Royal Australasian College of Surgeons

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 18 NO 8 SEPTEMBER 2017

Concussion in sport

Concussion management from a neurosurgeon's perspective

The ultimate gift

The Foundation of Surgery needs your help

Early days in Adelaide

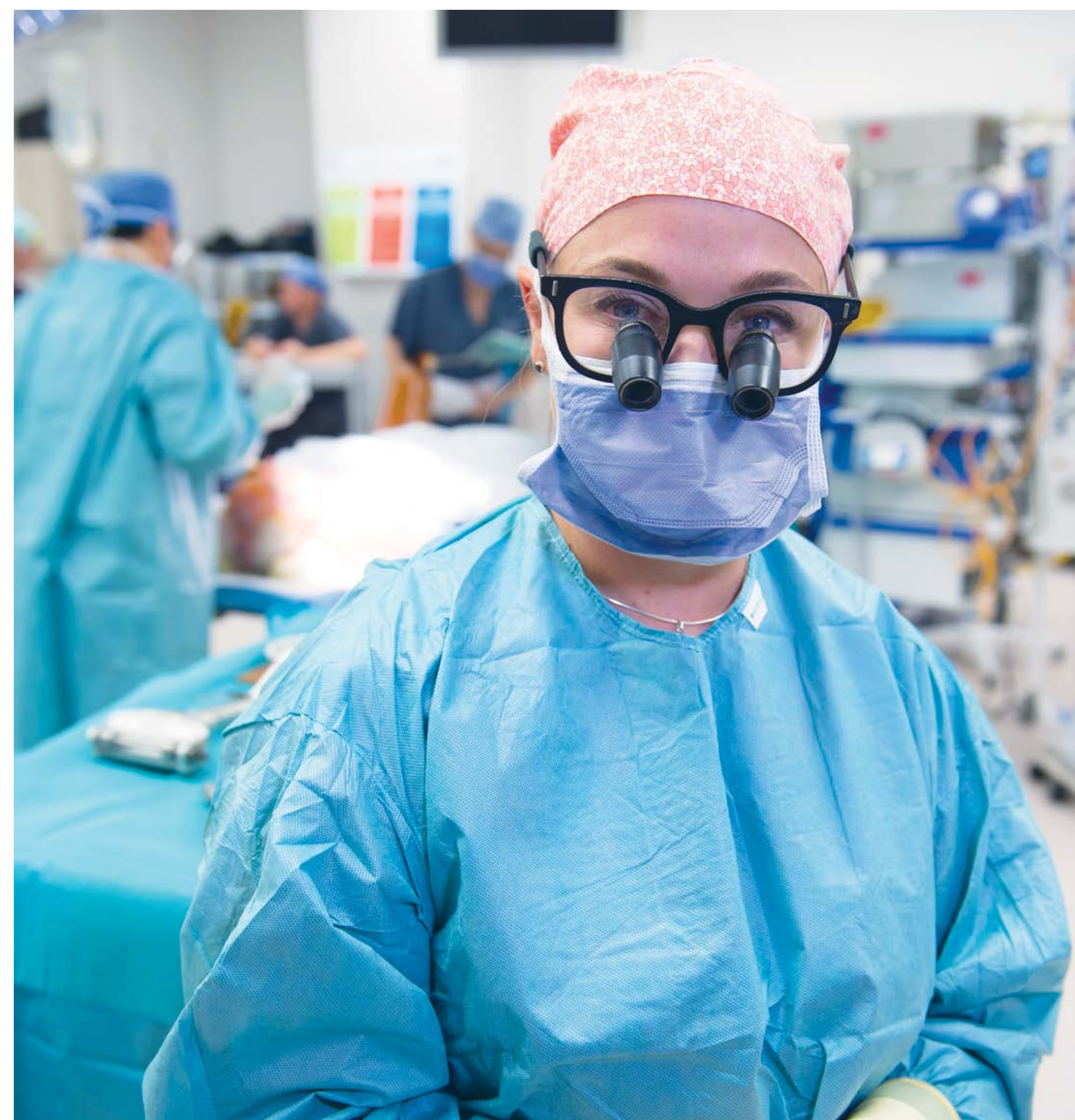
Phoebe Chapple, Violet Plummer & Archibald Watson

SURGICAL NEWS September 2017 Vol 18 No 8

Tablet Marking

A new age of examination technology

The College of Surgeons of Australia and New Zealand



When we deny our stories, they define us.
When we own our stories, we get to write a brave new ending.

Brené Brown

Speak to a RACS Support Program consultant to debrief and process some of the challenges, stressors and concerns that are faced by Surgeons, Surgical Trainees and International Medical Graduates.

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T: +61 3 9249 1200 | F: +61 3 9249 1219
W: www.surgeons.org

ISSN 1443-9603 (Print)/ISSN 1443-9565 (Online)

Surgical News Editor: RACS CEO

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Looking after ourselves

JOHN BATTEN
President

As surgeons, we often work long hours in our everyday practice to care for patients. This can come at our own expense, particularly when we neglect our own health. However, as we all know, if we want to provide the highest quality health care we need to take care of our own health and well-being. This edition of Surgical News highlights the ways in which we can all look after ourselves as professionals, to ensure we are in the best position to provide optimal care to our patients.

Mental Health & Wellbeing for Surgeons

RACS is very conscious of providing the best support we can for all our Fellows, Trainees and IMGs. Issues of mental health and wellbeing for surgeons are constantly raised and discussed at Council and at many other College committees.

We now have a strategy to assist and provide help and support:

The **RACS Support Program With Converge International** which provides free counselling sessions for all our members, has been well utilised and has now expanded to include support to family members – please refer to the article later in this edition of Surgical News for further information on this program.

A new **Peer Support Service for Complainants & Complaint Respondents** is being developed following unanimous support by Council. This service is specifically for Fellows, Trainees and IMGs who have made a complaint or had a complaint made against them through the RACS Complaints Framework.

Over the past 18 months or so, many Fellows have expressed the need to ensure the welfare of Fellows who are the subject of a complaint or are the complainant. It is important that as a community of Fellows we support Fellows, Trainees and IMGs to ensure they do not feel isolated from RACS and their peers. RACS has noted the need to provide such a service with increasing complaints being managed by the College.

Fellows have, in many cases, expressed the value of being able to talk to a peer or mentor when confronted by this situation. It is also important to be able to talk frankly, outside of the complaints process, with a trusted colleague. Many Fellows do this already, however I am aware that in some cases, enabling a connection to a peer is required.

Under this new scheme, we will develop a list of appropriately trained peer supporters representing the regional distribution of Fellows in New Zealand and Australia. The peer supporter role is to listen and enquire as to the individual's welfare, and recommend they seek any professional assistance required such as visiting their GP or a counsellor. The peer assures an individual that the College is not 'against them' and that a process needs to occur as part of natural justice. The peer will keep in touch with the individual periodically ensuring their welfare.

It is expected that this new peer support service will be rolled out by the Fellowship Services Department of the College in early 2018.

"Do you have a GP?" Campaign

I am also pleased to announce that Council has approved the development of a "Do you have a GP?" campaign, which was discussed in detail as part of June Council meetings. It is very important that all people, including surgeons, have regular contact with a GP, and this campaign will be launched later in the year.

Building Respect

Our "Building Respect" initiative is focussed on ensuring patient safety by improving behaviours and attitudes in the workplace. This has a direct impact on the mental health and wellbeing of surgeons. We must all rise to the challenge of ensuring our workplaces are safe environments to work in, and most importantly, safe places for our surgical trainees to be able to learn and develop their skills.

I am grateful to all Fellows, Trainees and IMGs who have completed the mandatory *Operating with Respect* courses.

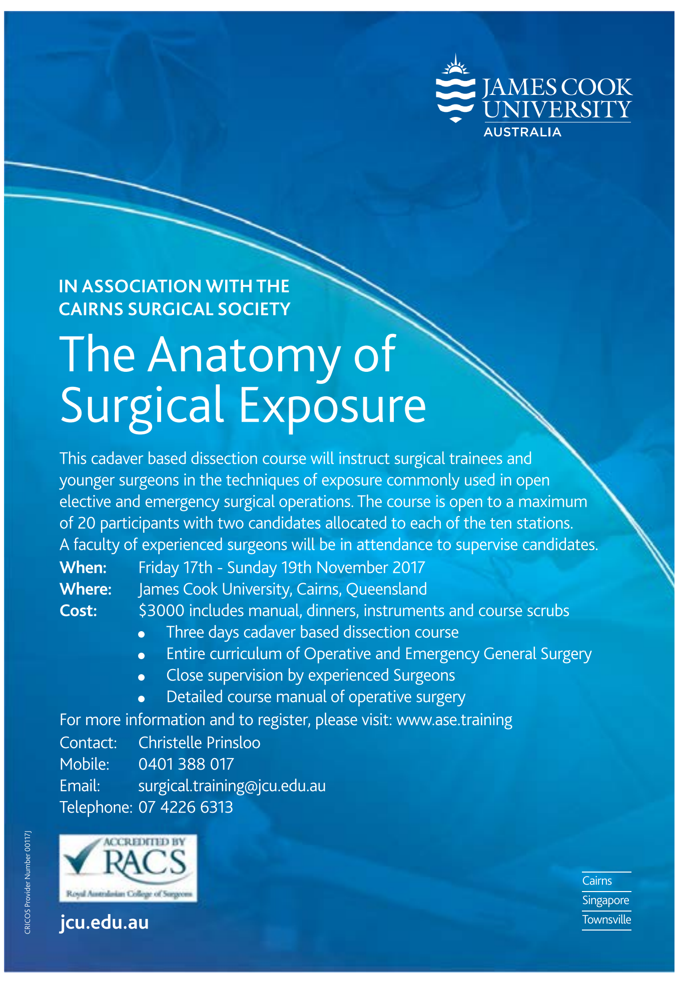
If you haven't already done the *Operating with Respect* e-module it is important that you do so as soon as possible. This module is very helpful in raising awareness of discrimination, bullying and sexual harassment. Often the behaviours that are the most challenging and most hurtful are those which may have been regarded as 'low level' or borderline, but it is essential that as highly trained professionals we recognise them, stand up to them and "call them out". The module is compulsory as part of Fellows' CPD requirements for 2017, and is also compulsory for all trainees and IMGs. You can easily link to it: https://www.surgeons.org/about-respect/what-you-can-do/

The Operating with Respect one day workshop builds on the e-module and is compulsory for all surgical supervisors and IMG clinical assessors. This excellent workshop provides advanced training in recognising, managing and preventing discrimination, bullying and sexual harassment. The aim is to strengthen patient safety by enabling participants to develop skills in respectful behaviour and practice strategies in responding to unacceptable behaviour. The workshop needs to be completed by the end of 2018 and several courses are available in a location near you.

If you haven't already done the Operating with Respect e-module it is important that you do so as soon as possible.

The above educational resources have been developed in-house by surgeons for surgeons, and tailored appropriately, with the help of our dedicated RACS staff and other subject matter experts. I would like to thank Adrian Anthony for leading the work in this area, as well as other Fellows on the Education Reference Group that was set up to develop the OWR resources.

Teamwork is vital to a high functioning surgical unit. The team at The Royal Victoria Eye and Ear Hospital is a shining example.



RACS support program update

CATHY FERGUSON
Vice President

Did you know that all RACS Fellows, Trainees and International Medical Graduates can access the RACS Support Program (RACSSP)? The program is provided by Converge International, a leading Employee Assistance Program provider, where members can access confidential support via counselling, coaching and advice on workplace, emotional and personal issues. RACS provides for up to four sessions per year. When you call the RACSSP you always speak with a qualified mental health professional. Consultants are registered psychologists and counsellors, and have extensive experience in their specialty areas with a deep knowledge of, and experience in providing care to people who work in the healthcare sector.

On behalf of Council, I am pleased to advise that the RACSSP has been enhanced with two new offerings from Converge International: the **Family Assist stream** and the **EAP Connect smartphone app.**

Extending support with Family Assist

Family Assist provides support to members of your immediate family/household (covering anyone currently living in your household plus your children), by offering qualified counsellors who are available to offer support and advice across personal and lifestyle issues.

Family Assist counsellors can help across a range of issues and areas including:

- navigating relationships
- resolving conflict
- balancing work and life pressures
- parenting challenges and more.

Members of your immediate family can access Family Assist by calling 1300 687 327 in Australia or 0800 666 367 in New Zealand at any time. Family members can access four sessions each year. The cost is covered by RACS.

Find out more about Family Assist by visiting the Converge International website: www.convergeinternational.com.au

Access information and services on your smartphone

You can access a range of information about the RACSSP on your smartphone! The Converge International EAP Connect app is available in the Google Play store for Android phones and in the iTunes store for Apple phones. You can download the app by clicking on these links or by searching 'EAP Connect' in Google Play or iTunes:

Using EAP Connect you can access a range of information including:

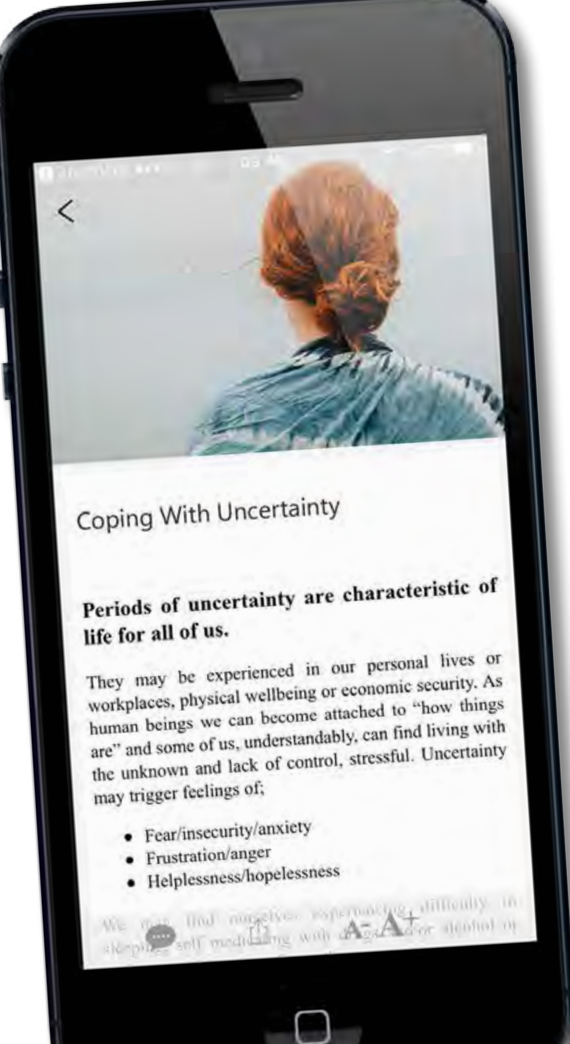
- Organising a RACSSP appointment
- More information about Converge International services
- Articles and resources on mental health and wellbeing in the workplace
- Converge International contact details.

Share your feedback about RACSSP

We strongly encourage all of those who access counselling services to complete the brief surveys sent to you by Converge after each session. By providing feedback about the services provided, Converge can improve their services and also supply aggregate data to RACS as to the effectiveness of the program. RACS Council is very interested in determining the ongoing success and viability of the program, and your feedback and the data will help us in this.

Please be reassured that at no time is information about you shared with RACS. Only high level data is provided to RACS to inform periodic reporting on themes of usage.

We are pleased to introduce these enhancements to you, and trust you will find them beneficial.



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John Flynn Private Hospital

Surgical Fellowship – Upper GI (1 position)

John Flynn Private Hospital (JFPH) and The Tweed Hospital (TTH)

Upper GI

We are pleased to announce the continuation of the Fellowship in Upper GI at both John Flynn Private (JFP) and The Tweed Hospital (TTH) for a one year period commencing February 2018. The Fellowship offers an outstanding opportunity for training in Upper GI with a substantial clinical workload in operating sessions, post op ward care and weekly multi-disciplinary meetings.

The holder of the fellowship will also be encouraged to participate in clinical research programs and will be offered the opportunity to initiate clinical/collaborative research study. Responsibilities would include the coordination of the Upper GI Multidisciplinary Team Meeting. The fellowship offers training and experience in Bariatric surgery, HPB, Oeoshago-Gastric and Hernia surgery with a focus on minimally invasive techniques including robotic surgery. There would be an on-call commitment. Medical student teaching at TTH will be a significant responsibility for the position.

Applicants should hold a FRACS; be eligible for registration with the AHPRA and NSW Medical Board; have recently completed advanced training in general surgery, and be seeking further experience in Upper GI surgery and management. The Fellow will work under the supervision of specialist surgeons and assist with private surgical operations.

The successful applicant for the position will be required to hold combined appointments both at JFPH and The Tweed Hospital. These appointments are mutually dependent.

You will require personal medical indemnity cover, but employer indemnity will be offered by Ramsay Health Care. Ramsay Health will pay a base retainer to the Fellow. Income will be supplemented from private surgical assisting, which can be retained in total by the applicant. In addition, a study grant to attend an appropriate conference during the year will be granted.

Remuneration and conditions for The Tweed Hospital are in accordance with the relevant NSW Award. Enquiries can be directed to Dr Candice Silverman – drcsilverman@gmail.com

Please send a cover letter addressing the selection criteria and a copy of your current CV to: recruitment.jfp@ramsayhealth.com.au. All applications will be treated in strictest confidence.

Applications Close: 30 September 2017

Successful applicants will be required to provide a current National Police Check

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Fav Flavs and Polyphenols

DR BB-G-LOVED

Many patients, including some of my medically qualified ones, are potential metabesics, quietly laying down body fat and expanding their waistlines during active, but often too busy, hypertensive professional lives. *Metabesity* is a new term that attempts to convey the connectedness of a range of conditions with shared metabolic roots – not only type 2 diabetes, obesity, and cardiovascular diseases, but also neurodegenerative disorders and aging. In response, patients often struggle to make meaningful lifestyle changes, particularly dietary ones. Many do not really believe "we are what we eat", or at least not until it's too late!

There is increasing evidence that gut microbiota is associated with obesity and metabolic syndrome. As there are more microbes in our gastrointestinal tracts than cells in our bodies, it is small wonder that gut metabolism has a profound effect on our health and wellbeing. The relative proportions of different microbes lurking and metabolising inside us depend on what we eat and drink, and their symbiotic needs can convert our cardiovascular system into a ticking time bomb. Amyloid may be misfolding, accumulating in your beta islets and destroying them. There is also a physiological connection between gut and brain, so that our neural, cognitive and mental health is associated with metabolites, gut permeability and inflammation. But with the right microbiota metabolising on the right diet (their diet as well as yours), you can be healthier, happier and some of the above life-threatening metabolic changes may reverse were you to have them.

These nutrients and their metabolites are polyphenols. There are two types, flavonoids and non-flavonoids, the latter include phenolic acids. There are over 6000 polyphenolic compounds divided into classes such as flavones, flavanols, flavanones, flavanonol, favan-3-ols, anthocyanins and isoflavones. Their three ringed structure is C6-C3-C6 – two C6 benzyl rings connected by a C3 chromane unit. Many polyphenols are poorly absorbed (5-10%) and are metabolised by microbial enzymes, particularly in the colon but whether absorbed or not they may be doing your microbiome and you good.

They are powerful antioxidants but have many other healthy effects too. Some have anti-diabetic and anti-obesity actions such as quercetin, tea catechins and gallic acids which inhibit glucose absorption, inhibit glucose transporters and modify hepatic gluconeogenesis. Anti-aging and anti-inflammatory effects are achieved by activating sirtuin 1. Benefits may well be enjoyed in the gut even without absorption. Plasma levels are generally much lower than those in the intestinal lumen, though catechins are rapidly absorbed. Resveratrol, green tea catechins and epigallocatechin gallate (EGCG) have been shown to suppress adiposite differentiation, and obesity-related inflammation, whilst improving body weight, cholesterol and lipid profiles. Meta-analyses of flavonoid rich cocoa have shown reduced insulin resistance and reduced risk of major cardiovascular diseases. Phenolic acids are the major metabolites of flavonoids found in the plasma and urine, and have, in the case of anthacyanin, anti-oxidant, anti-inflammatory, antihyperglycaemic, anti-atherogenic, anti-cancer and anti-aging properties. Olives (377mg polyphenols per 100g) and extra virgin olive oil (62mg per 100ml), important components of the Mediterranean diet, reduce the risk of metabolic syndrome by improving lipids, blood glucose and blood pressure control. They also have weight and visceral fat reducing effects. In addition to limiting carbohydrate digestion, enhancing insulin-mediated glucose uptake, down-regulating hepatic gluconeogenesis, suppress amyloid misfolding and aggregation in beta islets.

A whole range of foods are rich in polyphenols. Some will make you smile. Top of the Pops for polyphenol content are cloves and dried peppermint at 15,188mg and 11,960mg per 100g, though you're likely to consume more through dark berries (370-1900mg per serving depending on the berry), drinking coffee (408mg per cup), or sipping cups of green (197mg) and black (173mg) tea. You can even enjoy dark chocolate (1600mg per 100g) and imbibe red wine in moderation at 1mg per ml. High ranking foods are fruit and vegetables: apples, pomegranates, apricots and peaches, capers, red onion, carrots, spinach, broccoli; also spices such as ginger, cumin and cinnamon. And if you're going to Scarborough Fair get parsley, sage, rosemary and thyme.

Now it's time for Dr BB G-loved to enjoy a night cap. It might even be good for me. But do I choose black tea or red wine? Dare I risk some dark chocolate?

WHO invites Aussie researcher to speak at new tech conference

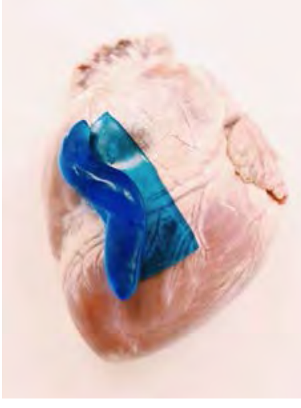
If you're unable to play video games the conventional way, just OrbIT! According to inventor David Hobbs of Flinders University in Adelaide, his motion controlled system allows those with hand impairments to play video games without needing to use buttons commonly found on a console. The system will support and provide independence for the more than 17 million people around the world affected by Cerebral Palsy and others with limited hand function. The commercial version of his device, the i-boll, which operates using a smartphone that registers the i-boll as a joystick, is expected to be available in 24 months, and was showcased for the first time at the World Health Organisation Assisted Technology Conference in Switzerland last month.

http://www.theleadsouthaustralia.com.au/industries/health/who-invites-aussie-researcher-to-speak-at-new-tech-conference/

Future surgeons use synthetic slug secretions

The leech has long been used in medicine. Known for its ability to extract blood through the surface of the skin, the leech has been used to treat everything from tonsillitis to haemorrhoids. But the slug? Less known for its healing qualities and more for its slimy nature, this has prompted researches to investigate the properties of its mucus, which turn out to be rather beneficial!

Slug slime could work even in the most slippery of surgical situations as a tough adhesive, according to Jianyu Li, co-author of the paper Tough Adhesives for Diverse Wet Surfaces, featured in Science magazine last month. Apparently, slug mucus works because it has positively charged particles that bind to any surface. It forms weak bonds with the atoms on the desired surface, and slimes its way into every crevice, becoming physically entwined with what it has adhered to. Jianyu Li explains that the result is a flexible, strong adhesive that holds as well or better than anything already on the market, but it also turns out to be non-toxic, an advantage that some alternatives can't match.



Jianyu Li said that considering that the human body includes blood and other bodily fluids, forming adhesions to those surfaces can be very challenging. In its current stretchy form, Li says that the adhesive is well suited for working on dynamic organs like the heart and lungs, which are constantly in motion throughout the day. Because the adhesive can stretch without losing strength, it can be used to patch holes in the organs, keeping blood or air safely in its place. Or it can be used to attach a device like a pacemaker while still accommodating the movement of the heart.

The next thing you know, we will be using the spider web as surgical mesh! Don't laugh! Some of the greatest inventions have spawned from what is already all around us in nature.

http://www.popsci.com.au/science/medicine/future-surgeons-might-patch-you-up-with-synthetic-slug-secretions,469615

Notable Retirement - Expression of Interest

CLINICAL DIRECTOR

Victorian Audit of Surgical Mortality (VASM)

10.5 hours per week (0.3 FTE)

The current Clinical Director VASM, **Mr Barry Beiles** FRACS will be retiring from this position in December 2017.

