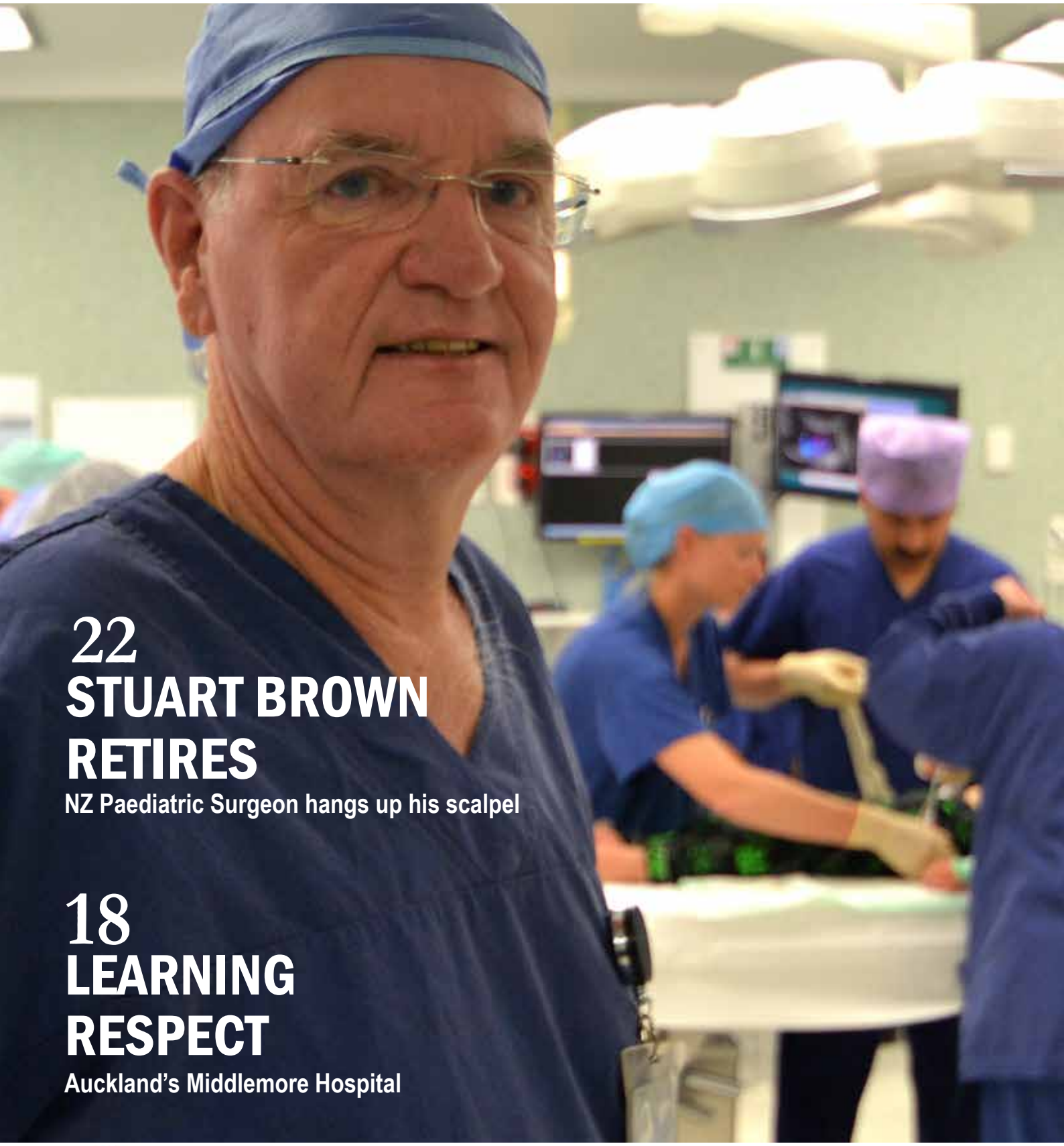
ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

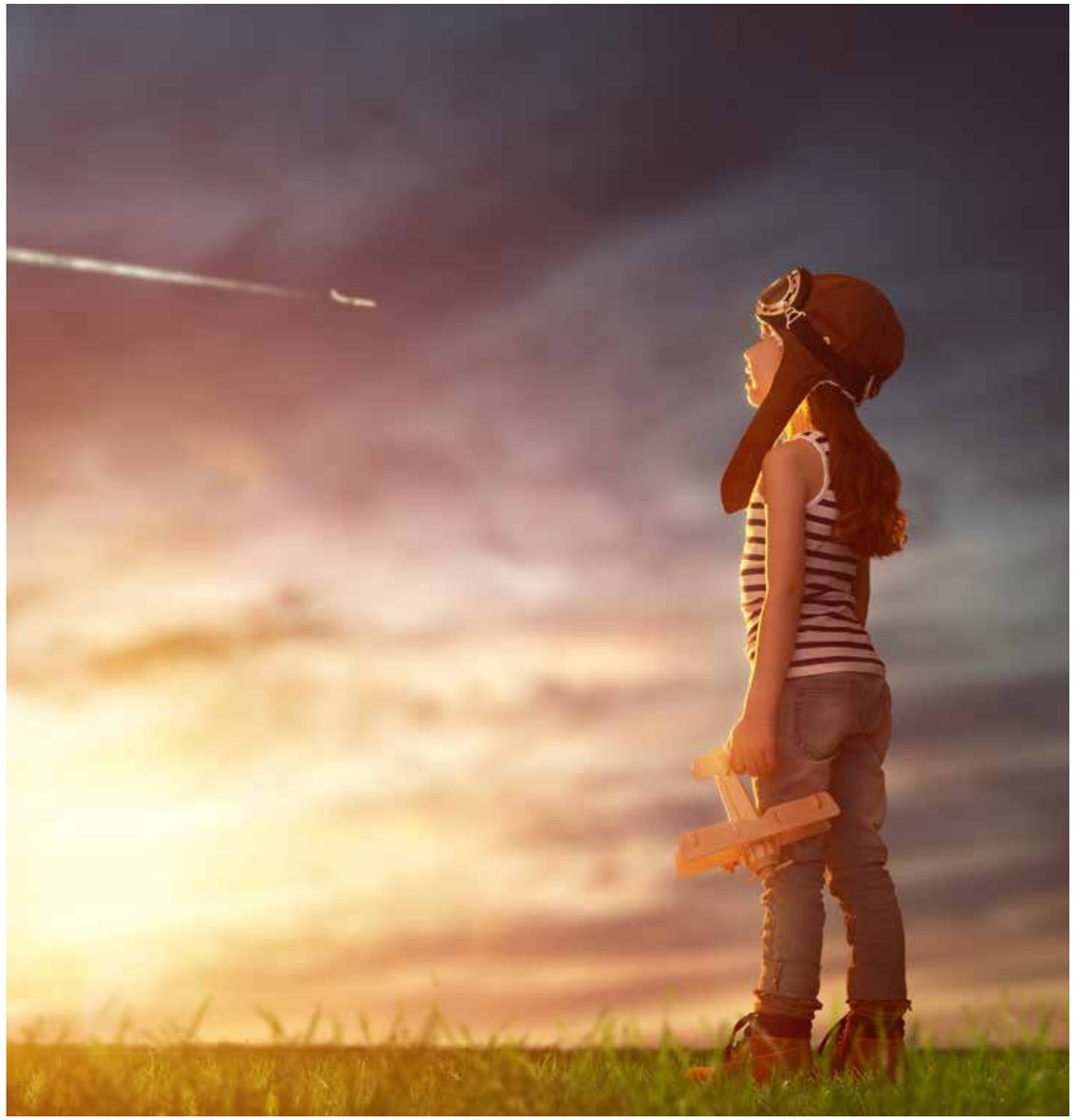
SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 17 NO 07 AUGUST 2016



RACS
LET'S OPERATE WITH RESPECT

The College of Surgeons of Australia and New Zealand



A dream is just a dream. A goal is a dream with a plan and a deadline. – *Harvey Mackay*

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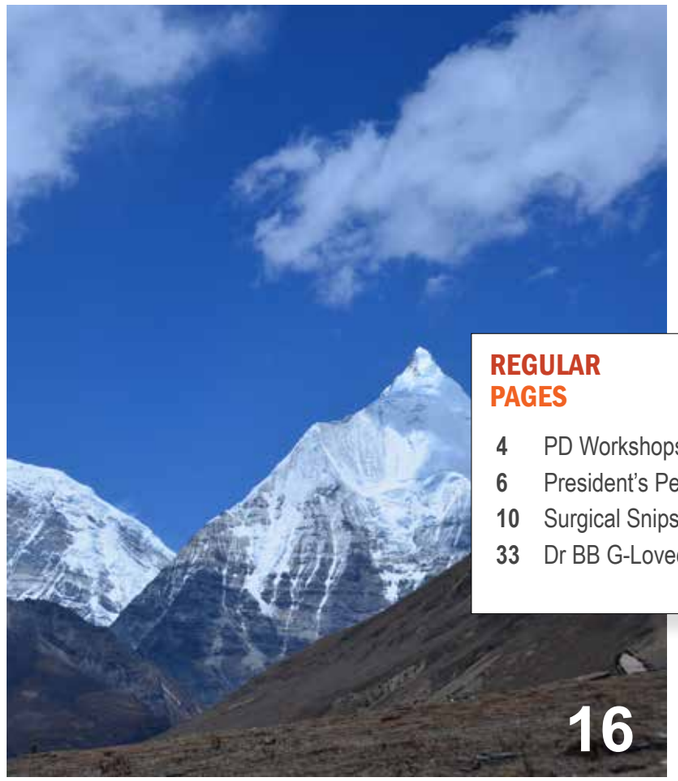

REGULAR PAGES

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PROFESSIONAL DEVELOPMENT

WORKSHOPS & ACTIVITIES

Online registration form is available now (login required).
Inside 'Active Learning with Your Peers 2016' 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.

Foundation Skills for Surgical Educators Course

25 August 2016 - Adelaide, SA, Australia
5 September 2016 - Frankston, VIC, Australia
17 September 2016 - Darwin, NT, Australia
23 September 2016 - Brisbane, QLD, Australia
30 September 2016 - Townsville, QLD, Australia
7 October 2016 - Logan, QLD, Australia
15 October 2016 - Box Hill, VIC, Australia
19 October 2016 - Christchurch, New Zealand
21 October 2016 - Melbourne, VIC, Australia
29 October 2016 - Adelaide, SA, Australia

The Foundations Skills for Surgical Educators is an introductory course to expand knowledge and skills in surgical teaching and education. The aim of the course is to establish the basic standards expected of our surgical educators within the College.

The course will further knowledge in teaching and learning concepts and look at how these can be applied into the participants own teaching context. This free one day course is targeted at senior Trainees, IMGs and new and existing surgical supervisors who teach. The Foundation Skills for Surgical Educators course is the first educational response to the RACS Building Respect and Improving Patient Safety Action Plan and is a **mandatory requirement** for all surgeons involved in teaching.

Non-Technical Skills for Surgeons (NOTSS)

9 September 2016, Auckland, New Zealand

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

Keeping Trainees on Track (KToT)

10 September 2016, Canberra, ACT, Australia
15 October 2016, Wellington, New Zealand

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

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

Supervisors and Trainers for SET (SAT SET)

10 September 2016, Canberra, ACT
15 October 2016, Wellington, New Zealand

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

Academy of Surgical Educators Forum

'Changes in Health Education 2016 and Beyond'
25 August 2016 - Adelaide, SA, Australia

The forum will be in Adelaide as part of the Adelaide Annual Scientific Meeting (ASM) at the Adelaide Crowne Plaza. This will look at the Changes in Health Education. Hear from our panel of speakers on what is up and coming in health education transformation and leadership in healthcare. The Forum is a a great way to connect and network with your peers as well as to understand the issues surrounding Health Education – an invaluable way to kick-start your ASM in Adelaide experience.

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

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Innovations in preventing harm to older people in hospital

2 September 2016 - Melbourne, VIC, Australia

The Forum will be held at the AMREP Lecture Theatre, Alfred Hospital, Commercial Rd, Prahran from 8.30am to 3.30pm. The aim is to bring together clinicians from all areas of health care and provide an opportunity to share and develop knowledge and capability for best practice in preventing harm to older people in hospital.
For more information and registration, please visit:

https://www.registernow.com.au/secure/Register.aspx?E=21029

Bioethics Forum

'Bioethical Framework Implementation in Clinical Practice'
22 October 2016 - Sydney, NSW, Australia

The Forum will stimulate robust bioethical discussions amongst surgeons.

The 2016 Forum has a broad clinical emphasis to reveal current medical, surgical and hospital practice and to bring into focus innovations in medicine, nursing, pain relief and surgery that continue to evolve.

July 2016 - August 2016

ACT
10 September 2016
Keeping Trainees on Track, Canberra

10 September 2016
SAT SET Course, Canberra

NSW
21 October 2016
Finance for Surgeons, Sydney

22 October 2016
Bioethics Forum, Sydney

NT
17 September 2016
Foundation Skills for Surgical Educators, Darwin

NZ
09 September 2016
Non-Technical Skills for Surgeons, Auckland

15 October 2016
Keeping Trainees on Track, Wellington

15 October 2016
SAT SET Course, Wellington

19 October 2016
Foundation Skills for Surgical Educators, Christchurch

SA
25 August 2016
Academy of Surgical Educators Forum, Adelaide

25 August 2016
Foundation Skills for Surgical Educators, Adelaide

29 October 2016
Foundation Skills for Surgical Educators, Adelaide

QLD
19 August 2016
AMA Impairment Guidelines 5th Edition: Difficult Cases, Noosa

23 September 2016
Foundation Skills for Surgical Educators, Brisbane

30 September 2016
Foundation Skills for Surgical Educators, Townsville

7 October 2016

Foundation Skills for Surgical Educators, Logan

VIC
5 September 2016
Foundation Skills for Surgical Educators, Frankston

10 September 2016
Communication Skills for Cancer Clinicians: Breaking Bad News, **Melbourne**

7 October 2016
Foundation Skills for Surgical Educators, Box Hill

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

STANDARDS ABOUT BEHAVIOUR

Getting the message out

PHILIP TRUSKETT
President

Excellent surgical care requires surgeons to be skilled in clinical judgement, decision making and collaboration as well as medical knowledge and technical expertise. Our Code of Conduct speaks to these requirements and importantly to the objectivity and compassion required when patients' interests are to be placed first and patients respected with dignity, individuality and autonomy. Importantly our Code of Conduct has been reviewed and strengthened to better reflect the longstanding ethical and professional principles but also the changing expectations of the community.

The last 18 months has seen the profession of surgery in the spotlight responding to issues of discrimination, bullying and sexual harassment (DBSH). It was a stark reminder that the expectations of the community as well as our Fellows, Trainees and International Medical Graduates have moved and sharply. No longer is training allowed to be based on techniques of decades ago where 'humiliation' was routinely utilised as an educational tool. No longer is the work place or the educational environment able to tolerate unacceptable behaviour. The expectation is that this behaviour is highlighted and brought to account – we do not walk past it.

In response to the work of the Expert Advisory Group chaired by the Hon Rob Knowles there were some very clear standards established. The first is that every patient has the right to expect that their healthcare is not compromised by discrimination, bullying or sexual harassment. Equally every health care worker and particularly every Trainee has a right to a workplace free of discrimination, bullying and sexual harassment. RACS has acknowledged that this is a long way from the reality of many healthcare workplaces and that we must work to see this changed.

In embracing its responsibility as a leader in setting standards RACS has updated its Code of Conduct so that expectations about behavioural issues are more clearly stated. Discrimination, bullying and sexual harassment are breaches of the Code. The Sanctions Policy has also been updated to more clearly deal with breaches of the Code. With a multi-step approach, RACS will always emphasise an educational approach where remediation is key. However, the Fellowship of individual Fellows can be removed for breaches of the Code of Conduct.

With clearer expectations, RACS has also created compulsory training in these areas. Already a leader in this for many years with courses focusing on communication, teamwork, professionalism and other non-technical skills training on discrimination, bullying and sexual harassment is a critical step to improve awareness. The e Module Operating with Respect was launched in July. It will be a compulsory component of CPD for all Fellows. It will be compulsory for all Trainees and be available to those completing the J-Doc framework. Able to be completed in 45 minutes it is a high quality production providing a good introductory grasp of the issues. It will be followed by a Face-to-Face course that will be compulsory for all Fellows, Trainees and International Medical Graduates involved more formally with RACS activities and committee work.

Also RACS is now highlighting that for Fellows to be involved with the Education and Training activities of the College, they must have key skills as an Educator. We are insistent that trainers and supervisors are required to provide feedback to Trainees in our competency-based educational framework. If this is given inexpertly, the style of feedback can be perceived as bullying. The Foundation Skills for Surgical Educators Course has been available for 18 months. This course addresses issues of educational style including feedback. It is designed for Fellows who have not done similar courses. It is now being substantially resourced to enable the 3000 Fellows involved with education and training to access the training over the next two years. Similar courses will be accredited. The course is compulsory for all Fellows who interact with our Trainees who have not done accredited educational courses.

