ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 16 NO 9 OCTOBER 2015

TIME FOR CHANGE

The findings of the EAG Report **p12**

The College of Surgeons of Australia and New Zealand

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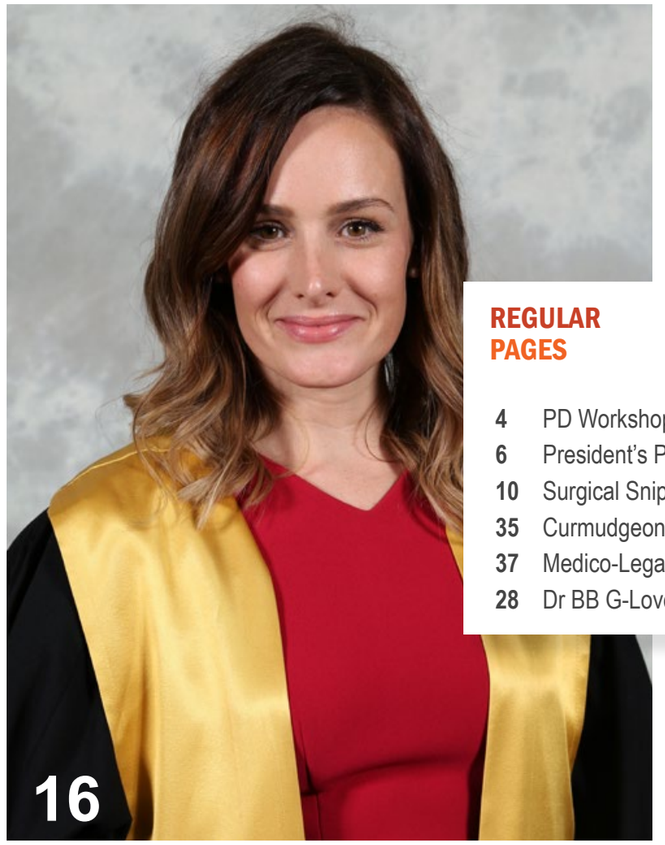

REGULAR PAGES

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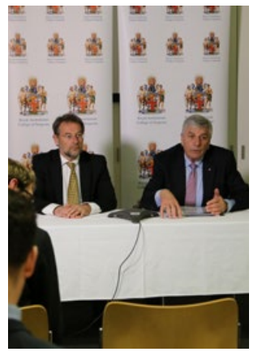
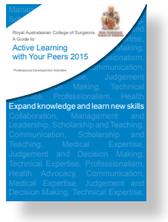


ON THE COVER:
Time for change, p12

PROFESSIONAL DEVELOPMENT

WORKSHOPS & ACTIVITIES

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



Foundation Skills for Surgical Educators

16 October - Hobart, TAS
17 October - Wellington, NZ

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

Critical Literature Evaluation and Reasearch (CLEAR) course for Consultants

16 - 17 October - Sydney, NSW

The CLEAR course for Consultants aims to provide Fellows with the tools to undertake critical appraisal of surgical literature and assist surgeons in the conduct of clinical trials. This consultant oriented CLEAR course will focus on topics such as running a journal club, supervision of trainee research and application of evidence in practice.

Safer Australian Surgical Teamwork

23 October - Bundaberg, QLD
30 October - Wangaratta, VIC

The Royal Australasian College of Surgeons (RACS) with the Australasian College of Anaethetists (ANZCA), the Australian College of Nursing (ACN) and Australian College of Operating Room Nurses (ACORN), is offering a combined workshop for surgeons, anaesthetists and scrub practitioners working in rural and regional Australia. The workshop focuses on non-technical skills which can enhance performance and teamwork in the operating theatre thus improving patient safety. It explores these skills using three frameworks developed by The University of Aberdeen, Royal College of Surgeons of Edinburgh and the National Health Service - Non-Technical Skills for Surgeons (NOTSS), Anaesthetists Non-Technical Skills (ANTS) and Scrub Practitioners' List of Intra-operative Non-Technical Skills (SPLINTS).

Keeping Trainees on Track (KToT)

31 October – Adelaide, SA
26 November - Melbourne, VIC

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

Supervisors and Trainers for SET (SAT SET)

31 October – Adelaide, SA
17 November - Sydney, NSW

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

Non-Technical Skills for Surgeons (NOTSS)

13 November – Melbourne

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.

October - December 2015

ACT
2 December
Clinical Decision Making, Canberra

NSW
16-17 October
Critical Literature Evaluation and Reasearch (CLEAR) Course for Consultants, Sydney
16 November
Foundation Skills for Surgical Educators, Sydney
17 November
Supervisors and Trainers for SET, Sydney

NZ
9 October
Keeping Trainees on Track, Auckland
17 October
Foundational Skills for Surgical Educators, Wellington

QLD
23 October
Finance for Surgeons, Brisbane
14 November
Building Towards Retirement, Brisbane face-to-face workshop; Online - live via web link

SA
31 October
Keeping Trainees on Track, Adelaide
31 October
Supervisors and Trainers for SET (SAT SET), Adelaide

TAS
16 October
Foundation Skills for Surgical Educators , Hobart

VIC
9 October
Clinical Leadership Group Forum, "Surgery and the frail older person", Melbourne
31 October
Communication Skills for Cancer Clinicians: Breaking Bad News, Melbourne
26 November
Keeping Trainees on Track, Melbourne

SORRY

The EAG has assisted the College with taking an important step forwards through an apology

DAVID WATTERS
President

In the stories submitted to the Expert Advisory Group, here are some direct quotes from some who have suffered bullying and harassment:

Although "the vast majority of consultants have been supportive and good role models as with any profession, a few rotten apples will spoil the cart." "The bullies are a small sub-set of surgeons ....who are repeat offenders.... Everyone knows who they are." "Yelling is more or less accepted as ordinary behavior." "He deliberately knocked my hand, then yelled at me saying I was incompetent." 'These ....occur in public, in front of patients, other health staff."

Such experiences, together with the prevalence study suggest that bullying and harassment do too frequently occur in our workplace, they are more common than we like to think, and that too many of us are silent bystanders, not speaking up to counter such behaviours.

International Medical Graduates were the most likely to suffer discrimination, Females were most likely to experience inappropriate comments about clothing, appearance, innuendo or frank propositioning.

Five independent studies by the Expert Advisory Group all confirm the same story. We as a College have to recognize discrimination, bullying and sexual harassment have too long been tolerated, that trainees and others have not felt safe to complain and that complaints have often been poorly managed when they have been made. Sometimes complaints and inappropriate and illegal behaviours have been poorly managed because of a lack of determination or partnership between employer (usually the health service) and the RACS and the specialty training boards responsible for Surgical Education and Training.

I and the Council Executive felt strongly our first response to the EAG report should be to apologise publicly. We did this on the day the report was released. This is what I said and made available on the College website and YouTube.

Everyone has a right to be treated with respect and to train and work without being subjected to discrimination, bullying or sexual harassment. Sadly, this is not the experience of all Surgeons, Surgical Trainees and International Medical Graduates.

The Royal Australasian College of Surgeons set up an Expert Advisory Group to find out the prevalence, and effects, of discrimination. The results of the research commissioned are, quite frankly, shocking.

They show that nearly 50% of Surgeons, Surgical Trainees, and International Medical Graduates have suffered discrimination, bullying or sexual harassment, many in recent years. The College recognises that some of our members have been perpetrators, often from their positions of power and authority. The individuals who took the time to share their stories, have described the devastating impact this has had on their personal and professional lives.

As president of the College, on behalf of all Fellows, Trainees and International Medical Graduates, I apologise. I apologise to every one of you who has suffered discrimination, bullying or sexual harassment by surgeons. I also apologise to all other health workers on whom surgeons have inflicted these behaviours.

I recognise that many of you have not felt you can trust the College to complain. The College must now earn your trust, by fairly and effectively dealing with these unacceptable behaviours.

I am sorry that too many of us have been silent bystanders. This silence has been part of the problem. We have failed to push back against the behaviour of the individuals responsible, and we should have done more to support those who have been affected.

The College accepts the draft report and its recommendations in full. We heed the call for more transparency and external scrutiny, as well as the need for cultural change. We commit to developing an Action Plan that addresses the issues raised and the recommendations made and we will be held to account against it.

We want also to work with public and private hospitals, government agencies, regulators, educators, specialist medical colleges and their societies, to make the health workplace a safer, more respectful and healthier place for us all.

There is no place for discrimination, bullying or sexual harassment in surgical practice or surgical training. The College will not tolerate these behaviours. We will not tolerate the abuse of power and authority by surgeons. The surgical profession must no longer be silent. The College will make it safe to speak out.

The College, the Specialty Societies and our Fellows now have a great deal of work to do. And we will do it.

So what is likely to be in the Action Plan? What does the future hold?

Our action must focus on 3 main issues: leadership and cultural change, education and the handling of complaints. Discrimination, bullying and sexual harassment are at best inappropriate and at worst criminal. These behaviours must not only not be tolerated but also be countered when they are observed. This will require education and training so that we have a common understanding and all achieve a certain standard – we need to know what is appropriate and what is not, we need to understand that perception can be reality, we should learn how to give critical and negative feedback without provoking accusations of being a bully, we should improve how we behave in positions of power and authority, leading well, respecting all, being a good role model. There will be minimum requirements for trainers and supervisors, there will be the provision of opportunities to learn more about discrimination, bullying and sexual harassment within CPD. The Expert Advisory Group has recommended this is necessary for all of us; such further education will surely be beneficial for our performance in the competencies of communication, collaboration and professionalism. Such recommendations will provide us opportunities for lifelong learning and ensure our workplace will not tolerate these inappropriate behaviours.

The Royal Australasian College of Surgeons will ensure the culture of surgery and the surgical workplace promotes respect, one of our RACS core values. We will take actions to create a healthier and safer workplace for Fellows, Trainees, international medical graduates and, indeed, our other colleagues in the health sector. Nursing staff and others with whom we interact will also be beneficiaries of cultural change in surgery. We need to work together in a way that respects the rights of every member of the healthcare team, that does not abuse power and hierarchies, and so ultimately deliver the safest and best outcomes for our patients and their communities. Patient care is compromised when staff are humiliated, intimidated, or angry.

Everyone has a right to train and work in an environment where they are treated with respect and which is free of discrimination, bullying or sexual harassment.

This is what we want, now and into the future.

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

MAKING HEALTHCARE SUSTAINABLE

An increasingly relevant approach to health services

GRAEME CAMPBELL
Vice President

Sustainability seems to be a buzzword of late and conjures up varying images when mentioned. For some, the term is all about environmentally friendly practices and reducing ones carbon foot print. The other dimension of sustainability refers to "continuing something for a long time at the same level."

According to the Australian Institute on Health and Welfare, in 2011-12, health spending in Australia was estimated to be $140.2 billion, or 9.5% of GDP. The amount was around 1.7 times as high as in 2001-02, with health expenditure growing faster than population growth.

The New Zealand treasury estimates government spending on health for this financial year to be $16 billion, about 20% of the Core Crown Expenses.

This growth can be attributed in part to societal changes such as population ageing, and to increased prevalence of chronic conditions, diseases and risk factors. Personal incomes, broader economic trends and new technologies also affect spending on health.

For both of our countries, it is fair to say that our health does not exist separate to the rest of our society. Rather, the two are inextricably linked, and the spending by our countries on health services reflects this.

So how can we as surgeons contribute to the sustainability of healthcare to ensure its ongoing funding by government, affordability by consumers and delivery of quality services?

RACS is involved in a number of initiatives on different fronts:

- Provision of advice on the review of Australia's Medicare Benefits Scheme
- Discussions with private health insurers and peak bodies regarding coverage of procedures
- Working with specialties on the Choosing Wisely Australia campaign

RACS has recently established a Sustainability in Healthcare Committee chaired by College Councillor, Dr Lawrie Malisano. The Committee has a few areas of focus initially including elective surgery prioritisation, private health insurance and identification of low efficacy procedures with the specialties.

The Choosing Wisely Australia® campaign aims to commence a national conversation about more appropriate health care. Medical colleges and societies have united to take the lead on identifying those tests, treatments and procedures they think are of proven low value or carry an unnecessary risk.

Among the lists are recommendations on food allergy testing, prostate cancer screening, vitamin D screening, monitoring of type 2 diabetes, benzodiazepine prescribing, emergency medicine procedures and ankle and spine imaging. Some surgical procedures will also be under the spotlight.

The medical colleges and societies that are participating have developed lists of recommendations of the tests, treatments, and procedures that clinicians and consumers should question. Each recommendation is based on the best available evidence. However, they are not prescriptive but are intended as guidance to start a conversation about what is appropriate and necessary.

And what of the role of private health insurers? Recently one private health insurer has suggested that some adverse events are so highly preventable that they will not be covered. This was marketed as an attempt to ensure quality. Many of you contacted RACS to express your concerns and this topic has been discussed at many of the regional committees. We believe that all surgical procedures carry a complication rate, and that, at least in the first instance, management of complications is best performed by the surgical team that knows the patient best. Financial concerns should not masquerade as quality improvement.

In the short-term, RACS is putting in place additional resources to ensure we are able to contribute in a meaningful way with interpretation of data, advice and voice of reason. Ultimately, patient safety relies on adequate resourcing of the healthcare sector. The health of our nations depends on our health as individuals and vice versa. A 'healthy' health system is fundamental to each of our countries and our personal wellbeing and prosperity.

I am always happy to receive comments and suggestions from our Fellows on these topics. Please contact me at **college.vicepresident@surgeons.org**

College Advocacy

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Social Media Surgery

What is 'Social Media Surgery'?

'Social media surgeries' originated in the UK, and were informal sessions led by local social media experts for voluntary groups and charity organisations, giving them a chance to learn about the web and how different social media platforms could be used. We're taking on the theme and passing on some great tips for you to get started with, or advance, your own social media use.

In preparation for next year's ASC, we're giving monthly insights into how to get involved on social media, so you can make the most of it at the conference. First cab off the rank is Twitter, the microblogging platform that has taken the medical world by storm. Wondering why you should be on Twitter? Here are just a few of the benefits:

Benefits of being on Twitter:

Some of the benefits of being on Twitter professionally include:

- Networking with peers, unrestricted by location
- Spreading information about a medical speciality or your research findings to a wider audience
- Learning about new research and technology that can assist your own practice
- Refining your communication skills (for example, being more concise and clear)
- Experiencing what's happening at medical conferences that you can't physically attend
- Building a practice, as patients searching online discover physicians' social media content
- Increasing your public profile and gaining different opportunities, such as guest lecturing, blogging, or providing expert opinions to the media
- Building your reputation as a 'thought leader' and an expert in your field
- Participating in TweetChats in areas of interest
- Understanding patient experiences and perspectives by listening online
- Increasing traffic to your other social channels, such as professional blogs
- Accelerating career advancement, especially in young physicians
- Having fun!

Keep 10pm close times

The Alcohol industry in NSW are fighting for later opening times for liquor outlets despite convincing evidence that 10pm closing times reduce assaults.

The Liquor Stores Association NSW say that regional bottleshops benefit from the extra business generated from later hours.

But the RACS Trauma Committee say that the societal benefits should be more important.

“The College is very keen to move quickly to lend strong support to retaining the whole-of-jurisdiction 10pm liquor sales restriction,” Trauma Committee Chair John Crozier has said.

Sydney Morning Herald, 16 September

Breaking the mould

An all women surgical team is changing the stereotype in Wollongong. Fellow Soni Putnis leads the first ever all female team that includes three trainee surgeons and two junior doctors.

Dr Putnis believes greater diversity allows patients to benefit from more choice.

“Surgery is one of the last areas in medicine where there is a gender imbalance that should be addressed, and it seems we are getting there.”

I’d like to encourage girls or young women to stay in surgery,” Dr Putnis said.

Illawarra Mercury, 31 August

Balancing health cover for all

The College has voiced its concern over patients being denied appropriate care due to private health insurers limiting what they will cover.

The RACS Director of Surgical Affairs Australia Dr John Quinn has said that private health care is a vital way for Australians accessing their health care.

“The Australian Health care sector relies on both public hospitals and private hospitals to deliver comprehensive clinical care for all Australians,” Dr Quinn has said.

The College is working to continue the sustainability of that system with key stakeholders.

Scoop News, 31 August

Real steel

A titanium 3D-printed sternum and ribcage from an Australian company has been used in surgery for a Spanish cancer patient in a world first.

Typical implants for the chest have problems with becoming loose and can create complications over time. The CSIRO has confimed the patient has been discharged and is recovering well.

“3D-printing was the most desirable method because the implant needed to be customised to the patient. No human body is the same,” Research Leader at the CSIRO Alex Kinsbury said.

