SurgicalNews

www.surgeons.org | October 2018, Vol 19, No 9

SurgicalNews | October 2018, Vol 19, No 9

www.surgeons.org

GAMMA KNIFE SURGERY

Revolutionary surgery successfully treats neurosurgical patients

ROAD SAFETY

The Inquiry into the National Road Safety Strategy 2011-2020

TRISTATE ASM

Highlights of this year's Tristate Annual Scientific Meeting

Travelling for RACS business

RACS has engaged Corporate Traveller as the preferred travel supplier to manage domestic and international travel services for RACS related business.

RACS has implemented an online booking tool through Corporate Traveller called Serko which will manage all your travel needs including flights, hotels and car hire online.

Log on to the RACS website http://portfolio.surgeons.org and under useful links select

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

BENEFITS TO TRAVELLERS

- Serko is available 24/7
- Automatic pre-approval authorisation
- Charge-back of hotel rooms to Corporate Traveller
- Simplified reimbursement process
- Personalised profile to select preferred seats, meals and any dietary requirements
- Memberships and frequent flyer details included
- Expedia is built into the online booking tool
- Flight discounts with Qantas and Virgin exclusive to RACS

CORPORATE TRAVELLER

Lucienne Oriander
Telephone: + 61 3 8535 1620
Email: lucienne.oriander@corporatetraveller.com.au
Website: https://www.corporatetraveller.com.au/

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Telephone: +61 3 9249 1220
Email: travel@surgeons.org
Website: www.surgeons.org

CONTENTS

RACS leadership group

President's perspective 4
Vice President's message 6

Articles of interest

Revolutionary precision of Gamma Knife Surgery successfully treats neurosurgical patients 8
Inquiry into the National Road Safety Strategy 2011-2020 12
Northern Territory, Western Australia and South Australia Annual Scientific Meeting 14
Hospital safety standards whistleblower to speak at RACS ACT ASM 18
Transplantation in Nepal: Ten years on 20
Thoughts on regional and rural practice 22
Tasmanian trauma meeting to highlight the dangers of gun violence 24
Fellowship Services 26
Topical issues for Australian surgeons 28
Dr BB-G-Loved 33
Should I be on LinkedIn 36
Beginners guide on how to form a union 38

Research

Study points to major advance in hip surgery for young patients 10
College supports world leading orthopaedic surgery research 16
"Nobody is going to be there to tell them" 48
A case note review 52

Education & development

Workshops 40
Skills training courses 43

Archives

The Great War ends... 50
Donations to the library collection 57

Above: Delegates sit down to dinner during the Tristate ASM at the Alice Springs Telegraph Station

Correspondence and Letters to the Editor to *Surgical News* should be sent to: surgical.news@surgeons.org
Surgical News Editor: Mary Harney, CEO T: +61 3 9249 1200 | F: +61 3 9249 1219 | W: www.surgeons.org
ISSN 1443-9603 (Print)/ISSN 1443-9565 (Online).
© Copyright 2018 - Royal Australasian College of Surgeons. All rights reserved.

All copyright is reserved. The editor reserves the right to change material submitted. The College privacy policy and disclaimer apply - www.surgeons.org. The College and the publisher are not responsible for errors or consequences for reliance on information in this publication. Statements represent the views of the author and not necessarily the College. Information is not intended to be advice or relied on in any particular circumstance. Advertisements and products advertised are not endorsed by the college. The advertiser takes all responsibility for representations and claims. Published for the Royal Australasian College of Surgeons by RL Media Pty Ltd. ACN 081 735 891, ABN 44081 735 891 of 129 Bourverie St, Carlton Vic 3053.

RACS advocacy produces good results

During the last few months we have shone the spotlight on a number of issues that RACS has been advocating strongly for and which have produced some good results.

Over the past decade there has been a boom in demand for cosmetic surgery. The decision to undergo cosmetic surgery is an individual one, and it is not my intention to encourage or to dissuade any one from going down this path. However, recent media attention, particularly the episode featured on ABC TV Four Corners titled 'Beauty's New Normal,' has shown some of the worst and most disturbing aspects of the profession.

It highlighted why it is so important for the public to understand the risks associated with any medical procedure, and why individuals should always be encouraged to investigate the qualifications of their treating practitioner.

A quick Google search for 'cosmetic surgery' will return many results for 'surgeons' in your area. It would be natural for a member of the public to assume that a doctor who calls himself or herself a surgeon has undergone the rigorous training program required by RACS.

But as we know, cosmetic surgery is not a strictly regulated area of surgical practice. While all medical practitioners must be registered under health practitioner regulation laws and comply with the standards and guidelines issued by the Medical Board of Australia, these do not specify the level and quality of post-graduate training that must be completed before a practitioner can refer to themselves as a surgeon.

Consequently, as opposed to the rigorous training that FRACS surgeons undertake, the Four Corners episode highlighted that some of the practitioners claiming to be cosmetic surgeons, have as little as two days' worth of formal specialist training.

RACS and the Australian Society of Plastic Surgeons have called for increased regulation at a state, territory and national level to ensure safe cosmetic surgery practice over a number of years. The RACS NSW Committee has been very active in engaging with the NSW Health Minister, the Honourable Brad Hazzard and others on this issue. Specifically, we have reiterated that further protections need to be put in place, particularly around confusing naming and that the title 'surgeon' should be protected for use by Fellows of recognised organisations such as RACS.

Delegates gather for the opening night traditional welcome from local drumming group, Drum Atweme.

On another note, I would like to extend my congratulations to our Northern Territory colleagues for the fantastic work they have done in bringing about change to the Territory's alcohol laws to combat issues such as the highest levels of both alcohol related hospitalisations and deaths in Australia.

In early 2017 the Gunner government established an Expert Advisory Panel to conduct a review of alcohol policies and legislation in the Northern Territory. RACS made a submission to this review, which focussed on the College's long standing position to reduce alcohol related harm.

While we were hopeful that the review would bring about positive change, we were delighted by the comprehensive nature of the recommendations. In total 220 recommendations were made in the review, all bar one of which were given bipartisan support by the Northern Territory parliament.

The review received widespread praise across the health sector, including being described by the Foundation for Alcohol Research and Education as one that would transform the Northern Territory from lagging behind the rest of the country to become a national leader.

RACS has been supporting the government's gradual implementation of the recommendations from the Review, often in the face of opposition from the alcohol industry. As an example, legislation was recently introduced in parliament which will make the Northern Territory Australia's first jurisdiction to put a floor price on alcohol.

The Health Minister, the Honourable Natasha Fyles, recently attended the Tristate RACS Annual Scientific Meeting in Alice Springs, where she signed a Memorandum of Understanding with RACS. While at the meeting, the Minister personally thanked RACS for the hard work that has been done in bringing about change in this area. She cited the example of minimum unit pricing and acknowledged that these types of reforms are made much easier when organisations like RACS decide to advocate for principled positions on public policy.

Finally, the last edition of *Surgical News* featured a story about the Tasmanian government's plans to loosen the state's gun laws. In the article the Chair of the RACS Tasmanian Committee, Mr David Penn, outlined risks involved with removing them. He also highlighted why this is such a pertinent issue in Tasmania, given that many of our surgeons operated on victims of the Port Arthur massacre. This was a tragic event, and the key reason why our gun laws are now some of the strongest in the world.

I am pleased to be able to update everyone that the planned changes have now been abandoned. The government noted that deeply held concerns and a lack of confidence from the community as the reasons behind its change in position.

This is an excellent result for Tasmania, and I commend my colleagues for their tremendous efforts. Their ongoing advocacy was critical in ensuring that common sense prevailed.

Well done to all for the hard work in these various areas of important advocacy. I look forward to working with you all to ensure that we continue to take informed and principled positions on issues of public health.

Mr John Batten
President

2019
RACS Diary

Place your order now for the 2019 RACS pocket book diary!

We are pleased to provide these on an 'opt in' basis to Fellows, Trainees and IMGs.

If you would like a RACS diary, please email Reception.Desk@surgeons.org with your RACS ID number and mailing address details or phone +61 3 9249 1200 .

The diary will be mailed to you within a few weeks.

Strengthening recertification for vocationally registered doctors

It's the best practice

RACS has been working closely with the Medical Council of New Zealand (MCNZ) and the Medical Board of Australia (MBA) as they undertake a review of their competency standards for medical practitioners. While the RACS Continuing Professional Development (CPD) program is closely aligned with current standards, RACS has commenced its three yearly review of the program to ensure it continues to meet the needs of Fellows and the regulators.

In reviewing the standards, patient safety remains the focus for both regulators with the aim to support doctors to maintain competence, ensure high standards of practice to strengthen accountability to the public, and provide safe, high quality care.

In September, RACS held a CPD workshop with representatives from across the Fellowship, specialities and special interest groups, that included a presentation from the MBA. RACS also attended the MCNZ annual meeting with medical colleges where the future of CPD was discussed. These consultations form the basis for the future of RACS CPD and will continue as the review progresses.

Consultation on New Zealand standards

The MCNZ continues to consider requirements for CPD and a vision and set of principles was proposed for consultation to encourage debate and discussion among the wider health sector. The vision and principles agreed upon in 2016 include:

- Evidence-based
- Formative in nature
- Informed by relevant data
- Based in the doctors actual work and workplace setting
- Profession-led
- Informed by public input, and
- Supported by employers.

Feedback from the MCNZ consultation however, indicated the need for further guidance on how medical colleges could develop their CPD programs to align with these vision and principles. A proposal outlining a strengthened approach was put forward by MCNZ, and in 2017 sector feedback was sought. This feedback provided the foundation for an approach which is profession-led and appropriate to the scope of practice, peer reviewed, evidence based, and relevant to the work setting.

In 2018 MCNZ sought further comment and reviewed the new strengthened approach towards CPD, and a Recertification Working Group will be making recommendations to MCNZ. These recommendations will be made available before implementation, and any proposed changes will be made in close consultation with the Medical Board of Australia (MBA).

Consultation of Australian standards

Actively taking part in the Australian Medical Council (AMC) accredited CPD programs that encourage regular reflection, collaboration with peers, and performance feedback is the core of the Medical Board of Australia's Professional Performance Framework, (the Framework) released late in 2017.

The Framework is based on five pillars:

- Strengthened CPD
- Active assurance of safe practice
- Strengthened assessment and management of medical practitioners with multiple substantiated complaints
- Guidance to support practitioners
- Collaborations to foster an open and transparent culture

The MBA has determined that the cornerstones of life-long learning is CPD, which is useful to the individual and shown by evidence to help to provide safe patient care utilising contemporary adult education.

Under the MBA's proposed changes designed to strengthen CPD, doctors will:

- choose an accredited CPD 'home' (specialist medical college or alternate AMC accredited provider)
- develop a Professional Development Plan (PDP) for each CPD period, which outlines their current scope of practice and documents their individual professional development needs and the activities they plan to undertake
- undertake a minimum of 50 hours per year of CPD activities that meet the requirements of their chosen CPD program and the revised Board registration standard for CPD
- allocate their minimum CPD requirements proportionally across three types of activities - educational activities, activities based on performance review and activities focused on measuring outcomes
- complete and reflect on their CPD activities as they prepare their PDP for the next year

It is important to note the MBA has stated that the Framework is not designed to increase the amount of CPD that doctors undertake, but to make sure the CPD is useful to them and shown by evidence to help them provide safe patient care.

When considering the future of the RACS CPD program the needs of the Fellows and the requirements set by the regulators will continue to form the primary consideration of the review. While we know the current CPD framework is closely aligned with current standards, any changes to the RACS CPD program will come into effect in 2020.

Ms Cathy Ferguson
Vice President

Mr John Fuller

Revolutionary precision of Gamma Knife Surgery successfully treats neurosurgical patients

New South Wales neurosurgeon Mr John Fuller earlier this year used Gamma Knife Surgery to treat an 11-year-old boy with a life-threatening arteriovenous malformation (AVM).

Mr Fuller conducted the treatment at Macquarie University Hospital (MUH) in Sydney to save the life of Jack Ottens, one of the youngest children to undergo such treatment in Australia.

The Melbourne boy, who had been born with the condition, had suffered two haemorrhages in the months before treatment but the location of the AVM made conventional surgery too dangerous.

After discussing the case with his neurosurgical and neurovascular colleagues in Sydney and the Mayo Clinic in the US, as well as designing the treatment in collaboration with radiation oncologists at MUH, Mr Fuller performed the Gamma Knife Surgery in July.

One of only two such systems currently in use in Australia, the Gamma Knife delivers radiation from 192 cobalt sources that converge on the focal point inside the machine, utilising a stereotactic frame positioned around the patient's head.

Unlike commonly used linear accelerator (LINAC) systems which emit X-rays, Gamma Knife Surgery allows neurosurgeons and radiologists to deliver precise doses of radiation conforming to the treatment area with a steeper dose gradient to reduce the potential damage to surrounding healthy brain tissue.

The MUH was the first hospital in Australia to purchase the equipment in 2010 and is one of the few in Australia to provide stereotactic radiosurgery under the direction and management of neurosurgeons in collaboration with radiation oncologists.

Mr Fuller said Gamma Knife Surgery for AVMs worked through the reaction of the blood vessels to the radiation in which scarring developed over time so that there was no more blood flow through the malformation.

He said there was no way to tell yet if the treatment had been a success and that Jack would undergo periodic MRI scans over the next few years and if they showed that the AVM had been obliterated, an angiogram would be done to confirm it.

"If Jack's AVM was not located in an eloquent part of the brain we could have operated, removed it and the risk of another haemorrhage would have disappeared in an instant but we couldn't do that without causing significant morbidity," Mr Fuller said.

"He had been diagnosed with the AVM six years before we treated him and had undergone LINAC stereotactic radiosurgery but unfortunately still had a residual AVM and while we know that the effects of radiation are cumulative, we believed that Gamma Knife Surgery offered less risk than repeating his previous treatment.

"There is a small risk that he could develop a neurological deficit or develop tumours later in life but we decided that the risk was worth taking given that he is so young and has potentially another 60 to 70 years of life ahead of him."

Mr Fuller was the first neurosurgeon in Australia to learn Gamma Knife Surgery techniques after spending time in Sweden in 2010 and is now one of only a small group of neurosurgeons in Australia to provide the treatment.

He said while the underlying technology had been developed in the 1960s, the new generation technology allowed for revolutionary precision and was now most commonly used to treat brain metastases, acoustic neuromas and meningiomas located in the skull base.

The radiation is delivered utilising a stereotactic frame attached to the patient's head. Using 192 cobalt radiation sources, the machine converges the gamma rays into an isocentre with the precision of less than a millimetre.

Mr Fuller said once the planning is determined by the team, the delivery of the treatment is fully automated to deliver the treatment as a day procedure.

He said that Gamma Knife Surgery was so accurate and effective that it had so far been shown to obliterate 90 per cent of metastatic brain tumours and halt the growth of 95 per cent of acoustic neuromas while delivering only a fraction of the radiation otherwise delivered through whole brain radiation.

> "Because we can focus the radiation with such precision, we can increase the dose while reducing the damage to healthy brain tissue"

"This means there are fewer side-effects in terms of cognition and memory and we only know this because people who develop metastases through such diseases as breast or bowel cancer are surviving longer than ever before allowing us to track their progress."

Mr Fuller said that most radiation clinics that offer similar treatment to Gamma Knife Surgery were run by radiation oncologists, with little neurosurgical input, but that MUH had taken the early decision to place the treatment within the Neurosurgery Department collaborating with radiation oncologists.

He said that decision had augmented the success of the treatment.

"Radiation oncologists know a great deal about radiation and the biology of disease but they know less about the anatomy of the brain," Mr Fuller said.

"We have a better understanding of what we are looking at, what might have been done through previous treatments, what parts of the brain to avoid and how best to limit any damage to healthy tissue.

"At the MUH we work as a multidisciplinary team, planning the procedures between us in exquisite detail so that only the target, which can sometimes be extremely small, receives the radiation."

Mr Fuller said the MUH treated approximately 100 patients per year with Gamma Knife Surgery but that it was underutilised because it did not have a Medicare Item Number and was only part-funded through the Medicare Safety Net.

He said the MUH offered Neuro-oncology and Neurovascular Fellowships to provide training in the technology, while all registrars and Trainees on rotation were exposed to Gamma Knife Surgery techniques.

"A lot of surgeons might be familiar with the LINAC system of radiation therapy but few would be familiar with Gamma Knife Surgery even though it is extremely effective in treating a range of intracranial conditions," he said.

Mr Fuller said he will continue to monitor Jack's progress through scans that can be performed in Melbourne under the ongoing supervision of his original neurosurgeon.

With Karen Murphy
Surgical News journalist

Professot Richard de Steiger

Study points to major advance in hip surgery for young patients

The results of a world-first study conducted in Australia could dramatically change the surgical care and management of younger patients requiring total hip arthroplasty (THA).

Victorian Orthopaedic Surgeon Professor Richard de Steiger has found that the use of a strengthened polyethylene in THA has led to a dramatic five-fold reduction in the rate of revision surgery for patients aged under 55 years.

The study was based on 16 years of data collected by the Australian Orthopaedic Association's National Joint Replacement Registry (AOANJRR).

It represents the most comprehensive analysis of the reliability and durability of cross-linked polyethylene (XLPE) in THA yet undertaken in the world.

Professor de Steiger and the team at the Registry analysed the outcomes of more than 240,000 patients who had undergone THA surgery, comparing the revision rates of patients with XLPE components against those with conventional polyethylene (CPE).

Over a 16-year period for all patients receiving a THA that had a polyethylene bearing surface, the study demonstrated a cumulative rate of revision surgery of 11.7 per cent in the CPE group against only 6.2 per cent in the XLPE group of patients.

He said that after adjustment for other risk factors, patients with CPE implants were about three times more likely to have revision surgery after nine years, compared to those with XLPE implants. Revisions directly related to the wear of the bearing surface occurred in 0.81 per cent of procedures that used CPE versus 0.05 per cent of procedures that used XLPE components.

However, Professor de Steiger said the most exciting finding related to the outcomes for younger, more active patients having THA.

"We conducted a subgroup analysis focused on approximately 18,000 patients who underwent THA before age 55 and found that the 15-year cumulative rate of revision was 17.4 per cent in the CPE group versus only 6.6 per cent in the XLPE group," he said.

"At seven years, younger patients with CPE hip prostheses were about five times more likely to need revision surgery.

"The most common cause of long term failure in hip replacement surgery has been loosening of the prosthesis caused by the wear of the bearing surface.

"There have been a number of attempts to address this, including the disastrous trials of using metal on metal, but only now do we have the data to show just how durable and tough XLPE components are."

Professor de Steiger is the Victor Smorgon Chair of Surgery at Epworth Healthcare and University of Melbourne, the immediate past President of the International Society of Arthroplasty Registries and the Deputy Director of the AOA National Joint Replacement Registry.

He described the durability of XLPE surface bearing components as representing a significant advance in orthopaedic surgery.

