ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 16 NO 7 AUGUST 2015

WOMEN IN SURGERY

How far have we come? p18

COLLEGE ELECTIONS

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40 YEAR ANNIVERSARY

The Australian Cranio-Facial Unit 1975-2015

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The Section of Academic Surgery presents...

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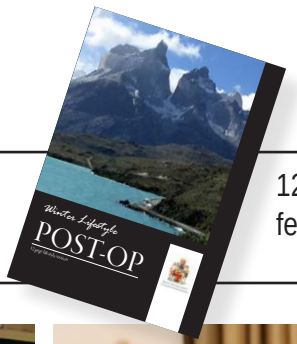

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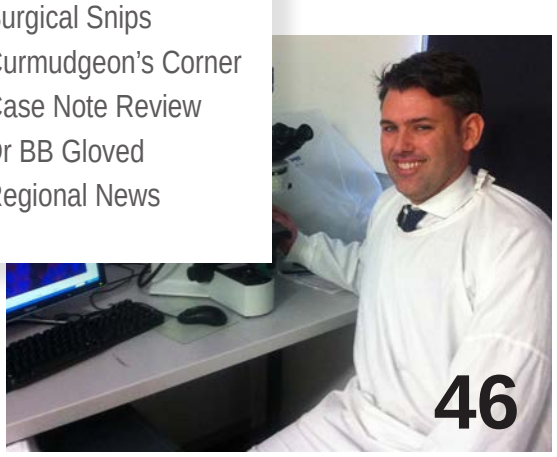

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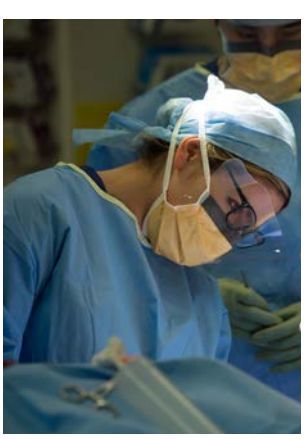

ON THE COVER:
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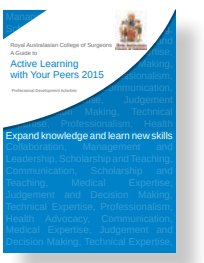
PROFESSIONAL DEVELOPMENT

WORKSHOPS & ACTIVITIES

Online registration form is available now (login required).
Inside 'Active Learning with Your Peers 2015' booklet are professional development activities enabling you to acquire new skills and knowledge and reflect on how to apply them in today's dynamic world.



Academy Forum 2015

12 November – Sydney

The Academy of Surgical Educators is proud to present the 2015 Academy Forum to be held on Thursday 12 November at the Amora Hotel in Sydney from 6.30pm – 10.00pm.

This year's topic will focus on People, Process and Performance: Human Factors. The evening will be convened by Associate Professor Stephen Tobin, Dean of Education and Professor Spencer Beasley, Chair, Academy of Surgical Educators and will feature preeminent thought leaders discussing progressive topics in medical education. Attendees will enjoy a three course meal and drinks whilst enjoying three quality presentations on Human factors.

Presenters at this year's forum include:

- Mr Phillip Truskett, FRACS - Chair, Training in Professional Skills (TIPS);
- Professor Francis Lannigan, FRACS - Chair, Non-Technical Skills for Surgeons (NOTSS) and Safer Australian Surgical Teamwork (SAST); and
- Mr Werner Naef - Director, Kalher Communications Oceania

The Academy Forum is an annual event for all interested and will include the presentation of the Academy Reward and Recognition Awards. The presentations will be recorded and made available to all Academy members on the learning management system. Academy members are $100 and non-members are $125. To register online refer to the Academy website page. For further information please contact **ase@surgeons.org.**

Communication Skills for Cancer Clinicians: Discussing Death and Dying

5 September - 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. In this four hour workshop, you'll work in a safe learning environment with a trained actor to replicate 'real-life' conversations.

Clinical Decision Making

8 September - Christchurch

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

Supervisors and Trainers for SET (SAT SET)

10 September – Canberra

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.

Acute Neurotrauma

24 September – Cairns

Surgeons will gain the skills to deal with cases of neurotrauma in the rural setting, where the urgency of a case or difficulties in transporting a patient demand rapid surgically-applied relief of pressure on the brain. Importantly, the workshop teaches these skills using equipment typically available in smaller hospitals, including the Hudson Brace. Participants will develop

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

workshop

a capacity to accurately evaluate whether on-the-spot treatment, using the procedures learned, is required. They will also learn to perform, through demonstration and practice on human cadaveric material: a burr-hole procedure with Hudson Brace, craniectomy, craniotomy and tap-shunt procedure.

Foundation Skills for Surgical Educators

16 October – Hobart

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 standardsexpected 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.

September – November 2015

ACT
10 September
Supervisors and Trainers for SET, Canberra
2 December
Clinical Decision Making, Canberra

NSW
16 November
Foundation Skills for Surgical Educators, Sydney
17 November
Supervisors and Trainers for SET, Sydney

NZ
8 September
Clinical Decision Making, Christchurch
9 October
Keeping Trainees on Track, Auckland
16-17 October
Critical Literature Evaluation and Reasearch (CLEAR) Course for Consultants, Sydney
17 October
Foundational Skills for Surgical Educators

QLD
24 September
Acute Neurotrauma, Cairns
29 September
AMA Impairment Guidelines 5th Edition: Difficult Cases, Brisbane
23 October
Finance for Surgeons, Brisbane
31 October
Keeping Trainees on Track, Adelaide

TAS
16 October
Foundation Skills for Surgical Educators , Hobart

VIC
5 September
Communication Skills for Cancer Clinicians: Discussing Death and Dying, Melbourne
9 October
Clinical Leadership Group Forum, "Surgery and the frail older person", Melbourne
31 October
Communication Skills for Cancer Clinicians: Breaking Bad News, Melbourne
26 November
Keeping Trainees on Track, Melbourne

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

DAVID WATTERS
President

24 MONTHS

Kennett's call to action

There is something confronting about Jeff Kennett AC, Chairman of 'beyondblue' warning Councillors of RACS and other senior members of the medical community that they 'have 24 months'. I was not working in the Victorian Health Sector during the 'Kennett era' (1994-99) but I have heard many stories of how he drove dynamic change, confronting difficult, if not impossible issues, from being in a 'parlous state' to being 'on the move'. I was even moved to feel just a smidgeon of sympathy for the demands that Kennett must have placed on Hawthorn footballers when he was President of that Premiership winning club. But they have been rewarded by responding and have enjoyed much success.

On this occasion Kennett was at the College, and focused on issues of Doctor's Mental Health in his role as Chairman of *beyondblue*. In numerous surveys, doctors are reported as having substantially higher rates of psychological distress and contemplation of suicide compared to both the Australian population and other Australian professionals. Add to these rates alcohol or substance use and abuse, workplace and life stressors, high levels of burnout, barriers to seeking treatment, lack of support and inflexible, unsympathetic attitudes towards doctors with mental health conditions. Today the medical and surgical workplace is recognised to be unnecessarily mentally toxic. The evidence suggests this is so much of a problem that Jeff Kennett is undertaking a vigorous lobbying campaign across Australia to demand action. And if our action does not achieve measurable improvements inside 24 months, then he has said he will start challenging politicians of all types to impose solutions. And as he warned us that these would not necessarily be pretty, nor what the profession would chose for itself.

The occasion of Kennett's confronting call to action was the formal launch of the RACS Support Program provided through Converge International. This program offers up to four free, confidential and independently provided counselling sessions per year for any Fellow, Trainee or IMG.

Converge International Managing Director Richard Kasperczyk, RACS President David Watters and Chairman of beyondblue Jeff Kennett.

It can be accessed by contacting the RACS Support Program (RACSSP) on 1300 687 327 (Australia) or 0800 666 367 (New Zealand).

I am pleased to report there has already been highly positive feedback across Australia and New Zealand about the provision of this confidential counselling service. The RACS Council is now developing further plans to support wellbeing. As an example we are developing links with Doctors Health Programs that are available through a variety of models in each region. Galvanised again by the 24 month challenge, we need to make a concerted effort that will include provision of information sessions, peer support activities and educational modules. These need to be incorporated not only into our training programs but also be made available for fellows' continuing professional development (CPD). Much needs to be done. The clock is ticking.

The RACS Support Program is deliberately profiled as providing counselling and support across all mental health issues. It is obviously invaluable for the distress that arises out of discrimination, bullying and sexual harassment. The RACS Council spent much time discussing the breadth of this issue in June. Importantly the Council formally received training in handling this. RACS has accepted it has substantial responsibilities in this space. Indeed as leaders within our hospitals and in the health sector, we have both responsibilities and expectations. Two of the most common themes being discussed with me relate to the endemic nature of this problem in the workplace and also how as an educational body

we can provide critical and challenging feedback to trainees when it is required, without it being perceived as bullying.

Those whom we train and supervise deserve and need to be given feedback that is honest and directed at their best interests. In this regard we need to consider the fundamental requirement of engaging with learners in ways that are likely to result in discernible change. That is what learning and teaching do focus on. Our comments for feedback need to be judged on their positive effect on learning and performance – we will need to monitor the tone and loudness of our voice or the pointedness of our comments. Importantly we need to establish a dialogue so that high quality work as well as professional behaviours can be identified by our Trainees and even our colleagues. We also must not duck the difficult conversations just as we have learned not to duck them with our patients. The next 24 months will offer many opportunities for improvement and learning.

So how do surgeons as leaders within the health sector create a workplace that is respectful, espousing appropriate professional behaviour that is mentally healthy for ourselves, our Trainees and other health workers? How do we ensure that there is support for those who need it? How do we correct and 'push back' at behaviour that is not positive and needs to be corrected? How can surgeons become positive role models so that we can influence, and change the culture of the organisations and the health sector in which we work? These questions need to be answered and Fellows need to develop more awareness of what may be perceived as discrimination, bullying or harassment. Then we need to be equipped with the skills to address these issues and those involved when they occur.

Jeff Kennett AC

The work of our Expert Advisory Group around discrimination, bullying and sexual harassment is helping to identify the options that we need to implement.

The prevalence and what can be learned from the actual stories will be revealed in the next few months. There will be an options paper following the 22 June issues paper, due in late August or September:

www.surgeons.org/media/21828366/eag-issues-paper-v7-2206-update.pdf

The next 24 months will pass quickly. Jeff Kennett and *beyondblue* are watching us. We are surgeons. With accurate data we can reflect on our performance. We are committed to continuously improving. Despite time being short, I believe we will deliver.

Julie Mundy, Marianne Vonau, Joanna Flynn and John Quinn

ELECTION TO COLLEGE COUNCIL

An opportunity exists to influence future directions of the College by becoming a Councillor

GRAEME CAMPBELL
Vice President

Why Nominate?

- The College is owned by its members.
- Members elect the 25 Fellows who form the Council that governs it.
- Sixteen Councillors are elected by the Fellowship at large.
- Nine Councillors are elected by Fellows in their own surgical Specialty.

Any Fellow in good standing may nominate for election. This year we will have at least four vacancies due to Councillors having served their maximum term of nine years.

Please consider whether you would like to become a Councillor and I would particularly encourage female Fellows to stand for election.

What does becoming a Councillor mean? It means becoming a director of a medium sized business with all the duties, responsibilities and rights that entails.

If that sounds daunting, let me assure you, you will be well supported. The College through the Australian Institute of Company Directors (AICD) provides annual training for all Councillors. The College also funds Councillors to undertake the intensive, highly regarded Company Directors course run by the AICD.

Besides formal governance training, Councillors receive induction and become members of a team with a strong culture of collegiality. There is enormous scope to contribute to all aspects of surgery and the life of a surgeon through the various committees. There is also enormous opportunity for personal growth and satisfaction.

Council sets the strategic direction of the College, its goals, business plans and budgets and monitors their implementation. In doing so it works closely with the CEO and senior staff. Our common goal is the sustainability of the College as a nationally and internationally well regarded professional organisation. Consistent with that goal is the maintenance of our accreditation with the Australian Medical Council, and the Medical Council of New Zealand to train and recertify surgeons, our ISO 9001 registration, legal compliance and financial stability.

As part of any good organisation's commitment to continuous improvement, Council itself undergoes an annual appraisal and implements whatever change such review indicates.

On Friday 21 August you will receive an email with a link to where you may nominate for election to Council.

I strongly encourage you to consider becoming involved in what has been for me one of the most challenging and rewarding activities of my life.

Why Vote?

Firstly, the authority of Council is enhanced by a strong mandate from the Fellowship.

Secondly, the authority of the College as a professional body is enhanced by evidence of strong engagement by its membership.

Thirdly, Councillors who are elected by a good proportion of the Fellowship feel a commensurate obligation to keep faith with their electors by doing the best job they can on Council and to be held accountable.

Not all Fellows may wish to or be in a position to stand for election, but by voting every Fellow demonstrates their engagement with the organisation which after appropriate training and assessment, bestowed their means of livelihood – the Diploma of Fellowship.

The College aspires to champion surgical standards and to this end actively promotes CPD, lifelong learning, mortality and morbidity audit and a Code of Conduct. On

our patients' and our Fellows' behalf we advocate on lifestyle issues such as the harm that can arise from excessive alcohol intake, the effects of smoking or obesity on health and operative outcomes and the risks in medical tourism.

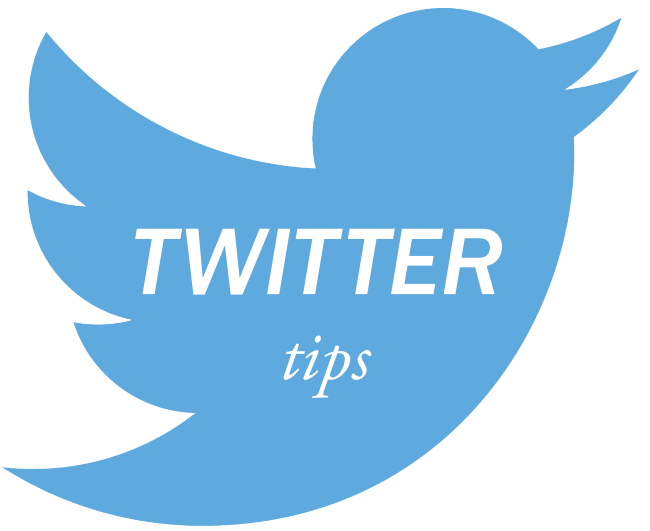
We ensure that surgeons have a voice and an influence on government agencies charged with monitoring performance in the health system. A motivated and wise Council is a pre-requisite to being effective in these and many other areas of College activity.

Candidates provide photographs and information about themselves. The Fellows supporting their candidacy make brief statements about why they think they would make good Councillors. These statements are intended to assist you in voting, whether or not you know the candidates.

As the College embarks on ever more rigorous advocacy on behalf of our members, it needs the best talent making decisions at the Council table. We need your vote.

On Friday 18 September you will receive an email with a link to the ballot to elect Fellows to vacancies on the College Council.

Please take the time to read about the candidates and submit your vote. Electronic voting makes the process even quicker and easier.



1. If you want to take a conversation offline, you can send someone a direct message. You can do this by clicking on the cog symbol on the top right hand side of a Twitter profile, and selecting 'Send Direct Message' from the drop down menu.
2. Make yourself easy to recognise by including a headshot of yourself in your profile picture.
3. Make the most of your Twitter bio by including your occupation or what interests you. This will encourage like-minded people to connect with you.
4. If you are new to Twitter and not sure of who to follow, look at the profile of a respected person or professional body in your field. Click on the 'Following' button on their profile, and you will see all the people and organisations that they find interesting.
5. Want to change the look of your profile? Simply click the 'Edit Profile' button in the top right hand corner of your profile page. This will let you change your header and profile image, your description and profile theme.

@RACSurgeons

Spray-on skin for Taiwan burn victims

Taiwan victims of a blaze from a water park will benefit from the revolutionary spray-on skin developed by surgeon Dr Fiona Wood.

The company commercializing the spray sent representatives to Taiwan in a humanitarian mission.

Dr Wood hoped that in commercializing the product would allow for funding of further research.

"But the primary driver was to make the technology available across the world and to see people benefiting across the world," Dr Wood said.
The Australian, 8 July

Rename obesity surgery

The College has called for more public funding for bariatric surgery in a position paper put out in June.

The call comes as evidence mounts to rename the surgery to 'diabetes surgery' to avoid stigma for patients.

Professor John Dixon says that only one in 300 people who are eligible for the surgery receive it each year.

He says that perceptions, even in the medical profession, of obesity as self-inflicted may contribute to the low uptake.
Medical Observer, 7 July

SA system not up to scratch

SA Health's planned Enterprise Patient Administration System (EPAS) could compromise patient safety, according to the College SA Regional Committee.

The system has been the source of complaints from medical staff where it has been introduced, and the SA Regional Chair Dr Sonja Latzel says still have a 'long way to go'.

"The feedback we are consistently hearing from our Fellows about EPAS is that it is still a very difficult system to use," Dr Latzel said.

Adelaide Advertiser, 3 July

World-best cardiac surgery

Cardiothoracic surgeon Paul Jansz will be one of the first in Australia to implant an artificial heart the size of a small battery.

The surgery is one of only a handful in the word part of an important trial of the Ventricular Assist Device (VAD).

Dr Jansz says St Vincent's Sydney is on the cutting edge of new technology for the area.

"We have so many great people working towards new and innovative treatments for patients with heart disease and I am really just part of a great team," Dr Jansz said.

Sunday Telegraph, 5 July

FOCUS ON THE EAG

Working with the EAG to make a difference

The fourth woman to be appointed as a judge of the High Court of New Zealand, the first woman President of the New Zealand Law Society and a Commander of the Order of the British Empire (CBE), Dame Judith Potter (DNZM) has given a lifetime of service to the law, equality and justice.

Now semi-retired in New Zealand, Dame Judith still retains judicial appointments as a Judge on the High Court of the Cook Islands and as Judge of the Court of Appeal in both the Pitcairn Islands and Tuvalu.

A community representative on the RACS New Zealand National Board since 2012, Dame Judith this year also agreed to serve on the College's Expert Advisory Group (EAG) established to investigate claims of bullying, discrimination and harassment within surgery.

Before becoming a judge, Dame Judith was one of the few women in New Zealand to specialise in commercial law and following graduation from the University of Auckland went on to become a senior partner at law firm Kensington Swan.

In the years following, she became the Director of the Electricity Corporation of New Zealand, Director of the New Zealand Guardian Trust Company, Chair of the Broadcasting Standards Authority and a member of the New Zealand Securities Commission.

Appointed to the High Court in 1997 where she served until 2012, Dame Judith presided over a number of important cases including a 2009 murder trial in which the jury rejected the defence that the accused had been provoked by the victim.

This case eventually led to the abolition of the defence of provocation in New Zealand.

Speaking about her career and time on the bench, Dame Judith said that when a secondary school teacher suggested that her logical mind would suit a career in the law, the comment was met with laughter.

"It was un-thought of at the time for a girl to study law but that comment actually did get me thinking and with the encouragement of my parents, when I entered university in 1960 I entered law," she said.

"I found commercial law to be of great interest which meant that I was in an even smaller minority, as a woman working in the law, than if I had chosen to specialise in, say, family law.

"When I became the President of the New Zealand Law Society I was the first woman President in the 120 years of its existence and presided over a council of 28 men.

Dame Judith Potter (DNZM)

"I accepted this as the way things were then but I worked to encourage more young women to consider a profession in the law while taking up those opportunities that came my way on the advice of colleagues.

"So although I was in a very conspicuous minority in many of the positions I have held, I got tremendous support from the New Zealand legal profession.

"I think I was seen as a catalyst for change and welcomed onto boards, into directorships and eventually onto the bench as a Judge of the High Court."

Despite this support, however, Dame Judith still laments the disparity in the number of women in senior judicial positions in New Zealand.

Though she is not a supporter of quotas, she does believe that those in positions of appointing senior judicial officers should be "highly mindful" of gender balance.

"It was un-thought of at the time for a girl to study law but that comment actually did get me thinking"

"There are only about 26 per cent of women in senior positions across all legal jurisdictions in New Zealand and that is obviously too few," Dame Judith said.

"There are now many extremely able women appearing before the courts in both criminal and commercial jurisdictions which suggests that there remains a disparity when it comes to making senior judicial appointments.

"I think quite often it comes down to the simple fact that there is comfort in appointing someone like yourself – which I call cloning – and those in the position to make senior appointments must attempt to create a better balance within the judiciary which reflects the 50-50 gender balance in society."

Dame Judith received her CBE for services to the legal profession in 1994 and became a Dame Companion of the New Zealand Order of Merit in 2013 for her service as a Judge of the High Court of New Zealand.

She said her career had been driven by both a fascination in the law and a passionate commitment to justice, including the need for gender equality within the profession and society.

Reflective of this commitment is her membership of the International Association of Women Judges, the New Zealand Association of Women Judges and the Auckland Women Lawyers Association.

"I have always been committed to the concept of justice in all its forms and I think we are incredibly fortunate in countries like Australia and New Zealand where we have respect for the judiciary and the rule of law and the separation of powers," Dame Judith said.

"Over the years of my involvement in the law, I have also become incredibly passionate about the importance of women participating in the law at all levels so that the law can evolve to best reflect the female experience in society just as it does the male experience."

Dame Judith said she had agreed to be a member of the College's EAG because she was familiar with a professional culture that attracted, included and retained fewer women than men.

