ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 17 NO 06 JULY 2016

RACS
LET'S OPERATE WITH RESPECT

The College of Surgeons of Australia and New Zealand

I have to wash my hands many times each day at work. I find it helpful to imagine that I am washing away any stress as I wash my hands.

- Dr H

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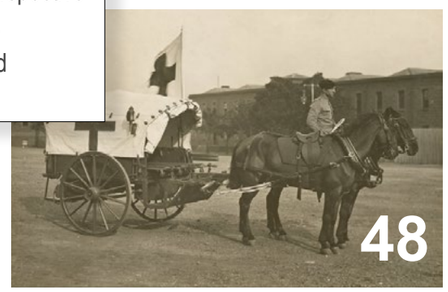

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PROFESSIONAL DEVELOPMENT

WORKSHOPS & ACTIVITIES

Online registration form is available now (login required).

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

Foundation Skills for Surgical Educators Course

9 July 2016 - Canberra, ACT, Australia
15 July 2016 - Melbourne, VIC, Australia
16 July 2016 - Gold Coast, QLD, Australia
28 July 2016 – Footscray, VIC, Australia
3 August 2016 - Queenstown, New Zealand
12 August 2016 - Launceston, TAS, Australia
13 August 2016 - Liverpool, NSW, Australia
25 August 2016 - Adelaide, SA, Australia
05 September 2016 - Frankston, VIC, Australia
17 September 2016 - Darwin, NT, Australia
23 September 2016 - Brisbane, QLD, Australia
30 September 2016 - Townsville, QLD, Australia

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

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

Keeping Trainees on Track (KToT)

20 July 2016 - Adelaide, SA, Australia
6 August 2016 - Melbourne, VIC, Australia
10 September 2016, Canberra, ACT, Australia

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

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

Clinical Decision Making

21 July 2016 - Perth, WA, Australia

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.

Non-Technical Skills for Surgeons (NOTSS)

22 July 2016 - Perth, WA, Australia
9 September 2016, Auckland, New Zealand

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

Supervisors and Trainers for SET (SAT SET)

20 July 2016 - Adelaide, SA, Australia
10 September 2016, Canberra, ACT

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

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

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Process Communication (PCM) Part 2

29 to 31 July 2016 - Melbourne, VIC, Australia

The advanced three day program allows you to build on and deepen your knowledge while practicing the skills you learned during PCM Part I. You will learn more about understanding your own reactions under distress, recognising distress in others, understanding your own behaviour and making communication happen. PCM enables you to listen to what has been said, while at the same time being aware of how it has been said. At times we are preoccupied with concentrating on what is said, formulating our own reply and focussing solely on the contents of the conversation. To communicate effectively, we need to focus on the communication channels others are using and to recognise when they are under distress.

Academy of Surgical Educators Forum

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

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

Bioethics Forum

'Bioethical Framework Implementation in Clinical Practice'
22 October 2016 - Sydney, NSW, Australia
The forum will stimulate robust bioethical discussions amongst surgeons.

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

July 2016 - August 2016

NZ
3 August 2016
Foundation Skills for Surgical Educators, Queenstown

SA
20 July 2016
Keeping Trainees on Track, Adelaide
SAT SET Course, Adelaide
21 – 23 July 2016
Surgical Teachers Course, Adelaide Hills
25 August 2016
Foundation Skills for Surgical Educators, Adelaide

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

TAS
12 August 2016
Foundation Skills for Surgical Educators, Launceston

VIC
28 July 2016
Foundation Skills for Surgical Educators, Footscray
29 -31 July 2016
Process Communication Model: Seminar 2, Melbourne
6 August 2016
Keeping Trainees on Track, Melbourne

WA
21 July 2016
Clinical Decision Making, Perth
22 July 2016
Non-Technical Skills for Surgeons, Perth

NSW
13 August 2016
Foundation Skills for Surgical Educators, Liverpool

Contact the Professional Development Department

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email **PDactivities@surgeons.org** or visit **www.surgeons.org**

select Health Professionals then click on Courses & Events www.surgeons.org/for-health-professionals/register-courses-events/professional-development

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

EXCELLENCE COMES FROM HARD WORK AND DEDICATION

Ka Mahi, ka inoi, ka moe, ka maki anō

PHILIP TRUSKETT
President

There are many reasons to be proud of this College as the President. We do demonstrate leadership in many areas. One of them is our ongoing advocacy for equity and the work we are doing through the Indigenous Health Committee. It is vital that we continue to focus on improving the health of the New Zealand Māori as well as the Australian Aboriginal and Torres Strait Islander populations. It is important that we understand that we also do this within the growing requirement for cultural competence as an essential part of being a medical practitioner and surgeon to our communities. The Australian Medical Council and the Medical Council of New Zealand have strengthened these requirements substantially within the accreditation requirements of our training and professional development programs.

As outlined in an article by Pat Alley earlier this year in Surgical News, the four step plan to address Māori Health inequities are developing an appropriate Māori workforce, analysing contemporary data on outcomes for Māori with surgical conditions, undertaking research where such data does not yet exist and raising the visibility of Māori within RACS at all levels. Supporting and profiling Māori Surgeons and Trainees is but one of the activities that will allow us to enhance our understanding of these complex areas and ensure that we more fully address the equity of health outcomes.

There is no doubt the health challenges confronting the Aboriginal and Torres Strait Islander people remain large. Despite ten years of the Closing the Gap initiative, the latest report presented to the Australian Parliament by the Prime

Dr David Murray, Mr Philip Truskett, Mr Perry Wandin, and the Honourable Mary Woolridge

PRESIDENT'S
PERSPECTIVE

Minister still demonstrates the patchiness of response to many activities. The life expectancy of Aboriginal and Torres Strait Islander Australians is still about ten years less than non-Indigenous. It is certainly unacceptable and again the biggest health issue confronting modern Australia.

It is essential that RACS plays a prominent role in addressing these inequities. To achieve this added effort must be made to provide something close to equal opportunity in our Aboriginal, Torres Strait Islander and Māori communities. We can start by cultivating cultural competence in our workforce, advocating on issues that will close the gap and increasing the numbers of Māori, Aboriginal and Torres Strait Islander surgeons is vital.

I attended the launch of the RACS Reconciliation Action Plan 2016 – 2017 in Melbourne. David Murray is now the Chair of the Indigenous Health Committee, which has oversighted the further development of the plan and he chaired the launch. There are three key goals of improving and extending relationships, engendering respect and

"It is vital that we continue to focus on improving the health of the New Zealand Māori as well as the Australian Aboriginal and Torres Strait Islander populations. It is important that we understand that we also do this within the growing requirement for cultural competence..."

enhancing cultural competency and creating opportunities for increasing the number of Aboriginal and Torres Strait Islander Fellows, Trainees and staff. There are remarkably similar themes and requirements across Australia and New Zealand.

The commitment to these areas by RACS is particularly strong. Fellows like Kelvin Kong who received the RACS Medal at the May ASC have lead the way. Others such as Harvey Coates, Francis Lannigan, Ollapallil Jacob Jacob, Jonathan Koea, Andrew Hill and Patrick Alley have all been outstanding in their contribution over decades. It is critical that their work and contribution is recognised and that we now develop responses across all areas of RACS activities to address these really important issues of equity and health outcomes.

Equity does not mean equal; it means equal opportunity. To achieve this extra effort is required. I do recommend the Action Plans to you for your on-going reading and meaningful consideration.

ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

Queen's Birthday Honours

Australia

Member (AM) in the General Division

Dr Gordon Dean Beaumont
Prof Daniel Thomas Cass
Dr Nicholas William Dorsch
Prof John Perry Fletcher
Mr Peter Charles Heiner
Dr Geoffrey Henry Hirst
Dr John Timothy Kennedy
Prof Avni Sali

Medal (OAM) in the General Division

Assoc Prof Brett Gerard Courtenay
Mr John Swinnen

New Zealand

Officer of the New Zealand Order of Merit (ONZM)

Emeritus Professor Bryan Parry

Members of the New Zealand Order of Merit (MNZM)

Associate Professor Patrick Alley
Dr Nadarajah Manoharan
Mr Garnet Tregonning

WHY IS THE UPCOMING CENSUS SO CRITICAL FOR YOU TO COMPLETE?

How can you help the College in workforce planning and advocacy?

SPENCER BEASLEY
Vice President

The unsolicited survey must be one of the greatest irritants of modern life. Just about everything you do – whether it be getting your car serviced, or staying in a hotel – seems to result in a request to provide feedback by completing a survey online. Many offer an estimate of how long the survey will take to work through, but sadly for us, they seem to apply 'surgical time': double it and add 20.

While we are reassured that our carefully considered responses are important to those running the survey, our time clearly is not. For those of us who live in a world where time is precious, that is not helpful. And where we see little evidence of a direct or immediate benefit to us we are tempted to delete these emails as quickly as we can, and without a second thought.

On the rare occasions we have acquiesced to a survey or research request it can seem that the questions demand irritatingly detailed information, and our initial goodwill soon evaporates. So often the options offered appear to be poorly worded or ambiguous, or cannot be answered without qualification.

And when we choose to skip a question that seems unanswerable, we are forced to revisit the page before we can proceed any further: how frustrating is that? Sometimes we tolerate the questionnaire in the forlorn hope that it is us who will win the enticement we neither need nor want.

But there is one survey coming up that is relevant to us all, and which we must complete diligently. This is the RACS Surgical Workforce Census

I strongly urge all Fellows to take it seriously and respond to each question as accurately as possible. The Census is an important tool in our workforce advocacy planning, but it does depend on as many Fellows as possible completing it if we are to have a comprehensive data set that is truly representative of our entire Fellowship.

Each year the annual RACS Activities Report provides data on Trainees and Fellows according to state, age groups and specialty. However, the need for more detailed information on workforce intentions and practices mark the difference between the Census and the Activities Report. Data from the Census helps to paint a more comprehensive picture of future workforce supply and helps identify trends in workforce demographics at an early stage.

Health workforce planning is an ongoing issue at state and Commonwealth levels. The Department of Health is steadily working through each medical specialty to predict future needs, to ensure enough doctors are being trained to meet demand. Our specialties will be targeted soon.

The interlocking factors of our political and economic environment, together with technological advances and changes to the configuration of surgical services have led to changes in medical career patterns.

Previous Census data has revealed that more of our Senior Fellows now continue to work well into their sixties and seventies. Many are relinquishing much of their clinical workload in both the public and private hospital sectors to move more into medico-legal work, administration, research and academia.

This has implications on how governments in the future will need to measure the medical workforce. For example, the methodology used in the Australian Commonwealth Department of Health's first published workforce projections for psychiatry appears to count only clinicians in their supply model ('clinicians' are defined as practitioners who spend most of their working hours engaged in the diagnosis and/or treatment of patients).

"The Census is an important tool in our workforce advocacy planning, but it does depend on as many Fellows as possible completing it."

Counting only those in clinical practice as being part of the medical supply may give a misleading impression of the true workload and workforce need; which is one reason we must make this distinction within our own Census data. In short, we must have our own independent dataset to verify the department's supply and demand projections when it turns its attention to surgery.

The Census also captures information on other important issues that affect our Fellowship. It was extremely sobering to note that the 2014 Census revealed that more than one in three respondents were experiencing stress as a result of workplace bullying or harassment.

The health and wellbeing of our Fellowship has not previously received the attention it has deserved – but times are changing. And so too will surgical culture as the Building Respect and Improving Patient Safety Action Plan is implemented.

Consequently, it should be no surprise that questions measuring stress and the mental health wellbeing of our Fellows will be included in the 2016 Census and become an important tool to assist our College track these changes. I suspect we would all hope to see this percentage decrease as we continue to work to reach our Action Plan goals.

Data collection will begin in August and all responses will be de-identified and remain confidential. Completing the RACS Surgical Workforce Census may seem arduous, but it is critical for workforce planning and for our discussions with governments around meeting surgical need.

So when you see the email pop up in your inbox this August, I strongly urge you to complete the Census as carefully and as accurately as possible, and avoid the temptation to click 'Delete'. Your support in completing the survey ensures we will have an independent data source that will assist your College in its advocacy work on your behalf when negotiating matters surgical.

Remember, press "Begin Survey".

SA Health to restrict elective surgery

South Australia Health has made moves to restrict elective surgeries in public hospitals, which could affect breast and skin cancer sufferers.

Opponents of the move say that the restriction of surgeries could effect good outcomes for patients and potentially create even longer waiting times.

Spokesperson for SA RACS Dr Nicola Dean said that the guidelines assumes that all plastic surgery was ‘cosmetic’.

“We don’t do cosmetic surgery in the public system and I support that absolutely, but many of these procedures under threat are important to good health outcomes,” Dr Dean said.
Adelaide Now, 20 June

More female speakers at meetings

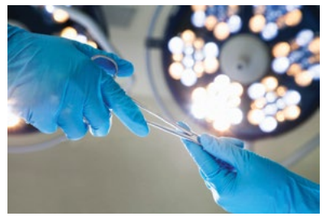
A recent report found that female representation at annual scientific meetings for many specialties is below the proportion of the membership, however RACS exceeded the proportion of female speakers when compared to the membership.

The authors suggested that improving the gender balance of speakers might also help in improving the workforce balance and also promote the careers of female speakers.

Dr Ruth Bollard, Chair of RACS Women in Surgery section has said it is only a matter of time for more women in surgery.

“There is 41 per cent of our Fellows under 35 who are female, so we know that things will evolve.”

“We’re very pleased to see that RACS was the only College whose proportion of females exceeded the proportion of women in the surgical workforce,” Dr Bollard said.
MJA Insight, 14 June



Saving lives with surgery

Urological surgeons Jeremy Grummet recently won the global prize for the British Journal of Urology International for a paper he authored on prostate biopsies.

The paper looks at a new technique to collect biopsy tissue in order to reduce risk of infection through traditional collection methods.

Mr Grummet says that he cannot see another profession that could deliver the satisfaction he receives from surgery.

“If you know you have really done the best operation you could have, then it’s very likely that patient is going to do very well and you may have well saved their life,” Mr Grummet said.

“I can’t imagine getting much more than that in anything you do in life.”

The Age, 6 June

Trauma surgeon honoured

Trauma surgeon and key member of the RACS Trauma Committee Professor Danny Cass has received a Member of the Order of Australia.

Professor Cass has worked in the field of trauma research and particularly accident prevention with articles published in many peer-reviewed journals.

Despite receiving the honour being somewhat of a surprise, Professor Cass has said he has had strong community support for his work.

“It has been an area in Australia that has been very good in that everyone seems behind it,” Professor Cass said.

“It can be difficult, but the fact that you are doing a job and also the contribution of the families to try and reduce similar heartbreak to another family is what moves us all on.”

Daily Telegraph, 11 May

RECONCILIATION ACTION PLAN

RACS Reconciliation Action Plan 2016-2017 - Launched

DAVID MURRAY
Chair, Indigenous Health Committee

The year 2016 is the 25th anniversary of the establishment of the Council for Aboriginal Reconciliation. To mark the beginning of this year's National Reconciliation Week, Council approved RACS' first Reconciliation Action Plan (or RAP), which was launched on 1 June 2016.

A two page summary of the RAP was circulated to all Fellows in the June edition of Surgical News and the full report is now available online from http://www.surgeons.org/member-services/interest-groups-sections/aboriginal-and-torres-strait-islander-health/

The plan was launched by RACS President Mr Phil Truskett, AM, FRACS and Indigenous Health Committee Chair Dr David Murray, FRACS. Local Wurundjeri Elder Perry Wandin began the proceedings delivering an insightful Welcome to Country. Mr Wandin was present one year ago when RACS committed to developing a Reconciliation Action Plan and was pleased to return 12 months later to speak with Fellows and staff about RACS' progress towards reconciliation.

President Truskett spoke on the importance of RACS demonstrating leadership and advocating for improved health care outcomes for Aboriginal and Torres Strait Islander peoples. Dr Murray spoke about reconciliation and the importance of considering the impact on Australia's history on the present state of Aboriginal and Torres Strait Islander health and developing strategies for the future.

The Launch was a resounding success with more than 100 guests attending in Melbourne and regional offices linked in online. Staff and Fellows attended from nine medical colleges as well as representatives from the Leaders in Indigenous Medical Education program, Australian Indigenous Doctors' Association, Johnson and Johnson Medical and the Honourable Mary Wooldridge, Victoria's Shadow Minister for Health.

Support for the RAP launch was received from across Australia and New Zealand with Regional Chairs showing their support for the importance of RACS' commitment to reconciliation.

South Australia

The launch of the RAP highlights the positive impact we can all have, as individuals and as an organisation, when we contribute towards a positive culture of respect, understanding and reconciliation.