"...every patient has the right to expect that their healthcare is not compromised by discrimination, bullying or sexual harassment. Equally, every health care worker and particularly every Trainee has a right to a workplace free of discrimination, bullying and sexual harassment..."

RACS is also distributing the posters of the Operate with Respect campaign. These are available on the RACS website, are being included in Surgical News and are also being sent to Hospitals to facilitate 'getting the message out'.

So where does that leave you – the Fellows of the College? All of these activities need surgical champions. Firstly, to take responsibility for your own actions. Secondly, to lead your surgical team with conviction about these issues. Importantly the third level is to provide leadership across the organisations where you are based. RACS will be resourcing our Regional Offices to a higher level, so they can work with the surgical champions of hospitals on this substantial program. We need surgeons to lead activities, to be trained in the appropriate educational and behavioural activities and then to train those around them. All of us are the solution to the problems of the past and the delivery of these important messages and programs.

So when you ask yourself, what is RACS doing on these issues - the program is there, the support is available and we look forward to you as the Fellows of this College in getting the message out.

ELECTION TO COLLEGE COUNCIL

Fellows are strongly encouraged to participate

SPENCER BEASLEY
Vice President

That time of the year is coming round where all Fellows are invited to nominate for Council. This is the time to decide whether you will put yourself forward to be involved in the governance and leadership of the College. If you do not wish to do that, it is the time where you have the opportunity to decide who will serve those functions on your behalf. As a membership organisation, it is your College and you have the right to influence how it is run.

Why Nominate?

College Council is made up of 25 Fellows:

- 6 Councillors are elected by the Fellowship at large.
- 9 Councillors are elected by Fellows in their Specialty.

If you are a Fellow - in good standing with no disciplinary sanction placed against you by a regulator or employer - you may nominate yourself for election. Your nomination is required to be supported by two other Fellows.

Please consider whether you would like to become a Councillor. In effect, it means becoming a director of a medium sized business with all the duties, responsibilities and rights that that entails. You will be well supported. For example, the College funds all new Councillors to undertake the intensive, highly regarded Company Directors graduate course run by the Australian Institute of Company Directors (AICD). It also provides annual training for all Councillors, again through the AICD. Besides formal governance training, Councillors receive formal training through an induction process and the culture of collegiality within Council ensures a smooth transition into the role of Councillor. Council encourages diversity, so age, gender, and ethnicity should not be considered barriers to nomination.

Council sets the strategic direction of our College, its goals, business plans and budgets and monitors their implementation. In doing so, it works closely with the CEO and senior staff. There is enormous scope for Councillors to contribute to all aspects of surgery through the various committees of Council. You will have the opportunity to understand the College's various activities as never before and the opportunity to influence our direction. Areas of exposure include SET training, professional standards and development, risk management, advocacy, global health and audits, to name a few.

Do you have the interest and inclination to commit to your College and to surgery through being on Council? On Friday 19 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 and help lead your College over the next few years.

"RACS ensures that surgeons have a respected voice and influence with health policy makers, regulators, funders and other stakeholders. A motivated and wise Council is a pre-requisite to being effective in the many areas of RACS advocacy and activity."

Why Vote?

All Fellows are entitled to vote and all are strongly encouraged to do so. But exactly why?

First, with your vested interest in the success of your College, you can influence its direction and determine who will lead it on your behalf. Secondly, the authority of Council itself is enhanced by having a strong mandate from the Fellowship – which includes you. Councillors who are elected by a good proportion of the Fellowship feel a commensurate obligation to keep faith with their electors and be held accountable as they act in the best interests of their College. Thirdly, the authority of our College as a professional body is also enhanced by evidence of strong engagement by its membership.

RACS ensures that surgeons have a respected voice and influence with health policy makers, regulators, funders and other stakeholders. A motivated and wise Council is a pre-requisite to being effective in the many areas of RACS advocacy and activity – and this is where you can influence that.

How it works:

Candidates submit information and a photograph of themselves. The Fellows supporting their candidacy make brief statements about why they think they would make good Councillors. These statements are intended to help you decide who to vote for, irrespective of whether you know the candidates or not.

As RACS embarks on ever more rigorous endeavours on our behalf to safeguard our professionalism and standards into the future, it needs the best talent available. By voting you will help us in these endeavours.

On Friday 16 September you will receive an email with a link to the ballot to elect Fellows to vacancies on the RACS Council.

Please take the time to read about each of the candidates and submit your vote. Electronic voting makes the process even quicker and easier. Here is your chance to influence the future of your College.

SURGICAL SNIPS

First time surgery

Australia's first in-utero surgery has been performed at Mater Hospital in Brisbane. With the help of a US specialist team, the revolutionary surgery was performed in a 24 week old in utero baby.

A condition that exposes the lower part of the spinal cord, spina bifida affects one in 2,000 pregnancies and the surgery was done overseas before now.

Neurosurgeon Dr Martin Wood said that it would guarantee the child a better life.

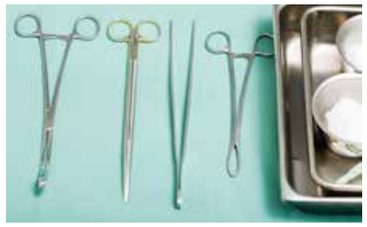
"It should offer this child and other children a very real chance of having a better level of functioning than they would have had otherwise," Dr Wood said.
ABC News, 25 July

Quad bike safety movement growing

A new subsidy scheme launched by the Victorian Government will target Quad bike injuries and fatalities in an effort to cut down the growing toll.

Launched at the Famers Federation conference, the scheme offers $600 rebates for eligible farmers to retro-fit rollover protection bars to existing bikes.

Alternatively farmers could receive $1200 towards buying a safer vehicle to use than quad bikes. There were 22 quad bike fatalities in 2015, and an the Tasmanian Coroner is currently investigating deaths in the region.
The Age, 25 July



The skills for surgery

Medical students were treated to a session on the basics of surgery at Latrobe Regional Hospital recently, supported by local surgeons and registrars.

Coordinated by the Monash University Surgical Interest Group (MUSIG), the Gippsland Surgical Skills Workshop consisted of the basics if suturing as well as the opportunity to use laporascopic simulators loaned from the Royal Australasian College of Surgeons.

A representative from MUSIG said it was a great chance to expose students to surgery.

"The events success has led to plans for a more advanced workshop later in the year," he said.
LaTrobe Valley Express, 22 July

New approach to cancer treatment needed

Treatment for cancer needs a rethink, according to leading NZ cancer research and surgeon Swee Tan has said.

With the exception of child leukaemia, breast and some brain cancers, there have been modest improvements in care despite thousands of dollars being spent.

Current immunotherapy drugs only treat cancer in a traditional understanding of the cells. Swee Tan would like to try a different approach, however needs funding.

"We have to transfer knowledge that we've gained from the laboratory to the treatment of patients," Dr Tan said.

Timaru Herald, 30 June

MAORI HEALTH MATTERS

New Zealand RACS focuses on Māori health

Hui attendees at Tuteri Tone Marae in Auckland, August 2015

RANDALL MORTON
Chair, New Zealand National Board

Tenā koutou, tenā koutou, tenā koutou katoa. It is fitting that I address the important issue of Māori health, as at the time of writing, it is te wiki o te reo Māori (Māori language week). Almost a year ago, RACS Fellows gathered for a hui (meeting) at Tutāhi Tonu Marae in Auckland to discuss the future of RACS' commitment to improving Māori health and Māori representation in surgery. While discussion at the hui was informative and inspiring, it also served as a firm reminder of the troublesome – and indeed unacceptable - inequity in New Zealand.

It is well documented that there are significant disparities in health outcomes between Māori and Pakeha (New Zealanders of European descent), and between Māori and other ethnic groups. Māori have a greater incidence and mortality rate for diseases such diabetes, cardiovascular disease and cancer, and a considerably shorter life expectancy.

As for the health workforce, Māori are markedly under-represented, with only 3.2 per cent (492) of New Zealand doctors identifying as Māori despite the fact that Maori comprise15.5 per cent of the New Zealand population. Although we do not know the exact figures, we believe that the proportion of Maori in surgery is less than the meagre 3 per cent cited above.

As the Tutāhi Tonu hui came to a close, it was clear that RACS could, and should, play a much more proactive role in addressing these inequities. To this end, RACS has developed a Māori Health Action Plan with a clear vision, i.e. "to achieve equity in health outcomes for Māori with a particular emphasis on how surgery and surgeons can contribute to this". In February this year the Action Plan was approved by the RACS Council and since then momentum has steadily built.

One of the main goals of the Action Plan is to develop the surgical workforce so that it better reflects Māori in New Zealand society. Although increasing the number of Māori surgeons alone is unlikely to significantly address health disparities, low representation ultimately presents the image of a workforce that may not be optimally responsive to, or understanding of, Māori healthcare needs and aspirations. It is timely then that 2015 marked the first year that the intake of Māori medical students into New Zealand's medical schools was proportionate to the Māori population. The challenge for RACS is to prepare and encourage these future doctors to pursue a career in surgery.

The current low proportion of Māori surgeons (and indeed Māori in most specialities) is likely a consequence of differential access to educational resources, opportunities and support. RACS must seek to address these essential inequities by offering mentorship, professional development opportunities and career advice. To this end, a number of career enhancement scholarships for Māori medical students and doctors have recently been created.

The RACS Māori Health Action Plan is prefaced by a whakatauki (proverb) which is most fitting: Kaua e whakaarohia te mahinga engari te otinga (think not on the labour, rather reflect on the completion). The journey that RACS has embarked upon is likely to be a long one. The Maori Health Action plan states it very well: we must "work in genuine partnership with Māori organisations and cultural structures to identify areas where College support would be advantageous".

Clearly there is no 'quick fix' for the inequities that have existed for decades. While the challenges are many and the solutions complex, the goal is most certainly worthy of the effort.

A copy of the Māori Health Action Plan is publically available on the RACS website. If you would like to be involved, or updated on the Plan's progress, contact: **College.NZ@surgeons.org.**

"It is timely then that 2015 marked the first year that the intake of Māori medical students into New Zealand's medical schools was proportionate to the Māori population. The challenge for RACS is to prepare and encourage these future doctors to pursue a career in surgery."

Cowlishaw Symposium

The 11th Cowlishaw Symposium will be held Melbourne this year, on Saturday 15 October in the Hughes Room at the Royal Australasian College of Surgeons, beginning at 10am.

Note this date in your diary!

The Cowlishaw Symposium is a day of presentations on subjects of medical and surgical history. Papers are based on the resources of the Cowlishaw Collection, one of the best collections of historic medical books in Australia / New Zealand.

Booking Forms in the next Surgical News.

For details contact Geoff Down, Curator, Royal Australasian College of Surgeons.

T.: +61 3 9276 7447
E.: geoff.down@surgeons.org

LIVE STREAMING

Social media's new frontier

Live streaming – social media's new frontier

The signing of a Memorandum of Understanding with St Vincent's Health was a milestone for the College, as the first event live streamed on the RACS Facebook and Twitter accounts. The event was well received, being watched by a number of people live, and hundreds more after the event concluded.

What is live streaming?

Live streaming – the ability to film a live event and have it shown in real-time to a designated audience – has been available in different forms for a while now, but the launch of live streaming by Facebook earlier this year really brought the technology to the masses.

Some of the options that you have for live streaming include:

Periscope

Periscope is a mobile-based live streaming app that burst on to the social media scene early last year. Once acquired by Twitter, Periscope was able to push competing mobile live streaming app Meerkat out of the market. The acquisition also enabled Periscope users to capitalise on their large Twitter followings, with the app enabling users to live stream directly onto Twitter and Periscope simultaneously.

Facebook Live

A relative newcomer to live streaming, Facebook Live allows users to live stream events through their Facebook accounts, with the live videos being archived and available to be viewed on the user's Facebook wall. Facebook Live also allows live streaming in Facebook Events and Groups, allowing users to take advantage of the technology with a smaller audience, rather than the general public.

YouTube

It shouldn't come as a surprise that video-centric platform YouTube is focusing more and more on live streaming. YouTube's Live Events utility allows any YouTube user with a verified account in good standing to stream live video to their account, which can be monetised with the inclusion of advertising. YouTube has also developed a great video broadcasting infrastructure. The platform records live streams twice, so if one stream goes offline, the other will pick up the slack, ensuring a smooth viewing experience without any breaking or buffering.

Blab

Marketed as a video chat app, Blab allows up to four people to have a live conversation simultaneously as an audience watches and provides comments. A unique take on a traditional video conference, Blab audience members can even switch places with one of the four hosts. Like Periscope, Blab is integrated with Twitter, with users signing in to Blab with their Twitter accounts.

SnapChat

A favourite of many a millennial, SnapChat has gained ground as a useful video messaging service. While not technically a live-streaming platform, SnapChat does allow you to send videos that can be viewed immediately by your audience, and will disappear after a certain amount of time, be it several seconds or a maximum of 24 hours.

How can live streaming be used by surgeons?

Live streaming opens the door to many opportunities for today's surgeon, such as improved patient care, providing and receiving medical education, and even promoting your practice.

Live streaming apps allow surgeons to provide real-time patient support. The technology can act as a cheaper, easily portable alternative to traditional telemedicine, and allow surgeons access to patients in remote areas.

Showcasing medical procedures can encourage patients to take control of their own health. The Mayo Clinic recently used Periscope to live stream a colonoscopy, to show patients how they are performed and remove the fear associated with the procedure. Live streaming platforms also allow surgeons to reach their target audiences where they already spend time, and spread important public health messages.

Live streamed medical procedures can support medical students, junior doctors and trainees in their medical education. However, care needs to be taken and the RACS Position Paper on live streaming needs to be carefully read and followed. In addition, conferences, seminars and other professional development events can be live streamed, enhancing the opportunities for continued medical education.

Surgeons can also use live streaming technologies to promote their own practices or services, encouraging aspiring surgeons and potential patients alike to tune in.

Any Fellows thinking of experimenting with live streaming should remember to take patient consent, confidentiality and privacy into account before proceeding, as well as any guidelines set by your own hospital or health service.

The relevant RACS position paper can be found on the website at: http://www.surgeons.org/policies-publications/publications/position-papers/ under "Live transmission of surgery".

CASE NOTE REVIEW

Postoperative management issues after facial fracture repair

GUY MADDERN
Chair, ANZASM

Clinical details

An elderly patient was involved in a low speed motor vehicle accident. Following treatment by paramedics, the patient was transferred to the Emergency Department of hospital 'A' where they arrived at 1730hrs the same day. A provisional diagnosis of facial fractures was made and appropriate investigations were carried out. The patient was reviewed by the maxillofacial registrar at 2330hrs and was admitted to the Intensive Care Unit (ICU) for observation overnight and planned for theatre the following day.

The operation, open reduction internal fixation of facial fractures, was uneventful and the patient was returned to the ICU. The patient was moved to the ward at 1600hrs the following day. Nursing staff sought the night resident's review of the patient due to confusion/agitation and was duly reviewed, but settled without intervention.

The patient was readmitted to the ICU the next day following an apparent cardiorespiratory arrest on the ward following administration of Diazepam for agitation. While in the ICU, restraints were applied due to persistent agitation which continued throughout the ICU stay.

The patient was discharged to the ward two days later. Almost immediately, a Medical Emergency Team call was made due to deteriorating oxygen saturation. This improved with deep breathing. Later the same day, a further review was performed by the hospital medical officer at the request of nursing staff for the same reason. The following day, nurses again requested a review due to delirium/agitation. No treatment change was made, however a neurological/neuropsychological review was suggested. There is no record of enquiry into the possibility of alcohol abuse.

The patient remained on the ward until the 10th postoperative day when they were found on the floor in cardiac arrest. The patient failed to respond to resuscitation and was pronounced dead.

Comments

The first area of concern relates to a perceived failure to consult early with a general or geriatric medical team to assist with or take over management. Once this patient had returned to the ward on the first occasion postoperatively, there was ample reason to at least involve a medical team. Certainly after the second ICU admission it was clear that the facial fractures were becoming a secondary problem.

The content of the medical record is the second area of concern. Documentation by the ICU/surgical teams was suboptimal with medical entries made primarily at the request of nursing staff. The reviewer could find no documentation relating to the apparent arrest that resulted in readmission to the ICU. There is record of a neuropsychiatric consultation being suggested but no results were found in the notes. The absence of such important documentation in the case of a patient who subsequently died leaves open serious questions around the nature, extent and appropriateness of care.

Thirdly, clearly no overall management plan was documented and thus the patient's care appears to have been reactive rather than proactive. There is no indication in the case notes that senior staff members were involved at any time. Without their involvement and with no formal plan, it is debatable who, or which team, were responsible for this patient. The initial impression was that this patient was admitted under the oral and maxillofacial surgical team and they certainly carried out the surgery. However, they do not feature in the postoperative period during the patient's stay on the ward. It would seem that postoperative care was left to nursing and junior general surgical residents.

