ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 16 NO 10 NOV/DEC 2015

PROFESSIONAL STANDARDS

Year in Review **p32**

SCHOLARSHIP PROGRAMS
Over 1.7 million funded for 2016

27

TRAINING IN PROFESSIONAL SKILLS
Upskilling junior doctors

40

The College of Surgeons of Australia and New Zealand

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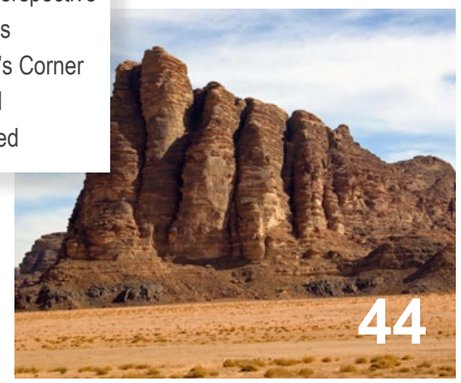

REGULAR PAGES

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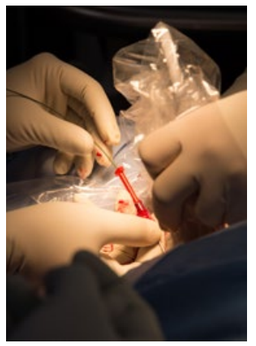


ON THE COVER: Professional Standards, p32

PROFESSIONAL DEVELOPMENT

WORKSHOPS & ACTIVITIES

Online registration form is available now (login required).
Inside 'Active Learning with Your Peers 2016' booklet are professional development activities enabling you to acquire new skills and knowledge and reflect on how to apply them in today's dynamic world.

Non-Technical Skills for Surgeons (NOTSS)

18 March 2016 – Sydney, NSW

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

Supervisors and Trainers for SET (SAT SET)

22 February 2016 - Sydney, NSW

8 March 2016 - Melbourne, Vic

23 April 2016 - Sydney, NSW

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

Keeping Trainees on Track (KToT)

23 April 2016 – Melbourne, VIC

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

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

Foundation Skills for Surgical Educators

23 February 2016 – Sydney, NSW

22 April 2016 – Melbourne, VIC

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

This free one day course will provide an opportunity for participants to reflect on their own personal strengths and weaknesses as an educator and explore how they are likely to influence their learners and the learning environment. The course will further knowledge in teaching and learning concepts and look at how these principles can be applied into participants own teaching context.

Younger Fellows Forum (YFF)

29 April – 1 May 2016 – Canungra, QLD

The Forum is a professional retreat of RACS Younger Fellows (a Younger Fellow is a surgeon who has obtained their fellowship within the last 10 years). In addition there are three international Younger Fellows; one each from the College of Surgeons of Hong Kong and Thailand, as well as a representative from the US Association of Academic Surgery (AAS). Participants will represent a mix of surgeons in terms of specialty interest, gender, type of practice and age. It offers a unique opportunity for a group of Fellows to share ideas and experiences and debate issues that affect their professional and personal lives.

All Younger Fellows are invited to nominate for the 2016 YFF. Applications are now open and can be submitted via an online application form or by completing a hardcopy form.

workshop

Feb 2016 - April 2016

NSW
22 February 2016
SAT SET Course, Sydney
23 February 2016
Foundation Skills for Surgical Educators, Sydney
18 March 2016
Non-Technical Skills for Surgeons, Sydney
22-24 April 2016
Process Communication Model: Seminar 1, Sydney

QLD
10-12 March 2016
Surgical Teachers Course, Gold Coast
29 April - 1 March 2016
Younger Fellows Forum (YFF), Canungra QLD

VIC
27 February 2016
Communication skills for Cancer Clinicians: Breaking Bad News, Melbourne
8 March 2016
SAT SET Course, Melbourne
21 March 2016
Clinical Decision Making, Melbourne
22 April 2016
Foundation Skills for Surgical Educators, Melbourne
23 April 2016
Keeping Trainees on Track, Melbourne
23 April 2016
SAT SET Course, Melbourne

HEALTH AND CLIMATE CHANGE

Fresh Air, Active Travel and Happy Holidays

DAVID WATTERS
President

"Like Lambs to the slaughter, they're drinking the water, and breathing the air." Tom Lehrer

Surely the RACS is not going to involve itself in climate change? Can this possibly be construed as core business? Why speak on a topic on which we have little expertise and no track record? In writing this month's column I am even fearful that some of my predecessors will shake their heads in dismay and wonder whether the College leadership has veered off track, melting to greenie heat through the warm (and getting warmer) days of summer. Please read on, hear me out, let me explain...

Our world of 7 billion is projected to increase to 9 billion. It is in a phase of warming. Although the earth's history has seen many cycles of warming and cooling, there is no doubt that we are contributing to the 21st century pace of warming, and also that the air we inhale is, in many cities, unhealthily polluted. This is bad for health, increases the cost of healthcare and thus is detrimental to well being and the economy. Climate change brings challenges for water quality and farming, with an ever-growing risk of shortages and disruption to supply chains that can become the underlying cause of conflicts across the globe. Our exploration of space has not yet provided an alternative planet for us to live on, and will certainly not do so in our lifetimes.

"*There is no plan B; there is no planet B*" so says Ban Ki-moon, the UN Secretary General, and he should know.

"*Tackling climate change could be the greatest global health opportunity of the 21st Century*". This was stated by a Lancet Commission on Health and Climate Change in June 2015, which called on Health Professionals to "*lead the response to the health threats of climate change*".

This Lancet Commission report on Climate Change was timed to motivate and inform health professionals of the health benefits of our nations' politicians reaching a global agreement in Paris in December. Margaret Chan, the head of WHO, wrote a commentary endorsing the growing movement for a cleaner, more sustainable and healthier future. She noted "*88 per cent of the world's population breathes air that does not meet WHO's air quality guidelines*" and this year the World Health Assembly passed its first ever resolution on air pollution (68/8). WHO's Executive Board has endorsed a new workplan on climate change and promote new metrics, to ensure health systems are scaled up and strengthened. It is estimated that populations and health systems are subsidising polluting fuel to the tune of $5.3 trillion per annum in lives lost and health system expenditure.

Atmospheric pollution is the result of short-lived climate pollutants (SLCP's) such as black carbon (2.4m deaths), methane and trophospheric ozone (150,000 deaths). They harm health, reduce food security, warm the atmosphere, increase ice melting and disrupt weather patterns.

"*What we eat, how we travel, and the energy sources we use are a function of policy decisions, institutions and infrastructure.*" The promotion of "*Active Travel*" would involve decisions by a plethora of government departments including transport, health and environment, never mind a consistent and determined approach across federal, state and provincial governments, never mind an integration with local strategic thinking by city mayors and town councils.

The evidence for the health effects of climate change is still being amassed, but epidemiological studies have shown in the SE Asian and other regions a significant association between temperature and childhood mortality. Infectious diseases, particularly respiratory and gastrointestinal, are the most prevalent cause, made all the worse by polluted air and contaminated water.

Carbon dioxide is responsible for longer lasting temperature rise, warming by its retention of the sun's heat. The world accepts that we should aim to keep the global average temperature rise to less than 2 degrees celcius and carbon dioxide emissions below 2900bn tonnes by the end of the century. Australia and New Zealand will certainly suffer from global warming, because Australia in particular has a lot of hot dry regions and much farmland at risk of being turned into barren scrub or desert. Australia has set a target by 2030 of 26-28 per cent reduction in greenhouse gas emissions on 2005 levels and New Zealand 30 per cent by 2030 (from 2020) and 50 per cent by 2050.

"The healthcare industry, including surgery and particularly operating theatres, is a high-energy consumer and so could get smarter."

Is this core College business? There is only so much advocacy energy to expend. We like to keep out of politics unless our patients' health is at stake. What can or should surgeons do?

We can consider how to use and convert to more renewable energy. The healthcare industry, including surgery and particularly operating theatres, is a high-energy consumer and so could get smarter. Some of us may have the opportunity to influence decisions in this regard. Our College buildings can become more energy efficient and this is a strategic direction that can be set for our CEO, the Directors and Managers – to ensure the RACS becomes greener in energy choices and utilisation. We are nowhere near setting targets, nor have we ordered solar panels for the College roof, but watch this space. The ability of the ACT to set itself one of 90 per cent renewable energy by 2020 is impressive.

In a recently published book '*The Influence of Climate Change on the Practice of Surgery*', Smith and Maddern highlight the ramifications that global warming will have for surgery and surgical practice. Perhaps a book worth considering for a Christmas present?

As we progress and warm up through the 21st century into 2016, I wish you the very best for the festive season, a happy new year and let's hope that our future and that of our children and grandchildren does not need to heed this further advice from Tom Lehrer in his song "*Pollution*"

"Just two things you must beware,

Don't drink the water and don't breathe the air"

We have only one world, we all need to mindfully take a deep and unpolluted breath and ensure a better future for everyone. I hope our leaders achieve agreements that secure our future in Paris. The College will do its little bit, but I promise also we will stay focused on all the other things you expect of us too.

PRESIDENT'S
PERSPECTIVE

RACS Support Program

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

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

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

How to contact Converge International:

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

Converge international

2015

It's all about mastering your ABCs

GRAEME CAMPBELL
Vice President

If you were to ask me what 2015 stands for in terms of College history I would say you could sum it up with three letters – ABC.

A is for Advocacy and the strong and consistent work RACS has been doing to influence the course of public health policy, largely through the work of the College's newly created Advocacy Coordination Group (ACG) and the dedicated policy and advocacy staff who are taking their lead from the Governance and Advocacy Committee (GAC) and the suggestions of the Board of Regional Chairs (BoRC) and turning ideas into policies, submissions, position papers and advocacy plans.

B is for bullying and one of the single most significant advocacy milestones in the College's history with the recent handing down of the Expert Advisory Group's (EAG) report into discrimination, bullying and sexual harassment (DBSH) in surgery, which will lead to fundamental changes in the way RACS interacts with hospitals, surgical educators, supervisors and Trainees, particularly women and International Medical Graduates (IMG).

C stands for Country Surgeons and with more than a quarter of the population of Australia living in rural areas and being serviced by only 15 per cent of Australia's surgeons, this is all about bridging the urban and rural divide and addressing the imbalance that may be contributing to poorer health outcomes in these areas.

Getting back to advocacy RACS has a strong history in this space, especially in lobbying for measures such as mandatory seat belts, drink-driving counter measures and compulsory helmets for cyclists. We have considerably stepped up our efforts in positioning the College as the leading advocate and authoritative source of knowledge and information in areas such as alcohol-related harm, DBSH, Indigenous health, trauma, obesity, smoking, domestic violence and sustainability of health care. Over the past 12 months we have made tangible process informing and shaping state, territory, district and national health policies in Australia and New Zealand and we have positioned the College as an effective advocate for surgeons and world-class surgical care.

Our highly successful push into the social media space has been crucial in maintaining informed decisions and in reaching far greater audiences than we ever thought possible. Our Annual Scientific Congress in Perth in May this year had more than 2.6 million views on Twitter.

Social Media has also been a great RACS communication tool for its advocacy work around discrimination, bullying and sexual harassment with over 3700 people viewing the President's DBSH Apology video on YouTube. The work of the independent EAG and its final report on DBSH has focussed the spotlight firmly and sharply on bullying in the medical profession and not only is it prevalent in the surgical profession but it is firmly entrenched in the culture of the broader health sector.

The EAG review pointed that not only was bullying prevalent in surgery, but also that it was an ongoing problem, experienced at all levels in surgery, and that the consequences were far reaching. It went on to say that there was no room for bystanders and hospitals, employers, governments, health professional and industrial associations and other partners in the health sector must all meet their responsibilities and make a sustained commitment to action. The report has provided RACS with a clear blueprint for an Action Plan to rid the profession of such behaviour and provide strong direction for other health industry organisation to follow and our President David Watters has already called on all Fellows, Trainees and IMGs to champion and model the high standards of behaviour that the College expects of others.

The other issue that raised its head in 2015 in my time as Vice President was that of rural surgery, and it is an issue around which I am extremely passionate. When I commenced practice in Bendigo, Victoria 25 years ago, rural surgery was facing a turning point. Back then the future for rural Australia looked grim - it was suffering from a shrinking population as well as a steady erosion of services such as banks, legal and other professional services that were being siphoned back into the larger regional centres and capital cities.

At the time I was part of a group with a shared vision of maintaining and expanding surgery across the whole country. This led to the formation of the Rural Surgical Training Program that I actually chaired for a period. We must have done something right because looking around rural Australia today the metamorphosis of the surgical landscape has been dramatic. Many rural centres are exhibiting strong population growth, especially down the eastern seaboard and the erosion of banking and other services has been stemmed.

Rural surgery really has a great future and the timing has never been more opportune for any Surgical Trainee wishing to consider a rural rendezvous. Despite what you may have been told you don't have to know how to ride a horse and the countryside is actually very pretty.

College Advocacy

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Social Media Surgery

Platform in focus: LinkedIn

What is LinkedIn and why should I be there?

LinkedIn is a business-oriented social media service, mainly used for professional networking. Launched in 2003, LinkedIn has over 364 million registered members. Over seven million users are in Australia, and over one million users in New Zealand.

With over 225,000 people listed as surgeons, you have a broad community of potential connections.

Benefits of being on LinkedIn

Some of the benefits to having an active LinkedIn profile include:

- Networking with peers
- Growing your professional circle
- Learning about new research
- Being able to publish articles for a professional audience that are less formal than those in medical journals
- Searching for new opportunities yourself
- Being approached by recruiters, other medical professionals, with new opportunities
- Being able to display links to your work, such as research projects
- Increasing traffic to your website or blog
- Refining your resume and career goals
- Building your reputation as a 'thought leader' and an expert in your field
- Keeping up to date with news from your alma mater
- Easy access to all of the people and organisations you are interested in, in one place

Getting started

Simply head to LinkedIn.com and follow the prompts to create a profile. You must use your real name (pseudonyms are not allowed) and current position. Including a clear headshot of yourself will guarantee you receive more views on your profile.

One important thing to note with the free version of LinkedIn is that it can alert you when a person has viewed your profile, which can be very exciting to new users. However, this feature works both ways – if you look at someone else's profile, they will also be notified.

If you would like to search for users without them being informed, you can do this by changing your privacy settings. However, this is also a two-way street – you will not be told if people have looked at your profile while this feature is activated.

Not sure which way to go? There is hope in sight – if you upgrade to a paid version, LinkedIn Premium, you can search anonymously to your heart's content, and still be alerted when people look at your profile.

Once you have decided which way you would like to go, start networking, and enjoy access to a world of connections at the click of a button.

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

Better targeting for outreach services

Research out of the Medicine in Australia: Balancing Employment and Life (MABEL) study has found that only half of specialists who provide outreach services to rural locations return to the same town within three years.

Authors of the study suggest that incentives to work in the areas need to be better targeted towards specialists who work exclusively in private practice.

RACS Executive Director for Surgical Affairs John Quinn said that it would be more practical for public hospital doctors to do the work as they can bring the patients back to the major centre for surgery if needed.

MJA Insight, 5 October

Obesity contributing to surgical deaths

Obesity is contributing to surgical deaths according to the latest Western Australian Audit of Surgical Mortality WAASM report.

Despite a decrease in the number of deaths, there has been a four-fold increase in the number of obesity and diabetes-linked mortalities.

"In 2002, the incidence of obesity as a comorbidity for surgical mortality was approximately 2.5 per cent but by 2014 it was almost 10 per cent," WAASM Clinical Director James Aitken has said.

"This strongly suggests that lifestyle issues contribute to riskier surgery," Mr Aitken said.

The West Australian, 12 October

Interlocks for young drivers

Alcohol interlocks have been suggested for P-platers by a national road safety lobby group.

A report by Austroads recommended the devices in an effort to reduce road trauma.

Member of the RACS Trauma Committee Dr Rob Atkinson said that research into the device is warranted.

"Any technology that potentially saves lives is worthy exploring," Dr Atkinson said.

3AW, 8 October

Reunion with heart

Melbourne surgeon Yves d'Udekem was reunited with some special patients recently – children with complex conditions from WA.

The young patients were transported to Melbourne by Heartkids WA to undergo lifesaving heart surgery.

The Deputy Director of Cardiac Surgery at the Royal Children's Hospital in Melbourne said the children hold a special significance for him.

"It's good to see them growing, they all mean something to me," Professor d'Udekem said.

PerthNow, 13 October

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

COURT OF EXAMINERS

FOR THE FELLOWSHIP EXAMINATION

Royal Australasian College of Surgeons

Applications from eligible Fellows willing to serve on the Court should be forwarded to the Department of Examinations of the College no later than Friday, 29th January 2016 for appointment in 2016.

Fellows are asked to note the following vacancies on the Court, in the specialties of:

- **Cardiothoracic Surgery**
- **General Surgery**
- **Orthopaedic Surgery**
- **Otolaryngology Head & Neck Surgery**
- **Urology**
- **Vascular Surgery**

Should you wish to apply to be a member of the Court of Examiners, please forward your completed application form with a copy of your curriculum vitae to:

examinations@surgeons.org

Or in hard copy to:

Department of Examinations
Royal Australasian College of Surgeons
250 - 290 Spring Street
East Melbourne
VIC 3002

- Application forms are available to download on the College website.
- Prospective applicants are advised to read the Appointments to the Court of Examiners and Conduct of the Fellowship Examination polcies, which can be found on the College website.

For inquiries, please email examinations@surgeons.org or call 03 9276 7471.

THE WAY FORWARD

The path to repect, transparency and professional excellence

DAVID WATTERS
President

The work of the Expert Advisory Group report on Discrimination, Bullying and Sexual Harassment has been profiled widely in the media. It has triggered many challenging discussions within the College, between Fellows and across the health sector more widely. The EAG report has shone a bright light and in that process, revealed disturbing issues. The report is based on data provided by our own Fellows, Trainees and International Medical Graduates. The data did not show what others thought of us. It showed what the experience of our own members has been.

The purpose of the EAG was to scope the problems we face and advise the College what to do. The report did not intend to trash the past. Indeed, it specifically sets us the challenge of taking what is best from the rich history of the practice of surgery and resetting it on foundations of respect, transparency and professional excellence.

RACS is doing that and we can share these lessons with the rest of medicine and the health sector more broadly. RACS is committed to dealing with the problems now identified and committed to action that will create the required change.

We must now move forward boldly and make sure the work we do leads to a safer workplace and removes discrimination bullying and sexual harassment. In doing this, we can build on the work we have been doing over many years to address these problems.

Articles by President Mrs Anne Kolbe in the June 2004 edition of *Surgical News* highlighted concerns about harassment and the work that was being done on our Code of Conduct. When this was published in 2006, it was one of the first internationally. It has since been revised and republished into a style consistent with the College Pledge. To complement this, we developed the Surgical Competence and Performance booklet that takes the nine RACS competencies and creates behavioural markers. This was first published in 2008 and been revised for a multi-source feedback approach and republished. We have been able to be clearer about what is appropriate and inappropriate behaviour.

"We need to develop a new, shared language that makes clear the risk to patient safety from discrimination, bullying and sexual harassment.."

In the October 2008 edition of *Surgical News*, RACS highlighted concerns about harassment in articles by President, Professor Ian Gough and then CEO of the Victorian Equal Opportunity and Human Rights Commission, Dr Helen Szoke, who was a member of the EAG. Professor Gough was one of the College champions whose energy and commitment drove us to develop the Bullying and Harassment booklet in 2009, which has now been revised and reprinted twice.

We developed ways of dealing with breaches of the Code of Conduct. Handling complaints in a membership organisation has been difficult and in the past the College viewed that the workplace or the regulator had the necessary authority to deal with these issues more definitively. Nonetheless, RACS was one of the first medical colleges to develop a policy to deal with breaches of the Code of Conduct. This was finalised in 2009 and Professor Grigg as Chair of the Professional Standards Committee wrote about this in 2010.