Council and RACS staff thank Barry for his meaningful contribution during his time in this role and wish him all the best in retirement.

RACS now invites expressions of interest/applications from suitably qualified Fellows for this position, based in Melbourne; the role is remunerated for 10.5 hours per week (0.3 FTE).

This role is responsible for the clinical direction and support to the Victorian Audit of Surgical Mortality (VASM) providing project oversight and acting as Chair of the VASM Management Committee. The Clinical Director also assists in engaging all health services/ hospitals and surgeons to actively participate and comply in this program. A close liaison with DHHS and other relevant stakeholder groups is also required.

A demonstrated ability to meet deadlines and excellent organisational and time management skills are required, as are superior verbal and written communication skills.

Expression of Interest Process

For full position information and further details please view

https://www.surgeons.org/for-the-public/college-positions-vacant/

For more information please contact

A/Prof Wendy Babidge, Director,
Wendy.Babidge@surgeons.org

or Professor Guy Maddern, Chair, ANZASM
Guy.Maddern@surgeons.org

Phone RACS +61 8 8219 0900

Applications will close on Sunday, 01 October 2017.

Tablet Marking

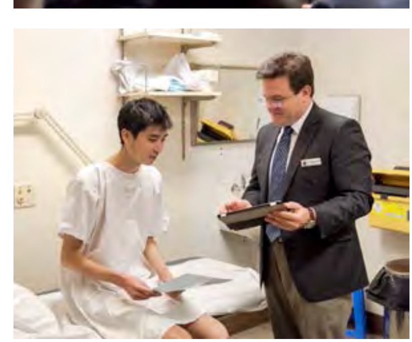
A new age of examination technology

MR RICHARD WONG SHE
Chair, Surgical Science and Clinical Examinations Committee

Cutting edge digital technology has been developed to assist examiners in marking the Clinical Examination. Tablet-based marking is not new, many universities and the Australian Medical Council (AMC) Examination Centre has introduced this technology. What is a first in Australia, and possibly the world, is the ability to use this technology with a mobile interface negating the need for a dedicated centre. This provides the mobility required to conduct the examination in hospitals across a number of major cities. Fellows have worked side by side with IT specialists and RACS examination staff to develop this unique and purpose built software that is providing examination delivery of world class standard and best practice. The new system is highly sophisticated and offers additional benefits.

Clinical Examination utilises hospital outpatient clinics in Australia and New Zealand and consists of 16 oral structured clinical exams (OSCEs) stations with the purpose of assessing at Surgical Education & Training (SET) Level 1-2, the trainee's ability across 4 domains - examination, procedure, communication and history taking. The candidate rotates through the 16 stations and is examined by several examiners. With paper based recording of the candidate's scores, recording and collation of scores was a tedious manual process. Tablet-based marking backs up locally in real time and transmits data securely to the server. Seemingly a simple process, the development presented several technical challenges and required close collaboration between Fellows and the IT developers.

Chair of the Clinical Examination Committee, Peter Cosman says on the development of tablet marking, *"the Clinical Examination Committee has been involved from its inception. We worked closely with the developers to design the user interface and specify the functionality of the iPad app, purpose built for the Clinical Exam. Committee members reviewed each iteration and put the app through its paces in mock examinations. Clinical Examination Committee members act as super-users and trouble-shooters assisting examiners to use the software efficiently and correctly, and to ensure the integrity of the results is maintained from the point of deployment to analysis and finally, the ratification of the results."*



Immediate past Chair of the Clinical Examination Committee, Michael Fink, considers the advantages of this new electronic marking system include improved security, improved entry of marks by examiners and more efficient turnaround time for results.

"The system requires examiners to comply with marking requirements and does not allow the examiner to progress through the marking system without providing valid scores for the candidate. Because this process enables more granular recording of results at a checklist item level, more detailed evaluation of question performance can be undertaken that will enable improvements over time. Importantly, the improvements in the processes will lead to more accurate, timely and detailed feedback to candidates." ▶

> *"While the introduction of tablet marking brings new challenges, the benefits (accuracy, security and speed) and risk reduction is enormous,"*
>
> *Richard Wong She, Chair Surgical Science and Clinical Examinations Committee.*

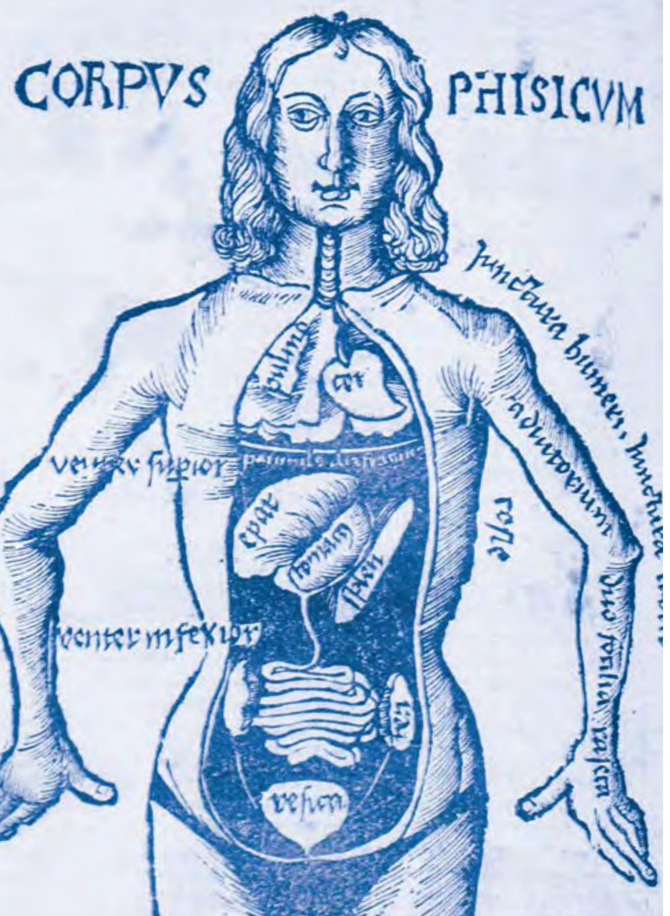
It is also possible to provide anonymised feedback to examiners on their marking behaviours compared to their colleagues, feedback that supports the professional development and upskilling of the individual examiner.

"Using this marking interface also ensures that constructive feedback is provided to poorly performing Trainees and their supervisors. In moving to this system, RACS has secured benefits to all interested parties – candidates, examiners, and staff – and is to be congratulated on its forward-thinking leadership in this arena," said Peter Cosman.

With these technological advances, the examiner experience has been streamlined and enhanced. Examiners can take away not only the satisfaction of being involved in the assessment of SET Trainees, and meet with colleagues from all over Australia and New Zealand, but also be among the first medical college examiners in Australia and New Zealand to use a digital marking platform. Training for new clinical examiners is provided and Fellows interested in joining the Clinical Examiners Committee can contact the Examinations Department at examinations@surgeons.org.

Now that tablet marking has proven to be successful for Clinical Examinations, the Examinations Department plans to extend tablet marking to Fellowship Examinations, a far more logistically challenging examination due to the higher number of candidates presenting and the need for multiple segments running at the same time across different venues.

The tablet marking project has taken a great deal of planning and piloting, hurdles have been jumped and challenges overcome, but RACS is confident this initiative will have great benefits now and into the future.



"Corpus Phisicum", illustration to *Margarita Philosophica Nova* by Gregorius Reisch, Straßburg 1508.

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Michael Wilson receives Victorian Rural Health Award

ASOHNS Victorian Section Chair, Michael Wilson, received an Aboriginal Health Award at the 12th Victorian Rural Health Awards ceremony held in Marysville on 25 March this year.

The Victorian Rural Health Awards recognise various health professionals who provide outstanding services that have significant positive impacts on the health and wellbeing of residents in Victorian rural communities.

The awards ceremony was hosted by the Rural Workforce Agency Victoria (RWAV) and sponsored by the Victorian Department of Health and Human Services.

Michael has conducted outpatient clinics and operations on indigenous patients for more than 20 years. He was also a visiting otolaryngologist at Swan Hill Hospital.

For the past 10-15 years he has regularly visited indigenous communities in the Kimberley in Western Australia, including Broome, Kununurra, Wyndham, Derby, Tenant Creek and Halls Creek conducting outpatient and operational services.

He also worked in the Murchison region of Western Australia where he provided outpatient clinics in Mount Newman, Meekatharra and Wiluna. He held an appointment at the Geraldton Base Hospital undertaking surgery for indigenous communities.

Michael has worked regularly at remote clinics and held operating and outpatient sessions at the Alice Springs Hospital. He now mentors the incumbent otolaryngologist at the Hospital, including video conferencing to both surgeons and GPs in remote areas.

For the past 12 months, with the support of the RWAV VicOutreach program, Michael has focused more on his home state, providing services to Aboriginal communities of both Bairnsdale and Sale, with regular outpatient visits and dedicated indigenous theatre lists.

Michael Wilson holding his Victorian Rural Health Award for providing ENT health services to Aboriginal communities with (from left) his wife, Georgia Wilson, and daughters.

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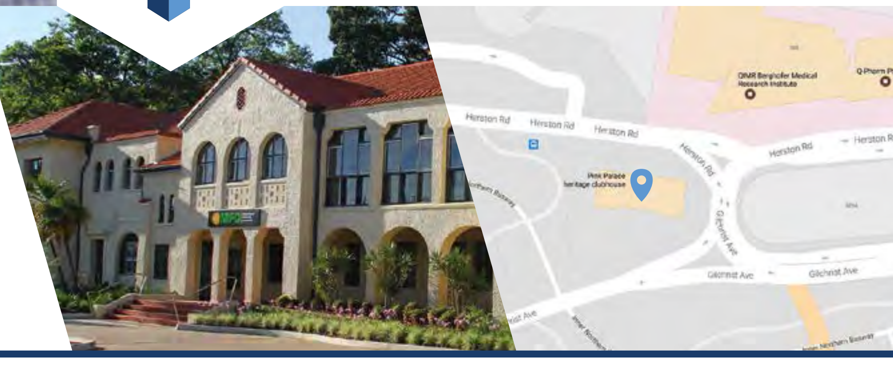

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Teamwork & Communication

Essential Tools for Success

PROFESSOR IAN CIVIL
RACS Past President

All operations have the potential for error. In the complex multidisciplinary team environment of the operating room (OR) errors are often a consequence of poor teamwork and communication and may lead to patient harm. Whether or not this arises from a failure to convey relevant facts to one another, a team lacking a shared understanding of the procedure, or individuals having difficulty speaking up and conveying crucial information is ineffective. Teamwork and communication are essential if we want the best possible outcomes for our patients.

In 2009, a paper was published in the New England Journal of Medicine titled *A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population*.[1] This research resulted from data which suggested that at least half of all surgical complications were avoidable and hypothesised that the introduction of a 19-item Surgical Safety Checklist into ORs and the associated culture changes that it signified could reduce these. Across the eight hospitals where the initiative was trialled, marked improvements in surgical outcomes were observed. Its presence is now ubiquitous throughout ORs in New Zealand and Australia.

The use of the Surgical Safety Checklist has proven to be an effective tool for improving the sharing of information among team members. Since 2012, New Zealand's Health Quality and Safety Commission (HQSC) has introduced, mandated and subsequently measured the performance of checklists in ORs across New Zealand as part of its Safe Surgery NZ programme. Recognising the impact that this has had on improving communication and teamwork, the programme now has two additional foci: encouraging surgeons to conduct a briefing and debriefing prior to, and after, operating lists, and improving the engagement of clinicians performing checklists..

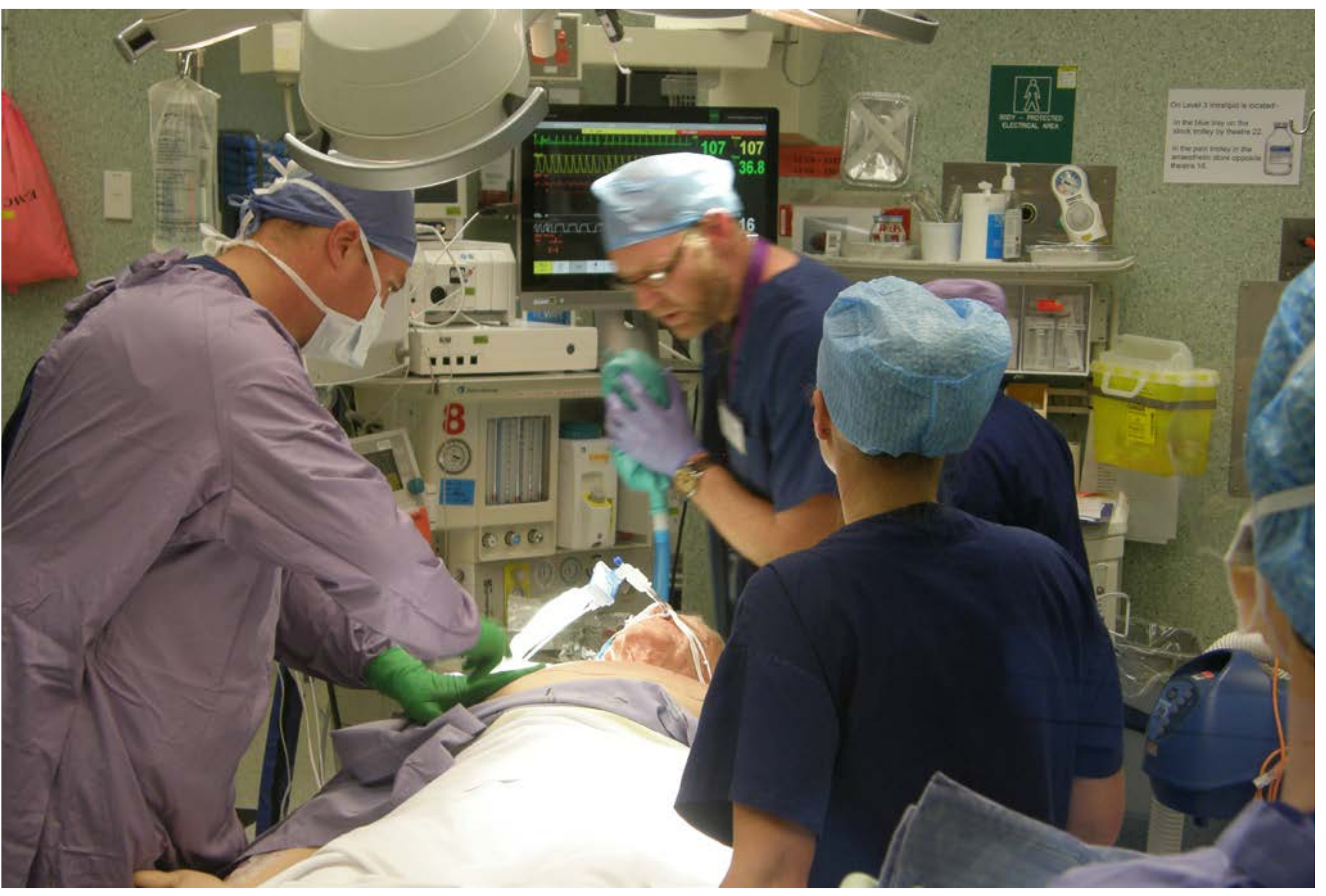
The inclusion of briefings and debriefings in the theatre environment may be perceived as an inconvenience; however there is strong evidence to support their use.[2] Communication failures are reduced by two-thirds, non-routine events are reduced by 25%, potential surgical safety hazards are identified earlier, and staff develop a shared mental model of the task at hand. This extra step of preparation ensures that equipment is available in advance and other teams such as radiographers are present at the right time. As a result, unexpected delays are also reduced – the small investment of time early is typically outweighed by the time saved later.

There is also a powerful link between regular briefings and a culture of teamwork and safety within the OR. Alongside making the operating day generally more enjoyable, the ultimate beneficiary of such a culture is the patient. With this in mind, the HQSC is encouraging all operating lists in New Zealand to introduce briefings over the next 12 months. Surgeons are key leaders in the OR, and our participation is essential for driving the briefing process. Along with the patients, we also stand to receive some of the greatest benefits from it.

While evidence supports a relationship between the use of briefings, the Surgical Safety Checklist and improvements in patient outcomes, their effectiveness is also dependant on how engaged the team is in the process. For the past year the HQSC has been collecting quarterly Quality and Safety Marker (QSM) data on levels of engagement with the Surgical Safety Checklist by District Health Board (DHB). Using one of the WHO's seven-point Likert scales, the QSM target is that 95% of surgical procedures score engagement levels of five or above. While the number of DHBs reaching this target is increasing, there is still plenty of room for improvement. As leaders in the OR, surgeons are best positioned to lead by example and encourage engagement.

> *Surgeons are key leaders in the operating room, and our participation is essential for driving the briefing process. We also stand to achieve some of the greatest benefits from it.*

Communication tools such as checklists and briefings are most effective in a receptive and supportive culture, a view which is consistent with the work that the College is doing around its Let's Operate With Respect campaign. Recognising this, the University of Auckland, supported by the HQSC and funded by ACC has developed MORSim (Multidisciplinary Operating Room Simulation), a high fidelity simulation which provides OR teams with a day of challenging surgical cases, debriefing and discussion. Underpinned by shared mental models, mutual trust and closed loop communication, MORSim helps teams to develop leadership, team orientation, mutual monitoring, back up behaviours and adaptability in a simulated surgical setting.



A pilot of the MORSim programme was run in 2012/13 for 20 general surgical teams at two large metropolitan hospitals.[3] The results were promising, demonstrating an improvement in scores for teamwork and communication following the programme.[4] Recognising that good teamwork and communication results in safer surgery, less errors, and potentially fewer treatment injury claims, MORSim will be rolled out to all of New Zealand' DHBs in the next five years, with a number having already initiated the program and run their first courses.

The OR is a team environment in which leadership is essential. At times, each of the OR teams have vital leadership roles and surgical participation and role modelling is essential. A culture of teamwork and strong communication results in safer surgery, more productive operating rooms, and most importantly, better outcomes for the patient.

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

1 Haynes, AB, et al. *A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population.* N Engl J Med 2009; 360:491-499.
2 Civil, I., and Shuker, C. 2015, *Briefings and debriefings in one surgeon's practice.* ANZ J Surg 85 (2015) 321–323
3 Weller, J, et al. *Can team training make surgery safer? Lessons for national implementation of a simulation based programme.* NZMF 2016;129:9-17.
4 Weller, J, et al. *Improved scores for observed teamwork in the clinical environment following a multidisciplinary operating room simulation intervention.* NZMJ 2016;129:59-67.

Advocacy Update: Busy Month in the Top End

When it comes to road safety the Northern Territory (NT) has by far the worst record of any Australian jurisdiction. Statistics show that you are at least three times more likely to die in a road accident when travelling on Northern Territory roads than anywhere else in Australia.

Equally alarming is the rate of alcohol misuse. Comparatively the NT has one of the highest per capita consumption rates of alcohol anywhere in the world. Consequently this has led to higher levels of alcohol related crime and domestic violence.

For RACS, advocacy has always been about effecting positive change in the community by adopting informed and principled positions on issues of public health. In recent years RACS has been particularly vocal in advocating for policies that will reduce road trauma and alcohol related harm. Therefore, the College was eager to be involved when the Northern Territory Government announced in early 2017 their intention to conduct one of the most comprehensive liquor reviews, as well as seek input in to a new Road Safety Strategy. The reviews and our responses are summarised below.

'Towards Zero' Road Safety Strategy:

Major NT highways rate poorly by national standards, and the isolated and remote nature of much of the geographical area presents added difficulties to emergency response teams when things go wrong. These are just some of the factors that contribute to a road fatality rate comparable with developing countries rather than other Australian jurisdictions. As a consequence this leads to devastating human, financial and community costs.

Our response was primarily based on RACS' Road Trauma Prevention position paper, but was also carefully nuanced to reflect the Territory's unique situation. It was emphasised that the Safe Systems approach (as outlined in the National Road Safety Strategy) must be one of the cornerstones of the new strategy if the Government is to successfully reduce the unacceptably high fatality rate.

Northern territory Alcohol and Policies Legislation Review:

Like many liquor reviews that have taken place across Australia, the NT Review queried how best to reduce alcohol related crime while maintaining 'vibrancy.' In response to this, RACS highlighted that vibrancy should not be viewed as attainable by easing restrictions on the sale and consumption of alcohol in a misguided attempt to appease industry concerns and generate economic activity. In order to create a successful vibrant culture, it is crucial to recognise the intrinsic link between vibrancy and safety. Vibrancy cannot be achieved when the community does not feel secure to enjoy a safe night out, and that adequate safety measures must be established. RACS' submission stressed that harm minimisation must be the central consideration of any revised liquor framework.

As the two reviews progress, RACS will remain involved and continue to advocate strongly for positive change on behalf of its Fellows and patients.

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

Essential Pain Management Débuts in Papua

ANNETTE HOLIAN
Chair, External Affairs

A young Papuan woman involved in an accident and suffering from a broken femur lies on a stretcher at the general hospital in Jayapura, awaiting treatment.

Surprisingly, she holds an expressionless look on her face despite not being on any pain medication though naturally admitting to being in great agony. The resident doctors explain to Dr Roger Goucke that this is likely due to a high tolerance of pain, learned through a 'hard way of life'.

Image: A group discussion assesses local pain management problems and solutions

The inaugural Essential Pain Management (EPM) workshop in Jayapura was held between 12 – 14 July 2017 as part of the RACS Global Health program in Papua and West Papua. The program, supported by Australian Aid, is focused on health services, workforce development and capacity building through medical education with local health personnel in the management, treatment and after-care of patients in the region.

Across the globe and especially in low-resource settings, inadequate treatment of acute and chronic pain is a vast problem. EPM is an international program developed by Dr Roger Goucke and Dr Wayne Morriss and began in Papua New Guinea, with workshops since held in over 40 countries. The EPM was developed to improve knowledge of pain and to address pain management barriers by providing a simple framework for treating pain.

Excitingly, EPM was brought to Papua, Indonesia for the first time in July this year. Papua is the largest and easternmost province of Indonesia, bordered by Papua New Guinea to the east with Jayapura the capital of Papua.

It was here in Jayapura where 115 enthusiastic participants attended 4 full-day EPM workshops over 3 days, conducted in both Bahasa Indonesia and English. Thirteen new instructors were certified and went on to run subsequent classes with mentorship and supervision.

Participants came from a wide range of surgical specialties including general surgery, orthopaedic surgery, paediatric surgery and urology. Medical backgrounds also included anaesthesia, obstetrics and gynecology, oncology, general practice, nursing and midwifery.

The Australian co-founder of EPM and visiting coordinator, Dr Roger Goucke observed that, "No matter what level of training, the attendees learned all we had to share very humbly and were open to the new approach to pain."

The Indonesian coordinator of the EPM, Dr Diah Widyanti, explained that EPM is needed in the region because busy healthcare providers at major hospitals in Indonesia are often limited by their understanding of pain, which leads to unnecessary delays in treatment for the patient.

Participants said they thoroughly enjoyed the informal and interactive format of the course and easy-going teaching style of the instructors, as well as the clear and structured material. They benefited from the workshop, both as a refresher and the new knowledge embedded through shared experiences by the instructors and colleagues from different specialities and hospitals.

Dr Rony, a surgeon from Yapen General Hospital in West Papua summed up general participant feedback. He said he gained a better understanding of pain management and will now think of combining different drugs and non-pharmacological treatments for different levels of pain, especially where there is limited access to medicine. He also said that when it comes to managing pain, delivering comfort and better treatment; EPM will help healthcare providers to remember that patients are people, not their illnesses.

Nurse Amatus Patiran from Dian Harapan Hospital in Jayapura felt that the workshop gave him new ideas on how to approach and work around barriers and found the Recognise, Assess, Treat (RAT) framework incredibly easy to recall and use for day-to-day pain scenarios.

Dr Goucke was pleased at the opportunity to bring the EPM to Jayapura, and said "It was fascinating and humbling conversing about patient's spiritual beliefs during the discussion on the meaning of pain and non-drug treatment options." He added that some challenges can be met locally by workforce education and through developing appropriate, targeted and informative material for patients.

