SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 16 NO 5 / JUNE 2015

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

ASC Perth 2015

Remembering the ANZACS **p12**

EXPERT ADVISORY GROUP

Profile on member Catherine Ferguson and the latest news

30

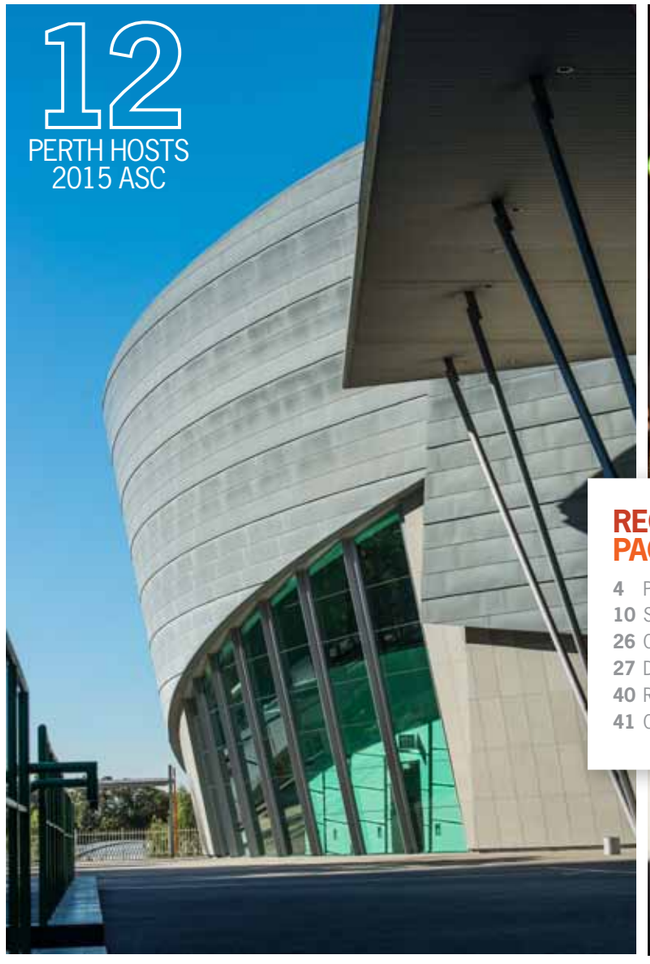
WOMEN IN SURGERY

Dr Nicola Dean on her career highs

38

COLLEGE OF SURGEONS OF AUSTRALIA AND NEW ZEALAND

CONTENTS



REGULAR PAGES

Correspondence to Surgical News should be sent to: **surgical.news@surgeons.org**
Letters to the Editor should be sent to: **letters.editor@surgeons.org**

T: +61 3 9249 1200 **F:** +61 9249 1219
W: www.surgeons.org

ISSN 1443-9603 (Print) / ISSN 1443-9565 (Online)

Surgical News Editor: David Hillis

Published for the Royal Australasian College of Surgeons by RL Media Pty Ltd. ACN 081 735 891, ABN 44081 735 891of 129 Bouverie St, Carlton. Vic 3053.

ON THE COVER:
Bugler opens the 2015 ASC.
Photo Credit Binh Nguyen

2015

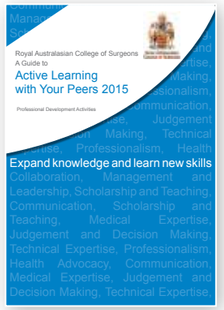
PROFESSIONAL DEVELOPMENT

WORKSHOPS & ACTIVITIES

Royal Australasian College of Surgeons

workshop

Online registration form is available now (login required).
Inside are professional development activities that enable you to acquire new skills and knowledge and reflect on how you can apply them in today's dynamic world. Don't forget that you can register online at www.surgeons.org



Professional development supports life-long learning. College activities are tailored to needs of surgeons and enable you to acquire new skills and knowledge while providing an opportunity for reflection about to apply them in today's dynamic world. Additional workshops are available from the 2015 Active Learning booklet.

Process Communication Model Seminar 1

26 to 28 June – Brisbane; 17 to 19 July - Hobart

Patient care is a team effort and a functioning team is based on effective communication. PCM is a tool which can help you to understand, motivate and communicate more effectively with others. It can help you detect early signs of miscommunication and thus avoid errors. PCM can also help to identify stress in yourself and others, providing you with a means to re-connect with those you may be struggling to understand.

Process Communication Model: Seminar 2

7 to 9 August - Sydney

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

Foundation Skills for Surgical Educators

17 July – Magnetic Island, QLD; 6 August - Darwin

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

Non-Technical Skills for Surgeons (NOTSS)

24 July – Brisbane; 12 August – Queenstown, NZ

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

Clinical Decision Making

28 July – Sydney; 8 September - Christchurch

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

Supervisors and Trainers for SET (SAT SET)

30 July – Gold Coast

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

Keeping Trainees on Track (KToT)

31 July – Gold Coast; 14 August - Auckland

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

Strategy and Risk for Surgeons

21 August - Melbourne

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

June – August

NSW

16 June, Sydney
Keeping Trainees on Track
28 July, Sydney
Clinical Decision Making
7 - 9 August, Sydney
Process Communication Model: Seminar 2

NT

6 August, Darwin
Foundation Skills for Surgical Educators

NZ

12 August, Queenstown
Non-Technical Skills for Surgeons
14 August, Auckland
Keeping Trainees on Track

QLD

26 - 28 June, Brisbane
Process Communication Model Seminar 1
17 July, Magnetic Island
Foundation Skills in Surgical Education
24 July, Brisbane
Non-Technical Skills for Surgeons (NOTSS)
30 July, Gold Coast
Supervisors and Trainers for SET
31 July, Gold Coast
Keeping Trainees on Track

VIC

23 - 25 July, Yarra Glen
Surgical Teachers Course
21 August, Melbourne
Strategy and Risk for Surgeons

TAS

17-19 July, Hobart
Process Communication Model Seminar 1

Royal Australasian College of Surgeons

THE THREE DELAYS

The Lancet Commission on Global Surgery has found that billions of people lack access to timely, affordable surgical care. RACS President David Watters attended the Commission's launch in London in April

DAVID WATTERS
PRESIDENT

Crowded hospital waiting room in Myanmar.

The highway was unsealed, the conditions were wet and the overcrowded truck was travelling too fast for a downhill bend in the road. A wheel skidded over the verge and as the vehicle tumbled down an embankment, its occupants were tossed in all directions. Sadly, the first level hospital 40km away had only one working ambulance; it was staffed by two doctors who had been qualified for three years and a nurse anaesthetist.

As those victims who did not die at the scene arrived at the hospital long after the golden hour, their primary treatment was compromised by no batteries in the laryngoscope, empty oxygen cylinders and a lack of blood. This was all in a week when general anaesthesia cases had been getting cancelled due to a failure of the hospital steriliser. In the aftermath of that tragic accident a number of families in the region were impoverished, losing not only loved ones, but also their principal wage earner.

Why do almost five billion people not have access to safe, affordable and timely surgery? Those living in the world's poorest countries face three types of delay in accessing surgical care. The first delay occurs because they do not seek help and present for surgical care, failing to recognise that the health system can effectively treat their condition, or fearing even if they did, they and their families could not afford it. The second delay arises because of the need to travel to a health facility, usually a first level (district) hospital with the capacity to perform surgery and anaesthesia. Transport may not be available or easily affordable and can take several hours over difficult terrain, certainly not ideal for those suffering a surgical emergency. The third delay is endured when the patient arrives at the hospital, but has to wait to be seen, wait to be investigated, wait for decisions to be made and wait to access theatre. Hospitals in Low and Middle-Income countries (LMICs) rarely have the capacity to treat all those who need surgery.

Despite the improvements in global health during the period (2000-2015) of the Millennium Development Goals (MDGs), including considerable progress on maternal mortality, the focus on single diseases and conditions (e.g. malaria, HIV, tuberculosis) has meant that cross-cutting treatments like surgery and anaesthesia have not been planned for, managed or reported. Further reductions in maternal mortality and morbidity (e.g. obstetric fistula) will require access to better access to emergency Caesarean Section, given that best practice demands that 10–15 per cent of pregnancies have complications which otherwise impose a terrible toll on mother and baby. In the world's poorest regions, mortality and morbidity from common conditions needing surgery have grown. Tragically, development of safe, essential, life-saving surgical and anaesthesia care in LMICs has stagnated or regressed. Without surgical care, necessary for up to 30 per cent of all health problems comprising the global burden of disease, case-fatality rates are high for common, potentially treatable conditions including appendicitis, hernia, fractures, obstructed labour, congenital anomalies, breast and cervical cancer. As a result 32.9 per cent of global mortality is associated with surgically treatable conditions.

Universal Access to safe, affordable surgical and anaesthesia care

Access to safe surgery can be measured in four dimensions: The first is being able to perform the three Bellwether procedures: an emergency Caesarean Section, laparotomy for an acute abdomen and appropriate operative management of an open fracture. If these three are available then it is likely that the other 41 essential procedures on WHO's Global Initiative for Emergency and Essential Surgery (GISEEC) can be done. The second dimension is timelines - "when needed" – and for the three Bellwether procedures this is two hours measured as the time it takes to travel to a facility performing them, no matter the terrain or road surface. The third dimension is receiving the treatment safely. The prime indicator of safety is the Preoperative Mortality Rate (POMR), measured as in hospital deaths over the number of procedures. The fourth dimension is affordability. Those in need should not suffer impoverishing or catastrophic expenditure for the care received or the associated cost of transport, food and loss of earnings.

The Lancet Commission on Global Surgery launch last April in London brought together 25 commissioners, a further 11 authors and consulted many world leaders. John Meara (USA), Andy Leather (UK) and Lars Hagander (Sweden) were the lead commissioners. I was honoured to join Fellows Russell Gruen and Rowan Gillies as a co-author of the report which was published on April 27. The Commission's five key messages are:

1. Five billion people are currently unable to access safe surgery when needed.
2. Scaling up surgical anaesthesia care will need at least 143 million additional procedures annually.
3. Affordability is critical as it is currently estimated that 33 million individuals face catastrophic health expenditure each year due to out of pocket payment for surgery and anaesthesia whilst a further 48 million are impoverished by associated costs of transport, food and loss of earnings..
4. Investment in surgical and anaesthesia services globally is affordable, saves lives and promotes economic growth.
5. Surgery is an indivisible and indispensable part of an integrated health system. It is essential for universal health coverage.

To perform 143 million extra procedures per year will require an increase in trained providers for surgery, anaesthesia and obstetric (SAO) care. The recommended minimum are 20 SAO's per 100,000 population. The commission has set a target for 2030 of 80 per cent coverage of the world's population to be able to access 5000 procedures per 100,000 population annually.

On May 22nd 2015, the 68th World Health Assembly adoptedthe first ever resolution on strengthening emergency and essential surgical and anaesthesia care. The resolution proposed by Zambia and co-sponsored by Australia was passed unanimously by the 194 nations and their ministries of health. At long last there is recognition of the cross-cutting importance of surgical and anaesthesia care to achieving the Sustainable Development Goal (SDG) - Universal Health Coverage by 2030.At the May ASC in Perth, there was unanimous support from the 17 Surgical Colleges represented that the Commission's key messages are both worth endorsing and imply a need to work with our governments and those of the nations with whom we partner to ensure its successful implementation.
So how will success be measured?
Again, the Lancet Commission provides us with an evidence based approach. The measures or indicators need to be reproducible around the world and are focused on access to timely essential surgery, specialist surgical workforce density, surgical volume, perioperative mortality rates (POMR) and protection against impoverishing or catastrophic expenditure.

In January 2014, Dr Jim Yong Kim, President of the World Bank, called for a shared vision and strategy for global equity in essential surgical care. He is a passionate believer in surgery being an indivisible, indispensable part of health care. With the work of the Lancet Commission and the full support of the World Health Assembly, there are now clear goals and a recognisable path to substantially achieve this by 2030. Investing $350bn will be required and although this may seem a substantial sum, the cost of not scaling up is modelled to be $12.3 trillion or almost 2 per cent of global GDP.

Certainly if we can achieve universal access to safe, affordable surgical and anaesthetic care when needed, our world will become a much healthier and more prosperous place.

Queenstown, New Zealand where surgeons will gather to discuss 'Choosing Wisely'.

BETTER AND CLOSER THAN YOU THINK!

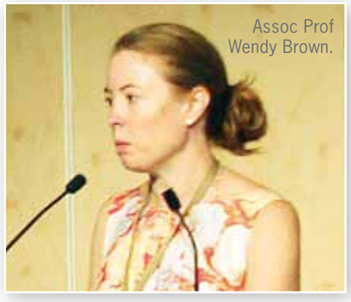
As part of the Vice President's portfolio, I am pleased to promote the upcoming Annual Scientific Meetings (ASM).

GRAEME CAMPBELL
VICE PRESIDENT

These are taking place in the second half of this year and provide a wonderful opportunity to hear quality and relevant presentations, gain CPD points, network with your colleagues and potentially experience new and different locations.

The regional ASMs attract not only Fellows but also a large number of Trainees, International Medical Graduates, Junior Doctors and medical students. Abstracts are now open for oral and poster presentations and I would encourage Trainees in particular to submit to their local ASM.

The Queensland ASM in Magnetic Island, July 17-19, is themed "Risk factors – are they killing us? – Smoking, Obesity and Alcohol." The College has recently had a strong interest in advocating on these issues and it is great to see a line-up of quality speakers, both Fellows and non-Fellows including Professor Simon Chapman, Professor in Public Health at the University of Sydney and Wendy Brown past President OSSANZ.



Assoc Prof Wendy Brown.

Western Australian and South Australian Fellows will be hosted by their Northern Territory counterparts this year at the "Tristate ASM" in Darwin. Extended Scope of Practice and Generalism in Surgery will be featured topics of the conference, held August 7-9. Professor Cameron Platell and Mr Robert Padbury will be among the speakers.

The College has also begun exploring the concept of 'Choosing Wisely' when it comes to surgical procedures and medical interventions. This theme will be picked up by the New Zealand ASM on August 13 and 14, entitled "Surgery 2015: I can but should I? Choosing Wisely."

Guests from Far and Wide

International guest speakers will include Professor Sir Murray Brennan, Vice President for International Programs, Memorial Sloan Kettering Cancer Centre, who will speak on futile systems and "conversation with the patient – delivering the news" and Dr Wendy Levinson, Chair "Choosing Wisely Canada" and Chair of Department of Medicine University of Toronto.

Regional Advocacy

It is encouraging that the strong relationships our Regional Chairs and Committees have built with their health ministries and departments of health opens the doors of opportunities for them to attend and participate in our ASMs. Dr Jonathan Coleman, Minister of Health in New Zealand will open the meeting. In Queensland, a full day is dedicated to a joint session with QHealth to discuss common issues. These relationships are key for continued effective advocacy.

This year, the Tasmanian and Victorian committees have joined forces for the first time to deliver a joint ASM in Hobart, October 16-17. The 'Coping with Change' theme will include presentations on "when push comes to shove" (dealing with stress issues) and the changing phases of a surgical career. Mr Peter Meyers will deliver the Henry Windsor Lecture. You will need to come to the lecture to learn the connection between Mr Meyers and Henry Windsor!

This year will see the third year of Surgeons' Month, which has been developed by the NSW Committee to offer a versatile month of involvement and interest for our stakeholders. There will be four main events, one every week, in November, as well as a number of other courses, events and talks to address some of the opportunities in the diverse world of surgery.

The overarching theme for Surgeons' Month this year is the Surgeon's wellbeing. The different events will be developed to meet the needs of various stakeholders within our sphere including Senior Surgeons, Younger Fellows, Trainees and IMGs, Prevocational development, and also the families and partners of the Fellows, Trainees and IMGs. It should prove to be an interesting, and hopefully useful Surgeons' Month to all that take part.

I look forward to seeing you at the events I am able to attend. I would encourage you to support your local ASMs and even if it is 'not so local' this year – traveling to a different location may provide just that bit of inspiration you need!

RACS Support Program

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

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

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

How to contact Converge International:

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

Converge international

Giving a hand

Surgeons have reattached a hand after it was severed in an accident with an electric angle cutter in the United Kingdom. Orthopaedic and Plastic and Reconstructive surgeons worked on repairing bone, tendons, nerves and vessels for Welsh man Gary Lincoln. Mr Lincoln woke able to move his fingers, "I cannot believe it," he said.

***MX*, 27 April**

Pacific recognition

Professor Eddie McCaig has been recognised for his contribution to surgery in the Pacific after being awarded the ESR Hughes medal at the RACS Annual Scientific Congress. Professor McCaig has led the Pacific Islands Surgical Association as President and been an external examiner for the Timor-Leste surgery program. Professor of Surgery at Fiji National University, Professor McCaig was described by the College as a "worthy recipient for his contribution to surgery, surgical education and training."

***Fiji Sun*, 9 May**

NZ push to ban quad bike

New Zealand surgeons are urging the government to ban quad bikes for children under 16. The call follows a study in the New Zealand Medical Journal highlighting the significant number of preventable injuries each year.

Chair of the New Zealand RACS Trauma Committee Mr Li Hsee has said injuries are increasing with the growing popularity of the so-called all terrain vehicle.

"Despite having four wheels, quad bikes … are unstable; most injuries and deaths involve the bike rolling on to the rider and can occur at low speeds," Mr Hsee said.

***Scoop News*, 21 May**

Cross-representing Tasmania

The College has highlighted the apparent Hobart-focus of members of Tasmanian clinical advisory groups and has recommended an open and transparent process to select members. In a submission to the State Government, the Tasmanian Regional Committee of RACS said the Southern focus can mean unbalanced health reform. Tasmanian Regional Committee Chair Brian Kirkby said there is importance in statewide representation. "If you're from Hobart you may not well understand the views from the North-West," Mr Kirkby said.