DESTINATION BHUTAN

WA Surgeon walks the walk and talks the talk

Western Australian Orthopaedic surgeon Mr Greg Witherow has long combined his professional expertise in sports medicine with his personal interest in physical fitness and outdoor pursuits. The former President of the Australian Knee Society and state Chairman of the WA section of the Australian Orthopaedic Association (AOA), Mr Witherow helps treat some of WA's elite athletes and sporting teams through his practice at the Perth Orthopaedic and Sports Medicine Centre, one of the state's largest Orthopaedic group practices. A specialist in adult lower limb Orthopaedic surgery, Dr Witherow completed a Fellowship in Sports Medicine and Arthroplasty at the North Sydney Orthopaedic and Sports Medicine Centre and later travelled to the UK to complete a Fellowship in Arthroplasty at the National Orthopaedic Hospital in Birmingham. Away from work, he is a keen skier, scuba diver, golfer and trekker. He talks to Surgical News about his recent trek in the glorious mountain kingdom of Bhutan.

When did you travel to Bhutan and why did you choose that destination?

My wife, Cath, and I left for Bhutan in early April for an eight day trek. We were booked the year before to go to Nepal but the earthquake occurred the week before we were due to leave. We changed that trip to Laos and Cambodia but we still wanted to do a trekking holiday. I felt that Nepal needed a bit more time to recover and I'd heard good things about Bhutan.

Was this your first trek?

We have done a number of walking holidays in New Zealand, Switzerland, Wales, Tasmania, Bulgaria and at home in WA. However, other than camping on the Overland track and some higher altitude walking in Switzerland, this was our first pure alpine trekking.

Which trek did you do in Bhutan and what was involved?

The trek we chose was called Chomolhari Base Camp and it required a few months of preparation working on our fitness and acquiring the right gear. We flew from Perth to Bangkok and stayed over-night before flying via Kolkata to Paro in Bhutan. Seeing Mt Everest out the plane window was amazing. The day after arriving we did a walk to the Tiger's Nest Monastery, which is at an altitude of 3,200 metres and used as a guide by the trekking companies to check people's fitness and ability to complete the trek. The following day we commenced the eight-day trek during which where we typically walked for five or six hours each day with the altitude steadily rising. The base camp is at 4,100 metres and a day is spent at the beginning to allow people to acclimatise before the next two days when we trekked through the high passes which are at 4,800 and 4,950 metres. The following days we walked back down the valley along the river to Thimpu. We had a night and a tour there before going back to Paro and then flying back to Bangkok.

How tough was it?

The walking was tougher than I had imagined. The altitude was challenging but fortunately neither of us was significantly affected other than being short of breath.

What resources did you have during your time in the mountains?

We travelled with World Expeditions who we have used before and they subcontract out to local groups. We chose to do a private trek so there was only the two of us with our guide, his helper, the cook and the man who looked after the nine pack horses.

What was the highlight of the trip?

The Himalayan scenery was spectacular and was the motivation for the trip but the sheer accomplishment of completing the trek was also a highlight.

How would you describe the culture of Bhutan given that it is famous for its measurement of Gross National Happiness?

The people were warm and friendly, the Buddhist culture pervades but I think the gross national happiness idea is oversold.

What are your other recreational and sporting interests?

Cath and I go on skiing and scuba diving holidays and we are both quite involved with competitive golf. Her handicap is seven and she still plays pennants and my handicap is three and I play club competition.

Do you have plans for another adventure and if so what are they?

The next trip is a walking holiday in Patagonia with a dive trip to the Galapagos.

Do you find it difficult to take time away from your practice or do you believe such breaks make you a better surgeon?

As I get older, I have decided to have more regular breaks in the hope that they will keep me fit and happier in my work. I don't think they make me technically a better surgeon, but I think they make me a happier person who therefore continues to enjoy his work and thus a happier doctor.

AUCKLAND'S MIDDLEMORE HOSPITAL EARNING RESPECT

One of the busiest surgical training hospitals in Australasia has created and introduced the first hospital-based protocols designed to tackle discrimination, bullying and sexual harassment (DBSH) within surgery

Based on the Vanderbilt Principles that underpin the College's policy to eliminate discrimination, bullying and sexual harassment (DBSH) from the profession, the Middlemore protocols were drafted by Mr Garth Poole, the deputy head of the General Surgery Department.

Mr Poole talks about a department that employs 19 consultants, 33 registrars, 76 interns and trains more than 100 medical students per annum and he felt it incumbent upon hospital leaders to design a process to address DBSH effectively and swiftly.

The protocols, introduced late last year, established a seven-member taskforce to address complaints and a five-step pyramid of action and increasing interventions to remove DBSH from the work place.

These steps are:

1. Zero tolerance of DBSH;
2. Acceptance that DBSH can occur;
3. Victims are supported to react swiftly and directly to the source of the complaint;
4. If DBSH is on-going, the taskforce members will intervene;
5. The involvement of external Human Resources and other medical bodies if the taskforce intervention fails to resolve the issue.

According to Garth Poole the taskforce at Middlemore was comprised of four surgeons - Dr David Moss, Dr Jon Morrow, Dr Maree Weston and Dr Jenny Wagener – along with two senior nurse specialists and the unit manager.

He said that the policy and processes had been accepted by all staff within the unit and had already proved so successful that not only had they been taken up by other surgical units in the same hospital but also by other hospitals including Nelson and Auckland Hospitals.

Poole said that older male surgeons needed to understand they could make mistakes in their interactions with junior staff, given that many had grown up in an era of "rampant sexism" and "casual racism".

"Under this policy we as surgeons are saying to everyone in the department, including nurses, that if we get it wrong we want you to call us out on it," Mr Poole said.

"It is, however, vital that the system is not used to avoid the appropriate firm direction to a junior from a senior in our clinically demanding environment and nor should it prevent the constructive criticism of poor performance.

"Yet, we want junior staff to feel empowered to stand up if they feel uncomfortable and simply say: 'Stop it! I don't like it'.

"The success of the system has so far shown that zero tolerance and support for victims as well as goodwill across all levels of seniority were key to eliminating DBSH even in a complex, busy professional environment."

"If that doesn't work, any person who feels affected by DBSH is encouraged to make a confidential approach to a member of the panel who will assess the complaint in context, and this usually involves both parties in seeking a resolution to the problem.

"If someone continues to be the focus of complaints, hospital HR managers and external agencies will become involved, a step which we would see as a collective failure."

Mr Poole said that all Trainees on rotation at the General Surgery Unit were advised of the protocols upon their arrival during orientation and were given the phone numbers of taskforce members, while posters of the pyramid were prominently displayed throughout the unit.

He said that since the process was introduced eight months ago, there had been scores of level three responses and seven complaints of DBSH that had reached Taskforce involvement at level four.

He said the majority of complaints arose at the level of junior doctor to junior doctor and that all complaints, including those involving senior surgeons, had been resolved to the satisfaction of both parties with no issues involving sexual harassment arising since the protocols had been established.

The process could also help protect older surgeons and hospital staff if they were treated with disrespect, he said.

Mr Poole said the success of the system has so far shown that zero tolerance and support for victims as well as goodwill across all levels of seniority were key to eliminating DBSH even in a complex, busy professional environment.

"I did a back-of-the-envelope calculation at one stage which indicated that senior teaching surgeons like me can have up to 250,000 professional interactions each year with around 400 interactions during one operation alone," Mr Poole said.

"All it takes is for one of these interactions to go wrong for someone to feel aggrieved and yet, while we can't avoid them and we don't want to sanitise our interactions with other members of staff, we must have a process to deal with everything from misunderstanding to abuse.

"As surgical educators, senior surgeons have to be able to teach in a firm and direct manner without fear or favour both in theatre and in the wards and Trainees are often learning how to accept criticism and instruction under pressure.

"This can make for complex interpersonal interactions but I believe the process we have introduced will enable us to resolve most issues."

Mr Poole said the new system had generated great excitement within the unit, particularly from junior doctors, because it was driving change across the spectrum of medicine.

"We are the first major hospital to tackle DBSH at a systemic level and we are very proud of that," he said.

"We developed this system so that we could fix problems as they arise because we want our junior staff to come to work feeling excited and enthusiastic and ready to learn.

"Our guiding philosophy is that no-one should come to his or her workplace in a state of fear generated by the anticipation of maltreatment by other staff members."

THE DAMIAN MCMAHON TRAUMA PAPER PRIZE FOR TRAINEES

RICHARD PERRY
Chair, Fellowship Services Committee

JOHN CROZIER
Chair, Trauma Committee

The Damian McMahon Trauma Paper Prize is awarded to the best trauma research paper, based on causes, prevention and/or management of trauma, presented by a Trainee at the ASC. All Trainees from the 9 speciality programs presenting trauma abstracts can be considered. The winning trauma paper at the ASC is entitled to compete at the ATLS Region XVI scientific meeting, a meeting held annually throughout all areas of the Asia Pacific. The prize money is expected to cover out-of-pocket expenses for the Trainee to travel to the ATLS Region XVI meeting.

The competition does not end here! The lucky winner of the ATLS Region XVI meeting is eligible to present their research at the prestigious American College of Surgeons Committees on Trauma (ACS CoT) scientific meeting in America in March the following year where the winning trauma research paper is published in the Journal of the American College of Surgeons. Quite a trajectory!

Damian McMahon

Damian McMahon FRACS (1958 – 2012) was an integral and influential member of the RACS Trauma Committee, Chair of the Trauma Verification Sub-Committee and a passionate educator of Trainees – especially in the area of trauma. As surgical supervisor, Trainee instructor and mentor to hundreds of Surgical Trainees, Damian is remembered by his colleagues as a brilliant and memorable instructor on Early Management of Severe Trauma, Basic Surgical Training, Care of the Critically Ill Surgical Patient and Definitive Surgical Trauma Care courses. He has been recognised locally, regionally, nationally and internationally as an outstanding medical servant of the people.

Damian McMahon was Director of Trauma at the Canberra Hospital where he developed the Shock Trauma Service and the Snowy-Hydro Helicopter Rescue Service both of which have left a lasting contribution to the emergency services of the Canberra region. As an act of respect and gratitude, the Snowy-Hydro rescue helicopter hovered low and long above Damian's coffin providing a poignant and life-long memory

Damian McMahon

for the hundreds of family, friends and colleagues who gathered at his funeral.

Damian McMahon died tragically whilst on holiday in Israel in 2012, aged 54. John Crozier, chair Trauma Committee, has dedicated his time in office to preserving Damian's memory, and to sustaining the legacy gifted to the College, its Fellows and the people of New Zealand and Australia, by so many in the RACS Trauma Section and RACS Trauma Committees who have contributed so selflessly in the prevention of injury, and the achievement of the best outcome for injured patients.

To recognise and honour the commitment and work that Damian gave to the College and to reward excellence in trauma research, the Damian McMahon Trauma Paper Prize was established in 2015. The prize has been made possible by a generous donor who pledged $3000 per annum for five years to secure the sustainability of the Damian McMahon Trauma Paper Prize. The following letter from Damian to the Trauma Committee Chair in 2002 is touching verification that Damian would have given the prize his unqualified seal of approval:

During my recent visits to the ACS CoT meeting in San Diego I sat in on the trauma research presentations at the resident paper session. These were the best papers from different regions within the USA and also Canada. Having a RACS region best paper presented at that meeting is a great goal we, as a Trauma Committee, should aspire to, or a combined RACS/ATS best paper. However we must crawl before we walk. I would like to see a prize for the best registrar /Trainee paper presented at the RACS ASC. I would be willing to donate some money toward that prize.

Inaugural Prize Winner – Dr Nikhil Agrawal

The inaugural *Damian McMahon Trauma Paper Prize* was awarded at the ASC in May 2015 to Dr Nikhil Agrawal for his research on '*The Role of Serial Imaging in Non-Operative Management of Blunt Splenic Injuries*'.

Dr Agrawal went on to present his research at the ATLS Region XV1 competition in Bangkok in August 2015, a trauma scientific meeting run in conjunction with the World Congress of Surgery. A bomb had been exploded at the Erawan Shrine Bangkok just before the Region XVI meeting. Lives were lost and many people injured. Associate Professor Michael Hollands (ATLS Region XVI chief) showed great leadership and support by planning to go ahead with the Australasian team's attendance. In acknowledgement of the tragedy a one minute silence was observed at the commencement of the meeting. The ATLS Region XVI meeting attracted over 50 attendees from Thailand, Indonesia, Pakistan, Malaysia, Singapore, Taiwan, Australia and Brunei. 6 papers were presented at the trauma paper competition. Dr Agrawal's paper was well received with questions regarding early signs on initial CT predicating pseudoaneurysm formation, management protocol of blunt splenic injuries and alternative imaging modalities in splenic injuries in developing countries were raised.

John Crozier with Nikhil Agrawal

Dr Agrawal won the ATLS Region XVI competition in Bangkok which took him to San Diego to present at the esteemed American College of Surgeons Committees on Trauma (ACS Cot) scientific meeting.

2016 competition

The second winner of the Damian McMahon Trauma prize, May 2016, is Dr Daniel McIlroy with his exciting trauma research on 'Mitochondrial DNA induces Neutrophil Extracellular Trap Formation Following Injury and Subsequent Surgery'. We extend our congratulations to Dr McIlroy and wish him good fortune at the ATLS Region XVI competition in Hong Kong November 2016.

Don't miss out

The next Damian McMahon trauma paper competition will be held at the Adelaide ASC in May 2017. To all Fellows, please tell all those budding researchers and ambitious trainees to start polishing up their trauma research in readiness for next year's competition. Abstracts open in October 2016 and close on 29 January 2017. And remember, you've got to be in it to win it!

STUART BROWN RETIRES

The first NZ surgeon to receive an Australasian Fellowship in Paediatric Surgery hangs up his scalpel

The crucial role of mentors in the selection, support and training of junior surgeons has become so widely accepted that it can come as a surprise to hear a surgeon talk about having to face the active opposition of senior colleagues in the early years of his career.

Yet one of New Zealand's first Paediatric Surgeons, Mr Stuart Brown, laughed when he recalled the reaction he received from senior surgeons when he made known his desire to pursue specialist paediatric surgery training.

"I enjoyed Paediatric Surgery more than any other specialty during my rotations as a registrar so naturally I gravitated toward it," he said.

"Yet, at the time in New Zealand, the people in charge of training were very negative about my desire to further my skills in Paediatric Surgery because they felt that it wasn't a specialty, but rather it was considered work that General Surgeons could manage as a part-time interest.

"But I persisted. I completed my General Surgery training and received my Fellowship in Auckland and, with Spencer Beasley, spent two years at the Royal Children's Hospital in Melbourne to gain my specialist training.

"When I returned to Waikato, I still faced resistance to the idea of paediatric surgery as a stand-alone specialty and was required to spend nine years doing general surgical work as well as paediatric surgery before I could concentrate on paediatrics alone.

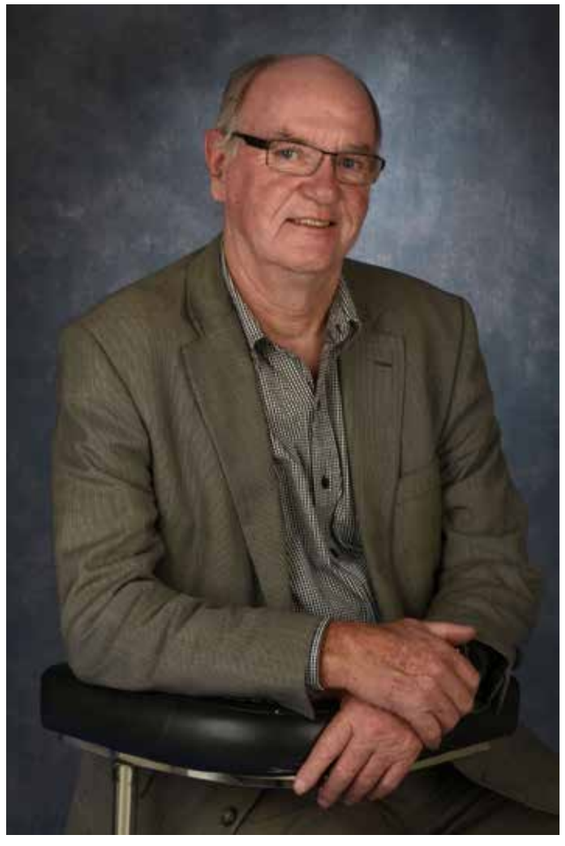
"That felt like a very long wait but when it was finally recognised as a specialty in its own right, deserving of specialist wards, specialist theatres, specialist anaesthetists and nurses it was a very good day indeed."

The main reason that New Zealand lagged Australia in the development of Paediatrics as a surgical specialty was the combination of a smaller population and the lack of a dedicated children's hospital that could attract specialists, funding and expertise.

Up until the mid 1980s, most surgeons who treated children were General Surgeons who had completed overseas Post Fellowship training.

"I have always greatly enjoyed working with children because they are so positive in their outlook and they heal quickly and I think those two things are linked."

