SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 16 NO 1 / JAN/FEB 2015

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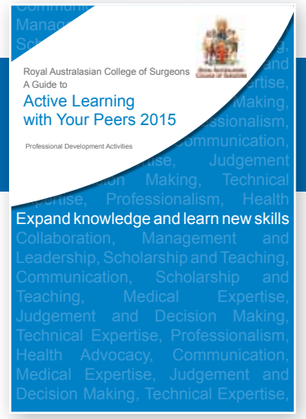
ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

2015 PROFESSIONAL DEVELOPMENT

WORKSHOPS & ACTIVITIES



The 2015 Active Learning with Your Peers booklet was distributed in late 2014.

Inside are professional development activities that enable you to acquire new skills and knowledge and reflect on how you can apply them in today's dynamic world.

Supervisors and Trainers for SET (SAT SET)

21 February - Sydney, 21 April – Melbourne

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

Communication Skills for Cancer Clinicians: Breaking Bad News

28 February – Melbourne

Delivering distressing news can be challenging for all involved; patients, family and clinicians alike. 'Breaking Bad News' is a four hour evidence-based workshop in which facilitators will guide you through 'real-life' scenarios with a trained actor. You'll learn effective communication techniques and be able to practise them in a safe environment.

International Medical Symposium

13 March – Melbourne

This one day seminar, hosted by the Royal Australasian College of Surgeons in collaboration with the Royal Australasian College of Physicians (RACP) and the Royal College of Physicians and Surgeons of Canada (RCPSC), will explore the subject of "The Future of Medicine". This will include contributions from the specialist medical colleges, a number of key note international speakers, as well as futurists and junior doctors.

Process Communication (PCM) – Part 1

21 to 22 March – Melbourne

PCM is one tool that you can use to detect early signs of miscommunication and turn ineffective communication into effective communication. This workshop can also help to detect stress in yourself and others, as well as providing you with a means to reconnect with individuals you may be struggling to understand and reach. The PCM theory proposes that each person has motivational needs that must be met if that person is to be successful. These needs are different for each of the 6 different personality types; each person represents a combination of these types, but usually one is dominant.

Keeping Trainees on Track (KToT)

25 March - Launceston, 21 April – Melbourne

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

Non-Technical Skills for Surgeons (NOTSS)

27 March - Sydney

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

Foundation Skills for Surgical Educators

20 April - Melbourne

The Foundations Skills for Surgical Educators is a new course directed at facilitating the education and training of surgical trainees and will establish the basic standards expected of our surgical educators within the College. This free one day course will provide an opportunity for participants to identify their own personal strengths and weaknesses as an educator and explore how they are likely to influence their learners and the learning environment.
The course will further knowledge and skills in teaching and learning concepts and look at how these principles can be applied into participants own teaching context.

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

workshop

February-April

Online registration is now available through the College website.

NSW

21 February, Sydney. *Supervisors and Trainers for SET*
27 March, Sydney. *Non-Technical Skills for Surgeons*

TAS

26-28 March, Tarraleah. *Surgical Teachers Course*
25 March, Launceston. *Keeping Trainees on Track*

VIC

28 February, Melbourne. *Communication Skills for Cancer Clinicians: Breaking Bad News*
10 March, Melbourne. *Academy Educator Studio Session*
13 March, Melbourne. *International Medical Symposium*
21-22 March, Melbourne & online. *Process Communication Model Seminar 1*
24 March, Melbourne. *Clinical Decision Making*
20 April, Melbourne. *Foundation Skills in Surgical Education*
21 April, Melbourne. *Supervisors and Trainers for SET*
21 April, Melbourne. *Keeping Trainees on Track*

Contact the **Professional Development Department**
on +61 3 9249 1106,
by email PDactivities@surgeons.org
or visit **www.surgeons.org**
- select Health Professionals then click on Courses & Events
www.surgeons.org/for-health-professionals
/register-courses-events/professional-development

POTENTIAL UK WINDFALL

Australian surgeons who have worked in the UK in the last 26 years should be aware of a potential monetary opportunity.

1. **Have you worked in the UK between 1988 and 2014 for two years or more?**
2. **Did you contribute to the UK NHS Pension?**
3. **When you left the UK, did you leave behind even a small pension account?**
4. **Are you aware of the fact that you may have an account still in the UK?**
5. **If so, you need to act immediately to reap the potential.**

WHY?

For a short period of time, a window of opportunity exists for you to transfer your benefit, no matter how small, to a qualifying super fund in Australia with a potential upside – the ability to transfer from British pounds sterling to Australian dollars up to 20 times your proposed annual pension as an un-deducted contribution to your qualifying Australia Super Fund. For example if your proposed benefit was £6,000 PA, you may be eligible for a transfer value up to £120,000 to a qualifying fund in Australia.

The deadline is April 2015, so please act now if you think you may be able to benefit from this ability to transfer.

For further information and to confirm if you qualify for the pension transfer, contact your financial adviser or Tony Bongiorno from the Bongiorno Group at tbongiorno@bongiorno.com.au

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REGULAR PAGES

Correspondence to Surgical News should be sent to: **surgical.news@surgeons.org**
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ON THE COVER:
jDocs Framework, p 20

MEDICAL COLLEGES

What does it take to keep our house in order?

MICHAEL GRIGG
PRESIDENT

I was elected by Council to be President of our College 15 months ago. At the time, I was asked what was it that I wanted to achieve during my term. For me, the answer was easy – I wanted our College to refocus and clearly articulate its "raison d'être" – to protect and enhance the professional status of surgeons for the benefit of Society.

I am sometimes asked by surgeons, "Why should I continue to pay my annual College subscription?" My answer is that this is what enables you to continue to practice as an autonomous surgical professional. As individuals we practice as surgeon professionals. Like it or not, our College is the interface between us, plying our surgical professional craft, and Society at large and the State, by which I mean Government.

Our College is the professional organisation of surgeons. The strength of the College can be considered in terms of the past, the present and the future. The past, through the efforts of our predecessors, has created a foundation of respect and prestige. For the present, our strength is dependent upon two things. Firstly, it is dependent upon the standards we profess, not only in terms of the outcomes we achieve, but also the way that we conduct our professional lives and, secondly, it is dependent upon the support from surgeons who are, in fact, the College. And the future? Always difficult to predict, but I fear that it will involve a test of our resolve in defending the standards that we hold dear.

The President's Perspective that I wrote at the end of 2014 was titled 'Surgeons of the 21st Century – Professionals or Tradesmen?' (And thank you to the numerous surgeons who contacted me after this was published.) In it I reflected on how the medical profession was under threat with increasing intrusions of accountability imposed by the State. And in a health care system that needs ongoing reform, which will occur, the health care professionals, particularly the 'autonomous' surgeons are viewed as substantial impediments.

I relied heavily on Lord Dahrendorf[1] who had delivered the Jephcott Lecture at the Royal Society of Medicine in 1983. It is an inspiring lecture. His central thesis was that in the United Kingdom there was an implied contract between the professions and society. This implied contract is the basis of professional autonomy, which in turn is one of the pillars of liberty. He stated that the alternative – the professions bound by the state – is certainly fearful.

But his warning and closing words were salient: "One must hope, therefore, that the professions will manage to keep their own houses in order, so that no doubt is cast on the legitimacy of their implied contract with society, and liberty prevails." I profess to having strong views as to how the medical profession has demonstrated its professionalism and its part of the social contract over the past 30 years. I have spoken on this subject both within Australia and internationally. Let me say that as I speak to surgeons around the world and most recently in India at their Annual Conference there is an international recognition that the profession must take much stronger ownership of the professional standards for medicine.

Ensure that trust is deserved

The eminent Jurist, Geoffrey Davies AO, who is undoubtedly a great friend of the College, describes the triangle of trust that must exist between the profession, the public and the State. This trust is essential for the social contract that exists between the profession and Society – a contract that specifically excludes the State.[2]

However, in a further article particularly focused on our collective responsibility for the competence of surgeons,[3] he is scathing of our efforts as a profession to ensure the professional competence of our fellow surgeons. We are violating the triangle of trust that exists. He states a very realistic expectation: "Those who are about to undergo surgery have a right to know if their surgeon is competent to perform the operation." If the profession does not act, are we 'more interested in protecting ... incompetent colleagues than ... in the health and safety of surgical patients?'

The era of compulsory continuing professional development has arrived – mandated by the State. It is tangible evidence, a warning if you like, that both Society and the State believe there is reason to re-examine a social contract with the medical professionals that has existed for more than 200 years.

The College has fought hard to have its CPD program recognised and this has been achieved though it means enforcement through the Code of Conduct where breaches can lead to removal of the Fellowship. However, as outlined by Hon Davies, we have much to do to be able to confirm for members of the public that all Fellows are competent and that their safety is assured.

Internationally our professionalism is under threat and this is a challenge for medical professional organisations such as the College. There is no hesitation for the expressed view that it will always be better for the profession to undertake this rather than have it imposed by external regulators or government bureaucracy. But to use that famous Pogo quotation: "We have met the enemy and he is us." As professionals we must do much more than merely become surrogate enforcers for the State.

How does a collegiate structure, like a medical college ensure the profession can move to position of supporting, indeed enforcing active auditing of the standards of our practice? The requirements are clear. We must be able to identify outliers and that their performance is brought back to appropriate bounds by training, remediation or limitation in scope of practice.

But I am indeed heartened that the flame of professionalism still burns within us. Deliberately in 2014, I made the issue of excessive fees an issue of concern for the College. I have been overwhelmed by the positive response across the breadth of the Fellowship on this issue. I have been actively joined by the Presidents of the Specialty Societies in highlighting that full transparency of fees is an expectation of modern day surgical practice. There is much to do, but it is important that we raise these issues for ongoing discussion across all groups associated with the College.

It needs to be the same with increasing rigour of our auditing processes and our peer review. Our systems need to be highlighted and be openly discussed so that our collective and collegiate path is so much clearer and fully able to withstand public scrutiny

The College has many responsibilities, but its prime one is to protect the professional standing of surgeons for the benefit of Society. As a College we have embraced this, and indeed have become a benchmark, for the training and initial certification of surgeons. We now face the challenge of demonstrably extending this reassurance for Society of our quality and standards throughout our surgical careers. As individual professionals, not only do we have responsibility for ourselves, but we also have a collective responsibility.

References

1. Dahrendorf R. In defence of the English professions. *J R Soc Med.* 1984 Mar;77(3):178-85.
2. Davies G. Professionalism of surgeons: a collective responsibility. *ANZ J Surg.* 2011 Apr;81(4):219-26.
3. Davies G. Ensuring the continuing competence of surgeons: a bridge too far, a sacred cow or burying your head in the sand. *ANZ J Surg.* 2014 Sep;84(9):609-11.

CHANGING LANES

Bike lanes, freedom and road safety

DAVID WATTERS
VICE PRESIDENT

In the last issue of *Surgical News*, Professor Grumpy in Curmudgeons Corner caused quite a stir with his negative spin on cycling. Within hours of publication, surgeons, anaesthetists and other irritated readers thumbed their social media to query the College's stand on bike safety.

Some were avid cyclists who routinely ride to and from work, and/or cycle on the weekends for fun and fitness. We always appreciate hearing from the readers of Surgical News, especially when they feel stirred!

While *Surgical News* allows the curmdgeonoid Professor Grumpy to express his views, cyclists are powerful lobbyists and their swift counter went viral [in social media pathoterminology]. This month, I do want to support the cyclists while defending the credentials of our editor to allow Surgical News to include the controversial and disturbing. *Surgical News* needs to stir, and sometimes even be outrageous! Recent events show how much we all value freedom of expression and the right to a sense of humour, even on sensitive topics.

So whether or not a cyclist is gripped by tight-fitting Lycra, wearing a uniform or business suit, we support them for their efforts in fitness and safety.

It is in our mutual interest to harmoniously share road space between cyclists, motorists and pedestrians. Bike lanes make all road users safer. Health advocacy, and road safety, includes bicycle safety. The College has a track record in advocating for the survival of cyclists, and it is largely our efforts that have made helmets compulsory. We need to strive to protect the most vulnerable as we travel.

Curmudgeon, as Curmudgeons are want to do, gave offence. The College's urgent response on social media was to direct readers to the College road trauma prevention position paper. As a College committed to defending the Professionalism of surgery, we must get out in the public eye, advocating directly or indirectly about minimising harm from road trauma. We are keen to prevent injury to all road users, as well as those dodging collisions on paths that act as both a cycleway and footpath.

In writing this article, I enlisted the help of Dr John Crozier, Vascular and Trauma Surgeon and Chair of the RACS Australian National Trauma Committee. John is a keen cyclist himself and has much experience in advocating for measures to reduce road trauma.

The College advocates for:

- ✓ Mandatory wearing of nationally approved safety helmets
- ✓ Regular review of compliance with the wearing of approved safety helmets
- ✓ Promotion by community, school and health groups for the wearing of helmets
- ✓ Expansion of bicycle path networks in cooperation with local government and other agencies, supporting those networks that separate motor vehicles, bicycles and pedestrians
- ✓ Use of tail-lights, reflectors and reflective clothing by cyclists
- ✓ Support for initiatives which encourage all road users to 'share the road'
- ✓ Development of national primary school bicycle education programs

Some sobering statistics show that pedal cyclists account for 17.4 per cent of all transport serious injuries (or approx. 1 in 7 transport related serious injuries) in Australia and 7 per cent in New Zealand. In 2013, Australia seemed to have had a bad year with 50 cyclists killed on the roads which accounted for 4 per cent of all road deaths. In previous years, fatalities hovered around 2-3 per cent. The toll in New Zealand for 2013 was 3 per cent.

I am sure most of us have been affected by or witnessed tragedy when appropriate regard for and by people travelling was not demonstrated – pedestrians being struck by cyclists, vehicles colliding with cyclists, and cyclists being hit by opening car doors, trams or buses. Those of us who drive vehicles or cycle in the inner city in particular, would likely all agree it can be stressful. Heightened awareness is required at all times.

Professor Grumpy was unhappy that his local council had converted one of two lanes on a major thoroughfare into parking spots and a bike lane (which apparently saw little use). These changes might cause angst for drivers due to losing a lane for traffic, but would have been welcomed by cyclists. Furthermore, the dedicated bicycle lanes could actually relieve stress for drivers trying to avoid cyclists while providing a safer passage for cyclists, enjoying the fresh air and some exercise, while the irritated Professor Grumpy is hardening his arteries.

Ride on Magazine reports: "Experts say that separating bike routes from motor vehicle traffic is key to encouraging people to take up riding as a mode of transport. From the example of Copenhagen, where between 1995 and 2005 bicycle trips increased by 30 per cent and bicycle-related crashes reduced by half, Australian cities have drawn inspiration to develop cycling-specific road facilities in an attempt to achieve a similar growth in people riding bikes."

We have made great progress in some of our major cities, particularly in Melbourne and Sydney. Cities like Brisbane and Wellington have also expanded their networks and have leading strategies for growth of separated networks. However, it is still not enough to encourage some riders. *Ride On* magazine reports that in most of our cities, female cyclists account for 25 per cent or less of the cyclists, but in countries that have segregated lanes, it is closer to 50 per cent.

Whether you think pedal cycling should be encouraged as a major mode of transport or not, I think we would all agree that one casualty is too many. As medical professionals and users of our roads, we should all applaud measures to improve road safety. Perhaps one day we might even see our Curmudgeon in lycra, riding to work, de-stressing, happy to use that converted lane and enjoy the benefits of exercise!

ANZGOSA
Australia & New Zealand Gastric & Oesophageal Surgery Association

Post Fellowship Training in Upper GI Surgery

Applications are invited from eligible Post Fellowship Trainees for training in Upper GI Surgery.

ANZGOSA's Post Fellowship Training Program is for Upper GI surgeons. The program consists of two years education and training following completion of a general surgery fellowship. A portion of the program will include clinical research. A successful Fellowship in Upper GI surgery will involve satisfactory completion of the curriculum requirements, completion of research requirements, minimum of twenty four months clinical training, successful case load achievement, and assessment. Successful applicants will be assigned to an accredited hospital unit. Year one fellows are given the option to preference a state but not a hospital unit.

For further information please contact the Executive Officer at **anzgosa@gmail.com** or the website **http://www.anzgosa.org/advertise_info.html**

To be eligible to apply, applicants should have FRACS or sitting FRACS exam in May 2015. Any exam fails will not be offered an interview.

Applicants should submit a CV, an outline of career plans and nominate four references, one must be Head of Unit, (with email addresses and mobile phone numbers), to Leanne Rogers, Executive Officer ANZGOSA, P.O. Box 374, Belair S.A. 5052, or email anzgosa@gmail.com.

Successful applicants will need to be able to attend interviews on Saturday May 30th in Melbourne.

Applications close 5pm, **Friday March 27th** 2015.

anz HPBA
Australia New Zealand Hepatic, Pancreatic & Biliary Association

Applications are invited from eligible Post Fellowship Trainees for training in HPB Surgery.

The ANZHPBA's Post Fellowship Training Program is for Hepatic-Pancreatic and Biliary surgeons. The program consists of two years education and training following completion of a general surgery fellowship. A portion of the program will include clinical research. A successful Fellowship in HPB surgery will involve satisfactory completion of the curriculum requirements, completion of research requirements, minimum of twenty four months clinical training, successful case load achievement, assessment, and final exam. Successful applicants will be assigned to an accredited hospital unit.

To be eligible to apply, applicants should have FRACS or sitting FRACS exam in May 2015. Any exam fails will not be offered an interview.

For further information please contact the Executive Officer at **anzhpba@gmail.com** or the website http://www.anzhpba.com/fellowship-training.html

Applicants should submit a CV, an outline of career plans and nominate four references, one must be Head of Unit, (with email addresses and mobile phone numbers), to Leanne Rogers, Executive Officer ANZHPBA, P.O. Box 374, Belair S.A. 5052, or email anzhpba@gmail.com.

