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WORKSHOPS & ACTIVITIES

Online registration form is available now (login required).

Inside 'Active Learning with Your Peers 2016' booklet are professional development activities enabling you to acquire new skills and knowledge and reflect on how to apply them in today's dynamic world.



Supervisors and Trainers for SET (SAT SET)

22 February 2016 – Sydney, NSW

8 March 2016 – Melbourne, VIC

23 April 2016 – Melbourne, VIC

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

Foundation Skills for Surgical Educators

23 February 2016 – Sydney, NSW

22 April 2016 – Melbourne, VIC

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

This free one day course will provide an opportunity for participants to reflect on 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 in teaching and learning concepts and look at how these principles can be applied into participants own teaching context.

Communication Skills for Cancer Clinicians: Breaking Bad News

27 February 2016 – Melbourne, VIC

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.

Surgical Teachers Course

10 to 12 March 2016 - Gold Coast, QLD

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

International Medical Symposium

11 March 2016 – Sydney, NSW

The Royal Australasian College of Physicians (RACP), the Royal College of Physicians and Surgeons of Canada (RCPSC) and the Royal Australasian College of Surgeons (RACS) in association with the Royal Australian & New Zealand College of Psychiatrists (RANZCP) and the Australian & New Zealand College of Anaesthetists (ANZCA) are pleased to host the 2016 International Medical Symposium: Future Challenges for the Medical Profession.

Non-Technical Skills for Surgeons (NOTSS)

18 March 2016 – Sydney, NSW

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

Clinical Decision Making

21 March 2016 – Melbourne, VIC

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



Keeping Trainees on Track (KTOT)

23 April 2016 – Melbourne, VIC

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

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

Process Communication (PCM) – Part 1

22 to 24 April – Sydney, NSW

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 communication types; each person uses a combination of these types but usually one is dominant.



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Feb 2016 - April 2016

NSW

22 February 2016

SAT SET Course, Sydney

23 February 2016

Foundation Skills for Surgical Educators, Sydney

18 March 2016

Non-Technical Skills for Surgeons, Sydney

22-24 April 2016

Process Communication Model: Seminar 1, Sydney

QLD

10-12 March 2016

Surgical Teachers Course, Gold Coast

29 April - 1 March 2016

Younger Fellows Forum (YFF), Canungra QLD

VIC

27 February 2016

Communication skills for Cancer Clinicians: Breaking Bad News, Melbourne

8 March 2016

SAT SET Course, Melbourne

21 March 2016

Clinical Decision Making, Melbourne

22 April 2016

Foundation Skills for Surgical Educators, Melbourne

23 April 2016

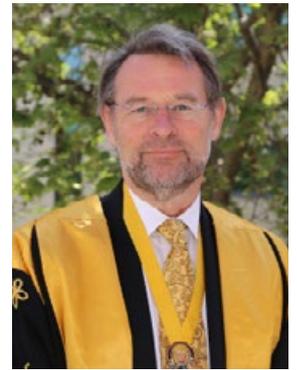
Keeping Trainees on Track, Melbourne

23 April 2016

SAT SET Course, Melbourne

VALUE

The health outcomes achieved per dollar spent



DAVID WATTERS
President

“Nowadays people know the price of everything and the value of nothing” - Oscar Wilde

Towards the end of 2015 the Australian system was being reviewed ‘top to bottom’ amidst ongoing global concerns about the increasing costs of health care, its style of delivery and the ongoing perennial question of ‘are we doing the right thing at the right time and in the right place?’ Similar activities were underway in New Zealand. Simultaneously there are now substantial reports about investigations, treatments and procedures performed which show significant variation as far as access and delivery is concerned. In all these reviews it is really important that as clinicians we contribute fully so we do not fall victim to the adage of Oscar Wilde. As cost and volumes can be quantified so widely and readily it will be critical that the value that the surgical profession delivers is clearly seen.

That is the key reason for the increased involvement of RACS in the numerous reviews being undertaken and the decision to more proactively be involved in all work around clinical variation. We need to have a clear understanding of the value of surgery. As the ongoing debate around sustainability in health care occurs, surgery should not and must not become victim to the economic rationalists’ viewpoint. However, it also comes with an obligation to be positively engaged and be professionally focused.

As a profession the words of John D. Rockefeller are particularly important ‘every right implies a responsibility; every opportunity an obligation; every possession a duty.’ It is critical that we advocate for the role and importance of surgery and surgical leadership. However it is also most important that the members of our profession understand the obligations. Consequently RACS has become more involved around

the issues relating to fees. As President I am disturbed about reported financial practices such as excessive fees, extortionate fees, undocumented fees, fee splitting and extraction of fees from other members of the surgical team. These are improper and RACS has already stated that they are in breach of the Code of Conduct. Our revised policy about breaches will lead to more appropriate censure of individuals when they do not maintain appropriate professional standards. Our professional standing and reputation has taken decades and even centuries to establish. We will not allow the momentary action by a few to tarnish it.

RACS will be updating and reviewing our strategic plan over the coming twelve months. It is timely and important. Over the past 5 years issues of professionalism have become substantially more profiled within the health sector and in the community more broadly. Cultural attitudes must change and RACS is committed to being at the forefront of that. Equally issues of variation are now more clearly understood with the impact of variation on clinical quality needing strong involvement and leadership from the profession. Again RACS is committed to being at the forefront of this discussion and debate.

As we consider our strategic discussion and words of price and value are interspersed with directional statements, it will be important to reflect on words by some of our communities’ luminaries. The first is Warren Buffet, the investment guru who clearly states that ‘Price is what you pay. Value is what you get’. Do we know the value of what we are delivering and how do we advocate for it? The other luminary is Albert Einstein who stated ‘Strive not to be a success, but rather to be of value’. It brings a subtle but incredibly important perspective to all our discussions.

I look forward to seeing many of you in 2016.

RACS Support Program

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

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

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

How to contact Converge International:

- Telephone 1300 687 327 in Australia or 0800 666 367 in New Zealand
- Email eap@convergeintl.com.au
- Identify yourself as a Fellow, Trainee or IMG of RACS
- Appointments are available from 8.30am to 6.00pm Monday to Friday (excluding public holidays)
- 24/7 Emergency telephone counselling is available.



Foundation for Surgery

Passion. Skill. Legacy.



This year, Tour de Cure is celebrating their 10th Anniversary with a Signature Ride from Brisbane to Sydney commencing Friday 29 April. Support them by joining the 10, two or three day rides, volunteering or donating.

A significant portion of the funds raised through this event go to the Foundation for Surgery's Tour de Cure Cancer Research Scholarship. This Scholarship is in its third year and aims to find a cure for cancer.

To find out more go to RACS Foundation for Surgery www.surgeons.org/foundation Tour de Cure Research Scholarship and www.tourdecure.com.au

2016

The year of collaboration



GRAEME CAMPBELL
Vice President

We often use the expression “it’s a small world.” In today’s age of globalisation, innovation and digital communication, I think we can all relate to this saying. As I am writing this article, China’s government is realising their efforts to contain a local disaster on their stock market is having huge ramifications on the global markets that they did not expect. Our impact as individuals and organisations seems to be more broadly felt these days. The ease at which collaborations can take place in this digital age is amazing. Yet the importance of nurturing relationships and creating partnerships through careful and deliberate actions cannot be underestimated.

As we commence 2016, it is important to consider the value of relationships for RACS. We face many challenges in the year ahead that we cannot tackle alone. Likewise, local and global organisations reach out to RACS in order to have us as a collaborator in endeavours they are spear-heading.

One of our collaborators I wish to acknowledge is Tour de Cure. Their year-end gift to the Foundation for Surgery of \$400,000 towards the Tour de Cure Cancer Research Scholarship is greatly appreciated. This collaboration began in 2013 with both organisations pledging funding to build a \$1.5 million corpus for cancer research. Thanks to the generosity and hard work of Tour de Cure, we are well on the way to reaching this target in the next few years. The scholarship is already funding promising research, with the third annual research scholarship just being awarded for 2016.

2016 will also see us reach out to hospitals and healthcare networks to formally unify our efforts to tackle discrimination, bullying and sexual harassment. We have already commenced meaningful dialogue with some hospitals including Monash Health and St Vincent’s Health Australia. As outlined in the RACS Action Plan: Building Respect, Improving Patient Safety, collectively we need to ensure provision of appropriate education, mechanisms for feedback, appropriate management of complaints, and remediation and support for surgeons.

I would like to acknowledge our Regional Chairs who maintain strong and effective relationships with their Health Ministers. RACS would not have a face or a voice with government without the continual interface of the Regional Chairs supported by their Regional Managers and other

RACS staff. Through these relationships, we have been able to influence change and provide expert advice to the formulation of government policy.

In 2015, we responded to over 35 government consultations, met with health ministers or staff over 90 times, and testified at two senate select committee hearings. We have advocated on various issues including surgical standards, alcohol related harm, end of life care, domestic violence and sustainability of healthcare. Further mileage is gained on advocacy issues through careful profiling in social media and through media releases. The ‘web of collaboration’ available through social media is remarkably effective and I would encourage you to follow the College on Twitter.

A key collaboration this year will be representation on the various clinical committees involved in the Medicare Benefits Schedule (MBS) Review in Australia. The President and I have spoken with Professor Bruce Robinson who is heading up the review and RACS has been invited to nominate specialists for these committees. I am pleased to be able to represent RACS on the General Surgery Clinical Committee and I trust the other surgeons on the committees will make the best use of these collaborations for the betterment of our health system.

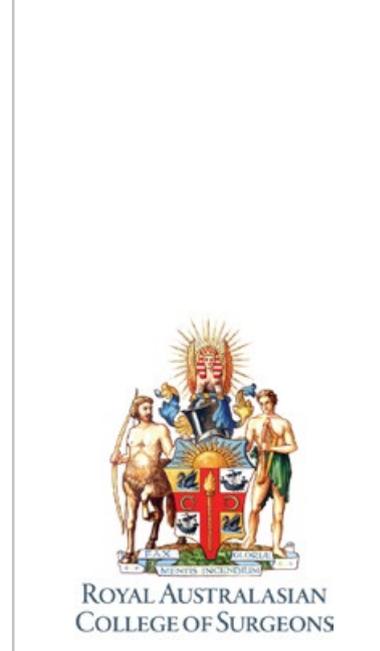
Lastly, I would encourage you to look after yourself this year so you can maintain healthy workplace and personal relationships. We all have the feeling of being overwhelmed from time to time, or we may be facing critical issues in our personal or professional life. We are not immune to depression, anxiety and stress. If you or a colleague are in need of confidential counselling or coaching, please use the RACS Support Program. This service provided by Converge International enables you to access up to four sessions per year for in-person, telephone or video-link counselling.

Call 1300 687 327 (Australia) or 0800 666 367 (NZ).

I wish you every success for 2016 and encourage your involvement in your College.



College Advocacy



Social Media Surgery

#AskAFellow - Why should I use Social Media?

You've probably been told that you should 'be on social media' at least once – but what does that mean, and why should you bother? Three RACS Fellows who have made a splash in the world of social media share their experience. In part 1, Dr Nikki Stamp explains.

Dr Nikki Stamp FRACS @DrNikkiStamp

When did you start using social media for professional purposes?

I only got involved with Twitter, purely in a professional capacity, in 2015. I have had some experience with the incredible utility of social media in medical education with the Life in the Fast Lane blog, which promotes free online medical education for emergency medicine. I have heard their authors many times tell me social media is a great way of getting information and joining with like-minded people around the globe.

What is your favourite social media platform and why?

I use Twitter predominantly for work purposes. It is really easy to use and get a huge amount of information, depending on who (or what) you follow. For instance, most journals have social media accounts and they push out important and interesting articles. Other people in your field also use it the same way, so it's a very effective way of sharing information.

I've also met many surgeons from around the globe and chatted with them about clinical and non-clinical issues. For instance, I have participated in Tweet chats on surgical topics a few times. This is where you 'meet' online at an agreed time and discuss usually around four questions over an hour on a topic. It's been tremendously educational and creates wonderful networking opportunities to promote education internationally.

What have been the biggest benefits of being active on social media?

The education side of things is excellent and very effective. However, I think the chance of 'meeting' people with whom you share a common interest is wonderful. For example, I have spoken to many other cardiac surgeons about clinical interests. It has also allowed mentoring opportunities, through online campaigns such as #ILookLikeASurgeon, designed to encourage women into surgery.

There are also numerous accounts on all social media platforms that are just great entertainment or interesting and have nothing to do with medicine. It's an amazingly diverse and rich world out there.

Why would you recommend that other surgeons get involved?

I think it's a little daunting at first joining social media in a professional capacity. It's something that we are rightly cautious about in order not to behave unethically or expose yourself based on something you have said online. However, done right, it's a great educational and networking resource. It also allows you to control what information you put out into the online world. Social media is an incredibly powerful tool nowadays and I think it's important to use it to be as connected as possible in a world that is moving very fast.

Have some feedback or ideas for future columns? Send us a tweet at @RACSSurgeons and let us know.

SURGICAL SNIPS



Violence sparks urgency

Queensland surgeons called for urgent action from parliamentarians in response to the recent spate of deaths from alcohol-related violence.

The call echoes those growing for the issue to be addressed in a report to be delivered in February.

Queensland Regional Chair Professor Owen Ung said that changed laws in Sydney resulted in a reduction in injuries.

“We need effective statesmanship and a bipartisan approach free from undue liquor industry self-interest and interference,” Professor Ung said.

AAP, 15 January



Territory recognition

Doctor Ollapallil Jacob has been lauded for helping shape policy and making Alice Springs a safer place to live.

In response to his receipt of the RACS Indigenous Health Medal, Dr Jacob has said that the number of stab injuries, interpersonal harm and alcohol related acute pancreatitis has all come down in his time in the red centre.

Humble about the difference he has made, Dr Jacob praised police and hospital staff for their efforts.

“Surgery needs good team work, it cannot be done by just one or two surgeons, it is a lot of people,” he said.

NT News, 8 December



Quad bike restrictions now

Recommendations for restrictions on quad bike vehicles should be implemented swiftly, RACS Trauma Committee Chair John Crozier has said.

The banning of children driving quad bikes and forcing others to get a license are among measures up for debate following an inquest from the NSW Coroners Court.

Trauma injuries from quad bikes have been steadily rising in recent years.

“For each quad bike fatality, there are an additional 40 hospital admissions and 40 non-hospitalised emergency

department presentations,” Mr Crozier said.

The Australian, 1 December



Zapping cancer

A new treatment for prostate cancer is being trialled at St Vincent’s Hospital that involves burning the tumour with electricity.

Urologist Professor Phillip Stricker has been using the treatment that involves 90 pulses of electricity passed between needles. The technology has been named the ‘nanoknife’.

“You can’t underestimate the potential of this technology,” Professor Stricker said.

“It’s going to save a lot of people from having unnecessary surgery.”

The Age, 19 November



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COLLEGE OF SURGEONS



RCS

ADVANCING SURGICAL STANDARDS



MAKING HISTORY

President of the Royal College of Surgeons (RCS) of England Miss Clare Marx says there are clear issues to address for medicine

In the past few years, a wave of senior women have begun taking up leadership positions in medical organisations across Britain.

While Orthopaedic Surgeon Miss Clare Marx last year became the first woman President of the Royal College of Surgeons (RCS) of England in its 214-year history, she is now far from the only female medical specialist to take up such a position of authority.

Women currently hold the position of President of the Royal College of Physicians, the Royal College of Ophthalmologists, the Royal College of Pathologists, the Chair of the Academy of Medical Royal Colleges and the position of Clinical Dean of Medicine at the University of Cambridge.

Yet although the election of Miss Marx to the Presidency of the RCS made history, taking up a position of leadership was not new to her.

Completing her Orthopaedic training and achieving her FRCS through training at St Mary's Hospital and St Charles Hospital in London, Miss Marx became the clinical director of the combined Accident and Emergency, Trauma and Orthopaedics and Rheumatology directorate at the Ipswich Hospital in 1993.

She became President of the British Orthopaedic Association in 2008, was elected to the RCS Council in 2009 and is now the Associate Medical Director of the Ipswich Hospital NHS Trust.

During her time on council, she has championed patient safety and quality measures, the need to advocate on behalf of surgical patients in an era of budgetary constraints, the importance of enhancing professional standards and the development of initiatives to encourage more women into surgery.

Speaking to Surgical News, Miss Marx said that she had three main priorities she wished to address during her presidency.

They are advancing surgery as a profession across the spectrum from training to medical leadership, attracting more women into surgery and enhancing professional standards particularly those outside the arena of technical and clinical expertise.

“There are major social and financial issues facing medicine here in the UK now from the delivery of GP services to the delivery of services through our hospitals,” Miss Marx said.

“We are addressing the question of how medical care should best be delivered and our role as surgeons within that debate.

“We want to ensure that the voice of the surgical patient is strong in a tight budgetary environment and that we take on an advocacy role instead of remaining more detached, as we may have in the past.

“When we engage in questions of how we deliver care, of course, we also have to take into account surgical training.

“We are now in the process of reviewing how we train, who we train and what we teach, particularly in regard to the challenge of delivering quality training in reduced working hours.

“Studies have told us that one in five junior surgeons are unhappy with their early training and we have to address this if we want to attract the best and brightest students while we continue to offer trainees support, particularly as medicine becomes more complex and stressful.”

Miss Marx said that like Australia, Britain was also grappling with the question of how to attract more women into surgery.

She said that while 54 per cent of medical students and 30 per cent of surgical registrars were women, these numbers dropped dramatically through the training system resulting in only 11 per cent of female consultant surgeons.

In her specialty, she said, the numbers were particularly low with only four per cent of Orthopaedic Surgeons being women.

“Women bring different skills and perspective to medicine and at its most basic it is simply about living and working in a balanced society.”

She said the numbers indicated that female trainees were changing their career choices in the time between finishing their core surgical training and taking up specialty training.

“We have investigated this and it seems to be that women are making different choices relating to the work/life balance, possibly at a time when they are thinking of starting a family,” Miss Marx said.

“Therefore, we are now actively working with Health Trusts across the country to design flexible training options so that women can have a family and complete their specialist training.

“Yet the issue of women in surgery does not just relate to training.

“Women here are still under represented in senior management positions and upon exam boards and training boards.

“While this may relate to how they wish to spend their time away from work, I think it might also be about aspiration, role models and mentoring and we are now reviewing what we senior surgeons can do to encourage younger women Fellows into such roles.

“This is an important issue for us. Women make up 50 per cent of the population and they have a right to see that reflected in the medical workforce.

“Women bring different skills and perspective to medicine and at its most basic it is simply about living and working in a balanced society.”

“The vast majority of us in medicine clearly understand that the best results come from cooperation and team work and as a College we have committed to doing everything we can to ensure that all Fellows are given the change to achieve their full potential.”

Miss Marx said that she had not faced any sexist backlash following her election as President of the RCS but rather that many people had been delighted and saw it as a sign of cultural and generational change.

Miss Marx said her third priority of enhancing professional standards had been advanced with the publication last year of a guide for surgeons called *Good Surgical Practice*, developed through the input of both surgeons and patient groups.

Written in the wake of the release of the General Medical Council’s updated *Good Medical Practice*, the guide for surgeons provides advice around four key areas: knowledge, skills and performance; safety and quality; communication, partnership and teamwork; and maintaining trust.

Two other guides were also launched by the RCS last year.

They were *Surgical Leadership – A Guide to Best Practice* and *The High-Performing Surgical Team – A Guide to Best Practice*.

Reflecting upon her career to date, Miss Marx said she had become attracted to life as a surgeon after spending time with a consultant on work experience as a secondary school student.

She said her decision to follow that calling had led to a rewarding and fulfilling career.

“I was particularly fascinated by the interface between the surgeon and the patient,” she said.

“I thought it was wonderful that a surgeon could talk to a patient, understand the problem and then call on intellectual and physical skills to conduct procedures that could change lives.

“So far I have been able to put together a 35-year career as clinician, surgeon and medical leader, serving the community and the profession, and all of that feels like an extraordinary privilege.

“When I stop to think about it, I am proud to be President of the RCS but being the first woman President is just the icing on the cake.”

With Karen Murphy



BRISBANE 2016

Preparations continue for the 85th Annual Scientific Congress

RICHARD LEWANDOWSKI

ASC 2016 Convenor

OWEN UNG

ASC 2016 Convenor

Dear Fellows and Colleagues,
All the programs are finished, section dinners are booked, session chairs appointed - all is ready for the 85th Annual Scientific Congress to be held at the Brisbane Convention and Exhibition Centre situated alongside the Brisbane River.