She said she had been impressed with the College's willingness to tackle such complex issues as bullying and harassment and the thoroughness of the research now being conducted.

"This is very important work and I commend the College for having the courage to take this on," she said.

"I think it is very important to deal with this in medicine, as it is within the law, because neither profession can afford to lose the intellectual resources of women.

"All the talent, intelligence, skills and energy of women are needed in surgery just as they are in the legal profession, particularly because both are complex professional fields which have significant impacts on society.

"I would also say that this issue does not just relate to women because I believe some men are discouraged by a culture that is perceived as antagonistic.

"I am pleased to work with the College on these issues and hope the work of the EAG will make a real and important difference."

With Karen Murphy

YOUNGER FELLOWS FORUM

Our 2015 focus on *The Healthy and Wise Surgeon*

2015 younger Fellows

MARY THEOPHILUS
Convenor, 2015 Younger Fellows Forum

After months of planning and a storm of emails, the tentative delegates for the 2015 Younger Fellow Forum (YFF) met at Perth airport and headed off on a picturesque three hour trip to Bunker Bay in the Margaret River Region of West Australia. Despite many being weary from prior travel, most used the journey to make new acquaintances and catch up with old ones. Spirits were high and the pre-planned icebreaker games were not required.

We were fortunate enough to have three out of our four international delegates with us on the bus: Amir Ghaferi from the Leadership Exchange, USA; Kraikope Jarupaiboon from the College of Thailand; and Yolanda Ho-Yan Chan from the College of Hong Kong. Our fourth international delegate, Peter Driscoll from the Royal College of Surgeons, Edinburgh, had braved the roos and travelled down the night before.

The Younger Fellows Forum is an annual event held for nominated Younger Fellows to retreat and discuss College issues relevant to them. The opportunity to escape to relaxed environs far from the stresses of surgical reality and meet peers from different specialties from all over Australia and New Zealand is refreshing, and offers a unique insight into shared values.

Furthermore, its worth lies in the format that allows the College President and two councillors to join in the program, enabling delegates to put forward their ideas directly to those who run the College. It also provides access to first-hand knowledge of the inner workings of the College, and a different perspective of its function.

Most of the delegates initially had no idea what to expect, but were pleasantly surprised when the program kicked off on day one with an emotive introduction from each delegate with an insight into their lives and the burning issues they wanted to tackle. The day progressed with a welcome and overview by outgoing Younger Fellows Committee Chair Richard Martin, followed by an inspiring talk from Associate Professor Phil Carsons, one of the invited Councillors. This really opened the floor for sharing of experiences and mutual understanding.

The theme for this year was *The Healthy and Wise Surgeon*, focusing on maintaining the psychological and physical health of the surgical workforce in an ever-demanding workplace. The forum included sub-themes of *The Surgeon in Crisis*, *The Holistic Surgeon, When Are We Ready?* and the very current *Bullying and Harassment*. Councillor and incoming College President Professor David Watters addressed the Fellows at dinner, speaking about the value of Fellowship and communication with the College. This dovetailed with an earlier talk by one of the invited speakers, Kris Boergrave, giving the group a brief on media and pitfalls in the realm of surgery.

The second day started with a focus on the inner self with a yoga session. While yoga may not be in everyone's comfort zone, the sunshine and chance to get out of the confines of the seminar room left everyone invigorated and ready for the later team building session, which was both entertaining and competitive (what do you expect from a group of surgeons?). A full day of mental and physical activities and challenges had everyone unwinding and reinforcing friendships over dinner at Palmer's Winery in nearby scenic Dunsborough.

Following an address from the outgoing President Professor Michael Grigg, the final day saw all the discussion and exchanges of ideas from the weekend coalesce into a think-tank session where the most important work of the forum takes place. This is the formulating of recommendations from the Younger Fellows' Forum to be formally presented to Council at their October meeting.

The weekend concluded with presentations to our international delegates and invited Councillors who had all contributed to the weekend's efforts. The convenors and administrative support were thanked, friends were made from acquaintances, and folk bid each other adieu during a light lunch before departing on the long journey home with the warm feeling of comraderie and the excitement of change in the air. Paraphrasing a former Councillors words: "if you want to effect change or are unhappy about how things run in the College, then don't whinge but participate and come forward! So start by nominating for the next YFF in Brisbane!"

More information about the Younger Fellows forum can be found at:

SHARING EXPERTISE

Making the most of our RACS Visitors

SPENCER BEASLEY
Chair, Academy of Surgical Educators

RICHARD HANNEY
Chair, Section of Academic Surgeons

Fellows, Trainees, International Medical Graduates and interested medical students cannot always attend the College's Annual Scientific Congress, so usually do not benefit directly from the expertise and wisdom that the RACS visitors offer. But fortunately, many international section visitors generously provide their time to other scientific and education activities in Australasia either before or after the meeting, and in this way more Fellows can gain access to them.

An example of the willingness of College invited guests to contribute to additional conferences and meetings was evident in Christchurch the week before the Perth meeting. Professors Carla Pugh and Anthony Gallagher (who contributed much to the Surgical Education sessions) agreed to be the key speakers in the one day Medical Simulation Symposium held in Christchurch the week before the ASC.

"We were incredibly fortunate to have such high calibre and engaging speakers at this conference. Their talks were outstanding and undoubtedly will have a longterm influence on those who attended. They were gracious in accepting a significant workload, and added real value to the day" said Spencer Beasley, co-convenor of the conference with MaryLeigh Moore from the University of Otago.

Though initial estimates anticipated 25 registrants, well over 100 attendees from both New Zealand and Australia enjoyed and benefitted from their input. In addition, several RACS Fellows and local speakers also presented work, including Ian Civil (former President), Richard Hanney (Academic Section Chair) and Richard Perry (Councillor). The meeting was designed to be provocative and challenging, and deliberately focused on the more difficult and controversial aspects of simulation in medical training such as its role in training and assessment, its current and future limitations, importance of developing validated metrics, issues around fidelity, its use for non-technical skills, measurement of its effects in reducing risk in patient safety, and resource implications. It generated some lively discussion and went over very well with those attending.

Christchurch continues to recover following the devastating earthquakes that killed 185 people four years ago. It is now in the rebuilding phase, assisted by thousands of Australian tradesmen. The Symposium, held as far from Perth as Australasia allows, provided an opportunity for entire multidisciplinary teams to benefit from the expertise and generosity of our two College visitors. With an increased focus on quality and safety of practice following the Bristol Inquiry in the UK, and the 1999 Institute of Medicine report in the US, future surgical training and practice will become increasingly dependent on simulation and Technology Enhanced Learning. The Australian and New Zealand College of Anaesthetists have recently mandated simulation assessment for both trainee qualification and consultant Continuing Professional Development recertification.

After the meeting, Spencer Beasley and Richard Hanney hosted the two RACS visitors at an informal retreat in North Canterbury. The snow-capped mountains contrasted by deep blue seas provided the inspirational backdrop for the four to bounce ideas off each other and refine their thoughts in a very conducive environment, even if the walk along the cliff tops of the Kaikoura Peninsula was somewhat bracing. The real value of this type of additional engagement of invited visitors to the ASC is the friendships that ensue, and the networking that is established.

It would seem that all Fellows and societies should be encouraged to avail themselves of the great opportunities that our overseas guests provide to an audience greater than that of the ASC alone, and not be hesitant to invite them to participate in other events in distant cities during their time in this part of the world.

Tony Gallagher and Carla Pugh

DIFFICULT CONVERSATIONS

New Zealand perspectives on life, death and choosing wisely

RANDALL MORTON
Chair, NZ Board

DAVE ADAMS
Deputy Chair, NZ Board

On the subject of death, the British philosopher A. C. Grayling observed that "we hide from death, and we hide death from us, until the last moment". Discussions about end of life choices, whether they be with our family, our friends, or our patients, are often very difficult to have. Nonetheless, these discussions are important as they can empower individuals with autonomy in situations where their decision making capacity is otherwise diminished.

In New Zealand, the debate around end of life choices has recently come back into the public spotlight, owing no small part to the High Court case of Seales v Attorney-General. In this case, Lecretia Seales, a Wellington based lawyer, was dying from a brain tumour and was thought to only have a few weeks left to live. Ms Seales sought a declaration that her doctor would be protected from prosecution should the doctor assist her in taking her own life. If her doctor was not permitted to assist her, she argued, then this would be a breach of her right not to be subjected to torture or cruel treatment.

Lecretia Seales' was ultimately unsuccessful in receiving the declaration that she sought, and passed away peacefully on 5 June 2015, the day that the judgement was delivered. The Judge, although sympathetic to Ms Seales' situation, felt that to allow her doctor to assist with her death would be much too large a departure from the current law and that it was the legislature's responsibility to instigate any such changes. The case garnered a significant amount of public attention, with strong support surfacing on both sides of the debate. Since this decision, the New Zealand Health Select Committee has indicated that they will be investigating the possibility of voluntary euthanasia further. We understand the Victorian Government is doing the same.

The debate around euthanasia is highly polarising, and no doubt there are proponents both for and against its legalisation within the fellowship. It is likely that the College will be asked to comment on this in the near future, and to this end a position paper is currently being developed. While the issue of euthanasia requires careful, respectful and compassionate consideration, discussion around the choices at the end of one's life should not just be limited to this one area. With the public's attention currently focused on the end of life, now is a good opportunity to promote discussion on the other pertinent issues including advanced care directives and surgery performed in the last six months of life.

Advanced care directives (ACD) are a tool that RACS strongly encourages patients and carers to develop prior to surgery. ACDs allow patients to express their beliefs, values and goals, and can be an invaluable aid to surgeons, patients and carers when deciding how to proceed in a crisis. Their utility is also not just restricted to terminal patients or those nearing the end of their lives. ACDs can benefit all patients regardless of whether their health is deteriorating or not.

Of course, ACDs do have their limitations; not all eventualities can be predicted or discussed with a patient. On occasion, an ACD may also conflict with the care required for a successful outcome after surgery, such as where a patient has chosen not to undergo intubation and ventilation. Faced with the reality of surgery, some patient's may change their minds as to the level of care they are willing to receive. It is important that these discussions with the patient are ongoing wherever possible and ACDs are modified to best reflect a patient's wishes at that point in time. Similar discussions may be required with a patient's enduring power of attorney when this is appropriate.

"Choosing Wisely" is an overseas initiative that aims to advance dialogues on avoiding wasteful or unnecessary medical tests, treatments and procedures. The New Zealand Annual Scientific Meeting, which is being held this month in Queenstown, follows a similar theme, titled: "Choosing Wisely – I can but should I?" It is expected that there will be robust discussion at this meeting.

In some cases, surgical intervention will be appropriate for critically ill and high risk patients. There will be cases however, where surgical intervention is futile, of a low value or not wanted by the patient. Whether this is the case may not always be clear, and can be dependent on the goals and expectations of the patient. These can be difficult conversations to have with the patient and their family, a difficulty that may be compounded if there is disagreement, between care givers or among the family, as to the benefits of an intervention, or to its cultural acceptability.

For Lecretia Seales, it was important that her illness did not rob her of her autonomy, dignity or respect. Although what she was arguing for was outside the realms of the law, these principles are no less relevant to every patient. It is therefore important that we, as surgeons, counsel our patients and provide them with the best possible information so that they may make the informed choices which best reflect their goals and values.

RACS Support Program

The College recognises that Trainees, Fellows and International Medical Graduates may face stressful situations on a daily basis. Coping with the demands of a busy profession, maintaining skills and knowledge and balancing family and personal commitments can be difficult.

The College has partnered with Converge International to provide confidential support to surgeons. This can be for any personal or work related matter. Converge counsellors are experienced in working with individuals in the medical profession.

- Support is confidential and private
- Four sessions per calendar year are offered (funded by the College)
- Assistance can be provided face to face, via telephone or online
- Services are available throughout Australia and New Zealand

How to contact Converge International:

- Telephone 1300 687 327 in Australia or 0800 666 367 in New Zealand
- Email eap@convergeintl.com.au
- Identify yourself as a Fellow, Trainee or IMG of RACS
- Appointments are available from 8:30am to 6:00pm Mon-Fri (excluding public holiday)
- 24/7 Emergency telephone counselling is available.

Converge international

WOMEN IN SURGICAL TRAINING

How far have we come, and why do women go?

RUTH MITCHELL
RACSTA Support and Advocacy

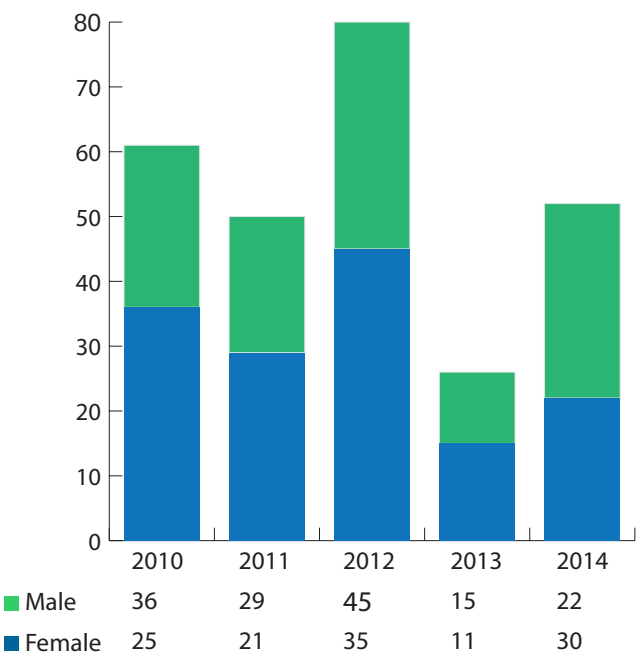
In the current environment there is a heightened awareness of issues around bullying, harassment, and sexual harassment. Discrimination and inequity are being discussed in the mainstream media, and extensively on social media, and at the moment the surgical profession is in the spotlight. I am frequently asked what it is like being a woman in surgical training, and I am mindful that every surgical Trainee has a different experience. I have become concerned about ways in which women experience training that are not just different, but detrimental.

Medical schools compared to SET programs and the surgical workforce

In 2013, 52 per cent of domestic medical students were female in Australia and New Zealand. Most medical schools have trained more women than men for at least a decade, and yet only 9 per cent of practising surgeons in Australia and New Zealand are women. It takes at least a decade to get from undifferentiated medical graduate to fully formed consultant surgeon, but still, where did all the women go? Women are under represented in surgical training, in every field except paediatric surgery. In 2014 only 28 per cent of Trainees were women, and this reflects the proportion of women applying to training.

For a range of reasons, women are not entering training at the same rate as men. My own suspicion for many years has been that small, hard earned gains in female selection are being countered by women leaving training without obtaining FRACS. In fact, when Trainee attrition is examined by gender, it becomes clear that women are over-represented in those leaving training, and make up almost half those leaving.

Figure 1: Trainee Attrition by Gender



Each year there are around 1250-1300 people who are RACS Trainees. The actual number of women and men withdrawing from training is small, for instance in 2012, 22 women and 15 men withdrew from training, 13 women and 20 men were dismissed. However, women are significantly over-represented in those leaving training, both for withdrawal and for dismissal reasons. The odds ratio (OR) of withdrawing if a Trainee is a woman is 2.5. The OR for being dismissed is 1.7.

Figure 1 shows the number of Trainees who left training in each year for whatever reason. A small number of those who leave re-enter training in the same or another specialty. So why do people leave training? Broadly speaking, Trainees either withdraw from training or are dismissed for failing early examinations within the specified timeframes. , Unsatisfactory clinical performance, or disciplinary reasons, are rare (around one per cent).

Information from RACSTA surveys

Some clues into what is happening for women in training arise from the results of the Royal Australasian College of Surgeons Trainee Association (RACSTA) end of term survey. This survey, which had 235 responses for the most recent term, tells us that just over a quarter of Trainees would be

interested in part-time training. In contrast, only 1per cent of Trainees surveyed are actually working part time, and this seems to be a significant mismatch. Is flexible training an important part of making surgical training more equitable? Would flexibility around parental leave, or the availability of part-time work while actively parenting, make surgery a more attractive career and make it easier for women to stay in training? The Royal Australian and New Zealand College of Obstetricians and Gynaecologists boasts 80per cent female Trainees, and has had more women than men in training since 1998. Their astonishing success in attracting women has at times been attributed to the flexibility they offer parents – Trainee programs are counted in weeks, any year except first year can be part-time, and up to two years parental leave is possible during training. Is flexibility what matters most to these women? Or is it their passion for women's health as a vocation? In our own college, paediatric surgery, with 57 per cent women in training, isn't especially flexible – lots and lots of moving and a whopping seven years for training do not sound like a lifestyle choice. A desire for a flexible workplace is clearly not the only factor driving women's choices.

Opinion about surgical culture

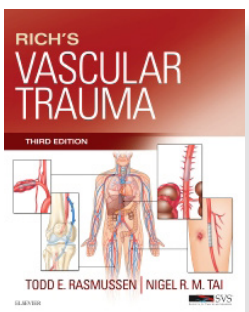
It is my view that there are major cultural issues making surgery a different experience for women and men. Not only do women in surgery spend more time explaining their role – "no, I'm not the nurse, I'm the doctor who did your operation" – but I believe that bullying, harassment, and certainly sexual harassment, are things that are experienced in a gendered manner. While we await the outcome of the survey being conducted at the behest of the Expert Advisory Group on discrimination, bullying and sexual harassment, we have some insights from our own RACSTA survey. In the last 6-month term 10 female, and 20 male Trainees reported experiences bullying and harassment. Women are consistently over-represented in those reporting bullying and harassment, and when we speak to Trainees, we learn of systemic, cultural issues undermining their progress towards autonomous surgical practice

Looking forward to the future

So here we are in the spotlight, and the community is watching. How we respond to the question of what surgical training is like for women, and the depth and sincerity of our introspection on the vexed issues of discrimination, sexual harassment and bullying will determine our future as a profession. When I'm asked, I can honestly say I love being a neurosurgery registrar, and for the most part, I've been supported and encouraged by the men and women around me. I'm looking forward to a time when that is the case for all Trainees, and I think that is possible.

NEW RESOURCES

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



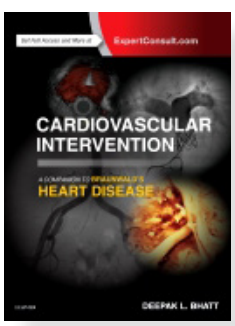
Rich's Vascular Trauma 3rd ed. 2015

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

Rich's Vascular Trauma draws on civilian and military authorities from around the world. These experts have come together to author chapters arranged in the following sections: Background, Diagnosis and Early Management, Definitive Management, and Hot Topics in Vascular Injury and Management. To allow for a diverse viewpoint the editors have embraced chapters from authors with a range of backgrounds including prehospital care, emergency medicine, trauma systems, and intensive care, as well as general, trauma, vascular, orthopedic, and plastic surgery. It is the editors' hope that this edition, as a whole, will not only provide important information for those seeking specific solutions but will also prove compelling reading in areas bordering on the fringes of one's traditional practice.

This third edition adds an International Perspectives section to its already impressive archive of recognized authors and chapters. Co-editors Rasmussen and Tai have reached out and have secured exclusive contributions from military and civilian leaders in vascular trauma from around the globe.

Cardiovascular Intervention: A Companion to Braunwald's Heart Disease 1st ed. 2015



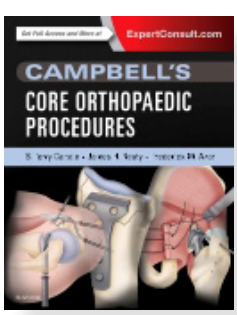
Available from Clinical Key in the library's e-resources.

The author, Deepak L. Bhatt, is Executive Director of Interventional Cardiovascular Programs Brigham and Women's Hospital Heart and Vascular Center and Professor of Medicine at Harvard Medical School.

This text focuses primarily on coronary interventions; it also describes interventions in valvular heart disease, congenital heart disease, advanced heart failure, as well as diseases of various systemic arterial beds and of the aorta. The author brings a wealth of personal experience to this task. As a practicing interventional cardiologist, the clinical problems that are discussed in this book are faced on a daily basis. He is also an experienced clinical trialist, which provides him with the ability to assess the validity of the myriad studies published in this field as well.

Dr. Bhatt has assembled a group of talented, experienced authors to prepare Cardiovascular Intervention. The book is well illustrated and contains 431 figures and 116 tables that summariSe an enormous amount of material.

This text is aimed at trainees and practitioners in this field, as well as to radiologists, cardiovascular surgeons and general cardiologists who interact frequently with interventional cardiologists.



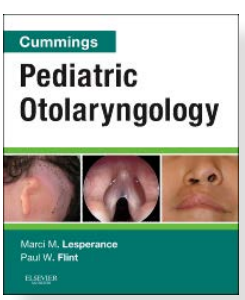
Campbell's Core Orthopaedic Procedures 1st ed. 2015

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

The purpose of this text is to describe the "core" procedures from Campbell's Operative Orthopaedics. These include some of the most frequently used

procedures at the clinic, as well as by orthopaedic surgeons worldwide. It picks what are considered to be the top 100 procedures without regard to specialiSation or complexity. These procedures are described in no certain order, but generally follow the outline in Campbell's Operative Orthopaedics, edition 12.