The training of Mr Brown and Professor Spencer Beasley at the Royal Children's Hospital in Melbourne changed that, particularly when Mr Brown returned home in 1985 to become the first NZ surgeon to obtain an Australasian Fellowship in Paediatric Surgery.



Then, in 1990, the Starship Children's Hospital in Auckland was opened to great enthusiasm and has since become one of the leading children's hospitals in the world.

Over the course of his career, Mr Brown not only helped establish the specialty of Paediatric Surgery in New Zealand through his own skills and commitment, he also helped train and support the new generation of Paediatric Surgeons, of which there are now about 20.

He has also conducted thousands of surgeries including the separation of two pairs of conjoined twins, one of which involved 22-hours of meticulous surgery and which was later hailed as representing an international surgical benchmark.

Mr Brown has watched the development of his specialty with great pride and late last year, after 40 years of service, he conducted his last procedure, said good-bye to his young patients and formally retired.

Yet while New Zealand's paediatric services are now among the best in the world, when Mr Brown began, he spent considerable time working with the on-site instrument maker at Waikato Hospital down-sizing surgical equipment or adapting what could be altered for the benefit of his smaller patients.

"We had to cut down some instruments, adapt others and try to solve problems as they presented," he said.

"We had difficulty in the early years in keeping babies warm, for instance, so a lot of improvisation went into designing warming units.

"I have always greatly enjoyed working with children because they are so positive in their outlook and they heal quickly and I think those two things are linked.

"Yet, it took a lot of persuading to convince people in authority that children were not just small adults, that they suffered from different conditions to those commonly affecting the adult population and that they required different care and expertise.

"It took even longer before we received accreditation to take Trainees but we got there.

"Those early days are hard to imagine when you see Waikato Hospital now."

From once working 80-hour weeks, Mr Brown was ambivalent but accepting of his retirement and plans to spend his time sailing and fishing upon the beautiful waters off the coast of Hamilton.

He said that while many cases and patients retained a place in his memory, his over-riding sense of satisfaction came from helping to develop the specialty of Paediatric Surgery for the benefit of the children and parents of New Zealand.

"When I think back, what really gives me the greatest pleasure is having witnessed, and contributed to, the development of the specialty and the improvements we made in the care of little ones, particularly those born with congenital abnormalities," Mr Brown said.

"I feel a great sense of privilege for having worked alongside very talented people but particularly for having been in a position to develop a specialty that had not previously existed, particularly one that was based on an age group and not an organ system as had always been the case in surgery.

"We did face some hostility in the early days from other surgeons because we were seen as taking a little bit of work away from everyone but that changed over time.

"Now, Paediatric surgery is not just an accepted specialty but an extremely dynamic area of medicine.

"Over the years I have worked in Paediatric Surgery I have seen the amount of expertise and knowledge expand enormously and it is gratifying that developments in our specialty also initiated further specialisation in other medical fields such as anaesthesia, nursing and radiology.

"Yet while this is professionally rewarding, my greatest personal reward was doing my best to give my young patients the best possible outcomes and medical care."

With Karen Murphy

RACS AND ST VINCENT'S COMMIT TO RESPECT LIVE ON SOCIAL MEDIA

The event was streamed live across Facebook and Twitter simultaneously

In the second of a series of commitments to stamp our discrimination, bullying and sexual harassment, St Vincent's Health Australia (SVHA) and the Royal Australasian College of Surgeons (RACS) signed a Memorandum of Understanding (MOU) to deal more effectively with reports of these issues in the surgical workplace and improve patient safety.

The event was also a communications milestone for RACS, being the first event livestreamed across its social media platforms. Two members of the RACS Communications team simultaneously filmed the MOU and livestreamed the event on Facebook (via Facebook Live) and Twitter (via Periscope).

RACS President, Mr Philip Truskett AM said at the signing on Friday 1st July, 2016 that hospital wards, operating theatres and outpatients were the intersection where surgical education and health service employment overlapped.

"It makes sense for employers and educators to look for new ways to improve the experience of Surgical Trainees, make hospitals a better and safer place to work and improve patient safety," Mr Truskett said.

"Research shows that bad behaviour has a negative impact on the whole team and not just the people at which it's directed. This MOU is an important step to improving patient safety by improving work environments."

St Vincent's Health Australia CEO Toby Hall said his organisation was serious about dealing effectively with these challenges and he was confident that the partnership with RACS would help SVHA to improve outcomes for patients as well as improve the well-being of staff.

In 2015 – as RACS established its Expert Advisory Group to examine discrimination, bullying and sexual harassment (DBSH) in the practice of surgery – SVHA established an internal program to address the same issues across its organisation.

SVHA's Ethos program brings together an electronic reporting system, an accountability framework and a comprehensive peer training initiative. It is underpinned by the recognition of a proven link between poor behaviours and adverse surgical outcomes.

"We are determined to confront these issues and play a leadership role for the benefit of our staff and patients. This agreement with RACS is an important way to help us achieve that,' SVHA CEO Toby Hall said.

The MoU commits both agencies to a shared vision to provide high quality training, education and experience in the practice of surgery.

Specific initiatives include:

- aligning or developing policies and processes to deal with DBSH using the 'Vanderbilt Principles' as a foundation (See appendix two in the RACS Action Plan: Building Respect, Improving Patient Safety);
- ensuring that complaints about discrimination, bullying and sexual harassment involving trainees, International Medical Graduates or College Fellows employed at SVHA are managed fairly and expeditiously and that the outcomes of complaints are shared within an agreed framework;
- ensuring that surgical supervisors have the necessary skills and attributes and are supported to provide training, assessment, feedback and support to Trainees and International Medical Graduates without engaging in DBSH; and sharing information and resources for training programs to address DBSH.

Collaborating with employers to build respect in surgery is one of RACS' core commitments in its Action Plan: Building Respect, Improving Patient Safety.

This MoU with SVHA is the first RACS has established with a national healthcare network and the latest in a series of agreements with hospitals and other agencies in healthcare, which employ surgeons or oversee health systems.

The livestreaming of the signing was promoted ahead of time across the RACS Facebook, LinkedIn and Twitter accounts, and RACS followers were encouraged to tune in. This was supplemented by support from multiple St Vincent's Health Twitter accounts, which shared the updates and encouraged their audiences to join the livestream as well. The event was viewed by a number of people during its live broadcast, and hundreds more after the event.

The Facebook footage from the event was particularly successful, and the event video on that platform has since attracted almost 400 views. Utilising this technology removed the geographic boundaries restricting people from attending, and allowed RACS to interact with its Facebook and Twitter communities in a different and unique way. RACS is dedicated to experimenting with new, innovative technologies that allow the spreading of RACS messages to a wider audience, and engage more meaningfully with its stakeholders.

RACS President Philip Truskett and St Vincent's CEO Toby Hall signing the MOU

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

IN MEMORIAM

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

2016

Donald (Scotty) Macleish, VIC
Kimbal D Frumar, NSW
Geoffrey Ward, SA
David Adamthwaite, QLD
Samir Bishara, NZ
Ralph Upton, VIC
Choo Teoh, Singapore

2015

William J Garrett, NSW
Donald Manton Llewelyn, Llewelyn

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

Informing the College

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

ACT: Eve.Edwards@surgeons.org
NSW: Allan.Chapman@surgeons.org
NZ: Justine.Peterson@surgeons.org
QLD: David.Watson@surgeons.org
SA: Daniela.Ciccarello@surgeons.org
TAS: Dianne.Cornish@surgeons.org
VIC: Denice.Spence@surgeons.org
WA: Angela.D'Castro@surgeons.org
NT: college.nt@surgeons.org

While RACS accepts and reproduces obituaries provided, we cannot ensure the accuracy of the information provided and therefore take no responsibility for any inaccuracies or omissions that may occur.

HEAD AND NECK EXPERTISE

SA Head and Neck Patients to benefit from local ENT Surgeon's Canadian training

South Australian Ear, Nose and Throat surgeon Mr Andrew Foreman is now one of the few surgeons in Australia with the skills to conduct complex tracheal and cricotracheal resections following a year spent working under the mentorship and supervision of Dr Patrick Gullane, an international leader in the field.

Mr Foreman spent 2014/2015 in Canada at the Toronto General Hospital as a Fellow of the Department of Otolaryngology Head and Neck Surgery, University of Toronto, with funding assistance provided through the RACS Margorie Hooper Travel Scholarship.

Now back in Australia and working at the Royal Adelaide Hospital and the University of Adelaide, Mr Foreman said the range of procedures conducted by the ENT team in Toronto gave him the opportunity to accelerate the expansion of his surgical skills and the procedures he could provide to South Australian patients.

While in Toronto, Mr Foreman conducted major head and neck ablative surgeries, microvascular reconstruction of head and neck defects, salivary gland, thyroid and parathyroid surgery including the management of locoregionally advanced thyroid cancer and performed sentinel lymph node biopsies for head and neck melanoma.

"With a catchment of 13 million people, working in the hospitals of the University of Toronto provided both broad case loads and exposure to rare conditions allowing him to return to Australia with a unique range of ENT surgical skills," he said.

This now enabled the ENT team at the Royal Adelaide Hospital to offer a more comprehensive surgical service particularly for cancer patients requiring both resections and reconstructive surgery.

"The Head and Neck Fellowship program at the University of Toronto is world-renowned as a centre of excellence in training surgeons in the full range of Head and Neck surgery," Mr Foreman said.

"This training encompasses major mucosal ablative procedures, surgical management of cutaneous malignancies, salivary gland and endocrine surgery as well as microvascular reconstruction of head and neck defects.

"The purpose of undertaking this Fellowship was to obtain advanced surgical skills in this small subspecialty of ear, nose and throat surgery and I achieved that objective.

"Microvascular reconstructions were not done by the ENT unit at the Royal Adelaide Hospital until I had the chance to learn these procedures and only one surgeon in Adelaide regularly performed tracheal resections.

"The skills I learned in Toronto now allow our unit to provide a more holistic and streamlined service for our head and neck cancer patients and I have completed a number of tracheal resections since my return."

Mr Foreman said a highlight of the Fellowship was working not only with Dr Pat Gullane but other international ENT leaders such as Dr Dale Brown, Dr David Goldstein, Dr Danny Enepekides and Dr Kevin Higgins.

"Pat Gullane is one of the world's most experienced surgeons in tracheal and cricotracheal resections and his mentorship gives Fellows working in the unit exposure to this relatively rare, and technically challenging, surgical procedure," he said.

"I also had the opportunity to attend multi-disciplinary meetings with some of these world's most experienced Head and Neck surgeons as well as leading radiation oncologists, medical oncologists and endocrinologists."

While in North America, Mr Foreman also took the opportunity to attend a number of surgical meetings including:

- The American Head and Neck Society Annual Meeting held in Boston;
- American Head and Neck Society Course on Thyroid and Parathyroid Surgery held in Boston;
- The Annual Meeting of the American Academy of Otolaryngology Head and Neck Surgery held in Orlando; and
- The 5th World Congress of the International Federation of Head and Neck Societies held in New York in 2014.

Having completed a PhD in 2010 investigating biofilms in chronic rhinosinusitis, Mr Foreman retains a strong interest in academic surgery and while in Canada he was awarded Fellow Teacher of the Year by the University of Toronto's Department of Otolaryngology Head and Neck Surgery.

During his Fellowship he also worked on a number of research projects including an investigation into the role of type 2 diabetes mellitus in Head and Neck cancer and the potential impact of metformin in head and neck cancer outcomes while also researching the effects of humidification devices for pulmonary rehabilitation post total laryngectomy.

Mr Foreman maintains a collaborative relationship with his mentors and fellow researchers at the University of Toronto, continues to add to the research programs he began there and consults with senior Canadian surgeons on complex cases.

He said he was now in the process of developing a Head and Neck cancer surgical research program in South Australia with plans to establish a Head and Neck Masters program at the University of Adelaide next year.

He also initiated further research upon his return to Australia and is currently focussed on investigating the use and accuracy of magnetic probes in sentinel lymph biopsy and the role of bacteria in the development of cancers in the oral cavity.

Mr Foreman thanked RACS for the support provided through the travel scholarship, which allowed him to work, learn and teach in Toronto while supporting his wife and two young children.

"The greatest advantage of Fellowships like the one offered by the ENT Department in Toronto is the accelerated skill development provided by high volume case loads and the ability to conduct numerous complex procedures for the more uncommon presentations," he said.

"I can now add my skills to those of my colleagues in the ENT and Head and Neck Units while passing on my knowledge to the Trainees at the Royal Adelaide Hospital."

The Margorie Hooper Travel Scholarship is designed to allow Fellows or Trainees from South Australia to undertake post graduate studies outside the state for the benefit of the surgical community of South Australia.

With Karen Murphy

Career Highlights

- 2016-2018: Conjoint Grant, Garnett Passe and Rodney Williams Memorial Foundation;
- 2015: Awarded Fellow Teacher of the Year, University of Toronto, Department of Otolaryngology Head and Neck Surgery;
- 2014: RACS Margorie Hooper Scholarship;
- 2013: Award for Excellence in Clinical Teaching, University of Adelaide;
- 2011: University Doctoral Research Medal, University of Adelaide;
- 2008: Surgeon Scientist Scholarship, Garnett Passe and Rodney Williams Memorial Foundation.

OPUS XLII

JOHN HENDERSON

The College's "Argyll Diamond"

FELIX BEHAN
Victorian Fellow

I read with interest in the April 16 edition of Surgical News the story featuring John Henderson. He was wearing his Henderson Argyll tartan waistcoat. The article recounts his photographic experiences at multiple RACS meetings verifying his interest in this artful science documenting history while pursuing a busy surgical career.

His initial photography experience was from his schoolboy days in Sydney with a Kodak SLX-20 Box Brownie Model C (my Grandmother also gave me a Box Brownie when I was 8 years old and this was my initial experience to the art of "exposure"!).

Kodak Box Brownie

John's metamorphosis throughout his surgical career blended nicely with this photographic talent – one feeding off the other. Later in life he became the indispensible record keeper (still and video images) for RACS ranging from provincial meetings to the ASC thanks to Peter King.

Quite appropriately at the recent meeting in Brisbane, John's contributions were acknowledged and he received the RACS Medal at the ASC Convocation ceremony on May 2nd 2016.

Interestingly at the May meeting John had his video-camera running for two hours recording the events of the Convocation even capturing Council Members in their resplendent regalia.

I am also a keen clinical photographer. My EXLIM Casio with 12 megapixels is always in my pocket. It is the one I have used for all my clinical publications amassing up to 250 gigabytes of data over 15 years. Anyone could use the automatic focus on the sound signal and using anti-shake could take the shots surrounded by the absolute pre-requisite clean clinical drapes surrounding the site.

I had my Casio there that day as did the College's ASC photographer and we both managed to get an image of John receiving his award. Dave Vickers, who taught me elementary photography in the 1960s, was also captured receiving his ESR Hughes award.

John Henderson

Later that evening John and I were relaxing. He handed me an article from the European Journal of Hand Surgery about Geoffrey Fisk, written in 2010 by F.D. Burke and Carlos Heras-Palou. It summarises the story of Fisk, who received three Hunterian lectureships, and his groundbreaking treatment in 1973 of mid-carpal instability by plicating the lose palmar ligament located between capitate and lunate.

At the request of Fisk, John recorded this operative series on 2 reels of Super-8 film on the morning of 28 February 1973 at St Margaret's Hospital, Epping. The authors had to tap into the hospital's payroll records confirming that John worked there between 1972 and 1973. This discovery in the Burke & Heras-Palou article reads like a Sherlock Holmes novel. Even John's original logbook is mentioned. John revealed that Wyn Beasley, an eminent RACS figure, was Fisk's registrar at St Margaret's. Geoffrey Fisk and his wife

John Henderson in his 'Argyll" waistcoat and David Watters

David Vickers and David Watters

Susan even attended the Beasley wedding. What a piece of documented surgical history spreading to the Antipodes.

Photographic departments in major teaching hospitals document clinical events and it is quite coincidental that I have been asked by Simon Donahue to review the photographic material of the old Peter MacCallum Cancer Institute before its relocation in Parkville. It contained images going back to the time of Benny Rank and Lena McEwen and parts of this collection will be going to the RACS archives.

The principle of pre and post-operative images are a relic of the days of early plastic surgery teaching. From the time of Gillies and beyond, cases from WW1 and the Sidcup days were recorded thanks to Daryl Lindsay and others. Elizabeth Millford at RACS could tell me there are up to 70 watercolours of patients' surgical procedures. Every patient would have had a simple black and white photograph, an x-ray record and a moulded plaster image to accompany the watercolour as a holistic view of their tissue destruction. I was with Benny in 1971 when he bought a Daryl Lindsay landscape at the Joseph Brown Gallery. We were there to organise art exhibitions for the 1971 International Plastic Surgical Congress.

I must mention my own photographic experiences which go back to my Peter Mac days. In1977 I was appointed by Fedora Trinker as a Head and Neck Surgeon with Brian Fleming. Arthur Wills and Charlie Frewin taught me the basic elements of clinical photography. Charlie now runs the new department in Parkville.

