ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 16 NO 7 / JULY 2015

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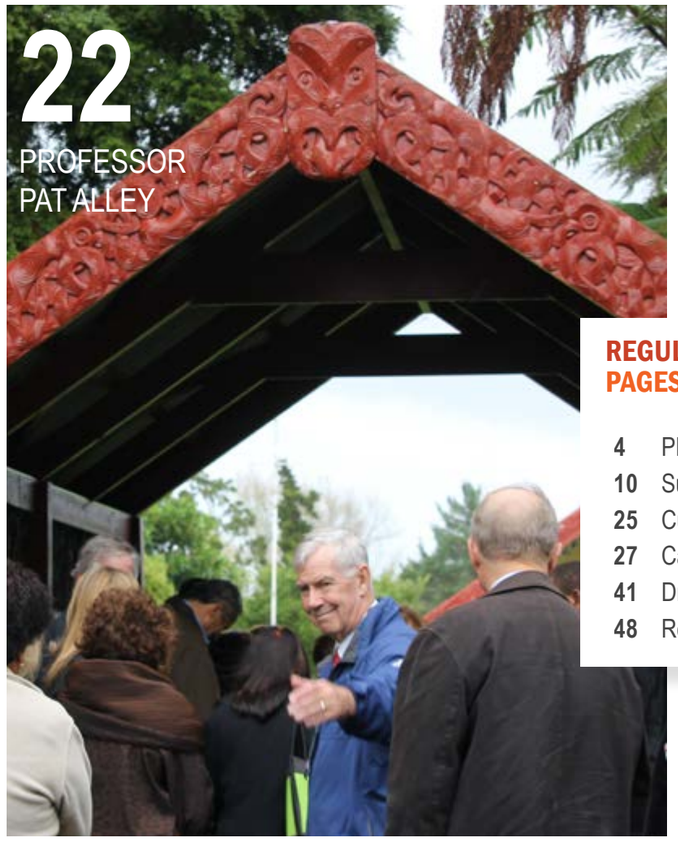

REGULAR PAGES

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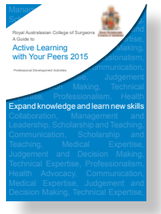
ON THE COVER: Indigenous Health Chair Kelvin Kong with a patient in Broome Photo Credit: Simone de Peak

PROFESSIONAL DEVELOPMENT

WORKSHOPS & ACTIVITIES

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



Clinical Decision Making

28 July – Sydney; 8 September – Christchurch

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

Supervisors and Trainers for SET (SAT SET)

30 July – Gold Coast; 10 September – Canberra

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

Keeping Trainees on Track (KToT)

31 July – Gold Coast; 14 August – Auckland; 31 October – Adelaide

This revised 3 hour workshop is aimed at providing professional development for Supervisors and Trainers in performance management of Trainees in difficulty. The workshop allows participants to explore strategies for diagnosing and supporting Trainees in difficulty, and helps them to understand the principles behind 'difficult but necessary' conversations.

Foundation Skills for Surgical Educators

6 August – Darwin; 16 October – Hobart

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

Process Communication Model: Seminar 2

7 to 9 August – Sydney

The advanced three day program allows you to build on and deepen your knowledge while practicing the skills you learned during PCM Seminar I. You will learn more about understanding your own reactions under distress, recognising distress in others, understanding your own behaviour and making communication happen. Advanced PCM concentrates more strongly on the failure mechanisms of distress, making it easier to apply PCM in order to resolve conflict and motivate others.

Non–Technical Skills for Surgeons (NOTSS)

12 August – Queenstown, NZ

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.

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

workshop

Strategy and Risk for Surgeons

21 August – Melbourne

This whole day workshop is divided into two parts. Part one gives an overview of basic strategic planning and provides a broad understanding of the link between strategy and financial health or wealth creation. It introduces a set of practical tools to monitor the implementation of strategies to ensure their success. There is also an introduction to a committee's and board's role in risk oversight and monitoring. Part two of the course focuses on setting strategy; formulating a strategic plan, the strategic planning process, identifying and achieving strategic goals, monitoring performance, and contributing to an analysis of strategic risk.

July – October 2015

ACT
10 September
Supervisors and Trainers for SET, Canberra

NSW
28 July
Clinical Decision Making, Sydney
7 - 9 August
Process Communication Model: Seminar 2, Sydney

NT
6 August
Foundation Skills for Surgical Educators, Darwin

NZ
12 August
Non-Technical Skills for Surgeons, Queenstown
14 August
Keeping Trainees on Track, Auckland
8 September
Clinical Decision Making, Christchurch

QLD
24 July
Non-Technical Skills for Surgeons (NOTSS) , Brisbane
30 July
Supervisors and Trainers for SET, Gold Coast
31 July
Keeping Trainees on Track, Gold Coast
24 September
Acute Neurotrauma, Cairns
29 September
AMA Impairment Guidelines 5th Edition:
Difficult Cases, Brisbane

TAS
16 October
Foundation Skills for Surgical Educators , Hobart

VIC
21 August
Strategy and Risk for Surgeons, Melbourne
5 September
Communication Skills for Cancer Clinicians: Discussing Death and Dying, Melbourne

ACTION

A focus on reconciliation and Indigenous health at the College

DAVID WATTERS
President

It was a cold and wet Tuesday morning in June as we gathered together in Spring St for National Reconciliation week. Perry Wandin, a Wurundjeri Elder from one of five tribes that make up the Kulin nation, welcomed us to the land on which the Melbourne College headquarters is sited. It was Perry's first visit to the College. His ancestors are said to have lived in the region for some 40,000 years, and he reminded us that it was only 10,000 years ago that Port Philip Bay was flooded and became a bay rather than a thoroughfare and a hunting ground. He told us how his late father, whose position as Elder he had inherited, was the first Indigenous Australian to play in the VFL for St Kilda. Back in 1952 Aboriginal Australians were not entitled to citizenship and felt that they hardly belonged in a country with a 'white Australia policy'. Despite the injustices experienced by his ancestors over many generations since the founding of Melbourne, Perry was warm in his welcome. What has been, has been, he said, and went on to paint a better picture of the future for Australia and its Indigenous peoples, who comprise some 2.5 per cent of the population.

When Associate Professor Kelvin Kong of the Worimi Tribe (Port Stephens) gave the main address, he presented a map of Australia outlining the Indigenous tribal lands (Figure 1). Kelvin is the first Indigenous Australian to become a Fellow of the College; practicing as an ENT surgeon in Newcastle. Kelvin even shared his excitement that he and wife Kiara were expecting their first child in September. This child will represent the fourth generation of a family that has lived through decades of prejudice. Kelvin introduced us to his grandmother, one of the Stolen Generation who was separated from her eight siblings and raised in isolation. Because of her disappointment she was resolute that she would bring up her own family in the one homestead. This meant that Kelvin's mother Grace received an education and became a nurse, even though Indigenous Australians were not entitled to citizenship until 1967.

Those in attendance were moved by the pictures of his family, their pride in their achievements and how they have reconstructed the true meaning of a 'family tree'.

The College meeting was held so that we could show our commitment to the RACS Aboriginal and Torres Strait Islander Health Action Plan. This was passionately explained by Kelvin who addressed four key areas in which we need to improve: Leadership, excellence and advocacy; increasing the number of Aboriginal and Torres Strait Islander Specialists (currently two Surgeons and one Trainee); educating the workforce to be culturally aware; and increasing the number of Aboriginal and Torres Strait Islander staff.The meeting also provided an opportunity to portray the College Statement of Commitment to develop a Reconciliation Action Plan, which had been signed by myself as RACS President on behalf of the College Council. This signing, which took place the previous Friday during Executive Council, was also timed for National Reconciliation Action week.

Four Key Areas of Improvement:

- Leadership, excellence and advocacy
- Increasing the number of Aboriginal and Torres Strait Islander Specialists (currently two Surgeons and one Trainee)
- Educating the workforce to be culturally aware
- Increasing the number of Aboriginal and Torres Strait Islander staff (currently none who have declared themselves).

Professor Harvey Coates AO, is a Paediatric Otolaryngologist and Senior ENT Surgeon at Perth's Princess Margaret Hospital for Children. He was presented with the RACS Aboriginal and Torres Strait Islander Health Medal. During his career, he has devoted much time and effort to treating Western Australian Aboriginal children, many of whom suffer from middle ear disease. He has travelled out to their communities and taken his skills to their people, in an attempt to minimise the three delays (see June President's perspective) that deny many access to the same standards of health care that most of us enjoy – delay in presenting for treatment, delay in transportation to a centre that can manage the disease, and delay in being treated when one gets there. Our Indigenous populations are prone to experience at least the first two delays, if not always the third.

President David Watters and Kelvin Kong, Indigenous Health Chair

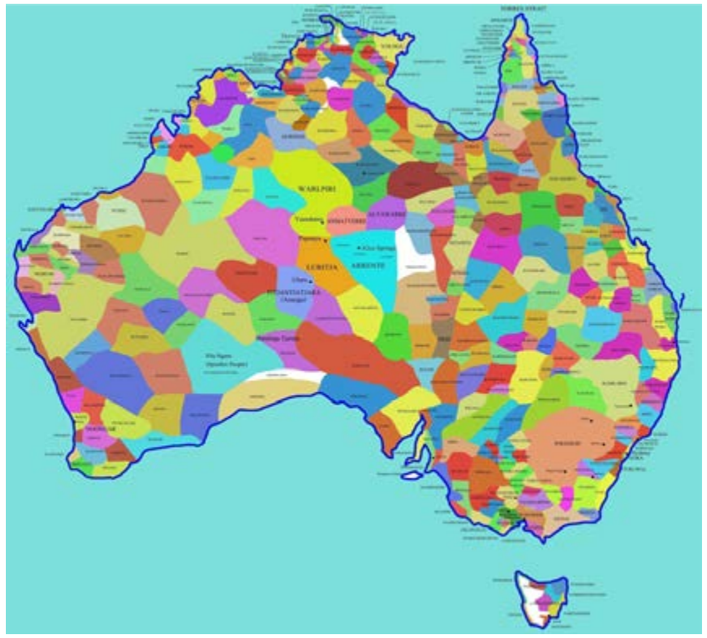


Figure 1 - Australian Indigenous Tribal Lands

Given our bi-national structure, RACS is also developing a Maori Health Action Plan to complement the work that has been undertaken in Australia. The Working Group chaired by Professor Pat Alley includes New Zealand Fellows and Trainees and a representative from Te ORA. It will particularly acknowledge the diversity in Maori cultures, languages and spiritual beliefs and their relevance to health and well-being.

This year Council awarded the inaugural RACS medals for excellence in Maori Health and Aboriginal and Torres Strait Islander Health to Professor Pat Alley, Associate Professor Jonathon Koea, Dr Jacob Ollapallil Jacob and Professor Harvey Coates. Two were awarded at the ASC in Perth and Harvey Coates received his as part of the June second ceremony to profile the Health Action plan. Associate Professor Koea will receive his medal at the NZ ASM in August this year. To encourage more Indigenous doctors to consider careers in surgery, the Foundation of Surgery sponsored six junior doctors and medical students from across Australia and New Zealand, comprising the first Aboriginal and Torres Strait Islander and Maori ASC Awards. The recipients were able to visit health services in Perth as well as attend the Indigenous Health program that particularly focused on breast cancer in Indigenous populations.

In 2014, Australia had 204 Indigenous doctors and 310 Indigenous medical students – but only a handful of these progressed to become specialists. Kelvin Kong has been a very effective champion and advocate for issues relating to Aboriginal and Torres Strait Islander health. His presentation to those gathered concluded with a slide depicting two beautiful three year old girls.

The first girl, a white three year old taken in a backyard in Sydney and the other, an Aboriginal three year old on a station in the Kimberley's in WA. Each had a glorious smile; each had the same unlimited potential. But as Kelvin highlighted, what will their future be in terms of opportunities for education, health, career and social progression? The image still lingers in my mind. Those questions are profound – both girls deserve futures as bright as the sparkle in their inquisitive eyes.

An understanding of the past and recognition of the present can inform our plans for the future. The College is not only moving to embrace the issues of Reconciliation; but to also ensure that it delivers on the commitments contained within the Health Action Plan. RACS also gave an Acknowledgement to Country during the May Council Executive the previous Friday, acknowledging the Wurundjeri as the Traditional Owners of the land on which we had gathered, and paying our respects to their Elders both past and present. That may even have been the first Acknowledgment to Country during College Council but I am certain it will not be the last.

SETTING THE PUBLIC HEALTH AGENDA

Surgeons have an opportunity to influence the course of public health policy

GRAEME CAMPBELL
Vice President

As surgeons we advocate through our employment in the public and private sectors, advising, influencing and developing health-related policies.

I strongly encourage your continued support, because it is through the collective strength of the FRACS and RACS brands that we can have the greatest impact highlighting the benefits of preventative and other health-related policies to the broader community. The ultimate outcome is improved treatments and models of care, and better health outcomes for our patients and communities.

RACS has a strong history in advocacy, including lobbying for measures that have helped reduce trauma.

Throughout the 1960s and 70s our Fellows were influential with policy makers and legislators, advocating for mandatory seat-belt wearing, drink driving countermeasures, and the compulsory use of helmets by cyclists to counter the rising road toll.

Over the past 12 months we have made tangible progress informing and shaping state, territory, district and national health policies and legislation in Australia and New Zealand.

We are doing this to better position the College as an effective advocate for surgeons and world-class surgical care, and to provide a framework to help shape public health policy.

At Council we discuss matters of strategic importance and identify the advocacy items that are important to us, our communities and our patients. Public health advocate Simon Chapman recently said the number one lesson he has learnt is to, "Always respect evidence, and if the evidence changes, so should you". We also need to be open to hearing about new issues as they arise, and shifting priorities where there is consensus among our Fellows. Policy development does not happen in a vacuum.

The College is presented with many opportunities to engage in the policy and advocacy process, through evidence and advice, public campaigns and advocacy and/or lobbying and negotiation. These opportunities present themselves from requests for consultation or involvement by external bodies and also through proactive attempts by the College to set agendas, inform debate and influence public opinion or the public policy process.

At a regional level we are proactively engaged with the various health ministers and work closely with government departments and advisory groups. We engage with political parties during and after election campaigns, respond to submissions on regional and national issues relevant to surgical care, and develop position papers that advocate for improvements to the health system and better patient outcomes. We are continuing to build strong relationships with other medical colleges, specialty societies, researchers, police, and hospital staff; as well as establishing new ones.

We are committed to consultation and information sharing across multiple College boards, committees and departments. A cross-department 'Advocacy Coordination Group' now meets fortnightly, contributing to advocacy efforts in the regions and nationally and ensuring that our position at all levels is strong and consistent.

Our push into the social media space has been highly successful and crucial to helping discussions about the College remain informed. Although some Fellows were/are dubious about RACS having a presence on Facebook, Twitter and other social media platforms, here are three reasons why we should:

- Those in the research world are familiar with the term 'publish or perish'. Social media can help journal publications 'go viral', prompting far more downloads and citations. Having a good online presence can also lead to collaborations and research grants.
- Politicians, organisations and media use social media to monitor public opinion and engage with their stakeholders.
- It allows the College to reach a far greater audience. The most recent ASC in Perth is a great example with more than 2.6 million views on Twitter, more than 2,000 tweets and 450 social media participants during the four day College event.

Leading US advocacy expert Jim Schultz developed nine questions for strategic advocacy which have been used in our own efforts to identify and analyse the problems, establish our priorities and goals, map our political landscape, understand our primary audiences and develop a clear strategy that allows us to move forward with a clear plan of action.

From here we will be evaluating our various strategies to determine whether what we have done has been successful.

We welcome your views on how RACS can be an even stronger advocate for surgeons and surgery, and whether there are other priorities that we should focus our advocacy efforts on.

