the Surgical Education and Training program, drive surgical advocacy positions and improve services to the Fellowship. This should be considered a forward looking, well-planned and balanced budget for 2018.

Overall Financial Position

The overall financial position of RACS is sound and we operate from a strong financial position. Our net worth has steadily grown over time mostly from appreciation in the value of investment assets, generous donations from Fellows and others, the previous sale of buildings and modest annual operational surpluses. Any investment income is wholly committed to funding research scholarships and grants programs. See figure 1.

Financial Categories

Figure 2 shows the three categories of activities that make up the RACS business. Council has long held a principle that Category 1, our core business, should generate a small surplus to fund initiatives of importance to our Fellows. Category 2 is for projects delivered under various funding agreements from third parties, including the multi-year Specialist Training Program (STP) that funds Trainee positions within hospitals. Category 3 is the Foundation, whereby monies generated are wholly committed to fund our grants, scholarships and philanthropic causes.

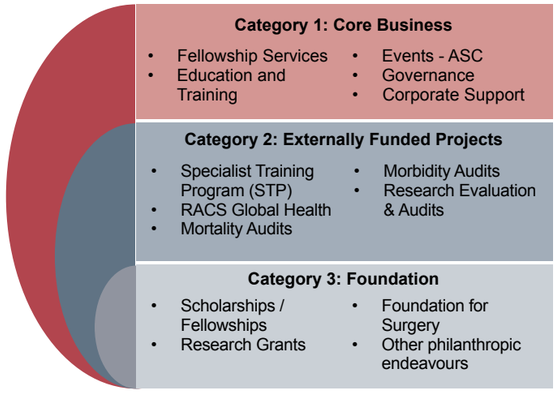


Figure 2: RACS Categories

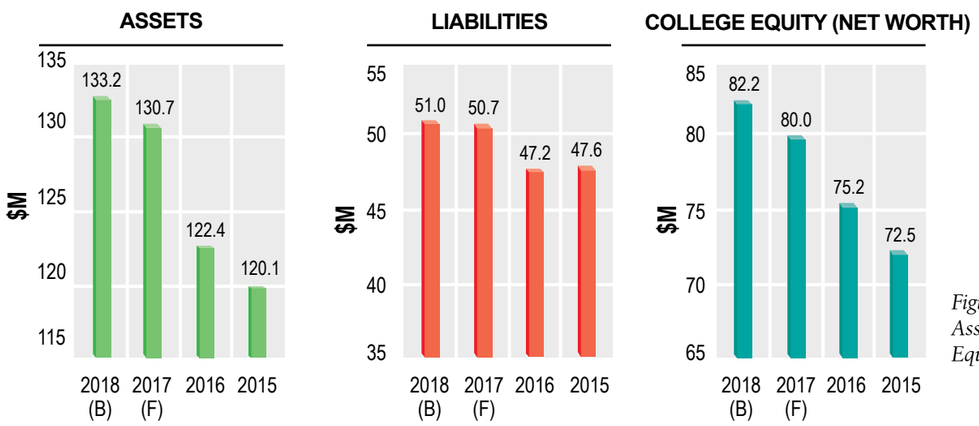


Figure 1: RACS Assets, Liabilities and Equity (Net Worth)

BUDGET
REPORT

Budget 2018 major items

There have been six key, frequently profiled, items for Budget 2018:

- Building Respect and Improving Patient Safety (BRIPS)
- Annual Scientific Congress
- Travel and Accommodation
- Staffing
- Core Revenues
- Investments and funding Scholarships

Building Respect, Improving Patient Safety

Budget 2018 has sufficient funding to continue the multi-year implementation of the recommendations from the Expert Advisory Group, which is work that has received much kudos for our profession locally and around the world. The total funding for 2018 inclusive of the mandatory Foundation Skills for Surgical Educators courses and other related initiatives has been set at $1.7 million. Other critical areas of action are continued engagement with MOU partner hospitals, development of assessment tools and establishing a peer support service to address the broader welfare of our Fellows.

Building Respect, Improving Patient Safety - Action Plan

Annual Scientific Congress (ASC)

The ASC 2018 will be a partnership with the American College of Surgeons and the Australian and New Zealand College of Anaesthetists. It will be held in Sydney with an anticipated higher attendance and stronger industry sponsorship than recent events. This will be offset with increased staging costs and supporting funds to ensure this remains the premier surgical education event of the year for our region.

Travel and Accommodation

This aspect of Budget 2018 is important as it supports our course delivery, examinations, governance, advocacy and educational work, as well as the travel arrangements of invited distinguished ASC speakers. As 11 per cent of the operational budget ($5.5 million), it must be adequately funded to respect the pro bono work of our Fellows across these portfolios. We also need to recognise that we are obliged to select the most appropriate and balanced options for travel and accommodation, when travelling for RACS.

Staffing

Staffing resources are the single biggest cost of RACS and represent 40 per cent of the core operational costs ($20.1 million). This excludes those staff employed under external funding agreements such as STP, who have set employment terms in line with the agreed funding (a further $3.6 million). Council remains prudent in adding permanent headcount to our operations recognising that there is always a need to provide improved services to the Fellowship. See figure 3 below.

Core Revenues

About 95 per cent ($49.5 million) of revenue comes from three activities. Training, examination and assessment fees make up 50 per cent; Fellows annual subscriptions 37 per cent; and conference registrations and sponsorship across various events is 8 per cent. Budget 2018 mitigates challenges and increased market competition in the skills training course sector. It also caters for lower numbers of prevocational exam candidates down from the peaks of 2016. We continue to run all events and courses ensuring balanced run costs and achievement of a valuable and sound educational outcome for those involved.

Investments and Funding Scholarships

RACS is very proud of its long-standing commitment to offer a large number of scholarships, awards, lectures and prizes under the umbrella of the Foundation for Surgery. We have carefully managed investment funds over many years, which now will fund a minimum commitment of $1.4 million in 2019. Council will consider even further funding in November 2017, as the operations and fiscal environment permits.

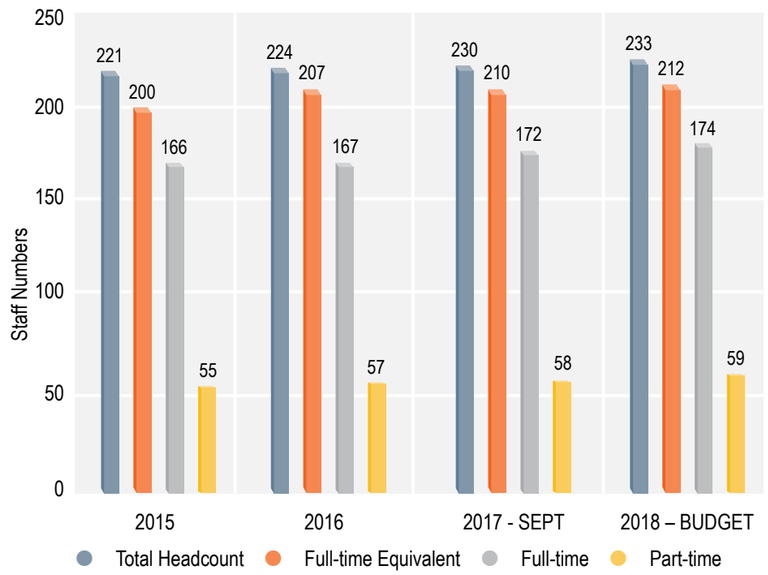


Figure 3: Staffing Numbers

Surplus

Council supports that each budget should aim for a modest surplus. Across all categories the goal is to achieve a surplus of $1.9 million representing a 2.5 per cent surplus return on overall revenues of $76.8 million. At the end of each year, this surplus can then be allocated to fund future new key initiatives (NKIs) or added to the Foundation. Budget 2018 has been carefully structured to aim for a surplus close to that this goal.

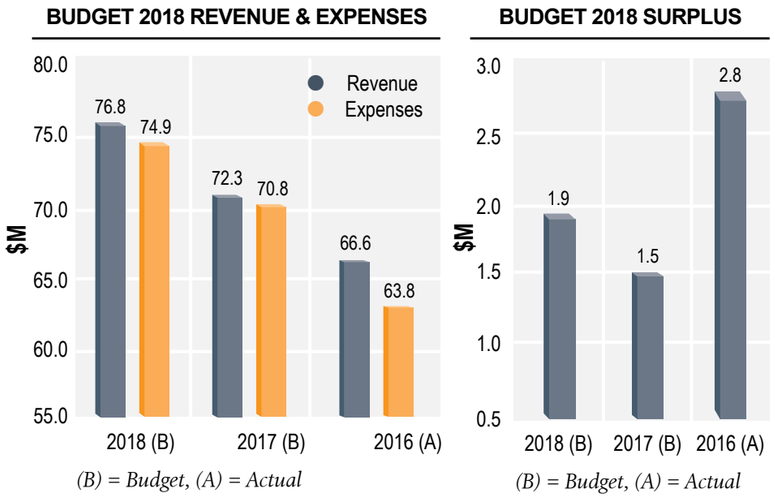


Figure 4: Budget 2018 – All Categories - Financial Performance

FEES SCHEDULE

SELECTION OF KEY 2018 RACS FEES

Fee description all GST inclusive (unless otherwise indicated*)	AUD$ 2018	NZD$ 2018
Annual subscription	3,095	3,460
Fellowship entrance fee	6,105	6,830
SET annual training fee - RACS	3,475*	4,275
Fellowship examination fee	8,330*	10,250
Pre Vocational – Generic Surgical Science examination fee	4,405	4,930
IMG Specialist assessment fee	9,975	N/A

For summary listing of key 2018 fees refer to RACS website www.surgeons.org *GST Exempt

New key initiatives

In selecting new initiatives, the focus has been very much on prioritisation of strategic imperatives, improving service, supporting our Fellows, Trainees and IMGs and quality improvements. Some of the key investments include:

- Establishment of a trainee led Clinical Trials Network in Australia and New Zealand.
- Developing a peer support program as part of the BRIPS complaints framework.
- Advancing the Surgical Education Training (SET) program to enhance and sustain educational activities.
- Further technology enhancements to support the Digital College including expense reimbursement automation and e-commerce.
- Examination delivery improvements including question management systems and tablet marking.
- Updating existing e-learning module on Aboriginal and Torres Strait Islander health as part of embedding cultural competency education into RACS core business.

All up the continuing work and NKI's for 2018 have a total funding allocation of $1.4 million.

Budget 2018 in summary

Council supports this prudent budget that takes into account many internal and external impacting factors. Budget 2018 ensures the core operations of Fellowship services and education and training are appropriately resourced, and support achievement of our strategic imperatives. We also remain committed to funding surgical research initiatives and charitable endeavours now and into the future. The Fellowship should see this as a sound budget enabling a modest surplus result that is sufficient to build future capacity and cater for any unexpected challenges, whilst maintaining good fiscal stewardship for RACS.

RACS Strategic Plan/Business Plan 2017-2018

A new era in trauma education

PROFESSOR JONATHAN SERPELL
Chair, Prevocational and Skills Education

DR KATE MARTIN
Chair, Early Management of Severe Trauma

In February 2018 the tenth edition of the Early Management of Severe Trauma (EMST) course will be rolled out.

This is a significant revision of the course. Improvements in simulation have resulted in the cessation of anaesthetised animals for teaching trauma surgical skills. The cost savings achieved by replacing live tissue with fit for purpose manikins has been passed on to course participants with a reduction in the course fee for EMST, effective from 2018.

Image: Chairs of RACS Skills Training Programs (L-R) ***TIPS Chair*** *Mr Philip Truskett AM,* ***EMST Chair*** *Dr Kate Martin,* ***CLEAR Chair*** *Dr Mary Self,* ***CCrISP Chair*** *Dr Rosalynd Pochin,* ***PSEC Chair*** *Mr Jonathan Serpell,* ***ASSET Chair*** *Mr Warren Hargreaves and* ***OWR Education Committee*** *Chair Mr Adrian Anthony.*

Lectures and didactic teaching have been largely removed from the format in favour of interactive discussions and more scenario-based teaching. Participants will have more time at the new skill stations.

To prepare for these significant changes, a large number of EMST instructors have been up-skilled during 2017 in a series of six workshops.

EMST committee members, along with Scott D'Amours FRACS, immediate past EMST chair, the EMST national coordinator, Lesley Dunstall and national educator, Debbie Paltridge have been heavily involved in the development of the tenth edition, being members of the select international working group developing the new curriculum. This is in part because the RACS EMST course is recognised internationally for its quality and is viewed as having unique instructor training and support programs.

Course participants regularly report the value of the extended time available with local consultants who act as mentors throughout the course - a unique feature compared to Advanced Trauma Life Support (ATLS) courses run in other countries. In addition, there are significant networking opportunities for attendees. The EMST course sees regular ongoing quality improvement with faculty training, curriculum development and equipment renewal. RACS engagement has resulted in a course that is highly reflective of Australasian clinical practice and standards.

About EMST

EMST is a part of the international ATLS program now delivered in more than 70 countries.

EMST aims to teach the management of injury victims in the first hours following injury, emphasising a systematic clinical approach. ATLS, developed in 1988 by the American College of Surgeons (ACS) has been delivered as EMST in Australia and New Zealand since 1989, under an agreement between the ACS and RACS.

RACS Skills Courses

The RACS skills courses are core components of surgical education for Trainees. EMST is mandated for all nine surgical specialties during training. RACS' other Skills Courses, ASSET, CCrISP, CLEAR and TIPS are also variously mandated at stages throughout surgical training.

Lengthy wait times to attend skills courses are a thing of the past. The new online system allows eligible doctors to enrol directly to a course, weeks before it commences. The scheduling and timing of courses is driven by attendee preferences with courses run predominately in major city centres. Consideration is given to avoiding other key RACS activities including other courses and examinations, as well as major hospital junior medical staff changeover times.

Upcoming courses are now regularly featured in *Surgical News*.

While ASSET, CCrISP, TIPS and CLEAR are predominantly directed at surgical trainees and JDocs, EMST enjoys a broader audience, including junior doctors from other craft groups such as emergency medicine, anaesthetics and intensive care, EMST training is crucial to rural practitioners and GPs.

The RACS skills courses are extremely highly regarded with wide recognition of their quality. RACS is proud of their reputation and recognition.

Leading by example

Dr Rachelle Love was awarded her Fellowship in Otolaryngology Head and Neck surgery earlier this year. With Ngāpuhi from the North of New Zealand and Te Arawa from Rotorua as her iwi, Dr Love is the newest member of a growing cohort of Māori surgeons. Currently undertaking a sleep surgery Fellowship in Wollongong, New South Wales, Rachelle shared with Surgical News her journey to becoming RACS' first New Zealand trained Māori female ENT surgeon, the impact that role models have had in influencing her career, and her desire to inspire the next generation of Māori surgeons.

"My interest in medicine was first sparked by a surgeon that I really connected with during highschool, Bob Kyd, who was an orthopaedic surgeon in Hamilton. There was a way that he conducted himself and interacted with his family that I really admired, and I saw a lot of my own traits reflected in him. Māori also suffer considerable health disparities and I saw medicine as an avenue to help address these.

During my time at Auckland Medical School and in my early years as a doctor I found I had a real interest in anatomy and loved doing procedural work, so surgery became a clear choice. I think I was also drawn towards the challenge that surgery presented; there weren't many female surgeons, and there certainly weren't many Māori doing surgery, so I was drawn to this path that not many have been down before me.

To begin with, I didn't have a specific interest in ENT. When I was a resident I was encouraged to try a variety of specialties, so I ended up experiencing a bit of everything: neurosurgery, plastics, orthopaedic, vascular, cardiothoracic. I really loved some of these, but my choice to become an ENT came back to role models.

In this case it was a Christchurch ENT who had 'retired' that drew me to otolaryngology. He had given up his private practice, but was still working in public practice - perhaps doing a tonsil list on a Friday, running the odd clinic, or doing administrative work for the department. I thought, "if you are post-retirement age and you are still contributing, teaching, and enjoying your work, then surely you have hit the jackpot".

Previously I had worked with some surgeons that had seemed really jaded. You would ring them when they were on call and they would just be irritated that you were calling them. You would ask them to come in to assist as you were struggling with a case, and because they had done this a thousand times it was a real annoyance for them.

I didn't connect with that. With ENT, here was this surgeon who was still contributing post retirement because he loved his work and was still doing a very effective job. And it wasn't just this surgeon; it was actually the whole ENT department in Christchurch. They had this tremendous level of enthusiasm and interest in their work.

These interactions made me realise that this was what I wanted – I wanted to be that doctor you could phone, who would be glad to hear from the person calling them, was interested in their work and wanted to be involved with whatever was going on.

> *I thought, "if you are post-retirement age and you are still contributing, teaching, and enjoying your work, then surely you have hit the jackpot"*

Another thing that I couldn't have anticipated was this tremendous sense of collegiality in ENT, particularly amongst women. I have had some sensational female role models and have really enjoyed seeing women in leadership positions such as Dr Cathy Ferguson and Dr Rebecca Garland. That has just been an incredible inspiration – these women are at the top of our field and it has been great to witness that.

However, there have been times when I have felt alone as there aren't many other Māori women surgeons. You do take up role models in other areas, but this has been a strong driver for me– being able to turn around and say to other Māori women: "you can do this too and you can do this better than me". I think that is important for people to see themselves in you. The more Māori surgeons you have, the more medical students will come through and see that

they can have the kind of life that they want in surgery. I have been very fortunate with the opportunities that I have had so far; I hope now that I can inspire other Māori women and help them to take their own opportunities.

At the time perhaps you don't really appreciate the impact that individuals can have on influencing your life. However, looking back now and reflecting on the role models that I have been fortunate to have peppered through-out my career, I realise how important these turning points were for me. Out of everyone though, my strongest role model has been my husband Hamish, who is an orthopaedic surgeon. His intelligence, drive and commitment is something I strive to achieve every day."

– Calum Barrett, Policy & Communications Officer
New Zealand National Office

Briefing to the Incoming NZ Health Minister

New Zealand held a general election to determine the membership of its 52nd Parliament in late September this year. Following almost a month of negotiations between parties, a coalition made up of the Labour Party and New Zealand First, with confidence and supply from the Green Party, formed the Government, edging out the National Party who had governed since 2008.

A change of government has also meant a change of Health Minister, with Dr David Clark (pictured, right), the MP for Dunedin North, taking on the role. To assist the Minister with his new portfolio, RACS has provided Dr Clark a 'Briefing to the Incoming Minister' (BIM). The objective of the BIM is to provide a brief overview of the College, a summary of the issues which we perceive to be of importance to the provision of quality surgical care in New Zealand, and the actions that we believe should be taken to address these.

A copy of the full BIM, as well as RACS' Election Statement and all the parties' responses prior to the election, are available on the advocacy section of the RACS website. An overview of the issues covered, as well as RACS' recommendations to the Ministry of Health, are summarised below:

Prioritisation of Elective Services

RACS recommends that the Ministry of Health supports the ongoing development and improvement of Clinical Priority Access Criteria and national prioritisation systems for elective surgery across all surgical specialties, and that the Ministry of Health continues to develop national prioritisation criteria and systems for First Specialist Assessment (FSA).

