SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 16 NO 2 / MARCH 2015

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ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

2015

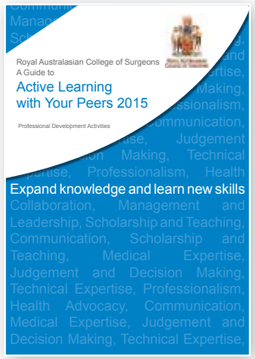
PROFESSIONAL DEVELOPMENT

WORKSHOPS & ACTIVITIES

Royal Australasian College of Surgeons

By now you will have received a copy of 'Active Learning with Your Peers 2015'

Inside are professional development activities that enable you to acquire new skills and knowledge and reflect on how you can apply them in today's dynamic world. Don't forget that you can register online at www.surgeons.org



Professional development supports life-long learning. College activities are tailored to needs of surgeons and enable you to acquire new skills and knowledge while providing an opportunity for reflection about to apply them in today's dynamic world. Additional workshops are available from the 2015 Active Learning booklet, which will shortly be published on the College website and distributed to all Fellows.

Foundation Skills for Surgical Educators

20 April – Melbourne; 4 May – Perth
(register via ASC website)

The Foundations Skills for Surgical Educators is a new course directed at those undertaking the education and training of surgical trainees and will establish the basic standards expected of our surgical educators within the College. This free one day course will provide an opportunity for you to identify personal strengths and weaknesses as an educator and explore how you can influence learners and the learning environment. The course aims to improve your knowledge and skills about teaching and learning concepts and looks at how these principles are applied.

Supervisors and Trainers for SET (SAT SET)

21 April – Melbourne; 4 May – Perth
(register via ASC website)

This course assists supervisors and trainers to effectively fulfil the responsibilities of their very important roles. You can learn to use workplace assessment tools such as the Mini Clinical Examination (Mini CEX) and Directly Observed Procedural Skills (DOPS) that have been introduced as part of SET. You can also explore strategies to help you to support trainees at the mid-term meeting. It is an excellent opportunity to gain insight into legal issues. This workshop is also available as an eLearning activity by logging into the RACS website.

Keeping Trainees on Track (KToT)

21 April – Melbourne; 20 May – Brisbane

This 3 hour workshop focuses on how to manage trainees by setting clear goals, giving effective feedback and discussing expected levels of performance. You can also find out more about encouraging self-directed learning at the start of term meeting.

Communication Skills for Cancer Clinicians:Transitioning to Palliative Care

13 June – Melbourne

When a patient's cancer cannot be cured, health professionals are often required to deliver difficult news and discuss challenging topics around death and dying. This communications module from Cancer Council Victoria is designed to equip clinicians with the tools to talk about death and dying professionally with empathy to patients and their families.

By developing your skills in the area, you can help create a more comfortable environment for your patients, promoting effective communication around the decisions they'll need to make at this time. This educational program is proudly supported by Cancer Council Victoria.

Process Communication Model Seminar 1

26 to 28 June – Brisbane

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.

Non-Technical Skills for Surgeons (NOTSS)

24 July - Brisbane

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.

workshop

April-June

NSW

16 June, Sydney
Keeping Trainees on Track

QLD

20 May, Brisbane
Keeping Trainees on Track
26-28 June, Brisbane
Process Communication Model Seminar 1

VIC

20 April, Melbourne
Foundation Skills in Surgical Education
21 April, Melbourne
Supervisors and Trainers for SET
21 April, Melbourne
Keeping Trainees on Track
13 June, Melbourne
Communication Skills for Cancer Clinicians: Transitioning to Palliative Care

WA

1-3 May, Margaret River
Younger Fellows Forum
4 May, Perth
Supervisors and Trainers for SET
4 May, Perth
Foundation Skills for Surgical Educators

Royal Australasian College of Surgeons

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

Surgical News Editor: David Hillis

Published for the Royal Australasian College of Surgeons by RL Media Pty Ltd. ACN 081 735 891, ABN 44081 735 891of 129 Bouverie St, Carlton. Vic 3053.

ON THE COVER:
Establishing Surgical Leaders

Surgical Leadership

Creating a section for Surgical Directors is an opportunity to develop our leadership in broader terms

MICHAEL GRIGG
PRESIDENT

Surgeons are leaders. Maybe it is part of our 'DNA'. Maybe it is what attracted us to be surgeons in the first place. We assume many leadership roles. Within our surgical teams, the responsibility for decision-making and direction setting is often ours. Within our direct clinical roles providing care to patients, our role is often providing options and discussing outcomes.

Despite the importance of patient-centric care, our expertise usually means that we provide advice about the next preferred stage in the clinical journey and that is accepted and then acted upon. Much of the training to become a surgeon provides us with the skills to be able to do these roles well. However, it is increasingly important that we think about leadership more broadly and enhance our roles across the health sector.

Sir William Osler noted that "Physicians as a rule have less appreciation of the values of organisations than members of other professions". And there lies one of the challenges for surgeons and for the College into the future. The complexity of health care, the increasing importance of understanding the opinions and the rationale of broader society, of stakeholders, of bureaucracies and Ministries of Health mean that we need to work more closely with many other groups that make up the health sector. These are not necessarily the skills or the required levels of patience that are highlighted and assessed within the surgical training program.

Gathering the leaders

I have been a surgical director for a large metropolitan health service for a number of years – some might say too many years. I have lived through numerous CEO's, chief medical officers and even three Professors of Medicine. I have come to realise that the continuity of a hospital's character is very dependent upon the clinicians, particularly those who have accepted leadership roles.

Having developed surgical services, understood the requirements of a unit structure within teaching hospitals then networked services through a regional structure, I have sat through many management meetings. The development of new hospitals and rebuilding hospitals is no longer a novelty. Indeed I am now personally aware of many of the pitfalls confronting the enthusiast. Perhaps most importantly I can now move 'almost seamlessly' from the language of a clinician to the jargon with which management surrounds itself. I have now prepared and reviewed more budgets than treasurers of many organisations.

Do you need all of these skills if you move into management type responsibilities? Well, perhaps not all, but what you do need is an understanding of how they 'fit together'. Importantly you need to be able to talk to your colleagues in similar roles to understand the 'rules of the game'. Unfortunately, surgical directors function to a large extent in an isolated environment. Their 'instructors' as they take on their new role may very well be the management that they are trying to influence.

Being a successful leader is a learned, not an inherent characteristic. The College in recognising this is now putting in the ground work to establish a Section of Surgical Directors within the College. As a starting point, there are more than 200 hospitals where we have Trainees. Most of these hospitals are in the public sector across Australia and New Zealand with a smaller number of private facilities. Many will have a formal clinical service structure with a surgeon 'in charge'. These are the people in the roles where the increased skills and ability to know how it all fits together is important.

Harness and develop skills

Given the challenges within the health sector and the inevitable reforms required to address the sustainability of health, this group should expect support from the College. This development is consistent with previous efforts of the College; for example the creation of the Academy of Surgical Educators with more than 600 members and the work currently being undertaken on developing academic surgical career pathways.

There are likely to be many benefits. If we are successful in establishing a Section of Surgical Directors, which will include collegiate support and enhancement of leadership skills, it will also be a real opportunity to impact the delivery of surgical care across both Australia and New Zealand. As we face ongoing healthcare reform, this group will also have the opportunity to be a powerful advocacy force.

The College is reaching out with both correspondence and surveys to surgical leaders, to identify the interest in this proposed section and also to obtain a clearer understanding of how support can be provided.

If you believe you are a surgical leader, but perhaps in a differing role, then please let us know.

To provide answers to the important questions that are identified in discussions around this topic requires all of our input, but particularly in the context of leadership within the organisations where we work. The College is determined to be prepared at both the level of the individual as well as the Fellowship more generally to be able to address this.

MEASURING SURGICAL PERFORMANCE

DAVID WATTERS
VICE PRESIDENT

Issues to be aware of in the advocacy space

The College's advocacy profile is gaining momentum. We are making considerable effort to promote our viewpoint on professional issues such as excessive fees, generalism and extended scope of practice, alcohol related harm and the implications of smoking and obesity on surgical outcomes. The College is using its expertise to inform and influence not only public health policy, but also public opinion in the hope of providing an impetus to action on these and other important surgical and health-related topics. One particularly sensitive issue that has been recently raised in New Zealand focuses on the information and data collected by surgeons in the course of their work and how surgical performance is portrayed to the public.

As consumers, we all have access to vast amounts of information. As health consumers, patients are encouraged to make informed choices, though this does not mean that patients need access to every detail about their care. Sometimes too much information can be confusing, or that which is provided can be irrelevant or misleading. An important and emerging topic for our profession, which the College may soon need to raise, is how much and what historical data pertaining to surgeons and their performance should be publicly accessible.

In a report released towards the end of 2014, the New Zealand Ombudsman, Ron Paterson, stated: "Surgeons are highly qualified specialists employed in the publicly funded health system to provide health services for patients. There is a public interest in members of the community and the media being able to access data about the nature (like the type of procedure and quantity) of work performed by specialists in New Zealand's public hospitals."

In his view, New Zealand lags behind international standards with respect to disclosure of performance data at an organisational, team and individual consultant level; he considers that District Health Boards (DHBs) should release data on the types of procedures and quantities of work that individual specialists perform every year in New Zealand's public hospitals. The Ombudsman was reviewing a DHB decision not to release information requested by a media organisation under the Official Information Act (OIA). His determination that some information should be released is likely to result in further OIA requests. Transparency within any health system is often desirable; however publishing procedural volumes and activity imply more is better, when in fact once a minimum number of cases is reached the outcomes do not appear to differ, if like is compared to like. We support transparency on outcomes, but mortality rates – which we are strongly supportive of for health systems – require considerable interpretation and risk adjustment. Publishing individual surgeon mortality rates (as in the UK) holds some risk of misinterpretation, as out of context such data forms only a part of the story. Many procedural outcomes are not ideally assessed by mortality, but rather by function than survival.

The assessment of individual surgical performance should cover the nine RACS competencies. Considering surgical outcomes, willingness to continue learning, reflection in daily practice, and the ability to adjust techniques or strategies to improve are all included within the competency framework.

Performance assessment covers medical knowledge, technical skill, judgement and decision making, handling emotions, values, habitual and judicious use of communication, teamwork, leadership and reflection, but also embraces how confidence, empathy, humanity, personability, forthrightness, respect or thoroughness are displayed in the workplace.

A surgeon's competency cannot be represented adequately simply by the number of procedures performed or a mortality rate. It also needs to be assessed in a multi-source manner which is why the College has developed a performance assessment tool, now available electronically, and generously awards CPD points for participation.

Publication of a surgeon's data faces a number of limitations:

- It is unreasonable to assume a surgeon is solely responsible for a patient's surgical outcome. Clinical responsibility may be shared with or passed to colleagues and many other health practitioners. Unit and service outcomes will be far more reflective of team performance and will conform closer to what it is the public needs to know to inform their decisions as to where to be treated. The College is supportive of unit and service outcomes, but believes surgeons should be consulted as to which numerators, denominators, benchmarks and time periods are selected.
- Where 'outcomes' are being compared, these are usually short-term (e.g. 30 day mortality) and for many conditions are only poor surrogate measures for quality.
- The College has been advocating for the adoption of perioperative mortality rates (POMR) at the health system level for some years and indeed have collaborated globally to ensure WHO adopts POMR as an indicator of surgical quality and safety. However, we do not support publication of individual surgeon POMRs because it can be challenging to compare like with like and perform adequate risk adjustment when single surgeon numbers are relatively small.

Publication can prompt risk-averse behaviour. For example, publication of surgeon-specific mortality data has the potential to discourage surgeons from operating on high risk patients, thus creating a perverse incentive towards self-preservation rather than patient care. To the public, surgeon-specific mortality data will end up reflecting a surgeon's competence. Yet, in reality, team consistency, operating theatre practices and patient characteristics are the key players. Not all patients are equal.

Adequate risk assessment and optimisation of comorbidities, adherence to best practice guidelines, enhanced recovery tools and multidisciplinary interventions are known to be associated with improved outcomes. Indicators of quality related to structure and process, such as staffing models and technology status, may provide some explanation for variation across institutions.

An option for recording surgical outcome and team performance may be to consider the 'Failure to Rescue (FTR)' measure as suggested by the Agency for Healthcare Research and Quality within the US Department of Health & Human Services. They identified that centres had the same incidence of complications after operation, principally related to patient comorbidity. A hospital's quality is put to the test when a patient develops a complication, and whether the patient survives will be a function of the care delivered by the hospital and its knowledge base, depth and facilities. Recognising and tackling critical events that determine survival; team consistency, intensive care staffing levels, patient to nurse ratios, nurse education, job satisfaction and burnout all affect FTR results. Poor human resource management and high FTR rates were found to be closely aligned.

Neither Australia nor New Zealand (until now) has publicly released individual surgeon's data. The move to transparency, the public's desire for information and international trends seem to be leading us into this arena. It is better that we consider and consult as to how to report surgical performance in a way that is appropriate and truly representative, rather than have individual surgeon outcomes imposed by an external agency.

Please email me at college.vicepresident@surgeons.org

NEW ZEALAND NEW YEAR AND AUSTRALIA DAY HONOURS 2015

Knight Grand Companion of The New Zealand Order of Merit (GNZM)

Professor Sir Murray Frederick Brennan GNZM FRACS FRACS (Hon), of New York for services to Medicine

Australia Day Honours

Officer (AO) in the General Division

Associate Professor Phillip David Stricker AO FRACS for services to urology

Member (AM) in the General Division

Professor Anthony James Costello AM FRACS for services to urology

Mr Andrew Harald Gatenby AM FRACS for service to colorectal surgery

Dr David Golovsky AM FRACS for services to urology

Associate Professor David Zachary Lubowski AM FRACS for services to colorectal surgery

Dr Stuart Malcolm Miller AM FRACS for service to otolaryngology

Associate Professor Kathiravelpillai Nadanachandran AM FRACS for services to humanitarian outreach, health care and medical training

Dr Christina Meredith Steffen AM FRACS for service to general and vascular surgery

Saving lives through Trauma

Trauma medicos are saving lives every day, with 1600 severe cases treated each year at Queensland's largest public hospital.
AnneMarie Lewis was one of the lucky ones, declared a red blanket patient when met by emergency physician Fran Williamson and trauma surgeon Associate Professor Daryl Wall.
'Red blanket' allows normal hospital rules to be surpassed.
"The only thing that matters is to stop the bleeding and stop the patient dying," Associate Professor Wall said.
***Courier Mail*, February 17**

Robot with spine

Spinal surgery has had its first robot operation in Victoria, allowing pinpoint accuracy for screws and rods. The big advance is said to minimise complications and help patients recover faster. But robots are still finding their place, says RACS spokesman Dr John Quinn.
"It does require a lot of training and extra skill to do it. The robots are fairly expensive, and to justify their use you need to show it's producing better outcomes than current practice."
***The Age*, February 9**

Lower the barriers for help

The mental health support organisation 'beyondblue' recently released a report that said that one in 10 doctors have had suicidal thoughts in the previous 12 months. But they should not face barriers, real or perceived, to seeking help, NSW Chair of RACS Mary Langcake says.
"Doctors have a right to confidential care without being concerned that they will be reported, or stigmatised by their colleagues," Dr Langcake said.
***MJA Insight*, February 16**

Audits reveal 12 year gap

Aboriginal Australians undertaking surgery in the Northern Territory are dying an average of 12 years younger than their non-Aboriginal counterparts.
The study in the ANZ Journal of Surgery has looked at data from the Northern Territory Audit of Surgical Mortality between 2010 and 2013.
Author Dr Peter Treacy has said the outcome is "no surprise".
"We are trying to do what we can, [however] … it can take a generation for positive changes to be seen," Mr Treacy said.
***The Guardian*, February 13**

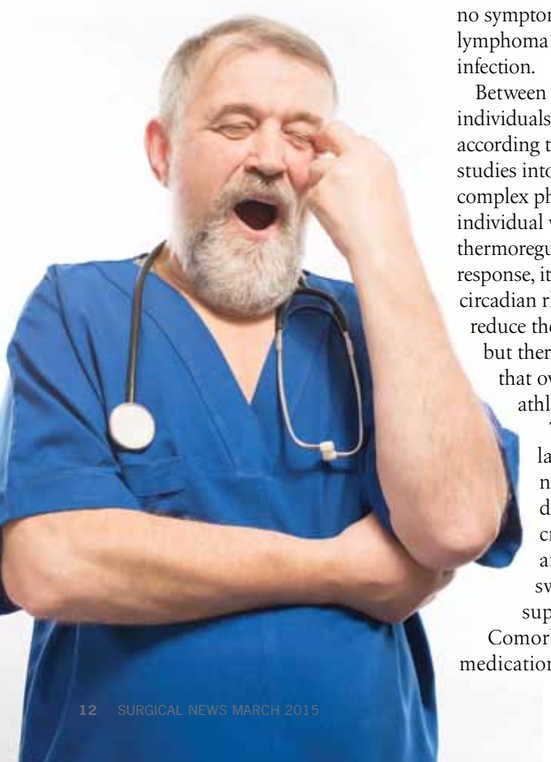
HOT NIGHTS

Is it just the weather?

DR BB G-LOVED

It's summer in the Antipodes and Downunder, with the 2014-15 summer accompanied by record temperatures to match the Northern Hemisphere's warm European winter. Hot summer nights have been the order of the season and have brought a string of sufferers with night sweats to the practice. Decades ago 'night sweats' prompted me to consider a diagnosis of tuberculosis, particularly if accompanied by weight loss, respiratory symptoms or abdominal pain; then TB held the reputation of being 'the great imitator'.

Nowadays, unless I were dealing with someone who had migrated from a country with endemic TB, night sweats in the absence of malignancy are more likely to be associated with weight gain and demands one consider a myriad of other conditions in the differential diagnosis. Even then, I may struggle to establish convincing evidence for the cause. The heat of the night may delight some, but drives others bonkers.



Recently I was consulted by Andre and Genevieve, a middle-aged medical couple, who were at their wits end. They were sleeping on opposite sides of the bed, or on particularly hot and sweaty nights escaping to different rooms and air conditioners. Their sleep was disturbed; they prowled the corridors at night. There are some basic remedies to trial ranging from hot showers before bedtime, improving aerobic fitness, to avoiding foods with spice (ginger, cayenne and pepper), or acid (citrus, tomatoes and peppers) and shunning evening alcohol and coffee. Andre and Gen don't smoke dope, another possible cause.

Although viral load, bacteraemic showers and interleukins may cause pyrexias and feeling sweaty, there was no clinical evidence such pathological stimulants were responsible for Andre and Gen's night sweats. Their thyroid function was normal and there were no symptoms or signs of malignancy, lymphoma or chronic inflammation/infection.

Between 10 and 30 per cent of individuals suffer from night sweats according to the limited number of studies into prevalence. Sweating is a complex physiological response, with individual variation, and degree of thermoregulation driven by hypothalamic response, itself undulating under circadian rhythm. Trained athletes can reduce their post exercise sweating, but there has been a suggestion that overtraining may increase an athlete's risk of night sweats.