College Advocacy - Domestic and Family Violence

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

The College is routinely requested to provide submissions on various topics. These requests may come from government and healthcare agencies in New Zealand, Australia and within states and territories.
Recent issues we have responded to include:

- Royal Commission into Family Violence (Victoria)
- FARE Policy Options Paper – alcohol and domestic violence (Foundation for Alcohol Research and Education)
- New Zealand: Submission to the Health Select Committee on Surgical Mesh
- Inquest into Quad Bike deaths (NSW)

Copies of the College's submissions are accessible on our website under the media and advocacy tab.

In Australia and New Zealand, the incidence of domestic violence is significant and highly under–reported. The most common physical injuries from domestic violence include contusions, abrasions and lacerations to the head and face, and fractures and dislocations of arms, hands and the face. The psychological and emotional damage on top of the physical damage can have long lasting impacts on the victim.

How does this affect surgeons and what can be done? The College has recently published a position paper on Domestic Violence. You can read this on the College website under the position papers tab.

Comments and inquiries can be directed to the College Vice President:

college.vicepresident@surgeons.org

TWITTER *tips*

1. Want to search for a topic or person? Click on the 'Search Twitter' search bar at the top of your page. You can search for a person or organisation's name, their Twitter handle (i.e. @RACSurgeons) or even hashtags.
2. When you reply to someone else's tweet, you can make your response public or private. If you start your reply with the '@' symbol, only the person who you are replying to can see what you're saying. To make your response public, put a '.' at the start of your tweet.
3. Tweets are only allowed at be 140 characters long. Try and keep yours to 100 characters though – it will leave enough space for people to make their own comments if they retweet.
4. Engage with others and show appreciation for their tweets by using the 'Favourite' button, which is the star–shaped icon shown under every tweet.
5. Use hashtags to join conversations and make your tweets easier to find. For example, #FOMed is the hashtag that is used for all information about Free Open Access Medical Education.

@RACSurgeons

Run to cure

Fellow Sarah Olson has again put her fitness to the test in the pursuit of a cure for brain cancer. The neurosurgeon took part in the Sunday Times Bridge to Brisbane run, raising money and awareness for the cause.

“It doesn’t matter if you are the best neurosurgeon in the world, you can’t cure cancer alone,” Dr Olson said.

“I didn’t want to get to the end of my career and think all I’ve done is operate, so I started to think of how to raise awareness and help patients feel involved.”
Sunday Mail, 31 May

When a surgeon is not a surgeon

A bill has been drafted by a NSW Labor health spokesman Walt Secord to close the loophole for those using the title ‘surgeon’.

Alerted to the concern by the Royal Australasian College of Surgeons, Mr Secord is pursuing legislation that only those who have completed specialist surgical training can use the title.

“There is nothing to stop you, if you are a general practitioner, calling yourself a surgeon,” Mr Secord said.

The draft law was released for consultation in June.
Daily Telegraph, 9 June

Vital operating room missing

The new Royal Adelaide Hospital is missing a vital operating room and will be ‘outdated before it even opens’.

South Australian surgeons have warned the ability to perform complex and often life–saving surgeries will be limited without the much–needed ‘hybrid suite’.

Despite promises from SA Health for a future hybrid suite, RACS SA Regional Chair Sonja Latzel says the detail is missing.

“There is still no time frame for when this may occur and nothing in writing for the Government to be held to account over this commitment,” Dr Latzel said.
Adelaide Advertiser, 16 June

Canberra Urology on notice

Urology training accreditation has been withdrawn at Canberra hospital until the environment can be made suitable for Trainees.

RACS Executive Director for Surgical Affairs Dr John Quinn said that the accreditation was revoked because of the environment of ‘discrimination, bullying and harassment’.

“The hospital has been disaccredited until there are changes in attitude in the surgeons and the ability of the hospital to provide a safe and supportive educational environment,” Dr Quinn said.
ABC News, 24 June

Foundation for Surgery
Passion. Skill. Legacy.

ACTION ON INDIGENOUS HEALTH

This year's ASC awards were a great success for Indigenous aspiring surgeons

KELVIN KONG
Chair, Indigenous Health

One of the key strategies identified in the RACS Aboriginal and Torres Strait Islander Health Action Plan 2014-16 and proposed in the Mâori Health plan that is under development is to support Indigenous doctors and final year medical students from Australia and New Zealand to attend the RACS Annual Scientific Congress. This year for the first time the Foundation for Surgery provided funding for up to six medical students and junior doctors from Australia and New Zealand to participate in Annual Scientific Congress in Perth to:

- Participate in the educational program
- Network with Fellows and meet influential healthcare professionals in the surgical profession;
- Gain an understanding of the activities of the College; and
- Discuss with Fellows career path issues for Aboriginal, Torres Strait Islander and Mâori medical professionals.

At the inaugural Indigenous Roundtable Breakfast the six recipients were presented with their Award certificates by Professor Kingsley Faulkner, Chair, Foundation for Surgery and the opportunity to interact with Fellows. These aspiring surgeons were able to network and discuss their career path options and also issues facing Aboriginal, Torres Strait Islander and Mâori medical professionals.

Jamie-Lee Rahiri is a doctor at the Manukau Super Clinic in Auckland. She is also a Surgical Research Fellow at the University of Auckland working towards a doctorate in Surgery and Hauora Mâori. "My conference schedule began with the *Developing Careers in Academic Surgery (DCAS) course. A wealth of knowledge was displayed; adding to our research knowledge platform. I was inspired by Associate Professor Carla Pugh. Her research around the use of simulation technology for medical and surgical education is enormously innovative and relevant to my learning as a junior doctor.*

Indigenous Health Chair Kelvin Kong and Foundation Chair Kingsley Faulkner (far right) with award recipients

Her anatomy teaching models are utilised around the world and are extremely beneficial to enhancing the learning of healthcare professionals. It was a privilege to hear this woman encourage us to be bold enough to take leaps and bounds in academic surgery."

Mikayla Couch is a final year medical student at the University of New South Wales. Mikayla has worked as a researcher with the George Institute on Road User Safety in Indigenous Communities and undertaken placements with the Redfern Aboriginal Medical Service in Sydney and the Broken Hill Base Hospital. "*Many of the topics and seminars were very advanced in new techniques and it was all based on evidence–based medicine. It was a great progression of my own knowledge from university lectures and textbooks. The Women in Surgery breakfast was a really great experience for me. In the hospital, I have met only three women surgeons. The breakfast gave me the opportunity to network and meet other inspiring women in medicine who are residents, surgical trainees, and surgical consultants.*

Since the conference, I have felt that becoming a surgeon is more achievable then I first believed. I understand it's a very tough job, and the application process is very difficult. But I haven't changed my mind on applying and am now focusing on building my resume, completing more research and getting an internship position with the rotations in the surgical specialties I am interested in."

Lincoln Nicholls is a junior doctor at Palmerston North Hospital in New Zealand. He served as a New Zealand Defence Force Medical Officer 2009-14 and spent a year at the Kiwi Base, Bamyan, Afghanistan. In 2011 he served as a Rugby World Cup Doctor in 2011. Lincoln's interest in orthopaedic surgery meant that his first few days were spent following the Military Surgeon sessions. "*I found these very interesting. The sessions covered a lot of trauma surgery, which is close to the surgical subspecialty of orthopaedics, which is where I would like to move towards….I was particularly inspired by the theme of the conference… It was amazing to listen to the talks about the pioneering surgical works that came from our ANZAC surgeons and military medical officers at the time*"

Mitchell Sutton is a final year student at the University of New South Wales and is drawn to trauma surgery. "*The ASC was fantastic. I started the conference on Monday by attending the General Surgeons Australia Trainee Day in Trauma, which provided a comprehensive overview of the subject and helped me to develop a solid understanding of basic concepts which were later expanded on throughout the conference…..Throughout the conference I was able to meet several prominent trauma surgeons and a multitude of current and former staff, who I'm sure will prove to be invaluable connections. Virtually everybody I was introduced to seemed highly supportive of my surgical career intentions and willing to help in various ways.*"

Wilemu MacFater is a junior doctor at the Whanganui Hospital. He was the clinical representative for the Te Oranga (Mâori medical students association) in 2012 and 2013 and currently provides mentoring to top Mâori and Pacific scholarship recipients. His conference highlight was the exposure to advancements in surgical research and how this could be translated to deliver benefits to his local community. *"Attending lectures gave me a lot of time to reflect on my goals and what I wanted to achieve in my career. This scholarship has been extremely rewarding especially as a doctor working in regional New Zealand. Although we are able to get valuable experience from the regional centres, we are often at a disadvantage as we are not exposed to many of the key decision making people for training. These decision makers are more often than not based in the major centres. This experience has given me the opportunity to meet the right people as I continue to pursue a career in surgery."*

Artiene Tatian is in his final year of medicine at the University of Western Sydney and is also completing a Master of Indigenous Health with the University of Wollongong. "*Dr Kelvin Kong told delegates that he believes in 'wise practice;' this being a combination of indigenous and Western medical knowledge that will come to benefit all people within Australia. As a future medical graduate, this is something that hit home as it did not divide my culture and 'the textbook' but sought to consolidate them in a method of practice*

The ATSI Motif

The Aboriginal and Torres Strait Islander motif symbolises the Royal Australasian College of Surgeons commitment to help Close the Gap in Indigenous disadvantage across Australia. With dual concepts in mind, the design features two snakes winding around the winged staff symbolising medicine, and can also be seen as Rainbow serpents entwined together carving out the land, creating our rivers and mountains.

The white dotted pathways descend from the mountains, flow through the rivers and ascend back to the skies reforming as rainbows, the spirit of the serpent. Symbolic of medicine, the two snakes winding around the winged staff also symbolise Aboriginal and Torres Strait Islander and non-Indigenous people coming together.

The heights of the rainbow also symbolise greater professional equity, as well as improved health, social and economic wellbeing for all Aboriginal and Torres Strait Islander people and communities across Australia.

The motif was developed by Marcus Lee. Born and raised in Darwin, he is a descendant of the Karajarri people and is proud of his Aboriginal heritage.

that I could implement in the future. The conference also featured professional and leadership development opportunities including the indigenous breakfast. They provided a unique learning space where I was able to network and form bonds with person role models and supervisors. The session allowed me to take away both a wealth of knowledge and respect for surgeons but also a hope for an increase in number of future indigenous surgeons that would practice to help close the gap."

"*The conference was an amazing experience, and a unique place to network and become part of the RACS family. It solidified my aspirations and informed me of the future work required to get onto surgical training and I hope to be able to attend the conference again in the future. The award made this a possibility I could not have afforded without and I thank the RACS for their support. The conference is something I am grateful to have experienced and was able to walk away with a new support network throughout medical school as well as a wealth of knowledge about my own future career and its direction as a future indigenous doctor.*" (Artiene Tatian)

This year's ASC Awards were a great success; not only because the outstanding quality of the recipients both professionally and character wise, but importantly for the inspiration and sense of pride they instilled in everyone who met them. For the six Indigenous students and doctors it was a chance to connect with other each other and Fellows, make new friends and identify new mentors and role models. As Wiremu MacFater commented, "I have a passion for indigenous health and it was excellent to establish relationships with the current indigenous surgeons and others I hope to be the future face for indigenous surgeons. It is not often we are able to convene in a forum such as this with many of the indigenous surgeons throughout Australasia. It was a great chance to form bonds with many of these colleagues whom I consider role models. Hopefully the formation of these relationships will help rectify the health inequities discussed at the conference. It was also refreshing to learn about how the college has committed to improving health inequities among indigenous populations."

The Indigenous Health Committee is very grateful to the Foundation for Surgery for its commitment and ongoing support for Indigenous health, and appreciates the tremendous work that it is doing to raise funds to help the College achieve its ambitions in respect to the health of our Aboriginal, Torres Strait Islander and Mâori people.

For further information on the Indigenous Health Committee and RACS work on Aboriginal, Torres Strait Islander and Maori health please visit Indigenous Health, Royal Australasian College of Surgeons

Council Executive Meeting

On the 29th May 2015 at Council Executive the President signed the Statement of Commitment to develop a Reconciliation Action Plan (RAP) over the next 12 months. Developing a RAP is one of the key activities in the RACS Aboriginal and Torres Strait Islander Health Action Plan 2014–16.

Reconciliation is about building better relationships between the wider Australian community and Aboriginal and Torres Strait Islander peoples for the benefit of all Australians. To create positive change we need more people talking about the issues and coming up with innovative ideas and actions that make a difference.

Meetings with Reconciliation Australia confirmed that we will be undertaking the "Reflect" stage of the reconciliation process in which the College will be laying the foundations for building respectful relationships. A Reflect RAP will review the College's achievements so far to gain a better understanding of Aboriginal and Torres Strait Islander culture and how the College can have a positive impact on Closing the Gap between Indigenous and non–Indigenous health outcomes.

College Executive Board (Left to Right):
Phil Truskitt, Graeme Campbell, Marianne Vonau, David Watters, Spencer Beasley and John Batten

Development of the RACS RAP will involve consultation with staff across our College including Aboriginal and Torres Strait Islander staff and/or Aboriginal and Torres Strait Islander stakeholders. The College will develop a Reconciliation Action Plan by May 2016 which identifies actions, timelines and targets for relationships, respect and opportunities.

The College has established a governance structure for the RAP development that includes a Steering Committee that meets quarterly and oversees the development of the RAP. To ensure appropriate engagement across the College there is also a RAP Inclusion Working Group which is developing and implementing ideas to raise awareness of Aboriginal and Torres Strait Islander issues.

College-wide Meeting

On 2 June at a special College-wide meeting for Indigenous Health the President, David Watters presented the Chair of the Indigenous Health Committee Associate Professor Kelvin Kong, the Statement of Commitment to develop a RAP. Also at this unique event Professor Harvey Coates, AO a well renowned ENT Surgeon doing outreach work in the Kimberley region of WA was presented with the inaugural RACS Aboriginal and Torres Strait Islander Health Medal for his significant contribution to indigenous health in Australia. In his acceptance speech Professor Coates graciously thanked all his colleagues and staff.

"The opportunity to alter the life of an Aboriginal child by restoring their hearing, and secondly their language, speech, self-respect and education outcomes is, in my field, rewarding to all the team involved. It is important to understand that this is a team effort with Aboriginal Health Workers, medical practitioners, nurses, allied health workers and surgical specialists playing a vital role in the treatment our patients.

This award sends a strong message to the Aboriginal and Torres Strait Islander community that RACS acknowledges the inequities in health in our First Nation people and are an important priority for our College. Those Fellows who are privileged to work with urban, rural or remote Aboriginal and Torres Strait Islander patients, in full consultation with the communities and in a culturally sensitive manner, develop a deep respect and camaraderie which is reciprocated "

Harvey Coates, AO


Royal Australasian College of Surgeons

Royal Australasian College of Surgeons

Aboriginal and Torres Strait Islander Health Action Plan 2014-2016

The Royal Australian College of Surgeons (RACS) Aboriginal and Torres Strait Islander Health Action Plan 2014-2016 has four key focus areas:

- Leadership, excellence and advocacy.
- Increase the number of Aboriginal and Torres Strait Islander Specialists.
- Educate the workforce.
- Increase the number of Aboriginal and Torres Strait Islander staff.

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

The RACS Indigenous Health Committee (IHC) is coordinating the implementation and evaluation of the Plan. The IHC has a broad section of Indigenous and non-Indigenous Fellows and Trainees from both Australia and New Zealand. It also has representatives from the Australian Indigenous Doctors Association (AIDA) and TeORA (Māori Medical Practitioners Association). A RACS Māori Health Plan is under development.

Guiding principles

- Acknowledges RACS role in Aboriginal and Torres Strait Islander health.
- Acknowledges changes to the culture and philosophy of the way the RACS conducts its business in respect to Aboriginal and Torres Strait Islander health.
- Embraces a whole-of-organisation approach to address Aboriginal and Torres Strait Islander health, where the RACS staff and Fellows are active participants.
- Promotes and adopts a best practice approach to workforce development, advocacy, education, leadership, and excellence.
- Recognises that RACS engagement requires on-going improvement, development and evaluation.
- Ensures that RACS will be an organisation that is culturally competent.

