SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 16 NO 4 / MAY 2015

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Middlemore's expansion

Raising surgical standards in New Zealand

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REGULAR PAGES

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ON THE COVER:
Middlemore Hospital's new Harley Gray Building allows for the space needed to tackle the long and complex cases

2015

PROFESSIONAL DEVELOPMENT

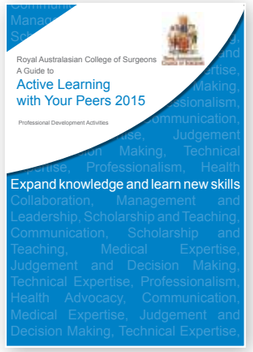
WORKSHOPS & ACTIVITIES

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, which will shortly be published on the College website and distributed to all Fellows.



Keeping Trainees on Track (KToT)

20 May – Brisbane; 16 June - Sydney
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.

Communication Skills for Cancer Clinicians:Transitioning to Palliative Care

13 June – Melbourne
When a patient's cancer cannot be cured, health professionals are often required to deliver difficult news and discuss challenging topics around death and dying. This communications module from Cancer Council Victoria is designed to equip clinicians with the tools to talk about death and dying professionally with empathy to patients and their families. By developing your skills in the area, you can help create a more comfortable environment for your patients, promoting effective communication around the decisions they'll need to make at this time. This educational program is proudly supported by Cancer Council Victoria.

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.

Foundation Skills for Surgical Educators

17 July – Magnetic Island, QLD
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
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
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. This workshop is also available as an eLearning activity by logging into the RACS website.

May-July

NSW

16 June, Sydney
Keeping Trainees on Track
28 July, Sydney
Clinical Decision Making

QLD

20 May, Brisbane
Keeping Trainees on Track
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

13 June, Melbourne
Communication Skills for Cancer Clinicians: Transitioning to Palliative Care
23-25 July, Yarra Glen
Surgical Teachers Course

WA

1-3 May, Margaret River
Younger Fellows Forum
4 May, Perth
Supervisors and Trainers for SET
4 May, Perth
Foundation Skills for Surgical Educators

TAS

17-19 July, Hobart
Process Communication Model Seminar 1

Royal Australasian College of Surgeons

THE YEAR AHEAD

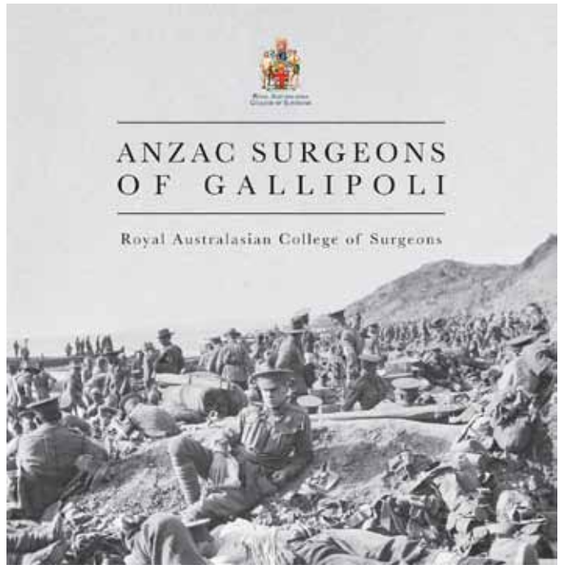
Now is the time to focus

DAVID WATTERS
PRESIDENT

This is my first President's Perspective and I would like to acknowledge that being President of our College is an enormous privilege and honour. Having been an active surgeon in a number of countries through my professional career, I can confirm that Fellows based in New Zealand and Australia should be proud of the prestige that comes from being a FRACS – a Fellow of the College of Surgeons of Australia and New Zealand – and the reputation that the College enjoys internationally, not only in our region but also throughout the world.

RACS is currently launching a book, 'Anzac Surgeons of Gallipoli', about surgical involvement in the Gallipoli theatre of World War One. It is remarkable how some substantial changes in our societies over the past 100 years are reflected through the 129 biographies of those surgeons who served the troops in the Dardanelles. It is also remarkable to consider how surgeons have always taken prominent roles in the health sector and in community life. As a professional group we individually and collectively do 'punch above our weight' by providing leadership, supporting standards and defining purpose to so many activities. Our contributions are characterised by energy, enthusiasm and effort; we should be proud of our record of service to health and society.

The Annual Scientific Congress in Perth with its dual themes of ethics and commemorating Gallipoli, highlighted such achievements by our collective Fellowship. I do acknowledge the outstanding contribution of the organising committee and the convenors. They, together with our Conference and Events department, produced a first rate scientific meeting with stimulating plenaries of high significance to surgeons. It was also a wonderful opportunity to acknowledge our ongoing close association with other Colleges of Surgeons at an international level, particularly the Edinburgh College, which played a major part in the program, highlighting the theme of service, especially military service. Those who visited Perth in person or via the Virtual Congress (http://asc.surgeons.org/virtual-congress/login/), will have learned much about the commitments and sacrifices made during World War One and better appreciate not only the ANZAC tradition at Gallipoli (Gelibolu), so important to both our countries, but also what Cannakale means to today's republic of Turkey.



I need to acknowledge the outstanding work of Michael Grigg in his 12 month Presidency. His contribution was enormous over nine years on Council representing Vascular Surgery, Professional Standards, being Chair of the Professional Development and Standards Board, then the Vice-Presidency. His year as President was defined by championing professionalism, his concern to safeguard the future of the profession, and the most active advocacy that has involved the College in recent times.

The issue of urgency at the moment remains discrimination, bullying and sexual harassment. As all are aware, an Expert Advisory Group has been established with Hon Rob Knowles AO as Chair and Dr Helen Szoke as Deputy Chair. The commitment shown by the College to deal with this topic meaningfully, positively and transparently has been favourably reported. We intend to bring meaningful changes to culture and practice, those that are sustained over time by us individually and collectively and will result in a better and more inclusive workplace. This will be one of our key defining activities – how a professional organisation positively influences the culture of healthcare, the hospitals and our workplace. We will all need to engage to make this happen.

> *"Fellows based in New Zealand and Australia should be proud of the prestige that comes from being a FRACS"*

However, also prominent and ongoing is our advocacy on the topic of the sustainability of healthcare. This has been a significant topic of discussion over a number of years and the College has frequently profiled aspects of this. It is something being actively considered by national governments around the world, including our own. We need, as a College, to earn a reputation for being appropriately concerned about sustainability and recognising the need to provide excellent healthcare that is affordable by individuals and society. Over the past 12 months there has been substantial advocacy around appropriate levels of fees. There has been active dialogue with government, hospitals, insurers and the Fellowship. There are continuing discussions around issues of futile surgery, procedures with limited effectiveness and end of life planning. Indeed the New Zealand scientific meeting this year will focus on this theme 'I Can – BUT Should I? Choosing Wisely'. There is substantial support for our ongoing involvement at all regional and national levels. We are truly joining in a global endeavour on this issue. Many Fellows may not be aware that the English National Institute for Health and Clinical Excellence has been formally looking at this since 2005 and the American Board of Internal Medicine Foundation launched the Choosing Wisely campaign in 2012. This approach is specifically inviting the profession as the stewards of finite health care resources to identify changes in practice that will improve patient outcomes through better treatment choices, reduction of risks and being cost-effective.

A constant theme over the past few years is that the profession needs to take ownership of our standards, how we implement these in practice and how we communicate these clearly and boldly. That does demand that we look at our own work practices and take individual and collective responsibility for how surgery is practiced across Australia and New Zealand. We need to ensure that we are the champions of what defines high quality surgical care and how we best deliver what society can afford. I look forward to leading these discussions over the next 12 months as your President.

SAVE THE DATE

Royal Australasian College of Surgeons and Lancet Commission for Global Surgery

Global Health Symposium

Sunday 25 October 2015
at the AMREP Lecture Theatre, Alfred Hospital, Melbourne

The Royal Australasian College of Surgeons (RACS) is hosting our 4th Global Health Symposium in association with the Lancet Commission for Global Surgery. The theme for the Symposium this year is Strengthening Safe Surgery and Anaesthesia in the Asia Pacific. The Program will focus on four key issues outlined in the recent Lancet Commission for 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 and ensuring sufficient quality and safety. The program is aimed at surgeons, anaesthetists and other medical specialists, trainees and medical students, donors and policy makers.

Please visit the RACS Global Health website: http://www.surgeons.org/for-the-public/racs-global-health/symposium-international-forums/

Enquiries to Stephanie Korin
RACS Global Health
+61 3 9249 1211;
Stephanie.Korin@surgeons.org

Photo: AMANDA CUNNINGHAM, PACIFIC ISLANDS PROGRAM

PLEDGE YOUR PROCEDURE

Pledge the amount of your most common major procedure to help continue the good work of your Foundation for Surgery

GRAEME CAMPBELL
VICE PRESIDENT

Through generous philanthropic support from Fellows, the Foundation for Surgery has achieved a great deal over the past few years to support many effective and worthwhile programs across diverse surgical specialties and sub-specialties.

As Vice President, I represent the College Council on the Foundation Board, and so it is gratifying that through your support of the Foundation, the surgical profession has clearly demonstrated its willingness to assist our colleagues from different countries and medical disciplines to improve patient care.

Your support makes a tangible difference. It assists colleagues working in disadvantaged communities where they struggle to provide the quality of care we give our patients. Your support also makes a difference for young surgeons undertaking research and for their surgical educators.

But there is still much more to do. Our sustained support is vital to ensure the Foundation expands and thrives. In doing so, it will continue to facilitate health programs that measurably improve the lives of many people in less fortunate circumstances than ourselves.

These programs will continue to address the health inequities in Australia's remote, rural and Indigenous communities, implement Indigenous surgical programs and encourage Indigenous doctors to consider a career in surgery.

They will increase surgical capacity and enable the provision of surgical training and quality patient care in many of our neighbouring developing countries, including Myanmar, Papua New Guinea, Timor Leste and the Pacific Island nations.

They will expand research across all surgical specialties and sub-specialties and provide assistance to young surgeons of promise through the conferment of scholarships and grants to enable new research, advanced study and surgical related travel opportunities.

The Foundation is an integral part of the College and I encourage you to help maintain our support of these important programs. To help fund these initiatives, the Foundation for Surgery will conduct its fourth annual major fundraising appeal 'Pledge a Procedure' during May and June.

Shortly you will receive a letter from the Foundation asking you to support programs in the area of surgical endeavour that is most important to you by donating the proceeds from just one performance of your most common major operation during May or June.

Foundation for Surgery
Passion. Skill. Legacy.

Photo: AITKEN

Inaugral recipient of the Senior Lecturer Fellowship Sarah Aitken

As we approach the end of the financial year in Australia and prepare to lodge our tax returns, I urge you to donate to the 'Pledge a Procedure' appeal. All donations are tax deductible. Your donation, irrespective of the amount, will make a real difference and I assure you, one hundred per cent will be used for the purpose for which it is given.

Donations to previous 'Pledge a Procedure' appeals have supported many important projects. These include the development of an emergency medicine program in Myanmar leading to a postgraduate Emergency Medicine diploma and skills courses conducted at the University of Medicine in the nation's capital, Yangon.

These sustainable, practical courses are delivered by volunteer surgeons and emergency physicians from Australia and Hong Kong. They have trained and mentored more than 1,200 local health care providers to implement trauma care systems in a country that previously had little or no primary trauma care.

Your donations in the past year enabled five talented health specialists from Nepal, Indonesia, Myanmar and Thailand to participate in practical training attachments at teaching hospitals in Australia. These attachments successfully enhanced the participant's knowledge of surgical procedures, with a resultant improvement in the health outcome for their patients and expanded surgical capacity in their home countries, as those trained, in turn, trained others.

Your support enabled the continuation of an annual trauma and fracture management course in Fiji. These practical courses, conducted by volunteer Australian surgeons, have enhanced surgical capacity in the Pacific Island nations by training local health care professionals in complex orthopaedic surgical procedures and the advanced management of all levels of trauma.

Indigenous and remote communities in Australia endure higher levels of injury and trauma injury than others in our region. To assist the development of initiatives to remedy the situation, donations to the Foundation supported three key-note speakers at a trauma symposium in Darwin. This provided opportunities for participants to explore multi-disciplinary and culturally appropriate strategies for the prevention and treatment of these injuries.

Scientific research is at the core of our profession, thus the conferment of scholarships and grants is vital for the expansion of surgical research and the provision of advanced study opportunities for Fellows and Trainees. Donations enabled the Foundation to award more than 40 scholarships and grants in 2014 to surgeons who are now undertaking research across a wide range of surgical specialities and to young surgeons who have embarked on further study in Australia, New Zealand and overseas.

I urge you to make a tax deductible donation to support our Foundation's major fundraising appeal 'Pledge a Procedure'. Your support is vital to ensure the continuance and expansion of worthwhile and effective programs such as these.

OPEN HOUSE MELBOURNE

SATURDAY & SUNDAY 25-26TH JULY

The College is again opening its doors to the general public as part of the Open House Melbourne weekend

A number of buildings not normally open to the public will be participating

If you would like to be involved and volunteer as a room presenter we would like to hear from you

For more information and to register as a volunteer please contact **Megan Sproule**
+61 3 9249 1220
megan.sproule@surgeons.org

No monkey business

Melbourne orthopaedic surgeon Marinis Pirpiris swapped for a different kind of patient when treating Melbourne Zoo's oldest orangutan last month. The 36-year-old primate Suma needed a general check-up after taking medication for arthritis in recent years. "With people it is easier to examine them, but it is just as rewarding with animals," Mr Pirpiris said.
"It is quite a special moment when we try to apply our own skill set on primates."
***Herald Sun*, 17 April**

Skill gap for NZ sex-change surgery

The list for gender-reassignment surgery in New Zealand is growing since the February retirement of the country's only sex-change surgeon Peter Walker.
Transgender groups say that those affected are at higher risk of suicide the longer the skill-gap remains unaddressed.
Mr Walker has revealed his frustration that procedures have halted and says there needs to be more encouragement for others to take up the role, such as a scholarship.
***The Press*, 16 April**

RACS Tasmanian Regional Committee Chair Brian Kirkby has backed plans for a health system overhaul in the state. Plans to shift complex operations to Launceston were revealed during Health Minister Michael Ferguson's visit to the hospital. Kirkby sees it as a move that would benefit patients.
"Ultimately [patients] will have access to services in the safest way possible they can be delivered," Mr Kirkby said.
***The Mercury*, 1 April**

Independent opinion for NRL

A tougher rule on player concussions has led to leading neurosurgeon Richard Parkinson offering his time for independent assessments.
Repeated breaches now mean that players diagnosed with concussion will not be returning to the field on game day under any circumstances.
"The sports doctors are excellent physicians and know how to assess a concussion. But the issue is also the conflicting interests of the players, officials and coaches," Dr Parkinson said.
"The concept of an independent physician would solve a lot of that."
***Sun-Herald*, 12 April**

TOWARDS A DIGITAL COLLEGE

Driving the College in the online space

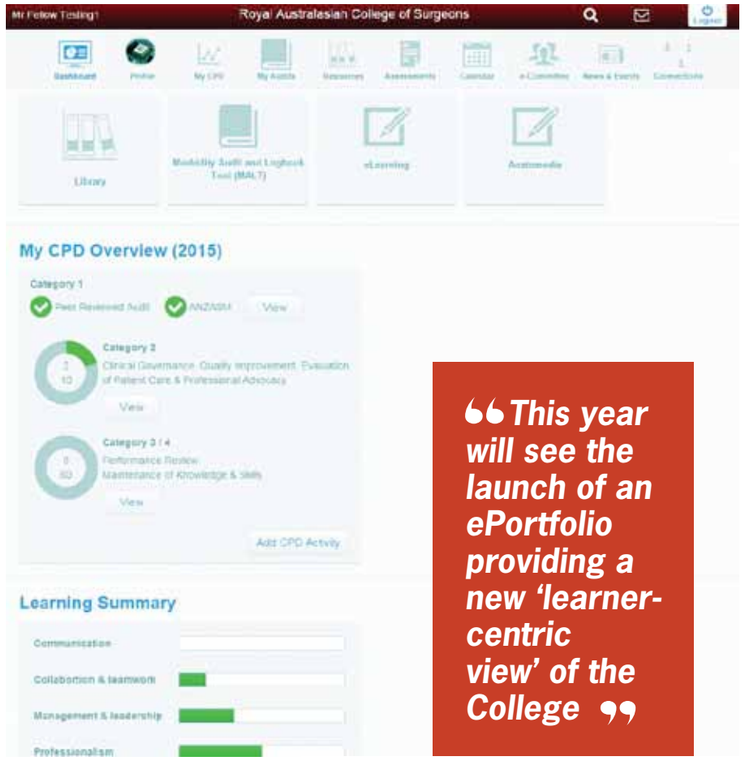
CATHERINE FERGUSON
CHAIR, FELLOWSHIP SERVICES

In today's digital world, rapid technological advancements have transformed the nature in which we communicate and access information. The instantaneous availability of resources is unparalleled, and provides convenience for modern day surgeons, as they balance ongoing learning with their busy work and private schedules.