There is a disappointing lack of evidence associating night sweats with specific diseases or medicines. Muscle cramps and restless legs are associated with night sweats (OR = 2.0). Magnesium supplements might then help.

Comorbid patients may be on medications or have conditions which are worth targeting or eliminating. The medications most likely to be responsible are anti-depressants.

Anxiety and depression are associated with night sweats. Sweating increases with depth of non rapid eye movement (REM) sleep, and tends to decrease during REM despite the increase in brain glucose metabolism, heart rate, and skin sympathetic activity. There is a physiological drop in core temperature at night, but this can be lost in sufferers with depression. Also patients on hypoglycaemic agents may be suffering bouts of hypoglycaemia, a condition from which up to 5 per cent of the non-diabetic population suffers and, though resolves spontaneously, may certainly give rise to anxiety, sweating and nocturnal awakening.

Hot flushes or flashes associated with the female menopause are an obvious cause for Gen and may be ameliorated by a variety of complementary medicines including phyto-oestrogens, or dietary tofu and soy. Hormone replacement therapy is an option to discuss when there are no contraindications, the risks are understood, but limited by a shortish duration of treatment (up to five years).

Whether there is a male menopause is open to question, but androgen deficiency might also be worthy of further consideration despite being a controversial subject.

For those of you who are suffering from night sweats, you may be heartened to hear two population-based studies have found no association between night sweats and survival. One was based on a series of primary care patients (842 aged over 65 followed for eight years) and another on geriatric clinic attendees (682 followed for seven years). This is good news for readers in this age group.

It is March. Downunder and in the Antipodes, though those 'Summer nights (are soon) drifting away.' For those of you feeling 'summer heat' that is no longer related to 'boy and girl meet,' I hope you have gained some ideas how to alleviate those disturbing night sweats. For those that ask, 'tell me more," I'll continue next month.

THE YEAR AHEAD

How will your Continuing Professional Development shape-up in 2015?

JULIE MUNDY
CHAIR, PROFESSIONAL STANDARDS

As the 2014 Continuing Professional Development (CPD) year has now drawn to a close, it is a good opportunity to look ahead and consider your professional development for 2015. The diversity of CPD activities that Fellows engage in is a reminder of the depth and breadth of the profession as a whole. The College CPD program provides many opportunities for Fellows to reflect on their practice and take up opportunities to refine skills and knowledge across the surgical competencies.

The range of approved activities the College offers is closely aligned to the needs of the Fellowship, with technical and non-technical competencies well represented. The College's CPD activities already feature a range of modalities so you can tailor your individual program to your preferred learning style. For a full list of College activities see the Active Learning with your Peers 2015 Guide and the CME Guide available on the College website.

In 2015 the College will populate CPD Online with all RACS activities you complete, making completing your CPD even easier. CPD Online is open for all users to begin inputting their 2015 CPD data, helping you to track your completed activities and monitor your progress throughout the year. For Fellows under verification, activity evidence can be uploaded at any time, which may include course/audit certificate of completion, summary of patient feedback report or a copy of published journal article, etc.

The College has also just completed and released a number of tutorial videos that guide users through the process of uploading CPD points, adding recurring activities and finalising returns. These videos are now available for Fellows and their office staff to utilise when entering their data for 2015. As the CPD program and regulatory environment continue to evolve, we encourage Fellows to continue to provide feedback on ways we can continue to refine and improve our service to you.

Any Fellows who would like further advice on meeting their requirements for 2015 should not hesitate to contact a friendly member of the RACS CPD Team. The Team can be contacted on +61 3 9249 1282, by email at cpd.college@surgeons.org or during business hours at the College offices in Melbourne.

Simply skin cancer

From the Provinces 2, a column from New Zealand

DR MIKE KLAASSEN
FRACS

My last column ('Surgical News' January/February edition) defined opportunities for the plastic surgeon in provincial New Zealand. This column provides some supporting evidence with the statistics on skin cancer. The National Institute of Water & Atmosphere (NIWA) published research recently showing that the town of Whakatane, in the eastern Bay of Plenty, enjoyed the most sunshine in NZ for 2014.

To be exact there were 2710 hours of sunshine recorded. This was 82 hours less than in 2013, but still ahead of nearest rivals Blenheim (2509) and Nelson (2486), also in the provinces. The Bay of Plenty population is only 6.4 per cent of NZ's total population, but still a significant 257,379 people live in the province.

Dr Franz Strydom of Mt Maunganui's SkinSpots Skin Cancer Centre recorded skin cancer statistics in the Bay Of Plenty for the five year period 2008-2013. The interesting feature is the majority (66%), are diagnosed and treated by GPs. Perhaps this is an indication for the provincial plastic surgeon to collaborate with groups of GPs specialising in the early detection, screening and multidisciplinary management of skin cancer, like the team of doctors lead by Dr Strydom at SkinSpots.

The following is a summary of the statistics: BCCs 26,394 (2008-2013), SCCs 15,015, Malignant Melanoma 2,058. The distribution of various practitioners treating these skin cancers was General Practitioners (66%), Dermatologists (21%) and Surgeons (10%).

There is potential for plastic surgeons to collaborate with GPs sharing and teaching the fundamental principles of general plastic surgery, including tumour excision margins, resting skin tension lines and reconstructive methods. This is an obvious advantage for the tens of thousands of patients in the provinces.

REFERENCE:
Personal Communication, Dr F Strydom, SkinSpots Skin Cancer Centre (2015)

IN MEMORIAM

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

Rex David Fairbairn, SA Fellow

Gavin James Douglas, Qld Fellow

Norman Albert Beischer, Vic Fellow

We would like to notify readers that it is not the practice of *Surgical News* to publish obituaries. When provided they are published along with the names of deceased Fellows under In Memoriam on the College website **www.surgeons.org**

Informing the College

If you wish to notify the College of the death of a Fellow, please contact the Manager in your Regional Office. They are

ACT: Eve.edwards@surgeons.org
NSW: Allan.Chapman@surgeons.org
NZ: Justine.peterson@surgeons.org
QLD: David.watson@surgeons.org
SA: Meryl.Altree@surgeons.org
TAS: Dianne.cornish@surgeons.org
VIC: Denice.spence@surgeons.org
WA: Angela.D'Castro@surgeons.org
NT: college.nt@surgeons.org

BY **PROFESSOR GRUMPY**

There is one thing that really annoys me and that is oversize. There are so many things that are oversized that we curmudgeons find hard to tolerate. Oversized meals are one such annoyance. I cannot go into the fast food restaurant chains as I get so too annoyed. Firstly the menus are so confusing – original recipe or the new zesty chicken, regular burger or family deal, what drink with that – coke or diet coke or zero or low caffeine or with fries or potato wedges with or without sour cream and what flavour sour cream? And no you can't substitute a coffee with that as coffees are on our café bar menu – you will have to see Priscilla the barista for that!

Then the persons behind the counter rattle off the options so rapidly that we curmudgeons can only get the first few and last few words. A request to repeat the list results in a look of incredulity – how can you be so silly to not know the difference between a special meal and a regular meal? The look says, yes I will repeat it, but listen carefully!

And then there is the killer question – would you like to upgrade to super-size for 50 cents? Now on my calculation the upgrade doubles the calories so how can it be only 50 cents more. The only logical answer is that the price for standard size is so high that they have made their profit already. If they have done so then there is only one reason to upgrade your meal for such a small fee – it is to encourage you to join the ranks of the oversized people.

Forget about diets and counselling and stomach banding; all we need to overcome the national (and international) epidemic of obesity is to banish meal upgrades at fast food chains. My usual answer to the upgrade question is to say somewhat frostily that if I had wanted an upgrade I would have asked for it in the first place. I suspect that before long I am sure a downsize to regular size will cost $2 more.

Then comes the 'meal' in a paper tray with eight napkins (I only need one I protest, but when the contents of the burger slide out onto my lap I see why eight have been provided). The fries are semi-cold as the time cycle of production is strictly regulated according to the day and time and the expiry time of the fries. If you come at the end of the time slot then you get the lukewarm ones. Of course, there is always the possibility of super large serve of fries for 50 cents more – why would I want even more lukewarm fries?

As for the drink it is largely melted ice as they scoop up a bucket load before they put in the drink. No, you can't have no ice as the drink is not chilled and health regulations do not allow that. However, there are free re-fills that double the calorie count. And at the end of all this they have the temerity to say, "Have a nice day!"

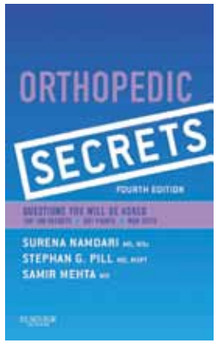
I will not. I am determined to have a horrid day and you have started me well along the way.

NEW RESOURCES

The library supplies the latest texts for up-to-date knowledge

Orthopedic Secrets 4th ed. 2015

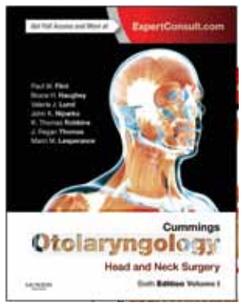
Available from Clinical Key in the library's e-resources.



The goal of this publication is to discuss orthopaedic topics that are commonly encountered in clinical practice, discussed on rounds, and found on board and in training examinations. The authors of each chapter have attempted to ask key questions and provide their best answers based on the current available literature. Authors have included appropriate cases as well as descriptive images and drawings for each chapter in order to provide a case-based approach to teaching. Each chapter in this new edition has been revised and updated, and several chapters from the previous edition have been merged to follow a subspecialty-specific format.

Cummings Otolaryngology. Flint, Paul 6th ed. 2015

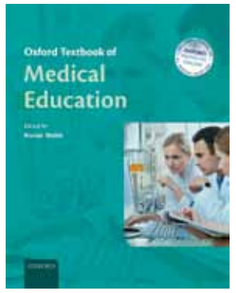
Available from Clinical Key in the library's e-resources.



The sixth edition of Cummings Otolaryngology – Head and Neck Surgery is written as a definitive resource representing, in all of its diversity, the major components of the specialty as well as the latest advancements in minimally invasive surgery, image guidance, robotics, cochlear implantation and more. Sections relevant to genetics of disease have been added or enhanced to address the most recent advances. In addition, the new chapter on evidence-based performance measurements is an outstanding reference for understanding the evolution of health care reform and value-based purchasing. Every chapter contains Key Points at the start and a "most relevant" Suggested Readings list. The video components provide an excellent opportunity to better understand the critical elements of these core procedures. There are 209 chapters covering a diverse range of topics. Early chapters include Outcomes Research, Interpreting Medical Data and Evidence-Based Performance Measurement.

Oxford Textbook of Medical Education. Walsh, Kieran 2013

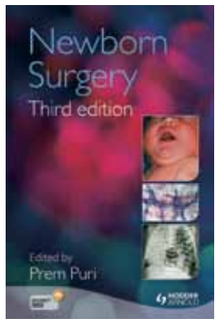
Available for loan as a print book from the library collection.



Providing a comprehensive and evidence-based reference guide for those who have a strong and scholarly interest in medical education, the book contains much that the medical educator needs to know in order to deliver the knowledge, skills and behaviour that doctors need. It explicitly states what constitutes best practice and gives an account of the evidence base that corroborates this, and features over 150 illustrations to help communicate complex educational theory quickly. It covers topics including curriculum, identities in medicine and social context, delivery, supervision, the stages of medical education, selection and dropout, assessment, quality issues, scholarship and research, medical education in emerging and developing markets, and the future of medical education.

Newborn surgery. Puri, Prem 2011

Available from EBL in the library's e-resources.



This e-book provides a comprehensive compendium of the pathophysiology, investigation and management of neonatal disorders. This includes detailed sections covering congenital anomalies along with comprehensive descriptions of operative techniques for each.

Areas covered include: Preoperative assessment, Anaesthesia, Postoperative management, Nutrition, Ethical considerations in newborn surgery, Head, neck, and chest surgery, Esophagus and gastrointestinal tract surgery, Liver and biliary tract surgery, Anterior abdominal wall defects, Tumours, Spina bifida and hydrocephalus, Genitourinary issues and Long-term outcomes in newborn surgery

With its uniquely comprehensive coverage of neonatal surgical specialties, this book can assist in supplementing knowledge in this broad and increasingly disparate field.

2015
ANNUAL SCIENTIFIC CONGRESS

Perth Convention and Exhibition Centre, May 5 to 8, 2015
Registration on the Congress website http://asc.surgeons.org

STEPHEN HONEYBUL, CONVENER
CHRISTOBEL SAUNDERS, SCIENTIFIC CONVENER

All the programs are finished, section dinners are booked, session chairs appointed – all is ready for the 84th Annual Scientific Congress to be held at the Perth Convention and Exhibition Centre in Western Australia.

Convocation and Welcome Reception – Monday 4 May

The official beginning of the meeting is the Convocation on the Monday afternoon. During the Convocation the Syme Oration will be delivered by Major General Michael Jeffery, and Honorary Fellowships will be awarded to Mr Ian Ritchie and Professor Timothy Pawlik. The Louis Barnett Medal for Service to Surgical Education will be presented to Associate Professor John Masterton. Professor Eddie McCaig and Mr Michael Sandow will receive ESR Hughes Medal, and Mr Robert Rae the RACS Medal for Service to the College. Mr Mark Moore will receive the International Medal. Finally, Professor Zsolt Balogh will be presented with the 2014 John Mitchell Crouch Fellowship.

Scientific Programs

At this Congress, 28 section and special interest programs have been convened and many of these have had the overall conference theme of ethics incorporated. There promises to be many discussions around some of the more difficult clinical decisions focusing less on what can be done but what 'should' be done. The conveners are to be congratulated on an outstanding educational program over four days of the meeting. Well over 400 abstracts have been submitted and the conveners have selected them for presentation and electronic posters. The posters can be viewed in the Exhibition Hall.

Orthopaedic Surgery

The Orthopaedic Surgery program in Perth will run on the Thursday and Friday of the ASC and some sessions will be combined with Trauma and Military Surgery. There will be a combination of keynote speakers including Ian Ritchie from Edinburgh and Professor James Hutchinson from Aberdeen, Scotland. The program has been built around the plenary sessions and will focus on Orthopaedic trauma, pathology, audit, training and ethical issues. Some of the program will be dedicated to free scientific papers of general Orthopaedic interest.

Head and Neck Surgery

This program has been convened by Desmond Wee. He has arranged an extensive program on head and neck malignancy in combination with the Endocrine Surgery program. The international visitor is Professor Chris Holsinger from the Stanford University Medical Centre. Professor Holsinger's surgical practice focuses on the surgical management of benign and malignant diseases of the thyroid, as well as head and neck cancers.

Medico-legal Section

George Sikorski has brought together an interesting medico-legal program covering such issues as 'The Conflict between Medical and Medico-Legal Paradigms.' The medico-legal section program will be conducted over one day. The day commences with a breakfast and the annual business meeting and later the James Pryor Memorial lecture will be given by Professor George Sikorski – 'In What Respect Does The Physically Injured Patient With A Financial Claim Differ From Non-Claimant Patients? A Literature Review'

Vascular Surgery

Stefan Ponosh has convened an outstanding vascular program with Professor Stéphan Haulon as the section visitor. The program will be over three days (Wednesday to Friday). The program will cover many of the key areas in vascular surgery and highlights will include the Wednesday Masterclass on 'Occlusion Balloon Techniques In Trauma'. There will be a number of combined sessions with the excellent Trauma and Military programs. Vascular Trainee papers will be presented on the Friday and later sessions on Carotid Surgery and the Diabetic Foot will be an excellent way to finish what will be an educational, entertaining and informative vascular program. The Vascular Section dinner will be held on Wednesday evening and is booked for the highly regarded 'The Old Brewery Grill'.

Evening functions

The Section dinners are on Tuesday, Wednesday and Friday nights and a number of leading Perth and Fremantle venues have been booked to host these dinners.

Thursday night will be the Congress dinner at the Perth Convention and Exhibition Centre. An outstanding banquet is planned. Places are limited so make sure you book your ticket early. Book for each of these events at asc.surgeons.org and click on registration or use the registration form.

Transport from Perth airport to the Conference Hotels

Taxi is the simplest way to travel from the airport to your conference hotel.

We look forward to seeing you in Perth.

Donald Murphy and President Michael Grigg unveiling the panels last year.

ILLUSTRATED HISTORY

Artefacts unearthed during the construction of the College Skills Laboratory sparked interest for former Medical Director Don Murphy

Victorian Urological Surgeon Mr Donald Murphy has designed and gifted to the College the first of a series of display panels which will explain the history of the College Gardens site as a continuing place of education from the 1850s to the present day.

The first two panels of the series were unveiled by President Professor Michael Grigg in December 2014.

Now affixed to the walls of the Skills Laboratory courtyard, the panels complement and explain the existing display of relics in the courtyard, which are the remnants of one of the first free, non-denominational schools established in Australia.

Known as the Model School, the institution occupied the site from 1852 to 1932 and was established by Lieutenant Governor Charles La Trobe with the support of the NSW Governor, George Gipps.

Mr Murphy was the Inaugural Medical Director of the College's Skills Laboratory and is a member of the College Archives Committee.

He said the first panel showed a reproduction of a painting of the Model School circa 1850s by artist Barry Bell AO along with text explaining the history of the site.

The second displays a painting of the maiden voyage of the clipper ship, the Lightning, which brought to colonial Melbourne, in the area then known as Port Phillip, the first headmaster and headmistress of the co-educational school, Professor Arthur Davitt and his wife Ellen.

Mr Murphy said he took on the project as a continuation of his role as Medical Director of the Skills Laboratory and because the site was of historical interest not just to the College but Australia.

"When we dug the foundations for the Skills Laboratory we found the earlier foundations of the Model School which were then carefully excavated by Heritage Victoria," he said.

"This discovery further developed my interest in the history of this site.

"The Model School, named because it was designed as a 'model for education', in a way represented the birth of the secular state in Australia because it provided free non-denominational education at a time when education in the colonies was only offered by the different religious groups.

"The selection of Professor and Mrs Davitt from Ireland to lead the new institution was also important because they were seen as model and modern educationalists," Mr Murphy said.

"Ellen Davitt later became Australia's first crime fiction novelist with her book 'Force and Fraud' published in 1865 and inspired the creation of the Sisters in Crime group while her name lives on in the Davitt Award.

"The site of the Model School also has links with two of Melbourne's premier state high schools.

"Segregation was always a central feature of the Model School and in 1929 the boys were moved out to a new site in South Melbourne that is now the Melbourne Boys High School.

"This virtually meant the abandonment of state education for girls until one of the student's fathers, Sir Macpherson Robertson, stepped in and helped to establish a new girls' school, now known as Mac.Robertson Girls' High School.

"It is even of interest to note that the Davitts came to Melbourne on the maiden voyage of the Lightning which set a world record for the speed of the journey."

Mr Murphy said the aim of the display project was to make sense of the relics of the Model School left in situ in the Skills Laboratory courtyard, to join the dots of the history of the site and to build upon the College's role as a museum.

He has even indulged in some personal sleuthing of his own.

"The existence of the Model School was quite forgotten when we came upon the remnants of the building so Geoff Down and I spent quite a bit of time sourcing photographs of it," he said.