Clinical photography not only has relevance as part of a teaching tool but also has legal implications. If a patient perceives there has been an apparent mismanagement and to quote an old Confucian idiom (possibly) – an image is worth a thousand words – a photograph may save your bacon!

Now back to Argyle diamonds (note the spelling).

John Henderson could tell me his Argyll tartan waistcoat was historically linked to his Scottish Grandfather's lineage and comes from the clan Campbell of Western Scotland.

The tartan is a woven garment and has a French link – Tiretaine – meaning a woollen and linen combination. Bonnie Prince Charlie popularised the use of the tartan as a clan uniform.

The stylistic diamond pattern was popularised by Pringle Knitwear and is part of any traditional golfing attire. The Pringle is associated with the dashing Duke of Windsor wearing Plus 4s on fashionable golf courses. Even Don Marshall still dons his Pringle - a memory of his golfing past.

Now to the Argyle Diamond link. The mine is owned by Rio Tinto and is situated in remote north Western Australia being the world's largest producer of multi-coloured (mostly pink) diamonds - pink being the Artisan's masterpiece. As the Argyle diamond company says: light radiates from its factes but with a softness and heartfelt expression. Doesn't this also sound like our own RACS photographic diamond, John Henderson!

CONGRATULATIONS

On your achievements

MISS CLARE MARX CBE, DL, PRCS

Honorary Fellowship

2016 George Syme Orator

The Council of the Royal Australasian College of Surgeons admits from time to time distinguished surgeons, scientists and other persons to Honorary Fellowship of the College in recognition of their contributions to Surgery, Surgeons and the College. The purpose of the award is to recognise significant work of eminent individuals in any field of endeavour.

Miss Clare Marx is the President of the Royal College of Surgeons of England, and indeed its first female President. She is also an orthopaedic surgeon. Taking up office in July 2014, she is the third orthopaedic surgeon in the past 20 years to become President of the College (Rodney Sweetnam 1995 - 1998 and Hugh Phillips 2004 - 2005).

She attended Cheltenham Ladies College, and proceeded to University College Hospital London, graduating with a MB ChB in 1977. She obtained her FRCS without delay in 1981 and progressed to orthopaedic training in London and Boston before being appointed to first St Mary's and then Ipswich where she is currently Associate Medical Director for the NHS Trust.

Clare joined the Council of the Royal College of Surgeons in 2009. She is a champion of surgical standards, and has been active in the College's acknowledgment of the need to report surgical outcomes transparently, a lead trustee for the RCS position on patient safety, and has been a member of College activities to promote professional responsibility, quality improvement, and good surgical practice, including the Never Events Taskforce.

She has been and is an active educator. She was an ATLS instructor and also led instructor courses. She has written trauma and orthopaedic curricula, developed educational material for Continuing Medical Education and been an examiner of medical students and candidates sitting the Intercollegiate Specialty Examination in trauma and orthopaedic surgery. She has been a hospital and regional representative on training committees, and been a member of Expert Advisory panels addressing the future of Surgical Training.

Clare Marx receiving her Fellowship from David Watters

She is a role model for women in surgery, as an orthopaedic surgeon, an advocate for surgical standards, professionalism and surgical training in the United Kingdom as well as internationally. She has been honoured not only by Presidency of her College of Surgeons but also in her appointment as a Commander of the Order of the British Empire (CBE), a Deputy Lieutenant of the County of Suffolk, and an hominem Fellowship of the Royal College of Surgeons of Edinburgh.

Citation kindly provided by Professor David Watters OBE

SHRIMP ON THE BBQ

Special Contribution

THE BARONESS

Oh Paul! Paul Hogan - where are you....?? We were again agonising on the difference between Shrimps and Prawns. Why did you throw them on the BBQ in that Aussie-ad back so many decades ago....??

It had been a great entrée. Honey prawns. On a base of fried vermicelli noodles, some really tasty sesame seeds and honey with a particular Tasmanian flavour. Leatherwood tree?? However, the prawns had been special. Large and very fresh. Well prepared and not quite deep fried. And then it started.

'Those are shrimps'. That from my friend – the American lawyer who had spent her corporate legal career life flitting between New York and Paris. And she had all the right references. Quoting them she stated that shrimp have claws on two of their five pairs of legs while prawn have claws on three of their five pairs of legs. I tried to close it down. They taste the same and we are in Australia.

'Yes', she responded 'but I brought a French seaside white wine to go with the shrimp. A Picpoul de Pinet from the Languedoc region of France. I know it goes with shrimp but I am not so sure it will go with prawn'. I looked at the bottle. OK, they are shrimp for tonight.....

A great entrée. A fantastic white wine. So what if we were a bit American in naming the Crustacean.

We were again relaxing between courses, when my American colleague acknowledged her 'special contribution' to the evening meal and then asked why her special contribution had not been recognised in her recent legal proceedings. It had been complicated. Her return to Australia after being a 'high flyer' had been domestically very challenging and had already been the focus of numerous discussions at our dinner reunions. Are you in, or not in a relationship? Even, how many partners can an individual have – in a relationship not a corporate sense.

She had held out for her special contribution to the previous relationship. You could understand why. She had the brains, the commitment and the bullion. She certainly had contributed but in the eyes of the Family Court there is no binding rule for 'special contribution'. She had agonised on what it all meant. Legally a special contribution is where one party contributes something so rare and unusual that it is beyond the everyday person to do this. Think Brett Whiteley who argued this in the 1990s. However, you cannot assume a 50 / 50 split either according to the High Court (Mallet v Mallet 1984). The Family Court loves getting involved and evaluating things in the context of the facts particular to that case. What would the judges do otherwise?

Indeed in a recent case the Justices involved, Bryant CJ and Ainslie-Wallace J in Fields and Smith held that "contributions from both particles were substantial and significant. The wife's contributions to the welfare of the family are in themselves significant contributions..... and does not suggest that one kind of contribution should be treated as less important or valuable than another".

Special contributions have always been a contentious area of family law property matters. And times are certainly changing. The contribution of homemaking and parenting is seen as being as valuable as other contributions such as the creation of a business and other more tangible assets. Indeed, the contribution of homemaking and parenting may well be seen as also indirectly contributing to those assets. Baroness Hale of Richmond may well be pleased. After all, in all these areas there are risks as well as commitment. That is what the courts try to value and balance. That is why the issue of special consideration is not enshrined; indeed it does not need to be recognised. All contributions to a relationship, to a family are valued, not just the financial ones.

However, that evolution had not helped my corporate lawyer friend who continued to make great choices in the wines. Her special contribution to the success of the evening was valued by all. Indeed we all wanted to know how we could start importing this wonderful drop.

However, her special contribution to her previous relationship, that had been such a bitter court dispute..... Well, not according to the Family Court.....

Legal material contributed by Daniel Kaufman, Special Counsel in Family and Relationship Law. Lander & Rogers.

NOTEWORTHY CONDUCT

Complaints are a part of professional life

MICHAEL GORTON
Russell Kennedy Lawyers

Most doctors are likely to receive one complaint or claim during their professional life. It is a 'life event', likely to be stressful and filled with uncertainty. None of us like our professionalism questioned or suggestions that we may have done wrong. These complaints can come from patients, but they can also come from fellow colleagues practice. In either case, it is best practice to remain professional and courteous in your exchanges with the complainant and it is an expectation of the Medical Board.

Keeping Notes

Doctors should also bear in mind that patients will also find an adverse outcome following medical treatments or procedures to be their own 'life events'. As such, the patients will apparently remember everything about their treatment, conversations, and even what they had for breakfast! The doctor, on the other hand, will have seen many patients that day and that week, and direct recollection of all of the events, all of the circumstances, and all of the details may be difficult. That is why professionals need to keep detailed records.

Maintaining detailed notes is a professional obligation, reinforced by the Medical Board of Australia, as part of expected good practice. Detailed notes and reasons in referrals are also an aid to other practitioners who may be scrutinising your work. Other doctors would not be able to speculate about your treatment and may better understand your reasoning if they had these.

Respecting Opinions

If you come across a situation where you think a colleague is in error, remember to treat them as you would want to be treated. It is important to first obtain all the facts, which is made much easier if detailed notes had been kept. In fact-finding, it is important to also speak privately and professionally to your colleague so that no premature conclusions are reached. In the end, it may be an error or a legitimate difference in professional opinion and quite often, the way in which it is approached can make a difference.

Mandatory Reporting

If a colleague is making a complaint against you, it is best to consider that it may not be a personal grudge, but rather, a mandatory reporting requirement and they are merely attempting to protect themselves. It is important for any practitioner to be aware of when they may report another practitioner for misconduct and even more important to be aware of when they must report a practitioner's misconduct. A national scheme for mandatory reporting of professionals who may place the public at risk of harm is under discussion by Australian health ministers. However, at the moment, each jurisdiction has its own different legislation and requirements. There are some jurisdictions in which failing to report misconduct will amount to unprofessional conduct or professional misconduct by the practitioner who should have reported. When faced with the possibility that a fellow practitioner may have been behaving improperly, it is always a good idea to first seek advice as to the appropriate course of action.

Best Practice

Ultimately, the maintenance of good relationships with other doctors and patients is integral to reducing complaints. By avoiding comments that would insinuate inadequate treatment by another doctor, you could save trouble for yourself and for your peers. Despite best efforts, disagreements may still occur, and it is important to remember that courteous communication is expected by the Medical Board and meant to facilitate the communication of difficult matters such as these without igniting sparks. Furthermore, objective and detailed file notes will also help to communicate your rationale and will be a doctor's best defence should a complaint arise.

2. Medical Board of Australia. Good Medical Practice: A Code of Conduct for Doctors in Australia. 2014. Retrieved from http://medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx

MANUP AND HYPER-TENSE

DR BB-G-LOVED

I've found there's nothing that hypes and tenses a male surgeon like measuring blood pressure! I don't mean to be gender in-equitous, but males are more afraid, display avoidance behaviours, and male gender is a risk factor for hypertension and cardiovascular sequelae. Be assured this article applies equally to hypertensive men and women, whether medically qualified or not. Hypertension is the world's most prevalent risk factor for disease, most of which is 'essential' and not secondary to some specific cause.

Last week Dr Manup had beads of sweat bursting from the forehead when I recorded the BP, and even slightly flaring nostrils. The readings stuck in the mild, Grade 1, hypertension range [systolic 140-159mmHg and/or diastolic 90-99mmHg] and were confirmed subsequently. So the anxious Dr Manup needs to consider other cardiovascular risk factors and whether anti-hypertensive therapy might be beneficial.

Cochrane's Hypertension Group [2012] reviewed four randomised controlled trials comprising 8.912 participants treated over 25 years ago with the drugs then available. These included the Australian Therapeutic Trial in Mild Hypertension [Australian National Blood Pressure Study begun in 1973 and reported through the 1980's], MRC [recruitment from 1973-1982], Systolic Hypertension in the Elderly Program [SHEP with some 20 publications in the 1990's], and a Veterans' Affairs study published during the late 1970s. They found antihypertensive therapy resulted in no reduction in morbidity or mortality, but 9% of patients discontinued treatment due to adverse effects.

One can imagine the hypertension this induced in those that market anti-hypertensives. It certainly raised the blood pressure for participants in subsequent trials designed to show treatment benefits.

If you have moderate, Grade 2 hypertension (systolic BP 160 -179mmHg and/or diastolic 100-109mmHg), treatment will reduce risk of cardiovascular events and death, though not as much as you might hope.

The Blood Pressure Lowering Treatment Trialists' Collaboration (BPLTTC) stratified risk according to age, sex, BMI, systolic and diastolic blood pressures, other anti-hypertensive treatment, smoking, diabetes and a history of cardiovascular disease. It found active treatment reduced cardiovascular (CVD) events (stroke, coronary heart disease, heart failure, cardiovascular death) at each of four levels of risk. The two lowest risk groups had a five-year CVD event risks of 4.1% and 8.3% compared with 6.5% and 13.2% for placebo. Thus giving 1000 patients treatment for 5 years would prevent 14 [CI 8-21], and 20 [CI 8-31] cardiovascular events. I would need to treat 71 patients in the lowest risk group or 51 in the second risk group to avert one event. The authors rightly concluded inconclusively, "these results support the use of predicted baseline cardiovascular disease risk equations to inform blood-pressure-lowering treatment decisions."

In May 2016, Astra Zenica's HOPE (Heart Outcomes Prevention Evaluation) showed no benefit of Candesartan (ACE inhibitor) and hydrochlorothiazide in reducing risk of major cardiovascular events compared with placebo for those at intermediate risk (men >55 or women >65 with at least one other risk factor - elevated waist to hip ratio, low HDL cholesterol, current or recent tobacco use, dysglycaemia, family history of premature coronary disease, mild renal dysfunction).

SPRINT (funded by NIH) compared intensive and standard treatment for high risk individuals (cardiovascular disease, chronic renal disease, a 10-yr Framingham risk index greater than 15%, age over 75 yrs) and a systolic blood pressure 130-180mmHg without diabetes. There was significant benefit in more intensive lowering systolic BP to 120mmHg compared to 140mmHg.

Large multi-centre, industry-sponsored trials such as LIFE (Merck), ACCOMPLISH (Novartis) and ASCOT (Pfizer) have identified "significant" benefits for regimens using their own ACE inhibitors and a calcium channel blocker to treat at risk individuals with Grade 2 hypertension.

Antihypertensive therapy is effective for those with sufficient risk. But 'to treat or not to treat' mild hypertension involves balancing risks with benefits. Dr Manup is addressing lifestyle, exercise, diet, alcohol intake and weight. We meet again soon, hopefully less anxiously during sphygnomanometry. If your lifestyle or genes have laid a hyper-tense time-bomb in your nest –the clock may be ticking - it may be prudent to lower blood pressure and risk before it explodes!

JOHN SHAW BILLINGS

Surgeon and bibliophile

PETER BURKE
Specialty Editor -
Surgical History: ANZ JSurg

Billings was born in Cotton Township, Switzerland County, Indiana on April 12, 1838.

Five years later the family moved to Rhode Island and Billings recalled that from about 5 to 10 years of age his life was that of an ordinary farm boy: planting crops and riding a horse for raking the hay crop.

He went to a country school for three months in the winter and "read everything I could lay my hands on. I managed to get a dollar for subscription to a little lending library in a bookshop". He was quite sure that he did not want to be a farmer.

He first had a sense of his own personality or individuality when about eight years old, resolving that everything in life was foreordained.

When he was ten years old, his father moved back to Allensville, Indiana where he kept a country store and was a postmaster. Young Billings read incessantly and asked a clergyman how he could learn Latin; he then obtained a Latin grammar and dictionary and set to work.

"In 1879, Billings began the first comprehensive index of journal articles, the Index Medicus, and now, MEDLINE is the electronic version of that publication."

"Then I made an agreement with my father that if he would help me through college in the least expensive way, all of his property should go to my sister, and that I must expect nothing more".

"I then got some Greek books, a geometry, etc., and went on to fit myself to pass the entrance examination for the sub-freshman class at Miami University, Oxford, Ohio".

"I succeeded in doing this in a year--and passed the examination in the fall of 1852. For the first two years I kept bachelor's hall, living on bread, milk, potatoes, eggs, ham etc., such things as I could cook for myself". He budgeted his food bills at 75 cents a week.

"The lessons gave me little trouble. Most of my time was spent in reading the books in the College Library. I was omnivorous, read everything in English as it came, philosophy, theology, natural science, history, travels and fiction".

Graduating B.A., second in his class in 1857, Billings was penniless and wished to study medicine: he took a job with an itinerant exhibitor of lantern slides and toured the Midwest delivering a rapid-fire running commentary on the startling scenes his employer flashed before an enthralled backwoods citizenry.

At the age of 20 in 1858 he entered the Medical College of Ohio, Cincinnati, and after a two year course he took his medical degree in 1860 and stayed on at the school as an anatomy demonstrator.

He had not attended the lectures very regularly: Billings wrote, "I found that by reading the text books, I could get more in the same time and with very much less trouble. I practically lived in the dissecting room and in the clinics,

John Shaw Billings

and the very first lecture I ever heard was clinical".

He lived in the hospital cleaning out the dissecting rooms and doing all sorts of odd jobs. At St. John's he was known to the nursing sisters as "St John of the Hospital" because of his melancholy mien and his austere ways.

At the end of February 1861 dark events were brewing and threats had been received against the life of the President-elect of the United States, Abraham Lincoln.

The American Civil War was about to commence and extend from 1861 to 1865, proving the most costly American conflict in terms of casualties, as an estimated 620,000 men died.

In Washington he took the examination for admission to the Medical Corps of the United States Army and passing first on the list, served a preliminary period as a contract surgeon and then was appointed First Lieutenant in April 1862.

ARTICLE
OF INTEREST

At the end of March 1863 he reported for duty to the Medical Director of the Army of the Potomac, encamped near Fredericksburg.