The College recognises the important role it plays in aiding this transformation, and is well placed to develop strategies that embrace the changing digital landscape. In 2013, work began on creating a comprehensive digital education strategy. The original planning efforts focused on the type of digital features needed, the investment required and a change strategy to drive maximum value for Fellows, Trainees and IMGs. In August 2014, the final business plan was endorsed by Council and a program of work called 'The Digital College' started.

Since this work started, a number of initiatives have been launched, including:

- An online registration system that was created to take registrations for College organised workshops and exams, with secure online payment and instant confirmation.
- A number of web-based mobile phone apps being made available. These include the ANZASM Case Note Review app helping to improve delivery of audit case note information with new cases added as they are available.



"This year will see the launch of an ePortfolio providing a new 'learner-centric view' of the College"

- Another app that was created to help increase awareness and gain interest in the Junior Doctor initiative and framework.

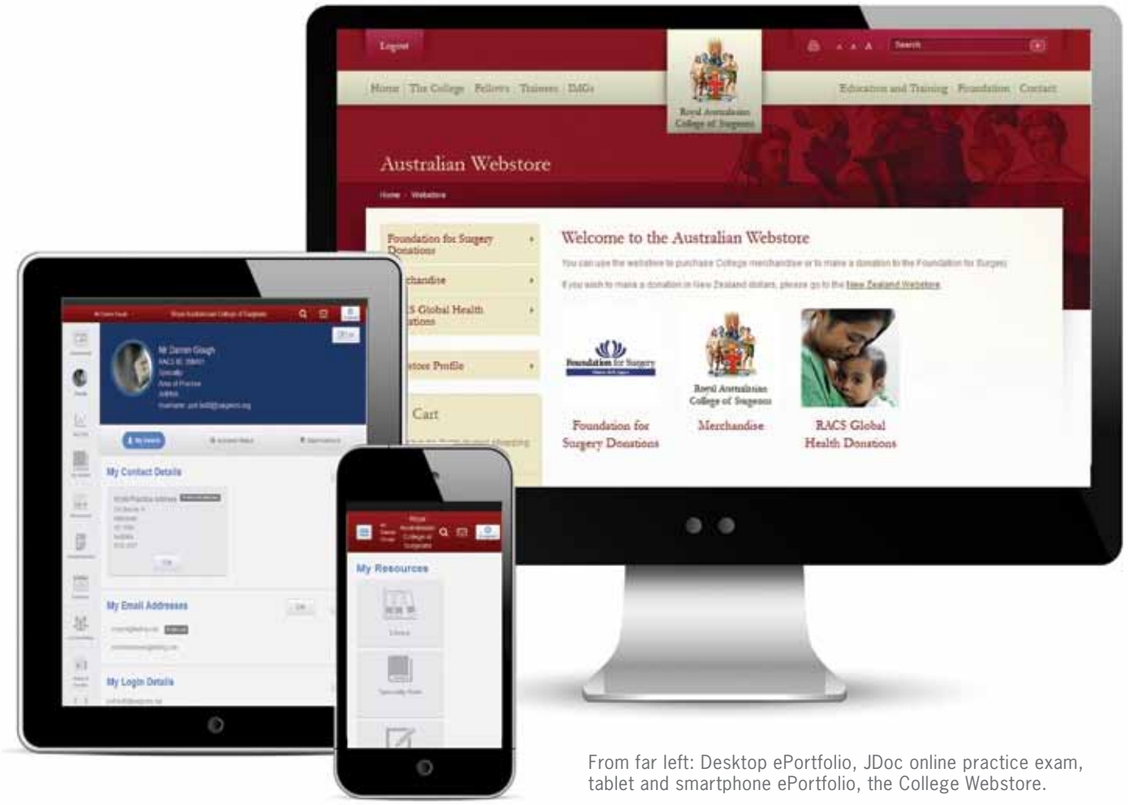
This year will see the launch of an ePortfolio providing a new 'learner-centric view' of the College. The ePortfolio is an easy to use, intuitive and consolidated location to manage everything from contact details, CPD activities, MALT procedures, supervision of Trainees and IMGs and much more. The ePortfolio is designed to be accessed from any device, in any location. A test version was made available for trial with selected Fellows and it is anticipated to make the first stage of the ePortfolio available to all College members in the third quarter of 2015 following further testing.

Alongside the Digital College program of work, other digital initiatives have been progressed and existing systems enhanced. These include:

- A comprehensive collection of eLearning courses available online which continues to grow.
- A world-class online library with access to books, articles and journals, grouped by specialty.
- CPD Online improvements including automatic updates through accredited events, such as surgical audit peer reviews and mortality audit participation (excl. NSW and NZ). The development of the ePortfolio will make it easier to upload CPD activities.
- The 'Find a Surgeon' online practice card, which is available to any Fellow of the College, allowing promotion of your surgical practice.
- The first College web store (opened in 2014), allowing for online purchase of merchandise, online donations and payment for courses, workshops and exams.
- In late 2014 the College ran the Generic Surgical Science Examination (GSSE) electronically and on-line for 200 Trainees across seven venues in Australia and New Zealand, followed by specialty specific exams in March 2015.

The College will continue to strive for digital excellence, and is committed to monitoring and updating the resources it provides to ensure that they remain relevant for the modern day and future surgeon.

"The ePortfolio is an easy to use, intuitive and consolidated location to manage everything."



From far left: Desktop ePortfolio, JDoc online practice exam, tablet and smartphone ePortfolio, the College Webstore.

TAKING THE LEAD WITH THE EXPERT ADVISORY GROUP

Who are the people heading the Expert Advisory Group and guiding direction?

DR HELEN SZOKE

The Deputy Chair of the College's newly established Expert Advisory Group is the well-known human rights advocate Dr Helen Szoke.

Dr Szoke has a PhD in Public Policy and became the CEO of international aid agency Oxfam Australia in 2013.

Prior to this appointment, she served as Australia's Federal Race Discrimination Commissioner after serving seven years as the Victorian Equal Opportunity and Human Rights Commissioner.

Dr Szoke said that she agreed to serve on the RACS' Expert Advisory Group because she believed the College had a unique opportunity to make fundamental changes to the inter-personal dynamics at play within the health care system that could change professional behaviour across the entire field of medicine.

She applauded the College for having the courage to tackle the issue of inequality and bullying and sexual discrimination.

"I think at times it can be difficult to imagine how systems or professions can be altered, particularly in a field such as medicine which is highly regarded and respected and framed around tradition and seniority," she said.

"I am very pleased to be part of this and to be given the opportunity to help create professional pathways that allow women to be the best surgeons they can be.

"If this work is successful, I believe the College could set benchmarks that could change the way medicine is conducted across Australia, which would be good for all doctors and good for their patients."

Currently Dr Szoke is Co-Chair of Make Poverty History, an international campaign comprising more than 60 member organisations including World Vision, Oxfam and Caritas designed to raise awareness of global inequality.

She is also both an Executive Committee member of the Australian Council For International Development (ACFID) and the ACFID Humanitarian Reference Group Champion, working to provide avenues for Australian aid agencies to share information, strengthen coordination and drive policy to improve humanitarian relief work.

In 2014, Dr Szoke received the University of Melbourne Alumni Award for leadership and was awarded the Law Institute of Victoria Paul Baker Award in 2011 for her contribution to human rights.

A graduate of the Australian Institute of Company Directors and a fellow of the Institute of Public Administration, Dr Szoke also sits on the Executive Board of Oxfam International.

During her time as the Federal Race Discrimination Commissioner she launched a national anti-racism campaign – called Racism: It Stops With Me – which is still being rolled out across Australia, while as the Victorian Equal Opportunity and Human Rights Commissioner she oversaw the modernisation of the Equal Opportunity Act and introduced the Victorian Human Rights Charter. Dr Szoke said a great deal of her work in all the positions she has held related to issues surrounding equality, fairness and justice including work to ensure fairness to women returning to work after pregnancy.

She described her current role at Oxfam Australia as an amazing opportunity to work towards justice in an international setting.

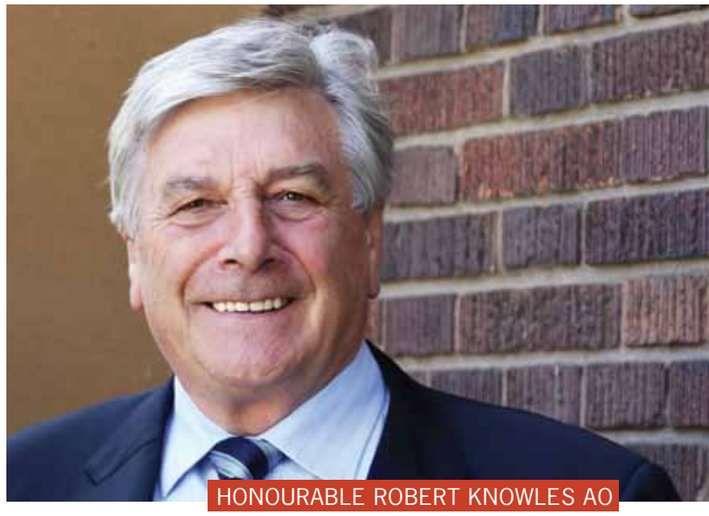
"While most people know that Oxfam works in long-term development projects in many countries as part of a global network of international aid providers, many people don't know that we also work with the private sector," she said.

"Through Oxfam Global Advocacy, we work with the top global companies to help them ensure that their workers around the world are treated fairly.

"We look at supply chains and we advocate for fair wages for agriculture works and for the empowerment of women, and to alert those in power to the risks and ramifications of land grabs.

"We also address the widening gap between the richest and the poorest on a global scale; we investigate banking investments and work with the major banks to encourage them to ensure they are only funding ethical enterprises.

"Gender equality is a cross-cutting theme in all this work because not only are women disproportionately affected by poverty and unfair trade practices, they are a significant part of the solution."



HONOURABLE ROBERT KNOWLES AO

The Chair of the College's Expert Advisory Group – established last month to investigate claims of discrimination, bullying and sexual harassment within surgery – is a former Victorian Health Minister, the Honourable Robert Knowles AO.

A member of the Victorian Parliament from 1976 to 1999, Mr Knowles served as Minister for Health, Aged Care and Housing during the Kennett Government and is a former member of the National Health and Hospital Reform Commission.

Mr Knowles said he agreed to become the chair of the College's Expert Advisory Group because he believed that issues surrounding sexual harassment, bullying and inappropriate professional behaviour had wider implications relating to the provision of quality health care. He said that while such behaviour could have a harmful impact on the people directly affected, it could also increase risk by creating a culture of fear that could limit the ability of colleagues to raise concerns.

"Surgery is often compared to aviation, and in aviation an enormous body of research has concluded that improving safety is not so much about improving technical skills – because they are already very high – it is about improving non technical skills such as inter-personal skills," Mr Knowles said.

"Clearly everyone has the right to work in a safe environment that is free from abuse, but while that is important to the individual, I believe there may be quality and safety issues in play that need to be addressed."

Currently, Mr Knowles serves as the Chair of the Board of the Royal Children's Hospital (RCH), the Chair of the Victorian Health Innovation and Reform Council (HIRC), is a commissioner with the National Mental Health Commission and is a member of the Australian Health Minister's Advisory Council.

The HIRC was established in 2014 to provide independent advice to the Victorian Minister for Health on the effective and efficient delivery of quality health services and the reform of the public health system.

A community member of the College Council, Mr Knowles received the honour of becoming an Officer in the Order of Australia in 2007 for

services to mental health and aged care and for his public service as a member of the Victorian Parliament.

He is also on the Board of Psychosis Australia Trust, which works to facilitate and encourage research and collaboration into the causes of, and treatments for, psychotic illnesses.

With a farm in central Victoria, Mr Knowles said he took on these roles because he was raised by his parents to consider public service a duty and a privilege and also because he was driven by a desire to translate knowledge into practical, systemic improvements, particularly in the health sector.

"This focus on creating practical improvements within broad systems has always been of intense interest to me," Mr Knowles said.

"As Chair of the Board at the RCH, for example, we are now working on ways to attract the best and brightest to the hospital for the benefit of patients and we have developed a focus on paediatric brain development and mental health services.

"We are now in the process of investigating how the RCH operates within the wider community of paediatric health services beyond the hospital doors so that we can determine pathways for families to access our expertise closer to their homes around the state."

Mr Knowles said he was now also closely involved in the work being conducted at the HIRC overseeing extensive research aimed at driving health system reform, based around best practice safety and quality assurance aimed at enabling the system to keep pace with demand.

He said the HIRC was currently analysing the causes of unplanned hospital re-admissions and investigating what changes could be made to systems of care to reduce such presentations.

He said that he was particularly attracted to working in the field of health care reform because of his family's experience of the system when his father was dying from cancer.

"My father died of cancer when I was a young man and my family and I felt a little let down by the health system as we went through that ordeal, and I thought that if ever I was in the position to improve that system I would give it my best shot," Mr Knowles said.