***The Examiner*, 23 April**

Credit: Binh Nguyen

ASC ATTRACTS MORE THAN 1500

Research presented at this year's Annual Scientific Congress (ASC) – which brought together more than 1500 delegates from Australia, New Zealand and surrounding countries as well as surgeons from the Royal College of Surgeons of Edinburgh – included studies that could revolutionise the treatment of cancer and reduce hospital admissions for serious injury

With the twin themes of paying tribute to the centenary of Gallipoli and analysing medical ethics and resource allocation in an era of increasing demand, this year's ASC was also chosen as the forum to announce a new bi-national group of senior surgical directors to work with governments as an advisory group on issues surrounding sustainable health care.

New Zealand's pioneers of facial reconstruction surgery who treated those injured in the trenches of World War I were honoured in the keynote lecture of the Congress and surgeons deemed to be making an outstanding contribution to Indigenous health were also recognised.

Associate Professor Brendon Coventry presented the findings of a unique 20-year collaboration between surgeons, immunologists, pathologists and scientists that could over-turn current understandings of breast cancer.

He told the ASC that while breast cancer had long been assumed to be non-immunogenic, the 20-year study suggested otherwise.

A/Prof Coventry, from the University of Adelaide, presented data that showed that the immune response appeared to be activated in some breast cancer patients where a noticeably higher count of specific white blood cells was present when compared with normal breast tissue.

"These findings indicate that the immune response appears to be already occurring in many women with breast cancer and that the strength of that response correlates with longer-term survival," he said.

"This opens the way for therapies that can boost the on-going immune response occurring in women with breast cancers and is reinforced by new findings using immunotherapies such as an anti-PD1 and vaccine therapies for breast and other cancers."

A/Prof Coventry also presented research that indicated that local injections into cancer masses had been found to not only produce size reductions in the injected areas, but wider unexpected effects in the body.

"The results of the study are promising and strongly suggest that many local treatments are often unexpectedly helping the patient more than just at the local injection site by producing longer survival times," he said.

"We have identified that the immune system repeatedly switches 'on' and reflexly switches 'off' and that administering doses of therapy at the correct time during this cyclical process appears vitally important for creating body-wide immune responses."

The gap between New Zealand and Australia's colorectal cancer survival rates continues to widen and could be the result of Australia's colorectal screening program, according to Dr Jeffrey Tan, a General Surgery registrar at Waikato Hospital, New Zealand.

He told the ASC that while there was only a slightly higher incidence of colorectal cancer in New Zealand as compared to Australia, the mortality rates were significantly higher.

"For some time, studies have demonstrated that colorectal cancer mortality is higher in New Zealand than in Australia (and) this new data shows that the (gap) is widening," Dr Tan said.

"There is a lot of evidence to suggest that detecting colorectal cancer at an early stage contributed to better outcomes (yet) while Australians have access to colorectal cancer screening programs there is no comparable nationwide screening in New Zealand."

Despite the digital revolution, surgeons are still the preferred source of information for patients with cancer, according Dr Mohd Rosli from Adelaide's Flinders Medical Centre.

Dr Rosli presented a study of patients diagnosed with colorectal cancer. The study was designed to find out how patients accessed information about their condition and how they rated their satisfaction with the information provided from a variety of sources.

It found that surgeons were listed as patients' first preference, but Dr Rosli stressed that surgeons should be aware of the multiple information gathering techniques now used by patients.

"Doctors should help guide their patients towards useful and reliable websites, to avoid misinformation or information overload from the Internet," he said.

The ASC also offered delegates a number of presentations on surgical training including research that indicated that while Trainees may take slightly longer to complete an operation, they caused no statistically significant difference in mortality or revision rates when compared to a qualified surgeon.

Presented by retired NZ orthopaedic surgeon Allan Panting, the study assessed more than 1,000 hip replacements over the course of ten years and suggested that Surgical Trainees only take an extra 14 minutes.

"When one considers that there is no significant difference in the quality of outcome, adding approximately 14 minutes to the operation time is a low price for the immense benefits that practical experience affords a Surgical Trainee," he said.

Other scientific papers presented at the ASC included a study that indicated that the wearing of bike helmets by those working on ladders could dramatically reduce head injuries and another that showed that intra-abdominal seat belt injuries in young children could be avoided with the correct use of age-appropriate seat restraints.

Providing and allocating health resources in an age of high demand is a key issue confronting governments across a range of jurisdictions and a matter of key interest to the College as part of its role in supporting the education and training of surgeons across Australia and New Zealand.

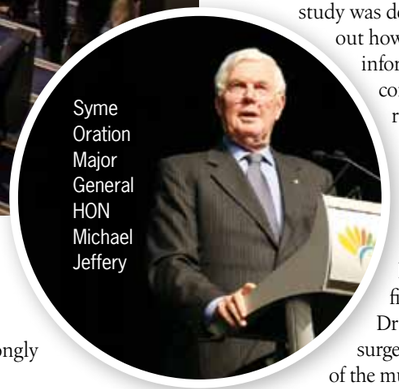
As part of its commitment to advocate on issues deemed critical to the advancement of health care in Australasia, RACS has established a bi-national group of surgical directors to provide surgical input to questions surrounding surgical leadership.

Launched at the ASC, the group is chaired by Professor David Fletcher, Head of General Surgery at Fiona Stanley Hospital in Perth, and will draw on the collective knowledge and wisdom of leading directors of surgery from across Australia and New Zealand.

"A major role of the group will be to improve the quality and efficiency of surgical services and contribute to a sustainable health system (and) it will be well-placed to offer meaningful direction in areas such as emergency surgery, elective surgery and management of waiting lists," Professor Fletcher said.

College leaders welcomed six Indigenous doctors to the ASC at the Indigenous Doctors' Breakfast where discussions were held on how best to attract and support Aboriginal, Torres Strait Island and Maori medical professionals in a surgical career.

Four surgeons were also recognised for their contributions to Indigenous health outcomes through the presentation of the inaugural Indigenous Health Medals. ▶



Syme Oration Major General HON Michael Jeffery

The recipients were:

Professor Harvey Coates AO, a senior ENT surgeon at Princess Margaret Hospital for Children who was largely responsible for establishing the neonatal hearing screening program in Western Australia;

Dr Ollapallil Jacob, a surgeon in Alice Springs who has been a prominent advocate for Indigenous health in central Australia for the past 15 years;

Professor Pat Alley, a Clinical Associate Professor of Surgery at the University of Auckland who has been a strong advocate for the bi-national focus of the College's Indigenous Health Committee; and

Associate Professor Jonathan Koea, a highly accomplished general surgeon at Waitemata District Health Board and Clinical Associate Professor of Surgery at the University of Auckland who has long advocated for improvements in health services provided to Maori communities.

Also honoured at this year's ASC were the pioneers of facial reconstruction surgery and the extraordinary contribution made to the field by New Zealand surgeons who treated the terrible injuries suffered by soldiers in World War I.

In the keynote lecture titled '100 years on – War Surgery of the Face and Jaws', Otago University lecturer and oral and maxillofacial surgeon Associate Professor Darryl Tong charted the development of facial reconstruction surgery.

"With the advent of the First World War, surgeons began seeing a lot more injuries to the face and jaw as trench warfare become more developed," said Associate Professor Tong.

"During this time, New Zealand born and raised Harold Gillies became the world leader in treating these types of injures and is recognised as the father of modern plastic surgery.

"Henry Pickerill, the first Dean of the Dental School at the University of Otago was another leading pioneer in plastic surgery and was a contemporary of Gillies during the First World War.

"This trend continued into the Second World War, with three out of the 'big four' recognised plastic surgeons in the United Kingdom also coming from New Zealand.

"When one considers its size, New Zealand's contribution to the development of facial reconstruction surgery is astonishing."

With Karen Murphy

ASC GAINED ATTENTION

This year's ASC attracted significant traditional and digital media attention across Australia and New Zealand, providing evidence of broad public interest in surgical and scientific research.

The Congress, held from 4 May – 11 May, generated:

> 864 articles in regional Australian and New Zealand newspapers and related publications;
> Seven feature articles in major metropolitan newspapers;
> Five radio interviews;
> Four television interviews;
> Number One spot on the medical events Twitter trending list;
> 2,608,160 impressions for #RACS15;
> 2207 tweets.

Convocation


01

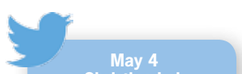

02


03


04


05


06



May 4
Christine Lai
@csl888 @timpawlik
Congratulations on becoming Fellow of @RACSurgeons **#RACS15** @AcademicSurgery **#recognisinggreat contributions**

Convocation


07


08


09


10


11


12


13


14

01: Shalinder Sadiq, Amir Butt & Anwar Choudhary
02: Kenny Low, Anthony Kiosoglous & Claire Fraser Taylor
03: Deborah Bailey & Julie Mundy
04: Zeng Yap Chuan, Chien Tan & David Bartolo
05: Margot Williams, Simon Williams & Phillip Carson
06: Robert Steele Graeme Campbell
07: Annette Holian, Martin Richardson & Perrin Richardson
08: Carolyn Vasey, Daniel Carroll & Richard Perry
09: Pecky De Silva & Marianne Vonau **10:** Hong Xia and family
11: Rebecca Field & family
12: Nikki Stamp & Indrajith Withanage
13: Siva Gounder and family
14: David Scott, Peter Field & Timothy Pawlik

Lectures


01

02

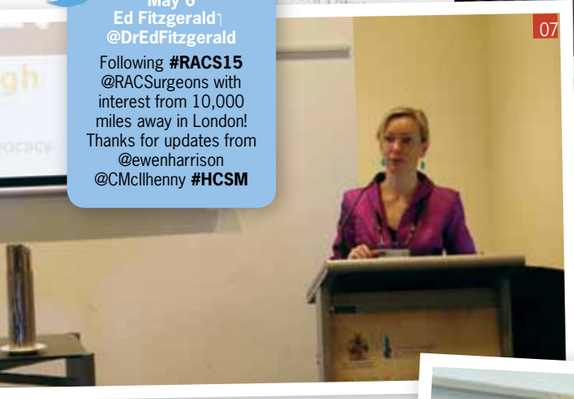

03


04


05


06

May 6
Ed Fitzgerald
@DrEdFitzgerald
Following **#RACS15** @RACSurgeons with interest from 10,000 miles away in London! Thanks for updates from @ewenharrison @CMcIlhenny **#HCSM**


07


08


09

01: Herbert Moran Lecture Stephen Hopper
02: International Forum Lancet Commission President Elect David Watters
03: President's Lecture Professor Rowan Parks
04: General Surgery Ethical Dilemmas David Bruce
05: General Surgery Ethical Dilemmas Grant Gillett
06: Michael Wertheimer Lecture John Crozier
07: Social Media Jill Tomlinson
8: Weary Dunlop President Michael Grigg & Michael Tyquin
9: Rowan Nicks Scholar Tahmina Banu

May 5
Jason C @ozvascdoc
Having a ball at the Younger Fellows Dinner! **#RACS15** **#YoungerFellows** @jdimick1


01


02


03


04

Younger Fellows Dinner

Industry Reception


05


06


07


08


09

01: Christine Lai, Michael Grigg & Richard Martin **02:** Younger Fellows have fun at Perth Zoo **03:** Jeanette and Ivan Thompson & Adam Boyt **04:** First row from the left – Jason Chuen, Christine Lai, Mary Theophilus, Amir Ghaferi, Julie Ann Sosa and James Lee. Second row from the left - Sanziana Roman, Justin Dimick, Andrew MacCormick, Richard Martin, Michael Grigg, Caprice Greenberg and Timothy Pawlik **05:** Kate Oniszk & David Verzoni **06:** Nathan Opie & Renee Mostyn **07:** Shane Pappas, Justin Rowe & Aggie Cox **08:** Industry Reception President Michael Grigg **09:** Ryan Powell, Caroline Jackson, Spiro Thomopoulos & Fiona Nay

ACROSS THE DITCH AND BACK AGAIN

Academic Surgery course in Perth was inspiring

CAMERON WELLS
4TH YEAR MEDICAL STUDENT
THE UNIVERSITY OF AUCKLAND

Academic surgery is certainly alive and well within the Royal Australasian College of Surgeons. After attending the Surgical Research Society (SRS) meeting in Adelaide last November, I was honoured to attend the 'Developing a Career in Academic Surgery' (DCAS) course in Perth as the winner of the DCAS prize.

My adventures started in November last year, the morning after my end-of-year exams finished. I flew to Adelaide to attend the annual SRS meeting, held together with the Section of Academic Surgery meeting. I spent the flight preparing the slides for a research project I had been working on, trying to memorise my presentation and anticipate questions I would be asked.

When I arrived at the Basil Hetzel Institute, I was a little nervous. Watching the sessions, I was impressed by the high quality of research, which was well balanced between biomedical, clinical and translational work. My presentation went well and I was pleasantly surprised to win the DCAS prize for best presentation by a medical student or prevocational doctor. Just as exciting was managing to get a copy of the late Professor Graham Hill's autobiography, which proved to be an inspiring read on my flight home – I would highly recommend it to anyone who is able to get a copy.

Fast-forwarding to 2015; next on my agenda was the DCAS course, recently held in Perth alongside the College's ASC. I was fortunate that my award included attending the DCAS faculty dinner, which was a lovely meal with great company. A new research project is already in the works thanks to a bright idea conceived over dinner-time conversation that evening!

I picked up more than a few pearls of wisdom from the DCAS course, though to share them all here would ruin the course for future attendees! Professor Barry Marshall's keynote: 'How to win a Nobel Prize in Medical Research' was particularly inspiring, as were many of the speakers from the US and Australasia. To be in such esteemed company was a real privilege. In the words of A/Prof Mark Smithers; "Any conference you leave with one good idea is a good conference." By that measure, this must have been a great conference, as I walked home bursting with new ideas and enthusiasm.

Lastly, I would like to acknowledge and thank my supervisors and mentors, Associate Professor Ian Bissett and Dr Ryash Vather; the time you have invested in me is truly appreciated. I would also like to thank Mr Richard Hanney and the Section of Academic Surgery for the opportunity to share my experiences in this article.

My final advice to medical students and junior doctors is to find a mentor who will open a door for them, give them an opportunity and invest in their career. With a healthy dose of luck, these kinds of opportunities are available for those willing to work hard and go the extra mile. I look forward to attending both the SRS meeting and DCAS course again in the future as my career progresses.
cameron.wells@auckland.ac.nz

"This must have been a great conference, as I walked home bursting with new ideas and enthusiasm"

Women in Surgery

01: Jacinta Cover, Tina Dilevska & Amanda Foster **02:** Women in Surgery breakfast
03: Ruth Mitchell & Mikayla Couch **04:** Kirstie MacGill &Suat Ling

May 7
Ruth Mitchell
@drruthmitchell
Amazing session at **#RACS15** with **#womeninsurgery**

Indigenous Health

05: Derbarl Yerrigan group **06:** Breakfast Med Doc Lincoln Nicholls Foundation Chair Kingsley Faulkner **07:** IH Chair Kelvin Kong Recipients Foundation Chair Kingsley Faulkner
08: Indigenous Health Awards Kelvin Kong, Pat Alley, Jacob Jacob & Maxine Ronald ▶

May 7
Mikayla C@mikkymai
Hot topics in today's **#RACS15** @KelvinKongENT Indigenous health has trended every day of the conference

Plenary

May 7
Craig McIlhenny
@CMcIlhenny

@profp_edinsurg talks about the benefits of @RCSEd Faculty of Surgical Trainers Standards for trainers at **#RACS15**


01


02

01: Thurs Plenary Michael Lavelle-Jones
02: Thurs Plenary George Youngson
03: Tues Plenary Opening Session Governor General Address
04: Wed Plenary David Read
05: Thurs Plenary Questions from the Floor
06: Thurs Plenary Craig McIlhenny


03


04


05


06

The College stand and the Exhibition Hall

Credit: Binh Nguyen

Gala Dinner

May 7
Ruth Mitchell
@drruthmitchell

Changing of the guard at **#RACS15** Congratulations @davidakwatters !

