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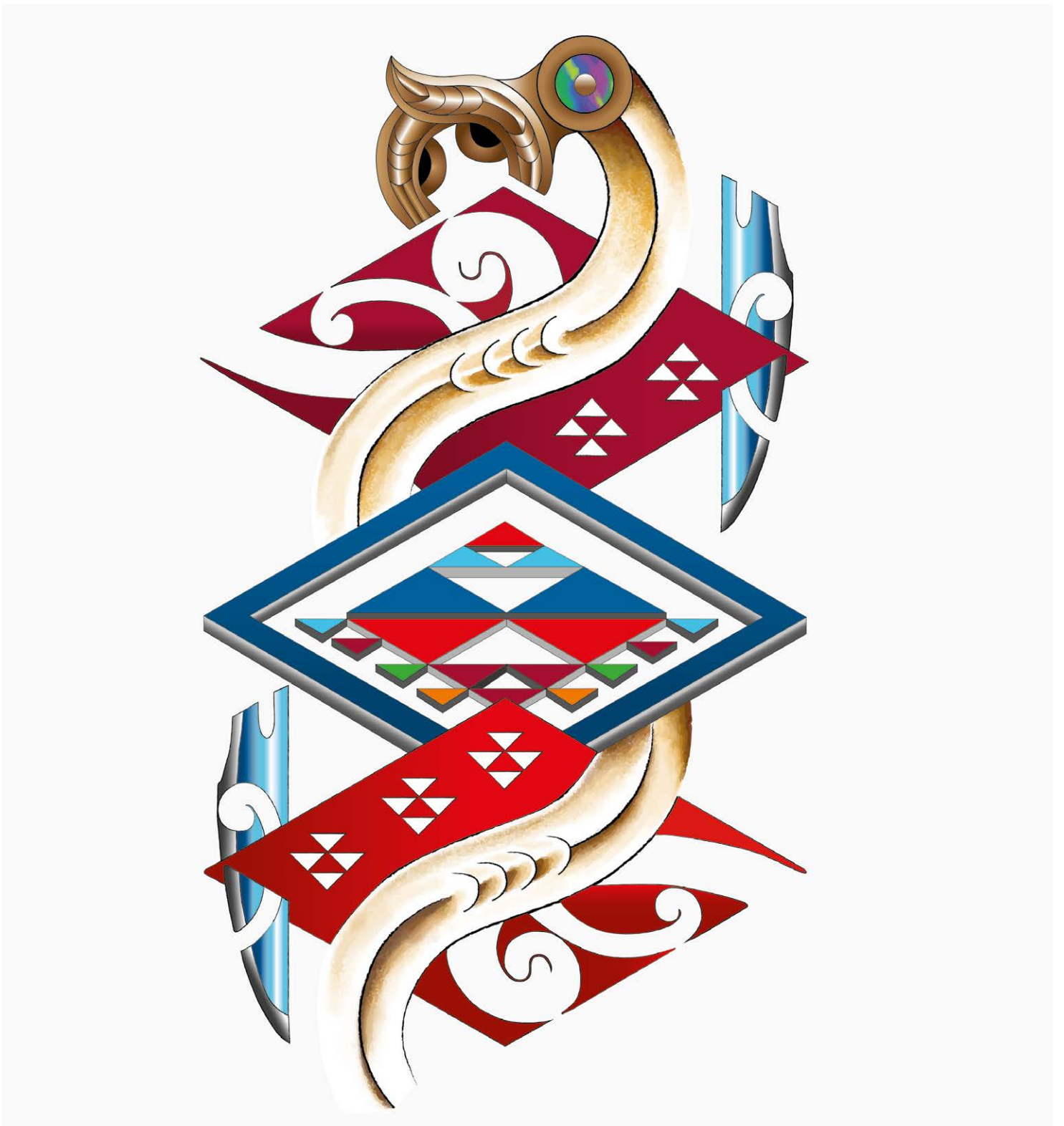
ROYAL AUSTRALASIAN COLLEGE OF SURGEONS



MĀORI NAME AND MOTIF

Ensuring the Māori world is visible in College activities

DO YOU HAVE A GP?

Recognising the importance of looking after your health

DR DAVID SMOLILO

Trainee breaks new ground in enteric nervous system research

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Your vote, Your Council.

RACS Council Elections 2018

The Royal Australasian College of Surgeons (RACS) 2018 Council elections process commenced on 31 August 2018.

Key dates

- 17 September 2018 - Nominations close
- 21 September 2018 - Ballot opens
- 5 October 2018 - Ballot closes

Your engagement and participation as a member is critical to the success of RACS.

For more information please contact College.President@surgeons.org

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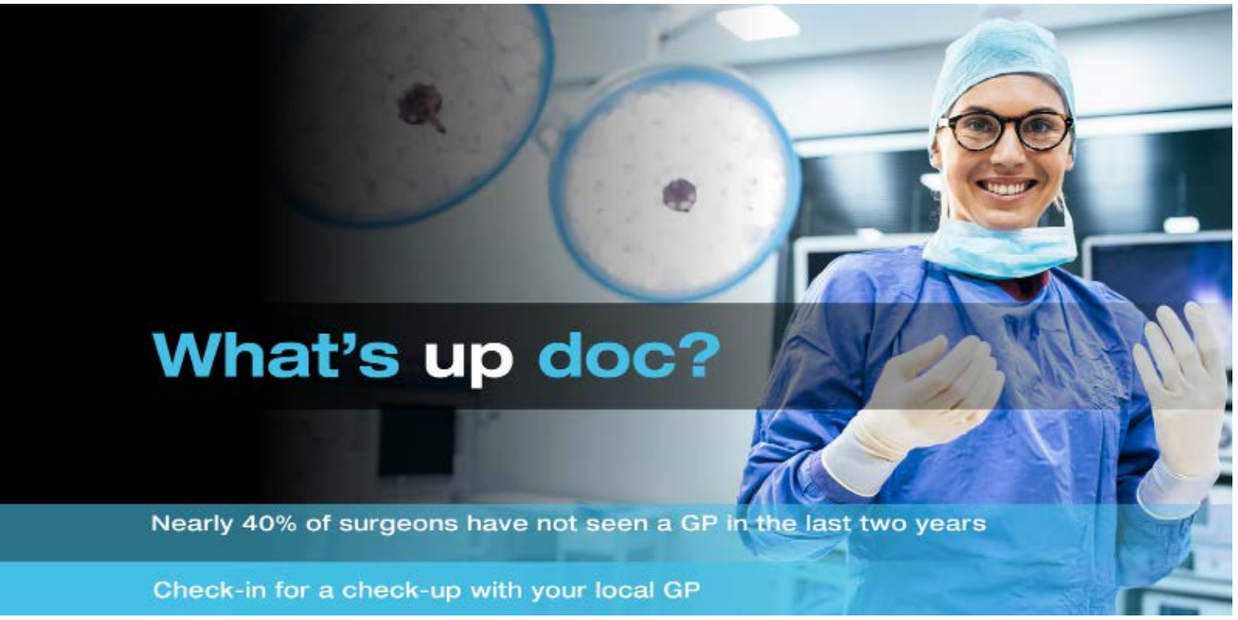


Do you have a GP?

Dear colleagues

We are all familiar with that age-old adage 'physician, heal thyself'. As surgeons we are trained to put the best interests of our patients first and rightly so as we serve the public, but what about our own health?

The RACS Code of Conduct exhorts us to maintain good physical, psychological and emotional health, regularly reflecting on whether any impairment, either temporary or permanent, will affect our individual performance or that of our team, always being mindful of any risks to patient safety.

It is vital that we promote a culture that recognises the importance of looking after our health. This is why we are launching the 'Do you have a GP?' campaign.

Many of you will agree with me when I say that we as medical practitioners tend to self-diagnose, self-medicate or ask our friends.

"Our RACS research shows that some 37 per cent do their own check-ups or have not had a check-up with a GP in more than two years, and only 11 per cent of Fellows seek professional assistance to deal with stress or other mental health concerns."

While there is no comprehensive comparable study in New Zealand, there are indications of similar levels of psychological distress among New Zealand doctors (New Zealand Medical Association, 2013).

We recognise that Fellows, Trainees 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.

Surgeons, like the rest of society, can struggle with depression, anxiety and poor mental health. The work environments that surgeons find themselves in may also contribute to high levels of stress due to administrative processes, fear of litigation and inappropriate behaviour such as bullying, discrimination and sexual harassment.

All these factors make looking after our own health critical. I know that as surgeons we are very busy people, but we must never ignore our own health. To do so would be to put not only ourselves, but our families and patients at risk. I encourage each and every one of you to attend a GP practice on a regular basis. This is important to maintaining and protecting our physical and mental health.

It is useful to note that there are many GPs who specialise in looking after other health professionals. They are mindful of issues such as privacy and are used to making it easier for other medical practitioners to access healthcare services.

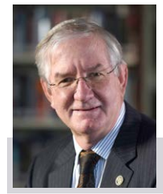
I am also aware that issues such as mandatory reporting may hinder some from seeking treatment. It is important to remember that GPs are required to make a report to the Australian Health Practitioner Regulation Authority if the behaviour they observe is a risk to the public. Frankly, if any of us get to this stage we really shouldn't be in practice until we are well enough.

RACS is committed to providing support to surgeons to assist them appropriately through difficult situations. We partnered with Converge International, a specialist in psychology, mental health and wellbeing. Converge provides confidential support to Fellows, Trainees and International Medical Graduates and their immediate family members. This arrangement allows you to access up to four sessions per year for counselling, coaching and support for workplace, emotional and personal issues.

The 'Do you have a GP?' campaign is yet another way we can support our community. By allowing another doctor to objectively manage your health, you will be free to do what you do best concentrate on the health of your patients.

To those of you who are actively looking after themselves and seeing a GP as part of their health care. Well done! Please encourage your peers to do so as well.

Let's make our own health a priority. Go and see a GP and make that a regular part of your health regimen.



Mr John Batten
President

Diversity and inclusion

What does it mean and where are we headed?

“Embrace diversity and foster gender equity” – Goal 4 of the RACS Action Plan – Building Respect, Improving Patient Safety. It was recognised in our investigation into discrimination, bullying and sexual harassment in surgery that significant change was required in the culture of surgery, and this included diversity and gender equity.