"During my time in Parliament, I developed a particular interest in systems analysis, particularly in how you make complex systems adaptable, accessible and responsive.

"As Minister for Health I drove the development of centres of clinical excellence in Victoria, worked to establish an integrated trauma system to streamline the care of the injured from the site of injury to a trauma centre and established the first comprehensive palliative care service.

"All of these are good examples of what can be achieved by systems analysis, research and evidence-based reform."

With Karen Murphy

SUE SWEET AND STU LUMPEE

When is a calorie not a calorie?

DR BB G-LOVED

So many of my patients are gaining weight and growing their waistlines. New Zealanders and Australians, together with their Pacific counterparts, are rapidly expanding, shooting up the global obesity charts.

Sue Sweet and Stu Lumpee are avid exercisers, but never manage to lose weight; they stay fit without shedding kilos. In despair, I was consulted after an unfortunate run-in with their dietician, frustrated by Sue and Stu's lack of will-power on a much needed vacation.

Tragically not all doctors, and certainly few surgeons, understand that we gain weight not only when we enjoy too many calories, but also when those calories are the wrong sort. By the wrong sort I mean sugar. Sugar, not fat, is the primary cause of obesity.

Sue chooses products that are marketed as 'healthy' or 'low fat' without recognising this term means extra sugar is added to ensure palatability. Sugar is sucrose, a disaccharide of glucose and fructose. Each is metabolised differently.

Stu inadvertently stuffs himself on fructose, abundant in fruit, fruit juice, and soft drinks. It is metabolised in the liver, but quite differently from glucose, not being a substrate for brain or heart metabolism, it is far more lipogenic. It does not stimulate Stu's insulin production or leptin, key hormones which regulate Stu's energy intake and expenditure.

Fructose behaves metabolically like fat even though it is physio-chemically a sugar. It certainly makes Stu put on the fat, inside and out. WHO now recommends reducing sugar and fructose intake to 5 per cent of total calories, in the hope of averting diabetes-related morbidity and mortality.

'That Sugar Film' [and book] was launched in March 2015 and features presenter Damon Gameau, who, for the sake of his movie, experimented by consuming the equivalent of 40 sugar lumps (1 lump = 4.2g = 16.8cal] per day. Within just six weeks he was able to gain 8kg of weight, 10cm of waistline, eating mainly foods that were branded as healthy.

These included Sue's low-fat yoghurts, sauces and breakfast cereals, as well as Stu's smoothies, fruit juice, soft drinks and muesli bars. In a few weeks Damon managed to develop a fatty liver with concomitant abnormal ALT levels, lipid dysfunction, staggering the four medical, psychological and nutritional experts who monitored his anthropometric and biochemical transformation!

Perhaps all the more remarkable was that this occurred despite continuing the same exercise program and maintaining his daily calorie intake at 2300 calories during both baseline and study periods. The conclusion: not all calories are equal when it comes to health and weight.

The sugar intake adversely affected his mood, energy and behaviour. He experienced the transient highs of sugar infused energy followed by, two to three hours later, the lows of insulin-induced hypoglycaemia (flagging energy and feeling down), then the nervy uptightness of catecholeamine compensation [anxiety, tachycardia and blood pressure) and craving for the next sugar-fix.

Corn syrup is made from maize and alpha amylase and is a form of carbohydrate that contains, in addition to glucose, maltose and oligosaccharides. It thickens, sweetens and retains moisture – thus freshness.

It is added to many processed foods, also candies, soft drinks and fruit drinks as it is both palatable and less expensive than sugar. High fructose corn syrup (42 per cent or 55 per cent of glucose converted chemically to fructose) has been introduced to foods since the 1970s and is associated with the obesity epidemic.

There has been deliberate, concerted and seductive marketing by food companies of corn syrup products. Sugar has escaped health promotion scrutiny while fat was blamed for fatness. Fructose, despite its lipogenic nature, was overlooked. No longer – its influence on diabetes and metabolic syndrome are being increasingly appreciated.

So Sue and Stu should read the labels on all food products, avoiding those with added sugar or high fructose corn syrup. They need to count not just calories, but also sugar and fructose intake, keeping sugar intake at or below 35-40g per day (8-9 tsps), including fructose. This will be around WHO's recommended 5 per cent, or 100 to 150kcal/day from added sugars for Sue Sweet and Stu Lumpee, amounts that are exceeded by the majority of the adult population!

FOOD OR DRINK ITEM
Equiv Teaspoons of sugar

Soft drink [Coke], *375ml can,* **10**
Mars bar, *53g,* **9**
Nutella, *1 table spoon 20g,* **2**
Nutri-Grain cereal, *1 cup 40g,* **2**
Low-fat Yoghurt, 6.5
Sultanas, *1 lunchbox pkt,* **8**
Apple juice, *1 glass (250ml),* **10**
Tomato Pasta Sauce, *1 serve,* **10-12**
Muesli bar, *1 bar,* **3-5**
Corn Syrup (glucose), *100g,* **19**
High Fructose corn syrup (HFSC 42 or 55), *100g,* 42% or 55 % fructose, **19**

Footnote: Teaspoons of sugar in common foods (1tsp = 4.2g = 16.8 cal)
Dairy products: the first 4.7g/100g is lactose, but the rest is sugar.

IN MEMORIAM

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

Frank Ham, Victorian Fellow
Maxwell P Redman, Victorian Fellow
Allan Tye, SA Fellow
John Wasley Smith, SA Fellow
John Maddern, SA Fellow
Peter Kudelka, Victorian 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

DIGITAL DILEMMAS

BY **PROFESSOR GRUMPY**

The benefits of new technology?

There is one thing that I can't stand and it is alarm clocks. Generally we curmudgeons like new technology and adapt well – however! My wife bought a brand new digital new one that allows her smart phone to dock in a slot on the top. This will allow her smart phone music to be played as the wakeup call and will also allow the time to be set according to the smart phone's time. That is great, but when we tried to connect her phone it would not accept the phone as the connection was the older model. Consequently we had to set it manually, which was an exercise in frustration.

All has been well over the past three months with only the occasional accidental activation of the 90 minutes snooze time button when turning out the bedside light. As I am sure you are aware, the default time is 90 minutes snooze and so a wakeup call at some time after midnight was not appreciated by me (my wife seemed not to hear it and slept through the music and my mutterings while trying to turn it off).

But the other night was the last straw. We had a power failure – for only a few seconds it would seem. When the power came on again it reset all automatic functions in the house such as the lights that are movement activated including the bedroom closet light. Then that cursed alarm clock started flashing 12.00 as the backup batteries were flat. Nothing I did would stop it.

We had an early start the next day so we had to get it fixed. The instruction book was found and the correct page found, but the font was so small I could not read it. In the meantime the resourceful Mrs Curmudgeon had simply set her phone alarm and gone back to sleep.

We curmudgeons do not accept defeat readily and so the next day I studied the book in detail. It would seem that you can have a gentle wakeup. Now surely the name 'alarm clock' means that you are alarmed – not gently serenaded. You can also have as the source of your alarm your smart phone music, the radio (but not my favourite AM station as it does not do AM), music on a USB memory stick and a whole range of hideous sounding alarms.

I decided that all this new technology was quite unnecessary and resurrected my sturdy, faithful old travel alarm clock that has woken me in many countries over many years without fail. I also decided that having the bedroom bathed in an eerie purple glow was unnecessary and probably dangerous to my health – my old clock is just a clock and does not have a light. I was determined to sort out that cursed digital clock.

You may wonder why I am writing this article on my laptop in bed. It is because the old clock goes tick-tick infuriatingly loudly and what is more I can't read the time as the clock has no light.

Mrs Curmudgeon is no help as she has gone to the spare room with her beloved digital clock.

RACS Support Program

A service for all RACS Fellows, Trainees and International Medical Graduates in need

The College is pleased to announce the launch of RACSSP. The new Surgeons Support Program is a 24/7 professional and confidential counselling service for RACS Fellows, Trainees and International Medical Graduates (IMGs).

Since the publication of the National Mental Health Survey of Doctors and Medical Students conducted by *beyondblue* in 2013, the College leadership has been exploring options of providing better awareness, education and support to surgeons. The results showed doctors reported substantially higher rates of psychological distress and suicidal thoughts compared to both the Australian population and other Australian professionals.

Additionally, the recent discussions about under-reporting of discrimination, bullying and sexual harassment in the medical workforce justify the College providing an avenue of support to Trainees, Fellows and IMGs.

This new initiative funded by the College provides you and your Fellow Surgeons, Trainees and IMGs with confidential access to counselling, coaching and support for workplace, emotional and personal issues.

The RACSSP also provides you with the opportunity to discuss confidentially the issues of mental health and workplace bullying and harassment, as well as any other areas of concern.

You can arrange to speak with a Senior Converge International Consultant face-to-face, over the telephone or via the internet.

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)

Availability

Support is available 24 hours, 7 days per week year round. Consultations can be conducted at one of Converge International's sessional offices or with their network of consultants across Australia and New Zealand. After hours there is access to telephone counselling and emergency support.

Confidentiality

You can be assured that your confidentiality is maintained through the RACS Support Program. At no stage will any details of your participation, issues or attendance be passed onto RACS or your employer. Converge International will periodically provide RACS with de-identified statistical data that do not identify any individual information.

Consultants

All Converge International Consultants are qualified professionals with extensive experience in their specialty areas and a knowledge of the health industry, including registered psychologists and experienced social workers.

Available Support

The RACS Support Program Consultants are trained to help you identify issues and options, and provide practical support in developing skills to realise positive change. It is short-term, solutions-focussed support that enables the early resolution of factors that may be impacting on your wellbeing, in a professional, accessible and confidential framework designed specifically to meet your needs. As a counselling and support service, they are unable to offer advice on complaints processes.

You can talk to your Converge International Consultant about:

- Interpersonal conflict and tension
- Work-related stress and overload
- Changes in your work environment
- Bullying, harassment and grievances
- Discrimination and sexual harassment
- Relationship or family matters
- Personal and emotional stress
- Grief and bereavement
- Alcohol and drug related problems
- Mental Health, including depression and anxiety
- Anger and violence
- Crisis intervention and trauma counselling
- Vicarious trauma
- Self harm and suicide

The RACS Support Program is funded by RACS and is free to you for up to four sessions per year.

Converge international

Call 1300 687 327 AU
0800 666 367 NZ
convergeinternational.com.au

Royal Australasian College of Surgeons

CLINICAL IMAGES AND CONSENT

With fines of up to $100,000 now in force under Federal privacy legislation for clinicians who incorrectly store or distribute clinical images, it is imperative that all doctors have tight security on mobile devices and understand their privacy obligations under the law, according to the Australian Medical Association (AMA).

Last year, the AMA developed a detailed policy covering the collection, use and disclosure of clinical images taken with personal mobile devices to help inform medical professionals about their responsibilities under changes to the Privacy Amendment Act 2012 that came into force in 2014.

It says that while taking a photograph of a patient may be a fast and practical way to help in diagnosis, treatment or consultation, such images are considered under the law as 'health information' and must be treated with the same privacy and confidentiality as any other health record.

Using such images for any purpose other than that for which consent has been gained or sharing them in a non-professional context can result in fines, complaints to the Australian Health Practitioner Regulation Agency (AHPRA) or subject the doctor to an internal hospital investigation.

The policy was developed through the AMA's Council of Doctors in Training and uses the term "clinical image" to include a photograph, video recording or audio recording. Images may be of a patient's body – such as an injury, skin lesion or body fluid – or an image of a pathology report, diagnostic image or medication.

Specifically, the policy advises doctors to:

- Consider the purpose for which you require the image and obtain appropriate consent – before taking the image;
- Ensure the patient understands the reasons for taking the image, how it will be used and to whom it will be shown;
- Document the consent process in the health record;
- Never send a clinical image to anyone unless you have the patient's consent to do so or if the patient would reasonably expect you to send an image for the purpose of their clinical management;

- Ensure that clinical images do not auto upload to any social media networks or back-up sites;
- Have tight password controls on all mobile devices to prevent unauthorised access;
- Delete any clinical image after saving it onto the health record and have the ability to erase images remotely if a device is stolen;
- Understand your health service or hospital policy covering the storage of clinical images and the systems in place to facilitate the storage of digital images;
- Seek advice from hospital management or a medical defence organisation if any clinical image is inadvertently sent to the wrong person as this is a breach of patient privacy.

The Victorian Vice President of the AMA, Orthopaedic Surgeon Mr Gary Speck, said the AMA had developed the policy to help doctors understand their privacy responsibilities because the threshold for damages had been lowered under the new amendments to the Privacy Act while sanctions for breaches had been increased.

"Patients now don't need to suffer loss to make a claim that their privacy has been breached," Mr Speck said.

"Informed consent must always be obtained before taking an image where it is possible to do so, just like it is required in all other aspects of medicine.

"Most hospitals and health departments around Australia have implemented clinical image policies, yet there is evidence that not all doctors are aware of them or follow these policies.

"The AMA encourages all doctors to familiarise themselves with these protocols and, if working in private practice or in private consultancies, to develop their own."

Mr Speck said that while the use of images taken on mobile devices was complex, doctors should follow four basic steps to guide their decision-making.

"Doctors should think first of consent, then consider who should take the image, then where it will be stored and finally its possible future use," he said.

"Gaining consent from a patient to take an image for therapeutic purposes, for instance, is not the same as gaining consent for the purposes of teaching.

"We would also strongly encourage doctors to download such images into the hospital's records as soon as practicable, delete them from any personal device and ensure that all personal devices have extremely tight access and password controls.

"Mobile devices have become so ubiquitous now and while the technology can be extremely useful and can speed up some aspects of medicine, the user of the device has responsibility under law to recognise that there are limits to that use."

With Karen Murphy

FELLOWS CAN ACCESS THE FULL GUIDE AT https://ama.com.au/sites/default/files/documents/FINAL_AMA_Clinical_Images_Guide.pdf

CASE STUDY FROM AMA POLICY

Mr Lim was admitted to the ED with a large laceration to his thigh. An intern obtained Mr Lim's consent to take photographs of the laceration for the purpose of sending them to the surgeon for review and advice regarding management. The intern forwarded the images to the surgeon and to medical records, as requested. Three months later, a member of staff witnessed the images being shown by the intern on their phone to other doctors on the ward. A complaint was made to the Director of Medical Services regarding the images being present on the intern's phone. It was found that the intern had breached the hospital's clinical image policy.

COVER STORY

ROOM TO MOVE

Middlemore Hospital's new Harley Gray Building allows for the space needed to tackle the long and complex cases

It cost $190 million dollars to build, took five years to design and two years to construct; it stands five stories tall, covers the equivalent area of five rugby fields and provides surgeons with 14 new state-of-the-art theatres.

It is the Middlemore Hospital's new Harley Gray Building, opened with much fanfare last year and named after the esteemed orthopaedic surgeon Professor Harley Gray, a consultant at the hospital for many years and a former President of the New Zealand Orthopaedic Association.

The new building, previously called the Clinical Services Building, stands at the heart of the Middlemore medical campus, the largest hospital in Auckland and the busiest acute hospital in the country.