"The average age for hip replacement surgery is 68 which means that many people will not need revision surgery so the results of our study are particularly relevant for younger patients who may need such surgery due to early onset osteoarthritis, the sequalae of childhood hip diseases or osteonecrosis," Professor de Steiger said.

"Until recently, if we performed THA on younger patients, we could predict they would need revision surgery over the course of their life and thus we have often deferred surgery.

"However, this analysis suggests some young patients may only need one revision if XLPE components are used which could radically alter how we treat and manage these patients."

Professor de Steiger conducted the study as one arm of PhD research titled *Improving Outcomes of Hip and Knee Replacement Surgery* through the School of Public Health at the University of Adelaide.

He said the new polyethylene was developed by researchers in Boston to solve the problem of wear occurring in the bearing surface of components and used a process by which the conventional polyethylene molecules were bonded together through exposure to radiation to strengthen the material.

Introduced into Australia in 1999, the use of XLPE components rose dramatically during the study period from approximately nine per cent of implants with polyethylene bearings in 2000 to 97 per cent by 2016.

Stainless steel and ultra high molecular weight polyethylene hip replacement

Professor de Steiger said the AOANJRR had waited to conduct the study so that there was enough data over a long period to ensure the research was as thorough as possible and said the study was the most comprehensive of its kind undertaken anywhere in the world.

"We have the second largest joint replacement registry in the world behind the UK and we collect such sophisticated data that it has gained the attention and respect of leading orthopaedic organisations from around the world," he said.

"This study is the most comprehensive follow-up of its kind undertaken anywhere and puts the results out there for everyone to analyse," he said.

"We can now show that the use of XLPE makes THA – already one of the most effective operations – even better than it has been in the past.

> "Wear-related and implant-longevity issues are particularly important in younger patients who are generally more active and have a longer life span than their older counterparts, but I think the results of this study show that we can treat patients earlier, thereby reducing their pain and improving their mobility, which would be wonderful."

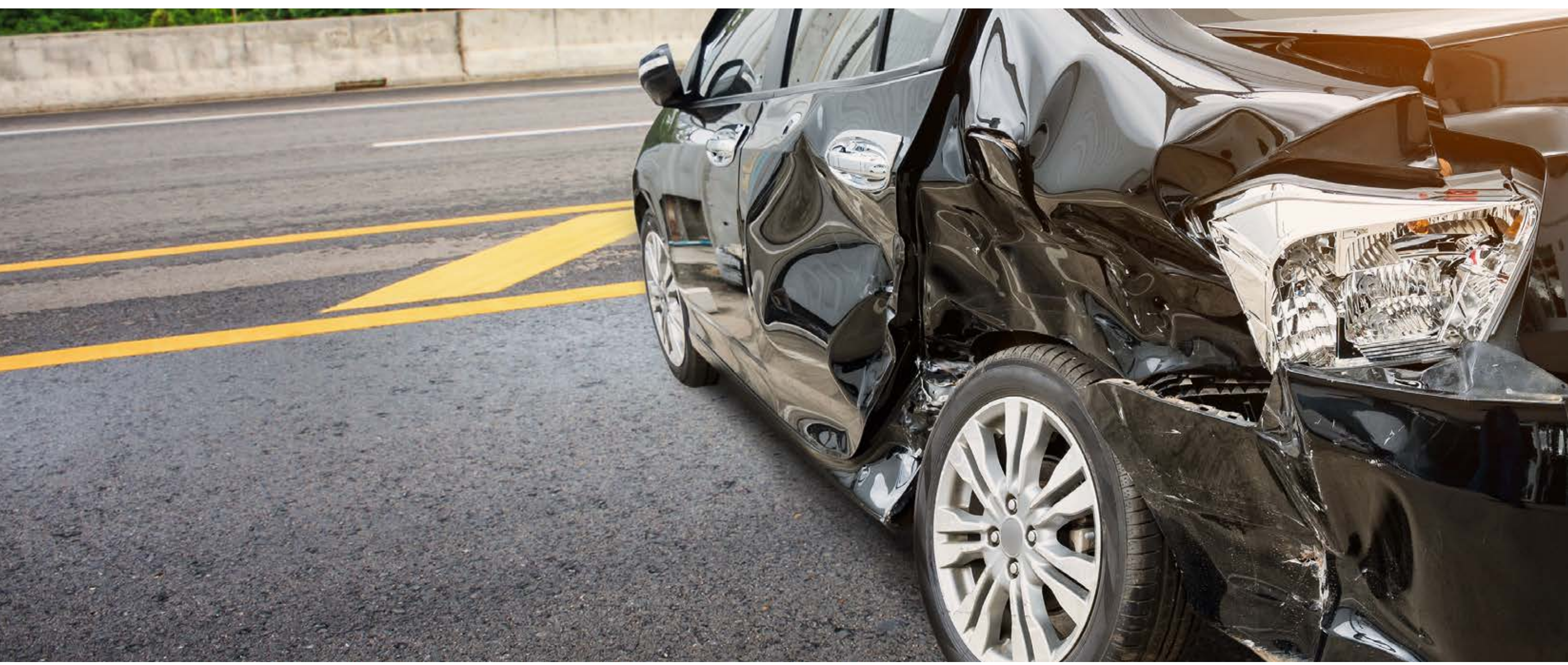
"We believe that the evidence of reduced long-term wear with XLPE is now so strong that, when a polyethylene bearing surface is used for THA, it should be XLPE particularly in younger patients."

The results of Professor de Steiger's study were published in the August issue of *The Journal of Bone and Joint Surgery.*

Professor de Steiger said he believed the use of bearing surface components made from conventional polyethylene would be phased out and urged patients to ask their orthopaedic surgeon that, if they were to use polyethylene when performing THA procedures, to ensure they used XLPE.

He also said that while XLPE components cost slightly more than conventional polyethylene, the reduced need for revision surgery easily compensated for the cost.

With Karen Murphy
Surgical News journalist



Inquiry into the National Road Safety Strategy 2011-2020

The Inquiry into the National Road Safety Strategy 2011-2020 (NRSS) launched last week, made 12 recommendations to lift the management of road safety to another level to ensure effective implementation of so many well-known actions to reduce road trauma.

The Inquiry was led by Associate Professor Jeremy Woolley from the Centre for Automotive Safety and Dr John Crozier, Chair of the RACS Trauma Committee, with support from Mr Lauchlan McIntosh, President of the Australasian College of Road Safety and Mr Rob McInerney, CEO of the International Road Assessment Programme. The amount of work grew as the Inquiry progressed, as did the voluntary efforts of the team.

Inquiries into road safety have come and gone and there has been much duplication in the various recommendations, yet limited action.

The Inquiry received many submissions and in its deliberations the panel determined that rather than try to prioritise actions, or ensure the implementation of effective programs, a new level of stimulus and accountability was essential.

Some stakeholders may not agree with all of the conclusions and recommendations made, but it is doubtful anyone would disagree with the need for substantial reform and significant resource allocation to 'halt the carnage'.

The Inquiry report was received in Parliament House on 12 September by the Deputy Prime Minister and his new ministerial team, in the presence of and support from the Shadow Minister for Transport and Infrastructure. However, specific actions on the recommendations are yet to be agreed.

There has been some discussion by the Government and Opposition about including recommendations from this latest Inquiry into the political parties' political platforms for the next election. While this has merit, it overlooks any urgency to act to reduce road trauma now.

The Inquiry recommended a "Governance Review" (Recommendation 6) be undertaken and completed by March 2019. This Review would:

- Engage Australian and global road safety experts to undertake a formal road safety governance review using established global procedures with reference to leading relevant countries (for example, Sweden, Norway and the UK).
- Through the Transport and Infrastructure Council and related health and welfare portfolios, agree on options to host the new national road safety entity. This should include consideration of suitable structures that capture areas for federal leadership and how state-led and other agencies and their organisational responsibilities can be best supported to provide an efficient Australian response to the road safety crisis and support for neighbours in our region.
- Confirm the host organisation/structure, budget and accountabilities for the new national road safety entity.
- Identify national priority investments that will create stimulus and scale across all jurisdictions at all levels of government.
- Recommend any skill development and capacity building priorities (including tertiary education) to be implemented during the National Road Safety Action Plan 2018–2020.

For that Review to happen and be completed on time, either the Federal Department or representatives on the Transport and Infrastructure Senior Officials' Committee need to commission the review quickly. This is realistic, achievable and necessary if the latest set of recommendations is to be implemented prior to the next NRSS.

The Inquiry did not specify exactly how the Review should be completed, but did outline the reasons for it, as well as some potential mechanisms and guidelines (see p50-51 of the Inquiry report). While specific decisions should be left to governments, the Review is a vital first step to lift road safety management in every jurisdiction and every local government area.

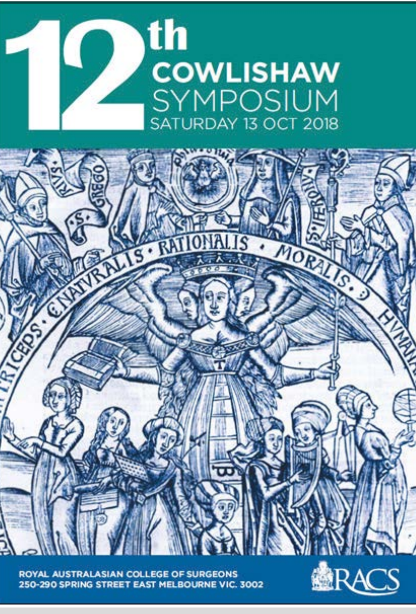
The NRSS Inquiry also recommended introducing the concept of 'mainstreaming' road safety in all government activities (Recommendation 10 - Make road safety a genuine part of 'business as usual' in all levels of government) which could be commenced by introducing the concept through the Transport & Infrastructure Council (TIC) and through the ministerial expectations of both the National Transport Commission and Infrastructure Australia. Their current 'expectation' briefs do not mention safety and with some new Ministers now in relevant positions this could be acted on immediately.

Deputy Prime Minister Michael McCormack is keen to discuss the Inquiry Report at the Transport Infrastructure Council meeting attended by all ministers responsible for infrastructure and road safety on 9 November this year. There is likely to be a special meeting of senior infrastructure officials on road safety prior to November to prepare for that.

The Inquiry's recommendations will be outlined at the Australasian Road Safety Conference in early October, and the Deputy Prime Minister is expected to make some comments in his address at the conference dinner.

Implementation of the recommendations is now a key task for us all. Any suggestions on upcoming events where the Inquiry recommendations can be presented, or how RACS can encourage adoption of the recommendations are most welcome, and should be directed to trauma@surgeons.org.

DrJohn Crozier
Chair, Bi-National Trauma Committee



PROGRAMME
13 October 2018
9:30 am - 5pm

Session 1

The 14th Kenneth Fitzpatrick Russell Memorial Lecture:
1783 - Anatomy of a Duel
Associate Professor Susan Neuhaus

Dieffenbach – The 'Father of Plastic Surgery'
Mr Robert Pearce

Session 2

The Fabric of Vesalius – 16th Century networking and a paradigm shift in surgical anatomy
Mr David Grayson

A female surgeon of the early 17th Century: Marie Colinet (1560-1640) of Berne
Professor David Watters

Session 3

'Sir Benjamin Collins Brodie- physiologist, surgeon, philosopher and administrator: His role in transforming surgery from a handicraft to a science'.
Mr Peter Burke

Le mort or la mort: The origins and cultural context of the Danse Macabre, with specific reference to Hans Holbein's sixteenth century woodcuts.
Elizabeth Milford

Session 4

The Decline and Fall of the Roman Empire
Mr Graham Stewart

Bibliographical Observations
Mr Geoffrey Down

Northern Territory, Western Australia and South Australia Annual Scientific Meeting

From 23-25 August, it was my pleasure to welcome more than one hundred Fellows, Trainees, IMGs and associates from Western Australia, South Australia and the Northern Territory to Alice Springs for the Tristate Annual Scientific Meeting (ASM). The three day conference was centred on the theme 'Infection: From head to toe.'

In recent years central Australia has experienced a noticeable rise in soft tissue infections, which has significantly impacted the surgical caseload. These are not just simple subcutaneous abscesses; they are often much more serious infections, like necrotising fasciitis and large carbuncles with sepsis and life threating head and neck infections.

While this presents a major challenge to the local hospital staff, it also presents an opportunity for others to learn. As an example, necrotising fasciitis is a much less common infection in metropolitan hospitals, but when it does present it is important to identify it early and treat it appropriately.

The ASM provided the perfect platform for this type of learning to occur, as surgeons from different backgrounds came together to listen to the perspectives of their colleagues from interstate, and share experiences of working in their own hospital environments. Below is a brief selection of some of the highlights from the event.

Opening night symposium

Hosted by the Australian and New Zealand Audit of Surgical Mortality, the opening night symposium featured a series of high quality presentations and generated a spirited discussion on 'The Changing Face of Infectious Disease.'

Although the nature of infectious disease differs depending on where in Australia or New Zealand you are located, one common problem confronting the entire medical profession is the increasing rate of resistant bacterial strains. This was just one of many topics discussed at the symposium, which set the scene for an engaging two day program to follow.

The symposium was convened by Mr John North, clinical director of both the Northern Territory and Queensland audits of surgical mortality. For those who were unable to make the Tristate ASM, he will also be hosting a similar symposium in Brisbane in November this year. The event will focus on infection in surgical patients, and current practices and protocols to manage them.

Scientific Program

The program was divided into five different sessions, involving 36 presentations, and featured many highlights. These included;

- The annual Henry Windsor Lecture, entitled 'Damage, Destruction and the Battlefield Surgeon' which was an inspiring presentation, delivered by decorated military surgeon, Associate Professor Susan Neuhaus.
- A keynote presentation from Darwin vascular surgeon, Mr Mark Hamilton. Among his many qualifications, Mr Hamilton is an expert on the diabetic foot. He also spoke at the opening night symposium, and provided an eye-opening account of the high burden of diabetic foot infections in the Northern Territory.

Performers from the group Drum Atweme who provided a traditional welcome

- Dr Bart Currie, a well-known infectious disease physician based in Darwin, delivered a keynote presentation on tropical infections in the north, via video link.
- An update from RACS Vice President, Dr Cathy Ferguson, who paid tribute to her NT colleagues for their proud record on trauma advocacy, and provided as insight into what the upcoming advocacy priorities are for RACS.
- A strong focus on Indigenous health. This included a presentation by Ngangkari, a group of Traditional Healers from central Australia.
- Rural surgery was also a prominent theme throughout the presentations, with many references made to the vast catchment area of the Alice Springs Hospital (an area of 1.6 million square kilometres), and the challenges this presents to health care services.
- A quality field of registrants for the paper and poster competitions. Congratulations to the prize winners Jessica Turner, for her paper 'Severe Soft Tissue Infections in Alice Springs' and Janine Vu for her poster 'Mesenteric Venous Thrombosis Managed with Damage Control Surgery in a Rural Hospital.'

Memorandum of Understanding (MoU)

We were very grateful to the Northern Territory Health Minister, the Honourary Natasha Fyles, for travelling from Darwin to personally sign a Memorandum of Understanding with RACS at the meeting. The signing of the MoU is the latest in a number of agreements that RACS has made across the health sector following the launch of the RACS Building Respect, Improving Patient Safety Action Plan, and is the first of its kind in the Northern Territory.

Social Highlights

The social program allowed delegates the opportunity to experience many unique cultural aspects of central Australia. This included a traditional welcome from Drum Atweme, a drumming group made up of young people

(Left to right) Mary Harney, RACS CEO; Cathy Ferguson, RACS Vice President; The Honourary Natasha Fyles signing a Memorandum of Understanding with RACS at the ASM; Dr Jacob Jacob and Mahiban Thomas, RACS NT Chair.

from town camps in Alice Springs. Another feature was the conference dinner which was held at the Alice Springs Telegraph Station, where guests were treated to a historical recount of the station by local experts, and a stargazing presentation under the clear desert skies.

The theme for the conference was engaging and very well received, and attendance was high across each of the three days. I would like to thank everyone who made this event a great success, particularly my colleague and RACS NT Chair, Mr Mahiban Thomas, and staff from the local office.

Preparations are already under way for the 2019 Tristate ASM which will be held in Port Lincoln, South Australia from 5-7 September 2019 on 'Robots in Surgery—Tsunami or just the next wave?' Dr Richard (Harry) Harris, SA Anaesthetist and cave diver instrumental in the Wild Boar Soccer Team Rescue will be delivering the SA Annual Anstey Giles Lecture at this meeting.

Mr Jacob Jacob
FRACS

College supports world leading orthopaedic surgery research

Orthopaedic Fellow Adam Watson has spent the past two years conducting research and completing sub-specialist training in Calgary and Toronto, Canada, with funding support provided through RACS' Foundation for Surgery.

Dr Watson received the prestigious Ian and Ruth Gough Surgical Education Scholarship in 2016 which allowed him to complete his Masters of Surgical Education thesis.

Working with world leaders at the University of Toronto, Dr Watson investigated Entrustable Professional Activities (EPA) in orthopaedic surgical training to develop a core list of EPAs deemed critical for Trainees exiting the program.

He said these ranged across a wide array of tasks, both inside and outside the operating theatre, such as patient assessment, post-operative management of common orthopaedic presentations, like a hip fracture. Upon peer review, the diagnosis and work up of patients with rare but important conditions such as bone cancers, was also deemed a core task.

He said he hoped the list would help guide Trainees, teachers and examiners in learning and assessing key orthopaedic surgical competencies.

"EPAs are firmly established as a potent assessment tool in surgery and the new curriculum designed by the Australian Orthopaedic Association, called AOA21, uses EPAs as an important part of its training and assessment rubric," Dr Watson said.

"My Masters of Surgical Education research developed a core list of EPAs, collated with the input of expert participants, which were deemed critical for Trainees to be able to manage, both independently and competently, before exiting an orthopaedic surgical training program.

"This work represents the first time a list has been formulated, with input from international leaders in the field, that spells out the key tasks involved in being an orthopaedic surgeon."

"I hope this research will benefit both Trainees and surgeons by defining clear tasks and abilities that are mandatory competencies for Trainees to master prior to leaving the orthopaedic training program.

"Ideally, in a competency-based training program, if a Trainee is deemed competent in all of these tasks at an early stage, they may be signed off to graduate from training."

Dr Adam Watson with his wife Dr Jane Mills and their daughter Rose

Dr Watson said that while lists of EPAs deemed crucial for other specialties such as Psychiatry and Internal Medicine had been developed in recent years, his research was the first of its kind to list core competencies required by orthopaedic surgical Trainees.

"My hope is that this work will help Australasian surgical educators provide cutting edge training in orthopaedics by itemising those tasks that are deemed critical for orthopaedic Trainees to master," he said.

Dr Watson completed his world-first research under the supervision of Dr Tim Dwyer, FRACS in Canada and Professor Debra Nestel at the University of Melbourne.