Funding

It was recommended that the Ministry of Health closely monitor and expand the collection of data to capture patients who either do not receive a FSA, or who do not receive elective surgery when their FSA has identified this as the appropriate treatment. Also, that the Ministry of Health continues to fund elective surgery to a level that minimises unmet need in the community and continues to minimise the inequity between funding for accident related conditions and those caused by other health conditions.

Registries and Audits

RACS recommends that the Ministry of Health works with relevant health organisations to develop and support Registries/ Audits for a wide range of surgical procedures.

Māori Health Equity

In order to address health inequity and improve Māori representation in the health workforce, RACS recommends that the Ministry of Health work with the health sector and supports research into improving Māori health outcomes.

Preventative Health

Obesity

RACS recommended that the Ministry of Health increases the availability of publicly funded bariatric and associated surgery for the morbidly obese.

Alcohol-related harm

It was recommended that the Ministry of Health investigate measures to reduce the availability of alcohol, including greater restrictions on trading hours, outlet density and the introduction of a volumetric tax on alcohol, and that it expands its public education to include the longer term impact of alcohol on individual health. RACS also strongly recommends that the Ministry of Health re-considers the Ministerial Forum on Alcohol Advertising and Sponsorship recommendations regarding youth exposure to alcohol.

Trauma

It was recommended that the Ministry of Health advocate strongly for road and firearm safety and for the restriction of the use of quad bikes by children.

In order to assist hospitals to enact systems that will improve care, RACS recommends that the Ministry of Health carefully considers the findings from the RACS New Zealand Trauma Review.

– Calum Barrett, Policy & Communications Officer
New Zealand National Office

2018 Scholarship and Grant Recipients

The ANZ Scholarship and Grant Committee thanks all applicants and congratulates the following successful recipients

ASSOC. PROF. KERIN FIELDING
Chair, Australia and New Zealand Scholarship and Grant Committee

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

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 Robert Fitridge, Miss Sarah Hulme, Professor Andrew Hill, Associate Professor Siven Seevanayagam and Associate Professor Christopher Young who all put in extra work towards this result.

Research Scholarship, Fellowship and Grant Recipients

John Mitchell Crouch Fellowship

Valued at $150,000

Associate Professor Wendy Brown - Victoria
Specialty: General

Professor Wendy Brown is Chair of the Monash University Department of Surgery at the Alfred Hospital, Director of the Monash University Centre for Obesity Research and Education and Clinical Lead of the National Bariatric Surgery Registry and Victorian State Upper GI Cancer Registry. It is of note that Professor Brown is the inaugural female recipient of this award. Professor Brown will use this Fellowship to further evaluate novel treatment strategies for obesity in the Australian public health care system. The title of her research project is "Optimising the treatment of obesity in the public health system".

Foundation for Surgery Senior Lecturer Fellowship – 2018 and 2019

Value: $132,000 pa, with 50% of this procured through the Research Department.

Ms Claudia Di Bella - VIC
Specialty: Orthopaedic
Head of Department: Professor Peter Choong

Ms Di Bella will use this Fellowship to focus on studying the "Application of innovative 3D bio-printing technologies for the regeneration of complex osteochondral tissues"

Foundation for Surgery Herbert and Gloria Kees Scholarship

Value: $66,000

Dr Justin Moore - VIC
Specialty: Neurosurgery
Topic: "The genetic and epigenetic basis of intracerebral aneurysms" as part of the Masters of Clinical Effectiveness/ Program of Clinical Effectiveness

Foundation for Surgery Tour de Cure Cancer Research Scholarship

Value: $125,000, including $25,000 procured externally.

Dr Toan Pham – VIC
Specialty: General
Topic: Exploring immunotherapy in advanced, metastatic and recurrent colorectal cancer
Supervisor: Professor Alexander Heriot

Foundation for Surgery John Loewenthal Project Grant – 2018 and 2019

Value: $100,000 pa

Dr Ahmer Hameed - NSW
Specialty: General
Topic: Normothermic machine perfusion of the donor kidney - Better organs, better outcomes

Foundation for Surgery Professor Philip Walker RACS Vascular Surgery Research Scholarship – Inaugural recipient

Value: 10,000
To be announced late 2017/early 2018
Specialty: Vascular

Foundation for Surgery Small Project Grants

Valued at $10,000 each

Chief Investigator: Dr Geraldine Ooi – VIC
Specialty: General
Project: Investigating the lipidomic profile of obesity - Driven nonalcoholic steatohepatitis (NASH)

Chief Investigator: Dr Vignesh Narasimhan – VIC
Specialty: General
Project: Peritoneal metastases from colorectal carcinoma: Exploring the potential of immunotherapy as a treatment adjunct

Chief Investigator: Dr Warwick Teague - VIC
Specialty: Paediatric
Project: Establishing an animal model to determine the cause of an important birth defect, duodenal atresia

Chief Investigator: Dr Kyra Sierakowski – SA
Specialty: Plastic & Reconstructive
Project: Developing the Hand-Q

Chief Investigator: Dr Bree Stephensen
Specialty: General - QLD
Project: A prospective observational study to validate the utility of C-reactive protein trajectory as a predictor of anastomic leak in patients with bowel anastomosis

Travel and Education Scholarship, Fellowship and Grant Recipients

Academic Surgery Surgical Education Scholarship – Inaugural recipient

Value: $10,000
Dr David Lam – VIC
Specialty: General

Anwar and Martha Girgis IMG Scholarship – Inaugural recipient

Valued: $10,000
Dr Yacob Myla – SA
Specialty: General

ANZ Chapter ACS Hugh Johnston Fellowship

Value: $8,000
Mr Yiu Ming Ho – Qld
Specialty: General

Foundation for Surgery Ian and Ruth Gough Surgical Education Scholarship

Value: $10,000
Dr Akbar Ashrafi – QLD
Specialty: Urology

John Buckingham Travelling Scholarship

Value: $4,000
Dr Sarah Renner - NZ
Specialty: General

Hugh Johnston Travel Grant

Valued at $10,000
Dr Lisa Brown - NZ
Specialty: General

Hugh Johnston Travel Grant

Valued at $4,000
Dr Hanumant Chouhan - SA
Specialty: General

Margorie Hooper Travel Scholarship

Value: $75,000
Dr Arjun Iyer - SA
Specialty: Cardiothoracic

Morgan Travelling Scholarship

Value: $10,000
Dr Christopher Ahn - NSW
Specialty: Plastic & Reconstructive

Murray and Unity Pheils Travel Fellowship

Value: $10,000
Dr Assad Zahid - NSW
Specialty: General

RACS ATSI SET Trainee One Year Scholarship

Value: 20,000
Dr Anthony Murray - NSW
Specialty: Orthopaedic

Preliminary Notice: Applications for 2019 scholarships will open in March 2018

Workplace reform needed to accommodate parent-surgeons

Surgical News talks to Dr Carolyn Vasey

If surgery is to continue to attract and retain the best and brightest in the modern era, significant workplace reform is required to accommodate the responsibilities of parents, according to Colorectal Surgeon Dr Carolyn Vasey.

Dr Vasey, a Clinical Fellow at the Gold Coast University Hospital, is in the process of finalising a Masters of Surgical Education thesis examining the perceptions of, and barriers to, parenthood which exist in the surgical profession.

Her qualitative research, which has been supported through the RACS's Ian and Ruth Gough Surgical Education Scholarship, is based on responses to a detailed survey and focus groups held during last year's Annual Scientific Congress (ASC).

She said her findings showed that there remain widespread barriers to surgeons being good parents and parents being good surgeons, and that those barriers are heightened for women.

She also said that many skilled, dynamic and talented junior doctors attracted to the profession were unwilling to pursue a surgical career because they could not see a way to combine both their career and personal aspirations.

Dr Vasey said that with women comprising 28 per cent of trainees and 12 per cent of Fellows it is time to dismantle the 'taboo' that still surrounds the issue of parenthood within surgery and re-examine a work-place culture that shrouds the subject in silence.

"The dominant culture of tenacity, silence and ambition that has existed within surgery has meant that parenthood is rarely addressed, despite its significant impact on the lives and career decisions of many surgeons and trainees," she said.

"Female surgeons and trainees have often felt uncomfortable talking openly about motherhood because of concerns around being dismissed by their superiors or colleagues as being insufficiently dedicated, while many men don't want to become the absent fathers of previous generations.

"While this issue has largely been unexplored in an Australasian context, American research demonstrates that there are significant barriers to combining parenthood with a surgical career including unclear or poorly-developed parental leave provisions, limited access to workplace breastfeeding or childcare facilities and systemic training and workplace structures that make combining these two important responsibilities difficult or impossible.

"There is also evidence that reproduction is often delayed by female surgeons until they are in independent practice, that infertility treatments are three times more frequently used in this group and that surgeons are more likely to encounter complications during pregnancy."

After preliminary analysis, Dr Vasey said that her research offered a number of practical solutions and said she looked forward to providing more detailed data analysis in forthcoming publications. Examples of such solutions include:

- Establishing Terms of Reference for accreditation of training experience on a pro rata basis;
- Providing stand-alone part-time positions, recruited top-down for every specialty;
- RACS pre-booking on-site hospital childcare positions on waiting lists to allow access for SET trainees on rotation;
- Ensuring access to workplace parental leave provisions that are transferable despite board-mandated training relocation;
- Developing return-to-work programs including simulation-based skills training, and
- Designing College fee structures for surgeons or trainees on parental leave or employed part-time which actively encourage new parents to continue to participate in CPD activities.

Dr Vasey said that RACS could drive change both in Australia and New Zealand in this area by developing position statements that could either be used to encourage change within hospital administrations or as enforceable mechanisms representing the minimum standards required to maintain accreditation.

These could include statements requiring hospitals to provide cover for parental leave with equivalently trained and funded positions, that the core business of surgical units occur within normal working hours, that advanced notice of allocation of training posts be given with more flexibility to accommodate individual trainee needs and that childcare be provided at all surgical meetings and conferences.

Dr Vasey said that where policy does exist, there remained significant gaps in translation of policy to practical implementation across specialty craft groups, hospital networks or states and that a cohesive bi-national approach was needed.

"While not an employer of trainees, RACS and the training boards of its specialty societies are in a position to act to ensure the working conditions of their trainees are fair and reasonable, do not discriminate on the basis of gender or parental responsibilities and are compliant with workplace legislation," she said.

"RACS and training boards regularly inspect hospitals and provide accreditation for training posts.

"My research has shown that a simple way to ensure hospitals and the College are compliant with the conditions set out in the *Fair Work Act and Sex Discrimination Act* would be to mandate recognition of previous service and transferability of leave entitlements from other hospitals and to make this a requirement of re-accreditation.

"This would allow RACS to rapidly improve conditions for pregnant trainees and those going on parental leave without having to change current legislation."

> *"The dominant culture of tenacity, silence and ambition that has existed within surgery has meant that parenthood is rarely addressed, despite its significant impact on the lives and career decisions of many surgeons and trainees."*

Dr Vasey has conducted her research under the supervision of Professor Debra Nestel, Professor of Surgical Education at the University of Melbourne, and Dr Rhea Liang, General Surgeon, Assistant Professor at Bond University and Clinical Lead Breast Services, Robina Hospital.

Her research findings are based on the responses to a 42-point electronic questionnaire which covered themes including surgical responsibilities, timing of children, leave following childbirth, discrimination or impact of having children and perceptions surrounding parent-surgeons.

Themes that emerged from the survey were further explored during focus groups held at the ASC in Brisbane in 2016.

Dr Vasey said she undertook her thesis research to investigate the lived experiences of both men and women within the profession of surgery and to provide an evidence base from which to develop future directions for mature change management.

She said it was time for the profession to ditch the out-dated and possibly harmful concept of the "medical martyr syndrome" which glorifies those who sacrifice everything for work.

"Until we have a more diverse leadership that demonstrates other ways of being a surgeon, the specialty will continue to be perceived as the most gruelling within medicine which potentially produces a range of negative outcomes," she said.

"The Expert Advisory Group report and RACS' response to the culture of surgery including bullying and harassment issues demonstrate a new awareness about the ability the College has to influence workplace culture, behaviour and policy.

"If we can change the culture within surgery in that area, we can change it to reflect and accommodate the aspirations of both female and male Trainees and Fellows who wish to have a balanced, well-rounded life both at work and at home.

"It's important to remember that this is not just a personal desire of a minority within the profession, but represents an obligation to improve workplace practices to ensure basic principles of equality are realised within surgery and that workplace laws are met, all of which will ultimately create better outcomes for our patients and the profession."

The Ian and Ruth Gough Surgical Education Scholarship was established to encourage surgeons to become expert surgical educators and is awarded on the basis of the applicant's expected contribution to surgical education in Australia and/or New Zealand.

– Karen Murphy, RACS writer

Career Highlights

2016: Colorectal Surgical Society of Australia and New Zealand (CSSANZ) & Association of Coloproctology of Great Britain and Ireland (ACPGBI) Travelling Fellowship: awarded for clinical research on laparoscopic lymphnode mapping to define splenic flexure lymphatic drainage.

2016: The RACS Ian and Ruth Gough Surgical Education Scholarship

2012 – 2014: RACS Councillor and Chair of the RACS Trainee Association (RACSTA)

Flexibility is the Right of Return to Work Parents

SUSAN HALLIDAY

An excellent starting point when discussing parenting and return to work is to avoid making assumptions. Every woman who ventures down the pathway of pregnancy, maternity leave and return to work, is an individual for whom stereotypes are inappropriate. Fathers who utilise paternity leave will have individual requirements as they map their return to work. Each case needs to be considered individually. It should be well understood that blanket rules and treatment are off the agenda.

Organisations need a policy framework that offers up a range of options for those with family responsibilities who are returning to work and education and training positions. The framework and how it is applied in practice needs to demonstrate an equivalency of opportunity as well as outcomes that do not result in detriment or disadvantage.

It has been the case for many years that new parents are generally entitled to part-time work and flexible education and training options. Yet to this very day culture, structural barriers and the attitude of decision makers can stand in the way of the rights of new parents. None of these are legitimate barriers and organisations have an obligation to identify and eradicate all that discriminates against return to work parents with family responsibilities.

Operational activity across the public, private and educational sectors has been challenged many times. The case law is clear. Organisations have been put on notice about direct and indirect discrimination on the basis of family responsibilities, and more specifically about less favourable treatment or detriment due to pregnancy and resultant maternity leave.

The good news is that government agencies in Australia and New Zealand have been promoting flexible work practices for those returning to work, for decades. In 1990 Australia took additional steps and ratified *ILO Convention 156 on Workers with Family Responsibilities 1981*, which requires governments to "make it an aim of national policy to enable persons with family responsibilities who are engaged or wish to engage in employment to exercise their right to do so without discrimination and, to the extent possible, without conflict between their employment and family responsibilities".

Interestingly, many of the excuses voiced in relation to flexible work practices and part-time employment today, mirror those that courts and tribunals have been responding to for over 30 years.

A case of interest that highlights some worthy points is from twenty years ago. It provides valuable insights about the attitudes of decision makers that fall short of what is required. In 1997 a full-time charge nurse in a government dental clinic in Western Australia took leave to coincide with the adoption of her child. When she sought to return to her job part-time, her employer refused her request. Her employer offered her, her old job back on a full-time basis or a part-time job with lesser status and responsibility.

Management took the view that charge nurse positions had never been job-shared or part-time, and could not be. Discrimination on the basis of family responsibility under the *Western Australia Equal Opportunity Act 1984* was then alleged against the Metropolitan Health Service Board.

The Tribunal determined the requirement to work full-time was, in all the circumstances, not reasonable, and that the requirement to work full-time in supervisory roles disproportionality affected people with family responsibilities. The Tribunal found the employer had failed to conduct any proper analysis or evaluation of the job-share proposal and ordered the employee be re-instated to the charge nurse position and financially compensated.

Twenty years on what has become clear is that detriment and disadvantage

are still not readily identified, nor well understood, when organisations are dealing with the return to work situations of new parents. Entitled to flexible options individuals should not suffer detriment. Interpreted broadly by courts and tribunals, detriment can be a disadvantage of any kind as long as it is not trivial. It can include non-economic loss such as loss of reputation, the impact of an unsupportive or hostile environment, injury to feelings, humiliation, bullying, distress or other consequences relevant to health and well being.

There are many examples relevant to mothers returning from maternity leave, that have left employers and education and training organisations ducking for cover when challenged about less favourable treatment and detriment. These include actions that have adverse consequences for the health and well being of mother and child, financial loss through denial of promotion or pay increase, financial loss or loss of status due to altered role or demotion, personal inconvenience or additional costs due to a transfer that would not have been required if maternity leave was not taken, unreasonable refusal for part-time work, loss of career status and negative impact on career advancement

due to the nature of duties assigned, withdrawal of an offer of employment, exclusion from consideration of promotion or developmental opportunities, scheduling regular meetings when the person cannot attend, conduct and comments that could amount to bullying, harassment based on a legally protected attribute, alteration of terms and conditions without agreement, and blanket policies and practices pertaining to return to work duties.

Another case worthy of note, comes from the legal profession. Some twenty years ago a solicitor was nominated for advancement to contract partner. Soon after she gave notice of pregnancy and her maternity leave arrangements were agreed; three months off and a part-time return of three days a week were planned. Prior to returning to work partners from the firm met with her to suggest that she reduce her practice and give up a number of case files given the part-time arrangement. She refused. A temporary replacement to progress the part-time arrangement was then denied by the firm. The solicitor returned working three days in the office and two days at home. The solicitor then received an unfavourable performance assessment that referenced it not being possible to run a practice and service clients three days a week. Soon after her partnership contract was not renewed. A complaint was lodged under the federal *Sex Discrimination Act 1984* with the solicitor claiming indirect discrimination on the ground of sex given that she had to work full-time to maintain her contract partner position. The firm responded that full-time work was an inherent requirement of that position. The Hearing Commissioner found that the blanket requirement to work full-time disadvantaged women aspiring to be partners and specifically that the requirement to work full-time imposed on the solicitor in order to maintain her contract partner position was not reasonable in the circumstances.

The Hearing Commissioner having found indirect discrimination on the basis of sex, and an entitlement to part-time work, provided guidance for all professions; maternity leave and part-time work policies that ensure minimum standards of fair and equal treatment in practice, covering off on changes to personnel, temporary replacements and associated recruitment are essential.

Human Rights, Equal Opportunity and Anti-Discrimination agencies distribute information that articulates the rights and responsibilities associated with return to work parents. The Australian Fair Work Ombudsman and Employment New Zealand publish guidelines for evaluating requests for flexible work.

There is no shortage of information for the medical fraternity. Yet while there has been discussion about flexibility in surgical training, and in relation to return to work circumstances for many years, progress has been limited compared to that of other professions, and other fields of medicine.

It should be noted that RACS policies allow for flexible training, but on the ground, trainees report that the opportunities are scarce. Currently under the auspice of the RACS Diversity and Inclusion Plan launched in November 2015, activity to promote and improve access to flexible work and training opportunities is underway.