We are continuing the theme of inviting our sister Royal Colleges to join in our meetings. The Royal College of Surgeons of England will be joining with us this year, after a successful program last year with the Royal College of Surgeons of Edinburgh.

You will have received your Provisional Program booklet by now, and can see the excellent schedule which has been arranged by the Scientific Committee.

Accommodation in Brisbane is in demand at this time of year, so visit the Congress website <http://asc.surgeons.org> early to register and reserve your room.

The Convocation and Welcome Reception is on Monday 2 May 2016 5.00pm, at the Brisbane Convention and Exhibition Centre.

The Syme Oration will be presented by Professor, the Lord, Ara Darzi of Denham, PC KBE FRS FMedSci FRCSI FRCS FRCSEd FRCPSG FACS FRCP. The title of his oration is 'Tomorrow's Surgeon – Innovations In Surgery And Training'

The theme of the Congress is "Surgery, Technology and Communication" and we will be joined by our colleagues from the English College who will present a plenary session.

The four plenary sessions will highlight the themes:-
"New Technology- Where Are We And How Far Can We Go"
"Data Management – How Does It Affect Patient Care"
"Innovation – Learning From The Next Generation"
"Technology And The Trainee"

An additional feature this year is the Presidents Plenary which will address current topics affecting all surgeons. This will be followed by the Presidents Lecture to be delivered by Lt. General David Morrison recently retired Chief Of Staff, Australian Defence Force. The title of his lecture will be "Driving cultural change - from the head and the heart".

There is an extensive scientific program arranged for the ASC in Brisbane which you can read in the Provisional

Program and a few are highlighted below. Other section presentations will be highlighted in future editions of Surgical News.

Senior Surgeons

John North has arranged an excellent program covering issues which should be of interest to all surgeons.

Topics such as 'Do you have a reliable GP?.... Why not?' by Miss Clare Marx PRCEng and 'Can Bad News Have A Happy Ending For The Surgeon?' by Associate Professor Michael Fearnside should challenge all of us.

Other topics such as "Defining Unethical Behaviour and Dishonesty" should be addressed by us all.

Pain Medicine

Leigh Atkinson has again been instrumental in arranging a comprehensive program covering interesting aspects of pain.

The session on trigeminal neuralgia will be of interest to those surgeons with a Head and Neck bent and the complexities of Pelvic Pain to surgeons whose area of interest is mainly abdominal surgery. The James Pryor Lecture will be delivered by Guy Maddern on "The Medico Legal Aspects of New Technology".

International Forum

Neil Weitzig has put together a comprehensive program which features the 25 years of the Rowan Nicks scholarships. A highlight will be the Rowan Nicks Lecture by Professor Godfrey Muguti an inaugural Rowan Nicks scholar who will deliver the lecture entitled "Plastic and Reconstructive Surgery in Zimbabwe: Challenges and the way forward".

The Section Visitor, Professor Christopher Lavy will add to the program his extensive experience with orthopaedics in the global surgery environment

Colorectal Surgery

David Clark and Carina Chow have arranged a comprehensive program with three distinguished visitors, Mr Chris Cunningham from Oxford, Professor Dion Morton from Birmingham and Dr Antonio Lacy from Barcelona who will cover areas of colorectal surgery including a focus on new trans-anal approaches to rectal tumours including TEM and Ta-TME and the role of robotic surgery in colon and rectal surgery

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

Register now through the Congress website asc.surgeons.org

COLLABORATE, COMMUNICATE AND CELEBRATE

A reflection on the 2015 AIDA conference

DAVID MURRAY

Chair, Indigenous Health

The 2015 Australian Indigenous Doctors' Association Annual Symposium (AIDA 2015) presented RACS with the opportunity to meet the new cohort of Aboriginal and Torres Strait Islander medical students and junior doctors eager for details on specialist training pathways. Held in Adelaide, the symposium attracted more than 200 Indigenous and non-Indigenous people from across Australia, New Zealand and Canada. The gathering reflected the growing numbers of Indigenous people entering the medical profession as doctors, researchers and educators; as well the increasing trend by non-Indigenous organisations and individuals to work in partnership with Aboriginal and Torres Strait Islander communities.



Stephen Tobin's presentation at AIDA 2015



RACS support of AIDA 2015 took many forms. At the 'Growing our Fellows' workshop, delegates were able to converse with Mr Graeme Campbell and Associate Professor Stephen Tobin about surgery as a career. Those delegates seeking specific guidance on the training application process attended the Networking Breakfast for Surgery I hosted in my capacity as the Chair of the Indigenous Health Committee.

It was inspiring to hear the enthusiasm which abounded from these young people who were interested in pursuing a career in general surgery, plastic surgery and cardiothoracic surgery. The group also discussed issues such as 'relating to other health professionals', 'how do you find referees?' and 'when did you decide you wanted to be surgeon?' A highlight of the conference was the presentation on JDocs by Associate Professor Stephen Tobin and Ms Jacky Heath. The presentation provoked a lot of questions and discussion on how to use JDocs to organise applications to specialist training.

The Mobile Surgical Simulation Unit added a popular interactive dimension to the RACS presence at the symposium. One student remarked "it was harder than I thought it would be, but great fun" and another commented "The bus has inspired me to consider pursuing a surgical career". Having the unit on site to support the workshops was a bonus, and contributed to the success of the conference. The challenge remains to convert the interest we witnessed in Adelaide into successful

applications for specialist training, and the delivery of more Australian Indigenous surgeons.

The success of RACS's participation in AIDA 2015 was made possible by the great support received from various sections of the College, including the staff from the Adelaide Office. The Indigenous Health Committee thanks all who contributed to the planning and success of all the activities we engaged in. Our commitment of people and resources to sponsoring the event and promoting surgery as a career, did much to enhance RACS profile and standing with AIDA and the wider Aboriginal and Torres Strait Islander medical community. This puts the college in good stead as it works towards implementing the Aboriginal and Torres Strait Islander Health Action Plan (2014-2016).

I congratulate the Board and staff of AIDA on the success of the symposium and thank them for the opportunity to be a part of this wonderful event.



ALLEVIATING PAIN

Delivery of the Essential Pain Management course to underprivileged neighbours helps to develop new skills

EPM course in Kigali, July 2013

The determination of two Anaesthetists from New Zealand and Australia to ease the preventable suffering endured by patients in some lower income countries has led to the development of a pain management course which has now trained thousands of health professionals around the world.

The Essential Pain Management (EPM) Course was designed and developed by Anaesthetists Dr Wayne Morriss and Dr Roger Goucke and was modelled on the train-the-trainer principles of the Primary Trauma Care (PTC) Course.

In just the first five years of its existence, the EPM Course has been delivered in 41 countries, and trained 4770 participants and 783 instructors.

The program is supported by the Australian and New Zealand College of Anaesthetists (ANZCA), the International Association for the Study of Pain, the Australian Society of Anaesthetists, the Ronald Geoffrey Arnott Foundation and the World Federation of Societies of Anaesthesiologists (WFSA).

The EPM Course has also received RACS support since its creation in 2010 through funding and administration provided through the Pacific Islands Program (PIP).

Funded by the Australian Federal Government, PIP has so far supported 27 EPM Workshops and 11 EPM Instructor Courses across the region including courses in Fiji, Samoa, Solomon Islands, Vanuatu and Tuvalu.

Since 2012, EPM and Interplast Australia and New Zealand have collaborated to contribute to the improvement of pain management in Bangladesh. Three internationally supported programs in Dhaka, Chittagong and Sylhet have provided the platform for a dozen

locally run workshops to improve pain management across the country.

With the support of anaesthesiology organisations, the EPM Course has also been delivered in many countries in Central and South America, Asia, Africa and Eastern Europe.

Co-creator of the EPM Course Dr Wayne Morriss – who works at the Christchurch Hospital in New Zealand - has a long history of working in lower and middle income countries since he first worked in Fiji in 2000.

Since then, he has participated in many PIP trips and is the current Chair of the Education Committee of the WFSA, a global umbrella organisation which represents anaesthetists from 145 nations.

Speaking to Surgical News, Dr Morriss said the EPM Course was designed to help hospital staff and GPs relieve the pain caused by trauma, childbirth, surgery, chronic pain such as arthritis and cancer.

He said that although there was a tremendous global imbalance in access to opioids – with the richest 25 per cent of people consuming 90 per cent of global morphine supplies each year – there were simple and cost effective ways to reduce pain that could ease individual suffering and lower the strain it can place on overburdened health systems.

He said that in many low and middle income countries, pain was often unrecognised and poorly treated but that effective pain management often resulted in fewer medical complications, earlier hospital discharge and improved quality of life.

To disseminate the skills needed to manage pain, Dr Morriss and Dr Goucke designed the EPM Course to transpose the easily

remembered ABC components of trauma care (Airway, Breathing and Circulation) to three core principles of EPM: Recognise; Assess; and Treat (RAT).

“There are four main reasons why pain is not properly managed in some lower income countries,” Dr Morriss said.

“They are a lack of systems and protocols to manage pain, the fact that overworked hospital staff sometimes don’t see managing

“Good pain management is very similar to good trauma management in that both are multi-factorial and require teamwork and a systematic approach if optimal outcomes are to be achieved.”

pain as a priority, a lack of access to drugs and cultural reasons for patients not seeking pain relief.

“I have been involved in delivering the PTC Course since 2003 and working with surgeons on PIP visits and I liked the underpinning philosophy of that type of trainer-the-trainer education.

“Good pain management is very similar to good trauma management in that both are multi-factorial and require teamwork and a systematic approach if optimal outcomes are to be achieved.

“Yet, while the PTC and the Early Management of Severe Trauma (EMST) Course have been around for quite a while, there was no comprehensive and cohesive approach to teaching basic pain management until we developed the EPM course.”

Dr Morriss said the EPM program was designed for any health worker who has contact with patients in pain and can be used by all types of health workers including doctors, nurses, allied health professionals and pharmacists.

The EPM Workshop comprises a one-day program of interactive lectures and group discussions with participants learning the basics of pain management, how to apply the RAT approach during case discussions and problem-solve pain management barriers.

The EPM Instructor Workshop is a half-day program in which participants learn the basics of adult learning, practice teaching and design their own EPM Course.

Dr Morriss said that since the course was established, 34 ANZCA Fellows had delivered courses around the world,

teaching the RAT skills to hospital and clinic staff.

“The EPM Course has been designed to provide a simple structure to guide pain management that we hope will become second nature for those who have been through it,” he said.

“We stress over and over the importance of the three simple steps of recognising not just that a patient is in pain but that it can be treated, assessing how bad the pain is and appropriately treating that pain.

“Often this requires doing simple things like giving the patient paracetamol regularly



EPM Lite Manuals

or regular oral doses of morphine or even a nerve block for more severe pain.”

Dr Morriss said that pain was sometimes not well managed in hospitals in lower and middle income countries because the basics of patient care were not adequately managed.

“We know, for example, that morphine is still the best and cheapest drug to treat cancer pain but it must be given regularly and at an appropriate dose,” he said.

“Sometimes this treatment is not provided because staff may not have the pharmacological training they need to have the confidence to treat pain, sometimes hospitals are so short staffed that patients cannot be given adequate attention and sometimes hospitals just don’t have access to sufficient drug supplies.

“Yet protocols and a systemic approach to pain management can help overcome some of these issues, particularly if the EPM principles are embraced throughout hospitals and clinics.

“Every time we deliver the course we seek a pain champion - an anaesthesiologist, surgeon or nurse - who will promote the importance of pain management and transfer the skills taught in the EPM Course.

“This approach has proven very effective. In 2012, I ran a series of workshops and an instructor workshop with my local counterpart at a hospital in Honduras. She had invited senior staff from all around Central America to attend the workshops.

“This meant that from just one series of courses, the EPM principles were disseminated across Central America.”

Dr Morriss said that like the PTC and EMST Courses, the EPM Course was only ever delivered at the request of those seeking training.

He said interest in the EPM Course continued to grow and that medical staff in European countries such as the Czech Republic, Belarus and Serbia had also requested training which he would deliver later this year.

Dr Morriss said he first became convinced of the need for training in pain management when he was working in PNG.

“I can remember seeing an 11-year-old girl with metastatic Ewing’s Sarcoma when Roger Goucke and I first began working on the EPM Course,” he said.

“She was in dreadful pain but getting no pain treatment at all so Roger and I used the occasion to teach the RAT principles to the nurses. Using a “butterfly” subcutaneous needle we gave her a small dose of morphine and then paracetamol and although she only had weeks to live, after the treatment she could almost even smile.

“This in turn delighted the nurses who had felt so powerless to ease her suffering.

“I would love to think there might be a time where all staff in all hospitals automatically think RAT whenever they think about pain management or see a patient in pain and I hope this simple mnemonic changes the language of pain medicine.”

Queensland Surgeon Mr Neil Wetzig, who now works part of each year in the Democratic Republic of Congo, said he realised some years ago that the EPM had the potential to improve pain management practices that he witnessed in some African hospitals.

In April this year, after discussions with Dr Morriss and Dr Goucke, he organised and taught the EPM course at the HEAL Africa Hospital in Goma.

“It is such a good course and it was exciting to see doctors, nurses and orthopaedic officers with varying levels of experience come together to learn about pain management, with some being selected to become trainers,” Mr Wetzig said.

“The EPM concept can bring sustainable change to pain management and I strongly support it.”

Dr Morriss said that any surgeon who was interested in becoming an EPM Instructor would be warmly welcomed into the program and said that enquiries could be made at www.essentialpainmanagement.org

With Karen Murphy



EPM course in Arkhangelsk, Russia

AHSS Welcomes Visiting Speakers

Combined meeting of the AHSS and ASSH will be held in Sydney

The AHSS (Australian Hand Surgery Society) is holding a combined meeting with the ASSH (American Society for Surgery of the Hand) in Sydney from the 30th March to 2nd April 2016. We are delighted to have as our guest Professor Yuan-Kun Tu from Taiwan. He is the current Professor for the APFSSH (Asian Pacific Federation of Societies for Surgery of the Hand) He is Professor & Superintendent E-Da Hospital / I-Shou University, Kaohsiung Taiwan. He has a vast experience of nerve reconstruction surgery and will be giving a presentation on Brachial Plexus Injury--- from double FFMT (Functioning Free Muscle Transplant) to triple FFMT.

At the 2016 RACS ASC Dr Donald Lalonde will be giving key note lectures on:

- Minimal Pain Injection Of Tumescence Local Anaesthesia Can Decrease The Need For



Professor Yuan-Kun Tu

- Sedation And General Anaesthesia All Over The Body
- Safe Adrenaline In The Finger Has Evolved Tourniquet/Sedation-Free Wide Awake Hand Surgery

Prior to the ASC Dr Lalonde will be travelling to Sydney, Melbourne

and Perth where he will be giving presentations to the local Hand Surgery societies, and following the meeting in Brisbane he will go to the Gold Coast for a final presentation.

Dr Lalonde is the past Chair of the Examination Board in plastic surgery for the Royal College of Physicians and Surgeons of Canada. He was President of the Canadian Society of Plastic Surgeons. Dr Lalonde edited the RCPSC plastic surgery written examination short answer question bank. His particular interest is in "Wide Awake" hands surgery on which he has written extensively.

He has a commitment to world medicine with many surgical missions with Operation Smile

The AHSS thanks the RACS for its generous support of these visiting experts and looks forward to its important educational contributions in 2016.



RACS Visitor Grant Program for 2017

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

Eligible groups are invited to apply for funding towards the cost of travel, accommodation and registration for the visiting speaker(s) to their 2017 annual scientific meetings.

Applications for meetings in 2017 close on 26 February 2016.

For more information please see the website or contact Philip Vita, Manager, Fellowship Services on (03) 9249 1105.

ASOHNS ASM 2016

Two renowned international speakers will present

LORNA WATSON
CEO, ASOHNS Ltd

Two world-renowned otolaryngologists, Dr Haytham Kubba from Scotland and Prof. Ian Witterick from Canada, will be presenting at the Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) 2016 Annual Scientific Meeting in March in Melbourne.

Sponsored by the Royal Australasian College of Surgeons, Dr Kubba and Prof. Witterick will join other prominent international guest speakers and Australia's own experts to provide excellent opportunities for continued learning and development and important peer interaction at the meeting.

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



Haytham Kubba

His main interests are airway surgery, congenital abnormalities of the head and neck and neurodisability and its effect on Otolaryngology in children.

He will be presenting plenary and subspecialty sessions on paediatric otolaryngology issues.



Ian Witterick

Prof. Witterick is Professor and Chair of the Department of Otolaryngology-Head & Neck Surgery, Faculty of Medicine, University of Toronto and Otolaryngologist-in-Chief at Mount Sinai Hospital, Toronto, Canada.

He is at the forefront of programs educating future skull base surgeons, particularly with respect to simulation and image guidance and measuring competency.

He has major subspecialty interests in the fields of Rhinoplasty, Advanced Sinus and Skull Base Surgery and



Head and Neck Cancer and Thyroid Surgery.

Prof. Witterick will present several plenary sessions on Functional Endoscopic Sinus Surgery (FESS) and skull base issues, as well as a session on training future surgeons.

The ASOHNS ASM 2016 theme is Back to Basics and the main program will be held from 6-8 March, 2016 at the Crown Conference Centre.

Pre-ASM satellite meetings will be held over 4-5 March and there will be a trade exhibition and an Otolaryngology, Head and Neck Surgery Nurses Meeting held concurrently with the ASM.

For more information and to register, go to:

www.asohns.consec.com.au

Contact: Mrs Lorna Watson:
(02) 9954 5856

lornawatson@asohns.org.au



PERSPECTIVES

Vic Tas ASM

SU-WEN LOH

Victorian Convenor

HUNG NGUYEN

Tasmanian Convenor

The combined meetings of the Victorian and Tasmanian Regional Committees, the 2015 Vic Tas ASM was held in Hobart over the weekend of the 16-18 October. This successful combined regional meeting provided opportunities for dialogue and debate surrounding the theme “Coping with Change” from Tasmanian and Victorian perspectives.

The workshops held on Friday provided professional development opportunities: The Vic Tas Younger Fellows Workshop and the Foundation Skills for Surgical Educators. The third workshop was the Victorian and Tasmanian Audit of Surgical Mortality which proved to be popular with over 70 participants.

On Saturday, following the Welcome to Country by local primary school girl, Amber Taylor, the meeting was formally opened by Tasmanian Health Minister, Hon Minister Michael Ferguson, MP.

The theme of “Coping with Change” was explored throughout the plenary sessions and symposia. Mr Peter Myers, presented the Henry Windsor Traveling Lectureship speaking to his topic “Adjusting to Forces”. The family connection is noteworthy: Peter is married to the Great granddaughter of Henry Windsor himself.

Throughout the day the scientific program included an update on Jdocs and the “Digital College”. Over two symposia we heard from Fellows, a surgical trainee and an aspirational doctor about the challenges faced during a surgical career, and the new challenge faced with confronting discrimination, bullying and sexual harassment in the workplace. The

scientific meeting held a frank and honest discussion about the College’s EAG into Discrimination, Bulling and Sexual harassment, and recommendations.

An important component of the regional meeting is to provide a platform for the presentation of local research. Of the 70+ abstracts submitted, 55 papers were assessed and the strongest were invited for presentation: 39 were presented orally, and another 15 were presented in poster format. All papers presented were judged and prize winners announced.

The Victorian Annual Surgical Meeting remembers late Victorian surgeon Mr G J Royal at the dinner and lecture held in his name. Also linking to the theme of Coping with Change, Assoc Prof Hamish Ewing took delegates on a journey through the technological advances of the past half century. This thoughtful and insightful lecture was followed by the “Pudding Pathology Quiz” which tested a knowledge of both culinary ingredients and pathology. The Victorian Convenor and his dining companions dashed the hopes of teams of fellow surgeons, junior doctors and medical students who all shared the common ambition of winning the “pudding hamper”.

Opportunities for networking and relaxing were provided during a cruise and dinner to Peppermint Bay. An informal excursion to MONA on Sunday morning left delegates equally amused, amazed, delighted and... unimpressed by the art work on display, creating lively conversation and a great way to close the meeting.

The regional meetings provide an important forum for cross-specialty collaborations. To meet the challenge of keeping the ASMs relevant and well attended, Fellows involvement and attendance is critical. The call is out to all RACS Fellows and Surgical Trainees to take an active role in shaping the 2016 meetings, and meetings into the future.



THE LONG JOURNEY

Munjed Al Muderis fled brutality in Iraq to become a FRACS in Australia

While Sydney Orthopaedic Surgeon Mr Munjed Al Muderis was forced to confront the brutality in Iraq under the tyranny of Saddam Hussein, it was the barbarism he faced in seeking asylum in Australia that came closest to breaking him.