Also one of the largest tertiary teaching hospitals in New Zealand, Middlemore Hospital treats more than 91,000 in-patients per year and specialises in orthopaedic and plastic surgery (including burn and hand surgery), spinal injury rehabilitation, renal dialysis and neonatal intensive care.

The new building, designed by specialised environments architects Klein, has been designed as a central block with three fins which connect to adjacent buildings to create seamless corridors from the clinical and surgical suites to the wards.

The surgery suites, located on the second floor, have been arranged in three "hubs", designated by colour coding to allow for the sharing of personnel and equipment while eight large screens give constantly updated OR status information.

"Two theatres have also been designed to give surgeons extra space, with each measuring a floor space of 60 square metres."

Two theatres have also been designed to give surgeons extra space, with each measuring a floor space of 60 square metres, to allow surgical teams to conduct complex plastic surgery or treat patients suffering from multi-trauma injuries.

The head of the Plastic Surgery Department at Middlemore, Mr John Kenealy, said the new building provided almost 50 per cent more capacity to allow acute patients to be treated in a more timely manner than was previously possible.

He also said the new larger suites allowed for larger medical and nursing teams necessary for the more complex surgical procedures to work effectively and efficiently enabling a reduction in operative times while improving outcomes. The ability to oversee Trainees had also been enhanced by the inclusion of technology such as in-light high-definition video cameras.

"The Middlemore Hospital is the busiest acute hospital in the country and we have seven acute surgical theatres in operation all day every day, even on weekends, with another surgical suite set aside for acute obstetrics cases," he said.

"Some years ago we divided off our elective cases, which are now conducted at 12 theatres in a separate facility so ours is a very busy, concentrated acute facility with some elective surgery in those theatres not assigned to acute work.

Mr John Kenealy in the new rooms at Middlemore Hospital.

"To have this extra capacity has made an enormous difference in how rapidly we can treat our patients. It was quite entertaining to watch this building grow up beside us floor by floor and now it is a great pleasure to work in it."

Mr Kenealy said the plastic surgery department had access to up to four of the new theatres each day and had a daily acute staff allocation comprising two consultants, one Fellow, two SET Trainees and one junior doctor.

He said more than 4000 acute plastic cases were conducted each year, including some trauma cases triaged through the National Burns Centre, also located at Middlemore Hospital, which treats burns patients from across the country and some Pacific Island nations.

He said the plastics team particularly appreciated the extra-large theatres.

"Before this building was opened, many of us, in Plastics, General and Orthopaedic surgery used to dread long and complex cases simply because of space limitations," he said.

"Now that we have purpose-built theatres for such cases we have reduced the time we take to conduct certain procedures because of ready access to equipment and supplies and having the room for staff to do what they need to do.

"In the larger theatres we have two sets of theatre lights, for instance, so that different teams can work at the same time on complex cases, reducing some of our procedures by two hours or more which is obviously much better for the patient."

Mr Kenealy said the theatres also had state-of-the-art camera equipment which was of great benefit to both surgeons and Trainees and their supervisors.

"The cameras are linked to monitors mounted on the ceilings of the theatre which means that I can step back and watch Trainees from the other side of the room and no longer have to breathe down their necks, which works for everyone," he said.

"These cameras and monitors can also be linked to microscopes while all the anaesthetic equipment has been updated so that we now have all of the patient's data, like blood pressure and temperature, shown on a large screen visible to the entire team.

"We have also found the electronic white board very useful in allowing us to know diagnoses and operating times so that we can all understand which patients are most in need."

Mr Kenealy worked as a senior registrar at Middlemore as a young man before working overseas for 18 years.

A new era

Returning to work there in 2009, he was somewhat disheartened to find that little had changed, but all that has faded into the past. Now he is not only delighted with the new facilities, but also praises the design process and the project management that allowed for a seamless transition from the old to the new.

"The operating suites at the Middlemore were getting a bit tired because they had been built 30 years ago and though our patient numbers kept increasing, we only had nine functional theatres to treat them in," he said.

"This new building has made a huge difference to the number and type of cases we can get through allowing us to see almost 50 per cent more patients.

"It now puts Middlemore up there with the most advanced public health facilities in the country, which is a credit to the designers and project managers who took the time to analyse feedback so they could tailor the space to provide for best clinical practice within the building's footprint.

"All practical issues were worked out in advance and due to superb project management we suffered no gap in services as we transitioned from the old building to the Harley Gray Building."

With Karen Murphy

EPIDEMIC

Increasing weight is an expensive problem, in both monetary and quality of life terms

MR ROGER PATERSON
COUNCILLOR,
ORTHOPAEDIC SURGERY

The evidence is overwhelming that the Western world is suffering an obesity epidemic.[1] As surgeons, we have to become vitally concerned and advocate for change to slow and hopefully reverse this trend. In Australia alone, the estimated annual cost of obesity is $58 billion, with $2 billion in costs to the health system and $1.9 billion in carer costs.[2]

There is an increasing weight (pardon the pun) of compelling evidence that patients with a BMI over 40 suffer disproportionately greater complications, morbidity and poorer results than the less obese, let alone those of normal weight (certainly, this is true for knee arthroplasty surgery).[3]

We must first understand the causes of this epidemic and recognise the current controversies and conflicts of interest that are driving the problem. Without a clear understanding of the causes, developing effective strategies to combat the problem will be difficult.

Simply, a big cause is sugar in our diet, not only in soft drinks (SSBs: sugar-sweetened beverages, that contain about 10 teaspoons of sugar or double the new WHO maximum recommended dose of sugar per day), but also hidden in processed foods and junk foods. In addition to sugar, there are the easy, cheap, palatable, addictive and extremely well marketed high-energy, low-nutrient foods in the market place that are now so ubiquitous as to render the argument facile, that it should be down to personal responsibility to avoid or resist such foods.

The irony is that Ancel Keys, who fallaciously claimed that saturated fats in our diet were the cause of cardiovascular disease, stimulated massive commercial enterprises in the manufacture and marketing of statins and low fat foods that necessarily required sweetening to be made palatable. Simultaneously, there was a farm crisis in the US and farmers were incentivised to produce corn, so that corn syrup could be used as a sweetener and as stock feed. Corn syrup contains disproportionate amounts of fructose (which is also 50 per cent of sucrose) and it turns out fructose is metabolised to triglycerides, which is arguably worse for the heart and arteries than saturated fats.

> *We must first understand the causes of this epidemic and recognise the current controversies and conflicts of interest that are driving the problem*

Not only did Ancel Keys mislead us about saturated fats, he caused an increase in the consumption of fructose and worse cardiovascular outcomes than if he had done nothing. He was instrumental (along with commercial bodies) in discrediting John Yudkin, the author of 'Pure, White and Deadly', who tried to warn us that it was sugar (in particular fructose), rather than fat, which was the true cause of cardiovascular disease.

Now all of that is not part of our position statement, but simply provides historical background about how we have come to such dire straits and illustrates who the enemy is in any community and government efforts to combat this serious pandemic. The food industry in Australia has cooperated with government in developing the voluntary five star rating of foods designed to advise the public on what is healthy and what contains excessive sugar/carbohydrates vs nutrients, to give those trying to make informed choices a fighting chance.

There is now strong industry push-back as they realise that failure to label foods under this system will risk raising suspicion, when the healthy foods are all carrying such labelling.[4] The same is happening in the UK, where the government has introduced an even better method of front-of-packaging education for the buying public with a traffic light system – red for bad, green for good and yellow for in-between – which is still nevertheless voluntary. We have to advocate for such labelling to be compulsory.

Contrast this with what could be achieved with such simple measures as a 20 per cent tax on SSBs, calculated to reduce the average community BMI by over 3 per cent. Coca-Cola is well-armed and ready to oppose any such tax. The world leader in this space is currently Mexico, which has taxed all junk food at 8 per cent since 2008, with reported significant early beneficial outcomes. Mexico is the only country in the world where PepsiCo profits have fallen.[5]

We have missed the boat when it comes to changing community attitudes regarding low fat diets for generations to come. Like the poisonous effects of tobacco, it will take another generation before we can expect to see substantial community acceptance of the health messages regarding the risks of energy-rich, low-nutrient foods and especially the risks of fructose – from corn syrup in processed foods or sugar in our foods and drinks. But if we don't start now in real earnest, then when should we?

This is a battle that has to be won. Governments are struggling in the face of highly-financed, serious lobbying from the food industry's multinational giants. It is up to the medical profession to blow the whistle loud and clear, and fearlessly, in the interests of our patients and the community as a whole. If not us, then who?

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HOW TO GET YOUR RESEARCH ARTICLE READ AND CITED

ASERNIP-S Top 5 tips to early career researchers

GUY MADDERN
CHAIR, ASERNIP-S

"The process of preparing and publishing a manuscript can be a difficult path, but this is only part of the journey. For our work to have true impact it needs to be read and, ideally, cited."

As researchers in surgical science we have an obligation to ensure that our work is published and visible to all. The process of preparing and publishing a manuscript can be a difficult path, but this is only part of the journey. For our work to have true impact it needs to be read and, ideally, cited. We owe this to the agencies that fund the research, the team that collects data that can be an additional workload above the group's normal role and, importantly, the patients who enrol in trials.

Through their collective experience, ASERNIP-S researchers have developed tips for new researchers to increase the chances of getting their articles accepted and, once published, having their papers read and cited. These tips have been adapted from recommendations on how to optimise citation provided by the publisher Taylor & Francis;[1] however, they should resonate with all irrespective of the research discipline and type of research article. ASERNIP-S tips are intended for the novice researcher, but also they are a useful resource for those of us who have the privilege of supervising and training researchers.

ASERNIP-S researchers' top 5 tips that will help the early career researcher get their article published, read and cited are:

1) Start with a clear and informative title. This will promote interest, command attention, and make the reader press the download link. Also make the title visible to database search tools, if the database search engine cannot retrieve the article then no-one can read it.

2) Write clearly. Make sure that the abstract has clearly stated arguments; take home messages and a statement on how the work contributes to current research in the field. Then make sure that your article is intelligible; your methods should be precise and concise, results clearly stated and your interpretation appropriate. Most readers are time-poor; give them what they want in a manner they can readily understand.

3) Perform high quality research that is current. Antoniou et al (2015)[2] analysed the endovascular literature for predictors of citation. They demonstrated that methodological quality, article length and study subject are the three main independent predictors of citation and impact of research.

4) Publish in reputable journals that have a wide distribution and are easily accessed. Aim high, but be realistic. If your manuscript is rejected then submit to another journal. Indeed, a recent analysis of manuscripts rejected by the British Journal of Surgery indicated that 65 per cent of those rejected were published in other surgery journals within six to 18 months.[3]

5) Tell people about your article. Engage in responsible social media, post your achievement on professional sites, update your university webpage, develop a personalised publication list in Google scholar that is public and include a hyperlink to your article in your email signature. Yes, this is self-promotion, but better that, than relying on the random chance of your article being found through search engines.

In summary, write from the perspective of a reader of the scientific literature. Avoid being satisfied too soon; rewrite and rewrite again, and then get others to critique your writing. Finally ask hard questions about your article to avoid your reader asking – so what and why should I care?

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

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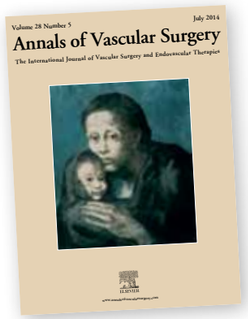
RESEARCH FROM THE COLLEGE



Only limited evidence to support the effectiveness of Sclerotherapy for percutaneous vascular malformations

Gurgacz S, Zamora L, Scott NA.

Percutaneous sclerotherapy for vascular malformations: A systematic review.

Annals of Vascular Surgery. 2014;28(5):1335-49.

ELSEVIER

General Review

Percutaneous Sclerotherapy for Vascular Malformations: A Systematic Review

Stefanie Gurgacz, Luis Zamora, and N. Ann Scott, Adelaide, Australia

Background: This systematic review assessed the available published evidence on the safety and efficacy of percutaneous sclerotherapy for patients with congenital vascular malformations.
Methods: A systematic search of various electronic bibliographic databases was conducted in May 2013. A grey literature search was also performed. Study selection, data extraction, and assessment of study quality were undertaken by one reviewer and checked by another reviewer.
Results: One systematic review, one randomized controlled trial, one nonrandomized controlled trial, and 24 case series studies were included. However, deficiencies in reporting, small sample sizes, and marked inter-study heterogeneity precluded a definitive synthesis of the data. Ethanol sclerotherapy appeared to be potentially effective in treating venous malformations, with the majority of patients achieving some lesion regression. However, it is associated with a 16% risk of major complications, including deep tissue injury, deep vein thrombosis, and nerve injury. While there was limited evidence that sclerotherapy with OK-432 was an effective treatment for lymphatic malformations, evidence for the use of sclerotherapy in patients with arteriovenous malformations was unclear.
Conclusions: Very limited evidence from case series studies suggested that sclerotherapy with ethanol and OK-432, administered over multiple sessions, was effective in the treatment of venous and lymphatic malformations, respectively. However, the value of percutaneous sclerotherapy as a pretreatment for or an alternative to surgery is not known. Further evidence is required to delineate which patients will benefit most from percutaneous sclerotherapy to ensure that the advantages of treatment will outweigh the risks.

INTRODUCTION

Vascular malformations are present at birth and typically grow commensurate with the child. These malformations manifest as either low-flow lesions (venous, lymphatic, capillary, or mixed malformations) or high-flow lesions (arteriovenous malformations and fistulae). Lymphatic malformations (LM) are further classified as macrocystic, microcystic, or mixed.[1–3]

Vascular malformations are present in <1% of all babies born worldwide, while LM occur in 0.5%.[4,5] Venous malformations (VMs) comprise 44–64% of all vascular malformations and arteriovenous fistulae make up 33%. Arterial defects are the least common, representing only 1–2% of all vascular malformations.[4,5]

The symptoms of vascular malformations are dependent on their location and the type of vessel affected. The clinical presentation of VMs can range from asymptomatic varicosities or vascular lesions to symptomatic lesions that cause airway obstruction, episodic pain, limb swelling, bleeding, or physical disfigurement.[2,3,6] LM commonly result in a painless focal mass (macrocystic) or diffuse tissue swelling or overgrowth (microcystic).[2] High-flow lesions can lead to venous

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Autologous fat breast augmentation: is safety equal to saline or silicone implants?

Leopardi D, Thavaneswaran P, Mutimer KLA, Olbourne NA, Maddern GJ.

Autologous fat transfer for breast augmentation: A systematic review.

ANZ Journal of Surgery. 2014;84(4):225-30.

REVIEW ARTICLE

ANZJSurg.com

Autologous fat transfer for breast augmentation: a systematic review

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Key words
breast implantation, breast implants, breast, mammoplasty, review.

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This paper was presented at the 7th Annual Meeting of Health Technology Assessment International (HTAi), June 2010, in Dublin, Ireland.