Also at this special event, Indigenous Health Chair Kelvin Kong launched the Aboriginal and Torres Strait Islander Health Action Plan 2014-2016

FOCUS ON THE EAG

Board Member Dr Joanna Flynn brings a GP's perspective to the College's Expert Advisory Group

A member of the College's Expert Advisory Group (EAG), Dr Joanna Flynn has spent her working life as a GP and an advocate for systems that ensure the highest possible professional standards in all medical disciplines across Australia.

Dr Flynn is the inaugural and current Chair of the Medical Board of Australia (MBA) and has given more than 20 years' of service in regulatory roles to develop General Practice as a distinct medical specialty and to design frameworks to ensure patient safety through the registration and regulation of medical practitioners.

She was willing to give her time to the College's EAG because bullying and harassment were antithetical to professional conduct and she believed the work done by the group could change the culture of medicine across all specialties.

"These issues are not isolated to surgery and they are not isolated to male surgeons, but recent allegations of bullying and harassment within medicine are a very strong wake-up call that there is a problem and we need to understand it and deal with it," she said.

"However, I believe there could be issues involved with this that relate to the nature of surgery, the nature of the people attracted to surgery and the nature of surgical training that could allow bullying to become normalised, but we won't know until we hear from the people affected.

"I also think we have a responsibility to our trainees to understand that the nature of learning medicine and gaining specialist expertise is stressful enough without adding a demeaning or traumatising overlay.

"I hope that the work we are now engaged in through the EAG will act as a catalyst for change across the entire medical workforce and the College should be commended for tackling such serious matters as bullying, discrimination and sexual harassment."

Dr Flynn has been President of the Medical Practitioners Board of Victoria (2000 to 2008), having first been appointed to the Board in 1989, the President of the Australian Medical Council (2003 to 2008) and was a member of the Board of the Postgraduate Medical Council for Victoria for eight years.

She chaired the Australian Medical Council (AMC) working party which developed the ground-breaking 'Good Medical Practice: A Code of Conduct for Doctors in Australia' and is the Chair of the Board of Eastern Health, one of Melbourne's largest metropolitan health services.

She has also served as an AMC representative on significant accreditation committees including the Expert Group on Legislation, Australian Health Ministers Advisory Committee, the Commonwealth Medical Training Review Panel and the Australian Medical Workforce Advisory Committee.

Dr Flynn has also given considerable time and input into medical training and is now an Exam Panel Member of the Royal Australian College of General Practitioners and a member of the Expert Advisory Panel for the Review of Medical Intern Training for the Australian Health Ministers' Advisory Council.

Her commitment to the profession and her patients was recognised in 2011 when she was awarded Membership of the Order of Australia for her services to medical administration and to the community, particularly in the areas of practice standards, regulation and professional education.

Dr Flynn has spent her working life as a GP in Tasmania, North Queensland, metropolitan and rural Victoria and recently retired from her partnership in a medical practice in the northern suburbs of Melbourne.

She said she had always been drawn to both General Practice and broader policy issues surrounding medicine and early in her career gained a Masters of Public Health from Monash University.

"I have always been interested not only in doing my best by my patients but also in the connection between health policy and patient care," Dr Flynn said.

"I believe that doctors from all specialties play a special role in the community and that it is fundamental that we in the medical profession are responsible for earning and maintaining public trust.

"That means we must hold ourselves to the highest possible standards in our professional conduct and in our continuing professional development and that there must be systems in place to regulate those standards.

"Many people in medicine believe the MBA Board must insist on the highest professional standards possible, while others would like to see less regulation, but I have always believed that public safety is best served by registration and regulation."

"These issues are not isolated to surgery and they are not isolated to male surgeons, but recent allegations of bullying and harassment within medicine are a very strong wake-up call that there is a problem and we need to understand it and deal with it".

DR JOANNA FLYNN

Dr Flynn is the daughter of a nurse and a veterinarian and said she was first drawn to becoming a GP through the influence of two local doctors who treated her as a child, particularly because of their ability to get to know and understand their patients and to offer treatment, information and reassurance.

Since her first GP posting in rural Tasmania, she has developed a particular interest in the care of the elderly and children.

She said that while it was difficult to retire from her practice, the sense of loss related more to her patients and colleagues than to the work.

"I had lots of lovely patients and found it hard to say goodbye to them, particularly some of my older patients because it is not easy to develop a new relationship with a new GP when you are elderly," she said.

"Yet I felt somewhat over committed earlier this year so I chose to retire from the practice so that I could concentrate on broader issues relating to medicine."

Dr Flynn described the highlights of her career as helping to develop the Good Medical Practice – the Code of Conduct for doctors in Australia – which has now become the central professional guide for doctors across the country – and her work as the head of the MBA in shifting Australia's medical workforce from state registration systems to a national scheme.

"It was a very difficult transition moving to a national scheme under Federal legislation but we made it and now the system is working very well, particularly in the fit partnership between the MBA Board and the Australian Health Practitioner Regulation Agency."

- With Karen Murphy

FOCUS ON THE EAG

RACS Vice President and General Surgeon Mr Graeme Campbell on the importance of the Expert Advisory Group


MR GRAEME CAMPBELL

RACS Vice President Mr Graeme Campbell has dedicated his working life outside theatre to the development of General Surgery as a distinct specialty, surgical education and training and to promoting the importance of regional and rural surgical services.

A College Councillor for the past eight years, Mr Campbell has been Chair of the Fellowship Services Committee, Chair of the Professional Standards Committee, Chair of the Professional Development and Standards Board and is a member of the Expert Advisory Group established by the College to investigate claims of bullying and harassment in surgery.

A General Surgeon with interests in breast, colorectal and emergency surgery, Mr Campbell has spent most of his working life in the large provincial town of Bendigo, Victoria, having completed his surgical training in Melbourne and undertaking two years of post Fellowship training in England.

He is now the Chief Surgical Officer at Bendigo Health and also works out of Castlemaine Health, St John of God Hospital and Bendigo Day Surgery.

With a career-long interest in surgical education, Mr Campbell has been Chair of the Rural Surgical Training Program, is the current Chair of the Care of the Critically Ill Surgical Patient (CCrISP) Committee and was a co-creator of the Management of Surgical Emergencies (MOSES) Course.

This year, he was honoured with the College's Rural Surgeons Award which is presented to Fellows who have given outstanding service to rural surgery and rural communities.

Mr Campbell has also given significant time and effort to General Surgeons Australia (GSA), serving as Vice President from 2006 – 2010 and President from 2010 – 2012 and described the achievements made by GSA as highlights of his career.

"When I was Vice President of GSA, it was a relatively young organisation, it wasn't financially secure and it had one part-time staff member," he said.

"This was partly due to the attitude even just ten years ago which held that a generalist was considered second–rate in comparison to a surgical subspecialist.

"But now GSA represents most of the General Surgeons in Australia, including breast, colorectal and endocrine surgeons, it has taken over the administration of training of General Surgery from the College, it has a very strong balance sheet, twelve full–time staff, a research arm and a public voice.

"GSA has also led a revolution in the development of emergency surgery which was once seen as the poor cousin to elective surgery.

"In public hospitals, about 30 per cent of general surgery work is emergency work yet this service was often provided on an ad hoc basis so the GSA developed a 12 Point Plan to improve emergency care by advocating for the involvement of consultant surgeons in the assessment and treatment decisions of seriously ill patients.

"We now know this involvement by emergency General Surgeons reduces complications, hospital stay and health costs and there are now acute surgical units in many hospitals.

"The GSA is now advocating for a consultant emergency General Surgeon to be available all day to the Emergency Departments of all public hospitals across Australia but we are not there yet."

Mr Campbell said he had chosen to pursue a career as a general surgeon because of its variety, his strong interest in emergency and trauma surgery and because of its importance, particularly for patients in rural and regional areas.

He said rotations to regional hospitals early in his career had exposed him to the delights of a life outside the city limits and said he would like to see more such rotations provided to specialist trainees such those in orthopaedic, ENT and neurosurgery programs.

"I think at the end of the process that the EAG has embarked upon, we will have a much clearer understanding of the issues behind this which might enable the College to be in a position to change the culture of medicine across the board."

"I liked the idea that as a surgeon I could do something over a matter of hours that could provide a long term improvement or solution for patients," he said.

"I also like emergency surgery, particularly the intellectual challenge of having to call on your skills and experience to make fast decisions and being able to help very seriously injured people.

"In the 1990s, rural surgery was at a crossroads. The number of surgeons was declining, the rural population was falling and all the talk was about specialisation and centralisation of services.

"But now the population in rural and regional Queensland, NSW and Victoria is increasing, the need for generalists is growing as a consequence and to be a General Surgeon working in regional centres has become both an acceptable professional role and title.

"I enjoy life in a regional centre because you become part of a community, both in the broad social sense but also in the professional sphere as a teacher, mentor and leader.

"I have four children and decided early in my career that I wanted to be both a surgeon and a father and living in a regional city means that I can spend more time with my family and my patients than in the car."

Mr Campbell said he had offered his services to the College as a member of the Expert Advisory Group because he had long been an advocate for more women in surgery and wanted to know if there were barriers that acted to deter them from the profession.

He said the RACS needed to know if there was a bias against women in surgery, if intimidatory teaching practices were affecting trainees or if broader factors were at play across the medical profession.

"The College has developed and disseminated positions and policies on bullying and professional conduct," Mr Campbell said.

"Every hospital has its own policies, so if such behaviour is continuing we need to understand why.

"I think at the end of the process that the EAG has embarked upon, we will have a much clearer understanding of the issues behind this which might enable the College to be in a position to change the culture of medicine across the board.

"The RACS has a proud tradition of taking the lead on a number of major social reforms such as seat belts, drink driving, professional reforms such as the need for Continuing Professional Development and through the EAG process we hope to become leaders in changing workplace cultures that have no place in modern medicine."

- With Karen Murphy

(from left to right): Converge International Managing Director Richard Kasperczyk, RACS President David Watters and Founding Chairman of Beyondblue Mr Jeff Kennett AC

RACS LAUNCHES SURGEONS SUPPORT SERVICE

- On Thursday the 25th of June, the RACS Support Program was launched by Mr Jeff Kennett AC, former Victorian Premier and founding chairman of national depression initiative *Beyondblue*.
- The College recognised a need to provide independent and confidential support and advice to any of its members in distress, including those struggling to cope with workplace, emotional and personal issues.
- The RACS Surgeons Support Program is a professional and confidential counselling service to College Fellows, Trainees and International Medical Graduates (IMGs).
- Since the publication of the National Mental Health Survey of Doctors and Medical Students conducted by Beyondblue in 2013, the College has been exploring options around how to provide better awareness, education and support to surgeons.
- Additionally, the recent media coverage, highlighting the issues of discrimination, bullying or sexual harassment has lent urgency to the need for the College to ensure there are extra avenues of support for surgeons.
- The RACS Support Program is an independent service provided by Converge International (incorporating Resolutions RTK).
- Converge International is experienced in assisting clients in the medical sector and provides services throughout Australia and New Zealand.
- The new support program has the full support of the College's Council and is funded by RACS and covers any Fellow, Trainee or IMG registered with the College and on a pathway to Fellowship.
- The program provides a range of counselling, coaching and support services.

RACS Support Program

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

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

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

How to contact Converge International:

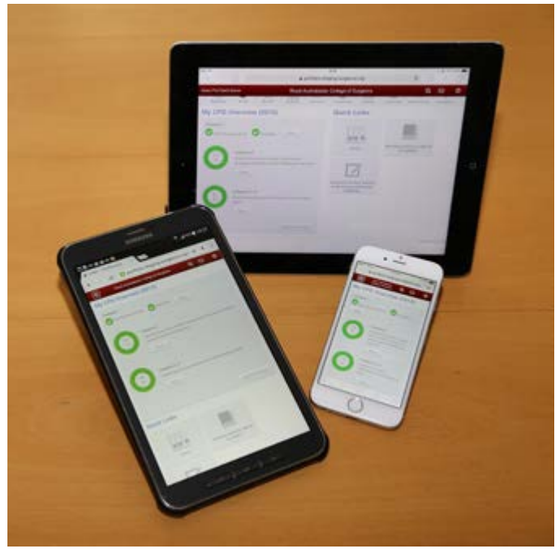
- Telephone 1300 687 327 in Australia or 0800 666 367 in New Zealand
- Email eap@convergeintl.com.au
- Identify yourself as a Fellow, Trainee or IMG of RACS
- Appointments are available from 8:30am to 6:00pm Mon-Fri (excluding public holiday)
- 24/7 Emergency telephone counselling is available.

Converge international

RACS PORTFOLIO LAUNCH

A comprehensive digital strategy will provide Fellows with easy access to a range of College resources

RICHARD PERRY
Chair, Fellowship Services



The RACS Portfolio is being rolled out this month. The RACS Portfolio is part of a comprehensive digital strategy to deliver better access to lifelong learning, professional development, and assessment and examination systems.

The Portfolio has been personalised, to save time and provide access regardless of whether someone is using a mobile, tablet or desktop computer.

The initial release of the Portfolio focuses on providing Fellows with easy access to commonly used College applications. It includes:

- a Dashboard with CPD summary and links to commonly used resources,
- an improved and easy to use CPD area optimised for adding activities while on a tablet or mobile phone,
- a Profile section with login, contact, account and qualification details, and
- links back to the College website where appropriate.

Over the coming months, other areas will be developed to make it even easier to access the tools that are most important. Plans include:

- MALT overview on the dashboard,
- easy access to online registration for courses and workshops,
- a notification system to alert you to important notices and reminders
- better integration with search, library and other resources such as eCommittees.

The RACS Portfolio can be found at:
https://portfolio.surgeons.org
A website login is all that is needed.
Please feel free to provide your feedback.

EMPOWERING OTHERS

Indigenous Health Medal recipient Professor Pat Alley praises the achievements of the Indigenous Health Committee

2015 Indigenous Health Convenor Maxine Ronald with Indigenous Health Medal recipient Professor Pat Alley

One of the inaugural recipients of the College's Indigenous Health Medal, Professor Pat Alley, laughed when he described how he first came to learn the Mâori language.

It was a skill he acquired, he said, through a combination of youth, hard work and hunger.

"As a medical student I worked in the farming sector during university breaks and sometimes I was the only white person in the harvesting gang," he explained.

"All of us worked together, camped together and socialised together and I very quickly realised that if I didn't learn Mâori I wouldn't understand the call to eat and wouldn't get fed.

"Hunger is a very strong driver for a young person.

"I suppose you'd call it learning the language through the immersion method but for me it was more about necessity and looking back, I feel very fortunate to have had that experience and to have had the early opportunity to make Mâori friends."

Professor Alley is now the Director of Clinical Training at Waitemata District Health Board (WDHB) and Clinical Associate Professor of Surgery at the University of Auckland.

A founding member of the Department of General Surgery at WDHB, Professor Alley was an inaugural member of the College's Indigenous Health Committee, established in 2009, and still serves on the committee to ensure the bi-national and bi-cultural focus of its advocacy and research work.

With a career-long interest in surgical education, Professor Alley also became the first New Zealander to be awarded the Confederation of Postgraduate Medical Education Councils (CPMEC) Clinical Educator of the Year Award in 2013.

Professor Alley received the Indigenous Health Medal at this year's ASC for his commitment to improving Indigenous health outcomes and for his understanding of Mâori culture which has assisted a number of College Presidents at ceremonial occasions and which has fostered trusting relationships with Mâori health and community groups.

Professor Alley said he was honoured to receive the medal even though he had "not one drop" of Mâori blood flowing through his veins.

Rather, he said he had been drawn to working with Mâori patients and advocacy groups through the networks he forged as a young man.

"Everything changed for the Mâori people in the 1970s after the original 1840 Treaty between the Crown and the Mâori was recognised which provided for self determination, land rights and political representation," he said.