The text is intended for orthopaedic residents and fellows and orthopaedic generalists and specialists. It is meant to be a source that is easily accessible in print, online, or via downloadable applications so that the user can find information about a specific procedure at the moment of need. For that reason, only detailed information about the surgical technique itself is included, and indications, contraindications, outcomes, complications, and alternate treatments are not provided.



Cummings Pediatric Otolaryngology 1st ed. 2015

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

Recent years have seen great changes in pediatric otolaryngology. It has been said that pediatric otolaryngology encompasses one third simple problems in healthy children, one third simple problems in children with comorbidities, and one third tertiary clinical problems occurring in healthy and medically complex children.

Treatment advances have greatly improved survival for many childhood conditions such as early prematurity, cancer, and congenital heart disease, to name only a few. This text is focused on the latter two categories to assist the practicing otolaryngologist in keeping up to date on these essential topics.

Reflecting the growing emphasis on multidisciplinary care of the complex pediatric otolaryngology patient, several chapters feature authors from multiple disciplines, including diagnosis and management of tracheal anomalies and tracheal stenosis, gastroesophageal reflux and laryngeal disease, aspiration and swallowing disorders, and pediatric head and neck malignancies.

This book also features a chapter on pediatric infectious disease, describing a practical approach for common clinical problems, as well as evaluation and management of the infant airway.

The chapter on pediatric obstructive sleep apnea is complemented by a chapter on pediatric sleep disorders to address the otolaryngologist's growing need to understand sleep disorders other than obstructive sleep apnea.

Please contact library staff on **+61 3 9249 1271** or at library@surgeons.org for more information or assistance with accessing online resources

DESERT SURGEON

Alice Springs Surgeon Ollapallil Jacob recognised for his unique skill

General and Trauma Surgeon Dr Ollapallil Jacob became an inaugural recipient of the College's Indigenous Health Medal earlier this year in recognition for 15 years of dedicated service working to improve the health and welfare of members of the Indigenous communities of Central Australia.

Trained in India under a multi-specialty program including General Surgery, Plastic and Reconstructive Surgery, Paediatric Surgery and Head and Neck Oncology Surgery, Dr Jacob has been described as one of Australia and New Zealand's most experienced General and Trauma Surgeons.

Having spent the bulk of his working life treating the poor and disadvantaged in India and Papua New Guinea, Dr Jacob arrived in Alice Springs in 2000 to take up the position as consultant surgeon at Alice Springs Hospital. Since then he has engaged closely with members of the Aboriginal and Torres Strait Islander communities of the region and now has extensive experience in severe acute pancreatitis, trauma, dog bites, vascular access for dialysis and diabetic soft tissue infections.

He is a passionate advocate for paediatric middle ear disease treatment and prevention and his research interests include dog bit injuries, stab injuries, single-occupant vehicle roll-over accidents and Acute Pancreatitis.

Recently, his lobbying and research prompted authorities to undertake a cull of the camp dogs that had become a significant danger to Indigenous Alice Springs residents.

Despite his heavy surgical workload, teaching commitments and research, Dr Jacob has presented many community and medical lectures on Indigenous Health issues in the Alice Springs region, has been an invited speaker to a number of the College's Annual Scientific Congresses and is a member of the RACS' Indigenous Health Committee.

Speaking to *Surgical News*, Dr Jacob said he felt privileged to work at Alice Springs Hospital, which covers a region of one million square kilometres and treats a unique patient caseload mix of Indigenous, white and tourist patients.

He said he had been encouraged to apply for the position of Surgical Director by former RACS President Bruce Barraclough when he was working in PNG and was delighted when he was accepted even though the surgical work was vastly different.

Dr Jacob (far right) with colleagues in Alice Springs

"I first moved to PNG in 1986 and worked in Mount Hagen for two years and then Port Moresby for 13 years as a General Surgeon and senior lecturer of the University of PNG," Dr Jacob said.

"Most of my work there involved treating patients with congenital abnormalities like cleft lip and palate, advanced head and neck cancers and surgical problems caused by TB like constrictive pericarditis along with a large number of trauma patients.

"Those were very satisfying years as a surgical specialist and we also started an advanced training program for Head and Neck Surgery so that there were two PNG national surgeons who could continue that work when I left.

"I learnt a great deal there, particularly when I first arrived in Mount Hagen and was tricked by the Medical Superintendent of the time who told me that all Post Mortems were done by surgeons.

"I performed about 100 while I was there and looking back I feel grateful for the chance to develop a deep understanding of the mechanisms of trauma especially penetrating wounds and gunshot wounds.

"The patient mix in Alice Springs, however, was vastly different to the illnesses and injuries I treated in PNG and I had to modify my work to provide the best for our patients.

"In this unique hospital, we have a very large number of end stage renal failure patients, acute pancreatitis, gall bladder disease and trauma patients. Central Australia has the highest incidence acute pancreatitis in the world.

"...Alice Springs is a very good hospital with excellent teams, we are now consistently treating patients ahead of government-mandated waiting times and it is a privilege to work here."

"Not many people may know that Alice Springs Hospital has the largest single standing dialysis unit in the Southern Hemisphere which brings in a huge amount of work for the surgeons.

"When I arrived the waiting lists were enormous and the number of patients entering dialysis with a fistula was very low.

"Gradually and steadily we reduced the waiting lists and out of 330 patients now on Haemodialysis 85 per cent have native fistulas.

"Alice Springs is a very good hospital with excellent teams, we are now consistently treating patients ahead of government-mandated waiting times and it is a privilege to work here."

Dr Jacob said that 80 per cent of the surgical patients treated at the hospital were Indigenous people from Alice Springs and remote communities, most of whom were suffering the physical effects of poverty, disadvantage and social alienation.

He said that while treating women and children with traumatic injuries from domestic and interpersonal violence was always difficult, he greatly enjoyed working with his Indigenous patients.

"They have a wonderful sense of humour, great intelligence and a deep understanding and love of nature," he said.

"It takes time to develop a trusting relationship with Aboriginal and Torres Strait Islander people but I have been here a long time now and they know me well."

Dr Jacob said hospital teams were now delivering and extending outreach services including setting up dialysis centres in outlying centres and sending out travelling clinics so that Indigenous people with chronic diseases did not have to undertake the arduous journey into Alice Springs for monitoring and treatment.

In an ideal world, he said, he would like the Indigenous health workers undertaking the outreach work to come from the communities they serve.

Such a program could be based on the model of the "barefoot doctor", which originated in China and involved providing basic medical education to members of rural and remote communities that did not have the populations or facilities to support trained doctors.

"The main issues that continue to confront Indigenous people of central Australia are unemployment, a lack of self-esteem and deficiencies in the fundamental factors required for physical, mental health and social connectivity," Dr Jacob said.

"We have to ensure that remote communities have food security especially for children because maintaining health is always cheaper than expensive drugs later on.

"As Nelson Mandela said: 'The most powerful weapon that can change the world is education'.

"I believe that job-oriented modified educational pathways need to be introduced to take into account the unique circumstances of their unique culture.

"Indigenous people are especially skilful in certain fields like sports, mechanics, tourism and land management but our Indigenous liaison officers at Alice Springs Hospital also show they are very gifted in the health arena.

"While much is being done in the cities and regional centres to attracted Indigenous students into medicine, I also think that a great deal could be achieved if we developed a shorter health diploma designed for students who have completed secondary school.

"This training would give young Indigenous people the skills to monitor and care for people in remote communities with illnesses such as diabetes and hypertension and it would allow patients to be cared for by people who spoke their own language.

"I think this would open up a new employment stream for the people of central Australia while improving health outcomes."

Dr Jacob is the father of three children, all of whom have entered medicine. He travels back to India most years to visit the country of his childhood, Kerala, which he described as a place of extraordinary natural beauty.

He said he was humbled to have been selected to receive the Indigenous Health Medal.

"I don't know if I deserve it but I think of it as recognition for the excellent team work done by the medical, nursing and allied health staff at Alice Springs Hospital," he said.

With Karen Murphy

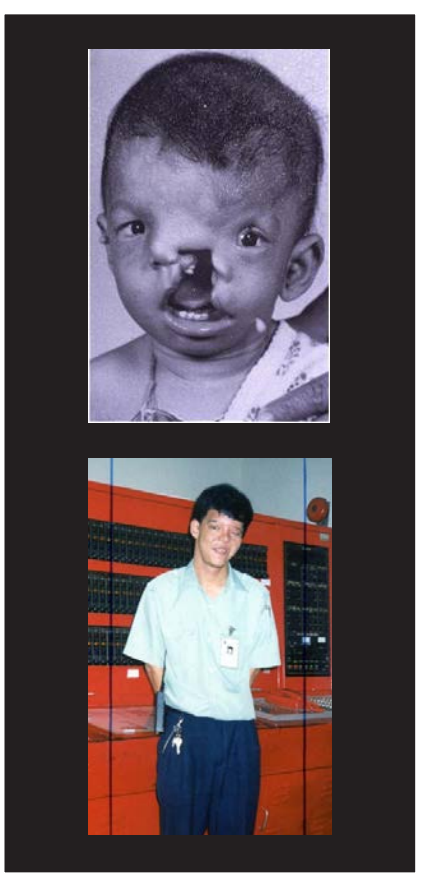
40 YEAR ANNIVERSARY

The Australian Craniofacial Unit 1975-2015

DAVID DAVID
South Australian Fellow

This stand-alone Craniofacial Unit has been operating for 40 years as a multi-disciplinary, patient centred, national and international organisation for the management of severe Craniomaxillofacial deformity.

In the early 1970s a group of surgeons and other health professionals in Adelaide banded together to implement the principles laid down by the French surgeon, Paul Tessier for the management of severe craniofacial deformity. The stimulus was the absence of any adequate treatment for these problems in the region. Initially patients were referred from around the country by word of mouth, mostly from plastic surgeons and neurosurgeons.



An Indonesian patient managed over a 25 year period now married with a family and employed as a manager

The management programs, and particularly the surgical interventions, were at that time, difficult, however successful outcomes brought the group to the attention of the then State Premier, Mr Don Dunstan, who was impressed by the concept of a patient centred solution where highly skilled professionals who had ambitions to work in a co-operative way and wished to establish a more formal unit.

Professionals from Plastic Surgery, Neurosurgery, Oral & Maxillofacial Surgery, Ophthalmology and all of the principal Dental specialities, Anaesthesia, Speech Pathology and Neuropsychology were incorporated into a "stand-alone" Craniofacial Unit, not under the formal banner of any of the silos of specialist surgery.

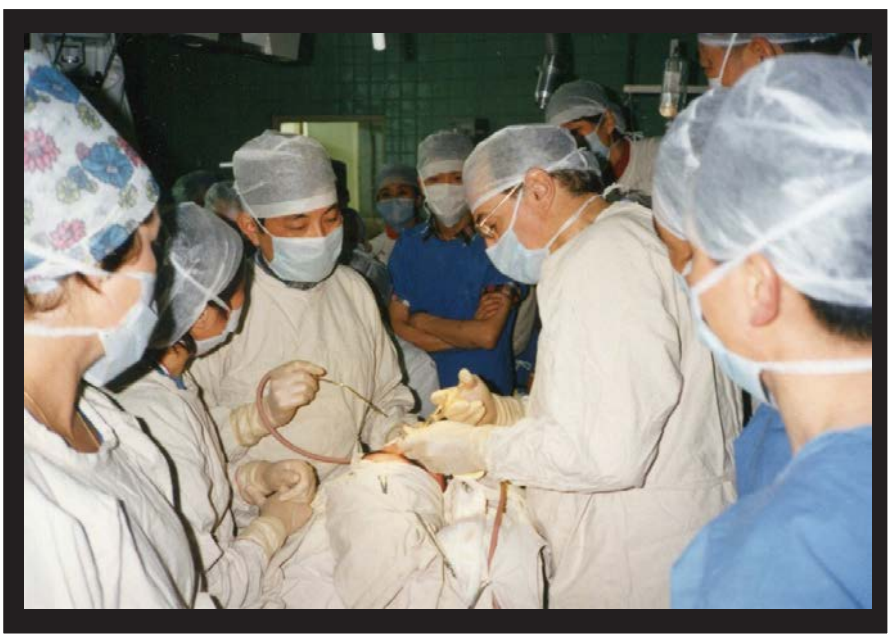
This concept fitted into the vision that the premier had for the state of South Australia and Australia at large and he formalised the then South-Australian Craniofacial Unit, facilitated the necessary adjustments to the standard employment processes and barriers between hospitals and sought to establish relationships with our near neighbours in South East Asia to partner with them in providing health care to these very complex conditions.

The delivery of healthcare to the craniofacially deformed was considered to be a new discipline and a new department was structured to focus on a multi-disciplinary, patient care extending from birth to maturity. The South Australian Craniofacial Unit became well established, and as a result of the inflow of work from Australasia and South-East Asia and the success of this system, a significant number of medical experts were attracted from around the country and overseas and patients were referred from far and wide, fulfilling the necessary case load laid down by the Founder of Craniofacial Surgery, Paul Tessier, when he said that a Unit treating major deformity needed to serve "at least 15-20 million people".

In the early 1980s due to the generosity of an Australia wide campaign undertaken by the Apex Clubs of Australia, which raised nearly $1 million, the Australian Craniomaxillofacial Foundation was formed. and acts to this day as a support and charitable arm of the now Australian Craniofacial Unit.

At the same time as the Foundation was formed, the State Minister of Health, together with the Premier gave a specific undertaking to support the research of the Unit and an amount of money was made available to establish a Research Unit which was initially headed by Professor Tasman Brown, Anthropologist and Professor of Dentistry at the University of Adelaide and today is headed by Professor Peter Anderson. Outreach clinics were established in Malaysia, Indonesia, Thailand and Hong Kong, Auckland and Christchurch. From the outset the South Australian Government facilitated the treatment of patients from neighbouring countries who were unable to afford this care on a pro bono basis.

In 1988, at the Combined State and Federal Health Ministers Conference, following the initiatives of the then Minister of Health in South Australia, the South Australian Craniofacial



The first craniofacial surgical demonstrations at the 9th Peoples Hospital Shanghai

Unit was designated as a Centre of Excellence and at that time the name was changed to the Australian Craniofacial Unit (ACFU). Since then the activity has continued to grow and increase with development of patient care systems, teaching, and research and outreach services.

Clinical Service

Over the Past 40 years in excess of over 15,000 patients have benefitted from some form of management from the Australian Craniofacial Unit, either within Australia or abroad. The core business has always been managing the more severe abnormalities as a result of craniosynostosis syndromes, rare craniofacial clefts, and severe transcranial traumas, benign and malignant tumours of the orbit and base of skull and other rarer anomalies.

Taking advantage of the centralised nature of the service, the Unit has been able to accumulate experience in many of the rare and complex deformities such as Crouzon syndrome, Apert syndrome, and the hypertelorism and orbital dystopias emanating from the rare craniofacial clefts and sincipital encepholoceles. The result is that protocols have been able to be rationally composed and patient management programs implemented in a scientific fashion.

After forty years of patient management and collection of long term data, outcomes have been measured and protocols developed for these rare and complex deformities.

Research

The ACFU researches contributed to the development of 3D imaging published volumetric studies and 3D positional changes following growth and treatment in various craniofacial abnormalities.

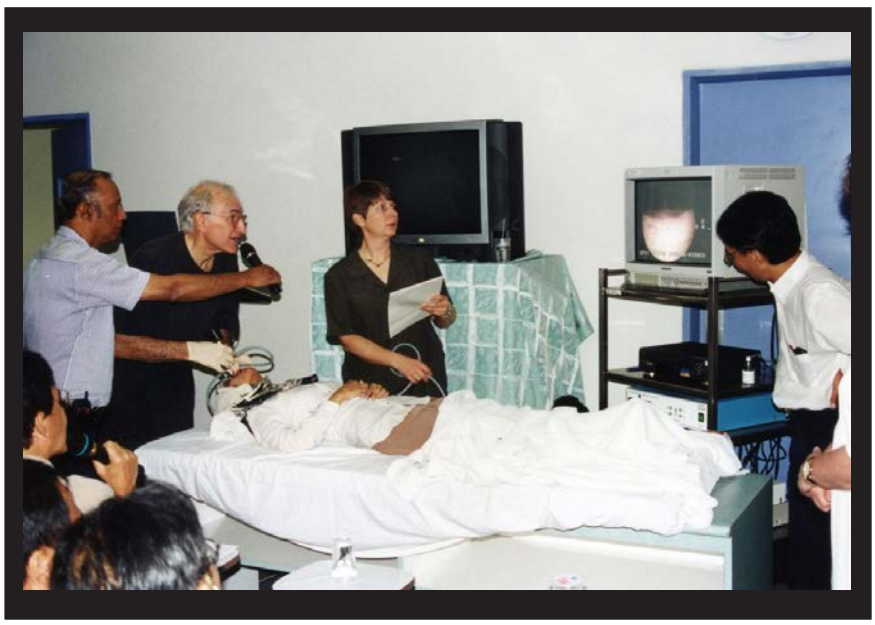
Having established tools of measurement for the phenotype, the emphasis is now on studying the genetics of craniofacial anomalies. Major contributions having been made to the discovery of the genes for Apert syndrome and other related anomalies in conjunction with UK, American, and Australian colleagues. During this time the Unit has contributed to multiple textbooks, been the progenitors of four and had some hundreds of papers published in reviewed journals as well as many hundreds of presentations at meetings held by Colleges of Surgeons and other learned societies.

Alexander Downer AC opening the second biennial meeting of the Asian Pacific Association of Craniofacial Surgeons in Adelaide

Teaching

From the very beginning this aspect of the ACFU's activities held a prominent place with teaching involving all of the relevant participating disciplines, in the first instance with a view to producing a cohesive organisation. It wasn't long before Outreach Services were providing teaching in Indonesia, Malaysia, Thailand, Hong Kong and other countries with a view to developing the infrastructure necessary for service in those areas. Within Australia the ACFU has contributed to undergraduate teaching within the University of Adelaide for medical and dental students, post graduate teaching has involved pre fellowship training for plastic surgeons, neurosurgeons and oral and maxillofacial surgeons.

Because there was a clear need for advanced training in the highly developed aspects of craniofacial surgery, the ACFU has teamed with Macquarie University and established a Master's degree in Advanced and Craniofacial Surgery that has been accredited by the Royal Australasian College of Surgeons and to date four candidates have participated in that programme. .



The ACFU team demonstrating Nasendoscopy for cleft palate patients in Surabaya

During that forty years that the ACFU has assisted in and supported the development of units in Kuwait, Oman, Bangkok, Hong Kong, Singapore, Malaysia and Shanghai.

Professional Support Networks

The critical decision of the South Australian Department of Health and the Premier of the day to create a stand-alone craniofacial unit well within a decade of the discipline being introduced by Paul Tessier, the acknowledged founder of the concept, enabled full participation of the Australian group in forming the International Society of Craniofacial Surgeons and the Head of the ACFU is a founding member of that organisation. Subsequently he was the Founding President of the Asian Pacific Craniofacial Association and then the Australian & New Zealand Cranio Maxillofacial Society. These networks have similar constitutions and are linked with the regional and national societies throughout the world.

The ACFU team in the early 2000 era with photos of some of the former Trainees

The Future

A formalised multi-disciplinary Craniofacial Unit which operates on very clear principles:

1. Be multidisciplinary
2. Be protocol driven
3. Measure outcomes
4. Manage the patient through the whole of development or through the whole disease process
5. Have a research arm
6. Be involved in teaching

THE QUEEN'S ENGLISH

Curmudgeons do not like being corrected!

BY PROFESSOR GRUMPY

There is one thing that really annoys me and it is being wrong. This month I have received a letter from a fellow curmudgeon surgeon in rural New South Wales. It reads:

"I greatly enjoy reading your column in the Surgical News and share many of your curmudgeonly complaints.

As a true curmudgeon I must take exception to your misuse, I believe, of the term the Queen's English.

My understanding is that the term should be the King's English, it having nothing to do with whoever sits on the throne on the moment but to the King James Version of the Bible and the English used therein. Keep up the good work."

It would seem that I was wrong about the usage of the term "Queen's English". However we curmudgeons are not willingly corrected. It is not that we are arrogant know-alls it just is that rarely are we wrong (Mrs. Grumpy wanted me to insert "it is just that we rarely admit to being wrong" but it is my article, not hers).

We don't admit defeat readily so I consulted my old friend, Prof Wikipedia. The King James version of the Bible was translated between 1604 and 1611 at the direction of King James I. I also found out that the first use of the term "King's English" was in "The Arte of Retorique" written by Thomas Wilson in 1550 or possibly 1553. On page 162 he laments the use of Italienated English by far travelled gentlemen who should be charged with "counterfeiting the King's English". Dare I point out to a fellow curmudgeon that the first usage is before the good

scholars started on their work for King James? That puts paid to the NSW argument. Now Edward VI was on the throne at that time so the use of the term the King's English is fair enough.

Unfortunately for my argument that it should be either Queen's or King's English depending on the gender of the reigning monarch is given a bit of a knock as the next notable use is in Shakespeare's "The Merry Wives of Windsor" which was written during the reign of Queen Elizabeth I. Mistress Quickly says "..here will be an old abusing of God's patience and the king's English". We curmudgeons are not easily put off so may I suggest that William S was confused or that the play is set at an earlier era when a King reigned.