In response to this, and to set expectations for all aspects of RACS activity, we developed and published our Diversity and Inclusion Plan at the end of 2016 - “Leading the way towards inclusive participation in the practice of surgery and life of the College”.

The Plan has the five pillars of:

1. Inclusive culture and leadership excellence intentionally creates a culture of inclusion amongst the surgical community, through advocacy, championing and communicating diversity.
2. Gender equity – increase the representation of women in the practice of surgery by removing barriers to participation and introducing flexible training models for any Trainees or surgeon, irrespective of gender.
3. Participation of all diversity groups – ensure the profession of surgery is accessible to all people regardless of their minority group status.
4. Diverse representation on Boards and in leadership roles – increase diversity and in particular, representation of women, on training boards and in all College leadership roles.
5. Benchmarking and reporting – be transparent and accountable for increasing diversity and making progress in implementing the Diversity and Inclusion Plan, by gathering data and reporting publically on progress.

Are we there yet?

So, what does this all mean and how are we going?

I will mention some of the work that RACS is undertaking across this broad plan.

In June I was honoured to participate in a mihi whakatau – a special Māori ceremony welcoming Maxine Ronald - our first councillor to the RACS College Council. It was a very moving ceremony with the ‘handing over’ of Maxine from the Indigenous

Health Committee to RACS Council along with the charge to nurture and support her on Council.

We have developed a Reconciliation Action Plan to address Aboriginal and Torres Strait Islander health disparities in surgery and a Māori Health Action Plan to address inequity and improve cultural competence among surgeons and Trainees. The Indigenous Health Committee is to be praised for the initiative to select ATSI Trainees onto surgical training as long as they meet the minimum criteria for selection, and I am pleased to report that some Training Boards have already taken up this option, while others are actively working towards it. We are also providing scholarships to indigenous medical students and junior doctors to attend the RACS Annual Scientific Congress.

The New Zealand National Board agreed to support and mentor potential Māori Trainees and to encourage selection committees to recognise knowledge of tikanga – Māori tradition and culture – and its application to patient care as a priority selection

RACS female participation, August 2018

	Applications to Surgical Training	Accepted into Surgical Training	Total of Trainees	New Fellows	Total Active Fellows	Women on Council and Main Committees (combined)
2016	30%	25%	29%	22%	12%	21%
2017	33%	31%	29%	22%	12%	23%
2018 YTD	33%	35%	29%	24%	13%	27%

Women on Council	**2016 - 2017**	29%	**2017 - 2018**	32%	**August 2018**	36%

criteria. The Board is also working to develop cultural competency guidelines for the Trainess and selectors. We have also adopted a Māori name and motif for RACS and these are presented on the cover of this edition of Surgical News.

In mid-July, I was part of a panel that spoke to the Dunedin Society of Aspiring Surgeons. One of their objectives is ‘to increase interest in surgery among historically and currently under represented people in surgery, namely women and Māori and Pacific people’. It was inspring to see so many young people of all backgrounds interested in surgery as a career, and not at all daunted by gender or ethnicity. I reflected that when I obtained my FRACS, only six per cent of surgeons were female, but numbers are changing only slowly – in 2017 (25 years later) only 12 per cent of surgeons were female.

There is a lot written about the inflexible nature of surgery, poor culture in surgery and the diffucuties encountered in surgical training. I would like to commend the tremendous efforts of the Women in Surgery Section (WiS) and the Fellowship Services Committee, who in conjunction with the Training Boards are working hard to enable flexible training models to be adopted. WiS is also actively engaging with surgical interest groups at the medical schools to encourage surgery as a career path for women. It is pleasing to note that now more than 30 per cent of current SET Trainees are women.

At the end of last year we developed a diversity dashboard to see a snapshot of what RACS is doing regarding female representation on RACS Boards and Committees. The dashboard is a new initiative and is regularly revised and updated, but already we can see that we are well on our way to reaching the 20 per cent target for most committees, which is very encouraging.

So, what can you do?

Encourage and support your Trainees who are seeking to participate in flexible training and actively work to facilitate these arrangements.

Actively support indigenous junior doctors to consider a surgical career. I urge all surgeons to think beyond the ‘old boys network’ when planning conferences and events, selecting speakers and session chairs, nominating for Specialist Society and RACS committees.

Actively seek to appoint women to positions and leadership roles – this positive discrimination is simply reversing the previous gender inequity and is not unfairly giving women an advantage.

Consider refusing to participate in events where there is no gender equity.

Refuse to accept that there was no available woman for the task in question.

Let us all work together to produce a surgical community in Australia and New Zealand that is as diverse as the community we serve.

Ms Cathy Ferguson
Vice President

Dr Matire Harwood at the 2018 New Zealand Annual Surgeons Meeting

Working towards Māori health equity

The Māori people account for about 15 per cent of New Zealand's population and make up the second largest ethnic group after Pākehā (New Zealanders of European descent or non-Māori) yet Māori have the poorest health of any New Zealand group.

There are considerable disparities in health outcomes between Māori and other ethnic groups in New Zealand with Māori having a considerably shorter life expectancy and a higher mortality rate for diseases such as diabetes, cardiovascular disease and cancers.

According to Jonathan Koea, Deputy Chair of the New Zealand National Board, member of the Māori Health Advisory Group and former member of the RACS Indigenous Health Committee, the gaps in health between Māori and non-Māori consume a significant amount of health resource and prevent New Zealand from fully developing as a society.

The Treaty of Waitangi guarantee Māori equity with non-Māori and this includes health and working towards a healthy Māori future as part of New Zealand's commitment to the Treaty of Waitangi.

Article 3 of the Treaty of Waitangi guaranteed Māori the same rights as British citizens (or non-Māori) and clearly in health terms this has not happened according to RACS Councillor Maxine Ronald, the first Māori to be elected to Council.

RACS Councillor Maxine Ronald

"It is unacceptable that Māori experience almost universally worse health outcomes compared to *Pākehā* in our own country,"

Addressing health inequality between Māori and the rest of New Zealand's population as well as ensuring that indigenous people's rights are protected remains an important responsibility for the New Zealand health system.

"Unfortunately the ethnic difference in health outcomes in New Zealand is probably the most compelling and most consistent health inequity that we have. In other nations it might be by gender or by socio-economic status but here in *Aotearoa* (New Zealand) it seems to be an issue between ethnic groups," said Dr Matire Harwood, a GP, Senior Lecturer and Director for Research at Te Kupenga Hauora Māori, Faculty of Medical and Health Sciences at the University of Auckland.

These health inequities can be caused by a number of socio-economic determinants that often result in people ending up at different points on the health system. Associate Professor Suzanne Pitama, a registered psychologist, and researcher at the University of Otago believes that we need to change our structures to improve health equity and recognise that people are different therefore we need to treat them according to those differences to ensure the same positive health outcomes.

Associate Professor Pitama has been involved in Māori health research for more than 18 years and is the Director of the Māori/Indigenous Health Institute (MIHI) at the University of Otago.

Māori views on health take a holistic approach and embrace four cornerstones of health: *te taha wairua* (the spiritual dimension) *te taha hinengaro* (the mental dimension) *te taha tinana* (the physical dimension) *te taha whānau* (the family dimension). For Māori with traditional views, the *wairua* or spiritual well-being is not only key to one's identity but also provides the link with one's *whānau* (loosely translated to mean family), thus connecting the individual with the larger community that provides sustenance, support and safety.

Māori culture emphasises familial and community ties and like most indigenous communities, Māori health is seen as holistic and this includes the involvement of *whānau* in the management of health.

Associate Professor Pitama says that the role that *whānau* plays a big role in the wellbeing of Māori people as Māori communities are based on collectivism, with wellbeing being measured by the ability to be connected with one's family members.

"Everyone knows that family, wellbeing, spirituality and connectedness are important but the structures we work in prevent us from being able to offer care that includes all of those pillars," she said.

"When we are looking at navigating health outcomes and equities, it is about being able to take the whole family on the journey. It means as clinicians, we can include the whole family as part of our management and treatment plan."

Another way of working towards health equality is by health providers thinking about ways that the system can be changed to be more accessible for Māori. For example, offering options for clinic times, planning surgical dates where possible well in advance to accommodate whānau and work obligations, and committing support to help people navigate through the health system.

RACS Councillor Maxine Ronald said that in surgical practice it is important to think about the concept of *tapu* and how breaches of *tapu* can be very unsettling and disturbing for Māori patients. ►

Associate Professor Suzanne Pitama at the 2018 New Zealand Annual Surgeons Meeting

During an operation, Māori may be concerned that under anaesthetic the wairua (spirit) may wander and offering *karakia* (ritual prayers) before surgery can help to alleviate those anxieties, she said.

Part of addressing these inequalities and working towards improving health outcomes is for health providers to recognise the significance of cultural competency when treating Māori patients. Improving providers' knowledge of Māori traditions will increase their cultural competence, helping them to communicate more effectively with their Māori patients. This, in turn, will reduce patients' delays in seeking care, improve the collection of clinical information, increase the understanding of Māori clients, and enhance communications between Māori clients and healthcare providers. Together these can lead to improved patient and whānau satisfaction and greater compliance with individual care plans.

Taking time to find out more about each patient, where they are from, who their *whānau* is, what they do as well as acknowledging the patients' family and how important *whānau* is to health, helps to establish trust, shows that you care, and ensures engagement with the health system.

> "All patients want a surgeon who empathises with them and understands their circumstances and for surgeons, understanding patients' cultural perspective contributes to their care."

In New Zealand there are a number of competency resources available through District Health Boards and the Ministry of Health.

"If in doubt, patients can often help. Approaching a patient with humble curiosity on the part of the surgeon will often answer many questions," said Jonathan Koea.

In addition to cultural competency, improving representation of Māori in the health workforce is yet another way of working towards positive health outcomes with Dr Matire Harwood saying that we need to have Māori across the field to address health needs. Māori are under-represented in the health workforce comprising just 2.7 per cent of New Zealand's active medical workforce with even lower representation within surgery.

The low representation within medicine and in surgery is a consequence of differential access to educational resources and support. The lack of a visible Māori presence and the very limited inclusion of Māori in the delivery of surgical care determine that the workforce is not optimally responsive to, or understanding of, Māori healthcare needs and aspirations.