He presented his work at a peer-reviewed meeting at the University of Toronto. It is currently prepared for publication.

He has previously pursued other research interests, investigating scapular involvement in rotator cuff repairs and conducting a randomised controlled trial into fixation of hip fractures.

While in Canada, Dr Watson also completed post-Fellowship training through a 12-month Sports and Arthroscopy Fellowship at the prestigious University of Toronto Orthopaedic Sports Medicine Program where he gained skills to treat complex and multiple ligament knee injuries and enhanced his arthroscopic treatments of complicated shoulder pathology.

He then spent a further year at the University of Calgary doing a high-volume Fellowship in Complex Hip and Knee Arthroplasty, including specific training in the Direct Anterior Approach Hip Replacement and complex revision procedures.

"Working at high volume academic hospitals in Toronto and Calgary provided a wonderful opportunity to focus on multi-ligament knee reconstructions and arthroscopic shoulder surgery followed by a 12-month Arthroplasty Fellowship focussing on revision hip and knee surgery and anterior approach hip replacements," he said.

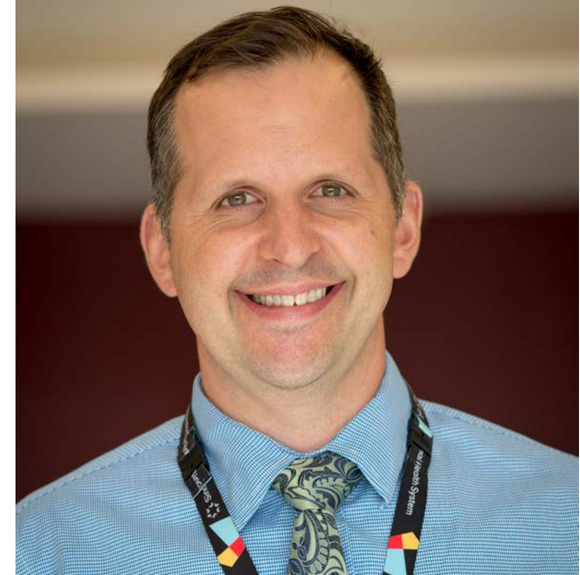
"I have a strong interest in Sports Orthopaedic Surgery so the aim of my subspecialist training in Shoulder, Hip and Knee surgery was to maximize the impact I have on my patients when I return to Australia to take up a position at the Royal Hobart Hospital in Tasmania."

Before travelling to North America, Dr Watson completed a 12-month Shoulder and Upper Limb Fellowship in Geelong, Victoria, under the guidance of Professor Richard Page. This was followed by a six-month Trauma and Arthroplasty Fellowship also in Geelong.

In 2015 he was awarded a travelling Fellowship as part of the ASEAN Orthopaedic Association/AOA Cooperation which allowed him to visit hospitals in Myanmar, Indonesia and Singapore to provide educational lectures and attend scientific meetings and in 2012 he worked at the Shriners Hospital for Children in Portland Oregon as an International Paediatric Orthopaedic Resident.

Dr Watson is married to Dr Jane Mills, a Breast and Endocrine surgeon from Hobart, and while in North America they welcomed the arrival of their first child, a daughter named Rose.

Dr Watson thanked RACS for the support extended to him. He is extremely thankful to the dedicated teachers and surgeons who have invested so much time in training him, both in Australia and Canada.



Dr Adam Watson

"During my time here, I've become more efficient and reproducible at several index operations in arthroplasty and sports surgery," he said.

"I hope that my research advances the assessment of Trainees to the benefit of the entire specialty of orthopaedic surgery and look forward to returning to Hobart to share the skills I have learnt and the EPAs we have defined with orthopaedic Trainees.

"My wife and I also enjoyed learning about the medical services in Canada and I think we can learn a lot from the systematic efficiency of their public health service.

"I feel hugely fortunate to not only have had the opportunity to broaden my surgical skills and complete my Master's Degree, but also to have had the time to spend with my wife and daughter while exploring various parts of Canada, including the wilderness in the Canadian Rockies which was a highlight."

Dr Watson will return to Australia later this year and will have a combined public and private practice at the Royal Hobart Hospital and Calvary Healthcare.

The Ian and Ruth Gough Surgical Education Scholarship was established to encourage surgeons to become expert surgical educators.

ACADEMIC HIGHLIGHTS

- 2016: Ian and Ruth Gough Surgical Education Scholarship – RACS Foundation for Surgery
- 2015: ASEAN Orthopaedic Association/AOA Cooperation travelling Fellowship
- 2012: International Paediatric Orthopaedic Residency, Portland, Oregon.

Karen Murphy
Surgical News journalist

Associate Professor Stephen Bolsin

Hospital safety standards whistleblower to speak at RACS ACT ASM

A British-born Anaesthetist who publicly exposed one of the worst surgical scandals of the modern era will be a keynote speaker at the October meeting of the RACS ACT Annual Scientific Meeting (ASM).

Associate Professor Stephen Bolsin revolutionised hospital safety standards in the UK after he went public in 1996 with details of the shockingly high mortality rates of babies and children treated at the Bristol Paediatric Cardiac Unit at the Bristol Royal Infirmary.

An enquiry sparked by his revelations was established two years later and found that 170 babies died needlessly through a combination of staff shortages, a lack of leadership, requisite surgical skills and oversight, secrecy and a desire by hospital leaders to retain funding associated with providing the service.

Reporting in 2001, Professor Ian Kennedy QC made several recommendations to transform standards of care in the National Health System (NHS) and to ensure that such negligence could not recur.

They included:

- The introduction of appraisal, continuing professional development and revalidation for all healthcare professionals to ensure they maintained the skills necessary to provide safe medical care;
- The creation of national standards of care for both clinicians and hospitals;
- An independent external monitoring service to identify good and failing hospitals.

Despite his efforts to protect vulnerable patients, Associate Professor Bolsin was ostracised by the medical profession in the UK after becoming a whistleblower, so applied for a position at Geelong Hospital in Victoria.

He was welcomed in Australia, took up a position of consulting anaesthetist in 1998 and later became the Director of the Department of Perioperative Medicine, Anaesthesia and Pain Management at Geelong Hospital.

He is now a Specialist Anaesthetist at Barwon Health and Medical Advisor at St John of God Hospital in Geelong.

Continuing his career-long dedication to medical safety, Associate Professor Bolsin is a Senior Principal Research Fellow at the Department of Clinical and Biomedical Sciences Faculty of Medicine at the University of Melbourne and an Honorary Adjunct Professor at the Department of Epidemiology and Preventitive Medicine at Monash University.

Since his arrival, Associate Professor Bolsin has been instrumental in improving standards of care and in 2000 he published papers showing that Geelong Hospital had the lowest wound infection and re-exploration rates in the world and the third lowest renal failure rate.

Speaking to *Surgical News*, Associate Professor Bolsin said he raised his concerns about the high mortality rate at the Paediatric Cardiac Unit in Bristol with senior surgeons, hospital administrators and members of the Health Trust board but was told to keep quiet for the good of the hospital.

He said that as an anaesthetist working with many surgeons, he knew those who were competent and those who were not but that an ‘old boys' mentality worked to cover up the failings in the service.

“This unit had a mortality rate of 30 per cent and everyone in the health system knew it was the worst in the country but refused to act,” Associate Professor Bolsin said.

“Parents were losing their children through sheer incompetence and negligence and I had to act but when I did it was made very clear to me that I would find it difficult to get work anywhere in the UK.

“I was still naive enough to be shocked by that because I thought trying to save children's lives would be sufficient justification for going public.

“Still, I have no regrets because within two years of raising the alarm and going public, the mortality rate of the unit had dropped to just three per cent.”

Associate Professor Bolsin will address the ACT ASM on new research he has conducted at the St John of God Hospital which he believes could further advance patient safety.

He has published a case study which introduces the concept of quantitative assessment of clinical engagement by measuring the number of patients managed according to specialist society guidelines.

He said his research showed that hospitals that worked with medical colleges and specialist societies to manage patients from the time they entered hospital to the time they left according to specialist guidelines could dramatically reduce complication rates.

“Clinical engagement is quantified as the percentage of patients who have been documented to have received specialist society or college-approved guideline-compliant treatment,” Associate Professor Bolsin said.

“This means following a surgical patient through their hospital stay to determine, for example, if they need antibiotics and that they then receive the right drugs at the right time.”

Associate Professor Bolsin said his clinical engagement model involved all hospital staff including medical, nursing, allied health and pharmacy and provided guidelines and assessments of individual and organisational compliance with those guidelines.

He described it as a novel means of measuring clinical engagement in an organisational setting across professional disciplines.

“Such quantitative analyses could then allow organisations to measure the adherence of specialty groups of clinicians against guidelines that the clinicians themselves select which can then be further used for individual and organisational accreditation,” he said.

“Some people believe that such complex systems as hospitals cannot achieve excellence in their provision of safe medical care but I could not disagree more with such thinking.

> “Working together we could transform hospital safety standards, drastically reduce cost burdens on the health system and allow both organisations and individuals to measure their performance against world-best practice guidelines.”

“Recently, it has been estimated that hospital complications cost the Australian health system approximately $5 billion annually but many costly complications like DVT's and infections could be avoided by improving clinical engagement and measuring outcomes.”

The RACS ACT Annual Scientific Meeting will be held on October 27 and will focus on the role of surgeons in health advocacy.

Other keynote speakers include:

- Dr Valerie Malka, a Trauma and General Surgeon and Deputy Director of Trauma at Sydney's Liverpool Hospital, who has special interests in quality assurance, patient safety and the maintenance of ethics in healthcare;
- Professor Jeffrey Rosenfeld, OBE, Professor of Surgery, Monash University, senior Neurosurgeon at the Alfred Hospital and Director, Monash Institute of Medical Engineering, and
- Current RACS Vice President, Dr Catherine Ferguson who has been Chair of RACS' Professional Development and Standards Board, Chair of Fellowship Services and Chair of the Post Fellowship Education and Training Committee, and is a champion of the College's *Lets Operate with Respect* campaign.

With Karen Murphy
Surgical News journalist

(Left to right) Hem Raj Shrestha, the first kidney transplant recipient, Associate Professor David Francis, and Gyani Shrestha, Hem's kidney donor, on 8 August 2018

Transplantation in Nepal: Ten years on

In 2006 I was asked by Dr Dibya Singh Shah, a nephrologist in the Institute of Medicine at Tribhuvan University Teaching Hospital (TUTH) in Kathmandu, to help establish the first kidney transplant service in Nepal. The aim was to initiate a self-sustaining program not reliant on visiting medical specialists, and that could develop into a reliable and effective component of renal replacement treatment within a Nepalese context. After two years of planning that included educating patients, and medical and nursing staff, as well as overcoming logistic, legal and cultural issues, the program commenced on 8 August 2008 when the first live donor kidney transplant was performed at TUTH[1]. I returned to Kathmandu in August of this year to participate in the celebrations of ten years of renal transplantation in Nepal (Fig 1).

Wednesday 8 August 2018 started with a gathering of more than 150 patients and relatives of the TUTH Renal Transplant Patients Team. The first transplant recipient, Hem Raj Shrestha, and his wife and donor, Gyani Shrestha, both of whom today have normal renal function, were in attendance (Fig 2). At midday, a meeting of about 200 hospital staff was addressed by several speakers including the Deputy Prime Minister and Minister of Health and Population for Nepal, the Honourable Mr Upendra Yadav. I too, gave a speech – the only one not in Nepali! The surgeons and nephrologists who inaugurated the program were presented with framed letters of appreciation. Later, in the evening, hospital staff that had been involved in the program over the last ten years were invited to a celebratory dinner.

Fig 1. A billboard in the hospital grounds announcing ten years of kidney transplantation at TUTH

The achievements of the transplant team at TUTH have been outstanding. Since August 2008, 508 live donor kidney transplants have been performed. Two-thirds of donors were female and the most frequent donor-recipient combination being wife-to-husband, perhaps reflecting the patriarchal nature of Nepalese society. The average age of donors was 45 years. Donor nephrectomies were performed using an open technique because of the higher cost of laparoscopic surgery (few urological procedures are performed laparoscopically in Nepal). There has been no donor mortality. The mean hospital stay for donors was 3.4 days. Significant early complications (1.4 per cent) included return to theatre for haemorrhage, and wound and urinary tract infections. One male donor developed the clinical picture of malaria on the third post-operative day, having travelled without chemoprophylaxis to the marshy jungle of the Terai region in southern Nepal several weeks before donating.

Fig 2. Hem Raj Shrestha on the third day after his kidney transplant in August 2008

Of the recipients, 356 (70 per cent) were male. The average age of recipients was 34 years. Patient survival at one and five years stands at 96 per cent and 92 per cent respectively, while allograft survival at 1 and 5 years is 95 per cent and 88 per cent respectively. The 2017 ANZDATA Registry[2] reports comparable Australian figures of 98 per cent, 96 per cent, 97 per cent and 91 per cent respectively. Eleven recipients (2.1 per cent) have died, most from infectious complications. Two patients ceased treatment. A 28-year-old woman, the second patient to be transplanted, died with normal renal function in the April 2015 earthquake.

Complications in the 508 recipients included wound infections (4.7 per cent), 22 vascular complications (4.3 per cent) of which transplant renal artery stenosis was the commonest (14), nine ureteric leaks (1.7 per cent) and five ureteric strictures (1 per cent), three lymphoceles requiring fenestration, and two cases of allograft rupture. As in all kidney transplant programs, the great majority of patients have done very well, including one, Mr Chhawang Sherpa, who subsequently climbed Mount Everest (Fig 3).

The Department of Nephrology at TUTH is now supported by nephrologists at Monash Medical Centre and, with their assistance, has undertaken five ABO incompatible kidney transplants and inaugurated a paired kidney exchange program.

Fig 3 Chhawang Sherpa, a kidney transplant recipient at TUTH, near the summit of Mount Everest

A deceased donor program will commence shortly, following recent passage by parliament of brain death legislation.

The success of the TUTH kidney transplant program has produced benefits far beyond its own patient cohort, particularly in focusing attention on kidney disease and its prevention and treatment in Nepal. Ten years ago, there were three haemodialysis centres in Nepal with fewer than 30 machines and only as many patients. Haemodialysis used to cost US$80 per session in 2008, in a country where the average annual per capita income was US$270. Consequently, many patients never started dialysis, and, of those who did, nearly all stopped within three months because of inability to pay. Now there are 51 centres with 401 machines and 3,000 patients on dialysis. Patients with enough money went to India and purchased a live donor transplant for US$50,000–100,000, although a good outcome was not guaranteed. Today, about 300 kidney transplants are performed annually in Nepal.

An important factor in the expansion of renal replacement therapies has been the strong support given by the Prime Minister, the Honourable Mr K. P. Sharma Oli, himself a kidney transplant recipient. Prime Minister Oli introduced free haemodialysis and transplantation for sufferers of end stage renal disease two years ago, and recently announced funding for a standalone nephrology, urology and transplant centre at TUTH.

Establishment of a viable kidney transplant program has fuelled optimism in Nepal's medical circles, as well as confidence in the abilities of their transplant specialists. Four other kidney transplant units have now been established and, of the estimated 1,000 transplants performed in Nepal, about half have been at these new centres. Bone marrow transplantation commenced in 2012, and the TUTH hepato-biliary team has performed two liver transplants.

Clearly, these are outstanding achievements for a country that has faced many challenges in its recent history, including poverty, a decade of armed civil insurrection, political turmoil, and a devastating earthquake in 2015. That fledgling start and enormous team effort made on the eighth day of the eighth month of 2008 at TUTH has mushroomed into a highly successful and internationally recognised kidney transplant program which, in turn, has fostered the development of other transplant and related services in the country. The transformation of Nepal into a solid member of the international transplant community demonstrates the immense benefits of collaborative first-world surgical and medical support for impoverished third-world countries.

References
1. Surgical News 10:8, September 2009, 26-27.
2. ANZDATA Registry. 40th Report, Chapter 7: Transplantation. Australia and New Zealand Dialysis and Transplant Registry, Adelaide, Australia. 2018. Available at: http://www.anzdata.org.au

Assocaite Professor David M.A Francis
FRACS

Thoughts on regional and rural practice

Let's consider how someone who lived their early years in eastern Melbourne reflects on many years of living in country Victoria and practising as a surgeon. It always was and remains a positive decision. This is a personal perspective.

Most Australians live in big cities, the largest two getting bigger at a rapid rate. Most surgeons and Trainees have grown up in the largest 10 urban areas, even though medical school intakes of students from rural origin are now around 28 per cent. Regional cities, with their rural clinical schools from 10 years ago, now often linked to the recent rural clinical training 'hubs' remain linked to metropolitan networks in general surgery. Regional cities receive Trainees in orthopaedics, urology and sometimes otolaryngology/head and neck surgery (OHNS) or vascular surgery via the national/regional training programs. Trainees uncommonly work in the smaller cities (<20,000), although regional surgeons often provide outreach service to these smaller towns, which Trainees sometimes participate in.

The Barwon-South West Victorian general surgery hub is a start, now with about 15 Trainees, but includes Geelong, estimated as the tenth most populous city. Could we do this in other areas of Australia?

Consider the next (by population) 20 cities and large towns of Australia. Many of these are growing at faster rates than the national average, especially if within 2-3 hours of the major cities. They often have extensive history, established infrastructure, suitable education options as well as busy public hospitals and private hospitals. General surgery, orthopaedic surgery, urology, OHNS and vascular surgery can be successfully practised in these big regional towns. In some centres, plastic and reconstructive surgery is also practised. They usually have extensive sporting facilities and the option of living on some acres. Road and rail connections will vary and the more distant cities have regular air services.

Looking back on 25+ years in regional Victoria with 'generalist' general surgery and 'speciality' colorectal surgery, what are the notable developments?

The medical system is larger, with more beds, rebuilt hospitals, improved ICU, medical students and suitable medical education facilities. There is general collaboration with departmental and speciality meetings and multi-disciplinary clinics. Morbidity and mortality meetings and Tuesday lunchtime surgical meetings (commenced 1993) remain on the schedule for surgeons: the dedicated non-service teaching sessions for anaesthetic Trainees remain as a laudable goal. There are seven accredited Trainees, compared to three, with many JDocs and non-accredited positions. Regional referrals bring sick patients in by helicopter and ambulance, while most serious trauma is directed to Melbourne. Less paediatric surgery is done, with crossover in teenage years depending on the speciality field.

Given sub-speciality colorectal training, engagement with the relevant society, the Colorectal Surgical Society of Australia and New Zealand (CSSANZ), has been important, and maintenance of a detailed database has enabled review of patient outcomes, and several presentations over the years. It is important that one can demonstrate that regional practice is at least equivalent to published metropolitan data. Early participation in the Bi-national Colorectal Cancer Audit (BCCA) database has also been useful. The shared 'colorectal' general surgical unit in public hospital practice has always been in demand by general surgical registrars, several of whom have gone onto post-fellowship colorectal training.