ABC News, 17 September

David Watters and Rob Knowles AO on the release of the EAG report

TIME FOR CHANGE

The EAG's report into discrimination, bullying and sexual harassment is expected to lead to fundamental changes throughout the College.

The Expert Advisory Group's (EAG) report into discrimination, bullying and sexual harassment in surgery is expected to lead to fundamental changes to College interaction with hospitals, surgical educators, supervisors and Trainees, particularly women and International Medical Graduates (IMGs).

The report, presented to and accepted by the College in September, now stands as one of the single most significant advocacy milestones in the College's history and is considered to have the potential to spark sweeping reforms to the way medicine is taught and conducted in hospitals across Australia and New Zealand.

After months of investigation and with significant rates of participation by Surgeons and Trainees, the EAG established beyond doubt that discrimination, bullying and sexual harassment existed in the practice of surgery.

In particular, the research found that:49 per cent of Fellows, Trainees and IMGs report being subjected to discrimination, bullying or sexual harassment;

- 54 per cent of Trainees and 45 per cent of Fellows less than 10 years post-Fellowship report being subjected to bullying;
- 71 per cent of hospitals reported discrimination, bullying or sexual harassment in their hospitals in the last five years, with bullying the most frequently reported issue;
- 39 per cent of Fellows, Trainees and IMGs report bullying, 18 per cent report discrimination, 19 per cent report workplace harassment and 7 per cent sexual harassment;
- The problems exist across all surgical specialties; and
- Senior Surgeons and surgical consultants are reported as the primary source of the problems.

The report reflects the findings of five major independent research streams and highlights gender inequity in surgery as a central issue that must be addressed.

It identifies three core areas for action: culture and leadership; surgical education; and complaints management.

It called for increased transparency and external scrutiny in College processes, making it safe for Surgeons and Trainees to make a complaint without risk to their future careers, to end bystander silence and improve surgical education and training.

"Treating people respectfully and decently should not be negotiable and I was interested in understanding a culture where some thought this was not occurring"

Upon the release of the report, College President Professor David Watters publicly apologised on behalf of all Fellows, Trainees and IMGs to everyone who had suffered discrimination, bullying or sexual harassment by surgeons.

"These behaviours have been too long tolerated and have compromised the personal and professional lives of many in the health workforce," Professor Watters said.

"It is time to bring about meaningful cultural change and address the problems caused by some members of our profession.

"The EAG Report has identified that many of those affected have not felt they could trust the College to complain.

"We must now earn that trust by fairly and effectively addressing these problems."

The EAG was established in March in the wake of media reports of bullying and harassment suffered by Fellows and Trainees.

It was chaired by the Hon Rob Knowles AO, a former Victorian Minister of Health and current Chair of the Royal Children's Hospital in Melbourne. The Deputy Chair was Dr Helen Szoke, CEO of Oxfam and former Victorian Equal Opportunity and Human Rights Commissioner.

Other members included:

- Dr Joanna Flynn AM, Chair of the Medical Board of Australia and Chair of Eastern Health Victoria;
- Mr Ken Lay, APM, former Chief Commissioner of Victoria Police;
- Dame Judith Potter, DNZM, CBE, former Judge of the

High Court of New Zealand;

- Mr Graeme Campbell, General Surgeon and Vice President of the RACS;
- Dr Cathy Ferguson, Otolaryngology Head and Neck Surgeon from New Zealand and Chair of the College's Professional Standards Committee.

In releasing the report, Mr Knowles congratulated the College for having the courage to establish the enquiry and provide the EAG with the resources to do its work.

He said members of the group had been shocked by the stories they had heard and the long-term impact of the behaviour upon victims including depression and suicidal ideation.

"Now that the extent and impact of these issues is clear, there can be no turning back," Mr Knowles said.

"The College must be bold and embrace this opportunity to make lasting positive change.

"There is no room for bystanders and hospitals, employers, governments, health professional and industrial associations and other partners in the health sector must also meet their responsibilities and make a sustained commitment to action.

Rob Knowles presenting the EAG report to Graeme Campbell with Joanna Flynn

"The College has made a serious commitment to understanding the scope of these problems and seeking the best possible advice about how to deal with them.

"We sincerely hope that the work of the EAG has created a tipping point for action – by the College, Specialty Societies, employers, government and other partners in the health care sector – that will increase patient safety by making discrimination, bullying and sexual harassment in the practice of surgery a thing of the past."

The RACS will prepare and publish an Action Plan by the end of November which addresses the issues raised and recommendations made in the EAG Report which is expected to include changes to surgical education including the incorporation of adult learning models and independent complaint investigation mechanisms.

Rob Knowles AO addressing the press

So comprehensive is the EAG Report and the scope of the changes recommended, it is being seen by many within the College as a milestone as significant as the investigation into RACS practices conducted by the Australian Competition and Consumer Commission (ACCC) in the late 1990s.

That investigation found there was a need to increase transparency, procedural fairness, clarity and accountability in the selection and treatment of candidates for surgical training, all of which the College agreed to undertake.

Then, as now, the investigation acknowledged the important role of the College in training and maintaining high standards of patient care.

College President Professor Watters re-iterated that the RACS had a zero tolerance policy on discrimination, bullying and sexual harassment.

He said that the EAG's final report provided 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.

"All Fellows, Trainees and IMGs will need to champion and model the high standards of behaviour we expect of others," he said.

"There is no place for discrimination, bullying or sexual harassment in surgical practice, surgical training or the health sector more broadly."

With Karen Murphy

The final EAG meeting discussed the findings of the last report provided to RACS

HEALING WITH STEEL

Meet Dr Nikki Stamp, Cardiothoracic surgeon

This is an edited version of an article first published on www.steelheels.com.au – an online mentoring platform aimed at increasing the self-confidence of working women. You can find the full article at https://www.steelheels.com.au/dr-nikki-stamp/

Dr Nikki Stamp is one of the nine female cardiothoracic surgeons in the Australia. Nikki, like Steel Heels, is passionate about being a role model for young women, saying, "Women and girls need strong, smart and real role models and deserve to be encouraged in to areas traditionally dominated by men". Nikki posts her observations, experiences and tips on her blog.

A 2012 study of 41 junior doctors, 27 of whom were women, were asked which specialties they would not take up, and why. Thirty nominated surgery, citing the lifestyle associated with surgery (66 per cent), the culture within the surgical work environment (53 per cent), a lack of interest in performing surgical work (36 per cent), and the training requirements associated with surgery (33 per cent). Both sexes had similar reasons for not wanting to choose a surgical career; but additionally, women referred to the male-domination of surgery, and the difficulty and inflexibility of the training program as deterrents.1

Tell me a little about your background – was this your high school dream job?

As an 8 year-old, I wanted to be a heart surgeon and finish the work of Dr Victor Chang, who was pioneering mechanical hearts and transplantation when I was small. In primary school I read anatomy textbooks so often that the teachers and librarians were concerned I was not reading age appropriate fiction. My high school dream job was to be a singer and actor. I never thought I had the aptitude to study and perform well at school so I studied music, English, French, drama. Because I wasn't sure I could do 'difficult' subjects like physics, chemistry or maths, I didn't apply myself as much as I could. My year 10 maths teacher told my parents that I would never be a doctor or a lawyer because I was rubbish at maths. Turned out that was very, very wrong because I've now studied university level maths, chemistry and physics!

"Women and girls need strong, smart and real role models and deserve to be encouraged in to areas traditionally dominated by men."

As I was considering the performing arts, my Dad (a civil engineer) insisted I get a 'real' degree. I considered studying accounting and business but my heart wasn't in it. So he asked me what I would do if I could do anything and I immediately told him I wanted to be a Doctor. I then set out working out how to get into medicine without the 'right' subjects from high school.

How did your career start? Who influenced your decision?

I knew I wanted to be a surgeon pretty early on. I loved anatomy and doing things with my hands. I think I recognised early on that those factors really suited a surgical career.

I chose cardiac surgery after doing a rotation as a junior doctor. I was fortunate enough to work for three surgeons who were inspiring and took an interest in teaching me. I did that rotation by accident, but I loved it so much, I never left. The moment I knew I wanted to do this was when I asked a patient who had just had a lung transplant how he felt. He told me 'You have no idea how good it feels to be able to breathe.' And that resonated with me. It's those inspirational mentors and inspirational patients that made me want to do this job.

Any problems you have encountered (challenges/barriers)…?

Being a surgeon is hard work, regardless of who you are. It has not been an easy pathway at all. But it has definitely been worth it. A number of people said that I could never do this. I wasn't smart enough, I didn't do the right subjects at school, I was a woman, and it's too hard. I have to be honest and say that I have gotten some enjoyment and satisfaction in proving every single one of them wrong!

The recent 4 Corners episode which highlighted bullying in medicine was quite dramatic – what other barriers are there in medicine?

Unfortunately, I think that being a woman in surgery can be tricky. I often get asked if I'm the nurse or device representative and not the surgeon who has performed the surgery. It seems that society still has a very strong perception that surgeons are middle-aged men. Some days, it's frustrating. There are still a number of people who work with me who really don't have much respect for women, especially ones senior to them, but that is their issue, not mine.

Even as medical students, women will notice that they have to work twice as hard to gain respect from other doctors, nurses or patients. It is slowly changing as we have more women doctors but we have a long way to go. The profession has come under intense scrutiny recently for bullying and harassment and the Royal Australasian College of Surgeons (RACS) has taken some positive steps so far to manage this problem. I don't really know any young doctors who haven't seen or experienced bullying which is a real shame. It does make your day absolutely miserable, destroys confidence and careers and could even put patients at risk. Some of the preliminary work for the College suggests that female trainee surgeons are particularly prone to bullying and harassment which is disturbing. I'm pretty happy with how things have been managed so far by RACS and I hope that we as a profession make a positive change in this matter.

Nikki Stamp

Have you ever had a moment of hesitation – the thought "Why am I doing this? Is it really what I love?"

Most definitely. I had some tough times during my training and I came close to quitting at the end of my penultimate year of training. I reflected on why I was feeling that way and I'm glad that I did, because it can be difficult to see light at the end of the tunnel. It would have been terrible if I had made a quick decision based on one bad time.

Who was your role model when you were growing up?

My parents have always been role models for me. They're both determined, hard-working and moral people who taught me that I can achieve great things if I put my mind to it and did the work. My dad certainly raised me to be a feminist. I've also had a number of mentors over the years and I've taken away lots of good points from all of them. Interestingly, most of my mentors have been men. That's surgery for you.

How have your experiences shaped you? What were some of the greatest lessons learnt?

The difficult times have shaped me the most. I worked hard to get better and regain my life and my career. As tough as it was, I'm glad that I had the opportunity to remind myself that I am resilient. It also taught me a huge lesson about the importance of work-life balance and self-care.

What would you do differently in your life knowing earlier what you know now?

I definitely would have paid more attention in maths! Other than that,

even though I didn't take the usual pathway to get where I am, I wouldn't change a thing. It's all shaped me to who I am today.

What are your future plans?

I'm going to head overseas to North America to gain some new skills and see how their hospitals work, especially for heart and lung transplantation. I'll also keep up with medical education by teaching and examining junior surgeons. I love teaching because it keeps me sharp and I really enjoy being able to help someone else learn.

I volunteer with Operation Open Heart. They do overseas trips to developing countries in the Pacific and Africa to perform heart surgery on children and adults. I was in Fiji recently and it was such an amazing, rewarding experience.

What advice would you give for other women considering a career as a surgeon?

Work hard and go for it. It won't be smooth sailing, but if you really love it, it will be its own reward. And keep a toothbrush in your locker.

What do you feel needs to be done in order to see an increase in females pursuing careers in surgery?

It's important to mentor young women into surgery. It's somewhat unchartered territory still and it's lovely to give advice from the lessons we have already learned. It's important for women surgeons to be more visible as mentors, as clinicians and in leadership positions in surgery to say to the younger generation 'I've done it so you can too!'.

STEEL HEELS
• SUPPORTING YOUR SUCCESS •

We also need to address some of the main obstacles for women entering a surgical career which includes looking at ways to offer interrupted and part time training (especially if a family factors into their plans) and by continuing to stamp out bullying and harassment.

What advice would you give to women starting their careers?

Women in professions should be themselves. What you have is what makes you different and an asset. I love this quote from the film Working Girl – "You're the first woman I've seen at one of these things that dresses like a woman, not like a woman thinks a man would dress if he was a woman."

Other than that – I say go for it! Work hard, learn a lot and kick ass.

#GirlsCanDoAnything

References
1. What junior doctors think about choosing a surgical career http://www98.griffith.edu.au/dspace/bitstream/handle/10072/47209/79288_1.pdf?sequence=1

Letters to the Editor

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

How far have we come?

Dear Sir,

In the August edition of Surgical News, in the article on "Women in Surgical Training" the question is asked "how far have we come?"

The answer is - clearly – not far enough!

For the photograph on the front page of the journal, of a young woman in theatre garb, is not of a woman surgeon but of a nurse – one that I routinely work with, in my theatre.

All women surgeons have experienced being mistaken for nurses – to have the college magazine ratify this, is contemptible.

Dr Karen Smith

Orthopaedic Surgeon

Middlemore Hospital

Auckland

New Zealand

I am a Surgeon!

Dear Editors,

I read with interest your letter: "When is a surgeon not a surgeon" by Dr Fred Betros in the September 2015 issue of Surgical News.

I was able to read this letter because I receive this journal, as I am a Fellow of the College of Surgeons (FRACS), as well as being a Fellow of the College of Ophthalmologists (FRANZCO).

I receive very little in return for the money I pay every year – as I have done since 1992 – and to add insult to injury, I now find I am not even acknowledged as a surgeon by the College!

The arrogant old boys club that is this College could do with a good spring clean on Spring St!

This is the kind of attitude that has us almost universally hated, except when people are in dire need of our services.

If I am no longer considered a surgeon, I no longer see the need to pay my annual subscription!

Perhaps it is time for a change of heart – as in opening them to embrace all surgeons – rather than judging some as more or less deserving of the title.

Yours truly,

Anne Malatt

MBBS,MS, FRANZCO, FRACS (for now).

Cold Packs - Is a Climate Change Necessary?

For many years it has been customary to put an ice pack on the site of a minor injury. This may control swelling and hopefully provide some pain relief. Repeated application of ice packs on a developed swelling has been used for some obscure reason.

What is the evidence for and the physio-pathological basis of these practices? Should they be reconsidered and their value reassessed?

We all learnt the characteristics of damage with its inflammatory response: Rubor, Calor. Tumor. Dolor and Functio lassa. We have all seen that the progress of healing requires a good blood supply, to wind back the features of inflammation until normality returns. We all know that poor or no blood supply slows or stops these processes.

So what does the ice pack achieve? By inducing vaso-constriction most of the inflammatory changes may be stopped or nearly so, including the beginning of recovery. What is gained by delaying the onset of swelling immediately after injury for it will develop as soon as a normal blood supply returns to produce a capillary source of fluid and an adequate perfusing pressure? Pain appreciation may be interfered with for the duration of effective cooling by reducing nerve transmission, Local bleeding is usually dealt with by the clotting mechanism before the ice pack effects reach the site. Larger vessel injury may need more than cold for its control.

Perhaps application of an ice pack for a local injury is of no great value, or even counter–productive. Would not gentle warming allow the normal responses to develop without interruption and also provide comfort to the patient? May we not assume that the evolution of the inflammation/healing cycle is not without purpose and that we don't need to be bemused by any aspects of it?

I should be interested in Fellows' views on whether we should begin to encourage a climate change!

B.N.Catchpole, M.D.,F.R.A.C.S.

E.Prof. of Surgery,UWA.

18/10/15

A WINNING PARTNERSHIP

Tour de Cure and the Foundation for Surgery team up to fund cancer research

Ground breaking discoveries and advances in medicine are achieved through years of painstaking endeavor by dedicated scientists and the provision of adequate research funding. To help facilitate pioneering new research, the Foundation for Surgery and philanthropic cycling organization, Tour de Cure, are working in collaboration to raise money to support the Foundation for Surgery Tour de Cure Cancer Research Scholarship.

The Chair of Tour de Cure, Mr Bruno Maurel commended the collaboration "we are very proud of our association with the Foundation for Surgery and our combined efforts to raise much needed funds to support innovative cancer research".

The Foundation for Surgery is also delighted to be associated with Tour de Cure, which is a professionally managed hard-working organization. Since its inception in 2007, it has raised more than $19 million to enable over 200 cancer research, support and prevention projects that have led to 16 cancer breakthroughs.