01


02


03


04


05


06


07


08


09

01: President David Watters **02:** Heather Anne Field, Peter Field Rosie & Gordon Low **03:** Ian Ritchie & David Watters **04:** Ian Young Darryl Tong & Peter Sharwood **05:** Julian Smith, Marianne Vonau, Catherine Ferguson & Graeme Campbell **06:** New President David Watters & Michael Grigg **07:** Singer Fiona Campbell **08:** Lee Jackson, David Scott & Bruce Waxman **09:** Andrew Warshaw, Sherryl Wagstaff Michael Grigg

Orthopaedics


01

05


02

06


03


04


07


08

01: Andrew Suchowersky
02: Allan Panting
03: Sarah Lonie
04: Corina Preda
05: Ian Harris
06: Matthias Russ (with panel John Batten and Nigel Willis)
07: Robert Capstick
08: Vincent Vinh Gia An

LOOK WHO IS TWEETING

2015 Academic Scientific Congress generated conversation

WILL PERRY
@williamperrynz / May 5

@LarsHagander **acknowledged for his work in Bangladesh by Rowan Nicks presenter Professor Tahmina Banu at international forum** at #RACS15

DAVID WATTERS
@davidakwatters / May 7

@RACSurgeons #racs15 **Gp Cpt Holian inspiring talk - example of leadership from above to promote gender equality**

MIKAYLA C
@mikkymai May 7

@SimonRBarron **we heard from the first chair of Women in Surgery, John Royle. A key movement maker in the** @RACSurgeons **college** #RACS15

CRAIG MCILHENNY
@CMcIlhenny / May 7

@profp_**edinsurg talks about the benefits of** @RCSEd **Faculty of Surgical Trainers Standards for trainers** at #RACS15

MOLLY GILFILLAN
@molly_gilf / May 8

Akrasia - **Hippocratic notion of gap between 'should do' and 'will do'. Still applies to med ethics today says Dr Daniel Sokol** #RACS15

ADAM WESTERINK
@adamwesterink / May 8

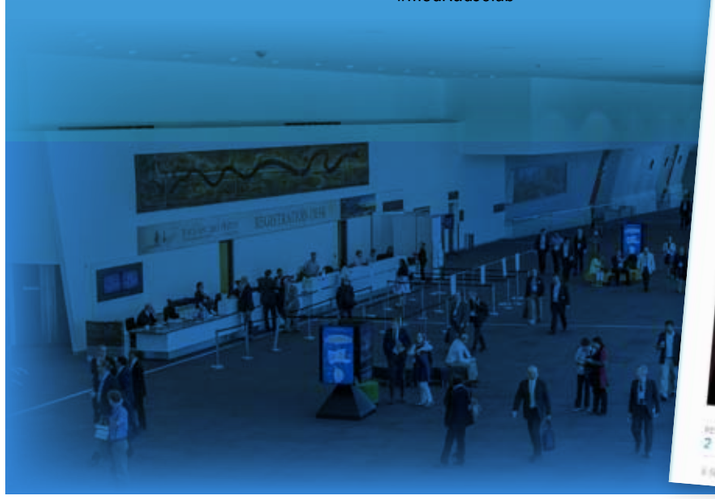
Watching a presentation from #RACS15 > **"Teamwork is the new black"** (http://cirrus.capstan.net.au/racs/asc/2015/pres/22902/player.html …). **Perfect prep for the next** #MedRadJclub

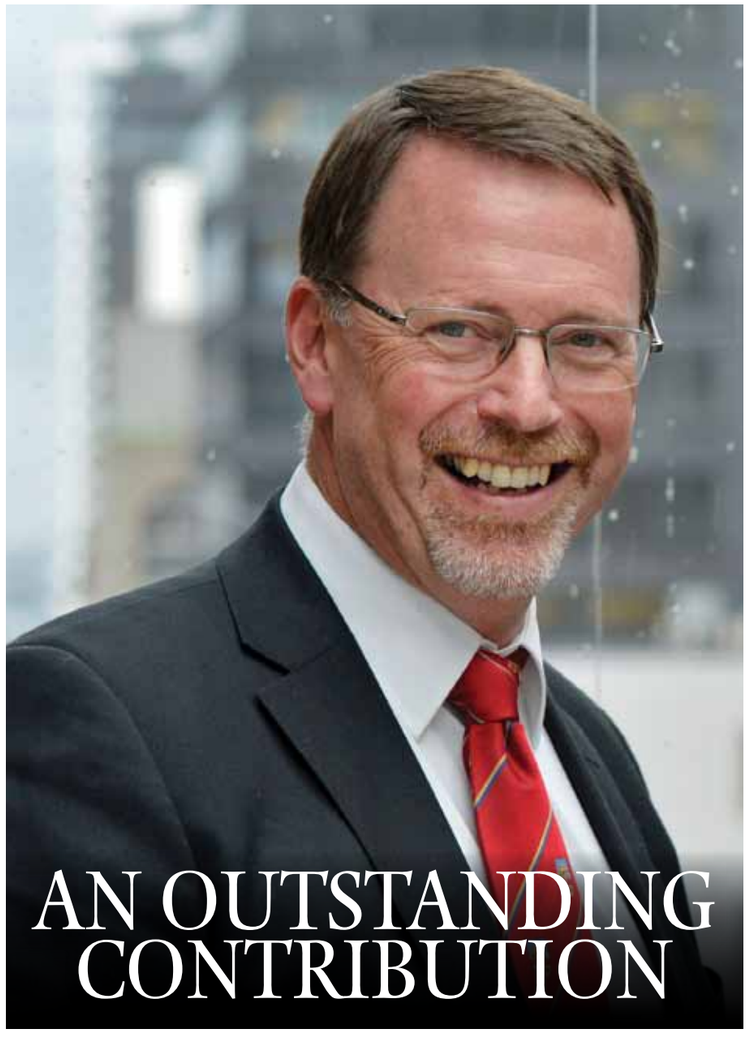
DEBRA NESTEL
@DebraNestel / May 8 Perth, Western Australia

Simulated consultants support trainees in learning professional practices... Great work Bruce Waxman #RACS15

JULIA MEDEW
@juliamedew May 6

Met a bariatric surgeon today who had had the procedure himself. I really liked that he was willing to share his own experience. #RACS15





AN OUTSTANDING CONTRIBUTION

Professor Windsor's recognition as a Fellow of the Royal Society of New Zealand is a rare honour

Professor John Windsor was recently elected as a Fellow of the Royal Society of New Zealand, a rare honour conferred to those who have made outstanding contributions to the advancement of science, technology or the humanities. Limited to just 400 Fellows from all disciplines, he is the only current practicing surgeon in the Society that dates back to 1867, when formed by Royal assent and an act of Parliament.

Professor Windsor's life in surgery began 50 years ago when he became enthralled by watching operations carried out by his missionary father in a small rural hospital in India. After returning to New Zealand in 1974 he completed a degree in Biochemistry and Physiology at the University of Otago before transferring to the University of Auckland to attend the School of Medicine. Surgical training in Auckland and a Fellowship in Edinburgh followed. In 1991 he was attracted back to Auckland as a Senior Lecturer and General Surgeon at Auckland Hospital specialising in hepato-biliary, pancreatic and gastro-oesophageal surgery. His particular interest has been the care of patients with pancreatic cancer and pancreatitis.

The last 25 years have been a very rewarding experience as a surgeon-scientist. With colleagues he formed the first HBP/Upper GI surgical unit in New Zealand, which is soon to comprise eight surgeons working in a truly multi-speciality environment to provide expert tertiary care within this demanding surgical specialty. He has helped to safely introduce a number of laparoscopic operations, including choledochotomy, splenectomy, anterior partial fundoplication, donor nephrectomy and percutaneous nephroscopic necrosectomy. Related to this 'laparoscopic revolution' he established the first purpose built advanced surgical training facility, where simulation courses allow the acquisition of surgical skills prior to patient contact.

Professor Windsor has also established a world-class research program. His primary focus has been to advance our understanding and management of acute pancreatitis, a common and potentially fatal disease bereft of specific treatment. His highly collaborative research has included studies revealing the role of gut-derived lymph in promoting systemic inflammation and organ dysfunction in acute and critical disease, developing ways to measure and treat mitochondrial dysfunction in patients, improving the classification of disease severity, and pioneering the accelerated liquefaction of infected pancreatic necrosis through percutaneous drains. In other fields of research he has helped delineate dysrhythmias of the stomach by high resolution electrophysiological mapping and developing cognitive simulation software for procedural skills training.

> *"Recognition of his surgical and scientific contributions are attested to by more than 280 peer reviewed publications, 200 invited and plenary lectures and many visiting professorships, including Harvard, Karolinska, Capetown and Singapore"*

Recognition of his surgical and scientific contributions are attested to by more than 280 peer reviewed publications, 200 invited and plenary lectures and many visiting professorships, including Harvard, Karolinska, Capetown and Singapore. Other recognition has included his election as a Fellow of the American Surgical Association and of the James IV Association.

Professor Windsor has made a number of contributions within the college and this was recognised by the award of the Gold Medal for Outstanding Service to Surgery. He helped to establish several courses, including CLEAR, Statistics for Surgeons, Surgeons as Educators, and Developing a Career in Academic Surgery (DCAS). He also convened the RACS Annual Scientific Congress in Auckland in 2013.

Through his work as chairman of the RACS Section of Academic Surgery (SAS) he has actively promoted academic surgery and been excited to note the rising membership, the re-birth of the Surgical Research Society (SRS), the strategic role of the November dual meeting of the SAS and SRS, and the formation of the Academy of Surgical Educators. He is currently focused on two ongoing projects; the development and introduction of a surgical research curriculum for all surgical Trainees, and the introduction of an integrated training pathway for clinical academics in all medical specialties.

All of these activities reflect an over-arching career commitment to the training of the future leaders in surgery. Professor Windsor has been very successful in recruiting young surgeons in training to devote time to full-time doctoral level research. He believes that that those who make this commitment gain a range of skills that will enable them to make significant contributions, including ensuring evidence-based surgical practice, development and evaluation of new technologies and management, and the acquisition and dissemination of new knowledge through research and teaching.

Professor John Windsor with wife Christine.

In his brief acceptance speech delivered in April at the Old Government House, Professor Windsor gave a warm tribute to his wife Christine for her extraordinary support over the years and also for their five children who continue to inspire him through their own careers in law, philosophy, teaching, medicine and bioengineering.

Professor Windsor described the Fellowship as a cherished endorsement of his passion to promote scientific research within the profession of surgery. He recalled when working as a Fellow for Sir David Carter in the old Royal Infirmary in Edinburgh about being "inspired by the vital synergy between science and surgery in the daily care of patients and of his ability to inspire Trainee surgeons to master both".

And on a more personal level, Professor Windsor said. "This recognition by the Royal Society, by this most distinguished company, is the ultimate in peer recognition as a scientist and I am deeply humbled." As with surgical practice, the pursuit of scientific research requires a team and he said he was 'immensely indebted to many colleagues, both junior and senior, for their inspiration, encouragement and collaboration'.

With Karen Murphy

CASE NOTE REVIEW

Delay in diagnosis of obstruction in an infant with enterocolitis

GUY MADDERN
CHAIR, ANZASM

This two-month-old infant was transferred to a tertiary paediatric surgical centre with necrotising enterocolitis (NEC). The baby was septic with a distended discoloured abdomen and associated respiratory instability requiring oscillation. AXR confirmed signs of NEC with a suggestion of perforation. A laparotomy was performed with confirmation of NEC with offensive purulent-free fluid, but no apparent perforation was seen. Formation of a double-barrelled ileostomy 90 cm from the duodeno-jejunal flexure was undertaken.

The baby was slowly weaned off ventilation and inotropes, but developed acute renal failure and a persistent ileus requiring total parenteral nutrition. Oral feeds were slowly introduced two weeks later, but were poorly tolerated with large bilious aspirates. The An Abdominal x-ray (AXR) showed dilated proximal small bowel loops in the left upper quadrant and a barium meal showed no passage of contrast through distended proximal loops. Feeds were ceased, but subsequently the ileus resolved with output from the stoma.

Feeds were slowly reintroduced, but unfortunately high stomal losses precluded full enteral feeding. A distal stomogram four weeks later appeared to exclude a distal obstruction with contrast reaching the rectum, and the baby underwent stomal closure and incisional hernia repair two weeks later. Intraoperatively it was noted that there were moderate adhesions around the stomal ends that were divided, but it is unclear from the operative notes how much of the remainder of the small bowel was inspected at the time of operation and no distal lavage of the small bowel was performed intraoperatively.

Postoperatively the baby had a persistent ileus for a week, but this appeared to resolve with decreased nasogastric losses and stool passed per rectum, so feeds were recommenced one week following stomal closure. The baby had a few mucus vomits associated with mild abdominal distension and an AXR showed dilated loops suggestive of a small bowel obstruction (SBO). There were also episodes of bradycardia and desaturation, with increased abdominal distension that necessitated reintubation. The baby had increased nasogastric losses and was not passing stool. Septic screens were negative.

A repeat AXR showed increased dilatation of small bowel loops with fluid levels, but no diagnostic features of NEC, which was considered clinically. A possibility of a distal NEC stricture and obstruction was raised in the radiology report and the option of performing a contrast study suggested. The baby needed high frequency oscillatory ventilation by the next day and the abdomen was noted to be erythematous prompting surgical review, but no change in management was suggested. A Barium study was not performed as the baby was too unstable to be moved.

Urine output dropped, requiring dopamine. Repeat AXRs showed progressively increasing distension of bowel loops with a radiological diagnosis of probable SBO, and became more cardiovascularly unstable. The baby was again seen by the surgical team and theatre was booked for a laparotomy the next afternoon.

The baby's clinical state rapidly deteriorated in the early hours of the morning with hypotension and tenderness with palpation over the left upper quadrant. A laparotomy was performed in the neonatal ICU a few hours later. The baby was found to have a small bowel obstruction secondary to adhesions and a terminal ileal NEC stricture, and an ileostomy was formed. Postoperatively the baby progressively deteriorated requiring increasing inotropic support, but despite this, urine output remained poor. The baby deteriorated further and became unresponsive. Treatment was withdrawn three days after the laparotomy and the baby died.

Reviewer's comments

It is unclear from the progress notes why the surgical team did not proceed to laparotomy two weeks prior to the eventual procedure. They may have been swayed by the patient's previous prolonged ileus. Despite concerns that the abdominal distension was secondary to an ileus, with radiological features suggestive of SBO and increasing instability, earlier exploratory surgery may have avoided the eventual demise of the patient, although there is no denying that the mortality risk of surgery in this patient was extremely high.

Stone age diets

The Paleo diet might have its merits, but...

DR BB G-LOVED

Young surgeons, Venus de Willenberg and Crô-Magnon, came independently to review their health profiles and set strategies for their lifestyle, hoping for healthy and productive surgical careers. They had taken a look at their senior colleagues and decided some had too much metabolism going on – evidenced by hypertension, hyperlipidaemia and progressing to type 2 diabetes in their 60s. Their supervisors and trainers had not only grown fine reputations in their communities, but also waist-lines! The decades of their surgical careers had witnessed a progression from normal weight (BMI 18.5-24 kg/m2), to overweight (BMI 24.5-30 kg/m2) with some tipping the scales into the first obesity class (BMI 30.5-35 kg/m2). Of course there is usually enough self-discipline amongst surgeons and their families to avoid morbid obesity (BMI >40kg/m2).

You only need to visit an airport bookshop to find food freaks or celebrities (the two are not the same) promoting their latest book on going 'Paleo'. Venus de Willenberg and Crô-Magnon each asked me whether they should adopt the in vogue Paleo diet, an approach inspired by the pre-farming Paleolithic era (pre-10,000 years ago. Homo sapiens evolved 200,000 to 100,000 years ago though it was only about 60,000 years ago that women and men first migrated from Africa.

In brief, that diet suggests that if you can't hunt, pick or gather it, don't eat it. It is hypothesized that these time periods have been insufficient for our digestive and metabolising genes to evolve and cope with the meal options we have developed. The premise is that modern foods overwhelm our ancient sluggardly genes so today's eating makes us gain weight, and develop inflammation and atheromatous plaques, type 2 diabetes, some cancers and degenerative diseases. Non-communicable diseases have come to the fore!

Whatever the Paleo diet's merits or demerits, it is sound in its opposition to processed and pre-prepared foods which are unhealthily spiked with sugars and salt. Most of us consume too many refined carbohydrates, particularly sugar and fructose, and they make us flabby. Our sodium and potassium intake have also become unbalanced, underdone on potassium and far too much sodium.

I explained that there is little doubt of the benefit of the Paleo diet for those of Venus de Willenberg's and Crô-Magnon's supervisors, trainers and mentors who have developed the abnormalities associated with metabolic syndrome. If they can discipline themselves to adopt it, by three months they are likely to lose 2cm of waistline, and within a couple of weeks their blood pressure, lipid profiles and blood sugar will improve. However, going Paleo is not their only option.

The Paleo diet does not contain gluten, nor grains. That might be important for the one per cent of the population who have coeliac disease, particularly the 50-75 per cent of whom have not been diagnosed. There may be a small percentage of others who will benefit from avoiding wheat, especially modern wheat, and going gluten free. However, the Paleo claim that our genes haven't caught up with 10,000 years of farming cannot be supported when only such a small percentage of the human race are sensitive.

The Paleo diet shuns dairy products, so if you are partial to butter, milk and cheese, you will find it challenging. If hyperlipidaemia is to be avoided your first approach should be to reduce fructose, and then to limit fat intake.

So what did I advise the still slim, but not so trim Venus de Willenberg and Crô-Magnon at the start of their surgical careers? Paleo is expensive [e.g. $25.99 for 500g of Paleo muesli], but it is healthy even if overkill – 25 per cent protein with lots of fruit and vegetables, plenty of fibre, potassium and avoidance of refined carbohydrates, fructose and sugar, and rich in omega 3s. Most of us don't need to completely shun dairy and, if not gluten sensitive, we don't need to avoid wheat, though you might want to be careful about the type of wheat.

The Paleo industry is out to convert us all. If they do they will make a lot of money. Still Paleo will usually be healthier than the average surgeon's cuisine, but it is both expensive and extreme – today's fad. The evidence base for the lack of genetic evolution is weak at best. I must also admit I am grateful for living in the twenty-first century, enjoying an average of eight decades of life, a wide variety of foods, and being fairly certain that in this life no one is likely to hunt or eat me. That is a perspective that is quite unPaleolithic and reassures me I can pass on my genes to and through the next generation.

BI-NATIONAL INITIATIVE ON ACADEMIC TRAINING

Working Party towards establishing a clinical academic training pathway

JULIAN SMITH
CHAIR, WORKING PARTY ON
CLINICAL ACADEMIC PATHWAYS

A bi-national Summit was convened in Sydney during November 2014, to discuss the significant challenges to building a sustainable clinical academic workforce, across all the medical disciplines. The RACS Section of Academic Surgery having initiated this meeting with the support of the Medical Deans of Australia and New Zealand, convened the very successful Summit. A Working Party has been established following the Summit to progress key recommendations, and to report their progress back to key stakeholders, including identifying recognised pathways for clinical academic and determining how best to support host institutions who wish to build new clinical academic training pathways with specific reference to different pathway stages.