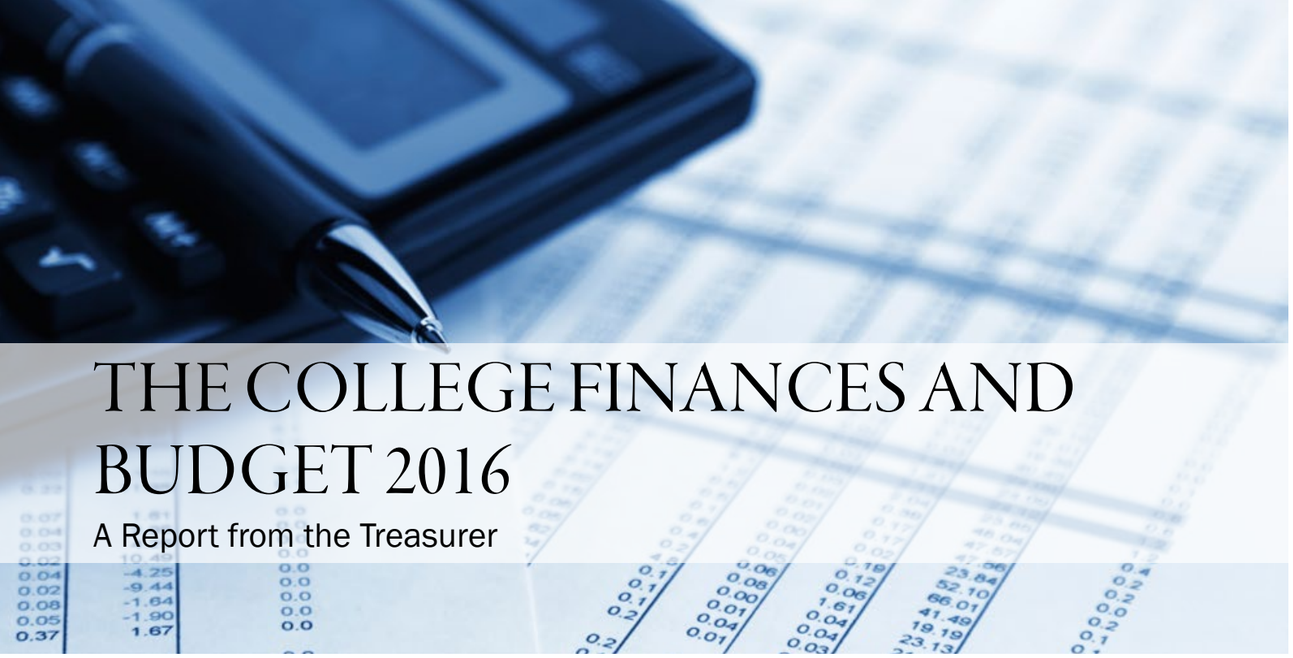
The College has relied on this policy to guide its actions to address breaches many times. The Executive Director of Surgical Affairs has investigated concerns and the College has taken action to try to make sure inappropriate behaviour is corrected. Fellows can lose their Fellowship of the College through the Breaches of the Code.

Previous Presidents have acted on their concerns about these issues that have worried us all. Their contributions have given us a platform on which to build.

But cultural change is hard and needs more than robust policies, clear expectations and good intentions. The EAG report, and the data from surgeons and hospitals that informed it, made it clear that the work we have done has not been effective enough to stop unacceptable behaviour.

For that I have apologised to all who have been affected by discrimination, bullying and sexual harassment. No person I have spoken to denies that every Trainee, Fellow and International Medical Graduate has the right to a workplace free of discrimination, bullying and sexual harassment. They agree this is fundamental to patient safety and quality health care.

The Expert Advisory Group has identified that we need to be much bolder, more transparent and more accountable. As a Medical College with a long history of positive contributions to the profession and the community, and justified pride in our professionalism, we must address and prevent these problems. We must not only do more to address these issues, but do things differently so we create effective change. In this, we must heed the advice of the EAG and make sure that our approach and our behaviour makes sense not only to ourselves, but that it withstands external scrutiny. I am sure that as surgeons we are up to that challenge.



THE COLLEGE FINANCES AND BUDGET 2016

A Report from the Treasurer

MARIANNE VONAU
College Treasurer

The College Budget for 2016 and the Scholarship Program 2017 Budget were approved at the October meeting of Council. The inclusion of the Scholarship Program 2017 Budget ensures appropriate funding is made available for the ongoing commitment to the College's significant research scholarships and grants program. The oversight of my last budget as Treasurer has presented a number of challenges as the College faces competing pressures on its finances. Primarily our steadfast commitment to deliver upon the Action Plan in response to the report by the Expert Advisory Group (EAG) on Discrimination, Bullying and Sexual Harassment (DBSH) within the surgical workplace will require significant financial resources next year and for future years to come. The College has already had to draw upon contingency funding and reprioritised its current budget in order to fund the anticipated $1 million in unplanned expenditures estimated for 2015. The impact of DBSH on College finances has required careful assessment by Council to ensure appropriate funds are allocated while also ensuring that our core business operations continue to be economically sound including allowance for ongoing investment in educational and member services.

College Business Activities

Fellows' subscriptions and Trainees' fees fund the delivery of broad range of educational and member related activities which I will outline further in this report.

The College activities are divided into 3 separate "Categories".

Category 1:

Activities related to the College's core purpose, namely education and training, professional development and standards, as well as regional and national advocacy. These resources are funded from your subscription and training fees.

Category 2:

A growing program of research, aid and audit projects, externally funded predominantly by government agencies. These projects provide multiple health programs from specialist training, indigenous health, audit and international humanitarian assistance.

Category 3:

Activities from philanthropic endeavours. The College has received substantial contributions from benefactors over many years including annual donations from Fellows to fund research activities and international aid. In recent years the College has continued to develop a number of key corpuses from any surpluses for designated activities and the current focus of these funds are related to research scholarships, international development, ASC visitors program, educational innovation and indigenous health.

The Budget is set to achieve a modest $1m or 2.2% surplus return on projected revenue from its Category 1 activities and demonstrates that the business plans continue to be financially sustainable. This budget outcome is dependent on DBSH expenditures remaining contained and will be closely monitored.

Key attributes incorporated in the budget strategy review and the budget processes were to:

- achieve a modest surplus return from core operations
- fees from Fellows, Trainees and International Medical Graduates need to support the costs of the infrastructure and governance of the College
- subscription fees have been set to ensure all Fellow related activities are fully funded from fees charged
- training, education and international medical graduate fees to be increased by Education Price Index to ensure all related expenditure is fully funded
- review of all NZD denominated fees to be charged at AUD equivalent to maintain equity in fee structure between the jurisdictions
- project related activity should be fully funded
- new key initiatives proposed will be assessed on the basis of adding value to Fellows and Trainees

Category 1

In 2016 revenue from operational activities is budgeted to increase by 7.6% to $43.9m (2015 - $40.8m) while expenditure is budgeted to increase by 7% to $42.9m (2015 - $40.2m).

Specific items of expenditure in category 1 activities include:

- personnel costs – increased by 9% to $17.1m (2015 - $15.7m) for salary increases in line with the general market, IT staffing to continue to deliver and support Digital College initiatives and other areas of growing business need.
- consultants fees – management and clinical – decreased by 7% to $1.3m (2015 - $1.4m) – anticipated cost savings in IT core operations and other main items to note being ACER and IT support for examinations and clinical/medical support and assessments, usually provided by Fellows of the College.
- printing and general office supplies – decreased by 11% to $1.3m (2015 - $1.5m) – Surgical News design and layout now administered by in-house Graphic Designer and other main items to note being production of the ANZ Journal of Surgery, Surgical News and prospectus for the Annual Scientific Congress.
- travel and accommodation – increased by 7% to $4.5m (2015 - $4.2m) – mainly for funding the EMST Education and Development Committee senior faculty workshop held every third year and other main items to note being governance activities, travel co-ordination for examinations and skills courses.
- property costs – increased by 7% to $2.0m (2015 - $1.9m) - leasing of office premises in Sydney, Brisbane, Perth, Canberra, Adelaide including full 12 month leasing costs for Wellington - New Zealand and scheduled maintenance and service programs.
- specialty society funding – increased by 2% to $4.0m (2015 - $3.9m) - provided for from Surgical Education Training (SET) fees in accordance with agreed training partnership agreement.

In addition to the delivery of core Fellowship services, training and education programs, the Budget also provides significant funding of $0.9m to further invest in strategically important activities including:

- development of web based applications for EMSF, Mini-CEX and DOPS evaluations and clinical assessors three monthly progress reports
- website review to ensure members experience continues to improve and is an adaptive experience across commonly used devices including mobile, tablet and desktop
- review of MALT offline application
- ongoing development of online and Information Technology based resources to support Fellows and Trainees in education and College related activities including CPD enhancements
- ongoing further expansion of library resources for the eLibrary for Fellows and Trainees

Category 2

In 2016 revenue for College project activities has increased by 1% to $19.3m (2015 - $19.1m) while expenditure is forecasted to be $19.7m (2015 - $19.4m). The overall result is a projected deficit of $0.4m which is primarily due to resourcing of the national office to oversight the various state based mortality audits.

The total contract value of currently operating projects is approximately $87m and demonstrates continuing significant government investment in specialist training programs, research, international aid and surgical audit.

Specific items of expenditure in category 2 activities include:

- personnel costs - $4.3m (2015 - $4.3m) represents ongoing level of staffing need
- consultants fees – $1.5m (2015 - $1.5m) – relates to professional services from external consultants for clinical / medical support and assessments provided to the College projects with activity under the funding contract for the Timor Leste Programs
- grants - $11.2m (2015 - $10.5m) predominately related to increased specialist training posts and rural loading hospital payments under the Specialist Training Program and Tasmania project contract.

Category 3

Revenue for all activities relating to the Foundation and Investments is budgeted to increase 9% to $6m (2015 - $5.5m) and mainly relates to increased pool of fund holdings associated with sound investment returns achieved in the 2012-2014 years and build-up of College corpora funds newly established since 2013. Expenditure is budgeted to be $4.2m (2015 - $3m) providing increased funding for new key initiatives, scholarships, fellowships and research grants and other philanthropic endeavours, resulting in

a forecasted surplus of $1.8m (2015 - $2.5m).

Fee setting for the 2016 - Annual Subscription

Council back in June set the budget parameters to ensure funding is aligned to the business plan and strategic direction. One of the underlining objectives is for core business activities to achieve a modest 2% surplus on operating revenue to enable ongoing investment in strategic initiatives outside the normal annual business cycle. The impact of DBSH in 2015 on College finances at the time these budget parameters were agreed had only started to emerge. The original setting for the 2016 annual subscription fee to increase by CPI did not at the time fully take into account the scope of resources that the College has subsequently had to apply this year and more importantly must commit to next year. In addition to allocating funds for aligned initiatives to DBSH such as the Code of Conduct Review and new course development for Professionalism – Surgeons as Leaders in Everyday Practice a further $665,000 has been allocated in the budget to progress the DBSH Action Plan in 2016. Upon further consideration by Council of the degree of uncertainty associated with the extent of impact of DBSH on the 2016 budget it was agreed that the annual subscription fee needed to be increased by 6% to provide the necessary additional budgetary funding. The decision by Council was a difficult but nevertheless prudent one and I sincerely hope that all Fellows will support their College at a time when it is critical that we must deliver a comprehensive Action Plan over next year and the years to come that will drive changes in culture and leadership, surgical education and complaints management as identified as core areas in the EAG Report.

Balance Sheet

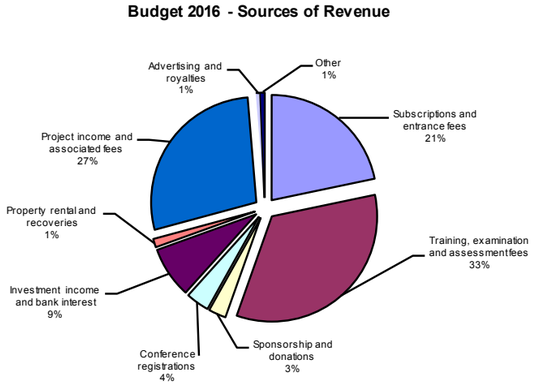
As at 31 December 2016, it is estimated that the College net assets will be $72.4m (2015 forecast - $70.6m).

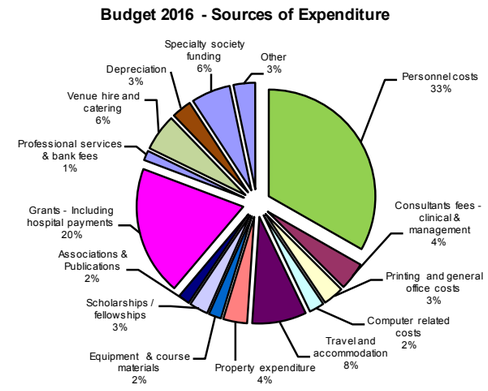
In Closing

As the year draws to a close the College continues to make significant progress regarding the key activities outlined in the Strategic Plan.

Total College Budget 2016 - All Business Activities (2015 Budget Comparison)

	Budget 2016	Budget 2015	Increase/Decrease
Revenue	$69.2m	$65.4m	6% increase
Expenditure	$66.8m	$62.6m	7% increase
Total Surplus	$2.4m	$2.8m	14% decrease





I would like to thank my Deputy Treasurer, Mr Andrew Brooks, for his continued support during 2015 and his oversight of property related matters.

I would also like to extend my warm thanks to the Honorary Advisors of the College, Mr Brian Randall OAM, Mr Anthony Lewis, Mr Stuart Gooley, Mr Michael Randall OAM, Mr Reg Hobbs, Mr John Craven, Mr Chesley Taylor and Mr Peter Wetherall for their ongoing advice and support. Also the advice, excellent service and support from Mr Graeme Hope, Investment Advisor, of J B Were have continued to benefit the College enormously. The expert advice and support provided by our Honorary Advisors over many years has been invaluable to the College and its Fellows.

Also I would like to thank the Resources staff and the Director, Mr Ian T Burke, for their commitment, support and hard work in assisting me in my role as Treasurer.

The budget has been set to continue to invest in core areas of service to our Fellows and Trainees with an ongoing commitment to focus on matters of strategic priority. Despite the challenges being faced the financial position of the College continues on a solid base and will be closely monitored for the year ahead.

November 2015

Fees for 2016

	2016 Aust Fees AUD (Incl AUST GST)	2016 NZ Fees NZD (Incl NZ GST)
SUBSCRIPTIONS & ENTRANCE FEES		
# Annual Subscription - 2016		
payable on 1 January 2016	$2,805.00	$3,285.00
Fellowship Entrance Fee		
payable in full (10% discount applies) or over 5 years - no CPI increase	$6,105.00	$7,150.00
EDUCATION & TRAINING		
Surgical Training		
Administration Fee - exam pending, interruption and deferral (SET)	$360.00	$420.00
Selection Processing Fee - (Note 6)	$815.00	$955.00
Selection Registration Fee	$530.00	$620.00
# SET Training Fee - College Component - 2016 *	$3,275.00	$4,220.00
International Medical Graduates		
Specialist Assessment Fee	$9,405.00	N/A
Supervision/Oversight Fee - onsite	$7,620.00	N/A
Supervision/Oversight Fee - remote	$21,750.00	N/A
Document Assessment Fee - AoN subsequent to specialist assessment	$1,425.00	N/A
Document Assessment Fee - College endorsement for AoN (Area of Need)	$1,425.00	N/A
IMG Administration Fee	$940.00	N/A
Short Term Specified Training Position Application Fee	$1,140.00	N/A
Examinations		
Clinical Examination Fee *	$2,170.00	$2,795.00
Fellowship Examination Fee *	$7,850.00	$10,110.00
Generic Surgical Science Examination Fee *	$3,780.00	$4,870.00
Orthopaedic Principles & Basic Science Examination Fee *	$2,840.00	$3,660.00
Paediatric Anatomy & Embryology Examination Fee *	$3,580.00	N/A
Paediatric Pathophysiology Examination Fee *	$1,420.00	$1,830.00
Plastic and Reconstructive Surgical Science & Principles Examination Fee *	$2,840.00	$3,660.00
Cardiothoracic Surgical Sciences and Principles Examination Fee Part 1 *	$1,432.00	$1,845.00
Cardiothoracic Surgical Sciences and Principles Examination Fee Part 1 *	$2,148.00	N/A
Specialty Surgical Science Examination Fee *	$1,890.00	$2,435.00
Pre Vocational Education and Training		
Generic Surgical Science Examination Fee	$4,155.00	$4,865.00
OTHER FEES		
Appeals Lodgement Fee	$8,580.00	N/A
MOPS - Maintenance of Professional Standards		
Australia & New Zealand	$3,050.00	$3,570.00

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

1. All fees are payable in either Australian or New Zealand Dollars as invoiced
2. All New Zealand fees will be subject to GST of 15% unless marked with (**) which are not subject to New Zealand GST.
3. All Australian Fees will be subject to GST of 10% except those approved Education courses marked with an asterisk (*) which are not subject to Australian GST.
4. Examination & training fees for Australian based activities have been approved by the Australian Taxation Office as GST free for all courses relating to the RACS Fellowship
5. Subscriptions and Fees marked (#) may be paid to the College by 4 equal instalments during the year by AMEX, Visa or MasterCard credit cards only. Further details will be made available when fees are raised.
6. Specialty programs may charge their own selection processing fees, these fees will be published by the respective Specialty Society
7. N/A relates to College services not charged in stated currency

A full list of fees can be found on the College website

ADVANCING SURGERY

With a long list of achievements, Professor Wendy Brown has a new title to add to her resume

Upper GI and General Surgeon Professor Wendy Brown became the first woman to hold the position of Chair of the Monash University Department of Surgery at the Alfred Hospital in October.

With sub-specialist interests in oesophago-gastric cancer, gastro-oesophageal reflux disease and bariatric surgery, Professor Brown is the Director of the Monash University Centre for Obesity Research and Education (CORE) and Clinical Lead of the National Bariatric Surgical Registry.

She is the immediate Past President of the Obesity Surgery Society of Australia and New Zealand (OSSANZ), the President Elect of the Australian and New Zealand Oesophago Gastric Surgery Society (ANZGOSA) and is the Deputy Chair of the College's Section of Upper GI, HPB and Bariatric Surgery.

With a career-long interest in surgical education, Professor Brown is also a senior RACS Examiner for General Surgery.

Professor Brown's research career stretches back to 1997 when she began her PhD evaluating the potential for preventing bowel cancer using non-steroidal anti inflammatory medications.

Her current research interests include health outcomes from bariatric surgery, animal models of bariatric surgery and basic mechanisms underlying satiety. She has also undertaken research into the effects of weight loss on infertility and joint pain.

In recent years, she has attracted more than $2.5 million in research funds from industry grants to support the work of CORE and government funding for the Bariatric Surgical Registry.

She has authored 60 peer reviewed journal articles, made 64 research presentations at national conferences and presented her work at 26 international meetings.

Professor Brown said she was thrilled to have been selected as Chair of Surgery at Monash University and said she would use the position to promote collaborative research projects between surgeons, scientists, engineers and hospitals around Australia.

"I'm delighted to have the opportunity to lead a dynamic group of surgeons at Monash University and the Alfred Hospital and to promote and develop surgical research and surgical education," she said.

"I am also proud to have gone through a surgical education and professional system that has given me such great support and mentorship since my early days of training.

"I don't think of this new role of Chair as an issue of gender, or cultural change, because they have never been an issue in my career.

"I simply see this position as providing a great opportunity to conduct and facilitate surgical research, support surgeons wanting to undertake a higher degree and promote clinical research in how we best deliver surgical care particularly considering how we incorporate new techniques and new technology.

"I plan to work with my surgical colleagues at both Monash University and the Alfred Hospital to establish broad collaborative projects that call on the skills of scientists and engineers and other institutions to advance both surgery and patient care.