To raise these funds, Tour de Cure has established a successful calendar of fundraising events. They include its flagship Signature Tour Cycle Ride, country and corporate bike rides including CAN4CANCER and Woolies on Wheels and for the second consecutive year, its acclaimed Tour de Cure Ball. The Foundation for Surgery is grateful to be the recipient of $200,000 of the annual proceeds from the Ball towards building a corpus of $1.5million to support the research scholarship.

In 2015, this scholarship was awarded to Dr Andrew Gogos through the University of Melbourne and the Royal Melbourne Hospital. Dr Gogos' research project is titled "the role of the Hippo-YAP pathway in glioma stem cells". His aim is to find novel therapies for patients with glioma by targeting tumor stem cells.

At this year's glittering Ball, Foundation for Surgery Board member and breast cancer surgeon, Dr Chantel Thornton together with her patient, Ms Shelli Whitehurst were the joint keynote speakers. They received a standing ovation for their speech as guests were visibly moved by a courageous Ms Whitehurst, who just days earlier had been advised that her breast cancer, which had been in remission, had returned.

Dr Thornton said "that is a conversation no surgeon ever wants to have with a 38 year old patient who is going blind from metastatic breast cancer. As a medical profession we are making huge leaps forward in cancer treatment. As a surgeon I would like to say that it's the surgery that cures patients and yes surgery has a place. But for patients like Shelli, surgery

Tour de Cure Snow Ball 2015

takes a back seat and it's the daily medications she takes that keep her alive. These medications are a product of marvellous modern medicines.

They are the drugs developed by incredible scientists, who are the unsung heroes of the cancer world. The drugs they develop have been made possible through generous donations.

Donations to Tour de Cure are invested in quality cancer research, support and prevention projects that will directly affect a patient's health and well-being. They provide funds to the Foundation for Surgery, and as a Foundation Board member, I have seen first-hand the results of research scholarships that Tour de Cure funds, and the Foundation is extremely grateful that we can support young surgeon scientists in their research endeavours".

Ms Whitehurst said "there is no cure for my cancer. It will kill me. I'm fighting it but there is not a moment when Chantel and her team aren't fighting harder. She has surrounded me with the best people in the industry and they fight hard so that I can stand here today, and while we may not be thankful for the cancer, we can be grateful for the doctors, the nurses, the researchers and the treatments that give me the chance to fight this.

If you are thinking about donating funds to Tour de Cure or the Foundation for Surgery please know that some of that money might go into a breakthrough drug that could keep me and others who suffer from cancer, alive".

To help increase funds to support cancer research, Mr Maurel said "I invite everyone, if you want to make a difference to your personal life, to society as a whole, please contact us. You don't have to be a cyclist. Our support crews are just as important. We would welcome you into our Tour de Cure family and I can guarantee you one thing, it will be hard work; however, it will be life-changing and a personally rewarding journey".

Chantel Thornton and Shelli Whitehurst

Surgical oncologist, Dr Guy Hingston accepted the invitation and has registered to take part in Tour de Cure's Signature Bike Ride in 2016. He is encouraging other surgeons and health care professionals to join him.

To register for Tour de Cure's 10th annual Signature Tour and make a significant contribution to funding quality cancer research please visit their website: www.tourdecure.com.au

To make a tax deductible donation to the Foundation for Surgery Tour de Cure Cancer Research Scholarship please fill in the form located on the back of this issue.

TOUR de Cure
RIDING TO CURE CANCER

HEARING OUT

Clinical Professor Harvey Coates AO was this year made an inaugural recipient of the College's Indigenous Health Medal in honour of four decades of tireless efforts to reduce ear disease and hearing loss suffered by Indigenous children.

Professor Coates is a Paediatric Otolaryngologist and Professor at the University of Western Australia and a past Chairman of the Aboriginal sub-committee of the Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS).

He was appointed an Officer of the Order of Australia in 2005 for his work and research in paediatric ENT and ear disease in Aboriginal children.

During the course of his career he has also been honoured with the ASOHNS Medal for his distinguished contribution to the art and science of Otolaryngology, Head and Neck Surgery (2012), the Deafness Council of WA Dr Harry Blackmore Award (2004), the Australian Lions Foundation William R Tresise Fellow Award for Humanitarian Services (2002) and the Fiona Stanley Medal (2001).

In 2000, his research and advocacy led to the creation of the first Newborn Hearing Screening Program in the southern hemisphere, a program which began in WA and is now provided as standard paediatric care across Australia.

A senior ENT Surgeon at Princess Margaret Hospital for Children in Perth, Professor Coates has a particular interest in the treatment of Chronic Suppurative Otitis Media (CSOM) and each year spends six to eight weeks in remote Indigenous communities and urban outreach clinics for Indigenous children.

Initially attracted to a career as a Plastic Surgeon, Professor Coates instead chose to specialise in Otolaryngology while in America completing a four-year Post Graduate Scholarship at the Mayo Clinic in Minnesota.

"Serendipitously, an ENT resident had been dismissed just prior to my having lunch with some ENT surgeons and the transfer was made and is one that I have never regretted," Professor Coates said.

"The Otolaryngology, Heath and Neck Surgery Department was dynamic and the opportunities to write and present papers and conduct research were tremendous and sowed the seeds to continue research when I returned to Australia.

"The opportunity and privilege of looking after children who were suffering from hearing loss, airway obstruction or repeated infections by relatively straight-forward surgery – with often significant improvements in a short time and the consequent educational and social benefits – was exhilarating."

Upon his return to Perth in 1977, Professor Coates was drawn into the care of Indigenous children after research indicated that CSOM was affecting up to 70 per cent of children in some communities, even at a time when the World Health Organisation described a four per cent CSOM rate as a massive health problem.

Professor Coates began research into CSOM in Indigenous Communities in 1981 when he helped initiate an intensive program of ear suction in Indigenous children with CSOM in Roebourne in the Pilbara.

That work reduced admission to hospital for the disease by over 90 per cent.

Since then, Professor Coates has spearheaded a number of epidemiological studies designed to determine the prevalence of CSOM in Indigenous children with the support of the Telethon Institute for Child Health and Professor Fiona Stanley.

He has also conducted research into the role of bacterial biofilms in children with chronic draining ears, the presence and role of invasive pneumococci in the mucosa of children with glue ear and the biological benefits of inserting ventilation tubes to aerate the middle ear in patients with CSOM.

Over the course of his career, he has published more than 70 scientific papers and written a number of surgical text book chapters.

In recent years, he and Professor Gunesh Rajan have led the Australian arm of a research project being done in collaboration with Profession Shin-Ichi Kanemaru from Japan into the use of bio-engineered fibroblastic growth factor (bFGF) to rebuild the tympanic membrane in CSOM patients.

Professor Coates said that more than 70 adults and children have now had tissue-engineered myringoplasties in Perth with the aim of introducing the program to a number of rural centres.

"The results so far show better graft takes in adults compared with children but studies examining various scaffolds are continuing as we search for the optimal scaffold with bFGF," he said.

David Watters, Harvey Coates AO and Kelvin Kong

"The next step in the research will to conduct longer-term studies comparing tissue-engineered myringoplasty with traditional myringoplasty."

Professor Coates said that he was proud of the research conducted by the Otitis Media research team at the Princess Margaret Hospital for Children, particularly their finding of the three bacterial preservation strategies present in Otitis Media.

He said he was still passionate about Indigenous ear health and would continue to lobby for the creation of a Chair in Paediatric Otolaryngology at the University of WA and the provision of a multi-specialty surgical bus for remote Western Australia.

Since becoming an ENT surgeon, Professor Coates has treated thousands of Indigenous children both in Perth and in their own communities, working to restore hearing and limit the spiral of social dislocation and educational disadvantage caused by the hearing loss associated with CSOM.

Still he travels to Indigenous communities around seven times a year, with four visits to the Kimberley and three to the Great Southern Region.

He said that treating the children of WA remained his greatest driver and greatest reward and said he did not lose heart at the remaining gap in the health and welfare indices between Indigenous Australians and the broader community.

"I enjoy these trips very much not only as a break from routine because it is enormously rewarding to visit remote communities and make a difference to the lives of children," he said.

"While we do our best to limit the damage done by ear disease in these communities, we will always have Otitis Media in communities where there is overcrowding, poor nutrition and hygiene and a lack of access to clean water and medical care.

"Being an optimist I am aware that it is sometime two steps forward and one backward when working in Indigenous health.

"Vaccines and a general improvement in the social determinants of health will be the main factors that will drive a reduction of Otitis in all populations in the future but especially in Indigenous children.

"I have always found it a great privilege to help manage their medical problems and over the years, these children and their families have taught me resilience, patience, perseverance and persistence."

Professor Coates said he was honoured to have received the Indigenous Health Medal as recognition of the work done by researchers, audiologists, nurses and Aboriginal Health Workers from the Princess Margaret Hospital for Children.

He also praised the College for the work done by the Indigenous Health Committee.

"It was humbling and a great honour to share this award with my colleagues who work with me in Aboriginal ear health," he said.

"I also commend the College for the support given to, and the work done by the Indigenous Health Committee.

"Under the dynamic leadership of Associate Professor Kelvin Kong, I believe that great strides in all aspects of Aboriginal and Torres Strait Islander health programs relevant to the College have been made – especially in reconciliation."

With Karen Murphy

BRAIN WORK

RACS Foundation scholarship recipient Dr Andrew Gogos is continuing research started by a previous RACS scholar with some exciting new discoveries

Melbourne Neurosurgery Trainee Dr Andrew Gogos is conducting PhD research into the properties and behaviours of glioma stem cells as part of a research project to find novel therapies to treat lower grade glioma and Glioblastoma multiforme (GBM), the most common and lethal primary brain tumour.

Dr Gogos is undertaking his research at the Department of Surgery at the Royal Melbourne Hospital and the Walter and Eliza Hall Institute, through the University of Melbourne.

He has received support from the College for his research through the Paul Mackay Bolton Scholarship for Cancer Research (2013) and the RACS Foundation/Tour de Cure Scholarship (2014).

Dr Gogos said that although most GBM occur de novo, approximately 20 per cent develop from lower grade tumours which progress. GBM remains universally fatal with a median survival of around 14 months after diagnosis.

He said a possible explanation for the difficulty in treating glioma was the existence of a small population of cells with stem-like properties.

Using patient-donated tumours, Dr Gogos and colleagues selectively culture glioma stem cells in order to study the molecular signalling pathways that control their behaviour.

"The Hippo pathway is involved in embryogenesis and organ size control and is active in adult stem cells, but not in differentiated tissue, including most cells of the adult brain," he said.

"That pathway, and its major effector Yes-associated protein (YAP), have been noted to be dysregulated in multiple cancer types. Work conducted within the Morokoff laboratory by Dr Katherine Holland, a previous RACS scholar, and others demonstrated that the pathway is abnormally active in GBM. Hippo pathway dysregulation may be part of how cancer returns.

"In normal physiology, YAP signals cells to divide and proliferate. Once an organ reaches maturity signalling is switched off but it appears to be dysregulated in some cancers, including brain cancer.

"We are hoping that by finding a way to target glioma stems cells and the YAP signalling pathways that we may provide long awaited therapeutic advances for patients with glioma.

"We have already demonstrated that YAP protein and mRNA expression is higher in GBM than lower grade tumours and that high YAP expression was associated with much worse overall survival for patients with Grade II and III glioma."

Dr Gogos said a distinctive feature of his research was the ability to study and grow GBM in the laboratory using tumours donated by patients treated at the Royal Melbourne Hospital.

"We are one of the few research units conducting this type of work," he said.

"That is a great advantage because it allows us to work on the best possible model of the disease."

As part of his PhD, Dr Gogos is also developing a knockout model to further explore the function of YAP in glioma stem cells.

Using cutting-edge technology, and a new method called CRISPR/Cas9, Dr Gogos is appropriating a defence mechanism found in bacteria an archea to cause mutations in specific regions of the genome. Tumour cells are transfected with a fluorescently labelled Cas9 and specially designed guide that is specific to the YAP gene.

Once activated, the Cas9 causes a double stranded DNA break within the YAP gene.

"This is very exciting science and quite new," Dr Gogos said.

"The double strand break is repaired with errors, creating inactivating mutations within the YAP gene. It shows us what can be achieved by targeting the YAP protein with drugs.

"We already know that YAP is highly expressed in brain tumours but not in normal brain cells so it makes it a great target to investigate.

"We are hoping that if we can knock it out, the tumour cells will stop proliferating.

"The CRISPR method was first described only two years ago so it is very new and has never been used in brain tumour research or on this specific gene.

Dr Gogos said the research team was also now analysing existing drugs to see which might have the potential to inhibit YAP while also testing novel drug therapies in the laboratory.

He said that while it was too early to put a time frame on the development of new GBM therapies, researchers were confident that technologies like CRISPR/Cas9 could add to the understanding of disease progression and recurrence.

"Glioblastoma is such a terrible disease and it's hard to witness great strides being made in the treatment of other cancers when the prognosis for patients with GBM remains dismal," he said.

"Harvey Cushing, who is considered the father of neurosurgery, said nearly 100 years ago that GBM was not a surgical disease, meaning that surgeons could not cure it.

"Unfortunately, this remains true today which is why so many of us who treat these patients are so passionate about finding new therapies.

"Hopefully, the work we are now engaged in might open new avenues of treatment for GBM and other gliomas and while my work is laboratory based, it is a vital first step in advancing our understanding of the genetic drivers and cellular pathways of the disease. "

Dr Gogos is conducting his research under the supervision of Professor Tony Burgess, from the Walter and Eliza Hall Institute, neurosurgeons Mr Andrew Morokoff and Associate Professor Kate Drummond, and scientist Dr Hongjian Zhu.

A SET 4 Neurosurgery Trainee, he maintains a light clinical roster at the Royal Melbourne Hospital, attends theatre to collect tumour specimens and attends regular neuro-oncology meetings.

His work has also received support through a Brain Foundation Research Grant, a Royal Melbourne Hospital Victor Hurley Medical Research Grant and an NHMRC Postgraduate Scholarship.

A member of the College's Section of Academic Surgery, Dr Gogos said he was grateful for the support given by the RACS, particularly in the early years of his research career.

"This support from the RACS is crucial if Trainees are to take time away from their clinical work to conduct research," he said.

"It was a difficult decision to make, given the time required to become a Neurosurgical Fellow, but my goal is to become a surgeon-scientist.

"The work I have been doing provides great intellectual stimulation in a quickly evolving area. Understanding how these tumour stem cells work and how that knowledge could directly help very sick patients is of greatest interest to me."

The Paul Mackay Bolton Scholarship for Cancer Research was established by Harry Bolton in memory of his late son, Paul, a distinguished surgeon, teacher and researcher who died from colorectal cancer in 1978 aged 39. The scholarship is intended to support applicants who wish to take time away from clinical positions to undertake a full-time research project into the prevention, causes, effects, treatment and/or care of cancer.

The Foundation for Surgery Tour de Cure Cancer Research Scholarship was established in conjunction with the College to support Fellows, Trainees and International Medical Graduates wishing to undertake a cancer research project.

The Tour de Cure raises funds for cancer research through an annual bike ride. Next year, the ride will stretch from Brisbane to Sydney and Dr Gogos intends to participate as both a rider and medical support officer.

With Karen Murphy

CAREER HIGHLIGHTS

- **2015** NHMRC Postgraduate Scholarship
- **2014** Foundation for Surgery/Tour de cure Scholarship
- **2013** Neurological Society of Australia Research Scholarship
- **2013** Paul Mackay Bolton Scholarship for Cancer Research
- **2013** University of Melbourne Melville Hughes Scholarship

Foundation for Surgery
Passion. Skill. Legacy.