The successful introduction of a training pathway for clinical academics has to start with an agreement that these individuals are vital to research, education and leadership in clinical medicine, and that current ad hoc approaches to their training carries significant long-term risk. It was agreed that a clinical academic is a leader who has acquired specific training and experience in research and/or education and who has chosen to make these a significant part of their professional career.

It was also agreed that a strong clinical academic workforce is a fundamental factor in delivering a cost-effective, evidence-based and quality health care system. But it was also recognised that there are many challenges to introducing a training pathway for clinical academics, including a reduced interest in clinical academic careers, low numbers of training positions and definitive jobs for career clinical academics, and inadequate funding for such posts.

These challenges have been addressed elsewhere, and the Summit attendees were fortunate to hear a presentation from Professor Stuart Carney, a key contributor to the integrated academic training pathway in the UK. Professor Carney discussed lessons learned through implementing their UK-wide program, and suggested strategies for adapting this to Australia and New Zealand.

> *“The future of medicine and surgery in particular, is highly reliant on research and education to acquire and disseminate knowledge and practices”*

An Open Forum

A number of issues and ideas raised during the Summit are being progressed by the Working Party, made up of representatives from the Royal Australasian College of Surgeons, Medical Deans of Australia and New Zealand, Royal Australasian College of Physicians, Australian Medical Association Council of Doctors in Training, Australian Academy of Health and Medical Sciences, Australian Medical Council, and a New Zealand representative. The Working Party has submitted three articles for publication, one of which will appear in the *ANZ Journal of Surgery,* with the purpose of raising the issue and generating discussion.

It has been considered important to identify existing training initiatives for clinical academics within Teaching Hospitals, Medical Colleges, Research Institutes and University Medical Schools. A comprehensive survey has been designed and delivered to these institutions. The results will enable the Working Party to draw on the experience and strengths of programs already underway and to identify potential host institutions for a pilot of a more formal integrated clinical academic training program. If successful, direct government funding will be sought to fund more clinical academic training positions.

The future of medicine and surgery in particular, is highly reliant on research and education to acquire and disseminate knowledge and practices. Ensuring a sustainable clinical academic workforce with high quality skills in research and education requires a more deliberate approach to training. It is hoped that this bi-national initiative will help to deliver this.

NEW CHAIR OF PROFESSIONAL STANDARDS COMMITTEE

Dr Catherine Ferguson has been a member of the College Council since 2010, the Chair of the Fellowship Services Committee for the past four years and is currently the NZ Censor.

A member of the RACS NZ National Board, Dr Ferguson is a past President of the NZ Society of Otolaryngology, Head and Neck Surgery from 2011 – 2013, is a RACS examiner and is Deputy Chair of the NZ Perioperative Mortality Review Committee.

She has a public practice out of Wellington Hospital and a private practice based at Bowen Hospital, and in her time away from theatre is an enthusiastic trekker, designing trips that allow her to walk through some of the most beautiful country in the world.

Having obtained her Head and Neck Fellowship at Greenlane Hospital in Auckland, Dr Ferguson became the hospital's first Head and Neck Fellow and now has a special interest in Thyroid surgery, Salivary Gland surgery, Head and Neck Surgery and Paediatric ENT.

With a strong commitment to both the profession of surgery and professionalism within it, Dr Ferguson said she had been inspired to become a surgeon through the influence of her father who was a Urologist.

"I was always attracted to the practical aspects of surgery, the idea of being able to do something to help 'fix' someone," Dr Ferguson said.

"Although there were few women at the time who chose to pursue a career in surgery, I always had great encouragement from all the surgeons I worked with as a Trainee and I regard my father as being a big influence.

"I have greatly enjoyed my career so far, particularly working with Trainees and seeing them go on to become great successes, working with my many patients and their families and even having the chance to be involved with several generations of the same family."

Dr Ferguson took up the elected position of Chair of the Professional Standards Committee following the ASC in Perth in May.

She said current issues before the Committee included investigating paediatric surgical services across a range of jurisdictions, the future sustainability of health services in NZ and Australia and on-going issues relating to professionalism.

"I agree with the (past) President, Professor Michael Grigg, that our role as professionals is at risk of being eroded, which is a serious matter," Dr Ferguson said.

"Surgeons are increasingly being considered, and seeing themselves, as members of a trade rather than members of a profession, particularly in the way we regard fees and in our approach to overtime and pro bono work.

"If we don't consider these matters as important aspects of our working lives, I believe we are at risk of losing the central defining aspects of what it means to work in a profession.

"Obviously, I understand there are issues around the work-life balance that impact upon all surgeons, but they also affect people working in other professions so our commitment toward unpaid or extra work comes down to whether or not we believe they are a part of our professional obligations."

In her role as Chair of the Committee, Dr Ferguson is also a member of the College's Expert Advisory Group set up to investigate claims of bullying and harassment within surgery.

The new chair of the College's Professional Standards Committee, Dr Catherine Ferguson, is an Otolaryngologist from Wellington, New Zealand

Expert Advisory Group

She said the College now had the opportunity to address bullying, harassment and discrimination in a way that could allow it to become a catalyst for cultural change across all aspects of medicine.

"At its most basic, this is about ensuring that all Fellows of the College and Trainees abide by the College's Code of Conduct," she said.

"However, issues around bullying and harassment are not confined to surgery.

"I think there is a need to change the culture across the entire health sector, across all aspects of the health system because bullying is found in medicine, nursing and in the allied health professions.

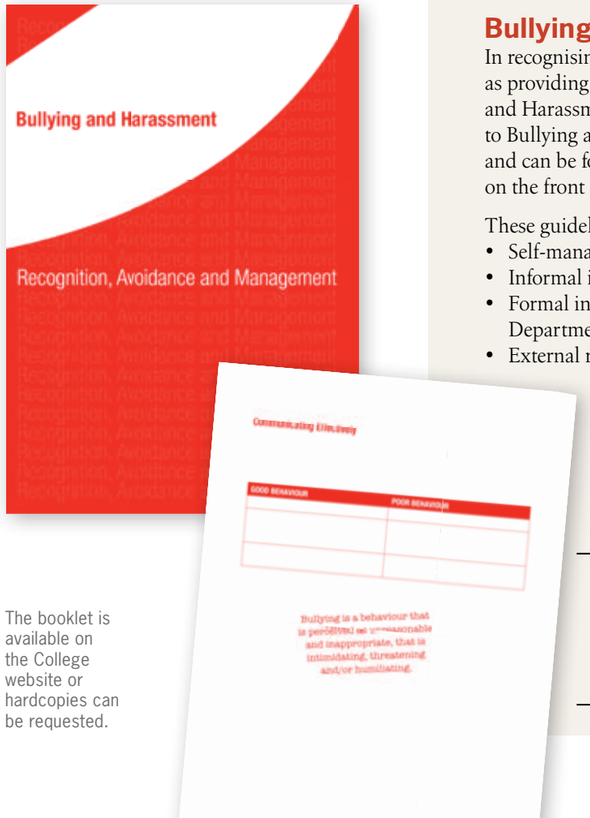
"Partly this is because medicine is based on hierarchy, and given that bullying is often about power, or the abuse of power, it occurs frequently in this setting.

"Hierarchical models are a factor, but they are not the only factor.

"I think bullying can also become perpetuated behaviour because people within the health system see it so often they don't see it for what it is; they don't recognise it as unacceptable behaviour.

"By taking this work on, no matter how uncomfortable it might be, we have the opportunity as surgeons and as a profession to set the highest standards by which other health groups could measure themselves and that can only be for the good."

With Karen Murphy



The booklet is available on the College website or hardcopies can be requested.

EAG UPDATE

The latest news from the Expert Advisory Group

A wide-ranging consultation and engagement campaign has been launched on discrimination, bullying and harassment. This includes:

Prevalance Quantitive Survey

- An independent quantitative Prevalence Survey of all College Fellows, Trainees and International Medical Graduates to find out the scope of the problem

Narrative Qualitative Survey

- A qualitative Survey with EAG calling for people who have been exposed to discrimination, bullying and sexual harassment but who do not wish to make a formal complaint, to come forward and share their experience

Issues Paper

- To be published – informed by research – seeking feedback about the cause of the problem and the actions needed to prevent it.
- To share your story you can register for interviews by telephone, Skype or face to face or by email to personalexperience@convergeintl.com.au or telephone:
- 1300 687 327 in Australia or 0800 666 367 in New Zealand.

Bullying and Harassment Guidelines

In recognising the College's role in protecting its Trainees and IMGs as well as providing guidance and safeguards for its Fellows, RACS has a Bullying and Harassment brochure available on its website. It is called Guidelines to Bullying and Harassment: Recognition, Avoidance and Management and can be found by following the link to the RACS Complaints Hotline on the front page of the College website.

These guidelines provide the following complaints resolution options:

- Self-management of issue
- Informal internal process
- Formal internal process through employer's Human Resources Department
- External resolution option.

RACS Complaints Hotline

For the lodgement of formal complaints in regards to discrimination, bullying and sexual harassment, the College also has a Complaints Hotline that can be found following a direct link from the front page of the College's website.

The Complaints Hotline phone numbers are:
1800 892 491 for Australia
0800 787 470 for New Zealand.

AN 80-YEAR-OLD CHAIN FINALLY BREAKS

With the passing of James Guest earlier this year, the College lost its last human link to the opening of the College headquarters in Melbourne.

PETER F. BURKE
SPECIALTY EDITOR
– SURGICAL HISTORY: ANZJSURG.

The recent receipt of the 'Minutes Recording the Proceedings of the Annual General Meeting of Fellows', held in Singapore in May 2014, confirm an apology from James Guest, in his 98th year.

Jim, as he was better known, was an indefatigable attender at all manner of meetings and this was no doubt a most genuine apology. His passing earlier this year also marks a most significant break in the chain of events which has stretched from the very foundations of our College and should not pass without comment.

On March 4, 2015, the College building in Melbourne had its 80th birthday; in 1935, the year of Melbourne's Centenary, the President of the Royal College of Surgeons of England, Sir Holburt Waring, officially opened the home of the then eight year old Australasian College. That evening the fourth Syme oration was delivered by Professor Frederic Wood Jones FRS.

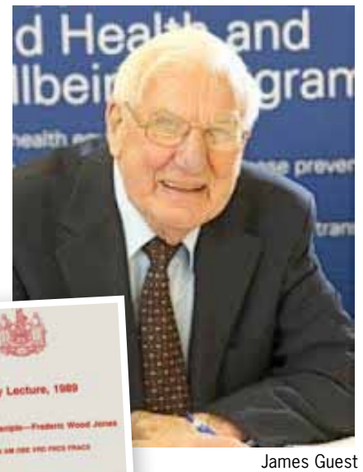
'The History of the Royal Australasian College of Surgeons from 1920 to 1935' was set down by Mr Julian Ormond Smith, the Honorary Archivist of the college, who concluded his account with the following words pertaining to Wood Jones: "The handsome, dark-haired orator with his beautiful speaking voice spoke, unaided by a note of any kind, for exactly one hour. The title of his oration was 'The Master Surgeon'. It was many, many years before any other Syme oration approached his in quality".

The death of James Stuart Guest breaks an all-important and probable solitary link with this anniversary. Our account begins in April 1919, when the Royal College of Surgeons of England and the Worshipful Company of Barbers instituted 'an historical lecture in anatomy or surgery' to be called the Thomas Vicary lecture.

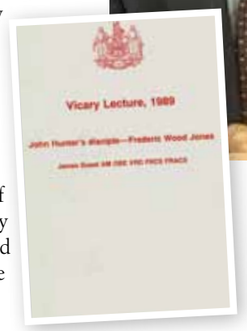
The lecture commemorates the role played by Thomas Vicary in the establishment of the Barber Surgeons Company in London in 1540; constituted by statute, the reception of the Company's Charter from the hand of Henry VIII was well recorded in the magnificent portrait by Hans Holbein, the original of which hangs today in the Barber Surgeons Hall, London, and a copy of which hangs in the Royal College of Surgeons of England. The person receiving that charter was one Thomas Vicary, the first Master of the new Company.

To be called upon to deliver this most prestigious lecture is a great honour and it was one which in 1989 fell to James Stuart Guest.

His superb presentation was entitled 'John Hunter's disciple – Frederic Wood Jones'[1]; reading his words now, one learns much about Jim Guest, of his student days and the indelible influence on his life that Wood Jones made.



James Guest



James, an only child was educated at Geelong Grammar School and from there entered Melbourne University in the Science Faculty, obtaining his BSc in 1938. It was at this very time that Wood Jones held the Chair in Anatomy at the University of Melbourne and with a group of science students he founded the 'McCoy Society for Field Investigation and Research'.

In his Vicary lecture Jim recalled meeting Wood Jones: "And it was as a zoology student in 1936 that I first met him. He was a superb lecturer, and an inspiring and popular teacher; this was when I got to know him well."

The Society was named after the first Professor of Natural Science in the University of Melbourne and expeditions were conducted in the long vacations, Wood Jones choosing uninhabited small islands providing a limited area of more or less unspoiled Australia for exploration and study.

"His tools were his eyes, his hands, a scalpel, a pen, a hand lens and (to hone the scalpel blades razor sharp) a small oilstone."

By night the student group worked, under the watchful eye of Wood Jones, writing up the day's findings and classifying and preserving specimens; the results were written up and published in the 'Proceedings of the Royal Society of Victoria'. There is little doubt that this time and the gentle discipline greatly influenced the remainder of Jim's life.

Having obtained his science degree and no doubt influenced by the opinion of Wood Jones, Jim switched to the medical course, graduating in 1941. He worked at the Royal Melbourne Hospital until 1943 and then joined the Royal Australian Navy seeing active service and pari passu developing his interest in surgery.

Following his war service the then standard course of travelling to England for further studies in surgery was undertaken; return to Melbourne leading ultimately to his becoming Senior Surgeon at the Alfred Hospital Melbourne and Dean of the Alfred Clinical School.

Ian 'Cas' McInnes has written a superb obituary of James Guest, which I shall not attempt to rephrase or paraphrase, simply to direct the reader to that most fitting Memorial.[2]

Frederic Wood Jones

During the life of James Guest, his extensive service to medicine and the community as a surgeon, anatomist, medical historian and philanthropist stands as a towering example to us all.

When one met 'Jim' Guest, one could be assured of a firm handshake, a big smile, a steady gaze and a warm, pertinent comment, usually tinged with humour; in this regard, he never failed.

From the medical history perspective he served as President of the Medical History Society of Victoria from 2003 to 2005. Over the years most of the papers that he presented to the Society related in some fashion to his association with Wood Jones.

Chance meetings with him in late 2014 summarised aptly his latter life interests. One in October at the Cowlishaw Symposium for the study of historical medical texts at the Royal Australasian College of Surgeons; the other function, in December, at the University of Melbourne, for significant donors to the Chancellor's 'Circle'.

> *"it would seem not inappropriate to acknowledge that James Guest was similarly, in turn, the 'disciple' of Frederic Wood Jones"*

Those who knew and admired this genial and unprepossessing man mourn his loss and will be forever grateful for his influence on their lives.

James Guest amply recorded the role that John Hunter played in influencing the career of Frederic Wood Jones; it would seem not inappropriate to acknowledge that James Guest was similarly, in turn, the 'disciple' of Frederic Wood Jones.

In the 'Lives of the Fellows of the Royal College of Surgeons of England 1952-1964', Frederic Wood Jones' entry concludes with these words: "His views were always original and stimulating and usually expressed without reserve or regard for persons, since he enjoyed controversy without animosity. He was essentially a humble, friendly person interested in the pursuit of truth in natural history."

These sage words apply in equal measure to James Stuart Guest FRACS, our last link with this most important College anniversary.

References:

1. *Ann R Coll Surg Engl.* 1991 Sep; 73(5):1-10.
2. http://www.surgeons.org/member-services/in-memoriam/james-stuart-guest/

Trauma clinicians are confronted with the impacts of alcohol-related harm on a daily basis. L-R Nursing Unit Manager Dominic Sertori, Director of Trauma Danny Cass, and Medical Head of Emergency Mary McCaskill.

IMAGE PROVIDED COURTESY OF THE CHILDREN'S HOSPITAL

WHY SURGEONS MUST SPEAK UP

Each week across Australia and New Zealand more than 100 people die due to alcohol-related harm

GRAEME CAMPBELL, VICE PRESIDENT
JOHN CROZIER, CHAIR, TRAUMA COMMITTEE

In July 2012, Thomas Kelly was walking through Sydney's Kings Cross at around 10pm when he was king hit by 19-year-old Kieran Loveridge. Two days later his life support was switched off in nearby St Vincent's Hospital. The following year, on December 31, Daniel Christie was admitted to hospital after an attack by 25-year-old Shaun McNeil in the same area. He died 11 days later in the same hospital.

The deaths of these two 18-year-olds triggered public debate about whether authorities were doing enough to combat violence in and around the Sydney CBD. Sadly, these types of assaults had been occurring every weekend with increasing frequency. It took their deaths to convince the wider community and the government what police, emergency physicians and residents of the area had been saying for years.

Under public pressure, the NSW Government moved swiftly to implement a suite of laws to address alcohol-related harm. A CBD-wide precinct was established, stretching from Kings Cross to Cockle Bay, and the Rocks to Haymarket and Darlinghurst. Within this zone, special licence conditions were imposed on venues, the most significant of which were the 1.30am lockouts and 3am last drinks. Small bars catering for less than 60 patrons, restaurants and tourism accommodation establishments were excluded. Mandatory minimum jail sentences of eight years for alcohol or drug-fuelled "one punch" assaults were also introduced.