There remains much work to be done if flexible options are to form part of the normal landscape, and to be accessed and utilised without concern. Everyone has a role to play. Flexible training can only be delivered in partnership with the hospitals that host training posts accredited by RACS and its specialty training boards. Equal Opportunity is only achieved when alternative pathways to reach full potential are sanctioned, available, safe and valued.

NOTE

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

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

Why all these courses?


ASSOC. PROF. STEPHEN TOBIN
Dean of Education

ADRIAN ANTHONY
Chair, Education Reference Group

If you are a surgical supervisor or trainer, you may be asking yourself 'if I am a good supervisor, why do I need to complete the *Foundation Skills for Surgical Educators* course, or the *Operating with Respect* online module?'

These courses are a genuine response to a serious issue that we, as surgeons, have an opportunity and obligation to address. Everyone in the profession has the power to do something when they encounter unacceptable behaviour – these courses are aimed at providing the tools to help you be a better surgeon, supervisor and colleague.

Foundation Skills for Surgical Educators (FSSE) course

Consider, why do Trainees often feel they get little or no feedback or that they are being bullied, harassed or discriminated when they receive feedback? Are you comfortable in giving timely and quality feedback to Trainees?

The recent RACSTA End of Term 1 survey for 2017 shows there is still progress to be made with how surgeons give feedback. Trainees noted:

"Feedback given but vague, broad strokes - "no one has a problem with you""

"My consultant only thought about his own work and if you count continued put downs and negative comments about "you can clearly see you have never done an operation before" and " why are you here if you can't even help me" were not appropriate."

"It did improve throughout the term but I had to push to get feedback. One consultant in particular was overly critical and I had to seek advice from my supervisor for how to deal with the situation."

One surgeon on the FSSE course walked away with the understanding that *"by teaching with respect, by teaching effectively, we're improving the standard of surgery and patient care for future generations."* FSSE can certainly help you develop feedback skills.

Operating with Respect (OWR) online module

Ask yourself, do you know how to respond effectively if you encounter unacceptable behaviour? How do you maintain high standards of behaviour even when feeling stressed?

What we know in surgery is that respectful interactions are necessary for maintaining patient safety.

More than 88% of those who have provided feedback on the ***OWR* online module** 'agree' or 'strongly agree' that the module is informative, relevant and helpful in prompting personal reflection on discrimination, bullying and sexual harassment. The feedback consistently shows that the content with videos are an effective and engaging way to improving understanding and awareness about the complex interpersonal challenges that face surgeons on a daily basis.

"At the end of my surgical career, I was sad that this had not been stressed earlier in my career and that now I will have little opportunity to carry out corrections, and guilty about my previous inappropriate behaviour"

"We need to continue to raise awareness of the endemic culture of bullying/harassment affecting surgical Trainees"

"This is a really impressive program, realistic and applicable to everyday work situations, and avoided 'demonising' bad behaviour but seeing it as a problem that real people have despite being 'good' people. I really enjoyed doing it."

"I thought I had never particularly experienced bullying. However, watching that video actually brought back quite stirring and emotional memories from over 10 years ago as a junior Trainee … this module has given me confidence about speaking up and putting my previous experience into perspective."

Will this module stop discrimination, bullying or sexual harassment and change the culture overnight? No, but we all need a good level of understanding and awareness to build upon and to show to hospitals, colleagues and patients that we have taken this first and very important step.

Fellows wishing to build further on their skills in this area can also complete the ***Operating with Respect* face-to-face course**, which has been met with similar positive comments.

On completing the face-to-face course, one Fellow remarked it was a *"necessity for the advancement of medical culture and the wellbeing of all healthcare workers."*

The Operating with Respect course is run for surgeons, by surgeons, which, one attendee remarked, *"gave the whole process much greater validity."*

The positive feedback received from Fellows has reinforced that these courses are making a valuable impact in their professional lives and importantly, are a step in the right direction toward sustained cultural change.

By completing these courses, Fellows are demonstrating a commitment to operating with respect whether in supervising Trainees or interacting with colleagues. They are demonstrating an understanding that this is a professional obligation.

Thank you to all the Fellows who have completed the online module so far – we have just exceeded 70%. Please note that time is running out to complete the online module and satisfy CPD mandatory requirements for all active Fellows before the end of 2017.

To complete the online course, visit surgeons.org/about-respect/ and follow the links to the online module.

Surgical Supervisors must register by 31 December 2017 to attend an FSSE Course. All details are on our website or please feel free to contact the college at professional.development@surgeons.org or via telephone at +61 3 9249 1200 (AU) or +64 4 385 8247 (NZ).

A chat with Tony Sparnon

Most people know Tony Sparnon as a skilled and dedicated surgeon with a generous and highly likeable nature. Fewer may know about Tony Sparnon the passionate horseman and prize winning gardener. But perhaps none of us in the surgical community would know Tony Sparnon at all if it wasn't for a dramatic incident on the football field that reshaped his future.

The unfortunate episode (which turned out to be rather fortunate) occurred when Tony was knocked out during a game of school boy football and taken to the emergency department. Up until that point he had his heart set on becoming an airline pilot, and after being shortlisted for an interview for the Qantas 747 pilot school that dream seemed inevitable.

While most people dread the thought of waking up in an emergency department, Tony was captivated by the experience. It was at that moment his career trajectory took a sharp turn.

"When I regained my senses I was fascinated by the energy, the chaos and the excitement that surrounded me," Tony recalls.

"Previously I had never considered anything other than becoming a pilot. But just like that my mind was changed. I went home that day and told my mother that I was going to do medicine instead."

Tony's opponent on the field that day was none other than Phil Carmen, also known as 'Fabulous Phil' due to his individual brilliance, but just as well known for his frequent visits to the AFL tribunal. Both men have since been able to see the funny side of the incident, and Tony recounts with a smile how Carmen renewed his role in the story some years later.

"About 30 years down the track Phil heard about what happened. He subsequently sent me a signed photo with an inscription that said he was pleased that he had helped me in my career choice."

Since his first visit to the emergency department, Tony has never looked back. After several surgical roles in Australia and the UK, Tony was appointed as Head of the Paediatric Burns Unit at the Women's and Children's Hospital in Adelaide, a role he reflects on with fondness and gratitude.

"It is always an incredible privilege to work as a paediatric surgeon with young people and their families. I will always feel humbled by the opportunities that have been extended to me and the experiences that I have had throughout my career."

When asked about his proudest moment it is not so much one individual memory that stands out, but rather the legacy that he was able to leave behind when he retired as head of unit last year.

"Burns is the epitome of team care and I think as a group we had some wonderful achievements, such as only one patient death in eighteen years.

"The proudest moment for me though is that all of the paediatric and plastic surgeons who are now working in the Burns and General Surgical Units at the WCH in Adelaide have at some stage worked with me as a student or a Trainee.

> *"The greatest strength of our College is our diverse representation with surgeons from nine quite different specialties and an even greater number of subspecialties."*

"I am pleased that 50 percent are female, and all of them without exception have gone on to be more skillful and better surgeons than me. The greatest tribute to one's efforts in education is to leave the place better than when you started."

As head of unit Tony thrived on trying to develop solutions to complex problems and it was similar reasons that motivated him to join the College Council.

"I enjoy the challenge and the stimulation that occurs when you sit on Council with lots of very intelligent people. Often we hold quite different views from one another, but at the end of the day it is all about working out a common way forward.

"The greatest strength of our College is our diverse representation with surgeons from nine quite different specialties and an even greater number of subspecialties.

"Our patients and the public do not view us by our specialty. They see us as surgeons with a common purpose, expertly trained and they have a high expectation in our results. I believe that it is imperative that at all times we compromise some of our differences to achieve the bigger goal.

"I also strongly believe in the importance of continuing to strive to make the College more reflective of society with respect to issues of gender, diversity and equality. The more we can continue doing this, the more we will raise the standard of the surgery our community now wants."

Away from medicine Tony is a proud grandfather and loves spending time with his family and granddaughters. He also enjoys the relaxation and the discipline of horse riding, although he believes a horse's best asset is its manure, which feeds his number one hobby of gardening. His garden contains many camellias, more than 150 roses, hundreds of liliums and thousands of tulips.

Earlier this year he was crowned champion of the 'Hybrid Stem' category at the Lilium and Bulb Society of South Australia's annual show. This is despite the fact that he initially entered his stem in the wrong division. Luckily for Tony he struck a sympathetic judge who took pity on him and moved it to the correct class.

"It was a little bit like orthopaedic examiners awarding a Fellowship in General surgery. I went to the wrong exam but they must have felt sorry for me and decided to award me first prize."

While Tony thoroughly enjoys his role as Censor in Chief and has just been elected to Council for another term, his ideal day would be spent outdoors enjoying his favourite hobbies.

"A perfect day for me now would be to go for a ride through the mountains on my horse and looking at all of the flowers. I would then finish it off by spending time with my family and enjoying a nice glass of cabernet sauvignon."

– Mark Morgan,
Policy and Communications Officer,
SA/WA/NT

RACS Advocacy 2017

RACS is presented with many opportunities for engaging in the policy and advocacy process, through evidence and advice, public campaigns and advocacy and/or lobbying and negotiation. Below are the highlights of our advocacy activity over the past several weeks: Recent submissions from RACS are listed below.

#EarHealthForLife campaign
Our campaign to improve the hearing health of Aboriginal and Torres Strait Islander children continues. We had an opportunity to meet with members of the Australian Indigenous Doctors Association in September. The meeting attended by 27 people, including National Congress Co-Chair Rod Little, helped finalise a terms of reference for a hearing health Ministerial Working Group which has been provided to the Commonwealth Minister for Health and Minister for Indigenous Health. Activity is continuing for the remainder of the year, with several conferences and events in Canberra with a focus on hearing health, and the launch of the AMA Indigenous Report Card.

Surgical mesh
RACS has written to the Therapeutic Goods Administration supporting its intention to up-classify surgical mesh following reports of adverse outcomes for some patients with mesh implants. In its submission RACS raised the concerns of specialty groups including the GSA and USANZ and consumer groups about the lack of a post-operative surveillance system in place in Australia for surgery involving mesh. An expert panel or working group to improve transparency, surveillance and quality was recommended.

Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions
RACS provided a response to the call for submissions on the Draft Report prepared for the Australian Health Minister's Advisory Council following a review of accreditation systems for health professionals. RACS is concerned about the potential cost of a new model of accreditation as proposed in the Draft Report, in the absence of any obvious benefits to patient care. RACS acknowledges the importance of ensuring that appropriate oversight and mechanisms are in place to allow scrutiny of accreditation processes and costs. While there is scope for improvement, RACS considers the Australian Medical Council (AMC) accreditation model to be efficient and cost effective while retaining a high degree of rigor and quality assurance.

RACS First Principles Review of the Medical Indemnity Insurance Fund
In our response to a review of the Medical Indemnity Insurance Fund, we stated the importance of emphasising the necessity of ensuring that affordability underpins any revised framework. The increasing costs associated with providing health services in Australia, including surgery, is already a significant challenge for the government and the health sector. In 2013-2014 public hospitals provided approximately 29 elective admissions involving surgery per 1,000 population and private hospitals provided approximately 57 per 1,000. When all factors are considered in conjunction with an ageing Australian population, improving life expectancy and increasing prevalence of chronic disease, a stable medical insurance industry is essential in ensuring we are able to continue meeting the challenges of providing universal public health care.

Mandatory Reporting Under the Health Practitioner Regulation National Law
In responding to the Mandatory Reporting discussion paper, RACS recognises that this responsibility is in vital need of a uniform and improved approach across the nation. It recommended to report on impairment only if deemed to pose current or future risk/harm, and report on conduct only if deemed to pose current risk/harm. RACS supports the same reporting requirements for students as for medical practitioners. RACS added that professional and ethical obligations remain strong throughout the medical profession; however, the current environment of public accountability requires more defined measures and responses to prevent a loss of confidence in the profession.

All RACS submission can be found on the RACS Advocacy page on the RACS website: https://www.surgeons.org/media/college-advocacy/

Introducing Christine Lai

The new Chair of the Women in Surgery Section

CHRISTINE LAI
Chair, Women in Surgery

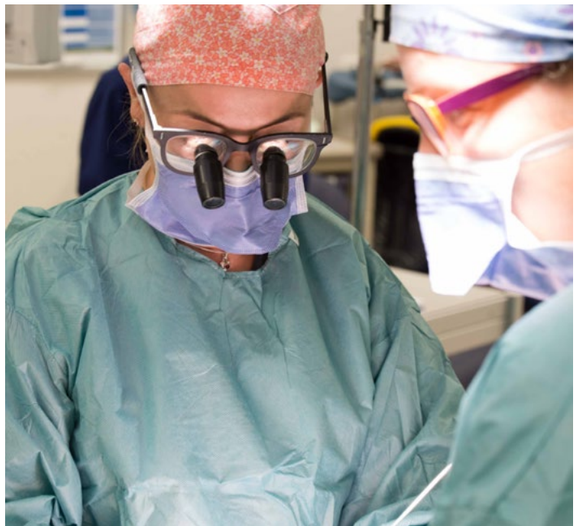
Thank you to Ms Ruth Bollard for chairing the Women in Surgery Section for more than three years. The Section Committee has been proactive in addressing the challenges associated with changing the culture of bullying, discrimination and sexual harassment in surgery. In particular, I would like to thank Ms Bollard for being the spokesperson for the committee and navigating through the challenges, as well as the RACS Training Boards for their work in continuing to look at implementation of flexible training for trainees.

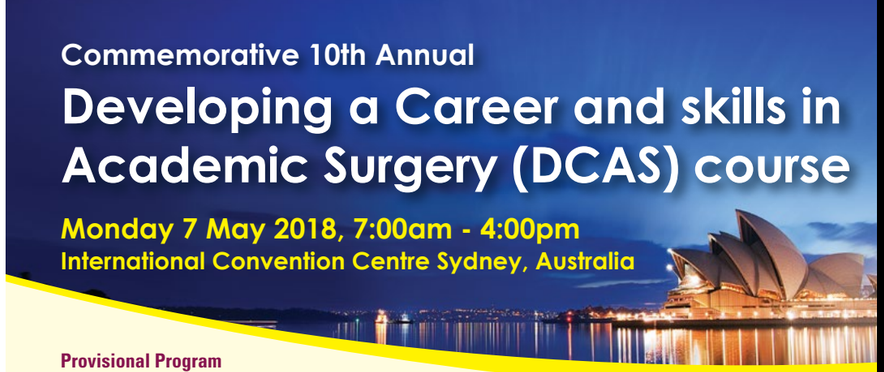
In my role as Chair of the Women in Surgery Section Committee, I hope to use my experiences to promote leadership, role modelling, flexible training and advocacy. I'm looking forward to continuing to support the great work the College has done with the Building Respect, Improving Patient Safety Initiative and assisting RACS with the broader efforts towards diversity, equity and inclusion.

The RACS Diversity and Inclusion Plan was launched in November 2016. Clear actions and measurable targets were set to create an inclusive culture and leadership excellence, increase representation of women in the practice of surgery, increase participation of all groups in surgery and improve the diversity of representation on boards and in leadership roles. If you have not yet had an opportunity to review RACS Diversity and Inclusion Plan, I would encourage you to do so at https://www.surgeons.org/media/24924140/2016_12_20_diversity_and_inclusion_plan.pdf

Outside of my committee role, I am a senior staff specialist in the Division of Surgery at The Queen Elizabeth Hospital, Adelaide, on the Breast and Endocrine Surgical Unit and a Senior Lecturer at The University of Adelaide. I have been involved with the Younger Fellows Committee since 2008, recently chairing that committee until May this year, and attending Council as the Younger Fellows representative. I am passionate about providing good role models for and mentoring medical students and junior doctors, as well developing leadership and mentoring programs for younger fellows. I am on the faculty for various RACS courses.

I look forward to 2018 and sharing more updates on the activities of the Women in Surgery Section. In the interim, I encourage all Fellows, trainees and IMG's to consider joining me and becoming a member of the Women in Surgery Section by contacting wis@surgeons.org.





Commemorative 10th Annual

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

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

Provisional Program

6:45am	Registration opens
7:15am - 7:30am	Welcome and Introduction
7:30am - 9:10am	**Session 1: Academic Surgery: The Quadruple Threat**
7:30am - 7:50am	Why I chose to become an academic surgeon
7:50am - 8:10am	Competing priorities: How I find time to research
8:10am - 8:30am	Competing priorities: How I find time to teach
8:30am - 8:50am	Competing priorities: How I find time to provide leadership
8:50am - 9:10am	Panel discussion
9:10am - 9:40am	Morning Tea
9:40am - 10:05am	**Hot Topic in Academic Surgery: Precision Medicine**
10:05am - 11:40am	**Session 2: Presenting and Publishing Your Work**
10:05am - 10:30am	Writing an abstract
10:30am - 10:55am	Writing and submitting a manuscript
10:55am - 11:20am	Communicating your research: presentation and promotion
11:20am - 11:40am	Panel discussion
11:40am - 11:45am	Introduction
11:45am - 12:15pm	**Keynote Presentation: Progress in an Evolving Professional Environment**
12:15pm - 1:10pm	Lunch
1:10pm - 2:40pm	**Session 3: Concurrent Academic Workshops**

Concurrent Workshop 1:
Early Career Development – What Should I Be Doing?
- Medical Ethics – top tips for successful navigation
- What can I do as a Medical Student
- What can I do as a Junior Doctor / SET Trainee
- Full-time research: Is it worth it?
- Winning awards / fellowships

Concurrent Workshop 2:
Types of Research
- Clinical Trials
- Health Services / Outcomes Research
- Lab-based Research
- Education Research

Concurrent Workshop 3:
Establishing and Running an Academic Department
- Assembling the team and establishing collaborations
- Promoting diversity in the Department
- Funding opportunities
- Running the Department: budget, staff and barriers

Concurrent Workshop 4:
Getting Published – What do the Journal Editors Want?
- JAMA Surgery
- ANZ Journal of Surgery
- Journal of Surgical Research

2:40pm - 3:00pm	Afternoon Tea
3:00pm - 4:00pm	**Session 4: Sustainability in Academic Surgery** Finding and being a mentor Work-life balance DCAS: the first 10 years
4:00pm - 4:05pm	Closing Remarks

DCAS course participation

Cost: $220.00 per person incl. GST

Register online: www.tinyurl.com/dcas18reg

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

Further information:

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

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

AAS Association for Academic Surgery

Royal Australasian College of Surgeons
Section of Academic Surgery

Proudly sponsored by: Johnson & Johnson MEDICAL DEVICES COMPANIES

NOTE: New RACS Fellows presenting for convocation in 2018 will be required to marshal at 3:45pm for the Convocation Ceremony.
CPD Points will be awarded for attendance at the course with point allocation to be advised at a later date.
Information correct at time of printing, subject to change without notice.
General Surgery Trainees who attend the RACS Developing a Career and Skills in Academic Surgery course may, upon proof of attendance submitted to: board@generalsurgeons.com.au, count this course towards one of the four compulsory GSA Trainees' Days.