TEACHING THE TEACHERS

Your guide to faculty development programming and how it all fits together

SPENCER BEASLEY
Chair, Professional Development
STEPHEN TOBIN
Dean, Education

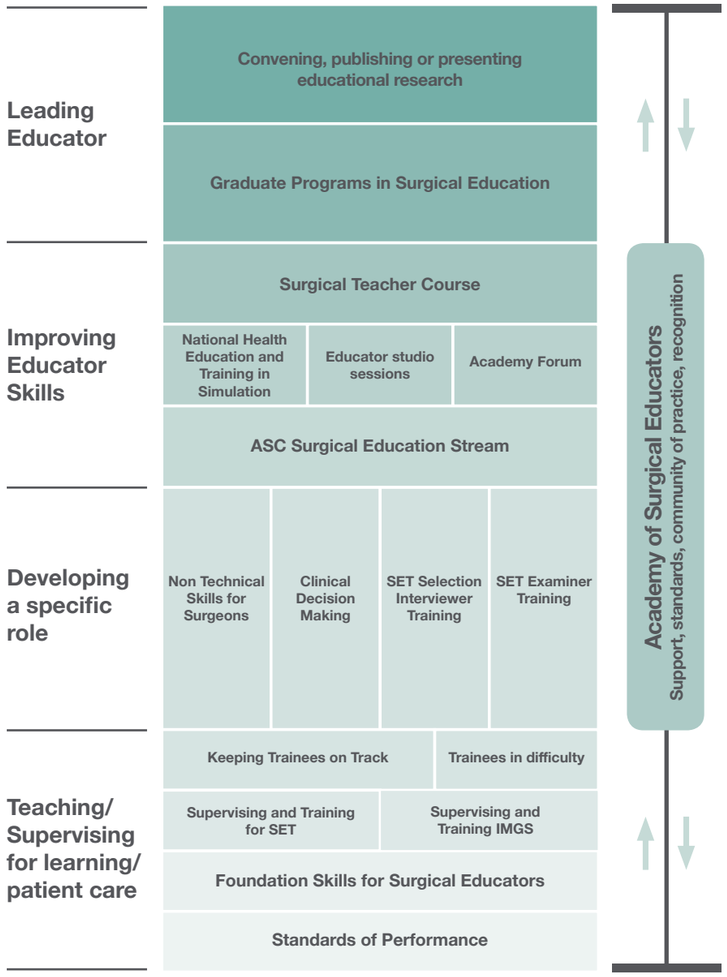
As a professional, the intrinsic responsibility to undertake professional development includes improving one's teaching skills. To neglect the pursuit of excellence in surgical training puts at risk the quality of patient care today and tomorrow. Indeed, it may even put at risk the profession as a whole.

Surgeons who are involved in teaching encounter many barriers when it comes to the delivery of effective teaching. These include balancing heavy clinical loads, paucity of time, isolation, keeping up to date, managing the assessment and reporting processes, legislative requirements (such as safe working hours) and heightened expectations of the patient, trainees, regulators, colleges and community. Despite this, we are no longer in an environment that accepts a substandard training program for our current and future specialists.

Effective faculty development programs use experiential learning, and provide quality feedback, facilitate interactions between peers and are based on sound educational principles. Programs are delivered using the most effective teaching modalities.

RACS delivers one of the most comprehensive and diverse faculty development programs of all the specialist medical colleges in Australasia. Every year, our College delivers about 50 educational courses and resources specifically tailored to support the competency of Scholarship and Teaching. Most are delivered free of charge or for a nominal confirmation of registration fee across Australia and New Zealand. Educational opportunities include upskilling in educational theory, educational design, facilitation technique, workplace based assessment processes, interview and exam implementation technique, feedback, managing underperformance, teaching skills, conducting difficult conversations, standards, hot topics in medical education, critical evaluation of literature and scholarship.

Surgical educators also have an opportunity to contribute to the community of practice that is the Academy of Surgical Educators. This is a group of surgical educators that has come together to discuss and explore issues in surgical education and provides a resource for those involved in surgical teaching. Professional development programming is delivered in a range of modalities including webinars, podcasts, blogs, workshops, residential workshops, online learning programs, blended learning, seminars and the Surgical Education stream at the Annual Scientific Congress.



The hierarchy of the various programs and the levels of complexity that they contain are graphically represented in Figure 1. It is not essential that the programming is experienced in this order but an understanding of the framework may help Fellows to plan and consolidate their learning. For many, it will help progress their surgical educator expertise to the next level of competence.

In order to access the educational programming available refer to the RACS Professional Development Department on +61 3 9249 1106, pdactivities@surgeons.org or register online at http://www.surgeons.org/for-health-professionals/register-courses-events/professional-development/

With the pressures of revalidation, professionalism, society and the pursuit of excellence in training, it is only a matter of time before training in education is mandated for all surgical educators including designated specialty supervisors and clinical surgeons supervising registrars. College members are well placed to transition into this new environment, assisted by easy access to widely available free and high quality professional development programming.

SURGICAL
EDUCATION

I agree to continue learning and teaching for the benefit of my patients, my Trainees and my community.
RACS pledge

As scholars and teachers, surgeons demonstrate a lifelong commitment to reflective learning and the creation, dissemination, application and translation of medical knowledge.
Surgical Competence and Performance Guide, RACS

Good medical practice involves seeking to develop the skills, attitudes and practices of an effective teacher, whenever you are involved in teaching,
Good Medical Practice: A Code of Conduct for Doctors in Australia, Medical Board of Australia

Teaching and the passing on of knowledge is a professional responsibility. When you are involved in teaching you should demonstrate the attitudes, awareness, knowledge, skills and practices of a competent teacher.
Good Medical Practice Code Medical Council of New Zealand

THE GRUMPIES

The inhalants, inheritants, insufficients and incomp-batants

BY **DR BB G-LOVED**

Many of my patients are elderly, some are grumpy, grouching with sharp cynicism towards the world at large and 'those that want to have it all now', those Gen X's and Y-ers who have grown up expecting to be given it all on a plate – or else! The Grumpies I refer to are usually baby boomers, who grew up protesting against war, the bomb, working conditions, racism, and the world economy, then emerged from their 20's to cut or coiffure their hair, dropped the pot, rolled up their sleeves, and became fat cats with pensions to purr for. Now, with greying white hair, or even lack of hair, their head-dress above sagging, once proud shoulders, the pot is back but as a protruding belly matured over decades, that belies distant memories of the fling through their 20's with slim flat abdos or muscular six-packs.

So why are Grand-py and Mam-py so grumpy? This is what I was asked recently by Dr A N Oyd who was suffering from what some call grandparent-itis. They were visiting and [over]staying for weeks. Can you prescribe something to de-pepper them? I am not fond of being asked to provide behaviour controlling drugs for active toddlers, and now I was being asked to do something similar for grumpy grandparents!

I explained that Grumpies come in four main types: the inhalants, inherents, the insufficients and the incomp-batants.

In their home setting old men and women are usually no more grumpy than the tired toddlers they love to hand back after a day of child minding, and probably less so. Their temper tantrums are certainly much more controlled and calculated, though some are ingrained. Toddlers get tired, so do the elderly. But is their tiredness normal? That depends. To recognise that one is tired requires insight, never present in the toddler, and often not in the Grumpies.

I like to ask each Grumpie about how they and their significant other sleeps. Although Nana naps are common and even pleasurable, tiredness as a result of heavy [and loud] snoring and sleep apnoea represent nocturnal hypoxia. Add some obesity, allergic rhinitis or circadian disturbance and you are all the more likely to have the inhalant whose tongue spends the night across their pharynx or whose nasal passages are reacting to some congesting allergen.

Approaching the grumpies holistically, their world view [positive or negative] needs to be considered – are they grateful or frustrated with the cards that life has dealt them. Some people can never be happy or not for long; they have an inner sense of being unjustly treated no matter how many blessings they might be able to count. People hold different perspectives on the same experiences or events. Even the two persons in a couple may not agree whether their glass is half full or half empty. The inherents behave like they've always behaved –irritated, negative, bitter and recalcitrant. They are probably incurable.

Next comes the insufficients - there are many possible insufficiencies or deficiencies. I assess their clinical status, including current medications. Significant (not mild) hypertension, hyperlipidaemia or hyperglycaemia may obtund their quality of life and temporarily affect their mood. Are they being treated with sedatives or anti-depressants? I consider their cognitive state, at least with a mini-mental; though even the mini-mental can make one grumpy. The early stages of dementia can be very frustrating for both the affected and the partner in the couple. Grumpiness can be a sign of failing to cope, not remembering, or fear.

I have a series of tiredness or insufficiency screening investigations. These include Hb and Iron studies, Thyrotropin, B12, calcium [too many hypercalcaemic patients suffer undiagnosed for years], magnesium, UEC [esp to exclude hypokalaemia in those on diuretics]. Vitamin D levels should be 70ng/L or more and sunshine without sunburn generally improves mood.

Then one needs to address the relationship. Some couples can co-exist during their decades of work and family responsibilities, but later annoy each other intensely by standing on each others toes at home, one following the other through the activities of daily living. In retirement Grand-py and Mam-py have no space to escape from each other, space and freedom they needed to survive each other earlier in life. They might be grumpy because they make each other so. These are the incomp-batants. Prognosis variable.

All said and done their grumpiness might related to being away from home, living with the irritations and quirkiness of the Oyds, and having to suck up their style and pace. But if you'll excuse me I'm having a bad day, too many patients are irritating .... So who's next to see Dr Grumpy?

THE BENEFITS OF RURAL TRAINING

A perspective from two rural surgeons

The Rural Clinical School in Western Australia was just in its infancy in 2004 but the reports had been promising and I applied and was accepted to fifth year medical school in Geraldton, five hours north of Perth on the coast. At this stage I was keen on Emergency Medicine and spent most evenings across the year in the Emergency Department treating acute cases as well as latching on to cases to follow into theatre and the rest of the hospital. I didn't spend a great deal of time with the surgeons but certainly enjoyed my year there and became a little enticed by rural practice, though perhaps more as a visiting specialist than as a resident.

I worked in Alice Springs in Emergency in 2007 as a resident and loved both the practice and the town. Keen to head back bush I took my first training job in Broome, working with Andrew Thompson, a truly excellent and talented general surgeon. I saw what a practice and lifestyle in the country could be like and started to get keen. I saw how an independent practitioner could be a true general specialist and treat a variety of conditions with skill and aplomb. I had a year off training after this to see the world and when I returned I was sent to the other end of Western Australia to Albany, and that's when the hooks really started to dig in. I felt very at home in the town, the region and the practice and since then I've been tailoring my training to get back there and offer as much as I can. I've been to Darwin for my last term as a registrar after FRACS exams and then taken a two year post in Geelong as a general Fellow which is shortly coming to an end.

In terms of what attracts me to rural practice, there are a variety of factors. There is no doubt the patients are incredibly grateful, helpful and generous. The staff generally have a 'can do' attitude and given it's usually a small group, teamwork is a must. The variety of work is second to none, you can be doing true bread and butter general surgery, you can add in some sub-speciality tastes, and you can get handed emergency neurosurgery on a very scary looking platter. The sense of community in a small town is a very warm feeling to experience, especially as you become someone who will generally have operated on a relative of everyone in the place.

There are downsides and challenges too. The first time you realise you are the only surgeon for 400km and 50,000 people, is when the first mistake you make results in a serious complication. These situations are difficult to deal with but add somewhat to the challenge.

I've been very lucky with my training and I think my experience has been a good example of planning and recruitment. Since working in Albany as a registrar and putting up my hand to say I wanted to head back there I have been supported incredibly well by the surgical team there, the State Board in General Surgery, the rest of the rural group in the college and at the Provincial Surgeons meetings.

Laurence Webber

Certainly workforce is an issue in rural areas. We need to continue to attract surgeons to the regions, to appropriately train and support them, and to encourage contact with the tertiary centres.

When I commence full time work in Albany I will be looking to stay involved with a tertiary centre in Perth at which I can do some visits to keep upskilling, as well as maintain professional contacts for advice and opinions.

For those interested in rural practice I'd recommend getting as much exposure and experience as you can, keeping an idea of what skills would be required where you intend to work, and what the workforce is looking like. The rural section of the College is working on mapping the rural workforce and improving succession planning and this is well underway.

Laurence Webber, FRACS

Carolyn Vasey flying to remote communities for surgical outreach clinics in the NT (Darwin 2012)

For me, training in rural and regional areas in Australia was a 'no brainer' – you were first in line for operative experience, you got warmly welcomed by the surgeons and their families, and it provided a breadth of experience that metropolitan jobs couldn't parallel. My medical husband and I travelled to many places we would never have otherwise lived, and often spent weekends exploring the area instead of racing back to the city. Cycling between wineries and local cheese factories, skiing the snowfields in winter, or rock climbing the Grampians sounds more like a holiday wish list than what you did on the weekend while learning to be a surgeon. As a junior registrar, training in regional Australia was fantastic.

There comes a time however, when the surgical world expects you to go back to the big smoke, form a study group and prepare for the Fellowship exam. It is a commonly held view that this is best done in a major metropolitan teaching hospital. My view was different. Darwin Hospital provided the perfect breadth of cases to cover most things the Fellowship exam could throw at me, and while there was no other SET 4 Trainee in the Territory at the time, the internet allows amazing communications with colleagues! Laurie Webber and I formed a Skype study group that meant there was no traffic to contend with after work.

Having got through the exam while working regionally, it was time to think about post Fellowship training opportunities. As I trained in regional areas and went to meetings like the Provincial Surgeons Annual Scientific Conference, my surgical mentors encouraged me to think about bringing a unique set of skills to an area where they didn't currently exist, or needed to be replaced. My sub-specialist interest area was colorectal, and despite perception that post Fellowship training programs prefer candidates that wish to work in large, sub-specialised teaching hospitals, my experiences thus far have been different.

Despite an intention to work regionally, many trainees find they spend much of their training years in city hospitals, especially true for those sub-specialties that may not offer regional training posts. Before long, you find yourself settled, having put down roots and seemingly forming attachments that can't seem to reconcile a move away. Moreover, it is easy to become subconsciously indoctrinated with the ideology that excellent surgical outcomes and professional standards are only achievable at quaternary hospitals.

My advice to those considering working in regional Australasia is go for it – dream large, and prepare for a future where there will be more and more dynamic, well-trained Australasian colleagues to support you professionally in these areas. In saying that, don't be concerned that moving to work in a regional area is a one-way street. Although, most find they wouldn't go back for quids.

Carolyn Vasey, FRACS

The 51st Provincial Surgeons of Australia Annual Scientific Conference is on in Lismore from October 29-31.

The theme this year is *Rural Surgery - How We Do it Well,* and the scientific program aims to explore complex surgical procedures, emergencies, and dilemmas in a rural and or remote setting, where metropolitan facilities are not always immediately accessible.

Topics and sessions will be dedicated to all areas of Rural Surgery including General, Vascular, ENT, Orthopaedic and Neurosurgery.

You can still register at:

psa.generalsurgeons.com.au/register-now.

THE HUCKSTEP NAIL

One of the many lifetime achievements of the late Professor Ron Huckstep

DREW DIXON
Chair, RACS Medico-Legal Section

The Huckstep titanium locking compression nail was developed while Professor Ron Huckstep was at the University of Kampala in Uganda. Prior to his transfer to Australia, Professor Huckstep had vast experience in the African landscape and had the world's largest series on Typhoid Fever and had written extensively on Polio. He designed this intramedullary nail for strong, stable fixation of femoral fractures particularly when long sections of bone were traumatised and when follow up was difficult. It was a unique design and the features of intramedullary nailing used multiple screws as one would when applying a long plate, and this distributed the stabilisation along the length of the nail, combined with the great material strength and mechanical efficiency of intramedullary fixation. Not only did it provide significant mechanical and practical advances over the forms of fixation of comminuted shaft fractures, particularly in osteoporotic bones, it also provided rigid stabilisation in the presence of established non-union and the fixation of pathological fractures. His design also allowed fixation through the top of the nail into the femoral neck for difficult sub-trochanteric fractures where the calcar was deficient.

Working with Professor Huckstep at Prince Of Wales Hospital in 1976 I was able to assist him with several applications of the Huckstep nail and used it later in private practice to do difficult non-unions and femoral shortenings. When attending the Combined English speaking Orthopaedic Association's meeting in 1976, hosted by the BOA in London, and listening to John Charnley's dissertation on the development of his prosthesis in the Festival Hall London, it occurred to me that if Sir John could have his prosthesis named after him, then the Kampala nail should be named after it's designing surgeon as the "Huckstep Nail". It was proposed to Professor Huckstep but he modestly declined, but at the same meeting we had the opportunity of talking with the manufacturing representatives and they too felt that Kampala was politically incorrect (reflecting on what had been happening in the dictatorship in Uganda) and that it could also be confused with that other K nail, the Kuntscher Nail. Reluctantly the Professor allowed the nail to be renamed and it was then marketed as the Huckstep nail.