By committing to this culture we can more effectively deliver on one of our core priorities as a College, which is to deliver better Indigenous health outcomes. The SA Regional Office commends all the hard working people who have made this possible, and we are delighted to offer our support to this wonderful initiative.

Dr Sonia Latzel
Chair
On behalf of the SA Regional Committee & Regional Office

New South Wales

On behalf of the NSW Regional Committee we would like to express our support for the launch of the RACS Reconciliation Action Plan.

We have shared a commitment to recognise Indigenous heritage by stating the 'Acknowledgement of Country' when holding significant events in NSW, and paying respect to Aboriginal elders past and present. RACS NSW Regional Committee recognises Indigenous Australians as the traditional custodians of the land.

"The Launch was a resounding success with more than 100 guests attending in Melbourne and regional offices linked in online."

We look forward to the launch of the Reconciliation Action Plan.

Dr Mary Langcake, FRACS, Chair
On behalf of the New South Wales Regional Committee

Tasmania

The Tasmanian Regional Committee is very supportive of the implementation of the College's Reconciliation Action Plan which demonstrates the commitment to reconciliation between Aboriginal and Torres Strait Islander people and other Australians.

Brian Kirkby, Chair
On behalf of the Tasmanian Regional Committee

New Zealand

Tānā koutou

The New Zealand National Board firmly supports the RACS Reconciliation Action Plan. As our countries pursue the principles of fairness and equity, we look forward to a strong, diverse future for surgery and equity of health outcomes.

Kia kaha.
Professor Randall Morton, Chair
On behalf of the New Zealand National Board

Northern Territory

Representing a jurisdiction that has easily the highest per capita population of Aboriginal people, we recognise the importance of developing positive relationships based on mutual respect and trust. Many of our Northern Territory surgeons work closely with Aboriginal people and communities on a daily basis, and are proud advocates for improving the health standards of Aboriginal people.

The NT Regional Committee and supporting Regional Office staff commend the College on the launch of the RAP, and for all the hard work that has gone in to making it possible.

Mr John Treacy, Chair
On behalf of the Northern Territory Committee

Western Australia

The WA Regional Office is proud to offer its support to the launch of the RAP and the principles that underpin it. In a country with the wealth and resources of Australia, and a state as prosperous as Western Australia, it is unacceptable that the gap in health, employment and education outcomes between Aboriginal and non-Aboriginal Australians remains so stark. The RAP is a significant milestone for the College, and will assist us in our efforts to develop respectful relationships, and promote increased opportunity and outcomes for all.

Mr Stephen Honeybul, Chair
On behalf of the Western Australian Regional Committee

Victoria

The Victorian Regional Committee would like to welcome the development of the Reconciliation Action Plan and its launch. With the aid of this plan, RACS will be able to increase ties to the Indigenous community and endeavour to increase the number of Indigenous fellows.

This will no doubt strengthen the diversity in RACS and maintain its relevance into the future. We look forward to a future with greater ties with the Indigenous community leading to better opportunities both in receiving and giving high quality surgical care.

Mr David Love, Chair (elect)
On behalf of the Victorian Regional Committee

ACT

The RACS ACT Committee supports the College's Reconciliation Action Plan, and congratulates those involved in developing it. We will strive to bring about positive cultural change in our workplaces in the ACT, and we are committed to reconciliation between Aboriginal and Torres Strait Islander people and other Australians. We are working to identify ACT Fellows with an interest in Aboriginal and Torres Strait Islander health, and other ways to support the important goals outlined in the plan.

Chair
Sivakumar Gananadha
On behalf of the ACT Regional Committee

David Murray

FATAL DISTRACTION - DRIVER DISTRACTION AND ROAD SAFETY

Driver distraction was the Trauma Symposium's focus on 18 November 2015, in particular the issue of driver and pedestrian distraction due to mobile phone technology

RICHARD PERRY
Chair, Fellowship Services Committee

JOHN CROZIER
Chair, Trauma Committee

BEN THOMSON AND VALERIE MALKA
Co-conveners, Fatal Distraction Symposium

In Australia, on average four people die and 90 people are seriously injured every day in road traffic crashes. This has an immeasurable impact on families and communities, a huge impact on our hospital system and results in considerable economic loss.

The annual economic cost of road crashes in Australia is estimated at $27 billion per annum. A multicentre study demonstrated that traumatic injury cost NSW trauma centres around $180 million annually. A 12 month analysis of the cost of road trauma injuries admitted to Liverpool Hospital, a major Sydney trauma centre, was calculated to be greater than $4.5 million.

The Royal Australasian College of Surgeons (RACS) has a long and successful history in road safety advocacy. We now are faced with a challenge of almost epidemic proportions, that of driver and pedestrian distraction. Distracted driving or walking is any activity that could divert a person's attention away from the primary task of driving or walking safely.

Each year, during RACS 'Trauma Week' the Trauma Committee holds a workshop focused on injury prevention and current trauma-related issues. Driver distraction was the Trauma Symposium's focus on 18 November 2015, aptly named 'Fatal Distraction', where we examined the issue of driver and pedestrian distraction, in particular the use of mobile phone technology.

Defining the problem

In Australia use of a mobile phone while driving is illegal unless used as a hands free device in a cradle. Learner and P1 drivers (P2 also in Victoria) must not use a mobile phone (hand-held or hands-free) for any function while driving (including while stationary but not parked).

Despite this a 2011 government survey showed 93 per cent of Australian drivers owned a mobile phone with 59 per cent reporting using their mobile phone while driving and 31 per cent of drivers reading, and 14 per cent sending text messages.

Not surprisingly, 17-24 years and 25-39 years report highest percentages of 94 per cent and 91 per cent, respectively – more likely to use a mobile phone while driving. The 17-24 year age group is the one consistently over-represented in road traffic crashes and it is believed that over 60 per cent of crashes in this group are distraction related.

The exact impact has, to date, been difficult to assess but is likely grossly under-reported. Police in most countries do not systematically report the use of a particular distracting activity in crash reports. We do know that driver distraction is a contributing factor in nearly 25 per cent of car crashes and over 70 per cent of truck crashes. Simply put, drivers using a mobile phone are approximately four times more likely to be involved in a crash.

Trauma Symposium attendees, 18th November 2015

Police and hospitals need to address the difficult issue of data collection. Currently no Australian trauma centre registries collect data on distractions associated with road related admissions. Intelligent transport systems (ITS) technology which can record mobile phone use while driving may assist future data collection.

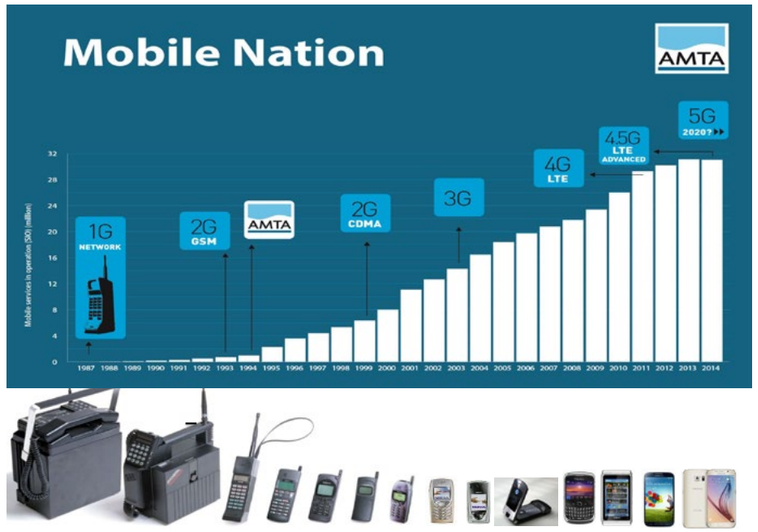
Improved data collection methods at crash sites (to record mobile phone use at the time of the crash) may also help. It is clear that a collaborative approach to data collection is needed to accurately quantify the involvement of distractions in road related traffic crashes.

Dr Ben Thomson, trauma surgeon at Royal Melbourne Hospital and Dr Valerie Malka, trauma surgeon at Liverpool Hospital collaborated with Dr John Crozier, Chair of the RACS Trauma Committee, to convene a successful symposium, bringing together key stakeholders from road transport, police, car manufacturing, telecommunications, insurance companies, health care workers, research scientists and advocacy groups. This was a dynamic program with experts from diverse fields, which also generated great media interest and once again RACS was seen to be a leader in injury prevention and community safety.

Raising awareness

Multiple solutions have been put forward to change the current culture and behaviour of our drivers, cyclists and pedestrians. It is clear that a comprehensive, nationally consistent public education campaign is critical to changing behaviour and alerting the community to the dangers and consequences of distraction.

Most mobile phones have 'car modes' that limit the functions available while driving. Phone cradles have been well supported to allow the hands-free functions to be used. Phone Apps that can assess driver's behavior are being supported by insurers to allow incentives for drivers to change behavior by a reduction in premiums.



The Pedestrian Council of Australia's new campaign "Don't Tune Out – Stop Look Listen" hopes to educate pedestrians of the danger of using electronic mobile devices when crossing roads or walking near roads and public transport.

Hospital-based programs such as the PARTY (Prevent Alcohol and Risk Related Trauma in Youth) program have shown excellent results overseas in changing young drivers' behaviours behind the wheel. Given the 17-24 year age group, particularly males, are the highest numbers of road injuries seen, these initiatives are critical.

Interestingly young drivers tell us that advertising campaigns do not make an impact on them but coming to a hospital-based program where they are confronted with the realities of road traffic crashes and the consequences of poor decision making have a huge impact.

The latest Victorian TAC campaign "Towards Zero" is working towards a future free of deaths and serious injuries on our roads. The successful NSW 'Get Your Hand Off It' online campaign was expanded to include television commercials, radio and cinema. The Queensland Centre for Accident Research and Road Safety has examined the issue of driver distraction extensively and are developing best practice public education campaigns to reduce mobile phone use while driving.

The Trauma Committee of RACS supports the National Road Safety Partnership Program (NRSPP) safe mobile use policy. It is partnering with the NRSPP to push the culture change required to decrease the trauma associated with the exponentially increasing use of distracting technology.

Trauma Week 2016 will be in Brisbane as part of the Queensland Annual Meeting 4-6 November 2016. The Trauma Symposium, convened by Cliff Pollard and Grant Christey, will focus on the influence of trauma registries, education, research and big data – "We collect data – let's put it to work". For further information email: conferences.events @surgeons.org or telephone: +61 3 9249 1260

HISTORICAL COLLECTION NOW ONLINE

The Russell Catalogue of historical books in the library of the College is now on the RACS website

CAMPBELL MILES
FRACS

Fellows are doubtless aware of the significant library of historical medical texts held by the RACS – principally the Cowlishaw and the Gordon Craig collections supplemented by smaller donated collections. In 1979 the College published the catalogue of these important collections written by the late Professor Ken Russell – 'Catalogue of Historical Books in the Library of the Royal Australasian College of Surgeons'.

I am pleased to advise Fellows and Trainees that RACS has had Russell's catalogue scanned. The book is now available on the RACS website as a PDF file that can be searched by author or title word.

RACS is to be congratulated on taking this important initiative that makes the resource more readily available for historical research. In addition, the recently donated O'Brien collection of historical orthopaedic texts collected by John Patrick O'Brien FRACS will also be available online.

9th Sino-Australia/New Zealand (RACS) Conference on Surgical Oncology

Expressions of Interest are invited for the 9th Sino-Australia/New Zealand (RACS) Conference on Surgical Oncology (SANZSO). This Conference will be held on Friday 28 October 2016 at the International Conference Center, Hangzhou, China

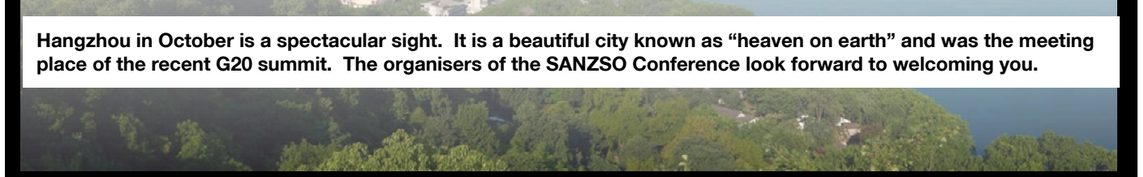
The Conference will focus on new concepts for multi-disciplinary management of Hepato-Pancreatic-Biliary Cancer and Colorectal Cancer. Keynote speakers include Professors Craig Lynch from the Peter Mac, Professor Bruce Waxman from the Monash University, Professor Ben Thomson from the Royal Melbourne Hospital, Melbourne. Conference accommodation will be at the luxurious and modern Intercontinental Hotel, Hangzhou, boasting magnificent views of the Qianjiang River.

Following this one-day meeting, on 29 October, the delegates from Australia and New Zealand are invited to join the Sino-US Colorectal Cancer MDT Symposium of the 13th National Colo-rectal Cancer Academic Conference in Songjiang, Shanghai. This is about a one-hour trip by car or by train from Hangzhou.

Hepatobiliary and colorectal surgeons who are interested in participating in this Meeting are encouraged to contact the Australian and New Zealand Convenor, A/Professor Bruce Waxman on 0412 388 126 or bruce@bpwconsulting.com.au

Registration forms are available on the China-ANZ page of the RACS website. General enquiries may be directed to sara.hudson@surgeons.org

This series of conferences on Surgical Oncology started in 2000, and have been held biennially since then, alternating between Guangzhou and one of the capital cities in Australia. The aim is to provide a platform for academic exchange and networking between the surgeons of the three countries. The Conferences are jointly sponsored by the Cancer Center of Sun Yat-Sen University and Project China of the College. The last meeting was held in Melbourne in 2014. This is the first time the Conference in China is held outside of Guangzhou.



Hangzhou in October is a spectacular sight. It is a beautiful city known as "heaven on earth" and was the meeting place of the recent G20 summit. The organisers of the SANZSO Conference look forward to welcoming you.

YOUR CODE OF CONDUCT

Why adherence to a Code of Conduct protects our autonomy and professional status

MICHAEL GRIGG
Past President

Around 400 BC, Hippocrates established medicine as a distinct field and defined a strict code of conduct for his followers and disciples. This is widely considered to be the beginning of professionalism in medicine.

The flame lit by Hippocrates was kept alight by Islamic physicians. An example is the 10th Century Code of Conduct that included these principles:

- Being expert role models
- Having a responsibility to patients
- Having a responsibility to medical advancement
- Compassionate behaviours
- Respect for patient confidentiality
- Prohibition of relationships with female patients
- Charging a fair and reasonable fee
- Having a responsibility to expose charlatans

It is a Code that would be recognisable not only to Hippocrates but also to modern Western medicine.

In his 1776 book The Wealth of Nations, Scottish economist and moral philosopher Adam Smith explored the importance of professionals. He sought to define professionals – highly trained and skilled, with autonomy from both State and Church enabling them to act in the best interests of their patients.

Smith recognised that there was a real risk in giving complete control to a particular group – that risk being degeneration into an exploitative monopoly. He insisted that professional autonomy had to be balanced by professional self-regulation – the professions defining and protecting ethical behaviour.

Sir Thomas Percival is credited with publishing the first modern-day code of conduct in 1803, the Medical Ethics, or a Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons. This has formed the basis of most modern-day medical organisation's codes of conduct. A social contract between doctors and patients developed that has persisted. Specifically, surgeons have autonomy, the right to monopoly and the right to charge a fee, in return for acting in the best interests of their patients and self-regulation.

"Professional autonomy had to be balanced by professional self-regulation – the professions defining and protecting ethical behaviour."

Unfortunately, there are perceptions of failures of self-regulation by the medical profession. These are perpetuated in the media and reports of avoidable medical error, exploitative fees, closed shop entry, suspect relationships with third party providers and corporatisation of medicine are becoming increasingly frequent.

If professional organisations do not have, or be seen not to uphold, high professional standards governments and the public will perceive self-interest, incompetence, or worse – corruption. The professional status of individuals will be threatened as will the valued doctor-patient relationship.

The Medicare Benefits Schedule (MBS) may be outdated and the ongoing freeze on reimbursements unpopular, but it does recognise and enshrine the autonomy of surgeons. Without it, we might all become employees. Could we still act professionally i.e., act in the patient's best interest, even if this conflicted with the employer's code of practice? The answer is "yes" but is dependent upon a strong professional organisation supported by Society at large.

For more than 200 years, Society has entrusted matters of professional standards – both practical and ethical, to the professions, purposefully excluding Government. But if Society comes to doubt professional self-regulation, it will predictably turn to Government for a regulated and controlling solution.