Successful applicants will need to be able to attend interviews on Saturday May 30th in Melbourne.

Applications close 5pm, Friday March 27th 2015.

WHAT'S MAKING NEWS

Help for Sri Lanka

Plastic and reconstructive surgeon James Savundra has joined a team giving up their holiday time to help war-devastated victims in Sri Lanka with Interplast.

Although it meant time away from his family and three children all under 10, he said they understood how important the work was.

Another operation helped an 11-year-old from losing a foot.

"That's a fancy operation anywhere," Mr Savundra said.

***West Australian*, December 15**

Support communities, not alcohol industry

The College's New Zealand Board has supported the rejection of a proposal by Wellington to extend licences to 5am.

New Zealand Chair Nigel Willis agreed with the Alcohol Regulatory and Licensing Authority decision, saying it was a step in the right direction in addressing alcohol-related harm.

"The paramount consideration of local councils should be the health and well-being of their communities; not the commercial interests of the alcohol industry," Mr Willis said.

***Yahoo.com*, January 23**

The real value

Outliers are the reason for driving up the average income of surgeons, and charging the public excessive fees.

President Michael Grigg talked to Fairfax Media about the rising cost of Medicare and some of the reasoning behind it, calling for patients to report overcharging to the College.

"There's a belief among patients that the more they are charged, the better quality service they get, and yet we have pretty good evidence that that's not the case," Professor Grigg said.

***Sydney Morning Herald*, January 24**

Organ donors needed

The quality of donor organs is now being discussed with the NHMRC released draft guidelines for review.

Organs once considered too risky to reuse may now be considered to help clinicians address the difficult waiting list.

Professor Richard Allan from RPA in Sydney has said that a decline in quality organs has meant the acceptable pool needs to be expanded.

"As a clinician you're more likely to accept a liver that has say 90 per cent chance of working … which is better than no per cent."

***ABC Radio*, January 20**

QUICKER ACCESS To College Digital Resources

Introducing QR Codes

QR Codes enable you to quickly access a web address, without having to type (or remember) complex URLs. Over the next few months the RACS team will look to make use of these codes in our publications to provide more convenient access to our Digital resources.

How do QR Codes work?

Like the older form of barcodes that we are used to seeing on books and groceries, QR Codes hold reference information in a form that can be read using the camera on a smart phone or tablet. Scanning a QR Code can quickly lead the user to a website, sending an email, or even dialling a telephone number without having to cut/paste or write down the details. QR Codes are about convenience.

What do I need to do?

The first thing that you must do is to visit your smart phone or tablet app store to download a QR reader. RACS does not have any preferred option, but listed below are some that have been used recently by staff and found to be effective. Similar to other smart phone or tablet applications, these are often free to use and for a few dollars you can purchase an upgrade to remove 'ads' or use extended functionality.

How do I use the codes?

Open the app, point the camera at the QR Code and it does the rest. For example, the QR Code below accesses the popular 'Find a Surgeon' page on the College website. The complete process takes a few seconds, from scan to arriving at the 'Find a Surgeon' page. When you click on a resource (a book or journal) you will be asked to log in (if you aren't already).

Give QR Codes a Go

Scattered around the page are several key links to popular on-line spots in the RACS Library and also a QR Code that starts the process of making a request for assistance from the staff. Please take a few minutes to download a QR Code scanner, then you will find after a few minutes that QR Codes are convenient and will save you time.

Popular QR Code Readers

- ✓ Apple
- ✓ Android
- ✓ Quick Scan
- ✓ RedLaser
- ✓ QRReader
- ✓ QR Droid

Why use QR Codes?

✓ Quick
✓ Easy to use
✓ Most QR Readers on mobile devices are free to download

What RACS will use QR Codes for in the next few months?

- ✓ Making references to our Digital resources like the Library
- ✓ Making enquiries with RACS, both phone calls and emails
- ✓ Adding RACS events into calendars

Summon Library Search

Find a Surgeon

Library Home

Library Feedback

Hoping it won't happen

What's my risk of Dementia?

DR BB G-LOVED

I wish all readers a happy and healthy 2015. In recent years the Dementors of Azkaban have entered literary history. Their ability to suck the joy and happiness from their victims, laced with a lack of discernment as to who is deserving of their unwanted attention, plus a reputation for chilling all goodwill and resistance, means they strike fear into all the characters that enrich Harry Potter folklore.

However, becoming demented should evoke similar fear and trepidation in ourselves, though I am always amazed how few doctors ever consider dementia as something that could happen to them. We spend our fertile years changing the nappies of our babies and toddlers, but how many of us want to have them change ours when we are old?

Many of us joke about Alzheimers, treating it as a condition that might be unavoidable, but still conveniently far away in a distant time and beyond imagination. There is no Patronus to ward off dementia – no interventions work as immediately as that. But there are positive and proactive things we can do to minimise our risk.

If you are already suffering, it's too late for a cure; most of the treatments available today are either aimed at amelioration or correcting contributing factors to decline. Sadly there are no disease modifying agents that correct the underlying pathology and restore neurological function.

Dr D Mentshah came to consult me this week, feeling weary and distressed. The concerned doctor has just put Mama Mentshah into a nursing home and was wondering what can be done to avoid a similar finale in decades to come.

I suggested there are some obvious health strategies to be followed – first, avoid smoking; most doctors do though there are still some surprising recalcitrants constricting and inflaming their cerebral, coronary and peripheral vasculature.

Second, ensure your platelets are not too sticky, which, providing you don't have some inherited coagulation flaw, is best achieved by a diet that avoids too many Omega-6s and carbohydrates, but includes Omega-3s or fish/krill oil supplementation.

Third, stay physically and mentally active. Fourth, make sure you are not vitamin D deficient. Get out in the sunshine, enough to keep your vitamin D above 70ng/L, while avoiding sunburn. That should ensure both your Vitamin D and Melatonin levels (not routinely measured) are proactively boosted.

Fifth, I had to check D Mentshah's B12 levels. Although a normal B12 for haematological health is above 156pmol/L, case control and cohort studies have shown for neurological health, and reducing risk of cognitive impairment, the level needs to be above 250pmol/L. D Mentshah's B12 was 170pmol/L with a corresponding raised Homocysteine and Methylmelanic acid indicative of deficiency. Parenteral B12 supplementation will easily restore balance without adverse effects.

"How well can you smell?' I asked a somewhat surprised Dr D Mentshah. Recent evidence has shown hyposmia is associated with both dementia and Parkinson's disease. Poor olfactory function predicts cognitive decline in the elderly. Portions of the olfactory cortex are affected early. Patients with mild cognitive impairment are all the more likely to progress to dementia if their sense of smell is impaired. Hyposmia can be grossly assessed by asking about normal olfaction, but formally tested using odours (Sniffin' Sticks or Open Essence Test).

I also discussed with D Mentshah the possibility of testing for genetic susceptibility. Apolipoprotein E is a protein which plays an important role in regulating cholesterol, triglyceride and lipid metabolism in the blood and brain. The APOE gene on the long arm of chromosome 19 regulates its expression and those with an APOE E4 (APOE4) allele are predisposed to late onset Alzheimer's disease as well as coronary artery disease.

It appears the APOE4 allele obtunds the protective effects of fatty fish, rich in long chain Omega-3's, perhaps by disrupting docosahexaenoic acid (DHA) kinetics. The evidence for this association has been amassed over almost 20 years in a number of populations since APOE4 was found to be associated with reduced glucose metabolism in the temporal, parietal, posterior cingulate and prefrontal areas on PET scans.

If D Mentshah wants to undergo genetic testing this is not available in Australia and New Zealand under public funding, though is available privately.

Compared with the normal homozygous APOE3, being homozygous for APOE4 markedly increases the risk of Alzheimers, or heterozygous, some 2-3 fold. Those with the relatively rare APOE2 have a reduced risk.

In the meantime D Mentshah would be wise to address the risk factors derived from diet and lifestyle; if opting for APOE4 testing, can one cope with knowing the result, particularly if APOE4? Skilled wizards may produce a Patronus, but genetic tests are more likely to unwittingly open the box of Pandora.

IN MEMORIAM

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

David Failes, NSW Fellow
John McArthur, Vic Fellow
Alan McKenzie, NZ Fellow
Ajay Poddar, SA Fellow
Geoffrey Serpell, Vic Fellow
Erwin Thal, Honorary Fellow
Arthur S Lim, Singapore Fellow
John Hard, Vic Fellow
William Maling, Vic Fellow
John Morgan, NSW Fellow
James Hyde, SA Fellow
Philip Walker, Qld Fellow
Robert Sutherland, Vic Honorary Fellow
Dipen Mitra, Vic Fellow
Ann Davies, NSW Fellow
James Guest, Vic Fellow

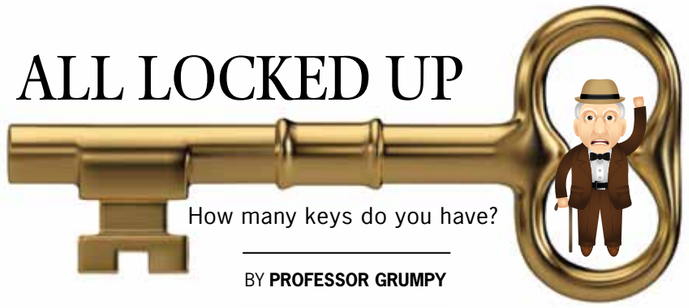
We would like to notify readers that it is not the practice of *Surgical News* to publish obituaries. When provided they are published along with the names of deceased Fellows under In Memoriam on the College website **www.surgeons.org**

Informing the College

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

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

ALL LOCKED UP



How many keys do you have?

BY **PROFESSOR GRUMPY**

There is one thing that really annoys me and that is door locks. Yes, I know that we need them but they can be so annoying to grumpy professors like me. In my house we have all external doors keyed alike – except the aluminium rear doors that are fire resistant. The ideal of one key for all the locks becomes two. Oh yes, and the door from the garage to the back yard needed replacing after four years, but that type of lock is not made any more – key number three is born.

The car shed has a different lock as it is a different type of construction, so key number four arrives. Then we have the padlocks on the gate to the lower paddock and the two back gates to keep the dogs in. Two different padlocks of course as the gates are of different types and the padlock will not fit through the predrilled hole. That is about seven keys. Now I have not started on my office or my car or my wife's car.

Of course with so many keys, the problem becomes which key is for which lock. Some look alike to the extent that I spent 10 minutes trying to fit the wrong key in the front door (and no, it was not after a poker night with the old surgeons' club). In this electronic age surely we can invent an electronic key that opens all doors. Oh, so it has already been done. That is great, but I would predict that being electronic and requiring a computer to run it something will go wrong.

"There has been a system failure – please reboot your key computer."

That is fine provided that you are not electronically locked in the toilet.

Key pads seemed to be the way to go – one number for all locks. But then why not make things really hard with the requirement that each code be of a different length (four or six or eight digits or a mixture of digits and letters). So let's add in an office, a change room in theatre (or two or three) and then add your house. To make matters worse, what about making everyone change their code every month and not use a previously used password or even part of a password. That would really confuse annoyed old curmudgeons who usually are limited to one four-digit number. One access point would not even accept my code of "expletive deleted" – to quote Richard Nixon's infamous oval office tapes.

My wife is a good country girl with common sense to spare. She tells me that in her country town the problem was solved by no one locking anything. In a way that is what I have developed as an answer, but by sheer absentmindedness. I simply forget to lock up the house at night. It works. I haven't been molested in my bed at night – as yet.

Then there is the issue of excess keys. When I moved house about 10 years ago I had about 25 years of accumulated keys for various locks that had long since been changed or forgotten.

I simply threw them out, which seemed at the time the best solution until we could not get into the beach house over Christmas.

A UK word on professionalism

Dear Sir,
Although a UK surgeon, having retired from clinical practice some years ago, I am an avid reader of Surgical News. I now sit on the Board of the hospital where I worked previously; a large hospital by any standards. There were two recent articles that struck a chord.

Your President expresses eloquently the vulnerability of surgeons, indeed clinicians as a whole, to de-professionalisation by governments that view the autonomy of clinicians as an impediment to the exercise of their authority, rather than a vital safeguard of standards.

I believe that most surgeons anywhere in the world recognise the threats to professional status that President Grigg outlines. This has manifest over here in a number of ways. These include a steady erosion of autonomy in the workplace, increasing micromanagement through protocols, guidelines and targets, the imposition of 'closed' clock-in/clock-out types of sessional and shift working contracts, etc, etc ...

Surgeons and most other doctors on our wards are now indistinguishable in the way that they dress from casual visitors, thanks to a somewhat questionable bare-below-the-elbows regime, whereas managers dress smartly wearing suits and ties.

Yet in the matter of striking a reasonable balance between value for money for their employers and protecting patients from unsafe financially driven system changes, doctors and nurses are the only ones equipped by their professional training and experience to strike a reasonable balance. It is vital, therefore, that their authority in the workplace is maintained and protected.

The problem is how. I would propose two key principles. The first is team cohesion and leadership; the second is vigilance. The lone surgical voice stands little chance of being heard in the face of a stifling bureaucracy and an aggressive policy of micromanagement. Whereas working as a group, clinicians can take absolute control of the care that their department delivers, providing they are clearly seen to be working in the best interests of their patients.

Conversely, time and time again one views with dismay how dysfunctional, non-cohesive departments fail; the Mid Staffordshire Hospital scandal provides a stark example of what happens when clinicians do not keep a grip on the standards of care that are being delivered.

An example of how team working can exert control over standards is prompted by John North's thoughtful article on surgical mortality in the same issue of *Surgical News*. There is an impression that the traditional Departmental M & M meeting in UK hospitals is evolving into something much more sophisticated and akin to a total quality assurance exercise that is owned and conducted by the clinicians.

The outcomes of these meetings, which take into account clinical audit, incidents and patient feedback in addition to M & M, are authoritative, underpinned by peer review and difficult to ignore. They are used to drive local quality improvement programs. I am aware that the Association of Surgeons of Great Britain and Ireland is about to issue recommendations along such lines.

As for vigilance, if we believe that preservation of our professionalism is essential for safe, effective care it is essential that our leaders are not allowed to sacrifice this on our behalf for short-term gains such as increased remuneration. Please learn from our mistakes.

Denis Wilkins FRCS
Lower Trevartha,
Pengover, Liskeard Plymouth UK

BEHIND THE MASK

We speak to vascular surgeon John Swinnen who first joined Médecins Sans Frontières (Doctors Without Borders) in 2011 and has since been on five assignments to the field

John's first field placement was in 2011, where he spent two months in Rutshuru in the Democratic Republic of Congo (DRC). He later returned to Rutshuru at the end of 2013 – his fourth assignment with Médecins Sans Frontières. Decades of conflict, lack of investment in the healthcare system and ongoing violence have left the people in DRC vulnerable to preventable outbreaks of cholera, malaria and measles, as well as the displacement of thousands. As the only expat surgeon in the Rutshuru General Hospital, John performed general and orthopaedic surgery, as well as vascular and burns/plastics surgery – his subspecialty areas. In 2013 more than 7,600 surgical procedures were performed in the hospital.

In 2012 John went to Hangu, Pakistan, for his second field assignment, which followed with a later placement at the end of 2012 in Aden Yemen. John is currently in Gaza with Médecins Sans Frontières France on an emergency mission. When he is not working in the field with Médecins Sans Frontières, John works as a vascular surgeon at the Department of Surgery, Westmead Hospital.

Why did you decide to work with an international medical aid organisation?

I have always wanted to do humanitarian work using my skills as a doctor and a surgeon. Particularly, we spend vast amounts of money in developed countries to treat old, dying people with incurable diseases, whereas in the developing world, healthy young people are dying of perfectly curable conditions for lack of basic interventions.

What was your role in Pakistan?

I was the sole surgeon at Hangu Hospital, together with an expat anaesthetist and excellent national staff; both doctors and nurses. Our hospital served a large population of Pashtun refugees from Afghanistan. Hangu itself is near the Khyber Pass and Afghan border, in the Pashtunkwha tribal area. We did mainly trauma surgery – 124 cases in one month, of which 85 per cent were the result of interpersonal violence: bomb blasts, gunshot wounds, stabbings and burns.

More recently you were in DRC. Could you describe the project you were working on?

The Médecins Sans Frontières France mission in the North Kivu has been going for many years, serving the population in what is a chronic war zone. This was my second mission to Rutshuru. On this occasion, the part of the North Kivu where we were was controlled by the rebel group, M27, and contact with the outside world was very difficult. Entering the mission by road had become too dangerous when I arrived due to fighting between the Congolese army and M27 rebels, so I was flown into the mission on a UN helicopter going to the Monusco base at Rutshuru. This proved to be the last helicopter flight into our base for the next month; the helicopter flight after mine was attacked by M27 artillery units outside Goma, and until the cease-fire six weeks later, the UN refused to fly Médecins Sans Frontières staff or equipment in or out of Rutshuru.

The work load at Rutshuru hospital was about 50 per cent obstetrics, often quite complicated – bladder injuries, ruptured uterus, etc – about 25 per cent septic problems especially osteomylitis and 25 per cent trauma. The trauma was either machete injuries, or AK47 gunshot wounds.

What does it take to go into the field in this area?

I do believe Médecins Sans Frontières is one of the best NGO's in the world for doing surgery in adverse circumstances, and they get it right most of the time. So when you go on mission, you must take it as it comes, regardless of the adversity that may be thrown at you. There are going to be 101 issues at every level – the right suture material in OT, brushing your teeth, communication with patients, no toilet paper, lack of imaging at the hospital, ceaseless gunfire at night keeping you awake, shitty food, etc.

However, with Médecins Sans Frontières, you can be confident that "this is as good as it gets", so deal with whatever issues you are faced with. Médecins Sans Frontières will ask you to do a 'Letter of Motivation' when you apply to join. It may seem a bit touchy-feely, but take it seriously! It is before you go on mission that you should make it clear, in your own head, why are going.

Did any patients make a particular impact on you?