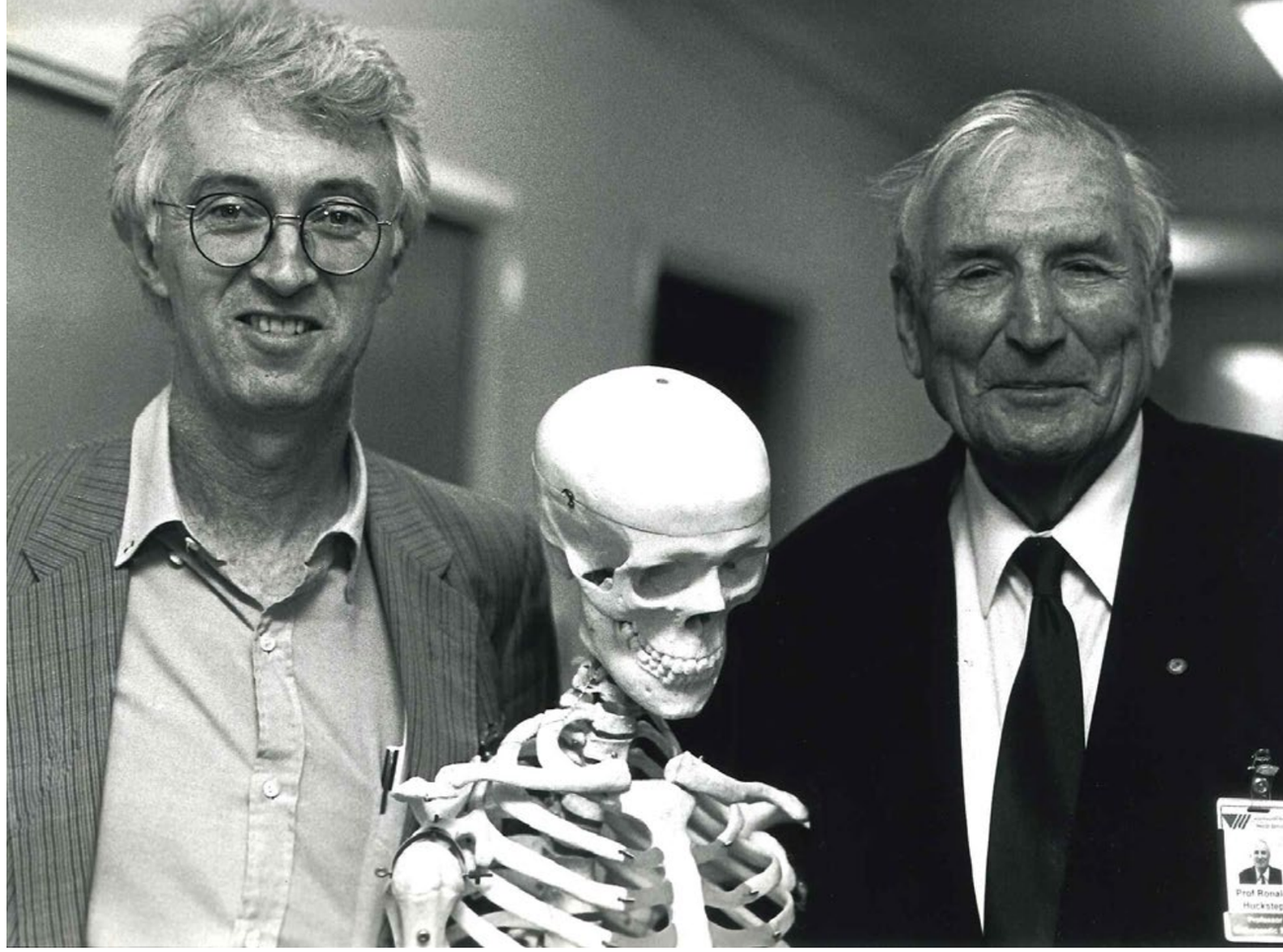
It became used in a number of applications such a comminuted fractures, pathological fractures, non-unions, fractures in Paget's disease, peri-implant fractures (which occur around a plate) and it has been used for arthrodesis of the knee as salvage for infected total knee replacement.

The Huckstep Nail is an intramedullary compression nail of solid titanium (an alpha beta titanium alloy with a mix of 6% aluminium and 4% vanadium). It is very bio compatible and because of its modular of elasticity it is just about half of those of stainless steel and chrome cobalt. It is also 1.1 to 1.8 times stronger than the average femoral bone. It's square cross-section makes medullary blood supply better to help bone healing. Large diameters are not required its common diameter being 10.5, 11.5 and 12.5mm with transverse holes at 15mm intervals where 4.5mm fine screw threads can be inserted and there are four oblique holes at an angle of 130 degrees proximally to enable insertion of lag screws at the neck of the femur in proximal femoral fractures.

When it was developed for severely comminuted fractures it provided rigid immobilisation for the entire femoral shaft fracture allowing the patient to do early weight bearing. The insertion of the cross fixation screws is facilitated by an external fixateur which is reasonably jigged and enables location of the screws in the transverse holes with radiological screening necessary only to position screws in the femoral head and neck. The diameter is relatively small making extensive intramedullary reaming, which may devascularise the bone, unnecessary. It does require the use of solid straight reamers and the nail is inserted by a gentle twisting motion to reduce the risk of impaction rather than hammering. The nail does not require a press fit, this enables compression to be applied at the fracture site and allows for later removal of screws to allow dynamization. It allows rigid fixation of pathological fractures and allows for cement augmentation to inject cement into the intramedullary cavity through screw holes after the nail is inserted.

It allows for bone grafting with difficult non unions and if compression is required the distal locking screws are inserted first then the fracture ends are compressed with the compression device screwed on to the top of the nail and bone grafts from the reaming can be placed around the fracture site.

The Huckstep nail deserves it place in traumatic and orthopaedic surgery and reflects the wide experience of it's developing Orthopaedic Surgeon and was developed and used first in 1967 and has found widespread applications throughout the global orthopaedic world.



E Sherry and RL Huckstep at a workshop in 1998

Professor Ronald Lawrie Huckstep

CMG, FTSE, Hon MA, MD, FRACS, FRCS, FAOrthA.

1926-2015

Orthopaedic Surgeon, Educator and Humanitarian.

The End of the Heroic Age of Surgery.

The facts:

- 1926 -Born in China to missionary parents. Early medical education in a Japanese Concentration camp, later at Cambridge.
- 1952 - in Kenya, wrote his MD thesis on typhoid.
- 1952-1960 - trained at Royal National Orthopaedic and St. Bartholomew's Hospitals London.
- 1960-1971 - Professor of Orthopaedic Surgery, Uganda.
- 1971-1994 - Foundation Professor, The University of New South Wales.
- 2007 - established WorldOrtho.

Ron's work and life was of the Heroic Age, an Age when men and women, dedicated themselves to the surgical care of patients way beyond what is or could be expected or dreamt of in these days of Key Performance Indicators and "stake-holder" committee medicine.

They worked tiredlessly, built huge departments, stretched the boundaries of surgery (invented the Huckstep Locking Nail for complex trauma, the Huckstep Hip, circlage clip, Huckstep ceramic knee, cannulated hip screws and spacers for tumour work, the skelecast for fractures, appliances for the developing World incl a special lightweight wheelchair in Uganda in 1967), wrote textbooks, (the imitable "the Simple Guide to Trauma", 5 editions and the Simple Guide to Orthopaedics),developed the surgical treatment of bone tumours which meant that patients could be pain free with dignity, and on the net (WorldOrtho-1997; recently Facebook).

Ron operated on humans, birds, elephants with the same zeal. The vets applauded when he said "the human trials are now complete, we can now safely use this device in animals".

Ron's work guided surgeons around the world and will continue to do so

- EG

LOANS FOR TRAVELLING FELLOWS

The Royal Australasian College of Surgeons provides interest free loans to Fellows who plan to undertake approved research and/or training outside Australia and New Zealand.

To be eligible to apply for a loan, an applicant must:

- Be a Fellow of the College
- Be in good financial standing
- Demonstrate financial need
- Be assessed as undertaking appropriate research and/or training
- Not have an application pending, nor have received, a RACS Scholarship within the last 5 years
- Not receive more than one loan in the past five years

Applications can be submitted at anytime with assessment being undertaken upon receipt.

Loans will not exceed AU$20,000 each and will be subject to the availability of funding. These loans are interest free for a period of up to two years.

Application forms can be found on the College website under College Resources

For further information please contact:

Megan Sproule

T: +61 3 9249 1220

E: megan.sproule@surgeons.org

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

IPOD DEAFNESS

Why are they listening to music instead of the sweet sounds of the world around them?

BY **PROFESSOR GRUMPY**

There is one thing that really annoys me and it is deafness. Now before you all jump on me and say how dare I make fun of or criticise someone with a disability, let me explain. I am sure that in time (well, as long as it takes you to read this article) you will agree.

Yesterday I was painting our front fence. Mrs Curmudgeon has been at me for months to do this, but who wants to paint in misty rain. Yesterday however was different – sunny and dry. What is more, my favourite football team has been eliminated from contention (quite unfairly as it happens – that umpire was so biased). We live on a road where a lot of walkers come by with their dogs and being a congenial chap I greet them all with an enthusiastic "Good morning". No replies! Again and again. The dogs look at me and wag their tails an extra beat or two but the humans – not a blink!

The only explanation I could come up with is that there was an epidemic of deafness in our area. Maybe it was just rudeness but it seemed to be mainly younger people who were walking their dogs, not grumpy old codgers. Then the penny dropped – they all had little buds in their ears and were listening to music. Well some might have been music but the ones that had less well fitted buds the sound escaping was not music.

Why would you walk in the Hills on a nice day with birds in the trees chorusing and other dogs barking to greet your dog and not want to hear this sound of joy? If it was Brahms or Mozart, maybe - but not if it was The Stones (or worse).

The epidemic is growing – indeed it is nearly a pandemic. People isolated from other people in their own little electronic cosmos. You see them in trains and buses, in the street and elevators, in shops and offices - quite oblivious to their surroundings. I must try an experiment and see if the ear-bud brigade respond if I say something rude to them – I suspect not.

There is a serious side to this deafness, namely that people are not aware of their surroundings when it matters. They may not hear the car coming or the shout on the golf course of "Fore". University of Maryland researchers found 116 reports of death or injury of pedestrians who were using a listening device between 2004 and 2011– the so called "i-podestrian" deaths. Of all the accidents in the study, 55 percent involved trains and 89 percent occurred in urban areas. In almost a third of the incidents, it was claimed a warning was sounded prior to the accident.

IN MEMORIAM

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

Sarah Kruger
New Zealand Fellow
Roderick D. MacDonald
NSW Fellow
Keith H. Langford
USA Fellow
Bruce Filmer
USA Fellow
Donald C McKinnon
South Australian Fellow
Platon Black
Queensland Fellow (2014)
John Talbott Dunn
Victorian Fellow (2014)
Robert James McInerney
NSW Fellow (2014)
Redmond B.G. Cook
NSW Fellow (2014)
Glen John Coorey
NSW Fellow (2014)
John Joseph Connors
ACT Fellow (2009)

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

Informing the College

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

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

CASE NOTE REVIEW

Headache plus cerebral aneurysm requires urgent treatment

GUY MADDERN
Chair, ANZASM

Case summary:

A young patient with a past history of hypertension and hypercholesterolaemia presented to a general practitioner (GP) with unusually severe headaches for a fortnight and with unspecified visual disturbance. The patient was referred to an ophthalmologist, who arranged magnetic resonance imaging (MRI) of the brain. The MRI demonstrated a large cerebral aneurysm (15–25 mm) with mural thrombus. At a follow-up appointment with the GP, a neurology outpatient clinic was arranged for the patient to be seen within a week. The patient then returned home, apparently fell asleep and became unrousable. An ambulance was called and on attendance recorded an initial Glasgow Coma Scale score of 5 with symmetric and reactive pupils.

The ambulance officers intubated the patient and issued a trauma call before transportation to a hospital emergency department (ED). By this time, which was late evening, the left pupil was several millimetres larger than the right. Computed tomography (CT) of the brain revealed a diffuse subarachnoid haemorrhage with intraventricular blood and early hydrocephalus. The neurosurgery registrar successfully inserted an external ventricular drain in ED and the patient was transferred to ICU where it was noted that the pupils were not reacting to light. The external ventricular drain became blocked by a blood clot and could not be flushed with recombinant tissue plasminogen activator, as suggested by the neurosurgery Consultant. A repeat CT of the brain demonstrated further bleeding and more 'mass effect'. The neurosurgery team advised that the patient was to be palliated. When the intracranial pressures rose to the extreme range, no action was taken by ICU.

Clinical lessons:

The quality of the hospital documentation was quite adequate. It would be of interest to read documentation from the GP or the ophthalmologist.

The main concern in this case is why a person with severe headaches, visual disturbance and MRI evidence of a large aneurysm containing mural thrombus was not sent to hospital for urgent admission and management, rather than told to attend an outpatient clinic several days later. Failure to refer the patient to hospital immediately almost certainly cost the patient their life and hence qualifies as an adverse event.

There were other issues, such as the time involved in preparing the patient for transport to hospital, time before obtaining a CT and time before inserting an external ventricular drain, each of which might not amount to much when considered separately but collectively amounted to a delay that could have made the difference between life and death. In a young patient with no significant comorbidity, it could also be debated that urgent clipping or endovascular occlusion of the aneurysm on the night of presentation might have led to a good neurological outcome, as it was clear from the notes that the ultimate deterioration was the result of a re-bleed.

This was perhaps potentiated by the use of tissue plasminogen activator in the ventricular drain. Many neurosurgery units have a policy of not operating on aneurysms after hours, arguing that the operating conditions are suboptimal and do not favour the patient, but it can equally be argued that some patients will die because of such policies.

COMPETENCY AND REVALIDATION

Recent developments

MICHAEL GORTON
Principal, Russell Kennedy

Registration with the Medical Board of Australia (MBA) requires a commitment to continuing medical education. The CME program of the College is sufficient to meet the MBA requirements.

The College's CPD program requires that each Fellow submit a return to the College either through the online process, or by an annual "Recertification Data Form". Confirmation of participation in required CPD is also subject to a College random audit of approximately 7% of Fellows. CPD includes a commitment to surgical audit, as well as continuing knowledge development.

During 2015 the MBA also started a discussion with the profession regarding extension of assessment of competency to include the possibility of revalidation. It was noted that the UK has an extensive revalidation program, to confirm and check the competency of doctors on a regular basis. Discussion of the success or otherwise of the UK program has been part of the public dialogue.

To aid the discussion, the MBA commissioned research in relation to revalidation systems around the world. That research is now publicly available and has assisted the MBA to develop three models for competency checks as set out below. The MBA is also establishing its own expert advisory group, which will review the research and the three options, to recommend one or more of the models for revalidation requirements in Australia.

The MBA is using the discussion in relation to competency checks and revalidation as part of its commitment to public safety, and managing patient safety risk. Part of that commitment requires that the MBA is assured that medical practitioners are up to date in relation to skills, knowledge and experience.

The three models being explored and considered are:

Model A

A low level model of revalidation operating online. Surgeons would be required to provide an online report in relation to evidence that they have taken part in mandatory self-directed continuing medical education and multi-source feedback. There would be a sign-off by a manager or supervisor, or equivalent professional body, each year. There may be limited opportunities for "reflective and collaborative learning". The CME would essentially be self-directed.

Model B

This enhances Model A. It still requires online reporting and self-directed learning, although some CME may be directed and required to be conducted online. It may include bi-annual appraisals for particular doctor groups, assessed by risk (for example doctors over 60 years of age). A formal appraisal would be undertaken for all doctors every 5 years.

Model C

This is a more extensive model that more actively confirms a doctor's fitness to practise. It would include self-directed, as well as directed interactive CME. There would be several requirements for different types of learning and appraisals and multiple source feedback. It would operate every 5 years and would require doctors to engage in annual appraisals with reflections on their own practice ability and fitness. It may include a review of patient complaints and learning from patient experience.

None of the models have yet been endorsed or formally considered by the MBA. The research is open for consultation and submissions may be taken by the Expert Advisory Group, as well as the MBA.

Given the moves in other jurisdictions to make CME more targeted, it is likely that some enhancement of CME and revalidation may be expected in the future.

RACS hosts the Victorian showcase of Educational Research in the Health Professions!

STEPHEN TOBIN
Dean, Education

The College hosted the 2015 Victorian Showcase of Educational Research in the Health Professions on 12 August, with 77 people in attendance. The Showcase is a collaborative effort between HealthPEER (Monash University), EXCITE (University of Melbourne) and the Graduate Programs in Surgical Education (University of Melbourne and Royal Australasian College of Surgeons). For Academy members, it is an opportunity to learn about the work of students enrolled in graduate programs in health professions education; while for educators and students; it provides a platform for sharing ideas, resources and tips for educational practice, evaluation and research.