An individual's ongoing professional status depends on the strength of their relevant professional organisation. For surgeons, this is our College. A professional organisation is strong if it is internally supported and externally respected for its values, standards and the upholding of these standards. As surgeons, current custodians of a noble profession, protecting and enhancing the professional status of our College is of benefit but is also a professional responsibility.

You can view the College's updated Code of Conduct in the publications section of the website at www.surgeons.org.

Patron: H.R.H. The Prince of Wales

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

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OFFICE OF THE PRESIDENT
Mr Philip Truskett AM

To all Stakeholders in the College,

In June 2015, the Hon Jeff Kennett AC former Victorian Premier and Chair of Beyond Blue challenged the Royal Australasian College of Surgeons (RACS) to deal effectively with discrimination, bullying and sexual harassment (DBSH) or watch other bodies take over and do it in the College's place.

This was in the midst of the extensive review of the prevalence of DBSH, chaired by the Hon Rob Knowles AO that saw a damning report published at the end of September 2015. The comprehensive response and the Building Respect, Improving Patient Safety action plan was released in November 2015. These comments were also in the context of reports released by Beyond Blue that highlighted substantial concerns with the mental and physical health of the medical profession.

Twelve months have now passed since the challenge was made and six months since the Building Respect, Improving Patient Safety action plan was published. RACS is committed to reporting publicly on our progress and sharing the highlights of the work undertaken.

The Action plan sets eight goals and outlines more than 20 projects now underway to achieve them. The details of these can be found on our website (www.surgeons.org). They are summarised on the attached outline that will guide us over the next three years of implementation. Cultural change will hopefully be occurring during all this time but will certainly be longer term.

Key components of the Culture Change and Leadership have included the launch of the Let's Operate with Respect campaign at our Annual Scientific Congress in May, which is prominent in the latest edition of our Surgical News (attached). This included week long programs run by world leaders such as Professor Gerry Hickson from the Vanderbilt University Medical Centre in organisational responses to unacceptable behaviour and the President's Lecture on Leadership by Lieutenant General David Morrison AO. In parallel to the campaign we have now established Memoranda of Understanding (MOU) with Hospitals and Health organisations. (A redacted version of the MOU is attached) The attached Code of Conduct has been updated to more fully reflect the expected standards for the Surgical Profession and with it our Sanctions Policy has been strengthened. Our draft Diversity Plan is now being circulated for active consultation.

Surgical Education developments have included substantial resourcing being made available for the Foundation Skills for Surgical Educators Course which will now be mandatory for all surgeons involved with educational or training activities. An eModule specifically addressing issues of DBSH will be released by the end of June and will be a compulsory component of our CPD for all Fellows. A further face to face course about handling DBSH is under development for surgeons in leadership positions. To ensure that the voice of our trainees is more effectively heard, their association now has dedicated staff to assist with coordination, collaboration and advocacy. We are working with all specialty surgical societies and training boards to ensure DBSH is properly addressed across all training and educational environments

Our complaints management process has been substantially reviewed and is much enhanced. A full time Manager for Complaints Resolution, increased legal advice, separate and external investigatory and review mechanisms are now in place. The RACS Support Program, provided through Converge International has been launched and is available to all Fellows, Trainees and International Medical Graduates. The Clinical Director role for International Medical Graduate assessment has been enlarged to specifically include support at both local and organisational levels.

Much has been done. There is still a comprehensive program of work in front of this College to address the challenge that was raised by the Hon Jeff Kennett. There is much to be done to change the culture, to ensure that discrimination, bullying and sexual harassment is an issue of the past. However, RACS is committed at all levels to ensure that we 'operate with respect' and provide leadership to this very important concern for the profession and the community.

I look forward to working with you and your organisation as we progress this substantial program.

Yours Sincerely,

Mr Philip Truskett AM

College of Surgeons of Australia and New Zealand

BUILDING RESPECT,
IMPROVING PATIENT SAFETY

RACS
LET'S OPERATE WITH RESPECT

The RACS Action Plan:

Goal 1	Build a culture of respect and collaboration in surgical practice and education
Goal 2	Respecting the rich history of the surgical profession, advance the culture of surgical practice so there is no place for discrimination, bullying and sexual harassment (DBSH)
Goal 3	Build and foster relationships of trust, confidence and cooperation on DBSH issues with employers, governments and their agencies in all jurisdictions
Goal 4	Embrace diversity and foster gender equity
Goal 5	Increase transparency, independent scrutiny and external accountability in College activities
Goal 6	Improve the capability of all surgeons involved in surgical education to provide effective surgical education based on the principles of respect, transparency and professionalism
Goal 7	Train all Fellows, Trainees and International Medical Graduates to build and consolidate professionalism
Goal 8	Revise and strengthen RACS complaints management process, increasing external scrutiny and demonstrating best practice complaints management that is transparent, robust and fair

2016 MĀORI HEALTH MEDAL

Colorectal Surgeon Professor Andrew Hill was this year awarded the RACS 2016 Māori Health Medal at the Annual Scientific Congress in Brisbane

Ever since he took up the position of Head of the South Auckland Clinical Campus of the University of Auckland, Colorectal Surgeon Professor Andrew Hill has set out to encourage Māori and Pacific Islander students to expand their academic horizons.

Working on the belief that more needed to be done to actively attract these medical students into surgery or other medical specialties, Professor Hill has each year since his tenure began employed at least one Māori or Pacific Islander student to conduct research under his mentorship.

His support has now helped multiple Māori and Pacific Island students and graduates to do research in a range of clinical disciplines with seven students having completed or completing PhDs and with one student recently accepted into the Masters Program at Harvard University in the US.

Of those students, two have chosen to pursue a career as Orthopaedic surgeons, two have chosen to train as General surgeons while other students have chosen to pursue careers in public health and radiology.

Earlier this year, Professor Hill's work with Māori and Pacific Island students was recognised when he was awarded the RACS Māori Health Medal at the Annual Scientific Congress in May.

Speaking to Surgical News, Professor Hill said that while New Zealand had just recently achieved proportionality in the number of Māori and Pacific Islander medical graduates relative to population, there was still an enormous gap in the number choosing surgery and other specialities.

The 2014 recipient of the John Mitchell Crouch Fellowship and highly regarded academic surgeon, Professor Hill said that many Māori and Pacific Islander medical students needed robust, targeted support if they were to overcome both overt and covert obstacles to high achievement.

He said that while Māori make up between 15 and 20 per cent of the New Zealand population and Pacific Islander people about 10 per cent, those numbers were nowhere near reflected in the number of medical graduates choosing to become surgeons.

While the number of Māori students entering medical school now reflects the population mix of Māori in New Zealand, most chose to become GPs and work in their communities.

However, Professor Hill said more could choose surgery or other medical specialties if they were given the time and support to consider all options open to them.

"Most of these students don't have friends or family in medicine or the broader health sector so they don't know how the game is played," he said.

"Most of them don't have parents or siblings who are professionals so the idea of spending years in vocational training or taking on a PhD is utterly new to many of them and an option that can seem somewhat overwhelming.

"Just going to medical school is a huge deal to some Māori and Pacific Islander students but many of them are extremely intelligent and outstanding human beings and hopefully this situation will be very different for the next generation."

Professor Hill has a Doctorate in Surgery and a Doctorate in Education, is a member of the RACS Council and has a clinical practice based at the Middlemore Hospital in Auckland.

With particular research interests in improving the outcomes from major abdominal surgery and medical education, he is the Head of the New Zealand and Australia Enhanced Recovery after Surgery Group (NZERAS) and has published more than 200 peer-reviewed papers in these areas.

Having attracted extensive research funding from the University of Auckland and external sources, Professor Hill employs two research Fellows each year, with one position allocated to an interested Māori or Pacific Islander student.

He said that he chose to do this to give these students the skills, qualifications and accolades to help them overcome the unconscious bias that sometimes still operates within the medical system.

"These young students not only conduct research, they learn how to design studies and experiments, conduct a review of the literature, present at national and international conferences and write up their work to the level necessary to be published in prestigious peer-reviewed journals," Professor Hill said.

"Most of these students don't have friends or family in medicine or the broader health sector so they don't know how the game is played."

INDIGENOUS
HEALTH

"All of this is not just great for their CVs, it helps them believe in themselves and that they have the right to be ambitious, to be anything they want to be and any advanced degree counts in the selection process for all surgical training schemes.

"I think the College understands that there can be unconscious bias operating in the selection of Trainees and while we continue to discuss the option of providing preferential treatment to Indigenous people both in New Zealand and Australia I am working to give my students the best possible chance of being selected into any specialty they wish to pursue.

"I think that if they have a Masters or PhD, they have prizes to their names and great referees they should get selected whoever they might be.

"As we have seen in the increased selection of women into surgery, the path is made easier when there are more women on the selection panels.

"I see my role as one of helping to get enough Māori and Pacific Islander students into surgery so that in 10 years they will be sitting on training boards and making the decisions and selections that will hopefully solve the problem of unconscious bias."

Professor Hill said that he was both delighted and surprised to be awarded the RACS Māori Health Medal.

"I feel this was given a bit early in my career but I was very honoured to receive it," he said.

"I will be excited when I see these students obtain their FRACS and while there is still a long way to go before that happens, that's when I will feel I have created a meaningful legacy.

"The students I work with are outstanding young people and we should be selfish about it and explicitly state that we want them in surgery."

With Karen Murphy

Andrew Hill receiving the Māori Health Medal from David Watters

SOCIAL MEDIA AND PUBLIC HEALTH ADVOCACY

A primer for surgeons

NIKKI STAMP
FRACS

The benefits of social media to today's surgeon are numerous. In an online world, there exists opportunities for collaboration in academia, educational opportunities, mentoring and networking. Increasingly, social media is being utilised by individual practitioners, specialty societies and journals as a modern tool for education and networking.

All doctors are aware of the difficulties of 'Dr Google' with reports of at least 35 per cent of Americans using Google to explore a diagnosis or seek health care advice. Social media is also flooded with so-called wellness experts who espouse to be experts in areas of health, nutrition, exercise science and offer up to the masses health care information, some of which is dangerously inaccurate.

Disgraced wellness blogger Belle Gibson, had amassed a following of millions across social media platforms where she claimed to have beaten brain cancer by healthy eating. Unsurprisingly to health care professionals, her claims were false. Falls from grace such as this have done nothing to stem the tide of bad information available to our patients online.

All health care workers have a responsibility to be public health advocates. RACS has a strong history of public health advocacy with policies or influence in areas such as road trauma, alcohol-related violence and helmet usage. As surgeons, we have a unique position in society as trusted professionals with experience on the front line or in academia to be able to provide the public with reliable, accurate information. Social media is an excellent vehicle we can use to this end.

June is traditionally the month the Heart Foundation uses to raise awareness regarding women's heart disease. Many women are unaware that this is the leading cause of death in women, nor do they understand the importance of prevention.

A number of cardiologists and cardiac surgeons who have an interest in women's heart disease have participated in social media-led campaigns to raise awareness with this important cause subsequently picked up by mainstream media where the hope is that we reach many at risk women. This is a relatively easy way of getting information to the masses as social media is fairly easy to use and transcends many traditional barriers to communication with the public.

"It's where our patients are
It's where our staff are
It's where our future staff are
It's where our critics are
It's where our experts are
And they are happy to engage with you"
- From Dr Chris Tiplady – Twitter @christiplady

A recent study from the University of Sydney and the Cancer Council of NSW has demonstrated that social media can help patients make small but important behavioural changes that has positive effects on health. These campaigns are relatively inexpensive yet reach a large number of participants. It is a medium that the private sector uses extensively for marketing and commercial success and is easily translatable to the public health arena.

It is essential that we as surgeons participate in efforts to improve the health of the population. Never more so than now when poor quality and occasionally downright dangerous information is available to anyone with a smart phone. It is incumbent upon the health care professional to be where the patients are and define ourselves as experts, as we rightly are, in our fields to give good, scientific health prevention information.

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RELATIONSHIPS
AND ADVOCACY

COLLEGE ADVOCACY

RACS continues in its efforts to have a seat at the policy table

Cosmetic surgery regulation

In January RACS was invited to make a submission to the NSW Government's review of the regulation of facilities carrying out cosmetic surgery.

Many medical practitioners in Australia have not undertaken FRACS accredited training, but are performing surgery under local anaesthetic or 'conscious sedation' in private clinics. In the past decade, two young women have died and several others have been rushed to hospital with serious complications after cosmetic procedures.

In collaboration with the Australian Society of Plastic Surgeons and the Australian and New Zealand College of Anaesthetists, RACS recommended that:

- Regulation of private health facilities should be based on the level of sedation rather than the procedure performed.
- Procedures requiring intravenous sedation, excluding dental, should only be performed in an accredited and licensed day surgery or hospital.
- Procedures conducted using large volumes of local anaesthetics or nerve blocks, which may reach toxic levels, should be restricted to licensed facilities.
- Cosmetic surgical operations should only be performed by practitioners who are registered surgical specialists.

"Our trauma surgeons are to be congratulated for their tireless efforts to ensure government legislation protects the right of people injured in road crashes to seek timely care of their choice."

Nationally consistent requirements for office-based facilities, including independent accreditation of facilities, credentialing of clinical staff, infection control, sterile supply, and clinical waste management, should be developed and implemented.

In June the NSW Government announced that cosmetic procedures would need to be carried out in facilities that have the same licensing standards as private hospitals. Facilities that carry out these procedures will have nine months to obtain the proper licensing under the Private Health Facilities Act and Regulation.

The ASERNIP-S department of RACS has done a comprehensive review of legislation and accreditation regulating hospitals, day procedure centres and office-based facilities in Australia and New Zealand. This review will inform advocacy efforts to better regulate cosmetic surgery in other jurisdictions.

Improving access to care for the severely injured

As of July 1, when Western Australia's 'no-fault' insurance scheme comes into effect, road crash victims who would have previously missed out on compensation will be able to claim against the existing Compulsory Third Party Insurance (CTP) scheme. The no-fault scheme brings WA into line with all other States, except Queensland.

RACS recently provided a submission to the NSW Government's review of the Compulsory Third Party insurance scheme. It is concerning that less than half of the Green Slip funds collected in NSW are paid to injured people following road crashes. Additionally, the majority of payments are made between three and five years after the accident, placing a significant financial and emotional burden on individuals and their families. RACS was invited to provide a witness to appear at a NSW Parliament hearing on June 17.

Our trauma surgeons are to be congratulated for their tireless efforts to ensure government legislation protects the right of people injured in road crashes to seek timely care of their choice.

College advocacy submissions can be viewed at: **www.surgeons.org/media/college-advocacy.**

Any comments can be made to the College at: **college.vicepresident@surgeons.org.**

ALL ABOUT DEATH

There is one thing that really annoys me and it is death

PROFESSOR GRUMPY

I realise that most of us want to avoid death for as long as possible but some aspects of it are very irritating. We curmudgeons are easily annoyed by things that are inconsistent.

When someone has died, usually in sad circumstances, the media describe the person, if she is a woman, as "mother of three" or "grandmother of six" but there is never a comment about a man's off-spring.

Perhaps the explanation is that if a man has children he is immune to death. I am sure that the feminists would (correctly) see the oft-repeated description of a woman's fecundity as an insult as it implies the woman's worth is defined by her fertility.

"No-one is ever described as a ratbag, a scoundrel, a womaniser, a fraudster, a narcissist or a laggard."

Then there are the obituaries. No-one is ever described as a ratbag, a scoundrel, a womaniser, a fraudster, a narcissist or a laggard. They are always honourable, cheerful, hard-working, enterprising, industrious and generous.

Perhaps this is code and enterprising really means that he (or she) would steal whatever he could and cheerful really means that he (or she) was really a sop for most of the time. Of course everyone is loving or greatly loved, never despised or barely tolerated.

Then there are the funerals themselves. It never ceases to amaze me that persons who have never been inside a church in the last 40 years are buried by a religion that they never knew.

I recall one great aunt who had two hates in her life – the "Catholics" and the "new Australians". As fate would happen her new daughter in law was Catholic and saw that she had a full mass given by an Italian priest who did not pronounce her name properly. Maybe there is a god and that "vengeance is mine" does occur.

Our society struggles with death. Even the word "death" is avoided. Someone passes on or passes over or goes to a better place or has departed this mortal existence or is the arms of Jesus or has fallen asleep or, in the case of a soldier, has fallen.

I recall a great uncle (oddly enough the husband of the above mentioned great aunt) who when someone said something about "when he goes" indignantly said "Go! Go! I am not going anywhere." A year or two later he did "go".

We curmudgeons are perfectly settled in our plans for our final exit. We will definitely die; we will not pass over or fall asleep. We will be proud to be described in the obituary as cantankerous old curmudgeons without any social graces.