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Abstract

Background: The role of autologous fat transfer (AFT) for cosmetic breast augmentation is uncertain due to ongoing concerns regarding its safety and efficacy compared with other breast augmentation techniques.
Objectives: The aim of this systematic review was to assess the safety and efficacy of AFT for cosmetic breast augmentation in comparison with saline and cohesive silicone gel implants.
Methods: A systematic search of several electronic databases, including PubMed and EMBASE, was used to identify relevant studies for inclusion. The inclusion of studies was established through the application of a predetermined protocol by two independent reviewers.
Results: There were no comparative studies available, necessitating that all comparisons be indirect. Eighteen studies were included, 11 of which reported outcomes for AFT. Complications associated with AFT occurred in only a small proportion of patients, with fat necrosis, cysts and lumps most commonly reported. No data examining the effect of complications such as microcalcification on long-term mammographic and cancer-related outcomes were identified. Reabsorption of fat occurred to varying degrees, usually during the first 12 months following the procedure. Patient satisfaction following AFT was high. Limitation in breast volume increase was the main complaint associated with this procedure.
Conclusions: Based on the limited evidence available, AFT was considered to be at least as safe as the nominated comparator procedures in regard to complications; however, its safety in regard to cancer detection could not be determined. The efficacy of AFT could not be determined.

Introduction

Breast augmentation by fat injection was criticized by the American Society of Plastic and Reconstructive Surgeons in 1987 for potentially obscuring carcinoma of the breast upon subsequent mammographic examination, necessitating repeat biopsies to assess the numerous false positives that may arise.[1] In 2007, the American Societies of Plastic and Aesthetic Plastic Surgeons issued a joint caution against fat injection of the breast, stating that its radiological sequelae would compromise the detection of breast cancer on subsequent mammography.[2] Despite this, both societies '. . . strongly support the ongoing research efforts that will establish the safety and efficacy of the procedure' (p. 1438).[1] In the most recent guiding principles statement released by the American Society of Plastic Surgeons in January 2009, it was stated that autologous fat transfer (AFT) should be administered with caution in patients at high risk of breast cancer and that physicians should provide appropriate informed consent for each patient prior to AFT.[3] However, others have argued that conventional breast augmentation via prosthesis presents as serious a challenge to mammography as fat injection, a view that has not gone unchallenged.[4,5] The long-term effect of AFT on mammographic screening for breast cancer has not been evaluated. Alternative imaging methods, such as magnetic resonance imaging (MRI), have been shown to be helpful in detecting primary and recurrent breast cancer in patients who have undergone breast augmentation with implants or autogenous tissue.[6] Therefore, these

PROGRAM 2015

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HAVE A LOOK AT SurgWiki

An international portal for Australasian surgery

JOHN P HARRIS
EDITOR IN CHIEF

In addition to the College website, **www.surgeons.org** there are two other College websites, **www.ANZJSurg.com** and **www.SurgWiki.com**, both related to the 'ANZ Journal of Surgery' and developed in association with our publisher, Wiley. They are assets of our College and were initiated by John Hall, designed to complement the 'ANZ Journal of Surgery' by augmenting the educational resources available to surgeons, Trainees and aspiring students.

The journal website, www.ANZJSurg.com was launched in 2010 and expands the content of the journal. It is orientated to the needs of our Specialty Societies by including collections of articles published online, papers of historical interest, surgical techniques and references to various scoring systems, as well as records of surgical conferences and scientific meetings. Each Specialty has its own area highlighting important websites or other resources as determined by that Society. The website places the College in a good position as the trend to electronic publication continues.

SurgWiki

Less well known is SurgWiki (www.SurgWiki.com), initiated in 2012 as a free, web-based surgical educational resource, administered by Wiley with ownership passed to the College in 2014. A Wiki is a website that users can add, modify or delete content from, either using a basic text editor or a rich-text format, similar to that used in word processors. The first Wiki was created and developed in 1994 in Portland, Oregon, by Ward Cunningham. It was intended to be "the simplest online database that could possibly work". Cunningham recalled taking the Wiki Wiki Shuttle bus that ran between Honolulu's airport terminals – Wiki being the Hawaiian word meaning fast or quick.

SurgWiki is based on the 'Textbook of Surgery', 3rd ed., edited by Joe Tjandra, Gordon Clunie, Andrew Kaye and Julian Smith. The original chapter authors are acknowledged on the website. SurgWiki takes the principles of Wikipedia, but focuses on general and specialty surgery. Each topic has been written by an expert in the field and lays the skeletal framework for other contributors to follow.

The site is gaining international credence as an important surgical education resource. There has been a steady increase in access to SurgWiki since its launch in 2012 and it now achieves more than 40,000 site visits each month. This is remarkable exposure for Australasian surgery.

Clearly, SurgWiki has opened new and international exposure for Australasian surgery. For the site to remain innovative, fresh and up-to-date, it does need interested surgeons not only to access the site, but also to modify the content in light of current practice. Access to SurgWiki is straight-forward with the main menu (see figure) structured under the headings of General concepts, Surgical technique, Peri-operative care and Specialty interests. The site can be searched for a specific interest not listed in the main menu.

There is no subscription or sign up required to read SurgWiki; however, unlike some Wikis where all users can edit content, SurgWiki contributors must be approved by the 'ANZ Journal of Surgery' Editor-in-Chief and require a minimum of a tertiary education qualification and publication of at least two peer-reviewed articles. 'ANZ Journal of Surgery' Specialty and Assistant Editors have agreed to monitor content to ensure any modifications are in keeping with the journal's academic standards.

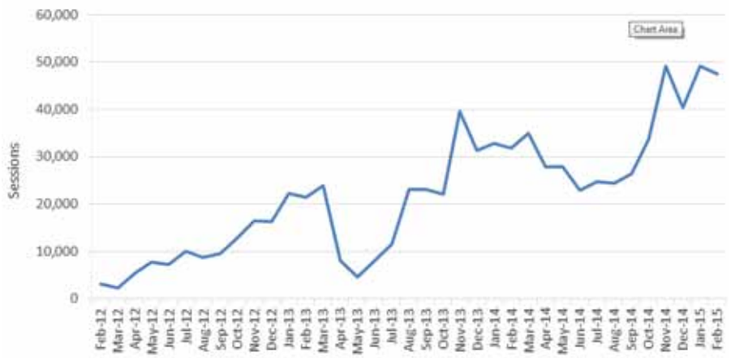
Contributors can use the Wiki process to update, modify, cull or edit content from an already succinct text, ensuring only the most up-to-date and relevant information is displayed. Once you are a registered contributor, making changes on SurgWiki is easy. After locating the text you wish to add to or modify, click 'Edit' at the top of the page, make changes to the text and then click 'Save'. Writing should be clear and concise, always aiming to improve the Wiki's content and relevance. Your contribution can range from fixing a spelling mistake to adding several pages. Before you save your work, there is an option to enter a short note in the Summary Box giving a brief description of what has been done; for example, "fixed typo" or "added more information about appendicitis". The summary gets stored alongside your edit, so that changes made can be tracked more effectively. There is a 'Show preview' button so that you can see what your change will look like, before it is saved.

There is always concern that the opportunity to modify content could invite submission of inappropriate or incorrect information. However, this is offset by the same openness to maintain quality and editorial supervision.

I encourage you to visit www.SurgWiki.com and hope that you will become an active contributor.

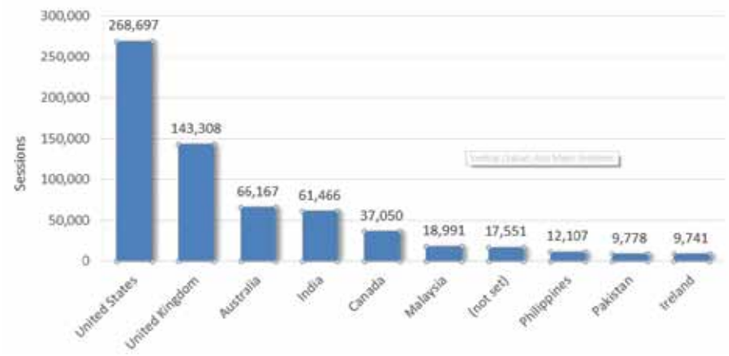
Acknowledgements: My thanks to Simon Goudie and Felix Gedye for their help in preparing this article.

SurgWiki Site Traffic 2012-2015



Growth in site visits to SurgWiki between 2012-2015.

Site Traffic by Country 2012-2015



Country of users accessing SurgWiki. Although China ranks 10th in accessing www.ANZJSurg.com access to Wikis is not allowed there.

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SAFE WORKING HOURS

Is it possible to train a surgeon in 38 hours per week?

LUKE BRADSHAW
VICTORIAN RACSTA REPRESENTATIVE

When it comes to safe working hours for Trainees, Australia is by no means at the forefront of this movement. Rather than catch up using blanket methods, we have been gifted the opportunity to learn from our international contemporaries. The overseas Trainee feedback demonstrates a general decrease in case numbers and clinical experience, with a UK review reporting that the restriction of 48 weekly hours resulted in a 20 per cent decrease in logged cases.1,2 Furthermore, patient outcome measures of error, length of stay and investigation ordering all increased.1 On this evidence, restricted working hours produced less experienced surgeons, for worse patient outcomes.

Currently, all registrars in Victoria are rostered for a 38 hour week, plus five hours allocated to protected clinical teaching or audit activities, in accordance with the current EBA and the 2005 National Code of Practice.3,4 On-call and weekend cover duties may add overtime to the 43 hours. Anecdotally, registrars fulfilling these obligations have had these additional hours counted in their overall allocation and are being rostered away from clinical teaching opportunities like elective operating sessions. Is this a response to the welfare of Trainees or an opportunity to trim medical workforce budgets?

The College Position

The College has responded to the changes prescribed to Trainee hours with a position paper titled 'Appropriate working hours for Surgical Training in Australia and New Zealand', published in October 2013 by the Safe Hours Working Party 2013.1 This paper incorporated the evidence from overseas about the effects of restricted hours on surgical training.

The key points are:

1) Shift work surgical Trainees (38hrs/wk) lead to more complications, longer hospital stay, more investigations and higher costs.
2) US, UK and European evidence recommends an ideal 65-hours/week to ensure adequate clinical exposure and opportunity for training.
3) Surgical training will need to increase by two years if restricted hours are enforced.
4) Lower quality training with restricted hours, in particular less generalist ability and a reliance on sub-specialty fellowships as "de-facto extensions" for complete training.
5) In endorsing a 65-hours/week, there is recognition of fatigue minimisation practices and safe rostering (i.e. 1 in 3 on-call rosters, 24 hours continuous period off per week).

The position paper then proceeds with recommendations for maintaining high quality training, yet mindful of the risk of fatigue.

EBA flexibility for surgical Trainees

One recommendation is to allow flexibility in future EBA agreements to provide different requirements for surgical Trainees, like 60 hours with five hours teaching and audit (including handover allotment).1 The current registrar mantra of 38+5 hours was developed as a generalisation from non-medical industrial awards with an incomparable work environment. While somewhat adaptable to non-procedural specialties, the added need to acquire technical ability in the supervised apprentice-type model places further burden on the weekly quota. Simulation provides an excellent adjunct, but is not a replacement. Furthermore, as surgeons, our responsibility to patient care continues beyond the operating theatre, where the consequences of pre and peri operative decisions are seen. As Trainees, the experience of managing complications with the support and guidance of a supervising surgeon is invaluable preparation. Post-fellowship patient care does not occur in shifts.

Night coverage and shared on-call

It is clearly unsafe and unsustainable to expect registrars to be onsite or on-call for extended periods of time, hence a role for night coverage and shared on-call duties. The position paper makes several points to this in minimal on-call ratios of 1:3 and provisions for fatigue and harm minimisation, including appropriate onsite accommodation and travel arrangements.1 These strategies need to be balanced across the spectrum of placements, from those rural ones in which workforce numbers may be low, to tertiary referral centres where night on-call may be even as onerous as during the day. This is further exacerbated by the demands of the 'four-hour rule' for emergency departments and the desire to fast-track patients to inpatient units.

One alternative model

No provision for on-call consultant fatigue is made in the setting of supervising more junior staff after hours.1 Likewise, minimal concessions are made for on-call registrars in some specialties where there is not the provision or preference for night staff. The position paper suggests utilisation of guidelines or pathways to facilitate and minimise non-urgent surgical referrals.1 A possible alternative is to have junior registrars/SHO rostered for night shift as a general or specialty registrar with training registrars available as a first on-call. This affords training registrars continuity of care for their inpatients and newly admitted patients and opportunity after hours operating of acute surgical conditions. It also allows non-urgent surgical patients to be formally seen by a member of surgical staff rather than generic guidelines applied.

In the UK, the preference of Trainees is for either long shift or on-call type coverage and it's likely that local Trainees would be similar, in order to protect their patients and training.2,5 Gone are live-in residencies and the extreme on-call periods experienced by many of our supervisors; most would concede that critical decision making by a zombie who hasn't slept in 48 hours is not in the patient's best interest. So what we're looking for is some middle ground; where Trainees are provided with adequate opportunity to develop all their technical and non-technical competencies and to minimise fatigue. Sixty-five hours appears to be a good place to start.

> "On this evidence, restricted working hours produced less experienced surgeons, for worse patient outcomes"

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Taking over WASHINGTON

Scholarship contributes to enriching and educating experience

Members of the American College of Surgeons Resident Associate Society Co Executive Committee and international visiting Trainees, from left: Dr Mouawad; Dr Vinci; Linda Chokotho, Dr Wang; and Dr Spaniolas

PhD Candidate and SET 3 Trainee Dr Laura Wang attended the 2013 American College of Surgeons (ACS) annual meeting in Washington DC as a guest of the Resident and Associate Society (RAS) of the College and with funding provided through the College's John Buckingham Travelling Scholarship.

Dr Wang, who is currently working on rotation at Liverpool Hospital in Sydney, attended the meeting with three other international Trainees as part of a program designed by the RAS to foster professional and academic collaborations and friendship among Trainees from around the world.

As part of the College scholarship, she also attended the RACS Annual Scientific Congress (ASC) held in Singapore last year and said that both experiences had enriched her professional life as a surgeon, researcher and research presenter.

Having already spent two years working in New York at the prestigious Memorial Sloan Kettering Cancer Institute conducting her PhD research, Dr Wang said she was still impressed with the size and breadth of the American College meeting.

"The ACS conference was conducted on a different scale to any meeting I have ever attended with more than 5000 surgeons and Trainees in attendance," Dr Wang said.

"Each day was packed with many interesting and provoking academic sessions with many concurrent subspecialty sessions run by the who's who of international expertise and thought leadership in each field.

"It was extremely impressive, but it was also valuable to have the chance to then attend the RACS conference in Singapore and to know without doubt that the research conducted here is of the same high calibre."

Dr Wang attended the ACS conference with three other international Trainees from Italy, Lebanon and Ireland; the three guests attending lunches and dinners organised by the RAS specifically to facilitate international relations.

Yet while she described the scientific program as "fantastic", she said she gained as much through the social and cultural connections she made there.