The Showcase hosted a number of speakers whose presentations ranged from women in surgical training, home birth simulations, and using Twitter to promote peer learning. For the first half of the Showcase, three streams of parallel presentations occurred involving the following speakers:

Dr Kirstie MacGill	Mr Leo Donnan
Dr Arunaz Kumar	A/Prof Jonathan Knott
Dr Felicity Crombie	A/Prof Martin Richardson
A/Prof Bruce Waxman	Mr Peter Subramaniam
Dr Jasmina Kevric	Dr Rosemarie Shea
A/Prof Stephen Tobin	Dr Rhea Liang
Dr Victor Lee	Mr Raymond Yap
Dr Margreet Stegeman	Dr Heather Crook
Dr Angaj Ghosh	Dr Kinh Luan (Louis) Ngo

Once the parallel sessions concluded, attendees gathered in the Hughes Room for the keynote address by Dr John Paige. His keynote focused on surgical teamwork and care, specifically the efforts undertaken at the Louisiana State University Health Sciences Center, New Orleans, Louisiana, USA. Dr Paige stressed the importance of needing to incorporate simulation-based, inter-professional team training into all levels of surgical education because of the constantly evolving nature of the field and advances in technology, the ultimate aim being improved patient care. He reinforced the importance for a practising surgeon to act more like a collaborative team coach than a "captain of the ship" when it comes to leading in the surgical operating room. Simulation-based training (SBT) that encourages inter-professional teamwork helps to develop that collaborative attitude in surgeons. His presentation provided an interesting perspective into how SBT can be used to promote behaviour as well as skills.

Following the keynote, Professor Julian Smith and Ms Alana Gilbee presented a plenary on "If I had known then what I know now". Prof Smith, Head of the Department of Cardiothoracic Surgery at Monash Health gave a perspective as a recently graduated Masters of Surgical Education student. Prof Smith's thesis was titled 'Threshold concepts and troublesome knowledge in cardiothoracic surgeons – challenges in the commencement of consultant practice'. Ms Gilbee completed her Masters of Health Professional Education in 2014 and her thesis was titled 'Error and open disclosure - experiences and perceptions of consumer advisors'. Both presenters gave an insight into the trials and tribulations of completing a research degree whilst continuing with everyday life.

Two awards were presented to surgeons for their outstanding research. The Debra Nestel Health Professions Education Research Prize was given to Dr Kirstie MacGill, a plastic and reconstructive surgeon at the Royal Children's Hospital, Melbourne. The Nestel Prize acknowledges high-quality research in the field, and promotes sustainable improvements in education in the health professions. The inaugural John Collins Educational Research Development Prize was awarded to Dr Rhea Liang, a general surgeon from Robina Hospital, Queensland. The College congratulates both winners for their fantastic research and contribution to health professions education research.

Highlights from the evaluation include:

- The range of presentations, supported discussions and "research idea" sessions.
- The opportunity to meet other health professionals with an interest in education.
- The high quality speakers and a broad range of topics.

The University of Melbourne's Excellence in Clinical Teaching program (EXCITE) focuses on clinical education at the graduate level and offers courses specifically designed for the aspiring clinical-educator, including Graduate Certificate in Clinical Teaching, Graduate Diploma in Clinical Education, and a Master of Clinical Education degree.

Monash University's HealthPEER Graduate Course program is facilitated by an interprofessional team within the Faculty of Medicine, Nursing and Health Sciences. Similar to EXCITE, HealthPEER offers graduate courses geared towards the clinical-educator, including a Graduate Certificate in Health Professional Education, Graduate Certificate in Clinical Simulation, and a Masters of Health Professional Education.

The College offers Graduate Programs in Surgical Education through the University of Melbourne's Department of Surgery, Austin Hospital and the Medical School Medical Education Unit. This program recognises the unique challenges that characterise the clinical setting including the advanced technologies as well as professional role of the surgeon. All of these themes are increasingly important in surgery and surgical training, while providing surgeons with formal skills in teaching and educational scholarship.

With the high quality of speakers and presentations and the impressive turnout, this year's Victorian Showcase was a resounding success. The bar has been set high and we can only hope for an even greater level of research and participation for next year's showcase. Thank you to those who contributed to the development of the showcase participated in the events and attended, especially to Professor Debra Nestel as the 2015 convenor. We look forward to seeing you next year.

Showcase for the budding research students with a passion for medical education

BRUCE WAXMAN
Clinical Director, Skills and Education Centre

It was indeed a great opportunity for health care professions from a variety of backgrounds, to present their research at all stages of completion to an audience containing some internationally recognized experts in medical education. The atmosphere was relaxed, the flow of ideas was wide ranging and the benefits for the presenters unparalleled.

It was a joy for me to witness this all happening at RACS headquarters, which has been the bastion of surgical education in the modern era for 80 years, now providing facilities through the Skills and Education Centre, ideal for such an event with a variety of venues for the presentations.

Although all sessions were of value, particularly for the novice, and some not so novice presenters, the highlight for me was the plenary session featuring our own Julian Smith and Alana Gilbee, a graduate nurse, who talked us through the trials and tribulations of her thesis. Both spoke on the topic 'If I had known then what I know now'. Julian, now an expert on Threshold Concepts, had just successfully completed his Masters in Surgical Education and with other fellows; Stephen Tobin, Adrian Anthony, Caroline Ong, Vijayaragavan Muralidharan and James Tan, graduated in August at a Ceremony at Wilson Hall at The University of Melbourne. In demonstrating much humility, he admitted that despite his position as Professor of Surgery at Monash University, he was able to adjust to the life of a student again, under the 'masterly' tuition of Debra Nestel.

The 'Showcase' formula is clearly extremely successful as a show piece for burgeoning research students in medical education, which could be reproduced in a similar context for Surgical Education and Training (SET) Trainees wishing to showcase their research projects. Something for the Specialty Boards and Board of Surgical Education and Training (BSET) to ponder.

CALL FOR SURGICAL CAREER STORIES

Have you had an interesting career path through Fellowship that has led you to where you are today? If so, we would like to hear from you!

JULIAN SMITH
Chair, Professional Development and Standards Board
MARIANNE VONAU
Chair, Resources Committee

The Navigating the Stages of a Surgeons' Career project is concerned with the development of a surgical career framework. This framework will highlight the key challenges that are pertinent to surgeons at various stages throughout their career trajectory. Each challenge will be explored by a surgeon's story, be mapped to the RACS Competency Framework, and the various supportive resources and programming that will help others experiencing similar challenges to navigate them. This latter section will involve inclusion of the pre-existing programs run by the RACS Professional Development Department and identification of external programs and resources. The framework will be progressively staged from when a surgeon enters practice as a Younger Fellow, through to the mid-career stage, and into the Senior Surgeon phase.

The framework will be portrayed as an interactive website and will also have a printed version and interactive online booklet, in order to cater for multiple learning styles. The surgical career stories will be told via audio and video interviews, or written vignettes. They can be identified or anonymous, depending on the sensitivity of the story.

Each story will be categorised according to the stage of the surgeon's career and the main challenges explored. The themes are:

- Careers in surgical practise – explores intrinsically and extrinsically motivated career choices, managing workload, transitioning to independence, managing a practice, returning to work and changing scope of practice.
- Lifelong learning – explores developing clinical and operative competencies, learning from adverse events, recognising limitations, self-appraisal, multi-source feedback and professional development.
- Professional standards – explores developing resilience, responding to and regulating inappropriate behaviours, role modelling, ethical practice and managing external influences.
- Personal and professional integration – explores balancing financial pressures, relationships with family, friends and peers, managing stressors, mental and physical health, hobbies and personal and professional identity.

The identification of diverse and interesting career stories is paramount to the relevance and significance of the resource. This will allow other Fellows to relate to the narratives in order to identify the various opportunities and challenges at each stage, appreciate the many roles that a surgeon adopts throughout their career and identify the educational resources available to them.

If you have a career story that you would like to share, please contact the Professional Development team on: Alicia.Mew@surgeons.org or +61 3 9249 1106.

THE SINKING OF THE SS MARQUETTE

The decision by the British authorities to embark had disastrous consequences

DAVID WATTERS
AND ELIZABETH MILFORD

In April 1915 the need for a New Zealand staffed hospital in Egypt was recognised and the 1NZSH was formed under Lt Col McGavin, with surgeons Acland and Wylie, an ophthalmologist and a dental officer. 1 NZSH sailed from Wellington on 20th May aboard the NZHS Maheno and was based at Port Said. McGavin had at his disposal one house, formerly a school, 25 square tents and some huts, but some of his equipment was shipped in error to Bombay. The hospital was increased from 200 to 500 beds in August and functioned until October when it was to be transferred to Salonika.

Although the hospital ship, *Grantilly Castle* was sailing from Egypt to Thessaloniki on the same day, the 1NZSH was allocated to the British troopship, *SS Marquette* for the journey to Salonika.

...it [1NZSH] embarked at Alexandria on 19th October on the s.s.Marquette, with 8 officers, 28 N.Z.A.N.S. nurses, 9 N.C.O.'s., 77 O.R., total 122, in company with the 29th D.A.C., comprising 500 officers and men, 500 mules, and a quantity of ammunition. [1]

This decision by the British authorities had disastrous consequences – in addition to the 1NZSH, the *Marquette* had ammunition on board and carried vehicles and animals from the Royal Field Artillery. She was therefore, a legitimate target for attack and was torpedoed in the Aegean Sea south of Salonika on 23 October 1915 by the German U-Boat *SM U-35*. As nurse, Edith Popplewell recorded, the ship sank very quickly:

Monument to the Marquette, Chicago

The Marquette sank as if she had been a tiny cockle shell, and so quietly. There was no explosion…

The sinking of the *Marquette* resulted in the deaths of 167 people including 18 from the NZMC and 10 nurses. The 8 officers aboard, including surgeons like Hugh Acland who spent 7 hours in the water, were amongst the 104 NZMC rescued from the sea.

We clung to our boat seemingly for an endless period, suffering intensely from the increasing exhaustion and only holding on by sheer strength of will. Then a hospital ship steamed up and picked up the survivors. [2]

A few days later a naval court of enquiry determined that no-one was at fault but the New Zealand government incensed by the loss of medical staff and nurses, requested that only hospitals ships be used for future transfers of medical staff.

Surgeons from the 1NZSH who were on the *SS Marquette* (all survived)

Donald McGavin C/O

Hugh Acland

Joseph Frazer-Hurst

John Leahy

Richard Martin

(Sir) Donald Johnstone MCGAVIN

Lt Col (1876-1960) LRCP 1899 MB, London 1900, MD London 1901, FRCS 1904, FRACS 1927

EARLY LIFE

Donald McGavin was born in Rochester, schooled in Birmingham and trained at the London, graduating (with the gold medal) in 1900. He studied for a time in Heidelberg, then served in the South African War, first as a civilian and then with RAMC in Natal. He then came to New Zealand, long enough to practise briefly in Hawkes Bay and marry in Wellington. He returned to London gaining the English Fellowship in 1904, before returning to settle in Wellington. There he became active as surgeon-captain in the local Volunteers, transferring in 1906 to the NZ Field Hospital.

GALLIPOLI

At the outbreak of war in 1914 he became PMO of the Wellington military district and in May 1915 he was appointed to command 1 NZSH, first at Port Said receiving casualties from Gallipoli, and later at Salonika.

Photo: Alexander Turnbull Library

In October, he survived the sinking of the transport *Marquette* in the Gulf of Salonika.

AFTER GALLIPOLI

When the NZ Division went to France in 1916, 1 NZSH was set up at Amiens and McGavin became ADMS; in this role he organised the Division's medical facilities for the Somme battles. He was on hand for the gala performance; in the final week of the war, when NZ troops captured Le Quesnoy by the old-fashioned method of escalade. He was mentioned in despatches four times and was awarded a DSO in 1917 for his contribution to the care of the wounded at Messines. This was followed by a CMG in 1918.

PROFESSIONAL LIFE AFTER WW1

In 1919 he returned to NZ to become DGMS, being knighted in 1921; and had risen to the rank of Major-General by his retirement in 1924. He then resumed what was left of his surgical practice and, with it, an appointment to Wellington Hospital.

He was one of six NZ founders of the College of Surgeons of Australasia which met in Dunedin in 1927, one of three on the *Marquette*. He had been chairman of NZ council of BMA; but had resigned in 1915 to go overseas, though he was again in office 1928-30. He was chairman of the board of the Dominion newspaper for ten years; and perhaps because of these various commitments he served only one year as president of the Wellington Club: 1932-33.

McGavin served as medical representative on the Council of Defence before the Second War, and throughout the war itself was on the medical advisory committee to the Minister of Defence.

Wyn Beasley

(Sir) Hugh Thomas Dyke ACLAND

Lt Col (1874-1956), MB Ch Otago, LRCP 1898, FRCS 1901, FRACS (f)

EARLY LIFE

Hugh Thomas Dyke Acland was born in Christchurch in 1874, the son of a pioneer Canterbury landowner, Hon. JBA Acland MLC, and his wife Emily, the daughter of Christchurch's first bishop, Most Rev Dr HJC Harper.

At Christ's College he was a prefect and in the First XV; he then had a year at Otago University before heading for London; as a student at St Thomas's Hospital he won the Cheselden Medal in surgery. At the outbreak of war in South Africa, he served as a civil surgeon attached to the RAMC and, back in London in 1901 he became a houseman in the obstetric unit at St Thomas's, and gained the FRCS. Returning to New Zealand in 1903, newly married to Evelyn Ovens (the obstetric ward sister), he was appointed as an honorary surgeon to Christchurch Hospital, the first 'pure' surgeon in the city.

GALLIPOLI

In 1913 he joined the New Zealand Medical Corps and at the outbreak of war, he again volunteered. He was appointed, as a major, to 1 NZSH, set up at Port Said in May 1915 to receive Gallipoli casualties.

AFTER GALLIPOLI

In October 1915 the unit moved to Salonika in the *Marquette* which was torpedoed in the Gulf of Salonika; 18 perished including 10 nurses, but Acland was rescued after seven hours in the water. After some months the 1 NZSH returned to Egypt, then moved to France in June 1916 to deal with casualties from the Somme battles.

Acland then commanded the surgical division of 1 NZGH at Brockenhurst,

was promoted Lt Colonel as consulting surgeon to 1 NZEF, and later, became president of a standing medical board at 2 GH at Walton-on-Thames.

PROFESSIONAL LIFE AFTER WW1

For a couple of years after his return to New Zealand in 1919 he was in charge of the military section of Christchurch Hospital. In 1921 he served on a commission looking into hospital funding and, in 1926, he became a member of the hospital board.

He was knighted in 1933, became a city councillor in 1936 – topping the poll – and served for five years, by which time he was ADMS of the Southern District and the recognised adviser on surgical matters to the DGMS in Wellington. He held the post until 1948. He had been chairman of the Peel Forest Board, administering conservation aspects of the station his father had helped establish a century before.

Wyn Beasley

References:

i Carberry, AD, *The New Zealand Medical Services in the Great War 1914-1918*, (Auckland, 1924), 121

ii Excerpt from a 'Nurse's Narrative', *Malborough Express*, 24 November 1915

NEWS FROM DARWIN - WHERE EVERYTHING IS DIFFERENT

RACS Tristate ASM (NT, WA, & SA.) Held 7th -8th August 2015, Darwin

PADDY BADE
NT/WA/SA Convenor, 2015

RACS Tristate ASM (NT, WA, & SA.) Held 7th -8th August 2015, Darwin

Even the agenda was different:

The Theme of the conference was "Extended Scope of Practice" (Generalism) and its role alongside Sub-Speciality Surgery. Over the two days, much wisdom was imparted about surgical governance, models of care and access to care in Regional Australia

The conference opened with clear presentations on surgical administration by active surgeons. Graeme Campbell, RACS Vice President, gave his account of college advocacy and changing work culture.

Phil Carson provided insights from Council, and Tom Bowles who gave an entertaining assessment of what life is like as a Regional Chair in WA.

Highlights: There was a multidisciplinary flavour, this included inspiring presentations from:

- Simon Quilty, a physician who has set up a solo specialist practice a Katherine Hospital NT.
- Joseph Carpini a psychologist from WA, who gave a stimulating talk on communication in the Operating Theatre auditing team performance.
- Vanitha Devi and Richard Bradbury two surgical fellows presented the diversity of general surgery performed at Darwin and their mastery of it.

The Registrar presentations were all of a high standard, and it was great to see young registrars involved, and presenting their research to the fellowship. Congratulations in particular to Tara Luck, for her winning presentation on 'Emergency neurosurgery in Darwin.'

Tara Luck

The audience was active, and engaged in spirited discussion throughout the two days. There was a lively and highly entertaining debate; "Does Quality in Surgery Require High Volume?" After much deliberation the audience 'clap-o-meter' awarded the points to the 'no team.'

Overall a total of 50 surgeons and eight sponsors attended the weekend; unfortunately the preconference surgical education course was poorly attended.

There was a great social programme, and the ASM coincided with the Darwin Festival for delegates to enjoy in their free time.