Speakers at the funeral can say "I could not stand him" or worse. Family members may or may not come as they see fit. But wait for the Will. All manner of mischief could be wrought by a clause establishing "CA" – curmudgeons anonymous.

CASE NOTE REVIEW

Delegation of care in a postoperative patient

GUY MADDERN
Chair, ANZASM

A very elderly unfit patient, ASA 3, with dementia, macular degeneration, and poor vision and hearing, did not appear to have significant cardiorespiratory risk. The patient had invasive recurrence of bladder cancer with failed radiotherapy. In these circumstances, cystectomy can be curative. If not curative, then cystectomy with ileal conduit urinary diversion is the best palliative procedure.

Surgery was undertaken by two consultant urologists at a metropolitan private hospital. The patient had been worked up by a general physician. At surgery, an inoperable bladder was fixed to the pubic bone. In these circumstances, an ileal conduit urinary diversion was entirely appropriate and appears to have been relatively straightforward.

The postoperative course was complicated by altered mental state, as predicted by the attending physician. The initial postoperative management was in the intensive care unit (ICU). It appears from the notes that the patient was transferred to the ward the first day postoperatively. There were no initial complications in the ICU. A soft diet commenced on the fourth postoperative day. The bowels opened two days later. A computed tomography (CT) scan of the abdomen was undertaken the same day although it is not clear why—there may have been some concern about abdominal distension. The CT scan reported that the patient had an ileus.

The patient was started on total parenteral nutrition by the Intensive Care Staff the next day. This may have been because of the postoperative ileus and abdominal distension.

The patient developed rapid atrial fibrillation on the seventh postoperative day and was transferred to the Coronary Care Unit (CCU). There was some concern that this may have been secondary to sepsis, but this does not appear to have been clearly diagnosed at that time. It appears that the patient reverted to sinus rhythm with treatment in the CCU and was discharged from the CCU the same day.

The patient was re-admitted to the ICU the next day with worsening confusion and deteriorating renal function. The ICU was concerned about septicaemia and commenced with intravenous antibiotics and inotropic support. Ultimately, the septicaemia was probably related to a chest infection.

The sepsis was improved in ICU and the patient returned to the ward on the thirteenth postoperative day. The patient's general condition again deteriorated significantly, but it was decided not re-admit to the ICU. The patient died on the seventeenth postoperative day

Comment:

This elderly demented patient failed bladder cancer management with radiotherapy, and the decision to operate was reasonable given that palliative care in these circumstances is quite a difficult strategy. None of the postoperative complications could be directly attributable to the surgery as the patient responded quite well to treatment. The ultimate decision to manage the patient palliatively was appropriate.

From the documentation, there is no fault with the patient's management. In retrospect, one could say that palliative management without surgery may have been appropriate.

IN MEMORIAM

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

2016

John H Williams, Tasmanian Fellow

2015

Etika S Vudiniabola, Fijian Fellow

Ian Henderson Warner, New South Wales Fellow

2011

Ronald Wonson, Queensland Fellow

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

Informing the College

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

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

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

S-LOW DOWN LIPIDS OR RISK STATIN?

Don't ignore the warnings

DR BB G-LOVED

Professor Struth has ignored personal health issues for almost a decade. Pretending there will never be consequences (which there may not), running the gauntlet on risk factors, avoiding blood tests.

Struth deserves an inferred allusion to the species Struthio camelus (ostrich), that is want to stick its head in the sand. "Struth!" abbreviated slang for "God's truth!" aptly describes Dr BB G-loved's frustration with the Professor's failures in personal health advocacy.

Do you ever wonder what is your risk of a cardiovascular event in the next five years? Might you need to adjust your lifestyle to lower 'bad' LDL cholesterol or blood pressure?

Cardiovascular risk is calculated using the Framingham Risk Equation based upon age, gender, total cholesterol, HDL cholesterol, smoking, systolic blood pressure and current treatment for hypertension. It stratifies risk into low (less than 10 per cent), moderate (10-15 per cent) or high (greater than 15 per cent). Approved Australian and New Zealand versions can be found at http://www.cvdcheck.org.au/ or, for those with type 2 diabetes, at http://www.nzssd.org.nz/cvd/

Good HDL/bad LDL ratios should ideally be above 0.3, though plasma lipoproteins, particularly the atherogenic apolipoprotein B100 (ApoB) to anti-atherogenic apolipoprotein (ApoA1) ratio is a better population risk predictor than HDL/LDL. (ApoA1).

- Systolic blood pressure ≥180 mmHg or diastolic blood pressure ≥110 mmHg,
- Serum total cholesterol >7.5 mmol/L,
- A previous diagnosis of familial hypercholesterolaemia
- Diabetes and age >60 years, or have diabetes with microalbuminuria (> 20 mcg/min or with urinary albumin:creatinine ratio >2.5 mg/mmol for males, >3.5 mg/mmol for females)
- Moderate or severe chronic kidney disease (persistent proteinuria or estimated glomerular filtration rate [eGFR] < 45 mmol/L/1.73m2).

The boxed conditions on the left, including type 2 diabetes, make you high risk and suggest anti-hypertensive and/or lipid lowering therapy is appropriate.

Those with low risk should certainly receive lifestyle advice on exercise, diet, weight reduction, reducing sodium and increasing potassium intake, magnesium supplements, managing stress, enjoying a vacation, sleeping well and long enough, exposure to sunlight – all topics that have been covered in these columns previously.

Persons should definitely be treated for hypertension if their BP is above 160/100mmHg. Options for mild hypertension (systolic 140-159mmHg and/or diastolic 90-99mmg Hg) will be discussed in next month's column. This month we need to review statins for LDL cholesterol, the world's most widely prescribed medication.

If your risk of cardiovascular disease is intermediate, statins do significantly reduce LDL levels by blocking the cholesterol synthesizing enzyme, HMG CoA reductase, in the liver. The Heart Outcomes Prevention Evaluation (HOPE)-3 trial published in NEJM compared treatment with statins or placebo for cholesterol lowering in those with intermediate risk but without cardiovascular disease.

Daily 10mg Rosuvastatin significantly reduced the risk of a cardiovascular event including death from 4.8 per cent to 3.7 per cent over 5.6 years. Such reductions were noted in all lipid subgroups, irrespective of C-reactive protein level, blood pressure and ethnicity.

The Cholesterol Treatment Trialists Collaboration (2012) studied 174,149 participants in 27 trials. Statin therapy halved the risk of a major vascular event even in those with < 5 per cent or 5- 10 per cent risk. There was a 21 per cent (CI 0.77-0.81) reduction per 1.0mmol/L LDL cholesterol reduction.

However, before considering a life on statins be aware of their side effects. Myopathy and muscle pains are the most common, and occur in up to 29 per cent and are the most common reason for discontinuing treatment. Changing the statin sometimes helps. Muscle damage can be monitored using creatinine kinase but there is that tiny risk of developing rhabdomyolysis, with fatal cases reported.

Liver enzymes and blood glucose also need to be monitored as liver damage or type 2 diabetes can be induced. Some have reported cognitive impairment that reverses on discontinuing treatment. One option to reduce or help treat side effects may be to add Coenzyme Q10, depleted by statin therapy but essential for electron transfer and mitochondrial respiration. CQ10 deserves its own column later in the year.

I've sent Professor Struth a link to calculate cardiovascular risk and a request slip for blood lipids. Let's hope that extracts the Professor's head from the sand and we can at least have a conversation!

References: http://www.cvdcheck.org.au/pdf/Absolute_CVD_Risk-Quick_Reference_Guide.pdf

SHRIMP ON THE BBQ

Choice?

THE BARONESS

The fame of these articles penned under the pseudonym of 'The Baroness' continues to spread. Not so much for the wisdom of ways to present a cooked shrimp or prawn or the choice of the best wine to accompany it but as to 'Who is the Baroness?'

Indeed I was attending a dinner of a close legal friend. We had just opened a port that had been bottled so close to the Douro River it almost spoke to me in Portuguese. But I wander. My friend was reflecting on some of the arcane but still respected traditions of the legal profession. The court structure in the United Kingdom would have to be in this category. Usually male dominated and many would say still with significant issues around equity and diversity.

The friends gathered practiced in a number of areas of law but very much in areas of social welfare and family law. Not for us the frantic commercial scrambles of mergers and acquisitions or the queasiness of criminal law.

"Rather than passing judgment on the past we have been trying to rebuild shattered lives for the future. We are bound to pick up a concern for the vulnerable and defenceless."

We were looking at what brought us together and my friend quoted Baroness Hale of Richmond – 'rather than passing judgment on the past we have been trying to rebuild shattered lives for the future. We are bound to pick up a concern for the vulnerale and defenceless.'[1]

We reflected on that. It sounded quite good – not the usual sentiment expressed about lawyers by others.

So how do you become a Baroness? One way is to be appointed the first female Lord of Appeal in Ordinary in 2004 and be created as a life peer under the Appellate Jurisdiction Act 1876. The United Kingdom does have its own unique way with titles, pomp and ceremony. Of course the Baroness did not stop there as she is now Deputy President of the Supreme Court of the United Kingdom to succeed Lord Hope of Craighead. She is the most senior female judge in UK history. An outstanding legal brain, academic and judge as well as a mother and grandmother.

And her work is so important because it is how she has not openly championed career options and possibilities and broken the glass ceiling in legal areas, but how her findings in family law have been so powerful.

Her views on family law are influencing generations. She views the legal system in areas of domestic violence, child abduction, complex parenting disputes and child abuse as tending to be oppressive of women. She emphasises the importance of 'real choice' in the roles that are undertaken by families in looking after the young, the elderly and the infirm. She continues to stress that undertaking the caring role and this is usually women are now increasingly recognised as vulnerable if relationships disintegrate. Individuals should not be made to suffer from the choices they make if circumstances change. It is vital to protect the vulnerable and particularly the children – those with almost no choice.

They are all important issues. And they take place in an environment where traditional work and home roles are being questioned, and perhaps becoming more fluid. What this means, when traditional "mum" and "dad" roles can become intertwined, and when work is more flexible but also more demanding, adds to the complexity and interest.

Even amongst lawyers, Brenda Hale is acknowledged as having brought enormous change to make the law much more child-centred.

The family lawyers nodded their heads. Yes choice. There are many. Many difficult, many hard. To the Baroness.

Legal material contributed by Daniel Kaufman, Senior Associate in Family and Relationships Law, Lander & Rogers.

References: 1.A Conversation with Baroness Hale. Feminist Legal Studies (2008) 16: 237-248 DOI 10.1007/s10691-008-9090-5

PREPARATION FOR PRACTICE

Let RACS workshops help you make the transition to consultant

PECKY DE SILVA
Younger Fellows Committee

CHRISTINE LAI
Younger Fellows Committee

During surgical training the main focus is to get through your years of training and pass your Fellowship exam. The sense of relief, once you know that you have passed, is suddenly replaced for many by anxiety about what the future will bring.

It is the following few months to years after you gain your Fellowship, that can be fraught with difficulty for the underprepared surgeon. You suddenly find yourself having to start in consultant practice and for many this involves setting up in private practice. The decisions you make early on can impact on you down the track if you start off on the wrong foot. There are a number of surgeons who have regretted early decisions, which have led to major financial costs.

As a young surgeon you have to make decisions about whether you set up as a sole trader or a company, which medical software you will use, whether you should have a website (or more to the point these days, which website company should you use) as well as a myriad of other questions.

For many Trainees who have only ever experienced the public hospital setting, there is a lot of information that has to be learned about billing Medicare and the private insurance companies.

Words such as no-gap, known-gap, AMA rates suddenly take on a new significance when it impacts on earnings. There can be significant anxiety when you go from a known income as a registrar to the relative unknown income in private practice, especially if you are the main breadwinner in your family.

Have a look at the Preparation for Practice checklist:

http://www.surgeons.org/for-health-professionals/register-courses-events/professional-development/preparation-for-practice/

to see all the things that you may have to consider when starting a new practice!

The lack of information about starting in private practice during surgical training was originally identified as part of the Younger Fellows Forum (a leadership forum held each year prior to the ASC where 20 RACS Younger Fellows share ideas, experiences and discuss issues affecting their professional and personal lives). Based on this feedback the Younger Fellows Committee established the "Preparation for Practice" Workshop.

This now well-established workshop is held in Australia and New Zealand to offer Senior Trainees and Younger Fellows from all specialities an opportunity to learn about the essentials for setting up in private practice, practical strategies and tools for practice operations and developing a practice framework.

It is organised by Younger Fellows and the focus of each workshop is on practical advice and the opportunity to learn from the prior experiences of senior colleagues. Last year, the workshops were held in Brisbane, Melbourne, Sydney, Adelaide and Auckland with 105 registrants across five workshops.

This year workshops will be held in:

Melbourne 20-21 August – registrations are now open:
http://www.surgeons.org/about/regions/victoria/

Wellington 24 August –
register interest at college.nz@surgeons.org

Some of the feedback from 2015 included:

"Great. Very useful not only for registrars but also for people in the first few years of practice."

"Well organised, very relevant, encourage more trainees to attend."

"Well done, great workshop"

Brisbane 29-30 October –
register interest at college.qld@surgeons.org

Sydney 12-13 November –
register interest at college.nsw@surgeons.org

Adelaide 2 December –
register interest at college.sa@surgeons.org

While the content of each workshop is aimed for a local audience, Fellows and Trainees from interstate have found them relevant to their practice. The courses are also open to practice managers and have been attended by spouses who plan on running their partner's medical practice in the future. The courses are open to Fellows of all specialities.

Why should you attend?

These workshops are organised by surgeons for surgeons! The main focus of these workshops is to try and make the pathway easier and smoother for those that are entering or have recently entered private practice.

The content has all been chosen to help you make the transition from registrar to consultant and having the responsibility of running your own practice. These workshops give you not only the opportunity to network with your colleagues at the same stage of their careers, but also with senior colleagues.

The programs do evolve from year to year based on participant feedback. This year in Sydney, for example, we will be having talks on many subjects including finance, accounting and Medicare but also on website creation, creating a positive social media presence, which medical software suits your practice as well as many other sessions.

A highlight of the workshops is the panel where four surgeons who have negotiated their paths already, sit down and give honest advice and can answer questions that the participants may have. During panel discussions there is an emphasis on learning from the previous experience of senior colleagues to try and avoid the same mistakes that they may have made!

I encourage all senior Trainees or Younger Fellows to attend these workshops – you will definitely gain a better understanding about setting up private practice. They are organised by surgeons who know the pitfalls they faced and want to give you the opportunity to avoid the same.

John Buckingham Travelling Fellowship Scholarship

Tarik Sammour attended the American College of Surgeons Clinical Congress in Chicago from 4 to 8 October 2015

TARIK SAMMOUR
FRACS

I would like to thank the RACS Board of Surgical Research for selecting me to be the recipient of the John Buckingham Travelling Scholarship.

I travelled to the American College of Surgeons (ACS) Clinical Congress in Chicago from 4 to 8 October 2015, and at the time I was well into my second year of Colorectal Surgical Society of Australia and New Zealand (CSSANZ) colorectal fellowship.

The main goal of my travel itinerary was to meet with my future colleagues at the MD Anderson Cancer Center where I was planning to do a third fellowship year. Several of the faculty were chairing sessions in colorectal surgery and presenting research papers, and this was an excellent opportunity to meet them and learn more about their clinical and academic interests.

The congress itself was a great learning experience. I attended didactic lectures and several research presentations delivered by a variety of experts in their fields. I also caught up with the latest advances in the management of complex colorectal conditions.

On a more social note, I had a great experience in Chicago – a city I had not had the pleasure of visiting previously, and was able to attend a couple of the excellent social events organised by the ACS.

RACS Visitor Program

Annual Scientific Meeting 6 – 8 August 2016

ANTHONY FREEMAN
Scientific Convenor

The ANZSVS is delighted to welcome Dr Andrew Holden to its 2016 ASM.

Dr Andrew Holden is Director of Interventional Radiology at Auckland City Hospital and Associate Professor of Radiology at the University of Auckland. He is also lead Radiologist for the Auckland Hospital organ transplant programme and Co-Director of the Auckland Endovascular Service. Dr Holden is a committee member of IRSA (Interventional Society of Australasia) and ARGANZ (Abdominal Radiology Society of Australia and New Zealand) and is an examiner for the RANZCR. He holds the EBIR (European Board of Interventional Radiology) Diploma.

After training in Radiology in the Auckland Radiology Training Programme, Dr Holden gained fellowship experience in Interventional Radiology and Body Imaging at Royal Perth Hospital, Perth and King's Hospital London.