"I found one which showed ornate gates and went in search of them only to find them at a park in Torquay where they sit quite incongruously in splendid isolation because there is no fence.

"This came about because the builders of the College Headquarters, JC Taylor, a building firm from Geelong, also had the contract to demolish the old buildings of the Model School so they took the gates back to the factory in Geelong.

"Years later, one of the Taylor descendents was a local councillor in South Barwon Shire when an application to the government resulted in a Crown Land grant to establish a park in Torquay. His family subsequently gifted the gates to the Shire when the Crown Land was named Taylor Park.

"As is sometimes the way with historical artefacts, these gates are now known as the W.D Taylor Memorial Gates."

Mr Murphy said he was now working on the design of the rest of the series in conjunction with Geoff Down – including images of the Model School set within the backdrop of developing Melbourne, through to the finished College East Wing including the Skills Laboratory – which he hoped to have completed by the end of the year.

With Karen Murphy

CEMENTING OUR ROLE IN INDIGENOUS HEALTH

RACS Aboriginal and Torres Strait Islander Health Action Plan 2014-2016

Council listens to Kelvin Kong (second from right) detailing the important ATSI Action Plan for the College.

MICHAEL GRIGG
PRESIDENT

CATHY FERGUSON
CHAIR, FELLOWSHIP SERVICES

On behalf of the College Council we are delighted to announce the RACS Aboriginal and Torres Strait Islander Health Action Plan 2014-2016.

Approved by Council in October 2014, the Plan represents the first comprehensive whole-of-College action on Australian Indigenous health.

The Plan prioritises work for the next two years in four key areas:

- Leadership, excellence and advocacy:
- Increasing the number of Aboriginal and Torres Strait Islander Specialists
- Educating the workforce
- Increase the number of Aboriginal and Torres Strait Islander staff in the College

The Plan seeks to increase the number of Aboriginal and Torres Strait Islander surgeons to help 'Close the Gap' in Indigenous disadvantage in Australia. It also aims to enhance recognition and awareness of Aboriginal and Torres Strait Islander issues, promote excellence of care, and improve understanding of culturally-appropriate treatment through education and advocacy.

Key commitments of the Plan include:

- The development of a Reconciliation Action Plan as an expression of our commitment to reconciliation between non-Indigenous and Indigenous Australians and embed initiatives into core business.
- The annual award of the RACS Aboriginal and Torres Strait Islander Health Medal to recognise Fellows who have made outstanding contributions to Aboriginal and Torres Strait Islander health.
- The introduction of Trainee recruitment and retention strategies for Aboriginal and Torres Strait doctors. Progression to specialist training is not commensurate with the rates in non-Indigenous doctors. There is a growing cohort of junior doctors that need to be supported to enable them to have equal specialist training opportunities as other medical graduates.
- The offering of annual Foundation for Surgery Aboriginal and Torres Strait ASC Awards to enable Aboriginal and Torres Strait Islanders doctors/final year medical students to attend our annual scientific congress.
- The establishment of a scholarship program to support Aboriginal and Torres Strait Islander Trainees.
- Implementing a positive affirmation policy to facilitate an increase in the number of Indigenous Trainees who have achieved the minimum standards for selection.
- The honorary appointment of an Aboriginal or Torres Strait Islander Community Elder in Residence to promote and support the incorporation of Aboriginal Australia in the culture of the College by providing opportunities to relate and identify with Aboriginal and Torres Strait Islander people, their cultures and social norms.
- The development of an advocacy strategy in Aboriginal and Torres Strait Islander Health to provide the context for College engagement with stakeholders, policy makers and the community.
- The identification, promotion and support of Fellows working with or have an interest in Aboriginal and Torres Strait Islander health
- The development of staff recruitment strategies for Aboriginal and Torres Strait Islander people. Increasing employment opportunities for Aboriginal and Torres Strait Islanders in the College is a desired outcome of closing the gap in Indigenous disadvantage. It also demonstrates recognition by the College that Aboriginal and Torres Strait Islander people bring unique skills and knowledge to the workplace and reinforces the College's ongoing commitment to, and provision of, a diverse and culturally rich workplace that reflects Australian society.
- Investigating opportunities for inclusion of cultural awareness and safety issues in the surgical training programs via the key competencies of the College. The College is responsible for the training of the surgical workforce and all Fellows are part of the health service delivery system. Ensuring that surgeons are culturally competent and are able to provide appropriate care to Aboriginal and Torres Strait Islander communities is consistent with this responsibility. The inclusion of Aboriginal and Torres Strait Islander health and perspectives in the curriculum will also put the College in a good position of compliance when the Australian Medical Council accreditation standards governing Indigenous health competency in the specialist medical colleges is introduced.

The Action Plan has been some years in the making, made possible by the efforts, dedication and leadership, over many years, of the College's Indigenous Health Committee. The IHC has worked hard to raise the profile of our work in Indigenous health and to build partnerships with the Indigenous communities in both Australia and New Zealand. We also acknowledge the contribution made by College Directors and staff to making this happen.

We invite the College community to embrace the Plan, participate in its realisation and join in the contribution we can make to improving outcomes for Indigenous Australians.

For further information about the Indigenous Health Committee or RACS Aboriginal and Torres Strait Islander Health Action Plan 2014-2016 please visit http://www.surgeons.org/member-services/interest-groups-sections/indigenous-health/

Why do we need an action plan on Aboriginal and Torres Strait Islander Health?

✓It acknowledges the College's role in Aboriginal and Torres Strait Islander Health.

✓It acknowledges changes to the culture and philosophy of the way the College conducts its business in respect to Aboriginal and Torres Strait Islander Health.

✓It embraces a College-wide and holistic approach to address Aboriginal and Torres Strait Islander Health, where the College staff and Fellows are active participants.

✓It promotes and adopts a best practice approach for workforce development, advocacy, education, leadership and excellence.

✓It recognises that College engagement requires on-going improvement, development and evaluation.

✓It ensures the College will be an organisation that is culturally competent.

✓It puts into action College aspirations in Aboriginal and Torres Strait Island Health as foreshadowed by the Position Statement.

UNSUNG HEROES

"At the outbreak of the First World War, female medical practitioners rush to volunteer in the Australian Army. They rudely were dismissed as 'too illogical or hysterical for service'. Despite this rebuttal, Australian women went on to serve with British units in theatres of war as diverse as France, Serbia and the Middle East. Their heroism and devotion to duty, and their struggle against a male dominated military hierarchy is one of the untold stories of Anzac."

Despite no encouragement and little support, still these women went to war

PROFESSOR BRUCE SCATES
CHAIR OF THE MILITARY AND CULTURAL HISTORY PANEL, ANZAC CENTENARY ADVISORY BOARD

As the dogs of war prowled across Europe in 1915 and the call for soldiers, doctors and nurses thundered across the British Empire, a small band of female pioneers chose to respond.

Quietly, with little fuss or fanfare, 17 of the 129 women doctors listed in the Butterworth's Medical Directory for that year overcame barriers, bureaucracy and sexism to serve as doctors in conflict zones such as France, Malta and Serbia.

Unable to serve with Australian medical units, these women could only provide their skills and service under the banner of Imperial British forces or specific British units because Australia did not admit women doctors into the armed forces until World War II.

Yet with no encouragement and little support, still these women went to war.

One of them was Dr Lillian Violet Cooper, the first woman to practice medicine in Queensland and the first woman to be admitted as a Fellow to the Royal Australasian College of Surgeons, now listed as number 108 on the College's Foundation Roll.

Responding to an advertisement by the Scottish Women's Hospitals in the British Medical Journal, Dr Cooper swapped her thriving public and private practice for the hellish conditions of a frontline military hospital in the mountains of Serbia as part of the Macedonian campaign.

Yet, as the effects of the winter campaign intensified, with soldiers dying en route between the front and the hospital, Dr Cooper was asked to run an advanced dressing station even higher up the mountains and closer to the carnage.

There in Dobraveni, the wounded were transported by mules, Dr Cooper worked within range of the guns and the only means of retreat was by foot, a 20 kilometre walk down the mountain.

According to a new book co-written by South Australian Surgeon Associate Professor Susan Neuhaus, Dr Cooper is one of the great unsung war-time medical heroes of Australia.

"Dr Cooper performed operations day after day in the harshest of conditions... (but) saw this as the culmination of her life's work," Dr Neuhaus writes.

"She performed multiple amputations, removed shell fragments, bullets and other shrapnel from men's bodies ravaged by war.

"From mid-January to the beginning of March 1916, the ambulances brought down 1,840 patients from the dressing station.

"(Yet) during her eight month period at the 40-bed dressing station, only 16 of the 144 patients Dr Cooper operated on died."

Associate Professor Neuhaus, who served for 20 years as both a clinician and commander in the Australian Regular Army and the Army Reserve – herself recognised with the Conspicuous Service Cross – describes Dr Cooper's astonishing service in a book that examines the role of women doctors in the Australian Army over the past 100 years.

Called 'Not for Glory', the book presents the stories of women doctors and medical personnel who have worked and served in conflicts from Vietnam and Afghanistan to regional peacekeeping forces.

An Associate Professor in Conflict Medicine at the University of Adelaide, Associate Professor Neuhaus said she became particularly fascinated with the courage and commitment of the women who served as doctors in the Great War.

"I was particularly blown away by Dr Cooper and somewhat ashamed that I didn't know her story," she said.

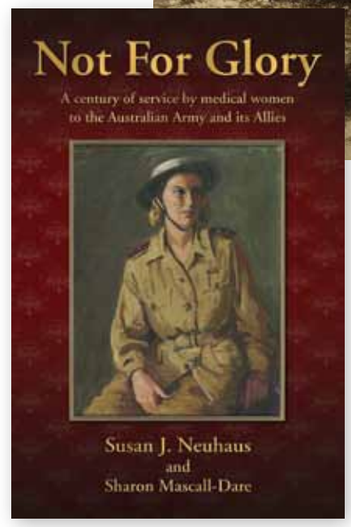
"She was incredibly courageous and willingly worked in horrific conditions, in range of the guns and where she sometimes had to operate in mittens because it was so cold.

"She did an enormous number of procedures, but even more incredibly, her survival figures would compare well with any teaching hospital in Australia.

"I couldn't believe that her experiences and her heroism – along with many other women – was not commonly known, so I set out to do something about it and we worked hard to have the book ready for publication this year in which we celebrate the centenary of Anzac."

Associate Professor Neuhaus said that while she was most impressed with Dr Cooper, her favourite female medical pioneer was Captain Vera Scantlebury, a petite woman who paid her own way to serve at the Endell Street Military Hospital, London, and who became known as 'the little lieutenant doctor' by her patients.

"Vera recorded her experience of war and working at a military hospital in 19 volumes of letters and diary notes written between 1917 and 1919 which are preserved in the University of Melbourne Archives," Associate Professor Neuhaus said.



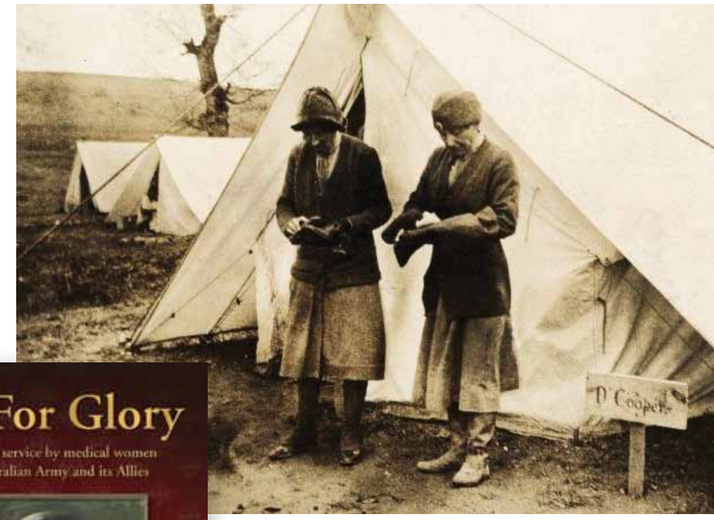
"She was 28 when she arrived in England, a year older than I was when I was first deployed overseas, so I completely relate to her feelings of being alone and isolated in a very foreign environment and a long way from home.

"She was so confident when she set out to do her wartime duty, but she found the reality quite daunting. She spent hours poring over text books at night, trying to develop new techniques and approaches to the traumatic injuries she was treating and feeling overwhelmed by the suffering she was witnessing.

"She was also conflicted by the suffragette movement that was swirling around her and found it very difficult at the end of the war to decide whether to come back home to her fiancé and become a dedicated wife and mother or concentrate on her medical career.

"Even now, women face that difficult choice – particularly in the military."

For the past seven years Associate Professor Neuhaus has trawled through Australian, New Zealand, British and European archives, walked the military sites that these pioneer women walked and, with co-writer Dr Sharon Mascall-Dare who conducted interviews with modern medical army women, reconstructed the stories.



LEFT: Colonel Susan Neuhaus with her daughter, Pulteney Grammar School Remembrance Day Service, 2011.

ABOVE: Dr Lilian Violet Cooper and Miss Josephine Bedford cleaning boots outside a tent, Serbia. Image: Bennett, Agnes Elizabeth Lloyd, 1872-1960. Courtesy of the Alexander Turnbull Library, Wellington, New Zealand (http://natlib.govt.nz/records/22333288)

Operating theatre at Royaumont (unknown surgeon). Image source: Crofton, Eileen, The Women of Royaumont, Tuckwell Press, Scotland, 1997

She said that while the story of battle-field nursing and nurses in conflict were widely recognised, the women medicos had been overlooked partly because of the range of roles they played and their historically small number.

"Within the Royal Australian Army Medical Corps (RAAMC), women have served in uniform as doctors, pharmacists, radiographers, physiotherapists, pathology technicians, medical logisticians and administrators," she said.

"Women doctors were denied even temporary commissions in the Royal Army Medical Corps until 1939 and permanent commissions were not instituted until 1962, yet today women account for almost half of new enlistments in the RAAMC and serve in a diverse range of roles and professions.

"I wanted to tell the stories of the women who had helped break down the barriers, women who had to struggle for social acceptance and struggle against the military mindset of the times, women who opened the door to let the rest of us through."

And they have certainly come through.

Now, the most senior health appointment within the ADF is held by a woman (Rear Admiral Robyn Walker AO, Joint Health Commander) as are the Heads of the each of Health Services for Army, Navy and Air Force.

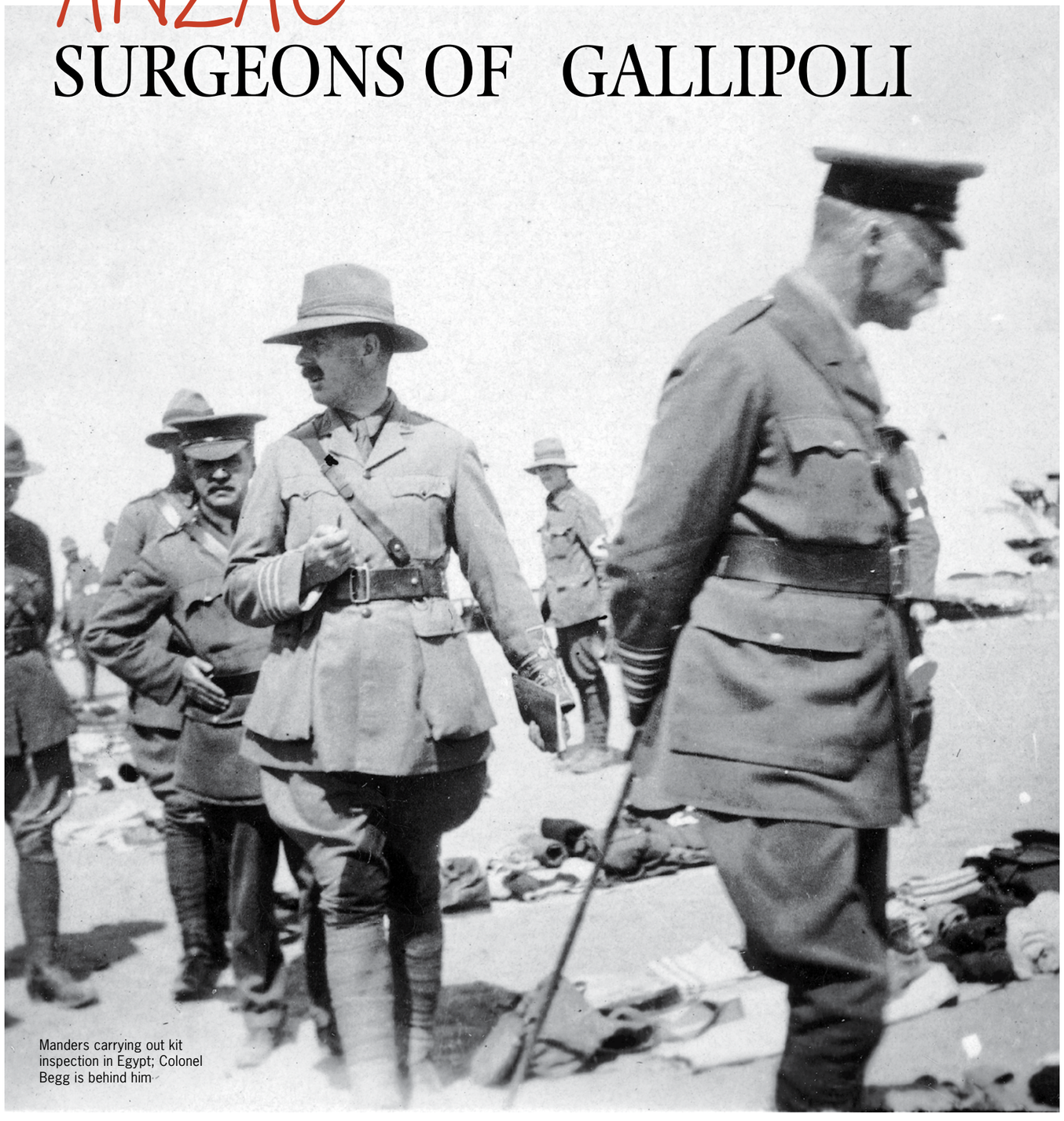
"My own experience is that the army is very much a meritocracy and that once you have shown that you can do the job and crack on and do it, gender doesn't really matter," Associate Professor Neuhaus said.

"But it did take the courage of women in previous generations to get us here and while I think some may have missed out on the recognition they deserved, I think it is important – particularly this year – that people know what they did in Australia's time of need."

'Not for Glory' is available through Boolarong Press at www.boolarongpress.com.au.

With Karen Murphy

ANZAC SURGEONS OF GALLIPOLI



Manders carrying out kit inspection in Egypt; Colonel Begg is behind him

The College's head office will host a special exhibition of ANZAC surgeons from 23 April. It will also release a book commemorating those who served in the Dardanelles campaign.