We curmudgeons have considerable respect for each other – it is almost a brotherly affection, a bit like a Lodge. I do not want to offend my NSW brother. I have thought long and hard about a solution and it has come. Why worry about whether it is the King's or Queen's English when a solution is so obvious. The term means English that is correct – correct grammar, correct spelling, correct syntax, correct punctuation and avoidance of the use of foreign words, abbreviations or teenage text words (OMG, LOL etc.). How about "Curmudgeon's English"? What do you think of that, fellow NSW curmudgeon?

IN MEMORIAM

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

John Doyle
Victorian Fellow

David Gunter
Victorian Fellow

Alexander Jeffery
New Zealand Fellow

Peter Kudelka
Victorian Fellow

John Jose
South Australian Fellow

John Maddern
South Australian Fellow

Christos Mitrofanis
NSW Fellow

George McLeod
Queensland Fellow

Kevin King
Victorian Fellow

Ross Campbell
NSW Fellow

Geoffrey Coldham
New Zealand Fellow

Victor Fazio
Queensland Honourable 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:

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.Spense@surgeons.org
WA: Angela.D'Castro@surgeons.org
NT: college.nt@surgeons.org

CASE NOTE REVIEW

Elderly patient with complicated pelvic sepsis

GUY MADDERN
Chair, ANZASM

CASE SUMMARY:

This elderly patient was admitted under the colorectal surgical unit with a short history of lower abdominal pain and distension associated with urinary retention. Comorbidities included steroid dependent polymyalgia, mild congestive cardiac failure, type 2 diabetes, temporal arteritis and oesophageal reflux. Medications included prednisolone daily, frusemide, esomeprazole, metformin, and clopidogrel.

Examination revealed low abdominal tenderness and distension but no frank signs of peritonitis. Clinical diagnosis was probable sigmoid diverticulitis with possible bladder involvement. A computed tomography (CT) scan showed what appeared to be a large ischio-rectal collection as well as a complex right sided adnexal cystic mass abutting the rectum. Initial treatment was conservative, with IV antibiotics and cessation of clopidogrel in case surgery was required.

An examination under anaesthetic (EUA) and drainage of an ischiorectal abscess took place a couple of days later. Progress was slow and a further CT was obtained, which showed a persistent pelvic/pararectal collection with the possibility of an underlying diverticular abscess. A decision was made to reduce the prednisolone dosage, and a further EUA and drainage per rectum were performed.

The patient's total length of hospital stay was just over month. During this time the patient underwent a total of four EUAs before a decision was taken, after a month, to perform a laparotomy due to continuing sepsis and poor progress. A code blue collapse occurred during this period, probably due to hypoglycaemia.

The eventual laparotomy revealed a complex diverticular abscess with an adherent cystic ovarian mass. The attending Trainee surgeon and a Trainee gynaecologist performed a Hartmann resection and removal of the ovarian mass. This procedure was complicated by persistent bleeding from the presacral region. The patient was transferred to the intensive care unit (ICU) for blood transfusion and correction of coagulapathy. The patient was returned to theatre the following day, due to continued bleeding from the presacral veins. This was partially controlled, and the abdomen closed with packs in situ.

Back in ICU the patient deteriorated with worsening coagulopathy and multi-organ failure. In consultation with family, a decision was taken to withdraw any further active treatment and the patient died just over a month after the original admission.

ASSESSOR'S COMMENT:

There are two significant areas of concern here.

Firstly the decision to perform a laparotomy was made far too late. An elderly patient on a significant dosage of corticosteroids who presents with a pelvic/para-rectal abscess secondary to diverticulitis needs early definitive surgery to have any hope of survival. This patient was in hospital for just over a month, and had several EUAs and attempts at abscess drainage before the decision was made to perform the Hartmann procedure. The patient's frailty and clopidogrel therapy influenced the delay in definitive surgical treatment, but ICU and haematologist support can allow surgery in these circumstances. The suggestion is that after the first perineal drainage was unsuccessful in controlling pain and sepsis, the Hartmann procedure should have been performed within the first week.

Secondly, it appears that all of the procedures were performed by surgical Trainees. The Hartmann operation in a complex case of diverticular abscess can tax the most experienced surgeon and requires a careful and methodical approach. The ureters are at risk and the presacral veins in the pelvis are easily torn. A consultant should either have performed the procedure or scrubbed in to assist the surgical Trainee.

On a positive note, the medical documentation was excellent throughout the admission.

A final more global comment on cases such as this:

This elderly patient with significant comorbidities spent just over a month in hospital including several days in ICU, had nearly a hundred pathology tests (mainly bloods), multiple abdominal CT scans, several chest x-rays, multiple electrocardiographies, nearly a dozen blood gas estimations, transfusion of multiple units of blood, platelets and fresh frozen plasma and underwent half a dozen surgical procedures. Despite all this the patient died. Clinicians have an obligation to make sure these resources are used wisely and in a timely manner.

PROGRAM 2015 - ANNUAL NOVEMBER ACADEMIC MEETINGS

Section of Academic Surgery (SAS), the Surgical Research Society of Australasia (SRS) and the Academy of Surgical Educators (ASE) Forum

Thursday 12 November & Friday 13 November,
Sydney College Rooms, NSW

Organising Committee: SAS/SRS: Richard Hanney, Andrew Hill, Guy Maddern, Leigh Delbridge, James Lee, Wendy Babidge, Tamsin Garrod ASE: Spencer Beasley, Stephen Tobin, Julian Smith, Michelle Barrett, Kyleigh Smith

DAY ONE – THURSDAY 12 NOVEMBER 2015

MEETING OF THE SECTION OF ACADEMIC SURGERY

Morning Workshop - Mid-Career Course:
Topics - The costs and benefits of succeeding as a clinical academic
Starting life as a Clinical Academic - lessons learned
Getting promoted
Choosing the societies to be involved in
The Section – How to get involved and what does the future look like?
Guest Speaker – SUS Visitor, Dr Joe Hines MD, "Hot topics in research"

Royal Australasian College of Surgeons

COVIDIEN

Afternoon workshop - Research, the College and the Section of Academic Surgery:
Concurrent Workshops:
1. Mentoring
2. Full time vs part time academic appointments
3. Commercialisation of research

EVENING OF THURSDAY 12 NOVEMBER 2015 ACADEMY OF SURGICAL EDUCATORS FORUM

DAY TWO – FRIDAY 13 NOVEMBER 2015

ANNUAL MEETING OF THE SURGICAL RESEARCH SOCIETY

SUS Guest Speaker – Dr Joe Hines MD, Professor in Surgery, UCLA, Los Angeles
AAS Guest Speaker – Dr Ankit Bharat MD, Assistant Professor of Surgery, Northwestern University, Chicago
Jepson Lecture – Professor Peter Choong, Professor of Orthopaedic Surgery, University of Melbourne

Presentation of original research by surgeons/trainees/students/scientists
Awards – Young Investigator Award, DCAS Award, Travel Grants and Best Poster Award

Registration is now open

Only $100 for SAS members to attend the SRS meeting

$130 for non-members *(become a member for free)*

Places will be limited at the SAS/SRS meetings

CONTACT DETAILS:

Tamsin Garrod. SAS secretariat, **E:** academic.surgery@surgeons.org, **T:** +61 8 8219 0900

THE ALFRED HOSPITAL

General Surgery Meeting

JONATHAN SERPELL
Director of General Surgery, Alfred Hospital

The Department of General Surgery at The Alfred Hospital, Melbourne, is once again holding The Alfred General Surgery Meeting from Friday 30 October to Saturday 31 October 2015 at The Pullman Melbourne Albert Park, Melbourne, Victoria.

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

The keynote speakers include Professor David Flum, a Gastrointestinal Surgeon from The University of Washington, Seattle, who has a wide range of interests including improving health care and undertaking clinical research into surgical outcomes for common conditions such as obesity surgery, appendicitis and diverticulitis. Professor Andrew Spillane specialises in surgical oncology, particularly melanoma, breast cancer and soft tissue tumours in Sydney. Professor Jonathan Fawcett from Brisbane has a major interest in hepatobiliary and pancreatic surgery. These three keynote speakers complement an extensive local faculty who will address common and important problems in everyday General Surgery practice.

'Practical Updates for General Surgeons' has been scheduled to enable attendance at the meeting, followed by a long weekend in Melbourne, with the option to take in both The Derby and The Melbourne Cup.

There are five scientific sessions including 'Emergency Surgery' covering burns for the general surgeon, abdominal compartment syndrome, splenic injuries, abdominal pain following bariatric surgery, and the role of antibiotics in uncomplicated appendicitis.

The second session on 'Difficult Problems in General Surgery' will cover the use and complications of mesh in the abdomen and the role of component separation, the role for elective colectomy in diverticulitis, mechanical bowel preparation in elective colorectal surgery, unresolved issues in liver surgery and the benefits of breast reconstruction.

There will be an update session on 'Operative Techniques', which will include how to avoid common pitfalls during anterior resection, the role of cholangiography in preventing bile duct injury, the changing face of breast surgery for cancer, where are we now with minimally invasive endocrine surgery and a debate for and against laparoscopic banding and sleeve gastrectomy for morbid obesity.

The session 'Cancer' will cover melanoma, interpretation of a malignant skin pathology report, newly published guidelines on the management of thyroid cancer, surgical resection for pancreatic cancer, and what to do with the primary in incurable stage four colorectal cancer.

A final session titled 'Common Problem Updates' includes cigarette smoking and surgical outcomes, large hiatal hernias, laparascopic inguinal hernia repair, fluid resuscitation in early trauma, management of the perforated oesophagus and management of torrential upper gastrointestinal haemorrhage.

The meeting dinner held on the Friday evening, will be a social highlight of the conference. The venue, The Royal Melbourne Yacht Squadron in St Kilda is a superb venue which provides picturesque views of Port Philip Bay.

This General Surgery Meeting on Practical Updates should appeal to all General Surgeons in all areas and in all subspecialties.

We look forward to your attendance; in the meantime you can connect with @Alfred_Meeting and join in the conversation on Twitter using #Alfred2015.

REGISTER ONLINE NOW:

http://tinyurl.com/alfred2015

For more information, contact:

RACS Conferences & Events Management
250-290 Spring Street EAST MELBOURNE VIC 3002

T: +61 3 9249 1158 or
E: alfred@surgeons.org

Location of Alfred Meeting Dinner
photo credit: food&desire

Winter Lifestyle

POST-OP

12 page lifestyle section

ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

Mr Baber appears second from left

THE PIPE MAJOR SURGEON

Mr William Baber has music in his bones with a specialty in the bagpipes

It sounds like a chapter from a Boy's Own Adventure and comes complete with haunting music, an isolated shore, an old man of the sea and a young boy on a boat.

Let us go there in our imaginations.

It is a special night for the old man as it is New Year's Eve and although it has been years since he left his home in Scotland for a new life in New Zealand it is this night that he misses that bonny land of his boyhood the most.

The light is fading as the evening draws in.

The old man settles upon his balcony, pours a glass of whiskey and waits.

On the water, the young boy sails out into the bay to fulfil his part of an annual bargain struck between the two in return for the old man's patience in teaching him the skills of sailing and the secrets of the sea.

Then, as he floats upon the waves, the boy picks up his bagpipes and plays the melodies that befit such a nostalgic night, the notes drifting over the water, melancholy and mesmerising, the boy piping the old man home, if only in memory.

It is a beautiful story and one that belongs to Auckland ENT Surgeon Mr William Baber who described this nautical ritual of his youth as a small price to pay for all he learnt from the man who lived near his family's isolated holiday home.

Now the Clinical Director of ENT at the North Shore Hospital in Auckland, Mr Baber is a member of the fifth generation of his family to enter medicine, the second in his family tree to specialise as an ENT surgeon and the first to play the bagpipes.

His great uncle, Mr E. Cresswell Baber, wrote a text book on the subject in 1886 romantically titled Guide to the Examination of the Nose and some of his surgical tools remain on display in London as part of Lord Lister's Collection at the Royal College of Surgeons of England.

Yet while most of the other medical Babers chose to become physicians, Mr Baber was drawn to surgery and completed his ENT training in the UK and Post Fellowship training in America before returning to New Zealand.

With a particular interest in neurotology, middle ear deafness and vertigo, Mr Baber pioneered the translabyrinthine excision of the acoustic neuroma into New Zealand in the 1980s, and was involved from the beginning of the cochlear implant program.

Such is his passion for his work that Mr Baber is a member of the Board for both the New Zealand Deafness Research Foundation and the Northern Cochlear Implant Trust and past chairman of the Cochlear Implant Clinical Committee.

Outside work, however, Mr Baber still makes time to practice and play the bagpipes and was recently promoted to the role of Pipe Major of the Signal Pipes and Drums, a traditional Scottish highland pipe band.

Originally formed in 1957 as the Pipes and Drums of the 1st Divisional Signals Regiment of the New Zealand Army, the band began as a military group whose members were soldiers before it became civilian in 1964.

And still it plays on after all these years at Christmas Parades, Tattoos, Robbie Burns nights and ANZAC day commemorations.

Asked why he first took up the instrument, Mr Baber said it was still a mystery to him.

"My mother was a professional musician, a soprano and pianist, so music was a central part of my early life," he said.

"I had started playing piano from the age of five but then one day when I was nine my father, who was a psychiatrist with a great sense of humour, saw the Mount Albert Highland Boys Pipe Band and was so taken with them he signed me up immediately.

"He used to say that he thought it might make me taller but although it remains a mystery as to why he did that I am very glad that he did.

"I loved it and would practice on the chanter, which is like a recorder.

"That allows students of the instrument to learn the piping without the bag which is how you learn to play the bagpipes without driving people mad."

So musical is Mr Baber, he then took up the trumpet and joined a Brass Band as a young man, continued playing the piano and took up singing while still playing the bagpipes at festivals and special occasions.

He said, however, that without a regime of continual practice, his piping skills became rusty until another bagpiper surgeon convinced him to join the band.

"I was getting worse because I wasn't playing or practicing enough and then eight years ago Professor Randall Morton asked me to join the Signals Pipes and Drums," Mr Baber said.

"He is a Professor of Otolaryngology at the Auckland University and is Chairman of the New Zealand Division of the RACS but the wonderful thing is that I get to tell him what to do in the band because I'm the Pipe Major."

Mr Baber said the current piping ensemble consider themselves as a Boutique Band and not long ago had the

"I had started playing piano from the age of five but then one day when I was nine my father, who was a psychiatrist with a great sense of humour, saw the Mount Albert Highland Boys Pipe Band and was so taken with them he signed me up immediately."

signal honour of having the oldest piper in the world who was still playing and marching at 92.

He said that while numbers vary due to the commitments of the players, the band usually comprised 18 musicians, including pipers, drummers, the Pipe Major and the Drum Major.

They usually perform at least once a month, resplendent in kilts and playing from a repertoire of 112 melodies.

"The bagpipes only have nine notes so it takes years to produce complex music and a sweet tone and everything obviously has to be memorised because we don't read the music as we march," Mr Baber said.

"And while some people might think it is an old fashioned instrument, we still have young people coming to us wishing to learn or play.

"At one time New Zealand had more traditional highland pipe bands than existed in Scotland but now that honour belongs to Canada.

"People are still interested in pipe bands, how we play, what we play and even what we wear and I don't know how many people have lifted my kilt to see what I'm wearing underneath which is quite outrageous.

"Yet while we mostly play in community settings, we are any Army Band at heart and recently played for the Signals Regiment to pipe in the new Colonel."

Mr Baber said he still loved picking up the pipes and playing for the public not only for the musical challenge but because of the opportunity it gave him to meet other people from walks of life outside surgery.

He said the dexterity required playing the pipes, manipulating the bag and marching in unison with other players also kept his hand, ear and eye co-ordination attuned, his rhythm keen and his memory sharp.

"I love playing the pipes because we play some lovely tunes, I get to spend time with a huge range of people and it allows me to stop thinking about work because it requires such concentration," Mr Baber said.

"I strongly believe in the health benefits of music too. Everyone has rhythm because even as a foetus, we are listening to our mother's heart beat so music can have a deeply soothing affect upon us.

"Playing a musical instrument also keeps your brain sharp.

"From what I have seen over the years, playing music is one of the best ways to stave off intellectual decline and allows people to stay younger longer than those who have no musical interests."

With Karen Murphy

Mr Lander and the Perito Moreno Glacier

PATAGONIA ADVENTURES

Richard Lander EDSA (NZ) on fishing, mountains and motorcycling

"I finally felt myself lifted definitively away on the winds of adventure toward worlds I envisaged would be stranger than they were, into situations I imagined would be much more normal than they turned out to be."

- Ernest Guevara, The Motorcycle Diaries: Notes on a Latin American Journey

In a lifetime there are a few things that will hold in one's memory, fishing and motorcycling in Patagonia are two of these.

Patagonia is known for its remoteness, its mountains, glaciers, lakes, rivers, wildlife, fishing, and off road adventures. The best of each day culminates in a glass of Malbec and a good steak.

On the eastern plateau of the Andes, Lake Strobel is a mecca for fishermen and Estancia Laguna Verde is the base for the most extraordinary trout fishing found in the world. The trout in the river and lake systems of the estancia grow to an enormous size on a diet of scuds, small freshwater crustaceans that populate the small streams and a vast windblown lake. Eager fishermen are the only


Father and son


Silver Rainbow Trout


Getting around in Patagonia


Patagonian barbeque lamb

predators and the season is short due to the wind and the challenging environment.

In pursuit of work life balance and in search of the biggest rainbow trout in the world a group of fishermen including an anaesthetist, helicopter pilot, ENT surgeon, farmer, builder, researcher, gib stopper and a surgeon headed for Patagonia and Estancia Laguna Verde.

Eight flew to the hub in central Argentina, El Calafate, geared up with rods, reels, waders, boots, fly-lines, and enough accessories to last a lifetime, and two with winter motorcycling gear as well. Five hours off road by four-wheel drive onto the plateau and foothills of the Andes, treeless and desolate, and ravished by a cold relentless wind, took the group to a small but comfortable lodge on the edge of one of the many small lakes. Each day was an adventure by 4WD or quad bike to the Barancosso River and Lake Strobel for eight to ten hours of Jurassic fishing. Ten pounders were common with the biggest fish in a week a massive twenty pounder. Catch and release preserves the fish stocks in this extraordinary fishery. An expert fly-caster could land up to a hundred fish a day. Prince nymphs and wet streamer flies on twenty-pound leaders and fifteen pound tippets were the guide's choice.

In the evening an aperitif followed by barbequed lamb or beef washed down with another fine Malbec complimented the stories of the biggest catch of the day.

At the end of the week six intrepid fishermen headed home and two stayed on for episode two of the South American adventure, motorcycling from El Calafate to Punta Arenas.

Patagonia Rider, a Chilean motorcycle hire firm based in Punta Arenas, delivered two bikes to El Calafate. Due to the relentless Patagonian wind, 1150 cc BMW adventure bikes were preferred both for their reliability and weight. An electrical fault on day one in the middle of nowhere, wind gusting at


Torres Del Paine


Fishing gear

Barancosso Rainbow Trout

more than 100 kph and foul weather almost put paid to the trip. We learnt that one other bike hire on that day gave up and rented a car!

The tar-sealed roads in Argentinean Patagonia are a motorcyclist's dream. Long smooth corners and endless straights with a speed limit of 120 kph make riding safe and comfortable if it wasn't for the wind that frequently pushed you to the other side of the road. Luckily traffic was light. Off road, gravel was challenging and best avoided with the heavy bikes.

Crossing to the border to Chile, and not speaking any Spanish was again a challenge but Patagonia Rider having all the paperwork in order ably assisted us. A brief customs search of the bikes for fruit, vegetables and other illicit contraband was undertaken before gearing up for the short trip to Puerto Natales, the gateway to the Torres de Paine national park. The bikes were rested for a day while we took a tourist bus around the highlights of the park.

Mountains, lakes, glaciers, guanacos, condors and the harsh environment make this place magical and well worth placing on the bucket list.

The last day of riding, Puerto Natales to Punta Arenas was easier, less wind and smooth roads. The descent from the highlands to the sea saw ever-changing flora as mountains gave way to coastal plains.

I imagined Patagonia to be a land of contrast and found both its harshness and beauty not unlike the combination of Fiordland and outback Australia except it was cold. Patagonia was sparsely populated but a rich and diverse place to explore the expected and the unexpected.

THE RIGHT TYPE

New Zealand surgeon Matthew Clark talks about releasing his creative side in design

Although the scrawled and scratchy handwriting of doctors has been notorious for centuries, one New Zealand surgeon has turned his written communications into typographical art. Associate Professor Matthew Clark is a General Surgeon and Surgical Oncologist and an enthusiastic amateur graphic designer. With broad general surgical interests, Matthew also has specialty expertise in melanoma, soft-tissue sarcoma and rare tumours. He works out of Middlemore Hospital in Auckland.

As a younger surgeon Matthew was told by one of his Professors to put effort into the appearance of his written work and thus was born his interest in graphic design. In recent years he has designed logos and graphics for a range of medical groups and businesses and in 2010 he put his mind to creating sophisticated, consistent branding for the College. He talks to Surgical News about the pleasure he takes in doodling, drawing and designing on his desktop.

Where did you do your training including your Post-Fellowship training?

I completed my training in the Auckland region with stints in the Waikato and Tauranga regions and did Post-Fellowship training in London and Birmingham, UK. While there, I did a one-year Fellowship in Surgical Oncology at the Royal Marsden Hospital in London, obtained my UK Specialist Registration and went to Queen Elizabeth Hospital, Birmingham, as a Consultant Surgeon.