"I am also working on ways that we can provide exciting research opportunities for younger surgical Trainees so that research becomes something they want to do rather than a mandated requirement of their training."

Professor Brown completed her medical training at Monash University in 1992 and said she had originally intended to become a GP or Obstetrician until a supervisor at the time, Professor John Masterton, convinced her to pursue a career as a surgeon.

"I like fixing things and so surgery appealed as it was very satisfying to see someone come in with a problem, undergo a procedure and then see immediate improvements in the patient's condition," she said.

"I thought it offered the chance to make a more immediate impact on patient's lives than do some other medical specialties and I was drawn to General Surgery because it often requires considerable diagnostic skills."

Professor Brown completed the bulk of her surgical training at the Alfred Hospital and received her FRACS in 2002. She then took up an Oesophago Gastric and Advanced Laparoscopic Fellowship at the Princess Alexandra Hospital in Brisbane before returning to Melbourne.

In 2008, Professor Brown received the RACS Prize for Outstanding Service, became a Fellow of the American College of Surgeons, was appointed to the College's Court of Examiners and promoted to Associate Professor of Surgery at Monash University.

Currently, she is a member of the Australian Medical Council (AMC) Board of Examiners, an AMC Assessor for Undergraduate Programs and the Academic Surgery Section Representative on the College's Board of Surgical Research.

Her clinical work is divided between Upper GI oncology and bariatric surgery and she has performed more than

"I am also proud to have gone through a surgical education and professional system that has given me such great support and mentorship since my early days of training."

1400 LAP-BAND procedures.

As the Director of CORE, Professor Brown has promoted a multidisciplinary approach to the study and treatment of obesity, integrating clinical obesity management with psychology, epidemiology, public health and professional and community education.

In recent years, CORE has completed five major randomised control trials comparing the effect of conservative weight loss therapies to surgery and their relative impact on metabolic syndrome, type 2 diabetes, sleep apnoea and adolescence.

The outcomes of these trials have been published in high impact medical journals such as the Journal of the American Medical Association and Lancet Endocrinology and Diabetes and have had a major impact on practice.

Recently, CORE completed a suite of studies addressing how the laparoscopic adjustable gastric banding system may be inducing satiety.

Professor Brown said she was drawn to bariatric surgery because it was a dynamic and modern specialty and also because she wished to help obese patients, many of whom continued to suffer from social stigma and misunderstanding.

She said she helped establish the National Bariatric Surgery Registry as a quality and safety audit mechanism to assess surgical outcomes in such a rapidly developing surgical field.

"I originally became interested in Bariatric Surgery because a mentor, Professor Paul O'Brien, had an interest in the field," Professor Brown said.

"It appealed to me as a way of helping people to return to health almost from the day following surgery and provides a nice balance to my oncology work.

"Around 27 per cent of the population is now obese yet still there is a societal stigma toward obese people and I wanted to stand up for them and work to find better treatments and to promote the idea that obesity is a disease, not a moral failure.

"On average, people don't have a lot of empathy for obese people and think they should just eat less and walk more but if it was that easy we wouldn't have this major health problem.

"It is also overwhelmingly a disease of economic disadvantage, which is one reason I don't support a "sugar tax" because it would place a disproportionate financial burden on those who can least afford it. I would prefer to see improved education and health literacy around healthy eating.

"However, while prevention would be the ideal, the fact is that a significant proportion of our population already suffer from this disease. We can now say that bariatric surgery is a viable treatment option for these people as there is significant evidence that all Bariatric procedures can help people lose around 50 per cent of their excess weight safely and keep it off with the consequent improvements to health and longevity.

"It's also a very exciting area because procedures change as our knowledge of the underlying mechanisms of obesity improves and conversely by studying Bariatric procedures we also improve our understanding of the underlying physiology of obesity. I enjoy the fact that my work covers the gamut of clinical surgery, research and public health advocacy and education."

Professor Brown described her new appointment as a highlight of her career but said her role as teacher remained her greatest reward.

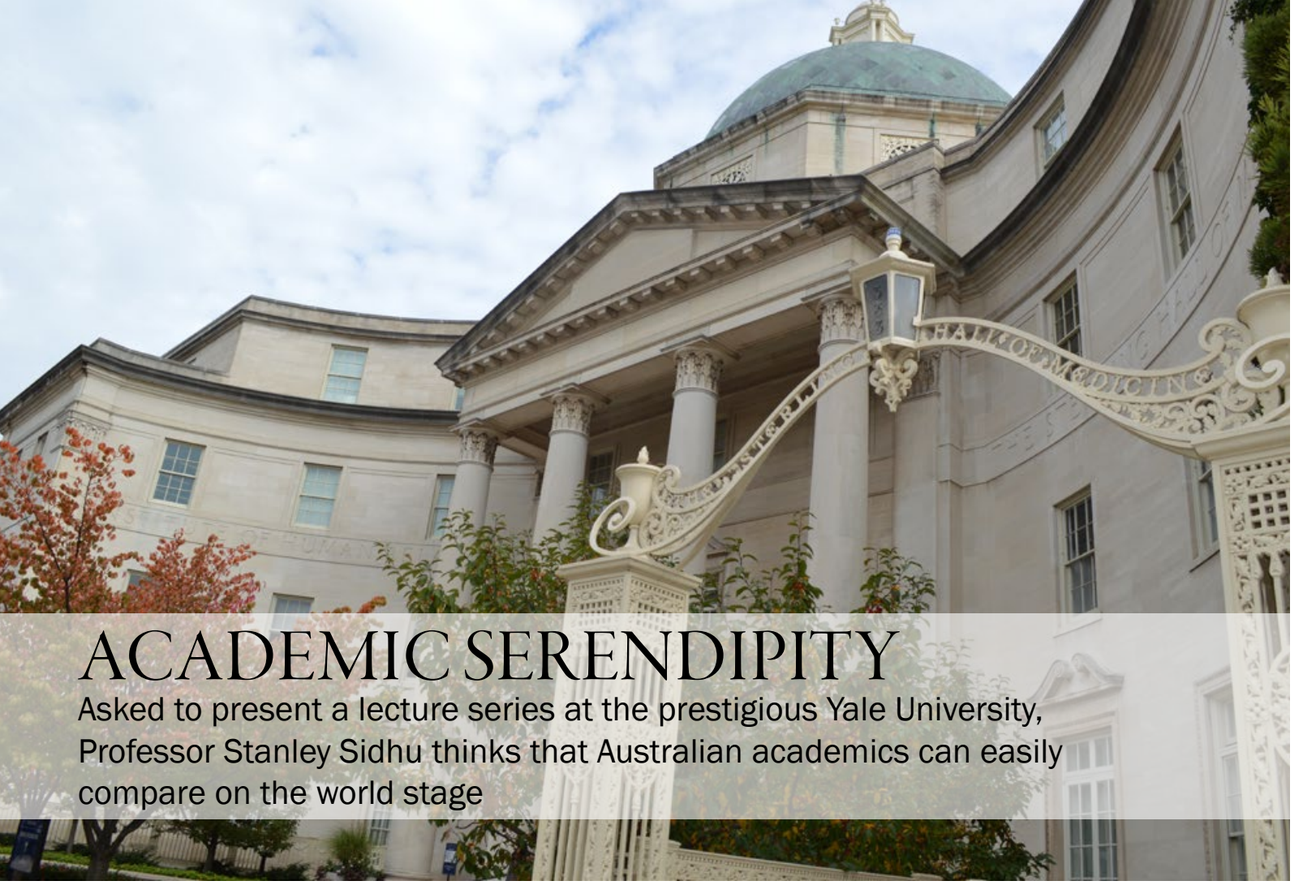
"Some of the first medical students I taught and mentored have now become surgeons, which I think is wonderful and one of my female students has even chosen to specialise in Upper GI Surgery," she said.

"In some ways, their progress means more to me than my own achievements and it is a great honour to be given a position that will hopefully allow me to inspire young doctors like I was inspired."

Away from her professional commitments, Professor Brown enjoys long-distance running and skiing and has recently taken up ballroom dancing.

"I'm enjoying ballroom dancing although it requires me to follow someone else's lead which can be a bit of a challenge for me."

With Karen Murphy



ACADEMIC SERENDIPITY

Asked to present a lecture series at the prestigious Yale University, Professor Stanley Sidhu thinks that Australian academics can easily compare on the world stage

Academic Endocrine Surgeon Professor Stanley Sidhu earlier this year became the first Australasian surgeon to deliver one of the most prestigious annual surgical lectures in America.

In May, Professor Sidhu accepted a Visiting Professorship which allowed him to deliver the 53rd Leon E. Sample Memorial Lecture, presented by the Yale University School of Medicine's Department of Surgery.

The lecture series, endowed in honour of a country surgeon who saved the life of the donor's young son, has been presented since 1957 by only the most distinguished and influential US academic surgeons.

While Dr Sample was asked to deliver the first lecture of the series, he declined the offer saying that he believed only the best speakers and surgeons should be chosen.

Yale respected both his request and vision and the list of past Sample lecturers includes the cream of American academic surgery.

It includes the inaugural lecturer, J Englebert Dunphy (1957), Edward Churchill (1963), Robert Zollinger (1972), William Blakemore (1980), Donald Trunkey (1985), Frank G Moody (1992), Karel Pacak (2002) and Steven K Libutti (2010).

Now Professor Sidhu's name is added to that roll call.

Professor Sidhu conducts his clinical work and research at the University of Sydney Endocrine Surgical Unit and as Senior Researcher in the Cancer Genetics Group Kolling Institute of Medical Research based at Sydney's North Shore Hospital.

His lecture to the Yale surgical and academic community was titled "Neuromonitoring of the Recurrent and External Laryngeal Nerves and Impact of Voice Outcome in Thyroidectomy".

In announcing Professor Sidhu's lecture, Yale described him as having made significant contributions to the understanding of the oncogenomics of adrenocortical cancer and the use of microRNAs as diagnostic, prognostic and therapeutic targets in adrenocortical cancer, malignant pheochromocytoma and thyroid cancer.

It also praised him for the impact of his 154 highly-cited original papers published in peer reviewed journals.

The literature published to promote Dr Sidhu's lecture reads in part: "(His) translational scientific articles have been published in leading cancer journals such as Cancer Cell, Clinical Cancer Research, Cancer and Cancer Medicine and specialty journals such as Endocrine Related Cancer, the Journal of Clinical Endocrinology and the Annals of Surgery.

"He has been a regular speaker at the scientific meetings of the Royal Australasian College of Surgeons and American Association of Academic Surgeons.

"For his scientific work, he was an invited speaker at the 3rd -5th International Symposia of Adrenocortical Cancer and has spoken at the American Association of Cancer Research (AACR) meeting .

"Speaking at the AACR is a rare privilege for an Australian Scientist.

"Professor Sidhu is President of Australian Endocrine Surgeons and Chairman of the Section of Endocrine Surgery at the Royal Australasian College of Surgeons.

"The Sample Lecture is usually given by only the most senior US academic surgeons in their field and of their time so to be the first Australian invited to present the lecture is an honour."

"He currently sits on the Editorial Board of the Oncologist and the Annals of Surgery, the leading and oldest surgical science journal in the world.

"Professor Sidhu is the first Australian surgeon ever invited to serve on (that) Editorial Board primarily because of a dual understanding of clinical and translational research in endocrine tumours.

"He has mentored 21 clinical Fellows in Endocrine Surgery and supervised 10 doctoral students in laboratory research whom have progressed to become leaders in clinical surgery and translational cancer research.

"His career achievement to date embodies the spirit of a clinically active and academically productive surgeon scientist and we are honoured to welcome Dr Stanley Sidhu as our 2015 Lecturer."

Speaking to Surgical News about the lecture, Professor Sidhu said he had enjoyed the experience but played down the honour of the invitation and said it had come about simply through serendipity.

"The past President of the International Association of Endocrine Surgery, Professor Robert Udelsman from Yale, attended the College's ASC in Singapore and attended the lecture I gave there," Professor Sidhu said.

"He found it quite stimulating and somewhat controversial and invited me to give the Sample Lecture at Yale which means that I was just the right person in the right place at the right time.

"Yet, the Sample Lecture is usually given by only the most senior US academic surgeons in their field and of their time so to be the first Australian invited to present the lecture is an honour."

Professor Sidhu spent two days in May this year as a guest of Yale, located in New Haven, Connecticut, where he visited an adrenal and thyroid cancer laboratory and attended surgery at the Yale University Hospital.

He described the invitation to speak as recognition of the quality of scientific research conducted in Australia which has been strongly supported by RACS for over a decade.

Professor Sidhu was initially a Sir Roy McGaughey-funded PhD student.

"We can't do the multi-million dollar research projects that can be done in the US simply because of our population size and the consequent impact on the money available to science," Professor Sidhu said.

"Yet we can keep up with scientific developments made elsewhere, read all the available literature and apply that knowledge to under-resourced areas of interest or rarer cancers in the hope of a break-through.

"There is no doubt that we can compete with the rest of the world in terms of scientific research, it's just easier to find the money in the US or Europe."

Professor Sidhu said that while the specialty of Endocrine Surgery in Australia had a long history of developing international networks, a Sydney-based collaboration was helping push Australian endocrine science into a position of global leadership.

He said that for the first time Australia now had a large multi-faceted endocrine cancer research group assembled through the Kolling Institute located at the Royal North Shore Hospital working in collaboration with the University of Sydney and biotechnology company EnGeneIC.

"This is one of the major research facilities in the country where there is a multidisciplinary team of clinicians and scientists focused on progressing translational research in endocrine cancers and it's a unique arrangement which developed from the merging of leadership in Endocrinology, Endocrine Surgery and Clinician Scientists," he said.

"Rare cancers like those we study are increasingly becoming the focus of international interest with technological advances allowing us to trial novel therapies which could have

Professor Stanley Sidhu

implications for more common cancers."

Professor Sidhu praised the efforts made by the College over the past 10 years to promote Academic Surgery to young surgeons and Trainees.

"The push to promote the role of academic surgeons in Australia during the past 10 years has also been important in advancing the quality of surgical science, particularly through the activities offered through the Section of Academic Surgery such as meetings and courses designed to help young surgeon scientists get established," he said.

"We have had nine surgeon scientists complete their PhDs through the University of Sydney Endocrine Surgical Unit and the Kolling Institute, all of whom were supported by Fellowships funded by the College's Foundation for Surgery.

"They have gone on to become leaders in their field and I am indebted to the College for making those funds available and helping us to train the leaders of the next generation of Academic Surgeons."

Professor Sidhu is currently leading world first research into the use of microRNAs to reduce adrenocortical cancer (ACC) and the use of long noncoding RNA as a biomarker to test for disease recurrence.

With Karen Murphy

IN MEMORIAM

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

Vanessa Wright	UK Fellow
Ross Adie	Victorian Fellow
David J Cohen	Queensland Fellow
Salil R Chowdhury	New Zealand Fellow
William B James	Queensland Fellow
Madappa Maitah	Victorian Fellow
Michael E Shackleton	New Zealand Fellow
John Walker	NSW Fellow
Kevin King	Victorian Fellow
Ross Campbell	NSW Fellow
Geoffrey Coldham	New Zealand Fellow
Thomas Nash	NSW Fellow
Graham Peck	Victorian Fellow
Labeeb McGuire	Queensland Fellow
Reginald Van Der Straaten	NSW Fellow (2014)
Graham Peck	SA Fellow (2013)

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

Informing the College

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

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

Leaving a gift in your will make a significant contribution to helping your Foundation for Surgery continue to change lives through surgery. To find out more about bequests please contact the Foundation of Surgery Manager, Jessica Redwood on +61 3 9249 1110

FINGER FOOD FESTIVITIES

Beware these perfidious morsels

BY **PROFESSOR GRUMPY**

There is one thing that really annoys me and it is finger food. With Christmas just around the corner it is just the right time to warn of these perfidious things. As I am sure that you all know one of the meanings of "perfidious" is untrustworthy. That is exactly what finger food is.

They appear delicious tasty morsels. The aroma precedes them usually towards the last 20 minutes of a "brief" welcome from the great man (I am not beING sexist here as the exceedingly verbose welcome is nearly always from a male – females usually just say what needs to be said and sit down). The smell of bacon, or curry or grilled cheese wafts around the room making it hard to concentrate on the words of the somewhat pompous chairman or president or whatever.

At last the food comes. Beware of the little sausages wrapped in bacon as they will squirt liquid if you bite them in half; never does the squirt go harmlessly into space but always towards you and your clean shirt or blouse. Don't forget the buried toothpick that will stab your gum or break an incisor. As for the chicken tandoori – don't take any yogurt with it no matter how firm it looks as the yogurt warms when added to the food and becomes runny- runny down your fingers and down your hand and onto your shirt cuff. The best way with these little suckers is to put the whole thing into your mouth at once even if that means that all intelligible conversation will be lost.

Mini pizzas seem safe enough but the cheese tends to congeal into a glob that has no adherence to the pizza base and comes off as a whole leaving itself dangling from the corner of your mouth – most inelegant particularly if you have a beard and it adheres to the whiskers. Again a whole of mouth approach is advised.

Mini pies (or party pies as they are called even if it is for use at a funeral) can be a trap. They pastry case is filled with just enough meat to cause a bite to squeeze some of the contents out which will immediately seek your tie or that special brooch. Pasties are slight safer as they are less runny but whatever you do don't add sauce as that adds another level of complexity.

I need hardly mention prawns, muscles or oysters. If you are silly enough to go for them you deserve what you get – smelly stick fingers and clothes if you spill any of the juices.

Then there are the other problems. Plates are not provided as that would make it plate food, wouldn't it? We only provide serviettes that are too thin and fall apart at the first bit of liquid. We generously give you little skewers in the meat but what do you do with 12 of these when the other hand has a glass in it?

So what is the curmudgeon's guide to finger food this Christmas? Pasties are safest but no sauce and definitely as a single mouthful. Cheese and biscuits are probably OK, but not olives (stones !) Chocolate is good also as long as it is solid and not mini-chocolate mouses (one bite and it runs – watch out).

Or you could do what this curmudgeon does – refuse all Christmas invitations that do not state silver service. Happy Christmas!

NICHE PORTAL LAUNCH

Website will provide resources for medical professionals working in Aboriginal and Torres Strait Islander health

The portal, which is a website that provides resources to medical professionals working in Indigenous health, was a collaboration between the Specialist Medical Colleges and the Australian Indigenous Doctors' Association (AIDA).

To kick off proceedings, Wurundjeri Tribal Council elder Ron Jones led a traditional smoking ceremony outside the College, while Wurundjeri musician Jesse Gardiner played the didgeridoo.

Associate Professor Kelvin Kong opened proceedings, and spoke on the benefits of the NICHEportal for all medical professionals working in the Indigenous health space.

"The NICHEportal will be an important tool for the Specialist Medical Colleges as they endeavour to encourage more Aboriginal and Torres Strait Islander doctors to undertake specialist training," A/Prof Kong said.

Uncle Ron Jones of the Wurundjeri people performing a traditional smoking ceremony

(L-R) Kelvin Kong, Prof Chris Baker, Kate Thomann, Jennifer Cahill and David Murray

"The portal will be part of a suite of initiatives to prepare for a future with a greater emphasis on Indigenous health with improved cultural awareness and understanding".

According to RACS President David Watters, the NICHEportal will also be useful in addressing one of the key RACS advocacy issues, improving Aboriginal and Torres Strait Islander health outcomes.

"The College views the NICHEportal as a valuable resource for Medical Specialists working in Indigenous health, and contributing to the goal of achieving health parity for all Australians," Prof Watters said.

Visit the NICHE Portal at www.nicheportal.org.

SCHOLARSHIP PROGRAMS

Over 1.7 million awards funded for 2016

Foundation for Surgery
Passion. Skill. Legacy.

IAN BENNETT
Chair, Research, Audit and Academic Surgery

Each year RACS offers approximately 35 research and travel scholarships, fellowships and grants to Fellows, Trainees, IMGs and other suitable applicants from all specialties. This year we were able to fund over $1.7m in awards to 38 new and continuing scholars in 2016 – a record amount. Many of our research scholars have been awarded grants by other key funding bodies such as the NHMRC, and when these grants, together with the required institution contributions, were added to RACS funding, $2,167,000 has been made available for invaluable surgical research and education.