INDIGENOUS
HEALTH

"That was a very exciting time in New Zealand and after I had attained my Fellowship, finished post-Fellowship training in Britain and returned home I wanted to reconnect with that culture so I began night classes to brush up on the language I had learned in my youth.

"This gave me an insight into the very sophisticated Mâori tribal culture while my work as a General Surgeon gave me exposure to their health issues and I was asked in those early days to assist various groups with Mâori health advocacy.

"Fortunately, those days are long gone now because Mâori are extremely capable of speaking up for themselves and representing their interests and concerns.

"Surgeons of the day thought me mad to get involved in this work and I received quite a lot of criticism at the time but thankfully those days are long gone now too."

Professor Alley said that in the 1980s he began campaigning for the RACS in New Zealand to develop a Mâori dimension within its committee structure as a matter of respect and recognition and also to help build relationships between surgeons and Mâori health leaders and patients.

He said it was a cultural necessity in New Zealand to understand "kawa" (protocol) when conducting formal engagements and meetings if outcomes were to be successful and respected.

He said Mâori had both a complex tribal culture and an extremely sophisticated understanding of what it means to be healthy, both of which surgeons needed to understand if they were to work with community groups to improve health outcomes.

"Mâori have a very elaborate ceremonial system to mark formal meetings and engagements," Professor Alley said.

"Attendees are called to meeting by women, the visitors are then challenged by a warrior, speeches must be given by both sides and blessings must be sought from the mountains, the water and the dead who are with Mâori all the time.

"They also have complex understandings of what it means to be well that range far outside physical health to include mental health and social and spiritual well-being.

"We would describe this now as a bio-psycho-social model of wellness and in a way the Western world is only now catching up with this view."

Professor Alley said that Mâori still faced a discrepancy in life expectancy compared to non-Mâori New Zealanders. They remain over-represented in the statistics for coronary artery disease, diabetes and obesity. However, some health outcomes were slowly improving.

With a passionate interest in medical and surgical education, Professor Alley has also been contributed to methods to attract more Mâori students into medicine and surgery.

He said the decision made in the 1990s by medical colleges and universities to create and implement affirmative action plans to attract Mâori into medicine had been an unqualified success.

"We now have at least 15 surgical Trainees that identify as Mâori which is very pleasing."

Now 73, Professor Alley praised the work being done by young Mâori surgeons and health leaders and said he was delighted at the outcomes achieved by the College's Indigenous Health Committee.

"We set up the Committee to raise the visibility of Indigenous people in New Zealand and Australia within a health framework and that's been done," he said.

"We also wanted to work out how to deal with the discrepancies that exist in the health indices affecting Indigenous people and that is an on-going challenge and we wanted to create a medical workforce that is more reflective of the community and that is progressing quite well, particularly in New Zealand.

"While there is more to do and achieve I think the College's Indigenous Health Committee has largely met these criteria and I believe there will be parity in health outcomes, particularly in New Zealand, within the next generation.

"It is a great joy to me to see Mâori surgeons doing so well and I am confident that we will see the number of Mâori surgeons becoming more reflective of the Mâori population of 12 per cent."

2013 ASC Indigenous Health Maori reception

Professor Alley said that while he was somewhat embarrassed to receive the Indigenous Health Medal given that he was not of Mâori heritage, he was pleased that his early interest in Mâori health and culture had empowered others.

"I see this medal as recognition of the work I did in the past in promoting Mâori health and people have said that I helped them to speak for themselves, particularly in those early days," he said.

"I feel honoured to have had the chance to learn from Te Ao Mâori (the Mâori world) and Mâori colleagues and patients and know that I leave this advocacy work in very capable hands."

The RACS Indigenous Health Medal is given to those Fellows who have made a significant contribution to Mâori, Aboriginal and Torres Strait Islander health care and advocacy.

- With Karen Murphy

LIBRARY ALERTING SERVICES

The number of services available is growing

In April's *Surgical News* information was provided about an alerting system available as an app on mobile devices or a program on desktop or laptop computers. This is called Read by QxMD (http://www.qxmd.com/apps/read-by-qxmd-app) and it was also demonstrated and then downloaded by many visitors to the College booth during the ASC in Perth. It can assist in keeping you up-to-date regarding the latest articles from a range of journals that you select.

Emailed Tables of Contents

In addition to this app, the College Library is offering a new service based on emailed Table of Contents alerts or notifications from subscribed e-journals. The service is called "eTOCs" (electronic Table of Contents). The eTOCs will be emailed directly to you, and you can access the articles by simply clicking the links and using your College Website login (only necessary once per session). Articles may then be read, printed or saved.

To start receiving eTOCs all that is required is your name and email on the opt-in form. If it is found that the service does not suit, it is easy to opt-out again.

To find out more or to sign-up to start receiving alerts, please go to: http://www.surgeons.org/my-page/racs-knowledge/library/etocs. Currently on offer are a selection of journals in Medical Education, Orthopaedic Surgery, Vascular Surgery, Otolaryngology Head & Neck Surgery and Plastic & Reconstructive Surgery. More Specialties will be available in the future.

Customised alerts

Assistance from the Library is offered in the setting up of alerts to individual e-journals or for a saved topic or subject search within the Medline or Embase databases. Saved searches will retrieve new citations (and usually abstracts) on a topic each time the database is updated – they are then emailed directly to you.

Please contact Library staff on +61 3 9249 1272 or college.library@surgeons.org for more information and support with any alerting options you are interested in.

eTOCS http://www.surgeons.org/my-page/racs-knowledge/library/etocs

Read by QxMD http://www.qxmd.com/apps/read-by-qxmd-app

MAGAZINE ADS

We are not fooled by snake oil salesmen!

BY **PROFESSOR GRUMPY**

There is one thing that really annoys me and it is advertising in magazines. I realise that advertising is essential for the viability of magazines but so often the first 40 pages is taken up by glossy advertisements. Then the last 40 pages are taken up by not quite as glossy advertisements. In the middle somewhere are the articles that caused you to buy the magazine in the first place. This pattern of magazine structure seems to be particularly so in glossy fashion magazines. You may well ask why does a curmudgeon look at women's fashion magazines. Quite simple – my daughter in law writes for them.

We curmudgeons can avoid this flurry of gloss by reading only bloke magazines. We don't need to know about various lip glosses and hair products or the ways to get rid of cellulite. (Incidentally I can't find the term cellulite in any anatomy book. Nor do I recall ever seeing a question in the RACS Basic Science exam – "Describe in detail the macroscopic and histological structure of cellulite.") Hair product advertisements are lost on curmudgeons as most of us are bald. Advertisements for hair restoration products are prominent of course but we are not fooled by snake oil salesmen.

Occasionally curmudgeons will buy a car magazine or a 4WD magazine. Now there is a proper magazine – real articles about things that matter such as performance of new cars, the advantages of certain types of tyres in mud compared to sand. There are no advertisements for lip gloss or imitation crocodile skin hand bags but advertisements for things such as the best engine oil or shock absorbers for off road work.

As anyone over 40 knows, life can be full of disappointments. As a curmudgeon I have learned with some reluctance to accept that most days have a disappointment or two in them. Some days it is the local football team result. If they had a real sponsor such as a car company rather than a sponsor such as a vitamin supplement company they might do better. "Play harder – do it for the image of the super duper new sport car by XYZ" would be more of a driver than "Kick straighter for multi B complex". Some days the disappointment is the weather, or the lack of a favourite ironed shirt in the closet or dinner. Yesterday's disappointment was within the covers of the occasionally bought sports car magazine. There it was on page 3 – a full page glossy advertisement for a man–bag. Now I ask you why do men need man–bags. Our clothes have lots of pockets for keys and wallets which is all we curmudgeons carry.

In despair and disappointment I turned to *Surgical News*. Now there is a magazine that surgeons (and especially curmudgeon surgeons) can rely on – no lip gloss advertisements. But it has happened – hidden away on the back cover it was there among a collage of pictures extolling the benefits of RACS Member Advantage. It was no less than a massage advertisement. I will speak to the editor!

IN MEMORIAM

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

John Taylor
WA Fellow

Anjaparavanda Chinnappa
Vic Fellow

John Kille
Tasmanian Fellow

Richard Freeman
Vic Fellow

Ronald L Huckstep
NSW Fellow

Robert Kyd
New Zealand Fellow

James Gray
New Zealand Fellow

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

Informing the College

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

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

FLEXIBLE LEARNING

Opportunities for online learning are increasing

SPENCER BEASLEY
Chair Professional Development

STEPHEN TOBIN
Dean of Education

Currently, there is a global demand for education that goes far beyond our ability to provide in the conventional way of face-to-face learning. In surgical education, we have confronted this challenge to train and educate our members with a flexible and adaptive approach which maintains the high quality of our educational programmes. Tighter finances, the larger numbers of learners, and safe working hours restrictions have not just compromised experiential learning opportunities but also have had the potential to affect our ability to provide effective education and training. For these reasons the College has explored more innovative and flexible models of learning delivery.

The College has been at the forefront of developing a broad array of solutions to enable learning and improve performance in surgical education. Fellows now have greater control over their own professional development with increased access to teaching resources across distance and time. This is achieved through a comprehensive suite of College professional development programs being offered via a variety of means that include: hub and spoke workshop models, forums, flipped classrooms, webinars, podcasts, blogs, articles of interest, interactive case studies, electronic tables of content circulars, and online learning workshops.

With the increased complexity of media and technology and the versatility it provides, online learning has allowed the College's flexible approach to progress rapidly. Online learning now provides courses and resources that are accommodating and contemporary, whilst at the same time reducing the cost and inconvenience to Fellows. They are time efficient. Not only do they allow for customisation of content, but also the ability to respond to different learning needs and preferences. The can be refined and modified quickly and cheaply.

The development of quality online learning programs has been a priority in order to complement the face-to-face course offerings, and extend effective learning opportunities to those who have difficulty attending conventional training courses and workshops.

The online learning programming available to Fellows, Trainees and International Medical Graduates is listed below:

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 teachers of SET Trainees. 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 SAT SET online modules have been redesigned to incorporate the new content of the face-to-face course. There are four interactive modules (see below). The modules include videos and an opportunity to practise using work–based assessment tools, such as the Mini-CEX and DOPS.

Currently available RACS online learning modules:

- Acute Neurotrauma
- Building Towards Retirement
- Clinical Decision Making
- Indigenous Health
- Intercultural Competency
- Foundation Skills for Surgical Educators
- Non–Technical Skills for Surgeons
- Surgical Teachers Course
- Selection Interviewer Training for the Surgical Education and Training (SET) program
- Supervisors and Trainers for SET
- Keeping Trainees on Track
- Trainees in Difficulty
- Academy of Surgical Educators

Content of the new online SATSET course:

1. Roles and Responsibilities;
2. Work-based assessment;
3. Assessment tools; and
4. Giving feedback.

The online KTOT course is targeted at College Supervisors and Trainers to help in the early detection of SET Trainees in difficulty, their subsequent performance management and how to hold difficult but necessary conversations. Course participants receive advice on how to set up effective start of term meetings, diagnose and support trainees in difficulty, how to deliver negative feedback and how to overcome barriers when holding difficult but necessary conversations.

The online modules for both SAT SET and KTOT have been produced as self-paced, interactive online workshops, and have been designed for responsive performance on personal computer, tablet and mobile learning technologies. Upon successful completion, continuing professional development (CPD) points will be awarded and automatically uploaded to a Fellows record.

Access to online learning is enabled through the College website. Members should log in to the website, **go to My Page,** and then **scroll down to eLearning** in the menu on the left hand side.

If you have further questions or suggestions regarding online programming please contact:
Alicia Mew, Education Development Coordinator, Professional Development Department on:
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CASE NOTE REVIEW

The postoperative course may bring to light comorbidities that previously had not troubled the patient

GUY MADDERN
Chair, ANZASM

An elderly person was admitted for elective left total hip replacement. The patient had been treated conservatively, for a number of years, for this osteoarthritic condition. The patient had been assessed and because of the increasing pain, surgery for the arthritic hip was recommended.

Although they had some significant risks, a full pre-anaesthetic assessment suggested the patient was more than reasonable for surgery (from an anaesthetic-risk point of view). The pre-anaesthetic self-assessment form that the patient completed did not identify any significant risk factors or cardiac issues.

It was noted however, that the patient had previously been treated by a Vascular surgical team for carotid atherosclerosis and this was considered stable and not warranting any surgery. The patient previously had peripheral vascular disease which was again considered stable, and was on aspirin as the only treatment for this. The patient had mild aortic stenosis with an ejection fraction of 65 per cent, again not considered worthy of significant treatment.

The patient underwent a standard, uncemented total hip replacement and anaesthetic progress through the procedure was uneventful. There was no excessive blood loss. The reinfusion drain collected only 200ml of blood.

The patient remained stable throughout the course of the operation and the recovery room observations. The patient then returned to the ward. Postoperatively however the patient deteriorated rapidly and suffered a large myocardial infarction with subsequent cardiogenic shock.

In spite of appropriate use of the intensive care, the patient went on to multiple organ failure and died shortly thereafter. The postoperative thromboembolism prophylaxis given was appropriate, as was the use of analgesic medications. There were no significant disruptions to the biochemistry or full blood count in the immediate postoperative period.

Reviewer's Comments

This patient clearly had a pre-existing condition involving their vascular tree, and despite the absence of cardiac symptoms, may have had a coronary artery disease.

The decision to operate seemed reasonable and the patient progressed well. A consultant performed the procedure and it did not take excessive time. No autopsy was performed but all parameters point to a substantial myocardial infarction with cardiogenic shock and death.

There will be times when despite a well done operation, and a well performed anaesthetic, the postoperative course will bring to light comorbidities that previously had not troubled the patient but become fatal in enduring a postoperative course from such surgical procedures.

FELLOWSHIP SURVEY

How has your voice improved the college?

RICHARD PERRY
Chair, Fellowship Services

In August this year all Fellows of the College will have an opportunity to help shape the future direction of their College by participating in the 2015 Fellowship Survey. The survey will seek feedback from the Fellowship to identify areas for improvement, strengths and the potential path Fellows wish their College to take in the coming years.

As preparations continue for the launch of the 2015 survey, it is timely to look back at the previous Fellowship Survey results and review how feedback from Fellows has been addressed.

The Fellowship Survey was last conducted in 2010, open to all active and retired Fellows. A response rate of 45 per cent (n=2,929) was achieved. Importantly, Fellows who participated were a representative sample of the broader Fellowship in terms of specialty practiced, regions, age and gender.

In 2010 Fellows reported that they were satisfied with the role of the College and the services provided with over two-thirds of active Fellows (68 per cent) and 84 per cent of retired Fellows reporting satisfaction. Seventy-six percent of respondents considered the College to be of 'real benefit' as a Fellow, which met a major key performance indicator for the College's 2010 – 2015 Strategic Plan.

A major focus for the 2010 Fellowship Survey was to seek feedback on areas the College could improve on. 1800 Fellows provided qualitative responses. Key responses included improving the Surgical Education and Training Program, relationships with Specialty Societies and Associations, promoting collegiality and unity, lobbying and political negotiations with external groups and government, communication with Fellows, protecting the title 'surgeon' and promoting the value of 'FRACS'.

So how has the College improved in response to this feedback?

Surgical Education and Training (SET) Program

We continue to evaluate and improve the nine training programs with better defined standards. The Specialty Societies and Associations have had an increased role in managing the surgical training programs, in partnership with the College. Our ongoing accreditation with the Australian Medical Council and the Medical Council of New Zealand signifies that we are a quality surgical education and training provider.

In 2012 'Becoming a Competent and Proficient Surgeon: Training Standards for the Nine RACS Competencies' was published. A major focus of resourcing for SET has been IT infrastructure. More online educational resources are now available along with the Morbidity Audit and Logbook Tool to better support and prepare trainees for professional practice. Monitoring training posts to ensure they are high-quality educational experiences, focused on acquiring the required skills and attributes continues to be core work for the College.