"It was having the chance to understand different health systems,

> *"Each day was packed with many interesting and provoking academic sessions with many concurrent subspecialty sessions run by the who's who of international expertise and thought leadership in each field"*

difference surgical training systems and different professional issues confronting different countries that I found of particular interest," she said.

"In addition to the academic sessions, for instance, I was struck by the number of sessions on cost-effective healthcare, leadership and life-balance sessions at the American College meeting.

"I also had the pleasure of meeting many international and Australian surgeons at the meeting including the recipient of the John Murray Scholarship, Dr Julie Howle, and Dr Stephen Smith.

"I was also pleasantly surprised to find many of the social events were run by the Australian surgeon Professor Steven Dean."

Dr Wang took two years away from her training in Australia to work on her PhD research investigating the prognostic characteristics of nodal disease in thyroid cancer and hopes to become a surgeon oncologist with an interest in diseases of the Thyroid and Head and Neck.

Now in the process of writing her thesis, Dr Wang has presented her research at meetings of the American Head and Neck Society, the American Endocrine Surgeons Society, the American Thyroid Association, the World Thyroid Congress and at the Australasian Scientific Congress.

She said that exposure to the academic presentations at the American conference had changed the way she now presented her own work.

"US academics present their work quite differently to people from a British or Australian background I found," Dr Wang said.

"The British tradition is based around a straight presentation of the data, which can be quite dry, but seems to have been designed to ensure that the presenter is not influencing opinion but simply laying out the case," she said.

"American presenters are quite different. They generally want to influence opinion, they want to capture your attention and it's as if they bring a sense of show business even into their academic work, which I found intriguing.

"Since my exposure to this, I am somewhat influenced by both styles of presentations as I can see that they both have merit."

Dr Wang said she was surprised and delighted to have been awarded the travel scholarship.

"This was the first College scholarship I had ever applied for and I didn't think I'd get it," she said.

"But then I read the mission statement behind the grant and I thought I might have a chance given my interest in both America and Australia and my research work in both countries.

"It was an absolute honour and privilege to be awarded the John Buckingham Scholarship and I would not hesitate to encourage other general surgery and subspecialty Trainees to apply for this grant in coming years.

"Not only are the professional links of great value, I believe that understanding other health systems and the way other surgeons work and conduct and present their research can only make us better surgeons."

The John Buckingham Travelling Scholarship was named in honour of the late John Buckingham who was a highly regarded specialist breast cancer surgeon who pioneered the sentinel node mapping technique. In recognition of his great love of teaching, the scholarship was established to encourage international exchange of information in the fields of surgical science, practice and education and aims to establish professional and academic collaborations and friendship among Trainees.

With Karen Murphy

AWARDS AND SCHOLARSHIPS of Trainee Dr Laura Wang

2013
John Buckingham Scholarship, American College of Surgeons, Royal Australasian College of Surgeons

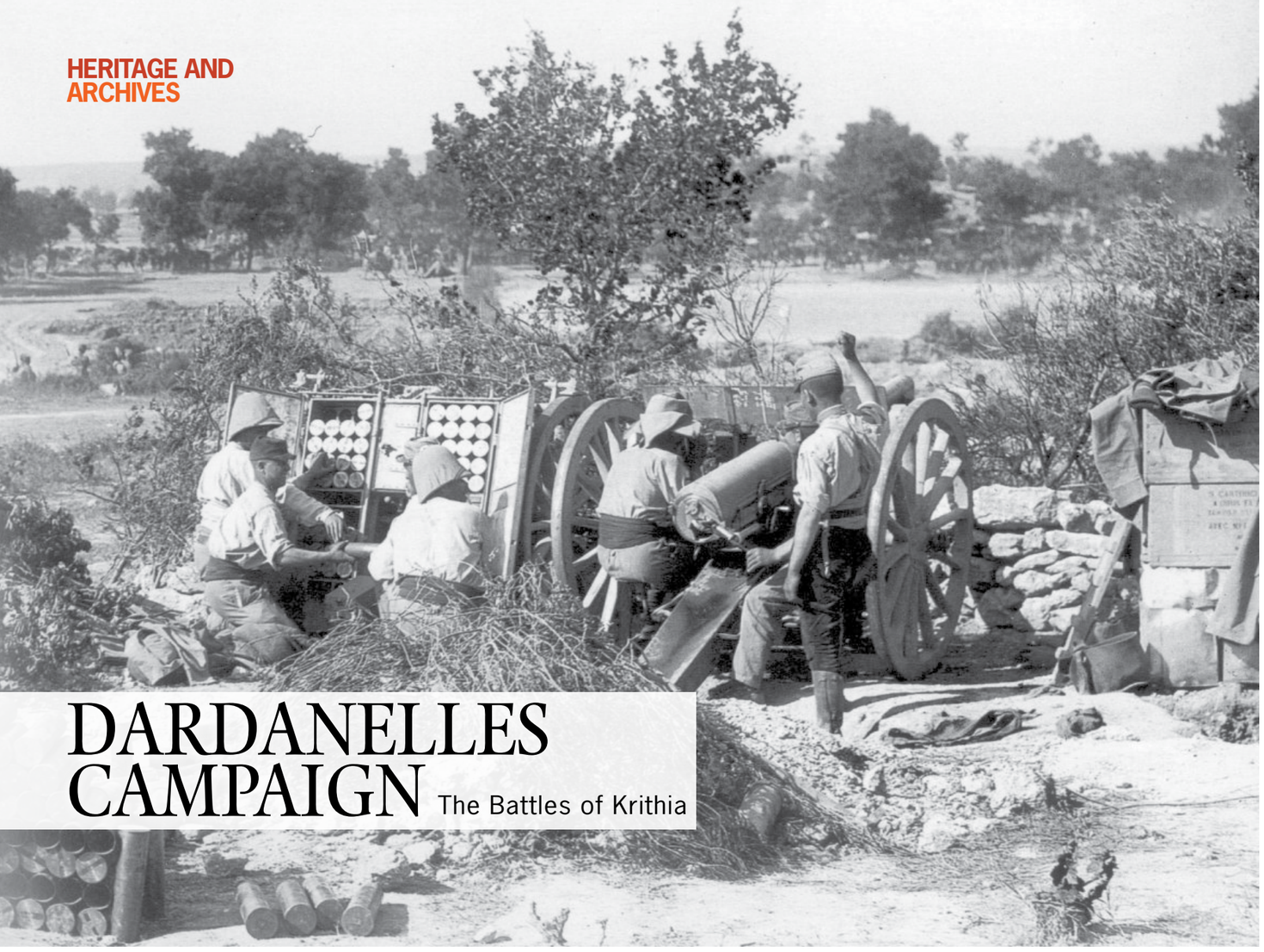
2013
American Thyroid Association, Trainee's grant

PRESENTATIONS

2015
American Head and Neck Society, Boston: Cost benefit of surveillance of low risk papillary thyroid cancer

2015
Australian Society of Otolaryngology and Head and Neck Surgery: Should incidental multifocality be an indication for completion thyroidectomy?

2014
American Head and Neck Society: Lymph node characteristics predictive of outcome in patients with thyroid cancer having a lateral neck dissection.



DARDANELLES CAMPAIGN

The Battles of Krithia

DAVID WATTERS
AND ELIZABETH MILFORD

On April 25 1915, the British 29th Division landed on beaches around the tip of the peninsula, Cape Helles, while the French Corps Expéditionnaire made a diversionary landing on the Asian side at Kum Kale. The Australian and New Zealand forces landed further up on the north coast along a narrow strip of beach at Anzac Cove beneath Ari Burnu. The allies underestimated the opposition and sustained heavy casualties.

The Turkish (but Greek-speaking) village of Krithia was north of Cape Helles and had the misfortune to be at the base of Achi Baba peak, a strategically important vantage point on the Gallipoli Peninsula. The first Battle of Krithia began on April 28, three days after the British, Anzac and French landing. It was the next attempt to advance up the peninsula from Cape Helles and involved 14,000 British and French troops, who sustained over 2,000 British and more than 1,000 French casualties. The attack was repulsed by a strong Turkish defence and convinced the British generals that the Turks were a significant and determined force.

A French Medical officer from Le Corps Expéditionnaire d'Orient wrote to his English wife:

I have been on board the Dugnay-Trouin to see our wounded there. The wounds are frightful… One sees a mass of dead on the Koum Kale shore. On the European side Krithia is burning. The distant hills are being bombarded. There are many ships everywhere.

The second Battle of Krithia occurred from 5-8 May and involved reinforcements from the British 42nd (East Lancashire) British Division, 29th Indian Division and Australian and New Zealand forces. The attack was poorly planned and similarly unsuccessful to the first, with some 6,500 casualties. The Australian 2nd Infantry Brigade suffered 1,056 killed or injured, a third of its 2,900 force. The NZ Infantry Brigade had 835 casualties.

On June 4 the third Battle of Krithia saw French and Indian troops make slight advances in the Cape Helles sector while subsequent Turkish counter-attacks almost broke the British line.

Another battle in the area took place during 5-13 August. The Battle of Krithia Vineyard was intended as a diversion to General Stopford's landings at Suvla Bay on August 6. A brutal and intense conflict, it resulted in over 4,000 British, and more than 7,000 Turkish, casualties.

"The Turkish (but Greek-speaking) village of Krithia was north of Cape Helles and had the misfortune to be at the base of Achi Baba peak, a strategically important vantage point on the Gallipoli Peninsula"

Today Krithia has been renamed Alçıtepe. Centenary visitors will find a number of memorials to the Turkish divisions that were garrisoned there, and the village still keeps its agricultural character. Wheat, barley, sunflower, sesame and cotton are its most important products. There are olive groves and the village owns two olive oil presses and an olive processing centre.

Eric Fitzgerald Harbison

Private (1894-1956) MB BS
Melbourne 1918, MS 1931, FRACS 1932

EARLY LIFE

Born in Numurkah, Victoria, at some stage Eric Harbison's family moved to Broadmeadows in Melbourne. He spent three years in the volunteer cadets at school and was also in the signaller corps at university. He began his medical degree at Melbourne University in 1913 and was in his second year when he enlisted in September 1914.

GALLIPOLI

Harbison was posted to 7 Bn as a private and served at Gallipoli until September 1915 when he was sent back to Australia to complete his medical studies. The 7 Bn took part in the landing at Anzac, forming part of the second wave, and during the first week they were involved in establishing the beachhead. On May 6-8 the Battalion was temporarily transferred to Cape Helles and on the 8th was involved in the second battle of Krithia, suffering heavy casualties, losing six officers and 87 men. The wounded were tended to by 2 Fd Amb and transferred to the Mashobra. In August 7 Bn took part in the battle of Lone Pine, defending trenches against Turkish Counter attacks.

AFTER GALLIPOLI

As he graduated in August 1918, Eric Harbison re-enlisted and was posted as a Captain in the AAMC and sent to the Sutton Veny near Warminster in Wiltshire. When the war ended, he lingered in England, but contracted influenza in February 1919 and was sent back to Australia.

PROFESSIONAL LIFE

Harbison held a variety of surgical posts when he returned to Australia – he was Honorary Surgical Assistant at the Melbourne Hospital and in the 1940s was an Honorary Surgeon and Pathologist at Prince Henry's Hospital. Like many of his generation, he continued as a member of the AAMC reserve.

– Elizabeth Milford ▶

ANZAC SURGEONS OF GALLIPOLI

Exhibition in the College Museum, 250-290 Spring St, East Melbourne, open 9-5 Monday-Thursday

The exhibition includes surgical instruments and equipment used by surgeons in the Dardanelles campaign, maps and memorabilia. Starting with a mock-up of a Casualty Clearing Station in the foyer area, the exhibition continues in the museum. An accompanying book of the same name can be purchased at the exhibition or by request. It contains the biographies of over 130 surgeons and medical students who later became surgeons and chapters including the management of wounds and the Turkish medical arrangements at Gallipoli.

“With the outbreak of the Great War, Pearless, despite initially being declined on account of his age, managed to gain appointment to the MCNZ for overseas service, due to his standing as an experienced war surgeon.”

Pearless family, Walter Pearless seated in the centre.

Walter Relf Pearless

Lt Col (1854-1924) LCRP, MRCS
London 1876

EARLY LIFE

Walter Pearless was born in Sussex, England in 1854 and at the age of 61 was believed to be the oldest New Zealander to serve on the Gallipoli Peninsula. Pearless attended St Bart’s Medical School and graduated in 1876, gaining the MRCS the same year. After practicing in East Grindstead, he immigrated to Australia in 1877 and worked at Alberton in South Gippsland until 1884, when he crossed the Tasman to become a public vaccinator in Waimea and surgeon-major in the Waimea Rifle volunteers. He remained commissioned in the Territorial Defence Force and served in the NZ contingent in the Boer War, returning to New Zealand in 1902.

GALLIPOLI

With the outbreak of the Great War, Pearless, despite initially being declined on account of his age, managed to gain appointment to the MCNZ for overseas service, due to his standing as an experienced war surgeon. He sailed in October 1914 and served on Gallipoli as RMO to the Canterbury Regiment. They landed on April 25, establishing a RAP at the foot of Walker’s Ridge, work for which he was mentioned in despatches. On May 7 at Krithia, he was seriously wounded in the thigh and evacuated to Egypt and subsequently to New Zealand in January 1916. One of his sons, L/Corp. H C Pearless, also fought on the Peninsula with the Canterbury Mounted Rifles.

AFTER GALLIPOLI

Pearless succeeded in arguing his way back to active service, sailing with the 12th Reinforcements for France on May 1, 1916, serving in various NZ military hospitals in France and England. He fell ill in late 1917 and was again returned to New Zealand. Despite further protestations to the Minister of Defence he was not considered fit for overseas service and so struck off the strength of the NZEF in April 1918.

PROFESSIONAL LIFE

Pearless retired soon after the war ended and suffered from declining health and difficult financial circumstances. Senior military colleagues unsuccessfully lobbied for a war pension. He died in Nelson on December 23, 1924.

– Andrew Connolly

NEWS FROM THE ACT

The ACT Audit is now collecting data from Anaesthetists under the ANZASM Qualified privilege

JOHN THARION
ACTASM CLINICAL DIRECTOR

The Australian Capital Territory Audit of Surgical Mortality (ACTASM) is a peer review audit of all surgically-related deaths within the ACT, which contributes data to the Australian and New Zealand Audit of Surgical Mortality (ANZASM). The ACTASM has been collecting data for four years, with 100 per cent participation of ACT hospitals and 99 per cent of surgeons. Fellows of the Royal Australian and New Zealand College of Gynaecologists (RANZCOG) have also been participating since 2012.

In 2012 the ACT Regional Committee of Australian New Zealand College of Anaesthetists (ANZCA) indicated interest in participating in mortality review within the ACT through ACTASM. Throughout Australia there are a variety of committees designed to review and report on anaesthetic deaths, including the longstanding NSW Special Committee Investigating Deaths Under Anaesthesia (SCIDUA).