Now a pioneering surgeon offering world-first prosthetic implant surgery for lower limb amputees, Mr Muderis was working as a surgical resident in Baghdad in 1999 when he and other surgeons were ordered by Military Police to mutilate the ears of scores of draft evaders and army deserters.

Designed as a brand of cowardice, the mutilations would result in a life time of shame, stigma and social ostracism.

When the senior surgeon refused, he was executed in front of the surgical team by a single gunshot to the head and Mr Muderis knew he faced a critical choice: comply and break the Hippocratic Oath; refuse and risk his life; or hide and then run.

Within hours of that life changing moment, he had grabbed a taxi to make a frantic farewell to his mother, gathered some cash and boarded a bus into Jordan.

Doctors at the time were forbidden from leaving Iraq, so false papers provided by a cousin transformed Dr Al Muderis, junior surgeon and scion of an ancient noble family, into Munjed the handyman.

From Jordan he flew to Jakarta where he boarded a crammed, decrepit refugee boat bound for Christmas Island.

Yet while he survived the treacherous 36-hour crossing in search of safety, civility and decency he did not find them for he was immediately incarcerated, along with his fellow

passengers, in the Curtain Detention Centre which has become widely accepted as the harshest of Australia's refugee camps.

Mr Muderis has now written a book describing his journey both to Australia and through its byzantine refugee immigration system called *Walking Free*.

Speaking to *Surgical News* about the book and his life since his arrival, Mr Muderis said he was more deeply scarred by his 10 months in detention than by the horrors that brought him there.

"In Iraq, the events occurred very rapidly and I didn't have much time to think about what I had witnessed, or leaving my home and family, I just had to make my escape," he said.

"But the Curtain Detention Centre was quite simply horrific, like hell on earth.

"As soon as we were taken there we were stripped of our humanity, our names were replaced by numbers and the treatment we received was extremely abusive.

"We were not allowed any contact with the outside world and had to live in very primitive conditions."

Mr Muderis became known as number 982 but the attempts to strip him of his identity, dignity and humanity did not work.

A highly educated, articulate man of 27 with good English, he soon began a campaign calling for human rights and legal representation and found a way to smuggle images out of the camp to local media, efforts that first resulted in solitary confinement on camp grounds and then imprisonment.

"At one stage I was taken from Curtain to the jail in

“My life is divided into three spheres of family, work and advocating for the human rights of asylum seekers to Australia.”

Karratha which seemed like heaven in comparison and which also, ironically, gave me the human rights of all prisoners in Australia,” Mr Muderis said.

“There I could use the phone, I could have visitors and I contacted human rights organisations to try to get help for all of the people held at Curtin.

“As soon as the authorities realised their mistake, they took me back to the Detention Centre and locked me up in the tiny suicide watch box and the one book I had brought with me from Iraq became my best companion.”

Mr Muderis said that when he was found to be genuinely in need of asylum, he was released from the centre and while other refugees released at the same time were given transport to regional centres, he was walked through the gates and told to make his own way across the vast expanses of Western Australia.

So he did, travelling by bus from Derby to Broome, from Broome to Perth, from Perth to Adelaide and he still remembers the day he walked free: 26 August, 2000.

In every town and city, he visited hospitals in search of work and spent what remained of his money sending letters to every medical centre and hospital in the country.

“At least I had the opportunity to see quite a lot of Australia,” he laughed.

“And finally, I got an interview and a position at Mildura Hospital as a resident in the Emergency Department so within one year of my arrival I earned my own pay which felt wonderful.”

From that joyful beginning, Mr Muderis went on to further his surgical training at the Austin Hospital in Melbourne before being accepted into the Orthopaedic training program. He received his FRACS in 2008.

Now he is an Associate Professor of Orthopaedic Surgery at Notre Dame University and a reservist for the Australian Air Force.

Mr Muderis said that while 90 per cent of his practice involved knee and hip replacement and major reconstructive surgery, his passion lay in osseointegration and limb reconstruction surgery.

This emerging field involves the placement of an implant into an amputee’s femur or tibia which, when integrated with the bone, allows for a simple, safe connection between the stump and lower prosthesis.

Mr Muderis is now one of only a handful of surgeons in the world offering the procedure and has established a unit – called the Osseointegration Group of Australia based at

Macquarie University and Norwest Hospital – to conduct the surgery, undertake research, provide patients with holistic care and assessment and monitor their outcomes.

This implant is an Australian design – known as the OGAAP-OPL implant – which is now being used by most of the other centres offering the service.

He said most patients treated had lost a lower limb through trauma, cancer or due to severe infection in the limb.

Since he began the work in 2009, he and his team have conducted 125 procedures, the largest series done by any unit in the world.

“This surgery offers patients a permanent attachment to link their prosthesis into their skeleton which is more comfortable and is far superior mechanically to the traditional socket,” Mr Muderis said.

“We also use cutting edge technology such as pattern recognition software placed into the soft tissue which means that if they walk on grass they can feel it or if they step on someone’s toes they can feel it.

“There is a risk of infection, however, and because the technology is new we don’t know how it will last in the long term so we monitor our patients very closely.

“Our team comprises physiotherapists, anaesthetists, psychologists, pain specialists, biomechanical engineers and researchers because we are aware that we are the first to do this work and we want to reduce the risks as much as possible while we gather data, analyse problems and find solutions.

“I am pleased to say, however, that we now have statistically significant evidence to show that the benefits outweigh the complications and that this procedure is cost effective in comparison to the old socket system.”

Recently, Mr Muderis met Prince Harry during his visit to Australia who offered him an invitation to travel to the repatriation hospital in Birmingham to work with British soldiers who had lost limbs while fighting in the Middle East.

Mr Muderis accepted the offer and plans to travel there mid-year to place implants into three patients.

Now travelling Australia and the world presenting his work and conducting procedures, Mr Muderis’ life seems unrecognisable to the one he lived upon arrival in Australia.

Yet that experience drives him still and is the reason he wrote the book.

“My life is divided into three spheres of family, work and advocating for the human rights of asylum seekers to Australia,” he said.

“I work with the Human Rights Commission, Amnesty International and was recently asked to be an Australian ambassador to the Red Cross which was a great honour.

“I believe that if the Australian public had more information



Mr Munjed Al Muderis

they would not allow the human rights abuses that I experienced to continue.

“Through my story, I wanted to show that asylum seekers are not the freeloaders they are often made out to be and that with 51 million people now displaced around the world, Australia can and should do more.

“There are 62,000 people who are living in Australia illegally by overstaying their visas as well as thousands who come by plane every year and then claim asylum, this is ignored in favour of the ridiculous three-word policy of ‘stop the boats’.

“Australia is the only country that I know of that incarcerates children indefinitely and I saw many unaccompanied minors in detention, totally lost within crowds of strangers.

“I am passionate about this and even though I may be at the top of the wheel now I am quite prepared to go back down to the bottom again for my opinions. If they put me back in jail, that’s alright. I’ve been there before.”

“Walking Free” is published by Allen and Unwin and is now widely available.

With Karen Murphy

New Zealand Association of General Surgeons

NZAGS
2016

12-13 March '16



SPENCER ON BYRON HOTEL
AUCKLAND, NEW ZEALAND

CALL FOR ABSTRACTS NOW OPEN

The NZAGS Conference Committee 2016 would like to invite registrars and trainees to submit an abstract for presentation at the 2016 conference. You may submit your abstract in the **NZAGS ORAL & POSTER AWARDS** or the **DAMIEN MOSQUERA AWARD FOR RURAL RESEARCH**

DEADLINE FOR SUBMISSION
15TH JANUARY 2016

For Abstract and Poster rules and regulations, as well as further conference information
WWW.NZAGS.CO.NZ

CASE NOTE REVIEW

Minimally invasive mitral valve repair with femoral cannulation resulting in inferior vena cava trauma and exsanguination



GUY MADDERN
Chair, ANZASM

Clinical details

This case involves a middle-aged patient with mitral regurgitation and significant coronary artery disease (CAD) who underwent elective minimally invasive mitral valve repair via a right thoracotomy using peripheral vessel cannulation.

A satisfactory repair was achieved but the patient deteriorated with progressive hypovolaemia over four hours due to retroperitoneal and intra-abdominal haemorrhage from damage to the inferior vena cava (IVC).

Return to theatre partially controlled the haemorrhage but the patient did not tolerate IVC clamping while in a state of severe hypovolaemia. Death occurred despite further attempts at resuscitation, including standard cardiopulmonary bypass and clotting factor replacement.

Comments

There were a number of issues identified in this case, as outlined below.

- Failure to recognise injury to the IVC either at the time of insertion or until the massive blood loss; there were clearly problems with insertion of the femoral catheters which seem to have been performed percutaneously.
- The surgeon's notes state that they did not have adequate assistance during the femoral cannula insertion and this should not be allowed to happen in the future. Femoral cannula insertion by any method is well known to have potential serious dangers, and an experienced assistant should always be present, particularly in an elective situation. Presumably

there was another surgeon present who was opening the chest and they should always help with the cannulation.

- Delay in returning the patient to theatre. At least four hours elapsed before returning to theatre, and the appropriate ICU notes are not present. It appears the patient required an excessive amount of intravascular filling without blood loss or other explanation. Time was wasted getting a Computed Tomography (CT) scan and in consultations with several groups of surgeons. It would have been beneficial for the patient to have been returned to theatre several hours earlier.
- Decision to not graft the left anterior descending artery. There was a significant stenosis in the left anterior descending artery. However, the artery was not grafted due to the patient's preference for a minimally invasive approach. The rationale behind the decision not to graft the artery is of concern. Failure to graft the artery, and the resultant persistent ischaemia of the heart, may have contributed to the inability to resuscitate in the setting of hypovolaemia.
- Noradrenaline and milrinone appear to have been used for resuscitating someone with hypovolaemia.

This should have been a very low risk procedure. It could have been carried out without the threat of fatal complications if a standard sternotomy had been used. The benefits of a minimally invasive approach to the mitral valve have not been demonstrated and this should be balanced against the risks demonstrated here (for example, long bypass and cross clamp time, peripheral vessel cannulation, poor exposure, inability to graft the coronary arteries).

A NEW E-LEARNING RESOURCE

Supporting the Standards of Performance

SPENCER BEASLEY
Chair, Professional Development

STEPHEN TOBIN
Dean of Education

The new eLearning resource 'Standards of Performance' is aligned to the 'Becoming a competent and proficient surgeon' framework that describes the five levels of performance for each of the nine surgical competencies.

The resource provides a rich learning experience for SET trainees. It allows them to assess their own performance against each level as they progress from a prevocational doctor to a proficient Fellow. It also helps supervisors, trainees and International Medical Graduates (IMGs) understand the levels of performance required for a trainee to progress as they become a practising surgeon.

The responsibility for learning is shared by the supervisor and the SET trainee. The performance of a trainee is assessed against agreed standards, according to the stage of their training; this is the crux of competency-based training. The eLearning resource 'Standards of Performance' is designed to encourage a collaborative approach to assessment.

A series of video resources provide supervisors, trainees, IMGs and junior doctors with the opportunity to practise assessing clinical

and professional performance within the 'Becoming a competent and proficient surgeon: Training standards for the nine RACS competencies' framework.

The resource allows participants to assess the performance of a trainee as they engage in a multicultural consultation or an end of term interview. Participants can rate their assessments against previous participants' assessments to gauge how well they are evaluating performance against the five levels of competence.

The third video observes two trainees and how they use the framework to assist them to develop and monitor their technical and professional competence. To learn from experience trainees need to undertake self-reflection, self-monitoring and a willingness to seek constructive and critical feedback, and modify their behaviour as they progress.

The resource supports supervisors by providing scenarios that enable a trainee to identify where there is a disparity between the stage of training and their level of competence. This helps trainees to engage and learn through observation, experience and reflection and gain the skills to monitor their progress. Where they identify a gap in their learning it can be rectified.

Access to online eLearning resources is enabled through the College website. Members can login to the website then go to My Page and then scroll down to eLearning on the left hand menu.

For further information please contact Kyleigh Smith, Senior Program Coordinator, Professional Development Department on Kyleigh.smith@surgeons.org or 03 9249 1212.

REPORTING ISSUES AND RAISING CONCERNS

It's time to complain... properly!

MICHAEL COLLIN
RACSTA

One of the key issues identified from the EAG report into bullying, discrimination and sexual harassment is the concerns that are raised about reporting the issue. Trainees both formally and anecdotally have reported that they feel uncomfortable about raising complaints or concerns about behaviour by those considered senior to them.

These perceived power imbalances leads to statements like 'don't rock the boat' and 'just put your head down and fly under the radar'

We know that historically there have been significant cracks in the College's complaints system, including trainees not being aware of how or where to register complaints and the internal College process of knowing how to deal with complaints and provide an effectual response.

In relation to trainees, one of the significant issues leading to concern about any complaints process is the possibility that it will adversely affect their training, be that at an individual surgeon or training supervisor level ('they won't sign my form') or at a higher level such as specialty board or college ('I don't want to be a difficult trainee').

It's time for trainees and fellows of the College to change this behaviour...

To do this, complaints need to be treated fairly, with the option for anonymity, and through a process with independence from the process for assessment and even independence from the College itself. RACSTA was pleased to be informed that the College is establishing a complaints process trying to meet these criteria.

The new complaints process involves an dedicated email address and phone number:

complaints@surgeons.org

1800 892 491 (Australia)

0800 787 470 (New Zealand)

Complaints can be made by fellows and trainees of the College as well as any member of the health care team, patients or other members of the public. The internal college process for dealing with any complaint will obviously depend on the complaint being raised, but may include information gathering, investigation panels, mediation and referral to any relevant regulator. Importantly, the process relies on consent from the complainant before contact is made with other parties including specialty boards, the respondent or hospitals. A complaint may also be referred to an external complaints advisor. At our November RACSTA meeting, we

were pleased to note that the process incorporates this option for external input in the complaints process, as well as the internal separation of the complaints process from operational areas.

Even in its infancy, the updated College complaints process has dealt with multiple complaints including a significant number relating to bullying and harassment. Issues raised have included swearing, yelling, abuse, crudeness, obscenities, humiliation and perceptions of junior staff feeling victimised, being 'set up to fail' and being rushed by the surgeon to the detriment of patient safety.

RACSTA will follow closely how the College continues to perform the role of receiving and dealing with complaints.

In the meantime, we all need to remember that standing in silence is effectively condoning poor behaviour.



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IN MEMORIAM

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

Arch Fletcher	South Australia
John R Talbot	New Zealand
Thomas Milliken	New Zealand
Fred Stephens	New South Wales
Vivian F. Sorrell	New Zealand
John Hall-Jones	New Zealand
Katherine Edyvane	Western Australia
Umesh Dhanjee	Queensland
Peter Catts	New South Wales
Dennis Craig Paterson	South Australia
Robin Williams	Victoria

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

Informing the College

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

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

ASERNIP-S

Promoting the College through international collaborations

GUY MADDERN Clinical Director, ASERNIP-S

Direct engagement with peers through conference presentations, as mentioned in my 2015 report, not only promotes the work but also the organisation. ASERNIP-S has been presenting and growing its peer network since inception, nearly 18 years ago and is an international leader in Health Technology Assessment for surgery. This high profile is supported by the key roles we have in the Health Technology Assessment International (HTAi) organisation and the International Network of Agencies for Health Technology Assessment (INAHTA). As part of INAHTA, ASERNIP-S collaborates with the 55 agencies from 35 countries around the world. Value networks operate in key areas across this global network, such as: Member agency assessment programs, processes & methods; Knowledge transfer, uptake & impact of HTAs; Education & training for member agency staff and Agency Development and Capacity Building. These value networks provide the ability of ASERNIP-S staff to be involved in developments in these areas and to contribute to communities of practice in key work areas.

International partnerships or collaborations can take a number of forms. They can be as simple as an opinion offered in an email, or as involved as presenting a workshop or mentoring developing agencies. Nevertheless, all collaborations provide valuable experience for staff, as well as worth for the organisation.

Some recent examples of international collaborations involve colleagues in Sweden, Italy and South Africa. The Swedish Agency for Health Technology Assessment and Assessment of Social Services contacted us seeking more information from one of our systematic

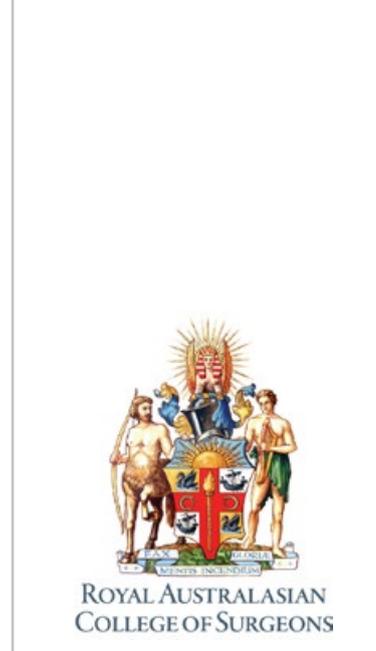
review publications on surgical simulation. Another request came from the National Agency for Regional Health Services the (AGENAS) in Italy. AGENAS contacted ASERNIP-S to ask for our review of their upcoming HTA publication. Similarly, collaboration between ASERNIP-S and CMeRC – the Charlotte Maxeke Research Consortium in Johannesburg, South Africa has led to Associate Professor Wendy Babidge being invited to give the opening key note address at the inaugural conference in September of the Southern African Health Technology Assessment Society (SAHTAS) and for Dr David Tivey to collaborate with local staff on an in-conference workshop, as well as give an oral presentation developing skills in HTA. Importantly, it is hoped that this collaboration will also result in greater ties between ASERNIP-S and the University of Witwatersrand.

These collaborations should be viewed as investments. Staff members gain valuable experience through collaboration, as it enhances skills and broadens understanding, creating opportunities to publish as well as potentially providing tangible research resources for the broader College community. An example of this is the workshop material developed for the SAHTAS meeting which will be re-used locally for staff and the broader College community. The collaborations also have a value in raising organisational awareness.

I believe that it is as a consequence of such awareness that ASERNIP-S has been commissioned by the likes of the World Health Organization and the National Institute for Health and Care Excellence (NICE, UK). These projects bring about a direct financial benefit, and I have no doubt that the work ASERNIP-S staff are currently undertaking, will pay an even greater dividend in the future.

CONGRATULATIONS

On your achievements



UK for further surgical experience. Like many, he went to “practice on the Poms” - in Bill’s case the Poms got a pretty good deal! Returning to Adelaide in 1959, Bill obtained his FRACS and was appointed to the surgical staff of the Queen Elizabeth Hospital (TQEH), an association that continued until retirement in 1993. During his time at the TQEH he was a teacher for many disciplines, innovative researcher (particularly in Endocrine Surgery), he was involved in some of the first renal transplant surgery in Australia, founded the legendary ‘Lumps and Bumps’, served as a senior examiner for the RACS Fellowship and was Head of the 4A Surgical Unit for many years. Bill also ran a busy and successful private practice throughout this time. Today in retirement, Bill is still remembered in current surgical practice by his many “Proudman’s Laws”. My favourites are “...the size of the specimen is directly proportional to the satisfaction of the surgeon....” -this gives a wonderful insight into the surgical mind, and of course”The size of the complication is inversely proportional to the strength of the indication for surgery....” -this reminds us of the immense privilege and responsibility that comes with operating on fellow humans.

Ladies and gentlemen I give you Mr William Proudman, a worthy recipient of the 2015 Henry Simpson Newland Award.

Mr David Walsh FRACS
General Surgeon

On Friday 13 November 2015, RACS South Australia held the Annual Dinner and Anstey Giles Lecture at the SA Museum. This year Mr Malcolm (Mal) Hyde, retired SA Police Commissioner, presented the Lecture on ‘Culture – Makes or Breaks an Organisation.’ Mr Hyde discussed the importance of culture and identity to an organisation, and reflected on his own experiences in successfully driving cultural change within the South Australian Police Force.

During the evening the Sir Henry Newland Award was also presented to retired Surgeon Mr William (Bill) Proudman. It was a memorable evening for Mr Proudman, his family members and Fellows who were Residents of Mr Proudman during their years of training.

CITATION – Mr William (Bill) Proudman FRACS General Surgeon

It is a privilege to present this citation for Mr William (Bill) Proudman as he receives the 2015 Sir Henry Simpson Newland Award tonight.

When Sir Henry was involved in the founding of the RACS in 1927, Bill Proudman was exactly the type of surgeon he would have imagined for the new College. Bill is a surgeon in the broadest sense - his career has involved teaching, research, examining, mentoring, innovation, leadership, combined with the highest levels of clinical and technical excellence in the act of surgery.