Overall, he said "It was terrific to see so many different medical specialists come along. While there were a good number of surgeons and representation from different surgical specialities, and such a small number of anaesthetists, pain treatment clearly is everyone's business!"

The Health Services Development Program in Papua and West Papua, Indonesia was established at the request of the Coordinating Ministry for Political, Legal and Security of Indonesia and at the invitation of the Provincial Health Authority in Papua.

– With Veronica Verghese & Gwyn Low, RACS Global Health.

Leading Surgeons

The Younger Fellows Forum (YFF) is an annual retreat drawing Younger Fellows (within 10 years of attaining their fellowship) together to share, discuss and debate relevant issues related to the College

NIPU JAYATILLEKE & UPEKSHA DE SILVA
Co-Convenors

The YFF is traditionally held the weekend before the ASC and is attended by 20 younger Fellows who are chosen via a competitive process after nominating themselves via the RACS website. Invited Fellows from Hong Kong and Thailand as well as the Association for Academic Surgery (USA) also attend. The Forum provides an avenue for Younger Fellows to discuss issues related to the College and makes recommendations, which are presented to RACS Council for discussion.

The President of RACS as well as two Councilors attends the Forum showing how valued the Forum is within the College. Important past recommendations include the need for Preparation for Practice courses held in Australia and New Zealand, the Mentorship program that is currently being trialed and well as childcare at the ASC.

Mt. Lofty House, nestled in The Adelaide Hills, was the beautiful location for the YFF this year. The indomitable duo of Peter Chin and Robert Whitfield co-convened a terrific forum on "Leading Surgeons". Past President, Phil Truskett, as well as the President, John Batten and Censor-in-Chief Anthony Sparnon, and the Chair of the Younger Fellows Committee, Christine Lai were also in attendance.

After the welcome to country, delegates introduced themselves which highlighted that there was representation from all parts of New Zealand and Australia as well as most of the surgical specialties.

The first invited speaker was Natalie von Bertouch, former captain of the Australian Women's Netball team who gave an excellent talk on Leadership. Christine Lai talked about the place of Younger Fellows within RACS and how we can all get involved with the College.

No start to a Younger Fellows Forum is complete without the inevitable Young Fellow Forum team building exercise - this year, it was "Survivor", complete with colour coded team bandannas; the interlinked physical and puzzle challenges culminated in the creation and performance of a team anthem. There was heated competition between the groups but the winning Team Red were worthy victors with President Truskett channeling Jay-Z in its haematologically accurate rap finale!

Day two kicked off with a series of fantastic talks given by our visiting delegates, and invited speakers. Topics ranged from practical tips on developing your research brand, by Dr Ash Ghosain (AAS Visitor), to an excellent and thought provoking lecture on doctors' mental health, with some heartbreaking statistics that highlighted the need for us to take better care of ourselves, and our colleagues.

From Hong Kong we had Professor Paul Bo-san Lai, the President of the Hong Kong College of Surgeons discuss Clinical Governance as well as Dr. Patricia Yam, our invited colleague from Hong Kong, who delivered an engaging and unique perspective, outlining her recent experiences in outreach surgery as a young surgeon in Africa. This facilitated a discussion on "non-linear" pathways to success.

The Honorable Trish White spoke about Women and Leadership, which is certainly a current topical discussion within RACS. Prof Robert O'Brien spoke on what makes a good team drawing on his experiences as the team performance consultant for the Essendon AFL team. President Truskett spoke about the importance of the YFF to the College reiterating that our discussions and recommendations carry real weight within the Council.

The diversity and depth of the morning's talks enhanced the enthusiastic brainstorming of ideas by the Younger Fellows; our international guests gave an extra perspective into some shared issues, and the invited Councillors provided the balance of experience, to help formulate our ideas.

The day concluded with a wine and cheese tasting session, which was a truly amazing gastronomic tour on our plates, from the tiniest of French villages to local producers whose properties we could see from the dining room of Mt. Lofty House. Dinner was at Walk the Talk restaurant, showcasing even more of South Australia's incredible produce. The topics discussed during the day led to many animated discussions over dinner.

Taking in the sunrise, followed by morning yoga overlooking the Adelaide Hills, provided an appropriately mindful start to a day of reflection, where our ideas were summarised as formal recommendations for RACS. Although we started the forum introducing ourselves to a group of like-minded colleagues, we ended the furum by saying goodbye to a group of new friends.

The 2018 Younger Fellows Forum will be particularly unique and truly reflect the theme of "Working Together" as we will be joining forces with the Younger Fellows of ANZCA, with a joint agenda. It will be held at the iconic Hydro Majestic Blue Mountains, perched on the stunning escarpment overlooking the world heritage listed Blue Mountains National Park. Away from the hustle and bustle of metropolitan Sydney, it is a perfect literal AND figurative backdrop for generating vibrant and progressive ideas for both our Colleges' future paths.

Are you within 10 years of obtaining your FRACS? Are there issues you feel the College could address better? Well, get off the sidelines, nominate, and be the change you want to see!

Looking forward to seeing you in 2018!

- Enjoy engaging cases, panel discussions, and video presentations
- Benefit from active participation opportunities throughout the conference
- Earn self-assessment credit toward Part 2 of the ABS MOC program

MARRIOTT WAILEA BEACH RESORT
MAUI, HAWAII
FEBRUARY 18–23, 2018
CE.MAYO.EDU/SURGSYMPOSIUM2018

The Do's and Don'ts of Live Tweeting

You may have heard of 'live tweeting' or seen an organisation like RACS cover an event such as the recent Annual Scientific Congress with the hashtag #RACS17. Live tweeting is an easy way to follow updates or join in the conversation from an event without actually being there.

Twitter is a great place to share regular updates of where you are, what you're interested in and what you're doing.

You may have heard of 'live tweeting' or seen an organisation like RACS cover an event such as the recent Annual Scientific Congress with the hashtag #RACS17. Live tweeting is an easy way to follow updates or join in the conversation from an event without actually being there.

If you do happen to be attending an event and decide to live tweet, here are some do's and don'ts.

DO

- Let your followers know you'll be attending the event early, and connect with others who may also be attending.
- Use the official hashtag for the event so others can easily find your tweets and join the conversation.
- Make sure you've got enough charge in your mobile device, laptop or iPad. Uploading photos and videos will drain your battery easily. Be sure to have a back-up device or an on-the-go charger.
- Quote speakers and useful tips. Ensure you know if the speaker has a Twitter handle so that they can be attributed.
- Interact with others using the event hashtag by retweeting, liking and replying.
- Add photos or videos to your tweets where tweet-worthy. Get there early and grab a good seat or viewpoint.

DON'T

- Stop tweeting mid-way through the event. If you've committed to tweeting, continue until the event has finished, even if you don't gain any engagement or followers.
- Forget to use the hashtag. Every tweet, every time!
- Finish without a sign-off. Continue to tweet any notes and tips you may have taken away from the event or pictures with you and your friends. If you're blog savvy, write a post summarising the event and tweet later that day.

If you can't attend an event but want to join in the conversation, simply follow the event hashtag and get tweeting!

– Aubrey Hamlett
Digital Media & Internal Communications Coordinator
Communications & Advocacy

The ANZGOSA Audit: a tool for research as well as quality assurance

The ANZGOSA Audit is directed by the Australian and New Zealand Gastric and Oesophageal Surgery Association and operated by the College's Research, Audit and Academic Surgery Division.

ANDREW MACCORMICK
Chair, ANZGOSA Scientific Research and Audit Committee

The audit is pleased to announce that after more than six years of data collection, the first research project on audit data has published results in the ANZ Journal of Surgery.

The ANZGOSA Audit was established in 2010 to collect data on patients treated for oesophago-gastric cancer or gastrointestinal stromal tumour (GIST) in Australia and New Zealand, and to provide a tool for self-auditing for members of the Australian and New Zealand Gastric and Oesophageal Surgical Association (ANZGOSA). The College has been managing the audit on behalf of ANZGOSA since its initiation.

The research project, headed by Sarah Thompson (then Chair of the audit), examined the GIST subset of the collected data. The paper shows that despite the voluntary nature of the audit, results of the research were shown to be consistent with other studies internationally, demonstrating the value of the dataset. Given the relative rarity of GISTs, the centralised data collected through the ANZGOSA Audit should be a valuable resource in analysing the disease and its treatment in this region.

For more details, see issue 87 of the ANZ Journal of Surgery:

Parameswaran, R., Roberts, R. H., Brown, W. A., Aly, A., Kiroff, G., Epari, K., MacCormick, A. D., Thomson, I. G. and Thompson, S. K. (2017), Surgery for gastrointestinal stromal tumours in Australia and New Zealand: results from a bi-national audit. *ANZ Journal of Surgery*, 87: 220–221. doi:10.1111/ans.13840

– With Katherine Economides, Manager, Morbidity Audits, Research, Audit and Academic Surgery Division

Concussion in Sport

Melbourne leading the way in clinical research

PROFESSOR GAVIN DAVIS FRACS

Concussion accounts for up to 90 per cent of all child traumatic brain injury (TBI), with major causes being falls and sports injuries. By the age of 10 years, 20 per cent, or 51,000 Australian children, will have had at least one concussion requiring medical attention. In the Australian Football League (AFL), there is an incidence of 7 concussions per 1000 player hours. Yet, for a condition affecting so many Australians, neurosurgeons have traditionally been reluctant to manage concussion, focusing greater efforts in the management of more severe TBI. Gavin Davis (FRACS) is a Melbourne neurosurgeon bucking this trend and leading the international community in the management of sports concussion.

Internationally, the peak body for the management of sports concussion is the International Concussion in Sport Group (CISG), a group sponsored by the International Ice Hockey Federation (IIHF), the Fédération Internationale de Football Association (FIFA), International Olympic Committee (IOC), World Rugby, and Fédération Equestre Internationale (FEI). The CISG meets in Europe in each Olympic year, and the outcome of the meeting is published as a series of papers, including a consensus statement, that guides the international community on the management of concussion in sport. The group has also developed a series of tools for the medical community, including the Sport Concussion Assessment Tool (SCAT), and for the lay person, the Concussion Recognition Tool (CRT). Gavin Davis, the only Australian neurosurgeon member of the CISG, has been a key member of the CISG since 2004, and has led the development of the recommendations for the management of paediatric concussion, and the development of the Child version of the SCAT. The most recent CISG meeting was held in Berlin in October 2016, and the outcome papers and new tools papers (SCAT5, Child SCAT5 and CRT5) were published this year in the *British Journal of Sports Medicine* (http://bjsm.bmj.com/content/51/11).

Image: Professor Davis (right) with Dr Allen Sills; Chief Medical Officer of the NFL (left) at an AFL game at the MCG, March 2017.

While continuing full time neurosurgical practice at the Austin and Cabrini Hospitals in Melbourne, Gavin works collaboratively with the team at the Florey Institute of Neuroscience and Mental Health (Austin Hospital), including Dr Michael Makdissi (sports medicine physician) and Prof. Paul McCrory (neurologist), and at the Murdoch Children's Research Institute (MCRI) with Prof. Vicki Anderson (neuropsychologist), Prof. Franz Babl (emergency physician) and colleagues. At the MCRI, the team is actively studying the natural history of concussion recovery in children, and predictors of prolonged concussion symptoms, in addition to clinical and laboratory biomarkers and potential treatment strategies. At the Florey, the team is studying concussion in elite level athletes, including AFL footballers. As a member of the AFL Concussion working group and the AFL concussion scientific committee, his research has included detailed analysis of neurological signs of concussion using video analysis. This research is critically important to international sporting bodies, because it provides clinical information to team doctors using available technology, and increases the likelihood that the team doctor will identify possible concussion in a timely fashion, which improves player safety and welfare. Gavin recently presented these data to the Health and Safety Committee of the National Football League (NFL) in New York, which affords the opportunity for further international collaborative research.

Many readers will be familiar with the prominence given to sports concussion in the international media and Hollywood movies, but may not be aware that a multidisciplinary team of talented researchers in Melbourne is leading the way in clinical research in the management of concussion in both children and adults. It is critically important that a condition that impacts so many Australian lives receives further research that will encourage children and adults to continue to pursue all sports safely, in the knowledge that active lifestyles are essential to reducing the national obesity epidemic. With these evidence based management paradigms, concussion can be managed well, reducing the risk of long-term neurological sequelae. While the international trend has been that practitioners from other disciplines, such as sports medicine and neuropsychology, are managing patients with concussion, it is important that neurosurgeons, as the experts on managing the full spectrum of brain trauma, maintain an active interest in managing sports concussion in both children and adults.

Picture this....

ASSOC. PROF. ALAN DE COSTA FRACS

Looking at a painting is an art; perhaps a science. The anatomy lesson of Dr Nicolaes Tulp, is a classic much beloved of surgeons. So, looking at the painting as art, there is the remarkable setting of a group of seven men, The Amsterdam Guild of Surgeons, where a space has been made for the painter, whose presence is recorded. A mastery of shadow and light with dark tints emphasising the body at its centre, glowing in a pale luminosity - a moment in time. Time itself is recorded 1632. This was a formal meeting occurring perhaps once a year, and hosted by the Praelector to the Guild. This was a prestigious position, and public anatomists had considerable cachet. Andrez Vesalius himself may have lectured in this very room in the University of Amsterdam years before. The room we are told, is still in use. The corpse is identified as Adriaen het Kint, who had been hanged that winter morning following a conviction for robbery with violence, the dissection being authorised by the civic authorities of Amsterdam. Rembrandt, whose fame was just emerging would have been commissioned by the Guild (whose names are on the list being held by the central figure) to commemorate the event.

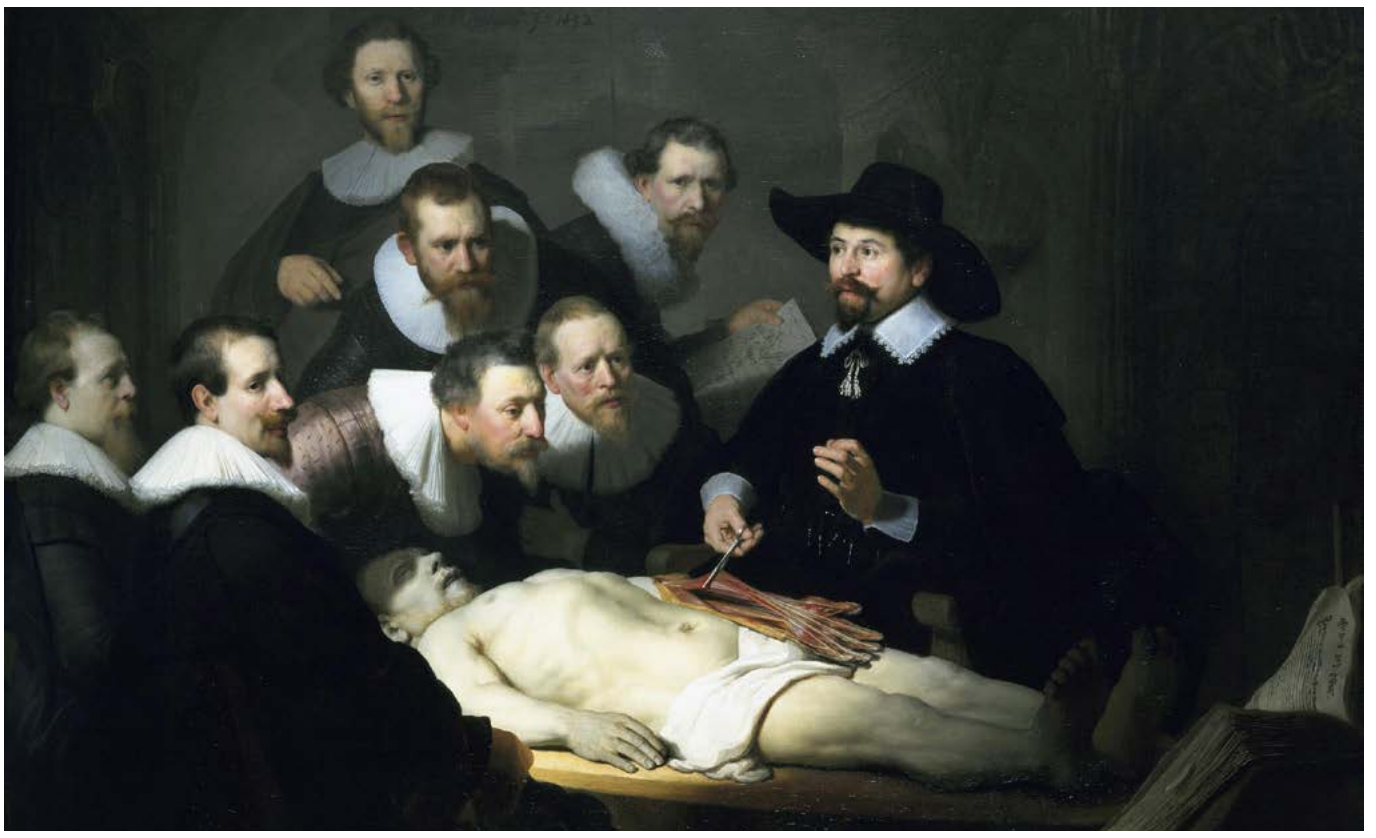
The painting tells us a great deal more. That in Amsterdam in 1632 public anatomy and science was uncontroversial. 500 years ago, Martin Luther tacked his epistle to the cathedral door lifting the veil on centuries of darkness. Vesalius became possible, and so did Hunter, Harvey, Malphigi and the rest. A hundred years later Dr Tulp's lesson was part of a scientific establishment. We are creatures of the enlightenment and should never forget it.

What does this painting show of the process of teaching and learning? As surgeons we are completely familiar with the setting and have participated in numerous similar exercises. Three of the surgeons in the picture are distracted, one recording the presence of the painter, another checking his list, a third looking at the audience. Dr Tulp is explaining the flexor tendons of the exposed left forearm (Rembrandt's anatomy is questionable) and their function, with his own left hand. The other three are intent on the exposed anatomy. Or are they? They are in fact looking at the opened book at the foot of the bed, presumably looking at a picture of the anatomy. The book may indeed be a copy of Vesalius' *De Humani Corporis Fabrica* of 1543. One conclusion is that we have to be taught what we are meant to see, and books and art are crucial to this enterprise. So the function of the dissection is to iterate that 'this is what you know looks like' and 'this is how it works'.

Perhaps another part of this lesson is 'how do you get to this point?'; the cutting, dissecting and mobilising. Chirurgery the handwork, the 'feel of it'. This is performance, and the anatomists of the time certainly knew about performance as art. Surgeons call this 'exposure' and an art essential to our science.

With apologies to Joseph Heller.

Alan de Costa directs The Anatomy of Surgical Exposure course in Cairns. www.ase.training



A reproduction of this painting can be found in the Hailes Room, Melbourne office. It is believed to be an 18th century student copy. – Ed.

An Update on Perioperative Mortality in New Zealand 2017

MR DAVID ADAMS
Chair New Zealand National Board

The RACS requirement for surgeons "to participate in the Australian and New Zealand Audit of Surgical Mortality" has rolled out successfully across Australia with amalgamation of mortality audits from each state united under the ANZASM umbrella. While theoretically New Zealand surgeons should be part of this process, there have been obstacles including statutory regulation. New Zealand has a history of government mandated mortality audits dating back as least as far as 1962.

With the enactment of the Public Health and Disability Act in 2000, a number of national mortality review committees were established including the Peri-Operative Mortality Review Committee (POMRC), which now conducts these statutory functions under the auspices of the Health Quality and Safety Commission (HQSC). New Zealand surgeons contribute to a number of bi-national audits such as the Australasian Vascular Audit, but POMRC represents the only assessment of total national surgical mortality. Until now it has not been possible to directly export the POMRC data to ANZASM. However, POMRC have recently advised that they have identified all procedures within the ANZ coding classification which are within their terms of reference and are able to share this list with ANZASM.

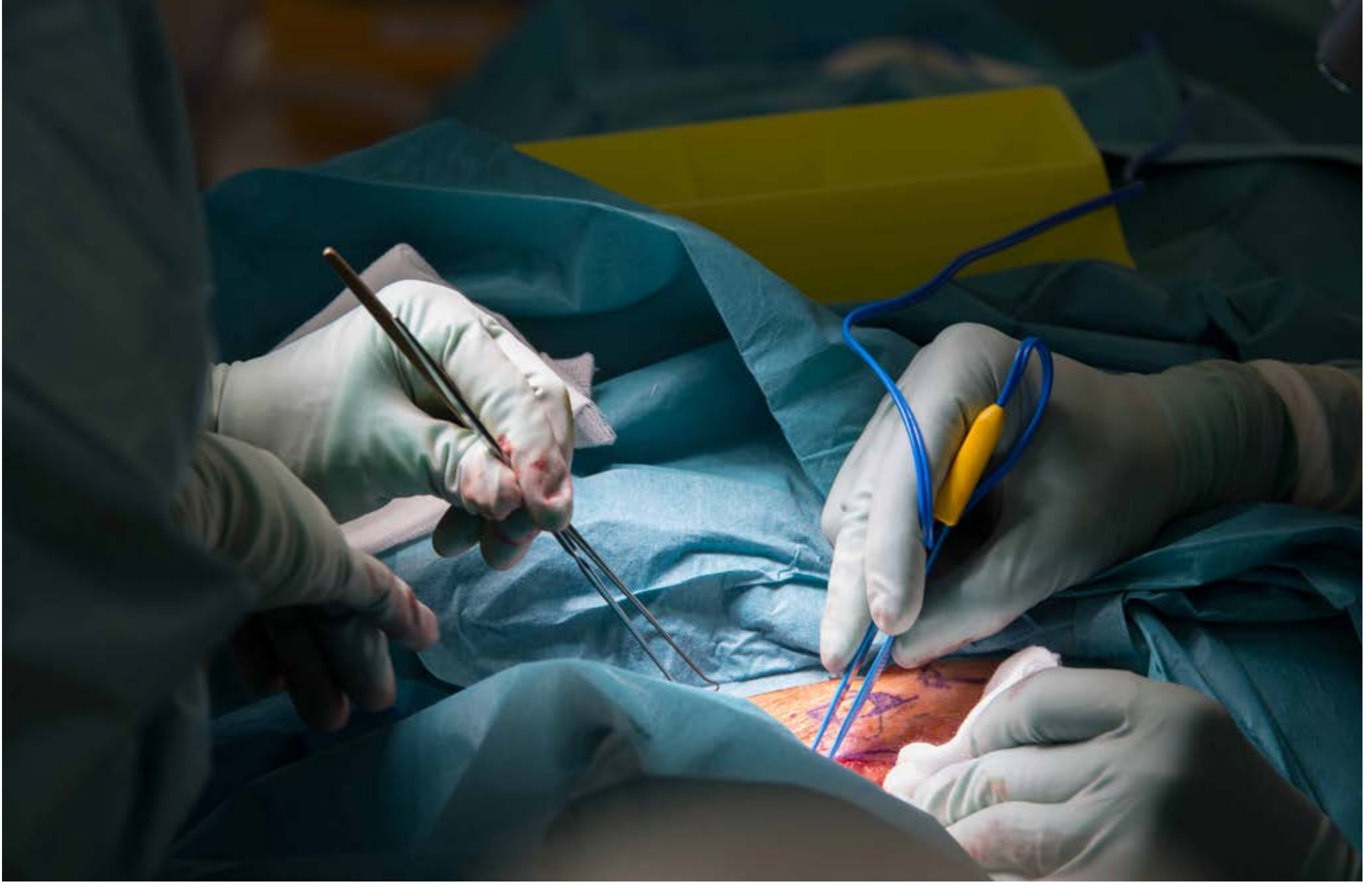
Since 2012, POMRC has produced annual reports on perioperative deaths, with the aim of supporting continuous quality and safety improvements. While providing overview data, these reports have tried to show continuity by focussing on some specific operations (e.g. cholecystectomy, hip arthroplasty) and have also attempted to identify areas for improvement in practice. In June this year, POMRC published its sixth report which included 2 specific topics: (1) The relationship between perioperative mortality and socioeconomic deprivation, and (2) Perioperative mortality following abdominal aortic aneurysm (AAA) repair.