"Indigenous students are attracted to [fields] where there is indigenous leadership. I don't think we have that level of capacity across all the disciplines yet, but I still think we can have indigenous leadership at RACS so that [indigenous] students see people who are like them and see that it is somewhere they can be and see a pathway for themselves," said Associate Professor Pitama.

The number of Māori medical students is now higher than it has ever been, and this will flow on to the specialist workforce. The RACS Māori Health Action Plan not only aims to increase the number of Māori Surgeons but also undertake actions that are necessary to improve health outcomes, particularly surgical outcomes, for Māori. However, unless the current situation changes, it is likely that few of those will pursue a career in surgery.

"I tell young Māori they can and should do whatever they want and be the best version of themselves that they can be. In terms of surgery, I say it's a profession that will challenge you daily, keep you growing, and surround you with interesting and challenging colleagues for your entire life … very few professions will do that," said Jonathan Koea.

Maxine Ronald echoed Jonathan's sentiments, saying that Māori medical students should not be put off the fact that there are so few Māori surgeons and by if they want to, they should pursue surgery because they are just as good as everyone else.

"To Māori medical students interested in surgery as a career I say *haere mai*! We need you! I think Māori are very well suited to careers in surgery – they are great team players, hard workers and have excellent communication skills and are usually very good at getting on with all types of people from all different backgrounds," Maxine said.

Maxine's advice for Māori medical students interested in a surgical career is to find mentors to help guide them on a successful pathway to surgery and that most, if not all, Māori surgeons are very happy to provide manaaki (support) and advice. There are also many non-Māori surgeons who are also very keen to have more Māori surgeons and who will support students who are keen and willing to work hard.

"I think it is important to find surgeons, Māori or non-Māori, who practice Māori values – surgeons who provide a supportive team environment, who care about their junior team and colleagues, who value their own families, who care about their patients and believe in improving quality of care – and ask them for support and advice on surgical training," she said.

"Surgery is a challenging specialty with significant sacrifices required but it is also a privilege that few people experience and it is humbling to care for patients and their families during what can often be one of the most stressful times of their lives.

"The vision of the RACS Māori Health Action Plan is to achieve equity in health outcomes for Māori with a particular emphasis on how surgery and surgeons can contribute to this," added Maxine

To read the Royal Australasian College of Surgeons Māori Health Action Plan 2016-18, please visit https://bit.ly/2w3bAjU

Agron Dauti
Digital Media & Internal Communications Coordinator, RACS

60th Victorian Annual Surgical Meeting

"TRAUMA SURGERY IN 2018"
Contemporary Surgical Management of Severe Trauma
Royal Children's Hospital – Education Centre

19 - 20 October 2018

photo by John Gollings

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Dr Michelle Locke

New Zealand plastics surgeons lead the way in gender equity

For the past few years, New Zealand has had an almost equal number of women and men in plastic surgery training, making it a leader in the field of gender equity and inclusion, according to Plastic and Reconstructive Surgeon Dr Michelle Locke.

Dr Locke works at Middlemore Hospital and the University of Auckland and has expertise in breast reconstruction and aesthetic surgery, while also carrying out melanoma and stem cell research. In her university role, she sits on the Phase 3 Curriculum Group and the Board of Examiners.

A proud member of the New Zealand Association of Plastic Surgeons (NZAPS), she was recently the co-convenor of the successful Australasian Society of Aesthetic Plastic Surgeons (ASAPS) and NZAPS Combined Conference held in Auckland.

During her training she completed a Doctorate of Medicine through the University of Auckland School of Biological Sciences and received her FRACS in 2010.

She then spent two years in North America, working in Atlanta and Toronto, honing her skills in aesthetic surgery and breast reconstruction surgical techniques such as the deep inferior epigastric perforator (DIEP) flap. She is married with two young daughters, the eldest of whom was born during her Fellowship in Atlanta.

Speaking to *Surgical News*, Dr Locke said the near 50-50 gender split in Plastic and Reconstructive Surgery training in New Zealand demonstrates that the specialty is welcoming of young women doctors and willing to support their training, provide mentorship and encourage their professional development.

She said that research had long indicated the importance of female role models if more women were to be attracted to surgery and that the rising number of young women in plastic surgery training may, in part, be attributed to an increase in the number of women working as senior surgical specialists.

“Research shows that the more women surgeons there are the more they attract younger women to the profession, simply by showing that it can be done,” Dr Locke said.

“At Middlemore there are six women in the Plastic and Reconstructive Surgery Department as well a female Orthopaedic surgeon in our Hand Department. We often receive great positive feedback from junior doctors and medical students when they work with us.

“This may be the first time a young female doctor has the opportunity to picture herself doing similar work which can be the first step in deciding to pursue a career in surgery.”

Dr Locke said she chose Plastic and Reconstructive Surgery because she liked the variety of the work, the problem-solving skills required, the benefits such surgery can provide to her patients and the collegiality of the specialty.

However, she said that while the profession of surgery had made significant advances in overcoming gender biases within its ranks, there were still changes that could be made to overcome some of the barriers that particularly effect women in training.

“I decided early in my medical training that I wanted to be a surgeon but it was only after doing a rotation in Plastics and working with wonderful, supportive people that I chose the specialty,” she said.

“It is delicate and demanding work, it requires great problem-solving skills, we can be asked to treat injuries from the head to the feet and no two plastic surgery patients are the same.

“Yet, in New Zealand there are only four training units and each Trainee has to relocate at least every two years which can be difficult if you have a partner or children.

“There are great benefits to this, in that Trainees get to learn different approaches and different surgical techniques in each department, but it can also present significant personal challenges in that you either have to uproot your family or consider long-distance relationships.

“When my husband, who is not a doctor, and I relocated to North America, his company assisted with the move, finding us housing and organising the necessary documentation.

“We provide nothing like that to our Trainees which indicates to me that this requirement to relocate remains based on traditional role modelling where the surgeon is a man with a housewife who can more easily relocate.

“It does not work as smoothly for either sex these days, with more women in demanding, professional work.

“This is particularly true when the surgeon is a woman and I think it would be a wonderful thing for both men and women if we could provide a relocation service to help our Trainees find accommodation, schools and even job assistance for partners so that surgical training is not so disruptive to family life.”

Dr Locke divides her working life between Middlemore Hospital and the University of Auckland where she works as a lecturer and conducts research.

She is currently involved in a research program aimed at developing novel culture techniques to facilitate full thickness skin growth to help treat major burns injuries through a university-linked biotechnology company which has received significant funding from several organisations including the US army.

She also collaborates with researchers from the Photon Factory at the university, a team which has successfully gained a million-dollar grant to develop a hand-held device designed to identify melanomas through the reflection of light particles (Raman spectroscopy).

With two young children aged under 10, Dr Locke said she was fortunate to have a husband willing to stay home to support the family and the freedom provided through her academic position at the University of Auckland to work around family needs.

“I couldn’t do the work I do and take on very long and complicated procedures without having someone with the children so his decision to support my work and the family is a wonderful gift that I’m always grateful for,” she said.

Dr Locke said while much had been done by RACS to help reduce the gap between the number of women entering medicine and the number choosing to pursue a career in surgery, out-dated perceptions may still be limiting the career aspirations of some women.

Dr Michelle Locke

“I think there might still be a perception that women are not welcome in some surgical specialties, that surgery provides less of a work/life balance and comes with greater stress than other medical specialties. Yet I’d say to any young woman that the barriers are crumbling and it can be a wonderful, invigorating rewarding profession for any woman.”

Karen Murphy
Surgical News journalist

Awareness to action

The challenge of doctors' mental health.

It takes courage to tackle a difficult topic like mental illness. It's much easier to refer the issue to someone else to be resolved. There is much misunderstanding and stigma around mental illness that it is natural for us who are not GPs or psychiatrists to shy away from this issue.

Mental health is an elephant in the room. If the Australian data is truthful[1], and if you work somewhere between Denham and Byron Bay, or between Cape Reinga and Invercargill, then one in five of your colleagues or Trainees at work today will have been diagnosed with, or treated for depression. Of more concern, one in four will have had thoughts of suicide. In your operating theatre, someone, perhaps you yourself, may have entertained suicidal thoughts. I have lost a colleague to suicide, and perhaps you have too. The rate of depression among doctors is comparable to the general population, but the rate of suicidality is statistically higher. If a debilitating disease affects 20-25 per cent of the working population, it would be considered a public health catastrophe, but we keep this elephant hidden and it's almost certain that very few of your colleagues or even yourself have taken actions on mental illness.

Why? Because of stigma and misunderstanding. There is the stigma that a diagnosis of mental illness is equivalent to weakness. There is a risk that seeking help for mental illness may endanger employability. If we know of a colleague who suffers from diabetes, we would encourage them to take sugar checks and breaks during long operations, but we withdraw when we know of a colleague with a mental illness diagnosis. A doctor with mental illness is not necessarily an unsafe or weak doctor. A doctor with well-treated mental illness can provide the same effective and safe care as a doctor with well-managed diabetic illness.

There is also the additional misunderstanding that mental illness and burnout are the same thing, and that resilience training is the solution. Mental illness, such as depression, is a specific DSM-V and ICD-10 diagnostic category.

Burnout is not. Burnout is defined as a psychological state characterised by emotional exhaustion, cynicism (or depersonalisation) and low work efficacy due to chronic occupational stress. The same Australian survey[1] reports that 47.5 per cent of doctors are emotionally exhausted. For surgeons in particular, a study[2] confirms that 40 per cent of us meet the criteria for burnout. Almost half of your typical surgical department is burned out, and therefore, ineffective. The causes are multifactorial. It is not just about work hours, it is the changing quality of work. The current administrative, technological, academic, legal and ethical demands on our work are not what they used to be. The world of surgery has changed as many jurisdictions have intruded on the doctor-patient relationship.

Burnout is the psychological sequelae of occupational stress. It is the symptoms and signs of poor institutional health which may ultimately affect individual mental health. We are complex beings and there are studies to tease out if depression and burnout are associative, causative or contemporaneous. Workplace factors, or institutional ill-health, are strong predictors for burnout. You may know a surgeon with no mental health diagnosis who is burned out and ineffective at work. You may also know a surgeon with a well-managed depression who is fully engaged in work providing key leadership.