Keynote speaker:
Mr Alex Gorsky BSc MBA
CEO and Chair, Board of Directors
Johnson and Johnson

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

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

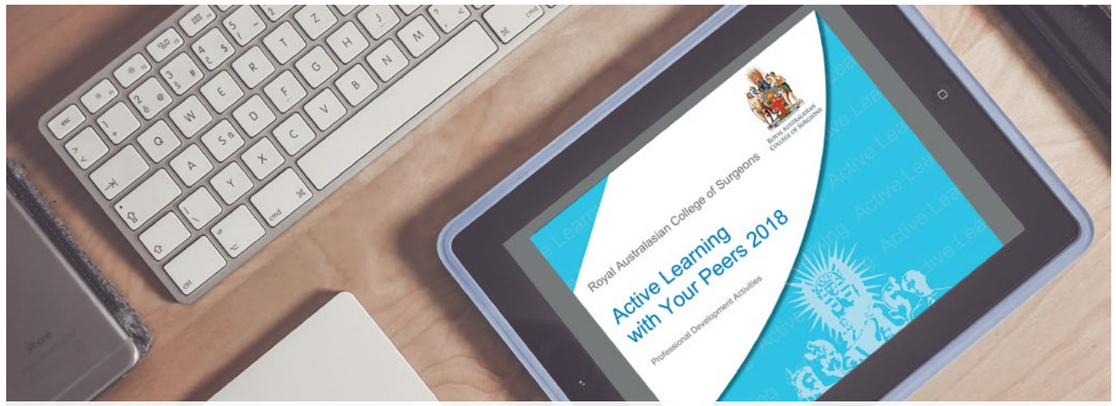
2017 comments:
"I will be recommending attending this to my surgically inclined colleagues"

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

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

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

Australasian Faculty includes:
Leigh Delbridge, New South Wales
Claudia Di Bella, Victoria
Marc Gladman, South Australia
Richard Hanney, New South Wales
John Harris, New South Wales
Alexander Heriot, Victoria
Andrew Hill, New Zealand
Sebastian King, Victoria
Michelle Locke, New Zealand
Guy Maddern, South Australia
Christobel Saunders, Western Australia
Julian Smith, Victoria
Mark Smithers, Queensland
Stephen Tobin, Victoria
Greg O'Grady, New Zealand
John Windsor, New Zealand
Fiona Wood, Western Australia



Workshops 2017/2018

Online registration form is available now (login required)

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

Mandatory courses

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

By the end of 2017

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

By the end of 2018

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

Foundation Skills for Surgical Educators Course

1 December 2017	Melbourne	VIC
4 December 2017	Sydney	NSW
11 December 2017	Sydney	NSW
12 December 2017	Sydney	NSW
3 February 2018	Sydney	NSW
3 February 2018	Melbourne	VIC
9 February 2018	Perth	WA
10 February 2018	Brisbane	QLD
16 February 2018	Wellington	NZ
17 February 2018	Sydney	NSW
18 February 2018	Sydney	NSW*
18 February 2018	Adelaide	SA
23 February 2018	Melbourne	VIC
26 February 2018	Sydney	NSW
26 February 2018	Wellington	NZ
2 March 2018	Brisbane	QLD
3 March 2018	Sydney	NSW
7 March 2018	Perth	WA
9 March 2018	Adelaide	SA
9 March 2018	Melbourne	VIC

**Faculty training day*

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.

Non-Technical Skills for Surgeons (NOTSS)

24 November 2017	Sydney	NSW
17 March 2018	Melbourne	VIC

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

Surgeons as Leaders in Everyday Practice

24 - 25 November 2017	Melbourne	VIC
23 - 24 March 2018	Christchurch	NZ

The 'Surgeons as Leaders in Everyday Practice' course is the first leadership course designed to meet the needs of the practising surgeon. Using an evidence-based model, the materials and principles in the course are applicable to Fellows, International Medical Graduates and Trainees. The aim of this course is to enhance the leadership skills within the context of surgeons. The vision is to offer a suite of educational resources related to leadership and surgeons. Using everyday examples, the course explores the role a surgeon has as a leader. Guided discussions promote insight where surgeons can enhance their leadership.

This course complements work being undertaken by the College in the Building Respect, Improving Patient Safety (BRIPS) Action Plan by empowering surgeons with skills to understand culture and influence change in their workplaces and the profession.

The course is based around four modules:

- Understanding leadership
- Understanding yourself
- Communication
- Leading teams

Clinical Decision Making

1 December 2017	Brisbane	QLD
24 March 2018	Canberra	ACT

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

SAT SET Course

10 March 2018	Sydney	NSW

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

Keeping Trainees on Track

10 March 2018	Sydney	NSW

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

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

Surgical Teachers Course

15 – 17 March 2018	Gold Coast	QLD

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

Process Communication Model Seminar 1 (PCM)

16 – 18 March 2018	Brisbane	QLD

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

PROFESSIONAL DEVELOPMENT WORKSHOP DATES

November 2017 – March 2018

ACT		
Clinical Decision Making	24/3/2018	Canberra
NSW		
Non-Technical Skills for Surgeons	24/11/2017	Sydney
Foundation Skills for Surgical Educators	4/12/2017	Sydney
Foundation Skills for Surgical Educators	11/12/2017	Sydney
Foundation Skills for Surgical Educators	12/12/2017	Sydney
Foundation Skills for Surgical Educators	3/3/2018	Sydney
Keeping Trainees on Track	10/3/2018	Sydney
SAT SET Course	10/3/2018	Sydney
NZ		
Foundation Skills for Surgical Educators	16/2/2018	Wellington
Foundation Skills for Surgical Educators	26/2/2018	Wellington
Surgeons as Leaders in Everyday Practice	23-24/3/2018	Christchurch
QLD		
Surgical Teachers Course	15-17/3/2018	Gold Coast
Process Communication Model Seminar 1	16-18/3/2018	Brisbane
Foundation Skills for Surgical Educators	10/2/2018	Brisbane
Foundation Skills for Surgical Educators	2/3/2018	Brisbane
SA		
Foundation Skills for Surgical Educators	18/2/2018	Adelaide
Foundation Skills for Surgical Educators	9/3/2018	Adelaide
VIC		
Foundation Skills for Surgical Educators	1/12/2017	Melbourne
Foundation Skills for Surgical Educators	3/2/2018	Melbourne
Foundation Skills for Surgical Educators	23/2/2018	Melbourne
Foundation Skills for Surgical Educators	9/3/2018	Melbourne
Foundation Skills for Surgical Educators	16/3/2018	Melbourne
Non-Technical Skills for Surgeons	17/3/2018	Melbourne
WA		
Foundation Skills for Surgical Educators	9/2/2018	Perth
Foundation Skills for Surgical Educators	7/3/2018	Perth

Contact the Professional Development Department

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

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

WORKSHOPS • ACTIVITIES • EVENTS

Skills Training Courses 2017

RACS offers a range of skills training courses to eligible medical graduates that are supported by volunteer faculty across a range of medical disciplines.

Eligible candidates are able to enrol online for RACS Skills courses.

ASSET: Australian and New Zealand Surgical Skills Education and Training

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

EMST: Early Management of Severe Trauma

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

CCrISP®: Care of the Critically Ill Surgical Patient

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

CLEAR: Critical Literature Evaluation and Research

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

TIPS: Training in Professional Skills

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

AVAILABLE SKILLS TRAINING WORKSHOP DATES*

November - December 2017

CCrISP	
Friday, 10 November – Sunday, 12 November	Adelaide
CLEAR	
Friday, 24 November – Saturday, 25 November	Auckland
EMST	
Friday, 17 November – Sunday, 19 November	Dunedin
Friday, 17 November – Sunday, 19 November	Brisbane
Friday, 24 November – Sunday, 26 November	Wellington
Friday, 1 December – Sunday 3 December	Melbourne
TIPS	
Friday, 17 November – Saturday, 18 November	Auckland

Contact the Skills Training Department

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

**Courses available at the time of publishing*

Appreciating Our Educators

Thank You to all of our SET Supervisors, PD Facilitators, IMG Clinical Assessors who have contributed to surgical education and training in the RACS community. We wish to acknowledge the following educators in achieving these service milestones (as of 31 December 2017*):

Those who have served for 9 years or more

SET Supervisor				
Dr Richard Rahdon	Mr Gerard Coren	Mr Ivor Galvin	Dr Sean Nicklin	Dr Roger Grigg
Mr Graham Sellars	Dr Linda Fenton	Mr Zakirhusen Akhunji	Dr Mathew Sebastian	Prof Glenn Guest
Mr Robert Stuklis	Mr Stephen Fulham	Mr Darren Tonkin	Dr Bernard Bourke	Dr Katherine Martin
Assoc Prof John Vandervord	Mr George Bursle	Prof Martin Jones	Dr Jennifer Chambers	Dr Phillip Puckridge
Mr Thomas Bowles	Mr David Mason	Mr Allen-John Collins	Mr Vikram Puttaswamy	Mr David Vokes
Dr Kirstie MacGill	Mr John Goldblatt	Mr Richard Lee	Mr Gordon O'Neill	Mr Michael Edger
Mr Stephen Jancewicz	Assoc Prof Geoffrey Croaker	Dr Eric Donaldson	Dr Mark Jackson	Dr Yves D'Udekem
Mr Andrew Parasyn	Mr Hee Soo Teng	Mr Stephen Smith	Mr Laurence Ferguson	Mr Subhaschandra Shetty
Assoc Prof Matthias Wichmann	Mr Ian Nicholson	Dr Andrew Hughes	Mr Alan Saunder	Mr Kevin Varty
Assoc Prof Vijayaragavan Muralidharan	Mr Simon Bariol	Mr Rupert Hodder	Mr Ralph Gourlay	PD Facilitator
Mr Allan Smith	Mr Paul Jansz	Mr Robert Winn	Mr Dilhan Cabraal	Mr Peter Sharwood

Those who have served for 6 years

SET Supervisor				
Mr Janaka Wickremesekera	Mr Russell Fowler	Mr Peter Randle	Dr Benjamin Wallwork	Assoc Prof Jenepher Martin
Dr Agneta Fullarton	Mr Michael Chin	Mr Grant Parkinson	Mr Kenneth Wong	Assoc Prof Richard Millard
Mr Peter Subramaniam	Mr Haemish Crawford	Prof Marcus Stoodley	Mr Adam Zimmet	Ms Meron Pitcher
Mr Philip Griffin	Mr Dawson Muir	Dr John Preston	Dr Catherine Temelcos	Prof Marcus Stoodley
Dr Damian Marucci	Mr Naveed Alam	Mr Agadha Wickremesekera	Dr Andrew Clarke	Assoc Prof Katherine Drummond
Assoc Prof Mark Sywak	Dr Margaret Pohl	Mr Andrew Audeau	Dr Francesco Piscioneri	Prof David Fletcher
Dr Visvanathapillai Manoharan	Dr Michael Wines	Dr Renata Bazina	Mr Henry Dowson	Mr Janak Mehta
Mr Jason Chuen	Mr Chris Ngar	Mr Geoffrey Hee	PD Facilitator	Dr Rhea Liang
Dr Craig McBride	Mr Scott Ferris	Dr Chi Huynh	Mr Patrick Bary	Mr Mark Cullinan
Mr Peter Ferguson	Mr Gazi Hussain	Mr John Jarvis	Assoc Prof Anthony Buzzard	Dr Marjan Ghadiri
Mr Simon Dempsey	Mr Etienne Truter	Mr Stephen Pearson	Assoc Prof Mellick Chehade	Mr Alan Scott
Mr Simon Hadlow	Prof Justin Roake	Mr Christopher Que Hee	Prof Patricia Davidson	Dr Nicola Mills
	Mrs Toni-Maree Wilson	Mr Dean Ruske	Mr Mervyn Lander	

Those who have served for 3 years

SET Supervisor				
Mr Gerard Bayley	Dr Danella Favot	Dr Muhammad Abdul-Hamid	Prof Fiona Wood	Mr Ulrich Dorgeloh
Dr James Southwell-Keely	Dr Suchitra Paramaesvaran	Dr Marianne Lill	Mr Stanley Chen	Dr Jamie Reynolds
Dr Pragnesh Joshi	Assoc Prof Frank Kimble	IMG Clinical Assessor	Mr William Lynch	Mr Matthew Ryan
Mr Adrian Fox	Mr Kenneth Lee	Mr Gerard Powell	Prof Peter Choong	Dr Kevin Seex
Dr Dominic Simring	Mr James Katsaros	Mr Adrian Trivett	A/Prof Michael Murphy	Mr Andrew Thompson
Dr Priscilla Martin	Mr David Bell-Allen	Prof David Watters	A/Prof John Alvarez	Mr Benjamin Witte
Prof David David	Mr Hamish Farrow	Prof David Wood	Mr Andrew Graham	Mr Vidyasagar Casikar
Mr Nigel Barwood	Mr John Crock	Dr Robert French	Dr Alison Taylor	Dr Thomas Edwards
Mr Vipul Upadhyay	Mr Stephen Brough	Mr Hugh Martin	A/Prof Surendranath Krishnan	Prof Andrew Carney
Dr Rodger Woods	Mr Francesco Bruscino-Raiola	Mr Gordon Arthur	A/Prof Gary Morgan	Mr Kevin Tetsworth
Dr Joanne Dale	Mr Bernard Carney	Mr Peter Pohlner	Mr Gerard Hardisty	Mr Nils Wagner
Mr Comus Whalan	Assoc Prof Anthony Freeman	Mr Garrett Hunter	Prof David Little	Mr Christian Sutherland
Assoc Prof Graham Stewart	Assoc Prof Larry Kalish	Mr Alan Scott	Mr Colin Reid	Mr Andrew Swanston
Dr Alys Saylor	Mr James King	Mr Donald Laing	Mr Russell Bourne	Mr Matthew Oliver
Mr Mohan Jayasundera	Mr Wingchi Lo	Mr Robert Ventura	A/Prof Thomas Hughes	Prof Zsolt Balogh
Mr Muhammad Abdullah	Mr Franklin Pond	Dr Stephen Clarke	Dr Robert Davies	Dr Yves D'Udekem
Dr Cu-Tai Lu	Mr James Savundra	Mr Stephen Clifforth	Mr Mark Duncan-Smith	Dr Rebecca Magee
Mr Kevin Chambers	Mr Edward Smith	A/Prof Phillip Spratt	Mr Andrew Mitchell	Mr Asar Alsaffar
Dr Cameron MacKay	Dr Jane Strang	Mr Peter Tamblyn	Mr Simon Ellul	Mr Bernard Whitfield
Mr Michael Johnston	Mr Damon Thomas	A/Prof Peter Deutschmann	Dr Ralph Stanford	Mr Arshad Barmare
Dr Heng-Chin Chiam	Dr Arvind Vasudevan	Prof Andrew Kaye	Mr Matthew Sharland	Dr Swapnil Pandit
Mr Franko Sardelic	Mr Vijith Vijayasekaran	Prof Mark Edwards	Mr Stephen Megson	Prof James Spark
Prof Guy Maddern	Mr Timothy Wagner	Mr Alexander Grant	Mr Matthew Nott	Dr Abdul Kadhim
Dr David McCallum	Mr Jeremy Hunt	Prof Noel Tait	Prof Andrew Biankin	Dr Grace Lim
Mr Kundam Reddy	Dr Michael Byrom	Mr Ian Campbell	Dr Timothy Elston	Dr Alan Atherstone
Dr Isaac Harvey	Dr Nishanthi Gurusinghe	A/Prof Elton Edwards	Mr Mark Hurworth	Mr David Wright
Mr Andrew Malcolm	Assoc Prof Alkis Psaltis	Mr Francis Quigley	Mr Arvind Deshpande	PD Facilitator
Mr Jeremy Rossaak	Dr Gabriella Vasica	Mr Jeffrey Myers	Dr Emma Corrigan	Dr Laurence Webber
Mr Michael Nightingale	Dr Emmanouel Roussos	Prof Robert Berkowitz	Mr Robert Eisenberg	
Mr Neil Roberts	Dr Michael Wagels	A/Prof Peter Devitt	Dr Michael Fish	
Mr William Blake	Dr Adrian Clubb	A/Prof Christopher Pyke	Mr Anuradha Jayathillake	
Dr Japinder Khosa	Mr Daniel Marshall	Mr John Stanley	Mr Philip Jumeau	
Mr Sanjeev Khurana	Dr Mark Romero	Mr David Hall	Mr David Scott	
Dr Andrew Lienert	Mr Alastair Hepburn	Mr Peter Bryan	Mr Melvyn Kuan	
	Dr Augusto Gonzalvo	Mr Ngalu Havea	Prof Richard Naunton Morgan	

**The Academy of Surgical Educators and the affiliated RACS departments endeavour to publish these lists as accurately as possible. If you know someone whose name is missing from the list, please contact ase@surgeons.org.*

The Journey to Fellowship: A perspective from the finish line.

DR SU MEI HOH
Training Portfolio, RACSTA

As the year winds down, and we approach the end of another training term, many of the senior Surgical Education and Training (SET) Trainees who have survived and attained Fellowship are approaching the long-anticipated finish line. This period of transition is one that provides a unique time to reflect on what it takes to make a surgeon.

My years as a Trainee have encompassed a constantly shifting landscape of surgical training. When I commenced, SET was in its infancy and General Surgery training had been reduced from six to five years. The paradigm was to train in the sub-specialty of choice from the start thus streamlining the experience and reducing time in training. However, it soon became apparent that the earlier admission into surgical training was suboptimal with less experience as a baseline for Trainees. Reduced training time, combined with the safe-working hours campaign has now graduated a generation of Trainees who assume a less confident role as new operating Fellows. Training boards across the specialties have responded to this challenge with varying approaches.

Paediatric Surgery has extended its programs to seven years while others have reduced the time on the program General Surgery has further reduced its program to four years but shifted the bar at program admittance. This constant flux has been unsettling for all and while an ideal training model has yet to be agreed upon, we certainly agree that a substantial number of FRACS graduates today are less secure in their preparation to assume the responsibilities of an operating surgeon.

My time in training has also coincided with individual training boards developing a host of early- and mid-SET specialty specific assessments. This was in response to both sub-streaming and new competency based models of training. However, like all things new there was no shortage of teething problems. The pressure from having to roll out new assessments without the luxury of time to calibrate, resulted in difficulties that were felt by all particularly the Trainees who had to sit those assessments. The most bitter of outcomes were where Trainees failed assessments not because of the lack of mastery of subject matter but because of uncalibrated tests. While overcoming such challenges provided a learning point in itself and an even sweeter victory when the exam was finally conquered, the unnecessary scars from such experiences are to be regretted. While constant evolution in education is vital to ensure a curriculum that fulfils contemporary training expectations, pause and reflection must accompany change.

Throughout my journey where the tides were ever changing and there were moments when it felt like there was no way to weather the storm that kept rolling in, there was one constant – the quiet (and sometimes loud) will of the Fellows who had already traversed this path and who later became my surgeon mentors. While training program requirements fluctuated, their expectations of Trainee achievements did not. There was no compromise in the accepted standard of clinical judgement, surgical precision or in the service we provide to the communities we serve. Their unwavering will and examples continue to forge the next generation of surgeons who are resilient to failure, criticism, uncertainty and disease while also having a measured response to success and accolades.