The thing that makes all the hard work and difficulties of a mission worthwhile is the obvious good you do for the patients, and the delight of working with national staff. Don't necessarily expect the patients to be 'grateful' – though often they are.

The patients are often shell-shocked, impoverished civilians with little education, for whom life is a dreadful struggle; they don't have the perspective to appreciate what great work Médecins Sans Frontières is doing for them under dire circumstances.

Two patients stand out in my memory. One was a fisherman, a man in his 30s, from Lake Edward, 50 kilometres north of our hospital in the Congo. His canoe was attacked by a large male hippo and he sustained a compound crush fracture to his left leg and right arm defending himself from the beast. After this attack, he was unable to swim with two broken limbs and started drowning. Fortunately his friends had the courage to hang around until the hippo left and they dragged him 200 metres to shore. They then put him on a taxi motorcycle – positioned between the driver and his mate at the back – for the 50 kilometre trip across rutted roads to our hospital. When I told the patient I admired his bravery in fighting off the hippo and putting up with all the pain he said: "Don't worry doctor, they gave me two panadols before putting me on the motorcycle!"

The other patient that stands out is a man in his 40s; he was in his hut at night when his neighbour, a widow with three daughters, was attacked by 'MaiMai' – bandits – who wanted to rape the daughters. He got up, took his machete and went to do battle with the four intruders. I understand he killed one of them and the others ran away, but he arrived at our hospital with multiple machete wounds to his arms and head, including seven severed tendons. It took almost five hours of operating to fix it all up.

Did it make you a better surgeon working in conflict ridden and resource poor settings?

It has expanded and re-animated my general surgical skills tremendously. Not only because of the huge volume of work, but because you learn new things from your national and expat surgical colleagues.

Were you able to apply the skills you gained in the field to your work in Australia?

Because I am highly specialised in Endovascular Surgery currently, there is no direct application. However, the learning and broadening of your knowledge and skills makes you a better surgeon and better doctor, I believe.

How has the experience changed or affected you?

People all over the world are fundamentally the same – the same needs, wants and desires. The reason they have bad health care and a lot of trauma, and we don't, is not because of whom they are or what they did; they just happen to be in a shit place and we are in a good one! Whether I am at the operating table in Westmead Hospital in Sydney treating a patient, or at the operating table in Rutshuru in the Congo, the basics are identical; the patient is in pain; he or she wants their pain treated and they want you to fix them up.

Every year, Médecins Sans Frontières' surgeons perform more than 75,000 major surgical procedures. Surgeons working with Médecins Sans Frontierès support independent surgical and medical care to people affected by conflicts, natural disasters or healthcare exclusion. Your skills and experience can support this important work.

Learn more about the rewarding experience of working as a surgeon with Médecins Sans Frontières at http://msf.org.au/findoutmore/

Perth PROGRAM SHAPES UP

Book early to assure your place in the west

STEPHEN HONEYBUL, ASC 2015 CONVENER
CHRISTOBEL SAUNDERS, ASC 2015 SCIENTIFIC CONVENER

The RACS 2015 Annual Scientific Congress (ASC) in Perth is already generating great interest among the surgical community. The Congress will be held at the Perth Convention Centre situated alongside the Swan River.

As well as exceptional conference facilities, the accommodation in Perth is in demand at this time of year so reserve your room as soon as you receive the provisional program because it will quickly book out.

In the last article we mentioned some of the highlights of this ASC, some of the named lectures and a short review of some of the section visitors and programs.

The Convocation and Welcome Reception is on Monday, May 4, at the Perth Convention Centre. The Syme Oration will be presented by Major General the Honourable Michael Jeffery, AC, AO (Mil), CVO, MC (Retd). At this convocation there will be two new honorary Fellows and eight other senior members of our profession who will be acknowledged for their outstanding contributions to surgery and the College

The theme of the congress is 'Ethics in Surgery and the Surgery of War' and we will be joined by our colleagues from the Edinburgh College.

The four plenary sessions will highlight:-

- ✓ 'Ethics in Surgical Practice'
- ✓ 'Ethics in War and Disaster'
- ✓ Royal College of Surgeons Edinburgh – 'Ethics and Surgical Practice in Edinburgh'
- ✓ 'Surgical Practice – Ethical Issues For The Future'"

Program review

More recently we have been pleased that programs in Orthopaedic Surgery and Paediatric Surgery will be part of the ASC 2015 in addition to Craniofacial Surgery which becomes a regular part of the ASC from 2015.

Indigenous Health

The Indigenous Health program has been focused to highlight the problems of breast cancer in the indigenous communities in Australia and New Zealand.

Surgical Education

Jeff Hamdorf has arranged an excellent program covering many issues in Surgical Education with the section visitor Professor Anthony Gallagher to deliver a keynote lecture on 'Human Factors In Acquiring Surgical Skills'. A scientific session will tackle an area of interest to all surgeons: Who 'Owns' Surgical Competence? This will discuss the various bodies who feel they have a claim on your practice.

Women in Surgery

Jessica Yin has arranged a wide ranging program covering such diverse topics as 'Ethics in War' and 'Managing Difficult Personalities' to be addressed by an experienced panel of visitors including Annette Holian and Associate Professor Susan Neuhaus

Surgical History

The visitor to Surgical History is Tom Scotland and he will contribute to an extensive program covering the First World War and developments in surgery which came out of that conflict.

In addition to the sections above there will be programs from the International Forum (Dr David Wood), Senior Surgeons (Dr Robert Pearce), Younger Fellows (Dr Richard Martin), and the Trainees Association (Genevieve Gibbons).

We sincerely trust you will join us in Perth for what is shaping up to be our most memorable ASC.

Register through the Congress website asc.surgeons.org

THE JDOCS FRAMEWORK

The College is now preparing doctors for proceduralist careers

SIMON WILLIAMS
CENSOR-IN-CHIEF

CO AUTHORED BY STEPHEN TOBIN,
DEAN OF EDUCATION

The College is pleased to announce the launch of JDocs, a competency framework supported by a suite of educational resources that have been designed to promote flexible and self-directed learning, together with assessment opportunities to record and log procedural experiences and capture evidence of personal achievements. These resources will be available online later this year and will continue to evolve and expand over time.

Why has the College engaged in the prevocational space?

In 2013, Council recognised the need and importance of re-engagement with prevocational junior doctors to provide guidance and education that would assist with their development towards a proceduralist career. Key to this was to ensure that the doctor entering SET should be well-prepared and clinically competent relevant to their postgraduate year, thus well-equipped to commence surgical training.

As a result, the College established JDocs, which is available to any doctor registered in Australia and New Zealand, from and including internship, with the level of engagement determined by the individual doctor.

JDocs does not guarantee selection into any procedural specialty training program, however, engagement with the Framework and its supporting resources describes the many tasks, skills and behaviours a junior doctor should achieve at defined postgraduate levels, and will help the self-motivated junior doctor recognise the skills and performance standards expected prior to applying to a specialty training program.

Extensive consultation with stakeholders, including senior medical students, junior doctor focus groups, hospitals and training networks, as well as State postgraduate medical training groups, has been undertaken to inform the development of the JDocs Framework. The College recognises that the Medical Council of New Zealand has established a mandatory program, including an e-portfolio for the first two postgraduate resident years, and has consulted with the MCNZ to ensure the JDocs Framework will complement this.

What does the JDocs Framework cover?

The JDocs Framework is based on the College's nine core competencies, with each competency considered to be of equal importance, and is described in stages appropriate for each of the first three postgraduate clinical years, as well as those beyond. In order to link the many tasks, skills and behaviours of the Framework to everyday clinical practice, key clinical tasks have been developed that are meaningful for the junior doctor. These tasks can be used to demonstrate achievement of the competencies and standards outlined in the Framework, and also make it possible for the junior doctor to show they are competent at the tasks and skills required in order to commence specialty training.

How can Fellows support JDocs?

This is a significant initiative and one which the College hopes Fellows will both support and foster. The resource provides junior doctors with a better understanding of what to expect when considering applying to a specialty training program, such as surgery, and provides guidance for the self-directed, motivated junior doctor. As consultant surgeons in the work environment, and in roles as clinical teachers, Fellows are encouraged to take the time to read the Framework to better understand the direction the College is taking to support junior doctors as they plan and work towards a possible career in surgery.

How is the College promoting JDocs?

Letter/emails

All Fellows have been sent a printed copy of the Framework, along with an introductory letter from the President. The College has also disseminated the Framework to Trainees, hospitals and networks, medical schools and other specialty training colleges. Further engagement with hospitals is planned this year to look at how the JDocs Framework can complement existing prevocational training programs.

JDocs website

The first phase of the JDocs website, http://jdocs.surgeons.org/signup.htm, enables the junior doctor to register for updates and download a copy of the Framework. Additionally, the College's website and social media feeds will also deliver updates as to JDocs progression and launch of resources, as they become available.

JDocs app

A shareable app has been developed that provides an overview of JDocs, as well as a sample of learning resources, and can be accessed in the following ways:

- SMS JDocs to +61 400 813 813
- Scan the following QR code

Social media

Twitter: @RACSurgeons, #RACSJDocs
Facebook: Royal Australasian College of Surgeons

The JDocs Framework is about the professional standards and learning outcomes to be achieved during the early postgraduate/prevocational clinical years. It describes and assists early career professional development for junior doctors aspiring to procedural medical careers, including surgery. The College sees this as an important initiative that should improve work-based assessment for the JDocs; from this group some will become future applicants for Surgical Education and Training.

Please contact Stephen Tobin, Dean of Education, stephen.tobin@surgeons.org or Kathleen Hickey, Director of Education Development & Assessment +61 3 9249 1291 or kathleen.hickey@surgeons.org with any comments.

ENGAGING WITH OUR INDIGENOUS MEDICAL COLLEAGUES

Working to build an Indigenous workforce

KELVIN KONG
CHAIR, INDIGENOUS HEALTH COMMITTEE

Dr Jaclyn Aramoana (TeORA symposium)

"What's really exciting for AIDA is that we now see the first wave of intergenerational Western-trained Indigenous medical doctors. This year we celebrated the graduation of two special Indigenous doctors; Dr Rebecca Hutchens, daughter of Professor Helen Milroy (Australia's first Aboriginal doctor) and Dr Gemma Hayman, daughter of Associate Professor Noel Hayman (one of AIDA's founding Members and Queensland's first Aboriginal doctor). Last year, we saw Dr Robert Grant graduate, son of Dr Simon Grant (Indigenous specialist physician)."

Dr Tammy Kimpton, President AIDA

"When Dr Jaclyn Aramoana decided to become a surgeon she contacted Māori surgeon, Associate Professor Jonathan Koea for advice. What eventuated has been an ongoing relationship of mentorship. So far, so very Māori. What became apparent and is perhaps only now really being looked at is that, while Māori practicing medicine continues to increase, Māori specialising in surgery not so much. Yet, if Māori Health inequality is to be truly addressed doesn't that mean Māori must be spread throughout the profession and how does that stack up when Maori surgeons number less than 20?"

TeORA

The Annual Scientific Congress Auckland 2012 celebrated the entry of two Māori doctors to the surgical community. Dr Maxine Ronald, General Surgeon, and Mr Vaughan Poutawera, Orthopaedic Surgeon, joined the small but increasing number of Māori medical practitioners to successfully complete specialist training.

Our reason to celebrate has been further fuelled by the recent announcement that Dr David Murray, a Dharug man from Sydney, New South Wales, has become the second Australian Indigenous Doctors' Association (AIDA) Aboriginal surgeon. David passed his fellowship exam in General Surgery last year. This is a wonderful achievement by David and a very proud moment for the College.

The development of the Indigenous surgical workforce is high on the list of priorities for the College's ambitions in Indigenous health in both Australia and New Zealand. Since 2009 the College has been a proud sponsor of the annual meetings of AIDA and TeORA, the Māori Medical Practitioners, giving us the opportunity to engage with and support Indigenous medical students and doctors with an interest in surgical training.

This year TeORA held its annual scientific meeting at Whangaehu Marae in Whanganu on the west coast of the North Island of New Zealand. This is the home Marae of prominent Māori politician and (retired) Minister the Honourable Tariana Turia. The Hon Tariana Turia was presented the Dr Maarire Goodall Award 2014 to acknowledge and honour her long service and commitment to Māori health.

Dr. Jaclyn Aramoana, a prospective Trainee from Auckland presented 'Advocating for an Indigenous Surgical Workforce'. Co-authored with Associate Professor Jonathan Koea, a former member of the College Indigenous Health Committee, the paper discusses the factors utilised by medical schools to attract Indigenous students into medical careers, the interventions necessary to ensure successful graduation and factors important in encouraging Indigenous medical graduates to enter specialist training programmes and achieve faculty appointments.

Growing Our Fellows Workshop panel (AIDA symposium). Left to right, Back Row: Dr Tammy Kimpton (AIDA President) , Dr Victoria Atkinson (RACS), Dr Murray Patton Associate Professor Stephen Tobin (RACS), Dr Liz Marles, Dr Marilyn Clarke

Front row: Dr Susan Carden, Associate Professor Lucie Walters, Associate Professor Sandra Turner, Dr Geoff Verrall, Dr Jenny Cahill

AIDA's conference, 'Science and Traditional Knowledge: Foundation for a Strong Future' was held in Melbourne in early October. Among the prestigious keynote speakers was Professor Helen Milroy, Commissioner Royal Commission into Institutional Responses to Child Sex Abuse. Helen was the first Aboriginal medical graduate in Australia. The College was invited to participate in two panel discussions, the 'Growing our Fellows Workshop' and 'Mentoring Workshop'. The 'Growing our Fellows Workshop' showcased Indigenous pathways to Fellowship in the 11 Specialist Medical Colleges that were represented.

Stephen Tobin, RACS Dean of Education, gave an overview of the JDoc Framework and announced the new annual travel awards to support attendance at the ASC by Aboriginal and Torres Strait Islanders doctors and medical students interested in surgical training.

Victoria Atkinson, a cardiothoracic surgeon from the Royal Melbourne Hospital outlined the steps taken by the RMH to establish an Indigenous intern post. The 'Mentoring Workshop' provided AIDA members the opportunity to discuss and exchange views on mentoring needs and how to make the most of a mentoring relationship.

The Melbourne conference saw the largest representation of College personnel and on behalf of the Committee I would like to especially acknowledge and thank Stephen Tobin, Michael Hollands, Michael Wilson, Victoria Atkinson, John Biviano, Kathleen Hickey, Philip Vita and Melanie Thiedeman for their support and contribution to the success of engagement with AIDA on the day. The 2015 AIDA conference will be held in Adelaide from September 16-19 and the theme for the program is 'Collaborate, Communicate and Celebrate'.

The major highlight of both meetings was acknowledgment of recent medical graduates. AIDA celebrated the graduation of 15 medical doctors and seven new Fellows, including David Murray our second known Aboriginal surgeon. TeORA celebrated the graduation of 32 new medical graduates and 12 new Fellows.

The College's sponsorship and participation in both these meetings is a wonderful reflection of our developing partnership with AIDA and TeORA. It is also a strong statement that we do take our obligations to Indigenous health seriously and are keen to support the work that is being done by groups such as AIDA and TeORA.

CASE NOTE REVIEW

Failing to make clear management plans can lead to conflicting directives

GUY MADDERN
CHAIR ANZASM

This case involved a patient in her 70s with high grade subarachnoid haemorrhage (SAH) secondary to ruptured anterior communicating aneurysm, who subsequently died from cerebral infarction as a result of complication during endovascular coiling of the ruptured aneurysm.

The patient was transferred from another hospital and intubated with diagnosis of Grade V SAH. Her GCS prior to intubation was 3/15 dropping from presenting GCS of 12/15. The computed tomography (CT) scan at the initial hospital confirmed extensive SAH with a small amount of intraventricular blood (IVH) and a moderate sized 3cm x 1.3cm right frontal intracerebral haematoma (ICH) and a thin 4mm acute subdural haematoma (ASDH) over the right convexity resulting 6mm of midline shift. There was no hydrocephalus noted.

Repeat CT angiogram at the treating hospital demonstrated the anterior communicating artery (ACom) aneurysm. The IVH, ICH, ASDH, ventricle size and mass effect were stable. The documented plan from the Neurosurgery Team was to wean sedation to assess neurological state. Later that morning, a right external ventricular drain (EVD) was inserted, however, the indication for this was not documented. The patient subsequently regained consciousness and was able to be extubated later that day. Her GCS was 13-14/15. Apart from agitation, she had no limb defects.

She underwent endovascular coiling the next day and the aneurysm was successfully coiled. However, the procedure was complicated by the embolic occlusion of a middle cerebral artery (MCA) branch and in the attempt to re-establish flow, the vessel tore and had to be sacrificed. This decision was made after discussion between the Endovascular and Neurosurgery teams. The patient returned to ICU and her management for the next two days was dominated by conflicting instructions among ICU and Neurosurgery Teams over issues such as need for sedation and paralysis, optimal blood pressure target for the vasospasm, how and the need to treat her raised ICP.

Her follow-up CT showed large left MCA and ACA territories infarcts with increase mass effect. Her ICP was high (40 in one nursing notes). Following further discussion between ICU and Neurosurgery Team, the decision then was made to continue "current ICU management" for next 24-48 hours which consisted of no sedation or paralysing agents, ceased monitoring of ICP and a wait to see if she improved neurologically. Predictably, she succumbed to raised ICP with the development of diabetes insipidus, cerebral herniation with fixed and dilated pupils and brain death one day later.