Bill graduated from the University of Adelaide in 1952, and by 1955 was a surgical registrar at the Royal Adelaide Hospital. Later he travelled to the

John Mitchell Crouch 1940-1977



WORLD-LEADING RESEARCH

John Mitchell Crouch (JMC) Fellowship funds research into key body responses post trauma that could save lives

The 2015 recipient of the College's prestigious John Mitchell Crouch (JMC) Fellowship, Professor Zsolt Balogh, has used the attached funding to help pay for equipment to advance his world-leading research into polytrauma, traumatic shock and Multiple Organ Failure (MOF).

Professor Balogh is the Director of Trauma at the John Hunter Hospital and Hunter New England Health District and is the Professor of Surgery and Traumatology at the University of Newcastle.

While he has been a leading Orthopaedic and Trauma surgeon and scientist for many years, Professor Balogh's most recent investigations centre on developing a greater understanding of the interaction between leukocytes and mitochondrial DNA.

This interaction, only discovered in the past decade, is now believed to drive the body's post-trauma inflammatory response which can lead to MOF, the most common cause of mortality for those trauma patients who survive the initial days following injury.

Professor Balogh used the JMC Fellowship funds to help pay for a state-of-the-art flow cytometry system that

enables him to conduct the rapid and detailed patient blood analysis required for surgical research at the John Hunter Hospital and University of Newcastle.

He said he began this stream of research to understand why severely injured trauma patients often suffered MOF three to five days post injury even though there was no sign of infection or specific damage to the organs and after researchers in America had found increased levels of free floating mitochondrial DNA in the blood of severely injured patients.

"The patients we are treating and researching are those who, in the past, would not have survived their injuries and the inflammatory response we are now seeing is like the body trying to self-destruct to end the suffering," Professor Balogh said.

"In other words, we are witnessing the results of a huge destructive energy transfer to the body, which has not been seen in the past because those patients could not be saved.

"We know that mitochondria controls life and death, that it is these genes that shut cells down when they decide it's time for the body to die and that it is mitochondrial DNA that is released from dying cells.

"We also know that mitochondrial DNA is ancient in its structure and that it resembles and functions much like a bacteria and that when it is released from cells it deranges the body's immune system, triggering the uncontrolled inflammatory response which manifests in MOF.

"We now believe this is because leukocytes respond to the mitochondrial DNA as they would to bacteria, which is a wonderful revelation because nobody knew that cells could react this way in the absence of infection."

Professor Balogh said he hoped the work would give surgeons a greater understanding of post-injury inflammatory processes and help reduce the occurrence of MOF, which has a current mortality rate of 25 per cent, compared to only three per cent of ICU polytrauma trauma patients who avoid MOF.

"We have found four independent predictors of MOF," he said.

"They are the severity of the injury, the severity of blood loss, the patient's genetics and the management of the patient, including surgical interventions.

"We can't do anything about how severely they're injured or their blood loss, we can't change how genetically

“In other words, we are witnessing the results of a huge destructive energy transfer to the body, which has not been seen in the past because those patients could not be saved.”

prone they are to inflammation, but we now know that the way we manage their treatment can directly impact on the degree of organ failure they will suffer.

“This could mean that while traditional thinking had it best for trauma surgeons to wait before conducting surgeries to stabilise the severely injured patient, faster intervention could actually reduce complications.

“In fact, I think we can do earlier stabilisation interventions than we previously thought, particularly orthopaedic surgeries, because studies have shown that immobilisation poses a greater risk to injured patients by creating stress that can further enhance the inflammatory response.”

Professor Balogh’s research was facilitated by the Hunter New England Health District, the Hunter Medical Research Institute and the University of Newcastle. His key local collaborators are Professor Phil Hansbro and his immunology team from the Hunter Medical Research Institute and University of Newcastle genomics expert Dr Doug Smith.

Originally from Hungary, Professor Balogh moved to Australia in 2005 after he was offered the position of Director of Trauma at the John Hunter Hospital and is now a dual citizen of both countries.

He received his MD and PhD at the Albert Szent-Gyorgyi Medical University in Hungary where he also completed his clinical training in Orthopaedics and Traumatology before completing several trauma Fellowships in the US and Australia.

Since his arrival in Australia, he has established the Traumatology Research Group through the University of Newcastle which has extensive national and international research collaborations with institutions such as Cornell University, USA, Leeds University, UK, the University of Aachen, Germany, the University of Texas-Houston Medical School, USA, and the AO Research Institute, Switzerland.

Among many editorial roles, he is an associate editor of the World Journal of Surgery. Professor Balogh has published 150 peer reviewed papers (H-index: 29, IF>500, Citations >4500), he is the current President of the Australian Orthopaedic Trauma Society, has held leadership positions in the Australian Orthopaedic Association, the RACS and the American Association for Surgery of Trauma and has received 22 national and international awards for his research.

However, despite such success and recognition, Professor Balogh said he was most proud to receive the JMC Fellowship, which is the highest accolade bestowed by the RACS.

“I was absolutely thrilled to be chosen because this is a Fellowship that I respect very highly,” Professor Balogh said.

“When scientists apply for most grants, we have to specify how we will

spend the money right down to details like photocopying costs, which is time consuming and dreary and a process almost designed to snuff out the spark of scientific curiosity.

“However, to receive the JMC Fellowship is to receive both wonderful professional support and crucial financial support from the College and Fellows.

“It is an amazing gesture that says, in effect, we like your work so here is some money so you can do even better work in the future.

“I don’t know of any similar Fellowship bestowed by any medical College anywhere else in the world and it is now recognised internationally as providing unique support to, and recognition of, the value of surgical science.

“The funding provided by the JMC Fellowship also came at a perfect time when I was trying to find the funds to equip our Surgical Sciences Laboratory at John Hunter Hospital.

“The new equipment allows us to continue to improve our care of the severely-injured patient and disseminate our findings out to the broader surgical profession both here and abroad. Our research focus on sterile inflammation has major relevance to many other pathologies such as cardiac disease, stroke, cancer, pancreatitis, thrombosis and rheumatological disorders.

“Even after working in this field for more than 20 years, I still find the research into the biological mechanisms driving the physiology of injury fascinating because still so little is known about it.”

The JMC Fellowship, first awarded in 1979, is the premier research award bestowed by the RACS to surgeons considered to be making outstanding contributions to surgical science and research.

With Karen Murphy



Zsolt Balogh and Michael Grigg



Letters to the Editor

President's perspective

Dear Editor,

I write about the "President's Perspective" in the present issue

To me it is unbelievable that the President of RACS has used the editorial to express his personal thoughts on global warming. It has become a political narrative and I do not agree with his thoughts.

It beggars belief that, with all this talk, the College still has not put solar panels on the roof to actually save some power.

Yours sincerely,

Brian Parker

Dear Brian,

Thank you for writing and I am pleased you have read the Presidential Column on Fresh Air and Active Travel in the December Surgical News.

You have suggested that I have strayed from core College business to politics. I would respectfully suggest that the health issues of Air Pollution and the need to be active (Active Travel) are irrefutable and nothing to do with politics. The health related aspects have been the subject of two Lancet commissions in recent years (2009 and June 2015). The medical evidence is again sound. This is not politics.

That world leaders could meet in Paris and not question the fact that our world is currently subject to global warming suggests there is consensus. That surgery is a high energy user within Health Care is not disputed either.

I did not promote a political view on climate change other than I would not be prepared to buy-in to trying to deny it. That wouldn't be founded on evidence and would be political.

As the article said, there has been an inaugural book produced on Surgery and Climate Change, the underlying work being done using a RACS Ethics Scholarship Grant, and co-authored by one of our senior

Professors, Guy Maddern. The health effects of climate change are more core business for RACP who have been active in advocacy on this issue. We have chosen as a College to focus more on advocacy issues that specifically relate to surgery, but I would still suggest that surgeons need to be promoting Fresh Air and Active Travel, and it is well worth our considering our carbon footprints.

We are currently evaluating solar panels on the roof but my article specifically implied that this was not what the column was focused on. I admit it was clearly timed to coincide with the Paris summit and I would suggest that this timing was indeed apt.

Professor David Watters OBE

President

Climate change

Dear Sir,

I was interested to read the article by Prof Kingsley Faulkner on climate change.

As this was published in an official RACS publication, which has always promoted evidence based science, I hope this means that the RACS will now give the evidence for these prognostications of climate change.

I am aware of the IPCC models, 140 of them I believe. The data behind these models is a mystery, at least to me. All of these models have been wrong in the prognostications made from them. Nevertheless the IPCC has raised its degree of certainty of a significant warming over the next 100 years from 90 percent to 95 percent. To an ex RACS surgeon, who has had the scientific method drummed into him for nearly 50 years, this hypothesis of man made CO₂ resulting in a dangerous rise in temperature, would seem to be disproved.

Is this strong belief in man made CO₂ as the sole cause of rising temperature now official RACS policy?

If so, the Dunning Kruger Effect seems to be a factor in such a belief.

Yours Sincerely,

Douglas Handley

Letters to the Editor

Bullying: I'm so angry I could...

A lot of people have worked very hard to influence the culture that seems to exist in some of our hospitals. It really is amazing! Yet in my small hospital it doesn't seem to be relevant, currently....

When I was training, and while I worked as a locum I worked in about 30 different hospitals in five or six different countries. For those of you with similar experience it comes as no shock: different surgical departments have different cultures. Our departments really do vary quite a bit. Some have a positive buoyancy, most are relatively happy and a few are quite unhappy.

My gut feeling is that probably only one in twenty surgeons exhibit behaviour that might be considered bullying, harassment or sexual harassment; the simple mathematics of each trainee working with a minimum of twenty surgeons explains the seemingly high prevalence. Most surgeons will work in departments of 5-10 surgeons; so may, or may not, have a bad apple within. This explains the 'shock' of the newspaper numbers.

This doesn't make it right.

What can I do?

I'm so angry I could Write a letter?

There are so many things a letter of this sort should say. Many of those affected might want to remain anonymous still. Typically it will be about the past. There are so many reasons not to act, but would that be fair?

Most people who bully are surprised that they might come across that way. It is unfair to leave a colleague talked about or excused. "Jim (not his real name) can be a bit abrupt"; "Jim's doing it again"; "Jim is having a bad day". Jim would probably want to know, Jim would probably not enjoy being this centre of attention.

I think it is time to take some personal responsibility. In the corner of this article is a letter any of us can send. If you think it might help a colleague clip it out and put it in the post. It's really that simple.

How the hell will that work? Well, if I got one of these letters I would think that I had really upset someone; if I got a few I would worry there was a bit of a pattern to my behaviour that

I really ought to think about; many more that and I would be doing a lot of self-reflection, after all, the next letter might have teeth.

Pictured below is a generic letter that anyone could send anonymously:

Dear Surgical Doctor,

I write to you about something that happened in the past.

I have been reflecting on the RACS current examination of bullying, harassment and sexual harassment.

While I think highly of you in many areas of your professional life, I am worried that by current standards your behaviour previously might not meet our current standards.

It would be really sad for you to be caught out by this change. It may be this was a 'one off' or that you have changed. I certainly hope so.

I hope if you are getting a few of these letters it will prompt you towards seeking some advice and help,

Kind regards,

Another Doctor.

Yours Sincerely,

Gowan Creamer

Women Surgeons of World War 1

College exhibition focuses on four female Surgeons

There is a small exhibition in the College walkway, focusing on four women surgeons who made their way to war. Agnes Bennett and Lilian Cooper worked for the Scottish Women's Hospitals near the Serbian front. Conditions were incredibly harsh but both women acquitted themselves well. They returned to successful careers in New Zealand and Australia respectively. Lilian Cooper was also our first female FRACS. Feminist Phoebe Chapple went to France in 1917 and while attached to the Queen Mary's Auxiliary Army Corps, was one of a handful of women to win the Military Medal. Vera Scantlebury was 28 when she arrived at the Endell St Military Hospital in London. Her diaries (held by the University of Melbourne Archives) record the evolution of a young and inexperienced doctor to a competent surgeon. Vera Scantlebury (Brown) was later fêted for her pioneering work in infant welfare.



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 compulsory 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 2016. 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 28th in Melbourne.

Applications close 5pm, Friday March 25th 2016.



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DOCTORS HEALTH

The Australasian Doctors Health Conference

RUTH MITCHELL & STEWART MORRISON
RACSTA Executive

The Australasian Doctors Health Conference was held in Melbourne from 22-25 October 2015, and the RACSTA Executive was well represented: Dr. Stewart Morrison as a member of the organising committee, and Dr. Ruth Mitchell as a presenting speaker. The conference has generated interest in many specialty and academic circles; the bold moves by RACS in addressing issues of bullying and harassment reflect a growing acknowledgement in the broader field of medicine of the cultural, wellness, and self-care aspects of our profession that will enable us to be safer, happier, and more effective doctors.

Have you ever wondered what you would do if you had a stroke and wanted to go back to work but weren't sure if you were ready or able? Dr Kym Jenkins, medical director of the Victorian Doctors Health Program spoke from her experience of working with doctors making the transition illness and impairment to clinical practice. While some doctor-patients lacked insight into their performance deficits and were not able to return to clinical work, there were some surprising and hopeful stories of doctors afflicted by stroke, traumatic brain injury, and alcohol-induced cognitive impairment. A collaborative approach between the employers and the health professionals looking after these complex patients has allowed some amazing success stories. The key elements to these stories are good insight on the part of the doctor hoping to return to work, a willingness on the part of the workplace to provide supervision for previously autonomous practitioners, including returning to registrar role, gradual reintroduction of work hours and on-call, and avoidance of fatigue. Ultimately, "competence is situation sensitive and task specific" and the best test of someone's competence to do a job is to see how they actually perform when observed to do a job. For doctors with dementia, however, there are really only two tips. "1. Go on holiday. 2. Stay on holiday."

The relevance of competence to surgical tasks, and surgical careers, was highlighted by the Prof. Carmelle Pesiah, who explored "How to grow old disgracefully." She applauded the Royal Australasian College of Surgeons on the Senior Surgeons Section, whose attention to planning for retirement and provision for mutual support ease the transition for surgeons nearing the end of their clinical careers. While some of us might worry that others will have to pry the scalpel from our cold, dead hands, Carmelle advocated a more gradual approach, which acknowledges both our future goals and our initial motivations for embarking on a career in surgery.

Academic sessions and keynote presentations also tackled resilience, pastoral care, and cultural sensitivity for medical students and junior doctors. A/Prof Jan Mackenzie's research detailed the coping strategies and resilience of medical students affected by the 2010 Christchurch Earthquake, highlighting the importance of place, and role of communication when students or doctors are face with catastrophe. Asiel Adan Sanchez (medical



student) explored issues faced by sexually and gender diverse medical students, drawing parallels with the structural violence often faced by gender-diverse patients: Concepts as simple as the 'male/female' tick box on a radiology request slip, a trans-woman requiring a prostate biopsy, or a trans-man requiring a pap smear have the potential to cause harm and fear, should they not be handled in a culturally sensitive fashion.

Dr. David Kopacz (Seattle, USA) presented his framework for "Re-Humanizing Medicine", the title of his recent book. At times we find medical curricula focus on being a "technician" rather than on being a "healer". It is easier to examine the former but it may not be the ideal endpoint. We are fortunate as surgeons to have a vast array of technology and described procedures at our disposal, which may be applicable to the patient in front of us: Our value as a healer, then is perhaps truly revealed, when the patient in front of us, falls outside of those innovations. How do we perform, then?

The conference's concluding hypothetical was Tolkenian in construction, but scarily close to the hearts of attendees. The management of a senior clinician with a substance abuse disorder was discussed, panel members assuming the roles of the medical board, hospital administration, general practitioner, psychiatrist, and the consultant's registrar. The ensuing discussion gave valuable insight into the importance of the concept of mandatory reporting, echoing Dr. Marie Bismark's review of AHPRA cases: Perhaps demonstrating that some of the paranoia surrounding mandatory reporting, has not eventuated, and when managed correctly such reporting is an invaluable way of supporting our profession.

The conference's ability to amalgamate academic research with round table discussion, exemplifies the diverse approach to the health of doctors that is required. Just as tackling bullying and harassment is not just about answering complaints, doctor's health as concept transcends simply treating those most unwell, but must be carefully and deliberately embedded in curricula, clinicians, and medical culture.

A special thank you also to Mr. Jason Chuen (vascular surgeon) and Deborah Jenkins (RACS) who also attended the conference.



AN OPEN LETTER TO THE PRESIDENT

We need to prioritise the cost-effectiveness of medical care

DAVID CLOSE
South Australian Fellow

We as health providers are facing a developing situation which in my opinion needs much more attention. Some surgeons seem to have a “head in sand” approach and the RACS does not appear to be giving it sufficient priority. Despite the current and predicted rapid increase in the cost of medical care to the nation, to which the word “unsustainable” is frequently applied, most surgeons and our body the RACS do not seem to be making determined efforts to contain costs.

To quote from the “President’s Perspective” in the May 2015 issue of *Surgical News*: “We need, as a College, to earn a reputation for being appropriately concerned about sustainability and recognising the need to provide excellent health care that is affordable by individuals and society.” This sums it up perfectly. But apart from my letter to the editor in the March 2014 issue, very little mention of the subject can be found in *Surgical News*.

Surgery, like other branches of medicine, is now an industry. Surgeons need to keep their lists full to earn the income they desire, pathology companies want to process as many tests as possible and the aim of radiology providers, usually companies paying dividends to shareholders, is to maximise throughput. This is all good business policy. But where is the brake or control? The funders of the system, namely Medicare and the private insurers have to pay out on demand, with no audit of services provided.

One can only imagine how the costs of car crash repairs would escalate if the insurers did not employ assessors.

It is no wonder that the Government and the insurers are starting to take steps like reviewing Medicare items, freezing the rebates and refusing to pay for readmissions for complications. Some of these steps are against the interests of our patients and those of ethical and responsible surgeons.

The providers of surgical equipment declare as many items as possible to be single use, without having to justify this. My observation is that no one in an operating theatre has any idea of the cost of items being used. In watching other surgeons and anaesthetists, including registrars, at work, one notes that some ask for and discard expensive items with almost “gay abandon”. The reasoning that “medical insurance will pay for this” is often used to justify this profligacy.

My letter in *Surgical News* described the reusable bladed harmonic scalpel, a valuable instrument in tonsillectomy, being replaced for no good reason by one with an expensive single use blade. More recently my experience with surgical drill burrs is even more alarming. For years I have used the Osteon surgical drill for mastoidectomies with a selection of approximately 6 cutting burrs and 5 diamond paste burrs available for every case, all resterilised and reused dozens of times. About a year ago I was informed that each burr was now single use at \$280 each. This would amount to about \$3000 per case. (surgeon’s fee max \$3000) On enquiry I was told that complete removal of bone dust from a diamond paste burr could not be guaranteed but I received no response from the company to justify cutting burrs being single use. As a result only 1-3 burrs are used per case which carries increased risk of patient damage.

When I commenced private hospital surgery in 1980, surgeons provided all their own instruments, including drills, prostheses and any other items such as grommets and haemostatic materials. In some cases ENT surgeons even had to provide their own operating microscopes. Anaesthetists provided their own equipment and drugs. Although this is no longer possible or desirable, cost control was not surprisingly near perfect, allowing the hospital to charge the paltry sum of \$200 for an overnight stay, with no operating theatre fee.

Currently an admission for extensive sinus surgery (operating time 1 1/2 to 2 hrs, surgical fee about \$2-3000) incurs hospital fees of over \$10,000 for an overnight stay and theatre fee.

The baby boomer generation is now aged 54-69 years, and it is inevitable that eventually each of us will require much expensive medical treatment. We all have patients who have had multiple treatments for cancer, cardiac disease and joint disease, possibly with periods in ICU, whose costs would have amounted to many tens of thousands of dollars, paid for by the insurance premiums of the healthy. The annual increase in these premiums of 6-7% would seem entirely justified, yet unsustainable long-term. Patients are generally not aware that the increases in their premiums relate to hospital costs and that Medicare fees for surgeons have increased so little over the years (and are now frozen) and therefore naturally question why their expensive insurance no longer covers surgical “gaps”

Control of the number of services provided can probably only be achieved by the health insurers gradually taking charge ie managed care - which seems eventually inevitable, as the Government is very poor at this type of cost control.

So what can and should the RACS do? The following are a series of my suggestions – no doubt many others will arise if the discussion of cost management is promoted in College activities and publications.

1.

Establish cost control/health economics committee(s)

2.