So as I pause just short of the finish line, I look back on my surgical journey filled with adventures and misadventures. I am glad for those who made it before me and those who stand next to me. I remember the others who started the race but did not finish. I am full of hope for those about to start the race and those still racing. I am delighted with the journey nearly over and am grateful for the opportunities afforded me in this unique privilege. Now turning towards my finish line, I am reminded of the principle my surgeon mentor taught me, that 'successful surgery is the ability to keep things safe, simple, sensible and humble'.

89th Tasmania Annual State Meeting

The 2017 Tasmanian ASM was held September 22-23 in Hobart with 35 local attendees, industry sponsors and local politicians.

The event kicked off with the ASM dinner, where retired Vascular Surgeon, Mr Alan Scott was presented the Outstanding Service to Community Certificate by his friend and colleague, Mr Hung Nguyen (pictured, below).

The Meeting's theme 'Surgery in One State, One Health System, Better Outcomes' reflected the Tasmanian Government's Department of Health and Human Services reform as outlined by Minister for Health, Michael Ferguson.

Mr Ferguson welcomed everyone to the meeting and said he was enamoured by the meeting's recurring theme from speakers regarding paediatrics. He also commended RACS in its understanding of the Tasmanian surgical community.

Clinical A/Prof Stuart Walker (pictured, below), a Specialist Vascular and Endovascular Surgeon presented a study he conducted on negative pressure dressings of amputation wounds. He found no difference between the PICO single-use negative pressure wound therapy or the woollen crepe in the outcome of improving a wound.

During questions, the cost benefit between the two forms of dressing became a rather hot topic of conversation between many Fellows.

Mr Walker also revealed he has been undertaking the Royal Hobart Hospital's Mortality Review as a way to identify Tasmanian deaths. He said more patients die in Tasmania of cancer than stroke and reinforced the need and importance of quitting smoking. Since 2010 until 2017, Mr Walker has investigated some 17,000 deaths out of 30,000 in Tasmania.

We were privileged to have Shadow Minister for Health, Rebecca White speak regarding health for all Tasmanians, particularly focusing on preventative health. Her speech generated plenty of discussion and debate among the attendees.

We also had several doctors and 4th year medical students present their research covering various topics such as paediatric cases of Crohn's Disease, the upstaging of Melanoma In-Situ following a shave biopsy, sutuerless gastroschisis closure and a digastric transfer in the posterior belly.

Our President, and local Tasmanian, Mr John Batten spoke after lunch on RACS matters such as the Building Respect and Improving Patient Safety Action Plan, saying two years down the line, Fellows should be proud of RACS and the work that has been done. However, Mr Batten did emphasize that there is still plenty more to be done.

Mr Batten spoke on issues such as revalidation, rural training, the incoming CEO Mary Harney and the review of our structure and governance. He also encouraged his audience to celebrate 'generalism' in the surgical profession, saying we needed to deliver a 'product surgeon' to fit the community they work in.

Overall, the meeting was enjoyable and informative regarding the outcomes Tasmanian surgeons are currently aiming towards. A special thank you to Di Cornish, Tasmanian Regional Manager who organised the annual meeting – this was her 36th ASM.

2017 - The Road to Operating with Respect

A year in review

DR SALLY LANGLEY
Chair, Professional Development
and Academy of Surgical Educators

ASSOC. PROF. STEPHEN TOBIN
Dean of Education

The Academy of Surgical Educators' membership base has grown to nearly 800.The Academy focuses on enhancing the surgical community whose interest is in surgical educator training and development. We have done this through engaging with the Building Respect Campaign, recognising surgical educators within RACS with awards, hosting educational events, collaborating with the TriNations Alliance, awarding research scholarships and working with the University of Melbourne Graduate Programs in Surgical Education.

The Academy has supported the actions of the RACS Building Respect, Improving Patient Safety (BRIPS) Action Plan and developed the Foundation Skills for Surgical Educators (FSSE) course over 2014-2015, as there was already a demonstrated need.

To this end, RACS staff including medical educators and surgeons trained as faculty have rolled-out 111 FSSE courses across Australia and New Zealand in the 2017 calendar year. The FSSE course is mandatory for surgeons who are involved in the supervision and training of RACS SET Trainees.

Two further courses are under development: the *Advanced Feedback* module/course and the *Surgeons as Everyday Leaders* course.

Participants at a recent FSSE course.

Educational events taken place this year:

TriNations Alliance

These workshop meetings with other medical colleges including the Royal College of Physicians and Surgeons of Canada were hosted by the Australian and New Zealand College of Anaesthetists (ANZCA), in Melbourne.

All colleges participated in the *Competency-Based Medical Education Workshop*, where discussions focussed on the need for appropriate work-based assessment tools and feedback. One afternoon was devoted to the concept of competency-based Continuing Professional Development (CB-CPD) in practice, specifically, Entrustable Professional Activities (EPAs).

The *Indigenous Workforce Development Workshop,* facilitated by Assoc. Prof. Papaarangi Reid, and Assoc. Prof. Gregory Phillips, was an extensive, thought-provoking day which focussed on colonisation from an indigenous peoples' perspective; the indigenous realm in terms of spiritual, mental, physical and emotional health. Notably, the indigenous medical/health professional trainees often carry a lot of responsibility, not just for their own studies but also for educating their trainee peers about indigenous concepts. The concept of equality (everybody starting from the same base) and merit-based selection (noting that selection tools were not particularly validated) was compared to the notion of equity (allowing for the inequality that indigenous medical and health professional trainees have encountered).

Close to 200 people attended the International Medical Symposium 2017 (IMS), which was hosted by ANZCA. IMS included presentations and discussions about leading change in the culture of medicine, in indigenous healthcare, in medical education and technology, and in systems and practice. Recordings of the presentations can be found at https://vimeopro.com/anzca/tri-nation-alliance.

Educator Studio Sessions

The Educator Studio Sessions showcase presentations from medical educators on topics of interest to members. Some of the speakers were:

- A/Prof. Margaret Bearman on the topic 'Working with underperforming trainees'
- A/Prof. Martin Richardson on the topic 'Teaching & Learning in the Operating Theatre'
- Dr Harsheet Sethi on the topic 'How Do Surgical Trainees Engage in 'Self-Directed' Learning in the Workplace?'
- Prof. Margaret Hay on the topic 'Principles of Selection – For Medical School Postgrad Specialist Colleges'.

Next year there will be one Educator Studio Session webinar each month, building on the partnership with University of Melbourne by showcasing presenters from the Master of Surgical Education Program. Other leading medical education and leadership individuals will also be involved.

Academy Forum

The 2017 Academy Forum took place in Sydney on 2 November and was held in conjunction with the RACS NSW Surgeons' Month. The theme was *Building Leadership, Improving Patient Safety.* The evening promoted the role of surgical leadership in improving patient safety. Prof. Larry Marlow, from University Technology Sydney, spoke about 'Leadership in Healthcare Teams' and Dr Sarah Dalton (Clinical Lead, Agency for Clinical Innovation) spoke about 'Involving Surgeons in Systems Improvement'. Hosted by the authors, the Forum concluded with presentations of ASE Educator of Merit Awards for supervisors and course facilitators.

Graduate Programs in Surgical Education

This combined RACS and University of Melbourne suite of postgraduate courses allows surgeons to formalise their skills in teaching and educational scholarship. About 20 colleagues commence these surgical education qualifications annually.

Semester 1 workshops were held at RACS Melbourne in February, while the Semester 2 workshops were held at RACS in August. Led by Prof. Debra Nestel, and supported by the Dean of Education, these workshops also include prominent medical educators.

There are core and optional subjects with flexible delivery modes. Subjects include: Contemporary Context of Surgical Education, Educational Methods - Practice & Theory, Curriculum Design in Surgical Education, Recruitment & Selection of Trainees, Teaching Human Factors and Professional Skills for Surgery. The content reflects critical issues in the broader education community together with specific challenges for surgical education - the role of regulatory bodies, balancing clinical service with training, ethical imperatives for simulation based education, safer working conditions including safe hours and more.

Annual Scientific Congress Surgical Education Stream

The 2017 Annual Scientific Conference (ASC) Surgical Education Stream was convened by Prof. Peter Anderson. Prof. Debra Nestel and Dr Pamela Andreatta were keynote speakers for the conference.

International Conference of Surgical Education and Training (ICOSET)

The ICOSET conference was held just prior to the RACS Annual Scientific Congress (ASC) in May. With 120 people in attendance, this two day scientific program included local and international faculty members and a prolific social media presence. The conference was co-convened by Prof. Peter Anderson and the Dean of Education, A/Prof. Stephen Tobin. ICOSET is dedicated to sharing global developments and innovative approaches in surgical education through interactive sessions and debates. The conference provided an opportunity to meet and network with surgeons, leaders in surgical education and policy makers from different jurisdictions. This year's theme was 'Rethinking Surgical Training'. The topics for discussion were:

- Outcomes of Surgical Training
- Selection for Surgical Training

Dean of Education, A/Prof. Stephen Tobin at ICOSET 2017

- Preparation for Surgical Training
- In-training Assessments
- Learning About Teams & Teamwork
- Learning Good Professional Behaviours

Introductory snippets of the talks can be viewed on https://www.surgeons.org/for-health-professionals/academy-of-surgical-educators/icoset-2017/

Reward and Recognition Program

The Academy recognises the contribution of surgical educators via the ASE Recognition Awards. Recipients of the Educator of Merit - Supervisor/Clinical Assessor of the Year Awards are:

- ACT: Dr Phillip Jeans, FRACS
- QLD: Dr Raymond Chaseling, FRACS
- VIC: Mr Jacob Goldstein, FRACS
- NT: Dr Peter Coverdale, FRACS
- NSW: Prof. Martin Jones, FRACS
- SA: Prof. Jeganath Krishnan, FRACS
- WA: Dr Ravish Jootun, FRACS
- TAS: Mr Stephen Brough, FRACS
- NZ: Mr Ian Stewart, FRACS

The Educator of Merit Award - Facilitator/ Instructor of the Year Award was awarded to Dr Stephen Wilkinson, FRACS. Academy Award winners were presented with their awards at the Academy Forum on 2 November in Sydney.

Prizes and Scholarships

ASE Surgical Education Research Scholarship

The Surgical Education Research Scholarship was established to encourage surgeons to conduct research into the efficacy of existing surgical education or innovation of new surgical education practices. This year, Dr David Lam, was the awardee of the ASE Surgical Education Research Scholarship. Congratulations, Dr Lam.

ASC 2017 Surgical Education Research Prize

Mrs Elizabeth Berryman, was awarded $500 for the Surgical Education Research Prize for her research "Daily collection of Self-Reflected Wellbeing (SRW) scores via a smartphone app in clinical medical students: A feasibility study" in the Surgical Education Stream at the 2017 ASC.

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 Rob Di Leva on +61 3 9249 1111 or email ase@surgeons.org

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

Why bullies win

MR IAN INCOLL
Past President, Dean of Education
Australian Orthopaedic Association

Many of you may identify a colleague's behaviour in what follows. I remember an *AOA Bulletin* article I wrote a few years ago, which described a de-identified bullying episode, constructed from multiple case studies. Soon after it was published, a few people contacted me, admonishing me for writing about their friends. These people had recognised the poor behaviour that had been clearly illustrated, yet chose to call out yours truly as the reporter for mentioning it, rather than the perpetrator. Therein lies the rub with bullying. Reporting it, it seems, is at your own peril, even when you may be an observing bystander.

The bullies can go even further, using an accusation of bullying as its own form of bullying. When attempting the 'coffee conversation' with a recalcitrant bully, many times I and others have been threatened with bullying counter-claims or legal action for defamation. The 'Vanderbilt' approach seems to work, at least in a hospital where each employee understands there is no security of tenure and a speaking-up culture already exists.

Almost everyone undertaking the initial conversation with a bully finds it intimidating and uncomfortable. It is not why we chose medicine. This is partly because we have the normal human emotions of empathy, courtesy and compassion. Even mild narcissists or psychopaths have these qualities in lesser amounts, and so have no qualms using a passive-aggressive silence or trite agreement to turn the focus or blame onto others, their accusers or even the interviewer.

It is arguable whether training in undertaking the 'coffee conversation' will help. It may enable those required to approach a bully a chance to practice in a simulated, 'safe' environment, and therefore experiment with different approaches. Recently I have been involved in this type of training and was asked to play the role of the bully. Employing the techniques that I have witnessed from the other side of the coffee cup, the poor participants were uncomfortable, diverted and distressed. Debriefing them afterwards, they were experiencing the same emotions that I have often experienced when approaching a bully: helplessness, disorientation and frustration. Despite having the facts clearly established, the accomplished bully or narcissist can always find an excuse and lay blame on those around them – in their mind it is they who are aiming for "excellence" and are being held back by those they torment.

There have been situations where a serial bully, who has been investigated for multiple poor patient outcomes and repeatedly reported for intimidating behaviour, can manage to have administrators removed by claiming to be the victim of bullying.

At the risk of self-incrimination, the more I read about leadership theory, the more I realise that bullies are quite successful in our systems. They progress, in part, because it is easier for non-bullies to acquiesce to their demands than to report or speak out against poor behaviour. Each episode prompts a similar reaction – no one else has so far spoken out so maybe I'm just being too sensitive or biased. The bully gets their way, moves ahead and the bullied move aside. Perhaps leadership training even equips the bully to be more effective?

> *"We must always take sides. Neutrality helps the oppressor, never the victim. Silence encourages the tormentor, never the tormented."*
>
> *- Nobel Laureate Elie Wiesel.*

Even when a more formal approach to bullies occurs, the outcome can be unsatisfying for those committing to the effort. Formal interventions in which all sides have agreed that the behaviour has been unacceptable regularly happen. Promises of contrition and behaviour modification are made. Yet afterwards, the bullies have claimed to all that they have been exonerated and continue business as usual, often after a short quiet time to allow attention to focus elsewhere.

Therein lies a glimmer of hope. This short quiet time, this reprieve from the intimidation, comes when a spotlight is turned towards the behaviours. When those around the bully are helped to clearly identify the unacceptable behaviours and empowered to speak out by others' recent efforts, most bullies who have succeeded are smart enough to temporarily reduce their intimidation. Bullies become less destructive when the bullying behaviour is explicitly pointed out.

"We must always take sides. Neutrality helps the oppressor, never the victim. Silence encourages the tormentor, never the tormented."- *Nobel Laureate Elie Wiesel.*

As with racism and genderism, turning a light on the behaviour and creating a conversation will likely help. This is what has motivated me today. One difficulty with this approach is what I alluded to earlier – calling out a bully brings the risk of receiving the same. Restricting the conversation to verifiable, witnessed behaviours is often recommended, but this overlooks the fact that harassment is a perception; an emotional experience often imparted with non-verbal language and psychological threat within private conversations.

I had a colleague recently who suggested that minor episodes of bullying were to be expected in normal workplace interactions and we surely must tolerate them. Sadly, this is how the disempowerment to speak up begins. When small bullying episodes are observed but not called out, the next time it happens will be more difficult for someone to begin. It is very easy, from a bully's perspective, to point out the acceptance of past behaviour and claim a double standard. The bully's ego allows them to become the victim.

As former Defence Force Chief, David Hurley first said, "The standard we walk past is the standard we accept".

This story was featured in the August 2017 Australian Orthopaedic Association eNewsletter. The AOA is working with RACS to implement the Building Respect Improving Patient Safety Action Plan.

Ardnell Report

Concerns about the culture of surgery including bullying, discrimination and harassment are high on the list of reasons some surgical trainees chose to leave their training, according to a study commissioned by RACS in 2015.

The study, by the Ardnell Group, was designed to help RACS better understand why some trainees left the program. It was commissioned in response to the work of the RACS' Expert Advisory Group into bullying, discrimination and sexual harassment. It is published on the RACS website: www.surgeons.org/about-respect/what-we-have-done/

The research was undertaken in the same year the EAG was established and included surveys and interviews with trainees who had withdrawn from surgical training between 2008 and 2015.

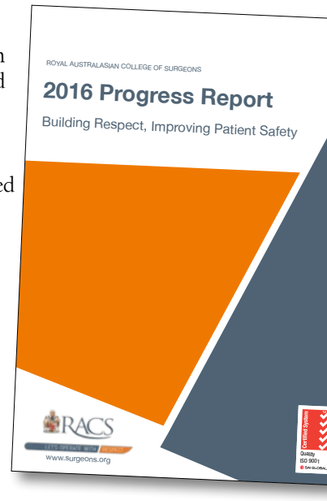
It found inflexibility in the specialty training programs, surgery being the wrong career choice (including for lifestyle reasons) and poor supervision were also significant factors in the trainees' decision to leave, as well as concerns about the culture of surgical training.

Lack of academic success was ruled out as a factor, with about 80 per cent of research participants continuing to work or train in medicine, almost all in other medical specialties.

The study results confirm the importance of the College's commitment to building respect and improving patient safety in surgery and are consistent with what we learned in 2015 from the EAG.

The study also validates the work RACS is doing to build a culture of respect in surgery and its efforts to keep good, bright people like these former trainees in our profession.

In early 2017, RACS published a progress report detailing what it has done to implement the 2015 Action Plan and will continue to do so, on an annual basis. The plan outlines a multi-pronged, multi-year program, with a key early focus on education and awareness-raising.



RACS recognises that the issues of discrimination, bullying and sexual harassment are not confined to surgeons and that change is needed across the health sector. RACS is pleased to have signed partnership agreements with 26 health jurisdictions, hospitals and health agencies, demonstrating a shared willingness to work together in fostering a culture of respect.

We also recognise that cultural changes takes a long time – some say, a generation of effort. RACS however, is fully committed to working towards this goal and in its action plan, has identified a very clear path ahead to achieve these goals.

SKILLS TRAINING

Share your experience, become an ASSET Instructor

PROFESSOR JONATHAN SERPELL
Chair, Prevocational and Skills Education

Teaching is a rewarding and motivating part of being a surgeon. Instructing provides opportunities to impart your expertise and provide emerging surgeons with expert feedback and guidance in developing essential surgical skills in a simulated setting. RACS is seeking Fellows interested in surgical education to become an ASSET Instructor.

The ASSET course provides surgical Trainees with the foundational skillset to become proficient surgeons. ASSET instructors bring enthusiasm and extensive knowledge to the course and are an integral part of ensuring that the next generation of surgeons develops a solid foundation of technical skills.

What you gain

- Enhance your teaching skills
- Claim Continuing Professional Development points (1 point per hour)
- Network with a multidisciplinary faculty
- Mentor emerging surgeons
- Share your passion and expertise and influencing the future in the field of surgery

The success of these courses is dependent on the generosity and voluntary involvement of Fellows from a variety of medical disciplines on a pro bono basis.

What you need to know

- Teaching placements are flexible – you can teach for half a day, or up to two days.
- Your day-to-day technical skills are all you need to become an instructor, there are no speciality skills or courses required.
- You'll teach basic surgical skills in a clearly defined course format, with assistive video demonstrations.
- Teaching tips and tricks are available for new instructors.

ASSET provides trainee surgeons with the foundational skills they need to become competent surgeons. Fellow involvement is integral to the success of the program. By becoming an instructor, you will be helping to ensure the next generation of surgeons develop a solid foundation of technical skills.