Dr Holden is the author of more than 60 articles in peer reviewed journals and the author of three book chapters. His interests include advanced endovascular aneurysm repair techniques, renal and carotid artery intervention, intervention in critical limb ischaemia and advanced liver imaging. Dr Holden is currently Principal Investigator in 20 trials including many "first in man" interventional radiology device trials.

Dr Holden will deliver presentations at the upcoming ANZSVS 2016 Conference on drug-eluting technologies and advantage of endovascular aortic sealing. He will also participate in panel discussions in scientific sessions.

The ANZSVS thanks RACS for its generous support of Dr Holden through the RACS Visitor Program.

ASC 2016 - LOOKING TO THE FUTURE

Looking forward to seeing you again in Adelaide in 2017

TOM ARTHUR
Trainees Section Convenor, ASC 2016

The 2016 Annual Scientific Congress proved to be an exceptional four days of May in the capital of Queensland. On behalf of the Royal Australasian College of Surgeons Trainees Association (RACSTA), I would like to thank Associate Professor Richard Lewandowski and Professor Owen Ung, the ASC Convenor and ASC Scientific Convenor respectively, for overseeing the broad and varied programme which proved inspirational and motivational to the Trainees in attendance.

The theme of the conference was "Surgery, Technology and Communication", a theme that allowed us to look in to what the future holds for our profession. This encompassed not only an exploration of the technological advances that may come in surgical practice, but also a broader exploration of what the culture of our profession will be in the years to come.

From a technology standpoint, the future is exciting. As pointed out in the opening plenary by Josh Guest, tech entrepreneur and founder of b2cloud, modified reality and wearable technology is going to transform healthcare in the coming years. Surgeons are going to be vested with an overwhelming amount of data collected by their patients utilising technology to monitor their own health. The training of the next generation of surgeons will also be supplemented by the use of these technologies. Dr Hugh MacGregor, in an excellent talk on mentoring and collaboration with technology, showed that wearable technology and modified reality in the operating room bestows great promise in the teaching and assessment of surgical Trainees.

New technology is not just enabling surgeons to operate on patients in more clever ways, or to train Trainees with intelligent gadgets. Technological advancement is enabling surgeons to collaborate in ways that were previously unfeasible. Several of our UK visitors spoke of the concept of research collaboratives, both at the trainee and broader levels. The Trainees were indebted to hear from Professor Dion Morton, who pioneered the concept of trainee led research collaboratives in the UK, a model of research which has proved transformative in how Trainees engage in research. Utilising mass collaboration over social networks, UK trainee-led research collaboratives have shown an ability to crowd-source research capital across national and international boundaries. The trainee led research model is going to take a significant role in the research landscape throughout Australia in the near future.

The future culture of our profession drew significant attention at this year's ASC. As part of the trainee's section we had Mr Kevin Cocks, Commissioner of the Anti-Discrimination Council of Queensland, deliver an excellent treatise on discrimination and what effect it has on our society. This is not an issue isolated to the surgical field, nor is it isolated to our part of the world, as was noted by our international guest Rachel Kelz in her talk on discrimination in surgery in the United States. The "Let's Operate with Respect" campaign, which was launched during the ASC, will hopefully serve to reduce levels of discrimination, bullying and sexual harassment within our profession. With the principles of this campaign implemented we can provide a leading example to the rest of the community in the coming years.

Congratulations to the Fellows who convocated in Brisbane. Congratulations as well to the Trainees who presented their research at the Congress and special mention to those who were awarded prizes for their contributions. Thank you for devoting your time to the ASC 2016, looking forward to seeing you again in Adelaide from May 8-12, 2017.

Joint ANZBCTG/COSA Annual Scientific Meeting

Registration is open for the Australia and New Zealand Breast Cancer Trials Group's (ANZBCTG) joint Annual Scientific Meeting (ASM) with the Clinical Oncology Society of Australia (COSA) from 15-17 November 2016

The joint conference will be held at the Gold Coast Convention and Exhibition Centre and is an opportunity for members of both organisations to share knowledge in the field of breast cancer research and to develop these important relationships between research and medical professionals.

The program will include three days of presentations and international speakers include:

- Dr Laura Esserman, Professor of Surgery and Radiology at the University of California, San Francisco (UCSF), and the Director of the UCSF Carol Franc Buck Breast Care Centre
- Dr Deborah Fenlon, Associate Professor in the Faculty of Health Science, University of Southhampton, UK
- Dr Shom Goel, Physician-Scientist at the Dana-Faber Cancer Institute and Harvard Medical School in Boston USA
- Dr Jay R Harris, Dana-Farber Cancer Institute USA
- Dr Melinda Irwin, Professor of Epidemiology in the Yale School of Public Health, Deputy Director of Public Health for the Yale Center for Clinical Investigation USA.

The conference website and registration pages are available at www.cosa2016.org.

The ANZBCTG is pleased to offer the John Collins Fellow Medal & Travel Grant to one Australian & New Zealand Surgical Trainee or recent Fellow who wishes to enhance their knowledge of clinical research, in particular breast cancer clinical trials research.

The recipient of the grant receives one full single registration (including all social functions) to attend the 2016 ASM. The grant includes one return economy class airfare and accommodation for the duration of the ASM. The awardee will be presented with the John Collins medal during the conference.

An online application form is available on the ANZBCTG website and applications close on the 11 July 2016.

For information about the award or the ASM, please contact the ASM Secretariat at asm@anzbctg.org or call +61 2 4925 5255.

Head and Neck Meeting in Auckland

Australian and New Zealand Head & Neck Cancer Society (ANZHNCS) Annual Scientific Meeting 2016 to combine with the International Federation of Head and Neck Oncologic Societies (IFHNOS) World Tour in Auckland

JOHN CHAPLIN
FRACS

More than 200 head and neck specialists are expected to attend the Australian and New Zealand Head & Neck Cancer Society (ANZHNCS) Annual Scientific Meeting and the International Federation of Head and Neck Oncologic Societies (IFHNOS) 2016 World Tour. The meeting will be held from Tuesday 25 October to Thursday 27 October 2016 at The Langham Auckland, Auckland, New Zealand.

Current Concepts in Head & Neck Surgery and Oncology is this year's theme. The program includes sessions focusing on cutaneous malignancy and melanoma, thyroid cancer, salivary tumours, operative techniques in head and neck surgery, oral cancer, larynx preservation, multidisciplinary therapy, reconstructive surgery, oropharyngeal tumours and skull base surgery. Dedicated free paper and allied health sessions will also be held.

Ashok Shaha

Register before Monday 12 September to take advantage of early registration rates. Registration details are available on the meeting website.

We appreciate the contribution of all faculty members and would like to acknowledge the following faculty members:

- Dr Bryan McIver, Endocrinologist, US
- Professor Jatin Shah, Head & Neck Surgeon, US
- Professor Ashok Shaha, Head & Neck Surgeon, US
- Professor Carol Bradford, Otolaryngologist, US
- Dr David Brizel, Radiation Oncologist, US
- Dr Claudio Cernea, Head & Neck Surgeon, Brazil
- Professor Robert Ferris, Otolaryngologist, US
- Dr Lisa Licitra, Medical Oncologist, Italy.

In 2012, a combined IFHNOS meeting occurred at the Brisbane Convention & Exhibition Centre boasting a strong program with almost 300 delegates attending. We look forward to another successful meeting with IFHNOS.

To view this year's provisional program or to register, visit the meeting website www.ifhnosauckland2016.org.

For further information, email: *anzhncs.asm@surgeons.org* or phone *+61 3 9249 1260.*

NEW TECHNIQUE FOR NEUROSURGERY

Sydney neurosurgeon Dr Timothy Steel hopes to give neurosurgeons a better understanding of the nature of brain lesions

Sydney neurosurgeon Dr Timothy Steel is working with radiologists at St Vincent's Hospital in Sydney to validate and standardise the results of new MRI technology that gives neurosurgeons a better understanding of the nature of brain lesions without the need for an open biopsy.

The new scanning technique called Dynamic Susceptibility Contrast Imaging (DSC) uses a technique called peak height and percentage signal recovery (PSR) to measure the effect of intravenous contrast material as it travels through the blood vessels of the lesion. This can allow neurosurgeons to differentiate between tumours such as gliomas, lymphomas or metastatic tumours.

Although still experimental, the technique has now been used on more than 70 patients at St Vincent's and Prince of Wales Hospitals which has allowed the research team led by Dr Steel to formulate and standardise the signal responses to the various lesions.

"As the contrast moves through the lesion, the moving blood causes the MRI scan signal to drop out for some seconds," Dr Steel said.

"The signal then returns back to baseline. It is the speed of that percentage signal recovery that can give us information about the type of blood vessels contained in the lesion. It is the characteristics of these blood vessels that tell us what type of lesion is present.

"We have accumulated sufficient data to show that certain tumours give a reliable common result i.e. a high grade lesion or glioma tends to give a PSR of around 60, radiation necrosis, which is often confused with high grade tumour has a PSR of around 85.

"Metastatic tumours tend to have a PSR of around 30 and lymphomas, which are usually packed full of cells, have a high PSR of around 95 per cent. The higher PSR indicates the blood vessels are not very leaky, hence the contrast material does not diffuse into the extracellular space.

"This is of considerable interest in neurosurgery because many lesions look similar when using standard MRI imaging techniques."

"This is of considerable interest in neurosurgery because many lesions look similar when using standard MRI imaging techniques. It is often impossible to know whether contrast enhancing lesions represent a high grade tumour, an abscess, a lymphoma or a metastasis."

Dr Steel said that while lesions such as cerebral abscess and lymphoma can be treated with needle aspiration/biopsy, metastatic tumours and high grade gliomas required open surgery with a full resection.

"The Holy Grail in the management of enhancing cerebral lesions is to have an imaging technique that gives a definitive diagnosis before we can go in so that we can develop an individualised detailed surgical plan," he said.

"This technology brings us one step closer to achieving this."

Dr Steel, the head of department of neurosurgery at St Vincent's Hospital, is conducting his research alongside radiologist Dr Joga Chaganti and with the assistance of master of medicine research student Miss Ananya Chakravorty.

The initial results of the new MRI technology were presented to the Neurosurgical Association of Australasia (NSA) in 2013. The latest results were presented at the most recent NSA conference in New Zealand as a poster in October 2015.

Dr Steel said that while PSR measurements have demonstrated great reliability, it was too early to state that standardisation of the results was possible.

"Unfortunately, the quality of the PSR is dependent on multiple factors including the setup of the individual MRI machine and on the skill set of the radiologist performing the measurements," he said.

"In some lesions, if the wrong area of the tumour is scanned or incorrect parameters are set, the results can be unreliable and are not standardised so at this stage we are only using it as an adjunct diagnostic tool and are not able to fully rely on it.

"It is time consuming and labour intensive to calibrate the MRI machines for each new patient so before this technique is widely used, I would imagine each major neurocentre would have to determine the benefits of the increased time and cost of using the new technology versus the individual caseload of the department."

Dr Steel is no stranger to pioneering advances in neurosurgery. He was the first surgeon in Australia to perform percutaneous fusion surgery using image fusion stereotaxy, he was the first to perform spinal cord stimulation of patients with severe chest pain due to angina and the first surgeon in Australia to perform bilateral nerve decompression procedures using a minimally invasive approach.

He has now conducted more than 2000 brain surgeries, 7000 minimally invasive spinal procedures and 2000 complex spine surgeries. He is also a senior lecturer at the UNSW and trains local and international surgeons and trainees through his Spine Surgery Fellowship program.

Dr Steel said that while the new MRI imaging technique could be of use in other specialities, it had specific value for neurosurgeons.

"It is only really in the brain where we see lesions that are difficult to differentiate and as the lesions are encased in the skull, there are no easy biopsy approaches," he said.

"This technology helps us more accurately assess the nature of the lesions meaning that we can conduct smaller less invasive procedures. This lowers the risk of complications and reduces the trauma to the patient.

"It also means if we can accurately diagnose a metastatic tumour, we may choose to offer patients palliative care rather than putting them through more suffering for limited benefit."

Dr Steel said he believed the development and take-up of the new MRI diagnostic technology would be driven and further refined by radiologists rather than surgeons.

"It is an exciting time for diagnostic radiology with astounding developments made in the field even in the past 10 years," he said.

"The image resolution of MRI scans is now incredibly good and there are likely to be ever more diagnostic sequences designed to define and measure biological material developed in the coming years. It is fair to say that we have never been able to look inside the human body and see as clearly as we can do now in the history of medicine.

"I imagine within the next 10-20 years, we will be able to simply flick a switch on an imaging machine, get reliable diagnostic data within minutes so that we can, if necessary, operate within hours."

With Karen Murphy

MULTIMEDIA RESOURCES

The Library E-Collection

RICHARD PERRY
Chair, Fellowship & Standards

Fellows, Trainees and IMGs have ready access to a wide range of multimedia materials to which the Library subscribes. Whilst the content in e-journals and e-books is a highly used part on the online resources provided by the College Library, video, images and podcasts are not as well utilised by RACS members. Links to most of these can be found on the Multimedia page (http://www.surgeons.org/my-page/racs-knowledge/library/multimedia/) after login to the RACS website and clicking on the link to go to the Library pages.

Two key anatomy resources are An@tomedia and Acland's Video Atlas of Human Anatomy. An@tomedia is a comprehensive, self-paced learning program that explores anatomy from four different perspectives. These perspectives teach you how the body is constructed (from regions and systems) and how you can deconstruct the body (with dissection and imaging techniques). Acland's Video Atlas is a quick way to renew anatomical knowledge, and also a way to help patients understand an ailment, injury, or procedure. A complete list of the URLs for all the videos in Acland's is also available and can facilitate direct access to required body regions.

Two other great sources for video content are Access Surgery and Access Medicine. Along with an extensive collection of procedural videos, Access Surgery has recently added Anatomic Exposures in Trauma which consists of twenty 6-8 minute videos on the most critical dissections in Trauma Surgery. These videos were done on fresh cadavers by the world renowned trauma surgeon Demetrios Demetriades at the University of Southern California. Like Acland's, Access Surgery and Access Medicine both have downloadable lists of durable links to their videos.

A further source of extensive multimedia content is ClinicalKey which boasts links to over 2.5 million images and over 20,000 videos. Search just images, just videos or both, within a variety of specialties (use the "Filter By" tabs).

Register/login to Clinical Key and you can add images straight into your presentation, complete with correct citation information. More detail about the Presentation Maker is available on the website or by contacting Library staff.

More specific multimedia content is found in Neurosurgery Podcasts, the Neurosurgery Video Gallery and the Journal of Neurosurgery's, Videos, Podcasts and "In Practice" (Videocasts).

For Orthopaedic Surgery, JBJS Essential Surgical Techniques features videos of procedures for online viewing. Both the Journal of Endourology Part B Videourology and Videoendocrinology provide similar content in their fields.

Plastic Surgery is covered with audio and video podcasts from the Plastic and Reconstructive Surgery journal's site.

The Journal of Laparoendoscopic and Advanced Surgical Techniques, Part B, Videoscopy is the online complement to the text journal and offers high-calibre video demonstrations of peer-reviewed, cutting-edge surgical techniques and technologies designed to enable viewing and evaluation of new surgical and microinvasive techniques.

The Multimedia page provides further links to the Lancet Multimedia Library, MJA (Medical Journal of Australia) multimedia and NEJM (New England Journal of Medicine) multimedia.

Of interest to General Surgeons are the Audio Digest Foundation's podcasts which provide audio presentations on a variety of General Surgery topics or the downloading of written summaries. The mp3 files can be downloaded for later listening or there is an Audio Digest app for either Apple or Android devices.

For further information on any of the above resources, please contact RACS Library staff on:
+61 3 9249 1271 or college.library@surgeons.org.

Multimedia

Access Surgery Videos

ClinicalKey

Audio Digest

ANATOMY EDUCATION IN AUSTRALIAN MEDICAL SCHOOLS

The Academy of Surgical Educators would like to congratulate Dr John Farey, Dr David Bui and Dr David Townsend for taking out this year's Surgical Education Research Prize at the RACS Annual Scientific Congress. The following article is based on their presentation

JOHN FAREY
Award Recipient

DAVID BUI
Award Recipient

DAVID TOWNSEND
Award Recipient

There is barely a medical student, junior doctor or registrar in Australia today who hasn't been told, at one point or another that their anatomy knowledge isn't up to scratch. We entered medical school in an era where, by historical standards, the amount of time dedicated to anatomy has been significantly reduced compared to previous generations.

For most students, long gone are the halcyon days of anatomy: dissecting rooms, surgical registrars as demonstrators and vivas under inquisition of career clinical anatomists. These traditional teaching methods, according to medical education experts, failed to promote a deep understanding of the subject, and were only of value to those pursuing a surgical career.