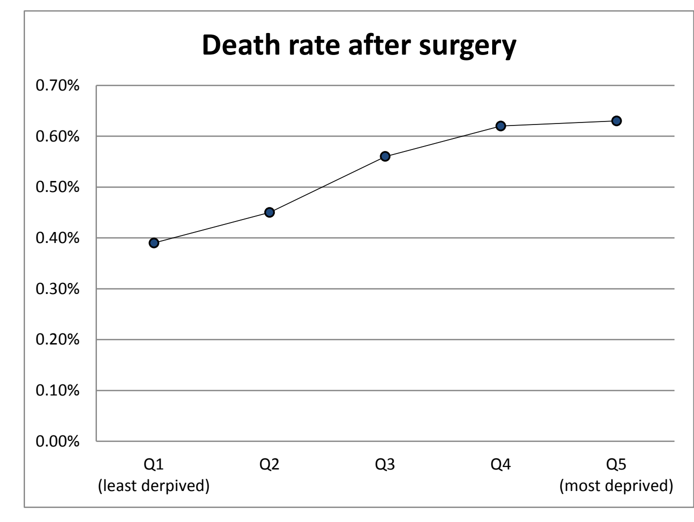
Socioeconomic status was derived using the University of Otago's New Zealand Deprivation Index, which assessed 2013 NZ Census data on factors such as unemployment, income, access to a car and internet, home ownership, and the ratio of household occupants to bedrooms. Each geographic area was then assigned a quintile from 1 to 5 (least deprived to most deprived) based on the average deprivation of households in that area.

POMRC considered patient data from 2009-2013 and found that as deprivation increased so too did admissions and perioperative mortality. Compared to the least deprived quintile, the most deprived had 14% more elective admissions and nearly twice as many acute admissions (fig1), accounting for 23% of all surgery and 27% of perioperative deaths. The report also found that even after adjusting for sociodemographic and clinical factors, perioperative mortality rates were 16% higher for Māori living in the most deprived areas, this finding reinforces concerns around inequity of healthcare and outcomes.

Compared to the least deprived quintile, the most deprived had 14% more elective admissions and nearly twice as many acute admissions, accounting for 23% of all surgery and 27% of perioperative deaths

That people with higher socioeconomic deprivation suffer higher rates of perioperative mortality is unsurprising (indeed previous POMRC reports had suggested such a relationship), but that does not make it acceptable. It is POMRC's position that socioeconomic status should not influence outcomes after surgery. This aligns closely with the RACS position paper on Equity of Access to Surgical Care and the aims of the Māori Health Action Plan.





The report suggested several possible explanations for the relationship between deprivation and perioperative mortality including poorer access to healthcare and surgical services, higher comorbidities, and greater illness severity at presentation for surgery. Recommendations were made into further research and the possibility of District Health Boards (DHB's) initiating programmes to increase equitable access to care.

The second topic investigated was perioperative death following abdominal aortic aneurysm (AAA) repair. In the five years between 2010 and 2014 there were 2,226 admissions for AAA repair with a thirty-day mortality of 7.7%. Only 31% of admissions were acute; however, these accounted for 79% of all deaths. Again, Māori fared worse in this analysis, having a higher ratio of acute to elective admissions. Mortality was higher for emergency cases aged over 80, those with an ASA score of 4 or 5, and for those undergoing open repair as opposed to endovascular (EVAR). As a result, POMRC recommends that EVAR at least be considered for all patients undergoing elective AAA repair. However, it should be noted that some international studies show better long term outcomes with open repair.

Although not mentioned in the POMRC analysis, it is generally acknowledged that higher volume centres achieve better outcomes with AAA. EVAR is not available within all DHB's in NZ electively let alone acutely. An "EVAR where possible" approach does potentially exacerbate the geographic inequities in access to surgical care, particularly considering that the condition often remains undetected until acute presentation and that many people die of ruptured AAA without ever reaching hospital.

However, POMRC has hinted at a solution by reviewing a recent successful pilot screening programme for AAA in Māori In Waitemata. Screening has the potential to identify cases that would benefit from elective treatment even in those who are geographically isolated from the treatment centre. Furthermore, in the U.K. perioperative death rates in screened populations have been shown to be lower than historical controls even with conventional surgery, suggesting that screening allows selection of a younger, healthier and better prepared patient group.

Rural surgical workforce

ASSOCIATE PROFESSOR FRANK MILLER
Rural Surgery Section Committee

While proximity to nature, lack of traffic jams, air to breathe, the opportunity to pursue interests such as farming, or messing about on boats are undoubtedly attractions to living and working in the country, I suspect that for many, like myself, the actual attractants are very different. These might include the challenge of a broad spectrum of work, a tangible awareness of contributing to not only the medical workforce but also the regional community and the mandate to manage an unwell patient. When there is no time or resources to get them to the city prior to life-saving surgery. It is not surprising that, according to the most recent College activity report, 11.3 per cent (728 surgeons) of the total Australian surgical Fellowship are based outside metropolitan zones. Of these, half will be general surgeons, third orthopaedic surgeons and the remainder urologists, ENT and paediatric surgeons with a few representing other specialties.

However, as every rural surgeon would be aware, recruitment and retention is a challenge. The ratio of surgeons based in the rural sector to the population who live in regional and remote parts of Australia (11.3%:33% (Australian Bureau of Statistics (ABS) 2016)) at a glance suggests that there is a major imbalance of surgeons to population. How accurate and helpful is this figure though? It is hard to say. There are confounding factors that include surgeons who are based in the city but provide a rural service, what is classified as a city to one data collector may be considered rural by another. Not everyone answers questionnaires (e.g. 39.5% response rate on the 2016 RACS Census).

Probably the best way to obtain accurate information is to ask the surgeons themselves, or at least speak to work colleagues who know them. A study published this year[1] examining the workforce in Western Australia alarmingly found that 20 per cent of rural hospitals that performed surgery did not have residential surgeons at all while only five out of 18 hospitals surveyed had the recommended number of residential surgeons. An older study performed by the College's Divisional Group of Rural Surgery (DGRS, now renamed the Rural Surgery Section (RSS)) estimated that in 2010 rural NSW had a potential number of 36 potential surgical vacancies while Victoria potentially had 23.

The situation is to an extent mitigated by locums and surgeons who have a fly-in-fly-out (FIFO) arrangement. The Western Australian study found that 88.9 per cent of the non-metropolitan hospitals surveyed relied on FIFO surgeons. While not denigrating the excellent work and onerous demands of travel and leaving one's normal practice that these surgeons face, it is hardly an ideal situation. There is an inherent risk in leaving post-operative patients behind, it may not be conducive to building community confidence in their medical service and the practice transfers the burden of post-operative care to either a surgical colleague or GP.

Fortunately, there have been many overseas trained colleagues who have decided to make Australia and New Zealand their home and have gone on to work in the rural setting. The above mentioned DGRS study (2010) estimated that 47 per cent of surgeons who had commenced practice in rural NSW in the previous 5 years had been internationally trained, while the equivalent figure for Victoria was 32 per cent and 62 per cent in Queensland. According to college records, the current number of internationally trained surgeons working in the country is 34 or 4.7 per cent of the workforce.

A further means of delivering surgical care in the country is provided by procedural general practitioners. This is currently under active discussion within the College.

Despite the various factors listed above, unfortunately the workforce still comes up short. Last year I conducted survey of 11 towns in Victoria that have "base" hospitals (unpublished data). In all, this represented 54 surgeons. There were 5 vacancies at that time equating to 5 out of 59 positions unfilled (8.5%). Over the next three years it was estimated that there would be a need for a further 11 positions when considering retirement and growth of services.

How then can the situation be improved? Several approaches have been used or are in action that range from general to specific. The federal government is currently instituting the Rural Health Multidisciplinary Training Program (2016-2019) at a cost of $54M that involves the construction of 26 new training hubs and 3 new university departments of health that should facilitate medical student training in regional areas. While a percentage of the students may go onto a career in surgery who otherwise would not have, this measure cannot increase the number of rural trainees who progress to work as rural surgeons – at least not unless the funding also includes more theatres, more theatre lists and larger hospitals to accommodate extra SET training positions.

A further approach could be to increase the number of SET graduates, although this too is limited (and probably at maximum capacity already) by the finite number of satisfactory training positions. According to the RACS 2016 Annual Report, each SET year has about 200 trainees across Australia and New Zealand. While some intend to follow a rural path, the majority will not. However, when the city consultant positions happen to be supersaturated, some may move to available rural positions whether they had initially entertained the idea or not.

The RSS itself oversees the Rural Coach Program (RCP). A continuation of the old Rural Surgery Training Program (RSTP), it is perhaps best described as an informal mentoring process, rather than a defined SET pathway. As a product of the RSTP myself, I found the advice and encouragement from the surgeons and College staff during my training to be invaluable. Since the RCP commenced in 2011, 49 trainees who were listed in the RCP have gained fellowship and 8 are now practicing in a rural area. There are currently 29 SET trainees in the RCP who have expressed an interest in working as rural surgeons.

Another initiative that has proved popular and very worthwhile is the small number of Rural Surgery Fellow positions advertised in Geelong, Bendigo and Darwin. These are great opportunities for the newly qualified surgeon to prepare for working in the rural sector. The RSS would certainly encourage other centres to consider developing their own fellowship training positions.

To my mind, the approach that is most likely to meet the "ideal" training process for a rural surgeon would be a custom-designed program - the focus of which would be to train rural surgeons. In 2013, the first SET intake commenced in the new training hub based in Geelong. Through a combination of country and city rotations, the aim is to prepare trainees for the demands of a general surgical career, and in particular - one in the rural sector. It has been a popular choice for SET applications and now has 15 trainees in the program with the first trainee to have passed the Part 2 exam this year. One of only a handful of similar programs in the world, the aim is bold but I think, likely to succeed. More programs of this type are needed.

1 Shanmugakumar S, Playford D, Burkitt T, Tennant M, Bowles T. Is Western Australia's rural surgical workforce going to sustain the future? A quantitative and qualitative analysis. Aust Health Rev 2017;41:75-81

Image (from top-left): Rural Coach Program Participants 2016; Rural General Surgeon, Frank Miller FRACS.

Scholarship Announcement

2018 Rural Surgery Fellowship for Provincial Surgeons

Call for Applications
The Rural Surgery Section (RSS) Committee is offering up to 3 travelling grants to assist non-metropolitan surgeons who wish to spend time away from their practice to travel and develop existing skills or acquire new skills in a field of benefit to the surgeon, RACS and the community.
Each fellowship will be valued to a maximum of AUD$10,000 (incl. GST) and is to be expended in the 2018 calendar year.

Eligibility criteria
The applicant must be a rural or remote based Fellow in Australia or New Zealand whose practice post code is non-metropolitan. At the time of submitting their application the Fellow must be a permanent resident or citizen of Australia or New Zealand, or an international medical graduate accepted into the College as a trainee.

Application Process, Selection and Reporting
Applicants are required to submit an online application form with specific details of the planned trip and visit. Selection will be dependent on surgical or clinical skills.

Full details of the criteria, conditions and application process are available at Rural Surgery Fellowship for Provincial Surgeons or contact the Rural Surgery Section Secretariat by email rural@surgeons.org or by telephone on +61 3 9276 7407.

Applications close 5.00 pm
Monday 19 February 2018

Rural Coach GSA Rural Surgery Grant 2017

Applications Open
To support Trainees and IMG's considering rural surgery as a career option; General Surgeons Australia [GSA] is offering several Registration Grants to attend the Provincial Surgeons Australia [PSA] conference in Armidale NSW 19 – 21 October 2017. The grants are valued at up to $770 [inc GST]

General Surgery Trainees and IMG's must first register and pay for the PSA 2017 ASC online.

Early bird closing is 18 September 2017

The online Rural Coach Program Application form must be completed and submitted.

For further information on eligibility or to join the RACS Rural Coach Program please contact ruralcoach@surgeons.org

Scholarship recipient returns to Australia with world leading cerebrovascular skills

Neurosurgeon Dr Johnny Wong has spent the past three years working at two of the top neurosurgical units in North America expanding his skills in cerebrovascular and endovascular neurosurgery, with financial support provided by RACS through two separate Stuart Morson Scholarships.

Having returned to Australia in July this year, Dr Wong now has the skills to conduct the revolutionary procedure of mechanical thrombectomy along with aneurysm coiling and clipping, Arteriovenous Malformation (AVM) resection and embolization and carotid endarterectomy and stenting.

From 2014 to 2017, Dr Wong spent one year at the Toronto Western Hospital, University Health Network, Canada, and two years at the Stanford University Medical Centre in California.

In Canada, Dr Wong was a Clinical Fellow in Cerebrovascular Neurosurgery while at Stanford he held the positions of Clinical Instructor in Neurosurgery and Fellow in Interventional Neuroradiology.

During his Fellowships, Dr Wong conducted research into the surgical outcomes of microsurgical AVM resection, approaches to aneurysm clipping, and outcomes of mechanical thrombectomy. Specifically, he investigated the characteristics of blood clots to determine if pre-operative identification could alter retrieval techniques and thereby limit the brain damage caused by ischaemic stroke.

Now working as a Visiting Medical Officer at the Royal Prince Alfred Hospital in Sydney, Dr Wong said the support of the College had allowed him to return to Australia with world-leading cerebrovascular skills such as the mini-craniotomy techniques he learnt in Canada that could be used in aneurysm surgery.

Dr Wong said that in Canada he had seen and treated more arteriovenous malformations and dural arterio-venous fistulas in one year than he had ever witnessed as a neurosurgical registrar in Australia. He also participated in more than 20 extracranial-Intracranial bypass operations, including some with the use of the Excimer Laser-Assisted Non-occlusive Anastomosis (ELANA) (procedure - a technique that is not available in Australia.

At Stanford University Medical Centre, Dr Wong acquired skills in cerebral and spinal catheter angiography, complex endovascular interventions including the use of balloon and stent-assisted aneurysm coiling, flow-diverting stent insertion and the revolutionary technique of mechanical thrombectomy.

Mechanical thrombectomy is an endovascular procedure in which a blood clot causing major strokes is removed with a stent retriever device that is introduced through a catheter, passed via an artery in the groin. Using guided imaging, the surgeon advances the catheter up to the clot interface and positions the stent past the clot, which then expands and traps the clot against the walls of the artery. The stent is then pulled backwards to remove the clot, which restores blood flow to the brain.

Dr Wong said that while mechanical thrombectomy was offered as an around-the-clock service in major medical centres across the US, it was not uniformly performed across Australia.

"This technique has revolutionised stroke treatment and represents a paradigm shift in the treatment of large vessel occlusion (LVO) strokes around the world," he said.

"There have not been any major advances in stroke care since the introduction of intravenous thrombolysis about 20 years ago. So, this technique is revolutionising the field.

"The most recent randomised trials published in the *New England Journal of Medicine* (NEJM) showed significant improvement in outcomes for thrombectomy in LVO strokes, however, the techniques and outcomes are still variable which means there is a continued need for research to pursue better outcomes and standardisation of techniques.

"The focus of my research in the US centred on investigating whether identifying different clot characteristics and using different treatment techniques can improve outcomes.

"Mechanical thrombectomy has been proven to decrease mortality and morbidity in stroke patients, many of whom can now be treated with this minimally invasive procedure and then return to normal brain function.

"It represents an amazing surgical advance and while it is now available around the clock only in some parts of Australia, certain areas are without 24-7 coverage.

"Australia conducted one of the major trials published in the NEJM but the lack of funding and necessary auxiliary staff may prevent this from being a commonly accessible treatment option in some parts of Australia.

"Also strokes are time dependent and vast transfer distances from rural areas may limit our ability to successfully apply this technique to all patients."

This aspect of time-critical care was also the driver behind Dr Wong's research into clot characteristics.

He said the mantra in stroke treatment is "time is brain". Therefore, it is critically important to reperfuse the brain as quickly as possible, and that every five minutes lost equates to a one per cent reduction in the likelihood of a return to independent function for the patient.

"One of the frustrations during clot retrieval stroke treatment relates to the number of attempts necessary to reopen a vessel, which may be related to underlying clot characteristics," Dr Wong said.

"We know that red clots from atrial fibrillation and atrial thrombus versus white clots such as those caused by an atherosclerotic plaque rupture in carotid stenosis have anecdotally had different reperfusion rates and the consequent number of attempts required to achieve reperfusion.

"While more work is needed in this area, the hypothesis of this research is that, if a difficult clot can be identified pre-operatively, we may be able to select the best procedure needed to achieve rapid reperfusion."

Dr Wong was also actively involved in a world-leading NIH-funded stroke trial (DEFUSE 3), conducted at Stanford. This trial investigated stroke outcomes in patients having mechanical thrombectomy beyond six hours after onset of stroke. In many of these cases, he was working as the main proceduralist. The results of this trial will be available within the next 12 months.

In Canada, he collaborated on more than 250 operative cases working under the supervision of Professor Michael Tymianski and Dr Ivan Radovanovic while in California he worked under the supervision of Professor Michael Marks, Professor Huy Do, Dr Robert Dodd and Dr Jeremy Heit.

Dr Wong said the highlights of his time abroad outside his hospital duties included welcoming into the world his first child, a daughter born in Toronto, and hiking across the Grand Canyon with Professor Tymianski.

During his time overseas, Dr Wong also wrote a number of research papers which have been published in the *Journal of NeuroInterventional Surgery*, the *Journal of Neurosurgery* and *Stroke*.

He thanked RACS for its generous support provided to take up the Fellowships.

"The skills I have acquired, particularly in the field of stroke invention procedures, will benefit the community. There is a high prevalence and morbidity rate associated with stroke in Australia and the limited number of physicians with skills necessary to perform stroke thrombectomy procedures is low."

The Stuart Morson Scholarship in Neurosurgery was established following a generous donation by the late Mrs Elisabeth Morson in memory of her late husband, Stuart Morson, a Sydney-based Neurosurgeon and is aimed at assisting young neurosurgeons to meet the costs of undertaking further training and/or research work in neurosurgery overseas.

– With Karen Murphy

Professional Highlights

2012 Peter Leech Memorial Prize for the best research presentation by a neurosurgical trainee at Neurosurgical Society of Australasia Annual Scientific Meeting 2012, Gold Coast

2013 Macquarie University Research Excellence Award in Human Sciences

2015 Royal Australasian College of Surgeons Stuart Morson Travel Scholarship in Neurosurgery for further training and research overseas (Awarded for open cerebrovascular Fellowship at University of Toronto 2014 – 2015)

2016 Royal Australasian College of Surgeons Stuart Morson Travel Scholarship in Neurosurgery for further training and research overseas (Awarded for interventional Neuroradiology Fellowship at Stanford University 2015 – 2017)

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Ending doctor - patient relationships

MICHAEL GORTON AM
Principal,
Russell Kennedy Lawyers

A high standard is expected of professional conduct and integrity within a Doctor-patient relationship. The relationship is personal, with high regard to privacy and respect for a patient's best interest and needs. Doctors work in close proximity to their patients to provide them with the adequate care they require. These relationships can evolve as treatment progresses, some long term some short term, creating an atmosphere where patients become reliant on the information and treatment of their doctors.

The medical industry maintains a strong moral compass with regard to what conduct towards patients is appropriate and inappropriate. However, there are circumstances where doctors are faced with predicaments in which patients actions are unacceptable, and these may be the situations where it may be necessary for doctors to terminate doctor-patient relationships.

Some patients can become vulnerable and familiar. During these times patients may misinterpret or perceive a doctors role to be beyond the ordinary boundaries, and request actions beyond their ordinary scope. This may include displaying emotions or make advancements that are not appropriate in that relationship. There must be safeguards for doctors in these situations where their service and roles within this relationship may be compromised by acts of aggression, sexual propositions and requests for relations outside common expectations. It may be necessary for doctors to assess what can be done in these circumstances to end a doctor-patient relationship.

The decision to say no to patients may be daunting and uncomfortable. Explaining and outlining the boundaries of the professional relationship must be communicated to a patient. Where these boundaries are overstepped by a patient, a doctor must endeavour to clearly communicate that the patient has overstepped, and request that those actions not be repeated.

Communicating openly and honestly may enable a doctor to avoid making the patient feel as though it is a personal affront or rejection.

In assessing how the situation can be resolved, a doctor may seek advice of senior colleagues or relevant medical defence organisations.

A formal process must be initiated where a doctor wishes to discharge their care of a patient or transfer the care to another practitioner. Contact and conduct outside of the treating relationship should be reported, and documented. Letter responses to the patient, and the date of specific conversations may also need to be factually documented. A doctors actions must adhere to the relevant Medical Code of Practice, and their conduct must follow any legal and professional obligations. Discussions of alternative practices or practitioners, between the doctor and patient may be necessary, with a list of alternatives to be provided. A reasonable deadline to make other medical treatment arrangements must be provided, and all relevant documents should be transferred. Practice staff should be advised as to the change.

Where the patient requires immediate or emergency medical attention a doctor holds a professional and ethical duty to assist. Where a patient is undergoing immediate or advanced medical treatment for a long term illness, a doctor may be required to render or continue treatment until such a time as a shift in practitioners would not negatively impact a patient's outcome. Further a doctor should seek to keep in mind the best interest of the patient, to avoid a lapse in care and avoid negligence where a doctor-patient relationship ceases. There must be compliance with providing a patient with information in regards to follow up on any further care.

These circumstances are never easy, but are sometimes necessary and unavoidable. If concerned, seek professional advice and assistance.

– With Laura Haffenden, Law Student

Informed consent – it's not just about material risk

DR DANIELLE NIZZERO
RACSTA

Informed consent for surgical procedures is a critical component of surgical care. Not only is the requirement entrenched in the RACS Code of Conduct, but we are all familiar with the standard set by Rogers vs Whitaker[1] of warning patients of a procedure's material and inherent risks – The junior doctor in a public hospital faces the additional challenge of obtaining informed consent from patients regarding their personal level of involvement in the patient's procedure. This involvement may range from assisting a consultant surgeon to operating independently.

As a surgical Trainee performing some or all of a patient's operation, the discussion with the patient regarding your role in their procedure can be a delicate one – balancing the patient's right to know your level of experience and decline your involvement based on that knowledge, with your requirement as a Trainee to develop your technical skills so that you can become a skilled and proficient surgeon in your specialty. Part of the RACS logbook used by some specialties asks whether the Trainee was the "Surgeon Alone" for that particular case, suggesting that Trainees are expected to perform procedures independently as they progress through their training. However, recent commentary indicates that although patients almost universally want to be informed of a Trainee's involvement in their surgery, they are often reluctant to consent to Trainees being the primary operator. A survey of 100 urology patients in the UK in 2009 demonstrated that 96 per cent wanted to be informed if a Trainee was to be involved in their surgery. Regarding the role of a Trainee in surgical procedures – 90 per cent were happy for a supervised Trainee operating as a general concept, but only 77 per cent were happy for a supervised Trainee to undertake their procedure. They were even less comfortable with an unsupervised Trainee operating – only 50 per cent were happy with the concept and just 10 per cent would agree to an unsupervised Trainee undertaking their procedure[2]. These figures were corroborated by a 2012 US survey of 316 patients scheduled for elective general surgery at a teaching hospital. 95.7 per cent of patients having a major procedure wanted to be informed if a Trainee was going to be involved. Of that 95.7 per cent however, only 25.6 per cent would be happy for a Trainee to perform their procedure supervised, even fewer, 18.2 per cent, would be happy for a Trainee to do their procedure unsupervised[3].