MANDERS, Neville, Colonel (1859-1915) MRCS, 1884

Born in England in December 1859 to a military family Neville Manders obtained his MRCS before entering the Army Medical Services in 1884. He was promoted Major in 1894 and in the Royal Army Medical Corps, saw active service in a number of campaigns including in the Suakim Campaign of 1885 and the Burmese Expedition of 1887-89. Manders was seriously wounded in the latter campaign. In 1908 he was appointed SMO in Ceylon, serving for three years following which he transferred to the Curragh Barracks in Ireland.

Gallipoli

When war broke out, Manders was sent to Egypt as DDMS, but in view of the looming Gallipoli campaign, Manders requested transfer to the NZ & A Division as ADMS. Thus on March 3, 1915, he joined the NZEF. As planning for the invasion gathered pace Manders appointed medical officers as Beach Masters. These officers were to oversee the categorisation of the wounded and control the embarkation of the wounded to the hospital ships.

Following the landings, Manders oversaw the rapid expansion of medical services at Anzac. He was instrumental in making the very necessary improvements to sanitation as well as to care of the wounded.

During the August offensive, the battle for Chunuk Bair saw the campaign for the Heights reach its zenith. On August 9 while at General Godley's HQ, Manders was killed by Turkish rifle fire while discussing plans to retrieve and evacuate the wounded from the Heights. He is believed to have been buried at the Old Number 2 Outpost cemetery at Anzac although the exact location of his grave is unknown. He was aged 55 years.

Neville Manders was mentioned in despatches during the Gallipoli campaign and also held a number of other decorations from his earlier military experiences. Outside of Medicine and the Army, Manders was a well-known and highly respected entomologist and a Fellow of both the Entomological Society and the Zoological Society.

Had Neville Manders survived the war it is unknown if he would have returned to the United Kingdom or perhaps settled in Australia or New Zealand. He would have been aged 68 when the College was founded.

- Andrew Connelly

HOWSE, (Sir) Neville Reginald Major General, VC, KCB, KCMG, KStJ (1863-1930), MRCS London 1886, LRCP 1887, FRCS 1897

Neville Howse was born in Somerset, attended Fullands School in Taunton, then studied medicine at the London Hospital (before emigrating to NSW for health reasons). He returned to London in 1895 and gained the FRCS. He then purchased a practice in Orange, NSW where he became a well-respected surgeon. He was commissioned as a Lieutenant with the NSW Medical Corps, and went to the Boer War. In July 1900 he galloped out to attend a wounded man under cross-fire and, despite his horse being shot dead, he continued on foot to treat his casualty. For this action he was awarded Australia's first Victoria Cross.1 He was twice mayor of Orange and married Evelyn Pilcher in 1905, with whom he had two sons and three daughters.

Gallipoli

Holding the rank of Lt Col, Howse was the PMO of the Naval and Military Expeditionary Force that took New Britain from the Germans in September 1914. Desirous to serve in Europe he left New Guinea and was appointed Assistant Director of Medical Services (ADMS) of the 1st Australian Division with the rank of Colonel. He took personal charge of the evacuation of the wounded men crowding Anzac beach during the first few weeks. In July he was evacuated to Egypt with dysentery and, in August, once recovered, was appointed DDMS. In November he was promoted DMS AIF, then Surgeon-General and awarded the CB.

After Gallipoli

He was responsible for medical services to AIF in Egypt until April 1916 when he moved to London. From there he made several visits to France and was knighted in 1917. In 1919 he was made KCMG and

KStJ. Plarr's 'Lives of Fellows' noted: he worked and played at high speed, hated slackness, and never suffered fools gladly. He had great gifts of organisation and administration, his decisions were rapid and fearless, and he never shirked responsibility.

Professional Life after WWI

He became a member of the House of Representatives in 1922 for the seat of Calare, which included Orange, as a member of the National Party. Within government from 1925-27, he was Minister for Health, Defence and Repatriation. In April 1927, he was forced to resign his position as Minister for Health due to illness. He lost his seat in 1929, but in 1930, chose to go to England for pancreatic cancer treatment where he died following surgery. He was buried at Kensall Green Cemetery, London.

- David Watters

REFERENCE

Hill A. J. Australian Dictionary of Biography. Volume 9, Melbourne University Press, 1983, pp 384-386. http://adb.anu.edu.au/biography/howse-sir-neville-reginald-6753

LEADERSHIP EXCHANGE

An opportunity to explore College networks with the Association of Academic Surgeons

CHRISTINE LAI
DEPUTY CHAIR, YOUNGER FELLOWS COMMITTEE

The RACS Younger Fellows (YFs) and Association of Academic Surgeons (AAS) Leadership Exchange has been an annual event for the past eight years. Each year the AAS sponsors a visiting Professorship for a Younger Fellow to attend the Academic Surgical Congress (ASC) and Johnson & Johnson has provided an educational grant for a member of the AAS to attend the College Younger Fellows Forum.

The AAS membership comprises surgeons in the pursuit of academic surgery within the first 10 years of their first academic appointment. The Association also serves to mentor and support younger surgeons, residents and medical students. These form common areas of interest between the AAS and YFs.

I had the great privilege and pleasure of representing the College Younger Fellows at the 9th Annual Academic Surgical Congress (ASC) which was held from February 4 to 6 in San Diego and conjointly run with the Society of University Surgeons (SUS). The Exchange provides an opportunity to further an interest in leadership, international relations and research.

The AAS were wonderful hosts at the meeting. I was matched with A/Prof Sandra Wong who was the visitor for the Younger Fellows Session at the RACS 2014 ASC and our AAS visitor at YFF. I had a busy schedule including the Congress, various events to attend each evening and the opportunity to attend the AAS Global Affairs Committee's meeting.

The ASC program included the standard fare of plenary sessions, oral research, lunchtime sessions and workshops. There were also 'QuickShot' sessions where speakers have two minutes to present their work with five slides, followed by three minutes of questions. The AAS's support of medical students and their endeavours was highlighted in the program with a Medical Student Quick Shot Competition, judged by past Presidents of the AAS, and a mentoring session specifically for students.

Other highlights included:

- The AAS Presidential Address, given by Prof Lilian Kao which was a TED-style talk on 'Real World vs Ivory Tower: The Challenge for Academic Surgery'.
- A session on 'Resident Readiness and Transition to Practice - Are Five Years of Training Still Good Enough?' where the current problems and perceived gaps in surgical training were discussed.
- A career development session on 'Putting Your Best Foot Forward - Professional Advancement through Personal Development'.
- The AAS Presidential Session on 'Innovation in Surgery' which included how surgeons can translate lab research to interventions for patient care, how technological advances can change the way Trainees learn in future and how social medial contributes to the exchange in ideas leading to surgical innovation.

I would like to thank the College for the opportunity to attend the ASC and the AAS continuing to support the Leadership Exchange. It was a wonderful opportunity to renew old friendships with members of the AAS, meet new people and to continue to foster the relationship between our Younger Fellows and the AAS.

WOULD YOU LIKE TO TAKE ADVANTAGE OF THIS EXCELLENT OPPORTUNITY?

If you are a Younger Fellow of the College (within 10 years of gaining Fellowship) consider applying to attend the 11th Annual Academic Surgical Congress, February 2-4, 2016, in Jacksonville, Florida, USA. Applications open May 1, 2015. To apply see the Younger Fellows page on the College website: http://www.surgeons.org/member-services/interest-groups-sections/younger-fellows/

NEW TRAINING for Vietnam and Cambodia

Fellow Chris Kimber is leading paediatric surgical training to treat children suffering from disorders of sexual development

LEFT: Truing endosurgery Siem Reap, Chris Kimber and Cambodian surgeons.

TOP: Craig Macbride demonstrating safe endosurgical technique Siem Reap 2013.

Victorian paediatric urologist Associate Professor Chris Kimber has launched a collaborative project with Vietnamese and Cambodian surgeons, to help develop a surgical service to treat children suffering from disorders of sexual development (DSD).

Assoc Prof Kimber, Head of Monash Children's Hospital Surgical Division, is undertaking the work using funds provided by Monash Children's International, a non-profit philanthropic organisation affiliated with the hospital.

Mr Kimber said the DSD project – which provides surgical training, Australian chromosomal and genetic testing of patients and in-country surgical treatment – builds on paediatric surgical training provided by Monash Children's Hospital surgeons in Vietnam over the past 15 years and in Cambodia for the past five years.

DSD is an umbrella term used to describe a broad spectrum of anomalous development of the uro-genital and reproductive tracts of affected individuals, including disorders of chromosomal, gonadal and phenotypic sex. At birth, it can be difficult to determine if a child will be male or female.

Mr Kimber said the DSD service was particularly needed in Cambodia, where there are no testing facilities or surgical expertise to help children affected by DSD. The need for support in Cambodia is amplified by the fact that 40 per cent of the population is aged less than 16 years.

Mr Kimber said without specialist care, such patients can suffer issues of social and gender identity, premature bone fusion, weight loss, complications from poor early treatment and in rare cases, early-onset cancers of the reproductive system.

While Australian children with DSD are usually treated within the first two years of life, Monash teams working with their Vietnamese and Cambodian colleagues have treated teenagers with DSD who have suffered a range of severe complications caused by a lack of surgical expertise.

"Some of these children are born with genital malformations or have internal structures that are maldeveloped, but until now Cambodia, in particular, has had no expertise in this area," Mr Kimber said.

"Over the years many highly skilled Cambodian and Vietnamese surgeons have struggled to understand how to help such children, particularly in very complex cases where genetic and chromosomal testing and multi-disciplinary input is required.

"On our visits, we have treated patients in their teens with DSD. These individuals pose particular challenges to unscramble the effects of either a lack of early treatment or lack of expert management."

Mr Kimber said the collaborative project will develop a DSD service based at Angkor Hospital for Children in Siem Reap, Cambodia, and at two children's hospitals in Vietnam; in Hanoi and Ho Chi Minh City. A team of specialists from Monash Children's Hospital, accompanied by other international experts in the field, will help build the service by providing seminars, mentoring and twice-yearly training visits.

The Cambodian program will provide:

- Local involvement in all clinical decisions and operating by the visiting team;
- Structured educational sessions for Cambodian clinicians including didactic expert lectures, skills-based workshops, case-based discussions and ongoing teleconferencing;
- Scholarships to support Cambodian surgeons to spend time in Australia and at other international units, to develop technical skills to manage DSD;
- Support to establish a national database to maintain continuity of patient monitoring and long-term care and for use in future research;
- The provision of laboratory work and diagnostic documentation to be kept in the patient's medical record in Cambodia to enhance patient care and knowledge in the field of DSD.

This commitment from Monash Children's Hospital has already been boosted by the College's decision to award an International Scholarship to Cambodian paediatric surgeon, Dr Sophy Kahn, to allow him to train alongside Mr Kimber in Melbourne this year.

Mr Kimber, who has travelled to Cambodia and Vietnam 18 times in recent years, said the great advantage of developing a DSD service in each country was the opportunity it provided to teach techniques across a broad range of specialties while treating children in need.

"When we first started working in these countries, the Monash Children's team made it very clear that we were there to teach – not just to treat – because our sole aim has been to help our colleagues build self-sustaining paediatric surgical services," he said. ▶

Siem Reap Team: Professor Pierre Mure (Lyon France), Dr Van Thy Cambodia, Dr Sophy khan Cambodia in front, Dr Mohan Murraliah, Assoc Prof Chris Kimber, Prof Anette Jacobsen Singapore, Mr Neil Price Aukland, Liem Vierboom, SET 2 Trainee, Dr Nathalie Webb Monash and Dr Vu Thun.

"Now in Vietnam, the surgeons are highly skilled, but have asked us to help them develop a specific DSD service. We have agreed to bring in the training to Hanoi and Ho Chi Minh, which they can then replicate across the country.

"Through a DSD service, we can teach paediatric reconstructive surgery, urology and oncology, along with allied specialties such as endocrinology, psychology and diagnostic procedures allowing us to up-skill local surgeons and specialists across a range of fields.

"Given the lack of sophisticated chromosomal and genetic testing facilities in both countries, we are also bringing back patient samples for testing here in Melbourne which has been an extremely complex process in terms of getting the approvals required to import such materials.

"Providing this diagnostic testing allows us to train our Cambodian and Vietnamese colleagues in sophisticated test analysis so that together, we can determine the best course of surgical treatment for the children affected with DSD."

Mr Kimber said international experts in the field of DSD from France, South America, Singapore and New Zealand had supported the push to develop a surgical service for affected children in the region by funding their own visits to Vietnam to provide training while surgeons from China and India had travelled there to participate.

He said the next Monash team would visit both countries in May and November this year with the team expected to comprise Mr Kimber, Paediatric Urologist Dr Nathalie Webb, Paediatric Radiologist Professor Michael Ditchfield and Paediatric endocrinologist Dr Phil Bergman along with the international experts.

Mr Kimber thanked the College for supporting Dr Kahn's visit as well as Monash Children's Hospital and the donors supporting Monash Children's International.

"Monash Children's Hospital is a young, dynamic organisation that punches well beyond its weight in international work," he said.

"We believe part of our role, as a first-class children's medical facility, is to help our regional colleagues tackle the global burden of disease.

"Up to 13 per cent of that burden relates to surgical cases with the top three being trauma, cancer and congenital abnormalities which obviously includes DSD.

"It has now been determined that surgery has been underutilised in terms of addressing the burden of disease and that surgical care can have a significant positive impact on reducing that burden.

"We are very excited about extending the Vietnam project because the establishment of a Cambodian national DSD centre is likely to have just such a far-reaching impact.

"A specialist centre, able to attract funding and support for the up-skilling of several Cambodian specialists is not only crucial to ensuring affected children receive optimal diagnosis and treatment for their condition, but will have application to the standard of care and collaboration in paediatric services across a range of fields beyond DSD."

With Karen Murphy

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

RECOGNISING THE RACS TRAINEES BRAND

Trainees of the College are looking for an identity linked to the College logo

STEWART MORRISON
COMMUNICATIONS PORTFOLIO, RACSTA

Following support granted by the Education Board Executive, the Trainee Association (RACSTA) has embarked on the process of developing its own logo to be used on official correspondence, at RACSTA run events and used to denote Trainee content within the rich print and digital media produced by the College. But how can we move forward without understanding where we have been? This provides us thus with an opportunity to go back over the history of our College Coat of Arms: A history that may surprise.

The College Arms traces its roots back to 1927 with subsequent modifications, the history and intense symbolism of which is explored by Geoff Down, college curator, in an article accessible via the college website (to which this article owes much of its knowledge). The central shield's black swans and lymphad (a Greek sailing ship) represent Australia and New Zealand, the red cross of the shield itself tracing back to Saint John's Knight's Hospitaller. Above the shield sits a helmet, also ornamented in a way that is a far cry from its military equivalent; the sphinx on top, Down points out, is not only decorative, but is facing forward, despite the helmet being depicted in profile: Aesthetic license to which the College of Arms objected at the time. Even the sphinx itself is culturally muddled, a Greek sphinx according to its female gender, but wearing the headdress of her Egyptian counterpart.

Further exploration of the myriad of symbolism represented by the College Arms seems to further confuse rather than demystify. Down postulates that the hybrid sphinx may simply be the victim of the 'Egyptomania' prevalent at the time, noting the Arms' 1927 beginning as being two years after the discovery of Tutankhamen's tomb. The figures each side of the shield are Chiron, the noblest of the centaurs discussed in Greek mythology (the creatures typically being barbaric in nature) and Apollo, the Greek god often associated with civility and healing, though even this association may seem tenuous by modern standards once Apollo's story of betrayal, femicide and rather violent caesarian section is examined.

The interpretation of this cacophony of symbolism is hence a formidable task, even Down acknowledging the 'iconographic deficiencies' contained within. The Arms, however, has stood the test of time, a bold, if slightly nebulous, representation of tradition and classical ideals. H. B. Devine's 1931 'Letters Patent' is backed now by the College's 'Coat of Arms' Governance Policy, a document that guides this amalgamation of four millennia of iconography, though the modern world of branding, electronic documents and Arial.

Contemporary design trends oscillate faster than Apollo's affection for his lover Koronis. One only needs to look to web start-ups, juice bars and even health services to note the current design-de-jour, a pastel minimalism of sans serif font and geometry, itself a rebellion against the animated skeumorphism pushed by Apple's iPhone in the late 2000s.

So it is in this context – a tale spanning from ancient civilisation to modern word processing – that RACSTA embarks on establishing its own visual identity. RACSTA's charge, as laid down in our terms of reference, is that of communication with and advocacy for surgical Trainees, as well as the promotion of inter-disciplinary relations between the surgical specialty groups. It is certain that at no time more than now should these roles be augmented by the emergence of an instantly recognisable RACSTA identity, an identity that unites Trainees as well as solidifies their role within the College governance structure.

And so, we would like to extend the call for design submissions to the Trainees and Fellows of the College. Hopefully the brief exploration of the College Arms affords an appreciation for the rich heritage and tradition involved, and inspires those Trainees or Fellows with an interest in design to try their hand at a RACSTA Logo to last for years to come.

While the design may incorporate elements of our prestigious arms, it should approach such subject matter with respect, and of course any such design must align with the broader RACS branding and corporate identity guidelines. The Fellows of the College (FRACS), in their logo, have in recent years achieved this; and we believe it is time for the Trainees Association to do the same.

Designs should be submitted in pdf or jpg format to racsta@surgeons.org before April 30, 2015. The designer of an appropriate selected design will receive a $500 Visa Card.

2016 Rowan Nicks Pacific Islands Scholarship & 2016 Rowan Nicks International Scholarship
2015 Rowan Nicks Australia & New Zealand Exchange Fellowship

The Royal Australasian College of Surgeons invites suitable applicants for the 2016 Rowan Nicks International Scholarship and the 2016 Rowan Nicks Pacific Islands Scholarship.

The Royal Australasian College of Surgeons invites suitable applicants who are citizens of Australia and New Zealand to apply for the 2016 Rowan Nicks Australia and New Zealand Fellowship.

Royal Australasian College of Surgeons

These are the most prestigious of the College's International Awards and are directed at qualified surgeons who are destined to become leaders in their home countries.

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

Application Criteria:
Applicants for the Rowan Nicks International and Pacific Islands Scholarships must:
- commit to return to their home country on completion of their Scholarship;
- meet the English Language Requirement for medical registration in Australia or New Zealand (equivalent to an IELTS score of 7.0 in every category for Australia, and 7.5 for New Zealand);
- be under 45 years of age at the closing date for applications.

In addition, applicants for the International Scholarship must:
- hold a relevant post-graduate qualification in Surgery;
- be a citizen of one of the nominated countries to be listed on the College website from December 2014.

Applicants for the Pacific Islands Scholarship must:
- be a citizen of the Cook Islands, Fiji, Kiribati, Federated States of Micronesia, Marshall Islands, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu or Vanuatu;
- hold a Masters of Medicine in Surgery (or equivalent). However, consideration will be given to applicants who have completed local general post-graduate surgical training, where appropriate to the needs of their home country.

Selection Criteria
The Committee will
- consider the potential of the applicant to become a surgical leader in the country of origin, and/or to supply a much-needed service in a particular surgical discipline.
- The Committee must be convinced that the applicant is of high calibre in surgical ability, ethical integrity and qualities of leadership.
- Selection will primarily be based on merit, with applicants providing an essential service in remote areas, without opportunities for institutional support or educational facilities, being given earnest consideration.