With the modernisation of medical curricula over the past two decades, the teaching of anatomy has become integrated within problem-based learning cases to emphasise only the most 'clinically relevant' aspects. Unfortunately this has meant that anatomy is now taught piecemeal by body system according to a limited series of clinical cases, and many medical students are left without a coherent understanding of a region before moving on to another.

In 2007, as part of the Australian Medical Education Study, less than 50 per cent of medical students felt they were adequately prepared in anatomy prior to graduation. Additionally, they ranked it as the top subject area in which they felt unprepared for specialty training.

Our research, sought to answer two questions: firstly whether contemporary medical students value modern over traditional teaching methods, and secondly whether exposure to dissection (as the archetypal traditional method) predicts satisfaction with anatomy knowledge and confidence to apply it.

What inspired the research?

In 2013, the three of us met as Australian Medical Students' Association (AMSA) representatives. Speaking to delegates from other medical schools, we recognised that anatomy teaching was a national issue.

Among their chief complaints were insufficient time dedicated to anatomy teaching, lack of access to cadaveric teaching material, over-reliance on self-directed learning, and anatomy being under-represented in assessment. Many felt that their knowledge was far less than what a graduating doctor should know.

When researching the topic, we came across Craig et al's 2010 review of anatomy teaching in Australian and New Zealand medical schools. The amount of variation was astounding; some schools received 506 hours dedicated to teaching and assessment, others a paltry 56 hours. We were also struck by the lack of evidence evaluating modern anatomy curricula delivery methods, especially comparing learning outcomes to traditional teaching methods.

Later that year, AMSA Council voted in favour of a policy we presented calling for national standards in anatomy teaching and assessment amongst Australian medical schools, subsequently published in the ANZ Journal of Surgery. We were inspired by the response to take it further, and we thought that a well-designed, cross-sectional national survey of medical students would suit our purposes.

Designing the survey

We developed a 19-item questionnaire according to the best practice guidelines set out by Artino et al (2014) in Medical Education. We were intent on using cloud-based and social media technologies to not only collaborate to prepare the survey, but disseminate it too.

The three of us were separated by distance and institutional divides, but we met regularly using Skype, and wrote our documents using internet-based real-time editing software, such GoogleDocuments. This allowed us to formulate our ideas and protocols as if we were in the same room.

We were surprised with how little had been written on the use of social media as a survey distribution method for medical professionals. Our background research indicated that more than 99 per cent of Australian medical students used Facebook regularly, so this was the ideal platform to share the survey.

Through use of the AMSA Facebook and various Medical Student Society pages, we were confident that we could promote the survey to a large audience of medical students, and achieve a nationally representative sample.

Snapshot of results

We received 1,101 complete responses. Our sample was comparable in proportions to the Australian government's own Medical Training Review Panel (MTRP) data, so we were confident that it was broadly representative of the Australian medical student population.

Demographically, students who were most satisfied and confident in their anatomy knowledge were male, in a shorter course, in the preclinical years, and had formal anatomy teaching prior to medical school.

We asked students to tell us what methods they had been exposed to during medical school, and then to rate how useful they found those methods for 'enhancing their understanding of the human body'. The results were surprising.

Dissection, small group teaching, prosection, tutorials and teaching during surgery came out on top as the most useful teaching methods, as voted by medical students. Modern teaching methods, such as those made possible by the digital revolution, were less likely to be rated as useful, despite being hailed by others as offering an efficient, cheap and cadaver-free method of learning anatomy.

Perhaps worryingly, the dominant ideology in Australian medical education in the past 20 years – problem-based learning – was rated as the least useful method of learning anatomy. For all students, we found that exposure to dissection increased mean levels of satisfaction with quality of anatomy course, and confidence to have the appropriate knowledge of anatomy for internship.

Where to from here?

The teaching of anatomy is an emotive subject, as we found when researching and designing our survey. Proponents of the new school of anatomy teaching often accuse surgeons and clinical anatomists of having rose-tinted glasses for the past. The reality is that the methods most valued by the main stakeholders in medical education – medical students – are currently underutilised.

We believe it is likely that an appropriate blend of both traditional and modern teaching methods will satisfy students' as to their current knowledge, and give them the confidence to apply it in future training and clinical practice.

"Anatomy is now taught piecemeal by body system according to a limited series of clinical cases, and many medical students are left without a coherent understanding of a region before moving on to another."

John Farey is an intern at Royal Prince Alfred Hospital. He plans to undertake a PhD during surgical training, and was the AMSA representative for the University of Notre Dame Australia, School of Medicine, Sydney in 2013.

David Bui is an intern at Royal North Shore Hospital and is passionate about Orthopaedics, Sports Medicine and Medical Education. He was the AMSA representative for the University of New South Wales in 2013.

David Townsend is an intern at The Maitland Hospital and is a board director of General Practice Registrars Australia. He is passionate about primary care and mental health and was the National Chair of the General Practice Students Network in 2013.

PROFESSIONAL
DEVELOPMENT

Opus XL

SOS - IT RANSOMWARE

A tale of technical woe

FELIX BEHAN
Victorian Fellow

The original SOS began as a radio signal in April 1905 when adopted by the German government and remained a maritime radio distress signal until 1999 when it was replaced by Global Maritime Distress and Safety System. SOS is still recognised as a visual distress signal even in the snowfields where it is still legible from an aircraft. It can even be read upside down!

In international morse code (three dits for an S – three das for an O) it is an easily remembered signal. In the popular vernacular it became associated with such phrasing Save our Ships or Save our Souls. I would like to extrapolate this a bit further to – Save our Systems. And here is why!

I have been the victim of the latest data annihilation called Ransomware.

What is Ransomware?

It is a malignant installation of computer software that infects the computer in some way that the owner/user must pay a ransom to retrieve data. It encrypts files on the system's hard drive with an encryption key that locks the system to facilitate a ransom payment in bitcoin (untraceable) so you can retrieve the data (if you're lucky).

My recent IT catastrophe should serve as a warning to all and sundry including hospital administrators about what can happen when CryptXXX2.06 hits the 'airwaves'. My monitor froze and a benign message appeared on a black background detailing the bitcoin payment process. It is interesting how the communication almost appeared friendly and inviting so if you followed the process all would be well. An urgent

"At the time I was in the middle of editing/correcting my medico-legal reports for the week. Then everything suddenly froze becoming irretrievable."

SOS went out to the technical company that does my IT backup and they warned me of its lethal potential.

At the time I was in the middle of editing/correcting my medico-legal reports for the week. Then everything suddenly froze becoming irretrievable.

The data on my computer amounted to 250 gigabytes, which had been amassed over the past 15 years. The medico-legal reports during this period would be in the thousands and the individual records of reconstructive cases including development images of the Keystone Principle were all now consigned to the Never Never. These documented digital images were my observational and scientific basis for publication at the evidence-based level – and were apparently unfindable.

Fortunately I had been advised some time ago to have an external back-up that I placed in a bank deposit box, valid only up until 2012, losing four out of 16 years of data. I became aware of the usefulness of back-up when my son Laurent told the story of the Twin Towers in New York on the events of 9/11. All stock exchange activity on Wall Street was potentially at risk and urgent back-ups became mandatory. How effective this was, one will never know.

My IT guru, Adam, explained that virus Cryptxxx2.06 is one of the most lethal in existence. The offer of retrieval was available if I paid a ransom in excess of $700 but there was no guarantee that the data would be returned once this demand was paid. Hence the origin of the word Ransomware!

During our conversation that morning Adam retrieved an article in World IT about the Hollywood Presbyterian Medical Centre in Los Angeles's 434 beds. This hospital was a victim of the same virus in February 2016 and the hijackers are reputed to have asked for US$3.4M to retrieve the data. One can only repeat I am obviously only a small fish in a big pond! The accuracy of that million dollar demand has been disputed but the payment was to be made in bitcoin even before the police were contacted.

The trick to falsifying the information is via email (though not through the obvious Australia Post, ATO or the Local City Council, banks etc, which usually rings a bell). The use of the person's name is possibly linked via Facebook from where they can glean a potential victim's place of employment and its internal circuitry – and the cat's out of the bag!

The solution? Get a reputable IT company to arrange a firewall – a systems back-up – which can be linked to all the business computers and their emails. Then have an external back-up in safe deposit box.

Finally I would say this is a sign of things to come as these 'rogues' are untraceable and are making millions.

Apparently the hacking of the Hollywood Presbyterian Medical Centre has forced doctors to revert to pen and ink inscriptions as the basis for clinical notes as they did in the past.

To date the encryptions are so detailed and accurate that reversal software does not yet exist for this Cryptxxx2.06. Victims of these cyber assaults, according to the FBI, have paid up to US$18M in the 12 months to June 2015.

One shudders to think of the universal application of this virus to all aspects of human existence and let us not forget that computer driven cars will soon be on the market!

Letter to the Editor

A response to the January/February edition of Surgical News

Dear Sir,

I read with interest in the January/February 2016 edition of Surgical News critical perspectives written by Brian Parker and Douglas Handley directed at Professor David Watters, the then current President and Professor Kingsley Faulkner, a former President of the RACS about climate change.

Mr Parker says it is 'unbelievable' that the President of the RACS uses editorial privilege to enunciate his ideas on global warming and tritely concludes with a reference to the absence of solar panels on the College. Let me observe that the ongoing repetition of climate change concerns in the Press (from C02 levels, to the hottest March 2016 on record and the extreme state of coral bleaching in the Barrier Reef) is a reflection of how the majority views these facts or can I say the naysayers do not believe the science? Let us not ever forget that the philosophical basis enunciated by Bacon in the 17th century is that observation is the essence of scientific advancement. Even Aristotle said you can only appreciate black when you have seen white!

David Watters responded politely and I could not help thinking his words reflected David Suzuki's concern about climate change when in an interview with Margaret Throsby recently said 'what legacy are we leaving our grandchildren'?

Handley quite rightly reverts to the evidence-based edict as part of our surgical educational development. Yet comments about rising C02 levels and their resurgent significance apparently feature in publications leading some to embrace an alternative view about these concepts.

I meet Peter Doherty regularly in Royal Parade – he going for his coffee, I heading for the newsagent. He recently gave me a copy of his book 'Knowledge Wars' in which he addresses the issues of scientific sceptics and their intransient attitude towards scientific publications and their meaningful interpretation.

Perhaps his book should be mandatory reading for all in these controversial times – it is a fountain of knowledge, erudite and has the touch of the master when dealing with aspects of scientific evaluation from both positive and negative points of view. Need I say more after all he is a Nobel Laureate? His academic career has been based on scientific evaluation.

One has only to review the scientific controversy created by the Wakefield publication on the link between Autism and MMR in Lancet in 1998 which had to be retracted in 2010. Twelve years of evidence-based medicine, published by one of the most prestigious journals in the world, has had egregious consequences and the fires are still smouldering. This controversy recently metamorphosed into a Hollywood Movie - Vaxxed: from cover-up to catastrophe - directed and co-written by the one and only Andrew Wakefield no less (as quoted by Linda Morris, The Age 28/3/16). Wakefield was subsequently struck-off the British Medical Register. Incidentally the British National Health Service has consistently found no causal link between MMR and autism. The editorial process is not always full(fool)proof.

One can only conjecture how many scientific articles worldwide under the guise of research grants from the oil corporations aimed merely at placating their position on CO2 emissions, some even say there is a touch of arrière pensée. Even the Rockefellow Foundation (whose wealth was based on oil) is now divorcing itself from any financial link where carbon pollution could be implicated.

Without the scientific wit of some of my contemporaries and lacking the ability to critically survey articles on climate change I still revert to Bacon's edict about observational findings. Or as Aldous Huxley said "facts do not cease to exist because they are ignored" or more simply phrased by John Cleese (in Fawlty Towers) – it's bleeding obvious!

I had to look up the 'Dunning-Kruger' Effect (Handley's letter) it means the inability of the unskilled to recognise their ineptitude. Being possibly of this classification I can only respond with my favourite quote about statistics. The late Carl Sagan, Astrophysicist, said during his Harvard days 'the absence of evidence is not the evidence of absence'.

A/Prof Felix C. Behan

April 2016

RACS supporting Surgical Teachers

ACADEMY OF SURGICAL EDUCATORS
Royal Australasian College of Surgeons

The Academy of Surgical Educators is an active community of practice to support, enhance and recognise surgical educators within the College. Since its inception, it has evolved to include over 650 members from Australia, New Zealand and internationally.

The Academy also recognises all serving Supervisors and Professional Development facilitators, with the annual Academy Recognition and Reward program. It offers a range of educational activities, resources and recognition to its members in order to support them in their role as a surgical educator.

The Academy is supported by an interactive online learning community where members can gather ideas, share interests and research, find resources and keep abreast of upcoming events. The environment is supportive, collaborative and fosters enthusiasm in surgical education.

UPCOMING ACADEMY EVENTS NOT TO BE MISSED!

Foundation Skills for Surgical Educators - Thursday 25 August 2016 - Crowne Plaza, Adelaide 9.00am – 4.00pm

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

Academy Forum – Thursday 25 August 2016 - Crowne Plaza, Adelaide 6.00pm – 9.30pm

"Changes in Health Education 2016 and Beyond "

For further details and registration on any ASE event please contact ase@surgeons.org

MEMBERSHIP

The Academy is open to all Fellows and Trainees and external medical educators who have strong educational interests and expertise. For more information on getting involved in Academy activities or how to become a member please contact Grace Chan on: *+61 3 9249 1111 or ase@surgeons.org*

ASE Event

CONGRATULATIONS ON YOUR ACHIEVEMENTS

Orthopaedic Surgeon and Microsurgery pioneer Prof David Vickers AM has received the ESR Hughes Award for Distinguished Contributions to Surgery

One of the College's most prestigious awards – the ESR Hughes Award for Distinguished Contributions to Surgery – was presented to Orthopaedic Surgeon and Microsurgery pioneer Professor David Vickers AM at the Annual Scientific Congress (ASC) held in Brisbane.

Professor Vickers, now retired, gained renown over the course of his career not only for his ground-breaking surgical procedures and anatomical discoveries but also for his design of novel surgical instruments developed to aid surgeons conducting hand and micro surgery.

In particular, he became an international authority on the early surgical treatment of Madelung deformity and his discovery of a ligament in the wrist not previously observed was later named after him to become known as the Vickers ligament.

His other novel techniques included the use of microsurgery and physeal (growth plate) surgery to correct traumatic partial growth plate fusion and to prevent progress of deformity in children with congenital abnormalities including Delta phalanx. He also described a method to separate syndactyly without skin graft.

The author of 14 chapters or contributions in nine medical textbooks, and 14 papers in journals, Professor Vickers' article on Madelung Deformity – titled Surgical Prophylaxis (physiolysis) – was chosen in 1995 by the American Society for Surgery of the Hand as one of the most important 50 papers in congenital surgery in the previous 50 years.

His ergonomic micro surgical instruments, commonly known as the Vickers Universal Microsurgery Set, won the British Design Council Award for Excellence of Design in 1982 and were sold in 30 countries.

Since then, a new set of his instruments for Hand Surgery has been manufactured in Germany and sold worldwide.

In 1994, Professor Vickers was a Guest Professor at the prestigious Mayo Clinic, Department of Hand Surgery. As a result of his presentations he was invited to write two chapters for the Mayo Clinic Textbook "The Wrist".

A former Chair of a number of national and international hand surgery societies and committees, Professor Vickers was made a Member of the Order of Australia (AM) in 2006 for service to medicine in the area of paediatric microsurgery

"I was asked by my boss at the time to look into microsurgery and one of the first things I discovered was that we needed new instruments that would allow us to perform delicate, time-consuming work"

through the development of surgical procedures to treat congenital deformities, to the design of specialised operating instruments and services to professional organisations.

The son of a doctor who became a pioneer of the Royal Flying Doctor Service of Australia, Professor Vickers said adaptation, persistence and lateral thinking had been pivotal aspects of his childhood which had naturally influenced his subsequent professional development.

"My father Dr Allan Vickers was asked by John Flynn to help save the flying doctor service – the first in the world – because it was failing in those early days 85 years ago and he opened several bases in outback Australia and established working protocols," Professor Vickers said.

"He and his pilot would set off with no radio assistance, few maps and in unreliable aircraft and they basically followed the railway lines to get where they were going.

"In the process he taught me that things can be done through planning and courage - no matter the challenge.

"I grew up in Charleville during WWII at a time when we had very little access to consumer goods so if you couldn't make it or fix it, you couldn't have it and that had an indelible effect on me."

Professor Vickers spent the majority of his working life combining his private practice with equal time working in the public health system at the Royal Brisbane Hospital and the Royal Children's Hospital in Brisbane.