Institutional health is the other elephant in the room. Dealing with this elephant requires more than shortening work hours or adding resilience training. Resilience training is a personal solution to an institutional challenge. We need creative institutional solutions to institutional challenges. To this end, RACS has provided strong courageous leadership by addressing cultural change and leadership through the Building Respect, Improving Patient Safety campaign. Improving the workplace culture will significantly reduce risk factors associated with burnout. It is not about softening the training program or lowering expectations. It is about strengthening the safety and support for our Trainees and colleagues.

Mental health is not a gender or generational issue. Males, females, Trainees, and consultant surgeons suffer from mental illness. It takes courage to tackle the issue of mental health as a professional College, but the time is right. We have the leadership momentum and the societal support. It is the natural extension of Operating with Respect.

How do we engage in this arena? The first step would be awareness and acceptance of our colleagues with mental illness. The recent #CrazySocks4Docs Day on 1 June is an example of an awareness campaign. By increasing awareness, we have the opportunity to shine a spotlight on the issue. The crazy sock was merely an object lesson to spark discussion. What really matters is not the socks, but the conversation after that.

The fourth line of our Fellowship Pledge says "I will be respectful of my colleagues, and readily offer them my assistance and support." Awareness must lead to actions, otherwise it will lead to apathy. I respect that one in five of my colleagues will have mental illness and I am to readily offer them my support. As a surgeon, I offer personal peer support and I encourage my colleagues to seek professional mental health support through their GPs, counsellors or psychiatrists. Collectively, as a fellowship of surgeons we have the obligation to improve the physical and mental safety around our workplaces. This may involve some changes. A safe workplace is a mentally and physically safe workplace for our colleagues, because our patients deserve fully engaged, competent and mentally healthy surgeons.

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Dr Eric Levi
FRACS

Younger Fellows Forum in Bangkok

Friday 3 May - Sunday 5 May 2019

The Younger Fellows Forum will once again precede the 2019 Annual Scientific Congress (ASC) in Bangkok, Thailand. The Forum provides a unique opportunity for a diverse group of Younger Fellows (those gaining Fellowship within the last 10 years) to meet and discuss current and future issues that are of importance to RACS.

Delegates will gain a greater understanding of the workings of RACS, meet new friends in a relaxed environment and have the opportunity to debate important issues facing surgeons in 2019 and beyond. Most importantly the Forum offers a unique opportunity for younger RACS members to collectively have a voice on important issues and present a number of collaborative recommendations to Council.

Participants come from diverse backgrounds and in addition to delegates from Australia and New Zealand, there is an opportunity to meet with international Younger Fellows from the College of Surgeons of Hong Kong and Thailand, as well as a representative from the United States Association of Academic Surgery.

The 2018 Forum held at the Hydro Majestic Hotel in New South Wales was a raging success bringing together a wide range of surgical specialties as well as our anaesthetic Colleges. The 2019 Forum is provisionally planned to be held in downtown Bangkok at the Marriott Hotel.

If you are a Younger Fellow who wants to be more involved in your College and in shaping its future, I would urge you to pencil the forum dates in your calendar and consider attending. All Younger Fellows who have not previously been to a Younger Fellows Forum, are invited to nominate for the 2019 Forum. Formal invitations will be circulated in September with nominations closing in December 2018. Airport transfers in Thailand to the forum, accommodation, meals and all activities at the forum are covered by RACS however participants must finance their own flights to meet the transfers.

Please keep a look out for future correspondence and if you have any questions please do not hesitate to contact me at sean.galvin@ccdhb.org.nz.

Sean Galvin
2019 Younger Fellows Forum Convener, FRACS

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Te Whare Piki Ora o Māhutonga

A Māori name and motif for RACS in New Zealand

Since 2016, RACS has been enacting its Māori Health Action Plan with a view to addressing health inequity and the under-representation of Māori in surgery. Steady progress has been made in the past two years, most recently in efforts to ensure that te ao Māori (the Māori world) is present and visible in College activities, image and culture.

One element of this is the development of a te reo Māori name for the College, which you may have already seen appearing on RACS publications. A number of possible Māori names were considered by the RACS Māori Health Advisory Group, but there was unanimous agreement on the name ***Te Whare Piki Ora o Māhutonga.***

The Māori name is metaphorical rather than a literal English translation and this broadly equates to The School (or House) of Ascension to Health under the Southern Cross. This encapsulates RACS' commitments to continued excellence in learning, its dedication to the attainment of good health, and the College's bi-national history.

Another element of incorporating *te ao Māori* into RACS' image was the development of a Māori motif, which can be used to represent RACS' Māori health initiatives. Hawkes Bay artist, Mr Mark Kopua (*Te Aitanga a Hauiti, Ngati Ira, Ngati Porou*), was selected to undertake this work on behalf of RACS. Highly recommended by Te Ohu Rata o Aotearoa (the Māori Medical Practitioners Association), Mark had previously completed similar work for the Royal Australian & New Zealand College of Psychiatrists. Members from RACS' Māori Health Advisory Group met with Mark Kopua in late 2016 to discuss the *kaupapa* (project), the work of the group and RACS, and imagery they considered important to Māori and surgery.

The final design of the motif brings together several key elements to represent RACS' Māori health initiatives. Through the centre of the design is the *taniwha* (serpent). In Māoridom the *taniwha* is symbolic in several areas, one of which is as a guardian or protector. It is a link between Māori and medicine, as it closely resembles the serpent on the Rod of Asclepius (the Greek god of healing) which has continued to be used in modern times in association with medicine. The head of the *taniwha* is that of *Rongomatane*, the Māori god of good health and wellbeing, medicine and peace.

The three parallelograms in the motif represent the three kete (baskets) of knowledge in Māori tradition – kete o te *wānanga*. Each symbolises a different type of knowledge – sacred (*Kete Tuauri*), ancestral (*Kete Tuatea*) and life knowledge (*Kete Aronui*).

The two scalpels represent *Te Āwhiorangi* (top right) and *Te Whironui* (bottom left), the principle blades used to sever *Papatuanuku* (earth mother) from *Ranginui* (sky father) in Māori legend, thus letting light into the world. While surgery is much more than procedures, scalpels are obvious and immediate imagery for surgery.

Other design elements include the repeated image of the *koru* (furled fern frond). This represents new beginnings, growth and regeneration, and is a symbol that has become synonymous with *Aotearoa* / New Zealand. The triangular designs throughout are commonplace in Māori art, often featuring on the *tukutuku* panels that decorate the walls of the *wharenui* (meeting house) on *marae*.

Travelling for RACS business

RACS has engaged Corporate Traveller as the preferred travel supplier to manage domestic and international travel services for RACS related business.

RACS has implemented an online booking tool through Corporate Traveller called Serko which will manage all your travel needs including flights, hotels and car hire online.

Log on to the RACS website http://portfolio.surgeons.org and under useful links select Book Travel

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- Serko is available 24/7
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Trainee breaks new ground in enteric nervous system research

South Australian General Surgery Trainee and PhD candidate Dr David Smolilo has discovered a new colonic circuit involving sensory neurons and excitatory motor neurons that until now has been inferred but never described.

With financial support provided via the RACS Foundation for Surgery WG Norman Research Scholarship, Dr Smolilo used immunohistochemistry and high definition confocal microscopy to identify and trace the circuit which is believed to form the basis of the polarised reflex in the colon.

Working on the guinea-pig colon, he found the circuit within the enteric nervous system (ENS) by showing that the sensory neurons of the colon have specialised processes which form basket-like structures around other neurons.

Since his discovery, further work has been performed which confirms and expands his findings while world-first trials of several human samples have already shown promising results.

Dr Smolilo said any advances made in the understanding of the ENS could help lead to treatments for common gastrointestinal disorders such as postoperative ileus, slow transit constipation and chronic bowel obstruction.

He said that despite the importance of the ENS to proper gut function, the neural and mechanical factors that control digestion remained poorly understood.

“The ENS works mostly independently of our central nervous system and is arguably the most primitive part of the nervous system in charge of the digestive tract that evolved ahead of the actual brain,” he said.

“The sensory neurons of the gut – also known as the intrinsic primary afferent neurons (IPANS) – make this organ unique because they respond to physical and chemical stimuli and relay this signal directly to the ENS rather than to the brain or the spinal cord.

“They are thought to be the first neurons in reflex pathways of the gut and drive neuronal circuits to initiate a response to the stimulus being ‘sensed’.”

Dr Smolilo said his research identified how the sensory neurons within the colon activated other neurons by creating basket-like structures to transmit signals.

He said the structures, known as calbindin baskets, were formed from a high concentration of neuronal varicosities and likely directed synaptic output from the sensory neurons.

“The target neurons were determined to be excitatory motor neurons and excitatory interneurons, essentially forming a direct reflex arc triggered by the sensory neuron and resulting in smooth muscle contraction on the oral side of the stimulus,” Dr Smolilo said.

“This circuit likely underlies the polarised reflex described in the gut over a hundred years ago and named ‘the law of the intestine’.

“This discovery is very exciting because if we understand how the sensory neurons are wired to drive the ENS circuits to make the gut contract normally, we could help in the development of targeted therapeutic interventions to regulate this circuitry and help people with motility related disorders.”

A paper describing Dr Smolilo’s discovery has already been published and featured on the front cover of the Journal of Comparative Neurology with his findings described as providing a significant contribution to the field.

He is conducting his research at the Visceral Neurophysiology Laboratory at Flinders University under the supervision of Laboratory Director, Professor Nick Spencer, Colorectal Surgeon Professor David Wattchow and scientist Professor Marcello Costa.

Dr Smolilo was born in Poland and lived in South Africa and Botswana before arriving in Australia in 2001 and later becoming an Australian citizen. He is currently a part-time general surgery registrar at the Flinders Medical Centre in Adelaide.

Dr Smolilo said the importance of the ENS for normal human gut function was exemplified by Hirschsprung’s disease, where a segment of the colon is congenitally deficient in enteric neurons, which can lead to babies suffering functional large bowel obstruction from birth.

He said that while a great deal of research had been done on the ENS in recent decades, there were still gaps in understanding how the different neurons interacted with each other, particularly in the large intestine.

> “Our understanding of the ENS is a bit like an orchestra in that we know a great deal about individual instruments and how they work but we still don’t entirely understand how they all work together to create beautiful music.”

“Neurons within the ENS may be classified functionally as sensory neurons, interneurons or motor neurons yet many more distinct neuronal populations have been identified.

“Already, the current classification of neurons in the guinea-pig colon reveals up to 17 distinct groups.