Appoint a full time health economist, possibly even to be a member of College Council, with sufficient experience, knowledge and authority to act for the College in discussions and negotiations with the stakeholders. Because of limited tenure, other committee work, and having to run busy practices at the same time, elected College office-holders are at a major disadvantage compared to the employees of Government health departments, insurance company officers and equipment company managers, all of whom can devote much time to making or saving money for their employers. He could also write regular articles for Surgical News.

3.

Improve consultation and cooperation with Government departments and insurers and persuade them that the College has similar cost containment aims. This may involve surveillance of surgeons and certainly will involve close cooperation in Medicare reviews. We must work with them rather than work against them.

4.

Determine methods of preventing unwarranted increases in costs of surgical equipment. By sponsoring our meetings the companies have cleverly minimised criticism of their prices. The whole question of sponsoring may need reconsideration, as has been the case with drug companies. Ways of making those in theatre aware of the cost of expensive items should be sought. There could be a system whereby surgeons are encouraged to report examples of apparently excessive cost increases or discrepancies, such as the two I have described. The College health economist could then write to the company concerned seeking justification for the increase or discrepancy. The College could have a panel of fellows - one from the appropriate speciality would be asked to review and comment on the company’s response. These proceedings could then be reported in Surgical News. Less expensive alternative equipment could be listed. Justification for making items single use would be required. Perhaps use could be made of newly retired but interested surgeons in these matters. To know that their cost structures are closely scrutinised in this way should serve as a disincentive to the companies to slip doubtful methods of increasing their incomes under the radar.

5.

Scholarships in surgical economics could be initiated. Presentations and panel discussions at meetings would stimulate further ideas.

We must expect Governments and the health insurers to take action to prevent further cost escalation. Seeking ways of saving money will probably be unpopular with surgeons. New and expensive equipment is very seductive. However, cost containment efforts will be forced upon us if we do not seek to initiate them on our own terms.

Note: Since submitting this letter, the article by Vice President Graeme Campbell in the latest (October) issue of Surgical News on this very subject has been brought to my attention. In particular he reports the recent establishment of the Sustainability in Healthcare Committee chaired by Councillor Dr Lawrie Malisano.

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Interested In Global Surgery and International Medical Development?

RACS International Forum at the ASC

The 2016 International Forum, convened by Dr Neil Wetzig FRACS, will be held on Monday 2nd and Tuesday 3rd May 2016 at the ASC in Brisbane. The program includes sessions on:

- Regional approaches to global surgery: case studies and perspectives from Timor Leste, Pacific Islands, China, Myanmar and Africa
- An international approach to global surgery: the Lancet Commission on Global Surgery and the WHO - are these real opportunities for change?
- The role of surgery in national health plans in low and middle income countries
- Presentations by Asia-Pacific representatives on their progress in collecting country data on the four identified global surgery metrics to contribute to a global dataset to measure population access to safe surgery and anaesthesia
- Rowan Nicks Scholars' presentations and research papers
- A Master Class on Tuesday 3rd May: Working as a surgeon in the global environment: Why? Who? When? and Where?

The provisional program is available at :

<http://www.surgeons.org/for-the-public/racs-global-health/symposium-international-forums/>

Enquiries may be directed to: stephanie.korin@surgeons.org



THE DEXTEROUS HAND

Zachary Cope, Surgeon and author 1881 - 1974

MR PETER F BURKE
Specialty Editor -
Surgical History: ANZ JSurg

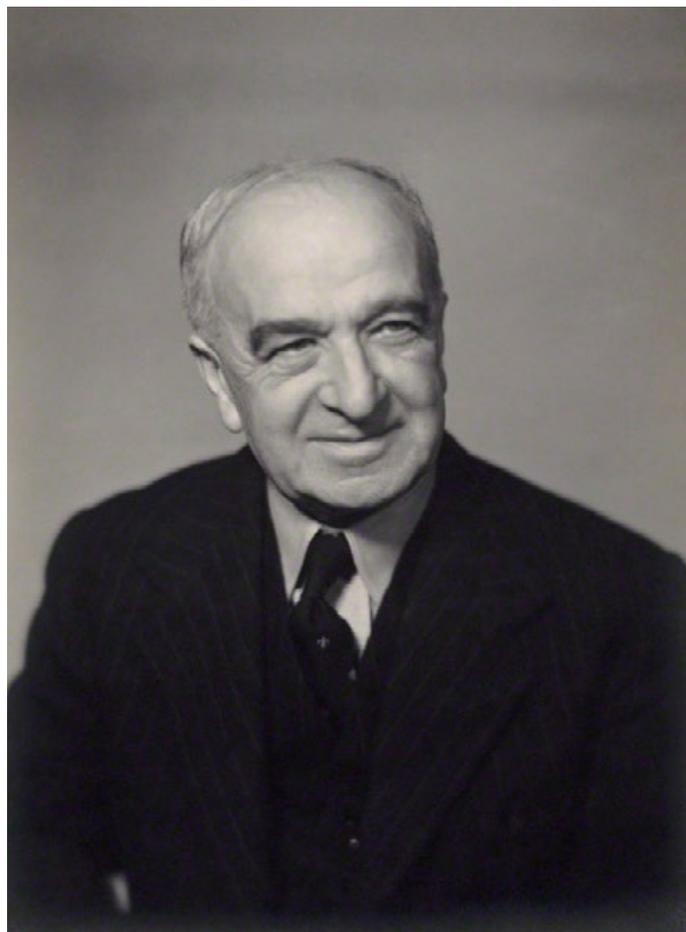
Many surgeons will have read “*Aphorisms and Quotations for the Surgeon*”, edited by Moshe Schein, and first published in 2003; this is a collection of over 1500 aphorisms and the like relating to the practice of surgery. The second most commonly used source for these entries is just one work, ‘*The Early Diagnosis of the Acute Abdomen*’, written by Zachary Cope and first published by Oxford University Press in 1921.

One such observation reads, “*the dexterous hand must not be allowed to reach before imperfect judgement*”, representing an appropriate introduction to this influential surgeon’s life and work.

Vincent Zachary Cope was born in Hull on 14 February 1881, the youngest of 10 children. The family moved to London in 1890 where apart from military service Cope spent the rest of his life: he was educated at Westminster School, ultimately gaining an entrance scholarship to St Mary’s Hospital Medical School: graduating with honours he was thence to remain at St Mary’s as surgeon and consultant.

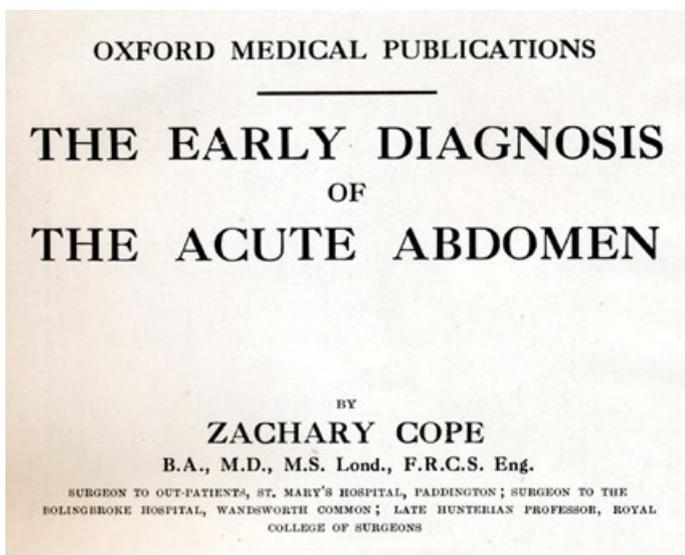
A popular clinical bedside teacher Zachary Cope was missed when he joined the RAMC in 1914, and saw active service in Mesopotamia from 1916 until 1919. Concern for the troops suffering with dysentery resulted in his first book ‘*Surgical aspects of dysentery including liver abscess*’ in 1920.

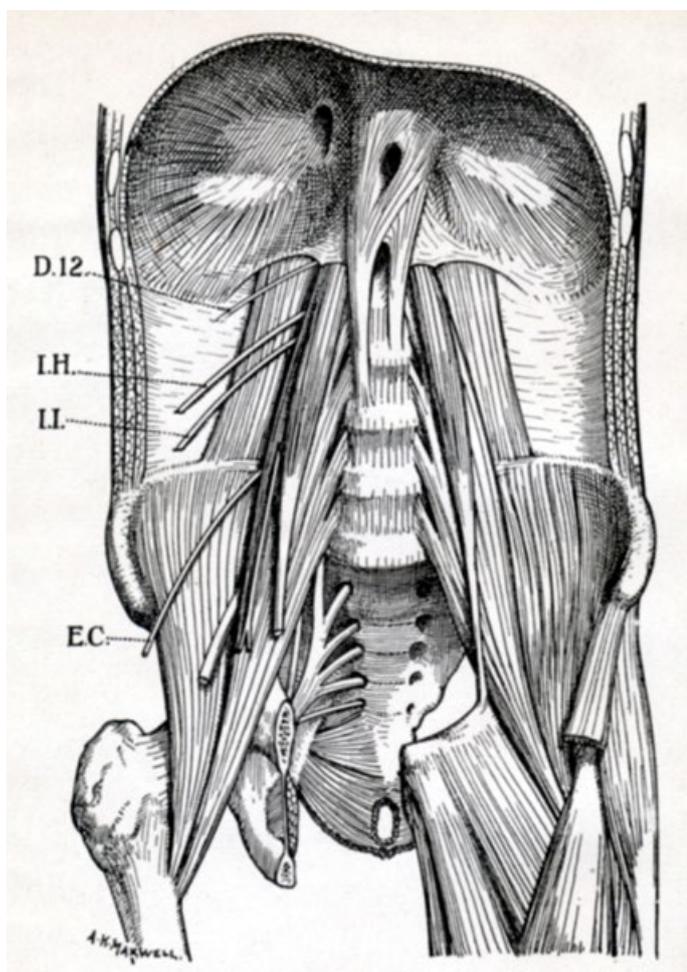
After the First World War he had returned to civilian life and



following his publication on dysentery he was no doubt led to consider the benefits to be gained from the early recognition and proper treatment of acute surgical abdominal disease before the terrible and largely untreatable complications of its later stages could set in. Then followed by his masterpiece ‘*The Early Diagnosis of the Acute Abdomen*’ in 1921; that book went to 14 editions during the next 50 years of his lifetime, he undertook final revision of the work aged 90, as it had remained in steady demand.

In the preface to that 1921 first edition Cope wrote that he had “*introduced many diagnostic points which he believes have either never previously been recorded or to which insufficient attention is usually paid. In the former category may be mentioned the localizing diagnostic value of phrenic shoulder-pain, the obturator test, and the test for differentiating between pain of thoracic and abdominal origin; whilst in the latter the area of hyperaesthesia caused by a distended inflamed appendix, the pathognomonic axillary area of liver resonance in cases of perforated ulcer, the psoas-extension test, and the confusing*





significance of testicular pain, serve as examples”.

The frontispiece, reproduced here, was a drawing showing “the parietal muscles of the abdomen which, by their rigidity, immobility, and tenderness, give important help in diagnosis of the acute abdomen”.

Cope must have been one of the first to bring to the surgical bedside the attributes of a clinical scientist; he liked to live close to his work so that he could walk to St Mary’s and this explained his familiarity with early abdominal cases. He was a small man, quieter and calmer than many and he used a wooden stool upon which to stand and operate, known as Mr Cope’s box.

In the years between the wars, besides his dedicated clinical teaching and operative work he served the RCS as a member of the Court of Examiners and on Council. His great interest in abdominal surgery is reflected in his later books: ‘Clinical Researches in Acute Abdominal Disease’ 1925, ‘Pioneers in Acute Abdominal Surgery’ 1939 and ‘A History of the Acute Abdomen’ in 1965.

The Second World War saw him increasingly involved in BMA and Government committee work, including a massive regional hospital survey of south-west England, as well as serving the group of hospitals based on St Mary’s.

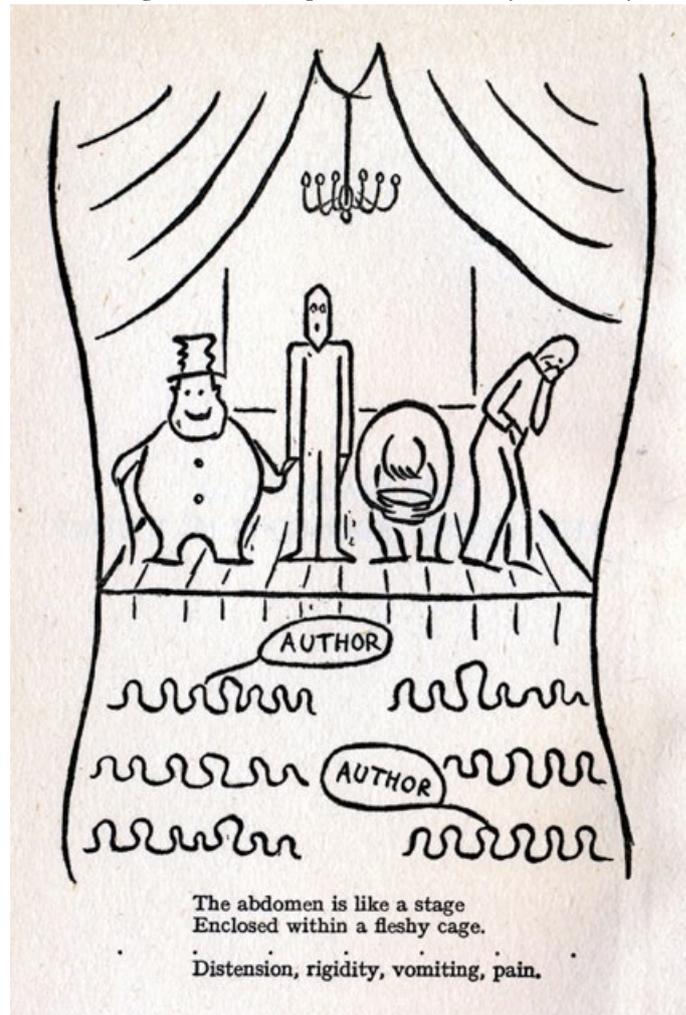
Following the war his committee work involved medical

education, proprietary medicines, the *British Pharmacopeia*, physical medicine, medical war relief and his Cope Committee with some 41 members enquired into the national registration of medical auxiliaries. Cope also compiled for the ‘Official Medical History of the Second World War’, the volume on ‘Medicine and Pathology’ (565 pages, 1952) and ‘Surgery’ (772 pages, 1953). His public work was acknowledged by the knighthood conferred in 1953.

The two great pleasures in his life comprised the ability to comprehend and appreciate the dramatic changes in modern surgery whilst remaining a humane and clinical exponent of the art and also his undoubted flair for writing.

His happy knack of compiling light verse with a serious message led him to write ‘*The Diagnosis of the Acute Abdomen in Rhyme*’ in 1947, under the pen name ‘Zeta’.

He observed that, “the abdomen is like a stage...enclosed within a fleshy cage”; and on that stage there are four principal actors, “distension, rigidity, vomiting and pain”. The drawings by Peter Collingwood are a superb feature as they accurately and



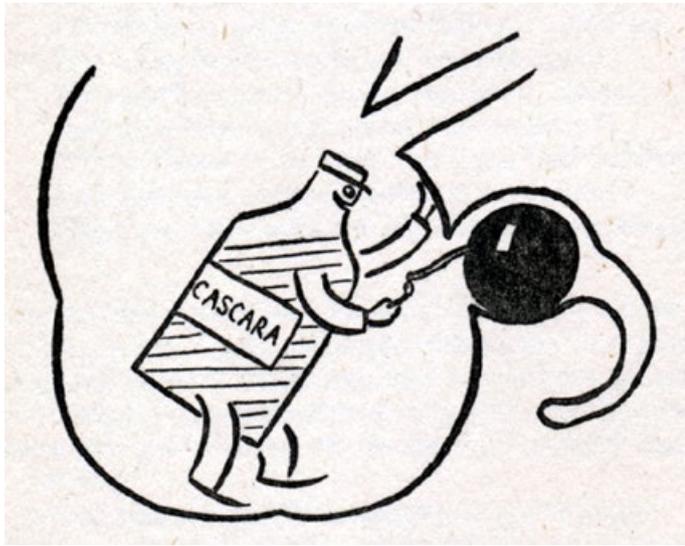
humorously support Cope’s witty words.

The book has 10 chapters and an ‘Addendum’: the chapter headings include, ‘Perforated Ulcer’, ‘Appendicitis and

INFLUENTIAL SURGEONS

Cholecystitis' and 'Abdominal Injuries': they can all be read with profit today by even the most experienced surgeons amongst our ranks.

Cope commenced this work with his 'general principles':
"The diagnostic problem of to-day



*Has greatly changed--the change has come to stay;
We all have to confess, though with a sigh
On complicated tests we much rely
And use too little hand and ear and eye."
"More harm is done because you do not look
than from not knowing what is in the book!"*

The 'Appendicitis' Chapter commences with these salutary words;

*"Of all the ills within the abdomen
Which cause affliction to the sons of men
There's none more often puts them in a fix
Than trouble in the worm-like appendix."*

His published books in the early years were clinical in nature, those of the later years were biographical including biographies of William Cheselden, Florence Nightingale, the History of St Mary's Hospital Medical School and the History of the Royal College of Surgeons of England.

In the preface to his history of the RCS Cope outlined the obvious difficulties encountered when writing a readable account of bland historical facts:

"When the President and Council asked me to write a history of the College I willingly accepted the great honour though I fully realised the responsibility of the task, for there was no previous authentic history to serve as a basis in the very voluminous records of the College would need long and careful scrutiny.

The perusal of these records proved indeed an enthralling occupation, though enjoyment was tempered by the humiliation of finding how little I had previously known of the bygone days of the College with which I had been

associated for so many years.

The deliberations of the Council have always been secret and discussions are not entered in the minutes so that it has often been necessary to refer to contemporary medical journals in order to understand more fully the questions at issue.

It has not been easy to reconcile the need for historical accuracy with the natural desire to write a readable story, and it is hoped that the reader will pardon those passages in which necessary detail may hinder or obscure the narrative".

From the formal College Minutes of 150 years he produced a lively account which maintained a comfortable balance between the domestic and public history of the College.

Cope's favourite approach was biographical and apart from editing two collections of medical historical essays, 'Sidelights on the History of Medicine' (1957) and 'Some famous general practitioners and other medical historical essays' (1961), he wrote no less than seven "Lives" between his seventieth and eighty-fifth years! A prodigious feat indeed.

It will probably not surprise the reader to learn that your current author was somewhat surprised to learn that his reference library at home contains no less than eight books written by Zachary Cope: a silent tribute to the versatility and utility of this great man's pen.

For many years he served as honorary librarian of the Royal Society of Medicine and after retirement was generally to be seen in that library researching for his next book: later in his career his studies and contributions related to subjects as diverse as actinomycosis, blast injuries, burns and the results of the atomic bomb.

In private life he was the most equable, modest and friendly of men: devoted to his family and loved by his friends.

A well-known story about his early days as senior assistant surgeon at St Mary's exemplifies his character.

Being called to the ward to see an emergency admission, he immediately went to the bedside, but was as swiftly ordered by a very new staff nurse, to go and sit on the bench outside the ward. "Zach" went without demur, and when, as he anticipated, the very senior ward sister soon returned from tea and he was still there gazing at the ground in apparent abstraction.

Sister swept on into the ward to inquire, "Why is Mr Cope sitting on the bench, Staff"?

Horried explanation was followed by an order for instant apology, and a quietly smiling surgeon entered the ward saying, "It's quite all right, my dear, we all make mistakes"; quite so, but men like Zachary Cope made fewer than most.

He often said that the good surgeon must feel for his patients but never let the sympathy disturb his judgement or treatment; he had the strength to obey this counsel of perfection in his own case.



KA MAHI, KA INOI, KA MOE, KA MAHI ANŌ

Excellence comes from hard work and dedication

PAT ALLEY

Chair, Māori Health Working Group

Te Kirihaehae Te Puea Herangi was a visionary Māori who was responsible for a large portion of the rapid development, acceptance and understanding of Māoridom in the early part of the twentieth century. In 1937, upon being made a Dame Commander of the British Empire and asked by the newspapers for a quote, she replied *Ka Mahi, ka inoi, ka moe, ka mahi anō* – excellence comes from hard work and dedication. This phrase was the inspiration for the theme of Te ORA's Hui-ā-tau and Scientific Conference in 2015, reflecting Te Puea's view that in the face of unsurmountable challenges, hard work continues to be of the utmost importance.