Following a recent amendment of the ANZASM Qualified Privilege to include anaesthetists, ANZCA commenced participation in ACTASM, using the same model developed by the Tasmanian Audit of Surgical Mortality (TASM). Data collection commenced in 2014 and it is anticipated that data collected by ACTASM will contribute to the next ANZCA Triennial Report.

Anaesthetic deaths can be self-reported by the treating surgeon; via the medical records department of individual hospitals or via question 18 on the ANZASM Surgical Case Form. Nationally between 2009 and 2014, 7 per cent of all ANZASM audited cases indicated that there was possible anaesthetic involvement in the death.

Reported cases proceed along similar lines to the ACTASM review process: the anaesthetist involved completes an Anaesthetic Surgical Case Form, which is then de-identified and sent for peer review. Individualised feedback is sent to the original anaesthetist and the data is collected for the Triennial Report.

This broadening of the scope of the audit can only strengthen the quality of our data, giving a more comprehensive picture of the deaths reviewed by ACTASM. We look forward to providing a more complete dataset, with greater insight into the ACT health system through the inclusion of both RANZCOG and ANZCA Fellows.

In order to investigate emerging themes and findings from the audit, ACTASM is planning a workshop and webinar in August 2015. Topics will include Aspiration Pneumonia and Ortho-Geriatric Combined Admissions.

LEADERSHIP EXCHANGE

Younger Fellow attends the 10th Annual Scientific Congress in Las Vegas as a guest of the Association of Academic Surgeons

RICHARD MARTIN

I was fortunate to be the exchange recipient between the RACS Younger Fellows and the Association of Academic Surgeons (AAS) to attend the 10th Annual Scientific Congress (ASC) held in Las Vegas from February 3 to 5, 2015.

The ASC focuses on a mixture of translational and clinical outcomes research at both an undergraduate and post-graduate level. The program is action packed, with meetings often beginning at 6am and finishing with a variety of committee functions going well into the night. In addition to the scientific lectures, the ASC also ran sessions and workshops on mentoring, tweeting, technology, success and other less defined disciplines.

The exchange recipient is invited to give a 'Visiting Professorship Lecture' during the ASC, attend a number of functions and meetings as part of the AAS Committees 'Global Surgery' outreach and to enjoy the wonderful hospitality of the AAS. All activities are

> *"The [AAS] ASC focuses on a mixture of translational and clinical outcomes research at both an undergraduate and post-graduate level"*

taken very seriously with awards and visitor recognition occurring regularly throughout the program.

As part of the exchange, the visitor is assigned a dedicated host and there is close and clear communication at all times to ensure everything runs smoothly. I was met at the airport, delivered swiftly to my hotel, and taken care of very much like a VIP from then on. I was a little worried by my itinerary, which seemed somewhat overfull, but like our own ASC, there are often choices that have to be made between two interesting and unfortunately competing sessions. A sign of a good meeting.

Life of a US surgeon

The exchange is a unique opportunity to spend time with our American counterparts, to get a feel for life as a surgeon in America, to hear how the American health system runs and to discuss the challenges facing our Northern Hemisphere counterparts. In many ways it is also an opportunity to reflect on how lucky we are to be surgeons practicing in Australasia.

The AAS is an organisation representing surgeons within 10 years of their first faculty appointment, which is roughly similar to being an Australasian Younger Fellow.

The AAS has a scholarship corpus made up from generous donations and profits from AAS activities, which is used to fund research grants, visitor exchanges and other Global outreach activities. The AAS activities run in parallel and often conjointly with the Society of University Surgeons (SUS), who represent the more established academic surgeons and provides great synergy and guidance for the Younger Surgeons. The AAS generously paid for accommodation, transfers, registration at the ASC and gave $2000 US to help with airfare costs.

The SUS ran a 'mid-career' course immediately preceding the ASC. This naturally focused a lot on developing an academic career as a university surgeon, but also looked significantly at topics such as 'Leadership, Negotiation, and Conflict Resolution'.

Understanding your 'style' of negotiation and approach to conflict was undertaken prior to the course by a validated questionnaire with some surprising results.

As with all things, a deeper knowledge of yourself can open new doors in approaching difficult situations. Knowing whether you are an 'avoider, compromiser, accommodator, collaborator or competitor' can help you approach negotiations in a different way whether it be with other hospital staff, management, clinicians or patients.

The AAS exchange was a real pleasure and a privilege, and I am grateful for the opportunity to have attended the ASC and the SUS mid-career course. Las Vegas was also an amazing experience and I took a couple of days extra to see some of the sights and the shows. I would highly recommend this experience to all younger Fellows interested in broadening their horizons.

LEADERSHIP EXCHANGE

Each year a Younger Fellow is invited to be involved in the Leadership Exchange Program between the Royal Australasian College of Surgeons (the College) and the Association for Academic Surgery (AAS).

The successful applicant travels to the US and attends the annual AAS Congress and AAS Executive Committee meeting in America. In 2016, the AAS Academic Surgical Congress is being held in Jacksonville, Florida, February 2-4, 2016. The AAS will cover airfares, accommodation, transfers and conference attendance expenses for the College's representative.

Applications for 2016 open May 1, 2015.
Application procedures can be found at: http://www.surgeons.org/member-services/interest-groups-sections/younger-fellows/younger-fellows-leadership-exchange/

Dr John Corboy (1969-2007) was elected chair of the Royal Australasian College of Surgeons Trainees' Association (RACSTA) in 2007.

Royal Australasian College of Surgeons

He was a great leader and a self-less representative of Trainees of the Royal Australasian College of Surgeons. He gave generously to his peers his time and wisdom. His energetic service to the profes-sion and his tenacious passion for surgery despite personal adversity was remarkable. This distinguished award for surgical Trainees com-memorates Dr John Corboy's achievements and recognises ex-ceptional service by other Trainees.

The John Corboy Medal may be awarded annually to a Trainee who demonstrates the characteristics for which John was admired.
As this is a unique award that recognises Trainees of the College the presentation is made at the Annual Scientific Congress (ASC).

The award is made to a candidate who shows some or all of the following qualities in the performance of his/her duties, in service to the surgical community, in the manner and approach to the fulfilment of their surgical training or by their commitment to and involvement with the community of surgical Trainees:

- Outstanding leadership
- Selfless service
- Tenacity
- Service to Trainees of the College

NOMINATIONS FOR 2015 are now open. To obtain a nomination form, or for any queries, please contact Ms. Fiona Bull, Manager, Surgical Training, at **fiona.bull@surgeons.org**.

Nominations will close 5 p.m. on Friday 25 September 2015.

GJ ROYAL LECTURE

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

MICHAEL GRIGG
FORMER PRESIDENT, RACS

Thank you for the honour of delivering this year's GJ Royal lecture, which is in fact the 23rd time that it has been delivered and the fourth time that it has been delivered by a current serving President of our College.

Over the years, I have sat in this audience and heard some very interesting and thought provoking presentations and it is clearly a challenge to match my predecessors.

This lecture bears the name of Geoffrey James Royal. Geoff was educated at my old school in Melbourne – Wesley College. He graduated from Melbourne University in 1964 with many honours and prizes and pursued a career in surgery that saw him appointed to the staff of the Geelong Hospital in 1969. Over the next 20 years, he established an outstanding career and reputation.

He had many interests – a keen sportsman, a breeder of thoroughbred racehorses and an enthusiast of musical theatre. Throughout his surgical career, he actively participated in and advocated for, surgical training. He inspired many young surgeons. From 1988 to 1990, he was Chairman of the Victorian State Committee and was awarded the RACS Medal for services to the College in 1990.

Geoff died tragically young, only 51-years-old, in January 1991. His colleagues and friends moved quickly to enshrine his legacy and the first GJ Royal lecture was delivered in October of 1991. The speed with which this was achieved attests not only to the decisiveness of surgeons, but also to the impact one man could have on others.

For a long time I wondered exactly what I should talk about this evening. Clearly it was always going to be a talk about me, but what aspect?

In the end I have chosen to speak about what might best be described as my formative years.

I was a Monash Medical graduate and did my surgical training at the Alfred Hospital in Melbourne. For my intern surgical term I had as my registrar Campbell Miles and little did I know it at the time, but this was to begin a career long association. During my registrar terms I managed two rotations through the Vascular Unit. It was during the second of these terms that Campbell returned from overseas to join the unit as a junior vascular consultant – he would go on to be Head of that Unit before prematurely relinquishing this position to become the ASC co-ordinator of the College's Annual Scientific Congress.

Prior to my own return from overseas I had been in Los Angeles and watched George Andros at work. He and his group always operated in pairs. When I returned from overseas I persuaded Campbell that we should operate together. To this day, I still spend many hours every week with him. I might say I spend substantially more time with him than some other people who are considerably closer to me!

I passed the second part FRACS exam in May and left Melbourne only three weeks later – prematurely before my last registrar term to head to the UK in June. This caused some consternation and I was told that I would never ever work in Australia again! I spent the next 10 months in Salisbury – a really beautiful Cathedral city in the west country of England. I lived in a small cottage on the edge of the water meadows adjacent to the Cathedral made famous by the artist John Constable. Every morning, exiting the front door, I was greeted by a view of the Cathedral – daily divine inspiration if you like.

The British way

In those days almost all surgeons in England were General Surgeons with an interest – the special interest for my Surgeon, who went by the name of Bonar Mackie, was Urology and I learnt to do cystoscopies, TURPs and the like. I also learnt about horse racing as Bonar was very involved.

It was not unusual to find myself driving around the country lanes of Wiltshire and Somerset, chauffeuring the boss to some racecourse or other, as he was known to enjoy substantial liquid refreshment at these meetings. He owned horses as well and he was always quite chuffed to look in the racing guide and see his name – except for one occasion when the journalist chose to record his first name as Boncer rather than Bonar. For weeks after, he was incensed that a noble Scottish name had been reduced to that of a London East End thug.

In Salisbury I met William Golding who as you no doubt know wrote a book titled 'Lord of the Flies' – it had been one of my favourite novels – at the time he was schoolmaster in Salisbury and who would go onto to receive the Nobel prize for literature. He clearly did not have a good impression of the children of Salisbury.

The Salisbury General Infirmary was the oldest still functioning hospital in Britain having been built in the 18th Century and commissioned at a time when John Hunter was still alive. The hospital was built astride the River Avon that flows through the market town of Salisbury. Looking out from the surgeons' change room on the first floor, one could view the River Avon bubbling along below. On the wall of the surgeons' private lounge there is a stuffed trout caught by a line cast from that window almost a hundred years previously. And the bait used – the recently 'harvested' foreskin following a circumcision procedure.

In the early 1980s one of the largest vascular services in the UK was situated in Yorkshire, or more correctly Humberside, in Kingston upon Hull. This had been a major English port city, the sixth largest city in England, the home of William Wilberforce who strove diligently and successfully to bring the slave trade to an end. The final emancipation bill passed through Parliament just three days before his death in 1833. Hull, as a major port city, had been decimated by German bombing during the Second World War.

An opportunity arose for me to head north and really get stuck into vascular surgery.

Bonar Mackie, at his paternalistic best, warned me against it, contrasting the beauty and serenity of Salisbury with the poverty and barbarity of the north and warning me that if God felt inclined to deliver an enema to the world he would most certainly introduce it through Hull! He also warned that to aspire to a career in Vascular Surgery was foolhardy for it would be a career of frustration and disappointment – aneurysms would never truly be conquered and lower limb bypasses only prolonged the patient's suffering until the inevitable amputation was performed or the patient's merciful death intervened. But I went nevertheless. I was only to see Bonar one more time – when I returned to Salisbury as a locum consultant some years later. He died after a short illness only weeks after retiring. It was such a pity, he had planned such a full retirement, and nature had lost a true gentleman.

My Vascular surgical exposure in Hull was unimaginably good, but intensely hard work – it was non-stop, most hours of the day and night, most days of the week. The notion of safe working hours was still a concept awaiting fertilisation let alone birth.

I worked for a spectacularly skilled and capable surgeon of Scottish descent, Ian Galloway, who could best be described as passionate, but probably volatile or volcanic would be more accurate. He used to have very grand morning ward rounds that involved a substantial entourage – the residents, students, allied health and nursing staff.

I had been warned that under no circumstance should I ever be late for these events, but one morning I was. I had been up most of the night and literally slept through the alarm. In a panic I pulled on a few clothes, drove like a maniac through the snow-covered streets, ran up the stairs, but the Ward Round had already begun without me. I gathered my strength and confronted undoubtedly the fiercest individual striding the planet.

"You are late," he bellowed at me in front of everyone.

"Yes I know," I humbly replied. "I overslept".

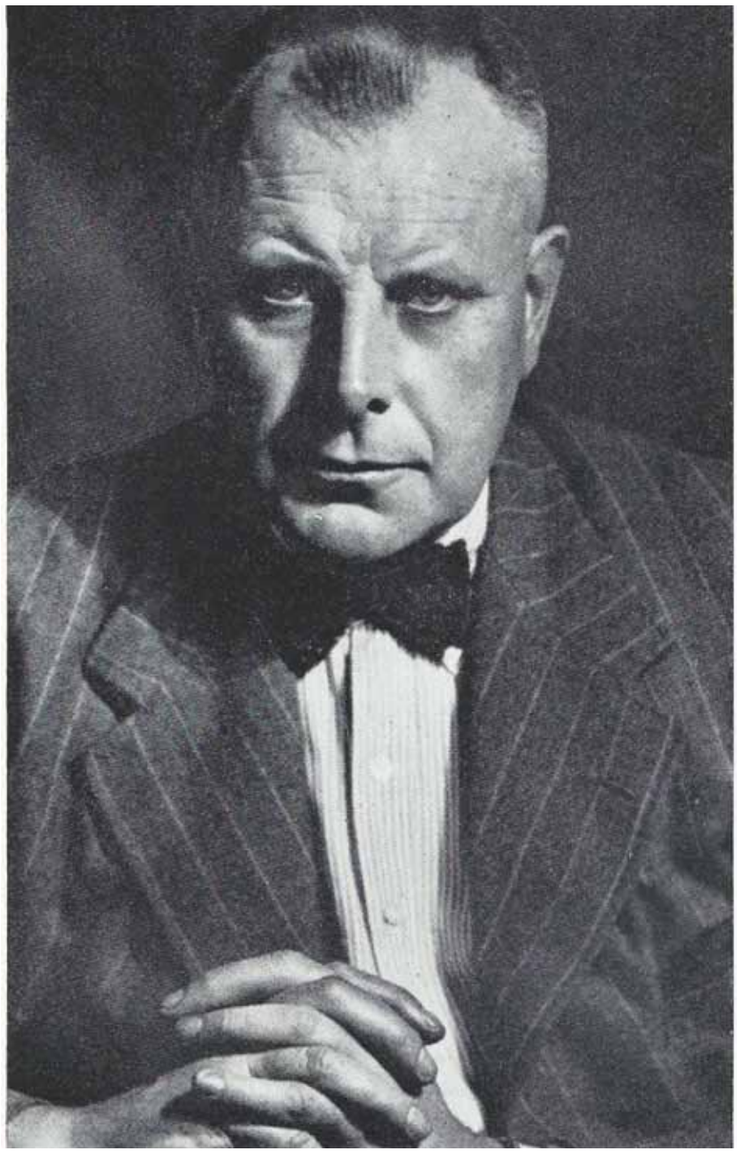
"That," he roared at me as I fully expected to lose part of my anatomy or at least be physically maimed, "is the only acceptable excuse!" And thinking about it afterwards, it was probably the only excuse that didn't involve at least the suspicion of lack of respect.