The Royal Australasian College of Surgeons' position paper on alcohol-related harm has been developed using scientific evidence and the expertise of our Fellows. For years, surgeons have advocated for the recommendations in this paper – which focus on reducing alcohol availability and promotion – to be adopted by governments.

Why should surgeons care?

Alcohol-related harms cost the Australian community an estimated AU$36 billion and the New Zealand community NZ$4.9 billion each year. In each surgical specialty, every day, surgeons receive call outs, often at an inconvenient hour, to treat patients with alcohol-related injury, most of which is preventable.

Surgeons advocate in partnership for governments to do something about the alarming number of emergency department presentations. In particular, St Vincent's Hospital surgeons Gordian Fulde, Anthony Grabs, Mark Winder and Timothy Steel have been vocal about the need to address alcohol harms. Doctors Mary Langcake and Danny Cass have also lobbied politicians on the issue.

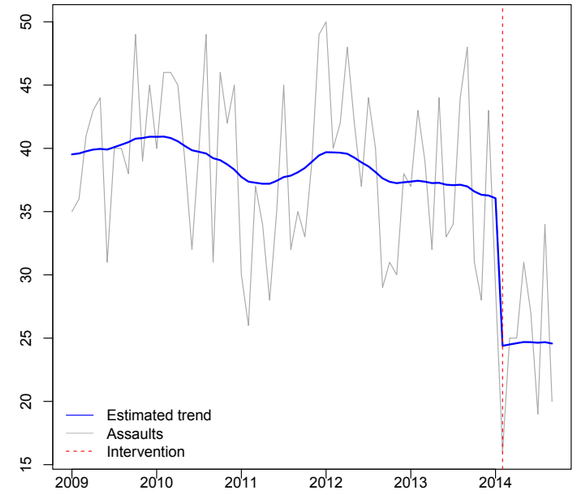
RACS is a constituent member of the National Alliance for Action on Alcohol Policy, a body formed in 2009, chaired by Professor Michael Daube. In 2013, the NSW/ACT Alcohol Policy Alliance was established and brought together 47 member organisations, including the Foundation for Alcohol Research & Education, resident action groups, and public health groups including RACS, the AMA, Cancer Council, the Public Health Association of NSW and the College of Emergency Medicine.

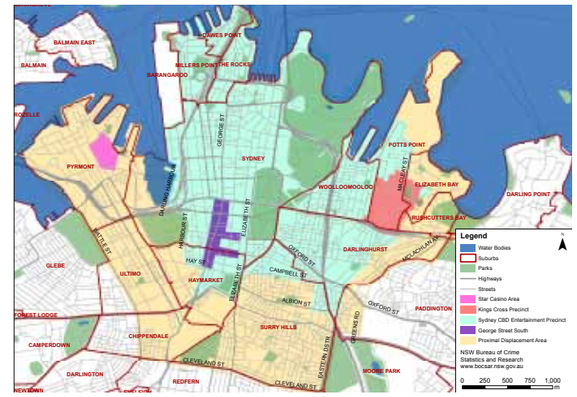
Newcastle-based solicitor Tony Brown has been an invaluable resource to various resident action groups, assisting communities to understand liquor licensing systems, processes and related regulations to address their alcohol-related concerns – in many cases pro-bono. In 2008, he helped introduce a new set of conditions in Newcastle which later became the model for the Sydney reforms. He has also helped residents in Byron Bay, Manly, Mosman, Liverpool, Casula, Bondi, and the Sydney CBD.

The NSW Police and its Association have also been pivotal in bringing about change, calling for measures that would help protect police officers dealing with violent assaults. After an officer was glassed in the eye, Police Commissioner Andrew Scipione began to use these types of attacks as a performance indicator, and introduced plastic glasses after midnight. Alcohol data was made a mandatory reporting requirement in the Computerised Operating Police System so they could track police effort dedicated to alcohol-related incidents. A joint taskforce was established, known as 'Operation Unite' and a media campaign involving surgeons and emergency physicians helped raise awareness about alcohol-related harms each year around Easter and Christmas.

What this demonstrates, is that with partnerships, government policy can be influenced to achieve major improvements in public health and safety. An evaluation by the NSW Bureau of Crime Statistics and Research published in April 2015 showed that since the legislative reforms were introduced, assaults in Kings Cross have declined by 32 per cent. Assaults in the Sydney CBD Entertainment Precinct dropped by 26 per cent, and in the sub-section area of George Street South, by 40 per cent. Across NSW there was a 9 per cent decrease. There was some evidence that assaults increased in and around The Star Casino; however, the effects were not statistically significant and the reduction in assault elsewhere was much larger than the increase around the casino.

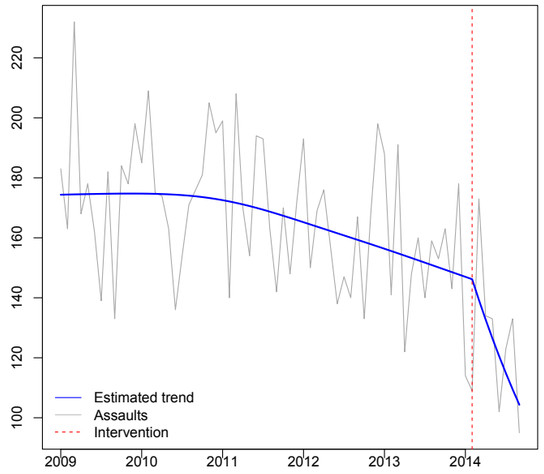
Estimated assault trend for the Kings Cross Precinct from January 2009 to September 2014. Assaults dropped by 32% after the reforms were introduced.

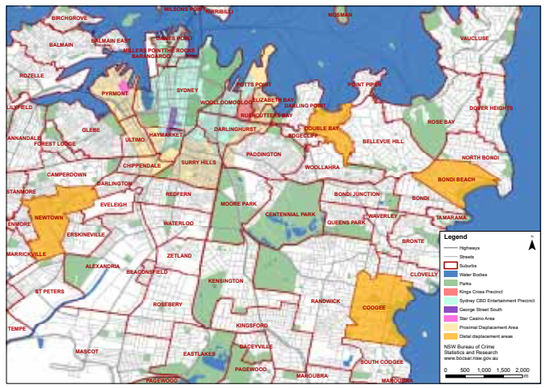




Two areas were targeted as part of the NSW legislative reforms - the Sydney CBD Entertainment including George Street South and Kings Cross.

Estimated assault trend for the Sydney CBD Precinct from January 2009 to September 2014. Assaults dropped by 26%, and by 40% in the sub-section area of George Street South after the reforms were introduced.





Distal displacement areas in orange including Bondi Beach, Coogee, Double Bay and Newtown were monitored for any increase in assaults.

The success of these reforms prompted the Queensland Labor Government in March to announce its plans to implement a state-wide roll out of the Newcastle model, which led to a drop in assaults and an increase in sales in other sectors. The RACS Queensland Committee lobbied both parties in the lead up to the March election, joining the Queensland Coalition for Action on Alcohol and including alcohol reforms as part of its election position statement.

Despite fewer assaults in NSW, particularly in areas where alcohol availability has been reduced, alcohol-related harm still constitutes a significant and concerning proportion of the surgical workload. A new study published in May in the journal *Addiction* shows that almost 5 per cent of the world's adult population (240 million people) have an alcohol use disorder. Each week, on average, 100 Australians and 20 New Zealanders die, and a significant proportion of emergency department presentations in both countries are alcohol-related. In 2011 there were 29,684 police-reported incidents of alcohol-related domestic violence in Australia for states and territories, where data is available.

Australia and New Zealand have social cultures which support alcohol abuse, assisted by industry sponsorship of major sporting events where many sporting heroes openly celebrate their achievements by getting drunk. Young people are increasingly exposed to alcohol advertising from a dazzling array of sources, most notably through social media, where there is almost no regulation. The alcohol industry has undue influence on policy makers and they should not be allowed to coerce the development of alcohol policy.

RACS public health advocacy efforts, in partnership, help develop alcohol policies that have the potential to improve community health, amenity and safety, and save thousands of lives.

With Amy Kimber

Doctor wins Surgical Education Research Prize

The Academy of Surgical Educators would like to congratulate Dr Pramudith Sirimanna for taking out this year's Surgical Education Research Prize at the RACS Annual Scientific Congress. The Surgical Education Research Prize is awarded for the best research paper presented during the Surgical Education program at the Annual Scientific Congress (ASC). Dr Sirimanna presented the findings of his educational research entitled 'Validation of a virtual reality simulation model for laparoscopic appendicectomy and incorporation into a proficiency-based curriculum'.

Presentations are scored using the following criteria: abstract quality (20 per cent), scientific merit (40 per cent) and quality of presentation (40 per cent). The Surgical Education Research Prize was this year judged by Surgical Education Convenor Prof Jeff Hamdorf, Dr Rick Satava and Dr Rhea Liang.

The prize is open to all RACS Fellows, Trainees, International Medical Graduates, researchers, junior doctors and medical students who present research papers in the surgical educational program at the ASC. The prize is a certificate and cheque for $1000.

An article on Dr Sirimanna's work will be published in the next edition of *Surgical News*

PROPOSED NEW RULES FOR COSMETIC SURGERY

Cosmetic surgery in Australia is a billion dollar sector. Over the years, a number of celebrated cases have highlighted the need for formal intervention or regulation

MICHAEL GORTON
COLLEGE SOLICITOR

The Medical Board of Australia is proposing new guidelines for cosmetic, medical and surgical procedures, which are now open for consultation.

The key changes include:

- ✓ The operating doctor should be the first point of contact with the patient.
- ✓ A full assessment should include reasons for the procedure, the understanding of the patient and clarity of the patient's expectations to determine if they are realistic.
- ✓ If there are indications of underlying psychological issues, referral should be made to a psychologist or psychiatrist who works independently of the treating doctor.
- ✓ Informed consent should be obtained, and reconfirmed on the day of the procedure.
- ✓ There should be a cooling off period of at least seven days between the initial consultation, the giving of informed consent and the procedure.

For patients under the age of 18, the guidelines consider:

- ✓ Full assessment of the patient's capacity to consent.
- ✓ Have regard to the views of parents, to the extent that it is practicable.
- ✓ If there is no medical justification for the procedure, a cooling off period of three months, followed by further consultation.
- ✓ Encouragement for the patient to discuss the issue or concerns with their GP.
- ✓ Assessment by an appropriately qualified health professional (psychiatrist, psychologist or specialist counsellor).

The practitioner should have a suitable patient management plan covering a range of specified information, together with full information regarding the financial arrangements and cost implications of the procedure.

Some States (Queensland) already have restrictions on cosmetic procedures for those under 18.

In addition, commentators have raised the expectations that the locations for the surgery should be at an equivalent standard to a registered day procedure centre. Issues of patient safety remain a concern.

Further details of the guidelines can be found on the AHPRA website in relation to the Medical Board of Australia

IMPROVING PLASTIC SURGERY

Dr Nicola Dean has had an extremely productive and sometimes hectic life since moving to Australia from her native Scotland in 1998

Dr Nicola Dean with daughter Eva Ullinger and son Samson Ullinger.

Prior to coming to Australia, Dr Dean completed her basic surgical training and received her FRCS (Eng) before working for a year in Plastic Surgery in Leeds. She then settled in Adelaide with her Australian husband and took up a research project investigating wound healing, a position made available through the strong professional links between local plastic surgeons and those in Leeds.

Then, with the long term goal of attaining a training position in Plastic and Reconstructive Surgery, she completed a PhD on skin pigmentation of the areola in breast reconstruction through the University of Adelaide and had two children, all in the space of three years.

Having completed her specialist training in 2007, Dr Dean then went on to help establish a dedicated breast reconstruction clinic at the Flinders Medical Centre in 2008, after spending a Fellowship year with her family back home in Scotland.

In the years following, Dr Dean served as the College's SET Trainee supervisor for the Plastic Surgery Unit at Flinders Medical Centre from 2010 – 2014, became a senior lecturer at Flinders University, conducted further research, designed and delivered a Basic Surgical Science course for medical students and supervised other PhD research.

Now, she is Head of Department of the Flinders Medical Centre's Department of Plastic and Reconstructive Surgery leading a team of 27 staff, including seven consultant surgeons and is in the process of co-editing a new chapter for the 'Oxford Textbook of Plastic Surgery'.

"I chose to begin my career in Australia this way because I have always thought that undertaking academic research is an important part of being a good surgeon," Dr Dean said.

"I think surgeon scientists are very important to the profession because it is crucial to question dogma and accepted practice; the history of surgery is full of people who have done just that and moved surgical care forward.

"I also knew that being a new migrant, I was not likely to get straight into specialist training so it seemed like a good time to have a family and while it was hard to be a Trainee with young children, I am extremely lucky to have a wonderfully supportive husband who took on most of the childcare responsibilities."

Dr Dean described her working life as comprising 70 per cent breast reconstruction surgery following mastectomy with the remainder comprising general plastic surgery treating facial fractures, hand trauma and skin cancer.

She said she had gravitated toward plastic surgery following a plastics rotation in Leeds.

"I was a student in Leeds at a time when surgeons there were doing very exciting reconstructive work and I could see there was great room for development in the field, particularly in that aspect that combines lateral thinking with scientific principles," she said.

"It's creative and fulfilling work and no two surgeries are ever the same.

"I also find the psychological aspects of breast reconstruction extremely interesting, in terms of how my patients see themselves and what they expect from surgery.

"My mother was a psychiatrist in the UK and was involved in the first randomised trial of breast reconstruction surgery conducted there and she was analysing just these issues while I, as a seven-year-old, stapled the survey questionnaires for her."

It was, in part, the interest in long-term outcomes in this group of patients that drove Dr Dean to establish a dedicated breast reconstruction unit at the Flinders Medical Centre.

She said she wanted to provide a dedicated service so that mastectomy patients would know where to go to explore their options in a sensitive environment and for the unit to act as a driver for breast reconstruction research.

Since its establishment in 2008, the unit has conducted 600 new patient consultations and completed over 300 breast reconstructions.

"When I was first appointed as a consultant at Flinders Medical Centre I could see there was an unmet need in our breast cancer patients particularly because the number of reconstructive surgeries was quite low compared to the number of mastectomies conducted," Dr Dean said.

"Some of these mastectomy patients had previously had to wait a long time for a consultation to discuss their options and when they did get an appointment, many of them were being seen in hectic clinics covering hand trauma and other general plastic surgical problems that made for an unconducive environment for discussing their problems.

"Post mastectomy reconstruction is a very emotive issue and these patients are people who have already survived something terrible and deserve to be treated with care so I felt very grateful at the time for the support of my colleagues in creating this dedicated unit."

Passion for Academic Surgery

Of particular research interest to Dr Dean is Clinical Effectiveness Research including Patient Reported Outcome Measures.

She said that one of the PhD candidates she was now supervising, Dr JiaMiin Yip, was analysing which factors played the greatest role in patient satisfaction rates post reconstructive surgery.

The results are surprising.

"This research indicates that over and above the size and shape of breasts and even recovery times, the single biggest factor was the patient's pre-operative experience, that is, how satisfied they were with their involvement in decision-making and their sense of personal empowerment," Dr Dean said.

"This fits in with a growing realisation within surgery that it's not enough to just measure mortality and morbidity; we should be measuring our results against the goals we established with our patients in the first place.

"In breast reconstruction surgery, for instance, we could measure complication rates, wound healing and DVTs, yet some patients are quite prepared to tolerate such complications as long as the end result is what they had in mind.

"Therefore, we need to know the patient's psycho-social well-being before and after surgery, their sexual well-being before and after surgery and physical symptoms such as pain and discomfort before and after surgery.

"We use very detailed questionnaires to help us analyse these factors, but I believe this type of analysis is important across all surgical specialties because it shifts the focus away from us as surgeons, and what we're happy with, back to the patient.

"Breast cancer treatment has come such a long way that where we used to be focussed on removing the cancer, we now have the opportunity to take a broader view to incorporate individual patient well-being."

Dr Dean said she was delighted to have made her home in Australia and particularly thanked those senior Fellows who had supported her early in her career. In particular, she thanked Dr Philip Griffin, the former head of the Plastic and Reconstructive Surgery Department at Flinders Medical Centre, Clinical Professor Rob Padbury, Director of the hospital's Division of Surgery and Professor David Watson, head of the Department of Surgery at Flinders University.

"Throughout my surgical career I have had wonderful support from senior male colleagues," she said.

"I have never experienced even a whiff of discrimination based on my gender, or because I was a foreigner, even from men who may have seemed outwardly conservative and traditional."

Yet perhaps her greatest supporter is her husband, John Ullinger, a potter and ceramic artist who works from a studio at home.

"Some people are surprised that an Australian artist and a Scottish surgeon would find each other, but there are a number of links in our professional work," she laughed.

"We both understand form and shape and modelling and moulding and I feel very fortunate that a holiday romance in Australia led to a wonderful family life."

With Karen Murphy

Successful information session

The outgoing ACT Chair reports that it's been a busy year so far in Canberra

WENDELL NEILSON
CHAIR, ACT REGIONAL COMMITTEE

Firstly I would like to welcome the new Health Minister for the ACT, the Honourable Simon Corbell. He has taken over the reins from Katy Gallagher, who has become a Federal Senator. I am looking forward to continuing the constructive relationship that exists between the ACT Health Directorate and RACS.

The reduction in alcohol fuelled violence that we have seen in some of Sydney's "hot spots" with the "lock-out" policy is very encouraging. I would like to see a similar policy introduced in areas of Canberra from where we frequently see unnecessary trauma arising. This will be one of the topics to discuss with the new Minister at our meeting in June.