Today's Scholarship program, underpinned by the Foundation for Surgery and overseen by the Board of Surgical Research, has come a long way since its establishment, not only with the funding available, but with the scope and variety of scholarships offered.

The Foundation for Surgery Small Project Grant was offered for the first time this year and generated much interest. The Small Project Grant is valued at $10,000 and is intended to support Trainees and Fellows who are undertaking or wish to undertake a small clinical or research project or who require limited funding to purchase equipment to carry out a research project. RACS was able to award three of these for 2016 and hope to double this number in 2017. In 2016 the three small projects funded included the following research proposals; "To define a clinically relevant biomarker profile in order to detect anastomotic leakage following elective colonic surgery", "High-resolution mapping of colonic motor activity in defunctioned bowel and response to nutrient stimulation" and "Microsatellite instability detection by high-resolution capillary electrophoresis".

The prestigious John Mitchell Crouch Fellowship, valued at $150,000, was awarded to Professor Alexander Heriot, a consultant colorectal surgeon and Executive Director of Cancer Surgery at Peter MacCallum Cancer Centre, Melbourne. He is an Honorary Clinical Professor at the University of Melbourne and has published more than 100 papers as well as a book on laparoscopic colorectal surgery. His current research program, for which he has received this Fellowship, covers a range of areas including anal cancer, rectal cancer, thromboembolism, neoadjuvant therapy and peritoneal disease.

The Foundation for Surgery Tour de Cure Cancer Research Scholarship continues to attract many high quality applications, with the 2016 scholarship being awarded to Dr Anthony Glover, a General surgeon from NSW, who will use the $125,000 to continue his research on "Understanding the role of RAS mutations in thyroid cancer".

Paediatric Surgeon, Dr Sebastian King, has been awarded the 2016-17 Foundation for Surgery Senior Lecturer Fellowship, which will enable him to become firmly established as an academic paediatric surgeon at the Royal Children's Hospital in Melbourne.

RACS wishes to continue to steadily increase scholarship values so that they stay at a level where it is viable for surgeons to take time out of their careers to study full-time, and to attract the highest calibre applicants. Expanding the program by increasing the number and type of awards offered will enable many talented potential academic surgeons the ability to conduct critical research. The Foundation for Surgery needs your help to continue to fund these significant research projects. Research done today will allow tomorrow's surgeons access to treatment options and for patients to have outcomes that we can only conceptualize today.

The knowledge gained and impact made from these research and educational projects is a valuable resource on the development of our surgeons. RACS looks forward to a successful research year ahead, with advancements made in many areas to benefit Australians and New Zealanders in the future.

2016 SCHOLARSHIP AND GRANT RECIPIENTS

The Board of Surgical Research thanks all applicants and congratulates the following successful recipients

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

ANDREW HILL
Chair, Board of
Surgical Research

Research Scholarship and Fellowship Recipients

The College wishes to acknowledge and thank our benefactors and sponsors for their generosity in funding many of the following scholarships and grants.

Where indicated * scholarship recipients must procure 25% of their scholarship from either their research department or by external award or donation.

There is a considerable amount of time and energy spent to properly evaluate the extensive number of applications that we receive. The Chair would like to thank all those involved, and in particular, Professor Julian Smith, Professor Marcus Stoodley, Dr Niall Corcoran, Associate Professor Christopher Young, Dr Romi das Gupta and Professor Robert Fitridge, who all put in extra work towards this result.

John Mitchell Crouch Fellowship

Valued at $150,000

Professor Alexander Heriot - Vic

Specialty: General Surgery

Professor Heriot is a consultant colorectal surgeon and Executive Director of Cancer Surgery at Peter MacCallum Cancer Centre, Melbourne. He is an Honorary Clinical Professor at the University of Melbourne and has published over 100 papers and a book on laparoscopic colorectal surgery. His current research program for which he has received this Fellowship covers a range of areas including anal cancer, rectal cancer, thromboembolism and neoadjuvant therapy and peritoneal environment and development of peritoneal disease.

Foundation for Surgery Senior Lecturer Fellowship

Valued at $132,000, with 50% of this procured through his research department

Dr Sebastian King - Vic

Specialty: Paediatric Surgery

Topic: Dr King will use this Fellowship to become established as an academic paediatric surgeon at the Royal Children's Hospital in Melbourne.

Supervisor: Mr Mike O'Brien

Foundation for Surgery Tour de Cure Cancer Research Scholarship

Value: $125,000, with $25,000 to be procured through his research department

Dr Anthony Glover - NSW

Specialty: General Surgery

Topic: Understanding the role of RAS mutations in thyroid cancer

Supervisor: Professor Stan Sidhu

Eric Bishop Research Scholarship

*Value: $66,000pa**

Dr Hong Chew - NSW

Specialty: Cardiothoracic Surgery

Topic: Enhancing preservation of donor heart

Supervisor: Professor Peter MacDonald

Fellowship in Surgical Education

Value: $77,000pa with the Queen's University providing funding for tuition and related expenses

Dr Guy Sheahan – Qld

Specialty: General Surgery

Dr Sheahan will be undertaking his Masters in Surgical Education at the Southeastern Ontario Academic Medical Organization (SEAMO), Queen's University, Kingston, Ontario, Canada

Francis & Phyllis Thornell Shore Memorial Scholarship

*Value: $66,000**

Dr Marlon Perera - Qld

Specialty: Urology

Topic: Minimising renal injury from ischaemia-reperfusion at partial nephrectomy or renal transplantation using nephron preconditioning

Supervisor: Assoc Prof Nathan Lawrentschuk

Paul Mackay Bolton Scholarship for Cancer Research

*Value: $66,000pa**

Dr Kai Brown - NSW

Specialty: General Surgery

Topic: Optimising a mouse model of colorectal liver metastases to investigate mechanisms of metastasis and recurrence related to the tumour microenvironment and study the efficacy of a biological nano particle chemotherapy delivery system

Supervisor: Dr Thomas Hugh

Sir Roy McCaughey Surgical Research Fellowship

*Value: $66,000pa**

Dr Amanda Chung - NSW

Specialty: Urology

Topic: Detrusor ultra-structural studies in geriatric lower urinary tract dysfunction: Correlation of features and development of a standardised protocol

Supervisor: Assoc Professor Vincent Tse

Foundation for Surgery ANZ Journal of Surgery Scholarship

*Value: $66,000**

Dr Glen Guerra - Vic

Specialty: General Surgery

Topic: Exploiting genomic discoveries and molecular targets in anal cancer management

Supervisor: Professor Alexander Heriot

Foundation for Surgery Catherine Marie Enright Kelly Scholarship

*Value: $66,000**

Dr Grace Kwok - NSW

Specialty: General Surgery

Topic: MicroRNA modulation of chemotherapy resistance and its therapeutic potential in adrenocortical cancer

Supervisor: Professor Stan Sidhu

Foundation for Surgery John Loewenthal Research Scholarship

*Value: $66,000**

Dr Joseph Kong - Vic

Specialty: General Surgery

Topic: Exploiting genetic analysis to predict response and to discover novel molecular targeted therapies for rectal cancer

Supervisor: Professor Alexander Heriot

Foundation for Surgery Peter King Research Scholarship

*Value: $66,000**

Dr Hari Ramakonar - NSW

Specialty: Neurosurgery

Topic: A pilot study to assess optical imaging for detection of normal cerebral and brain tumour vessels

Supervisor: Professor Christopher Lind

Foundation for Surgery Reg Worcester Research Fellowship

*Value: $66,000**

Dr Edward Buratto - Vic

Specialty: Cardiothoracic Surgery

Topic: Outcomes of repair of partial atrioventricular septal defect: A multicentre review

Supervisor: Professor Igor Konstantinov

Foundation for Surgery Richard Jepson Research Scholarship

*Value: $66,000pa**

Dr Ruth Mitchell - Vic

Specialty: Neurosurgery

Topic: Improved therapeutic targeting of Glioma

Supervisor: Professor Tony Burgess

Foundation for Surgery Research Scholarship

*Value: $66,000**

Dr Krishanu Chaudhuri - New Zealand

Specialty: Cardiothoracic Surgery

Topic: The "COMCAB" study

Supervisor: Mr Indran Ramantha

Foundation for Surgery Research Scholarship

*Value: $66,000**

Dr Shinichiro Sakata - Qld

Specialty: General Surgery

Topic: The effects of 2 and 3-dimensional laparoscopic and robotic technology on the stress and performance of novice and expert colorectal surgeons

Supervisor: Assoc Prof Marcus Watson

Foundation for Surgery Louis Waller Medico-Legal Scholarship

*Value: $66,000pa**

Ms Michelle Gunn – Qld

Topic: Healthcare rationing at the bedside

Supervisor: Professor Glen Gole

Foundation for Surgery Small Project Grants

Valued at $10,000 each

Chief Investigator: Professor Andrew Hill – New Zealand

Specialty: General Surgery

Project: To define a clinically relevant biomarker profile in order to detect anastomotic leakage following elective colonic surgery

Chief Investigator: Dr Greg O'Grady – NSW

Specialty: General Surgery

Project: High-resolution mapping of colonic motor activity in defunctioned bowel and response to nutrient stimulation

Chief Investigator: Dr James Toh – NSW

Specialty: General Surgery

Project: Microsatellite instability detection by high-resolution capillary electrophoresis

Lumley Surgical Research Scholarship

Value: $69,000

Dr Nicole Williams – SA

Specialty: Orthopaedic Surgery

Topic: Can orthopaedic surgery improve quality of life for children and young adults with mucopolysaccharidoses?

Supervisor: A/Professor Peter Cundy

Roy and Marjory Edwards Scholarship

Value: $66,000 pa

Dr Alistair Jukes – SA

Specialty: Neurosurgery

Topic: Haemorrhage control in endoscopic skullbase surgery

Supervisor: Dr Stephen Santoreneos

Travel Scholarship, Fellowship and Grant Recipients

Hugh Johnston Travel Grants

Valued at $10,000 each

Dr Hamish Alexander - Qld

Specialty: Neurosurgery

Mr Benjamin Robinson - NSW

Specialty: Cardiothoracic Surgery

Hugh Johnston ANZ Chapter American College of Surgeons Travelling Fellowship

Value: $8,000

Dr Yi Chen - Vic

Specialty: Cardiothoracic Surgery

Foundation for Surgery Ian and Ruth Gough Surgical Education Scholarship

Value: $10,000

Dr Carolyn Vasey – New Zealand

Specialty: General Surgery

John Buckingham Travelling Scholarship

Value: $4,000

Dr Christine Goh - Tasmania

Specialty: Cardiothoracic

Margorie Hooper Travel Scholarship

Value: $75,000

Mr Sam Boase - SA

Specialty: Otolaryngology

Morgan Travelling Scholarship

Value: $10,000

Mr David Oehme - Vic

Specialty: Neurosurgery

Morgan-Opie Travelling Scholarship

Value: $10,000

Dr Alenka Paddle – Vic

Specialty: Plastic and Reconstructive Surgery

Murray and Unity Pheils Travel Fellowship

Value: $10,000

Dr Meara Dean - Vic

Specialty: General Surgery

Stuart Morson Scholarship in Neurosurgery

Value: $30,000

Dr Johnny Wong - NSW

Specialty: Neurosurgery

Preliminary Notice: Applications for 2017 scholarships will open in March 2016

Developing a Career and Skills in Academic Surgery Course

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

Who should attend?

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

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

Keynote Speaker

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

Association for Academic Surgery and International Faculty including

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

Australasian Faculty including

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

For Faculty updates visit

tinyurl.com/DCAS2016

Further Information

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

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

Provisional Program

Information correct at time of printing

6:45am	**Registration Desk Opens**
7:15am - 7:30am	**Welcome and Introduction**
7:30am - 9:30am	**Session 1: A Career In Academic Surgery**
	Why every surgeon can and should be an academic surgeon
	Training to become an academic surgeon: pathways and goals
	Securing an appointment as an academic surgeon: options, contracts and responsibilities
	Getting started: research - ideas, process and outcomes
	Getting started: teaching, leadership and administration
9:30am - 10:00am	**Morning Tea**
10:00am - 10:30am	**Hot Topic in Academic Surgery:** Professionalism in Academic Surgery
10:30am - 11:30am	**Session 2: Ensuring Academic Output**
	Writing an abstract
	Writing and submitting a manuscript
	Presenting at a scientific meeting
	Panel discussion and questions
11:30am - 12:05pm	**Keynote Presentation: The UK clinical trials network**
12:05pm - 1:00pm	**Lunch**
1:00pm - 2:40pm	**Session 3: Concurrent Academic Workshops**

Workshop 1: Career Development	**Workshop 2: Tools of the Trade**	**Workshop 3: Practicalities of research**
What can I do as a:	Clinical research	Critical ethical issues in medical and surgical research
Medical Student	Lab-based / animal model research	Assembling the team and establishing collaborations
Junior Doctor	Education / simulation research	Funding opportunities
SET Trainee	Health services research	Grant writing
Fellow		
Consultant		

2:40pm - 3:00pm	**Afternoon Tea**
3:00pm - 4:00pm	**Session 4: Sustainability in Academic Surgery**
	Finding and being a mentor
	Work-life balance
	The future of academic surgery

Registration

Cost $250.00 per person incl. GST

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

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

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

Contact

Conferences and Events Management
Royal Australasian College of Surgeons
T +61 3 9249 1260
E dcas@surgeons.org

Presented by:

AAS Association for Academic Surgery

Royal Australasian College of Surgeons
Section of Academic Surgery

Sponsored by:

Johnson & Johnson MEDICAL COMPANIES

ASC BRISBANE 2016

Next year's ASC is already generating interest

RICHARD LEWANDOWSKI
ASC 2016 Convenor

OWEN UNG
ASC 2016 Scientific Convenor

The RACS 2016 Annual Scientific Congress in Brisbane is already generating great interest amongst the surgical community. The Congress will be held at the Brisbane Convention and Exhibition Centre situated alongside the Brisbane River in the first week of May 2016. This year we are continuing the theme of inviting our sister Royal Colleges to join in our meeting with Royal College of Surgeons of England joining with us after a successful program last year with the Royal College of Surgeons of Edinburgh.

As well as exceptional conference facilities, the accommodation in Brisbane is in demand at this time of year so reserve your room as soon as you receive the provisional program because it will quickly book out.

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

The Syme Oration will be presented by Professor, the Lord, Ara Darzi of Denham. The title of his oration is 'Tomorrow's Surgeon – Innovations In Surgery And Training'.

At this convocation, along with the presentation of our New Fellows, other senior members of our profession will be acknowledged for their outstanding contributions to surgery and the College .

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

The four plenary sessions will highlight:-

"New Technology– Where Are We And How Far Can We Go"

"Data Management – How Does It Affect Patient Care"

"Innovation – Learning From The Next Generation"

"Technology And The Trainee"

Program review

There is an extensive scientific program arranged for the ASC in Brisbane and a few are highlighted here. Other section presentations will be highlighted in future editions of *Surgical News*.

Orthopaedic Surgery

Nicola Ward has developed an excellent integrated program in Orthopaedic Surgery for the ASC in Brisbane to follow on from the successful orthopaedic program which ran in Perth this year.
This program will cover the latest information regarding surgical innovation and outcomes in orthopaedic surgery particularly hip, knee and spinal surgery.

Indigenous Health

Mr Kiki Maoate from Christchurch is the Section Visitor for the Indigenous Health program which has been focused to highlight the problems of head and neck pathology in the Indigenous communities in Australia and New Zealand. There will also be a round table breakfast meeting to discuss career paths and issues facing Aboriginal and Torres Strait Islanders and Maori medical professionals.

Surgical Education

Rhea Liang has arranged an excellent program covering many issues in Surgical Education with the Section Visitor, Professor Jonathan Beard to deliver the Hamilton Russell Memorial Lecture on "A Concise Guide To The Selection, Maintenance And Recycling Of Surgeons". A scientific session will tackle an area of interest to all surgeons – "How To Make A Surgeon: There Is No Simple Recipe".

Women in Surgery.

Teresa Withers has arranged a program including the Women in Surgery Breakfast and a session "Women as Leaders and Scholars", which will feature presentations from eminent surgeons from all over the globe to discuss this pertinent topic.

Surgical History

The visitor to Surgical History is Dr Robert Likeman and he will contribute to an extensive program covering the First World War and developments in surgery which came out of that conflict and present the Herbert Moran lecture titled "Luck Now And Then: The Extraordinary Life Of Dr William Brydon".

In addition to the sections above there will be programs covering International Forum (Mr Neil Wetzig), Senior Surgeons (Dr John North), Neurosurgery (Dr Bruce Hall and Dr Rumal Jayalath).

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

Register now through the Congress website asc.surgeons.org

PROFESSIONAL STANDARDS

Year in review

CATHY FERGUSON
Chair, Professional Standards

Each year the Professional Standards portfolio undertakes a diverse range of activities aimed at championing the highest standards of surgical care. In 2015 we have been proactive in developing positions that support this objective, responding to concerns raised by our Fellows about standards issues and ensuring that surgeons have representation on relevant consultations and reviews.

DEFINING STANDARDS

Open Disclosure

In response to concerns about existing open disclosure guidelines, the RACS developed a position that outlines the key steps that should be undertaken during the open disclosure process. The paper encourages surgeons to be transparent, factual and empathetic to their patients following an adverse event with a strong focus on ensuring appropriate support is in place. RACS position supports training sessions in open disclosure and on-going dialogue regarding legislative reforms that provide more consistent protection for surgeons and other staff during the open disclosure process.

Emergency Surgery

The RACS Emergency Surgery paper was updated to reflect the challenges facing surgeons providing emergency surgery across Australia and New Zealand. The paper highlights the importance of continued partnerships with government and health services to address shortfalls in service delivery and staff retainment, including the necessity for surgeons to be specifically trained in emergency medicine to ensure the broad provision of acute surgical care across all areas. Models of care that ensure services are consultant led and priority driven were highlighted as being of particular importance. The requirement for institutions to prioritise training and teaching of junior staff in emergency medicine was highlighted, emphasising the need to allocate time for staff to learn new skills and for senior staff to teach as part of their appointment.

Prevention of Healthcare Associated Infection

Amidst growing concerns about the impact of antibiotic resistance, the RACS revised its position on the prevention of healthcare associated infection to include a statement regarding the importance of antimicrobial stewardship. The RACS recognises the challenge posed by increasing antimicrobial resistance and endorsed the Therapeutic Guidelines: Antibiotic Version 15. Key principles for effective antimicrobial management were also outlined including the need for enhanced data collection and management at regional, national and international levels. The nature of this challenge requires the utilisation of data to formulate advice and develop alternative interventions for patients, which will be essential in ensuring the ongoing effectiveness of antibiotics.

Engagement with Consultations

Each year the RACS receives a significant number of requests for feedback from a diverse range of stakeholders including government departments and not-for-profit organisations. In responding to these requests we consult with specialty societies, College sections and other relevant stakeholders to ensure that our submissions are reflective of the broad and diverse areas in which our Fellows practice. In 2015 the RACS responded to a range of consultations including:

- Quality Standards for Australian Emergency Departments
- Response to Draft Clinical Practice Guidelines PSA Testing and Early Management of Test-Detected Prostate Cancer
- Medical Board of Australia 'Consultation – Registered medical practitioners who provide cosmetic medical and surgical procedures'
- ACSQHC National Consultation on the draft Hip Fracture Care Clinical Care Standard
- Optimal Cancer Pathways – Consultation – Oesophagogastic, Basal Cell, Squamous Cell
- Medicare Schedule Review and Individual Item number review requests
- NPS Medicine Wise Choosing Wisely Initiative

SUPPORTING SUSTAINABLE SURGERY

Sustainability in Healthcare Committee

A Sustainability in Healthcare Committee was established this year to support the development of strategies that focus on the long-term provision of high quality healthcare that is affordable and financially sustainable. The Committee has begun to work on a number of important initiatives including Choosing Wisely (see below), linking with private health insurers to ensure appropriate representation on issues impacting surgical care and identifying key research and submission development priorities.