Thank you to the organising Committee, Stephanie Weidlich, Lesley Stewart, Angela D' Castro, Stephanie Gillies, and Gayle Bradbrook

(Left to right): Nick Vrodos, David Fletcher, Michael Levitt, Graeme Campbell, Phil Carson, Tom Bowles

GLOBAL HEALTH SYMPOSIUM

Specialist Colleges come together to advance Universal Access to Safe, Affordable Surgical and Anaesthetic Care when needed, in the Asia Pacific

PHILLIP CARSON
Chair, External Affairs

On 26 October 2015, the Royal Australasian College of Surgeons and Lancet Commission on Global Surgery will convene a public Global Health Symposium to address the challenges and barriers to improving health systems and surgical services in many low and middle income countries.

Safe surgery and anaesthesia are vital to effectively treat much of the global burden of non-communicable diseases and injuries and contribute to the provision of safe child-birth where complications arise. Yet an estimated 5 billion of the world's population are unable to access safe surgery when they need it, and only 6% of the 313 million procedures performed annually are done in the world's poorest countries.

The evidence base for emergency and essential surgical care being necessary for any health system is sound. The Global Initiative for Emergency and Essential Surgical Care has succeeded in translating it into policy with the help of many countries, together with Colleges, Societies and NGOs representing surgeons and anaesthetists.

In 2015, the Millennium Development Goals, which never mentioned surgery, will be replaced by the Sustainable Development Goals. The health goal, Universal Health Coverage by 2030, includes surgery and the reporting of surgical indicators – a big win for all those people needing essential, safe surgery.

A WHO World Health Assembly Resolution on strengthening emergency and essential surgical care was passed by 194 member nations in May 2015. This resolution was critical because Ministers of Health are guided by the recommendations of the WHO when implementing healthcare decisions for their country. But it will require significant and sustained political commitment and substantial investment of resources by individual countries, to put policy into practice and improve surgical care at the country and regional level.

In late 2013 the Lancet launched a Commission into Global Surgery with the goal of promoting Universal Access to safe, affordable surgical and anaesthesia care when needed, where access encompasses safety, affordability, timeliness and capacity to deliver. The College is collaborating with the Lancet Commission to advance this agenda.

The Symposium Program will focus on four key issues outlined in the recent Lancet Commission on Global Surgery report as being critical to achieving universal access to safe surgery and anaesthesia by 2030: Strengthening health systems, Solving workforce issues, Sustainable financing of health care systems and Ensuring sufficient quality and safety.

The discussions at the Symposium will inform an Asia Pacific Leaders' Forum at the College on 27 October. The Forum will be attended by representatives from specialist colleges in the Asia Pacific including the Australian and New Zealand College of Anaesthetists, Australian Society of Anaesthetists, Royal Australian and New Zealand College of Obstetrics and Gynaecology, Royal Australasian College of Physicians, Pacific Islands Surgeons Association and Singapore College of Surgeons and a group of key decision-makers from throughout the region. This Forum will be tasked with developing a roadmap for professional colleges in the Asia Pacific, in promoting universal access to safe surgery, to 2030.

Registration for the public Symposium on Monday 26 October is open to health practitioners, public health specialists, trainees and medical students and the general public. Please refer to **www.surgeons.org** for details or contact:

stephanie.korin@surgeons.org to register.

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

QUAD BIKES

Quad bike injuries and fatalities on the rise

RICHARD LEWANDOWSKI
Queensland Fellow

In August this year, the Queensland Deputy State Coroner John Lock handed down findings in relation to the deaths of nine people involved in quad bike accidents. The deaths occurred between March 2012 and January 2014, and sadly, three were children.

It may not seem like a big figure, but tractors, quad bikes and farming equipment are the leading causes of deaths on Australian farms. The investigation was the most extensive ever conducted into quad bike issues by a Coroner in Australia and New Zealand, and took nearly two years to complete. There were three weeks of hearings, 34 witnesses called to provide oral evidence, and 30 different agencies and organisations consulted.

The inquest began because the Deputy State Coroner had been monitoring the large number of quad bike related deaths over the last few years. There was a lot of debate about what needed to be done. While many stakeholders seemed to agree about some things, the disagreement over other issues appeared to have halted reform. The inquest was designed to bring the issues to a head, so a clear path forward could be established.

Contrary to their common name, all-terrain vehicles (ATVs) are not suitable for use in all terrains. Despite having four wheels, quad bikes have a high centre of gravity and a narrow wheelbase, making them unstable. Most injuries and deaths involve the bike rolling onto the rider and can occur at low speeds.

Yet quad bikes are a remarkably useful machine on farms. This is evidenced by a steady increase in sales over the past decade, with the Federal Chamber of Automotive Industries reporting a 34% increase to a total of 4,509 units in the first quarter of 2011 compared to the previous year. They now represent around one fifth of total motorcycle sales in Australia.

Possibly because they are primarily used as off-road vehicles, they are not subject to the same safety requirements as other vehicles, yet they are just as dangerous.

Trauma surgeons have known for some time that the number of serious injuries and fatalities has been rising in line with increasing sales figures. Fourteen people have died in accidents involving quad bikes on Australian farms already this year, and data from the Australian Trauma Registry (ATR) shows that major injuries from quad bikes have also been rising, from 26 in 2010 to 51 in 2012.

An Australia-wide study by the Centre for Accident Research & Road Safety – Queensland, shows that around a quarter of all quad bike-related recreational fatalities between 2004 and 2014 were children, while ATR data reflect a similar pattern in the 111 major injuries which occurred from 2010-2012, with more than a quarter of the riders being under 25 years of age.

Why should children be exposed to death or serious injury because they are allowed access to off road adult-sized vehicles without the same precautions used in the on-road environment? Allowing children to ride adult quad bikes is a breach of manufacturer directions for use, and all available strategies to prohibit this should be considered.

"Trauma surgeons have known for some time that the number of serious injuries and fatalities has been rising in line with increasing sales figures"

Quad bike manufacturers have a history of resisting design modifications or other measures proposed by safety experts. But improvements in the engineering and design features delivered through the Australasian New Car Assessment Program (ANCAP) rating for cars are undeniable.

An equivalent program for quad bikes would allow customers to choose the safest machines available, and would deliver similar improvements, save lives, and reduce injury.

The recommendations from the Queensland inquest were extremely positive, because they laid out a clear road map which the Queensland Government, Safe Work Australia and the quad bike industry can use to improve the safety of Queenslanders when using these vehicles. In summary, the Deputy Coroner recommended:

- An improved and standardised quad bike and side by side vehicle nationally accredited training package.
- Legislation to mandate the completion of the nationally accredited training through a certification or licensing scheme.
- Investigation of limited standard training for casual users, for example, in quad bike tourism operations operating in a controlled environment.
- Subsidised training for those in remote areas to decrease participation barriers.
- Introduction of an Australia Standard for quad bike specific helmets, using the New Zealand standard as a guide, with a move towards mandatory use.
- Mandatory use of motorcycle helmets by all competitive recreational riders and road users.
- Legislation to prohibit the unsafe use of quad bikes by children.
- Legislation to prohibit carriage of passengers on quad bikes other than those specifically designed to carry an operator and passenger.
- Development of an Australian standard for crush protection devices, research to obtain 'real world' feedback regarding their effectiveness and guidance about what to do in the event of a roll over with a crush protection device.
- An Australian Standard for the design, manufacture, import and supply of quad bikes and side by side vehicles to Australia.
- Consideration of whether a different safety standard is required for workplace and on-road quad bikes.
- Development of a quad bike and side by side vehicle star rating program.
- A standardised investigation template for all quad bike and side by side vehicle related fatalities, to supplement existing reporting to the Coroner.
- Improved investigator training to cover specific issues arising in quad bike and side by side fatalities.
- Consultation with all other State and Territory Police Services in an effort to encourage implementation of similar initiatives, so that a national approach is taken.
- An ongoing public awareness campaign about how to avoid serious injury and death on quad bikes.

The NSW Deputy State Coroner is now conducting a similar inquest, to which RACS provided a submission. NSW Fellows John Crozier and Danny Cass provided evidence at one of the hearings in July 24. RACS will continue to advocate strongly for an Australasian New Quad Bike Assessment Program, all available strategies that will prohibit children under the age of 16 from riding adult-sized quad bikes, and the necessity of mandatory quad bike handling training for all new owners.

To view a video about quad bike safety research, log on to the WorkCover NSW YouTube channel at: www.youtube.com/user/workcovernsw.

CPD VERIFICATION

Verifying your CPD isn't as arduous as you think

CATHY FERGUSON
Chair, Professional Standards

With 2015 coming to an end, if you are participating in the RACS CPD program you will soon receive a reminder to complete your CPD before 28 February 2016. For some this will include notification that you have been selected to verify your participation for the 2015 year.

Quick Facts

- Each year 7% of Fellows participating in the RACS CPD program are selected to verify.
- For the 2014 year, 99% of Fellows selected were able to verify their CPD activity
- Fellows who successfully verify are exempt from selection again for at least 3 years
- From 2015 the College will be populating Fellow's CPD records for attendance at RACS or RACS approved CME activities.

Verifying your CPD isn't as arduous as you think. Whatever your situation, the CPD team at the College are here to assist you to get through the process as swiftly as possible and can go through the requirements with you at a time that suits your availability. We appreciate that Fellows practice across a variety of settings, and so we have put together some case studies to assist you if you are asked to verify next year.

Dr A

Dr A writes to the College after receiving a CPD verification reminder to say she is retired and only writes scripts and referrals.

Even though she is only writing scripts and referrals, Dr A still has a CPD requirement. The CPD practice type that is most appropriate for Dr Acorn's situation is 'Other Practice Type (research, administration, academic, teaching, assisting etc)'. This practice type requires 30 hours of CPD per annum and Fellows can claim participation in a variety of activities including journal reading, peer review of reports, presentation at surgical/medical meetings, teaching, examining and volunteer work. To verify her CPD Dr A provided a list of the journals she reads (up to 20 hours/points per annum) and a letter confirming her volunteer services (up to 20 hours/points per annum).

Dr B

Dr B writes to the College to ask for an extension to returning his CPD verification, noting that he has a number of competing priorities as the Head of Surgery at a large metropolitan hospital. While he is participating in more than enough CPD to satisfy the requirements, he is struggling with getting the documents together.

While attending the RACS ASC, Dr B spent a few minutes at the RACS booth to run through a CPD tutorial and was able to see that a number of activities he had undertaken through RACS had already been verified on his behalf (teaching on a recent RACS EMST course, acting as an examiner in May and attending a KTOT course). He was also able to confirm his journal reading which finalised his requirement in Performance Review and/or Maintenance of Knowledge and Skills. To finalise the remainder of his CPD (Surgical Audit and Clinical Governance), Dr B was advised to ask his hospital to provide a letter confirming his participation in surgical audit and attendance at more than 10 hours of hospital meetings (i.e. M&M).

Dr C

Dr C works exclusively in private practice. While able to verify his attendance at a variety of activities including skills courses and a Masters degree, he calls the College to discuss his concerns about verifying the requirements for Surgical Audit and Clinical Governance.

Mr Raji is advised that there are a number of options available to him to complete his Surgical Audit including participation in a society audit or by asking a peer to review a total or selected audit of practice. If these options are not available, he can also ask the College to assist in seeking a review. Dr C is also concerned that a lack of a formal peer review process at his private hospital limits his ability to participate in clinical governance activities. He is assured that there are a number of other ways he can meet this requirement including creating a network of peers or by participating in first and second line assessments with ANZASM who are regularly looking for Fellows to support the audit. Dr C noted that he had regular meetings with two of his peers to discuss issues relating to quality improvement and patient care, claiming these activities for Clinical Governance. He also submitted his audit data to his specialty society for review and satisfied his Surgical Audit requirement.

Things to Remember:

- Before collating your verification documents, please check your CPD Online via the RACS Portfolio to see what activities have already been pre-populated. All RACS courses and RACS-approved activities are automatically entered and verified in your CPD Online. If there is anything missing, please contact the provider of the course or the RACS CPD Team
- A letter from the Head of Department at your hospital can be used to verify participation in a range of CPD activity including peer reviewed audit, clinical governance activities, supervision and teaching
- Participation in ANZASM is compulsory and automatically verified by the College. As it can take some time to complete a surgical case form, please check to make sure there is nothing outstanding ahead of the CPD due date. To find out if you have a form outstanding, please review your CPD Online or contact your local ASM office. For Fellows in NSW, unfortunately the College is unable to automatically verify your participation. Please contact CHASM who will be able to provide you with this information and provide a certificate of participation.
- If you need assistance, please don't hesitate to contact the CPD Team on **+61 3 9249 1282** or at **cpd.college@surgeons.org**

JDOCS AND SURGICAL TRAINING

What do the latest developments in the pre-vocational surgical domain mean to SET Trainees?

SU MEI HOH
Skills and Education Committee, RACSTA

"…To teach them this Art, if they shall wish to learn it, without fee or stipulation; and by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples who have signed the covenant and have taken the oath to the law of medicine…"

The Oath of Hippocrates

The above oath has passed all our lips at some stage of our medical careers, usually recited in unison with our graduating cohort from medical school. It is a testament to the importance our profession places on teaching the next generation of would be doctors and surgeons. In keeping with this tradition the College of surgeons has long been, not only the guardians of the standards of surgical practice, but also the gatekeepers to surgical training.

Enter JDocs

The college's most recent development in the training of the next generation of surgeons is JDocs. In recent years, as more medical graduates have entered the workforce, so too has the increased number of pre-vocational years for junior doctors as they wait (and hope) for a spot among the finite positions for specialist training. Pre-vocational positions have long been seen as 'service' jobs, as there has not been a mandated training framework beyond internship/PGY2. It is this void that JDocs aims to fill for the generation of would be surgeons in waiting.

JDocs is a competency framework that aims to provide a guide for ongoing learning expectations and career development matched to PGY level. It is a road map of graduated clinical tasks and responsibilities based on the nine RACS competencies and in line with both the Australian Curriculum Framework for Junior Doctors (ACF-JF) and the New Zealand Curriculum Framework for Prevocational Training (NZCF). Like any road map, individual junior doctors can choose their own path towards a procedural career by meandering through as many of the highlighted tasks in a sequence that suits their journey.

The JDocs framework is supported by a suite of resources, such as e-learning and library resources, that can help to achieve the selected learning outcomes. Junior doctors can also track their progress, assessments and achievements through the use of ePortfolios and the MALT database. The framework and some resources are freely available from the JDocs website (Jdocs.surgeons.org) with a subscription option for extended resource access.

JDocs and SET Trainees

So what does a pre-vocational educational framework have to do with SET Trainees? Surely having managed to get our foot in the door at Spring Street means those pre-vocational days are a thing of the past. However, closer scrutiny of the JDocs key clinical tasks, reveal competencies that are part of SET curriculum, though possibly at the early level. As such the online resources continue to be relevant for all Trainees, SET or otherwise. On the recommendation of the Skills and Education Committee, the extended JDocs resources will be available to all Trainees (as well as Fellows and IMGs) as part of their existing college subscription.

Also in reality, SET Trainees serve as inadvertent ambassadors for surgical training to our junior colleagues. As those who have most recently been successful in achieving admittance to an increasingly competitive vocational program, current Trainees are a natural resource to elicit application savoir-faire. As such Trainees too should be aware of this purposefully constructed set of educational resources that would be most useful for our junior colleagues, particularly since the Generic Surgical Sciences Exam (GSSE) has become available in the pre-training domain.

As Trainees progress through training and graduate in seniority so to comes the increasing responsibility in supervision of junior team members. It is anticipated that senior Trainees will be increasingly called on to sign off on key clinical tasks as their juniors accomplish them. However it is unclear at this stage the role of SET Trainees in sign-off or if that prerogative will remain with RACS Fellows alone. I expect that information will be made available once the JDocs subscriptions with e-Portfolio and MALT access is available in Jan 2016.

Continuing traditions

While its more than two thousand years since the time of Hippocrates, the Hippocratic tradition of preparing the next generation of doctors and surgeons continues. While training may no longer be 'without fee or stipulation' (instead there is no shortage of both), the transmission of the Art of Surgery continues to be developed and delivered in keeping with traditional precepts but employing every other mode of instruction including a novel suite of online resources.