The Shock and Trauma Service at The Canberra Hospital has commenced its trial of 'The Prevent Alcohol and Risk-Related Trauma in Youth Program' (PARTY Program), and this has been extremely well received by the schools that have so far participated. The next challenge that faces us is to secure ongoing funding. The initial pilot program received funding for 12 months from the NRMA-ACT Road Safety Trust, which has subsequently been dissolved, and so ongoing funding is not guaranteed. Certainly the interest from the Education Department has been immense, with the pilot schools and the schools that haven't participated being very keen to go through the program.

The ACT Regional Committee of RACS invited Interns, Residents and 3rd and 4th year Medical Students interested in "Surgery as a Career" to hear first-hand about:

- The surgical training pathway and how do I get started
- Subspecialty training e.g. paediatric surgery, neurosurgery, plastic surgery and beyond
- The practicalities of running a surgical practice
- Rural vs Metropolitan Surgery
- Women in Surgery
- And many other topics

The information evening was held at the Canberra Hospital on March 24 and was very well attended.

The regional training hub has entered its second year, and is going strong. We have a range of Trainees at various SET levels and a range of positions to suit their level of experience. With the new SET selection criteria and the abolition of SET 1 positions, it has necessitated the juggling of some positions, but we are excited about the program that ACT provides. It has also made us look at our own teaching program for the senior resident/unaccredited registrars to try to ensure that they are qualified for the new program's selection.

I wish the incoming Chair, Siva Gananadha well in his new position. Gananadha is an Upper GI Surgeon who I have known personally since we were junior registrars together in Sydney. I have every confidence I am leaving the ACT in good hands.

ANNOYANCE OF THE GPS

Why the tone of arrogance?

BY **PROFESSOR GRUMPY**

There is one thing that annoys me and that is GPS. I used to love them as they could guide you in cities that you don't know and tell you how far away your goal was (and how late you were going to be to that concert). I am sure that the more recent GPS are programmed to annoy. Firstly there are the routes that they suggest. If you use them in a city with which you are not familiar they are fine as you do not necessarily know that the route is bizarre – you just need to show blind faith.

However, in your home city they can be damned annoying. On one occasion it told me to turn right just before a major intersection which was clearly absurd as it took me off the correct quick route. We curmudgeons are very determined and I spent several hours working out why this strange route was suggested. Eventually I found that the suggested route was 10 metres shorter – big deal.

On another occasion the devious electronic device sent me on a dirt road in the near country areas of my city. I was vaguely familiar with how I should get to my destination but not 100 per cent sure, so I obeyed the rather arrogant dominating voice. The road was so rough that I got a blowout from the potholes, was late for the social engagement, arrived with dirty hands and clothes from changing the tyre and paid $280 for a new tyre. What's more, I did not really want to go to the social event. In the interest of marital harmony I cannot say who persuaded me to go to that cursed event.

And then there is the voice. They always seem to have a tone of arrogance and superiority in them: "I know better – do as I say!" We curmudgeons also note that the default voice is always irritating - male or female. I have had some relief from the stress of being bossed around by this irritating voice by telling it off. However, that is not a safe option as the name of the disembodied voice in my car is the same as Mrs Curmudgeon.

I am sure that the programmer has made the voice get a little higher pitched and terse if you ignore the directions given. The implication is, "You imbecile, listen to what I am telling you". I am even more suspicious that a much more malicious intent is in the programming. Once, when driving west along the Great Ocean Road, I tried my usual stress relief. The response was that it kept telling me to turn left. There are no roads to the left – only a 100 metre cliff and the ocean.

IN MEMORIAM

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

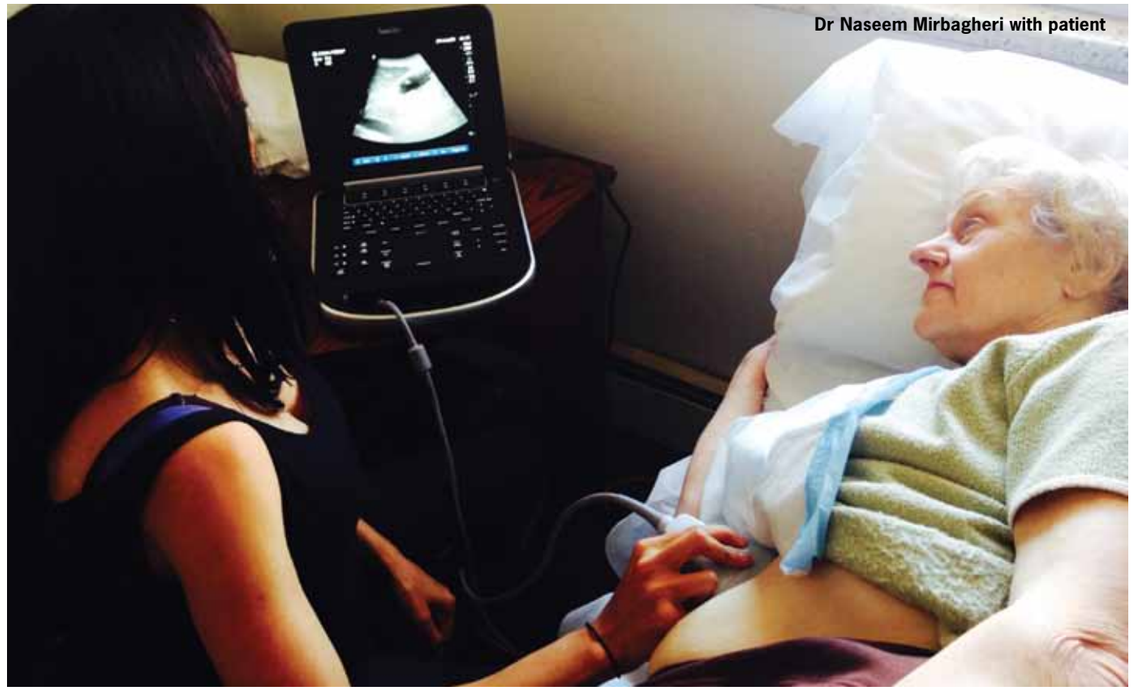
John Doyle,
Vic Fellow
David Gunter,
Vic Fellow
George McLeod,
Qld Fellow
John Jose,
SA Fellow

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

Informing the College

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

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



Dr Naseem Mirbagheri with patient

A USEFUL BEDSIDE MANNER

Foundation for Surgery Peter King Research Scholarship recipient Dr Naseem Mirbagheri has completed her study on using bedside sonography for measuring post-operative gut function

RACS Fellow, colorectal surgery Trainee and PhD candidate Dr Naseem Mirbagheri has conducted and completed a study investigating the use of bedside sonography to measure liquid gastric emptying as a means to assess post-operative gut function in patients who have had abdominal surgery.

The recipient of a 2014 Foundation for Surgery Peter King Research Scholarship, Dr Mirbagheri conducted her research to determine if bedside sonography could offer surgeons a reliable diagnostic tool to measure post-operative gut function.

For the study, conducted through the Academic Colorectal Unit at Concord Hospital, Dr Mirbagheri recruited 30 healthy volunteers and 30 patients who had undergone major colorectal surgery and measured gastric emptying using a portable ultrasound machine.

Each patient was given 250mls of water while Dr Mirbagheri measured the gastric antral cross-sectional area every ten minutes to determine gastric emptying, measured as time to complete emptying of water.

While her results are still awaiting peer review, she said the study was the first to find that sonographic assessment of gastric emptying – as a surrogate measure of gut function – was practicable and useful in patients after colorectal surgery.

"My main aim with this research was to find out if such a method of measuring gastric function was feasible in a postoperative setting," Dr Mirbagheri said.

"The rate of prolonged ileus alone is reported to affect up to 14 per cent of patients after major colorectal surgery, however, it is a poorly defined clinical term with no objective markers to assess risk factors and limited modalities to assist diagnosis," Dr Mirbagheri said.

"The clinical signs surgeons have traditionally used to assess post-operative gastrointestinal dysfunction, such as nausea or vomiting, abdominal distension, delayed passage of flatus or faeces, are unsophisticated, nonspecific and may be influenced by other postoperative factors.

"I wanted to determine if ultrasound technology could offer surgeons a more objective assessment to facilitate more tailored post-operative care.

"The secondary aims were to establish the normal range of gastric emptying in a cohort of healthy volunteers using our technique, measure changes in the gastric emptying rate after major colorectal surgery and to assess the impact of gastric dysfunction as assessed by sonographic technique on postoperative gastrointestinal outcomes."

Working under the supervision of Professor Marc Gladman, the Director of the Academic Colorectal Unit at Concord Hospital, Dr Mirbagheri said she was particularly interested in assessing whether sonography could give surgeons another diagnostic tool to measure post-operative gut function that would be less burdensome and expensive than the tests currently used such as transit studies.

"Gastric emptying scintigraphy is the gold standard technique, but this relies on ingestion of a radioactive test meal followed by gamma camera images of the abdomen and is not a bedside tool," she said.

"This technique is also limited by its exposure to significant amounts of radiation, costly gamma cameras, a time-intensive protocol, a lack of standardisation of the test meals and the position and timing of acquired images.

"Sonographic assessment of the gastric function, however, has several advantages.

"It has the capacity to provide both quantitative and qualitative information, imposes no radiation risk to the patient or technician and the technique has already been established and validated."

Dr Mirbagheri said that finding a useful bedside tool to measure gastric function was also important now that post-operative patients who had undergone abdominal surgery were routinely given food and water the first day following surgery as part of the Enhanced Recovery of Patients Program.

She said that this paradigm shift in surgery made it important to tailor this early introduction of oral intake based on the functioning of the gastrointestinal tract.

"Even though surgeons are not radiologists, we have the underlying anatomical knowledge so I believe surgeons can easily use ultrasound technology as an extension to their clinical armamentarium," she said.

RESEARCH HIGHLIGHTS of Dr Naseem Mirbagheri

2015
– Sir Roy McCaughey Surgical Research Fellowship

2014
– RACS Peter King Scholarship
– 3min PhD thesis competition winner
– Early Career Research Award - Concord Repatriation General Hospital
– NHMRC, Postgraduate Scholarship

2013
– Best Colorectal Paper Presentation, Peter Douglas Prize
– Australian Postgraduate Award, University of Sydney

2012
– Marshal Prize for Best Research Presentation

"We know that the sooner patients return to normal gut function, the shorter their hospital stay – so to have an easy and affordable way to measure this could also have benefits to the health system."

Dr Mirbagheri is also in the last year of completing a PhD Thesis on Phenotypic Variations in the Central and Peripheral Mechanisms of Sacral Neuromodulation in Faecal Incontinence with funding provided both by the College and the National Health and Medical Research Council (NHMRC).

She said she took on the sonography study while she gathered the resources and navigated the ethics approval system to begin her PhD and last year presented her findings to the Surgical Research Society of Australasia.

A mother of two young children, Dr Mirbagheri has won multiple research awards including being a finalist last year of the Early Career Research Awards and the 3min PhD thesis competition presented by Concord Hospital.

She said that she had been attracted to colorectal surgery because of an abiding passion in providing optimal care for patients suffering from pelvic floor disorders.

"As a female surgeon I have long wanted to help these patients, most of whom are women and most of whom suffer such disorders – particularly faecal incontinence – primarily because of obstetrics injuries," she said.

"However, we now appreciate that faecal incontinence is a multi-factorial disorder and possibly a progressive disease in some patients.

"We also know that sphincter injuries are quite commonly caused during childbirth, yet faecal incontinence is not so common immediately after birth with peak incidence during middle age.

"In recent years, it has become apparent that continence is dependent on far more than anal sphincter function alone. Rather, it represents a complex interaction between somatic, enteric and autonomic nervous systems and smooth and striated muscles under higher cerebral control. My PhD particularly focuses on the possible role that the central nervous system plays."

Dr Mirbagheri thanked the college for the support given to her over the past two years and said she would not have been able to undertake the research without it.

"I greatly enjoyed doing the sonography research because it was very clinically oriented," she said.

"I liked the fact that I could work every day with patients, I could understand their problems and felt like I could help them while they were helping me.

"I also appreciated for the first time that being a good surgeon is about much more than being good at surgery.

"I think academic research is vital in allowing surgeons to become good decision-makers, giving us the skills needed to understand complex data, appraise the literature, thus ensuring that we base our managements on the best current evidence.

"The downside with any research, however, is that you quickly realise how much you don't know and how much there is to learn."

The Foundation for Surgery Peter King Research Scholarship was established in recognition of the contributions of Mr Peter King to the College, particularly in the area of rural surgery. The purpose of the scholarship is to support research on a topic relevant to the practice of surgery outside metropolitan areas.

With Karen Murphy

Dr Mirbagheri

Audience, Impact & Conferences

The importance of conference presentations should never be overlooked

GUY MADDERN
CHAIR, ANZASM

In previous articles I've written on a measure of publication and author success (H-scores) and how to get your work noticed (5 top tips).

The one shortcoming of this measurement and promotion is that it doesn't provide feedback on your audience. There is little you can do to identify the readers of your work, or whether you even reached your intended audience. In addition, any dialogue related to a published manuscript is often limited to a letter in response, or more informal communication on the email which may not be representative of the readership as a whole.

One of the best ways to create impact and to get your work noticed by the right people is through conference presentations. Conferences bring together your target audience and place them right there in front of you – literally.

To date, ASERNIP-S research has been featured in 319 presentations and talks, and, I am pleased to note that ASERNIP-S staff have recently had a further three presentations accepted; two at the HTAi and one at the HTAsiaLink conferences.

HTAi is the leading international conference for Health Technology Assessment, and this year's conference is being held in Oslo. As it typically is the main conference for North American and European HTA agencies, it provides an excellent opportunity to reach a broad range of our counterparts quickly. HTAsiaLink is a newer conference, and although held less frequently it allows engagement with HTA agencies that are closer to home.

The ASERNIP-S research team will be presenting work completed for the Victorian Department of Health and Human Services, a Medical Benefits Scheme review and a recent report for the Health Policy Advisory Committee on Technology (HealthPACT):

- 'The application of rapid review and mini-HTA methodologies in the development of Australian health policy'
- 'Image guidance reduces total, major and orbital complications in complex sinus surgery: A systematic review and meta-analysis'
- 'Horizon scanning on a range of orthopaedic technologies: experience and outcomes'

Presentations like these allow us to demonstrate our achievements to our target audience; they provide us with opportunities to improve our professional networks; and – as we've all seen at the recent ASC – they provide researchers and innovators the opportunity to debate, test and develop new paradigms.

I believe conference presentations are an excellent way to promote ones' work because they provide a level of immediacy to one's peers. They are also critically important opportunities for ASERNIP-S and the College to continue to demonstrate our place as a leading surgical HTA and research agency.

GJ ROYAL LECTURE

The following is the second part of the GJ Royal Lecture given by Michael Grigg at the Vic ASM in October 2014

MICHAEL GRIGG
FORMER PRESIDENT, RACS

In those days, before political correctness came to rule the world, patronage was vitally important. Ian Galloway was the Senior Surgeon in Hull and a good friend of Averil Mansfield who had just been appointed to succeed the very well-known Felix Eastcott at St Mary's. Many 'firsts' had occurred within the walls of that great hospital – the first ECG, the first carotid endarterectomy and, of course, it was where penicillin was discovered. St Mary's was perhaps the most famous vascular surgery hospital in the world.

It was Ian Galloway who put my name forward. One day I travelled down to London by train for an interview and returned to Hull somewhat glum. Senior registrar positions at St Mary's were highly sought after. It was pointed out to me that I lacked even the most basic requirements and credentials – I was left with the distinct impression that I was an audacious, Colonial upstart who didn't even know the first thing about rugby.

Rugby, especially hospital rugby, was very big among the London medical schools and there was none bigger than St Mary's who routinely supplied a number of players directly into the national team. I was beginning to think that it might be time to head home when out of the blue the appointment to St. Mary's mysteriously materialised and, packing my car with all my worldly possessions, I headed south to London.

Accommodation in London has always been tricky. A friend of mine offered to sell me his apartment in Canary Wharf for 35,000 pounds, but it was a long way from St. Mary's so I turned him down. This turned out to be a bad decision as only few years later, while I was still in London, the same apartment sold for 950,000 pounds! Instead I settled for renting a spacious one bedroom flat within walking distance of St. Mary's in Old Marylebone Road. This was to be home for the next few years.

It had two things wrong with it; one it was a basement flat mostly below ground and secondly, it was beneath a brothel though many of my colleagues at St. Mary's did not see this as a distinct disadvantage. Entry to the flat was in fact through the brothel – not a problem since it was open 24 hours a day, but always required some explanation when bringing a young lady back for a cup of tea the first time! And I had the most prized possession of all – a reserved car parking space in Central London.

London Living

This came about through serendipity. You know what serendipity is – it is when you go searching for a needle in a haystack and find the farmer's daughter instead. Well in my case it was the rather attractive secretary of the Dean of St Mary's. I had met her whilst still in Salisbury; I had travelled up to London for a Fulham staircase party – you know the type – everyone wedged into a small flat standing around on the staircase, a drink in your hand, trying to make small talk. We had remained in touch, fortunately, meeting up every now and then, and on my first day at St Mary's she slipped me the car-parking pass with the advice not to say anything to anyone. Advice I strictly adhered to for the next few years.

At St Mary's I worked with three internationally well-known and highly regarded vascular surgeons – Averil Mansfield, John Wolfe and Andrew Nicolaides. I became friends with them all and each had different interests and strengths. Add into the mix the fiery unpredictable Professor of Surgery, Hugh Dudley, with whom I definitely had a 'love-hate' relationship, I found my political skills improving almost on a daily basis.