“Yet, while we know a lot about the different types of neurons in the ENS we are only starting to make inroads into the exciting area of functional studies, where neuronal circuits described using anatomical methods are linked to specific gut functions.

“Once we have a better understanding of how these neurons communicate then we’ll be able to develop a better understanding of disease processes and hopefully develop pharmacological agents to address and counteract them.”

ACADEMIC HIGHLIGHTS

- 2018: Flinders Medical Centre, Clinicians’ Special Purpose Fund PhD Scholarship
- 2018: Publication of research in Journal of Comparative Neurology titled ‘Morphological evidence for novel enteric neuronal circuitry in guinea pig distal colon’.
- 2017: RACS Foundation for Surgery WG Norman Research Scholarship
- 2010: Flinders University Staff Prize for Surgery Finalist

Dr Smolilo thanked RACS and its Fellows for the support offered him through the scholarship.

He said he has greatly enjoying the opportunity to conduct scientific research which he said would allow him a greater understanding of underlying biological processes affecting patients with gastrointestinal diseases.

“I find this work exhilarating in that we are making unique discoveries and adding to the corpus of medical knowledge for the good of humanity,” he said.

“It’s painstaking work but we have had a couple of Eureka moments when we’ve switched to a new antibody and the neurons have lit up showing circuits that have never been seen before.”

Dr Smolilo joins a cohort of young surgeons who have contributed significantly to research in the pioneering of Neurogastroenterology at the School of Medicine at Flinders University over the last four decades, many of whom are currently practicing colorectal surgeons.

The WG Norman Research Scholarship arose from a bequest to the Foundation for Surgery from the late Dr William Gowan Norman. Thanks to Dr Norman's generosity and forsight this scholarship will continue to fund advances in surgery in South Australia.

With Karen Murphy
Surgical News journalist

SA Surgeon establishes first-ever bequest for global health projects

Retired South Australian Neurosurgeon Dr Glenn McCulloch has become one of the first donors to the RACS' Foundation for Surgery to arrange a bequest in his will that specifically supports global health initiatives.

Dr McCulloch was this year awarded the prestigious RACS Medal in recognition of valuable and dedicated contributions to the College and also received the Sir Henry Newland Award, from the RACS South Australia (SA) Committee for distinguished service to surgery.

Having retired from full-time clinical practice in 2005, Dr McCulloch served as a College Councillor from 2002 – 2011. He was the Clinical Director of the SA Audit of Surgical Mortality until earlier this year and continues his role as the neurosurgical member of the Surgical Science Examination Committee and Deputy Chair of the RACS Anatomy sub-committee. Dr McCulloch is also the Vice President of the Neurosurgical Research Foundation.

In addition, he was recently appointed by the University of Adelaide to supervise medical students and surgical Trainees conducting surgical mortality research projects. Dr McCulloch spent most of his career working at the Queen Elizabeth Hospital in Adelaide, as well as providing emergency neurosurgical services at the Women and Children's Hospital and Royal Adelaide Hospital.

Dr McCulloch recently returned from a trip to Uganda where he and his wife helped fund a school. Dr McCulloch said he had specified global health in his bequest because he had not had the opportunity to participate in surgical team visits.

"I always wanted to work in developing countries when I was a younger surgeon but didn't have the opportunity because various family and work responsibilities took precedence," he said.

"However, while I haven't worked in poorer countries, I have travelled extensively and I understand the challenges facing many people who desperately need access to safe surgery and anaesthesia but cannot get it.

"Instead, I decided three years ago that I would make a bequest in my will to the Foundation for Surgery to support the wonderful work done by RACS' global health programs.

"The Foundation for Surgery does very good work overseas, something I think all Fellows should be proud of, and their projects represent great value for money."

RACS' Global Health provides specialist medical education, training, capacity development and medical aid to sixteen countries in the Asia-Pacific region.

Visiting teams and in-country personnel provide clinical mentoring and education to the national medical workforces and deliver train-the-trainer programs to strengthen the capacity of national health services in the region.

Dr McCulloch said that while he was a great supporter of scientific and surgical research, he had chosen to fund efforts that directly benefited people in need of surgical care and local medical staff seeking further training.

"There is quite a lot of money available for research but clinical advances derived from that research can take a very long time to take practical effect," he said.

"However, if we can help people in low income countries to overcome a disease, injury or congenital defect we can make an enormous difference by allowing them not only to return to health but add to the economy.

Foundation for Surgery
Passion. Skill. Legacy.

"It is also pivotal that at the heart of all RACS global health initiatives is the commitment to train and upskill the local medical workforce so the country as a whole can reduce its need for foreign aid."

Dr McCulloch urged other Fellows and supporters of the Foundation for Surgery to consider specifically supporting RACS' Global Health through a Bequest.

> "While I couldn't provide my surgical skills as a young surgeon to people in need in low-income countries, I can provide money so that others can do this important work,"

"I have absolute confidence in the RACS' Foundation for Surgery, its leadership and management and I would urge anyone considering giving to the Foundation for Surgery to go to their lawyer, change their will and create a bequest to support global health.

"Making this decision doesn't mean that family members will be deprived because leaving even three to five per cent of assets to support global health initiatives can make an enormous difference to people most in need of our help."

Include a Charity - September 2018

The Include a Charity month is part of a global movement to raise community awareness of the significant role played by charitable gifts in Wills to help fund the vital work of charities. This September, please consider including the Foundation for Surgery in your Will. Call us on +61 3 9249 1110 for more information

include a charity
Help the work live on.

Karen Murphy
Surgical News journalist

The practice of surgery in New Zealand

The surgical workforce

According to recent Medical Council of New Zealand (MCNZ) workforce statistics there are 872 vocationally registered surgeons (cardiothoracic, general, neurosurgery, orthopaedic, ORL, paediatric, plastic, urology and vascular) practicing in New Zealand.

Less than 15 per cent of New Zealand's surgeons are female. While there is little data currently on ethnicity less than two per cent of New Zealand's surgeons identify themselves as Māori. Encouragingly there are increasing numbers of women and Māori in surgical training programs.

Vocational registration

The MCNZ is the regulatory body for medical practitioners in New Zealand. To practise medicine in New Zealand, surgeons must first gain registration from the MCNZ. This ensures surgeons are competent and fit to practise. The MCNZ registers more than 1,500 new doctors each year and there are over 12,000 registered doctors practising in New Zealand. More than 40 per cent have trained overseas and come from over 100 countries. Registration in a vocational scope recognises doctors as specialists in New Zealand giving the right to practice independently in both public and private practice. If surgeons have the postgraduate qualifications that MCNZ require, and they believe they are fit for registration and competent to practise, they may be eligible for vocational registration. To qualify for vocational registration surgeons must: hold the prescribed qualification (i.e. a combination of qualifications, training and experience) that is assessed as being equivalent to or as satisfactory as the relevant approved qualification; be fit for registration (Health Practitioners Competence Assurance Act (HPCAA), section 16); be competent to practise medicine in the vocational scope applied for; meet MCNZs English language requirements, complete a period of practice in a provisional vocational scope of practice (if applicable); complete any assessment requirements within a provisional vocational period, and be competent to practise independently and without supervision. The MCNZ recognises that there are qualifications other than the FRACS that are suitable for vocational registration as surgeons in New Zealand. The MCNZ engages RACS to assess new surgeons to ensure they meet the MCNZ requirements. Approximately 13 per cent of surgeons vocationally registered in New Zealand are non-FRACS.

The funding of surgery

New Zealand spends approximately nine per cent of its GDP on health. The most recent figure for core Crown health spending in New Zealand is $16.2 billion for the 2016/17 financial year. There are 20 publically funded District Health Boards (DHBs) in New Zealand providing free health care to New Zealanders. There are two main funding streams in the public sector, funding from the Ministry of Health and from the Accident Compensation Corporation (ACC). The latter covers elective and acute accident/trauma treatment including surgery. Acute accident related work is primarily carried out in the public sector with bulk funding from ACC. Some DHBs have funding for elective ACC surgery but the majority of elective ACC work is carried out under contract in the private sector. In the private sector, procedures other than those covered by the ACC, are either self-funded or covered by private health insurance.

Public and private practice

Most surgeons in New Zealand work in both the public and private sector. The two sectors are separated, in that there are no private patients treated in the public sector. Private work is carried out in privately run consulting rooms and private hospitals. There are some publicly funded patients treated in private hospitals on a contracted basis.

Prioritisation of elective surgery in public hospitals

The general practitioner (or primary care provider) is the gatekeeper to elective surgery in the public sector and refers patients to district health board (DHB) hospitals to be assessed by a surgeon. DHBs are required to provide first specialist assessments within four months. If patients require public hospital treatment, the surgeon will determine a priority score, depending on need and benefit from treatment compared to other patients. DHBs make treatment available in priority order, given available resources. If it is decided that the patient meets the priority required for treatment, surgery should be undertaken within four months. Most surgical specialties have priority scoring tools developed collaboratively between specialist societies and the Ministry of Health. Patients who fail to reach pre-determined threshold scores for surgical intervention are either referred back to the original referrer or followed up by the surgeon after a predetermined timeframe.

Measurement of perioperative mortality

Data on perioperative mortality in New Zealand is collected by the government's Health Quality and Safety Commission. The Perioperative Mortality Review Committee (POMRC) is an independent mortality review committee that advises the Health Quality & Safety Commission on how to reduce the number of perioperative deaths in New Zealand. Data is collected independent of surgeons and reported annually in the public domain. The data is reported at DHB level and not at individual surgeon level.

Dr Nicola Hill FRACS
Chair, New Zealand National Board

The importance of the Australian Indigenous Doctors' Association

Social equity is a core value of the Australian psyche and every citizen should be given a 'fair go' to help them reach their potential. I am lucky to do a job in which I am well-rewarded, respected and challenged, which gives me a strong sense of self worth and success. I would like to think that it is all because of hard work and tenacity, but in truth, without my privilege that may not have been enough. Indeed for many indigenous people and other marginalised groups, opportunities have been missing, but thanks to groups such as AIDA this is slowly changing.

The Australian Indigenous Doctors' Association (AIDA) is a group, dedicated to improving the wellbeing of indigenous people through positive change in the health system. Their values include the pursuit of social justice and maintaining cultural integrity. AIDA envisions an Australia free from health and life outcome inequities and want to realise this vision through a number of ways, but most importantly through increasing the number of indigenous doctors. Their ultimate goal is to reach population parity of indigenous doctors in the medical profession.