The Te ORA Hui-ā-tau and Scientific Conference was sponsored in part by RACS and hosted by Tai Wananga Tu Toa - a school which suitably instils in its students the philosophies of diligence and achievement. Over the course of three days at the school's grounds in Aokautere on the outskirts of Palmerston North, attendees spoke on topics of Māori health disparities, Māori medical leadership, and the future of the Māori health workforce, before culminating in the awards dinner and celebration of the year's achievements. Interestingly the premier award was given to the former government statistician Len Cook for his work ensuring that robust demographic data on Māori was made more widely available. Something that our College will no doubt benefit from in the future.

As part of developing and inspiring the future Māori health workforce, Māori medical students are invited to attend the Hui-ā-tau and Scientific Conference with activities on the entire first day being reserved solely for them.

Alongside developing leadership and teamwork, Medical colleges are invited to speak to the students in this time to help provide guidance on their future careers. On behalf of the College, Mr Colin Wilson very kindly gave his time to speak to the students about his experiences as a general surgeon, and the challenges and rewards of career in surgery.

The Hui-ā-tau also provided a timely opportunity to seek feedback on the recently developed draft RACS Māori Health Action Plan, the ultimate aim of which is to improve the surgical health of Māori, and Māori representation within the surgical workforce. This opportunity took the form of a paper titled "Improving Māori surgical outcomes: the role of The Royal Australasian College of Surgeons".

The paper outlined the journey that RACS has already embarked on regarding Indigenous Health; from the formation of the Indigenous Health Committee in 2009 and the development of the Aboriginal and Torres Strait Islander Health Action Plan 2014-2016, to consultations on Māori Health and the hui held in August at the Tūtahi Tonu Marae in Auckland. Through this, RACS has devised a four step plan to address Māori Health inequities:

1. Develop an appropriate Māori surgical workforce
2. Analyse contemporary data on outcomes for Māori with surgical conditions
3. Undertake research where such data does not yet exist
4. Raise the visibility of Māori within RACS at all levels.

The Action Plan was well received by attendees and feedback has been generally positive. Nonetheless, it is clear that the Action Plan will require considerable hard work and dedication by the College if it wishes to improve Māori health. Hopefully by doing this, the excellence will follow.

RESET YOUR BAROCEPTORS

The salt our systems crave

BY DR BB G-LOVED

I have been monitoring surgeons' (and other doctors') blood pressure for a couple of decades. It's often been challenging to even persuade them to have their blood pressure recorded, and then listen excuses as to why 'today' is so stressful, that this raised life insurance reading isn't typical. "What you didn't have lunch, just grabbed a coffee, rushed here? They offer their arm still sweating, awash with catecholamines mobilising their metabolism –and all at the expense of their cardiovascular system. Strap them to a 24-hour monitor I can hear the smart physicians amongst you calling! Most won't make the time to re-attend for another check tomorrow, or at least not until after they've had an infarct or a stroke.

The scenario I've described above is not unusual. And hypertension is all too common. Missing meals is bad for blood pressure, because in response to hypoglycaemia the body must respond by releasing catecholamines to restore normoglycaemia. However, there are other simple reasons why so many of my patients struggle to remain normotensive. Two essential ions are often deficient - potassium and magnesium. I've written about magnesium before and how its actions as the natural balance to calcium are seldom appreciated, nor how it is so important for nerve, muscle, cardiac and metabolic function

[https://www.surgeons.org/media/18953603/final_low_res_sn_march.pdf].

This month I want to discuss another largely intra-cellular and often overlooked ion - potassium.

The symptoms of potassium deficiency are common to many conditions – lassitude, nausea, muscle weakness, paraesthesia, abdominal bloating and cramps, palpitations. Yet as most of the body's potassium is intracellular, serum potassium levels don't tell you what's going on inside your cells, nor what happening in the sodium pumps of your renal tubules, your baroreceptors, nor your vascular endothelium.

Clinical trials of supplementation have shown that potassium can lower blood pressure in both normotensive and hypertensive subjects. This has been known since the 1940's but ignored. Our genes have not caught up with the dietary changes of human development. Prehistoric humans consumed a sodium-poor and potassium-rich diet. The renal tubules of humans have evolved to conserve sodium and excrete potassium. Yet I am not promoting the Paleo diet, but rather advising those of us not in acute renal failure that we should be increasing our potassium intake.

In primary hypertension, reabsorption of filtered sodium by



renal tubules is also increased because of stimulation of several sodium transporters at the luminal membrane, as well as the sodium pump. Stress and corticosteroid secretion will exert the same effects as hypertension – sodium retention at the expense of potassium.

I'm not promoting some form of alternative medicine, my primary source includes a review in the New England Journal of Medicine. Today's diets are salt rich and potassium poor. Whatever your blood pressure, more potassium and less salt would be better long-term.

The pathophysiology goes like this: potassium augments aldosterone levels but reduces blood pressure, normalizes the circulatory reflexes of increased sympathetic activity, and corrects baroreceptor responsiveness. Sodium retention and potassium deficit, inhibit the sodium pump of arterial vascular smooth-muscle cells, thus increasing intracellular sodium. Increased intracellular sodium stimulates membrane sodium-calcium exchange membrane driving calcium influx. Hypokalaemia inhibits potassium channels in the cell membrane depolarizing it, activating voltage-dependent calcium channels in the membrane and sarcoplasmic reticulum, and the sodium-calcium exchanger. Increased cytosolic calcium triggers contraction of vascular smooth muscle. That causes hypertension and defective endothelial dependent vasodilatation. Sodium retention decreases the synthesis of the arteriolar dilator, nitric oxide.

In converse, a high potassium diet causes endothelial vasodilatation by hyperpolarizing – stimulating the sodium pump and opening potassium channels, decreases cytosolic calcium, and promotes vasodilatation.

Potassium chloride salt can be obtained but has a more bitter, metallic taste than salt, though 1ppm of thaumatin reduces this bitterness. Potassium though lethal in high doses intravenously, is harmless for alimentation with a LD50 of 2.5g/kg, and as safe as salt 3.75g/kg. There is a Lite-Salt version with 50:50 NaCl and KCl.

Potassium citrate is the potassium normally found in fruit and vegetables

The recommended daily intake is 4700mg per day. The best sources of potassium are avocado, spinach, white beans, yoghurt, broccoli, Swiss chard, lettuce, mushrooms, sweet potato, baked potato and banana. Some of these, such as the potatoes and banana, are high in carbohydrate (potato) and sugars (banana) and might not be the best source of potassium for your waistline.

2016 is a new year and this could form part of a new year's resolution. Increase your potassium intake; get your cytosol in sodium-potassium balance and your membranes polarized. Feel the buzz. You'll live longer and healthier that way.

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NEWS FROM NSW

Happy New Year and a farewell



MARY LANGCAKE

Chair, NSW Executive Committee

Happy New Year. This is my last article as Chair of the NSW Regional Committee. My term will end in June this year, so forgive me indulging in some reflections of my time as Chair.

Being elected to Regional Committee is a great honour. Subsequently being chosen as the Chair combines that honour with a sense of both responsibility and uncertainty:

responsibility as the representative for all of the Fellows within one's home state; coupled with uncertainty about the demands of the role and one's ability to exercise the responsibility as effectively as possible. It is a steep learning curve.

The workload is surprising with multiple meetings weekly. The Regional Committee Executive meets monthly, and the Committee bimonthly. I am a member of the Surgical Services Taskforce, part of the Agency for Clinical Innovation (ACI), which meets monthly and comprises representative of Local Health Districts and the Ministry of Health. The equivalent of ANZASM in NSW is the Collaborating Hospitals Audit of Surgical Mortality

(CHASM) which meets three monthly, and I serve as Deputy Chair.

On a bi-monthly basis I meet with a representative of the ACI, and the Medical Director of the Health Education Training Institute (HETI), which has governance over prevocational medical education in NSW. The RACS Board of Regional Chairs (BoRC) meets by teleconference every two months, and face-to-face at the ASC.

Building on the work of my predecessor Rob Costa, I have been fortunate to enjoy an excellent relationship with the NSW Minister for Health and the Secretary of NSW Health. This is vitally important, positioning RACS as the voice for quality and standards in surgery.

I attend a variety of meetings throughout the year. These have included the Medicare Benefits Schedule Review, and the Health Roundtable on End of Life Care, and in February I will attend the NSW Health Scope Of Clinical Practice Project Working Group, and a Health and the Arts Taskforce meeting.

So what have been the highlights for me thus far as Chair? I have been blessed with a great Deputy in Rafi Qasabian, and a strong and motivated Executive Committee. The Regional Committee itself is composed of a group of interested, engaged members who genuinely care about their role in representing RACS and/or their own specialty groups. We appointed an IMG representative for the first time.

A key goal at the start of my term was to engage more closely with our Fellows, IMGs and Trainees. I believe this has been achieved through a range of measures including the Chair's Newsletter, face-to-face conversations and listening to the key issues brought to our attention. A particular focus has been to engage with rural and regional

surgeons in an attempt to understand the particular issues that they face. I have been assisted by a strong rural representative on the Executive in Sally Butchers.

It is vital to give surgeons a voice and an opportunity to effect necessary change. To promote these goals RACS NSW held a pre-election debate in March 2015 involving the Minister for Health, the Shadow Minister and the Greens Representative. Each gave a presentation on key issues and then answered a range of thought provoking questions. I specifically prevented attendance by the Press, and all speakers commented that this enabled them to be more open and frank in their discussions. Three key issues were addressed including the need for more paediatric surgeons in NSW, the issue of who could call themselves a surgeon, and the ongoing gap in Indigenous health outcomes. The Minister confirmed the Government's commitment to fund six more paediatric surgeons. As a direct consequence of the Debate the Shadow Minister tabled a Private Member's Bill to quarantine the use of the term "Surgeon" to those practitioners who have recognised Fellowship training in surgery, including ophthalmology, gynaecology and oral surgery.

Furthermore, all three members agreed to engage more with RACS to address the critical deficiencies in Indigenous health. Kelvin Kong and I met with the Minister in August to discuss some potential solutions.

In February I was asked to comment on the critical need for an upgrade facing Tweed Hospital. My comments were published in the local paper, where I reminded the NSW State Government of its commitment to allocate funding for rural hospitals. The following week the Premier and the Minister for Health announced a major capital works program for the Tweed Hospital. While I am sure that my comments were not the deciding factor, it demonstrates why RACS has such an important

role in supporting surgeons and other members of the healthcare community.

Last year Allan Chapman and I visited Lismore, and over an enjoyable dinner with a number of surgeons, we listened to their concerns. Later in the year I was privileged to be asked to speak at the Provincial Surgeons of Australia meeting again in Lismore where I addressed the subject "I'm a Rural Surgeon: why do I need the College?" I hope I convinced them that they do!

In November the Regional Committee hosts Surgeons' Month which consists of a number of key events. This has continued to develop during my time as Chair. We have strong relationships with a number of sponsors who recognise our vision for engaging and supporting surgeons and Trainees in NSW. Two particular events stand out.

Following on from a successful Women in Surgery event in early 2014, and based on my commitment to see more intercollegiate relationships become a key part of RACS in NSW, we held a Women in Medicine evening at the College. This saw consultants from a wide range of specialities, as well as trainees and medical students. We were fortunate to have Dr Joanna Flynn, Chair of the Medical Board of Australia, speak about professionalism in the 21st century. This was followed by a discussion involving senior women from medicine, law, finance and health administration. The audience actively engaged discussing the issues that women face in progressing through each stage of a professional career.

Last November the keynote event was a multi-collegiate panel discussion addressing the topic "The Future of Healthcare in NSW", with representatives from the Colleges of Psychiatry, Surgery, and General Practice as well as the Committee of Chairs of the Medical Colleges, and HETI. In addition, the newly appointed CEO of the Clinical Excellence Commission, Ms Carrie Marr provided great input on her vision for the ongoing challenges of maintaining healthcare standards.

There have been other positives during my time as Chair. I have supported John Crozier in RACS advocacy regarding alcohol related harm. We have now met twice with representatives of the Office of Liquor Gaming And Racing, as well as members of the Colleges of Emergency Medicine, General Practice and Physicians to provide multi-Collegiate input into Government policies. The Regional Committee has fostered a greater awareness of the issues regarding mental health that may affect surgeons and Trainees. We have endeavoured to engage more closely with prevocational Trainees and students by attending the Golden Scalpel Games or speaking at various events. It was a privilege to be asked to open the PreIntern Conference last year.

Finally, a singular highlight was to meet His Royal Highness Prince Charles, the Patron of our College during his visit last year. I received two invitations as Chair and was delighted to have Phil Truskett accompany me to the garden party.

There have been challenges. The predominant issues for RACS last year were clearly Discrimination, Bullying and Sexual Harassment. I believe that our College should be congratulated

for the swift and powerful response that it made. There is no doubt that other medical colleges, indeed other professional organisations, should consider the initiatives that RACS has introduced.

There have been significant advances. In NSW, in addition to me being the first female Chair in NSW, there are now five other women occupying senior roles on the Committee. Five women were elected to Council, in addition to the four existing members. But more needs to be done. In all of its history there has only been one woman President. And there has never been a female Convenor of the ASC!

With respect to the Regional Committees I believe that College Council needs to engage more with them as they are best placed to know the essential issues within their own regions. Our Committees consist of dedicated members who stood for election because they want to make a difference. But they may become disillusioned if they feel the role is merely to review decisions made with little input regarding state issues. During the next five months my goals are to continue to foster intercollegiate relationships in NSW. I believe we share many of the same issues and should work collegiately to have greater representation addressing healthcare needs in NSW. I will continue to meet with the Health Minister and the Ministry to reinforce the essential role that RACS plays in the maintenance and promotion of high quality surgical care. We need to work more closely with the Doctor Spouse Network to gain a greater understanding of the stresses placed on families of medical and surgical trainees.

I took over as Chair inheriting a robust Committee from Rob Costa and I hope I will leave an equally strong one when I step down in June.



Mary Langcake and Phil Truskett

2015: THE YEAR IN REVIEW

Another year of growth and development

SPENCER BEASLEY
Chair, Academy of Surgical Educators

STEPHEN TOBIN
Dean of Education

The Academy of Surgical Educators (ASE) has enjoyed another successful year in 2015 and continues to grow and develop with the great support of its members. The ASE now has a membership base of over 600 and around 1200 people participated in various surgical educator related activities and courses.

In late 2014, Academy members responded to an electronic survey to provide feedback on the perceived value and effectiveness of the Academy's work and how well it was meeting Fellows' needs. In addition, the Academy reviewed the use of various technological platforms, and identified new opportunities to help Fellows improve the quality of their teaching. The survey and review confirmed that in the two years since its refined focus, the Academy of Surgical Educators was improving the level of support for its surgical educators; it had extended its educational offerings to deliver programming in a range of online and face to face modalities; it had developed a number of online platforms that house educational resources and had introduced a comprehensive reward and recognition program acknowledging surgical educators' contribution to the RACS education and training programs.

The Academy has evolved into an active community of practice. A number of Fellows who have provided outstanding service were recognised with awards. The Educator of Merit— Supervisor / Clinical Assessor of the Year Award recipients were: A/Prof Frank Miller of VIC, Dr Kim-Chi Phan-Thien of NSW, Dr Michelle Lodge of SA, A/Prof Mohammed Ballal of WA, Dr Jon-Paul Meyer of QLD, Dr Stephanie Weidlich of NT, Dr Frank Piscioneri of ACT, Mr Hamish Sillars of NZ and Dr Scott Mackie of TAS. The Educator of Merit Award – Professional Development Facilitator of the Year was won by Mr John North of Queensland. A number of award winners were presented with their awards at the Academy Forum on 12th November in Sydney.

The Expert Advisory Committee (EAG) recommendations to our College regarding the culture of the profession has implications for the Academy. For example, the Foundation Skills for Surgical Educators course will now become

a mandatory course for surgeons involved with trainee supervision. There will be many more courses in 2016/17 to help professionalise our surgical educator workforce.

The Academy continues to develop its public awareness campaign, with the Dean of Education continuing to promote the Academy of Surgical Educators and its educational products such as the Foundation Skills for Surgical Educators course. Presentations have been delivered at the RACS Annual Scientific Congress, International Conference on Surgical Education and Training (ICOSET), Australian and New Zealand Association for Health Professional Educators (ANZAHPE), and the Australian and New Zealand Medical



Attendees at the 2015 Academy Forum

Education Training Forum (ANZMET) incorporating the National Prevocational Medical Education Forum. RACS and the Academy were represented at ICRE in Vancouver by Prof Beasley and Dr Cathy Ferguson.

The Academy welcomed its 600th member in 2015. Mr Mark Omundsen is a colorectal, laparoscopic and general surgeon in New Zealand and attained FRACS in 2009. Mr Omundsen attended the Surgical Teachers Course earlier this year which has helped in developing his surgical education skills further.

In March the RACS, Royal Australasian College of Physicians (RACP) and Royal College of Physicians and Surgeons of Canada (RCPSC) hosted its 4th International Medical Symposium (IMS) entitled 'The Future of the Medical Profession'. This year's symposium saw the addition of two Colleges to this Tripartite alliance -The Royal Australian and New Zealand College of Psychiatrists (RANZCP) and The Australian and New Zealand College of Anaesthetists (ANZCA). The alliance is now referred to as the Trinations Alliance. The symposium attracted participants from a wide range of colleges, medical schools, health services and

regulators. A number of prominent local and international experts presented at the symposium, including speakers from Canada, the United States, the United Kingdom, Australia and New Zealand. The IMS was aimed at a futuristic view of medicine from the perspectives of the medical system, medical education, doctors commencing their careers and doctors in their senior years. The 2016 IMS will be held in Sydney on 11th March 2016 at the Amora Hotel and will build on the 2015 meeting.

The Academy hosted its third Forum at the Amora Hotel in November in Sydney. This year's topic focused on People, Process and Performance: Human Factors. Mr Phil Truskett, FRACS - Chair, Training in Professional Skills (TIPS) presented on 'TIPS: The tipping point'; Prof Francis Lannigan, FRACS - Chair, Non-Technical Skills for Surgeons (NOTSS) and Safer Australian Surgical Teamwork (SAST) presented 'Non-technical Skills and the Modern Surgeon'; and Mr Werner Naef - Director, Kalher Communications Oceania presented 'How we can create a positive clinical work environment?' The timing overlapped the meetings of the Surgical Research Society and Section of Academic Surgeons.

The Annual Scientific Conference (ASC) Surgical Education program was convened by Prof Jeff Hamdorf, FRACS. It exemplified the College's ongoing commitment to increasing its involvement and expertise in surgical education and also provided Fellows with an opportunity to benefit from hearing a number of eminent experts. Prof Anthony Gallagher presented two topics on 'Surgical Simulation for Outcome-based Training' and 'Human Factors in Acquiring Surgical Skills'. Prof Rick Satava provided a 'Brief history of simulation' as he was on the team that pioneered the first robotic surgery and first virtual reality surgical simulator. Other presentations included 'Measuring Surgical Competence'.

The College hosted the 2015 Victorian Showcase of Educational Research in the Health Professions on 12 August, with 77 people in attendance. The Showcase is a collaborative effort between HealthPEER (Monash University), EXCITE (University of Melbourne) and the Graduate Programs in Surgical Education (University of Melbourne and RACS). For Academy members, it is an opportunity to learn about the work of students enrolled in these graduate programs in health professional education. For educators and students it provides a platform for sharing ideas, resources and tips for educational practice, evaluation and research.

A major project over the past eight months has been the review of Supervisors and Trainers for SET (SAT SET) and Keeping Trainees on Track (KTOT). The ongoing interest in these courses indicates that attendees have found the content relevant and useful in their roles as surgical educators. Post-course feedback demonstrates that participants appreciate the opportunity to discuss with other Supervisors and Trainers the challenges of clinical assessment, legal issues, giving feedback and performance management. The online versions of these two courses have been fully revised and have been well received by participants.



Attendees at the 2015 Victorian Showcase

'Standards of Performance' is a new eLearning resource and is aligned to the 'Becoming a Competent and Proficient Surgeon' framework that describes five levels of performance for each of the nine surgical competencies. The resource provides a rich learning experience for SET Trainees. It allows them to assess their own performance against each level as they progress from a prevocational doctor to a proficient Fellow. It also helps Supervisors, Trainees and International Medical Graduates (IMGs) understand the levels of performance required for a Trainee to progress as they become a practising surgeon. It thus informs Trainee and IMG assessment in the workplace.

The Graduate Programs in Surgical Education offered jointly by the University of Melbourne and the College offer a suite of programs that address the specialised needs of teaching and learning in a modern surgical environment. The program currently has 25 students participating with a number completing their Masters. The program currently has 38 participants with a number completing their Masters. 2015 witnessed seven of the first graduates of the Master's program receive their qualifications at a ceremony in July.