After 18 months at St Mary's, I was beginning to think that I might not ever leave the UK, but I also decided to resign my secure clinical job and take an initially unpaid position in the Irvine Cardiovascular Research Laboratory. This was unheard of and brave I have to tell you – no-one resigns a senior registrar job since it will inevitably lead to the security of a Consultant's position, and living in London without an income could end up being very short-lived. But I was lucky, St Mary's made an extraordinary appointment; Averil Mansfield was supportive by way of private practice, John Wolfe secured a research grant and I commenced work in the relatively new world, for me at least, of research. The first few months were slow and then very productive and I published 29 papers in the next 12 months plus numerous book chapters.

Academic Surgery

So what did I publish on? Well virtually any and everything from DVT prophylaxis to infected aortic grafts and aorto-enteric fistulae. But in the mid 1980's, the Vascular world was just beginning to feel the rumblings of a new technology that was to revolutionise our practice as Vascular Surgeons. And that new technology was duplex scanning. In many ways, I was in the right place at the right time. I became immersed in physics and mathematics concepts of kinetic and potential energies – distant memories from my secondary schooling. I got to learn about fast fourier transform algorithm analysis, about pixels and about piezoelectric crystals. A new technological tool was emerging, in many ways an engineering masterpiece, but what was its application to be? How could it be applied to achieve translation into meaningful clinical practice?

Duplex was the term coined to describe the combination of two sorts of ultrasound information – B mode ultrasound and Doppler ultrasound. Ultrasound is high frequency sound waves. And waves have only two characteristics – the height of the wave and the frequency of the wave. B Mode referred to the height of the wave and Doppler to the frequency. And ultrasound can penetrate tissue. It was relatively easy to determine the speed of ultrasound in tissue and knowing this meant that one could determine the exact depth of tissue being sampled. For example, if it took one millisecond to reach point A within the tissues, emitting Ultrasound and waiting two milliseconds – the time for the wave to get there and then return – meant that one could interrogate point A. And by interrogation, I mean analyse the returning wave. Bmode refers to the analysis of the height or amplitude of the returning wave. At point A, some of the ultrasound is absorbed and some is reflected depending on the nature of the tissue. The amount of absorption affects the amplitude of the wave. For example, fluid absorbs almost all of the US appearing black on a normal Bmode image whilst bone reflects almost all of it appearing white. But in between various shades of grey are ascribed depending upon how much is absorbed and how much is reflected. In the beginning there were only 16 shades of grey, but now it is common to have 4096 shades. Indeed this is perhaps the biggest change in US – the vast improvement in the image resolution.

But the other analysis that we could undertake on the returning wave from point A was the change in frequency of the returning wave as compared to the emitted wave. And this is where things got very interesting because the only thing that would change the frequency of the wave was if it hit something that was moving. And of course in tissue the only things that are moving are the blood cells.

And more exciting, the change in frequency was directly proportional to the speed of the thing that it hits – for the first time we could measure the speed of blood cells. But how would this help us?

Publishing

In 1988, there were three major journals for Vascular surgical research – the J of *Vasc Surg, American, The European Journal of Vascular Surgery and the British Journal of Surgery* and in that year I managed to publish papers in each on different aspects of what I called the V2:V1 concept. V2V1 is still used in ultrasound labs all over the world today, but no-one remembers where it came from, but now I hope you do!

To explain the V2V1 concept I want you to imagine that you are watering your garden with a hose. For the younger members of the audience I want you first to imagine that you have a garden and you want to keep it alive! Well water is coming out the end of the hose. If you then put your thumb over the end of the hose to produce a narrowing to the outlet, the same amount of water comes out, just faster. And the change in velocity is indirectly proportional to the change in cross sectional area. So if V1 is any point in an artery and V2 is any other point, measuring the velocities at these points allows you to calculate the different diameters of the lumens of these arteries at these points assuming the flow is the same. So suddenly we had a method of knowing the degree of narrowing in arteries by Doppler wave from analysis.

Of course, I have given you a somewhat sanitised and simplified version of how duplex scanners work. There were innumerable complicating factors that had to be resolved like the effect of angles of insonation, the problems associated with branching vessels, etc. But the principles that I have imparted tonight will hopefully allow a better understanding.

The title of my talk was Ultrasonographers do it with greater frequency. This was the sign on the door of the Ultrasound Lab at the Irvine Cardiovascular Laboratory that greeted me the very first time I walked through that door. I thought at the time, I am going to enjoy myself here. Little did I know how much. After more than two years in the lab, I began my return to clinical practice contemplating and planning a career in London, but within a short time, an unforeseen cascade of critical events occurred, and I was back in Australia, but that is a story for another time.

Through unbelievably good luck I had found myself at ground zero as momentous changes took place. In many ways this has been the story of my career – being fortunate enough to be in the right place at the right time and associating with the right people.

So do my experiences have any relevance to others? Do I have any advice for Trainees and young surgeons of today and tomorrow? Well my experiences probably don't matter but as for advice I offer three things. Firstly, grasp every opportunity, remembering that opportunities always look bigger when they have passed you by as compared to when they are approaching. Secondly, remember change is inevitable, except from a vending machine; recognise enduring change, embrace it, use it. And thirdly, the best asset that you can ever accumulate is the quality of the people with whom you associate – it is perhaps the primary reason why I am delighted and thankful that I am a surgeon.

Thank you again for the invitation and the honour to present this year's GJ Royal lecture. I hope it is something that Geoff Royal himself might have enjoyed and I thank you for your attention.

RACS Dean of Education with Medical students at the International Medical Symposium.

THE FUTURE OF THE MEDICAL PROFESSION

The fourth International Medical Symposium

STEPHEN TOBIN
DEAN OF EDUCATION

On 11 March 2015 the Royal Australasian College of Surgeons (RACS), The Royal Australasian College of Physicians (RACP) and Royal College of Physicians and Surgeons of Canada (RCPSC) hosted its fourth International Medical Symposium entitled 'The Future of the Medical Profession'. This year's symposium saw the joining of two more Colleges to this tripartite alliance, The Royal Australian and New Zealand College of Psychiatrists (RANZCP) and The Australian and New Zealand College of Anaesthetists (ANZCA).

The symposium attracted participants from a wide range of colleges, medical schools, health services and regulators. A number of prominent local and international experts presented at the symposium, including speakers from Canada, the United States, the United Kingdom, Australia and New Zealand. The purpose of the symposium was to discuss how future medical practice may develop, from the perspectives of the speakers and the audience. Leaders in medical disciplines, education and training and medical regulation were present along with the wider medical community.

SESSION 1
International perspective on the future

The day started with four presenters discussing the themes of projects, medical hospital systems, medical education and medical careers, from the status quo leading into the future. The important theme of placing of the patient at the forefront of medical systems and decision-making emerged early. A phrase introduced during the morning session by Dr Carol Aschenbrenner, from the Association of American Medical Colleges (AAMC), was often repeated throughout the day: "...the patient will see you now...", the reversal of the medical cliché, "...the doctor will see you now..." This theme was reiterated throughout the day because patients, more informed, seek a greater role than ever.

Prof Nick Talley, RACP President, summarised the current Australian model as "provider-focused" as opposed to "patient-focused". Prof Talley spoke about the lack of integration of care that characterises many medical systems resulting in increasing sub-specialisation of physicians, care silos, communication failures within and across systems, and waste of money and time for both patients and providers. He discussed health disparities despite our excellent healthcare system and the need to consider training in a more generalist focused manner. There is a need for training and access in rural areas. We will see a series of new pressures which will affect the health system, medical practice and how and whom we train.

SESSION 2
Practice in the future

The most consistent theme that arose throughout the symposium was that of change – the changing patient, clinical care team, and health technologies – and the medical profession's need to respond.

Patient advocate, Jen Morris, described how medical care frequently required patients to attend multiple appointments with multiple specialists, with separate appointments for tests, providing significant obstacles to treatment. Assoc Prof Michelle Leech, Director of Clinical Teaching Programs at Monash University, stated "the power dynamic in teaching mirrors the power dynamic in healthcare delivery – and prevents doctors learning the most effective ways to relate to patients. I would love to say it's about the curriculum, but really it's about **being the change you wish to see in the world.** The way we teach influences more than what we teach."

SESSION 3
Generational differences

Presentations by four doctors in training, Dr Arnika Lundbeck, Dr Hannah Galloway and Dr Yvonne Nguyen, and Dr James Churchill gave insights into their passion for global health and the desire to overcome the imbalance of healthcare outcomes for disadvantaged people. Their topics included first steps toward becoming a 21st century medical professional, and a view from those entering the profession. Prof Robin Mortimer concluded the session with a view from those leaving the profession. Prof Mortimer suggested that doctors should see medicine as a constant learning opportunity. Promoting professionalism by role modelling and excellence in training is an opportunity, not a threat. Critical uncertainties and change are unpredictable but change should be embraced as it is inevitable.

SESSION 4
Challenges of Medicine

The final session of the day gave attendees an insight into the challenges for medicine. Professor Kim Mulholland suggested that global health is an integral part of medical education and that international public health should become a real specialty, with appropriately trained doctors. Prof Mulholland spoke about the cost of becoming a practitioner and the impact this will have on careers in global health. Dr Andrew Padmos, CEO of RCPSC, described the international outreach and collaboration of the Canadian college, showing that it was possible for colleges to take a global view of their role and capabilities. Dr Padmos spoke of the initiative of the 'Tripartite alliance' as being a way to learn from each other to obtain the best outcomes for patients. Prof Michael Grigg, former RACS President, spoke on professionalism and proposed that role of the medical colleges was to maintain standards. He suggested that the strength of colleges was based in its support by members, putting the interests of society and patients above their own.

Workshops focused on International perspectives for the future, the changing practice, generational differences and the challenges of medicine.

"The important theme of placing of the patient at the forefront of medical systems and decision-making emerged early."

Steps moving forward

The sessions were reported by Dr Leona Wilson, Dr Rowan Thomas, Dr Warren Kealy-Bateman and Dr Lisa Lampe, Fellows of ANZCA and RANZCP with suggestions for steps going forward.

These included:

SESSION 1

- Need to recognise the changing of delivery of healthcare, patient, community and technology.
- Valuing the generalist.
- Competency based learning and assessment.
- Need for team based learning.
- Including the patient as a part of the team or even considering them as the leader of the team.
- Integration of care so there is a smooth experience for all and so there aren't gaps between the specialists, teams or patients.
- Learning from each other, and from other industries (one what works well), what we can use in our industry.

SESSION 2

- An emphasis on the advanced technology that is catalysing change
- The voice of the patient has been given the opportunity to be engaged and become partners in their own healthcare.
- Recognising the patient's need for information, understanding and empowerment.
- Recognising that fully informed patients can help the most and cost less.
- New tools have become available for learning and improved communication and these should be utilised to their fullest capacity.
- Collaborative practice is a great way for a group of health professionals to learn together to achieve better health outcomes.

SESSIONS 3 AND 4

- Today's society has shown us that there are differences between the generations, cultures and societies and we now have a different workforce.
- The global theme is about action not just idealism and that global health starts at home.
- Flexible, sustainable, high quality learning prepares doctors for local and global practice in their chosen areas.
- Leadership from medical schools and colleges empowers doctors who want to participate in global health.

All recordings are now available via the Academy of Surgical Educators webpage at http://www.surgeons.org/for-health-professionals/international-medical-symposium-2015/. Scan the QR code in order to go directly to the page.

The topic for next year's International Medical Symposium is

The Future of the Medical Profession - Part II

on Friday 11th March 2016 at the Amore Hotel in Sydney.

AND THEN THERE WERE TWO…

David Murray is a General Surgeon specialising in Upper GI surgery from the Darug people in the Sydney area. He is Australia's second Aboriginal and Torres Strait Islander surgeon. This is his story.

DAVID MURRAY
NSW FELLOW

David Murray and Kelvin Kong at the Australian Indigenous Doctors Association Conference, Melbourne, October 2014

I grew up mostly in Queensland and my schooling was mainstream. Dad was a barrister and did a lot of work for Aboriginal legal services so I went along with him for some court appearances and conferences. I got to see from an early age what was happening and the challenges people faced. That was in the legal aspect, but I don't think it's much different in the medical field; lots of challenges to overcome, to reach that road.

Kelvin Kong became a Fellow quite a few years ago in ENT and I got my Fellowship this year in General Surgery. Getting into medicine is extremely challenging for anyone, getting onto surgical training even more challenging and completing the training is a long journey and very hard. I think for a long time the importance of Indigenous education and the challenges Indigenous people face hasn't been addressed, and the opportunities for Indigenous graduates to progress through surgical training haven't been there, but we have much higher numbers of Indigenous medical students now. Hopefully through Kelvin's example and my example, and all the Fellows of other Colleges, we'll see an expansion of numbers along with that.

I think one of the most valuable things is to get advice from someone who has been there and done that. Get a mentor who can support you in this. I think I probably realised that too late and so it was a bit of a hard slog for quite a while, but getting the help of senior colleagues, people who can help you out with research, courses, what to expect at exams, interview preparation, all those kind of things are key for getting into and completing surgical training; so I think hooking up with a mentor who can help you with that, point you in the right direction and link you to the right people, is absolutely the way to go.

When I was in university I had a lot to do with the Indigenous medical school and the medical staff through there, and so I can help Indigenous communities, not just through being a doctor in a remote community, but through my example. I hope what I've done will inspire someone to do the same, but the boots on the ground in the community are just as important; policy formation at the highest levels, we have professors and people here who have spoken today who have advised the Prime Minister about policy, so at every step, whether having achieved that goal and practicing in a capital city, whether it's working directly in a remote community, through that kind of lobbying, it all has a part and if I can contribute in one or several of those ways, which is my ambition and always has been, then hopefully I can make a difference.

For the full interview with David Murray go to: http://www.surgeons.org/member-services/interest-groups-sections/aboriginal-and-torres-strait-islander-health/

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

THE LANCET Commission on Global Surgery

The Royal Australasian College of Surgeons & Lancet Commission on Global Surgery present the 4th triennial

Global Health Symposium

Monday 26 October 2015, at RACS Headquarters, Melbourne

'STRENGTHENING SAFE SURGERY AND ANAESTHESIA IN THE ASIA PACIFIC'

Convened by Associate Professor Phillip Carson and Professor Russell Gruen
and co-chaired with Professor John Meara, Chair of the Lancet Commission on Global Surgery

Over the last four years, the College has been collaborating with international surgical bodies and advocacy groups to promote safe surgical care and anaesthesia to the World Health Assembly as part of a primary health care package, integral to achieving universal health coverage. Significant progress has been made at the policy level, and it is critical that we continue to work with our neighbouring countries and partner institutions to overcome the many challenges and barriers to improving health systems and surgical services that are faced by clinicians, administrators and policy makers on the ground. We believe that the regional specialist colleges have a role to play in leading this initiative. The aim of the Global Health Symposium is to start this conversation.

The Program will focus on four key issues outlined in the recent Lancet Commission on Global Surgery report as being critical to achieving universal access to safe surgery and anaesthesia by 2030:

Strengthening health systems
Solving workforce issues
Sustainable financing of health care systems
Ensuring sufficient quality and safety

The Provisional Program and Registration Form are available on the RACS website:

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

Conference Organiser

Ms Stephanie Korin
RACS Global Health
Royal Australasian College of Surgeons
250-290 Spring Street, East Melbourne VIC 3002

T: +61 9249 1211
E: stephanie.korin@surgeons.org

Timorese Registrars with Sandra Staffieri (middle) and Dr Manoj Sharma (front, far right).

A BRIGHTER BEGINNING

Melbourne Orthoptist Sandra Staffieri delivers the first paediatric opthamology training program in Timor-Leste

Ms Sandra Staffieri, Clinical and Research Orthoptist from the Royal Children's Hospital Melbourne, travelled to Timor-Leste in March to teach Trainees undertaking the Post Graduate Diploma of Ophthalmology (PGDO) in specialist skills in paediatric ophthalmology. The activity was funded by Lions Club International Foundation through the College-managed Lions SightFirst - East Timor Project and delivered in conjunction with the RACS Global Health's East Timor Eye Program (ETEP).

Currently, Timor-Leste has one national ophthalmologist for a population of 1.2 million people, and has relied heavily on international assistance to provide services and deliver training programs to enhance national capacity. ETEP has worked in Timor-Leste for over 14 years and aims to handover an autonomous, sustainable eye health system to the Government of Timor-Leste by 2020. The establishment and delivery of the PGDO to train and develop the Timorese health workforce is one such program designed to make this aim a reality.

Timor-Leste is a young nation with a bulging youth population – 50 per cent of the population is aged under the age of 18, and 20 per cent aged under 5 years (WHO 2012). Focusing on developing skills and knowledge of Timorese doctors and other eye health workers in paediatric ophthalmology is an important step in reducing the rates of preventable blindness in children.

Ms Staffieri highlighted the importance of establishing a paediatric ophthalmology service as part of the National Eye Centre in Timor-Leste.

"Children will be 'blind' for many more years than the adults will be, so it is only sensible and important that this group be included in specific screening programs, targeting potentially preventable blinding eye disease that can be avoided or minimised by early detection. Moreover, early identification of vision loss and impairment in children is paramount to enable the earliest possible access to low-vision services to maximise education and learning opportunities."

To begin the process of enhancing knowledge and skills in paediatric ophthalmology in Timor-Leste, Ms Staffieri worked alongside the PGDO Trainees at the National Eye Centre. Teaching and training activities included formal lectures in 'Paediatric Clinical Ophthalmic Examination and Skills', 'Diagnosis, Management and Treatment of Strabismus and Amblyopia', 'Retinoblastoma – Current Management and Treatment' and 'Genetics 101'. Clinical exposure and supervision was also a key element of the training, which was done with the Trainees and other eye heath workers at the daily Outpatients clinic at the NEC. This provided the Trainees with an opportunity to consolidate their formal learnings and for Ms Staffieri to provide her professional opinion and guidance on diagnosis, management and treatment of paediatric cases. As Ms Staffieri explained, "Clinical examination of children is a unique skill that is developed over time, and can only be improved with practise and experience."