Register to become an instructor

Visit www.surgeons.org and follow the steps below,
Click on Education and Training, then click Getting Involved as Faculty and select ASSET:

- Ensure minimum eligibility criteria is met
- Check against the course prerequisites prior to applying
- Complete Instructor Application form and submit curriculum vitae

For further information please contact the ASSET Program Administrator, Tel: +61 3 9249 1227, asset@surgeons.org, www.surgeons.org/asset

SURGICAL SNIPS

'Pen' device can spot cancer in 10 seconds

A device that appears much like a simple pen could enabling surgeons to trace cancer within seconds. The MasSpec Pen, designed by Dr Livia Schiavinato Eberlin of the University of Texas, releases a tiny drop of water on the tissue which then absorbs chemicals inside the cells. A mass spectrometer analyses the cells, delivering the results on a computer screen within 10 seconds. According to the Head of Endocrine Surgery at Baylor College of Medicine Dr James Sulibruk, the new technology will allow surgeons to be much more precise in what tissue is removed and what is left behind. The study has been published in *Science Translational Medicine* journal.
http://www.msn.com/en-au/news/techandscience/pen-device-can-spot-cancer-in-10-seconds/ar-AArrLVy

© Press Release The MasSpec Pen can identify cancerous tissue in 10 seconds Pic: University of Texas

Melbourne scientists are creating mini-livers in a dish

Using small samples of healthy cells extracted from surgeries conducted to remove liver cancer, researchers from the O'Brien Institute of St. Vincent's Hospital in Melbourne have devised a way to create liver organoids just millimetres long for the purpose of growing liver tissue to treat disease. The research team, led by Dr Geraldine Mitchell and Dr Kiryu Yap, is using a combination of three types of human cells, a human-derived liver gel and a biodegradable scaffold to create the mini livers. Two cell types are isolated from the samples: liver progenitor cells that change into the main cells that make up the organ, and liver endothelial cells which form the small tubes that carry blood throughout the organ. According to Dr Yap a small amount of liver tissue can be used in patients with liver disease to replace one or two liver functions.
http://www.heraldsun.com.au/news/victoria/melbourne-scientists-are-creating-minilivers-in-a-dish/news-story/18e4fdaafdde36498bbea39d95893bb4

Martin Ata'o, Curator of the Pathology Museum

Rejuvenation of pathology museum cultivates new life

Pioneering efforts at the University of Papua New Guinea will leave a legacy of lifelong learning.

Professor Robin Cooke, through his deep commitment to pathology has been instrumental in shaping the Pathology Museum at the University of Papua New Guinea (UPNG).

With *Surgical News*, Prof. Cooke reflected on the early years where the very first specimens were potted and mounted in 1962 by Kivovea, a national lab technician. This was accomplished under the watchful eye of Prof. Cooke who carefully selected the specimens from post-mortem and surgical pathology material.

That same year, the Papuan Medical College, teaching medical students, was expected to soon become the Faculty of Medicine of UPNG.

Five years later, the museum contained a good working number of specimens. The collection was augmented with donated specimens from the Universities of Melbourne and Sydney, further establishing a bilateral relationship between Australia and PNG, with various pathologists adding 30 - 40 specimens, contributing to a steadily growing collection.

At the time, Head of Pathology, Dr Swapna Kamal Sen Gupta, alongside Dr Prasantha Murthy made placards out of cardboard with noteworthy descriptions of each specimen. The museum was continuously used for teaching, however little maintenance was carried out due to lack of appropriately trained staff to handle the specimens.

Over the years, solutions had become cloudy, pots were leaking and the odour of formalin began to fill the air. The specimens were displayed on old stands that were becoming unstable.

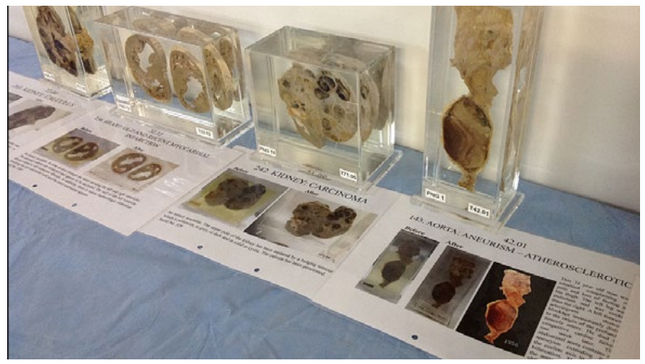
In 2014, the RACS Foundation for Surgery provided an essential grant to kick off the rejuvenation of the specimens for the purpose of ongoing teaching.

In August 2015, the Dean of Medicine of UPNG, Professor Nakapi Tefuarani officially appointed Medical Technologist, Martin Ata'o to be the Curator of the Pathology Museum.

Further strengthening the Australia-PNG relationship, Professor Richard Murray, Dean of Medicine at James Cook University (JCU), arranged to host Martin at the Department of Anatomy. Martin spent three weeks in Townsville learning how to prepare new perspex display containers for the old pathology specimens.

Logistics for the rejuvenation project was not a simple endeavour, people all across Australia were involved in bringing the project to life. Specimens in PNG had to be carefully measured so that the display pots could be custom made in Victoria. On top of this, National Association of Testing Authorities, Australia (NATA) approved boxes were purchased in Brisbane and then sent to PNG for transportation of the specimens from PNG to Townsville!

Excitingly and after much anticipation, in October 2015, the pots and the specimens arrived at JCU.



The old display boxes were broken and the specimens were placed into clean formalin solution and matched into their new homes of special pots.

While JCU students were on semester break, Dr Tess Aceret, Anatomy and Pathology Laboratory Officer at JCU re-potted 40 of the 46 specimens, leaving six for Martin to complete independently for training.

Martin arrived at JCU in mid-January 2016 and on the last day at JCU the re-potted specimens were ready for repackaging for their return journey back to PNG.

The transformation was nothing short of spectacular

A grant from the Australia PNG Association in Brisbane further allowed Martin to purchase two museum display cases from a local manufacturer.

In October 2016, a formal opening of the newly refurbished museum was held where Martin proudly displayed some of the 'new' specimens.

Working hard and with great initiative, Martin has since obtained funding from the Medical School and acquired nine display cabinets, purchased a further 64 new perspex pots for repotting specimens and changed the solutions in 61 pathology specimens and one anatomy specimen.

Martin is currently expanding the Laboratory Manual which he began during his time in Townsville. This includes photographs of the specimens and newly typed descriptions taken from the museum's cardboard placards. He also made some explanatory cards for teaching purposes.

Early in 2017, the Histo-technology Group of Queensland sponsored Martin to spend another week in Brisbane. He delivered illustrated lectures in four of the teaching hospitals in Brisbane and the Gold Coast and was introduced to the University of Queensland's' modern Pathology Museum.

2017 was a big year, with Martin becoming a medical student. He has set a stellar goal for himself; hoping to have completed the rejuvenation of the remaining 550 specimens before graduation in six years' time.

Martin could very well be the next Professor of Pathology in the University of Papua New Guinea, leaving a legacy of lifelong learning by Prof. Cooke and various patrons and pathologists across Australia.

– Professor Robin Cooke OBE, OAM
with Gwyn Low, Global Health

Cooke RA; OBE, OAM, MD, DCP, FRCPA, FRCPath, FACTM, Aceret T; BS (UP), MS UPLB), PhD (JCU), Ata'o M.; B. Med. Lab. Sci. (UPNG).

Images (From top): Museum as it was in 2010 when the first request was made for a possible rejuvenation of the specimens; Repotted specimens ready for packing to be returned to PNG. The result was spectacular, and all those involved in the exercise were happy with it; Specimens set out for study by medical students. To accompany each specimen there is photograph and a typewritten description of the specimen; Four newly acquired wooden display cabinets and five steel cabinets; With the executive of the Australia PNG Association. Who donated the first two wooden display cabinets.

Palestine 1917

The photographs of Harold Robert Dew

In August 1914, the Turkish Ottoman Empire entered the war and joined with Germany (and the Austro-Hungarian Empire) to form the Triple Alliance. This caused the British who had long-standing interests in the country, to declare a unilateral protectorate over Egypt. British concerns regarding Egypt were inextricably linked to the strategically important Suez Canal and the fact that 'Palestine' (consisting of Israel, Jordan, Saudi Arabia and Syria) was under Ottoman control.

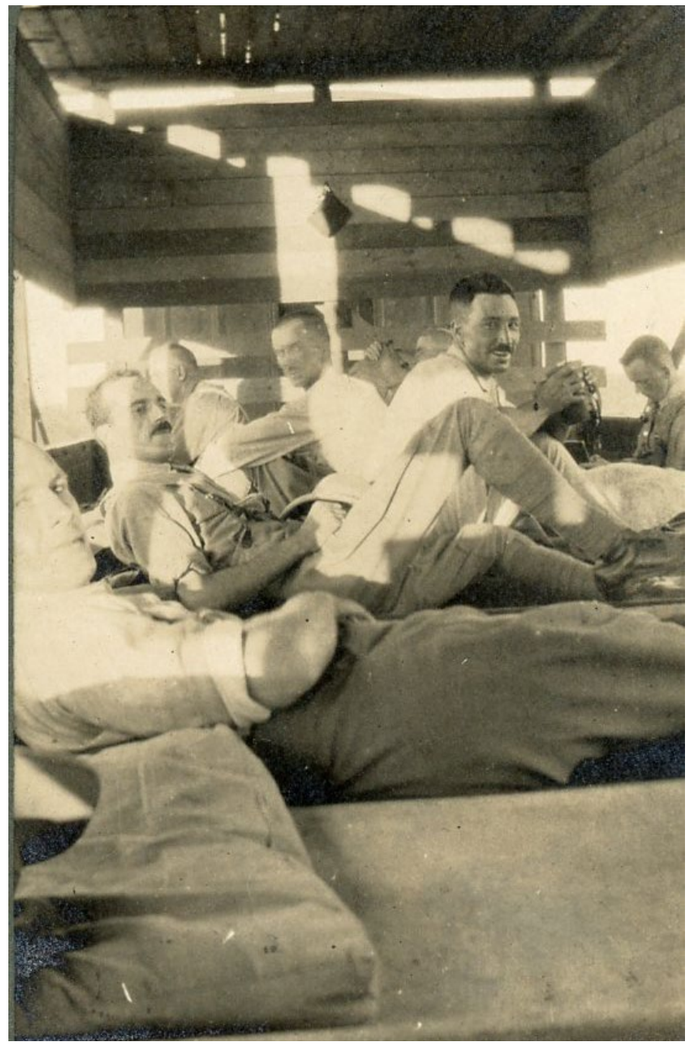
Early skirmishes in the 'Palestine' campaign were largely defensive and the British sought to protect the area around the Suez Canal from Turkish forces and Senussi tribesmen. This changed with the decisive Battle of Romani (August 1916) and in 1917, British, Indian and ANZAC forces aided by some of the Arab tribes, launched an attack on the Turkish forces in 'Palestine.' By December 1917 with General Allenby in command, the Turks had been driven from the Sinai Peninsula and the allies had captured Jerusalem.

Future PRACS (1953-1955) Harold Dew joined the Royal Army Medical Corps in 1915 and served in France, Egypt and Palestine. Two photograph albums in the RACS Archive illustrate Dew's war service. It appears that Captain Dew was in Egypt in early 1917 before going to Palestine and then, returning to Egypt. In January 1918, he was O/C of the Centronote (Cholera Laboratory) at the 3rd Egyptian Stationary Hospital in Kantara.

The 'Palestine' album (July-October 1917) gives some idea of the conditions under which the medical officers lived and how they and the wounded were transported. Sand carts, mules and camels were the preferred means of transport for both the medical corps and wounded. As TE Lawrence noted, apart from the Rolls Royce - *A Rolls in the desert was above rubies* - motorised vehicles tended to be unreliable and inappropriate for desert conditions.[i]

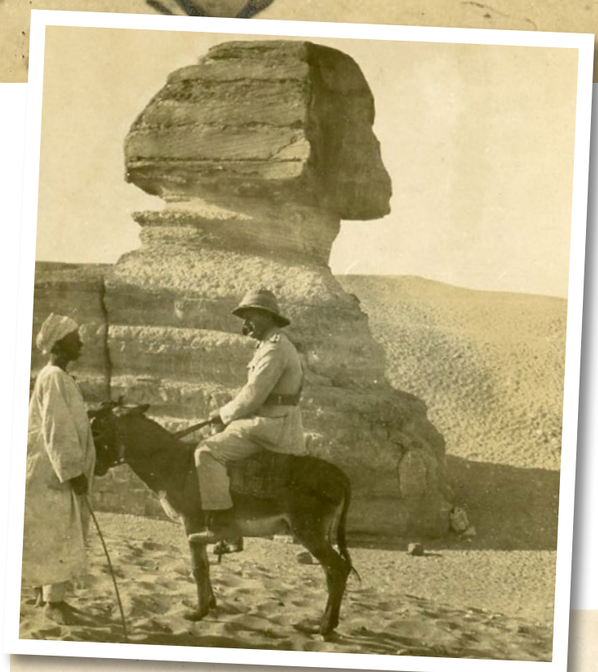
While in Egypt and 'Palestine', Dew also developed and interest in the pathology of diseases, including dysentery, cholera and the exotic Bilharzia or snail fever, caused by parasitic blood flukes. An English colleague commented that Dew was:

…an inspiring companion with a great zest for acquiring knowledge. It was a joy to collaborate with him, and by his keenness and perseverance he soon collected a fine series of pathological specimens illustrating the various diseases with which we were then surrounded. Well preserved specimens of amoebic and bacillary dysenteries and both forms of bilharziasis were collected for both the Imperial and Australian war museums. ▶



Opposite page (clockwise from top): Dew outside the Advanced Dressing Station (ADS), Wadi Ben; Egypt, 1917; Officer's Mess, Rafa; Washing Camels.

This page (From left): Harold Dew, c1915; Medical Staff En route to Rafa.



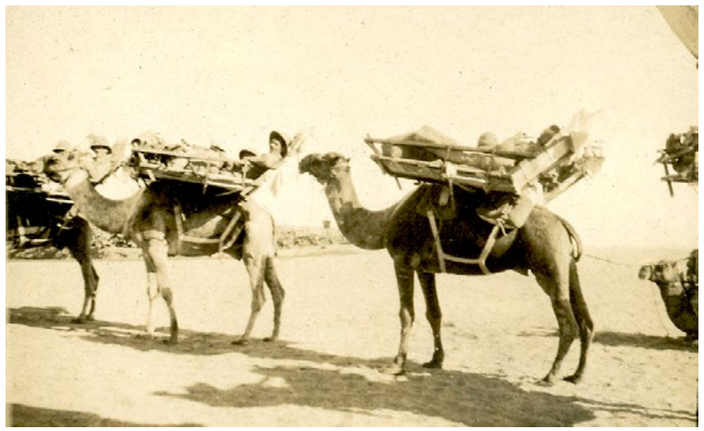
Dew was awarded the médaille d'honneur des épidémies by the French government in 1917 and when he returned to Australia, he continued his pursuit of diseases, working with his old schoolfellow, (Sir) Neil Fairley at the Walter and Eliza Hall Institute (1923-1926). His work culminated in two monographs on testicular cancer and hydatids.

Appointed Bosch Professor of Surgery in 1930, Harold Dew had an impressive career at the University of Sydney where he helped restructure the clinical curriculum, fostered research and advanced the specialty of Neurosurgery. His other legacy is his personal archive which includes the significant images found in his photograph albums.

– Elizabeth Milford RACS Archivist

Images (Clockwise from top-left): Camels; Sand Carts; Cacolets loaded with wounded; Harold Dew.

i Lawrence, TE, The Seven Pillars of Wisdom, London 1926

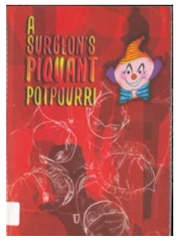


Donations to the Library collection

RUTH BOLLARD
Chair, Fellowship Services Committee

A Surgeon's Piquant Potpourri

Dallas Finney



The author is a retired surgeon who decided to share his experiences in a rather unconventional way. The chapters are in a random order – to quote the author's prologue: " I wondered, if instead of presenting the usual sequence of chronological episodes during a lifetime, it might be possible by examining a range of topics, elucidated by a series of random events, to draw together in a more meaningful way the thoughts and opinions of the author".

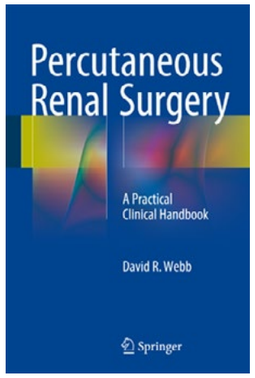
Chapters include personal views and opinions on: Aboriginal Australia, Euthanasia, The Dilemma of Medical Litigation and Combating Old Age, to name just a few.

The final two chapters are works of fiction. To again quote the prologue: "Several visits to Japan over the years and the relaxation of fishing are two experiences that have given me a great deal of pleasure, and I merely use this as an excuse for sharing my musings on these topics with my readers."

Donated by the author.

Percutaneous Renal Surgery: A Practical Clinical Handbook

David Webb FRACS



This textbook begins with the history and foundation behind percutaneous renal surgery, and progresses to review the critical anatomy, equipment, setup, surgical indications, and techniques required to achieve successful outcomes. The text provides a handbook of techniques illustrated to establish successful needle access and dilation into the renal collecting system for the purposes of kidney stone treatment, and it reviews in detail routine and complex scenarios as well as potential pitfalls and complications. The text includes 250 illustrations to demonstrate anatomy, techniques, and teaching points - each illustration was drawn by the author, and reproduced by a professional graphic artist for easy interpretation.

This handbook is a high-yield pocket reference for anyone performing percutaneous renal stone surgery, as well as an educational guide and pictorial tutorial for anyone looking to learn more about the history, techniques, and clinical nuances of percutaneous renal surgery.

Donated by the author.
This review was submitted by Greg Jack FRACS (urol)

– With Graham Spooner, RACS Library

The Editor,
RACS, CEO.
Dear Sir,
Re: Donations to the Cowlishaw museum collection.

Dr Behan mentions the textbook 'Armamentarium Chirurgicum'. published in Venice in 1665 A.D. and written by Ioh.Sculteus. The Latin is classical and would be accepted by Cicero, the superlative orator and vacillating politician of the first century B.C., the time of Augustus himself.

In "A Latin Dictionary" edited by Lewis and Short there are three references to "armamentarium"; two in the first century B.C. are attributed to Cicero and Sallust; one in the first century A.D. to Pliny.

Hence, Dr Behan is quite correct in surmising that "armamentarium" has a very long pedigree, well over two millenia sans any change in meaning or spelling.

"Case Note Review" by Dr Guy Maddern is always a must-read feature for me.

Surgery is a punctilious task master, as we surgeons all know. I have seen the best of the best have problems and how they managed them, a lesson for all of us. My advice is not to let a tyro into theatre sans close observation and support, whether it is an elective or emergency operation.

Yours sincerely,
William Renton-Power FRCS, FRACS.

jdocs Best Practice, Better Practitioners

Launch of JDocs View

In December 2015, Council approved that all Fellows, Trainees and IMGs have access to JDocs View following its launch for junior doctors in February 2016.