Comments:

1. Embolic event is a known risk with endovascular intervention. The Endovascular Team had taken appropriate steps to treat this very difficult situation, but unfortunately lead to further complications of a ruptured vessel in their attempt to re-establish flow. This is not, or should be, a negative reflection in anyway on the technical aspect of the endovascular team.
2. The issue of communication and conflicting medical opinions is not uncommon in these situations. The exacerbating factor in this case, was the lack of a common goal and recognition of the main life-threating process. The main medical concern that needed to be managed in this patient after the coiling complication was not vasospasm prevention or various other aspects of SAH, but cerebral swelling from her stroke. If this was made clear in the beginning, the management conflict might not have been an issue. The poor outcome may not have been so clear had the brain swelling been managed.
3. Based on the information available from the case note, a strong case could be made for microsurgical clipping instead of endovascular coiling, as clipping would also allow the mass effect of the ICH and ASDH to be addressed. However, decision on choice of treatment is complex and may have involved other factors.

AUDITS OF SURGICAL MORTALITY

At your fingertips

A new App for ANZASM National Case Note Reviews

Available on the App Store

ANDROID APP ON Google play

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
NATIONAL CASE NOTE REVIEWS

I would like to thank you for your ongoing commitment to the mortality audit process.

The Australian and New Zealand Audit of Surgical Mortality (ANZASM) program has now been operational for 14 years, beginning in Western Australia in 2001. Since 2010, the audit has included every state and territory in Australia. Each region is autonomous, being led by a Clinical Director who works with a Project Manager and staff to interact with surgeons, hospitals and their state or territory Department of Health to ensure that reports produced are relevant to all their needs and requirements.

The primary objective of the mortality audit is the peer review of all deaths associated with surgical care. The audit process is designed to highlight system and process errors, and trends associated with surgical mortality in an educative manner. Over time, the audit has been able to maintain a constant dataset across Australia.

Each of the Audits of Surgical Mortality (ASM) has produced a range of reports (annual, progress, surgeons and clinical governance reports) in addition to case note review booklets and newsletters. These can be accessed on the College website: http://www.surgeons.org/for-health-professionals/audits-and-surgical-research/anzasm/

Due to the substantial dataset now available, second-line case note reviews have been incorporated into an App format. The second-line case note reviews will continue to be displayed in a deidentified manner. The main features of the ANZASM National Case Note Review App will allow you to:

Search for cases – by specialty, key word searches and National Safety and Quality Health Service (NSQHS) Standards.

View – the latest monthly new case note review cases that were recently uploaded when you receive a notification.

Provide Feedback – have the opportunity to feedback your comments about the App.

View notices of upcoming events – view notices about up and coming ASM events around the country, as well as the release of ASM reports.

ANZASM is in a good position to utilise the extensive information learned to promote safer health care practices. The App has been based on the success of the second-line (case note review) assessment report booklets and e-magazines which contain a more in-depth investigation of key surgical issues and lessons that can be learnt from these.

The App will increase the quantity and quality of information available on issues that relate to clinical governance and patient care across the country. There are many benefits to the individual using the App. For example easy accessibility 24/7; it can be accessed while in a hospital /clinical environment and there is also no need to carry a hardcopy of the booklet.

This App is compatible for both Android and iPhone tablets and phones. Search for 'RACS National Case Note Reviews' on the Apple App store and on Google Play.

Thank you for your ongoing support.

Professor Doutor Aurélio Guterres - Rector UNTL, Associate Professor Glenn Guest - ATLASS II Project Director, Professor Michael Grigg - RACS President, Dr Antony Chenhall - ATLASS II Team Leader and Emergency Physician, Dr Joao Martins, Dean, Faculty of Medicine and Health Sciences, UNTL.

BUILDING HEALTH IN TIMOR-LESTE

New health diplomas see health professionals flourish

The College received a signal honour last year when the President, Professor Michael Grigg, was asked to deliver the keynote speech at the formal graduation ceremony of the first East Timorese Trainees to gain locally-delivered Post Graduate (PG) Diplomas in the health sciences.

The ceremony, held in Dili in November, recognised the achievements of students across a range of disciplines including nine Timorese doctors who completed PG diplomas in Surgery, Anaesthesia and Paediatrics.

The PG Diplomas were jointly delivered by the College, the Universidade Nacional Timor Lorosae (UNTL) and the Timor-Leste Ministry of Health (MoH) with support from the Australian Government-funded Australia Timor-Leste Program for Assistance in Secondary Services (ATLASS) Phase II.

Since gaining independence in 2002, East Timor has been progressively building its health system with the help of many nations. Australia has been a major contributor with the College playing a pivotal role since 2001 by developing programs to train medical staff both in and out of the country.

Cuba has also made a significant contribution in undergraduate training and the medical workforce has grown from a mere 20 doctors in 2001 to reach almost 1000 in 2015.

Going in at the request of the Timorese and the Australian Governments, the College first aimed to meet urgent service delivery needs before shifting its focus to education, training and the creation of a self-sustaining specialist PG education system.

Now, the ATLASS program includes eight staff at the national hospital in Dili including a Surgeon, Anaesthetist, Obstetrician and Gynaecologist, Paediatrician, Emergency Physician and program support staff. In addition, the College employs an ophthalmologist through the East Timor Eye Program (ETEP).

> *“As these Trainees complete their Family Medicine training, it seems a natural step that some of them will wish to go onto Postgraduate training and when they are ready, we’ll be ready”*

From 2012, the ATLASS program supported the development and delivery of the PG diplomas, including introducing regular teaching activities at the hospital in Dili, establishing a PG Resource Centre where doctors can access online resources and textbooks, providing mentoring and supporting the establishment of a PG diploma governance committee.

The PG diploma graduates are now able to build on these efforts by teaching and supervising junior doctors which in turn will help establish the national hospital as a teaching hospital.

The three Surgery graduates and three Paediatrics graduates are now actively involved in co-supervising and teaching doctors enrolled in the newly implemented Family Medicine Program (FMP) while the PG diploma graduates in Anaesthesia are now undertaking further postgraduate training in Fiji and Indonesia.

New skills and improved education

The Program Director of ATLASS II, Associate Professor Glenn Guest, said the graduation of the nine doctors was a wonderful achievement because it not only boosted the skills of the local medical workforce, but also means that East Timor now has increased capacity to deliver postgraduate medical education.

He said that while the surgery graduates were not yet specialists, they had the skills to manage simple bone fractures, treat complex wounds and identify critically ill patients in regional settings who required higher levels of care.

“The graduation of these doctors is a very significant achievement,” Mr Guest said.

“It is the first time that Postgraduate training in medicine has ever been undertaken within the country which we hope will form the platform to build further Postgraduate educational programs, including other specialty areas.

“In the past, all Postgraduate training has taken place outside East Timor – in Indonesia, Malaysia, Philippines, Fiji or PNG – which necessarily removed these doctors and their skills from the country for the duration of their training.

“The original idea to deliver Postgraduate training in East Timor was first discussed in the early years of the ATLASS program and it has taken a decade to bring that plan to fruition.

“Therefore, the graduation of these doctors is an achievement borne of 12 years of continuous College presence in East Timor which allowed all of us involved to understand local needs and priorities and create the relationships required to see it through.”

Mr Guest said that in addition to their roles as clinicians, the PG Diploma graduates had been trained to teach the next generation of East Timorese medical students.

He said, however, that while there was a great deal of enthusiasm toward the Postgraduate program, it had been temporarily put on hold at the request of the MoH while attention is focused on the training needs of the hundreds of Cuban-trained junior doctors, many of whom will be based at the country’s Community Health Centres.

He said the ATLASS team would be providing these doctors with supplementary training under the Family Medicine Program following completion of their undergraduate training.

“As these Trainees complete their Family Medicine training, it seems a natural step that some of them will wish to go onto Postgraduate training and when they are ready, we’ll be ready,” he said.

“All of this work has been done to put in place the initial steps required to allow East Timor to become self-sustaining in the provision of its health and medical workforce.

“Yet, there are still only a small number of East Timorese specialists so the ability for East Timor to independently provide post graduate training to its own doctors could still be many years away.

“In the meantime, the RACS will continue to provide support, educational resources and mentorship.”

Working hand-in-hand

Mr Guest said it was a great honour that the Rector of the UNTL, Professor Aurelio Gutteres, invited the RACS President to deliver the inaugural oration of the Postgraduate ceremony.

“Given how many countries have helped East Timor to rebuild, for the College to be given this honour indicates, I believe, how highly our work is regarded there.”

College President Professor Grigg said it had been a privilege to speak at the ceremony which was attended by a number of Embassy representatives from the countries now assisting in East Timor.

He said the long-term commitment by the College to the people and doctors in East Timor had been one based on philanthropy rather than charity.

“We have always been focussed on training one way or another which is a philanthropic endeavour because our aim has always been to assist our colleagues in East Timor to create a self-sufficient and self-sustaining medical workforce,” he said.

“It was quite an honour to receive the invitation to speak, yet while I was there I had a number of meetings with representatives from the Ministry of Health, University and Hospital all of which made clear how highly the College is regarded there.”

World Congress on Larynx Cancer

Book early for your spot in Cairns

ROBERT SMEE,
FRANZCR – CONVENER, WORLD CONGRESS ON LARYNX CANCER
CARSTEN PALME, FRACS
CO-CONVENER, WORLD CONGRESS ON LARYNX CANCER

Hosted by the Australian and New Zealand Head & Neck Cancer Society, the World Congress on Larynx Cancer 2015 will include more than 100 local and international faculty involved in the care of patients with larynx cancer, not only at presentation, but also in the years afterwards. Presentations relating to patient function, survivorship and disease outcome will be incorporated into the extensive program.

The congress will be held from Sunday to Thursday, July 26 to 30, 2015, at the Cairns Convention Centre. An impressive four day multi-disciplinary program has been developed. It is anticipated that in excess of 500 local and international delegates including surgeons, radiation oncologists, medical oncologists, speech pathologists, nurses, dieticians and other health professionals will attend.

The Cairns Convention Centre was recently awarded the World's Best Congress Centre / AIPC Apex Award. Several domestic and international airlines fly direct to Cairns, making the venue very accessible for delegates.

The provisional program can be viewed on the congress website: www.wclc2015.org Free paper sessions have also been incorporated into the program. Surgeons, Surgical Trainees and other health professionals are encouraged to submit an abstract for the free paper sessions which can be completed via the congress website by Sunday, March 1, 2015.

An interactive pre congress workshop, sponsored by Olympus, will be held at the Cairns Convention Centre on Sunday, July 26. To register for the congress and workshop, please complete the registration form or register online via the congress website. Early registration fees apply until Sunday, June 14, 2015.

For any enquiries, please contact the congress organisers, on +61 3 9249 1273 or wclc2015@surgeons.org

summer*lifestyle*

post op

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

12 page lifestyle section

TACKLING THE SIMPSON *Desert*

Surgeon faces challenge of the big dry

post op appears in *Surgical News* each season

A SURGEON'S GUIDE TO

Brisbane

Associate Professor Ben Panizza tells the sights and secrets of his city

The Director of Otolaryngology-Head and Neck (OHN) Surgery at the Princess Alexandra Hospital, Associate Professor Ben Panizza was born and raised in Brisbane and said he was delighted to return again after years overseas completing post Fellowship training.

It's easy to understand, for the shiny bauble that is Brisbane allows him to combine a hectic public and private practice with a robust family life all managed in a utopian environment of blue skies and ocean breezes.

The father of five children, Mr Panizza is also the Co-Director of the Queensland Skull Base Unit, the Director of the Queensland Head and Neck Cancer Centre – a $15 million collaborative research group based out of the Princess Alexandra Hospital – and is a College examiner with a busy private practice.

He said most Brisbanites were quite willing to let Melbourne and Sydney play their foolish sparring match over which city is best while they quietly enjoyed the increasingly cultured lifestyle now on offer in what has become one of Australia's most dynamic and fastest growing urban centres.

"I have been overseas both for my wife, Fiona's, Fellowship year in Manchester and for my own two years of post Fellowship training in London and Italy," Mr Panizza said.

"When we returned after our year in Manchester I was sent to Ipswich on the western outskirts of Brisbane and remember driving to work each day and just feeling elated looking up at the blue sky.

"We decided to return permanently to Brisbane because both sides of the family are based here and the extended family network was vital in helping to raise our family while both of us pursued our public and private careers.

"I have five children and two dogs and when I lock them in the garage for a couple of hours and open the door, it's pretty easy to see who really loves me!"

Mr Panizza said Brisbane also appealed because of its size and location.

"Brisbane is fairly easy-going and relatively easy to navigate and was a natural choice for us as its climate and proximity to beaches and mountains makes it a great place to live," he said.

"With my work in skull base surgery it was also necessary to have a large enough population to support the work.

"Little did I know then that the sunshine that we so love combined with the pale skin of the majority of its inhabitants would provide so much work given the prevalence of skin cancers that spread to the skull base.

"This combination has helped Brisbane become a leader in the treatment of, and research into, skin cancers and that is exciting to be part of.

"We also greatly enjoy the fact that all the children have had the chance to form strong relationships with their grandparents and cousins."

And so to Mr Panizza's tips for making the most of Brisbane, a city so beloved in that sardonic Australian way that it is also known to some as Brisvegas and to others as Brisneyland.

BRISBANE BEAN COUNTING

For those looking for a buzz of a different kind, Brisbane does great coffee, according to Mr Panizza. He listed his favourite coffee haunt as Grindhouse, one of the hidden gems of the local coffee scene which sources and grinds its own blends. He said that while it may be hard to find, it is worth the effort. "Grindhouse is tucked in behind the Stones Corner pub and it makes and sells great coffee. It also sits next to a couple of sex shops so those photos you've seen, I was getting a coffee."

summer lifestyle

ART AND ARCHITECTURE

The first thing to do when arriving in Brisbane, according to Mr Panizza, is to find a good hotel near the river which has become the grand backdrop to some of the city's finest cultural offerings. Outdoor restaurants, annual festivals and a delightful three-kilometre riverside walk attract both locals and visitors. The river walk also provides access to the historic Storey Bridge, the stunningly-modern Kurilpa Bridge, the Queensland Gallery of Modern Art, the Queensland Museum and the Queensland Maritime Museum.

"The first thing visitors should do is go for a jog or a walk along the river front to get a feel for the place," said Mr Panizza. "Turn left and go under the Story Bridge, then over the river walk and onto New Farm or turn right and head through the Botanical Gardens and over the Goodwill Bridge to South Bank. The art galleries, museums and library have great exhibitions, but the built environment itself is quite amazing. Walk on till you come to the Kurilpa Bridge and stare. Trying to figure out how it stays up and how it is put together is a blast, better than inhaling next to a university student."

GET ON YOUR BIKE

While Brisbane might be fondly known as the "river city" it is also increasingly becoming a bike rider's paradise. It now has more than 1100 kilometres of bikeways and bike paths with the 40km Brisbane River Loop the city's most recognised ride. Smaller rides are offered on the appropriately named Mini Brisbane River Loop while fitter riders can try the tough Mt Coot-tha Loop. Visitors can do any of these rides without having to bring their own ride because bikes are available to hire through Brisbane's CityCycle program.

"The cycle paths out to the University of Queensland at St Lucia and down to New Farm are for all visitors with a bad engine," Mr Panizza said.

"For those who think they're as good as Cadel now that he's nearing retirement, they should try going up Mt Coot-tha a few times while for the Cadel original there is plenty of mountain biking just outside the city and my colleague and great friend Randy Lomax would be more than happy to take you or show you the way."

THE LAY OF THE LAND

Brisbane is home to two million people, is the third largest city in Australia and forms part of the nation's fastest growing metropolitan region of South-East Queensland. With a climate that most people anywhere in the world can only dream of, Brisbane is a subtropical city that averages 28 degrees in summer and 23 degrees in winter. Based around the majestic Brisbane River, oddly named after a former governor of NSW, the city sprawls over hills and dales and across the river valley flood plains between Moreton Bay and the Great Dividing Range. Dotted with hills and spurs and mountains, stunning views are offered at the summit of Mount Coot-tha, Mount Gravatt and the outcrops of the Herbert Taylor Range. The city is both young (the largest demographic is the 24-40 year age bracket) and increasingly multicultural with almost 30 per cent of the city's population born overseas.

FABULOUS FOOD

Brisbane's premier social hub of South Bank is not only home to major cultural institutions, but also offers world-class fare in the many restaurants nestled within its 17 hectares of lush parkland. From the premiere riverfront dining experience offered by River Quay's five restaurants to the laid-back cosmopolitan charms of Little Stanley street, the dining options are broad and attractive. Mr Panizza listed his favourites as Esq (145 Eagle Street), E'cco (100 Boundary Street) and Julius Pizzeria (77 Grey Street). "Esq, which is on the river in town, is the less formal non-degustation side to the Esquire and won't disappoint, and if you want to take your own wine E'cco is happy to accommodate. For something more casual, Julius, across the road from the museum in South Bank, do great pizza and pasta."

SEE THE SEA

It would be remiss not to mention that Brisbane is, of course, not only a destination city in its own right but also the gateway to the Sunshine Coast and Gold Coast. With beaches in all directions and within easy driving, Mr Panizza said his favourites were Burleigh, Kirra or a day out at Noosa.

"If the beach is not for you and you want to avoid becoming one of my patients, wear a hat and check out the tracks and the waterfalls in the Lamington National Park. It's a gorgeous place."

With Karen Murphy

GREAT SOUTHERN LAND

Councillor Andrew Brooks found relaxation in the challenging sand dunes

One of the most inhospitable regions on earth – the vast emptiness of the Simpson Desert – has become a 'bucket-list' entry for an increasing number of people wishing to pit their off-road driving skills against endless miles of sand dunes.

Known as one of the world's best examples of parallel dunal desert, the Simpson Desert lies across the corners of three states – South Australia, Queensland and the Northern Territory – and covers an area of around 170,000 square kilometres.

With an average rainfall of less than 150ml per annum, it is one of the driest regions in the driest continent. It was the location and cause of the tragic deaths of explorers Burke and Wills and is still harsh enough and huge enough to kill the unprepared.

Yet still the drivers keep on coming.

One of these, this year, was Sydney Urology surgeon and College Councillor, Associate Professor Andrew Brooks.

Last July he took up an invitation from retired Plastic Surgeon Mr Allan Meares to join a convoy to drive the desert from West to East, a time of year when the daytime desert temperatures are temperate and the nights dip below zero.