We are all familiar with disparity in the rates of chronic disease, infectious diseases and life expectancy between indigenous and non-indigenous Australians. Most surgeons would also recount experiences of worse outcomes, delayed presentations and poor compliance from their indigenous patients. While there are many reasons for this, lack of engagement and the tyranny of geography are among key factors.

Aboriginal and Torres Strait Islander people need to have access to high quality and culturally safe care, provided in a way that builds responsibility for their own health. Recruitment and retention of indigenous doctors contributes greatly to enhancing the cultural safety of the health care system, improving engagement and better quality care.

RACS and the College's of Surgeons Trainees' Association (RACSTA) are committed to supporting and collaborating with AIDA. RACSTA shares AIDA's dedication to social equity and increasing the number of Indigenous doctors, particularly surgeons. We can be proud of several interventions from the past few years. In 2005 the RACS Indigenous Health Working Group was established which culminated in the Indigenous Health Committee (2009). Cultural awareness e-modules have been prepared along with the SET selection initiative. These have been taken up by some training boards and are being considered by others. The Board of Cardiothoracic Surgery has recently appointed

its first Trainee under the Aboriginal and Torres Strait Islander Initiative. Scholarships have also been provided for junior medical officers (JMOs) to attend the RACS Annual Scientific Congress (ASC) and also to provide financial assistance for surgical education and training (SET) Trainees. RACS' past President, Phil Truskett has also been named patron for the Association.

Non-Indigenous surgeons and Trainees interested in promoting these efforts can become associate members of AIDA (with support by the Board) or by attending the ASC. This year the AIDA Conferece will be held in Perth from 27 to 28 September 2018 with the theme *Vision into Action*. RACSTA will be on site to encourage consideration of surgery as a career and to share some experience on basic surgical skills.

AIDA is one very important part of the change occurring in Australia to combat disparity in health outcomes. Their leadership is valued by RACSTA and we look forward to supporting in any way possible. We challenge all Trainees to actively learn about the rich culture of local indigenous people and to value the importance of spirituality and identity for these custodians. For it is our perception, actions and behaviour that will welcome all patients to remain engaged.

Dr Leigh Archer
RACSTA Executive - Communications Portfolio
General Surgery (WA)

Subpoenaed medical records

What should practitioners do?

Medical practitioners are often requested to release their patients' medical records to courts under subpoenas. However some medical organisations have concerns that some subpoenas issued for improper purposes have the potential to stigmatise vulnerable people and damage patient–practitioner relationships. This article explains what a subpoena is and what practitioners can do if they want to object to their patients' medical records being used as evidence in court proceedings.

What is a subpoena?

A subpoena is a court order issued to a person at the request of a party in a court proceeding. A party may seek a subpoena as a way to obtain relevant information for use as evidence in a court matter. Subpoenas can be issued to compel a person to give evidence in court, produce documents to the court or both. A subpoena for production requires a person to provide the court with the documents outlined in the subpoena by a specified date and time. Importantly, these documents are provided to the court, and not to the party who requested that they be produced.

What does a practitioner need to provide?

If a practitioner has been issued with a subpoena for production of documents, the schedule to the subpoena will outline the specific documents that need to be provided to the court. Medical practitioners are often requested to produce patients' clinical notes, test results, reports and referrals.

Confidentiality and patient consent

The obligation for practitioners to maintain patient confidentiality is overridden when the law compels the disclosure of a patient's medical record.

If a medical practitioner receives a subpoena to produce the whole or a part of a patient's medical record, it is advisable that the patient should be informed promptly of the disclosure where appropriate. However, patient consent is not required when producing medical records under a subpoena. Even if a patient does not consent to the disclosure, a practitioner who is issued with a subpoena for production of a patient's medical record must provide the requested documents to the court. Failure to do so may result in contempt of court. The onus is on the patient to take action to oppose the subpoena and prevent the information being released.

Can a medical practitioner object to a subpoena?

If a medical practitioner believes that the whole or a part of a patient's medical record should not be disclosed because it contains clinically sensitive information or for some other reason, they can make an objection to the court. Practitioners wanting to object to the production of their patient's medical record will need to write to the court specifying the grounds under which the objection is made. Grounds include irrelevance, abuse of process, oppression or privilege. Subpoenas will not be valid if they amount to a mere 'fishing expedition'. This means that subpoenas cannot be issued to obtain documents which fall outside the scope of the issues in the proceeding. Patients whose medical records have been produced to the court under a subpoena can also object to their inspection under the same grounds.

If a patient's medical record contains sensitive information which may impact their patient's mental health if released, a practitioner may request that the court use their discretion to limit access to those records. In forwarding

information to the court, doctors can, in a covering letter, identify to the court the sensitive material, and suggest that the court consider how, when and to whom the information is provided.

Objections should be made by the patient before the day specified for the production of the material in the subpoena. Where an objection is made, a judge will conduct a hearing to determine whether the material should be produced. As such, practitioners wanting to object to the content of a subpoena should seek legal advice or advice from their indemnity insurer.

In any case, subpoenaed material should be produced to the court and the material objected to should be placed in a separate sealed envelope with a covering letter asking for the objection to be considered by the court before allowing inspection.

Position of peak medical bodies

Medical organisations have voiced their concerns about the potential for patient confidentiality to be undermined in the context of subpoenas.

Concerns have been expressed in submissions to the Australian Law Reform Commission's review of the family law system. They said that medical records are often improperly sought in custody disputes in order to damage the relationship between the children and one parent. It has been emphasised that effective psychiatric treatment requires patients to trust their practitioner – and when medical records containing highly sensitive information are produced in court, this can re-traumatise vulnerable patients and irrevocably damage the patient–practitioner relationship.

In its Ethical Guidelines for Doctors on Disclosing Medical Records to Third Parties, the Australian Medical Association (AMA) makes clear its position that the public benefit of disclosing a patient's medical record must outweigh the risk that, because of such a disclosure, a patient may not seek medical attention or falsify information given to practitioners in the future.

Things to remember

- Subpoenas are legal documents issued by courts which require a person to attend court and give evidence or provide documents to the court;
- A patient's right to confidentiality is overridden when medical records are requested under a subpoena;
- Practitioners must comply with subpoenas and seek advice in the event they wish to make an objection to the court, and
- A failure to comply with a subpoena can result in contempt of court.

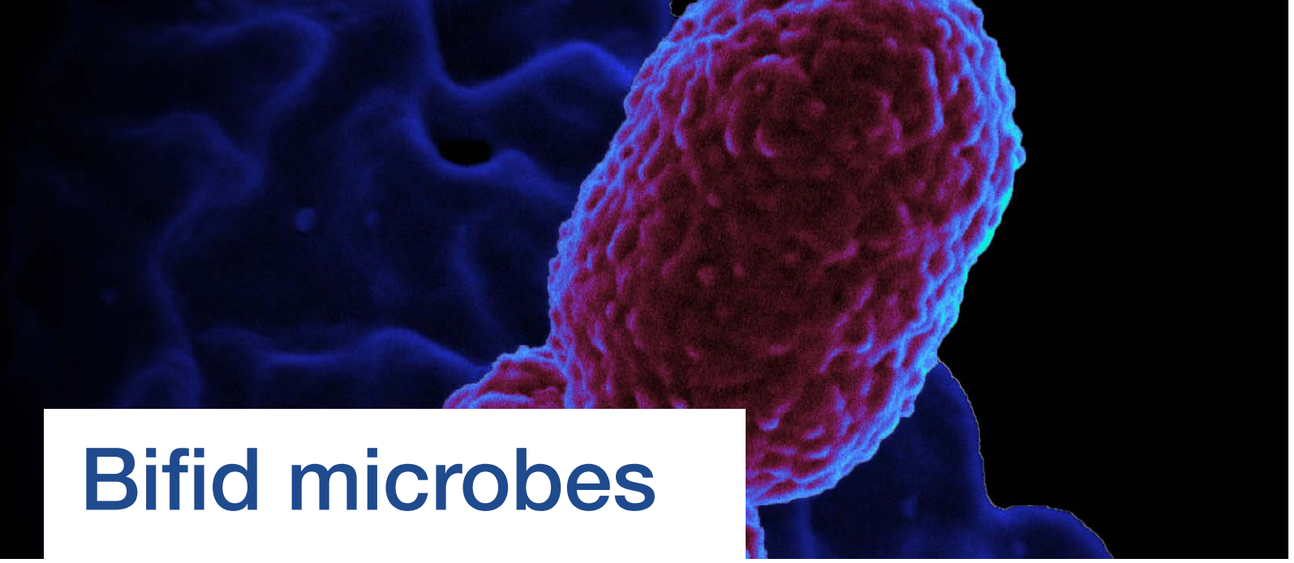
If in doubt consult your medical defence organisation or legal adviser.

For more information, please contact Michael Gorton at mgorton@rk.com.au

Example submission to ALRC:
https://www.ranzcp.org/Files/Resources/Submissions/RANZCP-submission-to-the-ALRC-review-of-the-family.aspx

AMA's Ethical Guidelines for Doctors on Disclosing Medical Records to Third Parties:
https://ama.com.au/system/tdf/documents/Ethical%20Guidelines%20for%20Doctors%20on%20Disclosing%20Medical%20Records%20to%20Third%20Parties%202010.%20Revised%202015.pdf?file=1&type=node&id=40681

Michael Gorton AM



Bifid microbes and surgical fortune

Ms Fortune and UN Luckie are struggling with complications of surgery. Ms Fortune and UN Luckie both had elective, but relatively urgent, colorectal surgery. Ms Fortune had a serious wound infection requiring her to have a prolonged stay in hospital. UN Luckie had an anastomotic leak, returned to theatre and subsequently experienced a significant abdominal wound infection complicated by incisional hernia. I had to reassure the unfortunate Ms Fortune and the unlucky UN Luckie that such complications do occur and despite them, they need to remain positive. My consultations also allowed the venting of anger, expression of upset and regret. UN Luckie still has to prepare for a somewhat challenging repair of his large incisional hernia and possible closure of an unwanted stoma.