After a year there, I was offered a one-year Locum Consultant position back at the Royal Marsden Hospital, and then a permanent offer was made to me. However, I had started a family while in the UK and wanted my kids to grow up in New Zealand. I had also left New Zealand with a job offer at Middlemore where I could work with fantastic colleagues and didn't want to stay away too long in case they changed their minds!

When did you develop an interest in graphic design?

One of my early mentors, Professor Jim Shaw, introduced me to the Apple Macintosh and told me to make my work for him "look good". I took his words to heart and started to read about typography. The book The Mac is Not a Typewriter taught me how to do complex page layouts, how to use special characters such as the correct dashes for medical data ranges and how the look of text influences readability.

When I later took two years out of the surgical training scheme in order to work towards my Doctorate I had the chance to put all this into action writing up my thesis. The typography interest then blossomed into the broader field of graphic design and I started using design software such as Adobe Illustrator.

Wood block "upcycled" from a recent kitchen renovation

"One of my early mentors, Professor Jim Shaw, introduced me to the Apple Macintosh and told me to make my work for him "look good". I took his words to heart and started to read about typography."

What do you enjoy about it?

I think many doctors have a creative streak in them but we sometimes suppress it for time reasons or through a perception that it's not very "scientific". For me, graphic design has been a creative way of tying in the content of the message to its medium – making sure that an important message is not being ignored because of lack of clarity in how it is conveyed.

Plus, it's fun! As a kid, I preferred technical drawing to art, and modern graphics programs have the flexibility to combine the precision and reproducibility of design ideas with artistic filters and overlays when needed.

What graphic design work did you do for the College in 2010?

Ian Civil, who was President at the time, was my earliest contact with the College when I tried three times to get onto the surgical program (the first two were just for practice!). I had for a while been mulling over the lack of a coherent visual identity for the College. We have a fantastic image with the Coat of Arms ,which ties into the College's rich history. However, this had not been integrated well into the copious output from the College's various groups and outputs.

I was a member of the ASSET Committee at the time, and had a fair bit of input into the logo and "look" of this group. I started playing around with a new logotype including developing an image based on the RACS' Coat of Arms with stylised text and some guidelines for use, and forwarded this to Ian for his perusal. He thought the College would be interested and submitted it for consideration. As I understand it, it was then approved in principle and I believe the College's in-house graphic designer has used some of the elements in the new designs.

Who else have you done design work for?

I have developed logos for the University of Auckland Advanced Clinical Skills Centre, the Australian and New Zealand Surgical Skills Education and Training (ASSET) committee of RACS, Café Urania (my brother's Espresso Bar) and Ormiston Surgeons, a private practice I worked with for some time.

Do you have other artistic interests?

I collect vintage posters and our walls at home are covered with various prints and other quirky artworks, with more awaiting framing under our bed. I am a big fan of mid-century modern design, and among my favourite objects

are a pair of original Cherner Chairs, which were featured on the front page of the Saturday Evening Post in September 1961.

I enjoy working with wood, often "upcycling" older materials. I recently made a knife-block from wood taken from a recent kitchen renovation, copper retractors that were being thrown out from our operating theatres, and various bits and pieces like an old ruler that were laying around. No surprise that this surgeon likes good knives!

What attracted you to surgery and general surgery in particular?

You have to enjoy the practical aspects of operative surgery but this is not sufficient in itself. I've always enjoyed the interactions with patients and colleagues, working as part of a team, and teaching. I love the variety of things that come through the door on acute call days in General Surgery.

Do you teach and if so through which University?

I'm an honorary Associate Professor with the University of Auckland and actively teach our students when they rotate through General Surgery. The bulk of my teaching is at registrar level and I really enjoy this aspect of my role.

What do you consider the highlights of your career so far?

My Doctorate was one. I'm the first in my family to go to University and it was great to be able to achieve this. It was a more difficult and prolonged project than I could have anticipated but it paid huge rewards in terms of my education and led to wonderful opportunities subsequently, including my Fellowship in London.

Another high point was being published in the New England Journal of Medicine (NEJM). When I was working at the Royal Marsden Hospital for the second time, I very cheekily cold-called NEJM to see if they might be interested in a review article on Soft-Tissue Sarcoma. Only an Antipodean could get away with this!

After a somewhat prolonged negotiation, and many, many drafts, our group made it into the journal. Most recently, I would consider becoming an Examiner in General Surgery as very fulfilling and a huge privilege as well as a big responsibility. It is a role I had always hoped I might someday perform but didn't expect it for a few years yet.

With Karen Murphy

Some examples of Mr Clark's designs

OPUS NO. XXXVIII

ENTENTE CORDIALE

Commemorative recollections from the Madeleine

FELIX BEHAN
Victorian Fellow

My French wife, Mariette, whom I met at the Marsden, and I have been going to the Madeleine area in Paris for over 40 years and now it is time to share with you a few recollections of our experiences from the 8th Arrondissement.

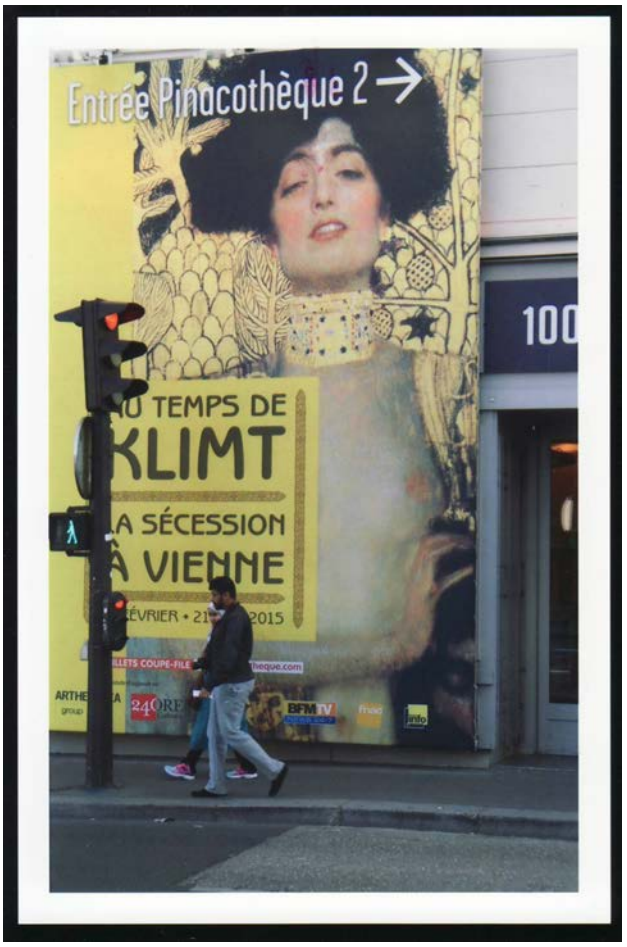
This time we arrived in France on that first weekend in May – the 70th anniversary of the Liberation of Paris, having seen our own ANZAC commemorations honouring ~60,000 who died and the ~180,000 wounded in WW1 for King and Country.

The ANZAC events contrasted remarkably with those on the European scene. That weekend we walked down from the Madeleine to the Champs-Élysées. The onomatopoeic experience of the clip-clop of the prancing horses on the cobblestones was incredible, with soldiers in their princely regalia riding towards the Arc de Triomphe it was a sight to behold. Our Light Horse Cavalry was from a different era.

These Madeleine links go back to my earlier training at PANCH. Here B.K. Rank taught me how to operate but Don Marshall taught me Plastic Surgical refinement at the VPSU. Other PANCH personalities spring to mind. John Carney and I did the General Surgical On-Call roster. The Orthopaedic Surgeon and former Censor in Chief at the RACS Brendan Dooley I see regularly at St.Carthage's in Parkville. Ken Brearley who wrote the definitive textbook on PANCH I still contact in the medico-legal circuit. John Upjohn, I meet at ASC meetings (I did my last on-call appendix with him in 1971).

The late Gordon Trinca came day or night to attend TAC emergencies documenting details and collecting data. His research culminated in the 1970 Seat Belt legislation in Victoria, which was adopted around the world and lead to his addressing the US Congress. (Even Lady Rank in 1973 reprimanded me for not having seat belts in my Zodiac whilst an 'Aide de C(h) amp' for Benny in London.) The late John Feathers, one of the 10 per cent Left-hand Brigade and one of the most dextrous surgeons with whom I ever worked introduced us to York Mason's forceps for cholecystectomy.

The late David Conroy who gave me my best advice at lunch in 1970 when he said "Felix now you have your Fellowship go to London, do the RCS course, stay at



KLIMT Exhibition Poster at the Pinacotheque de Paris - La Sécession À Vienne

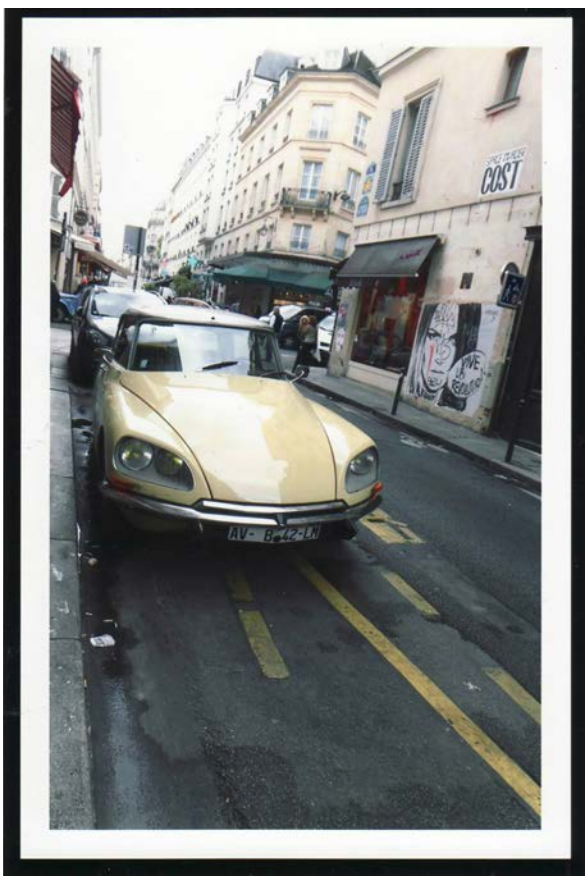
Nuffield House and sit at the feet of the surgical masters. Enjoy your London experience, quoting Johnson, who said, 'when you're tired of London, you're tired of life!'" I stayed three years at Nuffield College becoming Deputy Warden. I met many Presidents socially absorbing their pearls of wisdom. And on leaving these PANCH recollections I must acknowledge, Louise, a Parisian on the PANCH switchboard who recommended the Madeleine initially to me.

In the final months of my local training in Melbourne in 1971 the IPRAS meeting was held – an 'Olympic event' in Plastic Surgery which Benny had organised reflecting his political skills. Let's not forget the VPSU was the

teaching unit for Melbourne, Australia and Asia. Here five Melbourne teaching hospitals combining with two universities provided the patients for specialist care. At that meeting I met the international fraternity including French luminaries such as: Tubiana; Lalardrie whose textbook on Aesthetic Surgery I edited; and even Tessier the 'Father of modern craniofacial surgery'.

When I was staying in the Madeleine with my Father in 1973 I again contacted Raoul Tubiana. He established the Societe Francaise de Chirurgie de la Main and an international figure in the treatment of Dupuytren's Disease. He was a compleat surgeon internationally recognised from his days in San Francisco with Sterling Bunnell on a Fulbright Scholarship. How many know that war machinery still in Europe after the Nazis defeat was liquidated and converted to a fund post-war under Senator Fulbright – hence the name. Vernon Marshall and more recently Michael Finlay were worthy local recipients. Tubiana was gracious enough to receive a call from me on that day in 1973 when I was a non-entity and immature clinically and surgically (as John Heuston observed). He picked me up at the Madeleine (croissant in hand!) and invited me to his afternoon theatre list. It was intriguing to see Tubiana's Theatre Sister, elegant in every way, organise lunch including a glass of rosé for everyone beforehand.

Some years later staying at the Hotel Roblin, off the Madeleine I punctured my hand whilst opening a jar



The Citroen DS21 – John Heuston's model of car he drove over 30 years

Memorial plaque to Simone Jaffray below Sacre Coeur

of Foie Gras (another refinement of French food introduced to me by my wife). The penetrating wound needed repair. Daniel Marchac opened his Clinic. He was a leading light on the French scene whom Mariette and I had previously entertained in Melbourne, thanks to John Hueston's introduction. He co-authored with John, the Proceedings of the 1975 IPRAS Meeting in Paris where I was fortunate enough to have the word Angiotome introduced into world literature.

My enthusiasm for the Parisian scene has not waned. Mariette never tires of revisiting her favourite haunts along the Rue Haussmann where the Galleries Lafayette and the Printemps Department Store tempt her with fashion, food and fun reflecting the Parisian lifestyle, something she has endearingly taught me. She buys books of the French Masters by the kilo. (Let's not forget when Victor Hugo died all Paris turned out for the funeral.) She recalls that the French mind socially and philosophically usually leads the world in original thinking (today the French economist Piketty even wants to change the world tax rate to make it more equitable – currently 99% of the world's wealth is owned by 1%). It was, I believe, Jean Paul Sartre who famously said - To believe is to know you believe, and to know you believe is not to believe – I cannot understand this, whereas Descarte's 'I think therefore I am' seems quite logical! No doubt Sartre's ideas emanated from the Left Bank socialising with Simone de Beauvoir also from the Sorbonne – the Foundress of Continental Feminism.

Incidentally the Madeleine Church is a facsimile construction of the Pantheon in Rome and was originally constructed as a Napoleonic War Memorial. However with the completion of the Arc de Triomphe du Carrousel in 1808 the Madeleine reverted to its original role as a religious memorial - a church. When I was doing a reading at the Church on this occasion, I learnt of two interesting vignettes: Chopin, who lived nearby in the Place de Vendome, died in 1849 and

had requested Mozart's Requiem be played at his funeral service. As sopranos were banned from Church performances, an application was made to Rome for dispensation - this took two weeks and was granted on the condition they sing behind a black curtain at the back of the altar (which is still hanging there). Gabriel Fauré, Capellmeister at the Madeleine whose heart rending Requiem Op. 48 of 1893 was played at Bob Marshall's RACS memorial service, was summarily sacked one Sunday morning before playing the organ at Mass - dressed in a bow-tie reflecting possibly a night of wayward indulgence? History oozes from every alcove there!

As a man of habit I returned again to the antique bookshop 'Alain Brieux' in Rue Jacob on the Left Bank. Outside, 'out of mothballs', was a 'concourse condition' DS21 Citroen in preparation for the Concourse d'Elegance to be held on May 23rd. John Hueston, a Francophile, drove his DS21 until the mid 80s. When this aerodynamic vehicle was released at the Paris Motor Show in 1955 it broke all records with 12,000 ordered on the first day. John had an innovative mind and always on the lookout for the latest surgical developments as was reflected in this car's engineering.

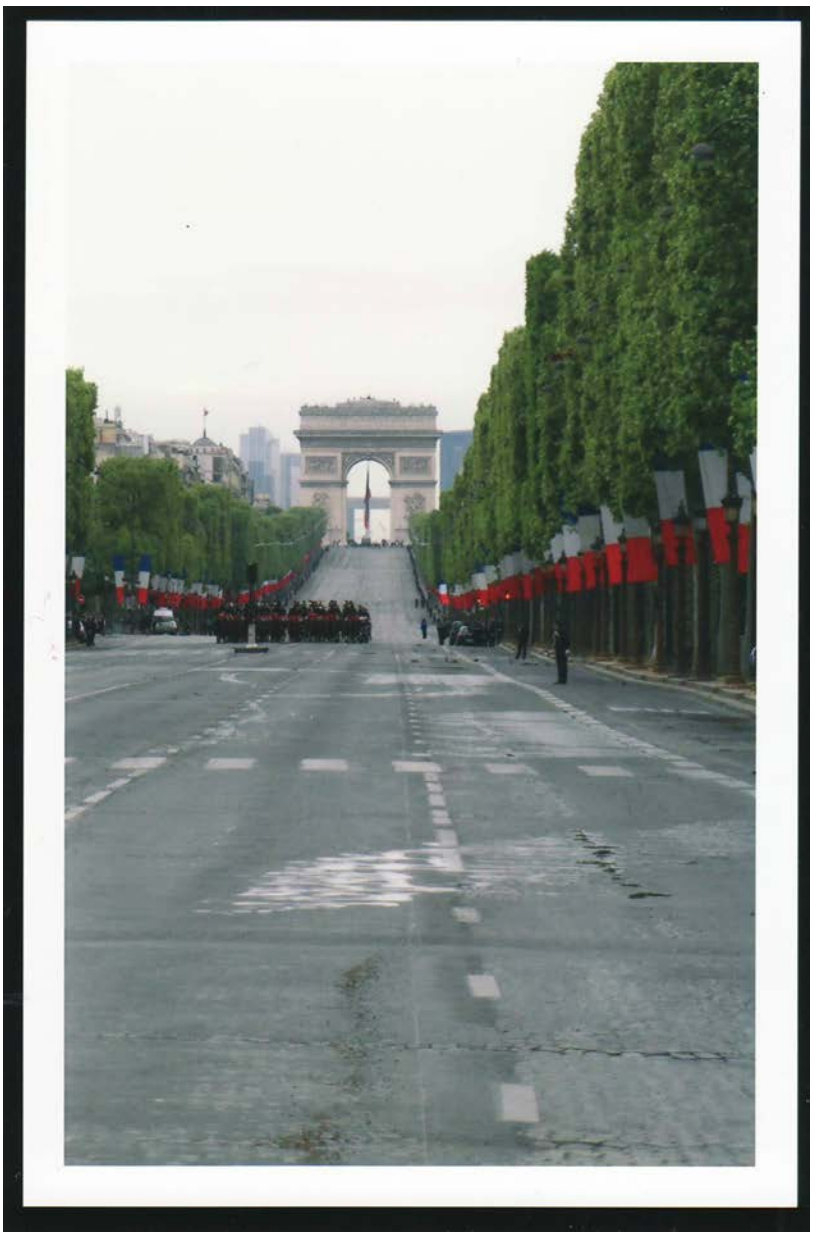
On the final hour of the final day at the Madeleine I went to the KLIMT exhibition showing his gold leaf *Kaleidoscopic, Luminescent Imagery, Mirroring the Times*. As art is a reflection of life and thus a portrayal of history I was beginning to understand the origins of the Great War. This exhibition reflected the opulence of the Austria-Hungarian Empire, with the bronze image of the assassinated Archduke Franz Ferdinand heir to the Empire clearly on display. That Serbian National on that fateful day 28th June 1914 assassinating the Archduke was the catalyst for WW1. The 'five week war' extended into almost a five year conflict with the loss of nearly 10 million (and some say 8 million horses). In 1914 the two main power alliances in Europe were called the *Triple Entente* aligning France, Russian and the UK – all genetically linked to Queen Victoria - and the *Triple Alliance* of Germany, Austria-Hungary and Italy.

The recent release 'A Woman in Gold' is a cinematic version of the above.

Finally this commemorative memorial plaque located below Sacre Coeur de Montmartre recalled the Gestapo invasion. It made my wife recount her family's experiences in the Bordeaux region (where my colleagues Jacque Baudet and Phillip Pellesier operate) when the family estate was sequestered by invading forces.

Finally back home, in July I see the French Consul awarded 25 senior Australians with the Legion d'Honneur – Napoleon's Knighthood – for their war services in France.

Ave Atqeu Vale - Catullus.



The Champs-Elysees on Commemoration Day with prancing horses

ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

CONGRATULATIONS

On your achievements

PROFESSOR TIMOTHY PAWLIK, MD, MPH, PHD, FRACS

Honorary Fellowship

Timothy Michael Pawlik has had a truly extraordinary surgical career to date, having been appointed Professor of Surgery and of Oncology as well as to the prestigious position of Chief of Surgical Oncology at Johns Hopkins University.

Born and bred in Massachusetts, Tim attended school in Danvers before moving to Washington where he received his undergraduate degree from Georgetown University. His leadership was soon apparent and he received the Daniel Power Award for outstanding achievement in academics and community service and later the Katherine Kroft Award for the student best exemplifying Jesuit ideals. He returned home to Boston and received his medical degree from Tufts University School of Medicine. He was President of Tufts University Medical School Student Council.

Tim completed surgical training at the University of Michigan Hospital where more awards including the Frederick A Coller Award and the James W Crudup Award followed. He then spent two years at the Massachusetts General Hospital as a surgical oncology research fellow. He completed advanced training in surgical oncology at The University of Texas M. D. Anderson Cancer Center in Houston. Whilst in Houston he was awarded the Lotzova Memorial Research Prize in successive years.

In 2006 Tim joined the staff at Johns Hopkins in Baltimore. In 2012 he became the John L Cameron Professor in Alimentary Tract Disease. He is Chief of the Division of Surgical Oncology, Director of the Johns Hopkins Medicine Liver Tumor Centre as well as Professor of Surgery and of Oncology. Tim's main clinical interests include alimentary tract surgery, with a special interest in hepatic and pancreatico-biliary diseases.