Having borrowed his son's four-wheel drive and stocked it with a fridge, camping equipment, water and fuel, Andrew drove from Sydney and through Broken Hill to meet up with the driving crew in the small town of Kingoonya, just south of Coober Pedy.

From there, they drove to Mount Dare, just below the Northern Territory border, then to Dalhousie Springs to link up with the French Line, the most demanding track across the Simpson Desert because of the 1200 sand dunes that mark its rugged passage.

"We decided to drive the Simpson from West to East because that is the direction that the sand hills are formed so they are slightly easier to get up," he said.

"But when I say slightly, I mean it. This is tough country and is quite strictly controlled by the national park authorities meaning that you have to get a permit to cross the desert; you can only go through at certain times of the year and you have to fit your car with a three-metre flag so that other vehicles can see you approaching over the dunes.

"The average speed of driving is about 20 kilometres per hour so it's hard going."

Andrew said the French Line, which stretches from Dalhousie Springs in the West to Birdsville in the East, was originally created by engineers looking for gas and speculators looking for oil, both of whom ultimately left defeated.

Yet, while it is only 438 km long, it takes days to cross with drivers having to negotiate sand dunes up to 50 metres high.

"You've got to expect to get bogged along the way or to help out someone else because the dunes are just so big," he said.

"The best way of describing it, is to say that it's like those turtles you see getting stuck on a rise in the sand and waving their flippers about trying to get traction.

"That's what happens to the cars when you crest one of these enormous dunes, but you don't manage to bounce down the other side.

"The cars get stuck on the top edge, unable to get traction and you have to dig them out until the wheels make sufficient contact on the sand to move off again.

"All of us brought ropes and pulleys with us so we could help each other out because it's wild driving.

"When you get to the crest of one of those massive dunes all you see is the sky and you have this fraction of a second when you have no idea what's on the other side, a bit like a boat in an ocean swell."

Andrew said the touring group comprised 12 people, all of whom had to bring their own water and fuel, with each providing two meals for the group over the course of the journey.

He said that given that lighting fires is forbidden within the Simpson Desert National Park, they drove off the track of an evening and outside the park perimeter so they could have the comfort of a campfire in the cold desert night.

Every morning, the team packed up camp and was on its way by 9am and drove most days until 5.30 with just enough light remaining in the day to put up tents and get dinner underway.

"That's pretty tight because it gets dark by 6pm so it means you're very busy getting the tents up, the fire going, the food on and then washing up afterwards," he said.

summer lifestyle

"I drove pretty hard to meet the group, covering 2000km in two days, so it felt a bit more pressured than I would have liked. It's such a magical place I'd take more time next time."

Mr Brooks said that while the sand dunes were the most overwhelming aspect of the landscape, the fact that part of the desert lies over the Great Artesian Basin meant that a surprising variety of plants and trees could find the water needed to survive while surface springs provided outback oases.

"The Simpson Desert, while vast and empty, is quite beautiful if you have any sort of affinity with the Australian bush," he said.

"The dunes are brilliant in their variety, but then there are also vast areas of grasslands, empty lakes and scrubland and springs that bubble up from below that attract an amazing array of birdlife.

"The skies are incredibly clear and the sand reflects the light creating gorgeous colours across the dunes of reds and oranges and ochres while the sunsets are absolutely spectacular.

"The place gives a wonderful feeling of remoteness – in some places you can see up to 50 kilometres of nothingness into the distance – and the only wildlife you see while driving the track is the occasional wedge-tailed eagle or lizards."

Andrew's off-road journey ended at Birdsville when he farewelled his desert companions to drive back to Sydney because of work pressures.

The trip lasted from July 10-21 and already he is planning another one for next year.

"It was a pity that I had to rush back to the city for work because I did feel incredibly rested, which might sound strange given the nature of the trip," he said.

"I think that's because I was totally occupied, working out where to go, how to get there, how to tackle the challenges posed by the track and setting up camp.

"There are hundreds of small tasks involved in getting across such an inhospitable place, but that added to the relaxation because I was so absorbed I didn't have time to think about work.

"Now I'm planning to do another trip based around Innamincka and the Coongie Lakes, hopefully in June 2015.

"I'll take a bit more time though and keep my fingers crossed that there has been some rain because then the bird life will be amazing."

With Karen Murphy

A VISIT TO *Gallipoli*

Gallipoli Lone Pine

Graeme Campbell In remembrance of those lost

Many Australians and New Zealanders may have wondered about visiting Gallipoli, especially as the centenary of the landings nears. We had no desire to join the crowds on ANZAC Day, but were keen to combine a brief visit to the battlefields with a holiday based in Turkey. Going in August pretty well guaranteed settled, if rather hot, weather.

The Gallipoli campaign was all about control of the Dardanelles. These straits have been fought over for millennia. Troy was situated opposite the entrance to the straits, probably drawing its wealth from passing trade. There are nine separate cities built on top of each other, the earliest dating from about 2500BC. It is well worth a visit, and again an experienced guide is the best way to understand the confusing series of excavations.

There is a naval museum in Canakkale, on the Asian side of the narrows. Here is a replica of the minelayer that laid the series of mines that sank three Allied battleships on March 18, 1915. This naval victory is celebrated by the Turks to this day, and forced the Allies to contemplate a ground invasion. There is also some information about the Australian submarine AE2, which managed to get through the Dardanelles defences into the Sea of Marmara before being sunk by a Turkish torpedo boat.

A short ferry trip brings you to the town of Eceabat, situated on the waist of the peninsula. Medieval fortresses guard each shore, and there remains some evidence of the Turkish gun batteries that defied the might of the Royal Navy. Across the peninsula, on the Aegean side, is the village of Kabatepe. The ANZACs landed just north of here. On the way there is a museum, incorporating an audio-visual program that takes you through 11 different rooms, describing the campaign from a Turkish point of view, with a variety of items from the campaign on display.

At Kabatepe we went on a small boat and motored up along the Aegean coastline, right past the ANZAC landing beaches. This gives an unparalled understanding of the problems they faced. The landings took place about 2km further north than planned. Instead of a flat beach they faced steep cliffs. The only good thing was that ANZAC Cove itself was fairly well protected from Turkish fire. It is possible to snorkel over a ship deliberately sunk off shore in 1915 as a breakwater.

Back ashore we visited Beach cemetery. This is at the southern end of ANZAC Cove. Any further south and they were exposed to Turkish guns at Kabatebe. This spot was nicknamed 'Hell's Spit'. John Simpson Kirkpatrick (Simpson of the donkey) is buried here. ▶

“Within a few minutes our guide was able to find an old bullet, two flattened bullet casings and a piece of shrapnel, all from 1915”

Saved by the enemy

We looked along ANZAC Cove. Erosion control work means there is little beach left and a road cuts into the cliff, nonetheless the hills and contours are little changed from 1915 pictures. At the other end of the beach is Ari Burnu cemetery. From here you can walk onto the remaining narrow beach of ANZAC Cove. At North Beach there is a grassed open area where they hold the ceremony on April 25 each year. It is nowhere near as big as you might expect from seeing it on TV. It must be a real squash when 10,000 people turn up. All the cemeteries are kept in immaculate condition by the Commonwealth War Graves commission.

We were driven up to Lone Pine. Like most of the other battlefield sites this is along the second ridgeline from the beach. A road runs up this ridgeline now, so you can see the various sites in turn. Apart from briefly on the first day the ANZACs couldn't get past the second ridge. The cemetery here occupies the site of the August battle. The ground is only a couple of hundred metres across, which is about how much ground was gained in the battle. A descendant of the original lone pine has pride of place.

We moved on to Johnston's Jolly. There are clearly visible ANZAC trenches on the left of the road, and Turkish trenches on the right side. The trenches were no more than 10-15 metres apart!

Further up the hill is a Turkish memorial to the 57th Regiment. This regiment was intensely engaged in the early stages of the battle. It is reported that no soldier from this regiment survived the war. The current Turkish army has a 56th and 58th Regiment, but will never again have a 57th.

Close to here is The Nek. While I had read about this place, I couldn't understand it until I saw the geography. There is a flattish area, maybe 70 metres wide. On the right side looking up is a steep gully (Monash Gully). On the left side is an even steeper gully. Flanking manoeuvres would be next to impossible. Charging across the narrow plateau into machine gun fire was criminal stupidity. A cemetery occupies the site of the battle.

We drove up to Chunuk Bair, the mountain that dominates the peninsula. It was briefly captured by the New Zealanders in August. There are views down to the Dardanelles, and some intact Turkish trenches, which were taken by the New Zealanders. Unfortunately they are quite exposed to fire from Hill 971, which is slightly higher than Chunuk Bair. The positions were lost within two days.

The next day we visited Suvla Bay, and Cape Helles. We were the only two taking this tour. In some ways these battlefields are forgotten. Suvla Bay was the site of a separate British landing in August 1915. This landing proved even more disastrous than the April landings and due to lack of leadership no significant gains were achieved. At Kangaroo Beach one can clearly see the submerged remains of an allied barge. On the way back we visited a couple of extra ANZAC sites. Hill 60 was the furthest North the ANZACs got. We also drove up into Shrapnel Gully. Seeing this steep gully explains how hard it was to get uphill and capture the high ground.

Then we drove to Cape Helles at the southern end of the peninsula. The British and then French landed here on ANZAC day. We went to see the French cemetery. More than 12,000 French soldiers died in the campaign, but our guide said that the site attracts few visitors. Nearby is the main Turkish memorial, an imposing structure built fairly recently. Around 86,000 Turks died in the campaign. There were a lot of visitors, nearly all Turkish. The memorial is huge and has a magnificent view overlooking the entrance to the Dardanelles. Close to here you can see French trenches and gun emplacements. ▶

Simpson's Grave

ANZAC trenches, Johnston's Jolly

GALLIPOLI DISPLAY – ASC 2015 PERTH

Your College needs YOU!

We are commemorating Gallipoli at the 2015 ASC and need artefacts and memorabilia to complement our display.

- surgical instruments from WW1
- diaries kept by surgeons
- medals won by surgeons who were at Gallipoli
- small items such as cards and letters to/from medical staff
- medical kits/items from WW1
- newspapers relevant to Gallipoli
- maps of Gallipoli

All material will be housed in a secure showcase and returned to owners at the conclusion of the ASC.

Please contact the college Archivist Elizabeth Milford: elizabeth.milford@surgeons.org

"Erosion control work means there is little beach left and a road cuts into the cliff, nonetheless the hills and contours are little changed from 1915 pictures"

Gallipoli Anzac Cove, Inset: Shrapnel from V Beach

We moved on to V Beach, where the British deliberately beached a ship, the River Clyde, with 2100 men on board. Unfortunately they were still 40m from shore and attempts to form a line of boats to get men to shore proved nearly impossible under the rifle fire of 290 Turkish troops on the high ground. It was a massacre. Today it is a peaceful little beach, overlooked by a medieval castle. Within a few minutes our guide was able to find an old bullet, two flattened bullet casings and a piece of shrapnel, all from 1915.

Overlooking this beach is the British war cemetery and memorial, also a very imposing structure. It is surrounded by fields of sunflowers and has lovely views. The next invasion beach was W Beach. There are still iron pilings sticking out of the water, which are the remains of landing platforms erected here in 1915 after the initial landings

We drove north towards the village now called Alcitepe. In 1915 in was called Krithia. On the first day a few British soldiers did reach Krithia, about 8km inland from the beaches. Due to lack of leadership, they went back towards the beaches and were never able to retake the place. It was the scene of two horrendous battles, which were little more than slaughter as the Allies charged machine gun positions for minimal gains. There were ANZAC troops at one of these battles, so there are ANZAC names on the British memorial at Cape Helles.

The visit to all these sites was very moving. One can't help but feel the futility of it all. So many young lives were wasted, in what proved to be a hopeless cause. However, the campaign did have a broader impact. The natural ties between Australia and New Zealand were cemented. This must be at least part of the explanation for why there now exists a trans-Tasman College of Surgeons. Many of the surgical leaders of both countries were involved in the campaign.

The Turks view the campaign very differently. They regard it as the first step towards forming an independent Turkish state out of the ruins of the Ottoman Empire. Mustafa Kemal, who was undoubtedly their best ground commander in 1915, went on to lead a war of independence, which was ultimately successful in 1924, and became their first President. They do not bear any ill will to Australia and New Zealand. On the contrary, they welcome visitors with open arms. Turkey is a beautiful country, and relatively inexpensive to visit. There are many other sights to see. I would commend it to you.

COVIDIEN

THE BEST YET

Another successful meeting of minds at the 2014 SAS and SRS Meeting

RICHARD HANNEY
CHAIR ACADEMIC SURGERY

The College November Academic meetings, held in Adelaide in 2014, were the most successful in recent years. Long-term host, the hard-to-impress Guy Maddern, was delighted with both the attendance and standard of work presented. The calibre of presentations at the 51st annual meeting of the Surgical Research Society (SRS) was so high that John Windsor questioned whether it was, in fact, the best ever.

This year's international visitors, Professors George Chang and Taylor Riall, hailed from the MD Anderson Cancer Center and the University of Texas in Galveston, respectively. They were delighted to congratulate Dr Deborah Wright from Auckland, on her winning the Young Investigator Award at the meeting; as a result, they will host her at their Academic Surgical Congress in Jacksonville, Florida, in 2016.

Now an annual two-day event, the meetings comprise a mid-career workshop for academic surgeons followed by a meeting of the Heads of all Academic Departments of Surgery in Australasia, together with other interested participants. The Academy of Surgical Educators hosts a dinner forum preceding the SRS meeting the following day.

The academic stimulation and international networking opportunities, welcoming registrants from the level of medical students and prospective surgical Trainees through to the College's most senior academic surgeons, arguably represent the best value meetings provided by the College. In 2015 they will be held in Sydney on Thursday and Friday, November 12 and 13, before being held in Melbourne in 2016.

Young Investigator award winner Deborah Wright

Andrew Hill again oversaw the Academic Mid-Career course on Thursday morning. Highlights included an elegant reflection by Marc Gladman on addressing the triple/ quadruple threat in academic practice, with Taylor Riall giving her keynote address on emerging trends in surgical research – think patient-centred outcomes.

Leigh Delbridge outlined how to make an international impact, and I addressed the definition of an academic surgeon: a leader who has chosen to acquire specific training and experience in research and/or education, and to make these dimensions a significant part of their career.

James Lee thoughtfully structured the Heads of Departments meeting around three constructive workshops:

Minimum research requirements in SET training – a subject into which many groups have input and interest. Jonty Karpelowsky has now convened a working party to follow on from earlier work, looking at surgeons as consumers of research, and at existing competency requirements. There will be an interim report provided to the Academic Section Executive in February.

Academic career pathways – this followed an international summit held in Sydney the previous day, convened by the College President, Professor Michael Grigg. Julian Smith will chair a Steering Committee to develop academic career pathways, with members also from the RACP, AMC, Medical Deans of Australia and New Zealand and an AMA Council of Doctors in Training representative.

College scholarship funding – Stan Sidhu and Alan Saunder looked at the $1.5 million RACS scholarship funding provided last year and explored ways to further enhance this figure, recognising that the RACP provides roughly twice this amount annually.

College Dean of Education Stephen Tobin welcomed attendees to the dinner forum centred around professionalism in training and practice, with thought-provoking addresses by David Hillis and Alison Jones. The relaxed atmosphere and excellent food led to a relaxing and valuable discussion.

Leigh Delbridge chaired Friday's Surgical Research Society meeting. Visiting guest Taylor Riall spoke on translating outcomes research in pancreatic cancer into practice, further refining patient selection and George Chang spoke on reducing margin positivity in the resection of rectal cancer. The 23 oral and seven poster presentations were of very high standard, with award winners listed in the table.

Deborah Wright's award winning talk highlighted that the error rates reported of up to 27 per cent in the datasets of cancer databases impact significantly on translational research findings from these same databases. Julian Smith's Jepson Lecture provided a thoughtful perspective on a continually evolving career as an academic cardiothoracic surgeon. The DCAS award to the highest scored presentation by a medical student or prevocational doctor remained popular and was well won by Cameron Wells.

The evaluation forms from the meetings suggested the registrants found the hectic two day schedule valuable and well worthwhile. The generous financial support from Covidien, as Foundation sponsors of academic surgery, produces excellent value for attendees and we look forward to welcoming this year's registrants to the Sydney meeting.

Award winners Cameron Wells, middle Pramudith Sirimanna, right Anannya Chakrabarti.

Congratulations on your acheivements

Award	Recipient	Institution(s)	Abstract Title
Young Investigator Award	Dr Deborah Wright	Dunedin Hospital, School of Medical Sciences, the University of Auckland, New Zealand	Impact of Inconsistencies in Clinicopathological Data on Survival and Molecular Analyses
Developing a Career in Academic Surgery Award	Mr Cameron Wells (Medical Student)	Department of Surgery, the University of Auckland, New Zealand	Temporary Diversion Ileostomy is an Independent Long-Term Predictor for the Development of Anterior Resection Syndrome
Travel Grant	Dr Steven Due	Department of Surgery, Flinders University, Adelaide, South Australia, Australia	The Oestrogen Receptor: a Novel Therapeutic Target in Oesophageal Adenocarcinoma.
Travel Grant	Dr David Liu	Surgical Oncology Research Laboratory, Division of Cancer Surgery, Peter MacCallum Cancer Centre, University of Melbourne, Victoria, Australia	APR-246/PRIMA-1met Delays Growth and Induces Apoptosis in Oesophageal Adenocarcinoma Expressing Mutant P53
Travel Grant	Dr Pramudith Sirimanna	Academic Colorectal Unit, Sydney Medical School - Concord, University of Sydney, Australia	Validation of a Virtual Reality Simulation Model for Laparoscopic Appendicectomy and Incorporation into a Proficiency-Based Curriculum
Travel Grant	Dr Anthony Glover	Kolling Institute Of Medical Research, University Of Sydney, Royal North Shore, Hospital and Engeneic Ltd, Sydney, Australia	Restoring Expression of Microrna-7 Inhibits the MAPK and Mtor Pathways and Offers a Novel Therapy for Adrenocortical Cancer
Best Poster Award	Dr Anannya Chakrabarti	Peter MacCallum Cancer Centre, University of Melbourne, Victoria, Australia	Targeting Minimal Residual Disease in Breast Cancer

RECONNECTING WITH REGIONAL ISSUES

Developing portfolios and Government relationships keep this committee busy

MARY LANGCAKE
CHAIR, NSW REGIONAL COMMITTEE

I became Chair of the College New South Wales Regional Committee in July 2014. The past six months seem to have flown past! The NSW Regional Committee comprises 12 elected members, as well as co-opted representatives of the surgical Specialties, Younger Fellows, the Trainees Association (RACSTA) and IMGs. In addition, we have two ex-officio College Councillors, and a representative of the Health Education and Training Institute (HETI), the State Government body responsible for pre-vocational education in NSW.