Despite protocols to minimise the risk of infective complications following surgery, they are still all too common. They result in unplanned readmissions, lengthened hospital stays, prolonged antibiotic use and cost billions each year. Never mind that the cost to those affected being high in suffering – an all-too-common experience of treatment in our health systems!

A meta-analysis of 31 studies involving almost 3000 patients caught my eye as it suggested that synbiotics might reduce the risk of surgical site infection. Are surgeons aware that surgery and perioperative antibiotics alter the composition of the patient microbiome in favour of unwanted, more pathogenic bacteria [the pathobiome]? Probiotics are micro-organisms while prebiotics are non-viable food components that induce the growth or activity of intestinal micro-organisms. In combination they are called synbiotics, deservedly so when their action is synergistic; for example, *Bifidobacteria* and fructo-oligosaccharides or *Lactobacilli* and inulins. The meta-analysis found that synbiotics significantly reduce the risk of surgical site infection (RR 0.28, CI 0.12-0.64), pneumonia (RR 0.28, CI 0.01 –0. 94), septic events, the likelihood of prolonged hospital stay and the duration of antibiotic use. There was no effect on mortality.

A Brazilian double-blinded randomised controlled trial on 91 patients given *Lactobacilli* (*acidophilus, rhamnosus* and *casei*) and Bifidobacterium with fructo-oligasaccharide reported a reduction from 21 per cent to two per cent in surgical site infection after colorectal resection. Preoperative antibiotics and surgery increased the proportion of pathogenic bacteria in stool samples but the population of Bifidobacteria and Lactobacilli were restored by both synbiotics and probiotics. They also resulted in faster recovery of GI function and a lower rate of postoperative diarrhoea and abdominal cramping.

A recent *British Journal of Surgery* special issue on surgical infection reviewed the potential role of rogue collagenase-producing microbes *E faecalis*, *P aeruginosa*, and *S marscens*, that may dissolve anastomoses or impair normal healing. Stressed and sparsely inhabited (by friendly bacteria) anastomotic tissues may release sufficient inflammatory mediators to activate collagenase secreting bacteria, which opportunistically bind to their sparsely-inhabited surfaces and secrete the enzymes that do damage. There is also recognition that the metabolites of *Bacteroides spp* and *Bifidobacteria* may also exert valuable counter effects acting on epithelial receptors and/or through the tentacles of dendritic cells squeezing their fine extensions between epithelia. These boost the host immune system so that remote sites (e.g. the lungs) have better chances of resisting infection. Although there is still much uncertainty as to the actual organisms and their precise mechanisms, we already know that a loss of microbial diversity and abundance in the gut due to surgery is associated with worse outcomes, and not just in gastrointestinal surgery. Leaky gut is bad for everyone.

Most of us hope to avoid abdominal surgery but probiotics and pre-biotics are also beneficial for mood and mental health via pathways involving 5-hydroxytryptophan and other neuroendocrine metabolites. They not only boost host immune defences but result in less inflammation. There is still a need for more trials and evidence before we get carried away on their ability to reduce postoperative infections. However, having the right microbes in residence generally makes for good fortune and luck. Not only for our patients but also for our health and wellbeing. I think we will hear more about the microbiota, perioperative synbiotics and their influence on surgical outcomes in the future.

DR BB-G-LOVED

Junior surgeons are making the cut in the ACT

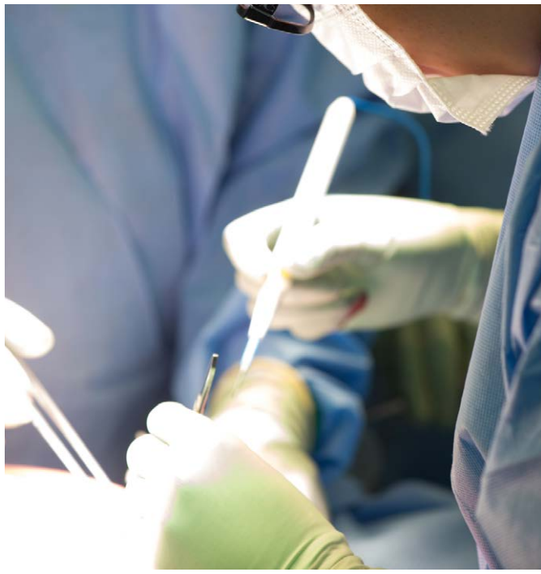
Late last year the ACT Audit of Surgical Mortality (ACTASM) released its sixth annual report. In general, the ACT performed well against Australian and New Zealand Audit of Surgical Mortality (ANZASM) national averages for 2016. Of note, the ACT report saw an increase in junior surgeons operating in more complex cases. In 2016, consultants operated in 53.6 per cent (30/56) of initial operations and 50.0 per cent (17/34) of subsequent operations. This marks a decline in consultants operating in subsequent procedures, with 75 per cent (36/48) of subsequent operations being performed by consultants in 2015. Subsequent procedures are made up of staging of complex procedures and unplanned return to theatre.

Of all 2016 operative cases, 12.5 per cent (7/56) involved an unplanned return to theatre. There is an assumption that subsequent procedures are going to be more complex in nature. Unplanned return to theatre, for example, is indicative of complications and brings with it higher risk of an ensuing procedure([1]).

In most cases in the ACT, the case assessor didn't see the grade of surgeon as an issue in 2016. Only one case indicated that it would have been more optimal to have a higher skilled surgeon performing the procedure. Furthermore, there was no increase in clinical management issues in the ACT which correlates with changes in operating surgeon's experience. This indicates that junior surgeons are given judiciously selected cases befitting to their level of experience. This ACT based shift, to have less experienced surgeons stepping up for subsequent operations, isn't reflected in the 2016 ANZASM national data for the comparative time period.

A recently published study using the national audit data from 2009-2015 looked at post-operative complications from emergency procedures performed by Trainees. This study found that Trainees have positive outcomes when supervised correctly and when they are provided with cases that are appropriate to their skill level([2]). This notion was also supported by a meta-analysis conducted in America comparing resident versus attending surgical outcomes, showing that residents had lower mortality rates and length of stay([3]).

There seems to be evidence which supports a shift away from the 'resident effect', where patients have or are seen to have a higher chance of poor outcomes



when procedures are conducted by less experienced surgeons. This could be in part due to inadequate training, support and exposure to more complex cases in a judicial manner. These are important trends to foster in preservation of a highly skilled future workforce.

Reference list
1. Pujol et al, Unplanned return to theatre: A quality of care and risk management index? Orthopaedics & Traumatology: Surgery & Research 101, (2015) 399-403.
2. Ferrah et al, Post-operative Complications Following Emergency Operations Performed by Trainee Surgeons: A Retrospective Analysis of Surgical Deaths, World Journal of Surgery, (2018) 1-10.
3. D'Souza et al, Comparative Outcomes of Resident vs Attending Performed Surgery: A Systematic Review and Meta-Analysis, Journal of Surgical Education, (2016) 391-399.

Dr John Tharion
Clinical Director ACTASM

with Angie Clerc-Hawke, Project Manager, ACTASM, RACS

2018 RACS Queensland Charity Ball

It's time to frock up and put your dancing shoes on for the inaugural RACS Queensland Charity Ball hosted by the Queensland Younger Fellows Group. The event, which will be held at the beautiful Blackbird Restaurant on Eagle Street in Brisbane, is one you should be part of.

On Saturday 10 November, Queensland Fellows, Trainees and IMGs will strut their stuff all in the name of charity, raising funds for the Foundation for Surgery and two very worthy projects; supporting Aboriginal and Torres Strait Islanders who aspire to a career in surgery, and providing essential Early Management Severe Trauma (EMST) training in East Timor.

Charity Ball MC and the first Aboriginal surgeon, Associate Professor Kelvin Kong, is passionate about building the capacity of Aboriginal and Torres Strait Islander people in the field of surgery. He is heavily involved in the #EarHealthForLife campaign, which is committed to closing the gap on hearing health.

"Aboriginal and Torres Strait Islander communities have some of the worst ear disease rates in the world," Kelvin said.

"This has devastating impacts on learning and education resulting in challenges in seeking employment and can entrench long-term social and economic disadvantage.

"I'm very proud to be a part of this exciting initiative. One critical thing we can do is invest in and support our aspiring Aboriginal and Torres Strait surgeons," he said.

In Timor Leste, there are over 2,000 road traffic accidents resulting in injury or death each year. This is huge for a population of just over one million people and these devastating figures are increasing each year. With a relatively young population these accidents disproportionately affect children and can lead to life-long disability and disadvantage.

East Timor is a nation striving to build capacity and infrastructure to respond to these incidents when they occur. "In our region there is so much need for the Australian aid dollar and there is never enough money to go around. External sources of funding are always needed," said Professor Glenn Guest, Director of the RACS Timor Leste Program.

Professor Guest initially commenced his involvement with RACS outreach to East Timor 16 years ago while juggling a fellowship year in Queensland. During that time he has seen significant improvement. "One important thing we need to continue is the upskilling of our young neighbours.

"We need to support East Timor by building its skills to respond effectively when these road traffic accidents occur and help to fund essential Early Management Severe Trauma training in East Timor," he said.

Liz Hodge, Chair of the Queensland Younger Fellows Group said that the Charity Ball aims to not only raise funds for a great cause but also to establish and nurture collegiate relationships within the profession. "Thanks to some very generous donations, several amazing live auction items will be up for grabs on the night.

"We would especially like to thank in advance, our well-respected senior colleagues who have proven that they are dedicated to the cause and have agreed to be involved in our 'Dancing with the Surgeons' live auction challenge. We would also like to thank our major sponsors to date—Montserrat Day Hospitals and Walshs Financial Planning and Accounting," said Liz.

Silent auctions and raffles will also be featured throughout the evening. Some incredible entertainment has been arranged which will surely get your feet tapping, so jump online at https://surgeons.eventsair.com/qld2018/onlinebooking and book your tickets.

The online booking system allows you to choose your seating, make donations in advance, and for those who cannot attend, a link is provided for you to still donate towards the event. All proceeds will go towards the final tally of funds raised.

Should you require any further information, please do not hesitate to contact the RACS Queensland State Office at charityball.qld@surgeons.org or +61 7 3249 2900.