The 2015 launch of JDOCS (a competency framework and suite of learning and assessment resources for junior doctors) is also helping to guide junior doctor with career development prior to entry to SET. The generic surgical science examination is now open to junior doctors prior to entry into SET and can be undertaken online.

Relationships and advocacy

The College considers strengthening relationships with Specialty Societies and Associations as well as other external stakeholders as a major priority. Growing recognition of the complementary roles of Specialty Societies and the College offers the opportunity to extend the influence and reach of the surgical profession. Much progress has been made with the establishment of partnering agreements for the delivery of the SET Program, allowing for our relationships with the Specialty Societies and Associations to become more principle based.

We are now better placed to advocate for a range of issues including patient safety, sustainability for the health sector, indigenous health, safe hours, alcohol induced trauma and road safety. More recently, excessive fees and discrimination, bullying and sexual harassment have been major issues the College is addressing. Regional advocacy has a particular focus on having collaborative yet purposeful relationships with Departments of Health. We are actively engaging with key stakeholders on these important issues on behalf of the community that we serve.

Collegiality and unity

Collegiality remains at the core of our relationships with our peers and is part of our values. We are now better placed to support Fellows in need through direct support offered by the Executive Directors of Surgical Affairs in Australia and New Zealand and the newly established RACS Support Program. Profiling the work of our surgeons and their achievements both on a bi-national and regional level is an important initiative and fosters collegiality. We continue to work with Specialty Societies and Associations on the strategic direction for surgery and in advocacy. Collaboration and collegiality enable your College to be the leading advocate for surgical standards, professionalism and surgical education in Australasia.

Communication

Communication with Fellows was highlighted as an area for improvement. The College has made changes to the mode and style of communication with Fellows, now offering *Fax Mentis* as an electronic weekly update in addition to the highly valued monthly publications of *Surgical News* and the *Australian and New Zealand Journal of Surgery*.

We now have a growing social media presence on Facebook, Twitter and LinkedIn. In addition we are better placed to respond to preferences as to how you would like to receive communications from the College. Improvements to the website and the newly launched electronic portfolio accessed via mobile telephone, tablet or desktop computer will also enhance communication and allow Fellows to manage their preferences.

Our regional offices continue to provide a local point of contact and an opportunity for Fellows to engage with their College. During 2013–14 all College staff undertook customer service training with an emphasis on telephone protocols. Ensuring Fellows are able to reach the appropriate person to assist with their enquiries in an efficient manner is a high priority.

Promoting the value of 'FRACS'

Since receiving feedback in 2010, the College has taken a number of steps to better promote the value of 'FRACS'. We promote FRACS not only as a quality qualification but also as a symbol of professionalism. The FRACS brand represents prestige and privilege among the medical profession and the community we serve. The introduction of a FRACS logo and branding as part of a corporate identity strategy in 2011 has been well received.

Our increased advocacy, social media presence and 'Find A Surgeon' register has promoted the value of FRACS externally. The publication of a 'Guide to College Services and Programs' has also assisted with promoting the value of FRACS within the Fellowship, along with our ongoing role to define and uphold standards for surgery.

Your College Council and staff have been responsive to Fellow feedback on improvements identified in the last Fellowship Survey. However, there is much more work to be done. This is your College and the College is your voice. I look forward to providing every Fellow with the opportunity to reflect on the College's performance and provide feedback on the direction of their College going forward.

Look out for your invitation to participate in the 2015 Fellowship Survey in your inbox this August.

FELLOWSHIP
SERVICES

Queen's Birthday Honours List

Australia

Companion (AC), in the General Division

Professor Stephen Vincent Lynch FRACS

Member (AM), in the General Division

Professor Ian Ronald Gough FRACS
Professor Ian Andrew Harris FRACS
Professor Ross Beresford Holland
(Anaesthetist, Member of Court of Honour)
Dr Michael William Lanigan FRACS
Professor Robert James Lusby FRACS
Associate Professor
John Richard (Jack) Mackay FRACS
Dr Clifford Walter Pollard FRACS

New Zealand

Officer of the New Zealand Order of Merit (ONZM)

Mr George Ngaei FRACS

ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

HEART-STOPPING COURSE AT VSEC MARCH 2015

Combining Bio-reality cardiac surgery simulation with skills training, knowledge acquisition and exam preparation

BRUCE WAXMAN
Clinical Director, Victorian Skills and Education Centre

What an awesome experience for a SET trainee!

The Australian and New Zealand Society of Cardiac and Thoracic Surgeons conducted the annual Cardiothoracic Trainees Course (CTS) over Thursday March 26 – Saturday March 28 2015 at the Victorian Skills and Education Centre (VSEC) at RACS Headquarters in Melbourne.

Co-ordinated by Associate Professor Andrew Cochrane, he brought together 10 faculty and 33 Trainees to VSEC, supported by a wide range of sponsors and a pot pourri of lectures, practical demonstrations, skills training sessions on manikins, practical models and aortic valve wet labs, practice oral exams in surgery and pathology and a research study incorporating Macquarie University, Faculty of Human Sciences on an Aortic valve and coronary artery simulator.

Andrew Cochrane, Paul Ramphal and Julian Smith after the Webinar

But the big draw card was Paul Ramphal and his high-fidelity cardiac surgery simulator, set up as a mock operating theatre in the Simulation Centre at VSEC.

Professor Paul Ramphal is a Cardiovascular and thoracic surgeon, who grew up in Jamaica and Toronto, Canada, and currently works in the Cardiothoracic and Vascular Institute, Nassau, in the Bahamas.

He has spent over a decade developing a high fidelity cardiac simulator, the Ramphal Cardiac Surgery Simulator (RCSS), and has worked in collaboration with the University of North Carolina, Chapel Hill, where his main co-investigator at UNC is Professor Richard Feins, of the Department of Surgery, who has been involved in the development of thoracic simulators [1].

Andrew Cochrane supervising Trainees in the cardiac surgery simulator

Paul previously came to the CTS in 2011, and he was a welcome return.

As well as running the simulator, he presented the Academy of Surgical Educators lecture webinar on "The Development and Application of Cardiothoracic Simulation-based Training Environments" in the Hughes room on the evening of March 26.

The RCSS model uses a porcine heart that is prepared with an intraventricular balloon in each ventricle. The balloons are inflated by a computer controlled activator. The computer program is able to simulate the beating heart, various cardiac arrhythmias, hypo and hypertensive states, cardiac arrest, and even placement of an intra-aortic balloon pump.

The model is perfused with a washable blood substitute. When placed in a replica of the pericardial well in a mannequin, the RCSS is capable of duplicating most aspects of cardiac surgery including all aspects of cardiopulmonary bypass, coronary artery bypass grafting both on and off bypass, aortic valve replacement, heart transplantation, and aortic root reconstruction.

The computer protocols also make experience with adverse events such as accidental instillation of air into the pump circuit, aortic dissection, and sudden ventricular fibrillation after discontinuation of cardiopulmonary bypass possible.

The equipment was shipped from the West Indies and set up with a perfusion device and manikin to simulate a cardio-thoracic operating theatre and Dr Ramphal took Trainees through a range of intra-operative complications, which was so realistic it had the Trainees totally immersed in the experiences. Truly an awesome experience!

Reference: 1. Ramphal PS, Coore DN Craven MP et al; A high fidelity tissue-based cardiac surgical simulator *Eur J Cardiothorac Surg* 2005; 27: 910-16

Letters to the Editor

Let's return to the fold – reuniting surgeons under one umbrella

I make these comments as a result of recent experiences with the Plastic Surgical Congress in Brisbane in May 2015 which was held concurrently with the RACS meeting in Perth. It is our loss that our separate specialties at the College are diverging and their separate meetings reflects this transition.

As Don Marshall has reminded me, in a somewhat burlesque manner, and I quote – "in sub-specialisation more and more is known about less and less and we end up knowing everything about nothing". Therefore why should we dilute our talent when the College survival is based on such merit? Talent with a technical aptitude creates the image of an excellent surgeon. We cannot afford to have this state of affairs continually eroded. Financially the College is in a different league compared with our Plastic Surgical Society. It was disappointing to see the poster presentations at the Brisbane meeting with acres of Velcro space available and no plasticised laminates visible to survey. The available alternative was that registrants had the privilege of sitting at individual computer desk-tops (x4) while munching on a muffin and partaking of tea – a test of anyone's dexterity! The College policy of having large video screens with individual terminals allows all and sundry to wander and watch the screens almost in a collegiate familiarity.

From my personal experience we had our own setback as our submission for an E-poster display (in association with Dr Rita Hardiman , School of Dental Science, University of Melbourne and Dr Imelda Motoroko, Western Hospital) was omitted from the printed program in spite of registration. Their solution was for a separate page to be printed and inserted into the program at the 11th hour. Yes, I voiced my objections.

Then the logistics of location arose – I know of members of our society who had to fly across the continent to participate in both the Breast Section of the RACS in Perth and then back to the Plastic Surgery Congress in Brisbane – yes, could something be wrong in the State of Denmark?

But please don't can the courier, I am merely repeating items of conversation recently held between myself and my Plastic Surgical colleagues in Melbourne, including academics. I welcome any overtures whereby the College meeting can embrace all our sub-specialties again. And I make the suggestion that the best papers from all the sub-specialty meetings held annually should be given prime time at the ASC. Let's not forget we have some excellent local talent. Additionally, with any published paper (local or international) of the past 12 months, the author should be invited to present at these annual RACS meetings.

I have now a whimsical quote from Sir Thomas Beecham who founded the Royal Philharmonic Orchestra in London in the post-war period, regarding talent. He said, "Why must we invite a range of 3rd rate international conductors to perform here when we have a surfeit of 2nd rate conductors to do the same job?". Could this have a surgical connotation?

And in closing I quote from a recent Orthopaedic source: ZJ Daruwalla et al in *Orthop Surg Res.* 2015 May 7;10(1):58. doi: 10.1186/s13018-015-0203-y, titled "Publish or perish" who conclude that:

"We suggest that the quality of a presentation is related to its subsequent publication in a peer-reviewed journal. Our findings support the general consensus that the annual meeting of the American Academy of Orthopaedic Surgeons (AAOS) is the gold standard for the dissemination of orthopaedic knowledge updates and advancements in our specialty. Each national orthopaedic association could determine the ratio of "presentations at ASM" to "publication within five years of presentation".

Let's not forget Lincoln's Republican Presentation in Illinois in 1858 which seemed to facilitate his election as President when he said "a house divided against itself cannot stand", reflecting the words of the Almighty from the synoptic Gospels. This embracing factor is an attitude reflected by the current President David Watters and perhaps he may wish to respond.

Felix Behan

Victorian Fellow

The first plastic surgeon in Australia

A great article by Felix Behan about Jerry Moore. I thought that to say the Medical course in Melbourne' was more prestigious ' was doubtful at the time.

The Queensland Medical School commenced in 1909 so he could only attend the NSW one started in 1856, or the Victorian which started in 1858.

Paul Robinson

Queensland Fellow

BEHIND THE MASK

Dr Daron Cunningham and Médecins Sans Frontières

In part three of the Behind the Mask series we speak to trauma surgeon, Dr Daron Cunningham. Dr Cunningham first joined Médecins Sans Frontières (Doctors Without Borders) in 2011 and has since been on four assignments to the field.

Dr Cunningham's first field placement was in 2011, where he spent four months in Kenya at the Dadaab refugee complex. Located on a desert plain in north-eastern Kenya, Dadaab is the largest refugee complex in the world. The population, mainly Somalis fleeing conflict and drought in their country, is approaching half a million. Médecins Sans Frontières has been the sole provider of healthcare in Dagahaley camp since 2009, working out of a 100 bed hospital, providing emergency surgery, adult and paediatric care, maternity services and treatment for HIV/AIDS and TB.

Since returning from Kenya, Dr Cunningham has since worked as a surgeon with Médecins Sans Frontières in Libya and Yemen. More recently, at the end of August this year, Dr Cunningham returned from a two month placement in Kunduz, Afghanistan. In Afghanistan the ongoing war and its consequences continues to restrict people's access to quality medical services. In the northern province of Kunduz, the Médecins Sans Frontières trauma centre provides free surgical care to victims of general trauma such as traffic incidents, as well as conflict– related injuries like gunshot wounds. Last year the staff treated 17,000 people and performed 4,500 surgical procedures.

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

Quite a few reasons, really. I wanted to work with populations who are genuinely in need of even the simplest healthcare; those who will get the greatest benefit from basic intervention. A lot of healthcare in developed countries involves trying to undo the damage people have done to themselves with years of indulgence, which gets a little tiresome. Médecins Sans Frontières is the opposite of that. I enjoy working with very limited resources. I've always been an avid traveler, and aid work gets me places that are otherwise off limits. To be honest, I also find it exciting.

You've previously been on assignment in Yemen, Kenya and Libya. What was your role for these assignments?

Kenya and Yemen were both in camps for internally displaced people, so it was general refugee health, both emergency and elective surgery. I did quite a lot of non-general surgery – pediatrics, gynecology etc – so that was satisfying. Libya was during the recent war, so it was mainly trauma surgery, plus a little bit of emergency general surgery.

You've just returned from Afghanistan. Can you describe the project you were working on?

The project is a trauma hospital in a region of Afghanistan that still sees a lot of violence, and will do for quite some time. The hospital treats trauma only, and is busy, really busy. There are a lot of very advanced cases, with complex injuries. It's a long-term Médecins Sans Frontières hospital, with lots of development and expansion going on.

What did your role involve?

Essentially I was there as a trauma surgeon, responsible for patient care from arrival until discharge, and as a surgeon-educator. I have subspecialty training in trauma, so I was completely in my element. The local surgeons are good, but their training is patchy, so there was plenty of teaching to do. It

"It's the patients who suffer disabling injuries but are still grateful, because they know it would have been much worse without our care."

was another great opportunity to do work in areas in which I have training – neurosurgery, vascular surgery, urology etc – but in which I don't get a lot of opportunities in Australia.

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

For me it just takes a backpack and a ticket of some sort, but I may be a little unusual. I enjoy the simple living, the trying conditions, the workload and the 'team-living'. I am not too bothered by the difficult conditions, so I tend to enjoy my missions, and don't really need to prepare myself psychologically. Also, as a surgeon, my missions aren't particularly long. I can put up with almost anything if it's only for a couple of months.

Did any patients make a particular impact on you?

Well, I could give some specific examples, but I'd rather generalise. It's the patients whose care goes better than expected, and they survive or keep a limb when the odds were against them, and they realise it. It's the patients who suffer disabling injuries but are still grateful, because they know it would have been much worse without our care. It's the children who can still laugh and play, in spite of their injuries. It's the children, who just shouldn't have their arms or legs blown off, and just shouldn't be there at all.

How does being a surgeon in a war torn country differ from working in Australia?

In a lot of ways I find it easier. There's less irritating bureaucracy and fewer non-clinical obstacles in general. There's much more of a feeling that everybody's working toward the same goal, and more of a 'can do' philosophy. Clinically, having fewer resources and options usually makes decision making easier, which is nice sometimes. Patients in war zones are usually more realistic in terms of expectations, and are generally happy for any care they can receive.

Dr Cunningham with a patient

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

I believe it does. I think it's always good to have to use basic clinical skills and simple, time-tested surgical techniques rather than relying on the latest technology or equipment. If anything, I have trouble in the other direction, and need to remember to make use of resources available in Australia. I worry about trainees who learn with everything at their disposal; it's much easier to quickly learn how to use a fancy resource than to learn how to do without it.

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

I always knew that I wanted to do this kind of work, so I made sure received training outside the usual realm of general surgery. With me, it's more a case of using the extra skills I gained in Australia, in the field. I guess field work does facilitate experience in non-general surgery, which occasionally comes in handy in rural Australia.

How has the experience changed or affected your life?