Medical student numbers locally have increased from 20 to nearly 100 FTEs, with the University of Melbourne retaining its presence, now with Deakin University (2010) and University of Notre Dame (2011). Careful scheduling and access to the private system has helped all of this along, and these 'local' students often return for their early prevocational years. General surgery, RACP basic Trainees, and anaesthetic Trainees can navigate a path through to speciality training. Accredited surgical Trainees and RACP advanced Trainees are supervised and supported. Almost the full complement of conditions and operations within general, orthopaedic, urology and OHNS can be managed to a high standard.

One could consider, therefore, that for 'generalist' practice, most of the training could be done in some of the larger regional centres, and/or with linked regional rotations. City time is important too. For general surgery Trainees, some time (1-2years) in the bigger metropolitan areas would complement the regional program 'base'. The other three (above) national/regional programs may be able to enable more regional years, within the overall usual five year time frame.

Above is all of the medical-surgical information, generally important in the formative career years. But there is so much more happening, too, in our regional and rural areas. The sense of community is strong, with opportunity for involvement in a wide range of organisations. In fact, there is usually active encouragement to get involved. The education sectors look for engagement as well: this can be more than parent-teacher interviews. Cultural facilities such as art galleries, museums and local attractions are rewarding to become a part of. There are restaurants and wine-bars and much of Victoria is dotted with vineyards. Sporting facilities are well developed. As one builds personal links, the support back from the community is often most helpful and usually speedy. Recently one of the local truckies retrieved one of our cars from interstate – an unfortunate accident with a kangaroo (no-one else hurt). Just that rural landscape may be good for one's wellbeing, too!

One may see one's patients in the community – on the street, in the shops, when out to dinner. This is usually positive and easily addressed with acknowledgement: no detailed medical discussions in the street. Unless living and working in one small area of the big cities, these friendly chats may initially be unexpected and are something to allow for—it is not easy to be anonymous. Should you choose to live outside of the town, the commute is pretty easy and those after-hours call-backs don't take too long to attend.

Finally, the cost of real estate is much less than the big cities. Without much training and experience, one can live on some acres, develop some equestrian facilities, plant grapes and make wine. You can extend your independence with tank water, solar power and batteries but do keep connected to the power grid! Internet depends on location but wireless NBN connections do usually work well.

Let's consider: RACS has community responsibility to provide the regional-rural workforce, as recently reminded by the Australian Medical Council. There are ways to be a surgeon in the country. You can stay on there too – recent conversations with one of my mentors (nearly retired) supported this strongly, saying his Melbourne friends and colleagues visited him to share an important country musical event.

Associate Professor Stephen Tobin
FRACS

Register Online Now
www.surgeons.org/NSW

Prep for SET
3 November 2018

Younger Fellows preparation for practice
10 & 11 November 2018

NSW Surgeons' Evening
Art Gallery of New South Wales
Graham Coupland Lecture:
Dr Gillian Dunlop 'should your daughter be an artisit?'
14 November 2018

Australian defence force in medicine
Victoria Barracks
22 November 2018

Women in Medicine: Leveraging your best self
30 November 2018

Tasmanian trauma meeting to highlight the dangers of gun violence

One of America's leading trauma systems specialists will be the keynote speaker at a combined meeting of the RACS Tasmanian Committee Annual Scientific Meeting (ASM) and Trauma Symposium.

Internationally renowned trauma surgeon Dr David Hoyt is the Executive Director of the American College of Surgeons (ACS) and has been President of the Pan American Trauma Society and the American Association for the Surgery of Trauma.

He was instrumental in helping to establish regional trauma systems and verification programs, is the author or co-author of more than 480 publications and was the 2007 recipient of the ACS' highest honour, the Distinguished Service Award.

Dr Hoyt has also participated in efforts by the ACS to reduce deaths and injuries caused by firearms, an issue that is of great interest in Tasmania following the Government's decision to hold an inquiry into plans to water down gun control laws that had been put in place following the horrific Port Arthur Massacre in 1996.

To be held over two days in November, the combined meeting has been designed to:

- Promote RACS Trauma advocacy and other trauma prevention initiatives
- Discuss the strengths and weaknesses of regional trauma services and hospitals across Australia and New Zealand
- Highlight the evolution of trauma verification programs, and
- Foster closer ties between Tasmanian Fellows and the wider Australasian trauma community.

Co-convener of the meeting, Hobart paediatric surgeon Dr Michael Ee, said Tasmanian Fellows had chosen to highlight regional trauma and the proposed gun law reforms to focus attention on public health and safety.

He said that while the Government had announced it would drop its pre-election policy to reform gun laws following strong opposition from a range of health organisations, it had recently changed its stance.

Dr Ee said the Tasmanian government was now intending to hold an inquiry into loosening gun control laws in the House of Assembly even though the Legislative Council had decided not to proceed after receiving 121 submissions.

The pre-election proposals include allowing greater access to pump action shot guns and self-loading rifles, allowing the use of silencers and doubling the duration that gun licenses can be held from five to ten years.

"We have put gun control laws at the forefront of the meeting because RACS has a very powerful voice when we choose to speak out on public health matters," Dr Ee said.

"The Tasmanian State Government has faced strong opposition to its gun law reform proposals from both RACS and Medics for Gun Control but it has not given up so we need to highlight the risks posed by the proposals.

"RACS has been hugely influential in guiding some of Australia's most effective trauma prevention advocacy work over the last few decades and the plans to change the National Firearms Agreement, put in place after Port Arthur, represent another challenge."

"Recognising the seriousness of the matter, the College recommends strict gun control including the compulsory national register of all firearms, the banning and prohibition of importation by individuals of semi-automatic and pump action rifles and shotguns and the licensing measures that have been in place in Australia since 1996.

"We are very fortunate to have David Hoyt as a keynote speaker at the conference because he has dealt first hand with the dreadful effects of gun violence in the US that continue to shock the world.

"Data from the US Gun Violence Archive shows that in 2018 alone, as at 21 August, there were 9,315 deaths, 18,143 injuries and 226 mass shootings already reported.

"In comparison, since the introduction of the National Firearms Agreement, there has only been one mass shooting in Australia which indicates the success of our current gun law regime."

Dr Ee said that a combined Annual Scientific Meeting and Trauma Symposium was quite rare and that surgeons, Trainees and other health professionals were coming from around Australasia to attend.

He said the meeting would address issues that particularly affect regional trauma systems.

He said the conference would discuss such issues as the timely retrieval of trauma patients in regional settings, triaging, timely access to surgery, clear understandings of the role of each hospital in the trauma care system and the availability of ICU beds for adults and children.

"We are currently working in Tasmania to create stronger partnerships between the Royal Hobart Hospital, as the state's trauma centre, with smaller hospitals around the state," Dr Ee said, speaking as a paediatric surgeon dealing with paediatric traumas in the state.

"We have had discussions around the particular role regional hospitals should play in the trauma system but we face particular challenges here because we are such a small state with limited funding and resources.

"In some centres, there are only one or two specialists and if they are not available the service suffers so we hope this combined meeting will help us identify ways we can improve the care of all patients and not just trauma across Tasmania and other regional centres."

Dr Ee said that despite much work and commitment, Tasmania still did not have a Trauma Registry to feed data into the national system and allow health professionals to assess trauma services across the state.

"Tasmania doesn't have its own fully functioning Trauma Registry, although we were told we would have one more than a year ago, so we have to get this off the ground because we should be collecting data not just for our own information but as a contribution to the national registry," he said.

"The funded Australian Trauma Registry (ATR) is a vital tool in tracking the burden of injury on the healthcare system and we need to know the burden of injury to drive positive changes at a local level."

The other keynote speaker at the combined meeting is Emeritus Professor Mary Sheehan AO from the Queensland University of Technology who will give a presentation on the findings of a large study on fatal road crashes in Queensland from 2010-2015.

The study compares crash investigation reports, autopsy findings, toxicology and emergency retrieval as contributing factors in death or survival in urban, regional and rural settings.

The 2018 ASM and Trauma Symposium will be held at the University of Tasmania's Medical Science Precinct and will run from 9-10 November.

With Karen Murphy
Surgical News journalist

Fellowship Services

(or as Monty Python might have put it “but what has the college ever done for us?!”)

Ruth Bollard, Chair, Fellowship Services Committee

It's spring time again and for RACS that often means Council elections and a request to assist the College to better understand and represent the Fellowship by completing the RACS census. I would like to thank all of our colleagues who have nominated for a position on the Council and everyone who voted in the recent election. In a few months the College will be requesting that Fellows pay their subscriptions and complete their continuing professional development (CPD). As part of RACS CPD compliance you may even be selected to complete an audit of your submission.

At times I'm aware that it can feel like RACS is asking a lot and in my role as Chair of the Fellowship Services Committee I sometimes feel like I'm stuck in a re-run of a *Monty Python* sketch when faced with questions from colleagues that amount to “I know that's all important… but what has the College ever done for us?!”

New Fellow

- Well I guess I do get a complimentary registration to the Annual Scientific Congress so I can convocate. Although it is a bit hard to decide if I should convocate in Bangkok next year or Melbourne in 2020.
- and I really did find that Preparation For Practice program run by the my state's Younger Fellows incredibly helpful. I was a bit daunted by all of the things I needed to manage in setting up my own practice, but it was great to hear from others who'd done it before.

Younger Fellow

- There is the scholarship funding for the International Fellowships and the opportunity to attend meetings run by other Surgical Colleges in America and Thailand.
- Oh, and I went to the Younger Fellows Leadership Forum this year in Sydney, and RACS covered all of the costs aside from the flights. This year it was combined with the Anaesthetists Meeting so I learned a lot about leadership in teams and the challenges faced by my colleagues.

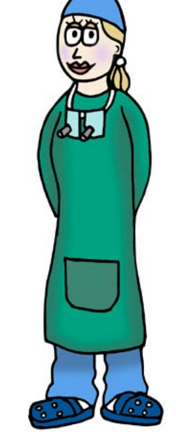
Rural Fellow

- Don't forget, the annual scholarships for regional and rural Fellows to support the increased CPD costs associated with being in a rural practice.
- …and I guess if you didn't win one of the scholarships or awards there are the 0% interest loans for travelling Fellows, which for me, come in pretty handy when I moved my family over to British Columbia for 12 months.

Mid-career Fellow

- I probably make most use of the library, with all of the resources organised by speciality. Generally I can find what I'm looking for online, if not the library staff can usually source it for me. I've also recently signed up for the colorectal ‘Electronic Table of Contents’ which emails me a regular list of new articles that I can access immediately.
- I'm also a member of the colon and rectal surgery section which helps keep me in the loop regarding upcoming opportunities.

Women in Surgery



- …and definitely the collegiality. I went to my second Women in Surgery Breakfast this year; it has probably doubled in size from previous years and it was a great opportunity to speak with some inspiring surgeons about leadership and promoting flexible training pathways.
- I've also signed up to be a RACS speaker at medical school events to encourage young women interested in pursuing surgery as a career.

Medico-legal

- ….and don't forget, regulators and hospital administrators regularly seek RACS's position on clinical, workforce and topical public policy issues. Last year I took part in the redevelopment of a RACS position paper on Day Surgery in Australia which was developed in conjunction with the College of Anaesthetists and the Australian Society of Plastic Surgeons.

Senior Surgeon

- This year RACS updated its position on senior surgeons in active practice, stem cell therapy, GP rural and remote services and the environmental impact of surgical practice.
- …and we should never overlook advocacy. RACS ensures the voice of surgeons is heard by government on issues like who should be called ‘surgeon’, patients' private health insurance, road safety, as well as the wearing of seat belts and more recently, open speed zones.

Military Surgery

- I really appreciate the opportunities for leadership development, both through educational programs and forums and through participating in RACS governance. Being involved with the College gives me an opportunity to work with other senior leaders from across the country on issues that impact surgical care and the health system more broadly.

Academic Surgery

- …and obviously there's the education! The support for research and travel scholarships, and the opportunity to discuss interesting research findings with our peers at state, national and bi-national scientific meetings is priceless.

Court of Examiners for the Fellowship Examination

Applications Open

Applications for Appointment to the Court of Examiners are now open for all specialties:

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

Please email your completed application form and a current curriculum vitae to Court.Examiners@surgeons.org by Friday, 9 November 2018 for appointment in 2019.

Application forms and relevant policies are available on the Court of Examiner webpage or by request from the Examinations Department. https://www.surgeons.org/about/governance-committees/committees/education-board/court-of-examiners/

For further information please email Court.Examiners@surgeons.org or phone 03 9276 7471.

Topical issues for Australian surgeons

As Surgical Representative to the Federal Australian Medical Association (AMA) Council, I attended my first AMA Council meeting in August. Susan Neuhaus, surgeon and RACS Fellow, should be acknowledged for her enormous contribution in this role formerly, and for her activity on numerous subcommittees. My dual role of AMA and RACS Councillor will I hope be beneficial to both institutions, considering the important common issues confronting surgeons and our patients.

One area of attention is the Medicare Benefits Schedule Review. There are potential difficulties with panels adequately representing all subspecialty views, so I would urge you to look at the MBS Review pages, on the Department of Health website, particularly those items that relate to your practice. There is the ability to make submissions if you do not agree with the review recommendations.

Another issue to be aware of is private health insurance reforms. The AMA advocates for the improvement of private health insurance value for consumers and the maintenance of a dual system of public and private care. Our RACS census shows that the majority of surgeons work in both sectors. The introduction of three tiers of private health insurance, bronze, silver and gold, allows consumers to choose a policy and pay a premium that meets their needs. However, they need to have a very clear understanding of what will be excluded from such policies, particularly if they opt for a lower tier of insurance. The AMA thus far, has been disappointed with the consultation process with key stakeholders. The AMA, as well as RACS, is working closely with the Department of Health to assist with appropriate consultation. The complexity of the task, which currently involves 65 committees, has created many challenges. Failure to get these reforms right for the consumer runs the risk of leaving patients inadequately covered for health needs or having to face the prospect of larger than expected out of pocket expenses.

On the issue of out of pocket expenses, the AMA has repeatedly informed the Departmentof Health of the inadequacy of the MBS schedules, the subsequent private health rebate and the resultant inevitability of out of pocket expenses. RACS absolutely supports a surgeon's necessity to charge fair and reasonable professional fees, but as a not for profit organisation, cannot be explicit or make specific fee recommendations. RACS condemns egregious charging or lack of transparency in billing such as split fees or booking fees, but is supportive of fairly determined and informed professional fees. The AMA however, can be somewhat more prescriptive, and a properly indexed schedule of fees is available to all AMA members as a guide. There has been much media coverage of private health costs and perceived over charging, though this is clearly being perpetrated by a minority of surgeons. Most surgeons will use their discretion to reduce fees for selected patients. This has always been understood by community minded doctors who place advocacy for their patients ahead of financial reward. In the next RACS census, you will be asked about your billing practices and your perceptions of what is a fair professional fee. I urge you to complete the census, as it provides important information about surgical practice in our community, available services and assists workforce planning.

Another item of considerable discussion in the broader community is 'My Health Record' (MHR). RACS lends its support, along with other learned medical colleagues, acknowledging that an absolutely perfect solution is impossible. With appropriate lobbying and consultation, the AMA was able to achieve immediate and important reforms to add significant layers of safety. The reforms, agreed by the Health Minister to the existing MHR, were to guarantee non access by other agencies and that a warrant, such as that which exists currently for health records, would be required for access beyond the usual use of the patient and their practitioner. If a person chooses to opt out of the MHR, the file will be completely

Professor Owen Ung

and irretrievably deleted. The opt-out period was extended for a further month but individuals need to be comfortable with the benefits and risks of a longitudinal accessible digital record. Even with the highest levels of encryption, there is nothing that a hacker might not attempt to breach, though this has never occurred to date with the current MHR. As surgeons, we have all been in a position where we may have doubted about a patient's anaesthetic suitability - if only we had that extra bit of information from their previous medical history.

Be prepared that your patients may wish to have a conversation with you about your views and indeed your intentions.

Whatever competing interests exist, as medical doctors we will always advocate for health and humanity above all else. At AMA council, a resolution addressing children in detention on Nauru was proposed by Jill Tomlinson FRACS. A statement directed to government assertively requested that actions be taken to prevent further harm and allow an independent medical delegation to gain access to make recommendations for appropriate care. The statement was unanimously passed.

I have touched on just some of the issues that are topical, important and impact on our ability as surgeons to deliver the best possible care to our patients. It is important to feel the pulse of our surgical community and to represent your views, so don't hesitate to contact me with issues that you feel are important to surgeons and your patients. A good way to stay connected is to read our RACS communications e.g. FaxMentis newsletter, Surgical News and updates on social media. RACS is your professional voice and advocate. Also, consider joining the AMA, to strengthen your professional and political voice. We are stronger and more influential as a collective.

Professor Owen Ung
RACS Councillor, AMA Councillor

Further information: E: Colorectal.com@surgeons.org | T: +61 39249 1139
Register Online: https://tinyurl.com/colorectal18 Early Registration closes Monday 17 September 2018

Update from the Victorian State Committee

This year has been a busy year one for the Victorian State Committee and Office and there are still a few key milestones to go. Importantly, the Victorian State Election is in November. All of us, at all levels of our careers, are leaders in the healthcare sector and it is incumbent upon us to ensure that we advocate for policy and regulation for the benefit of our patients. State elections are an important opportunity for surgeons to influence policy to ensure that Victoria has the highest standards of safe and comprehensive surgical care for the entire population.

The Victorian State Committee has sent an *Election Issues Position Statement* to all of the major parties outlining RACS' position on a number of important issues, asking for policy response.

- Teaching, training and research – ensuring appropriate resources and commitment to building and supporting a diverse surgical workforce.
- Delivery of surgical services – improving the management and resourcing of elective surgery waiting lists and outpatient services.
- Clinician engagement – ensuring a commitment to real and meaningful engagement with RACS and the surgical community on policy and regulatory issues.
- Victorian Audit of Surgical Mortality (VASM) – a commitment to further funding for VASM and the protection of Qualified Privilege (QP).
- Trauma – Strong policies to improve road safety and reduce the rate of injury and death on Victoria's roads.
- Alcohol related harm – A commitment to real action to reduce alcohol related harms to the community.
- Safety and security – Policy changes and resources to protect health care workers from abusive and unacceptable behaviours in hospitals and in their consulting rooms.

Ms Susan Shedda

The full submission is available on the Victorian Regional Office webpage and any responses received from the political parties will be uploaded. This year we are also providing an 'Election Policy Overview' tracking sheet to keep you updated on all the health policies being announced across the election campaign. This is also available on the VRO webpage and will be updated regularly.

This Victorian election is an important opportunity for all of us to contribute to the health and safety of our patients and community.