Billings recalled: "I began service and had three things with me that none of the other surgeons had: a set of clinical thermometers, a straight one and one with a curve; a hypodermic syringe and a Symes staff for urethral stricturotomy".

The Rappahannock River was crossed in April and Billings performed his first surgery in the field at the Battle of Chancellorsville in early May: two months later he was with the Second Division of the Fifth Corps at Gettysburg.

On July 9, 1863 he wrote to his wife from a hospital near Gettysburg, "I am covered with blood and am tired out almost completely and can only say that I wish I was with you tonight and could lie down and sleep for 16 hours without stopping. I have been operating all day long and have got the chief part of the butchering done in a satisfactory manner…".

"It is one thing to provide for wounded when the troops are advancing and leaving the hospital behind, and quite another thing to fall back with your wounded when the troops are retreating".

Billings observed that very few men performed operations which were unnecessary, and that the great majority were anxious to shift the responsibility and to get the simplest dressings on as soon as possible.

"My main criticism of the surgical work which I saw was that too much resection was attempted in cases of injury of the long bones. If a ball smashed a femur some surgeons wanted to get out all of the fragments, although in doing so they made the injury much more severe"

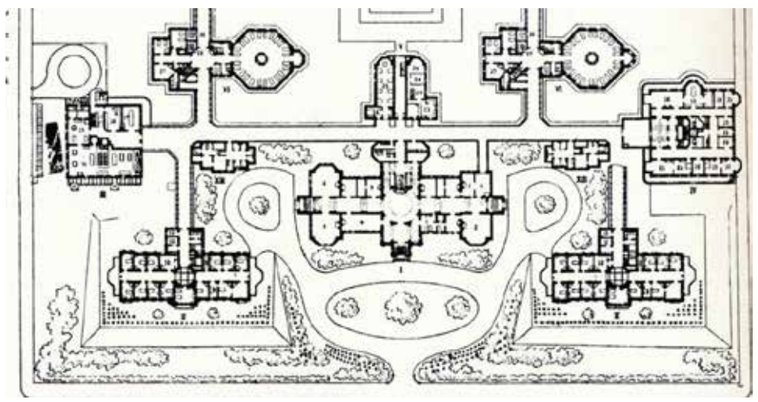
For a time he worked as Medical Inspector for the Army and in the summer of 1864 was invalided back to Washington, and in December assigned to the Surgeon General's Office where from 1865 to 1895 was the Librarian of that Office.

The library which had occupied a few shelves behind the Surgeon General's desk since the days of Andrew Jackson numbered about 1,800 volumes at the close of the war: when Billings arrived, the man and the opportunity met.

Billings recalled that after about six months of this work and correspondence he became convinced of three things.

The first was that it involved a vast amount of time and labour to search through volumes of medical books and journals for items on a particular subject, and that the indexes of such books and journals cannot always be relied on as a guide to their contents.

The second was that there were over 100,000 volumes of such medical books and journals in existence, not counting



John Shaw Billings' plan for John Hopkins Hospital

John Hopkins Hospital

pamphlets and reprints.

Thirdly, that while there was nowhere in the world a library that contained all medical literature, there was not in the United States any equivalent facility.

Billings determined to try to establish for the use of American physicians a comprehensive medical library with catalogue and index. The title, 'National Medical Library', first appeared in 1876.

The rise of the periodical form of publication of scientific literature had been spectacular during the middle third of the 19th century and Billings recognising its importance had clothes baskets full of journals delivered to his home in Georgetown where he worked at night checking the items in each issue which he wanted indexed. In 1879, Billings began the first comprehensive index of journal articles, the Index Medicus, and now, MEDLINE is the electronic version of that publication.

Billings also produced the Index-Catalogue, a monumental work which was a combined author and subject catalogue of the Library's growing collection of a wide assortment of materials: this resource was printed in 61 volumes in 5 series published from 1880-1961.

William Welch (1850-1934), professor of pathology and first Dean of the Johns Hopkins Medical School, considered the Index-Catalogue, America's greatest contribution to 19th century medicine.

Billings was detailed to inspect the condition of the Marine Hospital

Service in 1869-70 and prepared a reorganisation plan which led to that service renamed as the Public Health Service.

During the period 1870-75 he prepared long reports on Army hospitals and Army hygiene and became active in the affairs of the American Public Health Association.

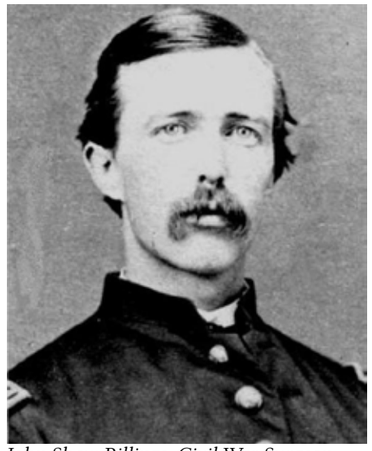
By 1880 the Library collections had grown to such a size that the need for a new building was imperative and Billings organised a building campaign: the new building was completed in 1887 at a cost of $200,000; the east wing was occupied by the Army Medical Museum, which had been formally placed under Billings' charge in 1883 and the west wing was occupied by the Library.

At this juncture the city of Baltimore was offered a university and a hospital, equally endowed by a local businessman, Johns Hopkins.

Hopkins instructed his trustees how he wanted this hospital built and run.

The trustees determined to build the best hospital in the world and wrote for guidance, suggestions and specific plans, embodying those suggestions, to five distinguished physicians who had made the subject of hospitals their special study: Billings' second plan was accepted.

Commencing in 1875, Billings had been closely involved in this



John Shaw Billings, Civil War Surgeon

development and he was the Chief Medical Advisor to the President of the new University and arranged the curriculum for the new medical school: he insisted that the school should train investigators as well as practitioners and was instrumental in bringing in Welch and Osler as the nucleus of the first staff.

In 1895, after 30 years at the Library, President Cleveland granted his retirement from the Army; a great banquet was held in his honour in Philadelphia and William Osler read a message of congratulations.

He was then selected as Director of the New York Public Library and from 1905 was engaged in drawing up plans for the Peter Bent Brigham Hospital in Boston.

During his last years he was frequently unwell and underwent five operations for facial cancer, the last performed by Dr William S Halsted involved a radical neck dissection; he suffered renal and biliary calculi and in 1900 was operated upon by Dr Charles McBurney.

John Shaw Billings died on March 11, 1913, and was buried in Arlington National Cemetery.

In 75 years he had fought a war, revolutionised hospital construction, been a prime mover in public hygiene and sanitation, had played a leading role in the development of vital statistics, had done more to advance American medical education than any other individual of his generation, had created a great national medical library and built for it bibliographical keys of comparable magnitude.

Billings was a tall figure of powerful build and commanding appearance; he had the rare gift of industry of the minute and seized upon essentials. An altogether remarkable man who dominated the American medical scene for almost half a century

Reference: 'Selected Papers of John Shaw Billings'. Compiled, with a Life of Billings, by Frank Bradway Rogers.

Medical Library Association. 1965

An artist's depiction of the Civil War

CONTRIBUTIONS TO RESEARCH INTO TROPICAL DISEASES IN PNG

A grant from the RACS to internationally-renowned Pathologist Professor Robin Cooke OBE, OAM is contributing to efforts by the University of Papua New Guinea (UPNG) to develop its medical faculty and museum into a world leader in the study of tropical diseases.

Last year, the Global Health Committee and the Foundation for Surgery provided Professor Cooke with $20,000 to enable him to save 50 deteriorated pathology specimens belonging to the University's Medical Museum.

All are considered to be of global or national significance and the selection includes samples of pre-Western contact and first contact diseases.

Having restored 50 specimens, with work underway to restore more, Professor Cooke is now in the process of obtaining and potting sections of extremely rare brain samples from patients suffering from the disease Kuru, the prototype Prion disease, caused by ceremonial cannibalism.

Professor Cooke also used part of the funds to support the training of Medical Technologist Martin Ata'o in the specialised skills required to unseal, clean, re-pot and re-present the delicate specimens.

As part of that training, Mr Ata'o travelled outside PNG for the first time to work under the supervision of Ms Teresita Aceret from the Anatomy and Pathology Department at the James Cook University (JCU) in Townsville.

Professor Cooke, who established the pathology museum in Port Moresby when he worked there from 1962 to 1967, said many of the specimens in the collection were irreplaceable but of diminishing quality and educational use through leaks, the evaporation of formalin and discolouration.

Mr Ata'o and Robin Cooke

Through the work of Ms Aceret and Mr Ata'o, the most valuable specimens selected by Professor Cooke have now been saved and presented in new containers and display cabinets for study by students at the UPNG School of Medicine.

The rejuvenated collection includes samples of:

A heart from a patient who suffered the sixth documented case of myocardial infarction in PNG (with heart disease now one of the most common causes of death in PNG);

- a Peptic ulcer (considered another disease of civilisation);
- a brain abscess caused by an arrow penetrating the skull;
- Madura foot, a chronic granulomatous disease characterised by localised infection of subcutaneous tissues by actinomycetes or fungi;
- A section of nerve from a patient with leprosy showing a marked granulomatous inflammation which has enlarged the nerve and replaced the normal nerve fibres;
- A section of lung infiltrated by multiple miliary tubercles from a patient with TB.

Professor Cooke said restoring the samples had been a painstaking process which involved breaking the old pots with a hammer and chisel, removing and cleaning the specimens, making new Perspex containers and mounts, applying gelatine patching, removing bubbles and labelling,

"When it comes to medical education, there is nothing better than to be able to see disease to appreciate how it works."

cataloguing and photographing the restored collection.

Earlier this year, he visited UPNG to see the revitalised collection and was delighted with what he saw there and the enthusiasm expressed by faculty leaders in the UPNG School of Medicine toward the project.

A strong advocate for the need of pathology specimens in the

GLOBAL
HEALTH

Robin Cooke (second from left) with his team

teaching of medicine, Professor Cooke is the author of a 2006 book titled The Rise and Fall of the Pathology Museum in the Teaching of Medicine.

He said that while many leaders in medical education had decided against the need for physical specimens of disease from the 1950s onward, opinions had now shifted back in favour of their use – even in the digital age.

"After WWII, the majority of medical schools were not interested in gathering together a pathology collection and by the end of last century many were throwing out their specimens," he said.

"Yet now we have had a generation of medical students who don't have very much pathology or anatomy and surgeons in many countries are complaining about this - as are the students - and in the UK, medical students are now paying for dedicated pathology courses.

"Many people now realise that if we keep pathology specimens in customised pots and present them clearly, digital images can be made based on three-dimensional disease which, after all, is what medical students will ultimately need to recognise, understand and treat.

"Not only are these collections important in all medical schools, they are particularly important in institutions like the UPNG which is aiming to become a world leader in a particular field, in this case the study of tropical diseases."

Professor Cooke said he was particularly keen to obtain samples of a Kuru brain for the UPNG given that the disease no longer existed and that there was currently no record of Kuru pathology in the country, not even a pathological report on any of the cases.

He said the disease at one stage exercised some of the greatest medical minds from around the world when it was first reported by western medical doctors in the 1950s.

"There were reports of a strange shaking disease from a remote area of PNG that was particularly affecting young women," Professor Cooke said.

"An American scientist went up to the remote area of PNG to investigate.

"With the Medical Officer who was stationed there at the time, he conducted post mortems on the brains of the victims and then sent samples to leading Neuro-Pathologists around the world with a simple telegraphed question: 'Is this a new disease?'

"A Pathologist in London verified that it was, indeed, a new neurological disease characterised by the presence of spongiform changes particularly in the cerebellum. It was shown to be caused by a new type of organism that was first called a 'slow virus' and later called a prion. "

"Only once anthropologists went in, was it found that Kuru was caused by the ceremonial custom of young women eating the brains of their dead relatives as a sign of respect.

"Now there is barely a trace of the disease left anywhere in the world but I believe the UPNG deserve a specimen of Kuru brain because understanding the disease was of great importance not just to the people of PNG but also to the international medical and scientific community."

Professor Cooke thanked the College for the support given to the project and said Mr Ata'o now had the skills to restore and rejuvenate many other pathology specimens.

"I don't think Martin had seen a museum in his life before he was given an appointment at UPNG, but he learnt a great deal when he was at JCU and his work is wonderful," he said.

"He has already begun his own re-potting project and has chosen and sourced new display cabinets which make the restored pathology collection appear almost sparkling new."

"The UPNG medical museum has around 700 specimens so Martin will be able to re-pot and re-present more of them because he now has unique skills which he can use to the benefit of the medical school I think this is exactly what the RACS wanted to achieve with this funding."

Mr Ata'o said he was delighted to be part of the project when he was asked to participate last year.

A recent graduate of Medical Laboratory Sciences, Mr Ata'o was already employed at the UPNG as a technical officer in the student pathology laboratory with particular responsibilities in preparing bacteriology and haematology classes for medical students.

He said that along with the potting skills he learnt at JCU, he also learnt human anatomy, pathology and the skills of embalming, and said he looked forward to using his new knowledge for the benefit of medical education in PNG.

"My plan is to help build the best museum of tropical human diseases by restoring and rearranging the old specimens and expanding and collecting newer specimens for preservation and storage," Mr Ata'o said.

"When it comes to medical education, there is nothing better than to be able to see disease to appreciate how it works."

MR FRANCIS LANNIGAN

Reducing the impact of chronic ear disease in Aboriginal communities

Born in Northern Ireland, trained in England and WA and now an Australian citizen living in Perth, ENT surgeon Mr Francis Lannigan was this year awarded the RACS Aboriginal and Torres Strait Islander (ATSI) Health Medal for his work to reduce the rates and effects of chronic ear disease in Aboriginal communities.

A consultant at the Princess Margaret Hospital for Children and a Clinical Professor at the School of Surgery and Paediatrics at the University of WA, Mr Lannigan has worked with Indigenous communities across the state since his arrival twenty years ago.

Since then, he has helped generations of Aboriginal families manage a range of ear diseases – particularly Chronic Suppurative Otitis Media (CSOM) - through the pro bono Aboriginal Children's Ear Clinic he established in the Perth suburb of Kwinana in 1998.

He also spends weeks working outside Perth each year as an Honorary Consultant to the Ear Health Programme of the Ngaanyatjarra Health Service at the Kalgoorlie Regional Hospital and provides telehealth services to the Central Desert to provide a clinical service to remote communities.

Mr Lannigan is also the visiting ENT surgeon to the Mandurah Community Health Clinic and the Leonora Community Health Clinic and, in the past, provided services to health centres across the Gascoyne area of WA and occasionally as far afield as the Kimberley.

The committed academic surgeon has published more than 60 papers in peer reviewed journals, made a significant contribution to the third Aboriginal and Torres Strait Islander Ear Health Manual and his myringoplasty information booklet is widely used by Goldfield ear team members.

"All children suffer from ear disease at one time or another but Indigenous kids suffer more."

Mr Lannigan said he first came to Australia to complete his Doctorate thesis and was invited to return by a colleague at Sir Charles Gairdner Hospital in Perth.

Already a Fellow of the Royal College of Surgeons of Edinburgh and the Royal College of Surgeons of England, Mr Lannigan made his first visit to the remote regions of WA in 1995 and was horrified by what he saw.

"I had no idea of the scale of the problem of chronic disease in Indigenous communities until my first visit to Fitzroy Crossing where I was astounded at the inequity of health care and housing in particular," he said.

"It was a problem I couldn't ignore so I set out to learn how I could offer my skills as an ENT surgeon to Indigenous health groups.

"I helped establish the clinic in Kwinana in 1998 because more Indigenous people live in that area of Perth than live in the Kimberly and because I had the support of local Indigenous health workers.

"At the time, only five per cent of my ATSI patients at the Princess Margaret Children's Hospital were able to access outpatient appointments yet from the start we achieved 87 per cent attendance at the clinic because it was run by Aboriginal health workers and therefore embraced by the community.

"The incidence of suppurating ears

has slowly reduced from 68 per cent of kids to the current rate of less than 30 per cent."

Since then Mr Lannigan has not only given his time as a surgeon to help reduce the impact of chronic ear disease he has contributed to a number of research projects to help determine the size of the problem in Indigenous communities and the best management strategies to reduce hearing loss in children.

These include the NHMRC adenoidectomy/Otitis media with effusion study in the Goldfields, the Kalgoorlie Otitis Media Project with Professor Deborah Lehmann AO and a population-based study of ear disease and management in WA which is one of the largest epidemiological studies ever undertaken in the world.

Mr Lannigan said that the cause of such high rates of CSOM remained as they did years ago and included overcrowding, diet, hygiene and a lack of access to clean water, all of which enabled and contributed to the early colonisation of pathogens in the nasophyranx.

Yet even after all his work in the field, he remains appalled at the unequal health care provided to Indigenous Australians.

"If 70 per cent of children in Toorak had chronic ear disease it would be a national outrage yet successive governments just accept the rate of chronic ear disease in the Indigenous community as if it is the norm," he said.

"All children suffer from ear disease at one time or another but Indigenous kids suffer more.