He said that while microsurgery was relatively new to Australia in the early 1970s, he found the challenge irresistible.

"I was asked by my boss at the time to look into microsurgery and one of the first things I discovered was that we needed new instruments that would allow us to perform

COLLEGE
AWARDS

David Vickers and David Watters

delicate, time-consuming work," he said.

"I designed those instruments in my own time and with my own funds and once that was done I began to investigate congenital musculoskeletal deformities that could be treated with microsurgical techniques.

"At the time, conducting orthopaedic procedures on babies or even tackling growth plate surgery was avoided as too risky because children were still growing, but I thought if we designed the surgery correctly we could change the lives of our young patients.

"Orthopaedic microsurgery was a very dynamic field to be involved in and I feel fortunate that I had the chance not only to teach myself but to teach others."

Throughout the course of his career, Professor Vickers presented 32 scientific papers at International Congresses and 51 presentations at Australian Conferences all of which described his new surgical techniques or his novel surgical instruments.

The winner for Best Presentation at the Australian Hand Surgery Annual Congress three times, Professor Vickers was frequently invited overseas to lecture and teach and he conducted 18 microsurgery workshop demonstrations both here and abroad.

He said that his greatest professional achievement was introducing an early surgical intervention to treat Madelung deformity, a treatment which had a great impact on the lives of affected children.

"Until then, surgeons often waited until the child had stopped growing which made for much more complex surgery which could not really correct all the damage," Professor Vickers said.

"When I first started researching this as a surgeon, I discovered the ligament responsible for the deformity which had not been identified previously because Madelung had described the condition in the days before x-ray or MRI scans were available.

"That was very exciting and it opened a whole new surgical treatment pathway for the condition.

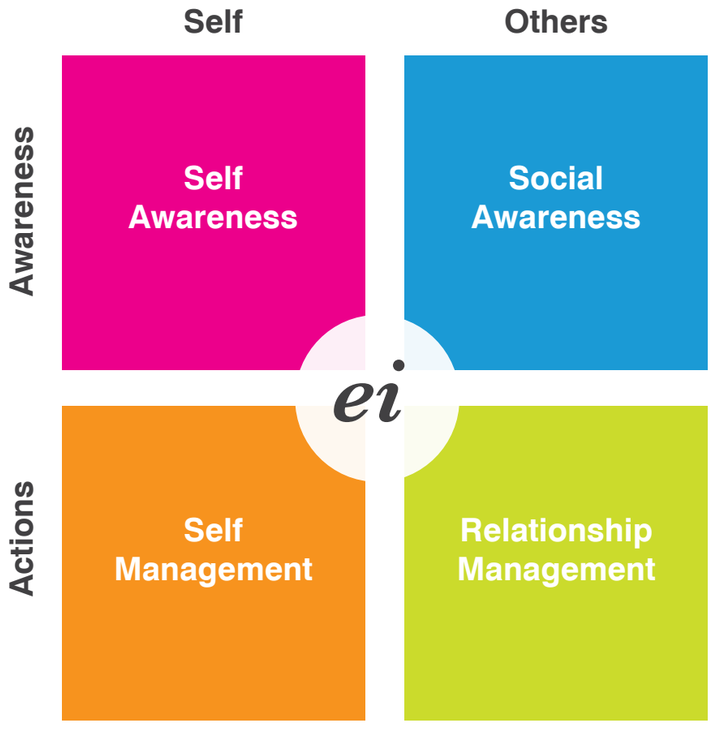
"I feel very privileged to have been working in such a dynamic field at such an early time and I feel enormously honoured to receive the ESR Hughes Award."

Inaugurated in 1998, the ESR Hughes Award was created in recognition of the outstanding contributions made to surgery by Sir Edward Hughes, a world renowned colorectal surgeon.

HIGH CONFLICT EMPLOYEES

The inevitable link between high conflict people, their behaviour and low emotional intelligence

PAUL GRETTON-WATSON
Director Professional Services
Converge International



I haven't yet met a manager or business owner with a bit of work experience under their belt who has not had at least one experience of working with or having to deal with a high conflict employee at some point in what is sure to be a memorable chapter of their work life – and not necessarily for the right reasons.

It is likely the high conflict individual may be described colloquially as "high maintenance", "like a dog with a bone", "utterly exhausting" or some other descriptor pitching this person at the most extreme end of 'challenging' compared to their peers and co-workers.

"As you prepare to read this list, I hazard to guess that you may already have somebody in mind that you suspect might be deemed to be 'high conflict'."

It should come as no surprise then that some of the populist literature refers to them as "emotional vampires". Let's explore what is going on and why they are such hard work.

Over the years, we have conducted formal research into what profile constitutes a high conflict personality, and more importantly, behaviour in the workplace. Through this research bolstered by our experience and learning through the various workplace mediations, team assessments and coaching engagements we have undertaken, we have formed some consistent insights into this particularly challenging employee type. As you prepare to read this list, I hazard to guess that you may already have somebody in mind that you suspect might be deemed to be "high conflict".

Listed here are some of the dimensions and factors that were identified. In addition, we have found a useful model and overlay is to consider high conflict behaviour in relation to emotional intelligence as there would appear to be a high inverse correlation between the two. That is, high conflict: low emotional intelligence (and dare I say, vice versa). These hallmarks and factors have been organised in terms of Daniel Goleman's four dimensions of emotional intelligence shown below as so much of what we experience with high conflict employees tends to reflect one or more dimensions of emotional intelligence that is poorly developed or non-existent.

I have taken the liberty of highlighting in bold some of the key dimensions that we find resonate strongly with clients we support when dealing with high conflict people (see right).

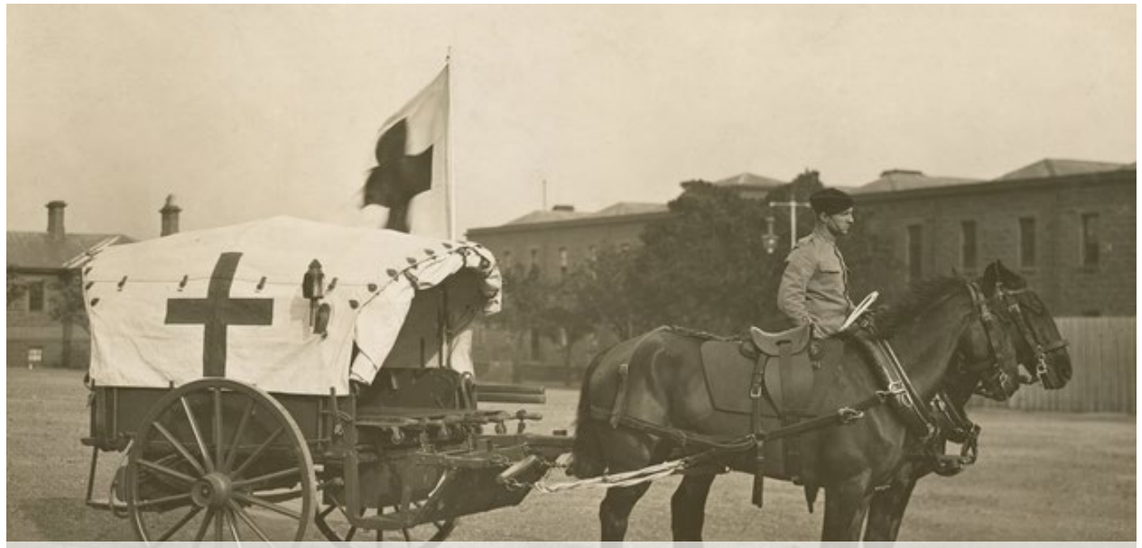
You may have noted on the right that the self management and management of others quadrants tend to be where the full challenge of dealing with high conflict employees is truly experienced.

So, step one is recognising that you might be dealing with a high conflict person in which case your usual "bag of tricks" may not be working, or everything you have tried has made little if any impact. Step two is learning some new approaches, disciplines and skills to improve how you deal with them. Some practical tips will be explored more fully in a follow-up article next quarter. Good luck.

Some of the distinctions in this article have been adapted from Bill Eddy's book, *"It's All Your Fault" – 12 Tips for Managing People Who Blame Others For Everything* (2012)

Self Awareness	Social Awareness
Lack personal insight and is unable to reflect on own behaviour	Lack empathy for others
Self-absorbed - focused on getting their own needs met (irrespective of the impact this might have on others)	Evidence high conflict thinking and reasoning driven by their inner world and deeply held fears
Rules apply to others not to them – they need to be treated specially	See their targets as either 'all good' or 'all bad' with no positive qualities at all – noting all goods can flip to all bads on a whim
May lack remorse for the impact they cause on others	Frequently misinterpret events and other people's intentions

Self Management	Relationship Management
Poor impulse control	Puts others down
Mood swings from charming to vindictive	May manage well upwards – often levels above direct line manager
Will not accept negative feedback and likely to respond in an aggressively defensive manner	Preoccupied with blaming others - it's always someone else's problem or fault
Arguments often lack logic or reason and tend to be argued more emotively	Rigid and uncompromising
More likely to make vexatious or multiple grievances or claims – can sometimes become querulous in their pursuit of a litany of grievances, allegations and complaints.	Preoccupied with blaming specific people (often their manager) who becomes their targets of blame
Avoid responsibility for both the problem or solution	Recruit others (negative advocates) to attack their targets
Find it difficult to accept and heal from loss	Often present as a convincing victim of some one else who, usually, has become their target of blame
Get easily stuck in conflicts over minor or existent events	Feel entitled to things (above others) and demand it now
Develop 'targets of blame' for whom they can become highly emotionally aggressive and blame totally for everything wrong in their life	Manipulate relationships to serve own interests



SURGEONS OF THE BOER WAR

A number of Australian surgeons volunteered for the South African war

Australian lightweight ambulance wagon, AWM HI398

ELIZABETH MILFORD
RACS Archivist

Spanning the years 1899-1902, the second Anglo-Boer War was fought between the British Empire and the Boer territories of Transvaal (South African Republic) and the Orange Free State. The British were supported by troops from Southern Africa and colonies such as Australia, New Zealand, Canada, Newfoundland and India.

The First Boer War (1880-1881) saw the British foiled in an attempt to annex the Transvaal, and the second conflict had similar territorial connotations. Gold had been discovered in Witwatersrand in 1886 resulting in an influx of 'Uitlanders' (foreigners) to the Transvaal.

"Spontaneous colonial participation' best describes Australia's early response to the second Boer War."

President Kruger, alarmed by the numbers of foreigners (many were British) denied them citizenship and signed a military pact with the Orange Free State. Incensed by the threat to their supremacy in South Africa, the British mobilised and, following a stalemate in the Transvaal, war was declared on 12 October, 1899.

'Spontaneous colonial participation' best describes Australia's early response to the second Boer War. Australia was nearing Federation (1st January 1901) but fervour for the 'mother country' was endemic. And the war was also seen as a way for career soldiers to gain practical experience in the field and, generally speaking, the same was true of the medical officers who volunteered for service.

Although its antecedents dated back to the time of Queen Anne, The Royal Army Medical Corps was officially formed in 1898 and during the Boer War, colonial volunteers worked under its auspices. A number of Australian surgeons volunteered for the South African war and significantly, most of them also served in World War 1.

Each of the colonies (soon to become states) organised contingents for the war. Surgeons from NSW included: WDC Williams (later PMO of the Australian and New Zealand forces), Neville Howse, Thomas Fiaschi, Robert Scot Skirving, Alexander MacCormick, and Bernard Newmarch. Of these Neville Howse was the most distinguished and won a Victoria Cross for his actions at Vredefort.

It was here that Howse saw a young Trumpeter writhing in agony from what appeared to be a stomach wound. A consummate horseman, he leapt on the nearest horse and galloped through a 'perfect hail of bullets' to collect his casualty. Although his horse was killed, Howse calmly dressed the Trumpeter's wounds and carried him to safety[1]

Robert Scot Skirving says of WDC Williams: '...God he was a bad surgeon! I know for I was his surgical colleague on the staff at St Vincents...' But Williams proved to be an excellent administrator and innovator, with his medical corps being tougher and better organised than some of his Imperial counterparts. In the 1890s Williams had designed lightweight ambulance wagons – this innovation, along with portable X-ray machines, went with him to South Africa.

Further demonstrating his foresight, his contingent included mounted stretcher bearers who kept up with the units they were supporting. Unlike the British forces, he also organised Field Hospitals and stretcher bearer companies to work together. This strategy was adopted by both the British and Australian Army Medical Corps prior to World War 1.

A fêted veteran of the Abyssinian Campaign of 1896, Thomas Fiaschi was to win a DSO in the Boer War. Williams noted one of his early exploits in his diary:

Young Fiaschi greatly distinguished himself about 16 days ago on patrol near Arundel, when Captain Jackson was mortally wounded. He with another trooper of the Lancers, named McPherson, galloped out under heavy fire and assisted, after applying 'first aid' to bring in dismounted, the unfortunate officer some 400 yards and he died in their arms.[2]

The South African wars were challenging in several ways. Boer forces in both wars were comprised of militias who engaged in guerrilla war. In the second Boer War the militia's weaponry was more sophisticated, with German Mausers (high velocity, small calibre weapons with smokeless cartridges) largely replacing the breech loading Martini-Henry rifles of the earlier conflict. Belt loading machine guns (developed from the primitive Gatling gun used in the American Civil War) were used by both sides. These new weapons changed the type of wounds.

Williams commented on the unusual pattern of wounding and the fact that several wounds could be created by one bullet. And Thomas Fiaschi wrote:

Orange River South Africa 14 January 1900

I saw several cases of Mauser bullet wounds that illustrated to me the fact that a Mauser bullet can go through an elbow or a hip joint without injuring it…Unfortunately, you see also wounds from shells and from Martini-Henry bullets which are of a much more serious character.

Similarly, the intrepid Archibald Watson noted:

The vast majority of wounds were, however caused by modern small, bore bullets. In our men, they were chiefly Mauser and shrapnel bullet wounds…

Armed with references from Sir James Way (the Chancellor of the University of Adelaide) and Baron Hallam Tennyson (the Governor of South Australia), Professor Watson made his way to South Africa and the war. From 1 March 1900, he was a consultant surgeon with the Natal Field Force. When the Natal campaign was finished, Watson sought permission to go to the Transvaal and Orange River colony. He then visited both Pretoria and Cape Town and researched infectious diseases.

Watson was described by Alan Lendon as an 'irresponsible free-lance from Australia'. As he certainly made his own choices, there is some truth in this assertion but his work and advice were highly regarded and his observations always interesting. In an entry in his surgical diaries of 2 April 1900, he observes Frederick Treves' operation on General Woodgate:

…knocked loose by a piece of shell on 24th Jan 1900, Spion Kop. Treves removed in excl' angular process Feb? ? [sic] days later ophthalmists having ensued Treves removed eyeball.

Like previous conflicts of the 19th century, the British forces were severely debilitated by disease, with slightly more than half of the casualties dying of diseases such as typhoid. Surgeons dealt with the sick as well as the wounded. Robert Scot Skirving was asked by Colonel Williams to take charge of an enteric hospital in Blomfontein. Already disillusioned by the war and feeling his surgical skills were not utilised, he reluctantly agreed. As the war dragged on, opinion at home was also noticeably ambivalent about the distant South African war.

Professor Archibald Watson, 1901

The second Boer War was a transitional conflict. Traversing a new century, surgeons needed new strategies to deal with more damaging weapons and a different type of warfare. Much of the knowledge learnt on the veldt was to be used again during World War 1. However, as the Gallipoli campaign demonstrated, the issue of disease continued to be an Achilles heel for the medical services.

References

1. From an account in: Tyquin, M, Neville Howse Australia's First Victoria Cross Winner, Oxford University Press, 1996, p. 21

2. Reference to Williams' diary in Tyquin p.11

PROCEDURES IN PROFILE

Hip Replacement

DAVID WATTERS
Chair, Clinical Variation Working Party

As highlighted recently in Surgical News understanding clinical variation is becoming increasingly important both locally and internationally. Fifty years ago medical interventions were limited, more straight forward and carried a much lower cost impact on the community. Today medical and surgical interventions have become incredibly complex, involving multidisciplinary decision making by sophisticated teams, and chronic disease must be managed for decades at substantial expense both to the individual patient, private health insurance and government funders.

Consequently it is a strategic priority for the College to work with health funders and other groups that 'own' big data sets, so we can understand the approach they use in interpreting them, and ensure that relevant and meaningful information is made available to all surgeons. The College needs to be actively involved in the discussions about how health care can be affordable whilst ensuring good surgical practice. An outcome that will certainly benefit our patients, as well as the profession.