Ms Susan Shedda
Chair, Victoria State Committee

Program highlights 2018

Annual Joint Academic Meetings

Thursday 8 - Friday 9 November 2018
University of Technology Sydney, Dr Chau Chak Wing Bld, Sydney NSW

DAY ONE – SECTION OF ACADEMIC SURGERY MEETING

Morning session: Mid-Career Course - Personal Development

- The ikigai of Academic Surgery - finding your balance
- Don't go it alone - collaboration is key
- Managing up, down and across
- Diversity in academia - beyond gender and ethnicity

Afternoon session: Concurrent workshops

1. Clinical Innovations
2. Creating Institutional Vision with Academic Excellence

The day will conclude with:

- Interactive session on pitching for funding
- Clinical Academic Pathways Update
- Clinical Trials Network Australia and New Zealand Update

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

DAY TWO – SURGICAL RESEARCH SOCIETY MEETING

Presentation of novel research

Society of University Surgeons Guest Speaker – Dr Rebecca Minter
A.R. Curreri Professor and Chair of the Department of Surgery
University of Wisconsin School of Medicine and Public Health, Wisconsin, USA

Association of Academic Surgeons Guest Speaker – Dr Heather Yeo
Assistant Professor of Surgery and Assistant Professor of Public Health Weill Cornell Medical College, New York, USA

Jepson Speaker – Professor David McGiffin
Head of Cardiothoracic Surgery, Alfred Health, Victoria

Held jointly with the Academy of Surgical Educators Forum Evening on Thursday 8 November 2018

We would like to acknowledge Medtronic as the Foundation Sponsor for the Section of Academic Surgery

Online Registration is NOW OPEN

Day one - Complimentary
Day two - Only $100 for SAS members to attend - *no membership joining fee*
Places will be limited at these meetings

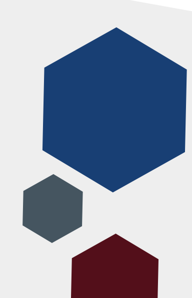
Contact Details

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

Travel with your RACS Member Benefits

Book all your summer travel essentials with these special offers and discounts to save hundreds on your next trip:

- Get an online quote for travel insurance.
- Join an airport lounge club before you leave.
- Save up to 60% off hotel accommodation.
- Choose between special offers with popular car rental brands in Australia and New Zealand.
- Use promotion codes for discounted tours, experiences and popular attractions.



For more information, email info@memberadvantage.com.au or call 1300 853 352.

Terms and conditions apply.

www.surgeons.org/memberbenefits

Clocks and CLOCK

The sundial at the entrance of the Royal Australasian College of Surgeons, Melbourne.

Our body clocks are important. Most of those reading this column have had the experience of trying to manage the disruption to our circadian rhythms when travelling across time zones. Many of us have favourite solutions to counter some of the exhausting effects of jetting from Australia or New Zealand late one evening and arriving 24 hours later to an early morning in London, Paris or Vienna. Melatonin tablets require you to stay awake long enough to take them at the right time. My own first-day approach is rather to get out in the sunlight, avoid driving after lunchtime, keep active but not exercise on the first day, eat regularly, and ignore the body clock which says 'sleep' until the local clock reaches 8pm.

Russell Foster, Professor at the Sleep and Circadian Neuroscience Institute of the University of Oxford, compares the impairment effect of driving a car in the early hours of the morning to being worse than being drunk. Between 4am and 6am our inability to perform mathematical calculations or other intellectual tasks is the equivalent of a few shots of your favourite whisky. The molecular biology of circadian rhythms is now being unravelled. The driving mechanism of the mammalian molecular clock is provided by two proteins, Circadian Locomotor Output Cycles Kaput (CLOCK) and Brain Muscle Arnt-Like 1 (BMAL1). Like clockwork, these heterodimers drive transcription of PER 1-3 and CRY1-2 genes to generate CLOCK protein complexes (PER 1-3 and CRY 1-2) which accumulate in the cytoplasm. Their levels fall to their lowest just before dawn. Light (the Zeitgeber or time giver) upregulates PER 1-3 and CRY 1-2 transcription. Activity, meals and social cues are other regulators of the circadian timing system. Once these protein complexes reach the nucleus they exert a negative feedback effect on transcription until they are phosphorylated and degraded by kinases. This process is essentially the same in bacteria, plants, animals and fungi. In mammals the circadian time keeping system has its central pacemaker located in suprachiasmatic nuclei (SCN) of the brain with subsidiary clocks in nearly every cell.

There are already well-established links between circadian disruption and mental health, with studies in schizophrenia, bipolar disorder, mood and cognition. Poor sleep also plays a major factor in circadian timing system disruption.

But what if our response to medical therapies were dependent on when in the 24-hour day the treatments were given? There has been a great focus in medicine on avoiding practitioner errors with safe working hours. But what if it is the patient's circadian rhythm that is also critical to outcome? None of us would choose to have an operation when jetlagged. Is a particular patient likely to have a better outcome if treated in the morning, afternoon or evening?

There is a growing science of chronotherapeutics. One mouse study involved the administration of bacterial toxin at two different times of the day. The difference in mortality between times of administration was from 80-20 per cent. A review of the 30 most commonly prescribed drugs in Australia found evidence of an optimal time of administration for ACE-inhibitors, angiotensin receptor blockers and statins favouring the evening. Some medications are not affected by circadian rhythm.

In cancer treatment, the aim is to match the human circadian cycle (rather than the nocturnal rodent of animal studies), to minimise adverse effects, maximise anti-tumour activity and patient well-being. Studies in childhood leukaemia have shown a higher relapse rate when chemotherapy is given in the morning rather than the evening. For cerebral metastases, giving radiotherapy between 8-11am resulted in most patients being dead within 6 months, whereas between 11-2pm survival extended to 24 months, and if given between 2-5pm there were still survivors at 36 months.

Clinical trials have shown a five-fold improvement in patient tolerability and near doubling of antitumor activity through chronotherapeutic delivery. In studies of chemotherapy for colorectal cancer, the optimal chronomodulated schedules corresponded to 1am or 4am for 5-fluorouracil-leucovorin, but 1pm or 4pm for oxaliplatin.

Circadian disruption may negatively impact outcomes. Future studies will need to be powered for both genders, as males and females may respond differently. Your CLOCK and the clocks are linked when it comes to individualising treatment. Timing it right might save a life!

DR BB-G-LOVED

App changing the face of learning

Have you downloaded it yet?

For the past 10 years RACS has published annual Case Note Review booklets, but did you know that you are now able to access all of this information in the palm of your hand?

Three years ago the Australian and New Zealand Audit of Surgical Mortality (ANZASM) launched the RACS Case Note Review App. The app has been based on the success of the second-line (case note review) assessment report booklets and e-magazines. These have enabled in-depth investigation of key surgical issues and lessons.

The app increases the quantity and quality of information disseminated on issues that have greatly affected clinical governance and patient care across the country. Once downloaded, you will easily be able to search for cases in any of the specialty areas and find summaries of those cases.

For example, it might be a general surgical case such as, 'Death following appendicectomy' or a vascular surgical case titled 'Where was the consultant?' Whatever it is you are looking for, you will be provided with great insight into the case notes and the comments regarding the case.

The release of the app is the latest evolution in RACS' broader audit programme, and an example of how we continually strive to provide users with the opportunity to access high quality information and valuable learning material, in a format that best suits them.

We will continue to publish our National Case Note Review reports on the RACS website in conjunction with the app, and as always we welcome any feedback on your experience in accessing this data in whatever platform you choose to use.

The app is free to download from the *App Store* and *Google Play*, and can be accessed by simply searching the *App Store* for 'Royal Australasian College of Surgeons – National Case Note Reviews'.

As always in the Audits of Surgical Mortality, the data is de-identified and to protect all parties, some data has been changed in a small but appropriate manner.

So download the app today, and enjoy the learning that comes from reading past cases that have been published. In total there are 574 cases that might be reviewed, and new cases are uploaded on a regular basis. We trust that you will use this wisely as a learning exercise.

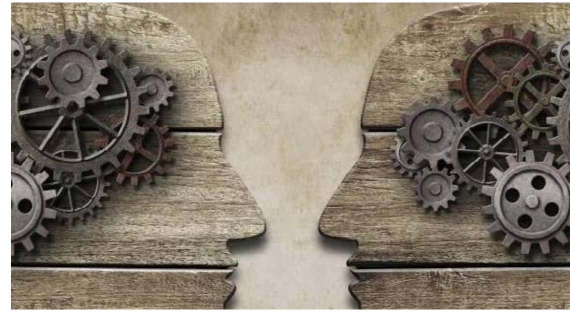
Professor Guy Maddern
Surgical Director of Research and Evaluation incorporating ASERNIP-s

Surgical snips

Nature and science join forces to fight surgical infections

The solution to post-surgical implant infection has been flying around us the entire time we have been battling antibiotic resistant bacteria through additional surgery, which is often less successful and poses an even greater risk of infection. The wings of the humble dragonfly, that bare tiny spikes that rip bacteria apart is being explored as a solution to counteract infection and kill harmful bacteria which often occurs after fractures, hip and knee replacements and spinal implants. Using nano-modification technology, researchers from the University of South Australia will test whether titanium implants using the surface of the dragonfly wing will kill harmful bacteria that cause infections. Australian researchers were the first to observe bacteria being killed on the dragonfly's wings, whose nano pillars (spikes) are about one thousandth of the thickness of a human hair.

https://www.scimex.org/newsfeed/nature-and-science-join-forces-to-fight-surgical-infections



World Mental Health Day

What are you doing?

World Mental Health Day – October 10 — is a day for global mental health education, awareness and advocacy. This special day aims to raise public awareness of mental health issues worldwide, and challenge perceptions about mental illness. A number of events and activities will be happening in every state and territory during the month of October, from mindfulness seminars, community fundraisers to morning teas and walks and fun-runs.

What will you be doing? Register now to participate in a mental health awareness activity in your local area and let *Surgical News* know of your experience. We'd love to know your thoughts and perceptions of how your community views the issue of mental health, and what some of the initiatives undertaken were.

World Mental Health Day focuses on ensuring the whole community recognises the part we all play in creating a mentally healthy society.

Mental Health Australia
https://mhaustralia.org/

To register
visit https://surgeons.eventsair.com/qasm18/delreg

Should I be on LinkedIn?

LinkedIn is a business-focused social media platform used by millions of people around the world to network professionally. The platform was launched more than 15 years ago and is now considered the world's largest professional network with almost 600 million users from all corners of the globe.

In the past, the platform was used as a place to advertise skills and experience to potential hiring managers – an online resumé or CV if you will. Today, LinkedIn has evolved to become a bona-fide social media network, used by professionals to grow their business network and keep abreast of industry updates.

In the past, networking was done at traditional networking events with an introduction, handshake and exchange of business cards. Today, millions are now using the internet to grow their professional networks, with many using LinkedIn to do so. The high-tech version of meeting other professionals in person, talking about what you do and exchanging information is to 'add a connection' on LinkedIn (similar to how you would on Facebook) and then chat privately.

LinkedIn can be particularly useful for networking at events and building professional connections. In situations where you do not feel comfortable adding someone on Facebook, adding someone to your professional network on LinkedIn could be a more suitable option.

The platform is proving incredibly useful for individuals who are interested in taking their professional life more seriously by providing an avenue to seek new opportunities for career growth and to connect with local and international colleagues. You can use LinkedIn to get back in touch with old work colleagues and even old schoolmates you would like to add to your professional network.

LinkedIn is not difficult to use and you may find the experience similar to that of Facebook. The newsfeed layout on LinkedIn does not vary too much from what you see on Facebook however your profile is comparable to an online interactive CV, with a record of your professional experience.

Social networks like Facebook, Twitter and Instagram are commonly used by people to keep in touch with friends (and share funny cat videos) whereas LinkedIn allows you to stay up to date with industry news and share professional achievements.

The platform also allows you to upload publications and share articles about you or published by you to your profile, building your credibility and showcasing your knowledge of a particular field. It also allows you to share honours and to publicise your professional interests with your network.

Other features on LinkedIn include the ability to set up and join groups as well as a jobs section where members can advertise open positions or apply for jobs. A great way to meet new professionals to connect with is to join groups based on your interests or current profession and start participating. People upload blogs, articles, comments, questions, and suggestions to LinkedIn groups in fields that you may have an interest in.

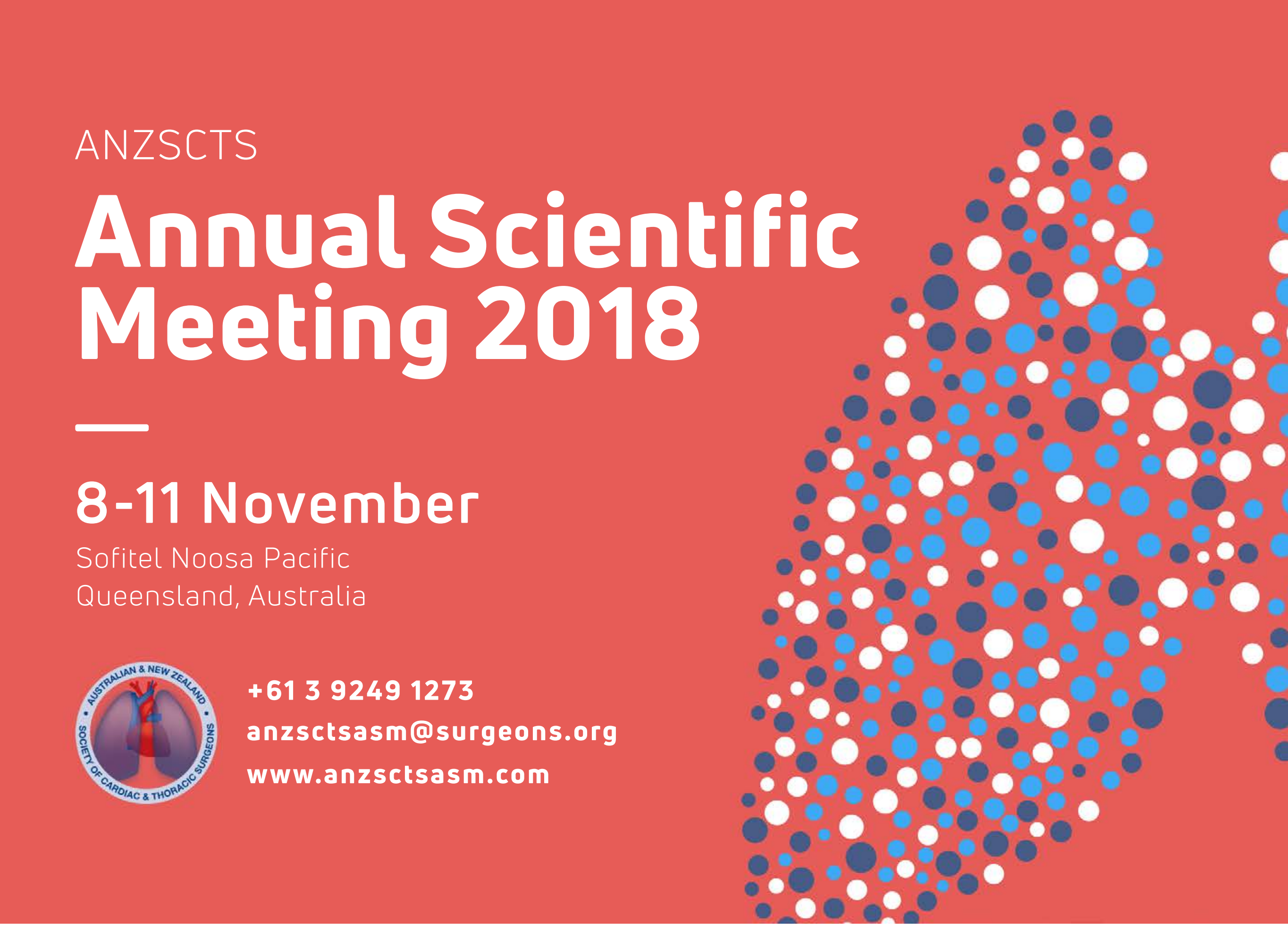
The good news is getting started on LinkedIn is easy. Create an account and complete your profile. In order to make sure people find the right information about you, complete your profile with your experience, skills, awards, training, education, and other background information.

Remember, the more sections you fill in, the stronger your profile is. For example, a suitable professional profile image and bio paragraph can help colleagues better identify you. Also, uploading articles or publications can identify that you are an expert in the field. If you feel comfortable doing so, upload contact information such as an email address, Twitter handle or website so that people can contact you.

Feel free to follow publications, educational institutions or organisations related to your industry to stay abreast of news from your professional circles.

Remember to follow RACS on LinkedIn and stay up to date with news and updates from around RACS as well as important information on upcoming courses and workshops. Thousands are already following RACS on LinkedIn so why not sign up today? Search for 'Royal Australasian College of Surgeons' on LinkedIn and follow us!

Agron Dauti
Digital Media & Internal Communications Coordinator, RACS



Beginners guide on how to form a union

If you look for a beginners guide on how to form a union you won't find one, and anyway, who would want to read such a book right?… But I found myself in the unenviable position of needing to form a union with absolutely no idea how to do it this year - lucky me. Here is a hitchhiker's guide on how and why I formed a union and the life lessons I learnt along the way.

First, a bit of background to the story. As a final year Orthopaedic Trainee in New Zealand, the last thing I wanted before my exams was a distraction. Unfortunately that is exactly what I got. In January 2017 we were facing junior doctor strikes for safer working hours in New Zealand, and I had only just been appointed as the New Zealand representative for the RACS Surgical Trainees Association. It's fair to say that I didn't know what I was doing (at first, anyway), but I felt a responsibility to ensure that any changes would not affect our New Zealand Surgical Trainees in a negative way. So with the help of some newly formed friends I poured over the literature on safer working hours, not something I would recommend unless your insomnia medication is no longer working. We also looked long and hard at our contracts.

The strikes went ahead and were successful, bringing in safer working hours, known locally as Schedule 10. These were brought in by New Zealand's only junior doctor's union, the Residents Doctors Association (RDA). The RDA is largely responsible for New Zealand having some of the best working conditions for junior doctors in the world. New Zealand has about 4,000 junior doctors, but less than half the surgical Trainees are members. Among Orthopaedic Trainees the number was less than 25 per cent. I myself had not been an RDA member for many years.

At the guts of it, Schedule 10 has two main ways of introducing safer working hours. First, by bringing in split night shifts and second, rostered days off. The rostered days off meant if you worked a weekend day you were allowed a rostered day off the next week and if you worked both weekend days you were allowed two consecutive rostered days off the following week. Sounds like heaven, right?! You work a weekend and have two days off the next week! The problem is the unintended consequences of those rostered days off and why I think the Schedule 10 'safer working hours' are not safe at all.