Choosing Wisely

Choosing Wisely is an initiative aimed at encouraging clinicians, consumers and health care stakeholders to consider and discuss tests, treatments, and procedures where evidence shows they provide no benefit or, in some cases, lead to harm. A number of medical colleges have already published a list of recommendations on tests or treatments that can be used to encourage conversations about what is appropriate and necessary care. RACS are currently consulting broadly with specialty societies to bring together a list of evidence based recommendations and hope to be able to contribute to this important initiative early in the new year.

COMMITMENT TO LIFELONG LEARNING

Continuing Professional Development

Our Fellows have again demonstrated their commitment to lifelong learning with 100 per cent of participants in the RACS program compliant for the 2014 year. The College continues to explore ways to better support its Fellows finalising their CPD, which in 2015 included the introduction of automatic population and verification of CPD points for Fellow's attending RACS courses or RACS approved CME activities. RACS has also recently released an online Portfolio which provides Fellows with user-friendly access to College activities including CPD, regardless of whether you're using your mobile, tablet or desktop computer. We anticipate that the introduction of the Portfolio and the automatic population of CME activities will minimise the administrative burden associated with CPD and reduce the documentation required to verify participation for those Fellows randomly selected each year. I would encourage all Fellows to login to their Portfolio and review their 2015 CPD activities.

The Year Ahead

The 2016 year promises to be a busy one for Professional Standards portfolio. The CPD Program will undergo a full review early in the new year with a view to maintaining a simple, robust and workable program for Fellows across all stages of their career. The College's Code of Conduct will also be revised to ensure that it remains relevant and up to date with contemporary issues. Next year this will include a strong focus on addressing the recommendations from the Expert Advisory Group into Discrimination, Bullying and Sexual Harassment to ensure that we do not lose momentum in tackling these challenges within our profession. In terms of championing standards the RACS will continue to engage with the Commonwealth Government's on-going review of Medicare, work with relevant bodies on issues relating to sustainability in healthcare and ensure that the voice of our Fellows is heard on consultations applicable to our practice.

I want to take this opportunity to thank all Fellows who have been involved in the range of activities undertaken in Professional Standards this year. I also want to further encourage you to bring to my attention key issues and challenges that you believe are important for us to advocate on for the Fellowship. As the pace of regulatory and systems change continues to increase, it is important that RACS is strategically positioning itself to be able to respond and ensure that we continue to further surgical standards throughout Australia and New Zealand.

KEEPING AN EYE ON EXCESSIVE FEES

The RACS is committed to addressing concerns on this issue

JULIAN SMITH
Chair, Professional Standards

The Royal Australasian College of Surgeons (RACS) is committed to addressing concerns from patients regarding surgeons who charge excessive fees for their surgical services. RACS has developed a clear position on excessive fees and a policy to manage complaints received from patients who feel that have been charged unreasonable fees that they believe to be extortionate or manifestly excessive by a Fellow. In reviewing complaints received by RACS many have not required any further action. There have however been a number of complaints that indicate the patient may have been charged an excessive or extortionate fee for a procedure.

Case 1

A patient contacted RACS regarding what they saw as an anomaly in the fee being charged by their surgeon. The patient was asked to pay in advance for their cancer treatment and while they were alarmed by cost of the surgery, their primary concern was that they were provided with two invoices. The first invoice amounted to approximately $5,000 and included the relevant MBS item numbers, fees and a modest gap payment. The second invoice was issued with a gap payment of approximately $10,000 and did not include MBS item numbers. In this case the invoice that the patient was able to provide to Medicare and their health fund did not reflect the true cost of the surgery and suggested that the surgeon was only charging $5,000 for the procedure when the total cost amounted to almost $15,000. Not only does this practice convey inaccurate data to Medicare and the patient's health fund, it also deflects attention away from the true cost being charged by the surgeon, which in this instance was required up-front by a cancer patient who was in an extremely vulnerable position.

Case 2

Presenting with lower back pain without neurological issues, a surgeon offered the patient a surgical procedure without first pursuing an appropriate trial of physiotherapy or conservative treatment. As the patient was suffering significant pain and it was implied that the surgery was urgent, an appointment was made for the next available operating list. The patient was informed that an up-front payment amounting to tens of thousands of dollars was required. When the family indicated that they could not afford the gap payment, staff at the surgeon's office arranged for a financial planner to phone the patient the following day who subsequently advised them how to re-mortgage the house. This case raises a number of concerns, particularly in regards to the necessity for promoting urgent surgery as the only treatment option to a vulnerable patient, and the highly inappropriate relationship between the surgeon's office and the financial planner.

While these two cases are an example of complaints received directly by RACS, the College also remains concerned about a number of other reports into the impact of high fees on patient's access to surgical care. A recent *Medical Journal of Australia* (MJA) Insight article highlighted the story of a patient who resorted to social media and crowdfunding to raise the required funds to pay for the gap being charged by a surgeon for a radical prostatectomy. Despite two surgeons offering to undertake the procedure free of charge, the patient declined to take up this option. While it is not known if the treating surgeon was aware of the patient's financial circumstances, the story does highlight the impact of high fees and also perceptions around the availability of surgical care through the public system or via private surgeons who do not charge a significant gap for their services.

RACS Excessive Fees Complaint Process

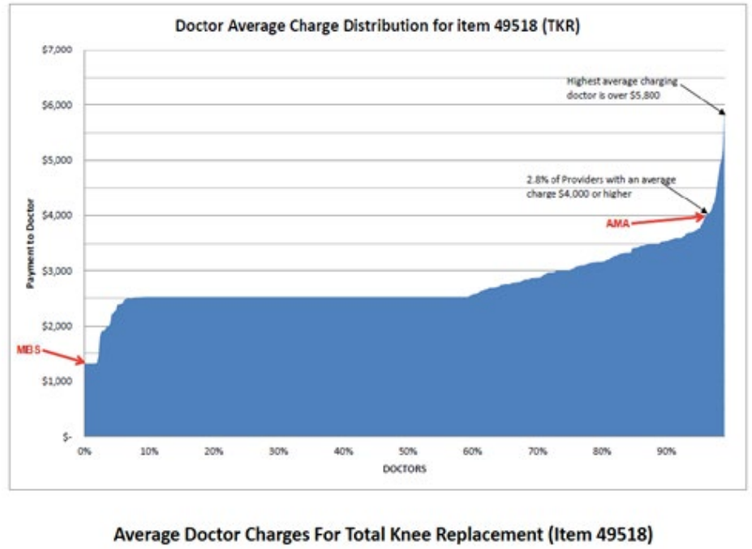
Any patient or relative who believes that a fee is excessive may make a complaint in writing to RACS. Fellows who engage in inappropriate billing practices and who are subject to a formal complaint will be given the opportunity to respond. Where there is found to be sufficient grounds to precede a committee of their peers, including appropriate specialty representation, will be established to review the complaint. Fellows who are found to have charged an excessive fee or engaged in deceptive practice will be sanctioned under the Code of Conduct, with the range of sanctions recently expanded to manage inappropriate practices or behaviours.

Advocating for Sustainable Fees

In addressing the issue of excessive fees, RACS is actively working on a number of initiatives. We continue to engage with private health insurers to support greater transparency which will allow patients to see where their surgeon's quote sits within the spectrum of fees charged. This not only supports patients in making an informed decision about the cost of their treatment but also validates that the vast majority of our Fellows charge appropriate fees. For example the chart below shows that only a small proportion of surgeons charge in excess of the Australian Medical Association (AMA) scheduled fees and that the majority charge considerably less.

Although only a small number of surgeons engage in excessive billing practices, it is clear that this practice persists and it is incumbent upon RACS to take a strong position on this issue. Surgeons who charge exorbitant or manifestly excessive fees not only exploit a patient's vulnerability and position of need, but also the trust on which the surgeon-patient relationship is founded. Rorting of Medicare and health insurance reimbursements is not only unethical but also jeopardises the sustainability of healthcare for future generations. If RACS and Specialty Societies are to maintain legitimacy in discussions around issues such as the current review of the MBS item numbers, we must not let the profession down by engaging in inappropriate billing. We must also be willing to call out those who do.

Surgical Leaders Forum, October 2014



Average Doctor Charges For Total Knee Replacement (Item 49518)

1. http://www.surgeons.org/media/20023066/2014-10-30_pos_fes-pst-036_excessive_fees.pdf
2. http://www.surgeons.org/media/21177448/2014-10-30_pol_fes-pst-045_excessive_fees_complaints.pdf
3. https://www.mja.com.au/insight/2015/39/henry-woo-prostate-toll
4. Similar graphs are available for all specialties

Elections to Council

Fellowship Elected Councillors

There were eight Fellowship Elected Councillor positions to be filled.

The successful candidates in alphabetical order are:

Re-elected to Council

John Batten (ORT, TAS)
Cathy Ferguson (OTO, NZ)

Newly elected to Council

Ruth Bollard (GEN, VIC)
Jennifer Chambers (VAS, NSW)
Kerin Fielding (ORT, NSW)
Annette Holian (ORT, VIC)
Christopher Pyke (GEN, QLD)
Nicole Stamp (CAR, NSW)

Orthopaedic Specialty Elected Councillor

Newly elected to Council

Gregory Witherow (WA)

Congratulations to the successful candidates and sincere thanks to all candidates who nominated.

The pro bono contribution of Fellows has been, and continues to be the College's most valuable asset and resource. We are grateful for their commitment. We are also grateful to the voting Fellows (23.5%) who demonstrated their engagement with the governance of the College.

The results will be tabled at the Annual General Meeting in Brisbane on Thursday 5 May 2016 when newly elected Councillors take office.

The poll results are verified by Mr Ralph McKay of BigPulse.

Rural Surgery Fellowship for Provincial Surgeons – 2016 Round

Call for Applications

The Rural Surgery Section (RSS) Committee is offering up to 3 travelling grants to assist provincial surgeons who wish to spend time away from their practice to travel and develop existing skills or acquire new skills in a field of benefit to the surgeon, the College and the community.

Each fellowship will be valued to a maximum of AUD$10,000 (incl. GST) and is to be expended in the 2016 calendar year.

Eligibility criteria

The applicant must be a provincial Fellow in Australia or New Zealand whose practice post code is non-metropolitan. At the time of submitting their application the Fellow must be a permanent resident or citizen of Australia or New Zealand, or an international medical graduate accepted into the College as a trainee.

Application Process, Selection and Reporting

Applicants are required to submit an online application form with specific details of the planned trip and visit.

Selection will be dependent on:

- the abilities and experience of the candidate,
- merit of the proposed travel plan
- and the potential benefits to the individual and/or other surgeons from the travel
- current membership of the Rural Surgery Section
- preference for secured structured visits / appointments to established units over less structured proposals

Fellowship recipients will be expected to provide a written report on their experience and present a brief descriptive paper at the annual conference of the Provincial Surgeons of Australia (PSA)

Full details of the Fellowship and application process are available on the College website at Rural Surgery Fellowship for Provincial Surgeons | Royal Australasian College of Surgeons

or by contacting the Rural Surgery Section Secretariat by email rural@surgeons.org or by telephone on +61 3 9276 7409

Applications close 5.00pm Friday 15 January 2016

2017 ROWAN NICKS AWARDS

Suitable applicants invited for Scholarships and Fellowships

Dr Vuthy Chhoeurn with patient

- **2017 Rowan Nicks Pacific Islands Scholarship**
- **2017 Rowan Nicks International Scholarship**
- **2017 Rowan Nicks Australia and New Zealand Exchange Fellowship**

The Royal Australasian College of Surgeons invites suitable applicants for the 2017 Rowan Nicks Scholarships and Fellowships. These are the most prestigious of the College's International Awards and are directed at qualified surgeons who are destined to become leaders in their home countries.

Rowan Nicks International and Pacific Islands Scholarships

The Rowan Nicks International and Pacific Islands Scholarships provide opportunities for surgeons to develop their management, leadership, teaching, research and clinical skills through clinical attachments in selected hospitals in Australia, New Zealand and South-East Asia.

The goal of these Scholarships is to improve the health outcomes for disadvantaged communities in the region, by providing training opportunities to promising individuals who will contribute to the development of the long-term surgical capacity in their country.

Application Criteria:

Applicants for both the Rowan Nicks International and Pacific Islands Scholarships must:

- commit to return to their home country on completion of their Scholarship;
- meet the English Language Requirement for medical registration in Australia or New Zealand (equivalent to an IELTS score of 7.0 in Australia or 7.5 in New Zealand, in every category);
- be under 45 years of age at the closing date for applications.

In addition, applicants for the International Scholarship must:

- hold a relevant post-graduate qualification in Surgery
- be a citizen of Bangladesh, Bhutan, Cambodia, Indonesia*, Laos, Mongolia, Myanmar, Nepal or Vietnam

**With preference given to Indonesian applicants from outside the major capital cities of Jakarta and Surabaya who will return to practice in regional areas.*

Applicants for the Pacific Islands Scholarship must:

- be a citizen of the Cook Islands, Fiji, Kiribati, Federated States of Micronesia, Marshall Islands, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu or Vanuatu;
- hold a Masters of Medicine in Surgery (or equivalent). However, consideration will be given to applicants who have completed local general post-graduate surgical training, where appropriate to the needs of their home country.

Selection Criteria

- The Committee will consider the potential of the applicant to become a surgical leader in the country of origin, and/or to supply a much-needed service in a particular surgical discipline.
- The Committee must be convinced that the applicant is of high calibre in surgical ability, ethical integrity and qualities of leadership.
- Selection will primarily be based on merit, with applicants providing an essential service in remote areas, without opportunities for institutional support or educational facilities, being given earnest consideration.

Value

Up to $50,000 for a 12 month attachment, depending on the funding situation of the candidate and provided sufficient funds are available, plus one return economy airfare from home country and support to attend the Annual Scientific Congress of the College, if the Scholar is in country at the time of the Congress.

Tenure

3 - 12 months

Rowan Nicks Australia and New Zealand Fellowship

The Rowan Nicks Australia and New Zealand Fellowship is intended to promote international surgical interchange at the levels of practice and research, raise and maintain the profile of surgery in Australia and New Zealand and increase interaction between Australian and New Zealand surgical communities.

The Fellowship provides funding to assist a New Zealander to work in an Australian unit judged by the College to be of national excellence for a period of up to one year, or an Australian to work in a New Zealand unit using the same criteria.

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Application Criteria:

Applicants must:have gained Fellowship of the RACS within the previous ten years on the closing date for applications.

- provide evidence that they have passed the final exit exam to allow them to obtain a Fellowship of the Royal Australasian College of Surgeons by the time selection takes place.

Selection Criteria:

The Committee will

- consider the potential of the applicant to become a surgical leader and ability to provide a particular service that may be deficient in their chosen surgical discipline.
- assess the applicants in the areas of surgical ability, ethical integrity, scholarship and leadership.

The Fellowship is not available for the purpose of extending a candidate's current position in Australia or New Zealand.

Value

Up to $50,000 for a 12 month attachment, depending on the funding situation of the candidate and provided sufficient funds are available, plus one return economy airfare between Australia and New Zealand and support to attend the Annual Scientific Congress of the College, if the Scholar is in country at the time of the Congress.

Tenure

3 - 12 months

Further Information

Application forms and instructions will be available from the College website from December 2015: www.surgeons.org

Closing date

Monday 6 June, 2016. Applicants will be notified of the outcome of their application by 31 October 2016.

Please contact:
Secretariat, Rowan Nicks Committee
Royal Australasian College of Surgeons
250 - 290 Spring Street, East Melbourne VIC 3002
Email: international.scholarships@surgeons.org
Phone: + 61 3 9249 1211 Fax: + 61 3 9276 7431

TRAINING IN PROFESSIONAL SKILLS

Upskilling junior doctors in non technical skills

PHILIP TRUSKETT
Chair, Training in Professional Skills and Censor In Chief

The College's standard of a competent surgeon is based on nine surgical competencies. The RACS competencies were defined in 2003 by consensus of Fellows and are modified from the eight CanMEDs competencies developed by the Royal College of Physicians and Surgeons of Canada.

The RACS competencies encompass

- Medical Expertise
- Technical Expertise
- Judgement – Clinical decision making
- Professionalism and Ethics
- Health Advocacy
- Communication
- Collaboration and teamwork
- Management and Leadership
- Scholar and Teacher

Each competency is considered equally important and forms the mosaic that defines a competent surgeon. All aspects of our surgical professional activities are defined and measured by these competencies, in particular, education. A great deal of work has been done over the past six years to develop resources to enable Fellows, Trainees and International Medical Graduates (IMGs) to understand and develop their skills in these competencies. Two booklets, "Surgical Competence and Performance" and "Becoming a Competent and Proficient Surgeon" are examples of such resources. Both of which are available on the College website.

From a training perspective, the College believes that all of these competencies are definable, teachable and assessable. Within the current SET competency training framework the challenge is to ensure that this happens.

Technical skills acquisition, as characterised by the competencies of medical and technical expertise, are an important focus of surgery. In general, surgeons are comfortable to discuss operative surgery and clinical decision making. Some of the so called "non-technical" competencies such as communication, teamwork, advocacy and importantly professionalism, can be less overtly discussed. These skills are usually learnt by example and observation; watching how surgeons behave with patients, relatives, staff and within a team. The College recognises that explicit training in the non-technical competencies is necessary and is developing a suite of resources to upskill Fellows, Trainees, IMGs and Junior Doctors in these important competencies.

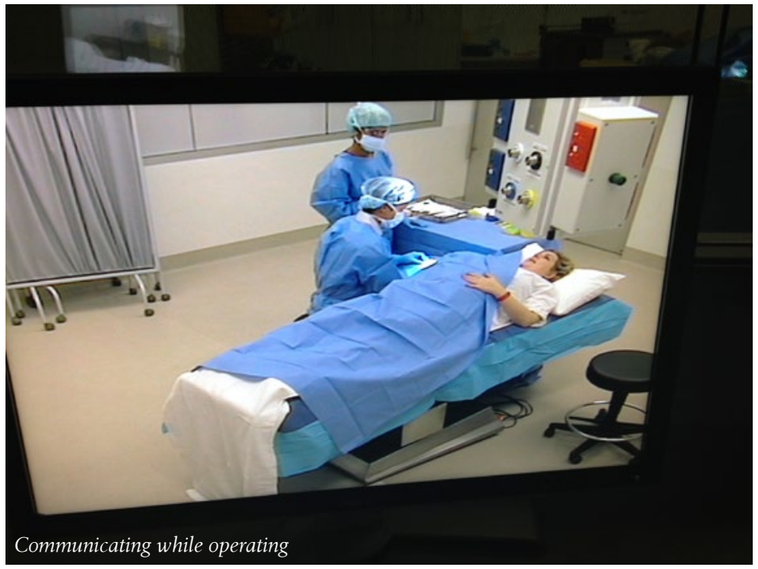
Training in Professional Skills (TIPS) is a course delivered by the College, through the Skills Education Committee and was initially designed for SET Trainees and is now more broadly available to International Medical Graduates, JDocs and Fellows. The focus of this course is designed to educate and challenge participants in dealing with clinical issues relating to professionalism, communication, teamwork and leadership.

The first pilot held in March 2009 was funded through the Australian Society for Simulation in Healthcare and developed in collaboration with RACS, Monash University, Southern Health and St Vincent's Hospital. Funding for this project came from the Specialists Training Program (STP) in acknowledgement, by the Federal Government, of the need to provide not only increased opportunities for clinical placements but different and enhanced modalities of training. The subsequent development and piloting of the program has been financially supported through an educational grant supplied by Applied Medical.