As Trainees, how do we balance the patient's right to informed consent with our need to learn? RACSTA has discussed this issue and has some suggestions to help Trainees raise the subject with patients:

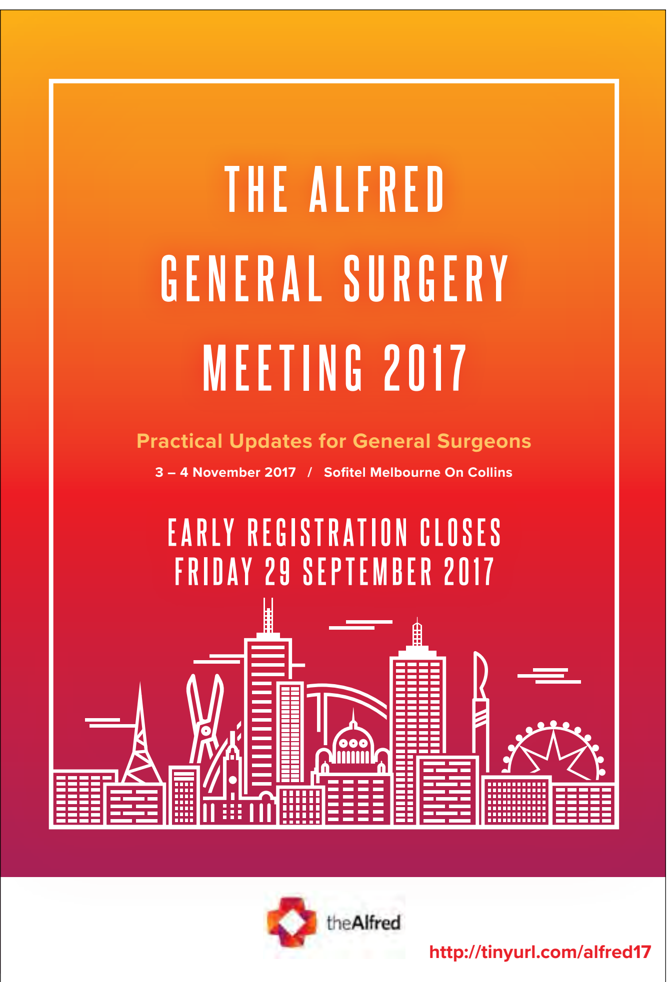
- Inform patients of your role as a surgical Trainee when you first assess them so it is not a surprise when you mention it during the consent process. This also builds on a trust relationship between Trainee and patient.
- Be specific with your language: "I will be assisting my consultant in your procedure" versus "my consultant will be assisting me with your procedure" versus "my consultant and I will each be performing parts of your procedure" versus "I will be doing your procedure with my consultant present" versus "I will be doing your procedure with a consultant available if required"
- For patients that request or appear to need further information regarding your experience, discuss how many procedures of a similar nature you have done before and reassure them of your level of confidence and supervision for the procedure.
- Ensure patients are aware that you have discussed the case with your consultant, and give them the opportunity to talk to the consultant if requested.
- Respect the patient's right to decline your involvement.

Consultant surgeons also need to be aware of this issue and ensure that any informed consent includes the involvement of the Trainee.

1 Aust Law J. 1993 Jan;67(1):47-55
"…the law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it."

2 Ritchie, R. W. and Reynard, J. (2009), Consent for surgery: will you be doing my operation, doctor?. BJU International, 104: 766–768. doi:10.1111/j.1464-410X.2009.08528.x

3 Porta CR, Sebesta JA, Brown TA, Steele SR, Martin MJ. Training Surgeons and the Informed Consent ProcessRoutine Disclosure of Trainee Participation and Its Effect on Patient Willingness and Consent Rates. Arch Surg. 2012;147(1):57–62. doi:10.1001/archsurg.2011.235



CLEAR

course for Consultants

DATE	24-25 November 2017
VENUE	Langham Hotel 83 Symonds St, Grafton Auckland 1010
FEE	NZ$1,815.00 (incl. GST)
WEBPAGE	CLEAR course for Consultants
CONTACT	Paul Holloway CLEAR Program Administrator
EMAIL	clear@surgeons.org

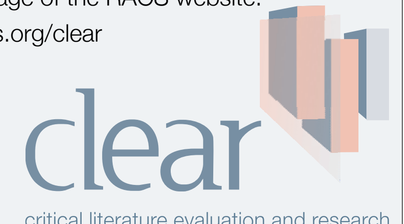
The Langham in Auckland welcomes the 2017 edition of the CLEAR course for Consultants.

Refresh your epidemiology and research skills with fellow peers and mentors, earn CPD points and unwind at the complimentary course dinner.

This Fellows only course includes topics on running a journal club, supervision of trainee research and application of evidence in practice.

For further information and to enrol please see the CLEAR Course webpage of the RACS website.

https://www.surgeons.org/clear



critical literature evaluation and research

Safety in surgery

The Victorian ASM will this year examine all aspects of safe surgical practice including audits and the changing political and regulatory landscapes.

DOUGLAS STUPART
Convenor

The theme of this year's Victorian Annual Scientific Meeting is Safety in Surgery and we will have the privilege of hearing speakers who have been highly influential in advocating for safer surgery both locally and internationally.

It has become incontrovertible that audits and registries are important in determining the performance of health care systems, and it is clear that we as surgeons will increasingly be required to be objectively audit and assess our own outcomes. What is often less obvious, however, is how we can best use these data to identify systemic problems and improve performance. We will hear from speakers who have experience not only in collecting data from large audits, but managing the challenges of trying to implement changes in response to those data not only at a local, but also in large scale health systems. We will specifically hear about the proposed regulatory and health system changes which are planned for Victoria and that will directly affect surgeons.

Multiple studies have examined the relationship between case volume and safety, and many authors have advocated a centralised approach to certain types of complex surgery, in which a small number of highly specialised and high volume centres perform most or all such cases. On the other hand, increasing regional populations and the logistic realities of providing optimal health care over a large area such as Victoria create a need for offering increasingly complex care in regional centres. It is clearly important that complex surgery is done safely in whichever environment it is performed, but how do we safely expand the surgical practice of one's hospital, and how do we ensure safety in the early stages when case numbers are insufficient for meaningful audit? Similarly, how do we address the catch 22 situation that any unit must, by definition, be low- volume when it starts out even if it develops into a high volume centre over time? We will hear from a number of surgeons who are successfully introducing innovative complex surgery to their hospitals, and will surely benefit from their personal experience in overcoming the multiple challenges in achieving this.

We welcome all Fellows, Trainees, IMG's and other interested health practitioners to this year's meeting. We are sure that we will all find the talks informative and thought-provoking.

For further information, visit the Vic ASM webpage, or contact the Victorian Regional Office with any queries:
e: college.vic@surgeons.org | Ph: 03 9249 1254

59th Victorian Annual Surgical Meeting

"Safety in Surgery"
Novotel Geelong
21, 22 October 2017

REGISTER ONLINE: www.tinyurl.com/ VicASM17

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www.surgeons.org/222042.aspx

REGIONAL MEETINGS UPDATE

83rd TAS Annual Scientific Meeting

Date: 22 - 23 September 2017
Venue: The Old Woolstore Apartment Hotel, Hobart

Surgery in One State, One Health System, Better Outcomes

A foundation course will be offered on the 22 September.

Find out more:
E: college.tas@surgeons.org
W: www.surgeons.org/about/regions/tasmania

59th Victorian Annual Surgical Meeting

Dates: 20 - 21 October 2017
Venue: Novotel, Geelong

Safety in Surgery

Find out more:
T: +61 3 9249 1188 • E: college.vic@surgeons.org
W: www.surgeons.org/about/regions/victoria

ACT Annual Scientific Meeting

Date: 4 November 2017
Venue: Australian National University, Medical School, Canberra

Systems of care: collaboration and innovation

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Find out more:
T: +61 2 6285 4023 • E: college.act@surgeons.org
W: www.surgeons.org/about/regions/australian-capital-territory

Workshops 2017

Online registration form is available now (login required)

Inside 'Active Learning with Your Peers 2017' booklet are professional development activities enabling you to acquire new skills and knowledge and reflect on how to apply them in today's dynamic world.

Mandatory courses

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

By the end of 2017
Foundation Skills for Surgical Educators course: Mandatory for surgeons involved in the training and assessment of SET Trainees

By the end of 2018
Operating with Respect one-day course: Mandatory for SET Supervisors, IMG Clinical Assessors and major RACS Committees

Foundation Skills for Surgical Educators Course

6 October	Sydney	NSW
14 October	Toowoomba	QLD
18 October	Armidale	NSW
3 November	Birtinya	QLD
12 November	Birtinya	QLD
20 November	Sydney	NSW

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

Operating with Respect course

4 November	Christchurch	NZ

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

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

22 September	Melbourne	VIC

The NHET-Sim Program is a nationwide training program for healthcare professionals aimed at improving clinical training capacity and consists of e learning modules on simulation-based education. NHET-Sim is funded by the Australian Government. The project, being undertaken in partnership with Monash University, offers a training program for healthcare educators and clinicians from all health professions. The curriculum has been developed and reviewed by leaders in the simulation field across Australia and internationally.

The e-learning component of the NHET-Sim Program takes approximately 12 hours to complete. Registrations are already open for the last of 2017 NHET-Sim course. (log in required).

Non-Technical Skills for Surgeons (NOTSS)

22 September	Brisbane	QLD
6 October	Auckland	NZ
24 November	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. This educational program is proudly supported by Avant Mutual Group.

SAT SET Course

23 September	Adelaide	SA

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

Keeping Trainees on Track

23 September	Adelaide	SA

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

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

Process Communication Model Refresher (PCM)

24 September	Melbourne	VIC

Participants will refresh the skills learnt during an earlier attended Process Communication Model workshop. A needs assessment is done at the beginning and the workshop then addresses any issues of interest. This way the course program will be adapted to each participant's needs. Participants will have the opportunity to practice the parts they consider most relevant to them. Note: In order to participate in PCM Refresher, registrants must have attended and be familiar with the content of PCM Seminar 1.

Surgical Teachers Course

19 – 21 October	Mandurah	WA

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

Process Communication Model Seminar 1 (PCM)

17 – 19 November	Sydney	NSW

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

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

Clinical Consultation Skills Education Retreat

Cancer Council Victoria and Deakin University's Centre for Organisational Change in Person-Centred Healthcare are pleased to present a Clinical Consultation Skills Education Retreat for oncology clinicians, 9-11 October at RACV Torquay Resort. This three day immersive residential education program will offer tailored, small group learning with other oncology clinicians, delivered by expert facilitators in a luxury environment away from workplace demands.

For more information please visit https://www.cancervic.org.au/clinical-consultation-skills-for-oncology-clinicians-three-day-retreat or register your interest education@cancervic.org.au

PROFESSIONAL DEVELOPMENT WORKSHOP DATES

September – November 2017

NSW		
Foundation Skills for Surgical Educators	6/10/2017	Sydney
Foundation Skills for Surgical Educators	18/10/2017	Armidale
Academy Forum	2/11/2017	Sydney
Process Communication Model	17/11/2017	Sydney
Foundation Skills for Surgical Educators	20/11/2017	Sydney
Non-Technical Skills for Surgeons	24/11/2017	Sydney
NZ		
Non-Technical Skills for Surgeons	6/10/2017	Auckland
Foundation Skills for Surgical Educators	14/10/2017	Auckland
Process Communication Model: Seminar 1	20-22/10/2017	Auckland
Foundation Skills for Surgical Educators	13/11/2017	Auckland
QLD		
Non-Technical Skills for Surgeons	22/09/2017	Brisbane
Writing Medico Legal Reports	12/09/2017	Brisbane
Foundation Skills for Surgical Educators	14/10/2017	Toowoomba
Foundation Skills for Surgical Educators	3/11/2017	Birtinya
Foundation Skills for Surgical Educators	12/11/2017	Birtinya
SA		
Supervisors & Trainers for SET	23/09/2017	Adelaide
Keeping Trainees on Track	23/09/2017	Adelaide
VIC		
National Health Education & Training in Simulation	22/09/2017	Melbourne
Foundation Skills for Surgical Educators	9/10/2017	Melbourne
Foundation Skills for Surgical Educators	5/11/2017	Melbourne
Foundation Skills for Surgical Educators	6/11/2017	Melbourne
Comm Skills for Cancer Clinicians	11/11/2017	Melbourne
Surgeons as Leaders in Everyday Practice	24-25/11/2017	Melbourne
Foundation Skills for Surgical Educators	26/11/2017	Melbourne
WA		
Surgical Teachers Course	19-21/10/2017	Mandurah

Contact the Professional Development Department

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

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

Global sponsorship of the Professional Development programming is proudly provided by Avant Mutual Group, Bongiorno National Network and Applied Medical.

WORKSHOPS • ACTIVITIES • EVENTS

ALFRED MEETING

The Alfred Hospital General Surgery Meeting 2017

PROFESSOR JONATHAN SERPELL
Chair, Prevocational
& Skills Education Committee

Professor Jonathan Serpell

The Department of General Surgery at The Alfred Hospital, Melbourne is once again holding The Alfred General Surgery Meeting from Friday 3 November to Saturday 4 November 2017 at Sofitel Melbourne (pictured below) on Collins.

The major theme for this biennial meeting is Practical Updates for General Surgeons, which targets general surgeons and Trainees with a wide range of surgical interests. The meeting highlights *'How I Do It'* sessions and updates on controversial, important and common areas.

Keynote speakers include gastrointestinal surgeon Professor Enders Ng, from the division of upper gastrointestinal and metabolic surgery at The Prince of Wales Hospital, Hong Kong. His wide range of interests include: helicobacter pylori and peptic ulcer disease, interventional therapy for peptic ulceration and surgical oncology for oesophagogastric malignancies.

Chief of Surgical Oncology at the Medical College of Wisconsin, Professor T. Clark Gamblin heads the liver program there with special interests in surgical oncology, liver, pancreas, gallbladder and bile duct tumours.

Christchurch Hospital's hepatobiliary pancreatic surgeon, Mr Saxon Connor includes safe cholescystectomy, enhanced recovery after surgery and pancreatectomy in pancreatitis as his key areas of interest.

Colorectal surgeon Professor Frank Frizelle is head of the University Department of Surgery in Christchurch with an extensive range of interests in diverticular disease and bowel cancer.

Professor Christobel Saunders is a Professor of Surgical Oncology at University Western with many areas of interest in breast cancer research including psychosocial, translational and health services research.

There are four sessions on Friday and two on Saturday morning. The first session includes dealing with difficult peptic ulcers at laparotomy, the impossible gall bladder, management of bile duct injuries, how to find and preserve the recurrent laryngeal nerve at thyroidectomy, and finding the missing parathyroid gland in primary hyperparathyroidism. This session also includes a topic on health checks for your practice, when things go wrong, how to figure it out and a series of cases on colorectal conundrums. There are also topics on advanced endoscopic procedures, both sub mucosal cancer resection and endovac for oesophageal leaks.

The second session highlights key issues and advances in management of acute pancreatitis, management of reflux in obese patients, benign breast conditions, healing an anal fistula, investigation and management of benign liver lesions and an update on laparostomy techniques.

The final session on Friday includes breast screening, when to and when not to, an approach to metastatic colorectal cancer in the liver, diverticular disease – it may not be what you think, an update on the surgical management of obesity, and an approach to retrosternal goitres.

On Friday evening, following the conclusion of the presentations, there will be a welcome reception in the Latrobe Ballroom of the Sofitel Melbourne on Collins.

On Saturday morning the first session is on cancer management, including gastrectomy for cancer, neo-adjuvant chemotherapy in breast cancer, is there an infective aetiology for a sporadic colorectal cancer, how to manage incidental gall bladder cancer, and pancreatic cancer.

The final session also includes incidentalomas at laparotomy or laparostomy, new techniques for localisation in the excision of impalpable breast lesions, a video presentation on TEPP hernia repair and some aspects of robotic rectal surgery. The meeting has been scheduled to enable delegates to go on to enjoy the long weekend in Melbourne with the option to attend Derby Day and the Melbourne Cup.

The Alfred General Surgery Meeting on Practical Updates should appeal to all general surgeons in all areas and in all sub specialties. We look forward to your attendance.

Register Online Now:

http://tinyurl.com/alfred17
For more information, contact:
RACS Conferences & Events Management
250-290 Spring Street
East Melbourne VIC 3002
T: +61 3 9249 1158 or E: alfred@surgeons.org

Skills Training Courses 2017

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

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

ASSET: Australian and New Zealand Surgical Skills Education and Training

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

EMST: Early Management of Severe Trauma

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

CCrISP®: Care of the Critically Ill Surgical Patient

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

CLEAR: Critical Literature Evaluation and Research

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

TIPS: Training in Professional Skills

TIPS teaches patient-centred communication and team-oriented non-technical skills in a clinical context. Through simulation participants address issues and events that occur in the clinical and operating theatre environment that require skills in communication, teamwork, crisis resource management and leadership.

AVAILABLE SKILLS TRAINING WORKSHOP DATES*
October – November 2017

Dates	Location
CCrISP	
Friday, 27 October – Sunday, 29 October	Sydney
Friday, 27 October – Sunday, 29 October	Brisbane
Wednesday, 1 November – Friday, 3 November	Dunedin
Friday, 10 November – Sunday, 12 November	Adelaide
Friday, 17 November – Sunday, 19 November	Sydney
CLEAR	
Friday, 27 October – Saturday, 28 October	Melbourne
EMST	
Friday, 6 October – Sunday, 8 October	Melbourne
Friday, 13 October – Sunday, 15 October	Sydney
Friday, 13 October – Sunday, 15 October	Gold Coast
Friday, 20 October – Sunday, 22 October	Perth
Friday, 27 October – Sunday, 29 October	Adelaide
Friday, 3 November – Sunday, 5 November	Wellington
Friday, 3 November – Sunday, 5 November	Sydney
Friday, 3 November – Sunday, 5 November	Brisbane
Friday, 10 November – Sunday, 12 November	Sydney
Friday, 17 November – Sunday, 19 November	Dunedin
Friday, 17 November – Sunday, 19 November	Brisbane
Friday, 24 November – Sunday, 26 November	Wellington
TIPS	
Thursday, 5 October – Friday, 6 October	Sydney
Friday, 17 November – Saturday, 18 November	Auckland

Contact the Skills Training Department

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

**Courses available at the time of publishing*

WORKSHOPS • ACTIVITIES • EVENTS

Darwin gets a Neurosurgeon

DR JOHN TREACY
NTASM Chair

The Top End of the Northern Territory (NT) covers an area of more than 500,000 square kilometres. It is home to 190,000 Territorians with 140,000 based in the greater Darwin region.

Since 1979, the NT has not had a resident neurosurgeon. The nearest referral hospitals for neurosurgical transfers are in Adelaide (over 2,600 km away). Patient transfers can take between 8 and 24 hours, and this is well beyond the Neurosurgical Society of Australasia's recommended guidelines of time to definitive decompression. Therefore, the majority of the Top End emergency neurosurgical procedures have been undertaken by resident General Surgeons at the Royal Darwin Hospital (RDH).

The RDH is the only major hospital for the Top End of Northern Territory and Western Australia.

The need for a Neurosurgeon in the NT has been great. General Surgeons at the RDH have been performing a wide range of emergency neurosurgical procedures, both for trauma and medical emergencies.

Results from the *Northern Territory Audit of Surgical Mortality* (NTASM) *Report 2010-16 (www.surgeons.org/* NTASM) have shown that of those patients who had an operation and subsequently died, one of the most frequent surgical diagnoses on admission was severe head injury and/or hypoxic brain injury, plus traumatic subdural haemorrhage. Many of these neurotrauma cases are due to motor vehicle accidents.

Published trauma data has shown that deaths in the NT, due to motor vehicle accidents, are nearly three times higher than for the rest of Australia, and one-quarter of NTASM trauma cases were associated with motor vehicle accidents. Unfortunately, many of the deaths in the NT occur at the accident scene rather than in the hospital.

A resident neurosurgeon was urgently needed in the NT to help manage and treat both emergency and elective neurosurgery cases. That neurosurgeon was also needed for regular collaboration with colleagues, and the ongoing education and maintenance of neurosurgical standards in the RDH. This maintenance of standards was, until recently, covered by a dedicated service from visiting Adelaide neurosurgeons.

Apart from benefiting from a local operative neurosurgical service, Top End medical specialists and primary care physicians welcome access to timely neurosurgical opinions. Travelling interstate for elective neurosurgery procedures is very costly for individuals and the Government (as well as being inconvenient for families).

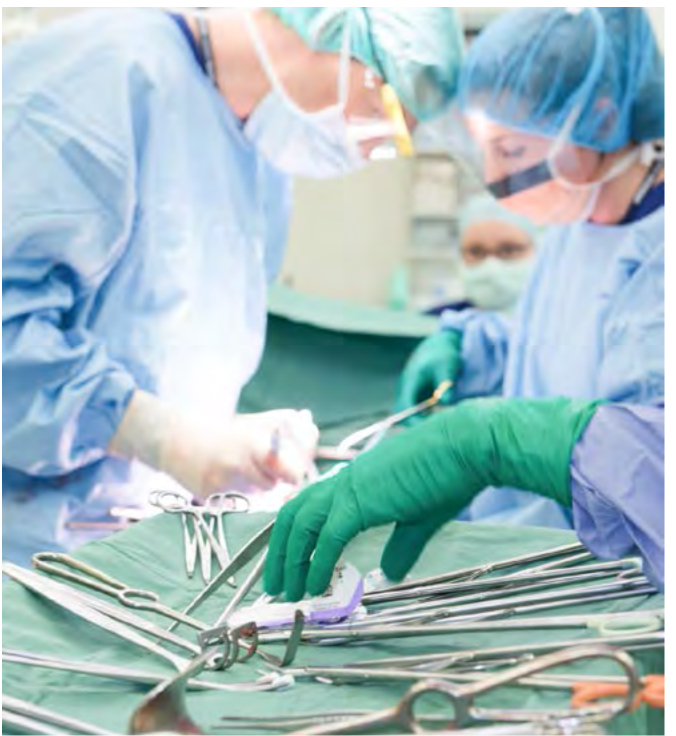
Finally and thankfully, the NT has a resident neurosurgeon. Mr Michael Redmond (pictured, above) knows the Top End well having been raised in Darwin. Since arriving from Brisbane, Michael has been developing and introducing a comprehensive neurosurgical service, not only for neurotrauma but also for spinal and elective surgery.

Neurosurgery is an expensive specialty to establish and maintain due to the high initial cost of equipment and support personnel.

The NT Government and the Top End Health Service recognised the need for a neurosurgery service and made the necessary funds available for an operating microscope, a neuro-navigation system, a spinal surgery table, and a range of operating theatre equipment. There is now provision for the recruitment of several neurosurgeons, a Fellow and a registrar.

This is an important development in surgical services in the Northern Territory and an impressive use of NTASM processes and data analysis.

CAPTAIN OF THE SHIP?
A SURGEON'S ROLE IN SAFETY AND QUALITY
QASM SEMINAR PROGRAM
10 NOVEMBER 2017
Gold Coast University Hospital
Southport QLD
https://qasmseminar2017.eventbrite.com



RACS Trainees' Association

INDUCTION CONFERENCE 2017

This conference has been specifically designed to meet the needs of newly selected SET Trainees. You will be oriented by RACS staff and senior Trainees, and receive insights from RACS leaders, with plenty of time to meet and socialise with your new colleagues. New Trainees will leave this conference equipped with the knowledge and confidence to succeed in surgical training.

Please join us in Melbourne on 11 November for the 2017 Induction Conference for new Trainees.

Date, Time and Venue Time
11 November 2017
Conference registration from 9.30am
Royal Australasian College of Surgeons
250-290 Spring Street, East Melbourne, VIC, 3002

Social Function
The conference will conclude with a tour of the RACS Building and an evening function

Further Information
Contact the RACSTA Executive Officer
racsta@surgeons.org or +61 3 9276 7490

Association of Thoracic & Cardiovascular Surgeons of Asia

27th Annual Congress to be held in Melbourne

ASSOC. PROF. ANDREW COCHRANE
Convenor

Dr Michael Borger (pictured, below) is one of the keynote speakers who will be presenting at the upcoming Association of Thoracic and Cardiovascular Surgeons of Asia (ATCSA) Congress in Melbourne.

Dr Michael Borger completed his cardiac surgery training and a PhD in Clinical Cardiovascular Sciences at the University of Toronto, Canada in 2001. After completing a one-year fellowship with Dr Fred Mohr at the Leipzig Heart Centre in 2002, he took a position as Staff Cardiac Surgeon at the Toronto General Hospital and Associate Professor of Surgery at the University of Toronto from 2002 to 2006 under the mentorship of Dr Tirone David. In 2006, Dr Borger returned to Germany as a staff surgeon at the Leipzig Heart Centre. He became Professor of Surgery at the University of Leipzig in 2008 and was appointed as Assistant Director of the Leipzig Heart Centre in 2009. In 2014, Dr Borger became the Director of Aortic Surgery and the Director of the Cardiovascular Institute at Columbia University Medical Centre (CUMC) in New York. He was also appointed the George H. Humphries Professor of Surgery at CUMC. In 2017, Dr Borger returned to Leipzig as the Director of Cardiac Surgery at the Leipzig Heart Centre.