The role of the Regional Committee is to address those issues that impact on the delivery of quality surgical services in our state, as well as to lobby the relevant bodies on matters that affect all Fellows and Trainees. Following on from the drive and enthusiasm of my predecessor Robert Costa, I have sought to strengthen the relationships that he developed with the Ministry of Health and Government representatives.

The members of the Committee have been allocated responsibility for particular portfolios including Advocacy, Rural Surgery, Surgical Education, and Prevocational Training, Trauma, and Surgical Focus Groups (CPD, Senior Surgeons, Women in Surgery, Younger Fellows and Indigenous Heath). The implementation of the portfolios arose from a desire to represent the surgical population in NSW more broadly and also to give Committee members a greater sense of involvement in progressing those issues about which they are passionate. The feedback I have received about this restructure has been positive and I look forward to working with the Committee to support and promote these stakeholder groups.

As Chair I am a member of the Surgical Services Taskforce, which comprises Surgeons, representatives from Ministry and members of the Agency for Clinical Innovation. In this way RACS NSW is involved in discussions related to the provision of quality surgical service for both elective and emergency patients.

One of the key areas of advocacy this year has related to minimisation of alcohol-related harm and violence. Those of you not based in NSW may not be aware that there had been a marked increase in episodes of alcohol related violence particularly around the Kings Cross area of Sydney, the so-called 'Entertainment Precinct', as well as in Newcastle. This culminated in the deaths of two young men, within a 12 months period, from single punch attacks by perpetrators who were violently drunk. Our College, both at the Federal level and through the NSW Committee, has advocated, in conjunction with the NSW ACT Alcohol Policy Alliance (NAAPA) to have restrictions implemented in accordance with an approach labelled HOT – Hours, Outlets and Taxes:

- Restriction on trading hours
- Reduction of the availability of alcohol through reduction of outlet density; and
- Application of a stepped volumetric tax on alcohol availability of alcohol, hours of service.

In response to these tragedies and the community pressure from multiple groups including our College, the NSW State Government instigated lockouts after 3am, last drinks at 1am and 10pm closure for all alcohol outlets in the state. These measures have seen marked reductions in the alcohol-fuelled violence in the CBD, as reflected by a drop in alcohol-related presentations to St Vincent's Hospital, anecdotal reports that individuals feel safer walking in the King's Cross area at night, and police reporting fewer incidents and arrests since the changes came in. The Government is to be congratulated on these initiatives, but will need our continued advocacy to resist the pushback from the Alcohol Lobby.

It is well known that people living in rural and regional areas are disadvantaged in accessing medical services and this is certainly the case in surgery. The NSW Regional Committee was invited to review the Ministry of Health Draft Rural Health Policy document and we were able to draw attention to significant areas that had been overlooked. These included enhanced ENT services to deal with the scandalous levels of otitis media-related hearing loss in Indigenous children, improved trauma services and the provision of rehabilitation services for rural victims of trauma. We will continue to lobby in this area. I have already visited Lismore to discuss with my surgical colleagues the challenges of providing equitable care for their regional population, and the members of the Committee and I plan to visit other rural centres throughout this year to further engage with those surgeons who dedicate themselves to rural surgery.

NSW has an election in March this year and the NSW Regional Committee plans to lobby the Government in three main areas:

Former AFL player, Mr Tim Peter Musgrove, FRACS, Mary Langcake and Troy Luff, Beyond Blue representative.

1. Provision of adequate specialist surgical training opportunities; preservation of dedicated teaching time for Trainees and their supervisors, development and funding of distributed infrastructure to support the surgical training environment, support for appropriate working hours and overtime to facilitate knowledge and skills acquisition.
2. Alcohol abuse and its impact on surgical trauma, as well as the community.
3. Timely and safe access to surgical care throughout NSW; in particular, reference to improving rural access to surgical services
4. The NSW Government's response to changes in Federal Budget Health Funding.
5. Establishment of an integrated training pathway for clinical academics to meet the future healthcare needs of New South Wales and the rest of Australia.

Throughout the year, with the invaluable assistance of the Regional Office staff, the Committee organises events and courses that are of interest to a broad range of Fellows, Trainees and Medical Students. In November 2014 we had our second 'Surgeons' Month'. This was a new initiative in 2013 designed to have our College re-engage with the Fellowship in NSW and due to its success it will become the keynote annual event. This year there were four main events in the NSW Regional Office which included lectures on a range of topics, careers events for JMOs and students, awards in recognition of outstanding service by Fellows, and the Henry Windsor Lecture, which was brilliantly presented by former president Ian Civil.

One thought-provoking session was provided by a representative of Beyond Blue who spoke about the prevalence of depression and anxiety within our society, and encouraged attendees to recognise the signs not only in colleagues, but in themselves. This is an issue that needs greater focus as none of us is immune to the stresses of our working lives and it is important to understand that support is readily available. This is a subject on which I plan to focus in a future Chair's News.

The final event of Surgeons' Month was a well-attended meeting entitled 'Women in Medicine – Professionals in the 21st Century'. The evening saw representatives from various medical Specialties, in addition to women, leaders from law, finance and health administration gather to discuss the issues that face women who pursue professional careers. The evening was an outstanding success, perhaps best summed up by one of our male attendees who said that the evening had been an opportunity to learn and understand more about his female medical colleagues. He expressed great admiration for what they achieve.

In 2015 the NSW Regional Committee has a full calendar of events planned. There will be presentations of interest to a broad range of attendees aimed at encouraging more Fellows and Trainees to become involved in College activities. Seminars will provide educational and topical content with subjects including financial planning, career support and balanced lifestyle. We will continue to promote health and well-being with ongoing advocacy for doctor's mental health.

The NSW Regional Committee is your Committee. We want to engage with you and share your views on issues that affect you as a Surgeon or Trainee, but we need you to be involved. Attend the events at the College, spend time and vote for colleagues willing to give of their time to become Committee members or College Councillors.

Our College will only ever be as good as those people who take the time to be involved.

The NSW Regional Committee wishes you all a belated Happy New Year and trusts 2015 will bring you every success in life.

AUSTRALIAN TRAUMA REGISTRY LAUNCH

Australian Trauma Quality Improvement Program

JOHN CROZIER
CHAIR, TRAUMA COMMITTEE

In October 2014 the inaugural report of the Australian Trauma Registry was released – the culmination of four years' work by the Australian Trauma Quality Improvement Program (AusTQIP) underpinned by more than 20 years work by the College and its collaborators. For the first time we have a national picture of serious injury, treatment and outcomes ushering a new era for collaboration between major trauma centres, advancing a national health priority and opportunities to improve care for future injured patients.

The collection of trauma data has been on the radar of trauma professionals for many decades. Two Government reports – the National Road Trauma Advisory Council report on Trauma Systems, 1993, and the Victorian Review of Trauma and Emergency Services, 1999 – recognised trauma registries as having the potential to improve care of the injured patent.

The Westmead Hospital Trauma Registry, first in Australia, was established in January 1985. Data was collected on all Westmead trauma patients (adults and paediatrics) admitted to the hospital to document the management and outcome of trauma patients (pre EMST Course) and severity of injury using the 1985 Abbreviated Injury Scale[1] and Injury Severity Score. Professor Stephen Deane and Christine Read-Allsopp were tasked with coding 50 trauma patient records to ensure the quality and severity scoring was accurate and reliable. When differences in injury severity were found, 'robust' discussions followed with each putting their case forward for their respective decision. Coding rules were established.

Weekly review of all trauma patients was undertaken with a small group of clinicians and a multidisciplinary team was established to review monthly every in-hospital death. Issues were identified and trauma education provided.

1988 The Westmead Hospital Trauma Group. L-R: Prof Danny Cass, Ms Trish McDougall, Prof Stephen Deane, Mr Rogan McNeil, Dr Paul Gaudry, Ms Christine Read-Allsopp.

Armed with 18 months of evidence and the strong leadership of Professor Deane, changes were instigated at Westmead Hospital to improve the care of the trauma patient.

- The first Trauma Team in Australasia was established and commenced at 8am on July 7, 1986. The first severely injured patient to meet the trauma team call criteria arrived at 9.05am with an instant response from the team.
- Designated Trauma Wards and High Dependency units opened.

Further trauma registries were established throughout Australia and the 'Trauma Team' was adopted by hospitals without having to provide their own 'evidence'.

The College Trauma Committee (CTC), chaired by Professor Glen Merry, held a multi-disciplinary Workshop in 1993 in Albury-Wodonga (convenor Assoc Professor Peter Danne) on 'Establishing a Minimum Data Set for Australasian Trauma' which resulted in the publication of a recommended Minimum Data Set.

Faculty included two Americans, Dr Wayne Copes, key designer Major Trauma Outcome Study and Prof Erwin Thal, American College of Surgeons Committee on Trauma, who both brought broad experience of registry development. Existing Australian trauma registries and the Major Trauma Management Study provided bases for comparison and discussion about nationwide opportunities in Australia and New Zealand.

In 2000 Assoc Prof Danne, then Chair CTC, invited Dr Cliff Pollard to head up the Systems Performance Improvement and Registries Sub-Committee of the Trauma Committee. With representation from all jurisdictions in Australia and New Zealand, Dr Pollard convened in 2001 a CTC workshop, 'Outcome Analysis in Trauma'. Trauma professionals from Australia and New Zealand attended the workshop and examined data collection and trauma registries throughout Australasia to identify deficiencies and strengths and to develop a way forward to a Bi-National Registry.

Four separate workshops investigated:

- Closing the loop
- Methodology of systems performance analysis
- Establishing a national trauma registry
- Data elements for a systems performance database

With generous support and funding from the College and the Centre of National Research and Disability and Rehabilitation, the National Trauma Registry Consortium (NTRC) was formed under Dr Pollard's leadership. The aims were to link together relevant stakeholders in Australia and New Zealand to facilitate the analysis of trauma systems data.

The Australasian Trauma Society (ATS) and the NSW Institute of Trauma and Injury Management added financial support. The aim of the registry was one of quality assurance to benchmark performance against national and international standards. However, problems existed in obtaining sufficient funding for the initiative and overcoming the hurdles of setting up a bi-national process for data collection, aggregation and reporting. As a result, contributors were limited to hospitals in both countries with established registries and leaders dedicated enough to work 'gratis'.

Since then a small number of state-based trauma registries have emerged and played an important role in advancing registries for monitoring system performance and improving the quality of trauma care.

The NTRC project published four reports of data, 2002 to 2005, based on incomplete de-identified aggregate data describing aspects of injury, including demographic characteristics, injury cause, description and patient outcome. The need for a comprehensive bi-national trauma registry using individual patient data, adjust patient outcomes based on injury severity and other characteristics was now a high priority. Only then would it be possible to benchmark injury management and improve patient outcomes.

With approximately $1.5m funding over four years from the National Trauma and Critical Care Response Centre in Darwin, and Alfred Health through the National Trauma Research Institute, the Australian Trauma Quality Improvement Program was launched in 2011 to develop a national trauma registry in Australia, and to work in partnership with parallel processes in New Zealand. It brought together stakeholders, including ATS and the renamed (CTC) Trauma Quality Improvement Subcommittee of the CTC, who provided expertise and in-kind support.

Project comes together

AusTQIP established a nationwide audit of trauma data and quality improvement practices, built a comprehensive collaboration framework and agreement signed by 27 trauma centres and two state-based registries, obtained ethics approval from all jurisdictions, and built a national registry and all the processes for data transfer, integration and reporting.

On October 4, 2014, at the Sydney ATS meeting, the inaugural Australian Trauma Registry Report was launched to rapturous applause of more than 300 attendees representing the trauma community of Australia and New Zealand. It contained a summary of national trauma information on injury occurrence; who was injured, injuries sustained, treatment and outcomes. It showed how in-hospital mortality outcomes varied between centres in a de-identified fashion. In December, 2014, confidential site-specific reports were provided to each Trauma Director showing how their centre and state fared in comparison with other centres.

The report quantifies Australia's collective response to over 20,000 critically injured individuals requiring treatment between 2010 and 2012.

Professor Russell Gruen, (AusTQIP Co-Chair, Deputy Chair CTC) said, "Injury is the leading cause of death for under 45s, and is the major cause of disability. This report looks at the work of Australian trauma centres responsible for saving lives by treating injuries and restoring independence and productivity. There is significant variance in outcomes across the country and we need to further understand this particularly in relation to mortality. The ongoing collaboration promises to streamline our efforts".

AusTQIP Steering Committee Co-Chair Associate Professor Kate Curtis said national data was needed to ensure consistency and high performance care throughout the country.

"We need to understand the implications of this research to have the best chance of survival if you are injured anywhere in Australia", she said.

The Report highlights:

- 15-24 year olds had the highest incidence of injury
- Nine-in-10 seriously injured patients survived their trauma after receiving hospital care, although there was great variability in unadjusted statistics
- Over half of all injured patients admitted were the result of vehicle-related accidents
- Falls were the largest contributor to mortality

Professor Gruen reflected on this landmark event for trauma care in this country, "We now have a registry and data, the ability to summarise, compare and contrast, to understand in a far more sophisticated fashion the need for and delivery of trauma care services, and a better means of communicating that to all the people who matter."

He emphasised, "This is a big step in being able to learn from experience, and from each other, to ensure that all future seriously injured people have the best chance of survival and recovery."

The report is available online at www.ntri.org.au or www.austqip.org

Reference:

1. Association for the Advancement of Automotive Medicine (AAAM), Barrington IL, USA. Abbreviated Injury Scale 1985.

RESEARCH FOR TOUGH CHOICES

Scholar recipient Dr Cherry Koh looks at the hard decisions patients must make

Understanding decision making surrounding recurrent rectal cancer is the subject of PhD research now being conducted by NSW colorectal surgeon Dr Cherry Koh.

Dr Koh is a 2013 recipient of a Foundation for Surgery Scholarship and is undertaking her research through the Surgical Outcomes Research Centre at the Royal Prince Alfred (RPA) Hospital in Sydney. The PhD project examines decision making from a patient and clinician, as well as societal, perspective.

"Patients with recurrent cancers in the pelvis often suffer from intractable symptoms especially pain. It is also not uncommon for patients to experience bleeding, bowel obstruction or fistulation as the tumour continues to grow within the confined bony pelvis." Dr Koh said.

"The only option for cure is to perform a radical procedure (also known as pelvic exenteration) that removes all organs within the pelvis that are involved in the recurrent cancer.

"Patients face challenging decision making as they weigh up survival versus the trades-offs from surgery such as the need for a colostomy or urostomy bag, sexual dysfunction and the possibility of lower limb problems from the need to remove the sacrum."

First used to treat recurrent cervical cancer, exenterative surgery can take from seven to 20 hours to complete and involves a large surgical team including colorectal, orthopaedic, vascular, urology and plastic surgeons.

Dr Koh said colorectal surgeons were now using exenterative surgery to treat advanced bowel and rectal cancers with the RPA conducting about 50 each year.

She said that the average survival without surgery is about 12 months and that chemo-radiation may prolong survival to 18 months, but is not curative.

"The process is analogous to applying the brakes on the car, but the wheels never stop spinning," Dr Koh said. "Eventually, the wheels start accelerating again.

"However, with surgery, up to 50 per cent of patients were still alive at five years.

"In many parts of the world including Australia, most patients would be palliated, but a small number of hospitals including the RPA Hospital in Sydney offer pelvic exenteration."

Dr Koh said that patients were carefully selected for such an intervention.

"They have to be fit and well to undergo such major surgery," she said.

"Even after discharge, patients often require prolonged rehabilitation and will need ongoing support to fully recover."

Dr Koh said it was not uncommon for patients to underestimate the magnitude of the operation.

She said the entire decision-making process involved more than just the patient and included the surgeon as the clinician offering the procedure and the society as the funding body for such procedures.

Both aspects are also incorporated into her PhD which examines how clinicians make decisions about patient selection and the cost effectiveness of such surgery.

Dr Koh is conducting that research through the University of Sydney under the supervision of Professor Michael Solomon, Professor Glenn Salkeld and Professor Jane Young.

To gather the data required, she is interviewing patients and clinicians, but is also analysing Quality-Adjusted Life-Year (QALY) data, a statistical measurement of disease burden.

"I want to know how the surgeon decides who is an appropriate candidate for exenterative surgery, why some patients jump at the option and others decline it and if such expensive surgery is in the social interest given tight budget environments," she said.

"About 5000 people get rectal cancer in Australia each year and of those, between 250 and 500 patients will have recurrent cancer and of those patients about half have inopererable tumours.

"Of the patients with potentially operable tumours, it is not clear how patients make decisions about surgery and I am in the process of interviewing patients to understand how patients make treatment decisions.

"So far I have conducted 30 patient interviews and I am hoping to get that up to 50."