Following the development phase, during which four pilot courses were held from 2009 – 2011, the final version was launched in Sydney in July 2011. By the end of this year 30 courses will have been conducted across Australia and New Zealand. The College aims expand the program to ensure wide availability and uptake.

Course Overview

TIPS is a two day course with a high tutor to participant ratio; with at least six instructors for 12 participants. The faculty often includes an expert educator. The target group



Communicating while operating

is Trainees between SET 2 and 4. Due to growing interest, a consultant only course is proposed for 2016.

The course comprises a small number of interactive lectures and small group discussions complemented by highly immersive simulation scenarios where skills are practiced and refined with well-structured debriefing and feedback.

Day one focuses on the concept of Patient Centred Communication. In lectures and small group discussions the meaning of this approach is explored. Techniques are used to recognise the individual needs of patients, recognising that emotions of anxiety, anger, disbelief and distress are frequently encountered in these circumstances. The participant has the opportunity to explore their ability in responding to challenging communication scenarios. Specific tools and strategies are taught so that the participant is better equipped to face these challenges. Professional actors are engaged as simulated patients and are briefed to respond to participants in a series of difficult clinical scenarios, so that communication skills can be practiced and refined. These scenarios are followed by structured debriefing sessions in small groups facilitated by the instructor, with input from the actor.

Also examined is the topic of what it means to be a professional and the concept of ethical decision making, a tool with which we can use to judge our own performance.

Day two focuses on communicating in teams and explores team dynamics, the role of leadership, followship and the fluidity of the "ad hoc" team. The important skill of graded assertiveness is discussed and practiced. Small group scenarios and creative team activities are used to develop skills and provide structured feedback. Two sessions are dedicated to practicing structured negotiation skills in the context of the workplace.

The TIPS course is an intensive but rewarding two days. Feedback shows that participants find the course extremely valuable, with many expressing that they have learnt concepts that they have never been exposed to before. Participants indicate they feel empowered by the experience and better equipped to communicate effectively and appropriately in the clinical setting.

Conclusion

TIPS has the potential to influence clinical practice, interactions with colleagues and the surgical team. It may also enhance the participant's confidence in communication skills, not only with patients but with colleagues and trainers. Enrolments for 2016 TIPS courses are now open via the College website.

The TIPS committee is interested in attracting Fellows who work in the perioperative environment and have an interest in human factors that may be interested in becoming a member of the TIPS faculty. If you have a particular interest in this area and wish to get involved in this stimulating endeavour please contact:
tips@surgeons.org

Lecture in progress

AORA ANNUAL CONFERENCE

The Australian Orthopaedic Registrars Association conference took place at the Brisbane Convention Centre on October 9 to 11

PETER MOORE
President, Australian Orthopaedic Registrars Association

The annual conference of the Australian Orthopaedic Registrars Association (AORA) took place at the Brisbane Convention Centre on October 9-11. This years meeting had a record attendance of more than 150, building on last years success of combining the usual scientific sessions with a series of Instructional Course Lectures based on the SET curriculum.

We were fortunate to have enlisted the help of some great speakers from across the country to speak on their topic of expertise, including sessions on upper and lower limb to all things bone tumour. The program also gave an opportunity to hear about a range of other topics, including an update from both AOA and RACS presidents, a rundown on AOA 21 by Ian Incoll and an inspirational talk by Prof. Bill Cumming on his work in Orthopaedic Outreach.

A highlight of the conference is always the gala dinner. This year's event was at the wonderful riverside venue of the Stokehouse Q. Aside from having the opportunity to share a meal and a yarn with fellow registrars from other states we heard from guest speaker Shane Heal. He shared stories from his long basketball career, with the message of the importance of determination and the importance of culture when it comes to success, no mater what field you are in.

In 2014 AORA decided to recognise those who contribute something special to our training, so we started the Excellence in Teaching awards. Each year one person from each regional training program will be awarded teacher of the year to honour all that they have contributed to training. I would like to congratulate the winners along with the winners of the best scientific papers at this year's conference.

I look forward to next years meeting in Cairns prior to the combined AOA/NZOA Annual Scientific Meeting.

Left to right: Adrian Cozenza, Peter Moore and Ian Incoll

Allan Frederick Dwyer Prize for Best Scientific Paper:

Dr. Andrew Kanawati (NSW)

The change in position of the sciatic nerve during the posterior approach to the hip

Runner Up:

Dr. Michael Galvin (VIC)

Review of Australian orthopaedic litigation claims

OTC Trauma Prize for best scientific paper on Orthopaedic Trauma

Dr. Peter Gifford (QLD)

The tibiofibular line; an anatomic feature to diagnose syndesmosis malposition.

Runner Up:

Dr. Rajat Mittal (NSW)

Crossbat (combined randomised and observational study of surgery for type B ankle fracture treatment) results of a multi-centre RCT

AORA Teaching Excellence awards:

Mr Stephen Tham, Victoria (2014)

Professor Richard Carey-Smith, Western Australia

A/Prof John Walsh, Queensland

Professor Michael Tonkin, New South Wales, Northside Program

Dr Chris Harrington, New South Wales, Newcastle

Dr Michael Stenning, New South Wales, Southside

Professor Jegan Krishnan, South Australia

RACS Library Document Delivery

This year, staff broke the all time monthly record for Document Supply

RICHARD PERRY
Chair, Fellowship Services

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

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

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

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

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

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

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

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

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

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

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

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

NOVEMBER STORM AND THE EVACUATION

The commander had vociferously opposed moves for the evacuation

DAVID WATTERS
AND ELIZABETH MILFORD

The commander of the Mediterrranean Expeditionary Force, General Sir Ian Hamilton had vociferously opposed moves for the evacuation of the Dardanelles believing losses would be high, up to 50% of his troops. The War Cabinet disagreed and Hamilton was briefly replaced by General Sir Charles Munro, a General with significant medical and New Zealand family connections, in October 1915. In November, General Sir William Birdwood who commanded the ANZAC forces was given overall command of the MEF.

The fate of the Dardanelles campaign was sealed when Lord Kitchener arrived at Gallipoli on the 12th November to inspect positions at Anzac, Suvla Bay and Cape Helles.

Rupert Laidlaw from the 2 Fd Amb commented:

Lord Kitchener looked very fine and conversed freely with the men, he thanked all ranks for what they had done at Gallipoli, we all think some big move will be on soon.

After Kitchener's visit, the weather began to change and sickness became endemic. Albert Coates recorded in his diary:

Weather is very cold. Jaundice is very prevalent among our boys, also septicaemia.

Disaster struck on the 27th November with a severe storm and blizzard. At Suvla Bay, torrential rain caused the low lying trenches to flood, then it snowed and the water in the trenches froze. There were over 280 deaths and 16,000 cases of frostbite and exposure. Claude Morlet had just gone to his new quarters at Anzac, an open bivouac on the hillside when the storm struck:

Shortly after dark the gale increased to a hurricane which blew away our blanket covers, and almost immediately, an absolute deluge of rain fell…Young Captain Loubert and I scrambled up the hillside frequently slipping and falling in the slimy mud and walked about on Artillery Road, which was then half under water. The rain had stopped, but the wind howled bitter and freezing with increasing fury! There was no dry place – not a blanket nor a garment and no shelter.

Rupert Laidlaw was right – the 'big move' he predicted came in mid- December when the British government finally decided to evacuate the Peninsula. At this stage, there were 130,000 allied troops, around 15,000 animals and close to 400 field guns still in situ. The carefully planned withdrawal was staggered with Anzac the first to be evacuated. Charles Bean wrote:

At dusk the first parties began, with padded feet, to move to the beaches, they wound along the well-known paths and trenches – all carefully marked for this night – to Anzac Cove and North Beach.

A great deal of effort was made to avoid the feared casualties during the evacuation. There was a charade of making life in the trenches look normal, even when units were being withdrawn. There were 3 Casualty Clearing Stations, a stationary hospital, two sanitary sections and an advanced depot of medical stores, comprising 110 MO's and OR's. The Allied positions were successfully evacuated without casualties in December and January with Anzac complete by December 20th, and Cape Helles by 8th January. The 13th British and 1 ACCS were allotted the honour of remaining till the last moment at Anzac to care for the wounded. From 11th December more than 60,000 troops were evacuated from Suvla and Anzac to Mudros and Imbros, not including over 20,000 sick and wounded taken off by hospital ships during this period.

Trenches during the November storm AWM H14004

i. RJ Austin, *Wounds and Scars: From Gallipoli to France, the History of the 2nd Australian Field Ambulance* (McCrae, 2012).
ii. *Diary of AE Coates*, 18 November 1915, SLV MS10345, Box 4082/7
iii. G Morlet, *Eyes Right* (Adelaide, 2007).
iv. CEW Bean, *Anzac to Amiens* (Penguin 2014)

Claude MORLET

Lt Col, DSO (1988-1972)

MB BS Melbourne 1913, FRACS 1931

EARLY LIFE

Claude Morlet was born at Toowoomba, to Jack and Mary Morlet (née Brown). Educated at Melbourne Grammar School and Melbourne University, he began his internship at the Alfred Hospital and joined the MEF in November 1914.

GALLIPOLI

Assigned to 1 AGH in Egypt, he worked as an assistant to Ophthalmologist, Major James Barrett and dealt with Eye and ENT problems amongst the troops.

After agitating to see more action at the front, he was sent to Mudros in September 1915 to join 1 ASH but was posted to 10 Bn at Anzac where his medical post was often subjected to major gun fire and shelling.

All day the guns had been thundering around us – shells whizzing overhead and rifles incessantly cracking, and bullets pinging and zipping about. I really am getting quite accustomed to the noise, and I'm not in the least bit nervous.

His medical duties included the treatment of the wounded, issues of sanitation, water supply and quality and 'Dardanelles dysentery'.

Everyone seems to be sick today! Whitburn has dysentery – Sawyer has malaria with the temperature of 105. Major Shaw has eczema and a tummy ache. Pierre has gastritis, and Richie, my batman, has diarrhoea!

A month later, Morlet himself became sick and with paratyphoid and at Christmas, was evacuated from Lemnos to Alexandria.

AFTER GALLIPOLI

Early in 1917, Morlet was promoted Major and he was posted 1 AGH, then at Rouen. When serving with 13 Fd Amb during the Third Battle of Ypres, while evacuating the wounded under severe gunfire and shelling, 'he showed coolness under extremely trying and dangerous conditions…' During the 1918 German offensive, his work under intense shellfire earned him the DSO.

PROFESSIONAL LIFE AFTER WW1

He returned to Perth and practiced as an ophthalmologist in St Georges Terrace.

When WW 2 broke out, he enlisted again and was with 2/4 AGH in Tobruk, already under siege by the Afrika Corps. Appointed Consultant Ophthalmologist to the AIF 1941, he also worked at the 4 AGH in Colombo; and then as Medical Director at HRH and Advisor in Ophthalmology to the DGMS, where he was responsible for all military ophthalmic services in Australia.

He was President of the Ophthalmological Society in 1948. A biography written by his older son, Dr Geoffrey Morlet revealed a sensitive, well- grounded, observant and literate man thrust into battle as a young and inexperienced doctor. He tragically lost his wife, brother and younger son in the post war years but continued to practice ophthalmology and remarried in 1963, consulting at home during his final few years.

A grandson, Dr Nigel Morlet has proudly continued the family`s ophthalmic lineage.

Kingsley Faulkner

GEORGE CRAIG

Lt Colonel, DSO (1871-1947) MB CM Edin 1890

EARLY LIFE

George Craig was an Auckland surgeon who served in the South African war as a Surgeon-Captain. Born in Scotland in 1871, in the late 1890s he and his brother provided surgical care in the Pacific islands before settling in New Zealand.

GALLIPOLI

On the outbreak of the Great War Craig volunteered for service. Initially instructed to sail with the Main Body, Craig sold his practice only to be informed his services were not immediately required. Craig appealed, citing 'interfering old women' in the Medical Corps as being responsible for this debacle. Supported by senior officers in the Auckland Military District, the decision was reversed and Craig sailed in October 1914.

Craig landed at Anzac and accompanied the New Zealand troops to Helles in early May, being wounded in the thigh and back. He rapidly recovered and continued to serve, taking temporary command of the medical services to the NZ Field Artillery on Gallipoli in August 1915.

AFTER GALLIPOLI

In November 1915 he was granted leave and returned to New Zealand. Returning to France in April 1916, by October 1917 he was the O/C of 1NZ Fd Amb. Craig ended the war as a Lt Col, was mentioned in despatches and awarded the DSO.

PROFESSIONAL LIFE AFTER WW1

After the war Craig resumed surgical practice, but he did not join the College. He died of a stroke in June 1947.

Andrew Connolly

RESPONSIBILITY FOR TRAINEES

Care and Safety

MICHAEL GORTON
Principal, Russell Kennedy

There is much evidence around that junior doctors and trainees are under great pressure arising from the general stress, lack of resources, budget cuts and low morale facing our healthcare system.

The AMA, medical colleges and others have undertaken substantial promotion of the "safe working hours" campaign for junior doctors and trainees in public hospitals.

As all medical practitioners will be aware, stress and pressure in the workplace, particularly the hospital environment, can have serious deleterious effects on training and education - quite apart from the personal pressures that young doctors will fact affecting their personal lives and health.

Medical Colleges should therefore consider their own responsibility to deal with these issues - and potential liability if they don't.

Liability

In many respects, issues involving trainees arise under the employment relationship between the trainee and the hospital. The College is indirectly involved through providing supervision of training and education. However, for some of the issues discussed in this article, there may be a blurring of liability and responsibility - especially given that College representatives may also sit on the hospital committees or occupy the hospital positions to which the trainees will report during their employment.

Because part of the arrangement for training and education by the College involves supervision and mentoring, there is also the possibility that the College will have some liability if they do so negligently. The College could be liable for negligently supervising a trainee, by placing the trainee in a position of danger or by allowing or authorising the trainee to carry out work for which they were not competent. Obviously, the extent to which the College will be liable will depend on the circumstances of the case.

However, it is clear that the College will need to consider these issues more and more - underlining the nature of the relationship the College has with the training hospitals. There is a need for greater clarity.

It is important for the College, in training handbooks and manuals, to clearly identify those areas where the College will have responsibility and those areas where the employing hospitals have responsibility.

Additionally, in some jurisdictions, notably New South Wales and New Zealand, industrial law can also make a training and education authority liable, similar to an employer, for trainees under their control or supervision. The interaction of industrial relations legislation in the trainee relationship therefore produces a complicated mix.

A Safe Working Environment

Under occupational health and safety legislation an employer has the responsibility to ensure that an employee operates within a safe working environment. Obviously, therefore, a training hospital will have a range of policies and procedures dealing with:

- needle stick injuries;
- lifting policy;
- infection control
- bullying and harassment.

There will be a range of other policies dealing with other health and safety issues.

The "Safe Working Hours" campaign identifies the potential stress and health effects of long working hours on doctors and trainees. It is an issue which hospitals (and to some extent, the College), can no longer ignore.

Harassment, Discrimination and Bullying

Employers have an obligation to ensure that they maintain appropriate policies and procedures dealing with sexual harassment, discrimination and bullying.

Because the College will be considered an education authority, complaints of bullying, harassment and discrimination can also be made by trainees against supervisors, mentors and other representatives of the College involved in their education and training.

It is appropriate that the College has policies dealing with discrimination, harassment and bullying, covering participants in the training program, and that those policies and procedures be appropriately disseminated and properly implemented. Obviously the College has produced an extensive response to these issues recently.

Contract

One of the legal relationships between trainees and the College is that of "contract". The College provides training and education services for a fee payable by the trainee. The College facilitates training, with training performed by Fellows under the umbrella of the public hospital system. The relationship is contractual. The training arrangements will also be subject to administrative law principles (natural justice, procedural fairness).

Accordingly, the initial documents outlining the training program, the training program manuals and materials and the general correspondence between the College and the trainees will all form part of the "terms and conditions" of any contract between a College and a trainee.

The College should therefore be wary about the promises and claims they make in relation to their conduct in the training program. Claims to "fully train" a trainee, or to provide "extensive training and education" sound grand and impressive - but may be hard to live up to if the training program is not as extensive or as all-encompassing as those terms might imply.

Procedural Fairness

Because of the nature of the training program, and the impact on the careers of trainees, the College must observe the requirements of "natural justice" or "procedural fairness" in the way that it deals with them. This applies to:

the selection process;

- decisions on progress of trainees - particularly unsatisfactory progress decisions;
- disciplinary action;
- removal or expulsion from the training program.

The College must act without bias, with adequate notice of the issues to trainees - particularly notice of material adverse to the trainee. The College must give due notice and allow trainees an opportunity to respond to criticisms or adverse material.

It is therefore important that the College has established appropriate processes, and clearly documented pathways for dealing with all of these issues.

Impaired Doctors

The College should also have appropriate policies dealing with trainees who may be or become impaired during the training program. The Medical Board of Australia has clear pathways dealing with impaired practitioners and it is appropriate that the College either utilise these processes or have their own processes in place to deal with trainees in these circumstances.

It is not sufficient to merely deal with poor performance or unsatisfactory process, but also issues relating to any general physical or mental impairment, which may be impacting on trainees.

ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

RACS Aboriginal and Torres Strait Islander Health Medal & RACS Māori Health Medal

Call for 2016 Nominations

The RACS Aboriginal and Torres Strait Islander Health Medal and the RACS Māori Health Medal are awarded annually to acknowledge significant contributions to Indigenous Health in Australia and New Zealand.

Criteria for Award

The award is made to a Fellow who has demonstrated excellence through leadership, practice, advocacy, community engagement, education or research of lasting and significant contribution to Aboriginal and Torres Strait Islander Health or Māori Health.

Eligibility

The Awards are open to all Fellows and the nomination may come from any individual Fellow, surgical society, regional committee, the Indigenous Health Committee, or the Indigenous community in Australia or New Zealand.

Nominations

Nominations for a RACS Aboriginal and Torres Strait Islander Health Medal and Māori Health Medal shall be made in writing to the Chair of the Indigenous Health Committee. The nomination shall contain a curriculum vitae and details of how the nominee meets the criteria for the award. Nominations without this information will be returned to the nominator for further documentation.
The Indigenous Health Committee will consider all nominations and recommend to the Professional Development and Standards Board to whom the medals should be awarded.
Closing date for nominations is 5pm Friday 29 January 2016.

Presentation

The Awards will normally be presented at the Annual Scientific Congress (ASC).
Registration costs for the recipients will be paid by the Indigenous Health Committee for the ASC at which the presentations are made. Travel and Accommodation are not provided by the College and costs will not be paid or reimbursed by the College.
For more information, please visit RACS Aboriginal and Torres Strait Islander Health Medal webpage and RACS Maori Health Medal or contact the Indigenous Health Committee Secretariat.

For more information, please visit RACS Aboriginal and Torres Strait Islander Health Medal webpage and RACS Maori Health Medal or contact the Indigenous Health Committee Secretariat.

Indigenous Health Committee Secretariat
Royal Australasian College of Surgeons
250-290 Spring Street
East Melbourne VIC 3002 Australia
Telephone: +61 3 9276 7407
Fax: +61 3 9276 7432
Email: Melanie.Thiedeman@surgeons.org

CASE NOTE REVIEW

Beware of ceasing anticoagulation in high embolic risk patient

GUY MADDERN
Chair, ANZASM

Clinical details

This patient was admitted under the Vascular Unit with acute ischaemia of the right upper limb in the background of coronary artery bypass surgery followed by atrial fibrillation, multiple cerebral strokes leaving the patient with weakness down the right side, and significant urological bleeding resulting in falls and hypotension which necessitated stopping warfarin. The patient was also in hospital for investigation of the urological bleeding.

While in hospital, the patient underwent brachial embolectomy. The patient had planned urological surgery delayed due to a high INR. In preparation for this procedure, both at the time of delay and when it finally went ahead, all anti-coagulation therapy was stopped.

Following the urological surgery, the patient developed further right lower limb ischaemia and embolectomy was, again, required. Following these procedures, the patient initially did well but because of difficulty with mobility, developed a chest infection, which was adequately treated, and subsequently developed a myocardial infarction and pneumonia, which were the terminal events.