Dr Borger's clinical and research interests include aortic surgery, minimal invasive and percutaneous valve procedures, aortic and mitral valve repair surgery, and ischemic mitral regurgitation. He is an author on over 300 peer-reviewed publications and sits on the Editorial Board of the Journal of Thoracic and Cardiovascular Surgery, the Canadian Journal of Cardiology, and AORTA. He is also the Associate Editor for the Thoracic Vascular section of the European Journal of Cardiothoracic Surgery, and an Associate Editor for the journal Structural Heart: The Journal of the Heart Team.

For further information regarding the ATCSA Congress, please visit: www.atcsa2017.com

Recognising discrimination, bullying, & sexual harassment

The Royal Australasian College of Surgeons (RACS) is committed to building a culture of respect in surgery and improving patient safety through identifying and addressing unacceptable behaviours.

Unacceptable behaviour adversely affects our co-workers as well as our patients, and it is up to all of us to take appropriate action to address it.

Legislation in Australia at Federal, State and Territory levels, and in New Zealand, defines specific types of unacceptable behaviours. Knowing the relevant legislation is everyone's responsibility.

Unacceptable behaviour covers a broad range of behaviours. Colloquially, terms such as bullying and harassment are often used interchangeably but sometimes incorrectly to describe rude or disrespectful behaviour. Legislation, however, defines and differentiates discrimination, bullying, and sexual harassment as specific types of unacceptable behaviours.

Bullying

Bullying is inappropriate behaviour that creates a risk to health and safety and that is repeated over time or occurs as part of a pattern of behaviour. Such behaviour intimidates, threatens, offends, degrades, insults or humiliates.

Examples include repeated hurtful remarks, attacks or abuse, such as making fun of a person's work or family, intentionally spreading malicious gossip or deliberately changing work conditions to make it difficult for someone.

Some practices in the workplace may seem unfair, but will not necessarily amount to bullying. Employers are allowed to transfer, demote, discipline, counsel, retrench, terminate employment or not renew contracts, as long as they are acting reasonably and have ensured procedural fairness.

Discrimination

Discrimination means treating a person less favourably, including offending, intimidating, harassing or humiliating on the basis of legally protected attributes or personal characteristics. Legislation outlines a list of attributes and personal characteristics against which discrimination is unlawful, including sex, age, religious belief, political belief, pregnancy, breastfeeding, disability, impairment, marital status, family responsibilities, sexual orientation, gender identity, race and cultural background.

Examples include passing over someone for promotion because of their racial background, denying someone operating lists due to their family responsibilities, or referring to female trainees as 'sweetheart' or similar terms.

Indirect discrimination occurs when a work requirement, condition, rule or practice appears neutral and seems to apply equally to everyone, when in fact it unfairly disadvantages an individual or a group of people on the basis of a legally protected attribute or personal characteristic.

An example would be requiring all staff to park in the staff car park located a block away from the hospital, including the doctor with a physical disability, when there are limited parking spaces closer to the hospital.

Harassment

Harassment, as described in legislation, is a form of attribute-based discrimination.

Harassment is unwanted, unwelcomed or uninvited behaviour that makes a person feel humiliated, intimidated or offended. It is based on specific attributes or characteristics and can include racial hatred and vilification, be related to a disability, or relate to the victimisation of a person who has made a complaint.

An example would be telling a registrar who made a mistake that her pregnancy and gender were letting her down.

Sexual harassment

Sexual harassment includes unwelcome sexual advances, requests and other unwelcome conduct of a sexual nature, which offends, humiliates or intimidates a person. A single incident can amount to sexual harassment, as can behaviour of a sexual nature that creates a hostile working environment.

Sexual harassment can include e-mail, text messaging or social media. It can also take place when interacting at a work-related social function, or during internal or external training.

Examples include staring, leering, wolf whistling or gestures of a suggestive or sexual nature, questions or insinuations about a person's sexual or private life, or sexually explicit jokes.

Sexual harassment, including stalking and obscene communications, can amount to a criminal offence.

Who decides what is unacceptable behaviour?

In determining whether a behaviour is unacceptable, the "reasonable person's test" is often applied. This refers to whether a reasonable person, having regard for all of the circumstances, would consider the behaviour to bully, discriminate or harass a person. A person's intent or motive is irrelevant – it is the impact and the nature of the behaviour that is considered.

What if I have experienced unacceptable behaviours?

If you have experienced unacceptable behaviour, seek support and advice from your peer network, mentor, colleagues or RACS.

- Document the event or nature of the behaviour;
- Discuss the event with your manager, a health and safety representative, or someone in authority to better understand your rights and options;
- Consider reporting the event or making a formal complaint to the Human Resources Department;
- Be familiar with your organisation's policies on discrimination, bullying and sexual harassment.

Reporting to RACS

You can also contact RACS to discuss or report your concern. Remember that you may remain anonymous.
Australia: 1800 892 491
New Zealand: 0800 787 470
Email: complaints@surgeons.org
W: www.surgeons.org/about/racs-complaints-hotline/

External Agencies

You may wish to make an inquiry or a complaint to an external agency. Remember, Australian Federal, State and Territorial as well as New Zealand legislation varies.

RESPECT IS THE FOUNDATION OF HIGH FUNCTIONING TEAMS.

Find out more:
www.surgeons.org/respect

The ultimate gift to advance surgical care

PROFESSOR KINGSLEY FAULKNER
Chair, Foundation for Surgery

For more than 30 years, the philanthropic arm of the Royal Australasian College of Surgeons (RACS) – the Foundation for Surgery, has funded research that has saved and improved the lives of countless patients.

Across every surgical specialty, from oncology to trauma and from neurosurgery to the surgical care of premature babies, the Foundation has funded research conducted by both young and established academic surgeons which has led to advances in their chosen fields.

Every year, the Foundation for Surgery selects the best and brightest trainees and surgeons to receive Awards, Fellowships, Grants and Scholarships that help fund world-leading research trials while it also supports Australasian surgeons who wish to gain expertise by travelling abroad to work under the supervision of international experts.

Since it was established in 1980, the Foundation for Surgery has supported:

- Part of the early development of the Cochlear Implant, now used to enable more than 200,000 children and adults around the world to hear;
- Advances in the field of transplant immunology;
- Research into the microbiology and genetics of cancer that is revolutionising cancer treatment such as the development of immunotherapy;
- The development of systems and procedures which have helped improve the survival rates of trauma patients;
- Research aimed at reducing post-operative complications such as inflammation and infection to speed up patient recovery;
- Major contributions to the development of world-leading breast and prostate cancer treatments;
- Broad-based research into the surgical care of complex patients such as those with obesity or diabetes; and many, many other areas of ground breaking research.

This world-class scientific research is now putting Australian and New Zealand surgical science at the forefront of international medical advances and scientific collaborations, with more doctors reading this published research than ever before and more international experts travelling here to attend RACS meetings.

Yet, the Foundation for Surgery also has a commitment to humanitarian and equity programs both locally and across the Asia Pacific region.

The Foundation for Surgery provides targeted support to Indigenous doctors in Australia and New Zealand who wish to pursue a career in surgery.

The Foundation also supports life-changing surgery for adults and children in the Asia-Pacific region, who wouldn't otherwise have access to surgical care in their home nations. It also works to increase the surgical capacity in some of the region's poorest nations by training and sponsoring training of promising surgeons from these nations, so they can meet the long term needs of their communities.

The funding that underpins all the work of the Foundation for Surgery has come predominately from the generosity of retired and active Fellows from Australia and New Zealand; a large portion from bequests.

Yet despite the achievements, challenges remain. Heart disease, stroke and cancer continue to afflict too many people, the rise of 'super bugs' and drug resistance require rapid responses, while our ageing population is changing our health needs in ways that are not yet fully understood.

The Foundation needs your help.

The on-going endeavour to help overcome some of the great health challenges of our time and into the future needs your support and the Foundation is issuing an invitation for you to make a long-lasting and important difference by including a gift to the Foundation in your Will.

Unlike other charities, no overheads or administration fees are deducted from your donations, as these costs are all generously provided for by RACS, ensuring that 100% of your gift is spent in your area of interest.

The work of the Foundation for Surgery is broad and if you make the compassionate decision to leave a gift in your Will, you can specify that your gift is invested in the area of greatest importance and interest to you.

Every gift the Foundation receives, no matter the size, makes a significant difference and is gratefully appreciated.

Leaving a bequest to the Foundation for Surgery is easy. Contact the Foundation today on +61 3 9249 1110 to find out how.

By supporting The Foundation's work through a gift in your Will, you leave a lasting legacy while also ensuring your area of specialty or passion is advanced forever.

When compassionate people are generous enough to remember the Foundation for Surgery in their Will.

We:

- Ensure 100% of you gift will be dedicated to your area of interest;
- Use your gift carefully and wisely so that it has the greatest possible impact;
- Respect your wishes to be publicly acknowledged or remain anonymous;
- Give you and your loved ones the opportunity to be connected with the work you are supporting;
- Handle your gift with care, sensitivity and respect.

Include a Charity – September 2017

The *Include a Charity* month is part of a global movement to raise community awareness of the significant role played by charitable gifts in Wills to help fund the vital work of charities. This September, please consider including a charity or the Foundation for Surgery in your Will. Please contact the Foundation today on +61 3 9249 1110 for more information.

Every gift the Foundation receives, no matter the size, makes a difference

The 1927 Society

This year, the Foundation for Surgery established a very special way to honour the extraordinary generosity of those who include a gift in their Will.

The 1927 Society is named after the year RACS was established and thereby acknowledges not just the College's history, but the critical importance of benefactors in the on-going work to provide ever higher levels of surgical care.

The health and well-being of future generations depends on the research done now and that research depends on support provided to the Foundation.

The 1927 Society is the College's way of saying thank-you to the compassionate men and women who choose to leave a bequest in their Will to the Foundation. It is the Foundation's way of letting them know that their gift is both treasured and recognised and that it will be remembered in their lifetime and into the future.

If you decided to include a bequest to the Foundation for Surgery in your Will, please let the Foundation know so that they can personally thank you and invite you to join *The 1927 Society.*

You will be given a distinctive pin, with thanks, to show your support for the Foundation for Surgery and membership into this honoured society. With your permission, your name will be inscribed on the Donor Board on display at RACS in Melbourne and you will be invited to attend prestigious Foundation events as a special guest.

A gift to the Foundation contributes to transforming lives of patients across Australia and New Zealand through surgical science, helps us to train surgeons in less fortunate countries and contributes to the work being done to improve health outcomes in Indigenous communities.

The 1927 Society allows the Foundation to show our appreciation for your generosity by creating a special relationship between benefactors, the Foundation for Surgery and the College. ▶

I am so glad I decided to make a Bequest, because if you're sick you deserve the best care available, no matter who you are or where you live.

Mrs Ann Carter, QLD

For more than 15 years Mrs Ann Carter from the Gold Coast in Queensland has been battling and beating cancer.

First diagnosed with kidney cancer in 2002, she has undergone a complete left nephrectomy and a partial right nephrectomy and has twice been told that she has less than a year to live.

Still vital, bright and engaging, Mrs Carter attributes her survival and quality of life to the skills and dedication of two urological surgeons – Dr Philip McDougall and Dr Scott McClintock – and Upper GI surgeon Dr Leigh Rutherford who helped navigate her through the complexities of metastatic pancreatic cancer in 2012.

Told by a physician that she would likely lose both kidneys and spend the rest of her life on dialysis, the two urologists worked tirelessly to save as much of her right kidney as possible so that she could live without the need for the debilitating treatment.

Having spent years of her life donating her time as a volunteer for a variety of organisations Mrs Carter decided to donate funds to the Foundation for Surgery and to provide a bequest following her death.

She said she made the decision as both a way of thanking the surgeons who had saved her life and continue to support her quality of life, but also as a way to help fund scholarships for young surgeons so they could gain similar expertise to help other patients across Australia and overseas.

"I hated the idea of dialysis but my surgeons told me they could do better and they did," Mrs Carter said.

"They were brilliant, they had great expertise and they took the time to explain my treatment plan and the options available to me.

"They were part of the reason I decided to make a bequest to the Foundation for Surgery in my Will but I also wanted to donate because I believe that everyone should be able to access the best possible care from doctors with similar expertise."

Mrs Carter has developed an on-going relationship with RACS since she first began donating to the Foundation and said she was particularly enthusiastic about the work done by the College in helping to train surgeons from the Pacific Islands and the support offered to Indigenous doctors who wish to pursue a career in surgery.

Every month she receives and reads *Surgical News* to stay informed about the research conducted and advances being made across all surgical specialties.

"Some of the research being done by young surgeons is absolutely fascinating and I have great respect for these young people who are willing to take time out from their training or consolidating their practice to make advances in their surgical specialty," she said.

"I also believe very strongly in the role of surgeons as mentors to younger doctors.

"The surgeons who treated me have incredible expertise, as do many surgeons in Australia, and that needs to be passed on to future generations through training and scholarships.

"I chose to make a bequest so that I can contribute to that effort by providing funds that can be put towards scholarships."

Mrs Carter described the Foundation for Surgery as "one of the best kept secrets" and said she was proud to contribute to its work.

She said that in an era in which it was becoming increasingly difficult to determine how charitable donations are actually being spent, it is reassuring to know that any funds given to the Foundation for Surgery are not diverted into administrative or advertising costs but used as intended.

"I am so grateful that I didn't have to go on dialysis and have been able to live well through the years since I was first diagnosed. I would say to anyone considering making a donation to a worthy cause, that if you are grateful for the work done by your surgeon, then one way of expressing that would be through donating to the Foundation for Surgery.

"I am so glad I decided to donate and make a Bequest because young surgeons deserve support in their endeavours and also because if you're sick you deserve the best care available, no matter who you are or where you live." Mrs Carter said.

– With Karen Murphy

If you would like more information about including a gift to the Foundation for Surgery in your Will please call +61 3 9249 1110 or email foundation@surgeons.org

Mr Graeme Campbell

Surgical News chats with our Clinical Director of IMG Assessment and Support.

Graeme Campbell was RACS Vice President during a particularly turbulent time for the College. Allegations of bullying, discrimination and sexual harassment had just surfaced in the media, and RACS was thrown in to the Australian and New Zealand media spotlight.

It was clear that an enormous task confronted RACS, but Graeme was adamant that he would not shirk his responsibilities. He was appointed as a member of the Expert Advisory Group (EAG) tasked with investigating the issues.

In this role he committed himself to helping to identify the scope of the problem, and to contribute towards implementing long term solutions and fostering a culture of respect.

It was little surprise, therefore, that when Graeme's tenure as Vice President concluded, RACS was keen to continue utilising his skill set. He was appointed as the Clinical Director of International Medical Graduate (IMG) Assessment and Support, a role that he remains in today.

According to Graeme the combination of his extensive previous involvement with RACS (including nine years on Council), and his experience working as a rural surgeon have served him well in the role.

"Because I practice in regional Australia many of my colleagues are IMGs, as are many surgeons in similar areas across Australia and New Zealand. I think this has always helped me to have a reasonable understanding of, and empathy for the issues that face IMGs."

"One of the clear findings from the EAG was that IMGs reported discrimination at an unacceptable level. There were recommendations that came out of the EAG report about better management of IMGs, so I was keen to see if I could assist in improving the assistance and support we provide."

As the title implies, there are two main components to the role of Clinical Director, IMG Assessment and Support.

The first component comprises of assessing the suitability of IMG applicants to work in Australia and New Zealand. This involves reviewing the documentation provided, and then conducting interviews with candidates who progress to the next stage of the process. The initial review of paper work is conducted by two surgeons, while the interview involves two surgeons and a jurisdictional representative. Graeme is usually involved in both stages.

The second component is to ensure that ongoing assistance is provided to IMGs once they commence working in the hospital system.

"As far as support goes, there are IMGs in nine specialties spread across two countries, and there are often varying issues that come up, particularly those that are assessed as partially comparable and are required to sit the Fellowship examination."

"IMGs often need some additional support and assistance to improve their chances of passing the examination, so we run a series of induction workshops to try and orientate them into their role.

"I work very closely with the training boards that have responsibility for supervising IMGs during this process, and I am available to take phone calls from IMGs and their supervisors should there be any issues that need to be resolved," he said.

As a Fellow now on staff, the role means that Graeme works physically in the RACS Head Office building one day per week. He then spends another one and a half days working remotely, attending meetings, and performing various other tasks.

He is also involved in teaching some of the College courses, particularly the Foundation Skills for Surgical Educators courses and the new Operating with Respect course. While the role continues to evolve, Graeme says that he is pleased with the progress that has already been made.

"We have had a lot of feedback from IMGs, particularly about the induction workshops we run and the availability of someone to talk with and to help sort through their problems.

"We have formed an IMG committee which includes a representative from each of the nine specialties. The aim of the committee is to improve and harmonise the assessment process so that an IMG with similar training and experience will be assessed in a similar way irrespective of which specialty they practice in.

"There is still some work to be done in this area but it has definitely been something we have made quite a bit of progress with. There have been several situations where we have been able to intervene in hospitals to improve circumstances for an IMG or to move them somewhere else for a better educational experience."

While the role promises to keep Graeme busy for some time to come, he says that he is positive about what lies ahead.

"We have just received a draft report from the Australian Medical Council. It is clear that we need to do better work-based assessments, rather than relying on the exams to assess performance.

"There is a body of work that needs to be done to develop a rigorous work based assessment process. I don't think this is a small task and it will be a long term project, but I am very optimistic and confident about our ability to meet this challenge and the direction we are heading in," Graeme said.

– With Mark Morgan, Communications & Advocacy

Congratulations!

PROFESSOR CHARLES BALCH MD FACS

Honorary Fellowship

Professor Charles Balch has had a distinguished career as a clinical and academic surgical oncologist. He is a leading authority in both melanoma and breast cancer, and has also made significant contributions to laboratory research in tumour immunology. He is the author of more than 760 publications and has lectured not only in most of the major academic centres in the United States but also in 42 other countries.

Professor Balch held leadership roles in three US comprehensive cancer centres (The University of Alabama, the MD Anderson Cancer Center and the City of Hope Comprehensive Cancer Center), prior to moving to Johns Hopkins Hospital in Baltimore, then to the University of Texas Southwestern Medical Center in Dallas, and most recently back to the MD Anderson. He has also held leadership roles in numerous cancer cooperative groups, NIH study sections and professional organisations, including the American Society of Clinical Oncology.

Professor Balch has organised or participated in several major international randomised surgical trials that have defined the current standards of melanoma surgery. In the area of breast cancer he was co-principal investigator of the only randomised surgical trial that compared radical mastectomy with modified radical mastectomy, and was one of the pioneers of skin-sparing mastectomy followed by immediate breast reconstruction. Professor Balch was elected President of the Society of Surgical Oncology in 1992, and has been Editor-in-Chief of the Society's journal, Annals of Surgical Oncology, since it was first published in 1994. He has been a member of the American Board of Surgery, the Association of Academic Surgeons and the Commission on Cancer, as well the American Joint Committee on Cancer.

Professor Balch has a longstanding and very close association with Australia. He first visited in 1982 when he spent six months in Sydney as a senior research fellow at the Sydney Melanoma Unit with Professor Gerry Milton and Professor Bill McCarthy. Since then, he has visited Australia more than 25 times and given many invited lectures at important national and international meetings as well as being a very popular Visiting Professor at several major Australian institutions. Professor Balch is well known to most surgical oncologists in Australia and has been a mentor and friend to many of them over several decades. He is one of the greatest academic surgeons of our time and a most worthy recipient of Honorary Fellowship of the Royal Australasian College of Surgeons.

Citation kindly provided by Professor John Thompson FRACS.

Image: Professor Charles Balch (left) with Past President Mr Phil Truskett AM.

Academic Gown Donation

The College would like to acknowledge Mrs Jan Hart, wife of the late Associate Professor John Hart, for generously donating his academic gown.

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

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

In Memoriam

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

Brian Leslie Cornish AM Orthopaedic Surgeon

30 December 1924 - 28 July 2017

A stroke ended Brian Cornish's long life of service and achievement on Friday 28 July 2017. He died peacefully aged 92, surrounded by his 4 children and their spouses. Betty, his wife of fifty-nine years, preceded him in 2009. His end came at Royal Adelaide Hospital where he started work as a junior doctor in 1947 and spent a professional life of surgery, teaching and service to the community, retiring as emeritus consultant orthopaedic surgeon in 2000.

He was born in the small town of Blyth in the Clare Valley, South Australia and brought up on a cereal farming block at nearby Kybunga. Primary schooling was in Kybunga with one teacher and 28 pupils. In 1936 the family moved to a grazing property about 11km from Coleraine, Victoria. Brian, with a bursary, completed high school as a weekday border at the Presbyterian College in Hamilton, 35km from the family property. With support from a maternal uncle in 1942, he enrolled in Medicine at the University of Adelaide, graduating in 1947.

Professor John Ludbrook

30 August 1929 - 9 June 2017

John Ludbrook undertook medical studies at the University of Otago in Dunedin, and showed an early interest in medical research by completing a B.Med Sci with no less than Jack Eccles, a Nobel Laureate. His residency training was at Green Lane Hospital, Auckland, with Douglas Robb. He received a NZ Universities Travelling Scholarship and a Leverhulme Research Fellowship, which allowed him to continue his post graduate surgical studies at St Mary's Hospital with Charles Rob, the celebrated pioneer of vascular surgery.

Following some time in a 'cutting job' at the Norfolk and Norwich Hospital to develop his surgical skill, he returned to New Zealand in 1959 as an Assistant in the Department of Surgery, University of Otago in Dunedin, under the guidance of Gus Fraenkel (later inaugural Dean of Medicine at Flinders University, Adelaide).

Dean Graham Mackie Otolaryngologist Head & Neck Surgeon

19 July 1923 - 12 January 2017

Dean Mackie was born in Adelaide and was educated with a scholarship at Kings College (now Pembroke). When the war came he enlisted in the RAAF and hoped to follow his brother as aircrew flying Wellington bombers but was disappointed to be found medically unfit for this. Attaining the rank of warrant officer he was involved in malaria control and building forward airfields as the Japanese were driven out of south-east Asia.

Under the ex-servicemen's program Dean studied medicine in Adelaide, earning income during his vacations in the back-breaking work of clearing scrub on Kangaroo Island. He travelled to the UK where he obtained ENT training in prestigious hospital departments, including one in Belfast under world-renowned ear surgeon Gordon Smyth. After gaining the Diploma in Laryngology and Otology, Dean returned to Adelaide in 1961 and was appointed senior registrar at the Royal Adelaide Hospital.

James O'Collins Urological Surgeon

20 December 1932 - 2 March 2017

A leading urologist of his own generation and younger brother-in-law of the urologist James Peters (deceased), Jim O'Collins contributed to the remarkable progress in treating the urinary system made during his years in that specialised field of surgery.

Born on December 20, 1932 James Patrick O'Collins grew up on his parents' property ("Rock Lodge") in the hills outside Frankston. Educated at Xavier College, he became a student at Newman College and in 1957 graduated MBBS at the University of Melbourne.

IN MEMORIAM

Our condolences to the family, friends and colleagues of the following Fellows whose death has been notified over the past month:

Brian Cornish AM (SA)
Keith Henderson (VIC)
Colin Holloway Hooker (NZ)
John Ludbrook (VIC)
James Patrick O'Collins (VIC)
Patrick Pritzwald-Stegmann (VIC)
Anthony Oliver Robertson (QLD)
Robin Rushworth (NSW)
Nigel Sacks (VIC)

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

Informing the College

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

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

'Our Languages Matter'

RACS staff celebrate NAIDOC Week 2017

DAVID MURRAY
Chair, Indigenous Health Committee

Ninna Marni! (A Kaurna word for 'hello, how are you?)

At the time of European arrival in Australia over 250 individual Aboriginal and Torres Strait Islander language groups covered the continent. More than half of these languages have been lost with many others at risk of extinction as the only remaining speakers pass away. Many organisations are leading the way in the preservation of Aboriginal and Torres Strait Islander languages. The Victorian Aboriginal Corporation seeks to revive, strengthen and see Aboriginal language thrive across the nation. In New South Wales the state government has also moved to draft legislation that would formally recognise the significance of Aboriginal languages and the importance of establishing mechanisms to preserve and prevent their loss.