Value: Up to $50,000 pro-rata, plus one return economy airfare from home country

Tenure: 3 - 12 months

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

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

Application Criteria:
Applicants must
- have gained Fellowship of the RACS within the previous ten years on the closing date for applications.
- provide evidence that they have passed the final exit exam to allow them to obtain a Fellowship of the Royal Australasian College of Surgeons by the time selection takes place.

Selection criteria:
The Committee will
- consider the potential of the applicant to become a surgical leader and ability to provide a particular service that may be deficient in their chosen surgical discipline.
- assess the applicants in the areas of surgical ability, ethical integrity, scholarship and leadership.

The Fellowship is not available for the purpose of extending a candidate's position in Australia or New Zealand, either in their existing position or in another position.

Value: Up to $50,000 pro-rata, depending on the funding situation of the candidate and provided sufficient funds are available, plus one return economy airfare between Australia and New Zealand.

Tenure: 3 - 12 months

Application forms and instructions will be available from the College website from December 2014:
www.surgeons.org

Closing date: **5pm Monday 4 May, 2015.**
Applicants will be notified of the outcome of their application by **30 October 2015.**

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

2016 Rowan Nicks United Kingdom and Republic of Ireland Fellowship

The Royal Australasian College of Surgeons invites suitable applicants who are citizens of the United Kingdom or the Republic of Ireland to apply for the 2016 Rowan Nicks United Kingdom and Republic of Ireland Fellowship.

The Rowan Nicks United Kingdom and Republic of Ireland Fellowship is intended to promote international surgical interchange at the levels of practice and research, and increase interaction between the surgical communities of Australia, New Zealand, the United Kingdom and the Republic of Ireland.

Application Criteria:
Applicants must
- hold his/her country's post-graduate qualification in surgery or its equivalent and must have completed his/her specialist surgical training program within ten years of the closing date for applications.
- provide evidence that he/she has passed the final exit exam which allows him/her to obtain a Fellowship of one of the United Kingdom or Republic of Ireland Colleges by the time selection takes place.

Selection criteria:
The Committee will
- consider the potential of the applicant to become a surgical leader and ability to provide a particular service that may be deficient in their chosen surgical discipline.
- assess the applicants in the areas of surgical ability, ethical integrity, scholarship and leadership.

The Fellowship is not available for the purpose of extending a candidate's position in Australia or New Zealand, either in their existing position or in another position.

Value: Up to $50,000 pro-rata, depending on the funding situation of the candidate and provided sufficient funds are available.

Tenure: 3 - 12 months

Wading through the Twitter Stream

So much to choose from, who should you really follow?

There is a wealth of information floating around on Twitter and it can be a great way to stay up to date on what is going on around the world, around the country and in our own backyard. The trouble many new Tweeters face is managing to stay afloat while connecting with the people and organisations that make the hassle of jumping in the Twitter tributary worthwhile.

The College is now very active in this space and it is worthwhile checking out the @RACSurgeons profile. Not only will you see our own tweeting, but also who and what we've been retweeting. It's a much more immediate way of getting across the College's activities. You'll also find the link to our lists for colleges and journals of surgery as well as the #HCSM and #FOAMed movements.

Most people would then go straight for the search bar to start finding people and organisations they know. This often works, but it can limit what information you end up seeing, and it also limits your ability to break out of your own network. This is where influencers are useful.

Influencers are individuals and organisations that are in the middle of the stream you're interested in. They're savvy content curators that usually stick to their subject and know it well. Useful because with the hundreds of tweets you could end up seeing each day, theirs will always be of some interest. No cat videos here – rather they're throwing you the good stuff out of the stream and onto your phone so that you don't have to get your digital shoes wet.

JOURNALS
@ANZJSurg The ANZ Journal of Surgery
@TheLancet The Lancet
@JAmCollSurg Journal of the American College of Surgeons
@BMJ_Open The open access division of the British Medical Journal
@theMJA The Medical Journal of Australia and MJA Insight

GOVERNMENT
@healthgovau Australian Government Department of Health
@minhealthnz New Zealand Ministry of Health
@sussanley Australian Minister for Health and Sport
@jcolemanmp New Zealand Minister for Health and Sport

MEDIA
@Medgadget for medical technology news
@TEDMED for health related TED talks
@ABChealthonline ABC Health and Wellbeing
@MedObserver News for medical professionals
@croakeyblog Crikey's health blog
@amaausmed The news publication of the Australian Medical Association
@bbchealth BBC health news

This is just a short list to get you started. You can try following all of them, or just some, but remember that if you don't want to see what they're posting at any time you can just unfollow them and they'll probably never know. In the meantime the ones you do like will lead you onto other great influencers.

If you have any suggestions for great surgical influencers on Twitter, just tweet @mentioning them and @RACSurgeons. That's how great minds connect on Twitter.

From left, Mr David Walters (deputy Chair), Dr Sonja Latzel (Chair), Dr Amal Abou-Hamden, and Dr Peter Bautz inspect the Emergency Department entrance at the new Royal Adelaide Hospital.

Transforming South Australian Health, the new Royal Adelaide Hospital and rationing of access to surgical procedures

WORKING TOGETHER

SONIA LATZEL
CHAIR, SA REGIONAL COMMITTEE

South Australian Health care is about to be transformed! We are in the midst of a strategic planning period instigated by the South Australian Government, with the publication in October 2014 of the 'Transforming Health' working paper, designed to introduce strategic goals for change within the metropolitan public hospital system.

Many of the proposals so far have been broad motherhood statements that are clearly non-controversial ideals promoting statements such as 'patients should be at the centre of care, and care should be delivered in the right place, by the right person, the first time and every time'. In other areas, the intention of the government is less clear, with indications of plans for a significant increase in task substitution and expanded roles for nurses and allied health.

The impact of the proposed changes on surgical training is of paramount importance to the College and is often overlooked by health bureaucrats in a system focused on cost and efficiency. We are particularly keen to advocate for Trainees on this issue. Questions persist around how the government will fund proposed changes given the parlous state of the health budget in South Australia.

The second stage, 'Transforming Health Proposals' has recently been unveiled and confirms suspected plans for closure of some hospitals including the Repatriation General Hospital and the downgrading of others, a change in service provision in a number and concentration of trauma and more complex surgery at three main hospitals. Several hospitals are earmarked to perform predominantly elective surgery.

Specific details are lacking and the impact on workforce and training can't be predicted on this early stage data. We are requesting more detail in order to determine the impact, particularly on surgical training.

From left, Dr David Walters, Dr Peter Bautz, Dr Sonja Latzel and Dr Amal Abou-Hamden discuss plans in the under-construction theatre suite at the new Royal Adelaide Hospital.

Clinical Commissioning

Another aspect of the transformation is a process called Clinical Commissioning. This concept was first introduced to us as a state committee a couple of years ago, with very loose descriptions of what it really meant. Despite repeatedly seeking clarification we still have no clear explanation on what is being considered.

With the release of the first commissioning document late last year on elective breast procedures, it is clear that Clinical Commissioning is a form of rationing of services to patients. It appears there is going to be a layer of bureaucracy inserted between surgeons and their patients, to control the indications for procedures and access to procedures, allowing for little variation without appealing to an Advanced Care Panel, the makeup of which is also unclear.

These ideas have been borrowed from a similar process in the United Kingdom, where the government sought to cut £15 billion from health expenditure. Clinical Commissioning bodies were set up around the country, employed by separate NHS Trusts to identify a number of 'procedures of low clinical value'. These procedures are now no longer funded in many jurisdictions or funded only when patients meet very specific indications predetermined by these bodies. The list of procedures and indications, or alternative therapies, which must be tried prior to qualifying, vary significantly across the country and according to a paper by the Royal College of Surgeons of England, appear to be leading to significant inequities based on postcode.

When examined, the evidence for determining effectiveness is often a lack of proof of effectiveness rather than proof of a lack of effectiveness. It is known that proving the effectiveness of well established procedures is often fraught with difficulty because patients in whom effectiveness is accepted are often considered at risk of harm from randomisation to a non-intervention arm and are therefore generally excluded from trials. This leads to the treatment of patients with lesser clinical indications, and the exclusion of the patients who would most benefit, resulting in a bias in favour of a lack of effectiveness. It is difficult to know how to address these issues, especially when the government's approach is to ask specialists from other clinical areas to review procedures outside of their specialty, so these biases are not identified.

We will continue to grapple with these issues in South Australia, trying to intervene to protect patients' access to procedures that improve their quality of life as well as productivity. However, it seems as though we may be veering towards a future where only urgent procedures are considered appropriate to be paid for by the public purse and those in the lowest socioeconomic strata will suffer most because they may be unable to afford private care for these conditions.

The other major South Australian issue is the building of the new Royal Adelaide Hospital (RAH). I joined several other state committee members on a tour of the site recently and it is a remarkable undertaking and should deliver a truly 21st Century facility for the citizens of South Australia. It has 700 single patient rooms with robots dispensing medications and state of the art operating facilities.

It is similar to the Fiona Stanley Hospital in Perth, in that it is being built with the expectation that the electronic records system will be up and running and be the basis for all record keeping. Similar to the Fiona Stanley, there is minimal desk and storage space for written notes, which likewise will create issues if the system chosen for the new RAH, EPAS (Enterprise Patient Administration System) is not running when the hospital opens.

The EPAS system has been fraught with problems in the few small hospitals in which it has been established so far. At present it has not been rolled out in any major teaching hospital in South Australia and plans to do so have been put on hold while all efforts focus on the current RAH. We have been active in advocating for surgeons who have had significant issues with the system decreasing efficiency and we continue to raise safety and security concerns.

The College is well positioned to advocate for patients and surgeons in relation to all of these issues and we look forward to receiving feedback on your experience. We envisage a busy time in the coming years.

Dean of Education Stephen Tobin with David Birks being presented the award by President Michael Grigg.

ACADEMY AWARDS

Recognising surgical educators

JULIAN SMITH
CHAIR, PROFESSIONAL DEVELOPMENT CHAIR, ACADEMY OF SURGICAL EDUCATORS

STEPHEN TOBIN
DEAN OF EDUCATION

In 2014 the Academy of Surgical Educators launched the first of its 'Academy Awards' to support, enhance and recognise surgical educators within the College. The inaugural winners of the Educator of Merit – Supervisor / International Medical Graduate Clinical Assessor of the Year Award recipients are the late Prof Phillip Walker for QLD and Prof David Hardman for the ACT. The Educator of Merit Award – Professional Development Facilitator of the Year award has awarded to Mr David Birks of Victoria. The award winners were announced at the Academy Forum on November 13, 2014.

Gippsland Surgeon wins inaugural Facilitator of the Year Award

David is a long-time resident of Moe in south-east Victoria and has been a surgeon for over 35 years at Latrobe Regional and Maryvale Private Hospitals. Surgery runs in his family; his father Gordon was also a surgeon in Moe and Darwin and his grandfather a surgeon in Broken Hill. David has shown a life-long commitment to medical education and greatly assisted with the development of formal surgical education at the College particularly after participating in the Surgeons as Educators Course in 2001. In fact his involvement with College courses began when he joined the Early Management of Severe Trauma (EMST) faculty in 1990.

Since then his leadership and insight have continued, with his expertise and enthusiasm contributing to the development of five professional development courses, which have been attended by hundreds of surgeons across Australia and New Zealand. These courses include Surgeons as Educators, Non-Technical Skills for Surgeons (NOTSS) and Safer Australian Surgical Teamwork (SAST). Before retiring from EMST he instructed on 23 courses. He has also taught on Training in Professional Skills (TIPS) courses and continues to be involved in Care of the Critically Ill Surgical Patient (CCrISP), having taught on 21 courses. In addition to his work for the College, David has been actively involved in educating medical students as a Senior Lecturer at Monash University's School of Rural Health since 1993.

David was among the first to show an interest in extending the reach of courses beyond traditional face-to-face training and was an early adopter of online education. This was demonstrated by his instrumental work in the development of the College online skills education modules in 2002/03. His commitment, support and passion for these projects was critical to their successful delivery.

In addition to David's other surgical qualifications of FRCSC and FRCSEd, he holds a Masters in Health Professional Education (Monash University). He has shared his experience and knowledge and helped to shape the content of surgical professional development courses through involvement in several College governance groups. For example he has chaired the Surgical Teachers Course, Non-Technical Skills for Surgeons, Foundation Skills for Surgical Educators working parties and the Rural Surgical Training Program. He has also been a member of the Academy of Surgical Educators Committee and the Graduate Programs In Surgical Education Reference Group.

The Academy's Professional Development Facilitator of the Year Award acknowledges David's significant contribution to surgical education. As the first recipient of this award, he sets a high standard for the future.

The nominations for the 2015 Academy of Surgical Educators Awards for Educator of Merit - Supervisor/Clinical Assessor of the Year and Professional Development Facilitator of the Year will be open in late March and open for one month. Invitations to nominate suitable College members will be sent to all State Executive Committees and Specialty Societies.

The Supervisor/Clinical Assessor of the Year recognises exceptional contributions by a surgical supervisor/clinical assessor in supporting Trainees and/or International Medical Graduates (IMGs) to fulfil the College's goals, values and mission. A Supervisor/Clinical Assessor of the Year award will be awarded in each region of Australia and in New Zealand where an appropriate candidate has been nominated.

The Professional Development Facilitator of the Year recognises an exceptional contribution by a course facilitator for a professional development program. The Professional Development Facilitator of the Year Award may be nominated by a College staff member, surgical educator colleague, Fellow, IMG or Trainee.

Academy of Surgical Educators membership is open to all Fellows and Trainees as well as external medical educators who have strong educational interests and expertise. For more information please contact Kyleigh Smith on +61 3 9249 1212 or ase@surgeons.org

Foundation Skills

An exciting new initiative

DAVID BIRKS
CHAIR, FOUNDATION SKILLS FOR SURGICAL EDUCATORS. ACADEMY OF SURGICAL EDUCATORS COMMITTEE

A practical new initiative in surgical education has been launched by the College this year – the Foundation Skills for Surgical Educators Course. This free one day course is targeted at senior Trainees, IMG's and new supervisors/trainers. It aims to establish the basic standards expected of our surgical educators. The course is particularly directed at better facilitating the education and training of surgical Trainees; however the course can also be applied to medical students, junior doctors and Fellows.

During 2014 the course was successfully piloted in four locations across Australia and New Zealand. The evaluation results from the 36 participants were very positive with most either agreeing or strongly agreeing that overall they were satisfied with the course. In addition, 81 per cent agreed and 14 per cent strongly agreed that the course met its learning goals and 95 per cent either agreed or strongly agreed that they learnt new ideas, approaches and /or new skills; 100 per cent stated that the new knowledge would be applicable to their work place and 89 per cent stated the course provided useful resources. Finally, 61 per cent of respondents rated the course resources as good and 22 per cent stated they were excellent.
The course gives participants an opportunity to identify their own strengths and weaknesses, which are likely to influence their learners and the learning environment. They can also further their knowledge and skills in relation to teaching and learning concepts then apply these principles into individual teaching contexts. The course's key objectives are to enable participants to:

- recognise the importance of educational theory and how it translates into practice;
- consider how to provide effective teaching, learning , feedback and assessment in different clinical settings;
- identify how to plan learning by using effective teaching, learning and assessment strategies.

The course explores a range of topics:

- Understanding myself as a teacher
- Planning a learning process
- Understanding and supporting learning
- Recognising teaching and learning opportunities
- Feedback and assessment

An initiative for the Academy of Surgical Educators, the course was collaboratively developed between the Departments of Professional Development, Dean of Education and Skills Training and Education Development and Research to ensure its relevance and applicability to all areas of surgical education. In addition, educators and subject matter experts from both the Scholar and Teacher Professional Development courses and Skills courses were engaged to present a consistent message and build on the knowledge and skills of the College's current courses.

The Professional Development Department would like to thank the Dean, Associate Professor Stephen Tobin and EMST Educator Ms Debbie Paltridge for their significant contributions to the course development.

Courses for 2015 are off to a racing start with two courses already full. Register online via the College website **www.surgeons.org** or contact Alicia Mew, Education Development Coordinator Professional Development Department: **alicia.mew@surgeons.org** or +61 3 9276 7440.

2015 Foundation Skills for Surgical Educators Courses
20 April, Melbourne, VIC
4 May, Perth, WA
17 July, Magnetic Island, QLD
6 August, Darwin, NT
16 October, Hobart, TAS

RECONNECTING OLD TIES

Scholar Sebastian King's Hugh Johnston Travel Fellowship allowed travel to a world respected centre for the care of children

Victorian Paediatric and Neonatal Surgeon Mr Sebastian King spent six months last year working at one of the largest paediatric hospitals in North America with financial support provided via a College Hugh Johnston Travel Grant.

Mr King spent his time working at the Hospital for Sick Children (SickKids) in Toronto, Canada, one of the few hospitals in the world to have a surgical Fellow dedicated to the Neonatal Intensive Care Unit.

Sebastian with wife Charlotte

Mr King, who has a subspecialty interest in paediatric colorectal surgery, filled that role from July to December 2014. He also spent time as a visiting Fellow at Nationwide Children's Hospital in Columbus, Ohio.

He said that in Canada he had managed more than 100 complex neonatal surgical patients, treating conditions such as oesophageal atresia and duodenal atresia in extremely premature babies.

"SickKids is a very large institution with a huge drainage population of around 7 million people," he said.

"It is one of the top three or four paediatric hospitals in North America and has this great combination of ethos between the can-do approach of the US and the socialised medicine of Canada.

"Surgeons and specialists from all over the world go there to work, learn and exchange skills and ideas and it is an exciting environment in which to work."

Mr King, who became a Fellow in 2013 and who works at the Royal Children's Hospital (RCH) in Melbourne, said during his time at SickKids he treated neonates as young as 22 weeks and worked with world leaders in the field of paediatric and neonatal surgery.

"The Neonatal ICU at SickKids had up to 25 surgical cases at any one time, while we would normally have 15-20 in Melbourne," he said.

"We had 22 cases of neonates with duodenal atresia in the six months and we treated a baby with oesophageal stenosis with a double fistula. This has only been described twice before and neither of the previous patients survived.

"I also initiated 10 research projects within the Department of General and Thoracic Surgery and learned from experts across a range of specialties including neonatal intensive care, radiology, gastroenterology and interventional radiology."

Mr King said the central highlight of his Fellowship in Toronto had been the opportunity to work alongside world leaders in paediatric surgery.

These included Professor Jacob Langer, a paediatric colorectal surgeon and world expert in the management of Hirschsprung disease and inflammatory bowel disease, Professor Paul Wales, an expert in the surgical treatment of short-gut syndrome, Dr Georges Azzie, a leader in minimal-access surgery and Professor Agostino Pierro, head of the hospital's General and Thoracic Surgery Division.

"It was a wonderful experience to be mentored by such internationally recognised surgical leaders," Mr King said.

"The chance to learn from Professor Langer, while working together on extremely complex cases, was a real highlight and has changed my clinical approach to a number of conditions.

"It was exhilarating to work in such a world-class environment, but it was also reassuring to know that our training stacks up to the best in the world.