The Academy is supported by an interactive online learning community where members can gather ideas, share interests and research, find resources and keep abreast of upcoming events. The environment is supportive, collaborative and fosters enthusiasm in surgical education. It includes: a discussion forum, resources, links to articles, e-newsletters, grant information and research opportunities, listings of workshops and courses, pathways to become Trainers and Supervisors and award information.

Membership of the Academy is open to all Fellows, Trainees, IMGs and external medical educators who have strong educational interests and expertise. For more information on getting involved in Academy activities or how to become a member, please contact Anne Jreige on +61 3 9249 1111 or ase@surgeons.org

**To access the vodcasts for the above sessions, login to the RACS website, go to My Page, eLearning, Academy of Surgical Educators, Resources.*

MORTALITY ONLINE

ANZASM Fellows Interface



GUY MADDERN
Chair, ANZASM

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) programme has been operational for over 10 years beginning in Western Australia. It has been operating nationally, with all states and territories contributing since 2010.

There are two important new enhancements to the 'Fellows Interface', the web-based Mortality Audit IT system, that have been designed based on feedback from surgeons using the system. Across the regions 55-65% of surgeons (excluding New South Wales) are currently using this interface as a means of submitting their surgical case and first-line assessment forms, and we would like to see this number increase.

1. Third party delegation of cases

The Fellows Interface has been enhanced to enable users to delegate the completion of their surgical case forms (SCFs) to a third party (e.g. trainee, registrar). Once the delegate has completed the SCF, the form is returned to the original case owner for review and approval before being submitted back to the audit office.

In brief, login to the Interface using your ID and password, highlight the case you wish to delegate and click on delegate case. Enter the email address of the person you are delegating the case to and then accept the terms and conditions, then continue on if the delegate is already

registered with the audit. They will then receive an email prompting them to complete the SCF, if they are not registered you will be asked to confirm the email address to ensure it goes to the correct person. Once a SCF has been delegated, it will appear in the "Delegated Surgical Cases" table. When the delegate returns the SCF to you, the status will change to green - "Ready for submission". Click the "View Case" button and review the SCF details. If you are happy with the details of the case click the "Submit Case" button. You will be prompted to agree that content is accurate and the form is returned to your audit office.

Fellows User Guide on Third Party delegations:

http://www.surgeons.org/media/22170587/2015-10-23_doc_third_party_delegation_fellows_user_guide.pdf

Delegates User Guide:

http://www.surgeons.org/media/22170555/2015-10-23_doc_third_party_delegation_user_guide.pdf

2. Self-notifying a notification of death (NoD)

Users are now able to generate their own notifications of death (NoD). From this NoD, Fellows Interface will create a new case with a unique study ID and enable the user to seamlessly complete

and submit the SCF online to their audit office.

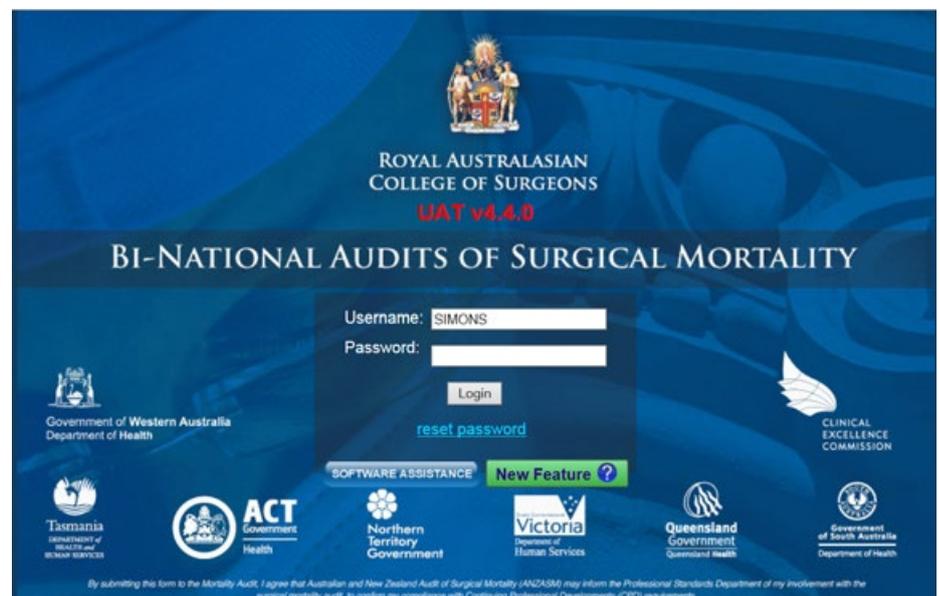
To self-generate a NoD via Fellows Interface: login into the interface using your user ID and password and then click on "Create New Case". Complete the SCF or if necessary save it for later submission. If you attempt to submit a SCF without populating all the fields a warning is generated highlighting all the incomplete fields. You will also be able to delegate the SCF, once the NoD has been generated).

Self-generate NoDs

http://www.surgeons.org/media/22170571/2015-10-23_doc_self-generate_nod_user_guide.pdf

The Fellows Interface system has been in use for five years now and the feedback I have received during this time has been encouraging. This initiative provides users with a dynamic, user-friendly tool to enter SCFs and complete First-line Assessments online. Completing audit forms has been made more convenient and faster. The process is more streamlined with less paperwork.

I am hoping that more users will try the new enhancements and would appreciate any feedback, both positive and negative. Staff are available to assist you. Please contact your regional Audit office for a user ID and password.



Donated Artwork

Fellow Harvey Coates AO has donated an artwork to the College

A painting by renowned Aboriginal and Torres Strait Islander artist Freddie Timms who hails from the Kimberley region of WA was donated by Harvey Coates AO a Fellow of the College. Freddie Timms worked on Texas Downs and many other stations in the East Kimberley and has intimate knowledge of the region. He depicts the landscape with accuracy in a distinctive mapping technique. In the words of Freddie Timms “This country is on Texas Downs Station. When we mustered the bottom country, the cattle were taken to the big camp here because this was the closest to the homestead. Easy for the drovers to get the cattle out along the Texas Road to the main highway then up to the meatworks at Wyndham. We made that camp right in the middle there, on the flatlands close to the water. All good grazing right around here”.

Freddie was born at Police Hole, Bedford Downs Station in 1944. He was a stockman and worked on many stations in the East Kimberley, in particular Bow River Station which was granted by the Government to the Timms Family, with Freddie’s uncle the late Timmy Timms as Chairperson.

Freddie painted with the best – Rover Thomas, Jack Britten, Paddy Jampinji, Henry Wambini. He has participated in numerous Group and Solo Exhibitions and his paintings have been collected and acquired by the most notable Galleries and Collectors both in Australia and overseas.

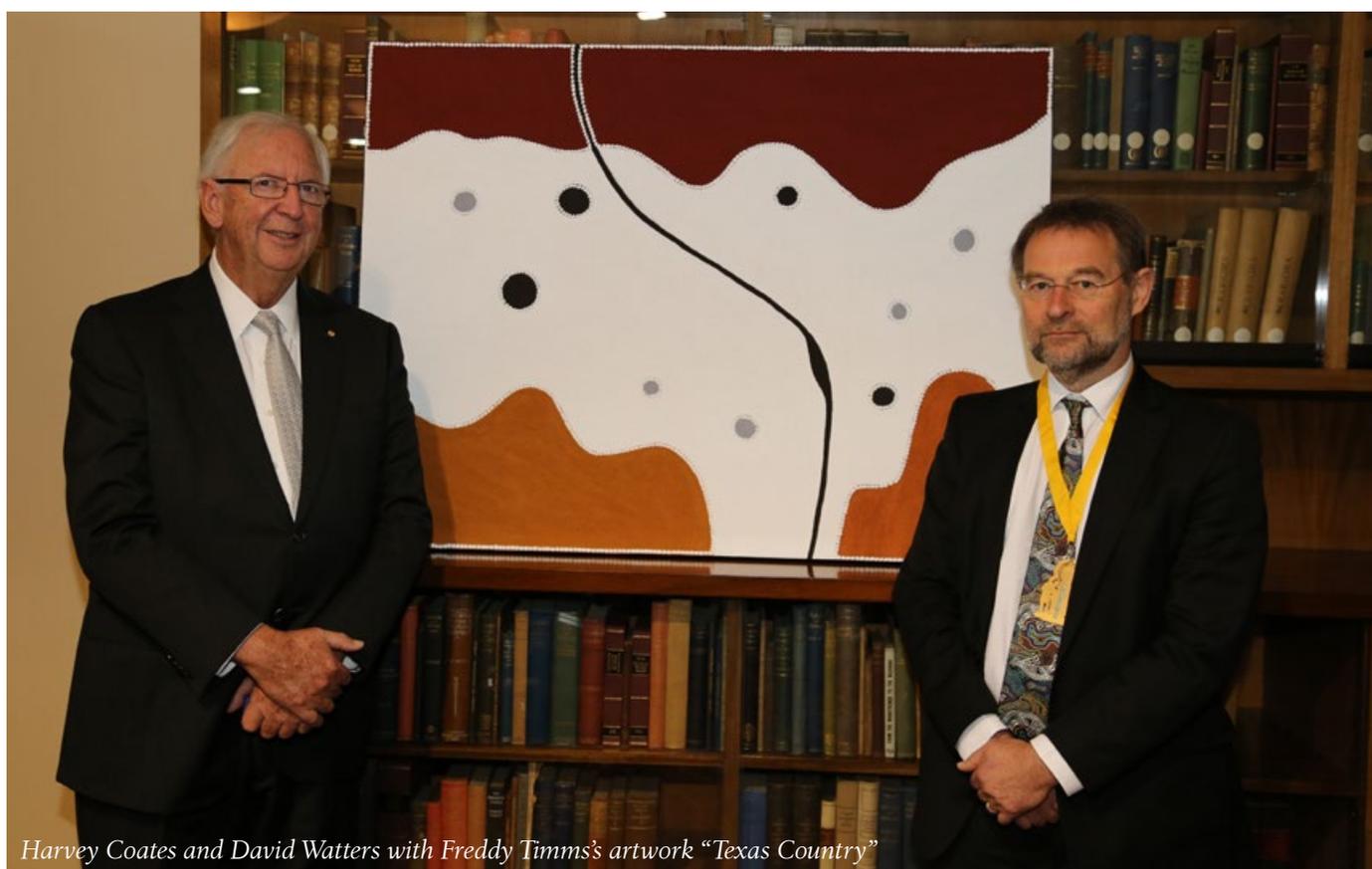
He travels frequently to attend Exhibitions within Australia, and



lives between Kununurra and Frog Hollow Community to the south, with his wife Beryline Mung.

The measure of Freddie’s status in the Art World is that his works have been included in prestigious exhibitions such as “Great Masters: From Tradition to Contemporary Art”, Aboriginal Art Museum, Utrecht, Netherlands along with only 9 other aboriginal artists including Emily Kngwarreye and Rover Thomas.

The painting has been hung in the Melbourne office.



Harvey Coates and David Watters with Freddy Timms’s artwork “Texas Country”

RURAL SURGERY - HOW WE DO IT WELL

PSA 2015 Lismore

SALLY BUTCHERS
Chair, RSS

The Provincial Surgeons of Australia (PSA) Conference, now in its 51st year, prides itself as a being a major event for surgeons working in regional and rural areas to come together to share and celebrate the challenges, benefits and experiences of rural practice. PSA 2015 Lismore was no different. Attracting over 120 delegates from all areas of rural surgery including General, Vascular, ENT and Orthopaedic, the scientific program showcased the evolving field of Rural Surgery. Included in the program were two special sessions for Trainees and medical students interested in rural surgery as a career, hosted by the RACS Rural Coach Project.

Among the delegates were an impressive and enthusiastic group of Trainees and medical students, keen to explore rural surgical pathways, gain and upgrade skills and develop professional networks. General Surgeons Australia (GSA) is extremely supportive of initiatives that encourage General Surgery Trainees and IMGs to become involved in regional and rural surgical careers, and in 2013 introduced grants to assist Trainees and IMGs attend PSA. Two visitors from Papua New Guinea, Akula Danlop and Professor Kevau added an international flavour with Akula being presented with a medal in acknowledgement of his achievement of the “top student award” for completion of the Master of Medicine in Surgery Qualification during the gala dinner.

Rafael Gaszynski, a SET 2 Trainee from Nowra, was one of this year’s eight GSA grant recipients. “It was an extremely worthwhile experience on many levels. Firstly I was able to present

abscess’s with a loop and drain method instead of the traditional incision and drainage technique. I am pleased that a few of my colleagues in attendance have since contacted me for further information regarding this technique. It also enabled me to consider further ways this technique could be used across a wider clinical range of settings. It was highly beneficial to meet other trainees, surgeons and staff of the GSA and the rural surgery association and truly feel part of a community and be able to network among like-minded people. We all get so busy in our immediate environments that I found it really helpful to briefly step outside this and be part of the Conference”

For Russel Krawitz, a SET 4 Trainee from Victoria, it was his first PSA. “I am getting close to the end of my training and have been exploring the different post fellowship opportunities. I have always lived in the city, so “going rural” is only something that recently has become a possibility. The conference was excellent. The quality of presentations was high and the organisation was great. What stuck out for me was the close knit community

that these rural surgeons, often living thousands of kilometres away from each other, had created. “The demands of working in a rural setting have created a group of surgeons who have a diverse set of skills, the true generalists, and there is a lot of appeal in that. I am very happy that I had the opportunity of attending the PSA this year, I met a number of rural surgeons and am now much more aware of the scope of practise and opportunities possible in the country. I look forward to going back to further meetings in the future.”

Much to our delight, the number of student delegates is on the rise and their presence and interest in rural surgery, adds an exciting dimension to the delegate mix and conference program. PSA was recognised as an eligible rural health conference, for the first time in 2015, under the Rural Australia Medical Undergraduate Scholarship (RAMUS) Conference Grants Scheme. The RAMUS Scheme assists selected students with a rural background to study medicine at university. Since its establishment in 2000 over 1,600 RAMUS scholars have graduated from medicine and more than 500 rural doctors across Australia participate in the Scheme as mentors. This is a great achievement and a great partner for RACS in securing the future rural surgical workforce.

For Grant Breadsell, a medical student from Cairns, PSA was a “rare and valuable opportunity to integrate with practitioners from similar regional areas. Personally, while there was an interest in surgery, the difficulty in gaining a position on the RACS training program was always a potentially discouraging factor. Training in surgery has, anecdotally, a ‘cut-throat’ reputation. However, as one of the surgeons said to me earlier that day when discussing available training places; ‘statistically,



none of us are meant to be here. But here we are. Just try it, you'll be surprised.' It was simple, but inspiring."

Rebecca Reardon, shortly to commence a rotation at Lismore Hospital, had never attended a surgical conference before and was unsure what to expect and unsure of what she would gain from PSA. "Having a passion to pursue a surgical career in the future, I wanted to gain an understanding of the speciality and particularly the pathways to gaining access onto the program. One of greatest things I gained from attending this conference was being provided the opportunity to meet many surgeons, registrars, residents and interns that currently work at Lismore. Through this I was able to gain a very good idea of how the hospital works, who is who in the hospital, which surgeons have which sub specialities and I was able to meet them all personally and introduce myself as a future intern with a keen interest in surgery. Overall, I had an amazing experience at the PSA conference. Not only was the conference of a very high scientific academic standard, but it also addressed a lot of issues that affect the rural surgical community. I found many of the speakers to be thought provoking and inspiring and as it was based in Lismore I was able to hear from many people who in the near future will be either my bosses or colleagues".

The major highlight of PSA Lismore was the presentation of the 2015 Rural Surgeons' Award to Graeme Campbell. The Award acknowledges significant contributions to surgery in rural settings in Australia or New Zealand. Graeme is a busy rural general surgeon based in Bendigo. In addition to running a busy and successful practice, and raising a family, he is a stalwart supporter and contributor to the work of the College and the Rural Surgery Section. He has made a significant contribution to the knowledge of General Surgery practice, and over many years dedicated to work with the College to champion the interests of rural surgeons, the rural community and more broadly for the Fellowship in general. His achievements include the establishment of the first rural surgical school in Gippsland Victoria; research and publications on rural colorectal surgical outcomes; advocacy and work in surgical education and standards; and contribution as member and chair on several committees including the Rural Surgery Section, Provincial Surgeons of Australia, Board of General Surgery, the Victorian Regional Committee, Professional Standards Committee, Professional Development Standards Board. Graeme has made a significant effective contribution as a rural/regional surgeon at the Council and Executive level culminating as the RACS Vice President in 2015. As PSA was held during October Council Week, we were honoured that Graeme was able to be in Lismore to receive this acknowledgment from his peers.

PSA has a reputation for putting on some memorable social events for delegates and partners. A good social program encourages Fellows to return to PSA and the networking and re-kindling of friendships that takes place is very



The "Trainees with Rural Coach session" run by Sally Butchers

valuable. After an interesting and stimulating day the first day of conference, it was just a short stroll from the site of the conference venue to a relaxing evening event at the bowls club. Despite the encroaching darkness, a number of people shed their shoes for some barefoot bowls; only the eventual loss of sunlight and the lack of any artificial light curtailed the fun. The BBQ which followed was tasty and very enjoyable for all with entertainment provided by a local comic from Mullumbimby. Her anecdotes about that town and her family and friends could probably be categorised as "not spoiling a good story with the facts". For Friday night's PSA Gala Dinner, delegates were bussed from Lismore to the beautifully restored A&I Hall in Bangalow. The historic hall, with beautiful pressed tin and warm timber, provided the perfect backdrop for a night of food, entertainment, and socialising. Hay bales provided seating for some, and fantastically carved Halloween pumpkins added to the atmosphere. A local live band performed music inspired by Folk, Blues, Gypsy, Latin, Celtic, and Spanish roots.

I would like to take this opportunity to thank the GSA staff for the terrific job they did in delivering a very successful and enjoyable conference. I also acknowledge the staff in the Fellowship and Standards Division for the great range of RACS resources they put together for delegates and for being at the conference to support rural surgeons.

Planning for PSA 2016 in Albany, 2-4 August has begun in earnest. We hope to see you there!

For updates on PSA 2016 please bookmark [PSA 2016 Albany](#). For further information about the Rural Surgery Section including membership please visit [Rural Surgery | Royal Australasian College of Surgeons](#) or email rural@surgeons.org.



MALT CELEBRATES MILESTONES

Birthday celebrations and the logging of the one millionth procedure

ANTHONY SPARNON

Chair, Morbidity Audit Committee

The Morbidity Audit and Logbook Tool (MALT) system continues to go from strength to strength. The College is celebrating two big milestones for MALT: its third 'birthday' and the logging of the one millionth procedure!

On this occasion, I have paused to reflect on MALT's journey to success, the history of the surgical logbook and to note some interesting facts on the way MALT is being used by members of the College.

The development of MALT

Several current Councillors and senior Fellows have contributed to its development during their role as Chair or Deputy Chair of the Morbidity Audit Committee (or its precursor the Logbook and Clinical Audit Oversight Committee): Professor David Watters, Professor Julian Smith, Associate Professor Ian Bennett, Mr Adrian Anthony and myself.

There have been six major stages of development in MALT:

1. **November 2011** - Web Logbook launched
2. **September 2012** - MALT launched (replacing the Web Logbook)
3. **March 2013** - MALT Mobile launched
4. **February 2014** - Import Tool and Custom Reporting Tool launched
5. **April 2015** - Peer review audit pilot commenced (using SNOMED terms)
6. **July 2015** - SNOMED migration commenced (existing users)

The history of the surgical logbook

The MALT Clinical Director, Associate Clinical Professor Franklin Bridgewater FRACS, has reflected on the way the surgical logbook has evolved over time:

In the 19th and 20th Centuries, individual surgeons maintained a log book primarily as a personal record of

experience based on the number of procedures performed.

In the 1950s and early 1960s, extracting patient data from Theatre Operation Registers and transcribing this information (perhaps typing with as many carbon copies as required) simply documented a list of procedures in which a person had a role. In Australia and New Zealand, this provided evidence to the College that those sitting for the Fellowship had a certain level of operative experience. This method was tedious and prone to error.

In the late 1960s, the College produced a hard-copy "Surgical Training Log Book". The log identified the date of procedure, the patient, the diagnosis, the operation, attending staff and their roles. Sections were provided for different specialties. The data was hand written and frequently entered retrospectively. Numbers of procedures and level of supervision could be identified. It allowed the Supervisor some insight to trainee experience. A summary was expected annually. This log book had to be submitted for perusal when sitting for the Fellowship examination.