Tim is a Renaissance man albeit living in the 21st Century. His diverse interests include medical ethics and he completed a fellowship in medical ethics at the Harvard School of Public Health as well as a Masters in Theology from Harvard Divinity School in Boston. In addition, Tim was awarded a PhD from the Johns Hopkins Bloomberg School of Public Health. He has achieved all of this, in addition to publishing over 45 book chapters and 320 papers – and all before the age of 45. Tim is widely sought after as an international keynote speaker and visitor.

He has made a major contribution to HPB surgery developing a staging system for intrahepatic cholangiocarcinoma that was officially adopted by the 7th edition of the AJCC Staging Manual as the new worldwide standard.

Despite his hectic clinical schedule Tim has a busy family life with his wife Megan and their four children, and still supports his beloved New England Patriots.

Tim is the immediate-Past President of the Association for Academic Surgery. It is his contribution to academic surgery that has been the cornerstone to his enormous contribution to surgery in Australia and New Zealand. An annual visitor to Annual Scientific Congresses since 2011, Tim has given more than 20 talks and Masterclasses, chaired sessions, actively contributed in workshops and keenly addressed complex and challenging subjects. He has regularly described the College's Congress as one of the most enjoyable meetings he attends, and has looked forward to it every year.

Tim Pawlik has selflessly and enthusiastically made himself available to medical students, junior doctors, Trainees and Fellows as a tireless and supportive mentor. He has hosted RACS Fellows at Johns Hopkins and left a standing invitation for colleagues to visit him when passing through Baltimore. Tim acts as a reviewer for the *ANZ Journal of Surgery* and remains a vocal advocate of the RACS. His substantial participation with and within our College over the last four years has contributed significantly to the reinvigorated activity and growing membership of the Academic Section.

Tim Pawlik is a leader in international surgery, but it is his contributions to the RACS Fellows and Trainees here and in the US that warrant his nomination for this great honour.

Citation provided by Associate Professor Michael Hollands, FRACS and Mr Richard Hanney, FRACS.

INFORMED CONSENT

Recent decision favours doctors

MICHAEL GORTON
College Solicitor

A recent Supreme Court decision confirmed that for a doctor to obtain informed consent from their patient, they must provide the patient with information about the known risks and side effects of the procedure, including those which may not be likely, but are materially important to the patient, prior to accepting the patients consent (ie. which may affect the patient's decision to undergo the procedure or not).

Providing this information enables the patient to decide whether the weight of the risks and side effects outweighs the benefits of the proposed procedure.

However, a doctor is not obliged to refuse the surgery if their personal view or a reasonable medical view was that the procedure is in some way unwarranted. This is important where there may be a lack of severity of symptoms or where the procedure is cosmetic in nature.

The information given to obtain informed consent can be provided either orally, in writing, or by a combination of both.

BACKGROUND

In April 2015, the Supreme Court of New South Wales handed down its decision in the matter of Morocz v Marshman. Ms Morocz claimed that Dr Marshman had been medically negligent by failing to warn her of the potential side effects and risks of the surgery and therefore failed to obtain informed consent from her.

The surgery was a bilateral endoscopic thoracic sympathectomy where Dr Marshman cut the nerves along Ms Morocz's T2 rib to sever the nerve connection which causes hyperhidrosis.

Hyperhidrosis is a medical condition that can cause excessive sweating on the palms.

The Court discussed the liability (if any) of Dr Marshman and discussed what is required in relation to the duty to warn. Further, they outlined how informed consent is obtained.

THE MEDICAL CONSULTATION

On 3 August 2006 Ms Morocz and Dr Marshman consulted about the hyperhidrosis. They discussed the history of Ms Morocz's hyperhidrosis, how it affected her and the fact her mother had also had the condition.

Ms Morocz did not let Dr Marshman examine her hands to assess the sweating.

They discussed prior treatment Ms Morocz had undertaken, which included an alcohol rub that had been largely ineffective and left her with very dry hands.

They discussed that Botox can be used and Dr Marshman pointed out that it can be painful and expensive and must be repeated.

Ms Morocz informed Dr Marshman she had read quite a lot about the surgery on the internet.

Dr Marshman informed Ms Morocz of an overview of the procedure, the success rate, the associated risks, the potential side effects and further provided her with a brochure from the Society of Thoracic Surgeons which set out the procedure and its risks and side effects in greater detail.

POST-OPERATIVE

Ms Morocz was spaced out and dizzy and not fully awake. She had bad nausea and vomiting and felt unwell. She became aware of breathing that was not normal and numbness of her upper chest, neck, face and arms. She had increasing pain. Her hands were very dry and very warm. She developed compensatory sweating. She had a slow heart rate. She developed a pneumothorax. She felt it difficult to adjust to different temperatures.

THE DUTY TO WARN

The Court discussed a doctor's duty to warn and Montgomery v Lanarkshire Health Board prior common law conclusions about how this should occur.

[70] "An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significant to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significant to it."

INFORMED CONSENT

After a thorough discussion of the relevant authorities on informed consent and the duty to warn, the Court determined that a doctor must identify known risks and side effects and inform the patient of these. The patient is then able to give fully informed consent. Whether or not the doctor has fulfilled this duty to warn a patient of the risks or side effects is a determination to be made by the Court.

FINDINGS

The Court looked at each allegation Ms Morocz made in relation to what she believed she had not been informed of and found that:

Dr Marshman was obliged to notify Ms Morocz of the known risks and side effects of the surgery. The Court found that as to the known risks and side effects (namely, return of the hyperhidrosis, compensatory hyperhidrosis and intercostal neuralgia) Ms Morocz was properly and adequately warned of the potential consequences of having the surgery.

Dr Marshman was not obliged to refer Ms Morocz to risks or side effects that were not known risks or side effects of the hyperhidrosis surgery, including those risks or side effects which did not have clinical implications for her. These included decreased innervation of the heart, bradycardia, intolerance to exercise, impairment of emotional responses, debilitating headaches, anxiety and depression, undergoing the procedure at all and the fact that Sweden had banned the procedure in 2003.

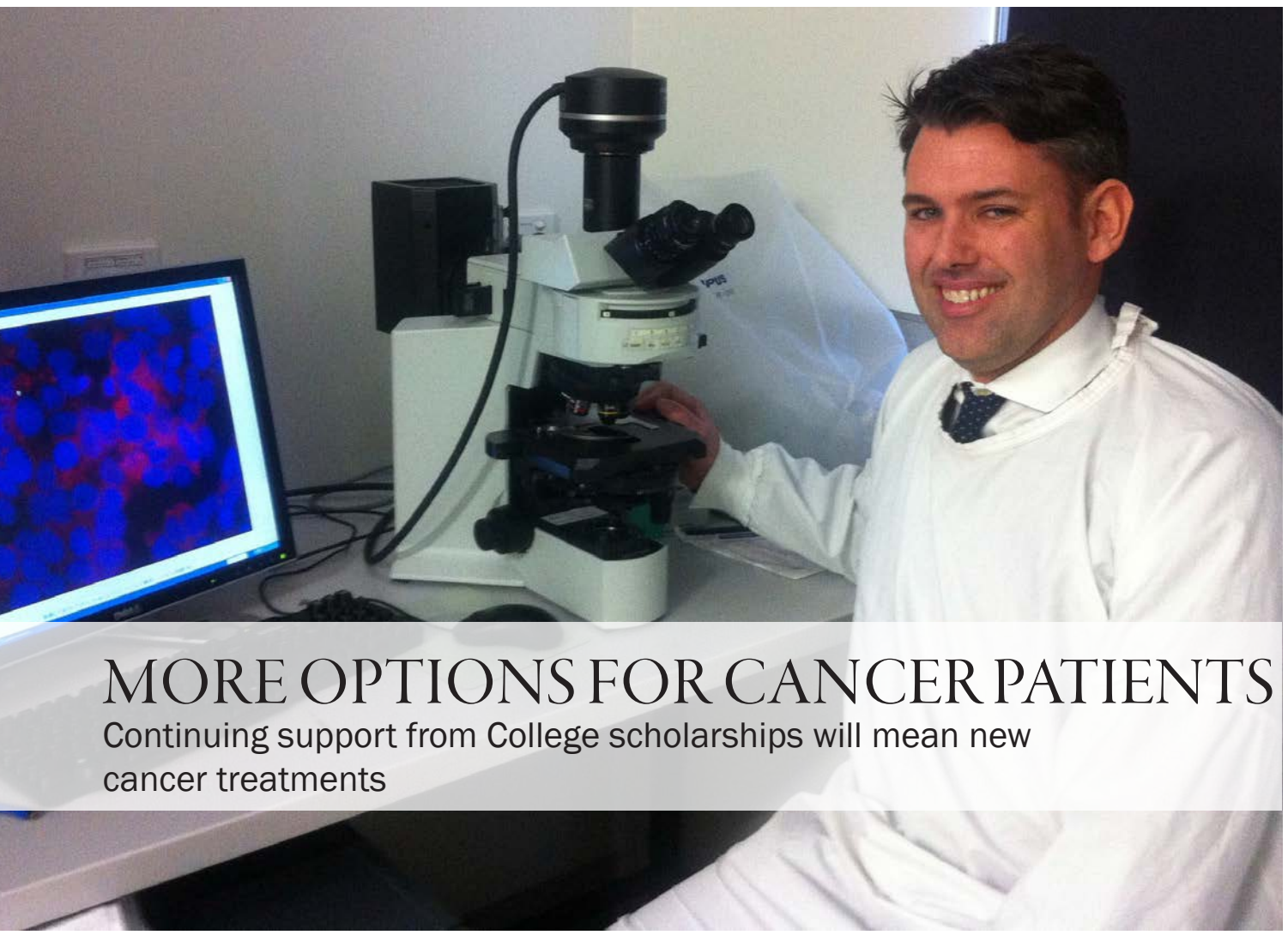
The Court determined that Dr Marshman was entitled to take into account Ms Morocz's presentation at the consultation, including the fact that she had obviously completed significant research prior to her visit.

The Court also found that a doctor was not obliged to inform a patient of rates of complications, medical literature discussions (including that the procedure had been banned in another country) and possible physical or physiological changes.

CONCLUSION

The Court found that Dr Marshman had not failed in his duty to warn Ms Morocz of the risks or side effects of the procedure. Further the Court stated that they were not satisfied that any breach had occurred and stated that even if Dr Marshman had warned his patient of these risks Ms Morocz raised in her pleadings, the Court found that she would have gone ahead with the surgery regardless.

With Sophie Bolzonello



MORE OPTIONS FOR CANCER PATIENTS

Continuing support from College scholarships will mean new cancer treatments

In the three years that General Surgeon Anthony Glover has been working on his PhD, he has contributed to two world-first discoveries, received the prestigious American Association of Cancer Research (ACCR) Scholar in Training Award and has published 17 peer-reviewed manuscripts.

With a research interest in endocrine cancer, Dr Glover has advanced current understanding of the molecular pathogenesis of adrenocortical cancer (ACC), a disease that mostly effects younger people and that remains one of the most aggressive and lethal of all cancers.

Working through the Cancer Genetics Laboratory, Kolling Institute of Medical Research, Dr Glover has discovered microRNAs reduce the growth of ACC and a long noncoding RNA that can be used as a biomarker to test for disease recurrence.

Both of these discoveries are now going through the Intellectual Property Protection process.

Dr Glover found that the tumour suppressor microRNA – miR-7 – which is deficient in patients with ACC, controls essential cancer pathways and that miR-7 could be used as a targeted replacement therapy.

Working with his supervisors and EnGeneIC (a Sydney biotechnology company), he has shown that ACC tumour growth is reduced in mouse models of ACC by delivering miR-7 replacement intravenously.

Dr Glover has also discovered that over 900 long noncoding RNAs are dysregulated between ACC, adrenal adenomas and normal adrenal cortex tissue. His description of one of these – PRINS – was the first to be reported in cancer research and was published earlier this year in Endocrine Related Cancer.

Now his work has formed the basis of further research by another two PhD students who have begun study this year to establish the effects of combining microRNA replacement therapy and microRNAs associated with long-term survival

of ACC patients.

A Fellow since 2011, Dr Glover has received financial support from the College to pursue his research through a Sir Roy McCaughey Surgical Research Scholarship in 2014 and a Foundation for Surgery Scholarship for 2015.

He has conducted his research through the University of Sydney and under the principle supervision of Professor Stan Sidhu, University of Sydney Endocrine Surgical Unit at the Royal North Shore Hospital in Sydney.

Dr Glover said that while major advances had been made in the detection and treatment of a variety of cancers in recent years, his research was exciting because until now, clinicians had only limited treatment options to offer patients with ACC.

"While ACC only effects one or two people per one million in the Australian population, patients face only a 30 per cent chance of five year survival after diagnosis," he said.

"Their only chance is to have surgery to remove the tumour but 50 per cent of ACC patients have recurrence of the disease and often the disease metastasises and then very little can be done.

"Professor Sidhu's unit is the national referral centre for ACC so we see it quite often and we have been working hard to try and find effective and non-toxic systemic treatments for ACC.

"While we know that RNA regulates cell function, we have now proven through experiments that miR-7 is low in adrenal cancer cells and that if they are replaced, they work to slow down tumour cell division making the disease less aggressive.

"This means it could be a new treatment, which is very exciting because when I began my PhD this was only a theoretical hypothesis so it's been fascinating to be part of developing this science."

Dr Glover said that while long noncoding RNAs were only a recent discovery, tests could soon be available to identify those associated with ACC recurrence through a tumour biopsy which would give clinicians a better understanding of disease aggression and progression.

"Having identified PRINS as a biomarker for ACC recurrence and metastasis means that we may be able to better tailor clinical treatments for ACC patients," he said.

"There are treatments available for ACC recurrence but most have serious side effects so PRINS could allow us to determine which patients could most benefit from more aggressive treatments."

Dr Glover is also undertaking his research under the supervision of Professor Bruce Robinson (Dean of the Sydney Medical School), senior research scientist Dr Jing Ting Zhou and Dr Patsy Soon from the University of New South Wales.

"...the most rewarding aspect of my work is that after 60 years in which we had no real advances in our ability to treat ACC, we now hope to see significant progress in our ability to treat our very sick patients."

His work follows on from that conducted by General Surgeon Patsy Soon who also received financial support from the RACS and who is now a Cure Cancer Researcher.

Since beginning his research in 2012, Dr Glover has published 17 peer-reviewed publications and presented his research at both national and international meetings.

He has won a number of awards including the Best Oral Presentation Award for Basic Biomedical Research at the 2014 Sydney Cancer Conference and the 2014 TS Reeve Prize for Best Science Presentation at the RACS' Annual Scientific Congress.

Last year he was also awarded the 2014 Northern Postgraduate Research Student Excellence Award at the Sydney Medical School.

Yet, despite all these achievements he retains an on-call weekend surgical roster, is a CCrISP and ASSET course instructor, a tutor with the Northern Clinical School of the University of Sydney and a co-supervisor of Honours medical students.

Dr Glover said his research could have an impact on the treatment for a number of other cancers including bowel, liver and lung cancer where microRNA-7 is under-expressed.

He said members of the Cancer Genetics Laboratory at the Kolling Institute were now waiting on the results of a clinical trial of microRNA replacement as a treatment for malignant pleural mesothelioma being conducted at the Asbestos Disease Research Institute (ADRI) at Concord Hospital.

"We are collaborating on this work in that we are using the same molecular science and biomedical approach but for difference cancers," Dr Glover said.

"Everyone in the field is watching and waiting on the results from ADRI. Encouragingly, the initial reports show the treatment is well tolerated and patients appear to get a real benefit."

Dr Glover said he first became interested in translational science following a Melanoma and Sarcoma Fellowship at the Royal Marsden Hospital in London and a Fellowship at the University of Sydney Endocrine Surgical Unit.

"When I was at the Royal Marsden I was involved in some new drug trials for melanoma where we had some really good results and that sparked my interest," he said.

"It is much harder to do this science in Australia because some experiments and investigations in molecular research cost hundreds of thousands of dollars to conduct and that money can be hard to find.

"But the Kolling Institute and the group that Professor Sidhu has developed is extraordinary and I feel extremely grateful to have been able to do my PhD here and have such support from my supervisors and the College.

"The past three years of research have been a wonderful experience which has broadened my view of both surgery and science.

"I have been to professional development classes to learn how to present my work and have taken a two week course through Stanford University on bio-innovation, entrepreneurship and translational science.

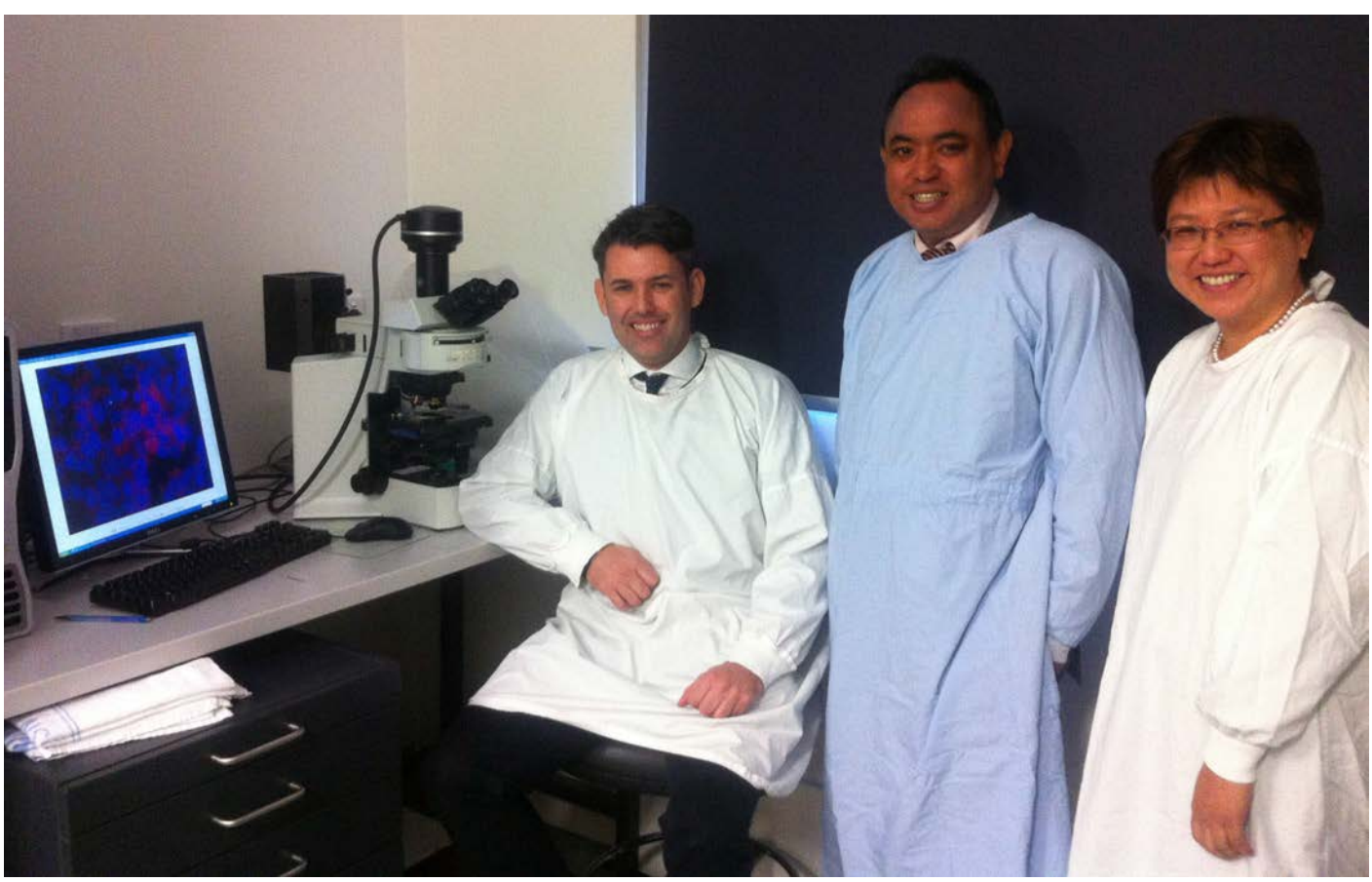
"However, the most rewarding aspect of my work is that after 60 years in which we had no real advances in our ability to treat ACC, we now hope to see significant progress in our ability to treat our very sick patients."

Dr Glover will be submitting his PHD at the end of the year and is now waiting to hear if he has funding from the NHMRC to undertake a collaborative research project into thyroid cancer through the Garvan Institute of Medical Research and the Memorial Sloan Kettering Cancer Centre in New York.

With Karen Murphy

CAREER HIGHLIGHTS

- 2014: Sir Roy McCaughey Surgical Research Scholarship
- 2014: American Association of Cancer Research (ACCR) Scholar in Training Award
- 2014: Best Oral Presentation Award for Basic Biomedical Research at Sydney Cancer Conference
- 2014: TS Reeve Prize for Best Science Presentation at the RACS Annual Scientific Congress
- 2014 Northern Postgraduate Research Student Excellence Award by the Sydney Medical School
- 2015 RACS Foundation for Surgery Scholarship
- 2015 Scientific Spokesperson for NHMRC Grant Review Panel



Dr Glover and his supervisors

ENGAGING THE NEXT GENERATION

An action packed couple of months for the Victorian Regional Office

JASON CHUEN
Chair, Victorian
Regional Committee

During June and July, the Victorian Regional Office has been involved in various medical student events. With support we delivered six laparoscopic workshops, a presentation on careers in surgery and JDocs, a trade show exhibition and a field trip to RACS.