"However, the sheer number of cases they see, their complexity and the surgeons' ability to collaborate with colleagues from around the world means that they can develop a different level of expertise in particular areas.

Sebastian King with team, second from left sitting down, Georges Azzie is second from right sitting down and Jacob Langer is last on right sitting down.

"It is a matter of population and geography largely, in that it is so much easier for European and American surgeons to travel to different centres to work and teach. They also have much larger caseloads to work on.

"As Australia is a long way away it makes travel grants and Fellowships so valuable."

Mr King said it had also been pleasing to re-establish a relationship between the Department of Paediatric and Neonatal Surgery at the RCH and SickKids.

"There are strong links between SickKids and some departments at the RCH including Intensive Care, Orthopaedics and Anaesthesia, but we have not had anyone from our Paediatric Surgery Department train there since the 1970s," he said.

"I am hopeful that my Fellowship there will help drive continuing cooperation between our Department and SickKids so that we can create more chances to develop combined research projects and clinical cooperation."

Mr King also said he had particularly enjoyed his visit to the Nationwide Children's Hospital in Ohio, because it is the pre-eminent centre for paediatric gastrointestinal motility, which had been the basis of his PhD research.

"The hospital in Ohio also has the busiest paediatric surgical service in North America and while there I studied under the supervision of Professor Marc Levitt, a world leader in anorectal malformations and Hirschsprung disease," Mr King said.

"I had worked with Professor Levitt in 2013 when we co-wrote a paper together on anorectal malformations and it was a great pleasure to collaborate with him again, particularly in such a busy and dynamic facility as Nationwide.

"I have been asked to participate in panel discussions at the World Congress of Surgery to be held in Thailand later this year and afterwards will be part of a surgical mission in the region with Professor Levitt.

"I am very grateful to the College for the support that was provided to me for my Fellowship at SickKids. The experienced that I gained and the contacts that I made will be of immense use as I progress my academic surgical career."

The Hugh Johnston Travel Grants aim to assist Fellows and Trainees to take time away from clinical positions to gain specialist knowledge or expertise oversees in a field to benefit the recipient, the College and the Australian community.

With Karen Murphy

Australian and New Zealand Post Fellowship Training Program in Colon and Rectal Surgery 2016

Applications are invited for the two year Post Fellowship Colorectal Training Program, conducted by the Training Board in Colon and Rectal Surgery (TBCRS). The TBCRS is a Conjoint Committee representing the Colon & Rectal Surgery Section, RACS, and the Colorectal Surgical Society of Australia and New Zealand (CSSANZ). The program is administered through the CSSANZ office.

For details about the Training Program and applications, please see **https://cssanz.org/index.php/training/about**

A Notaras Scholarship will be awarded in 2016. Further information can be obtained from A/Prof Christopher Young via the email below.

Application Closing Date: Friday 15 May 2015

Applications: Please include -

1. Covering letter *(please see the Selection Criteria document for information to be included).*
2. Curriculum Vitae
3. Contact details *(including email address and contact number)* for three referees.
4. Application Payment of $440.00 inc GST. *(See website link above for details).*

Email your application to:
Mr Andrew Hunter
Chair, Training Board in Colon & Rectal Surgery
E: secretariat@cssanz.org
P: +61 3 9853 8013

POSITIVE ASSESSMENTS

A paradigm shift in patient care evaluation

BARRY BEILES
CLINICAL DIRECTOR, VASM

Case study
Steps to optimise anaemia

PATIENT PROFILE
Age: Early 90s.
Comorbidities: Age, cardiovascular and hernia.

This patient presented to the hospital emergency department with abdominal pain, an inguinal hernia and constipation. The bowels were working by the time the patient was seen by the surgical registrar. The patient had been aware of the hernia for 20 years and examination showed it to be a large inguinal hernia with no tenderness, but containing a significant amount of bowel.

A discussion was held with the family regarding a semi-elective operation to repair the hernia and whether this would be in the patient's best interest. As part of the work-up, the patient was found to be anaemic with haemoglobin of 6.7 g/L. A gastroscopy and colonoscopy to investigate the anaemia were planned, and they were to be undertaken prior to contemplating surgery. The patient was also assessed by the anaesthetist as to whether they were fit enough to undergo the procedures. On the fifth day post-admission and prior to any surgical procedure, the patient was noted to have a productive cough, some vomiting and had developed respiratory signs.

Oxygen saturations fell and the patient appeared to deteriorate quite quickly. The Medical Power of Attorney was informed of the deterioration and it was agreed that the patient be managed on the ward, but was not for escalation to the Intensive Care Unit (ICU) or cardiopulmonary resuscitation. The patient was treated with intravenous (IV) antibiotics, omeprazole and oxygen. Despite this, the clinical condition continued to deteriorate and the patient passed away early the next morning. The cause of death was acute myocardial infarction, in the setting of a possible aspiration and pneumonia.

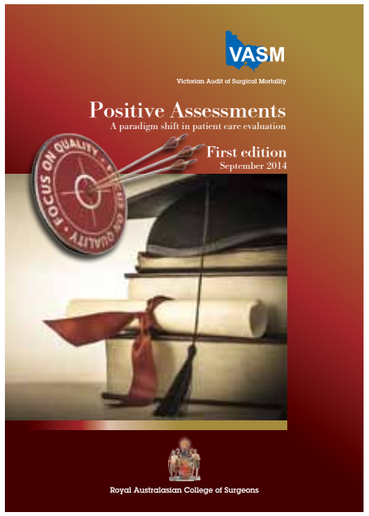
Comments:

The patient's care was appropriately managed. There were no areas of concern and the outcome was unavoidable. The treating surgical team made the correct decision in involving the anaesthetic and medical teams to optimise the anaemia rather than rush to surgery. The hernia was quite long- standing and was not incarcerated or obstructed. The clinical signs of obstruction (vomiting, lack of bowel actions and abdominal distention) were not present prior to the development of pneumonia, and it was reasonable for the patient to be on a light ward diet. Clinical notes indicate that the chest infection may have predated the vomiting, so aspiration may have occurred after the pneumonia rather than be the cause of it.

The quality of the record keeping was very good. The documentation was legible and all of the important events were clearly documented.

The benefit of a paradigm shift in patient care evaluation

The audits of surgical mortality review deaths that occur while under the care of a surgeon in the public and private hospital sectors. The first edition of the



Positive Assessments Case Note Booklet utilises a positive assessment approach which views the correct handling of clinical management issues as an important learning tool. Just as vital lessons are learnt from the errors made by others, so too can we learn from what others do well. The case that features in this study has been selected on the basis that it highlights how surgical Fellows, hospitals and a large spectrum of health professionals handle difficult situations appropriately and receiving positive comments from the assessors.

Building a positive assessment behaviour paradigm may initially seem incongruous given that mortality is a key criterion for inclusion in the audit. However, Victorian Audit of Surgical Mortality (VASM) patients tend to be elderly admitted as emergencies and with other severe health problems. They tend to require more complex surgical procedures that carry a higher risk of complications. In the selected Positive Assessment cases mortality did not result from a system or individual error, but from the combination of medical issues that made survival unlikely. Death resulted despite correct clinical management and there are positive lessons to be learned in areas such as problem-solving, active collaboration and the timing of palliative care.

As with all Case Note Review Booklets, all cases selected have gone through the full assessment process by a Fellow from either the Royal Australasian College of Surgeons or the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. The assessments have been edited to ensure that the patient, hospital, treating surgeon and assessor remain anonymous.

As a result of the audit's declared quality assurance status, the audit is unable to send feedback on the case to anyone other than the treating surgeon. Hospital management receive indirect and aggregated data on the cases assessed by the audit. Surgeons are encouraged to share these peer review feedback lessons with relevant staff ensuring that those responsible for delivering care can reflect on and improve their own processes and procedures.

Some hospital stakeholders were strongly supportive of these new types of Positive Assessment publications; however the surgical community provided divided views about this latest approach, favouring the Case Note Review booklet methodology where strong criticism resonates from cases. VASM wishes to continue with both publications as these are complimentary learning tools for our hospital stakeholders.

The audit staff would like to take this opportunity to thank all surgeons and hospitals participating in the VASM audit activity.

Case Note Review

PEG is a risky procedure in patients receiving peritoneal dialysis

GUY MADDERN
CHAIR, ANZASM

Summary

An elderly patient with weight loss and general inanition was admitted electively for percutaneous endoscopic gastrostomy (PEG). The history included chronic renal failure on peritoneal dialysis, asbestosis and restricted cardiomyopathy. The PEG was performed by a locum surgeon at a regional hospital without obvious incident. Post-PEG, the patient deteriorated rapidly with pain and development of peritonitis. The patient developed septic shock. The patient was treated for sepsis and hypotension and subsequently transferred to a major metropolitan hospital.

A laparotomy revealed ischemic necrosis of the gastric wall at the site of the gastrostomy with bilious peritonitis. A washout and oversewing of the gastric wall was performed and a repeat gastrostomy created using a Foley catheter. The surgery was performed by a surgical trainee with the consultant not in the operating theatre. Postoperatively the patient was managed in the intensive care unit with ventilation, inotropic support and antibiotics. Chest effusions required drainage. The patient failed to improve and nearly a week after a difficult weaning from ventilation it was decided to offer palliative care only. The patient died from respiratory failure.

Reviewer's comments

This case illustrates the danger of PEG, considered by some to be a safe and routine procedure. The patient developed septic shock within hours of surgery and therefore ischemia and perforation are likely to be excluded. Complications related to PEG such as the flange being pulled too tight to the abdominal wall would be likely to develop over a number of days, not hours. It appears this patient developed peritonitis as a complication of PEG placement whilst on peritoneal dialysis – such complications are well recorded in the literature (Fian et al in ADV peritoneal dialysis 2007: 17; 1498-152). This underlying medical condition was such that the patient was never going to recover from peritonitis even with the best available management.

In summary, the decision to proceed with a PEG in a patient being treated with peritoneal dialysis may be an adverse event and the decision to proceed with PEG in a patient on dialysis should include the treating renal physician.

A LIFE NOT SO ORDINARY

Grace Warren has worked to help people with her unique approach to surgery

For someone who was prevented from even applying to train as a surgeon simply because of gender, Dr Grace Warren has made a pretty good go of her life in theatre.

Over a career spanning more than 50 years, Dr Warren has been welcomed as a Fellow into both the RACS and the Royal College of Surgeons (RCS), been awarded a Professorship of the RCS, an Honorary Doctor of Medicine by the University of Sydney and was appointed a Member of the Order of Australia in 1986.

She is the recipient of the inaugural Sir Edward Hughes Award by the RACS, given only in recognition of outstanding contributions to surgery, was awarded the Star of Pakistan for Humanitarian Services, the highest humanitarian honour bestowed by the nation, and has the rare privilege of being a Consultant-in-Perpetuity at the Royal Melbourne Hospital.

An expert in the surgical care of leprosy sufferers with a particular specialty in the treatment of neuropathic bones, Dr Warren has worked in scores of developing countries, beginning with her first assignment in South Korea, and continues to advise surgeons and physicians around the world.

Now back home in Australia after decades of travelling to areas of need and to answer requests for training, Dr Warren describes herself as a rehabilitation surgeon.

"I'm a renegade I'm afraid and my skills don't fit neatly into any of the surgical specialties," she laughed.

"I was doing basic surgery before I began my work with leprosy patients and the RACS classifies me as a Plastic and Reconstructive Surgeon, but I think the term Rehabilitation Surgeon is most accurate because my entire focus is helping people return to a functional and respected place in society.

"That means I do anything I can to assist rehabilitation. I do tendon transfers, I rebuild noses, I do skin grafts, face lifts, bone grafts, arthrodesis of ankles and even eye-brow replacement surgery. That is because the absence of eyebrows in endemic countries suggests the person has leprosy, a suggestion that is often enough to stigmatise and drive the person out of society."

Although Dr Warren was drawn to surgery as a young medical student and would watch the plastic surgeons at work whenever time allowed, women in the 1950s were considered unfit for a life in surgery.

As the next best option, she instead completed good basic surgical training at the St George, Queen Victoria and Geelong Hospitals before completing a Diploma of Tropical Medicine, which she hoped would allow her to work with people in need in developing countries.

That opportunity came in 1957 when she was offered the position of locum tenens at a women's hospital run by the Australian Presbyterian Mission in South Korea.

It was during her 18-months there, that Dr Warren had what she described as the "excellent" experience of conducting medical work in a third-world country still recovering from war.

There, she learnt the art of improvisation that would help in later years while also gaining some experience working with leprosy patients from a nearby colony, many of whom were treated with fear and disgust by the local population.

But those attitudes had little impact on Dr Warren for she moved from there in 1959 to work as a locum tenens, at the Leprosy Hospital on Hay Ling Chau Island in Hong Kong, firstly as a medical officer and later as superintendent and surgeon.

It was there that she learnt the techniques of reconstructive surgery originally developed by the renowned surgeon Dr Paul Brand with whom she later worked in India.

Looking back at the start of her career, Dr Warren said she was drawn to do this work not only through her strong Christian faith and desire to work with those in need, but because of her family background.

"I am someone who genetically inherited the ability to work with my hands from my father and socially inherited strong problem solving skills from my mother," she said.

"My father was ingenious with his hands, but sadly was killed in Australia's first civil aviation disaster which left my mother to bring us up as a sole parent at a time when there was little support for sole parents.

"It was from her that I learnt how to make do, how to make the most with what I had.

"She often posed the question: What have you got, what can you do with it, how can you help?

Grace examines a young woman's foot surrounded by workers in Cambodia. Left: In Chiang Mai. Far left: Grace in 2013, image Courtesy of Southern Cross Prime for over 55s magazine. CREDIT: Anglican Media Sydney

"That attitude drew me towards a career in medicine and then surgery.

"Without orthodox training, I learned everything I could about surgery from other surgeons, physicians and text books.

"I tried to help in any way I could with whatever was available and sometimes I'd have to buy basic sewing supplies to sterilise and use when nothing else was available.

"Regular sewing cotton and silk worked very well and nylon fishing line made excellent sutures."

For most of the 15 years following her arrival at Hong Kong's leprosarium, Dr Warren combined superintendency with research into improved medical and surgical treatment methods for her patients while also providing training for other surgeons working in leprosy centres across Asia and the sub-continent.

It was during this time that Dr Warren first hypothesised and then proved that by applying a plaster cast to a fractured neuropathic foot for a prolonged period of time, it was possible to heal fractures previously considered to be non-healable and thus often amputated.

This research formed the basis of a thesis that won Dr Warren a Master of Surgery Degree in 1972 and five years later she was elected to become a Fellow of the RACS.

Later, Dr Warren worked with Professor Sydney Nade on a book called 'The Care of Neuropathic Limbs – a Practical Manual' as a way to share her pioneering treatment and the knowledge she had gained from decades working with leprosy patients.

Still passionate and galvanised by this work, Dr Warren believes her research and treatments have a direct bearing on the current surgical treatment offered to patients with diabetes.

"The central problem with the neuropathic foot is the lack of pain, which means that when a bone is broken the patient doesn't know and keeps moving it which means that it cannot lay down calcium to repair the fracture," Dr Warren said.

"For such injuries, for many years, the only option was amputation as marked deformity or infection developed.

"In the 1960s, I put these feet in plaster casts and they healed and by 1967 I had hundreds of x-rays and follow-up assessments which showed the healing over time. We also showed that after surgery, neuropathic bones would fully heal if adequately rested and protected for twice as long as in the normally sensitive limb.

"I used that data, based on more than 100 feet, to build my thesis for the Master of Surgery Degree.

"Since then, I have travelled everywhere I am invited to explain and teach this and in 1987 I was asked to give a Presentation to the RCS on the Conservative Management of the Neuropathic Foot where I stressed that the problem is not one of healing, but one of pain – or specifically the lack of pain. ▶

Grace receives MD, Honoris Causa, as Sydney University celebrates the centenary of women graduates - May 1985.

"You don't need to chop off limbs – you just need to keep them still and protected so they can heal.

"I believe the same is true of patients with diabetes. This is all about poor sensation. Sometimes, patients either don't move their feet often enough because they don't feel discomfort which prevents blood flow through the compressed tissues so that some die giving the appearance of poor circulation. Others I believe don't realise that they may have a fracture which requires rest for healing.

"I would love the College to look into this, to promote some research into the applicability of my work to the care of patients with diabetes because I strongly believe the key aspect in the care of neuropathic bone disorganisation relates to an abnormality in pain perception.

"I think radiologists need to take this on board too, they need to look for fractures because they are often, at first, only visible as a tiny crack. Perhaps referring doctors need to state exactly where the fracture may be so that radiologists can look more closely."

Since the Hong Kong leprosarium closed in 1975, Dr Warren has been travelling and teaching her limb saving techniques around the world.

She has now worked in 27 countries – often flying in for three-week visits to teach nurses, doctors, surgeons and physiotherapists her method of treating neuropathic limbs, leprosy and other disabling problems such as club feet.

Now, permanently home in Australia, Dr Warren continues to consult with surgeons and physicians across the country and is also now in the process of designing a dedicated website (www.neuropathiclimbs.com.au) on the management of neuropathic limbs.

As is often the way with people of remarkable courage, skill and dedication, she is modest about her achievements.

"I believe God wanted me to become a surgeon and opened the doors for me," she said.

"The most rewarding aspect of my life as a surgeon is knowing there are thousands of people around the world able to support themselves and be socially acceptable because surgeons like myself came along."

With Karen Murphy

SRI LANKA AND THE EVOLUTION OF SURGERY

Surgical workshop in laparoscopic surgery

MEHAN SIRIWARDHANE
QLD FELLOW

Most people arriving in Sri Lanka from Australia will arrive late at night and notice that the terminal would not be out of place in a 1970s movie!

Once through Customs you will immediately be aware of the dense humid air and lingering scents of flowers and spice as well as crowds of touts promising a cheap ride to your hotel.

If you had visited Sri Lanka 10 years ago, however, you would realise things have changed. The imposing presence of the military has been lifted and you may even be lucky enough to avoid the heat in one of the new air bridges connecting your plane to the terminal.

Sri Lanka is growing and like many places in Asia it is doing so at a rapid rate. The veil of a civil war that tormented this naturally beautiful island has slowly lifted and the people and the land in which they dwell are showing signs of progress. Medicine has not been left behind and it was here that we found our role as teachers and mentors to a class of budding surgeons.

My connection to Sri Lanka is through my ancestry. Many of my extended family still live there. My connection to the surgical world was made through a chance meeting with a surgeon who is both a pioneer and a true gentleman. Dr Kuda Galketiya is a general surgeon in Peradinya University Hospital in Kandy, a picturesque city in the heart of Sri Lanka bordered by many of the world's finest tea estates.

Galketiya has pushed the boundaries in Sri Lanka, having worked as Colombo Plan Fellow at Westmead Hospital during the early 1990s. He is trying to provide his patients with minimally invasive surgical options considered routine in Australia, but uncommonly performed and less commonly taught in Sri Lanka.

Prof Vincent Lam teaching the basics of laparoscopic cholecystectomy at the Peradinya medical facility.