The PGDO Trainees thoroughly enjoyed expanding their knowledge base to include paediatrics and working with Ms Staffieri, as highlighted by Dr Nico: "Now I can check visual acuity in children (by their age) and squint. Sandra really shows me how to do that" and Dr Julia: "We learnt how to use hundreds and thousands and other toys during eye examinations with children to keep them calm and focused (we practice on the patient)."

Ms Staffieri also delivered lectures to the Outreach Screening team on 'Paediatric Vision Assessment' to further strengthen the NEC's approach and knowledge in paediatric ophthalmology. She also extended the reach of her training to staff at Hospital Nacional Guido Valadares (HNGV), co-located at the NEC, by delivering a Grand Rounds on 'Blinding Paediatric Eye Disease'.

Ms Staffieri identified areas for growth at the NEC, including the implementation of an appointment system for patients requiring review, as there is currently no such system that places importance on review appointments.

Wounded soldiers after a naval battle

Hospital at Gelibou

TURKISH MEDICAL ARRANGEMENTS

Like the Allies, the Turkish forces, at Gallipoli faced similar challenges with treating their wounded

DAVID WATTERS
AND ELIZABETH MILFORD

During the Gallipoli campaign in 1915, the headquarters for the Ottoman 5th Army was at Gallipoli (Gelibou), a fairly prosperous town in the Dardanelles, situated on the Straits or Narrows. It was a town the Allied troops would never reach, though by the end of the year it was ruined by Allied bombardment. The Ottoman 5th Army, initially a relatively small force of 60,000 men, was commanded by the German General Liman Von Sanders.

During the Gallipoli campaign, the Ottoman Red Crescent organisation (Hilal-i-Ahmer) liaised with the Ottoman Army medical units. In readiness for war and casualties, all young men born before 1894 were conscripted. Darulfünun medical school in Constantinople was closed for 1915 and third to fifth year students were sent off to contagious disease hospitals or regiments. The German medical personnel based in Turkey were not assigned to the 5th army, but German and Austrian doctors, nurses and orderlies worked in Turkish hospitals. They also treated Germans who were evacuated back to Constantinople by sea from clearing stations on the peninsula.

Brandl [Vice-Sergeant Major of the Bavarian Light Cavalry] who had studied medicine for six terms in Munich, found a bullet wound in the middle of the breast, close to the heart, and tied me up with a field dressing… They laid me on a stretcher, already heavily soaked in Turkish blood, and carried me down the steep hill… General Hans Kanengiesser.

Arrangements on the battlefield were similar to the Allied medical structure. The wounded were carried by orderlies to the casualty area at the rear of the trench lines where their injuries were assessed. Dressing stations were located at Cape Helles and at Kocadere and Matikdere behind the third ridge at Anzac. These stations treated both the sick and wounded and performed some primary surgical procedures.

Like the Allies, the Turks had difficulty establishing hospitals in the rugged terrain. They only had *…one main field hospital with a few medical stations converted from tea houses as a feeder line to cater for the wounded.*

The slightly injured were dressed and returned to their units, but the seriously wounded were sent (often in carts lent by civilians) to the larger field hospitals located well away from the front. These included the hospital at Gelibolu supervised by the eminent Ottoman surgeon, Dr Talha Bey. At Anzac area hospitals were also based at Agadere, Akbas and Maidos. There was a German hospital at Bighali on the peninsula.

Surgical procedures were seldom, if ever performed at field hospital due to lack of equipment and supplies. Serious head, chest and abdominal wounds could not be surgically treated and many soldiers died as a result. As blood transfusions were not available in 1915, normal saline was given intravenously to prevent shock. The use of morphine tablets placed under the tongue was sometimes the only method of treatment. Turkish medical teams faced similar difficulties to their allied counterparts; coping with the unexpectedly large numbers of wounded, dealing with water shortages and addressing shortages of basic medical supplies such as iodine and morphine.

Charles Ryan at Gallipoli

Late in the 19th Century, Sir Charles Ryan served with the Turkish army; then in 1915, he was consultant surgeon for the ANZACS at Gallipoli.

(Sir) Charles (Plevna) Snodgrass Ryan

Major General, KBE, CMG
(1853-1926) MB ChB
Edinburgh 1875

EARLY LIFE

Charles Ryan was a colourful character – schooled at Melbourne Grammar before training at Melbourne and Edinburgh Universities. Postgraduate study took him to Europe where he saw an advertisement for military surgeons to serve in the Turkish army. Ryan enlisted and his service in the Russo-Turkish war (1877-1878) found him at the siege of Plevna and as a prisoner of the Russians.

When Ryan returned to Australia in 1878, he worked as an honorary surgeon at the Royal Melbourne Hospital and an honorary medical officer at the Children's Hospital. In 1880 he treated Ned Kelly who had been wounded at Glenrowan and compared his temperament 'with that of the patient stoic Turk'. His experiences with the Turkish army were never forgotten; in 1897 he wrote *Under the Red Crescent* and he served as the Turkish Consul in Victoria.

GALLIPOLI

Although he had retired in 1913, when war broke out Ryan was appointed as ADMS for the 1st Division AIF, but was replaced by Neville Howse. Transferring to the Anzac Corps as a consultant surgeon, he took part in the landings and was assigned to the *Lützow* – the ship had been used as a horse transport and Ryan described it as 'the dirtiest, nastiest boat I have ever been on'. He also worked on the hospital ship, *Soudan* at Cape Helles.

Ryan was at Gallipoli in May 1915 when an armistice was called to bury the dead and as usual he was wearing his medals from the Russo-Turkish war. At first the Turks thought the elderly surgeon must have taken the medals from one of their dead comrades, but Ryan dispelled their concerns when he told them proudly in Turkish: 'I fought at the siege of Plevna with Gazi Osman Pasha.'

AFTER GALLIPOLI

In June 1915, Ryan was reported as dead, but seriously ill with dysentery, he had been evacuated to Egypt, then to England. Just after his arrival in London Ryan was obliged to grapple with a burglar – this seemed to help his recovery. He was then appointed Surgeon General for the Australian forces and worked with the medical boards in London.

PROFESSIONAL LIFE AFTER WW1

Ryan was knighted in 1919 and as his health was deteriorating, he returned to Australia and retired from surgery. Ryan's sister was the botanical artist, Ellis Rowan; his daughter Maie married the future Governor-General Lord Casey and his son Rupert was a member of House of Representatives.

– Elizabeth Milford

NAVIGATING STAGES OF A SURGEON'S CAREER

The College is developing a 'career spanning' framework that provides support for surgeons from their early days to when he or she retires

PROF STEPHEN TOBIN
DEAN OF EDUCATION
JULIAN SMITH
CHAIR, PROFESSIONAL DEVELOPMENT AND STANDARDS BOARD

A surgeon may experience several phases of transition throughout their careers, each representing a significant period of change. For surgeons practising in their home country, transitional periods may result from a new role, new team, geographical move, changing scope of practice, response to technical and scientific discoveries, family needs, community needs, adverse health issues, business opportunities or re-entry after a period of leave.

For those who have moved to a foreign country to practise, there may be additional complexities including language and cultural barriers, differing disease management, varied patient expectations and working within a completely different health care system. While these changes often represent an exciting new phase in their career, they may be associated with increased stress, anxiety and vulnerability which can affect the mental health, competence and performance of the surgeon.

Awareness of the challenges surgeons face during transitional periods is important to ensure appropriate support mechanisms are in place. This benefits their own health and wellbeing and also the care they provide to their patients and community that they serve. The transitional experiences of International Medical Graduates demonstrates that formal and informal programs can assist; including education programs, mentoring programs, orientation programs, assistance with forward planning, help from supportive colleagues, the benefits of accumulated experience, codified protocols and care pathways, and networking with other individuals who have transitioned.

The Royal Australasian College of Surgeons (RACS) recognises the importance of providing support in this area and is developing a 'career spanning' framework that is progressively staged from when the surgeon obtains Fellowship to when the surgeon retires. Broadly, the stages that a surgeon progresses through as they move throughout their career have been identified as:

(1) The first 10 years of practice as a younger Fellow;
(2) The mid-career stage as an established surgeon;
(3) The senior surgeon phase or the final 10 years of practice.

In addressing each unique phase of a surgeon's career, the new framework will:

(1) Act to mark career progression;
(2) Encourage dialogue around these stages;
(3) Engage and identify with the narratives of surgeons who have successfully navigated challenging stages;
(4) Provide targets to guide professional development;
(5) enable surgeons to focus their learning activities more effectively;
(6) suggest learning activities that they can access.

The College already has a comprehensive professional development program that annually delivers 80 activities in a range of modalities to support the development of non-technical competencies in surgeons as they progress throughout their careers. The framework will align professional development activities to each career stage, including existing programs run by the College's Professional Development Department, identify areas for further program development and identify external programs, partnerships and resources that may be applicable.

Stage 1
Younger Fellow

A 'Younger Fellow' is defined as a surgeon in the first 10 years of practice. Challenges at this stage in their career include securing sub-specialty Fellowship training, joining a hospital department, establishing a private practice, family considerations, increased accountability, making and being responsible for decisions concerning patient management, and engaging with professional development.

The Younger Fellows Committee, comprising regionally elected Fellows in the first ten years of practice, influences the education and support programs associated with the 1500 surgeons in this stage. The College holds a number of programs specific to supporting younger Fellows such as:

(1) An annual Younger Fellows Forum, a three day transition residential program for aspiring leaders of the College to network and discuss topical issues pertinent to their stage;
(2) The Younger Fellows' education stream at the RACS Annual Scientific Congress;
(3) A Younger Fellows' Leadership Exchange between RACS and the Association for Academic Surgery in the United States of America;
(4) Six other scholarships and travelling grants for the exclusive benefit of younger Fellows;
(5) Preparation for Practice workshops held in each region;
(6) Marketing resources such as Find a Surgeon and Practice Card to broadcast their new practices;
(7) A webpage that lists all educational programs, Fellowship opportunities, blogs and resources specific to younger Fellows.

Stage 2
The Established Surgeon

The longest phase of a surgeon's career is as an established surgeon. This is often where surgeons will refine their scope of practice, move into management or leadership roles, build and maintain their private practice, adopt an educational role, contribute to their College or community in a pro bono capacity, and deal with the challenges of ageing parents and growing families.

The College has a comprehensive professional development program that primarily addresses this stage of the surgical career and all of the competencies required of a practising surgeon. There are 36 individual educational activities that are conducted around Australia and New Zealand, resulting in around 80 being delivered annually. Examples of the College's competency based programs include:

(1) Judgement and Decision Making: Clinical Decision Making workshop;
(2) Professionalism: an annual International Medical Symposium, Code of Conduct online program and a Multi-Source Feedback tool;
(3) Collaboration and Teamwork: the Non-Technical Skills for Surgeons (NOTSS) workshop and an associated online program;
(4) Management: Finance for Surgeons and Strategy and Risk Management for Surgeons workshops;
(5) Health Advocacy: the Indigenous Health and Cultural Learning online programs;
(6) Communication: Process Communication Model seminars and Communication Skills for Cancer Clinicians workshops.

Stage 3
The Senior Surgeon

A 'Senior Surgeon' is defined as being within 10 years of retirement and is typically transitioning away from a busy clinical practice. These Fellows may start to relinquish roles of responsibility, adjust their public and private case mix, take on outside consultancy work, make more time for outside pursuits, move into medico legal work, and pursue a more active education role with medical schools, specialty boards and the College. Challenges include succession planning, paucity of part time positions, and professional and personal identity conflicts. For some, there will also be health issues and deteriorating technical and mental capacity.

Building towards Retirement is a one day course conducted annually by the Senior Surgeons Section of the College, which addresses planning for retirement, the psychosocial factors of retiring, financial and legal advice, superannuation opportunities and tax requirements. The Section also coordinates an educational stream at the RACS Annual Scientific Congress, bringing together retired Fellows and those seeking to wind down from active practice.

In regards to pursuing a more active role in education, the College offers a range of professional development that supports the competency of Scholarship and Teaching. Programming covers foundation skills in educational principles, teaching for varied audiences in varied clinical settings, performance management, delivering feedback, work place based assessment tools and their use, evaluating educational research, supervision and training and standard setting. Formats range from one hour webinars to three year Masters Degrees.

The surgical career 'navigational' guide will be developed around an 'issues-based' structure.

It will articulate the challenges and opportunities that are unique to each stage, while recognising that many of the issues faced can occur at multiple stages of a surgeon's career. The guide aims to assist Fellows in describing the key competencies and behaviours that can assist them to take advantage of the opportunities that a career in surgery provides, and allow them to reflect on the attributes they need to develop more fully to meet the professional changes they may face ahead.

The guide will give voice to the personal stories of surgeons who have successfully chartered a course through the different career stages. It is hoped that these narratives will provide a valuable resource for learning about the lived experience of Fellows and, in doing so, it is envisaged that Fellows will have a better appreciation of the challenges they may encounter as they transition throughout their career and how their interests, inclinations, skills and life choices can steer them.

Perhaps most importantly, this guide will provide surgeons with a greater awareness of the programs and resources available to support them through these career phases. It is hoped that through the development and delivery of this new framework the process will be a unifying and transformational experience for the College, its members and associated stakeholders. This would position the College at the forefront of progressive curriculum development in medical education.

If you would like to be involved in this project please contact Michelle Barrett: michelle.barrett@surgeons.org or Kirsty Manders: kirsty.manders@surgeons.org

Thank you for donating to the Foundation for Surgery

Passion. Skill. Legacy.

Mr Robert Aitken
Mr Michael Bruce
Assoc Prof Ian Campbell ONZM
Mr Stanley Chang
Mr John Churchill
Mr Penaia Faumui
Dr Katherine Gale
Mr Lawrence Giutronich
Mr Peter Grant
Mr Koroush Haghighi
Mr Brian Haymet
Mr Niels Holmgaard
Dr Iain Kelman
Mr Matthew Kwa
Mr Pui Lau
Mr Robert Leitch
Dr Gregory Liao
Dr John Liddell
Ms Jenny Ling
Mr Kenneth MacGowan
Dr Liaj Matthew
Mr Mark Medownick
Prof Michael Morgan AO
Ms Judy Munro
Prof Stephen O'Leary
Mr Anthony Perks
Mr Keri Prabhakar
Mr Peter Raudkivi
Mr Andrew Roberts
Mr William Roberts
Dr Elizabeth Rose
Dr Stephen Rouch
Mr Paul Salteri
Mr John Sheehy
Mr James Stoney
Mr Harry Tsigaras
Mr Thodur Vasudevan
Mr Robert Wainwright
Dr Peter Wilson
Mr Alexander Wood
Dr Matthew Yalizis

Total $72,117

Royal Australasian College of Surgeons

Lumley Surgical Research Scholarship for 2016

Opportunity to undertake research or study in the UK

Due to available funding, the College is pleased to be able to re-advertise the Lumley Surgical Research Scholarship.

The funding for the Lumley Surgical Research Scholarship, which was first offered in 1962, incorporates the Edward Lumley Fellowship Fund and is supported by the Henry Lumley Charitable Trust. This scholarship is designed to enable a Fellow or SET Trainee of the College to spend a year undertaking research in the United Kingdom.

The scholarship is valued at $66,000 plus a return economy airfare up to the value of $3,000 and is for 12 months.

This opportunity closes on 30 June 2015.

For further information and an application form please go to **www.surgeons.org/scholarships** and follow the links, or contact the Scholarship Program Coordinator on **08 8219 0900** or via email at **scholarships@surgeons.org**

Foundation for Surgery

Passion. Skill. Legacy.

Patron: Prof. Richard Bennett AM, FRACS

PLEDGE A PROCEDURE

and help advance quality surgical care

Everyone, regardless of their circumstances deserves access to safe essential surgery.

You can help achieve this by donating the proceeds of one performance of your most common major operation to the Foundation for Surgery's annual fundraising appeal, Pledge a Procedure.

Your donation will help support our surgical colleagues working in developing countries, build surgical capacity in disadvantaged areas, address health challenges in Indigenous regions and expand quality surgical research across all specialties. All donations are tax deductible.

Make your donation today on the form below or online via the College website secure payment facility at **www.surgeons.org/foundation**

***'Pledge a Procedure'* June 2015**

Yes, I will help support the advancement of surgical endeavours by donating the proceeds of one performance my most common major operation during the 'Pledge a Procedure' appeal in June.
All donations are tax deductible. Your receipt will be sent promptly.

To make a donation online, please visit **www.surgeons.org/foundation**
Alternatively, please complete this form.

My most common procedure is/was: .....
and I donate the amount of:$ ☐☐☐☐☐☐ . ☐☐

To: ☐ Indigenous health
☐ International medical programs
☐ Scholarships and grants
☐ Where support is needed most

Name: .....
Address: .....
.....
Email: .....

Please find enclosed a: ☐ Cheque or ☐ Bank Draft (payable to Foundation for Surgery)
Please debit my: ☐ VISA ☐ Mastercard ☐ AMEX ☐ NZ Bankcard

Credit Card No: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiry: ☐☐ / ☐☐
Card Holder Name (block letters): .....
Card Holder Signature: ..... Date: .....

☐ I do not give permission for acknowledgement of my gift in any RACS publication.
☐ I do not give permission for this tweet by @RACSurgeons: Thank you ,<YOURNAME> FRACS of <TOWN/CITY> for your #pledgeaprocedure donation to the Foundation for Surgery

Make the most of your member benefits

Member ADVANTAGE®

To discover all your benefits, contact RACS Member Advantage: call 1300 853 352 or visit www.memberadvantage.com.au/racs