So, with my shiny new role, untainted by the battle to come, I approached the RDA and voiced some concerns. I was worried that Schedule 10 would dilute our training. I estimated that the average Trainee would lose six months of weekday training, and as weekdays are when important elective clinics and lists happen, this would potentially lead to longer training. The average Trainee works one in four weekends. That's 13 weekends a year and 26 rostered days off a year, which equates to five weeks a year away from weekday training. Five weeks every year for five years is 25 weeks which is just over six months. Longer training would be less attractive and worsen the shortages of rural surgeons (there is a direct correlation between years of training and the likelihood a surgeon will work in a non-rural centre).

I was also concerned about patient safety. The new rosters would necessitate an increased number of handovers as well as an increased complexity, and we know mistakes happen at handover! They also add cost and delay discharges. Lastly I was concerned about how we would staff these rosters. At the time I did some 'back of an envelope' calculations and came up with about 200-240 new junior doctors who would be needed to staff these roster changes. About 4,000 junior doctors working on average one in four to one in six weekends, is about 10 weekends a year and 20 rostered days off a year. Twenty days out of 365 is a 5.5 per cent reduction in work, so the workforce would need to increase by 5.5 per cent. 5.5 per cent of 4,000 equates to 220 new junior doctors.

I voiced my concerns to the RDA. The issues I raised were acknowledged but I was treated the same as a mother would treat a child who wakes from a

nightmare; a pat on the head a "there, there" and a monsters-aren't-real attitude. After a few more letters and a few more pats on the head I gave up on the RDA.

After much discussion and numerous attempts to circumvent Schedule 10 I felt powerless to find a solution to the problems I saw in it. What I couldn't understand was, if less than half of all junior doctors in New Zealand are represented by the RDA, why should all rosters change? Unfortunately, I still cannot answer that.

What transpired was that all junior doctors were either on an RDA contract or an independent employment agreement that for all intensive purposes looked like an RDA contract with some minor tweaks, but still included Schedule 10 changes. You can negotiate your own version of the independent employment agreement but very few have done this, its difficult and time consuming.

A year later the District Health Boards of New Zealand paid for an independent review on the affect Schedule 10 would have on Trainees, and what they came up with was almost word for word, the concerns I had been raising for nearly a year.

By this time my shiny role had lost its sheen and I had a deep fear I was going to leave the training programme in a worse state than when I found it. I started looking for a dummy's guide to starting a union but couldn't find one. I started reading New Zealand employment law, companies law and incorporated societies law, but I felt stupid. I have much more empathy for patients now. Legal jargon and legal language confused me in much the same way I am sure our jargon and language confuses patients.

It turns out, to form a union you need to become an 'incorporated society' with rules and a purpose. To become an incorporated society you need 15 people to sign up. After multiple discussions with Trainees in multiple specialties, all of whom shared my concerns, I went to my people – the Orthopaedic Trainees.

I presented them with my version of the issues and my suggestion of forming a union. With my heart very much in my mouth I asked 15 of them to sign up to my society, the Speciality Trainees of New Zealand (STONZ). After a short silence, the rough diamond in our group put his hand up to speak, "We trust you mate, where do we sign?". With more than the required amount of signatures, I set about turning the society into a union. I was now the Chair of STONZ – I had toyed with the title of 'Our Fearless Leader' when filling out the forms.

Elation turned to anxiety; how do you run a union and how do I create a union that persists after I have left the training programme? I had no idea. So I asked my colleagues for ideas. After a roller coaster of progress to dead ends I was given some advice from the New Zealand Council of Trade Unions – who ever knew we had such a thing!! It was clear I needed help. Long story short, after more dead ends the Public Service Association (PSA), New Zealand's largest trade union, agreed to help with the day-to-day running of the union, not including decision making, for a modest fee.

I am happy to say STONZ has got off the ground and will be negotiating with the district health boards to try to create a contract that will protect our training and allow us to care for New Zealanders in a team-based, collaborative manner with all of the skills we can muster. Am I doing the right thing? I think so. Some say I am being divisive, I would say the only reason my union exists is because of a division which occurred that we had no say in making. Only time will tell if I am right! Would I do it again? Yes, but reluctantly, this journey has left me with a few more scars than I had a year ago and I am sure I will get a few more before the year is out. But scars are what surgeons trade in.

Nothing worth doing is ever easy!

Dr Heath Lash
RACSTA New Zealand Representative, Orthopaedic Trainee

Courses for every stage of your career

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

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

Mandatory courses

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

- Foundation Skills for Surgical Educators course: Mandatory for SET Surgical Supervisors, Surgeons in the clinical environment who teach or train SET Trainees, IMG Clinical Assessors, Research supervisors, Education Board members, Board of Surgical Education and Training and Specialty Training Boards members.
- Operating with Respect one-day course: Mandatory for SET Supervisors, IMG Clinical Assessors and major RACS Committees.

Foundation Skills for Surgical Educators course (FSSE)

6 October 2018	Melbourne	VIC
14 October 2018	Brisbane	QLD
16 October 2018	Queenstown	NZ
1 November 2018	Adelaide	SA
3 November 2018	Brisbane	QLD
4 November 2018	Sydney	NSW
23 November 2018	Perth	WA
1 December 2018	Melbourne	VIC
2 December 2018	Canberra	ACT
8 December 2018	Auckland	NZ
10 December 2018	Melbourne	VIC

FSSE is an introductory course to expand knowledge and skills in surgical teaching and education. The aim of the course is to establish a basic standard expected of RACS surgical educators and will further knowledge in teaching and learning concepts. Participants will look at how these concepts can be applied into their own teaching context and will have the opportunity to reflect on their own personal strengths and weaknesses as an educator.

Operating with Respect course (OWR)

12 October 2018	Sydney	AU
13 October 2018	Sydney	AU
16 October 2018	Queenstown	NZ
11 November 2018	Hobart	AU
22 November 2018	Melbourne	AU

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

Academy of Surgical Educators Studio Sessions

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

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

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

Safer Australian Surgical Teamwork (SAST)

24 November 2018	Perth	WA

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

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

Surgeons as Leaders in Everyday Practice

23-24 November 2018	Melbourne	VIC

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

Process Communication Model Seminar 1

12 -14 October 2018	Perth	WA
16 -18 November 2018	Adelaide	SA

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.

Before the Introductory PCM course each participant is required to complete a diagnostic questionnaire which forms the basis of an individualised report about their preferred communication style.

Partners are encouraged to register.

Clinical Decision Making

30 November 2018	Adelaide	SA

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.

Non-Technical Skills for Surgeons (NOTSS)

23 November 2018	Sydney	NSW

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.

Bioethics Forum

27 October 2018	Sydney	NSW

The RACS Medico Legal Section presents the Bioethics Forum to stimulate robust bioethical discussions amongst surgeons. The Forum has a broad clinical emphasis to reveal current medical, surgical and hospital practice and to bring into focus innovations in medicine, nursing, pain relief and surgery that continue to evolve. Topics include Medicinal Cannaboids, Euthanasia Debate - Patient's rights to die, Futile case - Collaborating Hospitals of Surgical Mortality on Mortality Rate, Complaints handling in bioethical disputes, Advanced directives, Guardianship and Power of Attorney, Off-field behaviour by professionals and Conflict of Interest, Financial disclosure e.g. when a surgeon has been involved in the development of an implantable device, End of life issues and Healthcare proxy. The target group for this forum is Fellows, IMGs, Trainees and other interested participants.

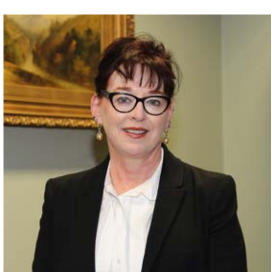
PROFESSIONAL DEVELOPMENT WORKSHOP DATES: October - December 2018

ACT		
Foundation Skills for Surgical Educators	2 Dec	Canberra
NSW		
Bioethics Forum	27 Oct	Sydney
Foundation Skills for Surgical Educators	4 Nov	Sydney
Non-Technical Skills for Surgeons	23 Nov	Sydney
NZ		
Foundation Skills for Surgical Educators	16 Oct	Queenstown
Foundation Skills for Surgical Educators	8 Dec	Auckland
QLD		
Foundation Skills for Surgical Educators	14 Oct	Brisbane
Foundation Skills for Surgical Educators	3 Nov	Brisbane
VIC		
Foundation Skills for Surgical Educators	6 Oct	Melbourne
Academy of Surgical Educators Studio Sessions	23 Oct	Melbourne
Surgeons as Leaders in Everyday Practice	23-24 Nov	Melbourne
Foundation Skills for Surgical Educators	1 Dec	Melbourne
Foundation Skills for Surgical Educators	10 Dec	Melbourne
WA		
Process Communication Model Seminar 1	12-14 Oct	Perth
Foundation Skills for Surgical Educators	23 Nov	Perth
SA		
Non-Technical Skills for Surgeons	26 Oct	Adelaide
Foundation Skills for Surgical Educators	1 Nov	Adelaide
Process Communication Model Seminar 1	16-18 Nov	Adelaide
Clinical Decision Making	30 Nov	Adelaide

Register online

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

New senior instructors



Kerin Fielding
Chair of Prevocational and Skills Education Committee

The Prevocational and Skills Education Committee congratulate the following RACS Skills Course Faculty on becoming Senior Instructors in 2017. In particular, acknowledging the multidisciplinary practitioners who teach on RACS skills courses.

To become a RACS Senior Instructor, faculty teach on over 10 courses over a period of four or more years.

ASSET: Australian and New Zealand Surgical Skills Education and Training Course	
Associate Professor Douglas Fenton-Lee, FRACS	General Surgery
Mr Gary Fermanis, FRACS	Cardiothoracic Surgery
Dr Zhen Hou, FRACS	General Surgery
Mr Ke Huang, FRACS	Orthopaedic Surgery
Mr Elie Khoury, FRACS	Orthopaedic Surgery
Mr Serge Lubicz, FRACS	Cardiothoracic Surgery
Professor Muhammed Memon, FRACS	General Surgery
Dr Christine Mouat, FRACS	General Surgery
Mr Paul Muscio, FRACS	Orthopaedic Surgery
Mr Cyril Tsan, FRACS	General Surgery
Dr Teresa Withers, FRACS	Neurosurgery
Mr Srinivasa Yellapu, FRACS	General Surgery

CCrISP®: Care of the Critically Ill Surgical Patient Course	
Mr Grant Broadhurst, FRACS	General Surgery
Dr Anthony Glover, FRACS	General Surgery
Dr Yen Lim	Anaesthetics
Dr Damien Limberger	General Practice
Dr Lakshmi Ramalingam	Oral and Maxillofacial Surgery
Dr Melinda Venn	Emergency Medicine
Dr Tarin Ward	Anaesthetics
Dr Man-Shun Wong, FRACS	General Surgery

EMST: Early Management of Severe Trauma Course	
Dr Haidar Balasem	Emergency Medicine
Dr Sylvia Boys	Emergency Medicine
Mr Jitoko Cama, FRACS	Paediatric Surgery
Dr Juliet Clayton, FRACS	Neurosurgery
Dr Gregory Hampson	General Practice
Dr Sandra Krishnan, FRACS	General Surgery
Dr Patrick Liston	Intensive Care
Dr Antony Mahindu	General Practice
Dr Melanie Sloane	General Practice

Skills training courses 2018

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

ASSET: Australian and New Zealand Surgical Skills Education and Training

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

EMST: Early Management of Severe Trauma

EMST Edition 10 has launched! EMST teaches the management of injury victims in the first 1-2 hours 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

CCrISP Edition 4 has launched! RACS has officially launched Edition 4 of the Care of the Critically Ill Surgical Patient (CCrISP®) course across Australia and New Zealand. The CCrISP® Committee has extensively reviewed materials provided by the Royal College of Surgeons of England (RCS) - resulting in an engaging new program which is highly reflective of current Australian and New Zealand clinical practice and standards in management of critically ill patients.

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 medical literature and decision analysis and Cost effectiveness studies.

TIPS: Training in Professional Skills

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

SKILLS TRAINING COURSE DATES
OCTOBER - DECEMBER 2018 | *Available courses

CCrISP	
Friday, 31 October – Sunday, 2 November	Dunedin
Friday, 2 November – Sunday, 4 November	Adelaide
CLEAR	
Friday, 19 October – Saturday, 20 October	Brisbane
Friday, 2 November – Saturday, 3 November	Adelaide
Friday, 23 November – Saturday, 24 November	Auckland
EMST	
Friday, 26 October – Sunday, 28 October	Adelaide
Friday, 23 November – Sunday, 25 November	Brisbane
Friday, 23 November – Sunday, 25 November	Adelaide
Friday, 7 December – Sunday, 9 December	Sydney

**Courses available at the time of publishing*

Contact the Skills Training Department

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

OPUS LIV (54)

Surgical and scientific anecdotes of Royal Parade

The Royal Melbourne Hospital – the continuing focus of many of these clinical contributions to the welfare of humanity.

The word 'Royal' implies 'aristocracy' and this word reflects anything of royalty, from dukes to kings and queens and even people of higher social status. So why was this boulevard so named? One interpretation comes from a London corporate director, a Marsden Hospital patient of mine who took the whole Oncology team to the Opera house, Convent Garden. His major corporation had a routine block booking of 10 seats for every program, to fraternize with the 'business fraternity and aristocracy'. On this occasion we saw the opera, Bizet's *Carmen* which was one of the highlights of my social time in London. How many of us have ever seen elephants walking across a stage?!

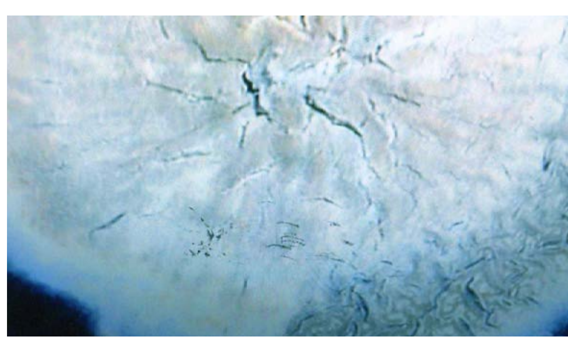
When this person, with his wife, visited us regularly in Melbourne, he explained that Royal Parade was to be the boulevard leading to the future Government House site. However the zoo now occupies this area. Word got out, and the decision was reversed placing the future Government House next to the Botanic Gardens. An alternative opinion from Dr Maxwell Lay attributes the royal name to the visit of the Duke of York, the future George V, who opened parliament in 1901.

My surgical associations with Royal Parade began with Benny Rank on my return from London, when he suggested that there was a house available nearby which would be ideal accommodation for my future wife who hailed from the Bordeaux region. Without a penny in my pocket and a willingness to try I cut my teeth as Benny suggested at Western Hospital, and became the 'King' of Emergency Hand Surgery, even working many a Christmas day.

Another surgical neighbour at No. 87 Royal Parade, Dr John Hueston taught me his refinement of Dupuytren's management having established an international reputation for his surgery for the 'fire break' technique in Dupuytren's fasciectomy. One great story now lost in history is of a German magnate who had had unsuccessful repeated procedures for his recurrent Dupuytren's disease in Europe. In exasperation when Hueston was suggested he promptly came to Melbourne to have his surgery, photographed in the press leaving with a straight hand.

We now progress down to Rank's establishment at No. 29. This was the focus of Plastic Surgery practice in Australia. A flurry of plastic surgeons at various stages of maturity and development were ensconced at this address including; Alan Wakefield, John Hueston, George Gunter, Lena McEwan, John Barnett with Don Marshall eventually becoming his partner. Subsequently Murray Stapleton and John Anstee followed suit.

Once when meandering up and down Royal Parade on the Moomba weekend in the late 70's, I noticed smoke billowing from Rank's room. I notified the Fire Brigade and the Ranks' accordingly. It transpired that Benny was the victim of a drug break-in/burglary, and the culprit had burnt the evidence vindictively in defiance. Benny was subsequently photographed sifting through the ashes and luckily had found the one photograph of the facial injuries of John Gorton (the future Prime Minister at the time) which he had sustained when his aircraft crashed during WWII near Indonesia.



Close up of agar plate and the 'pencil lines' of the penicillin mould

The next important development was when Benny, in his retirement phase, sold the premises to Dr Bob Thomas and Dr Tony Holmes. One of Holmes' crowning glories as a paediatric craniofacial surgeon, was as a team leader in the cephalic separation of conjoined twins, Krishna and Trishna, who now enjoy normal scholastic primary school education. I see them regularly as my granddaughter attends the same school as they do (but not in a post-operative capacity). Bob Thomas, after his professorial appointment at the Western Hospital, became Director of Surgical Oncology at the Peter Mac in East Melbourne, before its transition to the Victorian Comprehensive Cancer Centre, at the Royal Parade intersection.

The University of Melbourne Medical School

The late Keith Henderson, neurosurgeon at St Vincent's for more than 30 years and who lived at No. 107 Royal Parade quoted the story from the *Scientific American* of the 'scientific aristocracy' – three Nobel laureates (Florey, McFarline Burnett and Eccles) at the southern end of Royal Parade, where the Florey Institute is now located. This became the focus of the penicillin story which brings me to my next point.

Glyn Davis, another Queenslander who formerly worked in the Premier's Department there, and who has recently retired from the Vice Chancellorship of the University of Melbourne, also suggested I write some recollections of the Florey Institute at No. 30. The 1945 Nobel Prize was shared between Fleming the observer, Chain the biochemist and Florey who established its clinical development.

Another interesting factor evolving from this penicillin association is the fact that a recent episode of BBC British television program *Antiques Roadshow*, featured the preserved petri dish from Fleming's lab at St Mary's. It illustrated the 'pencil like brush strokes' characterising the ebony coloured mould on the agar plate preserved in perspex. This was the basis of Fleming's terminology using the word 'penicillin'.

It is interesting that after a career in surgery and having been brought up with penicillin as our lifeline it has taken me this length of time to visualise it scientifically.

Antiques Roadshow describing the penicillin mould being held by the interviewer with Fleming's lab technician's son who was given the prize

The new Peter MacCallum Cancer Institute reflecting the Zaha Hadid architectural influence is now part of the Victorian comprehensive Cancer Centre. This cross-bridge link to the RMH emphasises the importance of clinical material based on research developments.

Now let's cross the road to the Doherty Institute on the corner of Royal Parade and Grattan Street, named in honour of laureate Professor Peter Doherty, winner of the 1996 Nobel Prize for discovering how the immune system recognises virus infected cells. The Institute's location at the southern end of Royal Parade recognises the joint venture between the University of Melbourne and the Royal Melbourne Hospital occupying a site that was once a 10 story hotel. This building, with its curved glass exterior wall allowed one to visualise the corner spiral staircase on ascent.

I still remember Peter's lecture in the anatomy school of the University of Melbourne's Sunderland Theatre in the late 1990's - his humble words stick in my mind about his Nobel laureate: "I just happened to get it right 30 years ago". The Sunderland Theatre was so named after another Queenslander, Siddy Sunderland who became an eminent Australian scientist in the field of medicine, and was a Foundation Fellow of the Australian Academy of Science. He was made Dean of Medicine at the University of Melbourne.