In more recent times, the specialty training boards have set their own logbook formats and required reporting against specific procedures only. These were sometimes 'paper based' templates, though increasingly became computerised and, in a few cases, online.

Data has been recorded against hospitals in 10 countries:

Country	Case Count
Australia	667,150
New Zealand	108,974
United Kingdom	2,141
U.S.A	716
Singapore	506
Canada	270
India	136
South Korea	102
Ireland	73
South Africa	67

In the mid 2000's, under the direction of Professor David Watters, the College started planning an online logbook that would give supervisors/assessors greater and easier access to the operative exposure of the Trainee or International Medical Graduate. The system was designed to allow comments to be exchanged on individual cases, and to allow the optional recording of audit level data (such as complications and other surgical outcomes) against a dataset which reflected that recommended by the College in its Surgical Audit and Peer Review Guide.

The development of the MALT system reflects the attitude of the 21st Century. The community now expects each surgeon to be able to produce evidence of surgical proficiency in a number of different ways. MALT is a good way to achieve this, as well as a more efficient method for the supervisor to monitor the experience of a Trainee or International Medical Graduate, and a mechanism for comparing surgical outcomes with peers.

The future of MALT

The College is actively supporting and continuing to develop MALT in line with feedback from Fellows, Trainees and International Medical Graduates:

Quicker and easier

In the first version update to be released this year, there will be new functionality (requested by Trainees and IMGs in particular) which makes it possible to add another case auto-populated with the same characteristics as the case just logged.

Did you know?

MALT isn't so much one logbook as many: because each specialty has slightly different requirements, MALT has been designed to be easily configured.

Thus, every specialty logbook is slightly different.

Also, Supervisors will find it quicker and easier to review and approve cases with requested improvements to the Supervisor Journal and Supervisor Dashboard.

Hospitals where most cases have been logged (top 10):

Hospital	Location
Christchurch	NZ
Royal Adelaide	SA
Liverpool	NSW
Royal Prince Alfred	NSW
Westmead	NSW
Middlemore	NZ
Princess Alexandria & Health Service District	QLD
Gold Coast University	QLD
Royal Darwin	NT
Alfred	VIC

JDocs

MALT will be available to junior doctors participating in the College's new JDoc program.

SNOMED migration

Completing the migration of all logbooks to a SNOMED-based procedure list will be the principle focus of 2016. This list will be available to all specialties and member types. Using SNOMED as the source of the list has many advantages for members.

Peer-Review Audit

MALT is now able to link individual surgeons who wish to compare surgical outcomes with peers, following a successful pilot at the Royal Darwin and Mt Gambier Hospitals under the guidance of Dr John Treacy FRACS and Associate Professor Matthias Wichman FRACS respectively.

Participation is controlled by the individual surgeon (Fellow, Trainee or IMG). Data cannot be shared unless the surgeon goes into MALT and 'opts in' for this sharing to occur. The audit is limited to specific procedures determined by the peer group.

Quick Stats

- 8 of the 12 training boards either mandate or accept MALT being used by trainees
- All IMGs under assessment must use MALT
- 3 surgical societies mandate MALT for their Fellows sub-specialising: ANZGOSA, ANZHPBA and CSSANZ
- 2 other colleges have access to MALT: certain rural Fellows of RACP and RANZCOG were granted access with funding from Rural Health Continuing Education, as part of the Rural Procedural Audit.
- 1062 surgeons are using MALT
- 38,000 (average) procedures logged each month in 2015
- 14,585 procedures have been uploaded by 41 surgeons through the Import Tool
- The Import Tool is most popular with General Surgery Fellows and Urology Trainees.
- The first-ever user of the Web Logbook is still using MALT: Dr Ramex Ailabouni, an Orthopaedics trainee from New Zealand logged his first case on 12 December 2011.
- The first-ever user of MALT is still using it: Dr Hamish Alexander, a Neurosurgery trainee from Queensland logged his first case on 28 September 2012.
- The one millionth procedure was a laparotomy recorded by Dr Taina Lee, a SET 2 Trainee in General Surgery, on 3 November 2015 and was undertaken at Westmead Hospital in New South Wales.

MORBIDITY AUDITS

Procedure	Case Count
Colonoscopy	47,819
Laparoscopic cholecystectomy +/- cholangiogram	43,825
Appendicectomy (open or laparoscopic)	35,146
Gastroscopy	34,487
Simple excision (superficial or deep)	26,873
Cystoscopy and cannulation of ureter and procedure (retrogrades, stent, brushings, incise PUJ)	19,337
Flexible cystoscopy	18,979
Inguinal hernia (open)	15,817
On pump coronary bypass surgery	13,044
Laparoscopic groin hernia repair	12,705

Reports are online and in real time; they allow an individual to compare themselves against the aggregate of their peers or against particular member types (for instance, an individual Trainee may wish to compare their outcomes with the aggregate of the Fellows in the peer group).

The outcome reports have been designed in consultation with the MALT Clinical Director, Associate Clinical Professor Franklin Bridgewater FRACS, and include:

- Mortality
- Return to theatre
- Unplanned ICU
- Unplanned readmission
- Complications

This facility is expected to be most useful for:

- Regional hospitals without an audit system already in place
- Multiple surgeons in the one private practice who wish to audit their practice
- Surgeons in solo private practice to meet the audit requirement for CPD. MALT can link individual surgeons in solo private practice to create a remotely located 'peer group' for audit. This peer group need not be in the same hospital, same state or even the same country.

Contact the MALT Help Desk to register your interest in using this facility.

Locum Surgeons

A report is being developed currently that will be available to all but especially useful for locum surgeons who submit a logbook to the College in order to meet with audit requirements for CPD.

In closing, while the College is celebrating the milestones of MALT's third 'birthday' and the logging of the one millionth procedure, it is also timely to acknowledge the more serious goal that has been attained. In developing MALT, the College has given all members free access to a robust, mature and supported online logbook and audit system which supports the core business of the College: training, assessment and continuing professional development.

The College values your feedback! If you have suggestions or questions, please contact the MALT Help Desk directly on malt@surgeons.org or +61 8 8219 0939 (business hours ACST).

**[note: all names in the Quick Stats have been included with permission]*

"Congratulations on the one millionth procedure. The College already mandates participation in mortality audits as well as some form of morbidity audit which is subjected to peer review. The development of MALT has presented the College with many challenges to overcome, but always with the aim of delivering a means of electronic surgical audit on a convenient platform, such as was originally developed for rural surgeons in Filemaker pro some 15 years ago.

In addition to MALT being a trainee log book, it has many other reporting functions that will facilitate morbidity audits for the whole fellowship. The rural surgical and rural procedural audits were migrated into MALT in 2014, and to make it truly effective one needs to record surgical outcomes as well as surgical activity."

*Professor David Watters,
President*

Developing a Career and Skills in Academic Surgery Course

Monday 2 May 2016, 7:00am - 4:00pm
Brisbane Convention & Exhibition Centre
Queensland, Australia

Who should attend?

Surgical Trainees, research Fellows, early career academics and any surgeon who has ever considered involvement with publication or presentation of any academic work.

If you have been to a DCAS course before, the program is designed to provide previous attendees with something new and of interest each year.

Keynote Speaker

Professor Derek Alderson, Vice President of the RCS and Editor in Chief of the British Journal of Surgery

Association for Academic Surgery and International Faculty including

- Caprice Greenberg, Wisconsin, USA
- Jacob Greenberg, Wisconsin, USA
- Adil Haider, Massachusetts, USA
- Rachel Kelz, Pennsylvania, USA
- Julie Ann Sosa, North Carolina, USA
- Rebekah White, North Carolina, USA

Australasian Faculty including

- Paul Bannon, New South Wales
- Ian Bissett, Auckland, NZ
- Catherine Ferguson, Wellington, NZ
- Marc Gladman, New South Wales
- Jonathan Golledge, Queensland
- Andrew Hill, Auckland, NZ
- Julie Howle, New South Wales
- Thomas Hugh, New South Wales
- Cherry Koh, New South Wales
- Kelvin Kong, New South Wales
- Christine Lai, South Australia
- James Lee, Victoria
- Guy Maddern, South Australia
- Henry Pleass, New South Wales
- Julian Smith, Victoria
- Mark Smithers, Queensland
- David Watson, South Australia
- John Windsor, Auckland, NZ

For Faculty updates visit

tinyurl.com/DCAS2016

Further Information

New RACS Fellows presenting for convocation in 2016 will be required to marshal at 3:45pm for the Convocation Ceremony.

As per Regulation 4.10.3 of the Training Regulations for the Surgical Education and Training Program in General Surgery, Trainees who attend the RACS Developing a Career and Skills in Academic Surgery course may, upon proof of attendance, count this course towards one of the four compulsory GSA Trainees' Days.

Provisional Program

Information correct at time of printing

6:45am

Registration Desk Opens

7:15am - 7:30am

Welcome and Introduction

7:30am - 9:30am

Session 1: A Career In Academic Surgery

Why every surgeon can and should be an academic surgeon
Training to become an academic surgeon: pathways and goals
Securing an appointment as an academic surgeon: options, contracts and responsibilities
Getting started: research - ideas, process and outcomes
Getting started: teaching, leadership and administration

9:30am - 10:00am

Morning Tea

10:00am - 10:30am

Hot Topic in Academic Surgery:
Professionalism in Academic Surgery

10:30am - 11:30am

Session 2: Ensuring Academic Output

Writing an abstract
Writing and submitting a manuscript
Presenting at a scientific meeting
Panel discussion and questions

11:30am - 12:05pm

Keynote Presentation: The UK clinical trials network

12:05pm - 1:00pm

Lunch

1:00pm - 2:40pm

Session 3: Concurrent Academic Workshops

**Workshop 1:
Career Development**

What can I do as a:
Medical Student
Junior Doctor
SET Trainee
Fellow
Consultant

**Workshop 2:
Tools of the Trade**

Clinical research
Lab-based / animal model research
Education / simulation research
Health services research

**Workshop 3:
Practicalities of research**

Critical ethical issues in medical and surgical research
Assembling the team and establishing collaborations
Funding opportunities
Grant writing

2:40pm - 3:00pm

Afternoon Tea

3:00pm - 4:00pm

Session 4: Sustainability in Academic Surgery

Finding and being a mentor
Work-life balance
The future of academic surgery

Registration

Cost \$250.00 per person incl. GST

Register online at asc.surgeons.org or for a registration form email dcas@surgeons.org

Fifteen complimentary registrations are available for interested medical students. To apply email dcas@surgeons.org

CPD Points will be awarded for attendance at the course with point allocation to be advised at a later date.

Contact

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LIBRARY DOCUMENT DELIVERY

Fellows are able to request documents not held on site



RICHARD PERRY
Chair, Fellowship Services

The most heavily used, and arguably the most valued, library service is the facility to request delivery of documents not held in the online collections. Earlier this year, in July, Library staff broke the all-time monthly record for Document Supply with 775 items being delivered to RACS members, staff or to other libraries. This meant that 54 items were scanned from the print collection, 170 were sourced from our online collections and 280 were supplied by other libraries. The remainder were ordered from a variety of commercial sources.

How do RACS staff go about ensuring that requested articles are found and delivered to members in a timely fashion?

1. Firstly we check the A-Z Listing to see if we have a subscription. These are the most straightforward, but still require staff time to find, save and email a PDF version of the document.

Waiting times for articles can be minimised by checking the A-Z Listing personally, finding the article and producing your own copy. Short video demonstrations on the effective use of the A-Z List for identifying a journal (or book) are available electronically on the website at: <http://sss.xxx> <https://youtu.be/o2-YcDrel2Y>. For example, if you need information late on a Friday evening, checking holdings for yourself can be a great way of avoiding the wait for the library service to re-open Monday morning – and it saves on filling out forms.

For older items, we do still frequently use the print archive to make scans which we email out to requesters.

2. If we do not hold something electronically or in print, the next step is to call on our library colleagues as part of our membership of the Gratis interlibrary loan network. Hospital and other health libraries share information about which journals we subscribe to; we then access a website that allows us to easily request (and supply) individual articles from

fellow Gratis members. As the name implies, in the ethos of libraries sharing and cooperation, we do not charge each other for this service.

3. If we are still unable to source the article, we next call on fellow librarians, this time from the wider library world of university, national, state, college and even public libraries to supply us with information. Unlike Gratis, we do have to pay a non-commercial rate to such libraries to cover the costs of supply.

4. If the above steps fail we may need to pay a variety of commercial document suppliers such as OCLC or Copyright Clearance Centre to provide the document(s). Prices vary greatly, so we do, from time to time, communicate with requesters to confirm if the ordered item is really required before proceeding with an order.

Unfortunately, there are rare occasions when we have to disappoint a requester as we cannot find a location and therefore cannot supply the document. Please rest assured that we have gone down every path available to us before passing on this unwelcome news!

We do try to make it as easy as possible to make the request to supply the document. Over the last 18 months, we have added extra places where you will encounter a link to a request form. They have been available for many years on the RACS website's Library homepage, but can now be found when searching in Medline, Embase or in Summon. Completion of one of these forms is part of the copyright process so they are a requirement if Library staff are to supply the document(s) that you need. The use of the notes field to indicate when delivery is urgent is appreciated. We do not place limits on the number of requests, but if we receive a large number from a single requester over a short period of time we may need to spread them out to manage the workload and to avoid disadvantaging other users of the service.

Whilst the requesting and delivery of journal articles is by far the busiest aspect of the service, systems are also in place to obtain a loan copy of a book for research or evaluation purposes. Lending periods will vary depending on the conditions of the library from which the book is borrowed.

We welcome your feedback on any aspects of the library service.





In Memoriam

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

Sir Patrick William Eisdell Moore Kt, OBE,
17 March 1918 – 19 June 2015

Otolaryngologist, Head & Neck Surgeon

Patrick Moore was born in Bristol on 17 March 1918. His father Arthur Eisdell Moore (“Eisdell”), who was in England on a post-War surgical appointment at that time, met his mother, Alice, a nurse from Yorkshire, in 1915 when serving as a field surgeon with the RAMC on the Western Front. Patrick was the first child of three; two sons and a daughter, and although christened William Ernest Moore, he had been nicknamed “Pat” while still in utero in anticipation he (or she) would be born on St Patrick’s Day. The name stuck when that prediction proved correct. It was not until he reached the age of 21 that he formalised his adopted name by deed poll and changed Ernest to Eisdell.

<http://www.surgeons.org/member-services/in-memoriam/patrick-moore/>

John Kille,
22 December 1927 – 9 March 2015

Urologist

John Kille was born in Surrey, spent some time in Gloucestershire and then in Bristol in the UK.

He joined the army, the Coldstream Guards, and trained in the tank corps, was commissioned into the 4/7 Dragoon Guards Regiment and saw active service in Palestine till the end of the British Mandate in 1948.

He studied at the medical school in Birmingham, and did his postgraduate work in Surgery getting the Fellowships of the Royal Colleges of London and Edinburgh, following which he was appointed Consultant Urologist to the Royal Infirmary at Hull.

<http://www.surgeons.org/member-services/in-memoriam/john-kille/>

Mary Jean Murdoch AM,
21 December 1933 – 31 December 2014
Member of Court of Honour

Mary Murdoch is fondly remembered for her significant contributions to this College and her outstanding service to the community. She was a highly valued former member of the RACS Appeals Committee. In 1997 Mary was appointed to the Court of Honour, one its few lay members, and one of the College’s highest honours. Her wise counsel and generosity of spirit and friendship are remembered with gratitude.

<http://www.surgeons.org/member-services/in-memoriam/mary-jean-murdoch/>

Martin Hunter Christie
23 March 1946 - 8 February 2014
Neurosurgeon

Martin was born in Rhodesia (now Zimbabwe) in 1946. He was the eldest son of Richard Christie, an attorney and pilot, and the journalist Phillippa Berlyn. He attended boarding school from the age of seven. He was inspired to study medicine after a conversation with a family friend and consequently attended and graduated from the University of Rhodesia (now the University of Zimbabwe) in 1971.

<http://www.surgeons.org/member-services/in-memoriam/martin-h-christie/>

Thomas Paul Nash
1 August 1926 – 20 July 2015
Vascular & General Surgeon

Tom Nash was a seventh generation Australian of Irish extraction, born on the family property at Yass, NSW. He was educated at Christian Brothers Goulburn (Dux 1942) and Sydney University (1943 – 8, MB BS Hons 1). At St Johns College, University of Sydney, he excelled at rugby, cricket, swimming, diving, billiards and golf. He was later a competitive sailor and farmer.

<http://www.surgeons.org/member-services/in-memoriam/thomas-p-nash/>

The History of the Cowlishaw Collection

The Cowlishaw Collection is the collection of historical volumes held by the Royal Australasian College of Surgeons. The collection was created through the efforts of two men: Leslie Cowlishaw and Kenneth F. Russell.

Doctor Leslie Cowlishaw (1877-1943) was a bibliophile who became an honorary lecturer in medical history at the University of Sydney and the first honorary librarian for the Royal Australasian College of Physicians (RACP). His will gave the RACP first option on his collection but for financial reasons this offer was rejected. It was Kenneth F. Russell (1911-1987) who convinced RACS to acquire the collection, which he then spent a great deal of time protecting and cataloging.

The Cowlishaw Collection was originally housed in the Gordon Craig Library but now resides in the Council Room at the College. Robert Gordon Craig (1870-1931) was one of the RACS' founders. He bequeathed £60,000 to RACS for education and research. In his honour, the RACS library is named after him.

The Cowlishaw Collection contains some 2,000 volumes of outstanding quality. There are eight incunabula (books printed before 1501), including Guy de Chauliac's *Cirurgia*, Venice, 1499. Hippocrates is presented in eighteen editions, Galen in five editions, and Celsus in twenty-one, starting with the 1493 printing. Vesalius's 1555 edition of *De humani corporis fabrica*, and Pare's 1568 edition of *Tractie de la Peste* are also included in the collection, along with many English



books from the sixteenth and seventeenth centuries.

The Cowlishaw Symposium promotes the collection and is held every second even year and the next meeting is in October this year, 2016. Presenters choose a book(s) from the collection to underpin a presentation on an aspect of surgical history. The first Cowlishaw Symposium was held in 1996 and the symposium has been a popular event in the RACS calendar since that time.

Fellows and Trainees interested in researching a book from the collection or seeking further background information are asked to contact the Symposium Convener, Richard Lander: Richard.lander@surgeons.org or the College Curator, Geoff Down: Geoff.down@surgeons.org.

RACS ETHICS COMMITTEE

Intensive research course 2015

PAUL WALKER
NSW Fellow

Seven members of the RACS Ethics Committee attended the Intensive Research Ethics Course at Hepburn Springs, Victoria 29 November – 3 December 2015. They were Eric Chung (Fellow), Andrew MacCormick (Fellow), Andy McLeash (Fellow), Debra Phyland (lay member), John Quinn (Fellow), Neil Vallance (Chairman of the RACS Ethics Committee), and Paul Walker (Fellow).

The course focused on the roles of the Human Research Ethics Committee (HREC) in assisting, encouraging, and monitoring human research.

Historically, HRECs were established after the medical experiments of the Nazis, the Tuskegee syphilis trials which withheld treatment from black Americans, and Japanese trials of vaccines against tropical diseases in WW2, were widely recognised as unethical.

As well as discussing issues around privacy and confidentiality, consent, conflicts of interests, and big-pharma, potentially-vulnerable groups considered in detail included Aboriginal and Torres Strait Islanders, those with mental illness (whose ability to consent may change over the course of an illness), and those who were gender-ambivalent. Studies on these groups of Australians are important, but potentially challenging for the participants, and also for the researchers themselves.

A trial participant spoke about what he went through in a series of medication trials. This gave insight into what the trial participants look for in research projects, and touched upon the ethics of falsification of research data in order to gain access to a new drug treatment, for the benefit of the patient.

The normative ethical frameworks of deontology (it is never permissible to torture a terrorist), teleology (if sufficient innocents benefit then it would be permissible), virtue ethics and the four



RACS Ethics committee members, 2015

principles of autonomy, beneficence, non-maleficence and justice, were discussed in the context of ethical evaluation of research trials. These frameworks were utilised to assess research projects which the participants designed, and then presented for critique.

Simplifying the paperwork and aiming to avoid being an unnecessary stumbling block to successful human research were

emphasised. As was the importance of knowing how the final results might be used, and whether potential harm may result.

Perhaps the most attractive aspects overall were sharing solutions to challenging research proposals other HRECs have encountered, and the lively discussion in the dining room and lounge each night.

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