Before taking up her role at the RPA, Dr Koh had a Fellowship at the John Radcliffe Hospital in Oxford where she worked in the Inflammatory Bowel Disease (IBD) unit as well as the Oxford Pelvic Floor Unit. While there, she also gained skills in transanal endoscopic microsurgery and the management of complicated re-operative surgery for IBD.

She said she began conducting exenterative surgery after returning to Sydney.

"RPA has had a long history with pelvic exenteration starting with Professor Anthony Eyers," she said

"Professor Eyers has conducted quite a number of these procedures during his career in RPA and Professor Solomon then began to take an interest and since then, he has pioneered certain techniques used in pelvic exenteration, written book chapters and is frequently an invited lecturer on this subject around the world."

Managing expectations

Dr Koh said that while the surgery was radical and morbid, it does save lives.

The most important aspect was managing patient expectations.

"The quality of life of the patients who have this procedure is directly dependent on their expectations," she said.

"What Professor Jane Young and Professor Solomon have found so far is that such major surgery causes a sharp dip in patients' quality of life immediately after surgery, but as patients recover, their quality of life returns to their baseline quality of life and even overtakes that of patients with recurrent cancer, but who do not undergo surgery.

"So, this is not just about keeping people alive at all costs; patients actually return to their usual quality of life.

"There are some within the medical community who are sceptical about this surgical treatment and believe it is too invasive and too costly and they have the right to that opinion.

"It is a very interesting area of research because no-one has looked closely at this emerging treatment option or analysed the cost-benefit aspects in terms of medical funding."

Dr Koh thanked the College for its support and the funding attached to the Foundation for Surgery Scholarship.

"It was an honour to receive it because it represents recognition by the RACS for not just my research, but for the work being done by academic surgeons in both Australia and New Zealand," she said.

Dr Koh has also been awarded the Nataras Fellowship in Colorectal Surgery through the University of Sydney.

With Karen Murphy

DR KOH'S SCHOLARSHIPS

2013
AWARDED RACS FOUNDATION FOR SURGERY SCHOLARSHIP

2011
AWARDED ACPGBI TRAVELLING FELLOWSHIP
Travelling Fellow to:
- St Mark's Hospital, London, United Kingdom
- Basingstoke Hospital, United Kingdom
- Leeds General Infirmary, Leeds, United Kingdom
- University Hospital, Leuven, Belgium

2010
AWARDED BEST TEACHING AWARD BY ROYAL PRINCE ALFRED HOSPITAL SYDNEY

2009
AWARDED MITCHELL NOTARAS COLORECTAL FELLOWSHIP
By CSSA
(Colorectal Surgical Society of Australia)

2007
MASTER OF SURGERY
Awarded University of Sydney Colorectal Scholarship
Awarded Brian Smith Foundation Scholarship

2005
RIGID SIGMOIDOSCOPY STUDY
Awarded Selwyn Family Foundation Scholarship

A MEDAL FROM THE PRESIDENT

Raffi Qasabian mentors Armenia's first endovascular surgeon

AMY KIMBER

Mkhitar Heratsi was an Armenian physician of the 12th century, often called "the father of Armenian medicine". Nine centuries after his death, NSW vascular surgeon Raffi Qasabian has been honoured in Heratsi's memory, with a medal from the Armenian President for his contribution to the country's medicine.

For Dr Qasabian, it has been a 'full circle' return to his homeland, where he has made regular visits for a decade to undertake life-saving surgery and mentor a young Armenian vascular surgeon. Two generations ago the Turks drove his grandparents off into the Syrian desert in 1915. The social, economic and health impacts of what is considered to be the first genocide of the 20th century are still reverberating.

Since its independence, Armenia's health system has moved from a centralised system to one that is fragmented and largely financed from out-of-pocket payments. There is limited access to health services and most facilities lack modern medical technology, especially in rural areas. With an average monthly wage of US$400, it is perhaps not surprising that roughly three times as many Armenians live outside the country as inside.

Dr Qasabian's journey began in 2004 when he was offered an $8,000 grant by multinational medical technology company Medtronic to visit the Nork Marash Medical Centre in the Armenian capital, Yerevan. Twenty years earlier Hrayr Hovagimyan, an American Syrian Armenian paediatric cardiac surgeon, had embarked on a similar journey to the famous hospital, which resulted in the establishment of modern cardiology and cardiothoriacic services (adult and paediatric) in Armenia.

"I gave a talk to a group of around 40 people including surgeons and ancillary staff, and at the end Hrayr gave me a big hug and asked me to return," Dr Qasabian said. "You could say that I am standing on the broad shoulders of a giant of modern Armenian medicine to develop the vascular aspect of the cardiovascular services which he brought to the country.

"Since then I have been travelling to Armenia two or three times a year and slowly training Armenian surgeon Eduard Aghiyan to learn my specialty to a Western standard."

Dr Qasabian's visits have come at a considerable personal cost, but have brought great rewards.

"I really didn't know what I was getting myself into," Dr Qasabian said.

"I went thinking I would be able to show surgeons how to do endo-vascular surgery, but they didn't really have even open vascular surgery to speak of.

"I undertook the first thoracic stent graft procedure in the country, on a patient who had had an aneurysm. The scans were sent via Dropbox so I could discuss the case with Eduard before my arrival.

Stent grafts cost $10,000 which the majority of people in the country cannot afford. "People were dying of ruptured aneurysms on waiting lists, so I was obliged to offer open surgical repair of aneurysms with grafts (expired or near expired) that I brought with me from Australia.

"There are now a group of people depending on me to go back otherwise they'll be on the waiting list or they'll die. It's a lot of pressure for one person, which is why I'm investing the time to train someone who can do things while I'm not there."

In April 2013 Dr Qasabian took Dr Aghiyan to Charing Cross in London for his first international meetings. It was a great opportunity for the Armenian doctor to meet other surgeons and learn about what was happening in vascular surgery in other countries.

"My dream is to start a vascular surgical school and invite doctors out to Australia for training. If we set up a charity organisation we will be able to appeal to the Armenian community," Dr Qasabian said.

"Somehow I feel I am fighting that terrible beginning to Armenia's independence, by using the knowledge and skills I have learnt in Australia to help heal and to have a healing journey myself.

"It's a way of getting back to my roots and connecting with my fellow Armenians. It brings a tremendous sense of hope and joy to me and the people I work with. I have made amazing friends there, and those friendships are life-long."

RACSTA End of Term Evaluation

Trainees helping to improve training

WILLIAM PERRY,
TRAINING PORTFOLIO CHAIR, RACSTA

Our Trainees' Association (RACTSA) has been surveying New Zealand and Australian Trainees at the end of each rotation for the past four years. Questions have been designed to help us better understand the training experience, barriers to success, and strengths of the programs so as to help drive improvement in the delivery of training.

Some 224 Trainees across the nine specialties responded to the August 2014 survey. Nearly 60 per cent were in their first two years of training, with respondents dropping off in the latter training years.

Part-time training was of interest to 26 per cent. Interestingly, 78 per cent stated they would be interested in being involved in outreach or international work. This is certainly in line with a growing interest and understanding of global surgery.

Working hours were clustered around an average of 60 hours, with more than three quarters of Trainees working between 50 and 70 hours per week. Fifteen per cent of Trainees had no exposure to outpatient clinics, and those that did showed a large variation in the number of patients they saw.

The results of this August survey supported wider analysis undertaken by Petrushnko et al. about the impact of Fellows on Trainees. This group presented at the 2014 ASC, and concluded that Fellows may assist in the teaching and training of surgical Trainees, but that Trainees working with Fellows experience a reduced quantity and quality of training.

Various groups are currently working on other aspects of this data. One, for example, is exploring bullying and harassment – 13 per cent of Trainees who responded to this most recent survey said they had experienced bullying or harassment during their rotation.

That presented here is a mere snapshot of some of the results. The real value will come at the start of 2016, when a five-year analysis will be undertaken to explore trends in training across a broad range of topics.

In the meantime, the data is being used to better inform RACSTA advocacy and improve training. We urge all Trainees to complete the upcoming survey round, and hope Fellows of our College encourage them to do so.

OLDER DOCTORS MORE AT RISK OF COMPLAINT

Be aware of the questions asked

MICHAEL GORTON
COLLEGE SOLICITOR

Two research studies indicate that older doctors are more likely to face complaints.

An Australian study (MJA 2011, 195) indicated that doctors in private practice in Victoria have a one in five chance of a complaint over a 10 year period, based on data examined from complaints to the Health Services Commissioner in Victoria between 2000 and 2009. The study also indicated that a relatively small number of doctors accounted for a disproportionate number of the complaints in that study.

When stratified by years in practice, older doctors, especially those with more than 22 years in practice, had a higher risk of complaint than younger doctors, or doctors with fewer years in practice.

In addition, the study indicates that surgeons have a higher rate of complaint risk than some other specialists, and certainly more than GPs.

Additionally, a UK study (BMJ Quality & Safety 2013) indicated that older doctors, closer to retirement, are six times more likely to have a complaint to authorities in relation to poor performance than younger doctors. The UK study reviewed the profile of over 6,100 doctors over an eight year period who had been referred to the National Clinical Assessment Service, which assists poorly performing doctors.

Of the various characteristics of the doctors reviewed, doctors in the 55 years of age and over grouping had 12 referrals to the NCAS for every 1000 doctors, compared with two referrals per 1000 doctors for those aged below 35 years. The study was said to give support to the UK proposals for revalidation of doctors' skills and experience, as contemplated by UK authorities. It is interesting to note that the Medical Board of Australia is currently carrying out an exploration and consultation with the profession generally in relation to the potential for revalidation requirements in Australia.

While the research does not identify in detail the particular reasons why complaints may be more likely to be made in respect of older doctors, the research suggests that older doctors should consider taking steps to ensure that their practice remains current and contemporary, and that they particularly are abreast of current cultural and community expectations.

The RACS Senior Surgeons Group has issued guidelines for senior surgeons, which address issues such as:

- Surgeons remaining aware of their health, and ensuring that they are not impaired in any way in respect of the high levels of practice expected of them. It is recommended that senior surgeons should consider an annual health check, relevant to the nature of their work and practice. In particular, an ophthalmic assessment should be considered.
- Senior surgeons, as much as their younger colleagues, should maintain appropriate CPD and ensure that they are aware of contemporary research, techniques and practice requirements. Peer review and a review of log books and audit of outcomes is recommended, to ensure that there has been no deterioration in relation to the standards of surgery for the older surgeon. Obviously, participation in the RACS Audit of Surgical Mortality can assist.

It is hoped that senior surgeons will reflect upon their capacity and enable appropriate arrangements to be put in place in respect of their practice, as they approach retirement.

This research does not say that surgeons with insight, as they become older, necessarily are impaired or do not provide the appropriate standard of care and treatment for patients. The research does, however, indicate that some surgeons, as they age, are at greater risk of complaint – indicating that some senior surgeons may not remain contemporary, both in terms of care and treatment as well as the manner in which they deal with their patients.

The research provides food for thought.

From the provinces …

A column from New Zealand

MIKE KLAASSEN
NZ FELLOW

Research by B Adams et al in 2013 warned that provincial NZ would be further starved of basic plastic surgery services, without changes to the NZ plastic surgery workforce.

In 2012, I made a decision to commit 50 per cent of my career to the Eastern Bay of Plenty and base my private practice in the township of Whakatane. Serendipitously this has proved to be a revelation, personally and professionally.

The Bay of Plenty is true to its name. More than 50,000 people live in this most eastern corner of New Zealand's north island, facing north and bordering the spectacular Pacific Ocean. In a multi-disciplinary surgical clinic, juxtaposed to and integrated with a large provincial primary care practice of several doctors and nurses, many different surgical services are on offer. These include: plastic and reconstructive surgery, cosmetic surgery, hand and orthopaedic surgery, general surgery, gynaecology, ENT and urology.

The referral caseload has presented me personally with some of the most interesting and challenging plastic surgery cases of my more-than-25 year career! Educational and training opportunities abound in this provincial setting.

Reference:
Adams BM, Klaassen MF and Tan ST. The future of the New Zealand plastic surgery workforce. *NZMJ* Vol 126 (1372), 5 Apr 2013

RACS Grant Program for Visitors in 2016

The College is committed to excellence in surgical education and practice and recognises that Fellows within sub-specialties and other groups wish to enhance their conferences (non-College) by inviting scientific visitors of note from Australia, New Zealand and internationally. The College is supporting these initiatives through the RACS Visitors Grant Program.

Eligible groups are invited to apply for funding to cover the cost of travel, accommodation and registration for visitor(s) for non-College meetings in 2016.

The closing date for applications for meetings in 2016 is **28 February** 2015.

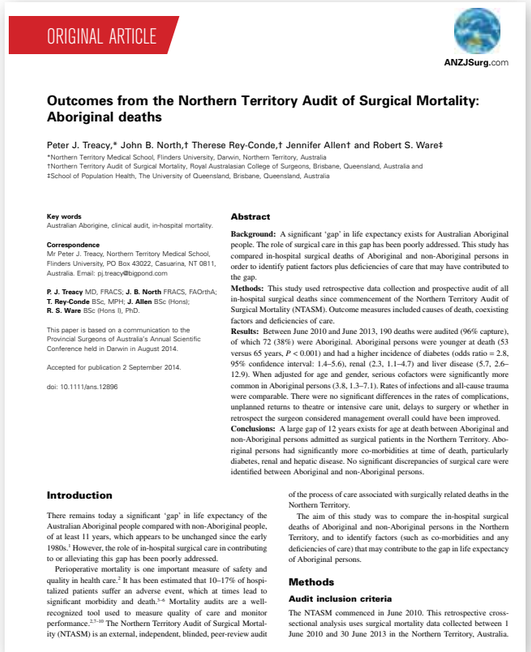
For more information please go to: http://www.surgeons.org/member-services/racs-visitor-program/
Or contact Philip Vita, Manager, Fellowship Services on +61 3 9249 1105.

RESEARCH FROM THE COLLEGE

Outcomes form the Northern Territory Audit of Surgical Mortality: Aboriginal deaths,

PJ Treacy, JB North, T Rey-Conde, J Allen, and RS Ware (2014)

ANZ Journal of Surgery doi: 10.1111/ans.12896 (PMID: 25365927)



ORIGINAL ARTICLE

ANZJSurg.com

Outcomes from the Northern Territory Audit of Surgical Mortality: Aboriginal deaths

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Key words
Australian Aborigine, clinical audit, in-hospital mortality.

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This paper is based on a communication to the Provincial Surgeons of Australia's Annual Scientific Conference held in Darwin in August 2014.

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doi: 10.1111/ans.12896

Abstract

Background: A significant 'gap' in life expectancy exists for Australian Aboriginal people. The role of surgical care in this gap has been poorly addressed. This study has compared in-hospital surgical deaths of Aboriginal and non-Aboriginal persons in order to identify patient factors plus deficiencies of care that may have contributed to the gap.

Methods: This study used retrospective data collection and prospective audit of all in-hospital surgical deaths since commencement of the Northern Territory Audit of Surgical Mortality (NTASM). Outcome measures included causes of death, coexisting factors and deficiencies of care.

Results: Between June 2010 and June 2013, 190 deaths were audited (96% capture), of which 72 (38%) were Aboriginal. Aboriginal persons were younger at death (53 versus 65 years, $P < 0.001$) and had a higher incidence of diabetes (odds ratio = 2.8, 95% confidence interval: 1.4–5.6), renal (2.3, 1.1–4.7) and liver disease (5.7, 2.6–12.9). When adjusted for age and gender, serious cofactors were significantly more common in Aboriginal persons (3.8, 1.3–7.1). Rates of infections and all-cause trauma were comparable. There were no significant differences in the rates of complications, unplanned returns to theatre or intensive care unit, delays to surgery or whether in retrospect the surgeon considered management overall could have been improved.

Conclusions: A large gap of 12 years exists for age at death between Aboriginal and non-Aboriginal persons admitted as surgical patients in the Northern Territory. Aboriginal persons had significantly more co-morbidities at time of death, particularly diabetes, renal and hepatic disease. No significant discrepancies of surgical care were identified between Aboriginal and non-Aboriginal persons.

Introduction

There remains today a significant 'gap' in life expectancy of the Australian Aboriginal people compared with non-Aboriginal people, of at least 11 years, which appears to be unchanged since the early 1980s.[1] However, the role of in-hospital surgical care in contributing to or alleviating this gap has been poorly addressed.

Perioperative mortality is one important measure of safety and quality in health care.[2] It has been estimated that 10–17% of hospitalized patients suffer an adverse event, which at times lead to significant morbidity and death.[3,4] Mortality audits are a well-recognized tool used to measure quality of care and monitor performance.[2,5–10] The Northern Territory Audit of Surgical Mortality (NTASM) is an external, independent, blinded, peer-review audit of the process of care associated with surgically related deaths in the Northern Territory.

The aim of this study was to compare the in-hospital surgical deaths of Aboriginal and non-Aboriginal persons in the Northern Territory, and to identify factors (such as co-morbidities and any deficiencies of care) that may contribute to the gap in life expectancy of Aboriginal persons.

Methods

Audit inclusion criteria

The NTASM commenced in June 2010. This retrospective cross-sectional analysis uses surgical mortality data collected between 1 June 2010 and 30 June 2013 in the Northern Territory, Australia.

Educational and health impact of the Baume Report: 'A Cutting Edge: Australia's Surgical Workforce'.

Hillis DJ, Gorton MW, Barraclough BH, and Beckett D.

Australian Health Review, 2014, 38, 487-494 (PMID: 25283509)

Lessons learned from national surgical audits.

Raju RS, Maddern GJ.