It certainly makes me appreciate the freedoms and opportunities afforded to me, as a result of nationality and personal circumstance. I also find that each mission confirms for me that all the training was worth it, and that being able to have a positive effect on the life of a stranger is a valuable reward for my efforts.

Do you have any advice for other surgeons considering work with an international medical aid organisation?

Definitely give it a go, but be well aware that it's very different from routine surgical practice in a Western country. Talk to surgeons who've done it, and research the various agencies to see what suits your intentions. There's a big difference between a fly-in-fly-out for two weeks of palate repairs organisation, and a group like Médecins Sans Frontières, so make sure you know what you're looking for.

Where next?

No idea. I tend not to make plans, if I can help it. I don't do this full-time, so I'll just see what comes up. My preference is definitely for conflict zones, and there're always plenty of those.

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

Learn more about the rewarding experience of working as a surgeon with Médecins Sans Frontières at

http://msf.org.au/findoutmore/

RESEARCH FOR EARLY DETECTION

Dr Simon Tsao's research has the potential to help surgeons and specialists who treat cancer patients

PhD Candidate and General Surgery Trainee Dr Simon Tsao is investigating the use of nanotechnology that can identify melanoma tumour markers via a simple blood test.

With financial support provided through two RACS Foundation for Surgery Scholarships, Dr Tsao is researching suitable biomarkers for the detection of circulating tumour cells (CTC) and circulating tumour DNA (ctDNA) and working with other scientists to develop a sensitive method capable of identifying and characterising CTCs.

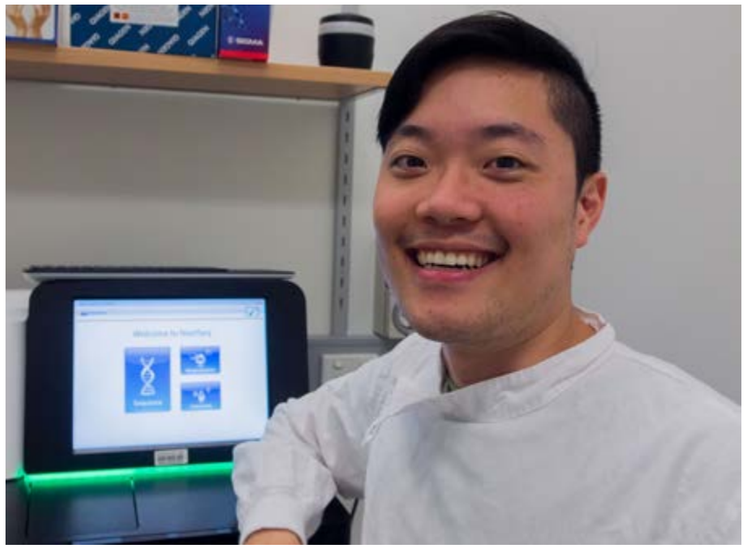
If successful, the work could aid in the treatment of melanoma by enabling clinicians to determine within days or hours if a patient's prescribed drug therapy is proving effective without the need for scans or biopsy.

Dr Tsao said that until recently there had been no known specific tumour markers for melanoma, the fourth most commonly diagnosed cancer in Australasia, that are easily detectable.

However, he said that his work at the Olivia Newton-John Cancer Research Institute in Melbourne had demonstrated the clinical implications of using ctDNA to monitor disease progression in melanoma patients in what has been termed a "liquid biopsy".

He said the goal of the research was to provide treating doctors with a means to diagnose and quantify a patient's CTC and ctDNA loads in clinic quickly to address several challenges faced with current melanoma management.

"CTC are cells that are released from the tumour during various processes and they are responsible for establishing metastasis," Dr Tsao said.



PhD candidate and General Surgery Trainee Dr Simon Tsao

"In many different types of cancers, higher numbers of CTCs have been shown to reflect higher tumour load and therefore the number of CTCs is a reflection of the seriousness of the disease. Quantification of melanoma CTC is extremely difficult for many reasons and we are hoping to find a solution.

"ctDNA, on the other hand, are fragments of DNA released constantly by some tumour cells and their quantity in any blood sample may inform us about the seriousness of the disease.

"ctDNA levels change very rapidly with changes in the disease status and therefore within two or three days of starting a new drug treatment we can know whether the therapy is working.

"If we rely on scans to tell us if the tumour has shrunk, we can still be waiting for months after the initiation of therapy to get a definitive result.

"Yet in the meantime, if the therapy is not working for a particular patient's tumour, we are not only wasting valuable time and money, we may also be subjecting patients to unnecessary side-effects with no benefits.

"With ctDNA detection, we aim to identify treatment responses and the emergence of resistant disease quickly and tailor the treatment accordingly."

Dr Tsao said that the identification of suitable biomarkers and the development of a quick diagnostic test to identify and measure them were of particular significance given the rapid development of targeted and immunotherapy treatments now available for an increasing number of cancers.

He said the research could be used in other cancers and could even allow clinicians to rapidly alter therapy to combat tumour resistance.

"Most tumours eventually develop resistance," Dr Tsao said.

"Yet, by monitoring the patient's ctDNA levels we can see when they are becoming resistant several months earlier than we could by using traditional scans.

"For prostate cancer the measurement of serum PSA is a proven biomarker and our research aims for a simple blood test to inform clinicians promptly to introduce new therapies rather than waiting for the tumour to grow again which is the case with our current melanoma management plan."

Dr Tsao is a SET 2 Trainee and is undertaking his PhD through the University of Melbourne and the Department of Surgery at the Austin Hospital in Melbourne.

He is working under the supervision of Professor Chris Christophi, Head of the Department of Surgery at Austin Hospital, Professor Jonathan Cebon, Medical Director of Austin Health Cancer Services, and Dr Andreas Behren from the Ludwig Institute for Cancer Research.

For the past nine months he has been conducting his research at the Australian Institute for Bioengineering and Nanotechnology at the University of Queensland in a collaboration with Professor Matt Trau.

Dr Tsao's work has been presented at the CTC symposium held in Sydney last year, won the John Ham Medal for Best Paper at last year's General Surgeons Australia ASC and has recently been accepted for publication in Nature's Scientific Reports.

He described the emerging field of CTC and ctDNA analysis as greatly exciting and one which had the potential not only to reduce melanoma cancer mortality rates but also fundamentally change the treatment of a variety of cancers.

"This is one of the hottest areas of cancer detection research around the world now because so many people can see the potential of the technology," he said.

"We think it has the potential to help move us from treating cancer as a potentially fatal disease to managing cancer as a chronic illness.

"It is as if all the necessary components to change cancer treatment have come together at the same time, from the development of new targeted therapies, to understanding the role of the immune system in fighting or spreading the cancer, to isolating bio-markers and the development of devices to identify and measure those markers in real time.

"We chose to study melanoma not only because it's one of the most deadly cancers affecting people living in Australia and New Zealand but also because it was one of the most challenging to study.

"It is as if all the necessary components to change cancer treatment have come together at the same time."

"Most tumour markers used so far were based on peptides or proteins secreted by the tumour cells such as PSA and CA15-3, but there are no known proteins specifically and consistently secreted by melanoma.

"That means we had to wait for the technology to develop to a point which could allow us to go looking for, and capture, CTC and ctDNA.

"Many major hospitals, particularly in America, are using CTC to identify colorectal and breast cancer but we are one of the first to do this work for melanoma which is very exciting.

"Within the next few years, we hope to be able to conduct these blood tests in clinics."

Dr Tsao received a *Foundation for Surgery John Loewenthal Research Fellowship* for the second year and a *Foundation for Surgery ANZ Journal of Surgery Scholarship* for the third year of his PhD, which he hopes to complete by the end of the year.

He thanked the College for the support extended to him.

"The scholarships allowed me to focus on my research rather than worry about work and finance," he said.

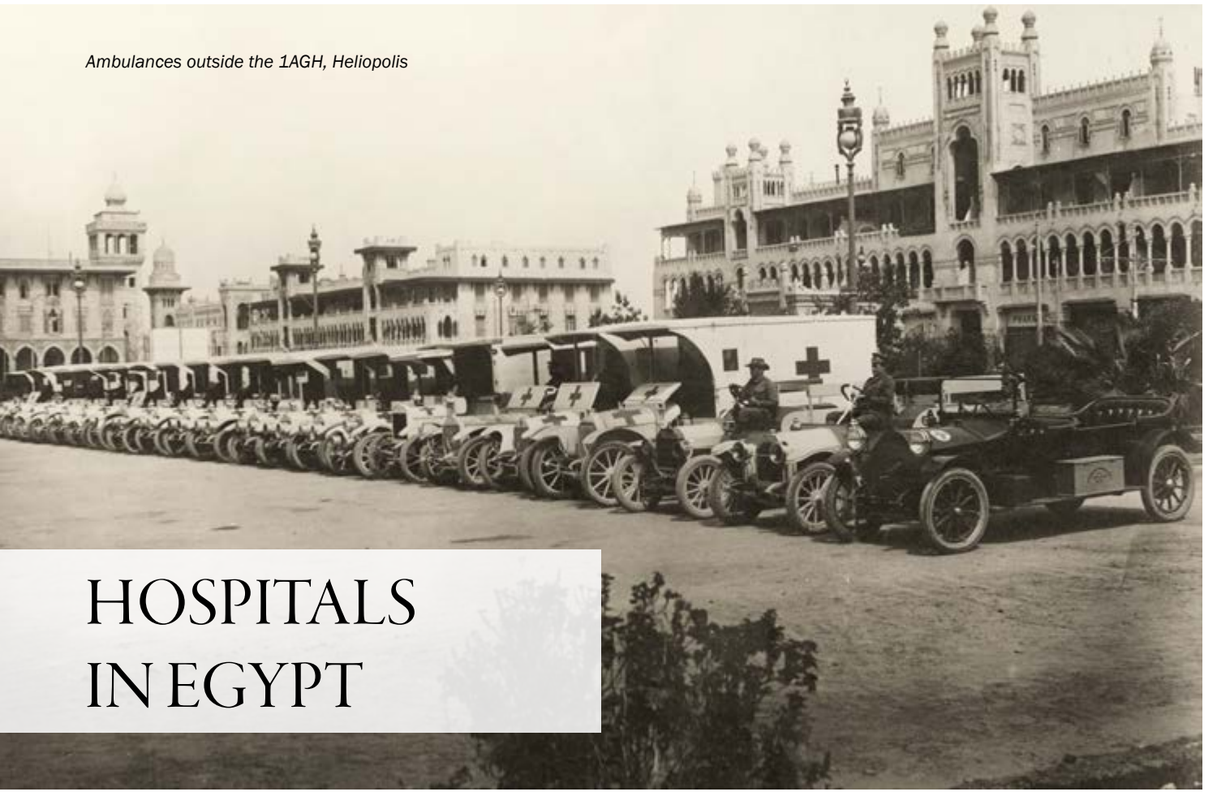
"More importantly, though, it's a formal recognition from the College that they support my work which I believe has the potential to help surgeons and specialists who treat cancer patients.

"Taking time off from formal surgical training is always stressful for a Trainee so it's reassuring to have the College's support."

-With Karen Murphy

CAREER HIGHLIGHTS

- 2014 RACS Foundation for Surgery Scholarship
- 2015 RACS Foundation for Surgery Scholarship
- 2014 John Ham Medal for Best Paper at General Surgeons Australia ASC
- 2014 Research presented to the American Society of Clinical Oncology
- 2015 Original research published in Scientific Reports and a review article at Frontier in Bioscience Landmark edition.



Ambulances outside the 1AGH, Heliopolis

HOSPITALS IN EGYPT

DAVID WATTERS
AND ELIZABETH MILFORD

Although the disadvantages of delaying treatment became evident as the campaign progressed, two Australian General Hospitals were set up prior to the start of the Gallipoli campaign and continued to receive casualties throughout the conflict. These were large base hospitals and the 1 AGH with its adjacent venereal disease camp, situated at the Heliopolis Palace Hotel near Cairo.

The two Australian Stationary Hospitals, 1ASH and 2ASH were established on Lemnos but during April and May 2015 they were full with the sick and so battle casualties had to be shipped to Egypt or Malta.

The 1 AGH medical staff included John McLean who wrote in May:

They came in covered in filth and muck. Many had not had their wounds dressed for days, and on undoing bandages in some cases wounded limbs were found gangrenous and had not been touched since the first dressing…the lightly wounded, able to look after themselves, arrived in very good condition…dressed excellently at the front…well cared for on the way.

In March 1915 Herbert Reynolds posted to 2 AGH at Mena House Hotel, recorded the quiet start:

Spent the morning packing and loading up our transport wagons. At 10am took two patients to Mena House in one of our horse ambulances. Mena House is situated near the Mena tram terminus, it was a well-known tourist hotel, but is now converted into a military hospital.

Inundated with Gallipoli casualties in April, the 2 AGH opened a second hospital unit at the Ghezirah Palace Hotel and a month later, it housed 1500 patients. Between February and September the hospital treated over 2000 battle wounds amongst over 7000 admissions. The journey time meant most of those arriving at hospital survived and 2 AGH only reported 46 deaths, 15 from wounds and the rest from disease, particularly pneumonia.

JW Spingthorpe, a physician, wrote in the *MJA*:

In my 28 years at the Melbourne Hospital I have never seen so many or such bad cases of pneumonia…. Our hospital at Mena was like a graveyard where corspses rose up and barked at you…. Then again there was the ubiquitous dust, and almost every patient had unusually severe throat trouble….As to typhoid, inoculation did not stop the disease which they are all want to call "enteric" [later shown to be paratyphoid]

In April the need for a New Zealand staffed hospital was recognised. This resulted in the formation of the 1NZSH under Lt Col McGavin, with seven officers including surgeons Hugh Acland and Wylie, an ophthalmologist and a dental officer. 1 NZSH sailed from Wellington on 20th May aboard the NZHS Maheno and was based at Port Said. Thirty-one nurses were also embarked.

Lt Col McGavin had at his disposal one house, formerly a school, 25 square E.P tents, huts for the messes and a recreation room but was short of equipment.

The flow of NZ casualties, 7,928 wounded and sick by 2nd May, resulted in 2NZSH being formed under the command of Lt Col Parkes. Its surgeons included prominent Auckland Surgeon Thomas Savage, arriving in Alexandria on 22nd July. Savage was dangerously ill as the ship landed and died of meningitis on 28th July. Parkes and 2NZSH was ordered to take over the Pont Koubeh Hospital. The two NZ hospitals in Egypt were also served by a convalescent home of 50 beds.

In August, 1NZSH accommodation was increased from 200 to 500 beds but in October it was transferred to the second front in Salonika. However, their transport *Marquette* was torpedoed en route by a German U boat on October 23rd 1915.The 8 officers aboard, including the surgeons, were amongst 104 NZMC rescued from the sea after a period up to 10 hours.

Australian General Hospital Cairo, September 1915

David Storer WYLIE

Col (1875–1965) CMG Manchester 1898,
FRCS 1903, FRACS1927, FACS (Hon)

EARLY LIFE

David Wylie grew up in England and did his medical course at the Victoria University of Manchester where he won the clinical prize in surgery in 1897, graduating the following year with first–class honours. He was a resident at the Manchester Royal Infirmary, then served as a civil surgeon in the South African war. He gained the FRCS in 1903 and the following year, came to New Zealand where he soon built a surgical reputation in New Plymouth.

GALLIPOLI

After the outbreak of war in 1914 he went overseas on the strength of 1 NZSH, which was established at Port Said in May 1915. In October after a brief trip to Lemnos, he was the third of the Founders to survive the sinking of the torpedoed Marquette when the unit was in process of moving to Salonika.

AFTER GALLIPOLI

On March 1916,he went to England to the command of 1 NZGH at Brockenhurst, with the rank of Colonel. In February 1918 he was seconded for a course in orthopaedics under Robert Jones at Shepherd's Bush in London, before. He then returned to NZ to take charge of the military and rehabilitation hospital in Christchurch. He spent a further year similarly engaged at Trentham before becoming Inspector of Hospitals with the Health Department. He was also consultant in 'special military surgery' to the Defence authorities.