We thank our Lap workshop facilitators: Mr Michael Hong, Mr Peter Gray, Associate Professor Craig Lynch, Mr Damien Loh, Ms Salena Ward, and Dr Asiri Arachchi. Dr Raf Ratinam (non-SET) was also on hand for assistance. Our future surgeons were given their first taste of laparoscopic training covering different tasks and techniques.

During a one hour lecture-style presentation, Dr Luke Bradshaw had the room enthralled and brimming with excitement at the prospect of becoming a surgeon and College Manager, Pre-Vocational and Online Education Jacky Heath introduced the students to the JDocs Framework. This session was overwhelmingly popular with standing room only.

The trade show exhibition showcased some of the projects that RACS and RACS' Fellows are involved in, including Global Health and Interplast projects, JDocs and various conferences and meetings. Mr Peter Field and Mr Gordon Low, along with many of our presenters spent time with the trade exhibition speaking with fascinated students about careers in surgery. Hopes, dreams and ambitions were discussed, along with more practical information about RACS, JDocs, careers in surgery and pathways to get there. At the stand, medical students were offered

The Victorian Regional office has been involved with a variety of student events.

Feedback to our sessions included "Awesome!", "Best session yet" and "Absolutely loved it!"

the opportunity to try their hand on the laparoscopic trainers that were supplied by our skills lab. This proved extremely popular.

On the field trip to the College, a delightful group of students were given a brief College history, then were taken on a journey through the horrors of early surgery and surgery in war presented by College Curator, Geoff Down. This was followed by a skills session in the Skills Centre by College Lab Technician, Arwen Tudor. The engagement of the students during this session was tested at the end by an informal "pop quiz". It can be reported that tricky questions were answered easily by our visitors who clearly enjoyed being at RACS.

All of our sessions were oversubscribed, and at times we recruited crowd control to direct the people traffic. Feedback to our sessions included "Awesome!", "Best session yet" and "Absolutely loved it!".

Thank you to all those involved for your support of our activities, and your help in bringing this all together. We hope that you will join us again.

THE BATTLE OF SARI BAIR

The August Offensive

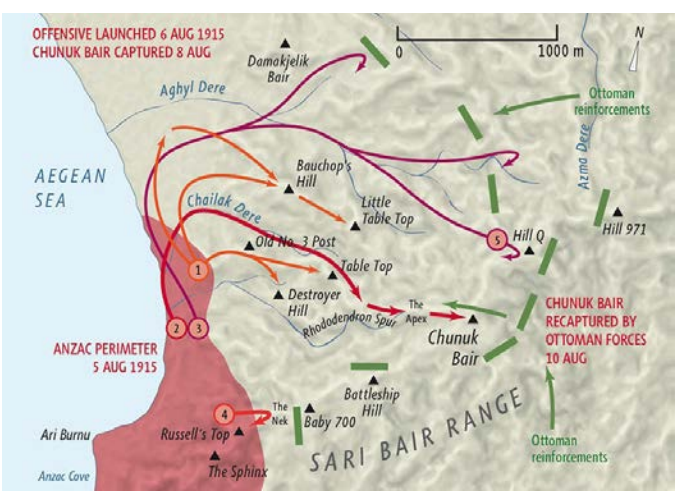
DAVID WATTERS
AND ELIZABETH MILFORD

July 1915 was spent in planning a new offensive and amassing the necessary troops. The August offensives were the last major attempt to take the Gallipoli peninsula and ultimately failed to achieve their objective.

August 6-29 is memorable also for individual campaigns that took Lone Pine, and the New Zealanders reaching Chunuk Bair, before their reinforcements were driven off by Mustafa Kemal's forces. The Turks know these battles as Anafarta and Conkbayiri.

The objective would be the same as on 25 April – occupying the high points Kocaçimentepe (Hill 971) and Conkbayiri (Chunuk Bair), but this time simultaneously with a landing of British troops of Kitchener's New Army, IX Corps, at Suvla Bay under Stopford. This would extend the foothold to a wider front and create a bigger supply base. A simultaneous three pronged assault from the ANZAC sector attacking the heights from different directions would achieve the objective. It was ambitious and complicated…[1]

New Zealand and Australian forces supported by Indian and Gurkha troops participated in attacks at Chunuk Bair and Hill 60. The Australian 1st Brigade launched an attack at Lone Pine (named for its solitary pine tree) on 6 August. The difficulty of the attack was exacerbated because reconnaissance aircraft had failed to observe that the Turkish trenches were roofed with pine logs. Although the main Turkish trench was quickly taken, Turkish counter attacks



and ferocious hand to hand fighting resulted in a large number of casualties – over 2,000 Australian and 5,000-6,000 Ottoman casualties.

Up at the Apex, the wounded of the Gurkhas and Aucklanders were lying on the forward slopes where the daylight attack on Chunuk Bair had been arrested. Many wounded were awaiting evacuation; stretcher bearers were urgently required… By 3pm both Aghyl Dere and Chalaik Dere appeared to be choked with wounded… The 4AFA much congested with wounded and could not advance further up the Dere, they were held up by fire.[2]

On the 9 August, the summit of Chunuk Bair was briefly captured by New Zealand forces (Otago Battalion and Wellington Mounted Rifles) but the position became untenable and it was recaptured by the Turks. A Turkish memorial plaque states that during this campaign Mustafa Kemal (Ataturk) was hit in the chest by shrapnel but it was deflected by his breast pocket watch and he was uninjured. It is said when he realised his good fortune, he roused his troops and drove the invaders off the summit of Chunuk Bair.

At the New Zealand Dressing Station at Walker's Ridge, Lt Col Begg held 200 casualties for evacuation but they had to wait until reinforcements made their way up the Chalaik and Aghyl Dere. The wounded waiting at the foot of Walker's Ridge could not be evacuated via Walker's pier till the tide turned, so only walking wounded could leave during the day.

Lt Col Begg wrote in a letter some months later:

It is quite possible that some wounded remained three days at No 3 outpost as the whole of the sea front was subject to shell fire and machine gun fire and it was impossible to get wounded away by sea from this point. All carriage was by hand through narrow saps and trenches and in this manner many thousands were transferred to barges.[3]

The August Offensive resulted in a stalemate that was challenging for the medical services. The intense fighting and number of casualties put pressure of the Australian and New Zealand Field Ambulances and effective evacuation of the wounded was a constant problem.[4]

1. Harvey Broadbent, *Gallipoli: The Turkish Defence*, MUP, 2015, 241
2. Captain Baigent's diary cited in Carberry: *The New Zealand Medical Service in the Great War, 86*
3. Erickson EJ. Mustafa Kemal *Atatürk*, Osprey Publishing, Oxford, 2013
4. Milford, E & Watters, D, *Anzac Surgeons of Gallipoli*, 2015

Photo: Begg Family

Charles Mackie BEGG

Colonel, CB, CMG, Croix deGuerre (1879-1919), MB ChB Otago1903, FRCSEd 1906

EARLY LIFE

Charles Begg was born in Dunedin in 1879. Educated at Otago Boys High School he entered the Otago Medical School in 1898, gaining his MB ChB in 1903 and FRCSEd in 1906. That same year he returned to surgical practice in Wellington where he was also appointed Honorary Consultant to the Wellington Hospital Children's Ward and commissioned Captain in the NZ Medical Corps. By 1909 he held command of the 5 NZ Fd Amb (Territorial Force).

GALLIPOLI

Begg sailed with the NZEF in October 1914 and saw early action in the battle to repel a Turkish attack on the Suez Canal in February 1915. At Anzac with NZ Fd Amb, Begg initially established a dressing station on the Beach which cared for many thousands of wounded and sick. In June Begg wrote:*Turks now enfilade beach from both ends and give us a rotten time.Have had half a dozen men killed just about [sic] hospital door.*

Begg was wounded a few days later and was treated at the Field Ambulance for concussion and a shrapnel wound to the knee.

During the offensive for Chunuk Bair, Colonel Manders, the ADMS, NZ & A Division was killed in action and Begg was appointed to this role. However within days he was stricken with paratyphoid and evacuated from the peninsula. He returned to Anzac in November 1915, resumed as ADMS, and was responsible for many of the medical aspects of the evacuation from Anzac in December.

AFTER GALLIPOLI

Begg served the remainder of the war in France and became ADMS in both the Anzac Corps and XXIII Corps on the Western Front. In these roles he was responsible for the delivery of medical care to tens of thousands of soldiers taking part in all the major Allied offensives from the battle of the Somme to the conclusion of the war. In October 1918 he was also given overall responsibility for the medical services of the French 5th Army as the war entered its final weeks.

PROFESSIONAL LIFE AFTER WW1

Following the Armistice, Begg was appointed Director of Medical Services in London, but he died of influenza on 2nd February 1919 aged 39. Charles Begg was the most decorated member of the New Zealand Medical Corps, ending the war with CB, CMG, Croix de Guerre and MID three times. Had he survived, this Edinburgh Fellow may ultimately have become a Fellow of the College.

Andrew Connolly

ALBERT TANGE DUNLOP

Major, DSO (1890-1981) MB ChM Sydney 1913, FRACS 1931

EARLY LIFE

Born in Ipswich, where his father Dr Albert Dunlop had moved for his tuberculosis, he was educated at Ipswich Grammar School and completed his medical degree in 1913.

GALLIPOLI

After completing his residency, Dunlop volunteered and was posted as an RMO to 18 Bn August 1915. This NSW battalion arrived on August 19th and was soon involved in the attack on Hill 60 on August 21-22nd when they lost half their strength.

Dunlop's work there earned him a recommendation for the Croix de Guerre: *For gallant devotion to duty in attending wounds in action in the open owing to the impossibility of evacuating wounded from the dressing station.* Wounded by Shrapnel in September he convalesced in Florence and went back to Egypt in December 1915.

AFTER GALLIPOLI

Sent to the Western Front with 5 Fd Amb, he was involved in major battles at Pozières, Flers and the Somme; and in 1917 at the battle of Ypres, his work with the stretcher bearer section of 5 Fd Amb earned him a DSO. He was also mentioned indespatches: *For gallant and conspicuous, long and able service in the Field.*

PROFESSIONAL LIFE AFTER WW1

Returning to Australia in 1919, he was to become senior surgeon at the Sydney Eye Hospital. By 1932 the two in-patient surgeons at the hospital were Dunlop and RB North who by tradition, jointly controlled all the beds and performed most of the major surgery. Most operations were performed under local anaesthesia. When a general anaesthetic was necessary it was administered by the registrar using ether with an intrapharyngeal tube connected to a noisy electric pump. Intravenous drugs, relaxants and specialist anaesthetists all came later.

Dunlop was a quiet taciturn man with a wry sense of humour. A safe but conservative surgeon, he was known to be very generous to his juniors. Active in a number of fields, he served on the Board of Medical Studies of the Sydney Hospital for many years, promoting the cause of undergraduate instruction in ophthalmology. He also held an appointment as a member of the Opticians' Registration Board.

Philip Sharp

COLLEGE ARTEFACTS

Important Colonial painting donated to the College

The Grampians by Henry Burn

On Friday 26 June an important Colonial painting was handed over to the College by Associate Professor Felix Behan. Professor Behan donated the painting under the Commonwealth Government's Cultural Gifts Program, and dedicated it to the memory of his mentor, the late Robert (Bob) Marshall.

The painting is a landscape by the English-born topographical artist Henry Burn. It is untitled, but depicts a scene in the Yarra Valley, on the road to Warburton. It is painted in oil on canvas, and is signed and dated 1873. It measures 58.0cm x 90.0cm within an elaborate gilt frame. It has become known under several names, including A Scene in the Yarra Valley and Road to Warburton.

Henry Burn was born in Birmingham about 1807, the son of a varnish-maker. His early years and education are not well recorded, and his artistic training is unknown. From his surviving works however it is clear that he was a competent draughtsman.

From 1840 to 1852 he travelled extensively throughout the Midlands, making many topographical views of towns such as Birmingham, Nottingham, Derby, Leeds and Halifax, and made his living from the sale of lithographs of these scenes.

On 16 October 1852 he sailed from Liverpool on the barque Baltimore and arrived in Melbourne on 30 January 1853. He came in search of gold, but soon set up as a lithographic artist and began printing scenes of Melbourne. The La Trobe Library has four of his lithographed Melbourne views, as well as nine of his topographical paintings of Melbourne.

On 3 July 1860 he married Susan Cane, daughter of a Collingwood baker, in St Peter's Eastern Hill.

In Australia Burn seems not to have made more than a meagre living from his art. He and his wife lived in humble circumstances in the Fitzroy-Collingwood area, taking rooms in a number of hotels. Burn himself was in 1877 admitted to the Melbourne Benevolent Asylum on the application of the licensee of the Studley Arms Hotel in Wellington Street Collingwood. He was discharged, but re-admitted less than a year later on the application of the licensee of the West of England Hotel in Fitzroy Street Fitzroy. His wife Susan returned to her father's care, and in his will there is provision for her, 'from whom God has seen fit to withhold many of the comforts of this life'. Henry Burn died in the Benevolent Asylum on 26 October 1884, and was buried in the Melbourne General Cemetery.

The College is most grateful to Professor Behan for this generous donation. It will be hung in the Library.

Ian Burke

THE CLINICAL VOICE IN HTA

Lessons learnt from two recent international meetings in Health Technology Assessment (HTA)

GUY MADDERN
Chair, ANZASM

Since my last article on the value of presenting your work to the right audience, colleagues at ASERNIP-S have presented at two international Health Technology Assessment conferences: HTAsiaLink in Taipei, and HTAi in Oslo.

HTAsiaLink, Taipei, 12-15 May

I am pleased to say that the ASERNIP-S presentation 'Horizon scanning on a range of Orthopaedic technologies: Experience and outcomes' was awarded 1st place in the Health Systems Research stream.

Perhaps the most interesting observation to come from the HTAsiaLink conference was the high level of importance of HTA demonstrated across the Asian region. Of particular note was the level of representation from regional governments, including several high ranking health officials from Taiwan, Thailand, and the Republic of South Korea. Conversations with delegates also identified the substantial number of HTA-related staff working within HTAsiaLink member organisations; for example, Chinese and South Korean HTA organisations currently employ 80 and 120 researchers respectively. The size of these organisations demonstrates the importance and growth in HTA activity, and the regional impact was substantiated by members commencing an in-principle process to invite HTA organisations from Oceania to be full members of HTAsiaLink.

HTAi, Oslo, 15-17 June

On the other side of the globe, several members of the College joined over 900 delegates at the 12th international HTAi conference in Oslo. This annual meeting provides a platform for producers, users and anyone interested in HTA to discuss new methods and paradigms in the evolving role of this developing field. As one of the few research groups that conduct HTA in Australia, the annual HTAi conference is the primary calendar event at which ASERNIP-S can showcase their work among international peers.

The involvement of the College was diverse. I presented "Surgical Procedures and devices – The life-cycle". Associate Professor Wendy Babidge (Director, RAAS) moderated two panel sessions:

- 'Using knowledge for the life-cycle management of medical devices', at which I was a panellist; and;
- 'International collaboration in HTA – Are we creating harmony or noise?'

In addition, Dr Tom Vreugdenburg (Senior Research Officer, ASERNIP-S) gave two presentations:

- 'The application of rapid review and mini-HTA methodologies in the development of Australian health policy'
- 'Image guidance reduces total, major and orbital complications in complex sinus surgery: A systematic review and meta-analysis'

The take home message

At both meetings, the importance of including clinician, patient and government perspectives in the evaluation of health technologies were highlighted. Involving this diverse range of stakeholders is essential for ensuring that clinical and policy recommendations are contextually appropriate. However, they are often lacking in HTA.

In this space, the College has a unique advantage. The interaction between ASERNIP-S and surgical Fellows is a valuable strength of the College, and one that is unique within the Australian, and indeed the international, HTA community.

This collaboration provides necessary context to our policy recommendations, and provides Fellows with a platform to participate in the health policy debate.

Ultimately, this partnership is the key strength of ASERNIP-S' work, and is of increasing importance to the national and international HTA community. I have no doubt that this will also lead to more presentations in the future.

More Information on the work conducted by ASERNIP-S can be found at:

web: www.surgeons.org/asernip-s
twitter: @RACSurgeons

For additional information contact Dr David Tivey:
david.tivey@surgeons.org

GI ZONE

Looking after your GM

DR BB G-LOVED

Respecting your faecal flora

My old chief used to tell me, "patients ask the difficult questions Dr G-loved, not examiners." I have found this to be true and have often been challenged to learn about areas I had previously overlooked. Mike and Flora recently did just that. Mike, an economist, is the partner of Flora, a female surgeon who has just discovered she is pregnant with their first child. They had read about the gut microbiome and wanted to know whether they could positively manipulate it to their advantage. Flora, still in full time practice had no time to study a new medical topic. I agreed to discuss this with them a couple of weeks later. This is what I presented.

We live in symbiosis with the micro-organisms that inhabit our gastrointestinal (GI) tract – our so-called gut microbiota (GM). Indeed we may have evolved to become superorganisms only with their help. We certainly depend on them for health. There are more micro-organisms living in our gut than cells elsewhere in our entire body.

We are born with sterile guts. Within a few hours, both quicker and better when there is a vaginal rather than Caesarean delivery, a baby's gut becomes colonized; initially the organisms are facultative anaerobes dominated by bifidobacteria but also Staphylococcus, Streptococcus, and Enterobacteriaceae. After weaning an anaerobic microflora is established which is by then similar to that of adults. There are 100 different bacterial phyla, but only seven are found in the human gut. These are Firmicutes, Actinobacteria, Proteobacteria, Verrucomicrobia, Tenericutes, Bacteroidetes and Fusobacteria [were you interested?]. The last two comprise 90 per cent of the ecosystem. These seven phyla spawn over 1000 species living within us. The total genome of our microbiome has been estimated to have 150 times more genes than the rest of us. We depend on some of their genes. Human beings have not evolved on our own but with and perhaps because of the microbiota within us.

Studies of families, including monozygotic and dizygotic twins, suggest that the environment is more important than heredity to determine an individual's microbiota. Diet results in marked changes to the gut microbiota, some of which can be detected even on the first day of a dietary change.

As it is possible to influence the constitution and balance of our microbiota, we all want to have the right balance.

Although the gut enterobiome is an organ still being understood, we already know it plays a huge role in both our physical and mental health. Even some of the physiological changes of pregnancy such as reduced insulin sensitivity, body fat increase, as well as vascular tone may be modified through Flora's GM , which adjusts with an expansion of the population of Proteobacteria and Actinobacteria that will persist until a month after delivery. There is increasing recognition of an association between the diet of the mother and life-long health of the fetus. What role and how the GM plays in this relationship would still be conjecture but the GM changes suggest there will be significant effects.

For all of us the GM is an important source of vitamins, co factors and secondary metabolites, it contributes to many other aspects of digestion, whether good or bad depending on our diet. Our immune function is dependent on it, not just as a layer of defence against the wrong sort of bacteria attaching themselves to our GI mucosa and secreting their irritant toxins. Another aspect is the gut-brain axis. Our neural and mental health partly depends on our microbiome and therefore on the food we eat.

We can improve our personal GM by eating well. We want the right microbes living within us. Research suggests if there is too much sugar, too much carbohydrate or too much fat, our microbiota will transform to recruit obesogenic ones, those that promote obesity, inflammation and over-absorption of fat. We don't want a pro-inflammatory GM. Too much luminal fat also paralyses some of your mucosal anti-carcinogenic defences, not something advisable over the many decades of your life. Probiotics might seem a promising future therapy but whatever microfloral changes they might make won't be sustained if we don't have the right diet.

Another chief of mine once quirked: "you are what you eat". The GI GM convinces me that statement was unwittingly true. Our food sustains the GM's needs and we all should be grateful for their metabolic effort. Those one hundred trillion microbes should not be disturbed. Leave them alone, they'll bring us home. Wish them a productive faeculent life in places you hope surgeons' hands will never need to probe.

STRONGER SYSTEMS

Improving the system from the ground up in Timor-Leste

A practical teaching session in Timor-Leste

The RACS clinical team based at the Hospital Nacional Guido Valadares (HNGV) in Dili, Timor-Leste, are working alongside their national colleagues to introduce a number of initiatives designed to strengthen clinical governance and supervision to help build and strengthen the hospital's role as a teaching hospital. The team includes five clinicians covering Surgery, Anaesthetics, Paediatrics, Obstetrics/Gynaecology and Emergency Medicine as well as program management support.

Since 2012, the RACS team, working through the Australian Government funded Australia Timor-Leste Program of Assistance for Secondary Services – Phase II (ATLASS II), has worked closely with the hospital executive to introduce:

- A three-tier hierarchy of doctors to provide supervision, teaching and mentoring;
- Formal train-the-trainer courses to transfer medical education teaching techniques, strategies and approaches;
- Regular Grand Rounds which are organised through a Timorese Committee and increasingly led by Timorese doctors;
- Morbidity and mortality audits and review meetings, particularly in the Paediatrics and Emergency Departments and the Department of Surgery; and
- A Post Graduate Resource Centre where doctors at all levels of training and expertise can access electronic resources and textbooks.

Since mid-2014, ATLASS II has been working with key partners to deliver a Family Medicine Training program (FMP) at the request of the Timorese Ministry of Health to help train and upskill recently returned junior doctors who have graduated through the Cuban medical system.

Designed to equip the junior doctors for work in Community Health Centres in rural and remote districts, the FMP is a two-year post-graduate training program consisting of mandatory, supervised, work-based clinical training delivered through rotations in surgery, obstetrics and gynaecology, paediatrics, internal and emergency medicine.