British Journal of Surgery. 2014;101(12):1485-7. (PMID: 25223480)

Leading article

Lessons learned from national surgical audits

R. S. Raju and G. J. Maddern

University of Adelaide, Discipline of Surgery, The Queen Elizabeth Hospital, Woodville, South Australia 5011, and Australian Safety and Efficacy Register of New Interventional Procedures-Surgical (ASERNIP-S), Royal Australasian College of Surgeons, Adelaide, South Australia 5006, Australia (e-mail: guy.maddern@adelaide.edu.au)

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Audits are an important part of a surgeon's life. Log book audits, mortality and morbidity meetings, chart audits, hospital death reviews, resource utilization audits and assessments of cost-effectiveness are all regular features of the surgeon's workload. Specialist surgical societies often have their own audits, and many surgeons participate in outcome audits of specific interventions, operations or diagnoses[1]. Audits are popular because of their multiple functions relating to surgical education, patient safety, comparison of outcomes, risk management, economic stewardship and evaluation of healthcare systems. Each audit, however, takes time away from the surgeon's clinical duties, and if an audit is to be introduced, particularly at a national level, benefit for the time, effort and cost of such large-scale data collection needs to be demonstrated.

National audits aimed at improving quality have been introduced into the USA, as in the American College of Surgeons National Surgical Quality Improvement Program (ACSNSQIP®) process adopted by many centres[2,3]. Although this enables comparisons between and within centres, it continues to fall well short of universal coverage. Similar efforts in the UK resulted in the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) initiative[4]. Both initiatives have led to improved clinical outcomes (reduction in complication[5], morbidity[5] and mortality[6] rates, and improved quality of care[5]) at participating institutions.

In Australia, a number of national audits have proven to be of significant value, despite the effort and cost associated with them. The Australian and New Zealand Audit of Surgical Mortality (ANZASM)[7] was modelled on the Scottish Audit of Surgical Mortality. It began in Western Australia in 2001, and over the following 9 years was extended to cover all of Australia. The basic premise of the national audit was peer review of every in-hospital death of patients in whose care a surgeon was significantly involved[8]. Feedback was provided to the treating surgeon on alternative ways of managing patients. De-identified patient summaries are published annually as an educational tool, with seminars and other educational activities based on issues identified. The audit provides aggregated data to State Departments of Health, and trends can be evaluated and analysed as well as variances investigated at a national level.

An important feature in the acceptance of the audit by surgeons was that patient data provided by the views of participants and reviewers were privileged and protected legally. Surgeons feel safe in disclosing patient details with the understanding that their reports will not be used against them. Assessors have been able to express their views honestly, knowing that they will not indirectly harm the surgeon being assessed. Even before participation became mandatory, more than two-thirds of surgeons had signed up for the audit, but the requirement of compliance in order to maintain a medical licence within Australia helped encourage the recalcitrant.

The Australian Orthopaedic Association established a National Joint Replacement Registry Audit funded through the Australian Government at approximately €1.4 million (AUD $2 million; exchange rate 31 August 2014) per year. This was based on the pioneering Swedish audit of joint replacement[9,10], adopted in both the USA[11] and the UK[12]. Such oversight of new technology and production is vital within all jurisdictions. Factors that influence the success of a device or procedure depend not only on the technology itself but also on the context into which it is placed, including factors such as the available medical infrastructure and associated training and skills sets[13].

This data collection monitors all joint replacements being put in or removed from patients within the Australian healthcare system[14]. Although participation is voluntary, more than 99 per cent of all procedures have been captured, with the publication of an annual report providing detailed information on the performance of various prosthetic devices. This information has been used to identify the poorly performing artificial surface replacement metal-on-metal hip joint, initially largely ignored by industry. This ongoing audit, with the high participation rate of orthopaedic surgeons at a national level, is now being used by hospitals, consumers and regulatory authorities to provide objective quality feedback on devices being implanted in patients by orthopaedic surgeons.

Educational and health impact of the Baume Report: '*A Cutting Edge: Australia*'s *Surgical Workforce*'

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Bruce H. Barraclough AO[3] MBBS, DDU, HonDSc, FRACS, FACS, FRCSEng(Hon), Emeritus Professor
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Abstract

Objectives. The Baume Report (1994) on Australia's surgical workforce had the potential to impact upon the health and educational sectors. This paper analyses the recommendations of this report and their impact at the time and 15 years later (2009).

Methods. A questionnaire-based study was performed with the 18 senior Fellows and the Royal Australasian College of Surgeons (RACS) solicitor who had been instrumental in facilitating responses to the review.

Results. The 19 respondents were asked to evaluate 22 areas from the Baume Report. The most highly ranked areas identified as being reasonable in 1994 were: additional funding being made available for more training positions, identifying workforce deficits, moving towards compulsory continuing professional development and having evidence of competence before introducing new technology. In 2009, the most highly ranked areas were: funding for more training positions; compulsory continuing professional development, involving the profession in improvements and broadening the training environment beyond public hospitals. Areas considered to be substantially addressed were: the selection process and encouragement of diversity, workforce numbers and deficits, confirming the educational merit of the training program and the role of professional colleges.

Conclusions. The Baume Report highlighted many issues including workforce planning, the role of professional organisations in society and the complex interface between health and education. Issues of ongoing standards through a surgical career, access for patients to surgical services, funding for more training posts to provide the appropriate workforce level and distribution, and the assessment and introduction of technology remain priorities. Time has not diminished the relevance of these issues.

What is known about this topic? The impact of key government reviews can always be substantial. The Baume Report was directed to postgraduate specialist medical training, particularly surgical training. There have been substantial changes in the health and educational sectors since the report, with significantly more regulation and transparency.

What does this paper add? Analysis of the Baume Report after 15 years by the senior office bearers of the RACS who were actively involved in handling and implementing many of the recommendations provides an insight into the dynamics of specialist training. It outlines the significant changes that have occurred and the things that still need to be done.

What are the implications for practitioners? Professional bodies have an influential presence across society. They are particularly focused on the standards required to become a practitioner of that profession and the ongoing maintenance of these standards. However, this comes with responsibility for and accountability to society and the community. External reviews, particularly with a political imperative, change both the dynamics and key relationships, issues that the professional bodies must commit to addressing in a positive manner.

Additional keywords: accreditation, education, medical colleges, surgeons, workforce planning.

ASERNIP-S continues to have a positive impact on healthcare

Providing research for peer publication on new techniques

GUY MADDERN
DIRECTOR, ASERNIP-S

In 2014 ASERNIP-S maintained and extended the group's profile by producing high quality peer-reviewed publications. Additionally, fit-for-purpose services were provided to stakeholders to identify and summarise clinical evidence to inform healthcare policy decision making.

ASERNIP-S is part of the Research, Audit and Academic Surgery Division of the College. Directed by Associate Professor Wendy Babidge and I, our team currently employs 13 experienced researchers with diverse qualifications in biomedical science, chemistry, public health, health technology assessment (HTA), biostatistics and medicine.

The primary goal of ASERNIP-S is to provide high quality, timely assessments of new and established surgical technologies and techniques. In achieving this aim, we are involved in a broad range of projects, including:

- full and rapid systematic reviews of peer-reviewed literature
- the facilitation of clinical audits, the assessment of new and emerging techniques and technologies through horizon scanning
- input into the production of guidelines

The majority of work conducted by ASERNIP-S is contracted by external stakeholders. The breadth of work conducted by ASERNIP-S speaks to the strengths and diversity within our research team. Most recently, ASERNIP-S has successfully completed work for:

- Medical Services Advisory Committee (MSAC), Commonwealth Department of Health
- Health Policy Advisory Committee on Technology (HealthPACT)
- American College of Surgeons
- Department of Health, Victoria
- Therapeutic Goods Administration, Commonwealth Department of Health
- World Health Organisation

This work frequently generates results that would benefit not only the requestor, but the healthcare sector more widely. As a consequence, much of this information is published in peer-reviewed journals. ASERNIP-S has a long and successful history of producing manuscripts for publication. Since 1997, ASERNIP-S has published 114 peer-reviewed journal articles, and in 2014, 11 peer reviewed articles were accepted for publication, three more than in 2013.

These more recent articles were published in journals including the British Journal of Surgery, the Annals of Surgery, the Journal of Surgical Education and the Medical Journal of Australia. A few examples of the topics covered last year are hyperbaric oxygen therapy, autologous fat transfer, and pedagoical approaches for simulation-based education. The diversity of topics covered and the journals publishing these manuscripts demonstrate the range of expertise and the high-quality written communication skills of the ASERNIP-S research staff.

The importance of ASERNIP-S publications is demonstrated in their impact within the scientific community. In 2014 our work was cited 325 times, bringing the total number of ASERNIP-S citations to 3,706. Although this is

only one measure of success it does demonstrate the acceptance and benefit of these articles. In future Surgical News articles we will be exploring other, more specific measures identifying the relevancy of our published work.

ASERNIP-S staff will continue to write, and publish, manuscripts on a variety of topics that will be of importance and interest to the surgical community. Increasingly we at ASERNIP-S will be utilising the College's various social media platforms to notify readers of our publications and other activities as they take place. We are excited about the manuscripts we have under development and look forward to their publication – and your feedback.

More information on the work conducted by ASERNIP-S can be found at: www.surgeons.org/asernip-s and through the College's Twitter feed (@RACSurgeons) and Facebook account.

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

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

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

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

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

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

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

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

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

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

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

Tenure: 3 - 12 months

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

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

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

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

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

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

Tenure: 3 - 12 months

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

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

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

2016 Rowan Nicks United Kingdom and Republic of Ireland Fellowship

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

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

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

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

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

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

Tenure: 3 - 12 months

NEW GRANT AVAILABLE

New funding means more support for small projects

IAN BENNETT
CHAIR, SCHOLARSHIPS

The College's Research and Scholarships Department is pleased to advise that applications for scholarships in 2016 open March of this year.

I am delighted to announce that last October Council approved the establishment of a newly crafted versatile grant that will be offered this year for the first time in the scholarship program to assist with the funding of equipment purchases or small research costs.

The Foundation for Surgery Small Project Grant is intended to support Trainees and Fellows who are undertaking or wish to undertake a small clinical research project or who require limited funding to purchase equipment to carry out a research endeavour. The funds might also be used to top up or to complete an existing project. Up to six grants will be made available each year. Each grant will be up to the value of $10,000.

The grant will be paid directly to the recipient (with institutional supervisor approval) and scholars may hold this grant in conjunction with another scholarship.

Details of all 2016 scholarships including application and eligibility requirements will be included in the March edition of Surgical News and on the College website www.surgeons.org

I look forward to the interest that the Foundation for Surgery Small Project Grant will undoubtedly generate.

A QUANTUM LEAP

from Charleville to the Mayo Clinic - The Vickers Legacy

Opus XXXVI

FELIX BEHAN
VICTORIAN FELLOW

This may seem a somewhat bizarre title for a surgical anecdote, but wait and see and all will be revealed in this excursional adventure. The genesis of this encompasses tales of the Outback and attitudes of mind where intuition may lead ultimately to innovation embracing the concept of 'necessity is the mother of invention'. I did not know the origin of this quote, but I found out that it was Plato who first enunciated such ideas, presumably when walking with Socrates in the vicinity of the Lyceum during the Third Republic, debating and teaching all and sundry. His concepts have stood the test of time, dying in 347BC.

I recently attended the 50th reunion of my graduation year at the University of Queensland and was invited to discuss my surgical experiences around the world. Interestingly on speaking to David Vickers beforehand he touched on his story from Charleville to the Mayo Clinic. His father, Allan Vickers OBE CMG, established the Royal Flying Doctor Service in 1943 at Charleville. He was a person with an inventive mind and an aptitude for solving problems. At Christmas he would say, "If you can't make it, you can't have it." In a true Hippocratic manner he also said, "No one in the outback should be deprived of medical attention." And yet he died so tragically. It is quite ironic that, as ship's surgeon, three days out of Cape Town, he died of a treatable medical problem without medical assistance.

The story of the Royal Flying Doctor Service really needs no amplification. But there are some, like me, who were not aware of its interesting past. The Reverend John Flynn established in 1912 the Australian Inland Mission (AIM) under the patronage of the Presbyterian Church. In 'Burke and Wills' style, he traversed the Outback attending to the local inhabitants of any colour, creed or credentials, covering spiritual, medical or social need. Incidentally Flynn was the one who campaigned for an aerial support service in Cloncurry and Dr Vickers Snr there joined the Flying Doctor Service in 1931 and was instrumental in its organisation over 36 years - a lifetime dedication.

The fledgling QANTAS under Hudson Fysh, whose inaugural flight went from Winton to Longreach, needed some financial help. This came from the Royal Flying Doctor Service. They used a single-engine fabric-biplane, of kite box design, called Victory, leased from QANTAS at two shillings per hour to serve the Outback. Communications were by pedal radio. That initial flight using a de Havilland plane flew in 1931 from Cloncurry to Julia Creek airstrip.

The next phase in this overview, really an apercu of the Flying Doctor Service, relates to my own experience. I was sent to Julia Creek in 1966 from the Royal Brisbane Hospital to do a locum at the hospital there to relieve my colleague Errol Maguire for his holiday break (Errol subsequently became a surgical academic and served years on the College Council). On one occasion the then Flying Doctor, Tim O'Leary, flew in for a Sunday morning barbecue and the cooling system for the stubbies, an outback characteristic, was to submerge them in the local creek.

But the most important item during my time there was that one of the local inhabitants had died. He had been lying in an artesian bore outside the township for 24 hours in stifling heat over 100°F. I was obliged to do my first port-mortem with the hospital matron as an assistant. I was talked through the procedure by the Department of Pathology at the Royal Brisbane Hospital on that Sunday morning (yes, it got me out of going to church) and indelibly arriere pensee etched a lesson on my mind – stick to living tissue!

I came upon a 'feel good story' relating to outback flying in The Age recently. It was written by Tony Wright about the inaugural KLM International Flight to Australia in the early 1930s. The plane refuelled in Darwin with a disparate load of international guests. It was flying over western NSW on the way to Wagga. It became lost. With darkness approaching and clouds encroaching, the outlook was ominous. An SOS was relayed to Wagga where a night time emergency landing plan was actioned with approximately 20 cars lining either side of the runway with their headlights on full beam. Thankfully the plane landed successfully and as David observed, it was a practice sometimes used by the Royal Flying Doctor Service in any night time emergency situation.

> "... but most importantly one can see Sister Garlick's body chart outline of 1951"

Reproduction of AUS $20

To conclude the story of the Flying Doctor Service let me tell you of my recent late awakening (the opsimath factor is surfacing again) regarding a $20 note, which I had never closely inspected before except to verify its fiduciary value.

As you can see from the illustration it shows Flynn's camels from the Inland Mission, the de Havilland cotton fabric, wooden aircraft, the pedal radio that produced so much crackle and static, but most importantly one can see Sister Garlick's body chart outline of 1951. She designed this simple grid pattern to specify complaints so the uninitiated could ▸

“... and Australia without even a Science Minister among the denizens in Canberra we may well fade into oblivion”

communicate across the airwaves. (Would a clock face pattern have been simpler?) Interestingly, David could recall the contents of the outback drug cupboards were individually numbered to identify specific medications for emergency needs.

Now Michael Long, a long term Board Member of the RFDS until 2007 deserves a mention. He was the recipient of the 2008 John Flynn Fellowship and was my surgical mentor in Head and Neck Surgery at PANCH in the 1970s. He took me through my first block dissection of the neck and introduced me to his refined surgical technique using a no. 15 blade for nodal clearance, as Don Marshall also did.

On another perspective he introduced me to a practical trick – I saw him put his wallet into his sock in the VPSU change room. On asking why, Michael amusingly said, “Felix, it is a navy trick, you will always walk away with your cash, avoiding any retrieval from the hospital laundry chute.” His head and neck expertise was renowned in Melbourne. I still remember the presentation he gave in the Maurice Ewing Lecture Hall in the RMH Department of Surgery in the ’70s. Everyone was in awe of what he brought back from the Bakamjian’s Unit at Roswell Park, popularising the use of the Delto-pectoral flap. But his flying expertise matched his surgical style, delivering aircraft to and from America, often with many a VPSU consultant on board.

Innovation equates to higher living standards

Now back to David’s Hand Surgery career. He had an aptitude for instrument design with more than 20 individual pieces, some patented and still in use today, particularly the microsurgical instruments. David received the British Design Council Award for Excellence in Design, presented by the Duke of Edinburgh. The set of micro instruments he gave me in their original box will soon be part of the College museum collection. The story of patents is an interesting sideline and, let’s not forget, Einstein worked in the patents office in Switzerland where in his spare time, he helped formulate Quantum Theory of Mathematics and the Theory of Relativity. I hope David puts these patent stories in print in the future.

In the Fairfax press recently the Office of the Chief Scientist has highlighted Australia’s lacklustre position in the global (atmos)sphere, quoting Professor Chubb. One reads that Australia’s research and development has fallen to a 30 year low whereas the number of international patents has increased by 1000 per cent in China and 300 per cent in Japan – and Australia without even a Science Minister among the denizens in Canberra we may well fade into oblivion, even Churchill had a scientist at his elbow (Enigma Code). What would my contact, Barry Jones, say?

The next important item of interest relates to David’s discovery of the embryological basis of the Madelung Deformity and the international scientific community have labelled this aetiological link, the Vickers Ligament.

The original publication of the Madelung Deformity publication of 1878 – ‘Die spontane Subluxation der Hand nach Vorne. Gesellschaft fur Chirugie, Berlin 1878?

Madelung Deformity is a premature fusion of the volar/ulna aspect of the distal radius allowing the ulna to develop with sublaxation into dorsal prominence with the lunate lying deeply between the radius and the ulna. David having explored the area of the epiphysial growth plate, he found this ligamentous attachment between lunate and the distal radius with premature fusion causing the Madelung Deformity.

He presented these findings at the Mayo Clinic as their Visiting Professor, which led to subsequent invitations to write textbook chapters on wrist and finger deformities for the international Mayo publications. The edicts of the Mayo Clinic embrace three principles. One: what is the best for the patient; two: done by the best available surgeons; three: using the most modern surgical advancements. David’s contribution admirably fulfils these prerequisites. It is a fitting conclusion that such surgical developments and scientific refinements reflect an intuitive mind, a mirror of his family background, including his brother, Robert, a retired General Surgeon in Toowoomba.

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