PROFESSOR JONATHAN SERPELL
Chair, Prevocational and Skills Education

ASSOC. PROF. STEPHEN TOBIN
Dean of Education

What is JDocs?

JDocs is a curriculum framework that describes the many tasks, skills and behaviours that should be achieved by doctors at defined early post graduate year levels, designed to assist in their development towards a career in surgery and other proceduralist careers. It is supported by a suite of educational resources, accessible from the JDocs Portfolio, which have been based on the College's nine core competencies, and designed to promote flexible and self-directed learning, together with assessment opportunities to record and log surgical experiences and capture evidence of personal achievements. There are many resources and information freely available from the JDocs website (jdocs.surgeons.org) and, for those who subscribe, much more is available, including a Portfolio and MALT logbook.

In both Australia and New Zealand, it may be some years before entry into surgical training or other specialty training after completion of internship. The JDocs Framework has been designed to address a major void in the early resident years of ANZ junior doctors.

The College sees this as an important initiative, and anticipates it will improve work-based assessment for the junior doctors in this group, some of whom will be future Surgical Education and Training (SET) applicants.

The JDocs Portfolio helps doctors to document their medical career

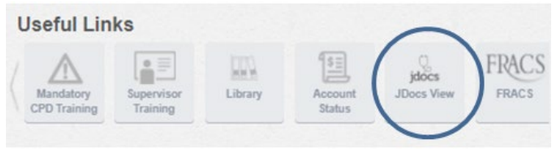
The Portfolio (menu pictured above) supports self-directed learning and reinforces the principles of lifelong learning, where junior doctors can progressively document their medical career as follows:

- self-assess against the learning outcomes of the Framework
- seek feedback on performance of Key Clinical Tasks in the workplace
- engage with JDocs-specific eLearning resources (developed by surgeons)
- prepare for, and practise, Generic Surgical Sciences examination questions
- access Operating with Respect eLearning module
- access online library resources (Access Medicine, Access Surgery, Anatomedia and Aclands)
- record surgical procedures and experiences in the MALT online logbook
- document evidence of clinical experience, achievements and assessments (e.g. certificates, end-of-term report, Mini-CEX, DOPS, key clinical tasks)
- upload any additional documents that support medical career progression
- extract a report that provides details of assessments, experiences and achievements that can support application to advanced specialty training (pictured, right).

Fellows can now access JDocs View

Fellows and Regional Office staff can now access JDocs View from the Useful Links area (pictured below) of their RACS Portfolio, with Trainees and IMGs to follow from early 2018. While in JDocs View, pop-up notifications will be visible, so that you can easily return to your personal Portfolio at any time.

JDocs View is a resource to gain insight to the functionality and educational resources that have been developed to support the JDocs Framework; it does not allow access to junior doctors' personal portfolios.



Supporting junior doctors in your hospital

As many of our Fellows support junior doctor education in their respective hospitals, this is an important step for Fellows to gain insight into the functionality and educational resources available to support surgical aspirants; it will also be useful to access the available teaching resources as a way in which to promote the JDocs Framework and Portfolio in their hospital.

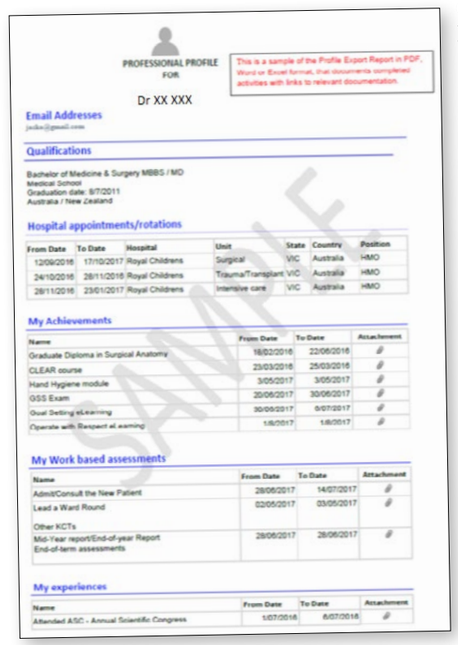
Supporting regional prevocational events

Access to JDocs View is also important for Regional Office staff, who not only support prevocational events within their region, but who also respond to queries from medical students and doctors who are interested in a surgical career. JDocs View will enable regional staff to demonstrate the educational resources and assessment tools available to help the self-directed doctor become better informed and prepared to pursue a career in surgery.

Since the launch of the JDocs Portfolio in February 2016, over 900 doctors have subscribed to JDocs. In 2017, 117 JDocs subscribers registered for the SET training program, 53 were identified as SET applicants, with 14 accepted into SET. The College hopes to have sufficient data next year to further analyse and evaluate the impact of junior doctor engagement with JDocs prior to entry to SET.

For further information please contact Jacky Heath, Manager Prevocational and Online Education (jacky.heath@surgeons.org).

– With Jacky Heath, Manager Prevocational and Online Education


PROFESSIONAL PROFILE FOR

Dr XX XXX

This is a sample of the Profile Export Report in PDF, Word or Excel format, that documents completed activities with links to relevant documentation.

Email Addresses

Qualifications

Bachelor of Medicine & Surgery MBBS / MD
Medical School
Graduation date: 8/7/2011
Australia / New Zealand

Hospital appointments/rotations

From Date	To Date	Hospital	Unit	State	Country	Position
12/09/2016	17/10/2017	Royal Childrens	Surgical	VIC	Australia	HMO
24/10/2016	28/11/2016	Royal Childrens	Trauma/Transplant	VIC	Australia	HMO
28/11/2016	23/01/2017	Royal Childrens	Intensive care	VIC	Australia	HMO

My Achievements

Name	From Date	To Date	Attachment
Graduate Diploma in Surgical Anatomy	16/02/2016	22/06/2016	
CLEAR course	23/03/2016	25/03/2016	
Hand Hygiene module	3/05/2017	3/05/2017	
GSS Exam	20/06/2017	30/06/2017	
Goal Setting eLearning	30/06/2017	6/07/2017	
Operate with Respect eLearning	1/8/2017	1/8/2017	

My Work based assessments

Name	From Date	To Date	Attachment
Admit/Consult the New Patient	28/06/2017	14/07/2017	
Lead a Ward Round	02/05/2017	03/05/2017	
Other KCTs			
Mid-Year report/End-of-year Report End-of-term assessments	28/06/2017	28/06/2017	

My experiences

Name	From Date	To Date	Attachment
Attended ASC - Annual Scientific Congress	1/07/2016	6/07/2016	

SAMPLE

Left: Report extract

Festive frolics fraught with faux pas !

SUSAN HALLIDAY

Is your festive season function likely to turn into a frolic fraught with faux pas?

Ahead of time, colleagues should be reminded about conduct unbecoming and the danger of mobile phone cameras. Employees are reminded to think about the importance of being at work the next day, accompanied by a zero blood alcohol level and clean clothes. Yet matters can get out of hand, with all too often both over familiar comments or hands featuring in workplace complaints that follow festive season functions.

The jokes will start with *'What did the reindeer say before launching into his comedy routine? …. This will sleigh you!'* By the end of the celebration the jokes will be usurping the most offensive reality TV you've watched this year.

Be proactive. Send that email out articulating the standard of behaviour required of all attendees, including partners and significant others, nice and early.

I hear that some consider this unnecessary, unreasonable or an insult to people's professionalism. I encourage the naysayers to envisage the scrutiny associated with failing to fulfil the obligation to take all reasonable steps and precautionary measures to lay down the behavioural ground rules before people let their hair down and turn into mistletoe monsters.

Others will shake their heads asking *'surely it is common sense?'* Given that social events outside the workplace fall within the remit of *in the course of employment* it is worth remembering that residing in a myriad of workplace files, there's endless proof that common sense is not common once festive-season functions get underway.

In January when the debates about who was to blame replace discussions about decorations and menus, memories blurred by alcohol are unhelpful. Gossip about who left with whom do little to assist the workplace harmony as people return from leave. Accusations about unwelcome conduct of a sexual nature and people claiming the retort to their *No-No-No* was a *Ho-Ho-Ho* take up a lot of time and effort.

End of year functions are here to stay; they do however appear to be evolving. With a rise in themed activities and pragmatic thinking about the risks associated with people giving anonymous gifts, paying attention to the importance of professional conduct at end of year functions is now on Santa's radar.

As with any other scenario that poses a work or work-related risk, a risk management strategy should be employed in advance of festive-season functions to help avoid the faux pas.

Alcohol? A dedicated bar person with responsible service of alcohol training could be useful if you are not at a licensed venue. But who is going to refuse their boss that last drink they're demanding? Plenty of non-alcoholic alternatives and drinking water should be available.

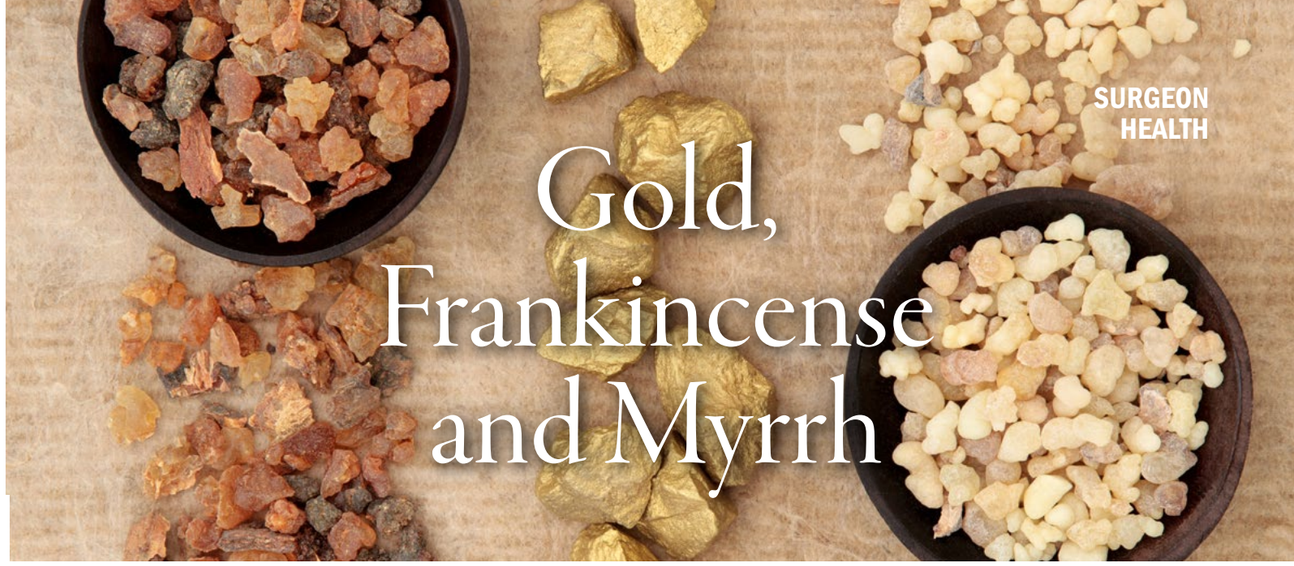
Food? Have plenty of food and serve it early. Do not venture down the 'rude-food' path. Ensure food is substantial and spans all dietary restrictions and vegan options.

Dress Code? Be clear that clothes need to be appropriate and need to stay on, even when someone has made the special effort to wear their Christmas undies.

Home time? Set a finish time and be sure people can get home safely. This may mean removing keys and diligent taxi management – so be it. Employers and those who represent the mind and will of an employer have a responsibility to avoid risk to health and safety.

Finally, a message from someone who needed to find a new role last January.

"If you have been delegated the job to dress in a red suit and to be very merry, remember the job comes with responsibilities. Side-step all physical contact despite endless temptation and avoid using the line 'so how about we forget the nice list …. cause I've got you on my naughty list' as it can be misinterpreted."



Gold, Frankincense and Myrrh

DR BB-G-LOVED

Another Christmas is coming, heralding a festival when we remember how wise men from the East, representing diversity of cultures and perhaps religions, if not gender, brought gifts of gold, frankincense and myrrh.

Some of the wisdom behind these gifts may have been medicinal. The gold may well have been intended to provide economic security with its purchasing power to fund emergency travel, fleeing from Israel to Egypt. Today gold has lost little of its precious metal shine with global trading in the range of US $1300 per ounce (28.349g). However, gold is fast becoming a 21st century medicine 'nano' hero, a potent particle to sensitise cancer cells for photo-thermal destruction, and activate apoptosis. Gold nanoparticles (20-80mA) have the ability to by-pass natural cancer cell defences, and armed with tumour-specific ligands, may increase the specificity of drug delivery without being redistributed elsewhere in the body. Nano-spheres of gold are non-toxic, non-immunogenic and one of the great hopes for a brighter future and longer life in cancer sufferers.

Frankincense has always been a traditional medicine of the East as well as a fumigant in religious ceremonies. The active compounds are Boswellic acids or Pentacyclic triterpenes, from the gum resin of the Boswellia tree. There are four species: the Indian *Boswellia serrata* (olibanum), China's *Boswellia carterii*, Somalia's *Boswellia frereana* and *Boswellia sacra* from the Middle East. The Frankincense bearing wise one might have originated from any one of those 'eastern' lands. AKBA (3-acetyl-11-keto-ß-boswellic acid) is the most active of the Boswellic acids, renowned for its anti-inflammatory properties in osteoarthritis (OA), inflammatory bowel disease and asthma. They are specific inhibitors of leukotriene synthesis; their anti-inflammatory molecular targets are 5-lipoxygenase, human leukocyte elastase, and glycosaminoglycans. Recent *in vivo* and human studies have also suggested some anti-tumour effects in cerebral (glioblastoma) and other tumours exerted through inhibiting topoisormerase I and II alpha, and stimulating apoptosis.

Randomised controlled trials in Knee OA sufferers have reported benefit but similar results have not been shown in rheumatoid arthritis. Trials on inflammatory bowel disease (Ulcerative Colitis and Crohn's) have reported 300-350mg tds B *serrata gum* resin had similar or better remission rates to sulfasalazine (normally used for maintenance). Other in vitro studies of the anti-proliferative, cytotoxic and apoptotic effects of Boswellic acids in cancer cell lines have also shown promise. The recruitment of pro-apoptotic mediators and downstream effector caspases is clear but the primary target protein initializing these apoptotic signals and the precise role of mitochondria remain to be elucidated. Their effects on mental health, on depression, anxiety and memory, are also being investigated.

Myrrh comes from the resinous exudates of trees of the *Commiphora* species (*C. mukul* in India and C. *molmol* in Egypt) and has long been used in Ayurvedic and traditional Chinese medicines as well as to embalm and scent the dead. There are a wide variety of compounds. C. *mukul* is the Guggul tree which has lent its name to the Guggulsterones, with anti-inflammatory, antioxidant, lipid-lowering and anti-tumour, apoptosing properties. Triterpenoids and diterpenoids are mainly responsible for myrrh's anti-inflammatory properties, sesquiterpenoids for anti-microbial, smooth muscle relaxing and analgesic effects, and lignans for cytotoxicity.

Gold, frankincense and myrrh were indeed wise choices for gifts, and offered wealth and health to one who was destined to change the world. Today each of the original gifts, offers new hope and fresh potential. Gold was, that first Christmas, the world's most precious metal, even if today gold frequent travellers have been outranked by platinum and elite, at least when flying kangaroo or koru. It is written these three wise men learned of the birth of Jesus from the stars. The science of medicine is now long parted from astrology, having making a pretty clean break over the past 500 years since the 16th century. Around about that time the third Mughal Emperor Akbar I (1542-1605) ruled and united the Indian subcontinent. He would have been well acquainted with the medicinal and Ayurvedic properties of frankincense, without being able to name the active ingredient 3-acetyl-11-keto-ß-boswellic acid (AKBA), almost his namesake. And two millennia after the first Christmas we may search powered by Google, but in ancient times we should remember that wise men from the East who searched the stars, brought baby Jesus the power of Guggul.

Merry Christmas.

RACS Visitor Grant Program 2017

RUTH BOLLARD
Chair, Fellowship Services Committee

As a Fellowship based organisation, RACS is committed to excellence in surgical education and practice. To assist this, RACS provides funding for scientific visitors of note from Australia, New Zealand and internationally to attend Specialty Society, Association and Sub-Specialty conferences.

RACS is pleased to profile the scientific visitors it has supported in 2017 through the RACS Visitor Grant Program (please see https://www.surgeons.org/member-services/racs-visitor-grant-program/ for further information on the program).

We would like to thank all applicants and congratulate the successful grant recipients.

Australasian Hand Surgery Society (AHSS)

Annual Scientific Meeting, 1-4 March 2017, Melbourne
VISITOR: Dr James Higgins, Chief, Curtis National Hand Center, CNHC Faculty, Alumni
Presentations:

- Vascularized Medial Femoral Trochlear Reconstruction for Scaphoid Non-Union
- Ectopic Banking of Amputated Parts
- Vascularised Medial Femoral Bone Graft
- Refinements in Micro Vascular Reconstruction of the Traumatised Upper Extremity
- Principles of Functioning Muscle Reconstruction and FMR to Replace
- Traumatized -Forearm -Flexors and Extensors
- Osteochondral Reconstruction for Advanced Kienbock's Disease

Australian & New Zealand Society of Cardiac and Thoracic Surgeons (ANZSCTS)

27th Annual Congress of the Association of Thoracic and Cardiovascular Surgeons of Asia (ATCSA 2017), 16-19 November 2017, Melbourne
VISITOR: Dr Michael Borger, Director of Aortic Surgery and the Director of the Cardiovascular Institute at Columbia University Medical Center
Presentations:

- Managing difficult situations in minimally invasive AVR & when to convert
- Rapid Deployment and Sutureless AVR
- Experience with TAVI in the USA and Germany - Different Systems and Approach
- TAVR Valves for the Calcific Mitral Valve

Australian and New Zealand Society for Vascular Surgery (ANZSVS)

ANZSVS 2017 Conference, 13-16 October 2017, Perth
VISITOR: Dr Sebastian Debus, Chairman and Professor of the vascular service of the University Hospital Eppendorf, Hamburg, Germany
Presentations:

- Keynote Lecture: Management of the Marfan patient'
- Invited Paper 'The SPIDER graft – A new concept for TAA repair'
- Invited Paper 'Fast track pathways for open AAA repair'
- Invited Paper 'The new ESVS guideline on mesenteric ischemia'

Australian Orthopaedic Association (AOA)

AOA 77th ASM, 8-12 October 2017, Adelaide
VISITOR: Professor Ian Curran, Vice Dean of Education and Professor at DukeNUS Graduate Medical School in Singapore
Presentations:

- Transforming leadership - exploring the importance of understanding the many different forms of innovation and how different leadership styles can complement or inhibit successful innovation.
- Is it time to rethink competency based education?

Exploring the argument for moving on from competence and competency-based education.