ARTICLE OF INTEREST

THE POLITICS OF OBESITY

Obesity is a complex illness and social issue and is increasingly prevalent

GEORGE HOPKINS
Obesity Surgery Society of Australia & New Zealand, President

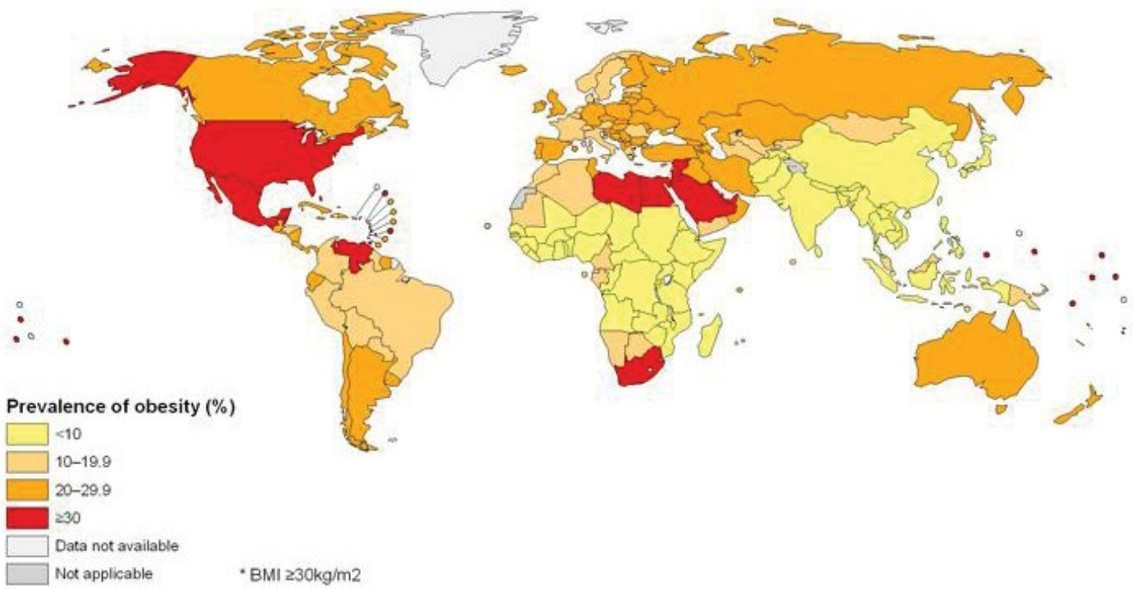
The growing incidence of obesity is one of the most challenging threats to public health worldwide. The World Health Organisation (WHO) estimates that more than half the world's adult population is either overweight (39%) or obese (13%). Since 1980, the worldwide prevalence of obesity has more than doubled and statistics also show a significant increase in incidences of childhood obesity.

Part of the problem is that we are eating more and doing less. But there is also a problem with the way obesity is perceived. It's not seen as a chronic disease by policy makers or the general public, and this is demonstrated by the fact that more than 90% of the weight loss surgeries that are carried out in Australia happen in the private hospital sector.

Obesity and other non-communicable diseases such as cardiovascular diseases, cancers and diabetes are now the world's biggest killers, causing an estimated 35 million deaths each year, 60% of all deaths globally, with 80% in low- and middle-income countries. We need to stop seeing obesity as an individual problem, which is up to the fat person to fix, and start viewing it as a global health crisis.

In July this year, Harvard gastroenterologist Lee M. Kaplan travelled to Australia for a range of speaking dates at some of Australia's biggest hospitals. His visit was a game changer, because he highlighted the fact that while obesity can be scientifically measured and estimated using a range of biomarkers such as body mass index (BMI), these markers should not define obesity.

It is a remarkably complex disease with wide patient-to-patient variability in responses to treatment options. Nearly two million Americans now have a BMI of more than 50, and there are 180 potential medical complications of obesity. The goal then, is to match each patient with the treatment most effective and suited to them.



The complexity of obesity

Obese patients who require surgery that is not weight loss related should still be encouraged to reduce their weight before surgery, especially if they have features of metabolic syndrome. Prescribed low calorie diets can help achieve preoperative weight loss.

A combination of preventative measures and an increase in the availability of treatment options for those who are already obese will help curb this disease. Examples of preventative measures include better labelling on food packaging and public education programs. There is evidence to suggest that education programs can have a positive impact on physical activity levels.

Where preventative measures have failed, there is strong evidence to suggest that surgery is an effective intervention for weight loss in the morbidly obese (BMI > 40), and that this may reduce the long-term costs and health impacts of obesity. Dr Kaplan points out that gastric bypass has the opposite effect to restrictive dieting, with energy expenditure and satiety going up, and appetite and stress response decreasing.

Providing access for weight loss surgery in public hospitals seems a difficult commitment for policy makers. In the face of overwhelming science this can be interpreted as a bias against the obese, as it is so often viewed rightly or wrongly as self-inflicted.

The other consideration is the overwhelming numbers that could and would stand ready for surgical treatment whenever and wherever this service is offered. Our experience at the Royal Brisbane & Women's Hospital certainly suggests that to manage the workloads and wait times, very strict parameters need to be applied to eligibility for surgical intervention. That said our clinics remain saturated and intermittently closed to new case referrals.

Access Economics estimates that the number of obese people in Australia is set to double by 2028 to almost 8 million. The medical, psychological and financial burden of obesity, coupled with the failure of conservative measures and the success of surgical interventions, is why weight loss surgery must be considered part of the package in addressing the obesity epidemic.

With Amy Kimber

TRAUMA VERIFICATION

Benchmarking Trauma Care 2015 and beyond

TRISH MCDOUGALL
Chair, Trauma Verification SubCommittee
JOHN CROZIER
Chair, Trauma Committee

Trauma Verification helps save lives, reduce waiting times and lower costs.

The Trauma Verification Program, which commenced as pilot programs in 2000, has continued to expand across Australasian hospitals, regional trauma centres/systems to include both adult and paediatric patients. There have been 47 hospital Trauma Verification reviews undertaken to date and these include 12 Formal Trauma Verifications.

Trauma Verification is a multi-disciplinary inter-collegiate process that covers all phases of acute care from pre-hospital through to discharge and identifies the strengths and weaknesses of the hospital's trauma service allowing hospitals to benchmark their services against international standards. Trauma Verification assists hospitals to analyse their systems of care for the trauma patient. Literature reviews report the benefits of Trauma Verification and impact on patient outcomes.

The Australasian Trauma Verification Program, conducted under the auspices of the Royal Australasian College of Surgeons is supported by the Australian and New

Zealand College of Anaesthetists, the College of Intensive Care Medicine, the Australasian Trauma Society and the Australasian College for Emergency Medicine. Members of all of these organisations are participants in the Trauma Verification review teams.

The benefits of Trauma Verification include:

- Decreased length of stay of the trauma patient
- Independent peer review of the quality of care for seriously injured patients
- Decreased morbidity and mortality rate
- Enhanced regional trauma system
- Defining specific education needs

The Program is continually evolving to ensure that updated peer review processes of Hospital Trauma Systems are benchmarking optimal care of the Trauma Patient. The multidisciplinary review Team assesses the injured patient's progress from pre hospital care; through to the Hospital or Trauma Centre; and all aspects of the patients in hospital care to discharge and rehabilitation.

The Trauma Verification team consists of experienced trauma surgeons, intensivists, emergency physicians and trauma nurses. Members are trained in the Trauma Verification process, including hospital visits. Care is taken to avoid potential conflicts of interest.

Two levels of review are available for institutions to undertake - Consultative and Formal Review.

Consultative Trauma Verification Review

A Consultative Trauma Verification review enables the hospital or trauma centre to benchmark its trauma resources, system and service provision against the current Model Resource Criteria (MRC) documentation. The MRC provides a guide as to what is necessary for optimal outcomes of trauma patient care within the system currently provided by that institution. This is a good starting point for not only hospitals first undergoing Trauma Verification in readiness for a Formal review but also it can be of great assistance when new trauma centres or hospitals are being built and then subsequently after the new facility opens. Once again this is to benchmark all the processes, equipment, documentation, and staffing needed to undertake and maintain high standards in trauma patient care within the hospital systems.

Formal Trauma Verification Review

The Formal Trauma Verification review will include a multidisciplinary team who assesses the hospital/trauma centre's adherence to the Model Resource Criteria and provides feedback in the form of Strengths and Weaknesses, and recommendations for improving trauma care to the patient. The Formal Trauma Verification status is awarded to the hospital if all the requirements are satisfied. If a Formal Trauma Verification is not given, then a Provisional Trauma Review may be granted together with the recommendations the hospital should fulfil in order to be granted full Formal Trauma Verification.

Steps for verification involve the hospital completing a – Pre- review Questionnaire (PRQ) detailing the strengths and improvement opportunities of the trauma service. The questionnaire assists the Trauma Verification team by providing facts of the individual hospital's trauma care and how it functions to achieve optimal patient care prior to the review. The Pre Review Questionnaire is sent to the hospital 4-6months prior to the date of the site review and is returned to the Trauma Verification team at least 12 weeks prior to the review.

During the site review at the hospital, a two day process is undertaken to review hospital resources, personnel and the systems against The Model Resource Criteria document. A detailed tour of the facility is undertaken to meet with the clinicians and hospital management. The Site team also reviews patient records and the trauma registry to ascertain the quality of trauma care being provided within the hospital.

After the site review, verbal feedback is provided on site to the hospital administration and the clinicians involved in the hospital trauma verification. A detailed and comprehensive written report, ratified by the Trauma Verification Sub-Committee, is provided to the authorising body within twelve weeks after the review

Where no critical deficiencies have been identified, the certification of Trauma Verification takes place after the review. The hospital receives a certificate valid for three years. After 3 years, a return visit for recertification can be sought by the hospital to ensure that up to date Trauma Care is maintained and benchmarked against the criteria set out.

View the program's web site and access important resource material such as the Model Resource Criteria , the Pre-Review Questionnaire and useful links at:

www.surgeons.org/traumaverification

Have you thought about being an instructor?

PHIL TRUSKETT
Chair, TIPS Committee and Censor in Chief

I first attended an Early Management of Severe Trauma (EMST) Provider course at Westmead over 20 years ago. I was a supervisor of surgical training at that time and went because I wanted to see what I was insisting that the trainees must do. I didn't need to know anything more about trauma management; I was a consultant after all at a Trauma Centre. Well I sure got that wrong. Not only was I taught a new structured approach to the trauma patient, I was introduced to a whole new form of adult education delivered by a well prepared bunch of surgeons, emergency physicians and anaesthetists. I was really impressed. Soon after, I was invited to an Instructors Course, in those days at my own expense; I jumped at the chance.

The Instructor Course was a whole new experience. I had been teaching medical students and surgical trainees for some years, by emulation. I had never been taught how to teach. At this course I was introduced to a multitude of concepts that were totally foreign to me relating to skills training, question construction, debriefing and lesson plan structure, to mention a few. It was a revelation. Soon after I instructed on my first of many courses with a bunch of people I had never met before, all with a common purpose. It's kind of nice to step away from your clinical practice and meet new enthusiastic group of people in such a safe teaching environment.

The Care of the Critically Ill Surgical Patient (CCrISP®) course started a year or so later and I agreed to teach on that. Before long I found myself on the EMST and CCrISP® committees, eventually chairing the EMST Committee. My committee involvement was also an important education. It taught me about issues relating to governance, strategic planning and course sustainability. As a result I got involved with College politics, I was elected to the NSW Regional committee and eventually becoming a generally elected College Councillor some eight years ago. My involvement in modular teaching has also allowed me to help in developing new courses such as Training in Professional Skills (TIPS) and Management of Surgical Emergencies (MOSES).

So what have I got out of being an instructor? I have a whole new bunch of friends both nationally and internationally. I have gained an extensive education in adult learning that has allowed me to do things that I would have never been able to do. It caused me to make a strong commitment to the governance of our College. Without all this, there is a significant chance that by now I would be a burnt out, somewhat cynical bystander.

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Australia and New Zealand Surgical Skills Education and Training (ASSET)
Do you enjoy teaching practical surgical skills? This well-established, hands-on course provides an educational package of generic surgical skills required by surgical Trainees in the Australian and New Zealand context.

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Are you experienced in managing acutely unwell patients? The CCrISP® course assists doctors in developing simple, useful skills for managing critically ill patients, and promotes the coordination of multidisciplinary care.

CCrISP

Critical Literature, Evaluation & Research
Are you involved in clinical research and/or clinical epidemiology? This hands-on course is designed to make the language and methodology of literature, and research relevant to surgeons in the day-to-day activities of their practice.

clear
critical literature evaluation and research

Early Management of Severe Trauma
Are you passionate about trauma management? This course teaches a systematic, concise approach to the care of a trauma patient, providing a safe and reliable method for immediate management of injured patients.

EMST
Early Management of Severe Trauma

Training in Professional Skills
Do you understand the importance of professional skills in surgical practice? This course teaches patient-centred communication and team-oriented non-technical skills in a clinical context.

TIPS
Training in Professional Skills

RARE BOOK WEEK 2015

The College has participated in Rare Book Week for the second year running

IAN BENNETT
Chair, Research, Audit and Academic Surgery

Melbourne Rare Book Week (http://www.rarebookweek.com/) commenced in 2012 and has since seen a growth in free events being held at libraries, literary and historical societies and bookshops througho ut Melbourne, attracting local, national and international visitors. The College has been a participant for the last 2 years. The author of this article, Graham Spooner has been in the position of Manager, Library and Information since November 2013 and has now been in attendance at RACS Rare Book Week events in both 2014 and 2015.

It was certainly harder this year to leave the comfort and warmth of home to venture into Melbourne's coldest winter in 26 years to return to the workplace for talks on both Tuesday and Wednesday evenings in mid-July.

Felix Behan is one of the few regular, "in-person" visitors to the library premises in Melbourne. He is usually looking for assistance on an eclectic range of projects, often centred on a column he is developing for this journal. His research requirements set Library staff some interesting challenges as he delves into surgeons from the history of RACS or the wider surgical world and other topics or requests which test both reference skills and powers of deduction. On the Tuesday evening, Felix delivered the first of the papers on Ambroise Paré, based on materials held in the marvellous historical collection.

Ambroise Paré is regarded as the father of modern surgery in France. His creed was "To eliminate that which is superfluous, restore that which has been dislocated, separate that which has been united, join that which has been divided and repair the defects of nature." He was the first to effectively treat gunshot wounds. He wrote many treatises, and his legacy ran strongly through the next two centuries. Plastic and Reconstructive surgeon Felix Behan drew on the Cowlishaw Collection to explore the importance and place of French surgical books of Paré and his successors. Of great interest was that he could well be considered one of the first adherents of evidence-based medicine; comparing the effects of the traditional method of treating wounds with boiling elderberry oil and cauterization with the effectiveness of a treatment using a recipe made of egg yolk, oil of roses and turpentine. He also documented phantom limb pain in amputees. Being able to be in the presence of his 1564 book, Treatise on Surgery was no doubt a privilege for the 30 or so in attendance on the night.

The College's museum curator, Geoff Down gave the Wednesday night talk on The Cowlishaw Collection which contains over 2,000 volumes. RACS library staff are not involved in the management of this collection with their time being spent developing, maintaining and promoting extensive e-collections or on meeting the high demand for document delivery from members.

In the Collection, there are eight incunabula (books printed before 1501), including Guy de Chauliac's Cyrurgia, Venice, 1499. Hippocrates is presented in eighteen editions, Galen in five editions, and Celsus in twenty-one, starting with the 1493 printing. The 1558 edition of Vesalius' De humani corporis fabrica, and Paré's 1568 edition of Traicté de la Peste are also included in the collection, along with many important medical books from the sixteenth to the early twentieth century. One title, a 1493 edition of Celsus, is a proof copy, and is thought by Geoff to be unique.

During several visits to Britain and Europe between 1906 -1908, Sydney physician, medical historian and bibliophile Dr Leslie Cowlishaw purchased many early medical books. These became the foundation for his library, amassed in the first half of the 20th century. Rich in rare medical and surgical classics, it is the most important of its kind in Australia. Geoff Down told the story of this fascinating library, how Cowlishaw went about collecting it, how RACS acquired it and why it is now a prized possession of the College. Unfortunately, Dr Cowlishaw housed the collection for a period in Cooma – something that has not assisted in the preservation of the works. Geoff has also had to rearrange the collector's classification scheme and is waiting patiently for the glue to dry out on the white stickers that Dr Cowlishaw placed on the spines of the books rather than undertake the risky procedure of peeling them off such old and often fragile covers. The books are housed in the Council Room and their weighty, historical presence on the shelves during staff meetings and their direct link with medical and surgical knowledge from centuries ago is a quiet pleasure for the long-term health librarians on staff.

The College also has The Cowlishaw Symposium which is held every two years to honour the memories of Dr Leslie Cowlishaw and Professor Ken Russell, and to encourage research into the Collection. The next will be in 2016.

RACS BENEFITS PROGRAM

New member benefit!

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