PROFESSIONAL LIFE AFTER GALLIPOLI

In 1923 he resumed civilian orthopaedic practice, this time in Palmerston North, where once again his reputation attracted patients from a wide area of the central North Island. Until 1937 he was on the honorary visiting staff of the public hospital (he was a firm believer in an 'open hospital' system), and he remained in practice in Palmerston North until his retirement in 1947. He was the first provincial surgeon to be an examiner for the Medical School in Dunedin, and enjoyed the unusual distinction of being an honorary FACS. After the foundation of the College of Surgeons of Australasia, he served on the College's Dominion Committee. He was a member of two medicine–related commissions (the Cleary and the Barrowclough) and twice president of the NZ branch of the BMA, in 1934 and 1949.

His retirement years were clouded by failing vision, but he was fortunate in having a loyal wife who would keep him up to date as his 'reader'. He died in retirement in Tauranga in 1965.

Wyn Beasley

ERNEST SANDFORD JACKSON

Lt Col, KB, CMG (1853–1926) MB ChB Edinburgh 1875


Ernest Sandford Jackson (right)

EARLY LIFE

Born in Victoria, Jackson was educated at Geelong Grammar School and Trinity College. In 1881 he became RMO at the Brisbane Hospital and was Medical Superintendent from 1882 until 1898. He purchased St Helen's Hospital in 1901 whose facilities were used by many prominent Brisbane surgeons. He was also a member of the militia becoming H/ Captain in 1912.

GALLIPOLI

Jackson enlisted in November 1914 at the age of fifty-four and was commissioned as a Major in 1 AGH. In Egypt, 1 AGH was established at Cairo's Heliopolis Palace Hotel where initially Jackson managed its venereal disease camp: Venereal diseases are very prevalent in Egypt. A considerable number of soldiers are now being returned to Australia, invalided, and in disgrace.

He was posted to 2 AGH at Mena in April 1915 as senior surgeon, and was soon operating on the large numbers of wounded soldiers arriving from Anzac. This was an exhausting time and apart from a few entries dealing with parasitic infections like bilharzia, his diary was neglected. Respiratory infections such as pneumonia were endemic among the troops. Jackson became dangerously ill with the disease and was evacuated to England where he required drainage of an empyema before returning to Australia in January 1916.

PROFESSIONAL LIFE AFTER WW1

Fully recovered and promoted to Lt Col, he became a visiting surgeon to 6 AGH at Yungaba in Kangaroo Point until January 1919. Continuing as Honorary Surgeon to the Brisbane Hospital until 1933, he maintained a busy private practice at St Helen's Hospital. Jackson became an advocate for the returned soldiers and sat on the Royal Commission established in 1924 to enquire into the methods of assessment of war service disabilities. Sandford Jackson held numerous positions: founding member of the Queensland Branch of the BMA and President on three occasions 1895, 1911 and 1926; twice President of the Medical Board of Queensland. He played a major role in the establishment of the University of Queensland and the Medical School.

He gave 51 years of service to the Brisbane Hospital. Two of his sons Jack and Charles were medical students in 1915. Both enlisted and served at Gallipoli. Each was evacuated with dysentery and returned to Australia.

Cliff Pollard

DEVELOPMENTS IN TRANSPLANTATION SURGERY

Application for recognition of prior learning (RPL)

MICHAEL FINK
Chair, GSA Transplant Training Committee

As Chair of the General Surgeons Australia (GSA) Transplant Training Committee, I am pleased to announce that the Committee was formed in 2013 to manage the delivery of the Post Fellowship Education & Training (PFET) Program in Transplantation Surgery in Australia and New Zealand. The Committee has six members, including Mr Henry Pleass, Mr Adam Bartlett, Prof Jonathan Fawcett, Mr Alan Saunder and Dr Nancy Suh.

The PFET Program in Transplantation Surgery is undertaken following successful completion of the RACS Fellowship Examination and SET Program requirements in General Surgery, Urology, or Vascular Surgery. The program comprises Education and Training in Transplantation Surgery over two years, in accredited transplant units. Trainees are awarded the Certificate of Australasian Transplantation Post Fellowship Training following satisfactory completion of the program requirements.

The GSA Transplant Training Committee acknowledges those Trainees who have undertaken training through the Royal Australasian College of Surgeons (RACS) Section of Transplantation Surgery training program between the period of January 2012 and February 2016 but are yet to be awarded the Certificate of Australasian Transplantation Post Fellowship Training.

The GSA Transplant Training Committee advises that any applicant who wishes for the Committee to consider their application for Recognition of Prior Learning (RPL) must have completed two years of equivalent training in Transplantation Surgery between January 2012 and no later than February 2016.

To find out more about PFET Program in Transplantation Surgery and Recognition of Prior Learning application process, please visit:

http://www.generalsurgeons.com.au/post-fellowship-education-training

or contact the PFET Executive Officer, Elizabeth Pedersen, on:

+61 8 8239 0811
elizabeth.pedersen@surgeons.org

A LONG WAY TO GO

Transfer and Communication Issues in Western Australia

JAMES AITKEN
Clinical Director, WAASM

This year, the Western Australian Audit of Surgical Mortality (WAASM) is planning to shine a strong light into the many uncertain areas associated with deaths relating to patient transfer. This light will come from different sources – the WAASM 2015 Report, a compendium case note review booklet and a symposium that will be built upon similar successful workshops in Queensland and Victoria.

Transfer problems come in many guises. Western Australia has remote and rural populations that may be many hours away from specialist care. Some patients are so unwell that the necessity for transfer is obvious. The Royal Flying Doctor Service provides a magnificent service transferring many unwell and unstable patients. Other patients may not be so unwell and could be managed locally if they are not deteriorating, but if that occurs, the patient may then have to be transferred when unwell and unstable. It is the old problem of balancing 'stay and play' or risk the necessity for later having to 'scope and run' with a now, unwell patient.

The Perth metropolitan area has non-teaching hospitals that, for any number of reasons, may not be able to cope with emergency or deteriorating inpatients. These patients will quite appropriately need to be transferred to tertiary centres. The WAASM has reviewed a number of deaths following such transfers. Cases in which such transfers have occurred may have been complicated by errors at the very start of the process, with patients being sent to the wrong hospitals - why would residential care facilities send patients who have had a fall and sustained a fractured hip to a non-teaching hospital that has no orthopaedic surgeon? As is necessary, these cases require a re-referral to a tertiary hospital which often occurs late at night and, as such, delays surgery to the next day, greatly extending the preoperative period.

Patients with sepsis are also often re-referred to a tertiary hospital, but if the seriousness of the sepsis is not appreciated, the transfer delay may be substantial. In the meantime the patient is not a priority having been 'transferred' and the slow but progressive deterioration not fully appreciated. The patient may then arrive in a tertiary hospital that, although aware of the transfer, is not informed clearly about this and further, often substantial, delay is incurred. In WAASM's experience, a total delay from initial presentation to arrival in (the tertiary hospital) theatre that exceeds 24 hours is not unusual. In the untreated septic patient, in whom the mortality risk-rate rises at seven percent an hour, such a delay can be fatal. In some cases, for example gastrointestinal bleeding, even short delays may impact on outcome.

Transfers between teams within the same hospital (eg, ICU to surgical unit) are also problematic and are also known to contribute to patient death.

Lack of communication is a key component. This has multiple causes, common reasons being the initial team underestimating the seriousness of the problem, the patient languishing in limbo between two teams or the receiving team not 'fast tracking' a patient whose management in even ideal circumstances has been delayed. Other issues can include the difficulty of the receiving team accessing blood and, in particular, radiology results that have been undertaken by a different service provider at a different site and sometimes having to be repeated.

In many cases the route of transfer is well trodden. By the end of the year, the WAASM team hopes that standard, robust protocols will ensure that patient transfer takes place early, rapidly and with minimum delay on arrival.

DR BB G-LOVED

MILKING AN ANCIENT COW

Last month we were discussing the paleo diet, based on our own genetic make-up from 10,000 years ago. The paleo diet shuns dairy products which those of us who are not lactose intolerant tend enjoy, sometimes to our detriment. This month I want to discuss the implications of another possible genetic change that happened around 10,000 years ago about the time Homo sapiens started to farm.

Cas O'Morphy came to discuss young Casein who was listless, with declining school performance, and who had other vague symptoms including abdominal bloating and headaches. Cas asked me – could it be due to milk?

Milk comes in two basic protein types, apparently due to a genetic mutation in European cows 10,000 years ago. These cows produce the protein, A1 -casein. However A1 -casein may affect gastrointestinal motility and cause GIT or generalized inflammation through the release of beta casomorphin-7. The β-casein derived peptide has the sequence Tyr60-Pro61-Phe62-Pro63-Gly64-Pro65-Ile66 and is known as β-casomorphin-7.

Cows from India and Africa produce A2 beta casein and A2 milk has been introduced in recent years to New Zealand and Australia.

A recent Australian-based double-blind cross-over trial, albeit with only 41 human participants, found a positive association between abdominal pain and stool consistency when participants were on the A1 milk protein diet but not the A2. The study was of course funded by the A2 milk company which provides some insight into the willingness of food companies to milk their conflicts of interest! The researchers who take the funding seem very willing to suck on the golden udder! However, the study did obtain a statistically significant result, and was published by the reputable Nature Publishing Group in the *European Journal of Clinical Nutrition*. Though a much larger trial is needed to confirm these findings, it suggests some individuals who suffer may wish to consider their own two week periods off and on A1 or A2 while awaiting convincing evidence one way or the other.

Over the past 10 to 15 years there have been further claims that A1 -casein may be implicated in the development of type 2 diabetes. The proposed mechanism is autoimmunity. Inflammation within the cardiovascular system might also lead to coronary artery disease. However, current evidence does not support these hypotheses and was originally based on epidemiological associations between exposure to cow's milk and the development of these conditions.

Today the milk in New Zealand and Australian supermarkets may not even come from cows (Table1). There are soy milks and mixtures of cow and soy. 'Heart Active Milk' claims to reduce cholesterol by an average of 10 percent – such claims brandished on the label! There is a CalciYum range of flavoured milks – added strawberry or banana or chocolate – sugar rich options and among the worst choices for health – also almond, coconut, rice and hemp milks, some with added omega-3's.

Milk contains many essential nutrients: protein, calcium, low-GI carbohydrates (lactose), zinc, magnesium, phosphorus, as well as vitamins A, D, B2 and B12. Milk brands market the fat content of their products, as milk contains saturated fats, primarily as triglycerides, that may raise cholesterol, though in moderation are quite healthy. Whole milk contains 3.5percent fat, skimmed milk 0-0.5percentand semiskimmed 1.7percent fat. Cholesterol in 1percent milk is 5mg, in 2percent 8mg and 3.7percent has 14mg per 100g or 100ml. Most fresh milk is pasteurized (71.7 degrees celcius), unless longer shelf lives are needed (eg UHT - 135oC) and also homogenized to break up the fat globules spreading them evenly through the milk so a layer of cream does not form on the top.

Now back to the O'Morphys, whose gastrointestinal motility and permeability might possibly be being upset by casomorphin-7. I suggested once we know that young Casein is not lactose intolerant, a trial of A2 will do no harm other than doubling the cost of their milk. But for most, the claim we need A2 will likely prove a load of bull.

Content/ 100ml	Full Cream	A2 Full Cream	Lite Milk	Soy	Heart Active	Organic Low Fat	Skim	No Fat Cal	New Milk
Energy	269kJ	271kJ	176kj	160kJ	174kJ	182kJ	147kJ	163kJ	216kJ
Energy (Cal)	64 Cal	65Cal	42Cal	38Cal	42Cal	43Cal	35Cal	39Cal	52Cal
Protein	3.3g	3.1g	3.2g	3.1g	3.3g	3.4g	3.5g	4.0g	3.5g
Total Fat		3.6g		0.9g	1.0g	1.0g	0.1g	0.1g	2.0g
Saturated Fat	2.3g	2.8g	0.8g	0.1g	0.5g	0.7g	0.1g	0.06g	1.3g
CHO	4.7g	5.0g	4.5g	4.8g	4.8g	5.1g	4.9g	5.4g	4.9g
Sugars	4.7g	5.0g	4.5g	2.0g	4.8g	5.1g	4.9g	5.4g	4.9g
Sodium	48mg	48mg	46mg	45mg	45mg	58mg	45mg	50mg	44mg
Calcium	115mg	117mg	127mg	123mg	123mg	126mg	132mg	140mg	130mg

SURGERY IN EASTERN CONGO

Mr Wetzig and his wife Gwen will spend up to six months per year working with doctors and patients at the HEAL Africa hospital in Goma

Twelve years after his first visit to the war-torn region of Eastern Congo, Mr Neil Wetzig this year resigned from his position as Senior Visiting Surgeon at the Princess Alexandra Hospital and private practice in Brisbane to give his skills to the doctors and patients at the HEAL Africa Hospital in Goma.

Mr Wetzig and his wife Gwen will now spend up to six months each year working, teaching and training at the hospital, one of only three tertiary referral hospitals in the Democratic Republic of Congo which has a population of 75 million people.

A joint-founder of the AusHEAL charity, established by a small group of Brisbane surgeons to support the hospital, Mr Wetzig has led and organised multi–disciplinary team visits to Goma every year since 2006.

The annual visits have included a Plastic and Reconstructive Surgeon, Oral and Maxillofacial Surgeon, Obstetrician, Uro-gynaecologists, a Radiologist and Sonographer, a Cardiologist, Emergency Physicians, a Dentist, Hospital Administrator, Physiotherapists and specialist nurses.

A General Surgeon with special interests in breast and endocrine surgery, Mr Wetzig decided he could make a greater contribution if he spent more time in Congo and now is a Visiting Surgeon to the HEAL Africa Hospital.

Now back in Australia, Mr Wetzig is participating in advocacy and fundraising activities for the hospital and trying to organise a future ENT visit.

He said it had been an extremely difficult decision to give up his working life in Brisbane for the highs and lows of life in Africa.

"The Princess Alexandra Hospital has been my medical home for 35 years so it was tough to leave but I decided that if I wanted to work in the developing world it was extremely important that I be young enough, fit enough and still operating well to be of most value to both doctors and patients," he said.

"Living and working in Goma allows me to facilitate more team visits, triage patients in advance of those visits, oversee their follow up care and provide supervision and training for the doctors at the hospital.

"My wife and I spent more than a year thinking about this, including the financial implications, but we decided that it was an experience we would like to share and a journey we would like to take together.

"But it's a tough environment to work in. It's hot and humid, the power supply is variable, the air conditioning in the Operating Theatres quite often fails and the equipment is very basic.

"We don't have reliable diathermy, laparoscopy equipment or even new technologies like harmonic scalpels so virtually all operations are open surgeries."

Mr Wetzig said, however, that three Australian surgeons had donated their personal equipment and he thanked Mr Spiro Raptis, Mr Andrew Bell and Mr Tony Robertson for their generosity.

Still an examiner for the College and the African representative on the College's Global Health Committee, Mr Wetzig and Gwen now plan to stay in Goma for two stints of three months each year, allowing them to return for College exams and the Annual Scientific Congress in May.

While there, he works alongside a 2013 recipient of the RACS a Surgeons International Award, Dr 'Luc' Malemo Kalisya, one of only six qualified surgeons in Eastern Congo which has a population of approximately 30 million people.

The Director of Surgery at the HEAL Africa Hospital, Dr Luc spent four weeks observing procedures he wished to learn at the Princess Alexandra Hospital during his visit and is one of only two local general surgeons working at the 197–bed facility.

Mr Wetzig said he had forged a close bond with Dr Luc during his visits to Goma and that the decision to spend more time there had been driven by a desire to help him in his efforts to improve patient care and the training of junior doctors.