RACS and Medibank have established a collaboration to progress the analysis of the administrative data sets that Medibank has available from over one million surgical interventions per year. By focusing on high volume procedures, we are developing an approach in reporting that can be applied across most areas of surgical practice and enable a careful review of clinical practice.

The data is published in the report on a global basis as well as a regional basis, where appropriate. We are looking into making the data available at a hospital level without identifying any individual surgeon. RACS and Medibank are currently exploring a way to provide information to individual surgeons who wish to know where they are within the global data-set. This process will take several months to develop and will be via a direct enquiry between the surgeon and Medibank with consent being given for the data to be extracted.

RACS will never have individual surgeon performance data made available to it.

The role of RACS is to ensure a meaningful approach is established and that education can be provided across the entire Fellowship as to what variation exists. We are very fortunate that Medibank has engaged so productively with the College in this endeavour. We are hopeful of progressively replicating this process with other funders and their data sets.

We are presenting these initial reports through Surgical News as the first part of a broader communication strategy. The procedure within this report is Hip replacement.

Hip replacements

In 2014 Medibank funded a total of 4,423 operations in private hospitals for which a hip replacement was recorded as the principal procedure (highest value MBS fee from the medical claim) for the hospital admission. This specifically refers to primary unilateral hip replacements (MBS codes 49318 and 49321). It does not include revisions, bilateral hips or hip replacements following fractures. The analysis is limited to those 4,423 procedures. 561 surgeons (identified through the stem of their Medicare provider number) billed Medibank for those procedures. 299 (53%) of these surgeons undertook five or more procedures. Surgeon level analysis of indicators has been limited to those surgeons with five or more patient separations.

Of course the surgeons could also be doing many more of these procedures in the public sector or on patients with other private health insurers. The Medibank dataset does not have this information.

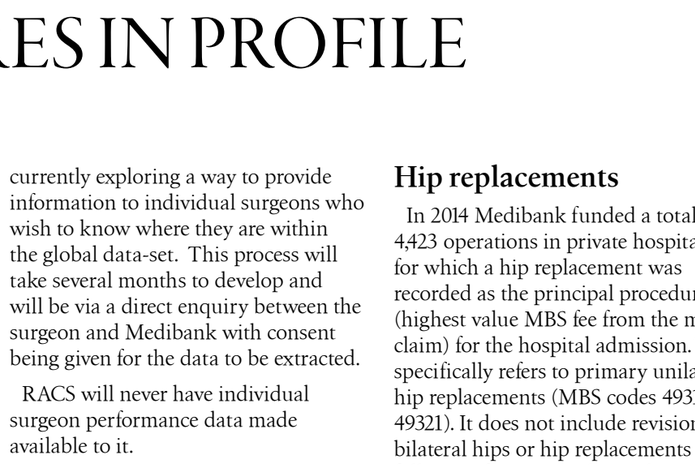


Figure 1: Median length of stay in hospital (nights)

For the 299 surgeons who performed at least five procedures, the median length of stay was five nights. (Figure 1) The range was from one night to nine nights. You will note that some surgeons with less than five procedures have a length of stay above this on the graph but the analysis has only been undertaken on those with more than five procedures.

Across the total sample of 4,423 hospital separations, patients were transferred to inpatient rehabilitation following 1,623 hospital separations (37%) (Figure 2). Inpatient rehabilitation is defined by the Department of Health's Guidelines and states that patients require multidisciplinary treatment in a specialist rehabilitation unit for the treatment goal of improving function.

For the 299 surgeons who performed at least five procedures 51 (17%) had no patients referred to inpatient rehabilitation, 229 (77%) surgeons had one or more patients referred to inpatient rehabilitation and 19 (6%) had all of their patients referred to inpatient rehabilitation

The percentage of a surgeon's patients that were transferred to rehabilitation ranged between 0% and 100% with a median of 29%.

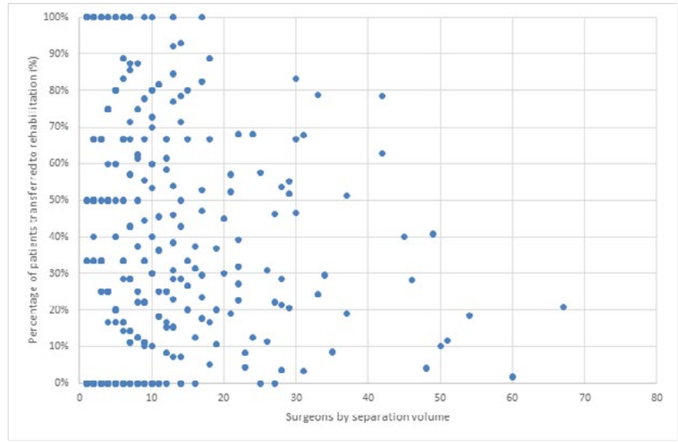


Figure 2: Percentage of patients transferred to rehabilitation for hip replacements

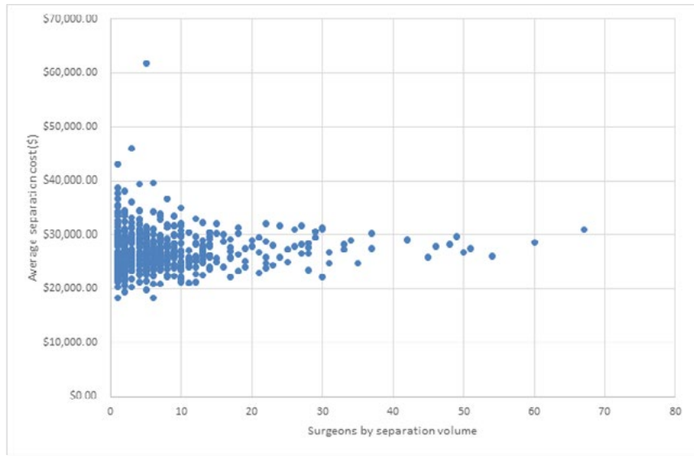


Figure 3: The average separation cost for hip replacements

The separation cost includes the total charges for the hospital separation, including payments made by Medibank, Medicare and the patient. Costs include hospital, prostheses, medical practitioners and diagnostic services.

The average total cost per hospital separation was $27,310 (Figure 3).

For the 299 surgeons who performed at least five procedures, the average separation cost of a surgeon ranged between $18,309 and $61,699 with a median of $26,661.

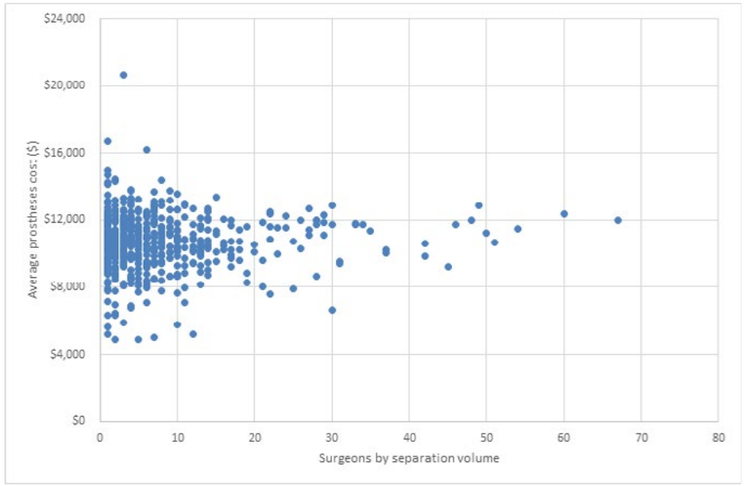


Figure 4: Average prosthetic cost for hip replacements

The average cost of prostheses items was $10,766 per hospital separation.

For the 299 surgeons who performed at least five procedures, the average cost of prostheses used by a surgeon ranged between $4,908 and $16,178 with a median of $10,727 (Figure 4).

Patients were charged an out of pocket fee by the principal surgeon in 39% of separations and the average out of pocket charged was $1,778.

For the 299 surgeons who performed at least five procedures, 142 (47%) did not charge any of their patients an out of pocket for the hospital admission. The average out of pocket charged ranged from $0 (no out of pocket charged) to $4,057 with a median of $15 (Figure 5).

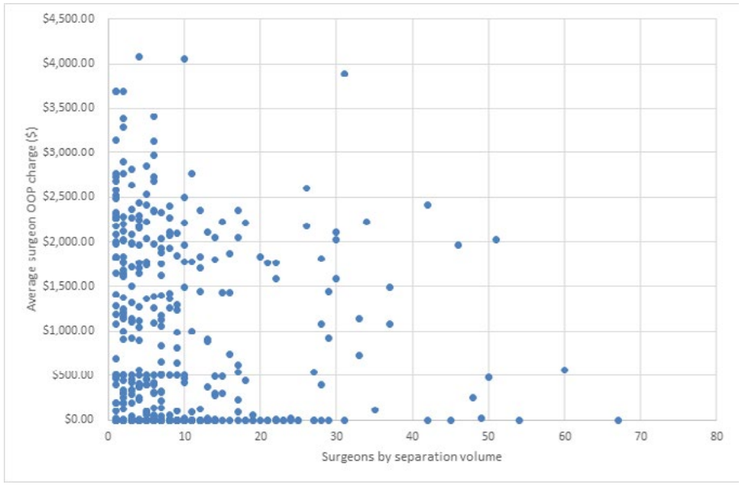


Figure 5: Average surgeon out of pocket cost for hip replacements

Like all reports of administrative data sets there is substantial work in ensuring the data is represented in a meaningful and relevant style. I would like to acknowledge the commitment of Medibank in accessing and representing this data in a way that can be usefully interpreted. I would also like to acknowledge the Clinical Variation Working Party including general surgeons, cardiothoracic surgeons, orthopaedic surgeons, otolaryngologists, urologists and vascular surgeons who are now reviewing the data and its presentation.

In this procedure about Hip Replacement the contribution of Dr Lawrie Malisano, Mr Simon Williams and Mr Richard Lander has been particularly instructive.

The Working Party is trying to ensure that these reports can be sent to surgeons and that they will be seen as valuable despite their limitations. The reports will become progressively available over the coming months.

And that is when both the interesting and challenging part starts. As Fellows of RACS we need to have an understanding of what drives variation in health care. We are all responsible for the quality of care that our patients receive and the resources that are utilised in providing that care.

I would be delighted in receiving feedback about this process. Also, if you wish to pursue this data with questions to Medibank our key clinical contact is Dr Linda Swan, Chief Medical Officer, Provider Networks and Integrated Care at Linda.Swan@medibank.com.au

In Memoriam

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

Edgeworth David McIntyre
20 April 1925 - 12 December 2015
Orthopaedic Surgeon

David was born and educated in Launceston, completed his Medical degree (MBBS) at Melbourne University in 1948. After two years as a Resident Medical Officer at Launceston General Hospital, he furthered his studies at Edinburgh University, and working for a further three years at Haymeads Hospital & Royal East Sussex Hospital, obtained his initial Fellowship (FRCS Edinburgh), in Orthopaedic Surgery. Subsequently, David also obtained Fellowships of the Royal Colleges of Surgeons of England and Australasia.

In 1954 David was invited to return to Northern Tasmania to assume the post of Registrar in General Surgery at Launceston General Hospital, and subsequently Surgeon Superintendent at Mersey Hospital, Latrobe (1955-56) where his principal role was the provision of consultative and operative orthopaedic services to Northern Tasmania.

For the full version see the webpage: http://www.surgeons.org/member-services/in-memoriam/edgeworth-david-mcintyre/

Alan Bromwich OBE KStJ RFD
23 February 1924 - 18 October 2015
General Surgeon

Mr Alan Bromwich had the reputation of a fearless and fast surgeon, but at the same time a gentle and knowledgeable man.
Born in England in 1924, Alan graduated in Medicine from King's College Cambridge in 1945, then served with the Royal Air Force from 1946 to 1948. Thereafter he gained his English surgical fellowship and worked as a Surgical Registrar, until by 1956 he was tempted to work overseas. For two and a half years he found himself in Aden, South Arabia, as surgeon in the oil refinery, but left due to the deteriorating security situation.

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

Val Lishman AM
General Surgeon
14 February 1930 – 21 April 2016

Driving through an English snowstorm, on the way to board a ship and emigrate, Val Lishman's mind was on fresh horizons. An Australian summer beckoned for him, wife Jean and three children. Six weeks later glaring reality hit. "We had read all about the beautiful Wildflower State but ....everything seemed dried up and withered," he would recall of that "blistering" day in February 1965, in a memoir written long after they had all adjusted perfectly to life Down Under.
The Lishmans soon learnt to enjoy the sunshine. Bunbury liked them too. This was the town's first resident surgeon. Local surf lifesavers were delighted when Val became the club's honorary medical officer. And when new Oxy-Viva resuscitation equipment arrived, he was able to give an expert demonstration.

For the full version see the webpage: http://www.surgeons.org/member-services/in-memoriam/val-lishman-am/

Andrew Malcolm Jenkins
Plastic and Reconstructive Surgeon
1949 - 2016

Andrew Malcolm Jenkins (1949-2016) was born 19 May 1949 to Claude and Nora (nee Webb) in Hastings UK. With his sister Hilary, he emigrated to Australia in 1957. His father was the secretary of the Queensland branch of the AMA and his parents sent Andrew to Brisbane Boys Grammar where he became head boy. After completing his medical degree at the University of Queensland, he worked at the Royal Brisbane Hospital and became just the third registrar to be appointed to the plastic and reconstructive surgery programme in Queensland.

Married to Frances (nee Roe) in 1974, they had Esther, Clarissa, Toby, Morgan and Mardi who have brought untold happiness and a tribe of grandchildren.

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

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

DOCTORS v THE HACKER

Doctors need to avoid complacency when it comes to technology

MICHAEL GORTON
College Solicitor

Recent experience at The Royal Melbourne Hospital in which a serious computer virus infection substantially affected the hospital's technology and communications systems for several days highlights the risk of hacking in our modern age.

So many of our systems are now technology based and our organisations are increasingly dependent on software and systems to ensure that our businesses survive. We have increasingly experienced massive technological advances, increasing our ability to communicate, grow, learn, profit and connect.

However, there are those who will always seek to profit from our businesses reliance on technology, and we now face the age of hacking and cyber assault.

Infection by computer viruses occurs on a regular basis. More pernicious hacking attempts occur through a person in another country with a screen and keyboard. Cyber theft occurs as hackers seeks to acquire online property, intellectual property and access to bank accounts.

Despite this, there are reports that less than 40 per cent of Australian corporate boards are currently aware of the extent of their own cyber protection. Small businesses, such as doctor's practices with less resources are at particular risk and there are reports that a staggering 60 per cent of small businesses who are hacked are forced into closure within six months of the hacking.

Doctor's practices, in particular, hold highly sensitive patient information which could be used for identity theft, blackmail, insurance fraud and general breach of privacy.

Doctors therefore need to avoid complacency. We sometimes have a false sense of security in relation to cyber safety. Companies must keep updating their cyber defences, because hackers are always adapting and existing firewalls are consistently challenged. A recent KPMG report indicated that Australia cyber security incidents rose by 109 per cent. Reports indicate that cyber hacking steals an average of $3.6 million per company every year – including not for profit businesses like hospitals and aged care facilities.

Cyber risk should therefore be a significant part of any risk management framework for a medical practice to consider. It may be considered part of a doctor's obligation to maintain patient confidentiality and privacy.

Strategies for cyber protection include:

- More complex passwords and equipping all devices with password protection.
- Update all software regularly and consider deleting susceptible programs.
- Maintain cyber protection software including firewalls, antispyware, antivirus and anti-malware.
- Ensure deletion of personal files from any hardware that is discarded or transferred.
- Use more creative ideas for security questions.
- Use two step authentication processes where possible.

Doctors and their advisers have a role to play in oversighting management of cyber security issues. Doctors should be proactive in seeking appropriate assurance that the practice has appropriate systems in place, that they are updated regularly and that IT services are aware of the most up-to-date hacking issues.

The challenges for Doctors to consider and the questions to be raised include:

- What level of resources is the doctor prepared to invest to deal with cyber risk?
- Does the doctor's business strategy include reference to cyber security with protections directed to the most valuable assets or the most strategic software and client connection systems?
- Businesses survive on data. Where is it stored, how is it secured and what are the systems in place for protection?
- Many businesses use contractors and other third parties to provide systems, access data, and managed processes. What protections are place to ensure that third parties observe your cyber security requirements?
- How do you manage access to your systems whether by staff, third parties or even customers?
- Do you have a plan for a breach of your systems from cyber attack? What are back up plans for your data and systems? How do you deal with reputation risk, to secure your business operations and maintain that trust and confidence of your clients?

With Alexander Dickson, Student

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