The surgical team for a live demonstration performed at Peradinya university hospital, centrally from left to right is Dr Lawrence Yuen, Dr Mehan Siriwardhane, Dr Kuda Galketiya, Prof Vincent lam, Dr Tony Pang.

The nation is becoming more prosperous and many hospitals – even very small regional facilities – have the equipment and facilities to perform laparoscopic surgery. Despite this, the average general surgeon will start his/her career in an unsupported rural setting, having performed fewer than ten laparoscopic cholecystectomies. As you can imagine they are not easy cases, most patients present after many years of symptoms! Consequently there has been a spate of bile duct injuries that provided the impetus to develop a workshop on laparoscopic surgery for surgeons and Trainees from the central region of Sri Lanka.

The idea was simple. Provide a practical, video based workshop addressing the basic principles of laparoscopic surgery. Many of the videos specifically addressed trouble shooting in laparoscopic surgery and in particular cholecystectomy. All the videos were created from real cases and we collected examples of most surgical challenges and misadventures. Our video on bile duct division was downloaded from the internet! Collecting and editing the videos took over 12 months.

With the help and support of the former College President, Professor Michael Hollands, the workshop was supported by both RACS and the Sri Lankan College of Surgeons.

The workshop was held at Peradinya University and was designed to be a pilot project. The group that finally undertook the task of creating and presenting the workshop consisted of both skilled laparoscopic surgeons and enthusiastic teachers.

Professor Vincent Lam, Dr Lawrence Yuen and Dr Tony Pang were the surgeons who gave their time and expertise. Our team would have been incomplete without the organisational and liaison work carried out by clinical nurse Ms Jane Sinclair who was supported by the Westmead Hospital Association Charitable Trust to travel with us.

The workshop consisted of two days of video based lectures and lap simulator work followed by a half day of live demonstrations. The facilities at Peradinya were excellent and the audio visual staff facilitated the process with great skill and effort, the highlight being the streaming of the live demonstration to a large viewing audience of surgeons located at a separate facility.

The participants were a mixture of Trainees and local surgeons. An initial shyness and reluctance to interact was largely due to cultural politeness. This quickly dissipated during the lap skills sessions and we soon had a vibrant interactive exchange.

Feedback for the project was very positive. This being a first course we will make some improvements and have listened closely to our Sri Lankan colleagues' feedback so when we return next year the course will be even better.

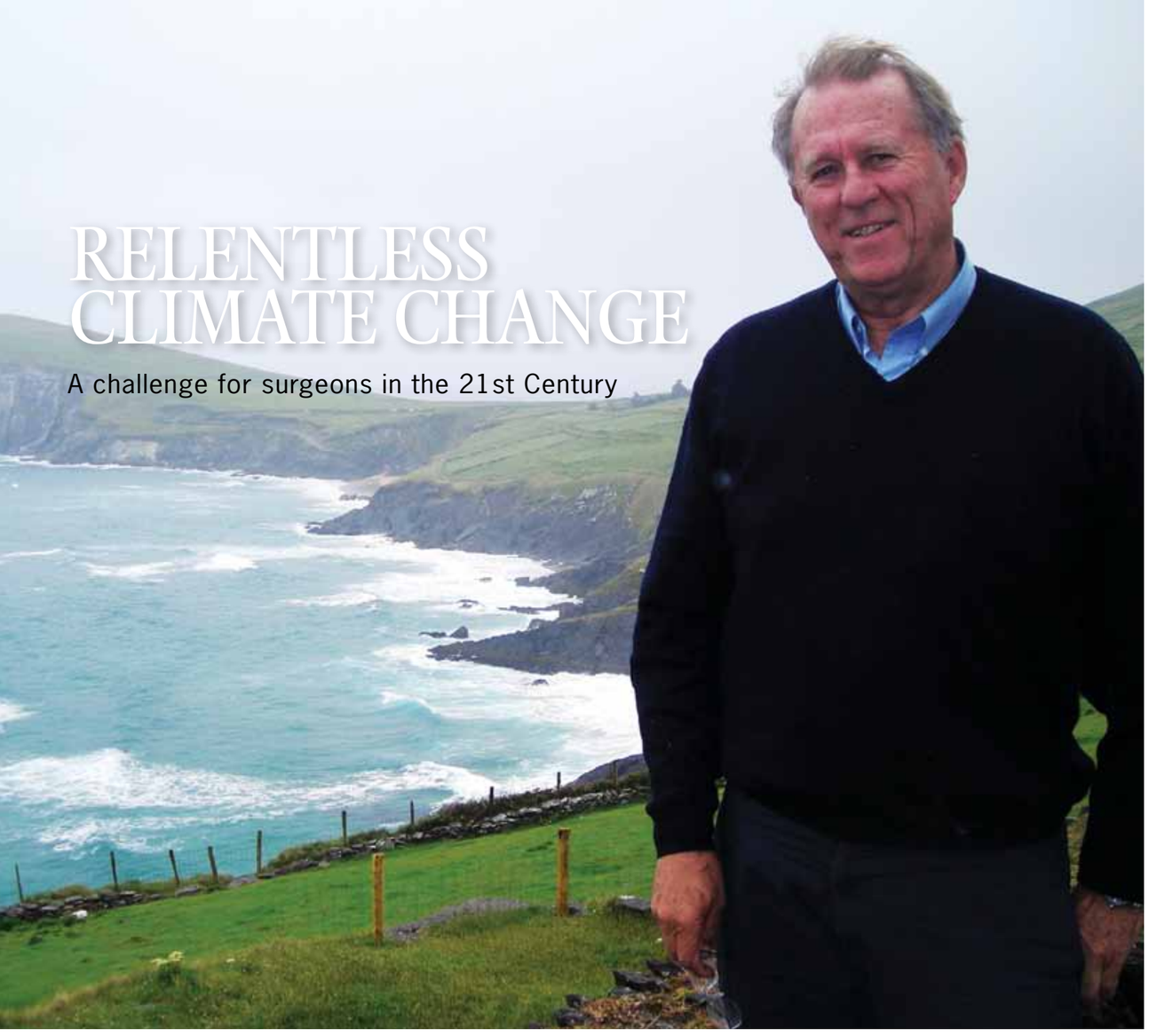
We rounded off our visit by presenting at the local medical symposium on current and future roles of surgery in pancreatic cancer.

The journey would not have been complete had our group not experienced some of the beauty, history and ambience of Sri Lanka. We managed to visit the highland tea estates of Nuwara Eliya, the ancient rock fortress of Sigiriya and taste the flavours of the renowned Kandalama. An undeniable connection was made between the group and the faculty at Peradinya.

Thanks are due to the Westmead Association and Mrs Georgette Hanna for assisting with the costs of preparing course materials. Professor Michael Hollands' advice and support was invaluable and Sri Lankan visionaries like Dr Galketiya and Head of Department Professor Lamawansa ensured the success of the project once we reached Kandy.

Many surgeons in Australia and New Zealand have Sri Lankan roots. There is real potential for cross cultural connections between our two surgical worlds.

After decades of war Sri Lanka is now at peace. Now, we, as surgeons, can make a contribution towards the evolution of surgical care and capacity in this beautiful country.



RELENTLESS CLIMATE CHANGE

A challenge for surgeons in the 21st Century

PROFESSOR KINGSLEY FAULKNER AM
CHAIR, DOCTORS FOR THE ENVIRONMENT AUSTRALIA (DEA)
WWW.DEA.ORG.AU

Surgeons have responded promptly, often with great courage, innovation, determination and energy, during times of major wars and natural disasters.

Centennial commemorations of the commencement of World War I have been held during 2014.The RACS Annual Scientific Congress (ASC) to be held in Perth from May 4 to 8, 2015, will have a major focus upon Ethics and upon Gallipoli and the development of the ANZAC tradition cementing the strong sense of linked nationhood within Australia and New Zealand.

The ASC will be an opportunity to reflect upon some of the self-sacrifice, heroism and important advances in surgical management of trauma and disease which were developed during the Great War.

When other challenges to health in a broader sense arise, the role of surgeons may not be so obvious. Surgeons have had a leadership role in times of conflict, but are not usually in the vanguard of public health leadership when the problems are not primarily surgical in nature. Major water contamination and unsanitary conditions contributing towards the outbreak of infectious diseases or lung problems such as silicosis arising from the mining industry have generally been matters addressed by other medical practitioners and civic leaders.

The ongoing disaster of asbestos is a clear example where the medical profession, mainly respiratory and general physicians, and public health professionals, took the lead. They warned the relevant commercial and political leaders of the time to cease the mining and widespread usage of this substance to prevent further long term harm. The scientific evidence was clear, but the advice was ignored for far too long. Thousands of people have died and many more will continue to do so. The costs of compensation continue to mount.

When the multiple major health consequences of tobacco usage became apparent, it was obvious that many of the malignancies, as well as cardio vascular and peripheral vascular disease problems, would involve surgical care.

Combatting powerful entrenched opposition, surgeons individually, and through organisations such as the Australian Council on Smoking and Health (ACOSH), the AMA and the RACS, have joined others to take on leadership roles in research, public education, garnering community support and eventually persuading political leaders to enact effective tobacco control legislation. Smoking rates continue to fall and Australia now leads the world in this sphere.

Next on the public health agenda

The 21st century will have some old and many new problems. Poverty, inequality, famine, conflicts, displacement of people and now terrorism on our doorstep will be amongst them. Although the process began with the onset of the industrial revolution, what is unique about this century is the issue of anthropogenic influences now resulting in dangerous climate change.

The debate about the causes and consequences of contemporary climate change has raged with great passion, but the evidence is now so powerful that only two or three percent of climate scientists still challenge the hypothesis that human activity is the major driver of this problem. The overwhelming volume and level of evidence is far in excess of that which we as surgeons rely upon for making our diagnoses of diseases and for adopting the surgical manoeuvres used to tackle them.

Rising atmospheric and oceanic CO2 levels, rising global atmospheric and oceanic average temperature levels, melting glaciers, the shrinking Arctic Ice cap and incremental sea level rises are all measurable and unequivocal. Extreme weather events are harder to predict, but the evidence for them becoming more frequent and more destructive is now compelling.

Australia is a sunburnt country already prone to droughts and floods. Climate change will make these fluctuations more frequent and more damaging. Coastal sea surges are already becoming an issue and cyclonic activity is predicted to become worse. Water supplies will be affected by decreasing rainfall and agricultural production will be at additional risk. Associated mental health problems in rural communities not uncommonly have tragic consequences. Bushfires are expected to be more frequent and more vicious. Australians need no reminding about the cost to lives and to property from such events. Insurance costs are rising and there will be many other economic consequences from climate change.

It is also predicted that diseases more associated with the tropics will become an increasing problem further south in Australia. New Zealand is less vulnerable than Australia to many of the aforementioned problems, but it will not be immune from some of them. The Pacific Island nations, which are near neighbours to both our countries, are already being affected by sea level rises, sea surges, salt water contamination and cyclonic activity.

Globally it is predicted that widespread loss of coastal land, especially in low lying nations like Bangladesh, will lead to major movements of environmental refugees with all of the humanitarian and geopolitical risks associated with their plight.

The fundamental problem is the use of fossil fuels releasing CO2 and methane emissions at a rate which the planet cannot bear. Direct pollution from coal mining and transportation and from coal-fired power stations also increase the rates of respiratory disorders, cardio-vascular problems and some cancers.

It could be argued that most of the health problems outlined above are not specifically surgical ones. Burns from bushfires, injuries sustained during cyclones and other extreme weather events, and some of the malignancies associated with pollution may require the professional care of surgeons, but many of the other problems are of a medical nature.

However, the issue is no longer one of insufficient evidence being needed before acting decisively. The evidence will continue to be sought, as science always demands, but to delay decisive action in Australia and New Zealand, along with other nations across the globe at this time, is grossly irresponsible. History will judge our generation very harshly indeed if short term personal, commercial and national self- interest remains the primary motivation and urgent and effective measures to tackle the looming crisis are not introduced very soon. Australia is not showing real evidence of appreciating the seriousness of the issue. New Zealand may be more aware.

The Lancet Commission, the British Medical Association and WHO are convinced that climate change is the most serious global threat to health of the 21st century. That view is widely accepted by an increasing number of medical and non-medical organisations and individuals across the world. It will be the young who are going to have to bear the major long term burden of inaction, but the vulnerable are already suffering across the globe.

As very responsible and influential members of the community well trained in the scientific method and used to acting decisively from a strong evidence base, individual surgeons and the College should now play more active roles. We will need to do so in collaboration with the AMA, other medical organisations and individual colleagues in helping to understand and address these problems. I urge you all to make your voices heard.

Along with economic, environmental and security considerations, the matter has now become a major health and ethical issue. It demands widespread community involvement and eventually multi-party political wisdom and will.

More than $1.2 million on offer!

Travel and Research Scholarship Opportunities for 2016

The Board of Surgical Research invites Fellows, Trainees and other eligible applicants to apply for the following Scholarships, Fellowships and Grants for 2016.

PLEASE NOTE:

- **The availability of the advertised scholarships and Fellowships is subject to funding.**
- **Successful applicants may be required to procure 25% of the value of the scholarship from their research department for some research scholarships and Fellowships.**
- **These advertised opportunities are to be used as an initial guide only. Please consult the College website (www.surgeons.org/scholarships) from 2 March 2015 for detailed information, including application forms and award policies. Ensure that you read the Important General Information Section application before applying to ensure eligibility**
- **Applications for scholarships and Fellowships below must be received by midnight ACST 27 April 2015**
- **Where applications are open to all SET Trainees, applicants to surgical training are also eligible to apply in anticipation of their acceptance into the SET Program. They must be accepted into the SET Program by 1 August in the year prior to the commencement of the scholarship in order to take up the award.**
- **The values of these awards are in $AUD unless otherwise stated.**

Research Scholarships, Fellowships and Grants

John Mitchell Crouch Fellowship

The John Mitchell Crouch Fellowship of $150,000 is awarded to an individual who in the opinion of the Council is making an outstanding contribution to the advancement of surgery, or to fundamental scientific research in this area.

The Fellowship commemorates the memory of John Mitchell Crouch, a Fellow of the College who died in 1977 at the age of 36. The Council of the Royal Australasian College of Surgeons invites applications or nominations for the above Fellowship.

Applicants must meet the following criteria:

- The applicant must be working actively in his/her field.
- The award must be used to assist continuation of this work.
- The applicant must be a Fellow of the Royal Australasian College of Surgeons who is a resident of Australia or New Zealand.
- Applicants must have obtained their College Fellowship or comparable overseas qualification within the past 15 years (2000 or later)
- The successful applicant is expected to attend the convocation ceremony at the 2016 Annual Scientific Congress (ASC) of the College for a formal presentation. The Fellowship recipient must be prepared to make a 20-25 minute oral presentation at the ASC on their research work including the contribution arising from the award.
- The successful applicant is to produce a report in the format required at the end of their Fellowship for inclusion in the John Mitchell Crouch book, which is published approximately every five years.

There is no formal application form. A new application must be made for each year of application. Applications must include the following:

- A brief statement about current research work and future plans.
- Detailed CV. Included must be a list of what they consider to be their five most important publications as well as the five most important national or international lectures they have been invited to deliver.
- Important publications must also state impact factors and the impact range for their sub-speciality. ▶

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Foundation for Surgery Senior Lecturer Fellowship

The Foundation for Surgery Senior Lecturer Fellowship is intended to provide salary support for a surgeon, early in their career, to assist them to establish themselves in an academic surgery pathway.

Applications are open to Fellows of the College who are permanent residents or citizens of Australia or New Zealand. The emphasis of the Fellowship is to be clearly focused on research and/or educational activities. Funding will be provided to individual applicants who will be employed by an academic department which has agreed to match the funding provided by the College.

Gross value of this Fellowship is **$132,000** per annum, comprising **$120,000** stipend plus $12,000 departmental maintenance. The College will fund **$66,000** and the applicant's institution will be expected to co-fund to the same amount (**$66,000**). Tenure is for up to three years.

Foundation for Surgery Tour de Cure Cancer Research Scholarship

Tour de Cure is a pre-eminent health promotion charity that raises funds for cancer research through cycling and other events. Together with the Foundation for Surgery, Tour de Cure has generously offered to fund the prestigious Foundation for Surgery Tour de Cure Cancer Research Scholarship.

Applications are open to Fellows and SET Trainees and International Medical Graduates on a pathway to Fellowship who are proposing to undertake an important cancer research project.

Gross value of this Scholarship is **$125,000** comprising **$112,500** stipend plus **$12.500** departmental maintenance. Research departments will be expected to provide the remaining **$25,000.** Tenure is for one scholarship year.

Foundation for Surgery Small Project Grant ***NEW***

This Grant is intended to support Trainees and Fellows who are undertaking or wish to undertake a small clinical or research project or who require limited funding to purchase equipment to carry out a research project. Fellows, Surgical Trainees of the College and International Medical Graduates on a pathway to Fellowship can apply. Each Grant is valued at **$10,000.** This year up to three grants may be offered. Tenure is for one scholarship year.

Surgeon Scientist Scholarship

The Surgeon Scientist Scholarship was instituted by the College to make a combined PhD/FRACS program an attractive option for surgical Trainees. Open to Fellows and SET Trainees enrolled in or intending to enrol in a PhD. Gross value **$77,000** per annum, comprising **$66,000** stipend plus **$12,000** departmental maintenance. Tenure is for up to 3.5 years.

Eric Bishop Research Scholarship

The establishment of the Eric Bishop Research Scholarship was made possible due to a donation from the late Eric Bishop, who was a Queensland pastoralist, and is open to Fellows and SET Trainees enrolled in, or intending to enrol in, a higher degree. Gross value $**66,000,** comprising **$60,000** stipend plus **$6,000** departmental maintenance. Tenure is for one scholarship year.

Fellowship in Surgical Education

The Royal Australasian College of Surgeons and Queen's University, Kingston, Ontario, Canada, are offering a joint Fellowship to fund Fellows and SET Trainees wishing to undertake a Masters in Surgical Education at the Faculty of Health Sciences, Queen's University, Canada. The successful applicant will exclusively pursue the educational activities involved in the Master's program. The Fellowship is for a period of up to two years subject to satisfactory performance. It is valued at AUD**$77,000** stipend per annum with the Queen's University providing funding for tuition and related expenses.

Foundation for Surgery Catherine Marie Enright Kelly Memorial Research Scholarship
Foundation for Surgery John Loewenthal Research Scholarship
Foundation for Surgery Reg Worcester Research Scholarship

The Catherine Marie Enright Kelly Memorial Research Scholarship arose from a bequest of the late T D Kelly, FRACS, of South Australia, and was first awarded in about 1987. The John Loewenthal Research Scholarship was established in honour of Sir John Loewenthal who served as President of the College from 1971-1974. The Reg Worcester Research Fellowship arose from a gift by the late Alan Worcester, FRACS, to memorialise his brother, Reg, a great educator, doctor and humanitarian. These scholarships are open to Fellows and SET Trainees enrolled in, or intending to enrol in, a higher degree. Gross value **$66,000**, comprising **$60,000** stipend plus **$6,000** departmental maintenance. Tenure is for one scholarship year.