Comments

The case notes provided an adequate record of the patient's course in hospital for this procedure, as well as an adequate record of previous hospitalisations. It confirmed the necessity to cease the warfarin due to excessive blood loss prior to admission and it also confirmed that prior to starting warfarin, the patient had multiple cerebral infarcts. The patient was obviously at considerable risk given the past history and comorbidities.

Review of the history shows that this patient underwent vascular surgical procedures in a timely manner and they were carried out by appropriately qualified surgeons.

The delay in the surgical procedure to be carried out by another discipline resulted from the patient's INR being high on the day of surgery, leading to cancellation. This, unfortunately, meant that complete cessation of all anticoagulation treatment was required on more than one occasion.

There was no documentation that the patient was looked after in HDU. Had this occurred, there is a possibility that the initial postoperative chest infection may have been recognised and treated earlier.

The areas of concern raised by first-line assessment were:

1. The delay in surgery for urological bleeding at a time when the patient was off all anticoagulation. There is no doubt that this led to a second embolus to the right leg requiring a further surgical procedure. This patient had a well-documented history of embolic events, requiring anticoagulation at all times. There is no indication in the history that the urological unit understood the significant nature of this patient's risk.

2. That this patient developed a chest infection postoperatively was not unexpected given the past history of multiple strokes and the other comorbidities. The final event was the development of myocardial infarct, with a marked increase in troponin level, and subsequent pneumonia development. Palliative measures were undertaken after this occurred, which was appropriate.

This patient's progress illustrates the problem of cessation of anticoagulation in a patient who has had multiple embolic episodes while not anti-coagulated. Unfortunately, complete cessation is unavoidable under some circumstances, especially where significant bleeding is occurring and where particular operative treatments are required, for example, the urological surgery.

It is up to the surgical units and hospitals to be aware that unnecessary delays in treatment are catastrophic for patients such as this and this patient illustrates that very well. It may be that hospitals should have a method of prediction of thromboembolic risk for patients when they are off anticoagulation.

This patient's postoperative course was almost inevitable given the comorbidities and multiple surgical procedures. It may be that a short period of time in HDU may have recognised the early stages of chest infection and instituted treatment prior to the fourth postoperative day. Once the chest infection had occurred, because of this patient's immobility and comorbidities, it was difficult to obtain a good outcome.

HOMEO- or ALLO-PATHY

How dilute can your GP get?

BY **DR BB G-LOVED**

Everyone I sit next to seems to be coughing, spluttering droplets laden with virus everywhere. I am often asked in winter, how to avoid colds and stay healthy?" Taking a holistic approach to health and sustaining resistance to infection is important, but many spend a great deal of money on remedies that have no proven efficacy. Most doctors look disdainfully on natural therapies including homeopathy though I am always surprised that few personally review the evidence.

I need to introduce you to Sam. Sam believes in Dr Hahnemann, owns a cupboard full of homeopathic remedies – bottles with tiny white lactose spheres or dropper vials, each promising diluted delivery of a strangely named healing agent for different symptoms or moods. Homeopathy, devised by Samuel Hahnemann in 1796 was popularised through the first half of the 19th century, being founded on a principle of "like cures like". It delivers infinitesimally small doses of what might normally be toxic but in dilution is somehow curative, all within a holistic, individualised, patient-centric approach. I am only consulted when Sam recognises the need for "allopathy". Admittedly when the original Dr Sam (1755-1843) was developing his theory of disease based on miasms and a materia medica based on extreme dilutions, 19th century medicine [allopathy] still offered purging, bathing, cupping and blood-letting. However, that didn't stop America's Oliver Wendall Holmes (1842), Edinburgh's James Simpson of chloroform fame (1843) and London's Sir James Forbes, physician to the Queen, denouncing homeopathy as useless or deluded.

In June, my College [RACGP] published a consensus opinion which is damning of homeopathy, suggesting it is not only ineffective but may also result in patients with real disease delaying their presentation for "proper" treatment. Not only are homeopathic remedies ineffective for the common cold but they also fail to beat placebo for all other ailments too. They pose some danger to public health if patrons prefer homeopathic vaccines to conventional ones. Such a belief has been inherited from its [disputed] reputation for efficacy against infectious diseases, gained during 19th century cholera epidemics.

The College's consensus supports a March 2015 NHMRC position statement, "there are no health conditions for which there is reliable evidence that homeopathy is effective as a treatment." We [RACGP] are calling for Pharmacists to take homeopathic products off their shelves, and for Medicare and Health Insurers to stop reimbursement for homeopathic

remedies. In recent years the UK and Switzerland conducted independent studies which found no evidence of effect, though Switzerland, to avoid a public outcry, retained reimbursement for homeopathy.

The laws of physics and chemistry suggest the active, intended ingredient is unlikely to be present. To concoct a homeopathic remedy the 'like' substance is diluted in water or alcohol many times and then shaken (succussed) repeatedly on an elastic body. Since the least amount of a substance in a solution is one molecule, a 30C [C= Dilutions] solution would need a minimum of 1060 molecules of water, requiring a container more than 30 billion times the size of the Earth! A homeopathic dilution of 12C is the equivalent of putting a grain of salt into the North and South Atlantic Ocean and expecting it to exert some therapeutic effect. Chemically, there are no detectable molecules of active ingredient in most homeopathic medicines – they are indistinguishable from water. When Hahnemann developed his theories and studied his human subjects [provings], atoms and molecules had not been discovered. So his dilutions were multiplied to the extreme. Later, it was suggested that water has a memory for what it has been in contact with, but since water is constantly recycled it has been in contact with the good, the bad and the disgusting.

The time has come for GP's to no longer refer patients to homeopaths. Despite the lack of evidence, I must still concede that those that believe in it may be more likely to adopt a holistic approach to their own health and wellbeing, something that in itself may bring benefits. Holistic medicine, and thus a patient-centric approach, has to be better sometimes than some of my rushed consultations that ignore many aspects of general health. Those who take their health seriously are more likely to be healthy even if homeopathic remedies are no better than placebo. Competing complimentary therapies such as Vitamin C and Echinacea don't prevent colds either. There is no known way of avoiding those miserable symptoms due to those common coryzal viruses.

By the way, Sam consulted me about another condition and mentioned this winter has been coryza free. Alas that was not my experience, so excuse me while I sneeze!

XXXIX

SEVEN PILLARS OF WISDOM

Attributes of a surgical personality - what makes a competent surgeon?

Rock formation at Wadi Rum in Jordan

FELIX BEHAN
Victorian Fellow

I was reading recently about T.E. Lawrence's 1923 book '*The Seven Pillars of Wisdom*' an autobiography of his experiences as a Liaison Officer working in the Arabian Desert and the conflicts of the Ottoman Turk invasion 1916-1918. His title is taken from the Book of Proverbs Chapter 9, Verse 1 and upon perusal I found a striking similarity between such profound comments and what may characterise a competent surgeon.

Thus I thought it appropriate to use the title of his text '*The Seven Pillars of Wisdom*' to focus on the attributes of a surgical personality as listed:

Upon further perusing I noted that the Female Personality gender is evident in these scriptural writings - **She** was called Wisdom and had hewn a house from seven pillars of rock (as illustrated).

1. Prudence
2. Knowledge and Discretion
3. Fear of God
4. Counsel
5. Sound Wisdom
6. Understanding
7. Power

SNIPPETS
AND SILHOUETTES

1. Does Prudence exist in surgery?

The answer is unequivocally yes. In the scriptures, prudent people showed self-restraint and sound judgement – evidence of wisdom and discernment. A surgical episode reflecting this notion for me, occurred in London in the 1970s with Charlie Westbury, Senior Surgeon at the Westminster. Charlie was entertaining me at dinner - drinking Mouton Rothchild (a gift from a patient whereas my level was Asti Spumanti !!). To hear Charlie on the phone discussing management of melanoma with total empathy for the husband, in reference to his wife's condition in the manner of an impromptu surgical lecture, full of clinical expertise and erudition, was one of the best examples of surgical prudence I have witnessed.

2. Knowledge and Discretion

One *must* have knowledge and discretion. The Hebrew word for discretion is *Mezimmah* - using wisdom to act and plan, create and cure. In other words plan and execute with knowledge and experience. I asked Brian Courtice (my mentor in General Surgery in the 1960's) recently what was the most important attribute of a successful surgeon - he said after empathy 'one has to spend 95% of one's time living and breathing surgery' sentiments also echoed recently to me by Sam Mellick and Ken Brearley in developing knowledge.

3. Fear of God

This third Pillar of Wisdom is ingrained in history. Yet at the memorial service for John Masterton on 24th October the speaker said John was 'soft on religion but high in spirituality' – so embracing for all. John in life avoided any hubris which is an absolute surgical prerequisite. How often do we hear 'Surgeons think they are God'? It is not my place to discuss such principles and I think it best to leave this line of thinking for others. Anyone who states '*I never get complications*' is inviting disaster or, as they say at the Royal Marsden (where I spent three years), '*only liars don't get complications*'; the French say '*just wait*', or as David Watters observed recently in *Surgical News* '*if you're not getting complications, you're not doing enough operating*'!

After major Head and Neck resections with Andrew Sizeland and Steve Kleid at the Peter Mac thoughts along these lines could surface. Thanks to the Public Health System (the only place to go when you're ill) I often had three tiers of surgical assistants (Seniors, Juniors and International Fellows), often embracing Christian, Jewish, Muslim, Hindu, Buddhist and Agnostic beliefs. In any dire surgical situation a human trait is often to call upon a little numinous intervention (as one would no doubt do in any impending crash landing) or as Mike Klaassen said to me recently on hearing this episode, his expletive of choice would have been J.C.!

4. Counsel

This fourth Pillar of Widsom relates to Advice. At the Peter Mac combined consultative input is part of the surgical strategum (outwitting cancer) combining Radiotherapy and Chemotherapy. After all King Solomon was not too proud to seek counsel and advice from his contemporaries. Advice may be accepted or rejected but certainly voiced and is the basis of discussion leading to a second or third opinion if necessary. which is good counselling.

5. Sound Wisdom

The fifth Pillar of Wisdom harks back to the Hebrew word *tushiyah* which means wise behaviour – doing what is right and appropriate. We have all witnessed those inoperable cases where fungating mass become a point of social rejection. Surgery is often the final resort to create a harmonious environment creating empathy with the patient in their final stages. Such cases occur in major oncological centres, again reflecting sound wisdom.

6. Understanding

The sixth Pillar of Wisdom relates to understanding people. The surgeon with the most experience often produce the best results. Another vignette which I must repeat relates to my late colleague Stuart Archbold: a Battle of Britain pilot; staved off the Luftwaffe from bombing the Vatican; a Qantas Captain, and a source of social engagement in my lean days in London. He would often on visits take me to Browns in Soho (costing a week's wages) for a meal. His son had been diagnosed with inoperable ulcerative colitis and was pre-terminal. But Bertie Coates of RMH fame operated contrary to other opinions quite successfully, and the patient went on to become Professor of Geology at Melbourne University. Bertie Coates, a Changi survivor, started his working life at Australia Post and graduated to the top of the surgical tree. He had a different pattern of thinking reflecting another facet of this pillar of wisdom based on his experiences. Stuart introduced me to Bertie Coates at Maxim's Restaurant in Toorak upon my return to Melbourne in 1974. Bertie was a gentleman without a touch of arrogance or hubris and provided a pearl of surgical wisdom which has stood me in good stead for over 40 years and I quote Felix - '*tumours that grow towards you are welcoming, those that grow away from you are sinister*' – trite but succinct and still true to this day reflecting a version of this 6th Pillar of Wisdom, understanding pathology.

7. Power

This seventh and final Pillar of Wisdom is crystallized by Francis Bacon's quote '*knowledge is power*'. Any link between power and corruption is not condoned and not part of this dissertation. The more knowledge one


Miniature French Commode

has, the more convincing one is. When one combines knowledge and technique this becomes the epitome of surgical excellence. I include a photograph of a miniature French commode illustrating the technical perfection - once the apprentice can achieve this level of expertise, he is invited to join the French equivalent of the Furniture Guild. The College makes us sit for an exam under similar strict guidelines. Thus we encourage those types, clones of our own personality, to carry on in the footsteps of the Maestros.

Now let us return to T.E. Lawrence. He had a mind for design and loved speed, which was eventually his downfall as he was killed whilst racing his Brough motor cycle. From weathering the storms of the Arabian Desert as illustrated in *Lawrence of Arabia*, he focused in civilian life on speedboat design. Not many know that these water craft rescued RAF personnel from the Channel, during the Battle of Britain. Archie McIndoe concluded that the first aid treatment of emersion in cold, salty water reduced the depth of the burn, a technique now standard practice in burns units around the world – more observational science.

When the Queen Mother visited injured pilots at Roehampton Plastic Unit during the war, she remarked to Archie 'what marvellous work you are doing'. His response, raising his hands like the Dürer etching (see illustration – of 1508), said 'Ma'am, it is thanks to these hands' (as Tom Robins reminded me recently). Archie was a necessary ingredient in this story because he embraced surgical characteristics mirroring the Pillars of Wisdom; he was *intelligent, technically refined, an artisan, clinically astute, showing great empathy, collegiate, clinically and politically wise and academically inclined, while dedicated to his patients* –his 'Guinea Pig Club' is part of history. His final goal however eluded him –Presidency of the RCS. Lord Porritt invited Archie to nominate. Porritt said 'it is impossible for me to be President of the BMA and RCS simultaneously and the job's yours'. Could there have been a taint of antagonism in that final Council count and decision? Were some aware of his implied 'playboy image' (he had patients in the film star set – Kay Kendall)? And


Dürer etching

an *Antipodean*! Whatever the reason he died soon after of a broken heart – to quote John Hueston's (Archie's protégé) description of events., A faded power, sadly .

Surgical personalities continue to reflect the principles behind the *Pillars of Wisdom* and experiences continue to produce pearls of wisdom.

Traditionally the apprenticeship school of surgical training is where the character is moulded in the manner of the master.

Always trust your instincts then the world is your oyster – *Le monde appartient a ceux qui se levent tot.*

Finally, one always has time to read next year's blank diary! The latest 2016 edition that arrived on my desk this week had the RACS College Values listed. Being in that phase of life where mental activity is a testing imposition, I thought of putting a little lexicon for these listings:

Service,
Empathy,
Respect for all,
Virtuous in dealings,
Integrity,
Compassion to all, and
Equally collaborative.

This acronym says it all: service.

It has taken me years to understand the value of the proverbs and not least of all quoting the Holy Scriptures even in a surgical article yet wonders never cease.

Provenance: externally peer reviewed, not commissioned.

The Academy of Surgical Educators

From strength to strength

ACADEMY OF SURGICAL EDUCATORS
Royal Australasian College of Surgeons

"Learners learn from the social interactions they have with other students, teachers, and people around them."

Since 2012, RACS has worked hard to build the Academy of Surgical Educators (ASE) into a resource to support all people with an interest or involvement in surgical education. Like any aspect of surgical learning, surgical education is a life-long process. It starts with foundation training and is followed by high-quality, continuing medical education within a supportive community of practice.

The over-riding aim of the Academy of Surgical Educators is to foster and promote the pursuit of excellence in surgical education. An interactive online learning community helps members gather ideas, share interests and research, find resources to assist in educational activities and helps its members keep abreast of upcoming educational events. The environment is supportive, collaborative and fosters enthusiasm in surgical education. It includes: a discussion forum, resources, links to articles, e-newsletters, grant information and research opportunities, listings of workshops and courses, pathways to become trainers and supervisors and award information.

The ASE would like to congratulate and welcome the 600th member into the Academy.

MR MARK OMUNDSEN, FRACS

Colorectal Surgeon

Could you please tell us something about yourself?

I am a colorectal, laparoscopic and general surgeon. I was awarded my Royal Australasian College of Surgeons (RACS) Fellowship in 2009 and successfully applied to the Colorectal Society of Australia and New Zealand (CSSANZ) subspecialty Colorectal Fellowship program the same year. I spent the next two years gaining subspecialist expertise in the field of colorectal surgery and successfully completed the fellowship program in 2011.

I am especially interested in minimally invasive approaches such as laparoscopic and single incision laparoscopic surgical (SILS) techniques in the management of colorectal diseases, abdominal wall herniae and gallbladder pathology.

My subspecialty interests include surgical management of colon and rectal cancer, inflammatory bowel disease, rectal prolapse and defaecatory disorders such as incontinence and obstructive defaecation.

I am accredited with the New Zealand Conjoint Committee for the performance of both upper (gastroscopy) and lower (colonoscopy) gastrointestinal endoscopy.

I have been working in Tauranga Hospital as a consultant Colorectal Surgeon since 2012 managing a wide range of general and colorectal pathologies.

What involvement have you had in surgical education?

We have three to four SET trainees attached to our unit each year and four to five non-SET trainees. I am actively involved in their training as well as the education of our house surgeons (residents). We also often have fourth, fifth and sixth year medical students attached to our team.

How did you get involved in the Academy?

I got involved in the Academy through the Surgical Teachers Course (STC) that I participated in earlier this year in order to work on developing my surgical education skills further. I found it a very useful and enjoyable experience.

Why is surgical education important to you?

Surgical education is important as it is our responsibility as consultant surgeons to train our successors adequately to ensure our profession is left in good hands.

Do you think it is important to have a supportive community of practice in surgical education, and why?

It is important as it takes effort and skill to train junior surgeons. A supportive community can help you improve your training techniques. It also provides a valuable forum for discussing particular issues or difficulties you may be finding with training. I think being involved in the Academy will make me a better teacher.

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

RACS GLOBAL HEALTH SYMPOSIUM

Asia-Pacific countries and specialist colleges unify to advance safe, affordable surgical and anaesthesia care in low and middle income countries

PHILLIP CARSON
Chair, External Affairs

On 26 and 27 October at the RACS Global Health Symposium, surgeons and anaesthetists, regional specialist colleges, health economists and public health specialists from 16 countries came together and discussed the major barriers and strategies to improving access to safe, affordable surgical and anaesthesia care in low and middle income countries in our region.

The Symposium was convened by Associate Professor Phill Carson, Chair of the RACS Global Health Committee and Professor Russell Gruen, and delivered in association with the Boston-based Lancet Commission on Global Surgery.

The program was a highly interactive forum, structured around the four key issues highlighted in the recent Lancet Commission 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 speakers highlighted that safe surgery and anaesthesia is an indivisible, indispensable part of healthcare and needs to be incorporated into existing health plans. It was acknowledged that surgery causes financial ruin for many people around the world, and participants discussed solutions to ensure that essential surgical care is affordable for everyone who needs it.

The meeting discussed the challenges in building a health workforce and strategies for retaining clinicians in less developed countries and resource-poor environments. First level hospitals in low and middle income countries need to have the capacity to perform a basic package of surgical procedures. In some countries, increasing access to surgery may mean task-sharing with clinician non-doctors, provided these clinicians are able to provide an extended scope of practice, are accredited through appropriate training, and are working in a supported, supervised system of care, with the ability to refer.

The meeting emphasised the importance of ensuring that the workforce configuration in any country reflects the local services and the population needs. Representatives of specialist colleges ANZCA, ACEM, RANZCOG, RACP (physicians), RACS and the Australian Society of Anaesthetists acknowledged that despite their specialty areas, an important part of their role in supporting neighbouring countries is to train generalists who are more likely to work at the district hospital level.

The meeting heard that developing country clinicians want greater recognition and support so that they feel inspired to stay and serve their countries, and, if they do leave, to ensure that they feel welcome when they are ready to return. There is a need for health ministers and local leaders to promote career pathways for local clinicians that offer opportunities and the appropriate professional and financial recognition.

The key themes that underpinned all of the sessions were the need for strong local leadership and that streamlined data collection against agreed global surgery indicators is essential for planning, persuading health ministers to allocate resources, and for measuring success.