He also said that the creation of a fragile peace in the region had created new challenges for the hospital and for Dr Luc and his recently trained colleague, General Surgeon Dr Medard, who has been mentored by Plastic Surgeon Mr Paul Millican.

"The region is more peaceful than it was, with most of the rebels defeated and while you can travel around Goma quite safely, there are areas outside the city that are still quite dangerous," Mr Wetzig said.

"Yet this peace means that the HEAL Africa Hospital is now seeing patients with advanced pathology coming in, because it is safe for them to travel, and their management presents significant challenges.

"This ability of patients to travel safely also means that we are becoming aware of a lot of surgery being conducted in outlying towns by doctors with limited skills, resulting in patients coming in with a range of very serious complications.

"These patients are described as presenting with 'abdominal catastrophes' and they are stretching the expertise of the local surgeons which was another reason that urged me to make this decision."

Mr Wetzig said the hospital had established a Family Medicine Program to train junior doctors in basic surgery to treat trauma and burns and to conduct C Sections and appendectomies in a bid to avoid such serious complications.

He and Dr Luc are working with the College of Surgeons of East, Central and Southern Africa (COSECSA) to determine if the HEAL Africa Hospital could receive support and accreditation to becoming a teaching hospital and Mr Wetzig is also in discussions with COSECSA exploring the possibility of becoming an examiner for General Surgery.

Recently, Mr Wetzig also took the opportunity to attend the launch of the Lancet Commission on Global Surgery held in London in April on his way home to Australia to assess how the work of the hospital will fit into the growing recognition of the need for surgery in low and middle income countries (LMIC's) and the global surgery initiative.

Mr and Mrs Wetzig with Congalese colleagues

"The Commission's goal is to provide 'universal access to safe, affordable surgical and anaesthesia care when needed' and we know that 33 million people each year face 'catastrophic health expenditure' due to payment for surgery and anaesthesia care," he said.

"They simply cannot afford basic surgical procedures. I also attended the Lancet launch to see what was proposed to financially support surgical care in LMIC's by global or private funding agencies.

"I believe the HEAL Africa Hospital has a role to play in reducing this burden not only through treating patients but by

training doctors so they can perform basic surgical procedures and offer anaesthesia services in rural areas outside the cities in Africa.

"The hospital in Goma receives no Government money, there is no co-ordinated health system in the country, most patients are extremely poor and while Dr Luc has been tireless in his efforts to convince Government leaders of the need for a more co-ordinated approach to surgical services and training he has not met with much success.

"We are discussing the option of approaching corporations such as mining companies to think about developing philanthropic programs to help the people of the region.

"The hospital is also trying to build its internal medicine capabilities and provides a paediatric HIV outreach service."

Mr Wetzig said he would like the RACS to offer 'in principle support' for surgical training in the Democratic Republic of Congo and Africa in general. The provision of short-term Scholarships for African surgeons to upskill in Australia or New Zealand may be one approach.

Because of his endocrine surgical specialty, he is now also trying to raise funds to support goitre surgery at the hospital.

"There are a large number of people in the region suffering with massive goitres caused by a diet that is iodine deficient

"I'm still young enough to be of use which I think is very important and Gwen teaches English in the hospital which means that we get to spend more time together than we did in Australia and we get to share this valuable experience."

and based around cassava which blocks the production of the thyroid hormone," he said.

"However, funding bodies do not see it as a disability, war injury or an emergency even though such patients are stigmatised and ostracised by their communities.

"The procedures only cost about $US350 each so those of us involved in AusHEAL are now trying to think up ways to raise funds to support the work."

Mr Wetzig wished to particularly thank those RACS surgeons who have given their time and skills to the HEAL Africa Hospital including Mr Paul Millican and Upper GI surgeon Mr Andrew Smith and acknowledged retired hospital administrator Mr David Kelly who has regularly travelled to Goma to teach hospital staff administrative skills and systems management.

After his recent stay in Goma Mr Wetzig said he was pleased to have made the difficult decision to work in Africa.

Gwen Wetzig with a student

Meeting of surgeons in Goma

"I'm so glad Gwen and I made this decision because even in this first short stint I can see great scope to make a difference," he said.

"I'm still young enough to be of use which I think is very important and Gwen teaches English in the hospital which means that we get to spend more time together than we did in Australia and we get to share this valuable experience."

Not long after his return to Goma from his Surgeons International Scholarship visit to the Princess Alexandra Hospital in Brisbane, Dr Luc successfully saved the life of a Belgian Prince who was shot and brought to the HEAL Africa Hospital with major open thoraco-abdominal trauma.

Now, he is the preferred local referral surgeon for Medecins Sans Frontiere, is consulted by doctors working at the international aid organisation Operation Smile and has even been consulted by the President's Office to offer his expertise.

He described his visit to Australia as a great privilege and said observing procedures had improved his skills in Upper GI surgery and in his ability to deal with liver tumours and perform bowel anastomosis.

Before arriving in Brisbane, Dr Luc faced a major problem with the leakage of some anastomosis that resulted in faecal fistulae after bowel occlusion repair yet since his return he has faced no such complications.

Yet although he is confronted every day with the problems associated with having limited equipment and technology, an inability to train junior doctors and treat all the people that need his care, he remains optimistic and committed.

In a feedback report to the College, Dr Luc wrote: "The most pressing needs facing us relate to abdominal cases such as bowel occlusion, biliary obstruction and cancer, paediatric surgical cases and trauma.

"Around Goma, surgery is performed by non-trained doctors and nurses which is resulting in abdominal catastrophes like faecal fistulae, vesico-vaginal and rectal fistulae and we would like to gain accreditation in order to offer formal surgical training to these young doctors.

"We are now working to decrease morbidity and mortality due to the complications of surgery and I am trying to augment the coverage in the number of surgeons from one surgeon per one million to one surgeon for 100,000 people.

"I would like to become a voice for improved surgical care to my community and help to find ways to source the equipment necessary for good surgery."

In particular, Dr Luc said the HEAL Africa Hospital lacked diagnostic equipment such as imaging facilities and pathology for histology, simple instruments like retractors, sutures, theatre lights, electro cautery and bedside monitoring systems.

He wrote that he had become both a better surgeon and medical leader through his Scholarship visit.

"I am more confident performing surgery and even my wife told me: 'Since you came home from Brisbane, your appetite is better, you are less distressed when you come home from hospital and the family is happier'.

"If possible, I wish I could have more such surgical rotations every two years (which) would continually improve my development."

- With Karen Murphy

NEWS FROM TASMANIA

Change is on the way with major health reform

BRIAN KIRKBY
Chair, Tasmanian Regional Committee

Things are very busy in Tasmania from a surgical point of view this year. We are currently well down the track with preparations for the first state ASC to be run in combination with Victoria. This will be held in Hobart from 16–17 October. We are pleased to see this occur as we envisage an invigorated meeting given the increased surgical numbers that the meeting is expected to attract in comparison to the relatively small meetings that Tasmania has conducted in the past given the relatively small numbers of surgeons that reside here.

Tasmania has been undergoing significant reform in the area of health with a particular focus on surgery. The Health Minister from the reasonably new Liberal government has driven this process despite a rocky start and has shown himself to be particularly well engaged and with an enthusiasm to try and achieve real change rather than just political point scoring. He has demonstrated a willingness to consult outside the usual boundaries and has worked closely with the College to instigate significant reform.

There is a need to change the way in which health services and surgical services are delivered in Tasmania. Statistically we are one of the worst performing states when it comes to healthcare and we have some of the longest waiting lists in the most co-morbid population in Australia, along with some of the worst performances when it comes to health outcomes. Whether these deficiencies can be addressed just by reforming the way in which things are done or whether additional funding for the healthcare sector is required remains to be seen. A significant impediment for delivery off all public services in Tasmania is the relatively poor economy of the State. Tasmania has one of the poorest average socio-economic statuses in Australia with a very high proportion of the population dependant on welfare and the total State budget is very small in the context of budgets run by the more populous States.

The reform process has gone through a green paper, white paper process with the development of a clinical services profile, defining what surgical services are provided in which geographical location. While in parallel to this the previous three area health services in Tasmanian are in the process of being amalgamated into one overarching health service. All of this has been occurring with significant input from the College, which is pleasing to see and be involved in.

From the point of view of infrastructure for the provision of surgical services, the Launceston General Hospital is just completing a capital works program with a new Theatre suite, ICU, Sterilising Department and Emergency Department. The Royal Hobart is just about to embark on a complete rebuilding of the hospital on the same site, which will see some disruption to services for several years but will ultimately see a brand new hospital, which should provide the entire necessary infrastructure for the delivery of quality surgical services into the future. This redevelopment of the Royal Hobart Hospital has been an absolute necessity for some time but has been held up due to financial constraints.

COLLEGES UPHELD

IMG fails in challenge to assessment system

MICHAEL GORTON
College Solicitor

The NSW Supreme Court recently rejected a challenge by an international medical graduate against the Australian Medical Council and AHPRA in relation to an IMG Assessment.

In the decision of Tanious v AMC and AHPRA [2015] NSWSC 447 the IMG sought to challenge the assessment process for general registration, involving a written multiple choice exam and a practical clinical assessment component.

While the IMG had passed the multiple choice examination, he had, on four occasions, failed the clinical component. He was assessed in respect of a total of 16 stations, 15 of which he failed.

While the action by the IMG failed on the basis of procedural issues, it highlights the difficulty in challenging examination outcomes before a Court, seeking the Court to make a different decision, or substituting its own decision for that of the examination process.

The IMG was, in effect, asking the Court to adjudicate upon academic or examination standards, which it was clearly not in a position to do. It asked the Court to assess the accuracy of the results of the clinical assessments, which was not possible within the context of Court proceedings.

The Court concluded:

"The [IMG] is, in effect, asking this Court to substitute its own views for those of the appropriately qualified representatives of the [AMC] who supervised the assessment and who assessed the [IMGs] performance. ... There is no legal foundation for doing so. No reasonable cause of action is disclosed ..."

This case highlights the difficulties of anyone challenging the outcomes of examinations or assessments, where appropriately qualified people are asked to make a clinical judgment or a professional assessment of the skills and standards of an applicant.

While there are some circumstances where the Court determines that there is a procedural error in the examination or the assessment, at best the Court is likely to refer the matter back to the relevant body for the examination or the assessment to be conducted afresh.

This decision has implications for the processes of all medical colleges and all professional bodies undertaking examinations or assessments of health practitioners.

HELP ME, HELP YOU

The Academy of Surgical Educators stakeholder survey results

SPENCER BEASLEY
Chair, Professional Development

STEPHEN TOBIN
Dean of Education

The new Academy of Surgical Educators (Academy) was launched in 2012 and already has almost 600 members, comprised of surgeons, Trainees, International Medical Graduates and medical educators. The Academy's vision is to provide leadership for the College's educational programming focusing on the recognition and support of surgeons who teach.

Academy Objectives

- Foster and promote the pursuit of excellence in surgical education
- Provide members with a stimulating and dynamic program of professional development activities
- Develop a thriving community of practice with opportunities for networking, interactivity and support for surgical educators
- Explore partnerships with external organisations and universities to deliver professional development and conduct research into surgical education
- Recognise and reward the important role of surgical educators and make them feel valued and supported.

If you would like to become a member of the Academy please contact Kyleigh Smith on +61 3 9249 1212 or ase@surgeons.org, or visit our webpage at:
www.surgeons.org/for-health-professionals/academy-of-surgical-educators/
or scan the QR code attached.

The Academy oversees 12 professional development activities and 6 faculty training programs, associated with Scholarship and Teaching.

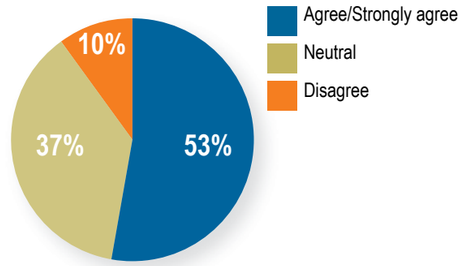
Programs supported by the Academy:

1. Foundation Skills for Surgical Educators
2. Becoming a competent and proficient surgeon: Training Standards
3. Supervisors and Trainers for the Surgical Education and Training program (SAT SET)
4. Keeping Trainees on Track (KTOT)
5. Non-Technical Skills for Surgeons (NOTSS)
6. Surgical Teachers Course (STC)
7. Graduate Certificate, Graduate Diploma and Masters in Surgical Education
8. Educator Studio sessions
9. National Simulation Health Educator Training Program (NHET SIM)
10. Academy Forum and awards ceremony
11. Surgical Education and Training Selection Interviewer Training (SET SIT)
12. Faculty training programs for SAT SET, KTOT, STC and NOTSS
13. Faculty training programs for Care of the Critically Ill Surgical Patient (CCRISP), Early Management of Severe Trauma (EMST) and Training in Professional Skills (TIPS)

In October 2014, 23% of Academy members responded to an electronic survey which was designed to get feedback on the perceived value and effectiveness of the Academy's work and how well it was meeting Fellows' needs. It also reviewed use of various technological platforms, and identified new opportunities for the Academy to help Fellows improve the quality of their teaching.

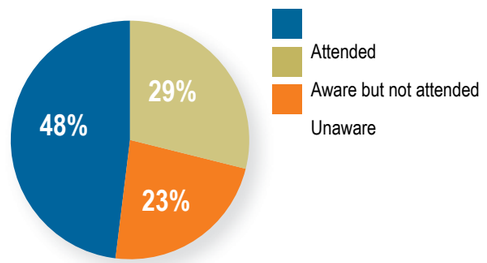
Members' perception of value and effectiveness

I feel more supported as a surgical educator



Since becoming Academy members, respondents generally felt more supported in their teaching roles within the College. Increasing recognition of our surgical educator's value and worth is one of the key objectives of the Academy and is being explored further. The feedback received suggests that more opportunities for members to interact with each other, either online or face to face at networking and educational events, may help address this. The Academy Studio Sessions and SAT SET course were shown to make surgeons feel more confident and supported in the areas covered. The Educator Studio Sessions are very popular with Fellows. The SAT SET program was the first course established, some ten years ago, that supported our surgical educators within the College and enjoys excellent face validity as a result. It is also compulsory supervisor education for a number of specialties, especially for their surgical supervisors. This course is relevant for any surgeon who has SET Trainees.

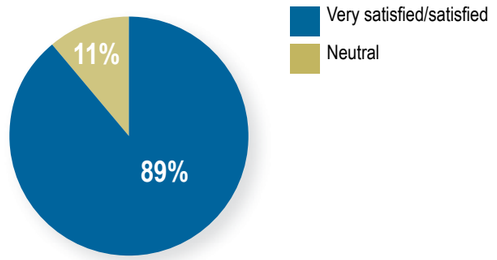
Awareness and attendance of Academy programs



If the courses are of benefit to surgeons who have Trainees or are involved in teaching, then there would seem to be advantage in having them well attended. Yet of the twelve Academy programs listed in the survey, only one quarter of respondents had participated in them. Almost half of the respondents were aware of them but had never attended, and an alarming number were completely unaware of them. Clearly, there is more work to be done in this area.

The vast majority (89%) of those who attend Academy professional development courses found them helpful.

Satisfaction with Academy programs



Further exploration of the barriers to attendance is planned, as well as greater attempts to reach the 'unaware' members - and convince the 'aware' members to attend. It would seem the courses are perceived as being well designed, well conveyed and generally meet the needs of the attendees. The challenge is getting those who would benefit from them to attend.

In the two years since its refined focus, the Academy of Surgical Educators has made good progress toward supporting its surgical educators better. It has extended its educational offerings to deliver programming in a range of online and face to face modalities; it has developed a number of online platforms that house educational resources and has introduced a comprehensive reward and recognition program to say thank you to the surgical educators who support the College's education and training programming. However, with only half of respondents believing that the Academy makes them feel more valued, we still have a long way to go.

To attend any Academy programs then register online through the College website. All programs are either free to attend or charge a nominal fee and are delivered across Australia and New Zealand.

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