Peter has become a close associate of mine over the years. We still meet often on Royal Parade; he going for the morning papers and I heading to the local store, as we always seem to be out of milk!?

He continues to be in high scientific demand walking the world stage and only recently he revealed to me that he had just returned from an International Symposium on 'The Future of Truth' at Gothenburg, Sweden with American economist Joe Stieglitz. His books, *The Knowledge Wars* and recently published *The Incidental Tourist* are well worth a read, summarising Peter's life. As former Minister Barry Jones said on the front cover of The Incidental Tourist, Peter is "A great scientist, an acute observer and a passionate advocate and a compelling writer."

Associate Professor Felix Behan
Victorian Fellow

"A psychologically healthy workplace fosters employee health and wellbeing while enhancing organizational performance and productivity,"

Sodexo 2017 Global Workplace Trends

Healthy workplaces have higher productivity

Speak in total confidence to a Converge International consultant.
Australia 1300 our eap (1300 687 327) **New Zealand** 0800 666 367
International +613 8620 5300 or **visit** convergeinternational.com.au

2018 RACSTA Induction Course

The Royal Australasian College of Surgeons Trainees' Association (RACSTA) will host an Induction Conference for 2019 SET1 Trainees in Melbourne on Saturday 27 October 2018. This annual one day conference welcomes new trainees and provides advice to help them make the most out of their surgical training. Topics will focus on the evolution of SET towards competency-based training, professional and personal wellbeing, getting the most out of feedback, as well as panel discussions including research, women in surgery, rural surgery and flexible training. The conference will conclude with a dinner at an iconic local restaurant.

This year our invited speakers include:

- Mr John Batten, Orthopaedic surgeon from Launceston and current RACS President.
- Miss Ruth Bollard, Breast/Endocrine surgeon from Ballarat, current RACS Councillor, the immediate past Chair of the Women in Surgery Committee, and current Board member of the Rural Surgery Hub (Ballarat).
- Associate Professor Stephen Tobin, Colorectal/Breast surgeon from Ballarat and current RACS Dean of Education.
- Mr Adrian Anthony, Upper Gastrointestinal surgeon from Adelaide, current Chair of the RACS Board of Surgical Education and Training, and a member of the Foundation Skills for Surgical Educators faculty.
- Mr Eric Levi, Otolaryngology, Head and Neck surgeon from Victoria who has a special interest in the mental wellbeing of doctors.
- Dr Christine Cuthbertson, General Surgeon practicing in the areas of colorectal, rural, breast and endocrine surgery from Victoria.

On Sunday 28 October 2018 *Johnson&Johnson* will be running a half day haemostasis workshop at no extra cost to participants. This limited numbers workshop will include tutorials on coagulation as well as provide a hands on opportunity to use various haemostatic agents.

Last year's conference was a great success and RACSTA is committed to keeping this strong tradition ongoing. It is an engaging forum where new Trainees can glean advice from both Fellows and senior Trainees and gain a running start into their new careers as tomorrow's surgeons.

For more information see:

https://www.surgeons.org/RACSTA
or contact racsta@surgeons.org

- **2018 RACSTA Induction Conference**
  Saturday 27 October 2018
  Conference registration from 9am
- ***Johnson&Johnson* Haemostasis Workshop**
  Sunday 28 October 2018
  Limited places available

  Royal Australasian College of Surgeons
  250-290 Spring Street, East Melbourne VIC, 3002

“Nobody is going to be there to tell them”

Development of a framework of factors and behaviours which influence assessment of competence of urology Trainees.

During the 2018 Annual Scientific Congress in May, Mr Dennis King was awarded the Surgical Education Prize. Below is a summary of his research.

Introduction

Urology Trainee performance in the operating theatre has long been regarded as one of the most difficult areas to assess for several reasons. Work place assessments are difficult, the degree of interaction between supervisor and Trainee can vary and the operative caseload may be insufficient to make judgements, particularly with complex cases. Further, the environment of urology training is rapidly changing with work hour regulation, increasing public expectations, administration oversight of outcomes, and increasing numbers of Trainees. These changes, when coupled with a fundamental change from apprentice-based training to competency-based training, have increased the need for reliable and valid assessment tools of urology Trainees. It is therefore timely to explore how decisions about Trainee’s operative competence are made and to make explicit the factors and behaviours supervisors consider in making these assessments.

Methods

The research question was addressed using an epistemological stance of inductive thematic analysis. Semi-structured individual interviews were conducted with consultant urologists and a focus group enlisted from the Victorian Urology Training, Assessment and Examination committee.

Findings

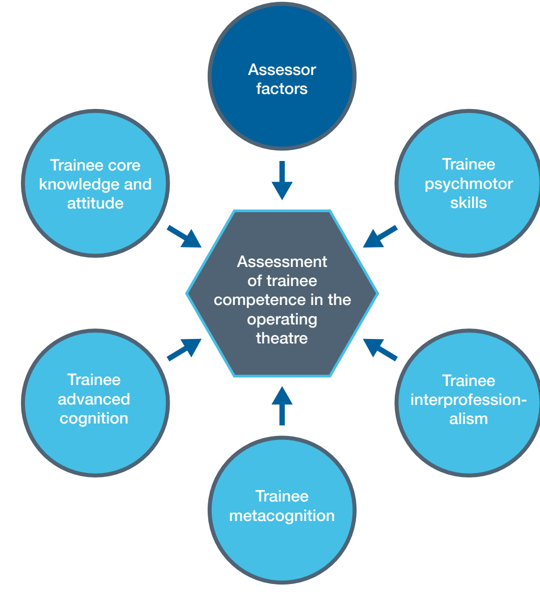
A framework of operative competence was developed, identifying the themes of core knowledge, advanced cognitive skills, metacognition, interprofessionalism, psychomotor skills and supervisor influence.

Mr Dennis King

Discussion

There is a changing emphasis in surgery towards competency rather than apprenticeship-based training. This changing perspective forces us to examine fundamental questions about how competency judgements are made. Trainees are exposed to summative assessments throughout their medical careers. As urology Trainees, they present for the Part I and II examinations, where summative assessments are made of their knowledge of basic sciences, clinical knowledge and judgement. However, there is no such assessment about their performance in the operating theatre where there is no final test to be passed.

The framework of factors and behaviours underpinning competence emphasise the importance of cognitive functions and the ability to work in a team environment which belies the belief that surgery is primarily a technical competence.



Framework of behaviours and factors influencing supervisor assessment of urology Trainees in the operating theatre

Core knowledge involved knowing the relevant basic sciences of anatomy, physiology and pathology, understanding the steps of the surgery and the literature underpinning the operation. This is required to understand the foundations of an operation and furthermore, Trainees are expected to be able to apply and integrate core knowledge in developing solutions to more complex situations.

Advanced cognitive skills comprise those mental activities whereby objects and behaviours are identified, defined, evaluated and categorised. In the operating theatre environment. Participants place particular importance on these abilities. This is expressed in the subthemes of recognising and assessing operative deviance, creating options, assessing response and managing complications.

Metacognitive skills involve the awareness and understanding of one’s own thought processes and are recognised in the areas of managing operative variance and complications, which require an awareness of personal limitations, an ability to manage personal stress responses and match these against the surgical challenge.

Psychomotor skills in the operating theatre received much less coverage, in comparison to the other behaviours in competency judgements. The lack of discussion about psychomotor skills suggests that toward the completion of training, these skills have become embedded and that surgical competence becomes more dependent on the other described framework factors. This makes sense in the context of Fitts and Posner's model of motor skill acquisition where motor function becomes increasingly autonomous with increasing competence.

Interprofessional skills of teamwork, collaboration, communication and leadership repeatedly cropped up in our interviews, emphasising the importance of these skills in the operating theatre environment. This is consistent with the prominence given to these skills recognised by their inclusion of competency frameworks outlined by CanMEDS and RACS. These non-technical skills reflect the domain in which surgery is performed and illustrate the need for the Trainee to be able to lead and work in team environments.

Supervisors base assessments on observations of knowledge, skills and judgements integrated into real life performance. Using direct observation for in training assessment has validity as judgement is based at the apex of Millers pyramid. The supervisor has a substantial influence on the assessments process. The findings show that all participants intuitively linked assessment with the concepts of entrustment and progressive autonomy. These depend heavily on the degree of trust between the supervisor and Trainee. Increased autonomy depends greatly on establishing a trusting relationship between supervisor and Trainee. Supervisors exert a significant but underappreciated effect on the assessment process. This may be related to a variation in the supervisors own abilities; either to perform an operation or to rescue Trainees from difficulties, and this can influence evaluations of competence.

Conclusion

I have explored how supervisors make competency judgements about their urology Trainee's operative performance and have developed a framework outlining the factors and behaviours which are considered in competency assessments. The most important behaviours originate from cognitive functions of core knowledge, advanced cognitive skills and metacognition. The significance of interprofessional behaviours; communication, teamwork, leadership and collaboration are a reflection that surgery occurs in a community of practice and the need for conduct which facilitates this environment. Psychomotor skills are of obvious importance in surgery and assessment is based on overall global impressions rather than atomisation of individual skills.

There are significant questions about the training in the operating theatre as we move to new viewpoints of competency based education. Assessment is said to drive learning and it is perhaps fitting that we examine how we judge in order to understand what we wish our Trainees to learn.

Mr Dennis King
FRACS

The Great War ends...

The Great War ends…

It was an unforgettable day. Amiens, Villers-Bretonneux, Hamel, Corbie, Hangard are no longer merely names… vague ideas and mere names are pushed away by something vivid and concrete…

Along the roadside are piles of war rubbish, petrol tins, rusty barb wire, rolls of camouflage etc… on top of the hill stands Villers-Bretonneux, or what is left of it. To our boys names so different to the rest of the names in France (that terrible unnatural France that only soldiers knew). A name irradiated by something – a feeling, a light. Every other name had grown to have one meaning to them – the death of hope, but Villers-Bretonneux means not only its birth, but the place where hope sprang full grown in every consciousness, to spur exhaustion with thoughts of victory…

These are the impressions of Jessie Traill who travelled around northern France in July 1919. Traill, an established Australian printmaker before the war, had enlisted with the British Voluntary Aid Detachment in 1914. She worked at the No. 8 British General Hospital near Rouen from July 1915 until February 1919.

The 11th of November marks the centenary of Armistice Day so it is apposite to reflect on the closing battles of the Great War. These include the second Battle of Villers-Bretonneux (April 1918), Le Hamel (July 1918) and Amiens (August 1918).

The aim of the German Spring Offensive in 1918 was to take the strategically important city of Amiens. On 24 April 1918, the Germans launched an attack on the nearby town of Villers-Bretonneux. Nearly 4,000 Australian troops engaged in a counter-attack to reclaim the town and despite casualties of 2,600 men, the attack was a success. The odds against a successful outcome were significant. Charles Bean who was billeted nearby stated that he: "…went to bed thoroughly depressed…feeling certain that this hurried attack would fail hopelessly."

Railway station at Villers-Bretonneux, 1918, AWM P01861.008

It was also important for the allies to retain Le Hamel, situated on the Villers-Bretonneux plateau. American and Australian troops were involved in the Battle of Le Hamel on 4 July, 1918. The battle plan formulated by the Australian commander, Lt General John Monash, involved the co-ordinated use of infantry, artillery, tanks and aircraft. It was the first use in battle of the Mark V tank and aircraft were used both for reconnaissance and as ammunition carriers. Once again, the attack was a surprise and the tactic of shelling enemy positions before an attack, was abandoned. Le Hamel was successfully retained and this time, casualties were limited.

Australian stretcher bearers, Battle of Hamel, 4 July 1918, AWM E02691

The Battle of Amiens on 8 August 1918 effectively signalled the end of the First World War. British, Canadian, Australian and French forces comprising 75,000 men, 500 tanks and 2,000 planes advanced from Villers-Bretonneux and Hamel and attacked German lines. The result was a significant victory and a series of smaller offensives further eroded German lines. On 29 August, British and New Zealand forces drove the Germans out of the town of Bapaume. The Armistice was signed just over two months later.

By 1918 transport routes to the larger base hospitals such as the 2AGH and 1AGH at Rouen, were well established and casualties often travelled to hospital by train. This was another reason why it was important to retain control of a major railway junction like Amiens.

Wounded Australians beside a tank, 9 August 1918, AWM EO2880

Victor Hurley (2nd from left), c1914, AWM C01681

Many of the medical practitioners who began their military career at Gallipoli, finished their service on the Western Front. Surgeons such as William Upjohn and Victor Hurley were both posted to the 2AGH at Boulogne in 1918 and worked at the hospital until the following year. During his time in France, Upjohn researched ways of controlling gas gangrene. Alan Barton from New South Wales was also posted to the 2AGH then and spent the last few months of the war at a Casualty Clearing Station near Péronne.

Other medical personnel spent most of their time on the Western Front. Officers involved in the battles of 1918 included Hugh Trumble, a RMO with the 14th Battalion and FGTC De Crespigny who served with the 7 Field Ambulance. Significantly, at the Battle of Hamel the Field Ambulances introduced Resuscitation teams. This innovative idea enabled the seriously injured to be treated in the field – blood transfusions, anaesthesia and surgery – rather than sending them on an arduous journey from Advanced Dressing Station to Casualty Clearing Station. In 1918, Phoebe Chapple from Adelaide who served with the Women's Auxiliary Army Corps, was one of only two women sent to the front at Abbeville.

Reflecting on the war, Jessie Traill further notes:

To see these ruins, the collapsed walls, the broken walls, the tragedy seems so near that one almost expects to hear again the whine of the shells and the thump and roar of still more explosions. But silence reigns.

The Great War is history and its scars are long healed, but it has evoked a plethora of memories that will not be forgotten. This article concludes our commemoration of World War 1. Thank you to everyone who has contributed to the centenary.

Elizabeth Milford
RACS Archivist

RACS Post Op podcasts

Latest episodes

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

World-first research supports a link between non-severe burns and cardiovascular disease

Gun violence as a health issue: strict gun control is necessary to minimise mass shootings

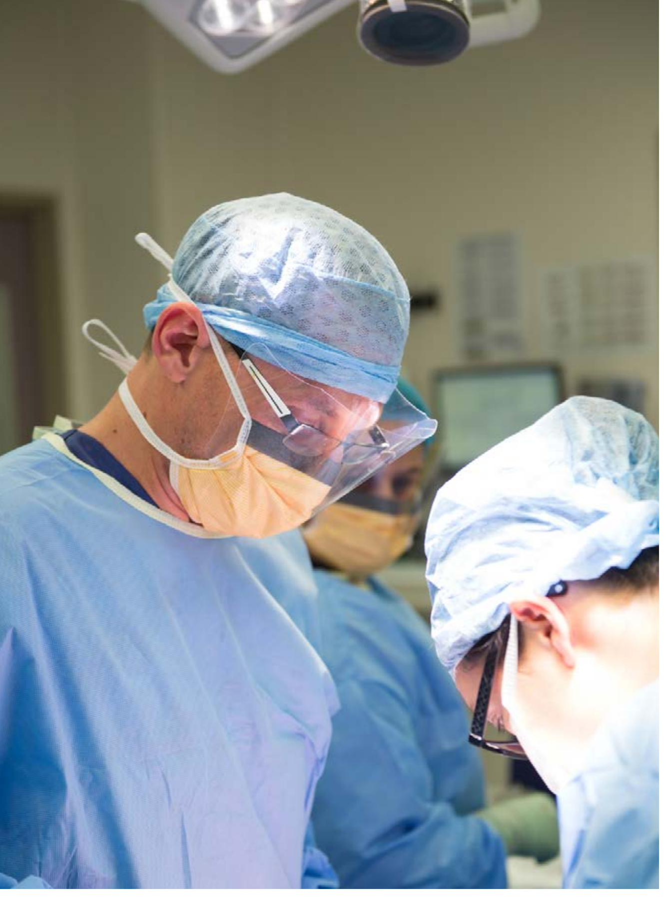
Grappling with burnout, mental health and 'institutional health'

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

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

Listen on iTunes
Search 'RACS Post Op' in the Podcast app on iPhone or in iTunes on desktop

Listen on Stitcher
Search 'RACS Post Op Podcast' on stitcher.com



A case note review

To tube or not to tube

A very elderly patient was admitted to a private hospital for an elective laparoscopic-assisted right hemicolectomy for a caecal carcinoma. The preoperative anaemia was corrected with transfusion preoperatively.

The patient had a history of reflux, was taking Omeprazole and had diet controlled non-insulin dependent diabetes mellitus (NIDDM)/glucose intolerance. The patient had an abnormal heart rhythm, presumably atrial fibrillation - managed with Digoxin, and asthma managed with Seretide and Ventolin. The patient also had previous bilateral inguinal hernia repairs.

Preoperative nursing and anaesthetic assessments seemed thorough. The operation took 1.5 hours, with the main difficulty involving the division of pelvic adhesions related to previous hernia repairs. The operation was completed laparoscopically except for the extracorporeal stapled ileocolic anastomosis.

The first two postoperative days were relatively unremarkable, with nursing concerns mainly relating to the patient's reluctance to use the patient-controlled analgesia, and intermittent runs of venous thromboembolism (self-limiting and without haemodynamic compromise). The anaesthetist reviewed the patient on days 2 and 3. Deep vein thrombosis (DVT) prophylaxis was given.

On days 1 and 3, the patient was seen by a surgeon who was happy with the patient's progress. Given the difficult division of adhesions, the surgeon was concerned about the likelihood of postoperative ileus, as suggested by a nursing entry associated with the day 1 review by the surgeon: "patient at high risk of ileus – observe and report". The nursing records noted that the patient had bowel movements on day 3. However, on day 4 there were increasing symptoms of reflux and nausea. It was noted by both the surgeon and the anaesthetist that the patient's abdomen was very distended. The patient also complained to the surgeon of chest pain and was in atrial fibrillation. A cardiologist reviewed the patient, excluding ischaemia as the cause of the atrial fibrillation and indicating that it could be due to the patient's abdominal distension and emphysema. In general, the patient was not feeling well on day 4, with increasing small bowel obstruction and lethargy.

In the morning of day 5 the nursing staff noticed worsening abdominal distension and nausea. A surgeon was contacted and gave instruction to insert a naso-gastric tube (NGT). Thirty minutes later a Code Blue was called, after the patient was heard vomiting in the bathroom and had become unresponsive after being brought back to bed. Emergency medical staff in attendance promptly found the patient covered in a copious volume of faeculent vomitus. The patient was also in bradycardia (with no measurable blood pressure [BP]) that quickly deteriorated to asystole. About 700 mL of vomitus was suctioned out of patient's trachea and endotracheal tube during intubation. Cardiopulmonary resuscitation was maintained for 20 minutes with no success.