"Aboriginal and Torres Strait Islander children experience approximately 30 months of ear disease by the time they are aged five whereas non-Aboriginal children average three months.

"This means that too many Indigenous kids can't hear at critical times in their life, such as when they first start school and are often learning English as a second language.

"Obviously, if children cannot engage with the education system simply because they cannot hear they are more likely to disengage which can have life-long consequences.

"It's shocking to consider that while Aboriginal and Torres Strait Islander people make up only three per cent of the Australian population, they make up 50 per cent of those in juvenile detention and 25 per cent of the prison population.

"I still get angry with people who think that Aboriginal and Torres Strait Islander people get money thrown at them because the average Indigenous person receives one-third of the health dollar that goes to the rest of the community and that is not good enough."

Mr Lannigan said he had been thrilled and honoured to have received the Aboriginal and Torres Strait Islander Health Medal and that he had enjoyed working with Aboriginal children and their families since his arrival in Australia.

He said he felt privileged to have been welcomed into Indigenous communities across WA, particularly when the Elders supported his visits and his work.

"I particularly like working with Aboriginal health workers and getting to know the Elders in the more remote regional areas," he said.

"Often when I first go into a community to run a clinic, the Elders visit even though they have no problems with their ears but simply so they can see if I am a suitable person to work with.

"It's an honour to meet them and, more importantly, they make a huge difference to health outcomes by supporting the need for the ear service, encouraging parents to bring their kids and welcoming the health workers."

Mr Lannigan is currently contributing to research aimed at identifying the appropriate management of Aboriginal and Torres Strait Islander ear disease through a multicentre trial.

The current WA Chair of the Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS), he remains a passionate advocate for his young Indigenous patients.

He is now in the process of working with other committed colleagues to establish a dedicated, national multi-disciplinary group to lobby for adequate resources to fund ear health in Indigenous communities and drive research.

"I still get frustrated that Aboriginal ear disease is not recognised as having the same importance as eye disease and funded appropriately," he said.

"We need sufficient funding to be able to provide Indigenous communities with their own health workers and educators and doctors and surgeons as a simple matter of justice.

"Chronic ear disease is a disease of disadvantage and politicians and the broader Australian community cannot pay lip service to 'Closing the Gap' without addressing the unacceptably high rates of CSOM in the Indigenous population."

With Karen Murphy

SOCIAL MEDIA UPDATE

Savvy or silly?

SUSAN HALLIDAY

Australia's former sex and disability discrimination commissioner

As it approaches eight years since Virgin Atlantic sacked 13 flight attendants for inappropriate chatter on Facebook it's clear that people in both professional and personal environments have failed to take note that cyber-space is a public place, and that when you post in the modern sense of the word, you publish in the traditional sense of the word.

Having called customers 'chavs', commented on the six-legged variety of frequent-cockroach-flyers travelling for free, and criticising the airline's flight safety standards, the behaviour of the flight attendants way back in 2008 was declared 'totally inappropriate' and it was found that their commentary had 'brought the company into disrepute'.

Fast forward to 2016 and there's a plethora of people posting on-line who still fail to understand they're professionally aligned with a workplace, as their fingers are busily typing before they think. For the record 'typing before you think' is usually far more dangerous than 'speaking before you think'! Be it Facebook, Instagram, Twitter, Snapchat, Blogging, Wikis, Flickr, Youtube, LinkedIn or a group text message, it's important to ask oneself "would I be happy to read that comment or see that picture on the front page of the newspaper with my name, and that of the relevant employer or medical practice, attributed?"

I routinely ask people when working with groups, about when they last updated their Social Media Policy. I regularly receive the same pained looks in response. I hear myself repeating "it's time" and note that the 2016 Workplace Info Social Media Index survey having interviewed 371 Australian businesses, found that 23 per cent of organisations experienced bullying of their employees via social media, and that 38 per cent of bullying primarily involved employees making inappropriate, derogatory and disparaging comments about their co-workers. Furthermore, inappropriate on-line treatment of employees by colleagues had included stalking, threats, releasing information about a co-worker, group bullying, and the posting of inflammatory material, videos and photographs.

As facial expressions alter from pained to interested, it's fair to say that the topic of social media defamation always draws a decent crowd, with the odd faces looking particularly worried. The recent twitter-tale of a former Orange High School lad who found himself in a spot of defamatory bother and out of pocket $105,000 in damages - at the ripe old age of 20 - tends to cement my point. Bearing a grudge against a teacher at the school, he took to Twitter and Facebook to publish his grievances. The judge was clear that the teacher in question was defamed given the public 'false allegations' and in turn determined that the effect on her 'was devastating.'

The internet has provided a platform for ordinary people and employees to publish 24/7, and dare I say they are very busy. Privacy settings are irrelevant and for every comment and every photo posted online there is likely to be a permanent record, and the odd subpoena. The key point here is that defamation is actionable irrespective of the medium.

Defamation lawyers are struggling to keep up with the workload of late as social media fortifies their area of expertise, mindful that the traditional principles of defamation apply, in that if information is spread intentionally and it causes injury or damage to another person, organisation, association, practice or company's reputation, it is likely to be problematic.

To boot, in this new age, if a person who did not create the defamatory material, but chose to share or re-publish it, or is enough of a twit to re-tweet it, they too could have a defamation case pending. As a cautionary note I always tell the now anguished faces in the crowd to read the 38 Facebook comments before you share or re-publish the Facebook post that is accompanied by the 38 comments!

Turning to all those with somewhat shocked faces amidst social media site administrators (both personal and professional) it is time to come to terms with the lay of cyberspace-land. It's fair to say that the more astute and risk averse have already worked out that they are responsible for everything on the personal and professional social media sites that they administer. But the question begs, why would you allow people to post anything on a social media site that you administer before you have pre-screened and approved it for publishing? Further, does the person who administers the organisation's Facebook page and Twitter feed have the relevant duties and responsibilities detailed in their job description?

In October 2015 the Supreme Court considered whether an administrator of a Facebook page could be liable for comments posted by another user. Justice John Dixon made it clear that an administrator could be liable as a secondary publisher as the person had the power to remove the comments. And yes - this case was related to a medical practitioner and Facebook posts.

Reflecting, brick walls and virtual walls are basically the same. If there is defamatory graffiti on the outside brick wall of your medical practice, and you don't remove it, the law says you are responsible for it. Now think Facebook wall, Twitter feed, false and misleading statements on LinkedIn and Instagram pictures accompanied by comments, and set some time aside to work on your 'privacy' and access settings.

PRE-OPERATIVE FASTING

ANZCA has updated its guidelines

The Australian and New Zealand College of Anaesthetists (ANZCA) has updated its guidelines for fasting before operations.

The aim of fasting prior to a surgical or medical procedure is to decrease the risk of perioperative regurgitation, which may result in aspiration syndrome. This may be associated with chemical pneumonitis, bacterial pneumonia or airway obstruction depending upon whether foreign material (food) and/or gastro-intestinal fluids (gastric acid, bile or other bowel contents) have been aspirated into the lungs. Such patients may require treatment in critical care units. The fasting guidelines refer not only to situations pertinent to the administration of general anaesthesia but also includes those related to regional anaesthesia/analgesia and sedation.

"As part of ANZCA's document development process, this has been approved for a 12 month pilot for feedback, which will then be incorporated in the final version. There already has been extensive consultation incorporated into these Fasting Guidelines."

Prolonged fasting from fluids for more than 6 hours fails to achieve an optimally empty stomach and may have deleterious metabolic effects as well as an impact on patient wellbeing. Consideration may be given to the provision of clear carbohydrate rich fluids, specifically developed for perioperative use, up to two hours prior to commencement of anaesthesia. The duration of fasting should be sufficient to minimise the risk of aspiration but adults and children should be encouraged to drink clear fluids up to 2 hours before elective surgery. A volume of up to 200ml per hour up until two hours before a procedure is currently recommended for adults. A safe upper limit for volume has not yet been clearly identified, and will vary from patient to patient, however many studies have shown that in adults it is safe to administer up to 400 mL of clear fluids 2 hours prior to surgery. Proposed timing of anaesthesia/sedation should be taken into account and patients instructed accordingly. The practice of "fasting from midnight" for a morning procedure is appropriate for solids but not appropriate for clear fluids in most circumstances.

The guidelines are as follows:

- For adults having an elective procedure, limited solid food may be taken up to six hours prior to anaesthesia and clear fluids may be taken up to two hours prior to anaesthesia. Clear fluids are regarded as water, pulp free fruit juice, clear cordial, black tea and coffee. It excludes particulate or milk based drinks.
- For children over six months of age having an elective procedure, breast milk or formula and limited solid food may be given up to six hours and clear fluids up to two hours prior to anaesthesia.
- For infants under six months of age having an elective procedure, formula may be given up to four hours, breast milk up to three hours and clear fluids up to two hours prior to anaesthesia.
- Prescribed medications may be taken with a sip of water less than two hours prior to anaesthesia unless otherwise directed (for example oral hypoglycaemics and anticoagulants).
- An H2-antagonist, proton pump inhibitor or other agent that decreases gastric secretion and acidity should be considered for patients with an increased risk of gastric regurgitation.

These fasting guidelines may not apply to certain patient groups at increased risk of perioperative regurgitation or vomiting. This includes patients having emergency procedures and those with known/suspected delayed gastric emptying or oesophageal motility disorders, and obstetric patients in labour. Patients who have had bariatric surgery (in particular those with adjustable gastric bands) may also fall into this category. The practitioner responsible will need to exercise discretion regarding adequacy of fasting times versus the risk of aspiration. In any of these situations it may be necessary to delay the planned procedure and/or use airway protective manoeuvres, both physical and pharmacological.

Chewing gum must be discarded. This is primarily due to its risk as a foreign body rather than increased gastric content.

For more details on the PS07 Guidelines on Pre-Anaesthesia Consultation and Patient Preparation go to: *www.anzca.edu.au/getattachment/resources/professional-documents/ps07_guidelines_pre-anaesthesia_consultation_patient_preparation.pdf#page=5*

You can also refer to the Guidelines on Pre-Anaesthesia Consultation and Patient Preparation and the accompanying background paper.

As part of ANZCA's document development process, this has been approved for a 12 month pilot for feedback, which will then be incorporated in the final version. There already has been extensive consultation incorporated into these Fasting Guidelines.

RACS Visitor New Zealand Association of General Surgeons Annual Scientific Meeting March 12-13 2016

RICHARD PERRY
Chair, Fellowship Services

The NZAGS ASM was held in March in Takapuna (North Shore) with a diverse program. The Saturday afternoon included a session on '"Better Data'", featuring Shaw Somers (RACS visitor from England) who gave insights into the public reporting of surgeon's' outcome data in the UK. Shaw was spending three3 months in New Zealand and Australia, and he was also the visiting speaker for the Bariatric Section at the RACS ASM in Brisbane in May.

The second day of the NZAGS ASM included an hour long session on discrimination, bullying and sexual harassment featuring then RACS Vice President Graeme Campbell, RACS councillor Cathy Ferguson, and New Zealand Executive Director for Surgical Affairs, Richard Landers.

At the final session of the meeting the focus moved to Surgeons Health, including North Shore surgeon Pat Alley speaking on planning retirement. Congratulations to Pat on being named a member of the New Zealand Order of Merit (MNZM) at the Queen's birthday honours list, for services to Health. Dr Tony Fernando, psychiatrist, gave an entertaining talk on '"Happiness'".

Both invited speakers to the NZAGS meeting were supported by the RACS Visitor Program. Professor Sue Clark from St Marks in London and Professor Richard Schulick from the University of Colorado both addressed the ASM twice. They also spent an entire day with the General Surgical Ttrainees on the training day which that precededs the ASM. In addition, both visited North Shore Hospital surgical units. Professor Sue Clark visited the colorectal team, and Mike Hulme-Moir, head of the colorectal unit is planning to visit Professor Clark at St Marks in London later this year. Sue is an accomplished sailor, and very much enjoyed the conference dinner, which was held at the Royal New Zealand Yacht Squadron. Professor Richard Schulick met with Jonathan Koea (RACS national board member) and the Upper GI team at North Shore Hospital and there may be opportunity arising in the future for collaborative research between North Shore and Colorado. It was great for our New Zealand general surgeons to strengthen ties with these two highly regarded invited speakers and their world- renowned institutions.

Sue Clark

Richard Schulick

The NZAGS thanks RACS for its generous support through the RACS Visitor Program.

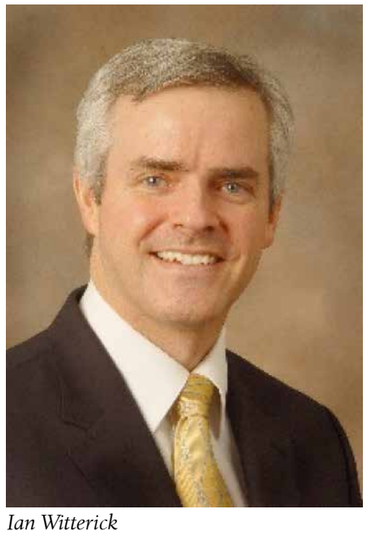
RACS Visitor Program ASOHNS ASM 2016

Successful OHNS meeting featured two renowned international speakers

RICHARD PERRY
Chair, Fellowship Services

The presentations given by two world-renowned otolaryngologists, Dr Haytham Kubba from Scotland and Professor Ian Witterick from Canada, were well-received at the Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) 2016 Annual Scientific Meeting held in Melbourne in March.

The speakers were sponsored by the Royal Australasian College of Surgeons (RACS) and joined other prominent international guest speakers and local experts in providing valuable information to more than 490 attendees.



Ian Witterick

Dr Kubba, based in Glasgow, is one of the few exclusively Paediatric Otolaryngologists in the UK, having trained in the UK, Switzerland and the USA.

His presentation demonstrated that the "Snotty Nose Kid" was a worldwide phenomenon and might be even more prevalent in Scotland's cold climate.

Dr Kubba's main interests are airway surgery, congenital abnormalities of the head and neck and neurodisability and its effect on Otolaryngology in children. His discussions of difficult paediatric cases assured an attentive audience.

Prof. Witterick is Professor and Chair of the Department of Otolaryngology-Head and Neck Surgery, Faculty of Medicine, University of Toronto, Canada.

He has major sub-specialty interests in Rhinoplasty, Advanced Sinus and Skull Base Surgery and Head and Neck Cancer and Thyroid Surgery.

He presented in both plenary and concurrent sessions in the ASM's main program and was the main guest presenter in the satellite meeting, Contemporary Approaches to Skull Base Tumours – a 360 degree Perspective, held just before the main meeting.

At the forefront of programs educating future skull base surgeons, especially simulation and image guidance and measuring competency, Professor Witterick demonstrated that teaching is both an art and a science and inspired his audience to ensure continuous skills maintenance in years to come.

Overall, the ASM was very well received by attendees, with 80 per cent rating it '"excellent"' or '"very good"'.

Haytham Kubba

The ASOHNS thanks RACS for its generous support of Dr Kubba and Professor Witterick through the RACS Visitor Program.

IN FOCUS:

Aboriginal, Torres Strait Islander and Māori health

RICHARD PERRY
Chair, Fellowship Services

RACS has recently formalised its commitment to working with the Australian Indigenous Doctors' Association as part of the Reconciliation Action Plan and with Te Ohu Rata O Aotearoa (Māori Medical Practitioners or TeORA) as part of the Māori Health Action Plan. RACS has long standing relationships with both organisations which has included attending and supporting annual scientific meetings over a number of years.

This year there are two exciting opportunities being supported by RACS that Fellows, Trainees and International Medical Graduates with an interest in learning more about and supporting Aboriginal, Torres Strait Islander and Māori health may wish to attend.

AIDA 2016 is the Australian Indigenous Doctors' Association's annual event. RACS' support for the event includes profiling initiatives to support and encourage growth in the numbers of Aboriginal and Torres Strait Islander surgeons, including a comprehensive scholarship program, JDOCS and key contacts for interested medical students and junior doctors. RACS' will also be supporting workshops and the annual growing our fellows forum.

The Pacific Region Indigenous Doctors Congress (PRIDoC) 2016 is a biennial meeting of Indigenous doctors from around the Pacific including the Australian Indigenous Doctors Association, Association of American Indian Physicians, Ahahui o nā Kauka – Association of Native Hawaiian Physicians, Indigenous Physicians Association of Canada, Medical Association for Indigenous Peoples of Taiwan and Te Ohu Rata o Aotearoa – Māori Medical Practitioners Association. This year's event will bring together members and supporters from all of these organisations in Auckland, providing a space to discuss ideas, action and evidence transforming Indigenous Health.

Asia-Pacific surgeons seek your help with essential CME

Help support continuing medical education for Asia-Pacific surgeons by donating your used copies of the ANZ Journal of Surgery, World Journal of Surgery or other appropriate journals

Our surgical colleagues in Papua New Guinea, the Pacific Islands, Timor-Leste and Myanmar are hungry for access to the ANZ Journal of Surgery, but for many people in these low and middle income countries, the subscription fees are unaffordable.