RACS Scholarship Program Coordinator, Sue Pleass with Head of Linguistics, University of Adelaide, Dr Robert Amery.

The importance of recognising and celebrating Aboriginal and Torres Strait Islander languages was selected as the theme for this year's National Aborigines and Islanders Day Observance Committee (NAIDOC) Week, which took place between 2-7 July. In introducing the week, the National NAIDOC Committee Co-Chair Anne Martin said that languages are 'the breath of life for Aboriginal and Torres Strait Islander peoples and the theme will raise awareness of the status and importance of Indigenous languages across the country'.

She said that Aboriginal and Torres Strait languages are not just a means of communication, they express knowledge about everything: law, geography, history, family and human relationships, philosophy, religion, anatomy, childcare, health, caring for country, astronomy, biology and food.

The Royal Australasian College of Surgeons celebrated NAIDOC Week by inviting Dr Robert Amery, Head of Linguistics at the University of Adelaide, to speak at the South Australian Regional Office about his extensive experience working with the Kaurna (pronounced Garna) language, the Indigenous language of Adelaide and the Adelaide Plains. Dr Amery has worked intensively with the Kaurna language for over 25 years, playing a critical role in the revival and promulgation of the language. Despite being the original language of Adelaide, the Kaurna language ceased being spoken on a daily basis from the early 1860s, and over the next one hundred years the language became largely extinct. After the 1967 Referendum in Australia, there was a gradual movement back towards reconnecting Adelaide with Kaurna country, with initial concerns being placed on site protection. From the mid-1980s much greater emphasis was placed on reviving Kaurna as a spoken language.

Through Dr Amery's presentation staff gained many insights into the many languages (not dialects) of Aboriginal and Torres Strait Islander peoples across Australia and were also saddened by the thought of what languages have already been and continue to be lost. Less than 10 of the hundreds of languages that once echoed across this great land are taught in educational facilities, with Kaurna being recognised most for its importance.

The lunch and presentation was a thoroughly engaging and fascinating glimpse into an otherwise little known part of Australian history. Throughout the session staff were also taught how to say and pronounce many common Kaurna words, expressions and place names, and even learnt and sang a song!

Some of the staff reflections following the event were;

"Very interesting; I can certainly say that I know a lot more than I did before about Kaurna culture and history."

"It was fascinating to learn about the languages of the Kaurna people, on whose land we live and work. I was sad to realise I knew so little about them, and I'm glad to know a bit more."

"Very interesting, and was eye opening how little I knew about the history of the indigenous peoples of Adelaide."

For more on the revival of Kaurna, download the recent publication Warraparna Kaurna! Reclaiming an Australian Language from University of Adelaide Press: https://www.adelaide.edu.au/press/titles/kaurna/ (Free Download)

See also the film Buckskin - http://buckskinfilm.com/about-the-film/

Case Note Review

Death after hernia surgery – was surgery required?

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

Summary:

A middle-aged patient underwent a repair of a right direct inguinal hernia. This was performed as a mesh hernioplasty, under general anaesthetic by an experienced registrar. This patient had multiple and extensive comorbidities, including end stage renal failure from a failed transplant which required haemodialysis. There were also various vascular problems and a red cell dyscrasia. The consultant surgeon who had reviewed the patient arranged a preoperative anaesthetic opinion, and offered to repair the hernia under regional or local anaesthetic.

In the days following the repair of the hernia, the patient became progressively unwell and developed abdominal pain. This was rather nonspecific and four days following surgery discharge planning commenced. The next note is dated a further four days later and was made by the intensive care unit (ICU) registrar following the patient's admission into the ICU. The patient was very unstable with a metabolic acidosis and a lactate of 5.9. On clinical examination the patient had an acute abdomen.

The patient subsequently underwent a laparotomy. The findings were of sero-sanguinous fluid and extensive adhesions from previous surgery. The surgeon found it difficult to mobilise the bowel because of the dense adhesions and one inadvertent enterotomy was repaired. The surgeon noted that this was "an ischaemic bowel therefore likely to leak early".

A week later a small bowel leak was suspected and a second laparotomy was performed by the consultant. Copious amounts of faeculant fluid were found throughout the abdomen. The consultant obviously struggled to mobilise the small bowel and a 25 cm section was eventually resected. No areas of dubious vascularity were seen and the small bowel was re-anastomosed. A lavage was carried out and multiple drains placed into the abdomen.

Following this laparotomy, a decision was made to support the patient but not to offer further surgery. Surprisingly the patient made good progress but two days later developed a gastrointestinal fistula through the midline abdominal wound. During the next week, good progress was made initially without any peritonitis, but subsequently the patient developed increasing pain and tenderness with a rise in the white cell count. A computed tomography scan with contrast showed intraperitoneal leakage of the dye. The consultant surgeon therefore elected to return the patient to theatre. Small bowel content was found throughout the abdomen, having come from a completely dehisced small bowel anastomosis. Once the small bowel loops had been freed up an ileostomy was bought up into the left iliac fossa.

Progress over the next four months was prolonged and difficult. The patient was eventually discharged from the surgical ward for long-term rehabilitation. On the latter ward the patient had numerous episodes of hyperchloremia probably related to chronic renal failure and had numerous medical emergency team calls and at least one ventricular fibrillation (VF) arrest. The patient subsequently died from a further VF arrest.

Comment:

There are a number of issues that need to be considered here:

1. Was it necessary for a high risk patient to have a direct inguinal hernia repaired as the risk of surgery may have outweighed the risk of strangulation?
2. Given the high risk it is not clear why the patient underwent the operation under general anaesthetic rather than regional or local anaesthesia.
3. It was not clear what caused the patient's medical status to deteriorate prompting the first laparotomy. The probability is that it was ischaemia of the small bowel, which was presumably a consequence of the patient's medical status. The registrar could have benefited with consultant support at this operation.
4. The enterotomy leaked, presumably secondary to ischaemia therefore was a further small bowel anastomosis the correct choice of procedure?

Despite these surgical problems the patient survived and eventually discharged to the surgical ward only to die whilst undergoing rehabilitation. It would not appear that death was a direct result of surgery although presumably the patient's complex postoperative course caused further debilitation making the patient susceptible to various comorbidities.

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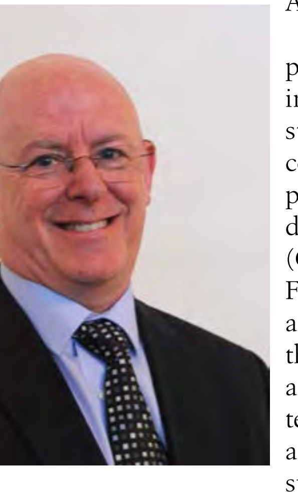
CONTACT:
SUE 0438 260 508

Past President of USANZ joins RACS Council

Professor Mark Frydenberg, the immediate past President of the Urological Society of Australia and New Zealand (USANZ), this year joined the Royal Australasian College of Surgeons Council as the specialty representative for Urology.

Chair of the Department of Urology at Monash Health for 20 years and Professor of Surgery at Monash University, Professor Frydenberg is also the Clinical Director of the Prostate Research Group at Monash University and a member of the Board of the Prostate Cancer Foundation of Australia.



With a particular interest in professional standards and continuing professional development (CPD), Professor Frydenberg is also a keen advocate of the use of registries and data capture technologies as a way to provide surgeons with feedback regarding their outcomes and to help provide data that better informs the public about their treatment options.

He is on the steering committee of the Victorian Prostate Cancer Registry and the Prostate Cancer Outcomes Registry – Australia and New Zealand (PCOR-ANZ) and is involved in USANZ efforts to introduce a registry in renal surgery.

"Most specialties now have their own registries under development and I believe they are crucial in allowing surgeons to compare their skills and outcomes against their peers while they are also provide crucial information to Government health authorities and consumers."

Professor Frydenberg said he was also committed to reinforcing the work done by the Expert Advisory Group (EAG) on discrimination, bullying and sexual harassment (DBSH) within the profession of surgery.

As President of USANZ, he issued one of the strongest responses of all the specialties to the findings of the EAG, acknowledging that 50 per cent of Urologists or trainees reported being subjected to DBSH during their career and admitting that change was urgently needed.

Upon the release of the EAG's report, he echoed the College's apology to any past or present Urologist or trainee affected by DBSH and urged his colleagues to work to create a fair and safe environment for all trainees, IMGs and Fellows.

"While I believe the message has filtered through and behaviours and attitudes are changing, I think this is an issue that requires continuous reinforcement," he said.

"I believe that the ethics and behaviour of surgeons towards their colleagues and their patients are of critical importance to the profession and I hope to continue to contribute in this area during my time on Council."

"I am also committed to representing the best interests of patients through advocating for surgeons to charge appropriate fees and provide the necessary information to allow patients to make the best choices about their own treatment.

"Patients need to be fully informed about their treatment options and empowered so that they clearly understand that paying considerable out-of-pocket expenses is not the only way to access first-class health care."

> *"I believe that the ethics and behaviour of surgeons towards their colleagues and their patients are of critical importance to the profession and I hope to continue to contribute in this area during my time on Council."*

"As President of USANZ I had considerable interaction with the College and I thought I could continue that contribution as a member of the RACS Council," he said.

"I am particularly interested in the on-going development of CPD, particularly in terms of developing transparent mechanisms that allow us to measure the competence, skills and behaviour of surgeons through bench marking and registries.

Professor Frydenberg was awarded his FRACS in Urology in 1990 and spent the following two years as the Urologic Oncology Fellow at the Mayo Clinic in Minnesota before returning to Melbourne.

He has published more than 160 peer-reviewed articles in medical literature and has been an invited speaker at many national and international meetings. He is on the Editorial Board of the *World Journal of Urology* and *Seminars in Urological Oncology* and is a regular reviewer for these and other medical journals such as *Urology, Journal of Urology*, *BJU International*, the *ANZ Journal of Surgery* and the *Medical Journal of Australia*.

He is also involved in research relating to survivorship issues and patient reported outcomes following treatment for prostate cancer.

"Through the work of the registries we were able to fully understand the outcomes following treatment for prostate cancer and alter our approaches based on that research," Professor Frydenberg said.

"Now most men with low risk disease don't get therapy but are closely monitored while those with aggressive disease are treated and then encouraged to report on-going health impacts.

"There are good therapies available to treat advanced disease, incontinence and impotence but men need to know how to access that care.

"Early in my career I had the good fortune to supervise PhD psychology candidates researching men and prostate cancer therapy and I continue to have a strong interest in survivorship issues and how we provide men with the best quality of life possible following treatment."

Professor Frydenberg thanked his colleagues for the confidence they had shown in him through selecting him to be their representative on Council.

He said he would also like to use his time on Council to become involved in the College's Global Health initiatives as well as working to promote support for rural surgery services.

"I think the College has done some amazing international aid work, particularly in terms of teaching and mentoring surgeons in neighbouring countries, and it would be wonderful if we could find ways to expand that work as well as promoting surgical access and care throughout Australia," he said.

From the earliest days of his surgical practice, he provided an outreach prostate cancer service to Bairnsdale Hospital in Gippsland, Victoria, and from those visits fell in love with the Gippsland Lakes region.

When time permits, he spends free weekends with his family at a holiday home near the lakes and is a keen water and snow skier and an enthusiastic photographer.

– With Karen Murphy

Dear Editor,

I was interested in Assoc. Prof. Greg O'Grady's paper in the recent (July 2017) *Surgical News*. His new pressure sensing apparatus seems to have great potential and I shall look forward to reading his future results.

I'm not sure about his conclusions of hyper activity following colonic resection. The innervation of the right and left sections of the colon are significantly different as pointed out by those who have studied the anatomy.(1,2). So the location of the resection sites and recording levels are very important.

Working on the left side of the colon, (3.) found contrary to Prof. O'Grady, that motility was reduced by segmental resection of the rectum when recordings were made before and after surgery in the descending colon. Obviously further study is indicated in multiple locations pre- and post- segmental resection of the large bowel. There is much to do!

References:

1.Mitchell,G.A.G. Anatomy of the Autonomic Nervous System . 1953. 190. E&S Livingstone, Edinburgh & London.

2.Lannon,J., Weller,E. The parasympathetic supply of the distal colon. *Brit .J. Surg.*,1947,34.,373-8.

3.Catchpole,B.N. Motor pattern of the left colon before and after surgery for rectal cancer: possible implications in other disorders. Gut.,1988, 29., 624-630.

Mr. B.N.Catchpole
2.8.2017.

To the Editor, Surgical News,

I enjoy reading *Surgical News* immensely.

The News is a wonderful magazine, and I take it home and share it with my family and non-medical friends, the depth and breadth of articles is quite extraordinary.

Please pass on my sincerest congratulations to the Editorial Team.

With very best wishes.

Yours sincerely,

Associate Professor
David Webb

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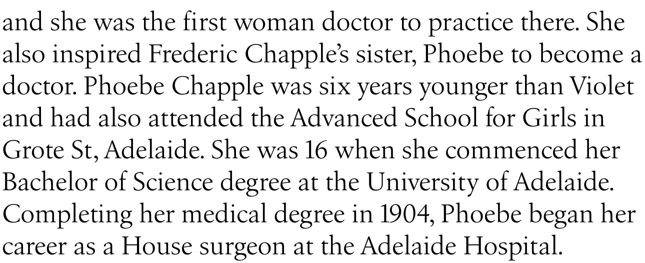
Early Days in Adelaide

Phoebe Chapple, Violet Plummer and Archibald Watson

In the middle of 1916 Archibald Watson returned from his somewhat controversial war service in Egypt and Greece. He resumed his job as Elder Professor of Anatomy at the University of Adelaide and continued his association with practicing surgeons. Integral to this association was his habit of observing operations and recording them in his surgical diaries.

Watson's diaries from March to June 1916 are of particular interest because it is here that he observes the work of two influential women surgeons - Violet Plummer and Phoebe Chapple. These women were from similar backgrounds and had taken agnate paths to medicine. Violet was born in Camperdown, NSW in 1873. She was educated in Adelaide and enrolled in a Bachelor of Science at the University of Adelaide. By 1893, she had passed her last year in Science and first year in Medicine. However, Violet and fellow student Frederic Chapple, completed their medical degrees in Melbourne. According to the November 1897 Quiz and Lantern:

Miss Plummer was one of the medical students who, on account of the unfortunate hospital dispute [involving Dr Leith Napier and Dr Ramsay Smith at the Adelaide Hospital], *left for Melbourne to prosecute her studies, and her success will astonish.*



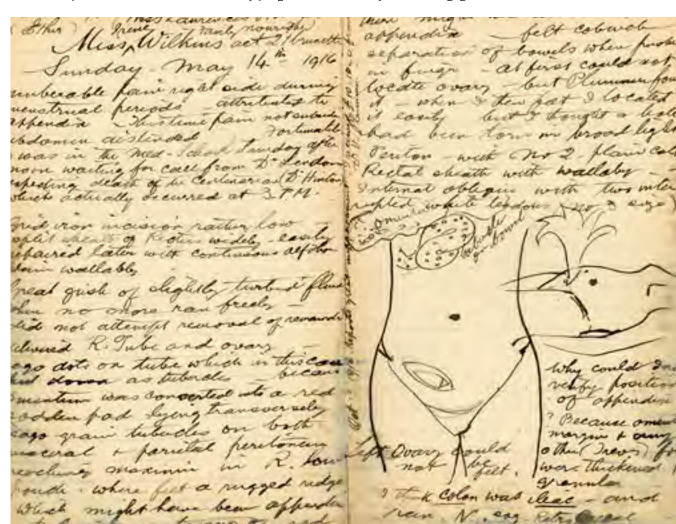
Violet Plummer did return to Adelaide and in 1900 and she was the first woman doctor to practice there. She also inspired Frederic Chapple's sister, Phoebe to become a doctor. Phoebe Chapple was six years younger than Violet and had also attended the Advanced School for Girls in Grote St, Adelaide. She was 16 when she commenced her Bachelor of Science degree at the University of Adelaide. Completing her medical degree in 1904, Phoebe began her career as a House surgeon at the Adelaide Hospital.

Violet and Phoebe became lifelong friends and they sometimes worked together. On 8th May 1916, Professor Watson observed their operation on 'Miss Wilkins who had suspected appendicitis. In his record of the procedure Watson when searching for the appendix, noted:

…felt cobweb separation of the bowels when pushed in finger – at first could not locate ovary but Plummer found it – where I then felt I located it easily…

With characteristic curiosity, he also comments:

Why could I not verify position of the appendix? Because omentum margin and any other folds were thickened and granular. I think the colon was ileac [sic]*…*



It is clear that Watson was not only observing but to some extent, advising on the procedure. This indicates a collaborative process designed to ensure the best outcome for the patient and also, to gather anatomical knowledge.

Two months earlier, Phoebe Chapple had performed an operation with her brother Frederic and Watson. The patient was a 66 year old man, Mr J W Hilton who had *…remarked a lump growing under ramus right side.* During the procedure, the surgical team *…prolonged the wing of incis - & removed a normal gland (ie the one in front of the salivary gland)*

Once again, Watson was working with younger surgeons and an interesting aspect of the operation was the use of kangaroo tendon for suturing:

On the bad side turned up skin and clamped all around and divided and tied with kangaroo tendon removed 5 days previously from one of Mr Rymils arrivals which had been killed.

Phoebe Chapple and Violet Plummer worked with Watson on several procedures in 1916 but then, their paths diverged. In early 1917, Phoebe made her own way to Europe, joined the Queen Mary's Auxiliary Army Corps and served with distinction on the Western Front, winning the Military Medal at Abbeville in May, 1918.

Throughout her long career, Phoebe Chapple worked with the poor and disadvantaged and was an advocate for medical women. She was a founding member and later President, of the South Australian Women's Association and in 1937, attended the Medical Women's International Association Conference in Scotland as an Australian representative.

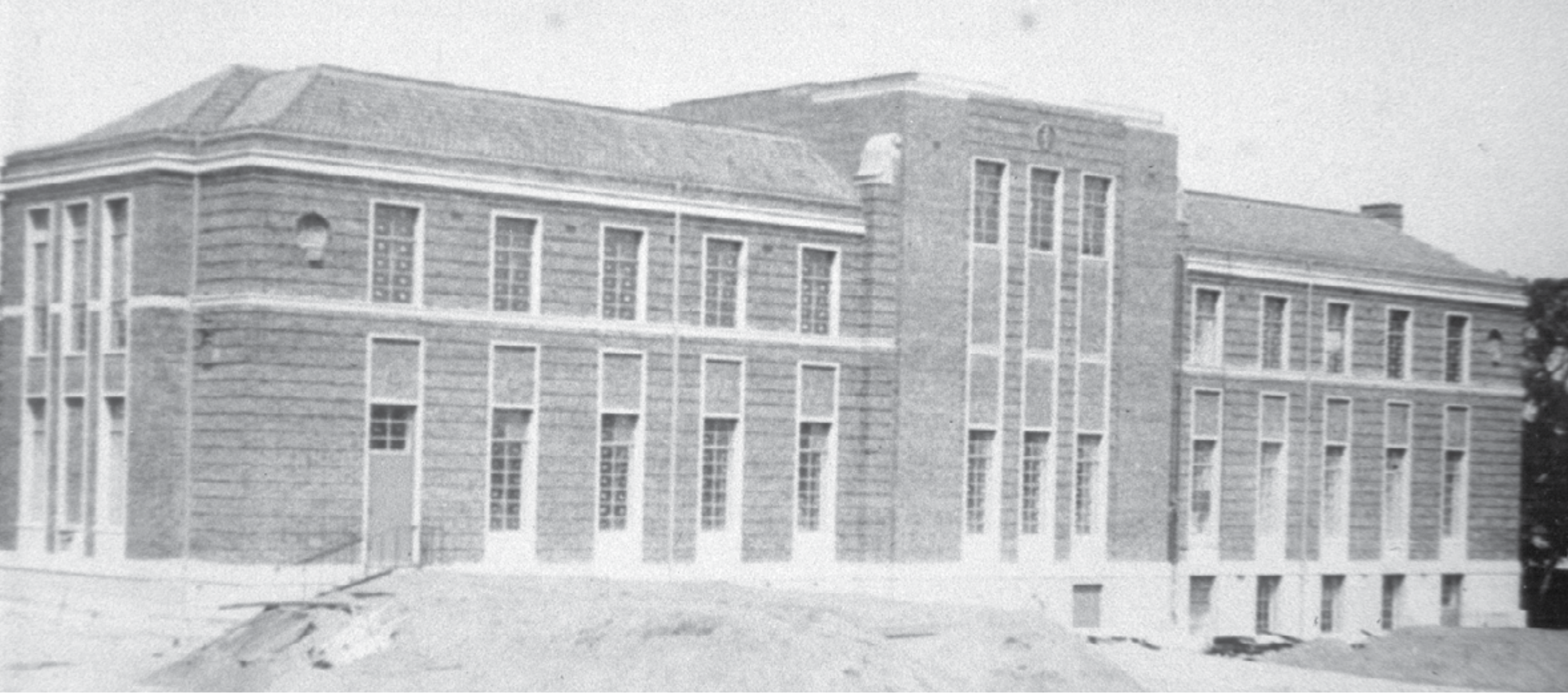
Violet Plummer continued to be an inspiration for young women aspiring to a medical career. And in the late 1930s, Violet, Dr Helen Mayo, Dr Constance Finlayson and Lady Pauline Grenfell Price were instrumental in founding St Ann's College, a residential College for women studying at the University of Adelaide.

The incurably inquisitive mind of Professor Watson was active long after he had left the University of Adelaide.

He spent his last years on investigating topics such as the wildlife on Thursday Island or devising a scheme to exterminate rabbits. However, his surgical diaries go beyond such interests and illustrate the personalities, methods and concerns of early twentieth century surgery.

– Elizabeth Milford, RACS Archivist

Images (From far-left): Professor Watson 1915; Operation on Miss Wilkins, 8th May 2016; Dr Violet Plummer, SLSA; Dr Phoebe Chapple, AWM P10871.005; Operation on Mr Hilton, March 2016.



How Did We Get Our Name

Celebrating Our 90th Birthday

MR GORDON LOW AM
Victorian Fellow

In 2007, the College, which was officially founded on 5 February, 1927, turned 80. Interestingly, a close look at our history shows that the title *Royal Australasian College of Surgeons*, actually dates from 1931. Between 1927 and 1931 we were called the *College of Surgeons of Australasia*, but since 1930, the word "Royal" has been included in the College's title. However, the wording on the College mace is: *Royal College of Surgeons of Australasia*. This paper traces the steps of the College's founding, and details what we might have been.

Each year at the time of our Annual Scientific Congress, we parade the names of Syme, Devine, Barnett, Russell and many others. They were some of the founding fathers of our College. Today, we have inherited a rich legacy of their yeoman tasks which have shaped our College.

Later that year, the first sod in the foundation of our College was turned by Louis Barnett, Professor of Surgery of the University of Otago in Dunedin. He proposed the formation of a New Zealand Association of Surgeons and also had a concurrent proposal for an Australasian Surgical Association. At a meeting of the Surgical Section of the Australasian Medical Congress in Brisbane, Hamilton Russell moved a resolution supporting Louis Barnett's proposal. However, it was not accepted.

Within the Surgical Section of the Congress, George Syme was opposed to Barnett's idea and suggested the New Zealand Association of Surgeons should become a section of the New Zealand Branch of the British Medical Association. Similarly in Australia, Syme, supported by Robert Gordon Craig, also favoured the BMA attachment. This was not surprising because at that time, nearly all the members of the surgical fraternity in Australia and New Zealand were members of the BMA.

William Mayo and Franklin Martin, major players in the

> *"If the mantle of Surgery which we hand on to succeeding generations is to be of Cloth of Gold, may the Surgeons of this hospital weave into it many threads of precious metal, free from dross"*
>
> *F.P. Sandes (1876-1945)*

In the autumn of 1920, members of the surgical staff of the Melbourne, the Alfred and St. Vincent's Hospital formed the *Surgical Association of Melbourne*. Membership was open to only the senior surgical staff of these hospitals, and limited to 50. The first president was F.D. Bird and the vice-presidents, Hamilton Russell and G.A. Syme. Across the Tasman, New Zealand Surgeons who were disenchanted with the British Medical Association (BMA), supported the formation of this surgical body and it quickly spawned committees in other centres.

founding of the American College of Surgeons in 1912, visited Melbourne in 1924. After their visit, they invited Hugh Devine and others to attend their Annual College Meeting in 1925. While cruising in Mayo's houseboat on the Mississippi, Mayo said to Devine, 'My boy, go home and found your own College and make it fit into your own Australasian conditions and circumstances.'