Comment:

This elderly patient vomited profusely on the fifth postoperative day, aspirated, collapsed and was not able to be resuscitated. The deterioration occurred gradually from day four onwards, which would fit more with a picture of paralytic ileus, perhaps exacerbated by the division of adhesions. The alternative diagnosis was early postoperative small bowel obstruction, despite the reassuring passing of flatus and bowel motion. Should an NGT be placed during the operation? It often comes down to surgeon preference.

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

RACS 88th Annual Scientific Congress
Monday 6 May to Friday 10 May 2019
Centara Grand & Bangkok Convention Centre | Bangkok, Thailand
Convened by RACS New Zealand

asc.surgeons.org #RACS19

PROGRAM AT A GLANCE

Correct at time of printing (October 2018). May be subject to change.

	MONDAY 6 MAY 2019	TUESDAY 7 MAY 2019	WEDNESDAY 8 MAY 2019	THURSDAY 9 MAY 2019	FRIDAY 10 MAY 2019
Breakfast Session 7:00am – 8:20am		Masterclasses (Ticketed Event)	Masterclasses (Ticketed Event) Breakfast Session (Ticketed Event)	Masterclasses (Ticketed Event) Breakfast Session (Ticketed Event)	Masterclasses (Ticketed Event)
Session 1 8:30am – 10:00am		Opening Plenary	Scientific Sessions	Scientific Sessions	Scientific Sessions
10:00am – 10:30am	Pre-Congress Workshops	Morning Tea with the Industry	Morning Tea with the Industry	Morning Tea with the Industry	Morning Tea with the Industry
Session 2 10:30am – 12noon		Scientific Sessions	Plenary Session	Plenary Session	Plenary Session
Keynote 1 12noon – 12:30pm		Keynote and Named Lectures	Keynote and Named Lectures	The President's Lecture	The President's Town Hall
12:30pm – 1:30pm	Transplantation Program	Lunch with the Industry	Lunch with the Industry	Lunch with the Industry	Lunch with the Industry
Keynote 2 1:30pm – 2:00pm		Keynote and Named Lectures	Keynote and Named Lectures	Keynote and Named Lectures	Keynote and Named Lectures
Session 3 2:00pm – 3:30pm		Scientific Sessions	Scientific Sessions	Scientific Sessions	Scientific Sessions
3:30pm – 4:00pm		Afternoon Tea with the Industry	Afternoon Tea with the Industry	Afternoon Tea with the Industry	Afternoon Tea with the Industry
Session 4 4:00pm – 5:30pm		Scientific Sessions	Scientific Sessions	Scientific Sessions	Scientific Sessions
Evening Functions 7:00pm – 11:00pm	**Convocation Ceremony** 5:00pm – 6:30pm **Welcome Reception** 6:30pm – 7:30pm	Section Dinners (Ticketed Event)	Section Dinners (Ticketed Event)	Congress Dinner (Ticketed Event)	

ASC EXECUTIVE

ASC Convener	Nigel Willis
ASC Scientific Convener	Craig MacKinnon
Executive Members	Catherine Ferguson Simon Harper Swee Tan Lupe Taumoepeau
ASC Coordinator	Ross Ferguson
ASC Manager	Lindy Moffat
ASC Program Manager	Ally Chen
New Zealand Manager	Justine Peterson

CONGRESS ORGANISER

Conferences & Events Management
Royal Australasian College of Surgeons
College of Surgeons Gardens
250 – 290 Spring Street
East Melbourne VIC 3002
Australia

T: +61 3 9249 1158
F: +61 3 9276 7431
E: asc.registration@surgeons.org

ABSTRACT SUBMISSIONS

ABSTRACT SUBMISSION WILL BE ENTIRELY BY ELECTRONIC MEANS.

This is accessed from the Annual Scientific Congress website **asc.surgeons.org** by clicking on Abstract Submission.

Several points require emphasis:

1. Authors of research papers who wish to have their abstracts considered for inclusion in the scientific programs at the Annual Scientific Congress must submit their abstract electronically via the Congress website having regard to the closing dates in the call for abstracts, the provisional program and on the abstract submission site. Abstracts submitted after the closing date will not be considered.
2. The title should be brief and explicit.
3. Research papers should follow the format: Purpose, Methodology, Results and Conclusion.
4. Non-scientific papers, e.g. Education, History, Military, Medico-legal, may understandably depart from the above.
5. Excluding title, authors (full given first name and family name) and institution, the abstract must not exceed 1750 characters and spaces (approximately 250 words). In MS Word, this count can be determined from the 'Review' menu. Any references must be included in this allowance. If you exceed this limit, the excess text will NOT appear in the abstract book.
6. Abbreviations should be used only for common terms. For uncommon terms, the abbreviation should be given in brackets after the first full use of the word.
7. Presentations (slide and video) will only have electronic PowerPoint support. Audio visual instructions will be available in the Congress provisional program and will be included in correspondence sent to all successful authors.
8. Authors submitting research papers have a choice of two sections under which their abstract can be considered. Submissions are invited to any of the specialties or special interest groups participating in the program except cross-discipline.
9. A 50-word CV is required from each presenter to facilitate their introduction by the Chair.
10. The timing (presentation and discussion) of all papers is at the discretion of each Section Convener. Notification of the timing of presentations will appear in correspondence sent to all successful authors.
11. Tables, diagrams, graphs, etc CANNOT be accepted in the abstract submission. This is due to the limitations of the computer software program.
12. Authors must be registrants at the Congress to present and for their abstract to appear in the publications, on the website or the Virtual Congress.
13. Please ensure that you indicate on the abstract submission site whether you wish to be considered for:

BEST RESEARCH PAPER PRIZE

- Bariatric Surgery
- Breast Surgery
- Cardiothoracic Surgery
- Colorectal Surgery (Mark Killingback Prize for Younger Fellows & Trainees)
- Craniomaxillofacial Surgery
- Endocrine Surgery (Tom Reeve Prize – Trainees)
- General Surgery
- Global Health
- Hepatobiliary Surgery
- Medico-legal
- Military Surgery
- Orthopaedic Surgery
- Otolaryngology Head & Neck Surgery
- Paediatric Surgery
- Pain Medicine
- Plastic & Reconstructive Surgery
- Quality and Safety in Surgical Practice / Surgical Directors
- Rural Surgery
- Surgical Education
- Surgical History
- Surgical Oncology
- Transplantation Surgery
- Trauma Surgery (Damian McMahon Prize for Trainees)
- Upper GI Surgery

The submitting author of an abstract will ALWAYS receive email confirmation of receipt of the abstract into the submission site.

If you do not receive a confirmation email within 24 hours it may mean the abstract has not been received.

In this circumstance, please email Binh Nguyen at the Royal Australasian College of Surgeons to determine why a confirmation email has not been received.

E: binh.nguyen@surgeons.org

IMPORTANT INFORMATION

TO SUBMIT AN ABSTRACT GO TO asc.surgeons.org AND CLICK ON 'ABSTRACT SUBMISSIONS'.

THE CLOSING DATE FOR ALL SCIENTIFIC PAPER ABSTRACT SUBMISSIONS IS SUNDAY 27 JANUARY 2019.

PLEASE NOTE THAT PAPER OR FACSIMILE COPIES WILL NOT BE ACCEPTED, NOR WILL ABSTRACTS BE SUBMITTED BY COLLEGE STAFF ON BEHALF OF AUTHORS. If there are any difficulties regarding this process please contact Binh Nguyen for assistance.

T: +61 3 9249 1279
E: binh.nguyen@surgeons.org

SCIENTIFIC POSTERS

All posters will be presented electronically during the Congress and will be available for viewing on plasma screens in the industry exhibition. Posters will be placed on the Virtual Congress in addition to the abstract.

IMPORTANT DATES

Abstract Submission opens	October 2018
Closure of Abstracts	Sunday 27 January 2019
Closure of Early Registration	Sunday 17 March 2019

RACS 2019 ASC SECTION CONVENERS AND VISITORS

Correct at time of printing (October 2018). May be subject to change.

SECTION	Convener	Visitor	City/Town	Country
Bariatric Surgery	Alexandra Gordon Andrew MacCormick	Prof Amir Ghaferi Dr Torsten Olbers	Ann Arbor Gothenburg	USA SWEDEN
Breast Surgery	Eletha Taylor Ineke Meredith	Prof Shelley Hwang Prof Andrew Baildam	Durham Alderley Edge	USA UK
Cardiothoracic Surgery	Sean Galvin	Prof Joanna Chikwe	Stony Brook	USA
Colorectal Surgery	Elizabeth Dennett Ali Shekouh	Prof Ian Bissett Mr Paul Rooney	Auckland Liverpool	NZ UK
Cranomaxillofacial Surgery	Peter Anderson	Assoc Prof Quenten Schwarz	Adelaide	AU
Endocrine Surgery	Simon Harper Rajesh Patel	Prof Deepak Abraham Prof Sally Carty Dr Lawrence Shirley	Vellore Pittsburgh Columbus	INDIA USA USA
General Surgery	Hugh Cooke Atul Dhabuwala	Prof Fred Luchette Dr Caroline Reinke	Maywood Charlotte	USA USA
Global Health	K. Jitoko Cama James Kong			
Hepatobiliary Surgery	Todd Hore	Prof Stephen Wigmore Assoc Prof Fabian M. Johnston	Edinburgh Baltimore	UK USA
Indigenous Health	Jonathan Koea	Prof Papaarangi Reid	St Johns	NZ
Medico-legal	Haemish Crawford	Prof Sir Malcolm Grant		UK
Military Surgery	Burton King Darryl Tong	Dr Rhys Thomas	Liandeilo	UK
Orthopaedic Surgery	Robert Rowan Fredrick Phillips	Prof Peter Kay	Appley Bridge	UK
Otolaryngology Head & Neck Surgery	Philip Bird Sam Greig	Assoc Prof Thomas Somers Prof Erin Wright	Antwerp Edmonton	BELGUIM CANADA
Paediatric Surgery	Toni-Maree Wilson	Assoc Prof Dave Lal	Milwaukee	USA
Pain Medicine	Christopher Hoffman	Prof Hamilton Hall	Markdale	CANADA
Plastic & Reconstructive Surgery	Rita Yang Jonathan Wheeler			
Quality & Safety in Surgical Practice / Surgical Directors	Catherine Ferguson Simon Bann	Prof Charles Vincent Dr Karl Bilimoria Prof Gerald Hickson	Oxford Chicago Nashville	UK USA USA
Rural Surgery	R. John Kyngdon John Lengyel	Dr J. Patrick Walker	Crockett	USA
Senior Surgeon Program	Allan Panting	Prof David Watters	Geelong	AU
Surgical Education	Rebecca Garland Andrew Malcolm	Prof Richard Murray	Douglas	AU
Surgical History	John Collins Campbell Miles	Prof Sean Hughes	London	UK
Surgical Oncology	S. Kusal Wickremesekera Andrew Ing	Dr Swee Tan	Newtown	NZ
Trainee Association	Roberto Sthory			
Transplantation Surgery	Dilip Naik Lupe Taumoepeau Adam Bartlett	Mr Peter Friend	Oxford	UK
Trauma Surgery	Ian Civil Li Hsee	Prof Kjetil Soreide	Bergen	NORWAY
Upper GI Surgery	Alexandra Gordon Andrew MacCormick	Prof Mary Hawn	Stanford	USA
Women in Surgery Program	Jane Strang Aleksandra Popadich	Dr Heather Logghe	Reno	USA
Younger Fellows Program	Sarah Usmar Andrew MacCormick			

#RACS19 **asc.surgeons.org**

Donations to the library collection

Hiatal Hernia Surgery: An Evidence Based Approach edited by Professor Muhammed Memon FRACS

This book aims to address the recent advances and controversies on the subject of hiatus hernia and antireflux surgery. The field of antireflux surgery is undergoing a lot of changes and traditional concepts are being challenged.

Readers are provided with an evidence based approach to assist surgeons' decisions in developing a preoperative investigative algorithm prior to offering a surgical solution for either primary or recurrent hiatal hernia surgery based on supporting evidence.

Chapters further investigate the latest trends in minimally invasive hiatal hernia and antireflux surgery, both for primary and recurrent hernias.

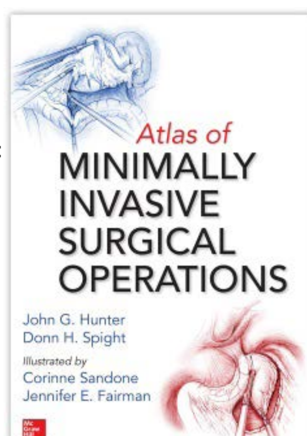
There is a long list of international contributors and many colour illustrations included within its 19 chapters.

An online e-book version is also available to RACS members at: bit.ly/2vG2rhf

Donated by the author.

New and updated content on AccessSurgery bit.ly/2LXyV1d

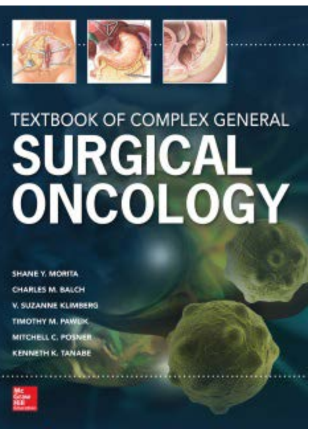
Atlas of Minimally Invasive Surgical Operations



This is a first edition that includes nearly 1,000 state-of-the-art illustrations of 62 minimally invasive surgical procedures. An excerpt from the Preface: The book represents the best thoughts and voluminous experience of the pioneers in laparoscopic surgery in the United States who have taken common open operations and adapted them to an MIS environment, bringing things they learned from each other and from masters in Europe, Asia, South America, and Australia into focus at the end of a rod lens telescope. These procedures have evolved over a quarter of a century—they have even evolved since the first figure in the book was drawn, forcing revision of the atlas as it was created.

Available at bit.ly/2ndzMfB

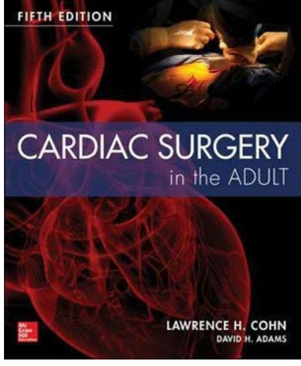
Textbook of Complex General Surgical Oncology



Recently published in its entirety after several online first chapters were released. An excerpt from the Preface: The focus of this book is to ensure discussion of core principles as well as to provide guidance in the management of various cancer sites and types. The initial aspect of the book contains an overview of germane general concepts while the vast majority comprises sections categorized as breast, endocrine, gastrointestinal, head and neck, hepatobiliary, melanoma and other cutaneous malignancies, pancreatic, peritoneal, sarcoma and other soft tissue neoplasms, reconstruction, and thoracic.

Available at: bit.ly/2MmzU7j

Cardiac Surgery in the Adult, 5th Edition



Recently updated - provides thorough, up-to-date coverage of operative strategies, techniques, and pre- and post-operative management skills for treating the adult cardiac patient. Sections include: Fundamentals, Perioperative/ intraoperative care, Ischemic heart disease, Aortic valve disease, Mitral valve disease, Valvular heart disease (other) of the great vessels, Surgery for cardiac arrhythmias, Other cardiac operations and Transplant and mechanical circulatory support.

Available at: bit.ly/2ndFrSH

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:

Ivan Cher (VIC)
Frank Spencer (USA)
Hunter Fry (NSW)
Clem Nommensen (QLD)

Informing RACS

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

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

In memoriam

RACS publishes abridged obituaries in *Surgical News*. We reproduce the opening paragraphs of the obituary. Full versions can be found on the RACS website.

Donald Simpson FRACS
Neurosurgeon
1927 - 2017

Donald Simpson was born 91 years ago into a Unitarian family with a strong tradition of learning and service.

He grew up in Burnside in the Adelaide foothills and travelled to school at St Peters College by pony or bike. He lived and died close to his original family home.

His academic record was outstanding - Tennyson medal for English Literature in the state school exams and then a series of scholarships and medals during his medical studies at the University of Adelaide.

He graduated in 1949. During his subsequent year as resident medical officer at the Royal Adelaide Hospital he published a study on neuroanatomy, the first of many research papers. He published his last paper, on medical history, in 2013.

In 1951 he began studies in Oxford in neuroanatomy under Professor Sir WE LeGros Clarke then undertook research in neuropathology and training in neurosurgery at the Radcliffe Infirmary under Mr J.B Pennybaker.

Full obituary can be read at https://www.surgeons.org/member-services/in-memoriam/donald-simpson/

Bruce Neil Procter Benjamin FRACS
Otalaryngologist
1931 - 2018

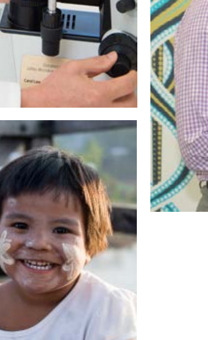
Bruce Benjamin, who died aged 86, was an otolaryngologist and leader in the field of ear nose and throat, head and neck surgery. He devoted himself to the development and refinement of techniques for study of the airway in infants and children and made extensive teaching contributions in his field of expertise.

Bruce Neil Procter Benjamin was born in Wagga on 20 December 1931, son to Neil and Lena (Neely) Benjamin, and brother to Clifford. After schooling in Wagga, with a move to Sydney, he attended Sydney Grammar School from 1946 to 1949.

He won a scholarship to attend Sydney University from 1950 to 1953 where he studied medicine, staying at St Paul's College which he represented in athletics, cricket, tennis, billiards and golf.

In 1956 he gained his qualifications with a Bachelor of Medicine and Bachelor of Surgery and in 1961 a diploma of laryngo-otology from Sydney University.

Full obituary can be read at https://www.surgeons.org/member-services/in-memoriam/bruce-neil-procterbenjamin/



Thank you!

Thank you for your extraordinary compassion and generous support to the Foundation for Surgery.

Thanks to you many more children, families and communities have access to quality surgical care when they need it most.

All costs for the Foundation for Surgery are provided for by the College so that 100% of your donation can achieve its maximum benefit to the community.

Silver ($1,000 - $10,000)

Anonymous Donor	Emeritus Professor Bryant Stokes

Bronze (Up to $999)

Mr Laszlo Borbely	Anonymous Donor	Mr Simon Tratt
Ms Megan Bridger-Darling	Anonymous Donor	Anonymous Donor
Associate Professor Maurice Brygel	Mr Robert Jager	Dr James Wynne

To find out more, please join us at **www.surgeons.org/foundation**

60th Victorian Annual Surgical Meeting

"TRAUMA SURGERY IN 2018"

Contemporary Surgical Management of Severe Trauma
Royal Children's Hospital – Education Centre

19 - 20 October 2018

photo by John Gollings

REGISTER ONLINE:

www.tinyurl.com/VicASM18

PROVISIONAL PROGRAM:

www.tinyurl.com/VicASM18Program

Contact RACS Victorian Regional Office

T: +61 3 9249 1254 | E: college.vic@surgeons.org

#VicASM18

www.surgeons.org