Dr Kaeni Agiomea, Head of Anaesthesia at Honiara Central Hospital in the Solomon Islands said,

"The information shared during the meeting has laid down a platform for us to build on and help us advocate improving surgery and anaesthesia services throughout our country, especially for the rural population. Our challenge now is to arm ourselves with the local data and other useful indicators to show to our health planners the reality of the need for us to get these services down to where the people are."

Representatives from the Solomon Islands, Vanuatu, Tonga and Timor-Leste with RACS staff and Pacific Islands Project Director Kiki Maoate after the Symposium

The meeting was an outstanding success, with the Australian, New Zealand and Singapore specialist colleges agreeing to support the Asia-Pacific countries in advocating the agreed messages at the WHO Regional Committee meetings and to the Australian, New Zealand and Singapore governments and other funding bodies. The country representatives resolved to obtain country data on the four identified global surgery metrics to contribute to a global dataset to measure population access to safe surgery and anaesthesia. RACS committed to support a working group for the region-wide effort, to ensure that individuals can access the expertise and support they need to collect the data for their countries. The group also undertook to provide an update on progress at the International Forum at the RACS Annual Scientific Congress in Brisbane in May 2016.

Professor John Meara FACS, FRACS, Chair of the Lancet Commission on Global Surgery and keynote speaker said after the meeting:

"The Asia-Pacific region could very well lead the way for the rest of the world in terms of demonstrating how an entire region of nations adopts a cohesive surgical strategic plan that is an integral part of overall health planning for a region of nations. Your commitment to presenting regional data in May 2016 at the RACS Annual Meeting is a bold move. I am also so proud to see RACS take on a role of "servant leadership" in helping to make this possible. Their explicit commitment to a spirit of accompaniment is a model for all colleges around the world".

"I have not seen this much cohesion in any other region of the world so far. There is great interest in other regions, however, they are not as unified in approaching global surgery as part of health system strengthening and doing it together!"

Rowan Nicks Scholar Dr Tanvir Chowdhury (Bangladesh) during a panel discussion

Panel discussion with Lord Vliami Tangi (Tonga), Prof David Watters and Dr Prasit Wuthisuthimethawee (Thailand)

The Symposium was sponsored by the RACS Foundation for Surgery, the Australian and New Zealand College of Anaesthetists and the Australian Medical Council.

Interested in Global Surgery and International Medical Development?

Come and join discussions at the International Forum at the RACS Annual Scientific Congress, held annually in May. The 2016 Program is convened by Dr Neil Wetzig and includes sessions on:

- Regional approaches to global surgery: case studies and perspectives from Timor Leste, Pacific Islands, China, Myanmar and Africa
- An international approach to global surgery: the Lancet Commission on Global Surgery and the WHO – are these the real opportunities for change?
- The role of surgery in national health plans in low and middle income countries
- Rowan Nicks Scholars' presentations and research papers
- A Master Class on Tuesday 3rd May: Working as a surgeon in the global environment

The provisional program is available at:

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

Enquiries may be directed to:

Email: *global.health@surgeons.org*

Phone: *+61 3 9249 1211*

Foundation for Surgery
Passion. Skill. Legacy.

DELIVERING ON THE DIGITAL COLLEGE

Further initiaves introduced for 2016

RICHARD PERRY
Chair, Fellowship Services

In the May edition of Surgical News we reported on the development of the Digital College in response to a world of rapid technological advancement and the transformational nature of communication and information access. As the Digital College advances, RACS recognises the challenge for modern-day surgeons, as they balance their ongoing learning with busy work schedules. The emphasis has been on facilitating access and streamlining information flows, requiring less effort on the part of surgeons.

As we near the end of 2015 further initiatives have been introduced.

RACS Portfolio

The RACS Portfolio was launched in June 2015, providing a new 'learner-centric view' of College resources. The initial release was focused on providing Fellows with an easy-to-use way to access CPD and manage their details with the College. The RACS Portfolio is designed for use on any device, in any location. Two updates to the Portfolio since the launch include a MALT summary and easy access to eLearning resources.

A further upgrade of the Portfolio is planned with two key improvements:

- Incorporation of assessment information for Fellows supervising International Medical Graduates (IMGs), and access to online assessments for IMGs.
- Access to courses and workshops through an Events area to help Fellows find courses and other educational resources for their own continuing professional development.

The RACS Portfolio dashboard will soon be the entry point into the College website that all Members use after they login.

Online Registration

Online registrations have expanded to include registration for specialty-specific exams and for skills courses. This is especially convenient for Trainees and junior doctors who can securely register and pay online, and receive instant confirmation any time of the day or night.

Online Registration will continue to deliver further online registrations for Exams as well as enrolment capability for SET, IMG Assessment and MOPs.

Mobility

An online assessment app for management of IMG MiniCEX and DOPS was delivered for use between IMGs and their supervisors via an iPhone. For those without an iPhone, online MiniCEX and DOPS Assessments can be conducted through a smartphone or tablet browser. This has increased the capability to conduct a MiniCEX and DOPS assessment at the patient bedside or after theatre using personal mobile devices.

Other initiatives

In tandem with the Digital College initiatives, other online resources are being enhanced and extended. These include:

- Evolution of the online Multi-Source Feedback (eMSF) assessment tool. Initially evaluated with IMGs, it will soon be piloted with a group of Fellows as part of your College's commitment to improve performance feedback.
- Plans to allow online delivery of the written Fellowship Exam as well as tablet-based marking of the Objective Structured Clinical Examination (OSCE).
- An improved smartphone and tablet-friendly website that will be available in the near future. This is in keeping with the overall direction of the Digital College to improve access to online resources.

Feedback

Your feedback is always welcome as we develop new initiatives; in fact it is essential if you want your College to meet your needs. So please send your comments and suggestions via the feedback form on the lower right hand side of the RACS Portfolio page.

Your College will continue to strive for digital excellence in 2016 with a commitment to the ongoing evolution of the Digital College and related initiatives.

Fourth Plastic Surgery Congress

Australian Society of Plastic Surgeons

CAMERON MCKAY
Chair, ASPS Education Committee

The fourth Plastic Surgery Congress (PSC 2015) was held in Brisbane, 6 - 10 May 2015. Over 380 medical delegates attended including fellows, SET registrars and unaccredited registrars from a wide range of surgical specialties and their subspecialties to learn about contemporary and basic plastic and reconstructive surgery.

ASPS was pleased to announce that, as agreed with the New Zealand Association of Plastic Surgery, the RACS Visitor funding for plastic surgery was dedicated to Dr Helmut Fischer in 2015. Dr Fischer is a Professor and Consultant from the Plastic Surgery Department of Marienhospital in Stuttgart, Germany.

He studied medicine from 1971 to 1978 followed by practical experience in internal medicine, surgery and more specifically orthopaedic surgery. He served as a doctor in the military and developed a passion for rhinoplasty and nasal reconstruction. His plastic surgery residency began in 1988 at Marienhospital where he continues through to today.

Dr Fischer's private practice includes aesthetic surgery of the eyelids, periorbira, ears, lips, face, forehead and brows. Dr Fischer is the instigator and convenor of the first international Stuttgart nasal reconstruction congress to be held in 2016. Luminary rhinoplasty surgeon, Wolfgang Gubisch, describes Helmut Fischer as: "He is to Europe what Burget and Menick are to the USA".

Dr Helmut Fischer

Australian Hand Surgery Society AGM

With guest lecturer Professor Kevin Chung

The Australian Hand Surgery Society was fortunate to have Prof Kevin Chung from University of Michigan as the invited guest lecturer at the scientific session of the Annual General Meeting held in Hobart on the 4-7 March 2015.

Prof Chung is Chief of Hand Surgery at the University of Michigan; he has been Director for the American Board of Plastic Surgery and the American Board of Surgery.

He has published over 420 peer-reviewed manuscripts, over 200 book chapters, and 15 textbooks. Prof Chung is the Deputy Editor for the *Journal of Hand Surgery* (American), the Editor for *Hand Clinics* and Associate Editor for *Journal of Hand Surgery* (European). He is the Outcomes Section Editor for *Plastic and Reconstructive Surgery.*

He brought his vast experience in publishing and research to stimulate the Society through seven thought provoking lectures on various topics. These included evidence based management of Distal Radius and Scaphoid, biomechanical studies in flexor tendon repair, Rheumatoid surgery, and wisdom about the process of medical publication. He made a valuable contribution to the meeting, willingly commenting on many of the other papers presented and entering into the discussion sessions with vigour.

Prior to the meeting he attended the NSW Hand Surgery quarterly evening meeting, where a number of complex cases were presented and discussed, as well as presenting a stimulating lecture on the epidemiology of Distal Radius Fractures

The Society would like to thank the RACS for its generous support of Prof Chung's visit through the RACS Visitor Program.

In Memoriam

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

Frank J Ham FRACS FRCS
9 November 1931 – 16 March 2015
Plastic Surgeon

Frank Ham was born in Kew, schooled at Scotch College and obtained his MB.BS at the University of Melbourne in 1955. He courted and married Elizabeth Bennett in 1957 whilst training for his Fellowship of the Royal Australasian College of Surgeons which he obtained in 1961.

He set off with his young family to train for 2 years in Plastic Surgery at Frenchay Hospital in Bristol under the guidance of Fitzgibbon and Bodenham, disciples of Sir Harold Gillies. Whilst there he sat and passed the FRCS of England.

http://www.surgeons.org/member-services/in-memoriam/frank-j-ham/

Keith Howard Langford FRACS FRCS
2 October 1925 – 28 August 2015
Neurosurgeon

Keith was born in Melbourne October 2, 1925 and died in Birmingham, Alabama on August 28, 2015.

He was a man of enormous zest for life with a wide range of interests and friends that he maintained until the end which came rather suddenly when an infection supervened on top of a long battle with cancer.

http://www.surgeons.org/member-services/in-memoriam/keith-howard-langford/

Kevin King FRACS FRCS
6 May 1933 – July 2015
Orthopaedic Surgeon

Kevin was a close friend to all of us and I first met him in 1969 in the Orthopaedic Outpatient Department at Saint Vincent's Hospital. According to the history of that unit he had appointed acting relieving assistant overseas in 1964, so I am not sure what I would have called. I noted his diligence and spidery handwriting and concluded that he was different.

Kevin was different. He was widely read, particularly on English History and Naval Battles. He loved cricket and often recalled bowling out the opposition top batsman while playing for the London Hospital. He was asked to stay on as a Consultant but returned to Oz. He didn't like football. I took him to a match once and he thanked me for an enjoyable afternoon, but it was only ½ time when he left.

http://www.surgeons.org/member-services/in-memoriam/kevin-king/

Robert Bruce Filmer FRACS FRCS
1 June 1938 – 23 August 2015
Paediatric Surgeon

Dr Robert Bruce Filmer, 77, of Quarryville, PA died on Sunday, August 23, 2015 at Hospice & Community Care, Mt. Joy. Born in Sydney, Australia, he was the son of Albert Robert and Janet Isabel Watson Filmer and spouse of Thomas Howard Mitchell.

Bruce served his fellowship in Australia, England, and the United States. Bruce was a graduate of the University of Sydney Medical College and served his residency in Sydney and the United Kingdom.

http://www.surgeons.org/member-services/in-memoriam/robert-bruce-filmer/

John Masterton AM FRACS FRCS
20 May 1928 - 17 October 2015
General Surgeon

John Masterton epitomised the term "canny Scot" and also adopted the Aussie characteristic of giving everyone "a fair go". The Royal Australasian College of surgeons has indeed been fortunate that John chose to spend the last 52 years of his working life since 1963 here in Melbourne.
The College would say 52 years because John never stopped working and contributing to the College. Most of his contributions were pro-bono. This year he continued to chair the Rowan Nicks Committee, and was an active member of the International Committee and represented it on the RACS Foundation Board. He attended our Annual Scientific Congress in Perth and participated in both the International and Surgical History programs. To those sections he gave many fine papers over the years to the benefit and enjoyment of so many colleagues.

http://www.surgeons.org/member-services/in-memoriam/john-masterton/

Médecins Sans Frontières operates in Syria

A unique personal and professional challenge

Médecins Sans Frontières teams are currently delivering emergency medical assistance in more than 60 countries, and Médecins Sans Frontières surgical teams perform more than 75,000 major surgical procedures every year. Tamaris Hoffman is an Australian surgeon who worked with Médecins Sans Frontières in Syria. Here she recounts her story.

Médecins Sans Frontières team operates inside an inflatable hospital in northern Syria

"I've wanted to work with Médecins Sans Frontières since I was a medical student at the University of Queensland. They seemed the best organised – the people who went where others didn't and responded the fastest to humanitarian crises. When I was offered my first placement in Syria my family wasn't very happy but I was pleased; I knew I hadn't signed up for a Club Med holiday.

It was the middle of winter when I arrived and freezing – there was snow on the mountains. We walked across the border from southern Turkey early one morning and were whisked away in a car. I wasn't at all nervous. Médecins Sans Frontières obviously knew what they were doing and had done it hundreds of times before.

Our clinic was in a village house. On the ground floor we had the casualty and outpatient departments, resuscitation, the operating theatre and sterilisation. The next floor up were the wards and the office and the laundry on the rooftop. We slept in a separate house about 50 metres up the road.

The equipment we were using was familiar but not the standard I am used to in Australia. For example the portable operating theatre light was quite old but it worked, you could see with it, but it's just when you come from a theatre where the lights are suspended from the ceiling and are easy to move, you have to get used to the clunky one that stands on the floor. There were a few things I missed, but you would have to just make do.

Most days we would probably have anywhere between six to ten patients but I remember one day we had 30. It was a Friday, we had a call to say there had been heavy shelling and gunfire in Idlib. The prison had been bombed, there were a lot of injuries and they were bringing them to us. They started to arrive about three in the afternoon by any means they could. They kept arriving in waves of five or ten, the last just after midnight.

We finished operating at 3am. Gunshot wounds aren't very common in Australia, I'd done a few but not to this extent. But I knew the principles of war surgery, so it was just doing that. Myself and the accident and emergency doctor triaged the patients and if the injury was inoperable we would have to leave them. If someone was bleeding they would take priority, someone whose limb was at risk without an operation, they were a priority and then the rest were the walking wounded and they would have to wait. In that case we were still operating on them on Monday morning. All but one patient survived.

I remember one of the patients, Mohammed, had been shot in his left foot. We cleaned him up as best we could and talked him through his options. It was looking like he we would have to do a below the knee amputation, but I wasn't keen on that. Without his leg, his life would be pretty miserable.

So we did a series of operations.

Every other day we would take him back to the theatre and only take the tissue that had died. We did it bit by bit and got to a stage where what he had left was healthy tissue and with a bit of plastic surgery, I could fashion him half a foot. Our physiotherapist said, 'Well, if you can get him half a foot, I can make him a prosthesis so he can walk.'

After his foot healed we got him up and bearing weight on it. When the swelling had gone down we bought him a special boot and the physiotherapist designed another half a foot. We got him up and he walked out of hospital. I was pretty pleased with the outcome as I know that without the surgery he would have developed gangrene and lost his leg.

Everyone was just so busy that night we had to get on with it. At the end of the day I wasn't too bad, I was a bit tired but we just went home, went to bed and started again in the morning."

Patient name has been changed.

MALT IS MOVING TO SNOMED

The what, why, when and how explained

ANTHONY SPARNON
Chair, Morbidity Audit Committee

Where SNOMED has been implemented around the world:

- Royal Hobart Hospital, Tasmania
- Emergency Department Information System – Wairau and Nelson Hospitals, New Zealand
- Hospital-wide eHealth record – Rotherham UK
- Wait time management system – Canada
- Patient management system - Moorfields Eye Hospital, London UK
- Kaiser Permanente, USA

For other implementations:

http://snomedinaction.org/sct-table.html

This year has brought many enhancements and improvements to the College's Morbidity Audit and Logbook Tool (MALT). Most significantly, peer-review audit functionality has been developed and piloted at Mount Gambier Hospital and the Royal Darwin Hospital as part of the Regional Hospital Pilot.

To successfully accommodate peer review capabilities in MALT, the College in collaboration with the CSIRO eHealth Research Centre has developed a customised SNOMED 'universal surgical procedure list'.

SNOMED stands for Systematized Nomenclature of Medicine and is considered to be the internationally pre-eminent clinical terminology.

The exchange of clinical information relies on a common coded clinical language (clinical terminology). As the world moves towards integration of health care records ('electronic health records') where information follows the patient, it is important that information is consistent and transferable within and across all the health care settings where a patient may be treated.

Did you know that MALT already uses SNOMED to capture diagnoses?

Here are the top five most recorded:

1. Acute appendicitis
2. Morbid obesity
3. Acute cholecystitis
4. Biliary colic
5. Polyp of colon

SNOMED has been implemented in over 50 countries. In Australia/New Zealand, the College is an early adopter; however SNOMED has been endorsed by both the Australian and New Zealand governments for use in eHealth patient records.

The process of defining the new SNOMED procedure list in MALT has been lengthy. It has involved reducing the 50,000 procedure terms in SNOMED to 14,000 relevant terms based on existing MALT procedures across all specialties.

In addition to providing standardised terminology to support the new peer review functionality, the SNOMED procedure list allows for the following:

- International data comparability
- Option to record any procedure with as little or as much detail as desired (i.e. just 'colonoscopy' or more precisely 'fibreoptic colonoscopy through colostomy' etc)
- Increased reporting power.

The SNOMED list is also far more extensive than the lists now available in MALT (which are based on the SET/IMG procedures required by the training boards). This is of particular benefit to the Fellows who have requested the ability to record additional procedures. There will be 14,000 procedures available, compared to at most 300 now.

Additionally, all surgeons have the same list, so that procedures are named exactly the same irrespective of specialty (for instance, a cystoscopy is always called a cystoscopy, whether performed by a SET in general surgery, in urology or in paediatrics. Currently these specialties all use slightly different terms to describe this procedure).

The MALT system has been significantly enhanced for the implementation of the SNOMED procedure list. All existing MALT users will gradually be migrated to use the new procedure list. All College members as well as training boards can utilise the exciting new functionality outlined in Table 1 (above).

The work on migration has commenced:

- All Paediatric Surgery, Plastic Surgery Australia and Otolaryngology, Head and Neck Surgery SET and IMG logbooks will soon be using SNOMED terms in early 2016.
- The Paediatric Surgery Fellow logbook is currently being prepared for use by the end of 2015, with Plastic Surgery and Otolaryngology, Head and Neck Surgery Fellow logbooks being available shortly after.
- The New Zealand Association of Plastic Surgeons has recently endorsed the move to SNOMED for their SET logbook. Plastic Surgery Trainees in New Zealand will commence using the new procedure list mid-2016.

All existing data in MALT will remain available - automatically mapped to the new SNOMED list.

The migration process involves the MALT team working closely with the MALT Clinical Director, Associate Clinical Professor Franklin Bridgewater, to review and verify the procedure maps. Each specialty will be asked to identify a training board representative to confirm that the SNOMED terms proposed match the intended meaning of the current list.

If you would like more information please contact the MALT SNOMED Project Team:

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Table 1	Currently available in MALT	Available with SNOMED
Record cases and generate training board reports	✓	✓
Record training board approved terms	✓	✓
Training board endorsed Logbook Summary Report: shows board approved procedure totals by supervision level	✓	✓
Keyword searching for procedures and viewing most 'recently used' procedures	✓	✓
An enhanced user interface to find the procedure quickly; 'most commonly used' procedures, ability to flag procedures as 'favourites' and searchable synonyms		✓
Ability to record ANY procedure term with training board required terms still clearly distinguishable for SET/IMG and Fellows sub-specialising		✓
Peer review audit capability for Fellows, SETs, IMGs and JDocs		✓
Flexible reporting on total case log; expand and collapse feature that reveals/hides procedure detail as required		✓
Training boards able to generate reports on all procedures logged OR only training board required procedures		✓
More detailed reporting on the surgical exposure of SETs that could be used by training boards during the hospital accreditation process		✓

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