Devine returned to Melbourne fired with the enthusiasm to found a 'college of surgeons.' He was an eloquent man, and many colleagues, including George Syme fell to his persuasion. Syme was influential – he had just retired but he commanded enormous respect within the surgical fraternity.

On 19 November, 1925 F.P Sandes of Sydney composed the now famous 'Foundation Letter' or Exordium which was sent to all the senior surgeons and the surgeons of the public hospitals in Australia and the Dominion of New Zealand. It was signed by George Syme, Hamilton Russell and Hugh Devine. The Eighty one surgeons who responded to the letter were to become the Foundation Fellows of the College. The opening sentences of this letter are as follows:

Senior Surgeons and Surgical Specialists in all States of Australia have noticed with much concern, a growing disregard by younger practitioners, of recognized ethics in Surgical Practice, combined with a spirit of commercialism tending to degrade the high tradition of the surgical profession.

Difficult and dangerous surgical operations are undertaken by practitioners who have not been properly trained in surgical principles and practice, and who divide fees with colleagues who refer the patients to them.

1926 was a busy year for the Founders. The constitution was written although there were concerns regarding finances. These included the threat of being sued by those members of the BMA, who wished to join the association but who had no surgical qualification. This was of major concern because there was no examination for admission to Fellowship at that time. The lack of an entry examination may also be the reason that some of the senior surgeons preferred the model of the American College of Surgeons. Other issues concerned where the headquarters of the new organisation would be situated and what would be the name of this new body of surgeons.

Much activity took place in Sydney and Melbourne in 1926 and a number of important meetings took place between April and August. After much deliberation, on the 8th August 1925 , Professor F.P. Sandes wrote to Devine, informing him of the general feeling of the Sydney surgeons and thus, giving the Melbourne group full support in their efforts to create the new College.

Items discussed in the minutes of the 20th August 1926 included:

- That the name of the Proposed Association of Surgeons should be the
- College of Surgeons of Australasia.
- That members of the College be designated as Fellows and be entitled to place after their names the letters F.C.S.A.

  F Fellows
  C College
  S Surgeons
  A Australasia, which includes New Zealand.

On the 30th March 1931, another milestone was reached when it was determined that:

Acting upon the authority confirmed by the Council at its meeting held in Sydney, the 7th September, 1929, the Executive Committee forwarded an application to His Majesty the King, through His Excellency the Governor- General of the Commonwealth of Australia, and His Excellency the Governor-General of the Dominion of New Zealand, for inclusion of the prefix "Royal" for the title of the College. The Executive Committee has been informed by the Secretary to the Right Honourable the Prime Minister of Australia, that His Majesty was greatly pleased to grant this application. Fellows were therefore, be asked for approval of a resolution that the title of the College should be altered from the "College of Surgeons of Australasia" to "Royal Australasian College of Surgeons"

Letters Patent recording the College Coat of Arms were granted to the *College of Surgeons of Australasia* on 30 January, 1931, following a petition by Sir Hugh Devine to the College of Arms in London. Although the prefix 'Royal' was granted on 23 December, 1930, by King George V, it was too late for the craftsmen who were making the mace to alter the inscription already carved thereon- *The Royal College of Surgeons of Australasia*. In his presidential address at the Fourth Annual Meeting of the College in March, 1931, Sir Henry Newland announced the new name: the *Royal Australasian College of Surgeons*.

This is an abridged version of an article written by Gordon Low, AM FRACS for Surgical News in 2007

Images (from left): College building 1935; Coat of arms.

Opus

XLIX

Donations to the Cowlishaw museum collection

FELIX BEHAN
Victorian Fellow

The Cowlishaw Collection of historic library books is the legacy of Dr Leslie Cowlishaw the Physician and Bibliophile from Sydney. This Collection realistically is a synopsis of medical history from time immemorial to the present era. Cowlishaw graduated in medicine from the University of Sydney in 1906 and became a world traveller, collecting many text books of medical, social and historic interest.

He made great connections, especially Sir William Osler, Regius Professor of Medicine at Oxford. Osler called him "the Bibliophile from the Bush" the nickname reflecting his colonial background and his interest in medical history. One is only to read quotes from Osler reflecting his knowledge and experiences - as relevant today as it was 100 years ago. For example "Observation is the basis of medical science and medicine is the science of uncertainty and the art of probability".

Past President Mr Phil Truskett AM, Assoc. Prof. Felix Behan and Geoff Down

Geoff Down, Curator of the RACS Museum quoted to me recently when I was preparing this story one of Cowlishaw's famous lines was that - *"much of what is done today has actually been done before"* reflecting the value of historic references in any scientific collaboration. By reading more, information is generated and pearls of wisdom emerge from the oysters. Cowlishaw's succinct expression reflects this historical perspective. I replied to Geoff that afternoon with my own quote *"what's new under the sun"* – not knowing its origins and I said I must check its source. Geoff, spontaneously and without prompting could remind me these were the words of King Solomon in the Book of Ecclesiastes 1:4-11 which I must now quote.

What has been is what will be,
and what has been done is what will be done,
and there is nothing new under the sun.

I never thought after a career in surgery with umpteen publications and text books, I would revert to biblical references in any surgical context. Thus the significance of the written word perhaps is more appreciated in our maturing years. We can hark back regularly on things past and events achieved which are only recorded best in books. Thanks to IT expertise however, digitalisation facilitates access. When I was compiling another article recently on Keystone Island Flaps, I asked my Librarian team had they any references on J.S.F. Esser, the originator of Island Flaps reconstructions in the early 20th Century.

Graeme Lister, a former Senior Registrar in the UK, was the first to make us publicly aware by way of Plastic Surgical Literature of the importance of Esser. Graeme then transferred to Louisville, and he became an eminent force in Reconstructive Hand Surgery working at Louisville, Kentucky under the great Harold Kleinert.

My local library found a reference on Esser, I printed their emailed response thinking it would be just a page or two. It turned out that the email included a 200-page facsimile (zine) of Esser's text book. I was so impressed with its content that I have ordered one from my French bookshop in Paris on the Left Bank – *Alan Brieux*, and will give this to the Cowlishaw Collection because of its Plastic Surgical significance. Geoff could inform me there is no record in the Cowlishaw Museum at the moment.

The life story of Esser is interesting. He graduated in Medicine and Surgery from Holland's most prestigious university at Leiden. He eventually became a pupil of the great Theodore Billroth. He was also an international Chess Champion at the Hague in 1902. He was also an art collector, and his home was like a museum (sounds familiar, ask my wife). Having done further training, under Philipp Bockenheimer he published his first book on Plastic Surgery 1912.

This eminent Plastic Surgeon in the early part of the 20th Century popularised Island Flaps in reconstructive surgery. His book is an eye-opener and recounts possibly the initial references to such procedures as a 2-stage toe to hand transfer; the use of the second toe to replace the index; he quotes *"Krause was the first to employ the attachment of the big toe to the thumb in 1906"*. Esser carried out 14 toe-to-hand transfers and was first to transplant multiple toes to replace mutilating hand injuries, all victims of the Great War. Patrick Clarkson published his toe replacement article in the late 1960's - decades later. Then came the beginning of the micro-surgical era. So *"What's new under the sun"*.

Esser was of Dutch extraction and offered his services to the British Army in WWI but was rejected (like Valadier) and ended up serving the German Army on the Western Front utilising his advanced surgical expertise.

This renaissance in General and Reconstructive Surgery placed him in an ideal situation to contribute to the surgical management of the major problems resulting from trauma in the Great War somewhat emulating the likes of Gillies and Valadier on the Allied side. The adage that war creates the need for surgical expertise reflects history and thus the Great War, if I can use the phraseology, carried on this tradition.

On further perusal through the Esser text, reference is made to Ombredanne and Nealoton text featuring the original cross leg flaps. Our traditional teaching has been this design technique developed from the time of Gillies if not its instigator. On reading this text I can only repeat my quote that the cross leg flap was done 30 years before its prominence on the British scene. So - *"What's new under the sun"*.

Benny Rank brought home from his UK days a lot of the Gillies techniques including tube-pedicles when he worked with him at St James' Balham and this was the basis for its introduction onto the Australian scene.

Now back to the Esser's text, there are many illustrations of surgical reconstructions which only came into prominance in the 70's and I refer McGregor's work on the Forehead (superficial temporal artery) Island Flap. I wonder how many would know its significance dates back possibly to Esser which invites again the famous quote above.

My research activity in London was involved with investigating the vascularity of forehead island flap in the head and neck field, thanks to my boss Iain Wilson. I developed the principle of the Angiotome (the combined nerve and blood supply in arterialised flaps designed within the dermatomes thus reverting back the embryological principles.)

On an earlier visit to Paris I managed to purchase quite fortuitously that Ombredanne's book from the Alan Brieux bookstore. Yes, the cross-leg flap technique is illustrated. This text is close to my heart historically and I will eventually give my book to the Cowlishaw Collection. As a little aside it is worth repeating here, an Ian Jackson story. He was one of my former mentors on the London scene initially, from Cannesburn, and could relate the Jack Mustarde experience. Jack was an Orbital and Reconstructive Plastic Surgeon from Scotland who missed out on his second year at Roehampton in 1947 under Gillies. I wonder why? He had "sprung the master" reading this secret textbook hidden on top of a wardrobe and with the door half ajar Mustarde could see Gillies was reading, surreptitiously, this hidden text. It was subsequently confirmed to be Ombredanne's volume. As Mark Twain says *"a poker player keeps his cards close to his chest"* – a Mississippi masquerade

Incidentally, in the International Plastic Surgery Congress in Melbourne in 1971 organised by Benny Rank with Bernard O'Brien in charge of the audio-visual display. This was possibly the first time colour television was used at a clinical meeting and Jack Mustarde was one of the International Surgeons illustrating his bat ear correction technique.

Now back to the Cowlishaw donations, it was during the recent presidency of Phil Truskett when I donated these 5 text books to the Collection. It was former RACS CEO David Hillis who suggested we do a photographic presentation of this contribution for Surgical News (see illustration).

Finally I must mention one particular snippet which relates to one of the texts by Ioannes Scultetus, and titled: *Armamentarium chirugicum* text book from Venice of 1665.

Historically, I did not realise this particular word Armamentarium dates back to the middle of the 17th Century or even earlier. Every time one read a review of a new plastic surgical procedure the reviewer invariably used this word to describe the technique as being part of the *Armamentarium* – so in other words, 'adding another arrow to your quiver'.

The Colophon of the Sculteus text.

I first heard this word in the late-70's when John Hueston hosted an international visitor, Dr Lindsay, the Canadian equivalent to Benny Rank - who was giving a lecture on the future developments of Plastic Surgery. This event was organised by John, he being a World Stage figure in reconstructive surgery and was constantly visited by the international fraternity. On this occasion, under John's jurisdiction, the clinical meeting and dinner was held, and I remember Dr Lindsay using this word in his presentation. Incidentally, I even managed to reference "Armamentarium" from the 1665 publication, into a recent paper from PRS co-authoring with Saint Cyr and Mohan, on the Keystone experiences at the Mayo Clinic.

So in conclusion, the words of Solomon keep surfacing over many plot-holes.

List of donations:

- Scultetus, Joannes: *Armamentarium chirurgicum.* Venice 1665. **See illustration.**
- Sédillot, Charles: *Traité de médecine operatoire. Paris* 1866 *(2 vols)*
- Petrequin, J. E.: *Chirurgie d'Hippocrate.* Paris 1878
- Fabricius ab Aquapendente, Hieronymus: *Opera chirurgica.* Padua, 1647.
- Spigelius, Adrianus: *Opera ominia quæ extant.* Amsterdam 1645.

Images (above): Armamentarium Chirurgicum by Iohannes Scultetus (Venice, 1665).

Changed by the Irish

Associate Professor David R Webb shares his journey to Dublin and how it shaped his career in Percutaneous Renal Surgery.

Upon his arrival in Dublin, Ireland in June of 1983 with his future wife Robina, Associate Professor David R. Webb was warned by an elderly Dubliner, 'once you have lived in Ireland, you will never be quite the same'.

Indeed never the same he was.

Arriving in "pre Celtic Tiger" Dublin after completing his Fellowship in 1982, Ireland's economy was poor but the people of Dublin were charming and welcoming. A telephone was hard to come by, let alone heating, and waking up the neighbouring publican to use the telephone to page the hospital, had some complications, until David was able to pull some strings via a Christian Brother.

"Dublin showed what you could do with limited resourcing. We saw beautiful scenery and met fantastic people," David explains.

"Even with limited funding, Dublin medical standards were world class. I learnt that research was essential. My chief ordered me to research percutaneous renal surgery. This translated into the continued development of techniques and instruments, and a lifelong commitment to teaching PRS. It changed my life".

David began as Senior Urology Registrar at the Meath Hospital, Dublin. However this wasn't his first choice. A rather confident David thought he would have been offered the Australasian Fellowship at the Institute of Urology in London, but he was not even to be short listed! Jobless and depressed fate stepped in, and David ended up in the second biggest urology unit in Europe.

Teamed with the youngest Irish urology consultant at the Meath Hospital Professor John Fitzpatrick, research into keyhole surgery of the kidney began David's charmed life in Ireland.

Reaching the end of his research at Trinity College Dublin, David was dealt an unexpected blow.

"Just as I finished my Masters I was told, 'sorry old chap, as you as are not a Trinity College Dublin undergraduate we can't examine your thesis'.

"So my Master of Surgery was awarded by the University of Melbourne. I was always sad that I didn't have something to show for my work at Trinity College."

His career back in Melbourne expanded. Along with Paediatric colleague Professor Hock Lim Tan, he developed instruments for keyhole surgery of the kidney in children. David continues to travel and teach in Percutaneous Nephron Lithotomy (PCNL) workshops from Sumatra to Vietnam and Burma.

The combination of teaching and the development of instruments and paediatric PCNL resulted in a Doctor of Medicine, and a recent textbook Percutaneous Renal Surgery.

During those thirty years, David and Robina had three children, Anna, Prudence and Rowan. David also enjoys many hobbies include Royal Tennis or as he describes it, 'Real Tennis' playing three times a week. He's an avid reader, having recently finished two books by Yuval Noah Harari, Sapiens and Homo Deus – notably reviewed by former American President Barack Obama and tech genius Bill Gates.

Describing his passion for wine (he drinks red), David recalls his University holidays, Jackarooing on the Darling Downs in NSW and harvesting grapes at his grandparents vineyard along the Murray River.

David reflects that his father was a general surgeon and that he is the last – for now at least. His children have been deterred from medicine after tagging along during his hospital rounds. However, David's legacy continues after serving as Chairman of Training in Victoria for RACS Urology trainees.

"I can lay some claim to this…over 15 years ago, we only had one female Urologist and that was Professor Helen O'Connell. By the time I'd finished three years later there were four out of 10 female trainees in Victoria and its now 50 per cent. Urology as a speciality was a pioneer in revolutionising women in surgery and particularly women in urology."

Over 30 years on, and having contributed greatly in Australia and internationally in the development of percutaneous renal surgery, David returned to Ireland to present his invited address, *'Dublin to Dublin – a thirty year Endourological Odyssey'* for the TJD Lane Lecture, and be presented with the TJD medal.

Image: TJD Medal

Tom Lane, whom the lecture and the award is named, was "The Father of Modern Irish Urology". The Lane Lecture is one of four named Public Lectures in the Faculty of Medicine, Trinity College Dublin and is delivered by a selected Urologist who has contributed greatly to urological practice.

It is important to note that this honour has never before been bestowed upon an Australian.

"TJD Lane was the founder of the Urology unit where I worked in Ireland…the Irish were ahead of most of Europe and 20 or 30 years ahead of the English so it was very sophisticated, very advanced. TJD Lane set all that up. The medal is from Trinity College Dublin Medical School and it's in honour of him," David tells.

"So, it's quite emotional to me really, to have been honoured with a Professorship of Trinity College and the TJD Lane medal."

Finally, David had something to show for his Trinity and Irish experience, which lead to the advancement of his career and work in percutaneous renal surgery.

And, it seems as though his time in Dublin still follows David to this day.

"I'll tell you a funny story, [the medal] came in a box, it was a beautiful little box…a jeweller's box and it had Weirs [Weir & Sons] of Grafton Street printed on it. My wife said, 'that's where our wedding ring was made'. Ireland has followed me around the world."

– Aubrey Hamlett,
Digital Media & Internal Communications Coordinator
Communications & Advocacy

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Please confirm bookings by 15 September to foundation@surgeons.org

Sir Benjamin (Benny) Rank as I knew him

MR TOM ROBBINS
Victorian Fellow

When I was Consultant Plastic Surgeon at Frankston Hospital I was surprised to be told by the plastic surgical registrar who was in the College training program that he had never heard of Sir Benjamin Rank. This was despite the existence of the B K Rank Lecture and of l references to him in College publications..

It was the efforts of Sir Benjamin Rank that established Plastic Surgery as a separate specialty in Australia. I first met Benny when I was seconded as a junior resident to the Plastic Surgery Department of the Royal Melbourne Hospital. The registrar had gone off on prolonged sick leave.

My first case assisting him was a full thickness skin graft to the nasal area. I had to "suck to see". He said during the procedure; "if this graft up goes the sucker son, you will be going up after it".

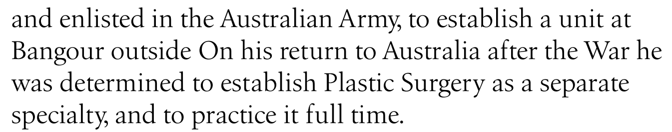
My subsequent associations with Benny was seeing him at plastic surgical meetings when I was seconded as a junior resident to the Plastic Surgical Department of the Royal Children's Hospital, Melbourne (the appointed resident had resigned in a fit of pique?) As registrar at the Victorian Plastic Surgery Unit (VPSU) and later, the Peter McCallum Clinic he arranged sessions for me to 'keep the wolf from my door' when I returned from plastic surgical training in the United Kingdom. Later again when he retired to the Mornington Peninsula where I practiced, we also became friends.

I addressed him in succession as Mr. Rank, Sir Benjamin, Sir Ben, Sir Benny, and finally, Benny.

Plastic surgical procedures for the restoration of form and function have been practiced over the centuries; but it was Benny who after the Second World War, sought to establish it as a specialty in its own right. He encountered strong resistance but was successful and Plastic Surgery is now divided into sub-specialties.

In the 1930s, Benny trained and worked in the United Kingdom with Sir Harold Gillies, his cousin Archibald MacIndoe (later Sir Archibald) and Rainsford Mowlem (all New Zealanders by birth). Gillies who had been involved in establishing facial units at the Queen's Hospital, Sidcup, helped establish plastic surgery in Britain after the First World War.. . It was a slow process - during the same period, Plastic surgery had rapidly expanded in United States but had 'stalled' in the United Kingdom.

While Benny was working with Gillies, MacIndoe and Mowlem, the Second World War became imminent and the British Government asked Gillies to establish plastic surgery units throughout Britain to receive the anticipated casualties. He also asked Benny who graciously declined



and enlisted in the Australian Army, to establish a unit at Bangour outside On his return to Australia after the War he was determined to establish Plastic Surgery as a separate specialty, and to practice it full time.

He was offered general surgical consultant positions but refused them. After some time and lobbying with people with whom he was well connected, he was given his own Plastic Surgical Unit at his alma mater, the Royal Melbourne Hospital.

Benny told me that he attended the Royal Children's Hospital weekly for a year without being referred any patients, so he decided to resign. Finally, he was offered a cleft lip to repair but persisted with his resignation, offering the post to Alan Wakefield. Wakefield had worked with Benny in the army and later, in private practice at Heidelberg House in Melbourne. He has since established a worldwide reputation for the Plastic Surgical Unit at The Royal Children's Hospital and has been described by Willie White, erstwhile chief of plastic surgery, Pittsburgh, and President of the American Society of Plastic and Reconstructive Surgery, as 'one of the be best plastic surgeons in the World'.

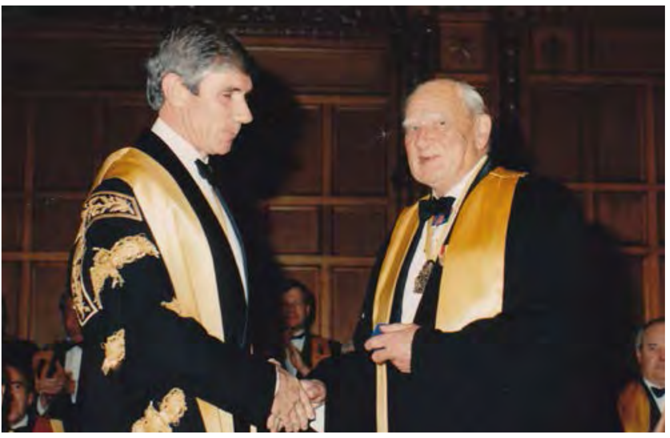
It took someone like Benny with political skills, leadership, determination and persistence to establish the specialty. Although a very high achiever himself, he was not afraid to select those who might be better; people like Alan Wakefield, George Gunter, John Hueston, Don Marshall. They all strengthened the specialty. Other plastic surgical units were established at the other major hospitals: Prince Henry's (George Gunter) the Alfred (John Snell) St. Vincent's Hospital (where Berny O'Brien established the world renowned microsurgical unit).

Benny also did not discourage anyone else who was fascinated with the specialty and keen to be part of it and willing to work hard. That category included me. On several occasions I heard him say he respected anyone who "came up the hard way".

He was Vice President of The Medical Association in Victoria and fought for the establishment of The Victorian Plastic Surgical Unit (the VPSU) at Preston Hospital. This brought together plastic surgeons from the major hospitals for plastic surgery and clinical meetings.

Benny established hand surgery as a sub-specialty of plastic surgery. Hand injuries were considered as acute emergencies rather than being put on the next convenient list. (Some orthopedically trained surgeons practice hand surgery, but they usually do it exclusively; and their relation with plastic surgeons is symbiotic). Rank and Wakefield wrote a surgical best seller, with multiple editions; "The Repair of Injuries as Applied to the Hand".

He organised in Melbourne the International Congress of Plastic Surgery which was held every four years. Organised by plastic surgeons from Australia and New Zealand, this brought together plastic surgeons from all over the World. Colour television has not yet arrived in Australia but Berny



O'brien overcame obstacles to organise colour transfers of operations performed by overseas plastic surgeons from St. Vincent's Hospital to the meeting at the College.

When I was his registrar at the VPSU Benny was the President of the Royal Australasian College of Surgeons. At the same time he was the President of the British Association of Plastic Surgeons, the first and only time a non-British plastic surgeon has been elected to that position.

And, just a note on Benny's origins. The Ranke family came from Denmark and settled in the English town of Hull where they were flour millers and devout Methodists. The 'e' was dropped from the name. They established flour mills all over the United Kingdom and according to Benny had "a mill in every port". Those of us who have spent time in the United Kingdom will know of Rank Hovis MacDougal, an organization that sells bread throughout Britain.

Being devout Methodists, the Rank Family used the early movies for missionary purposes. This was soon abandoned by the missionaries because picture theatres were unsuitably dark. But one member of the family continued with films and established, the J Arthur Rank Film Organization in Britain. The films were introduced by Bombardier Billy Jones banging the big gong. J Arthur Rank was Benny's cousin. The Rank organization also had a chain of picture theatres throughout Britain (From memory they were called the Gaumont theatres.) The same family is associated with Rank Xerox and Rank Arena televisions.

When Benny was knighted, he went to Buckingham palace to receive his knighthood from the Queen. After the ceremony he was feted by the Rank organisation in London and then visited their vast Scottish estate.

It has been said that when Benny was knighted the Queen said "are you a doctor". This is not quite true. The Queen said "are you the surgeon". Benny certainly was a surgeon, remarkable for his pursuit of the specialty of plastic surgery. He was also my good friend and colleague.

Images (From far-left): BK Rank in India, 1950s (3rd from right); BK Rank c1940; BK Rank with President, John Hanrahan, 1992.

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