What do you do with your copies of the medical journals once you've finished reading them? Why not donate them to the Vaiola Hospital library in Tonga, or the Journal Club at Port Moresby General Hospital? You will be helping your fellow surgeons in a neighbouring country continue their medical education, while helping the environment and giving your office that much needed clean out!

We are seeking 12 sponsors to commit to donating their used copies of the ANZ Journal of Surgery and other appropriate medical journals to the overseas institutions listed below, for a minimum of one year.

At over AUD 2,500 per year for a print subscription for an institution in the Asia-Pacific region (more than double the subscription fee for Australian and New Zealand Institutions) the ANZ Journal of Surgery is unaffordable for many hospitals and medical universities in Asia-Pacific countries.

Medical journals, particularly the ANZ Journal of Surgery are highly sought after in these countries and will be read by many. Your donation will have a significant multiplying effect as the journals will be consigned to the hospital libraries, ensuring that all staff and trainees can access these valuable educational resources.

Donating your journals is easy. Select which institution you would like to support and make a donation of AU $200 to cover the international postage from Australia to the recipient country for the year ahead. RACS Global Health will send you a prepaid satchel each quarter (at our expense) to send your journals to the College for distribution, once you've finished reading them. You'll receive a photograph of the institution and the surgical team that you are supporting, and an annual update on the benefits of your generous support.

Paediatric Surgeon Dr Basil Leodoro and the Emergency Theatre team at Northern Provincial Hospital in Santo, Vanuatu

The ANZ Journal of Surgery online has been made available either free of charge or at a very low cost to institutions in developing countries through the World Health Organization's Hinari program. Donating your hard copy journals to these institutions' library collections will significantly augment the local surgeons' access to essential CME.

Please contact RACS Global Health on +61 3 9249 1211 or global.health@surgeons.org to participate. We look forward to hearing from you!

Institutions in need of your support:

Myanmar
University of Medicine 2, Yangon

Papua New Guinea
Port Moresby General Hospital

Kiribati
Tungaru Central Hospital

Tonga
Vaiola Hospital

Vanuatu
Northern Provincial Hospital, Santo
Vila Central Hospital

Samoa
Tupua Tamasese Memorial Hospital

Solomon Islands
National Referral Hospital

Fiji
Colonial War Memorial Hospital
Lautoka Hospital
Labasa Hospital
Fiji National University - College of Medicine, Nursing and Health Sciences

RACS VISITOR GENERAL SURGEONS AUSTRALIA

Mr Brendan Moran

RICHARD PERRY
Chair, Fellowship Services Committee

- Consultant General and Colorectal Surgeon, Basingstoke, UK
- National Clinical Lead SPECC (UK Significant Polyp Early Colorectal Cancer) Program
- Founder and Former Director, UK Pseudomyxoma Peritonei National Centre, since 2000
- Assistant Director Basingstoke International Peritoneal Malignancy Institute

The 2016 GSA ASM Organising Committee is privileged to have world-renowned expert Mr Brendan Moran's involvement on the Scientific Program.

Brendan has been working at the Hampshire Clinic since 1995 as a Consultant Colorectal Surgeon and General Surgeon. He has been a Consultant Surgeon at the Basingstoke and North Hampshire Foundation Trust since 1995, and is now National Lead Clinician for the Low Rectal Cancer National Development Pilot Programme. Until this latest appointment, he was the Director of the UK Pseudomyxoma Peritonei National Centre, having developed the centre into the largest peritoneal malignancy treatment centre in the world. Other principal appointments include Honorary Senior Clinical Lecturer at the University of Southampton, Cancer Sciences Division, Member of Council of the Association of Coloproctology of Great Britain and Ireland, Lead Surgeon of the National Multidisciplinary Team and the TME Development Programme.

Brendan has a long-standing interest on rectal cancer management and treatment, appendiceal tumours and Pseudomyxoma Peritonei. He has set up and delivered the English Low rectal cancer programme, and recently he has commenced the SPECC - Significant Polyp Early Colorectal Cancer UK National Program. He has published over 100 peer- reviewed articles, has written many book chapters, and edited Farquharson's Textbook of Operative General and Manual of Total Mesorectal Excision by Heald and Moran. He is the Principal Investigator in a Multi-centre, Multi-national, Multi-disciplinary Low Rectal Cancer study.

Brendan undertook his Registrar training in Hampshire and became a Fellow of the Royal College of Surgeons of Ireland in 1984 and of England in 1997.

Presentations

1. Keynote Address

Low-rectal cancer: Optimal modern management

2. Keynote Address

Managing the unexpected appendiceal tumour

3. Keynote Address

Colorectal peritoneal metastases... A challenging problem

4. Debate

Conference pearls change my practice

Does attending a conference affect your practice?

The GSA thanks RACS for its generous support of Mr Moran through the RACS Visitor Program.

Brendon Moran

RACSTA INDUCTION CONFERENCE

26 November 2016

NICHOLAS LOW
RACSTA Representative

Following on from Dr. Ruth Mitchell's article in May 2016, I agree that successes should be celebrated and recognised when they are discovered. With the 2016 SET selection process almost wrapping up, there are sure to be celebrations across Australia and New Zealand for applicants who are successful.

The annual Royal Australasian College of Surgeons Trainees' Association (RACSTA) Induction Conference to be held on 26 November 2016 serves as an opportunity to acknowledge the hard work by incoming trainees as they are victorious in striving to secure one of the highly competitive and coveted SET training spots in both Australia and New Zealand. Put simply, it heralds a milestone in a doctor's post medical graduate working life, as they embark on their SET training, with the expectation that a surgical career awaits them.

For all of these incoming Trainees, the Royal Australasian College of Surgeons (RACS) will no longer be 'the College'. Rather, there will soon be a paradigm shift as I share 'my College' with them, thus becoming 'our College'. This was something that was impressed upon me when I attended my induction 2 years ago. Never have I thought that I would now be in a position to write for 'our College' and reciprocate the favour as what my predecessors have done for me.

The Induction Conference, held in the historic and original Melbourne RACS building, comes packed with speakers providing advice and practical support so new trainees not only survive but thrive in surgical training. The Induction Conference is also a chance for non-Victorian Trainees to visit an icon in Melbourne and explore its rich history with a College tour included as the last leg of its program.

With policies and training regulations stretching out to more pages than you want to read plus endless acronyms for assessments/exams/feedbacks, prospective trainees would find it particularly useful to attend to help them navigate through the 'ins and outs' and 'do and don'ts' of SET. Senior Trainees from all specialties will be on hand to help provide informal advice and counsel. The program includes sessions on leadership and professional skills, tips on how to manage the underperforming junior, something no doubt everyone has come across at some point in their careers; tackling research, a key hurdle now in SET for all specialties and managing feedback.

For me personally, the RACSTA Induction Conference was an extraordinary opportunity to meet with the 'who's who' of the College and make new acquaintances and friendships, as participants get to mingle with Trainees from all 9 specialties. At least now I know there's someone I can always rely on or call for help irrespective of the surgical issue/geography or should I unluckily find myself in a rough spot.

In addition, it helped me realise current Fellows and senior Trainees who are all part of RACS are no different than you and me. Again, I fondly remembered how a senior Trainee (who now works in the higher echelons of the College committee structure) loved her specialty exams so much that she did them three times!

They certainly are not striving to be God's infallible right hand man or woman and you might be surprised to hear directly from some of them who share their experience in going through the hurdles of exams and training. This certainly does put some perspective into the broader picture and helps to ensure SET does not take over all aspects of a Trainees' life.

Recognising the challenges of catering to trainees of various specialties and coming from multiple areas, the RACSTA Induction Conference will be held on 26 November so there is ample time for upcoming participants to plan and come. To Fellows who are fortunate to be working with a successful incoming Trainee, I congratulate you and hope you will actively support and encourage them to attend. To the incoming Trainees, well done on getting this far and I highly recommend you make an effort to come to Melbourne. Our College does listen with great interest and values your opinion.

RACSTA is able to help upcoming Trainees with a letter of support for your employer should you intend to register. All you have to do is send an email to Racsta.chair@surgeons.org

The quality of your training is dependent on and directly proportional to how much you put into it and whether you actively participate in College activities. The onus is now on the successful SET applicants to register and plan their trip to Victoria.

Looking forward to seeing as many of our College's new Trainees!

RACSTA
Your Trainees' Association

In Memoriam

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

Donald Gordon "Scotty" Macleish AO
Vascular Surgeon
5 December 1928 - 22 May 2016

I first met Scotty when I was an intern in the Casualty Department in my first week at the Royal Melbourne Hospital in 1958. Scotty was the senior surgical registrar. Three of us new graduates had each seen the same patient and managed him poorly. Scotty took us all aside and explained what we should be doing. He did not tell us off. He just quietly explained how we should look at the total management of a patient, and not just the immediate problem.

For the full version see the webpage: http://www.surgeons.org/member-services/in-memoriam/donald-gordon-%E2%80%9Cscotty%E2%80%9D-macleish/

John Hartley Williams
General Surgeon
22 October 1926 - 6 June 2016

John Hartley Williams died on the 6 June 2016 on the eve of his 90th year in Hobart. He was, for many years, one of the corner stones of the Department of Surgery of the Launceston General Hospital and our Fellowship mourns his death.
John Williams qualified first as a pharmacist after the WW II, then turned his hand to Medicine. He therefore arrived to surgery a little later than his counterparts with a more mature attitude. He gained his Fellowship of the RACS in 1962 and was the surgical fellow at the Launceston General Hospital in 1963. He furthered his surgical studies in Leicester, England before returning to be on the staff of the Launceston General Hospital in 1967 as a general surgeon.

For the full version see the webpage: http://www.surgeons.org/member-services/in-memoriam/john-williams/

Victor Desmond Hadlow
14 November 1930 - 4 February 2016
Orthopaedic Surgeon

Victor was born in Papatoetoe, Auckland in 1930, to Edgar Hadlow and Elsie Collins. Edgar, a wine and spirit company managing director, was born in London, a Cockney, and Elsie was of Irish descent. Vic had two older brothers, Lawrence and Malcolm. He attended St Heliers Primary School and then in 1943 commenced as a boarder at King's College. This was made possible by Lawrence, then a young RNZAF trainee pilot officer, who paid the initial fees.
During his first five years at King's Vic was involved heavily in sporting activities, bird watching, and listening to jazz - but this was insufficient to see him matriculate in his 5th year! Vic was a potent fullback for the 1st XV and selected for the Auckland Schoolboy Reps.

For the full version see the webpage: http://www.surgeons.org/member-services/in-memoriam/victor-desmond-hadlow/

Peter Mann Meffan
17 April 1930 - 25 March 2016
Urologist

Peter Meffan was a pioneering spirit with self-belief, an optimist with old school values that provided clear sign posts for life. He liked to blend traditional conservativism with a signature flash of colour and was recognized for his daily hand-tied bow ties. For him no dream was too big, no barrier insurmountable. He taught his friends and family to get up early and drive through the night if there was an adventure to be had, and he encouraged all to believe that everything is achievable if you are open to finding out how.

For the full version see the webpage: http://www.surgeons.org/member-services/in-memoriam/peter-mann-meffan/

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DON'T STAND SO CLOSE TO ME

Making sense of issues of aggression in a medical workplace

SUSANNA NELSON
Freelance writer and editor

When you consider the vital role the medical profession plays in the community, it seems shocking that doctors are subject to workplace aggression. But a staggering 70 per cent of doctors have reported being on the receiving end of aggression in the past 12 months, with one third experiencing physical attacks. This impacts on their health, general wellbeing and career decisions.

Important research conducted by Dr Danny Hills, Assistant Professor in Nursing at the University of Canberra, using Medicine in Australia: Balancing Employment and Life (MABEL) survey data, seeks to make sense of aggression against doctors in the workplace – what type of doctor does it most affect? Who perpetrates it? What are the preventative and risk factors? It is his hope that understanding aggression against doctors will help to prevent it.

Risk factors for experiencing workplace aggression

The data show that GPs and specialists report fewer incidents, with younger doctors, Trainees and hospital-based doctors bearing the brunt of workplace aggression. "If we combine source and doctor type, the most vulnerable group are younger doctors who work in a hospital setting," says Danny.

It's not surprising – hospitals are high-pressure, high-volume places. A hospital is an acute environment and at times an unpleasant one for both staff and patients; consequently, it is harder to manage patient expectations.

"We found that GPs and specialists seem to pay more attention to things like optimal patient waiting conditions – and they reported the least aggression," says Danny. "This can include a range of factors – the light in the waiting room, the temperature, whether staff can see patients; whether patients are informed of waiting times or about what to expect. This sort of optimised waiting environment is a protective factor against aggression."

Risks are also higher for doctors who work more hours, whose work hours are more unpredictable, who may be socially or professionally isolated and who don't feel they have a support network of medical peers.

"These are all risk factors for experiencing workplace aggression," says Danny. "Then there are doctors who feel that their patients have unrealistic expectations about how they can help them, or that the majority of their patients have complex health and social problems."

Danny has found that personality type and age also play a part. "On the whole, younger doctors are subject to greater levels of workplace aggression. We don't know whether this is because, with age, these doctors may have developed better communication skills or whether it's a basic respect for age on the part of others," Danny says. "We only know that the statistics suggest that the older you get, the less likely you are to experience aggression."

Those with internal control orientation – who believe that they are responsible for their actions and the outcomes – "most doctors, I might add" – are less likely to encounter aggressive behaviour. On the other hand, doctors who exhibit external control orientation – thinking that fate controls outcomes – is a risk factor.

Patients and patient advocates, such as family members and carers, may constitute a large and obvious source of aggression, but recent attention has focused on the shocking levels of aggression and bullying among medical co-workers, for example, the recent revelations about the treatment of female Trainee surgeons by their clinical supervisors. Danny found that, for hospital doctors, physical aggression from co-workers ran at up to 25 per cent.

Considering the number of media reports this subject attracts, it is surprising to find that the MABEL data, and Danny's research, paints one of the few comprehensive pictures of the problem.

What does it mean for workforce retention?

The experience of aggressive behaviour in the workplace can be so profound that some doctors consider leaving the profession.

"I have examined the impact of workplace aggression on personal and professional wellbeing," says Danny. "The three things I looked at were intrinsic job satisfaction, satisfaction with life in general and self-rated health."

Both aggression from co-workers and aggression from external sources were strong predictors for decreased job satisfaction, decreased satisfaction with life in general and decreased self-rated health among doctors. "I controlled for a range of factors, and workplace aggression still came out as a strong push factor," Danny says.

"We found that workplace aggression is also a risk for decisions around continuing to provide patient care and remaining in clinical practice. When you talk to doctors about this you can see it affects them – they remember this stuff," Danny explains.

"Some doctors will avoid certain patient types or that they feel fearful around certain types of people or won't work in certain areas or won't work after hours or do home visits." The implications for community health are clear.

Prevention and minimisation

The solutions to the problem of aggression from external sources are surprisingly practical. "There are, broadly speaking, three tiers of prevention and minimisation," says Danny.

"Firstly, there is the focus on the individual's communication and response, then there is the environmental design – which includes things like optimal waiting room conditions – and then there are the systems and processes, including the policy and legislative framework."

An environmental design that protects against aggressors or aggression may include practice rooms that provide an adequate means of escape from the consulting rooms. "A room designed so that staff members are closer to the exit than visitors and patients may allow a means of escape from an assailant," says Danny. "In other words, design in your safety first."

Visible duress alarms can provide a deterrent against potential assailants, as can working CCTV cameras and the visibility of staff – patients and visitors who are aware that staff are aware of their presence may be less inclined to aggressive or disruptive behaviour.

Barriers such as wide reception desks and a well-controlled flow of people through the building – with limited access for visitors to certain areas – can also help to protect safety.

From a patient perspective, information and communication are vital. Those who have clear expectations about wait times and limitations of care, and who understand how hospital triage systems work, may feel more comfortable about the process.

Finally, progress on the broader policy front is necessary to effect longer-term change. Work Health and Safety regulations could include specific provisions about designing and running a workplace that protects against aggression.

"Risks are also higher for doctors who work more hours, whose work hours are more unpredictable, who may be socially or professionally isolated and who don't feel they have a support network of medical peers."

Doctor-to-doctor aggression

The solutions are more complex when it comes to incidents of co-worker bullying and aggression, because structural issues – and power imbalances – are often at play. As the news stories attest, bullied doctors may feel intimidated by their co-workers and disinclined to report these problems for fear of losing their job, or facing further repercussions.

Danny believes a combination of better education and training for clinical supervisors, improved reporting and responsibility, and managerial accountability is the key.

"The steps by the Royal Australasian College of Surgeons are to be commended," he says. "Clinical supervisors may need specific training; managers need to be made accountable. It is also vital to report and respond adequately and appropriately where these issues flare up."

"A finely calibrated combination of individual, organisational and legislative solutions can help to reduce some of the depressingly widespread reports of workplace aggression I have encountered in my research."

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