The system of a tiered hierarchy of medical staff at the HNGV was introduced to support this work by formalising roles and responsibilities to ensure that the junior doctors receive adequate exposure to clinical cases along with appropriate supervision and teaching.

Under the new initiative, mid-level doctors supervise and teach the FMP trainees utilising the "big brother/big sister" approach, while specialists provide overarching supervision, management and departmental leadership.

Dr Antony Chenhall, an Emergency Physician from Australia, did the majority of his emergency medicine training and consulting at St Vincent's Hospital in Melbourne before embarking on medical assignments in PNG, Myanmar and Timor-Leste. With a commitment to improving medical services and education in developing countries, Dr Chenhall and his family (including three young children) moved to Dili, Timor-Leste in 2009/2010 for Dr Chenhall to work with the RACS program and returned again in 2013 to join the ATLASS II team. He has been the team leader since 2014 and has been closely involved with his Timorese clinical counterparts in the establishment of these new systems and approaches at the HNGV.

Dr Chenhall said the Ministry of Health had asked ATLASS II to provide FMP training to up to 200 of the expected 1000 junior doctors who will ultimately be trained through the Cuban program.

He said that given the large number of returning junior doctors and the size of the hospital, the FMP is limited to 40 trainees per year to ensure they have adequate access to clinical case loads and dedicated supervision and training.

"The Timorese quite rightly aspire to deliver self-sustainable medical training in-country through their national hospital but they will continue to require outside support for this in the medium term"

He also said that while a hierarchical medical structure had been new to the HNGV, it had already resulted in improvements in patient care by improving lines of communication, supervision and responsibility.

"Previously at HNGV, the medical workforce structure was very flat without a clear system to define which doctors needed supervision or who had sufficient experience to teach, supervise and mentor. But it is clear that all teaching hospitals need to provide doctors with clearly defined roles and responsibilities which allow for supervision and training from senior consultants down to junior doctors. This new structure is just one aspect of the changes we have implemented to develop the role of the HNGV from one of just pure service delivery to that of a national teaching and training hospital," Dr Chenhall said.

"Now, gradually this is becoming increasingly normalised with junior doctors wanting supervision, mid-level doctors wanting to take up teaching opportunities and specialists encouraging both."

Dr Chenhall said that this enthusiasm to both learn and teach had been demonstrated by the success of the formal, fortnightly Grand Rounds which had been introduced at the HNGV in 2012 by ATLASS II and which have now become an embedded part of the hospital's teaching culture.

He said that 75 per cent of Grand Round presentations and discussions had been led by Timorese doctors in the past year compared to only 20 per cent in 2013 and that attendance rates had remained stable.

The Grand Round discussion format now in operation involves a junior doctor presenting a clinical case, a mid-level doctor discussing interesting aspects of that case and a specialist providing higher level teaching on the topic.

"These Grand Round discussions along with the train-the-trainer courses and the morbidity and mortality audit and review meetings are all part of our work designed to push cultural change and provide the junior doctors with the support they are seeking," Dr Chenhall said.

"All of these meetings and discussions are aimed at promoting learning based on identifying opportunities to improve patient safety and care. "They also offer doctors exposure to essential aspects of good medical practice, encourage continual professional development and further develop the teaching culture at the HNGV."

Timorese General Surgeon Dr Alito Soares, who recently returned from Fiji following completion of his Masters of Medicine (Surgery), funded by the Australian Government through the RACS Program said "The fortnightly Grand Rounds have been a great benefit to our [surgical] department as we are able to sit together to discuss cases – the end result is better service to the patient as we all learn from each other".

The program also includes activities aimed at improving the skills of the mid-level and specialist doctors in teaching and supervision. More than 20 Timorese mid-level and senior doctors have also participated in educational training activities on topics such as bedside teaching, appraisal and assessment, recognising the doctor in difficulty and modern approaches to clinical and skills teaching.

Dr Chenhall said the delivery of Instructor courses in Primary Trauma Care (PTC) were helping to expand expertise and teaching skills and that there are now seven trained and qualified Timorese PTC trainers who are actively coordinating and delivering PTC training to junior doctors.

Timorese surgeon and HNGV Clinical Director, Dr Joao Pedro Xavier, whose overseas Masters of Medicine (Surgery) studies in Papua New Guinea were also funded by Australian Government through the RACS Program, has worked closely with RACS in Timor-Leste over many years. He notes the impact that RACS' training and strengthening activities have had on the national hospital: "The ATLASS program has been very helpful. Because of its long term involvement they have been instrumental in the long term planning and implementation of training of doctors and specialists, helping us with our aim of becoming a teaching hospital"

He said "These are important improvements for our National hospital and health system. We all have to work together ensure the culture changes necessary happen".

Dr Chenhall notes that while the roll-out of medical services and training in Timor-Leste presented a unique challenge to all involved and that while the challenge will be ongoing for some time, substantial advances were being made.

"The Timorese quite rightly aspire to deliver self-sustainable medical training in-country through their national hospital but they will continue to require outside support for this in the medium term," he said.

"In the meantime, the ATLASS II program continues to train the FMP doctors who are in their first and second post-graduate years, we continue to train and mentor other mid-level doctors and specialists, and we are continuing to take up each and every opportunity to strengthen the role of the HNGV as a national teaching hospital.

"All the clinicians working here under the program are very proud of the trainees we are working with while I am also very proud of the ATLASS II team who work tirelessly to deliver high quality training and mentoring to national counterparts and management and have been able to be flexible and focused when the Ministry of Health's training priorities have changed. "

2015 SURGICAL EDUCATION RESEARCH PRIZE

Validation of a virtual reality simulation model for laparoscopic appendectomy and incorporation into a proficiency-based curriculum

PRAMUDITH SIRIMANNA
Award Recipient

The Academy of Surgical Educators would like to congratulate Dr Pramudith Sirimanna for taking out this year's Surgical Education Research Prize at the RACS Annual Scientific Congress. The following article is based on his presentation.

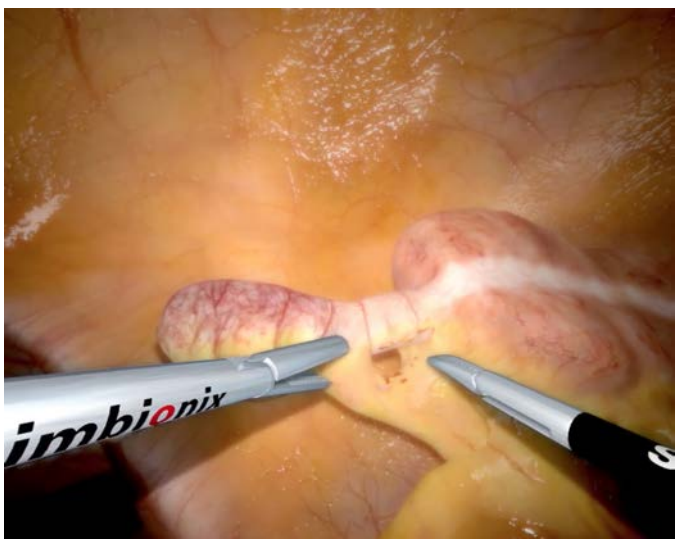
For over 100 years, the philosophy of most surgical training programs has been based on a time-based apprenticeship model, where learning usually occurs through serendipity. Despite this, the fulfillment of expertise is the ultimate ambition of all surgical Trainees. Currently, this requires extensive repetitive practise on patients which can result in errors, complications and mortality. This is an unacceptable side effect of surgical training. Indeed, it is well known that two thirds of all adverse events experienced by hospitalised patients are related to surgery and that half of these are preventable. Additionally, the implementation of restricted working hours has been shown to reduce learning opportunities within the operating theatre, with the inevitable effect of prolonging the learning curve. Thus, to overcome the challenges that face the next generation of surgeons, a shift in the pedagogical ideology of surgical training is required to one that utilises strategies to reduce harm to patients and is underpinned by the demonstration of competence and proficiency.

Surgical simulation has repeatedly been shown to facilitate acquisition of surgical skills in a risk-free environment. Indeed, training using these educational tools within a structured curriculum, results in improved performance and reduced errors in the actual operating room compared to conventionally trained surgeons. However, despite being among the most common emergency surgical procedures, there are limited studies on training of technical skills for laparoscopic appendectomy (LA). While this index operation frequently provides surgical Trainees with their first experiences in laparoscopy, it is associated with a notable learning curve of up to 30 cases. The resultant situation is one where the most junior surgeons are attempting to overcome this learning curve by practising one of the most prevalent emergency surgical procedures directly on patients.

Consequently, we aimed to develop a technical skills training curriculum for LA using a virtual reality simulator. In order to do this in an evidence-based manner, we were first required to validate the simulation model as a training and assessment tool, and define benchmarks of proficient skill level to use as performance goals within the curriculum.

The study utilised the LAP Mentor™ Virtual Reality (VR) laparoscopic surgical simulator (Simbionix Corporation, Cleveland, Ohio, USA), which is a high fidelity VR simulator with haptic feedback. The software includes five 'guided' tasks that deconstruct the LA into its constituent steps and teach users to perform a LA step-by-step using a number of techniques including using clips, an energy device or a stapler to control the appendicular artery, and endoloops or a stapler to divide the appendix. Additionally, the simulator contains an 'unguided' task that allows users to perform a full LA without guidance, using any technique they wish.

Ten experienced (performed >50 LAs), eight intermediate (10-30 LAs) and 20 inexperienced (<10 LAs) operators were recruited. The intermediate and experienced surgeons initially performed two repetitions of the five 'guided' tasks, followed by two repetitions of the unguided task using three separate techniques to reflect various international practises. These involved either using clips to control the artery and endoloops to divide the appendix, an energy device to control the artery and a stapler to divide the appendix, or a stapler to both control the artery and divide the appendix. The inexperienced surgeons were stratified into two arms, where group Group A conducted ten repetitions of the five



Simulation practise assists with performing laparoscopic appendectomy in a stepwise manner

'guided' tasks and group Group B conducted ten repetitions of the 'unguided' task using the three techniques described above.

Performance was assessed using simulator-derived metrics such as number of movements, path length, idle and task time. Using these, we evaluated if the simulator was a valid assessment tool by looking for performance differences between the three groups. Additionally, we assessed if the simulator was a valid training tool by looking for improvement in inexperienced group performance over the 10 sessions. Finally, the performance of the experienced surgeons were utilised to establish benchmarks of proficient skill.

Statistically significant performance differences were observed between the three groups for all simulator-derived metrics during all 'guided' and 'unguided' tasks, where the experienced group performed the best, the inexperienced group performed the worst and the intermediate group performance fell in between. Thus, each task's ability to accurately assess technical skill was validated. Additionally, all 'guided' and 'unguided' tasks were validated as training tools as evidenced by the presence of statistically significant learning curves, which illustrated that the inexperienced group performance improved with repetitive practise practise towards the level of the experienced surgeons. The difficulty of each task was determined by evaluating the length of the associated learning curve, with a longer learning curve equating to a more challenging task, and benchmarks of proficiency were obtained using the median performance of the experienced group.

Using the above results, we then created an evidence-based curriculum based on validated tasks and objective performance goals, designed to train skills required to perform a LA in a stepwise manner. The pathway through the curriculum is analogous to the pathway to obtain a driver's license. Initially 'learner' surgeons undergo guided training, where they perform all five 'guided' LA tasks, followed by repetitive practise practise of the two of the hardest tasks. Once the benchmarks of proficiency are obtained at these tasks, users can obtain their 'Red P Plates' and progress to the next stage of the curriculum. The 'Red Platers' then practise the unguided task using the three techniques previously described until the corresponding benchmarks of proficiency are achieved. Only once this occurs can users obtain their 'Green P Plates' and complete the curriculum. These 'Green P Plate' surgeons will be pre-trained novices that can enter the operating theatre with an attenuated learning curve thereby potentially improving operative performance and reducing the risk to patients.

This study demonstrated that a VR model of LA is valid as a training and assessment tool, and subsequently we developed the first technical skills curriculum for LA that is evidence-based, internationally applicable and requires the demonstration of proficiency for completion. One could envisage a paradigm where junior trainees can obtain their surgical 'Green P Plates' using such curricula, then undergo supervised training on patients with continual objective assessment and feedback using validated assessment tools. This would allow a cycle of training and assessment, where specific weaknesses can be identified, practised practised deliberately and re-assessed for improvement, until a proficient level of performance is attained.

Dr. Pramudith Sirimanna is a research fellow at the Academic Colorectal Unit at Concord Hospital, and is currently working towards a PhD dedicated to surgical skills training and assessment with the University of Sydney under the supervision of Professor Marc Gladman. His interest in surgical education developed while a medical student, where he was involved with multiple research projects pertaining to innovative strategies to enhance laparoscopic surgical skills under Professor Lord Ara Darzi at the Department of Surgery in St. Mary's Hospital, London.

Following completion of his medical degree from Imperial College London in 2010, Dr. Sirimanna accepted the opportunity to migrate to Sydney to work with Professor Marc Gladman at Concord Hospital as a surgical senior resident and researcher, and began working towards a PhD in surgical education in early 2013 funded through an NHMRC postgraduate scholarship. He has a number of publications relating to surgical education in peer-reviewed journals, and is the author of book chapters on 'Simulation and Patient Safety' in the 'Comprehensive Textbook of Healthcare Simulation' and 'Simulation and Assessment' in the upcoming 'Oxford Textbook of the Fundamentals of Surgery'.

VICTORIAN AUDIT OF SURGICAL MORTALITY

The first eight years

BARRY BEILES
Clinical Director, VASM

The Victorian Audit of Surgical Mortality (VASM) has been running for eight years. It is funded by the Victorian Department of Health and Human Services and managed by the Royal Australasian College of Surgeons (RACS) to undertake quality assurance programs in all Victorian hospitals that provide surgical services. The aim of the program is the continual improvement in surgical care through an investigation into the deaths of surgical patients. It has an active participation rate of 97 per cent of all Victorian surgeons.

The audit involves an independent clinical review of all cases where patients have died in hospital while under the care of a surgeon. Deaths notified to VASM are reviewed by at least one surgeon, practising in the same surgical specialty, but from a different hospital. These First-Line Assessors are unaware of the identity of the treating surgeon, the hospital in which the death occurred or the name of the patient. Where there is insufficient information for the first assessor to reach a conclusion, or if a more thorough review of the death is considered necessary, a detailed case note review by another independent surgeon is conducted. All independent peer review assessments of patient management are then formally directed back to the treating surgeons as part of the process to improve quality surgical care.

External reviewer assessment of VASM's performance

In 2011, an external evaluation was commissioned to determine the extent to which VASM had met its contractual performance objectives. The major outcomes of evaluation focused upon identifying strengths and areas for improvement in relation to the scope of activities undertaken by VASM, the efficiency and effectiveness of current program operations and suggestions to improve the impact of VASM activities. Key recommendations from this evaluation helped further streamline the operational processes and outcomes of the audit activities. A follow-up external evaluation was also conducted on VASM in 2015. This review highlighted that VASM has made significant progress in 23 of the 25 recommendations outlined in the 2011 review. The current recommendations require ongoing attention to maintaining levels of hospital participation, individual surgeon participation, inter-rater reliability, audit coverage and perceived value of outputs generated by VASM to a variety of stakeholders.

VASM publications

1. The 2014 Report

The report contains clinical information on 8,971 deaths reported associated with surgical care between 1 July 2007 and 30 June 2014. From this pool, 4,905 audited cases were peer-reviewed. The report also interrogated the Victorian Admitted Episode Dataset (VAED) to establish that during the seven year audit period 3,969,898 patients underwent surgery in Victoria. It resulted in a comparatively low number of 13,526 (0.3%) deaths that occurred primarily among elderly patients with pre-existing health conditions.

Other findings from the 2014 Report indicated that:

- The majority of the demographic trends confirmed the findings from previous years where the majority of surgical deaths occurred in elderly patients with underlying health problems, admitted as an emergency with an acute life threatening condition often requiring surgery.
- The actual cause of death was often linked to their pre-existing health illness. Death was most often adjudged to be not preventable and to be a direct result of the disease processes involved and not as a result of the treatment provided.
- A detailed case note review, or second-line assessment, was deemed necessary in only ten per cent of audited cases. This figure is similar to the rate recorded in other Australian regions.
- Unplanned return to the operating theatre is often, but not always, necessitated by a complication of the initial procedure and is associated with increased risk of death. Consultant involvement in such cases is highly desirable. Direct consultant involvement continues to increase significantly throughout the audit period.
- Since the inception of VASM, there has been a significant decrease in the frequency with which assessors are identifying clinical management issues.
- Despite intensive educational efforts, some errors are ongoing, albeit in the presence of steadily increasing numbers of patients who die without identifiable clinical management issues. The patients are generally elderly with multiple comorbidities and are admitted as emergencies, but delay to treatment and inappropriate or futile surgery are top of the list again this year. These issues will be at the forefront of VASM's educational efforts into the future.

Concordance between the treating surgeons versus the first- and second-line assessors was achieved. The key areas of

variance between the treating surgeon and assessors were in the clinical management issues section. The assessors perceived there were more issues in clinical management than the treating surgeon. This is not an unexpected finding and supports the value of independent peer review.

2. Publications in peer-reviewed journals

- Hansen D, Retegan C, Woodford N, Vinluan J, Beiles CB "Comparison of the Victorian Audit of Surgical Mortality with coronial cause of death": *ANZJS*, 2015 May 28. doi: 10.1111/ans.13185.

  This paper compared the cause of death reported to VASM by the treating surgeon and verified the details with the Coronial dataset.

- Vinluan J, Retegan C, Chen A, Beiles CB "Clinical management issues vary by specialty in the Victorian Audit of Surgical Mortality": a retrospective observational study, *BMJ Open,* doi:10.1136/bmjopen-2014-005554

  This paper utilised the data from VASM to identify differences in the incidence of issues between surgical specialties in order to address areas of care that might be improved.

- Beiles CB, Retegan C, Maddern GJ "Victorian Audit of Surgical Mortality is associated with improved clinical outcomes": *ANZJS,* 2014 Jul 18. doi: 10.1111/ans.12787.

  This paper utilised the data from VASM and the VAED to highlight specific areas of clinical improvement and reduction in mortality over the duration of the audit process.

- Retegan C, Russell C, Harris D, Andrianopoulos N, Beiles CB "Evaluating the value and impact of VASM": *ANZJS,* 2013 Oct;83(10):724-8.

  This paper outlined the findings from the external review on the performance VASM as a robust quality control program which achieved the trust of its stakeholders. It highlighted the educational value of the audit to the surgical community.

The current VASM publications can be downloaded from www.surgeons.org/vasm under the Reports and Publications section.

VASM data requests

VASM began promoting data request submissions from surgical Fellows and research collaborators for future scientific publications. The Australia and New Zealand Audits of Surgical Mortality will consider regional and national requests for data extracts.

The audit is a declared Quality Assurance Activity and is required to work within specific requirements of the declaration. ANZASM must protect the confidentiality of the information it receives, to respect the privacy and sensitivity of those to whom it relates and maintain high-level data security procedures, thus only de-identified data can be released. Requests have been received by VASM from Fellows and Trainees expressing their interest in the data.

VASM educational activities

The VASM educational seminars commenced in 2012 as a collaboration between VASM, the Victorian Department of Health and Human Services, the Victorian Regional Office, Victorian Surgical Consultative Council and Victorian Managed Insurance Authority. Some of the recent VASM educational programs included;

- *Perioperative care. How can we do better?* held on 18 Feb 2015

  The aim of this seminar was to focus on improvements in perioperative care of the surgical patient.

- *Understanding the literature and preparing for journal submission*, held on 1 May 2014

  The seminar focused on how to conduct literature review, how to apply critical thinking and preparation of journal submissions. Opportunities to request and use the VASM data for future clinical research and publication were highlighted.

- *Surgical emergencies and shared care,* held on 19 February 2014

  The seminar focused on current problem areas in the care of surgical emergencies, as revealed in clinical audit. It looked at the risks and challenges posed by shared care, and how surgeons and trainees may improve the safety of patient care in such settings.

Upcoming VASM educational events

Would you have changed the management of this patient's course to death? To be held on 16 October 2015, Grand Chancellor Hotel, Hobart. VASM would like to extend its invitation to Fellows to become a second-line peer reviewer. This role contributes to the educational value of the audit. The aim of the workshop is to provide guidelines on how to conduct second-line peer review assessments. The workshop will feature specific case studies from the current audit data.

Conclusion

The success of VASM is dependent upon highly motivated participating surgeons and health services; with their help in the last eight years VASM has built a solid foundation. VASM will continue to identify, assess and review factors associated with surgical mortality and will continue to develop action plans, educational programs and recommendations for further patient care improvements in Victoria. This activity remains unique in that it is an independent, peer-reviewed surgical mortality audit that is now widely supported by the majority of surgeons and gynaecologists in Victoria.

LOANS FOR TRAVELLING FELLOWS

The Royal Australasian College of Surgeons provides interest free loans to Fellows who plan to undertake approved research and/or training outside Australia and New Zealand.

To be eligible to apply for a loan, an applicant must:

- Be a Fellow of the College
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- Not receive more than one loan in the past five years

Applications can be submitted at anytime with assessment being undertaken upon receipt.

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Application forms can be found on the College website under College Resources

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