Foundation for Surgery ANZ Journal of Surgery Research Scholarship
Foundation for Surgery Research Scholarship

These two scholarships are open to Fellows and SET Trainees enrolled in, or intending to enrol in, a higher degree. Gross value **$66,000**, comprising **$60,000** stipend plus **$6,000** departmental maintenance. Tenure is for one scholarship year.

Please note that from time to time new scholarships may be offered during the year and advertised on the College Website, in Surgical News and other relevant publications.

Foundation for Surgery Brendan Dooley and Gordon Trinca Trauma Research Scholarship

This scholarship was established to honour the late Mr Gordon Trinca, a trauma surgeon who was instrumental in the introduction of the Early Management of Severe Trauma Program, and to retired orthopaedic surgeon Mr Brendan Dooley who contributed greatly to the work of the College's Road Trauma Committee. It is open to Fellows, SET Trainees and Medical Scientists who are conducting a research topic relating to the prevention and treatment of trauma injuries in Australia and New Zealand. This scholarship offers a stipend of **$10,000.** Tenure is for one scholarship year.

Foundation for Surgery Louis Waller Medico-Legal Scholarship

Established to honour Professor Louis Waller's contributions to the Monash University Faculty of Law and medico-legal issues over more than 35 years, this scholarship is intended to promote and support research into the legal issues faced by surgeons. Open to Fellows, SET Trainees and Law Graduates. Applicants must be undertaking, or intending to undertake, doctoral research on the topic of medico-legal risks and the law in this area. Lay applicants must be sponsored by a Fellow of the College. Gross value **$66,000** per annum, comprising **$60,000** stipend plus **$6,000** departmental maintenance. Tenure is for up to 3.5 years.

Foundation for Surgery New Zealand Research Scholarship

Open to Fellows and SET Trainees enrolled in, or intending to enrol in, a higher degree. Applicants must be a New Zealand citizen currently residing in New Zealand. Gross value **$66,000**, comprising **$60,000** stipend plus **$6,000** departmental maintenance. Tenure is for one scholarship year.

Foundation for Surgery Peter King Research Scholarship

Established in recognition of the contributions of the late Mr Peter King to the College, particularly in the area of rural surgery, this scholarship is open to Fellows and SET Trainees enrolled in, or intending to enrol in, a higher degree. Applicants with a topic relevant to the practice of surgery outside of metropolitan areas will be given preference. Gross value **$66,000**, comprising **$60,000** stipend plus **$6,000** departmental maintenance. Tenure is for one scholarship year.

Foundation for Surgery Research Scholarship in Surgical Ethics

Open to Fellows, SET Trainees and members of the public with a special interest in ethical issues of modern surgery. Lay applicants must be sponsored by a Fellow of the College. Applicants must be enrolled in or intending to enrol in a higher degree with a topic relevant to ethical problems confronting surgery. Gross value **$66,000**, comprising **$60,000** stipend plus **$6,000** departmental maintenance. Tenure is for one scholarship year.

Foundation for Surgery Richard Jepson Research Scholarship

The late Professor Richard Jepson was the foundation Chair for Surgery at the University of Adelaide. This Scholarship has been established in his honour due to a generous donation from his wife, Dr Mary Jepson, in order to assist needy and deserving younger researchers. Open to Fellows and SET Trainees enrolled in, or intending to enrol in, a higher degree. The gross value will be **$66,000** per annum comprising **$60,000** stipend plus **$6,000** departmental maintenance. Tenure is for up to 3.5 years.

Francis & Phyllis-Mary Thornell-Shore Memorial Trust for Medical Research Scholarship

Open to Fellows and SET Trainees enrolled in, or intending to enrol in, a higher degree. Gross value **$66,000**, comprising stipend plus **$6,000** departmental maintenance. Tenure is for one scholarship year.

Lumley Surgical Research Scholarship

This scholarship is designed to enable a Trainee of the College or Fellow to spend a year undertaking research in the United Kingdom. The Fellowship is valued at **$66,000** plus a return economy airfare up to the value of **$3,000**. The Fellowship is for 12 months.

Paul Mackay Bolton Scholarship for Cancer Research

This scholarship was established by Harry Bolton in memory of his late son Paul. Professor Paul Bolton was a distinguished surgeon, teacher and researcher who died from colorectal cancer in 1978, aged 39. The applicant's research topic must focus on the prevention, causes, effects treatment and/or care of cancer. Preference may be given to applicants who are currently working in Queensland or Tasmania. Young reserachers, who are relatively early in the careers and show promise will be looked upon favourably over more senior established researchers. Preference may also be given to projects which are likely to have clinical relevance within a relatively short period of time, as well as to applicants who are enrolled in or intend to enrol in a higher degree. Gross value **$66,000,** comprising **$60,000** stipend plus **$6,000** departmental maintenance. Tenure is for up to two years.

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Roy and Marjory Edwards Research Scholarship

Roy and Marjory Edwards owned a large pastoral company in South Australia. When the property was sold and Mr Edwards passed away, the late Mrs Edwards donated income from her investments to the College. This scholarship is open to Fellows and SET Trainees enrolled in, or intending to enrol in, a post-graduate degree at a South Australian university. Gross value **$66,000** per annum, comprising **$60,000** stipend plus **$6,000** departmental maintenance. Tenure is for up to 3.5 years. Continuation each year is dependent upon satisfactory progress.

Sir Roy McCaughey Surgical Research Scholarship

This scholarship was established as a result of a bequest to the College from the late Sir Roy McCaughey. Open to Fellows and SET Trainees enrolled in or intending to enrol in a PhD. The research must be conducted in NSW. Gross value **$66,000** per annum comprising **$60,000** stipend plus **$6,000** departmental maintenance. Tenure is for up to 3.5 years.

WG Norman Research Fellowship

Open to Fellows and SET Trainees, resident in South Australia and enrolled in, or intending to enrol in a higher degree. Applicants must be resident in South Australia, with their research being conducted in South Australia and topics which have a trauma focus will be given preference. Gross value **$66,000,** comprising **$60,000** stipend plus **$6,000** departmental maintenance. Tenure is for one scholarship year.

Travel Scholarships, Fellowships and Grants

Margorie Hooper Travel Scholarship

The Margorie Hooper Travel Scholarship has been made possible through a bequest from the late Margorie Hooper of South Australia. The Scholarship is open to Trainees and Fellows of the College who reside in South Australia. The Scholarship is designed to enable the recipient to undertake postgraduate studies outside the State of South Australia, either elsewhere in Australia or overseas. It is also available for surgeons to travel overseas to learn a new surgical skill for the benefit of the surgical community of South Australia. Preference will be given to the latter. This scholarship is for 12 months. The stipend is **$65,000** and there is provision for accommodation and travel expenses upon application.

Stuart Morson Scholarship in Neurosurgery

The Stuart Morson Scholarship in Neurosurgery has been established following a generous donation by Mrs Elisabeth Morson in memory of her late husband. The Scholarship is designed to assist Neurosurgical Trainees or young Neurosurgeons within five years of obtaining their Fellowship of the College (2010 or later) to spend time overseas furthering their neurosurgical skills by undertaking research or further training. The Scholarship is also open to exceptional young surgeons who are registered to practice neurosurgery in Australia or New Zealand, but are not Fellows of the College. Overseas surgeons who wish to spend time in Australia or New Zealand to further their training and/or research in neurosurgery are also eligible to apply. Overseas applicants cannot have commenced travel prior to applying for the scholarship. The value of the Scholarship is **$30,000** and is intended to contribute to the costs of undertaking further training and/or research work in neurosurgery. This scholarship is for a minimum program duration of three months.

Hugh Johnston Travel Grant

The Hugh Johnston Travel Grant arose from a bequest of the late Eugenie Johnston in memory of her late husband, Hugh Johnston. This **$10,000** Grant is designed to assist needy and deserving Fellows and Trainees of the College to gain specialist training overseas. Applicants must not have commenced their travels prior to the closing date for applications.

Ian and Ruth Gough Surgical Education Scholarship

The Ian and Ruth Gough Surgical Education Scholarship, valued at **$10,000**, was established by Ian and Ruth Gough to encourage surgeons to become expert surgical educators. Applicants must be Fellows or Trainees of the College, with permanent residency of Australia or New Zealand. Tenure is for one scholarship year.

Morgan Travelling Fellowship

The Morgan Travelling Fellowship was formed following a series of donations made by Mr Brian Morgan. The purpose of the Fellowship is to fund a Fellow of the College to travel overseas to gain clinical experience or to conduct research for a period of approximately one year. To be eligible, the surgeon must have gained his/her Fellowship in the past five years. The scholarship is open to a Fellow from any specialty. The scholarship must be the only College funding secured by the Fellow, but the candidate is permitted to obtain alternative external funding concurrent with the Morgan Travelling Scholarship. The value of the scholarship is **$10,000** and the duration is for up to 12 months. Applicants must not have commenced travels prior to closing date for applications.

Morgan-Opie Travelling Fellowship
NEW

The Morgan-Opie Travelling Fellowship was started following a bequest from the estate of the late Dr Richard Opie, a General Surgeon. To be eligible, the surgeon must have gained his/her Fellowship in the past five years. The scholarship is open to a Fellow from any specialty. The scholarship must be the only College funding secured by the Fellow, but the candidate is permitted to obtain alternative external funding concurrent with the Morgan Travelling Scholarship. The value of the scholarship is **$10,000** and the duration is for up to 12 months. Applicants must not have commenced travels prior to closing date for applications

Murray and Unity Pheils Travel Scholarship

The Murray and Unity Pheils Travel Scholarship was established following a generous donation made by the late Professor Murray Pheils. It has a value of **$10,000** and is awarded to a SET Trainee or recent Fellow of the College to assist him/her to travel overseas to obtain further training and experience in the field of colorectal surgery. Similarly, overseas graduates wishing to obtain further training and experience in a specialist colorectal unit in Australia or New Zealand are also eligible to apply. Applicants must not have commenced their travels prior to the closing date for applications. The Scholarship is for up to 12 months.

Hugh Johnston ANZ ACS Travelling Fellowship

The Hugh Johnston ANZ Chapter American College of Surgeons Travelling Fellowship is intended to support an Australian or New Zealand Fellow of the College to attend the annual American College of Surgeons (ACS) Clinical Congress in October 2016. It forms part of a bi-lateral exchange with the ACS and is open to Fellows who have gained their College Fellowship in the past 10 years (2005 or later). Applicants are expected to have a major interest and accomplishment in basic or clinical sciences related to surgery and would preferably hold an academic appointment in Australia or New Zealand. The applicant must spend a minimum of three weeks in the United States of America. While there, they must:

- Attend and participate in the American College of Surgeons Annual Clinical Congress in 2016
- Participate in the formal convocation ceremony of that congress
- Visit at least two medical centres in North America before or after the Annual Clinical Congress to lecture and to share clinical and scientific expertise with the local surgeons.

Applicants must not have commenced their travels prior to the closing date for applications. This Fellowship is valued at **$8,000.** More information about the ACS can be found at www.facs.org

John Buckingham Travelling Scholarship

This scholarship was established to encourage international exchange of information concerning surgical science, practice and education, as well as to establish professional and academic collaborations and friendships amongst Trainees. It is open to current SET Trainees to enable them to attend the annual American College of Surgeons (ACS) Clinical Congress in 2016. This scholarship is valued at **$4,000.** More information about the ACS can be found at www.facs.org

Additional information and links at www.surgeons.org/scholarships
Scholarship Program Coordinator, Mrs Sue Pleass,
Royal Australasian College of Surgeons,
199 Ward Street, North Adelaide SA 5006.
Tel: +61 8 8219 0900; Fax: +61 8 8219 0999;
Email: scholarships@surgeons.org .
Applications close midnight CST Monday 27 April 2015.

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Australia leads world in cancer care

AMY KIMBER

Cancer Australia CEO Helen Zorbas credits the use of a strong evidence base and collaboration as key success factors

Last year 123,920 Australians were diagnosed with cancer, more than double the number of cases 30 years ago. In the eighties, less than half those patients would survive five years past their diagnosis, but now two out of three patients do.

The increasing size and age of the population will inevitably lead to more cancer diagnoses in Australia. Population based screening programs, technological and treatment advances have also resulted in Australians generally having better survival prospects compared with other countries and regions.

The Concord-2 study assessed survival rates for ten cancers in adults and childhood leukaemia in more than 25 million cancer patients in 67 countries. It found that the five-year net survival in Australia was high for all eleven cancers, but particularly for cancers of the colon, rectum, breast and prostate.

Across the spectrum of cancers, there are significant differences in survival rates and outcomes. Some cancers are easier to diagnose and prevent early on. Australia has led the way on recommendations to improve early detection of cervical cancer. For others, such as pancreatic cancer, there are no obvious signs or symptoms and the disease is often advanced at diagnosis.

Cancer Australia CEO Helen Zorbas says that while the overall survival rates improve year on year, there are still variations in outcomes depending on the type of cancer, where people live, their socioeconomic status and whether they are of Aboriginal or Torres Strait Islander descent.

Professor Zorbas recently participated in the World Cancer Congress and Leaders' Summit in Melbourne in December. The events bring together key experts and decision makers from around the world and this year focused on the economic case for investing in cancer preventions, treatment and control, to address the growing cancer challenge.

"It was a privilege to be among so many influential leaders in the one place, and to have it held in Australia for the first time," Professor Zorbas said.

"It was also important to hear the focus the international community has on cancer. Cancer has a substantial impact on countries all around the world. It isn't just a 'first world' disease, in fact two thirds of all new cancer cases are predicted to occur in less developed regions of the world."

Looking forward there are a number of challenges for the heath sector. The increasing number of people affected by cancer and living longer with the disease means they are also likely to have a number of other co-morbidities.

"Cancer treatment is becoming increasingly complex, so having a system which supports an evidence-based approach and pathways of care is really fundamental to delivering optimal outcomes," Professor Zorbas said.

"Cancer treatments and technology are progressing rapidly, so how do we best evaluate and translate that into improved screening, diagnosis and treatment?

"In Australia, cancer treatment is delivered in both public and private system and more than half of cancer surgery now occurs in the private system. We need to ensure that people don't fall between the cracks, and that the same standards of care apply in all systems.

"With Australia's annual health care spending at nearly $150b, we need to ensure the best possible use of existing and future resources."

How can surgeons play a role?

Surgery is often the primary treatment for many cancers, and surgeons are involved in the ongoing care of patients. The increasing complexity of cancer care requires multi-disciplinary input and shared knowledge to deliver optimal care.

Professor Zorbas emphasises the collaborative partnership approach among the cancer control community. She says she was 'humbled' by the recognition of receiving an Order of Australia for her service to the public health sector.

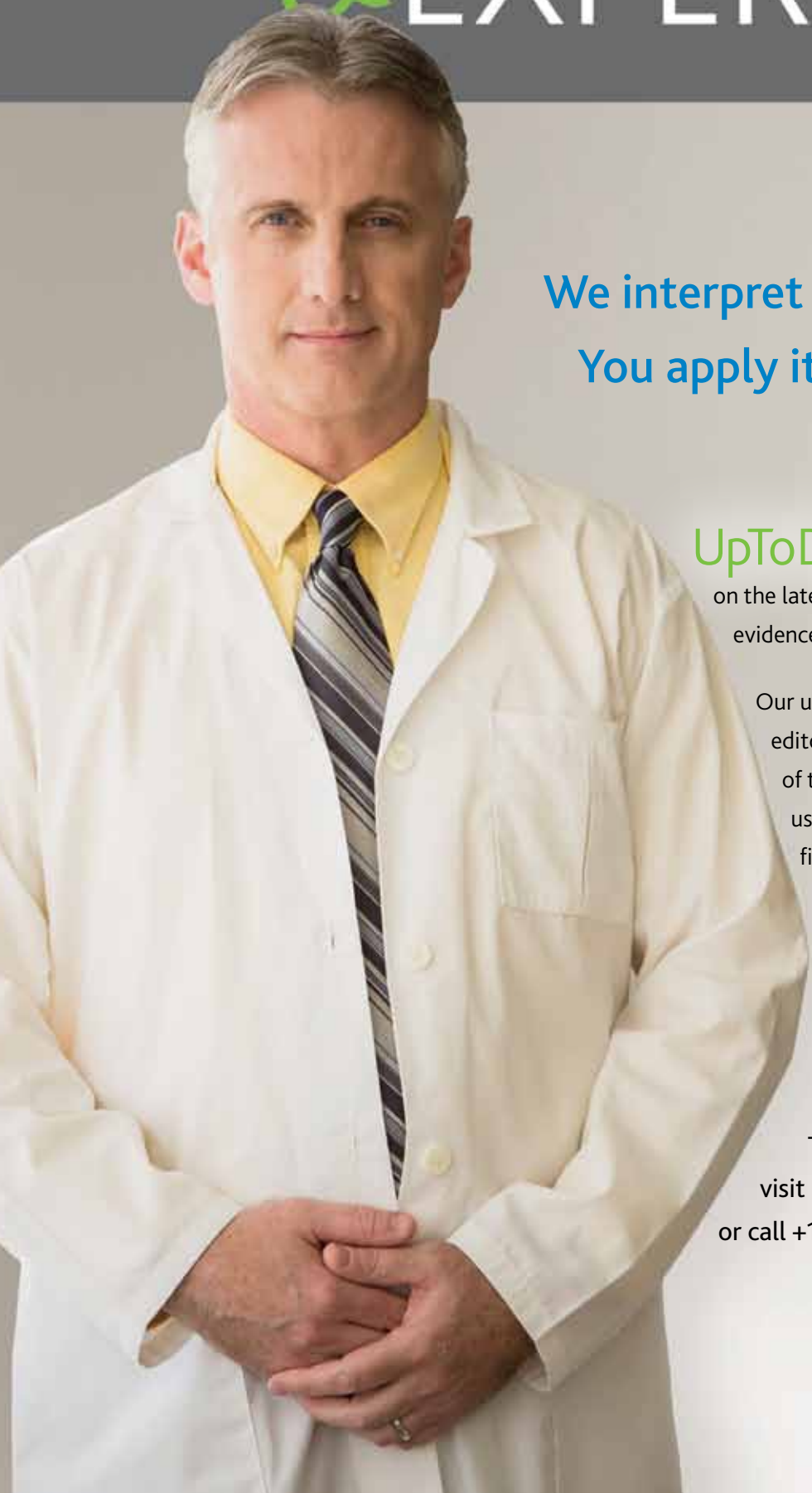
"That kind of recognition isn't possible without a whole team of people. I've been extraordinarily lucky to work with people who are passionate, inspiring and committed," Professor Zorbas said.

"People involved in cancer care exemplify this to a very high degree, and it is a strong driving factor to keep doing what I'm doing. It's a privilege to work with such people and see the improved outcomes.

"There is a high level of collegiality in the surgical profession, and in my experience surgeons have a genuine interest in best practice care for patients. If we can all come to the table with that approach, that's a great enabler."

Cancer accounts for about three in ten deaths in Australia. It is important surgeons continue to contribute to the cancer agenda, by advising on best practice in cancer care, research and investment.

EVIDENCE & EXPERIENCE



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