Australasian Society of Aesthetic Plastic Surgeons (ASAPS)

40th Annual ASAPS Conference, 19-22 October 2017, Melbourne
VISITOR: Dr William Adams, Clinical Professor of Plastic Surgery, University of Texas Southwestern Medical Center, Dallas
Presentations:

- Breast, soft tissue and fat: A pundits perspective
- Round or Anatomical Implants
- Augmentation Mastopexy – to stage or not to
- Treating Tuberous Breasts
- Revision of unsatisfactory breasts
- Capsular contracture – 50 years of darkness, now we see light
- Calipers and Cleansing Ales: The process to take Breast Augmentation to the next level
- ALCL: World Experience: What is important for MDs and patients
- US Update/ Micromort Analysis
- Doctor Delivered Media Messaging in Web Marketing

Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS)

ASOHNS ASM, 23-26 March 2017, Adelaide
VISITOR: Professor Robert Jackler, Edward C. and Amy H. Sewall Professor in Otorhinolaryngology and Professor, By Courtesy, of Neurosurgery and of Surgery, Stanford School of Medicine, Stanford, USA
Presentations:

- E-Cigarettes – A Primer For The Otolaryngologist
- Practical Suggestions On Managing Cholesteatoma
- Contemporary Trends In Skull Base Surgery
- Facial Nerve Dissection

Australian Society of Plastic Surgeons (ASPS)

Plastic Surgery Congress 2017, 1-4 June 2017, Gold Coast
VISITOR: Dr J Peter Rubin, Chair of the Department of Plastic Surgery, the UPMC Endowed Professor of Plastic Surgery, and Professor of Bioengineering at the University of Pittsburgh.
Presentations:

- The science of fat grafting and adipose stem cells
- Novel use of fat grafting for face and limb reconstruction
- Operative techniques for the massive weight loss patient: a comprehensive approach
- Preventing and managing complications in the massive weight loss patient
- Staging and combining procedures in MWLP

General Surgeons Australia (GSA)

2017 GSA ASM, 29 September – 1 October 2017, Canberra
VISITOR: Dr Bruce Ramshaw – Knoxville, Tennessee, Professor and Chair, Department of Surgery - the University of Tennessee Medical Center
Presentations:

- Technique of laparoscopic ventral hernia repair
- The management of ventral hernia repair complications
- Mesh explantation analysis
- Keynote address Applying complex systems science to abdominal wall hernia repair
- Implementing a multidisciplinary patient-centered hernia team to improve outcomes

Provincial Surgeons of Australia (PSA)

PSA 2017 ASC – Bookends of Surgical Practice, 19 – 21 October 2017, Armidale
VISITOR: Dr Noah Tapaua, General Surgeon and Cardiothoracic surgeon at the Port Moresby General Hospital, Papua New Guinea, Honorary Senior Clinical Lecturer at the University of Papua New Guinea Medical School and Surgical Coordinator for the surgical Division at the Port Moresby General Hospital.
Presentations:

- Cardiothoracic surgery in PNG
- KEYNOTE: Surgical life in PNG: What rural surgery can do for PNG – A rural perspective

Neurosurgical Society of Australasia (NSA)

NSA 2017 ASM, 30 August – 1 September, Adelaide
VISITOR: Dr Christopher Shaffrey, Director, Neurosurgery Spine Division, University of Virginia
Presentations:

- Complex spinal surgery: Lesson learned the hard way
- Keynote Presentation - Risk Reduction in Major Spine Surgery
- When do degenerative conditions need to be treated with deformity techniques?

New Zealand Association of General Surgeons (NZAGS)

NZAGS Annual Conference 2017, 25-26 March 2017, Palmerston North
VISITOR: Mr Simon Paterson-Brown, Consultant General & Upper Gastrointestinal Surgeon and Honorary Senior Lecturer, University of Edinburgh

- Presentations: Management Of Giant Hiatus Hernias
- Complications Of Upper GI Surgery
- The Role Of Human Factor And Non-Technical Skills In Improving Surgical Outcomes

New Zealand Association of Plastic Surgeons (NZAPS)

NZAPS and ANZSOPS Joint Scientific Meeting, 4-6 August 2017, Queenstown
VISITOR: Dr Michael Grant, Paul N. Manson Distinguished Professor of Plastic and Reconstructive Surgery at the R Adams Cowley Shock Trauma Center, University of Maryland Medical Center, and Professor of Surgery, Program in Trauma, University of Maryland School of Medicine.
Presentations:

- Lower eyelid blepharoplasty: refining the algorithm, management of complications"
- Challenges in primary and secondary orbital reconstruction"
- Individual patient solutions (IPS) in Orbital Reconstruction"

- Digital Workflow in Craniofacial Reconstruction: What have we learned?"
- Applications of Tissue Engineering in Craniofacial Surgery

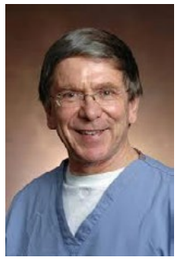
New Zealand Orthopaedic Association (NZOA)

2017 NZOA ASM, 15-18 October 2017, Auckland
VISITOR: Professor Timothy Briggs, Consultant Orthopaedic Surgeon at the Royal National Orthopaedic Hospital Trust
Presentations:

- Innovation in Orthopaedics - John Sullivan Memorial Lecture
- Elective targets in the NHS
- Getting it right first time (Presentation by Professor Briggs followed by a panel in which he takes part)
- Are you feeling harassed about bullying? (Panel)

(New Zealand Society of Otolaryngology Head and Neck Surgery (NZSOHNS)

Australian New Zealand Society of Paediatric Otorhinolaryngology (ANZSPO)
Australian and New Zealand Rhinologic Society (ANZRS)
4th South Pacific ORL Forum (incorporating the annual 70th ASM of NZ society of Otolaryngology HNS, 32nd ASM of Australian and New Zealand Paediatric Otolaryngology, 10th ASM of the Australian and New Zealand Society of Rhinology), 9-12 July 2017, Hawaii



VISITOR: Professor Robin Cotton, Director of the ADEC Program – Head and Neck Surgery, Children's Hospital Medical Center, Cincinnati, USA
Presentations:

- Paediatric Airway - What Next?
- Debate: CTR is better than LTR
- Building a Department and Leaving a Legacy

Urological Society of Australia and New Zealand (USANZ)

USANZ 2017 ASM, 24-27 February 2017, Canberra
VISITOR: Dr Donna Hansel, Director, Anatomic Pathology, UC San Diego School of Medicine
Presentations:

- Evolving reclassification prostate cancer pathology – clinical implications
- Panel Discussion: Small renal masses: role of biopsy and other management dilemmas
- Review of urothelial cancer pathology

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/

John Royston Crellin OAM
General Surgeon

18 July 1941 - 20 August 2017

Bass Coast Health has lost one its notable contributors with the passing of Dr John Royston Crellin OAM MBBS FRACS on 20 August 2017. John commenced practice as a general surgeon at Wonthaggi Hospital in 1973 and served the Hospital in that role with extraordinary commitment until his retirement in 2011.

During that time, John was Honorary Medical Director for 30 years, President of the Board of Management from 1980 - 1992 and senior Vice-President in 1993. As President of the Board he advocated for the hospital to be rebuilt and his energies and determination were rewarded in 1991 with the completion of the acute ward and the administration offices. John was awarded Life Governor of the Hospital.

Lindsay Grigg
Cardiothoracic Surgeon

16 September 1927 - 18 June 2017

Lindsay Grigg undertook his training in Melbourne, and then went to London where he undertook training in cardiothoracic surgery before returning to Australia.

He also worked for a few years in Uganda where he did thoracic surgery and wrote about management of pyopericardium.

Colin Holloway Hooker ONZM
Orthopaedic Surgeon

20 April 1930 - 3 August 2017

Colin Hooker's two passions in life were his profession and his family. With his motto for the way he lived, a quotation from Thomas Huxley, "Try to learn something about everything and everything about something", he participated fully in all life offered.

Colin Hooker was born in Pukeroro just outside Cambridge (New Zealand) the son of James Stanley Hooker, a dairy farmer, and Betty Cohen. He was the second youngest of five children - Aubrey, Desmond, Brian, Colin and Yvonne. Commencing at Cambridge Primary School he next attended Cambridge High school where he excelled, topping New Zealand in School Certificate Latin (helped by learning Latin verbs while milking, these having been carefully written out on paper and pasted on the cow bails). In 1945, at the age of 15, he had to leave school to work on the farm, because his oldest brother had been called up for service in the Pacific.

Raymond Barry King
Vascular Surgeon

30 July 1935 - 23 March 2017

Barry King graduated MB BS from Melbourne University in 1958. After initial postgraduate training at Prince Henry's Hospital and the Repatriation Gen Hospital he went to England in 1966 and gained his FRCS. From 1966 until 1968 he worked with Peter Martin, first at Chelmsford and then at the Hammersmith Hospital. He returned to Australia in 1967 a well-trained general and vascular surgeon. He immediately obtained his FRACS and was appointed to Prince Henry's Hospital and the Western Hospital in Footscray where he established the vascular unit.

A foundation member of the RACS Section of Vascular Surgery, he became Secretary and then President of its successor, The Australian and New Zealand Society for Vascular Surgery (1995-97). He subsequently became vice president of the International Society of Vascular Surgery. He served on training and examining bodies of the RACS while an active surgeon and on retirement he served on the Heritage and Archives committee. He enjoyed showing visitors around the college treasures to which he donated several significant historical books.
Thanks to Mr King for his generous bequest to the Foundation of Surgery

John Garland Lester
Orthopaedic Surgeon

15 January 1933 - 4 March 2017

John Lester was born in Christchurch, the eldest child of Stephen Lester (a stock and station agent) and Eleanor West-Watson (secretary to her father, Bishop of Christchurch). He had a younger sister, Elizabeth, and brother, Michael. John commenced school at Fendalton Open Air Primary School and then attended Christs College. At College John excelled at sport, playing rugby for the 1st XV and cricket for the 1st XI - as captain in his final year. He went on to represent Canterbury in the Brabin Cup team.

In 1951 he commenced at Otago University gaining entry to the Otago Medical School the following year. During his time in Dunedin he resided at Selwyn College, his entry into which was no doubt helped by his grandfather being the Anglican Archbishop of New Zealand. John graduated MB ChB in 1956 and the next year worked in Greymouth spending time with the then legendary West Coast surgeon, Steve Barclay. With his appetite for surgery stimulated, John sailed for the United Kingdom working his passage as a cargo ship doctor.

Nigel Philip Michael Sacks
General Surgeon

23 March 1957 - 7 July 2017

Nigel Sacks FRACS, FRCS (Eng Hon), FACS died Friday 7 July in Melbourne. Nigel was a member of BreastSurgANZ and a Consultant Breast and Oncoplastic Surgeon at Maroondah Breast Clinic and Eastern Health, and Senior Lecturer at Monash and Deakin Universities.

He was also my friend and teacher for more than 25 years and I will miss him dreadfully.

A University of Melbourne graduate (1980), Nigel trained in surgery first at the Royal Melbourne and later in the UK in Nottingham, Oxford and Guilford. He was appointed consultant surgeon to the Royal Marsden Hospital in 1990 at age only 33, which is where I first met him. His extraordinary surgical skills, sharp brain, love of art and great love of life made him an ideal teacher of us young surgeons (well only just younger than him!). Nigel was a great innovator being one of the first to adopt reconstructive surgery and in 1997 sentinel node biopsy. I have just done a therapeutic reduction mammoplasty this morning in Perth-a procedure Nigel taught me back in the early 1990s.

George John Alexander Wilson
Otolaryngology Head & Neck Surgeon

7 June 1925 - 27 May 2017

George Wilson was a pioneer of ENT surgery to the people of Northland, providing a marvellous regional service for over 30 years. He was the sole ENT surgeon in the region for 26 years and during that time made a major contribution to improved hearing.

George was born in Auckland to David Wilson (a plumber) and Edna Flannery (a registered nurse). He had two younger siblings - David (Buster) and Mary. George attended Whau Valley Primary School and subsequently Whangarei Boys High School. He commenced medical intermediate at Otago University in 1943 entering Medical School the following year.

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:

Lindsay Grigg (ACT)
Alan Donald Hewson (NSW)
Raymond Barry King (VIC)
Beverley Lindley (NSW)
Geoffrey Claude Morlet (WA)
Brian Otto (NZ)
John Simpson (NZ)
Maxwell Bruce Simpson (NSW)

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

Case Note Review

Late Prosthetic Valve Endocarditis

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

Case summary

This case study describes the management and outcome of a patient in their seventies with a remote history of an aortic valve replacement who presented to another hospital with a history of fever and feeling unwell. Investigations at that hospital revealed a severe paravalvular leak due to partial valve dehiscence and signs of endocarditis. The patient was transferred to a hospital with cardiac surgery services.

The patient spent some weeks being treated with intravenous antibiotics, with evidence of some left ventricular failure (LVF) and slowly worsening renal function. Surgery was delayed until some 5 weeks after admission on the basis of no obvious sepsis and stable cardiac failure. Surgery was planned to be aortic valve replacement (AVR) and mitral valve replacement, but only AVR was done (Possibly due to lessened mitral reflux [MR] on intraoperative transoesophageal echocardiography [TOE]).

The immediate postoperative course was marked by bleeding, with massive transfusion and two returns to theatre for control. The patient remained intubated and ventilated in the intensive care unit (ICU) for quite some days. He had slow atrial fibrillation (AF), complete heart block and was VVI paced via external wires at a rate of 60. After being extubated, the patient developed type II respiratory failure and was re-intubated after 14 days. A few days later, a surgical tracheostomy was performed to facilitate weaning. The patient was deconditioned and had problems with sputum retention. The patient was also noted to be auto-anticoagulated with international normalised ratio >2 and elevated activated partial thrombin time on minimal heparin.

Two weeks later, a transthoracic echo showed satisfactory function of the aortic bioprosthesis, severe MR, moderate mitral stenosis. The patient was slowly weaned from the ventilator and had an uncuffed tracheostomy tube in situ. Again, about two weeks after this, there was an unplanned decannulation. The patient had been coping, so recannulation and re-intubation was not needed.

A few days later, the patient's level of consciousness deteriorated. A computed tomography (CT) brain scan showed multiple old infarcts and a new bleed. This resulted in a revision of the anticoagulation strategy. The patient was returned to ICU with further respiratory failure, secondary to LVF, and a pleural effusion. Re-intubation was required a few days later, possibly as sepsis also became apparent. More brain imaging showed further bleeding and the tracheostomy was reinserted. At about this time, a family conference was held and, with the patient's agreement, further extra-ordinary measures were ruled out. A one-way wean was agreed. At this stage, the patient was showing signs of increasing Type II respiratory failure and after more than 90 days in hospital, he passed away.

Clinical lessons

The patient's course was well documented in the chart, which facilitated this review. There are a number of issues to be considered. Whether any of these may have altered the outcome of course is less certain.

- Time from diagnosis to surgery. This was quite prolonged. There was evidence of ongoing cardiac failure and renal impairment. Despite the apparent control of sepsis, the patient had aortomitral discontinuity with a severe paravalvular leak. Early surgery, after a few days of appropriate antibiotics, was probably indicated here. This may have also contributed to the conduction disturbance.
- Ongoing bradyarrhythmia. There was a reluctance for insertion of a permanent pacemaker (PPM), but also either failure of the epicardial wires or lack of use. Pacing at around 90, especially postoperatively, may have improved the cardiac performance. The reluctance to insert a PPM is also an issue. The proximity of the conducting system to the site of infection should have raised some concern, and the development of a high grade block expected.
- Residual significant cardiac pathology. The patient was left with haemodynamically significant MR after the operation. This was a major contribution to the outcome. The risk of double valve replacement in this situation was greater, but the risk of a poor outcome was raised even more by failing to correct the mitral pathology. A TOE under a general anaesthetic is very artificial and needs to be carefully considered before accepting that as the usual situation.
- With the advantage of hindsight, given the relatively recent history of a cerebrovascular accident and the difficulties with swallowing, a CT brain scan preoperatively may have altered the strategy. The multiple bleeds in the latter part of the patient's stay certainly contributed to the outcome.
- Anticoagulation. Again, maybe avoiding anticoagulation, despite the ongoing AF, may have helped. Just aspirin may have been adequate.

Prosthetic valve endocarditis is a challenge for the whole team that manages such cases. This case demonstrates nearly all of those challenges. Overall, the management was appropriate and well documented.

MALT records 2 millionth procedure

Morbidity Audit and Logbook Tool (MALT) recently celebrated the recording of the two millionth procedure. The procedure was a successful gastroscopy done by Dr Tara Luck, a General Surgery Year 3 Trainee, as primary surgeon at Box Hill Hospital on the 30th August under the supervision of Peter Grossberg.

Mr Peter Grossberg and Dr Tara Luck

Did you know?

- An average of 50,000 procedures are recorded in MALT each month.
- Work is underway to make entering data easier. A MALT App is being developed that will allow data to be entered with or without internet connectivity.

We love to hear your feedback – contact malt@surgeons.org

– Dr John Treacy FRACS, Chair, Morbidity Audits Committee
With Katherine Economides, Manager, Morbidity Audits

Cutting a cake to celebrate MALT 2 Million Procedures: Prof Guy Maddern, Adrian Anthony, Christine Lai, Glenn McCulloch, Phil Worley and John Treacy (Adelaide, August 2017)

Image: Mr Allan Panting and
Past President Mr Phil Truskett AM

Congratulations!

MR ALLAN PANTING FRACS

Induction into Membership of the Court of Honour

Allan Graduated MB ChB from the University of Otago in 1970. He attained FRCS Edinburgh in 1977 and FRACS in Orthopaedic Surgery in 1978. Allan spent most of his training years in Christchurch before spending his Fellowship years in Melbourne and Edinburgh. Allan began his consultant career as a tutor-specialist in Christchurch before moving to Nelson in 1980.

Allan has provided overseas aid to Qui Nhon, Vietnam through the New Zealand Vietnam Health Trust participating in seven trips up until 2006. The Vietnamese community has benefited immensely from Allan's assistance is developing basic trauma services in that country.

Allan has been a Past President of the New Zealand Orthopaedic Association as well as holding many other positions of responsibility within the Association. Allan has been instrumental in developing New Zealand's national web-based surgical prioritisation system for a number of specialties and is a strong advocate for patient's equitable access to surgical services.

For many years Allan has served RACS in a number of capacities as well as service to the NZMA, the NZ Federation of Sports Medicine, the New Zealand Orthopaedic Association, and many community groups.

Allan has served as an examiner for RACS, and held the position of deputy chair of the Court of Examiners for New Zealand. Allan has been the recipient of the RACS Colin McRae Medal and the New Zealand Order of Merit.

Most recently Allan has been the Executive Director for Surgical Affairs (NZ) for RACS, a post that he held for six years. Allan's contribution in this role was exemplary, particularly for his support of the welfare of colleagues. He represented RACS at a high level at Government, Ministry of Health, Health Workforce New Zealand, the Health & Disabilities Commission and the ACC. In this post he was well, and still is, respected by his peers, College Councillors, College staff and the community at large.

Allan continues to serve RACS by researching and writing obituaries for recently deceased Fellows, contributing to the RACS ASC 2016 as an invited guest speaker and mentoring the current EDSA (NZ).

Allan is certainly worthy of his election to the RACS Court of Honour.

Citation kindly provided by Mr Richard Lander FRACS

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