To be continued...

THE LIFE OF HAMILTON BAILEY

A well-known name with a tragic tale

RANDAL WILLIAMS
SOUTH AUSTRALIAN FELLOW



Hamilton Bailey was one of the great surgical teachers of the 20th century and his name is a byword with generations of medical students and surgeons. He published 13 books, including three iconic textbooks, and while others contributed to these, Bailey was the energy behind them. However, his own life was punctuated by tragedy.

There are two biographies. SV Humphries' account1 is brief and arguably sanitised, while prominent UK surgeon Adrian Marston's biography2 is more detailed and candid.

Early life

Henry Hamilton Bailey was born in 1894, the son of a Hampshire GP. Known always as Hamilton or Ham, he grew up with an absentee father, alcoholic mother and schizophrenic sister. Commencing medical studies, Bailey came under the influence of surgeons Lett, Souttar and Treves and their strong emphasis on surgical anatomy. The Great War intervened and Bailey volunteered with the Red Cross in Belgium and briefly was imprisoned as a spy. Later he joined the Navy as a surgeon lieutenant, serving in the Battle of Jutland. He obtained the FRCS in 1920.

Surgeon and teacher

In 1924 Bailey's left index finger was surgically amputated after infection contracted in the operating theatre. He ignored advice to give up surgery, later claiming that his slimmer hand was advantageous in exploring small surgical spaces.

In 1926 he married Veta Gillender who became his photographer, typist, organiser and lifelong companion.

"He developed a reputation as a tireless operator, enthusiastic teacher and prolific writer"

Bailey joined London's Royal Northern Hospital in 1930, where he was to remain through his professional life.

Even in this period of strict medical hierarchy, Bailey was a daunting figure to nurses and junior medical staff. Reading about him one is reminded of Richard Gordon's fictional surgeon of the period, Sir Lancelot Spratt. Bailey could be abrasive, had few social graces and cared little for medical etiquette and ceremony.

He was one of the true general surgeons of the day, but particular interests were genitourinary and head and neck surgery.

He developed a reputation as a tireless operator, enthusiastic teacher and prolific writer. Popular with referring doctors because of his constant availability and prompt feedback, he built up a large practice.

Bailey was not a neat surgeon, but he had the virtue of speed in a time of limited anaesthetic and perioperative supports. He would take on cases others refused, but was known to be impetuous and prone to mistakes.

Bailey worked six days a week and wrote on Sundays, dictating letters and book chapters using a portable wax-cylinder 'dictaphone' both at home and also in his Rolls Royce car. Veta organised him from morning to night. Entertaining at home often was interrupted by emergency cases or truncated to allow him to return to writing.

As an author

Bailey's legacy is his books, derived from his own experience, powers of observation and detailed anatomical knowledge .The books were written clearly and concisely and heavily illustrated. He never failed to acknowledge, in footnotes, the work of others.

Diagnosis was almost entirely clinical in Bailey's time and 'Demonstrations of Physical Signs in Clinical Surgery' (1927), one of the first textbooks to utilise color photography, instructed generations of doctors.

'Emergency Surgery' (1930) guided surgeons in remote areas, including the Australian Flying Doctor Service, and is his most influential work.

'Short Practice of Surgery' (1932), co-authored by colleague R. McNeill Love, universally known as 'Bailey and Love' is still being published (amazingly, Bailey and McNeill Love did not socialise and rarely spoke).

Arguably, these are the most influential medical texts ever written and hundreds of thousands were sold worldwide.

Bailey also published texts for nurses and dentists and contributed over 120 journal articles.

At the outbreak of World War II he produced 'The Surgery Of Modern Warfare', which he and Veta proof-read during the London blitz. The entire first edition bought by the US Army.

Bailey was by this time known internationally. His books were highly popular in the US, where he was awarded an honorary FACS and membership of the International College of Surgery. Recognition in the UK was less forthcoming. Bailey never achieved an appointment to a major London teaching hospital, was not interested in medical politics and did not seek advancement in his own College.

Visitors from around the world often were disappointed by the reality of his operative skills. A colleague commented, "on the whole he would have been better off sticking to writing his books".

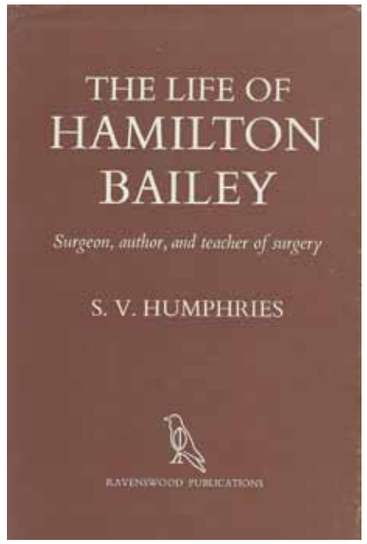
Death of Hamilton Jnr

In 1943, his only child Hamilton, a bright boy of fourteen, tragically was killed when he leaned out of a railway carriage and was almost decapitated by an open door of a passing train. After this horrific event Bailey buried himself further in work and writing. He endowed an eponymous prize at his son's school, Mill Hill.

Illness and decline

During the War Bailey continued his punishing workload, but afterwards had trouble adapting to social changes and introduction of the National Health Service.

He became increasingly irritable and unpredictable with declining operative performances and frequent sick leave when he should have been at his surgical prime.



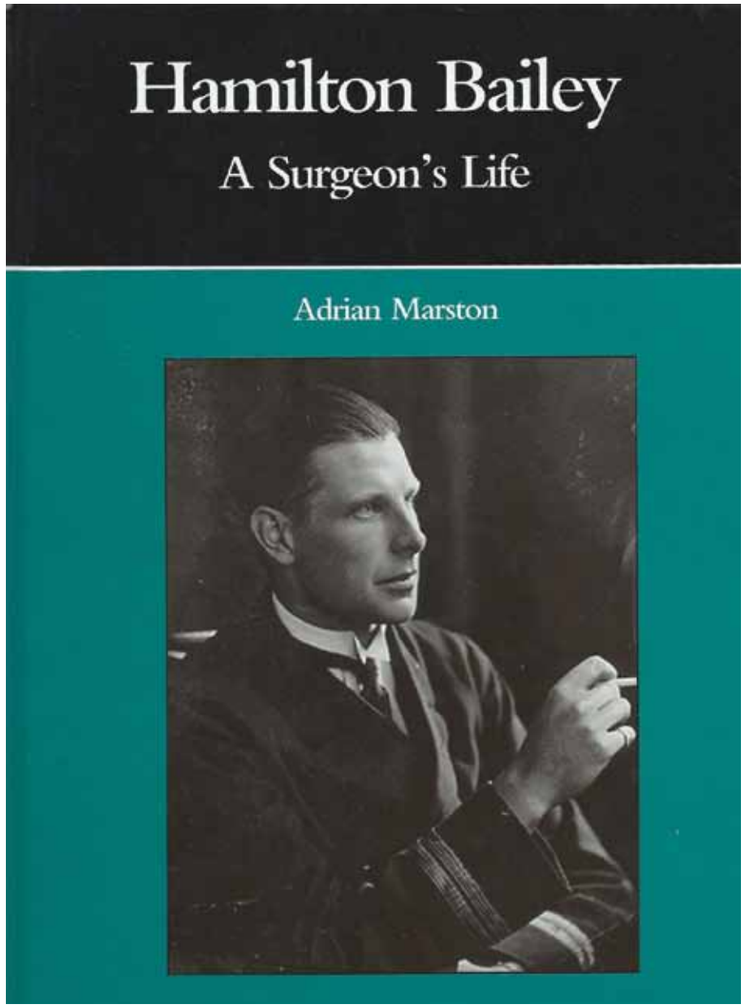
Further deterioration led to a diagnosis of manic depressive insanity and he was obliged to cease practice in 1949, at only 55. After unsuccessful treatments including ECT, Bailey was admitted to a mental hospital in 1951, where he remained for three years.

Eventually a prefrontal leucotomy operation was planned to control his increasingly antisocial and occasional violent behavior. David Moore, a young Australian registrar suggested a trial of new lithium carbonate treatment used successfully in Sydney. The effect was spectacular. Bailey's behavior improved dramatically and he was discharged from hospital in the care of his wife.

There was no question of returning to clinical work, but Bailey continued revising and editing his textbooks, with the help of colleagues such as Alan Clain. The iconic 'Bailey & Love' has since been revised and updated by many distinguished surgeons.

Death

Bailey retired to live in southern Spain where he hoped to continue writing and editing, but in 1961 developed malignant colonic obstruction. ▶



Against all his own surgical principles, Bailey persuaded the local surgeon in Malaga to perform a sigmoid colon resection with primary anastomosis. This, and his failure to seek help from one of his surgical colleagues, reflected his disturbed judgment.

Predictably the anastomosis leaked resulting in Bailey developing septicaemia and a colonic fistula. A number of salvage procedures were performed to no avail.

Hamilton Bailey FRCS, FACS died in Malaga on March 26, 1961, aged 66 and is buried in the British cemetery there.

There were obituaries and biographical sketches in the major medical journals. In 1968 new operating theatres in the Royal Northern Hospital (which closed in 1992) were named after him.

Veta outlived her husband by nearly 30 years, remaining in Spain until her death in 1990. She kept a close eye on new editions of his books as well as the international scholarships and library funds they had set up.

Veta assisted with the Humphries biography. He never met Bailey, but his lifetime of work in Africa had been aided immeasurably by Bailey's books. He suggested that Bailey's mental illness was the result of his son's horrific death, but this is simplistic. Marston believes that Bailey's enormous energy derived from the early phases of what would now be classified as Bipolar I disorder, which cut short his career and contributed to his premature death.

Randal Williams is an Adelaide General Surgeon who admits to a nostalgic affection for Hamilton Bailey's books and highly recommends Marston's account of his life and times.

References

1. Humphries, S.V. 1973 The Life of Hamilton Bailey. Beckenham Kent England; Ravenswood Publications
2. Marston, Adrian. 1999 Hamilton Bailey. A Surgeon's Life. London UK; Greenwich Medical Media. Alden Press Ltd Oxford

Books by Hamilton Bailey

Demonstrations of Physical Signs in Clinical Surgery, 1927 (nineteen editions)

Branchial Cysts and Other Conditions in the Cervicofacial Region, 1929

Emergency Surgery, 1930 (thirteen editions)

A Short Practice of Surgery (with R J McNeill Love), 1932 (twenty four editions)

Surgery for Nurses (with McNeill Love), 1933 (seven editions)

Diseases of the Testicle, 1936

Clinical Surgery for Dental Practitioners, 1936

Recent Advances in Genitourinary Surgery (with N.Matheson), 1936

The Surgery of Modern Warfare, 1940

Notable Names in Medicine and Surgery (with WJ Bishop), 1944 (four editions)

101 Clinical Demonstrations for Nurses, 1944 (five editions)

Pye's Surgical Handicraft (Bailey edited four editions from 1938-1944)

CASE NOTE REVIEW

Case study: a cardiac and vascular spiral

GUY MADDERN
CHAIR, ANZASM

A patient in their seventies with a history of hypertension and type 2 diabetes with previous coronary artery stents previously, presented with a six-month history of exertional angina and developed a non ST-elevation myocardial infarction (NSTEMI) for which they were admitted to hospital.

Clinical examination indicated that peripheral pulses were present, but that 'there was decreased circulation in both feet due to diabetes'. Coronary angiography was performed two days after admission and revealed a left main stenosis 70 per cent, left anterior descending (LAD) occlusion, 90 per cent circumflex stenosis and 90 per cent right circumflex artery (RCA) stenosis with an ejection fraction of 0.25–0.3. Surgery was performed several days later and consisted of a left internal mammary artery (LIMA) to LAD, saphenous vein graft to the intermediate and to the posterolateral branch of the circumflex. An intra-aortic balloon (IAB) was inserted preoperatively – the exact reasons for this were not apparent from the case notes. There also appears to have been no anti-coagulation measures whilst the IAB was in place. It is acknowledged that anti-coagulation is not always used with an IAB. Initially the haemodynamic status was stable and therefore the pulmonary artery catheter and the IAB were removed within 24 hours of operation. However 48 hours after operation there was deterioration in the haemodynamic situation, requiring reintubation and further cardiac support.

One of the complicating features was that the patient developed a new problem, namely peripheral vascular ischaemia. The pulse chart suggested that the right pedal pulses were not palpable; the distal right leg became cool, the patient complained of being unable to feel the leg and subsequently complained of pain in the leg. Within a few hours the leg was pulseless and Doppler confirmed no distal flow. More than 24 hours after the deterioration in vascular function of the leg an embolectomy and thrombolysis on the right leg was performed, combined with dilatation of the superficial femoral popliteal and posterior tibial arteries. More than 24 hours later it was suspected that a compartment syndrome had developed, but no fasciotomy was performed for a further 12 hours as a vascular Registrar was not available.

At the same time that the peripheral circulation was deteriorating, there was also evidence of an acute abdomen with abdominal distension and x-ray evidence of dilated proximal small bowel loops and large volumes of faeculent losses via the NG tube. By this stage it was decided that exploration of the abdomen was not indicated.

The combination of these three factors (haemodynamic deterioration, leg ischaemia and the evolving acute abdomen) resulted in a downward spiral of sepsis, cardiogenic shock and acidosis which resulted in a decision to withdraw therapy. The patient died shortly after.

Clinical lessons

1. The patient appeared to have a routine early postoperative course in ICU until the removal of the IAB when distal ischaemia was demonstrated. There is no evidence of the nature, if any, of the type of anticoagulant therapy employed during the first postoperative day, that is, whilst the lAB was in situ. There was also nothing in the notes to indicate whether IAB was placed on the same side as the leg ischaemia. The question must be raised whether these factors contributed to the lower limb ischaemia.
2. Vascular consultation was not obtained until approximately 24 hours after the development of lower limb ischaemia, and embolectomy and thrombolysis was not performed until a further four hours later. This is a significant delay.
3. Subsequently, the patient developed a distended abdomen, which may well have been due to ischaemic bowel (post-mortem showed a 70 per cent stenosis to the superior mesentery artery). In view of the two areas of peripheral ischaemia (gut and leg), one must wonder if atrial fibrillation with distal emboli was a factor, but the case report is silent on this issue.
4. A late fasciotomy did nothing to lessen increasing acidosis and haemodynamic deterioration.
5. The final area of concern is why the right coronary artery or its branches were not grafted. The angiogram describes a 90 per cent stenosis of the RCA (at post-mortem a 70 per cent stenosis was noted), but no branch of right coronary artery appears to have been grafted. If this is the case, then this may have contributed to the patient's

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