Program highlights 2018

Annual Joint Academic Meetings

Thursday 8 - Friday 9 November 2018
University of Technology Sydney, Dr Chau Chak Wing Bld,
Sydney NSW

DAY ONE – SECTION OF ACADEMIC SURGERY MEETING

Morning session: Mid-Career Course - Personal Development

- The Ikigai of Academic Surgery - finding your balance
- Don't go it alone - collaboration is key
- Managing up, down and across
- Diversity in academia - beyond gender and ethnicity

Afternoon session: Concurrent work shops

1. Clinical Innovations
2. Creating Institutional Vision with Academic Excellence

The day will conclude with Working Party updates:

- Clinical Trials Network Australia and New Zealand
- Clinical Academic Pathways

Royal Australasian College of Surgeons

Held jointly with the Academy of Surgical Educators Forum Evening on Thursday 8 November 2018

DAY TWO – SURGICAL RESEARCH SOCIETY MEETING

Present your research; submit an Abstract NOW.

Abstract submission closes Friday 28 SEPTEMBER 2018

Awards for the best presentations; Young Investigator Award, DCAS and Travel Grants

Invited guest speakers

Society of University Surgeons Guest Speaker – Dr Rebecca Minter
A.R. Curreri Professor and Chair of the Department of Surgery
University of Wisconsin School of Medicine and Public Health, Wisconsin, USA

Association of Academic Surgeons Guest Speaker – Dr Heather Yeo
Assistant Professor of Surgery and Assistant Professor of Public Health Weill Cornell Medical College, New York, USA

Jepson Speaker – Professor David McGiffin
Head of Cardiothoracic Surgery, Alfred Health, Victoria

Medtronic

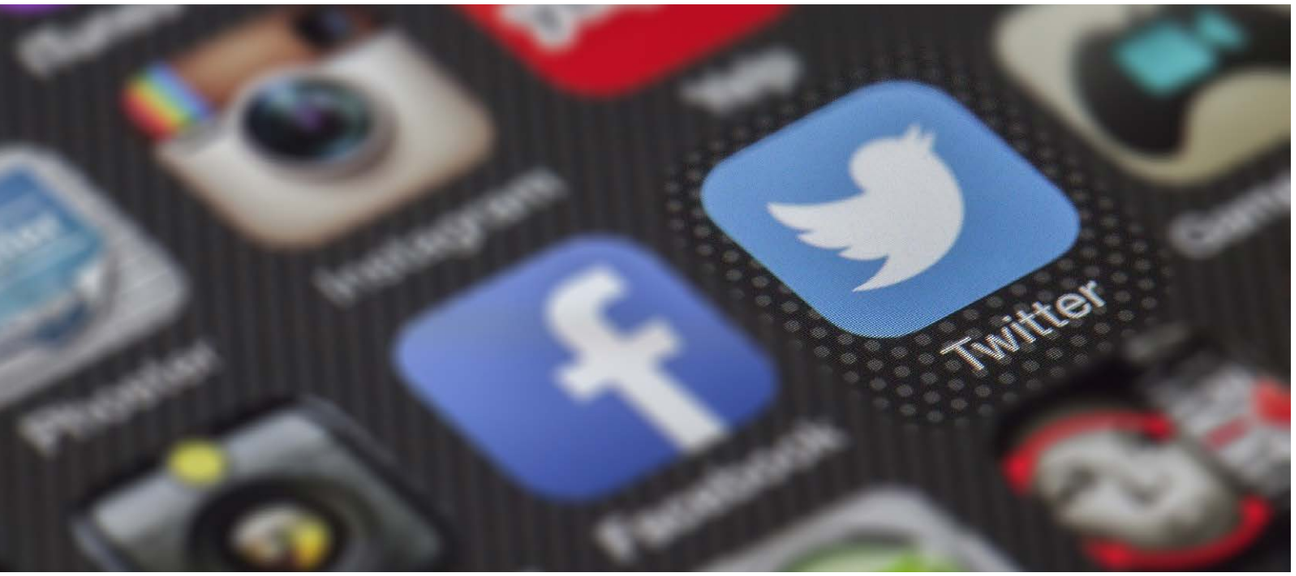
We would like to acknowledge Medtronic as the Foundation Sponsor for the Section of Academic Surgery

Online Registration is NOW OPEN
ABSTRACT SUBMISSION CLOSES FRIDAY 28 SEPTEMBER 2018

Day one - Complimentary
Day two - Only $100 for SAS members to attend - *no membership joining fee*
Places will be limited at these meetings

Contact Details

E: academic.surgery@surgeons.org T: +61 8 8219 0900



Getting started on Twitter

Twitter is just one of many social networks out there but it is one of the biggest. Politicians, celebrities, athletes and everyday people all use Twitter to communicate and stay up to date on what is happening around them.

Even if you don't want to actively tweet yourself, you can use Twitter as a source for accessing breaking news. By following news aggregators, rolling news channels, and journalists, you can get the inside scoop of a story just before it hits mainstream news outlets. As well as breaking news, Twitter works as a way of tracking online trends around the world.

RACS has a strong presence on Twitter, and provides daily updates on news both internal and external and on a number of advocacy initiatives. It shares links to interesting articles that Fellows can access as part of the RACS Library service, as well as information on events and courses around Australia and New Zealand.

Conversations are now shifting from face-to-face communication to the online space. An example of this is during the 2018 RACS Annual Scientific Congress when attendees used the #RACS18 hashtag to create a mini community during the event. Delegates were able to start and join conversations under the hashtag while others used their Twitter profile to document their time in Sydney.

During the Congress, discussions took place on Twitter around a range of topics like the latest research, workplace issues, diversity and inclusion, mental health and even whether using Twitter during conference sessions takes away from learning. In addition, Twitter allowed delegates to connect with one another while being in different places and also form connections, enabling them to remain in touch after the event ended. The popularity of Twitter was demonstrated with an estimated 14.2 million people exposed to tweets under the #RACS18 hashtag.

Now those numbers may seem staggering but what is truly amazing is the number of people already on Twitter. There are a total of 1.3 billion accounts and if Twitter was a country, it would be the second most populous country after China. However, only 330 million are active users (the population of the United States). There are 500 million tweets sent each day which equates to 6,000 tweets every second. In the time it has taken you to read this article, over one million tweets were sent out by users all over the world.

As you can see, Twitter is one of the most important ways that people can communicate today. The good news is that getting started on Twitter is easy. Establishing an account is free and only takes minutes to create. To download the social network app, visit the App Store if you have an Apple device or the Google Play store if you are on an Android device and search for 'Twitter'.

Set up a profile, select your areas of interest, fill out the 'about you' or 'bio' section and start following the people in your social and professional circles. After you are signed up and logged in, remember to follow RACS on Twitter by searching for @RACSurgeons to receive all the latest news and updates.

Agron Dauti
Digital Media & Internal Communications Coordinator, RACS

Do ✓

- use a **strong password** and check **privacy settings**
- know who you're sharing your information with
- investigate exactly what information any third-party add-ons, games, extensions, etc. will be privy to
- interact online but remember to model good behaviour – our online activity may feel private, but we all know it leaves a permanent mark
- network and have fun! Like, reply and repost on Twitter!

Don't X

- give your social media passwords to anyone
- upload anything you wouldn't want everyone to see
- post something that will leave a poor reflection on yourself and/or your workplace
- use anyone else's likeness or identity online
- provide your location or personal address on social media

ASC Bangkok 2019

The Complete Surgeon: Backing the future

We are working hard to ensure that the RACS ASC Bangkok will be a meeting that the Fellowship will want to attend. We are pleased to introduce a new session titled 'President's Town Hall' on Friday 10 May 2019 in the afternoon. This is a new initiative that we think will offer value to the fellowship and provide an opportunity to meet the new RACS President and hear about their vision for your College.

We will also have a wide range of topics of interest to surgeons of all the craft groups. This meeting is about all of us. Without you there is no Annual Scientific Congress and certainly no College.

We encourage you and your colleagues to attend but also to participate. Become a presenter, submit a poster or a paper for presentation or chair a session. It's your meeting so please get involved.

See you in Bangkok 2019.

Nigel Willis
ASC 2019 Convener, FRACS

An account of a medical support visit to Nepal

In April 2015 Nepal was hit by a 7.8 magnitude earthquake, which killed nearly 9000 people and injured another 22,000. So ferocious was the impact, that more than 800,000 homes were destroyed or damaged, and deaths were reported right across the districts of Nepal and in neighbouring areas of China, Tibet and India.

For Darwin based orthopaedic surgeon, Dr Kush Shrestha, the scenes emerging from his home country were devastating, and he immediately signed-up to provide humanitarian medical support. He arrived in Nepal six weeks later, equipped with orthopaedic implants valued at almost AUD $100,000, the funds for which had been generated by the collective efforts of the Nepalese-Australian community.

Dr Shrestha delivered the implants to a major teaching hospital to be used on earthquake victims, and carried out training of the local orthopaedic surgeons on how to use them.

In May this year, after two years of planning, Dr Shrestha in his role as the General Secretary of the Australasian Nepalese Medical and Dental Association (ANMDA), organised a group of 16 clinicians from Darwin to travel to Nepal to run an International Hip and Knee Arthroplasty Symposium and Workshop, in collaboration with the Nepal Orthopaedic Association.

While at the event, Dr Shrestha also signed a Memorandum of Understanding (MoU) on behalf of the ANMDA with the Nepal Orthopaedic Association. As part of the MoU both parties agreed to collaborate with one another to conduct various projects that will improve orthopaedic and trauma care in Nepal.

Since his return Dr Shrestha has established a foundation called ‘AussieMed Foundation.’ The foundation will raise funds for similar medical missions in thefuture. If people are interested in getting be involved please contact the foundation via its website which will be launched shortly.

Many faculty members and participants from the symposium including Lesley Stewart (third from left), Dr Kush Shrestha (centre with blue and white striped tie).

Lesley Stewart, one of the team members who travelled to Nepal for the symposium, shared an account of her visit. Lesley worked for many years as a registered nurse in the Northern Territory in various clinical roles. She now splits her nursing role with working part-time as a support officer in the RACS Northern Territory office.

Our group of eight arrived at Tribhuvan International Airport on Tuesday 29 May to a warm Nepalese day. Dr Shrestha had a very busy and well planned itinerary for us, and we were soon back in the bus on our way to visit a newly built private hospital, Nepal Mediciti, the motto for which is “For a Healthy and Prosperous Nation”. This was a new private hospital, which offers various clinical specialities including: emergency department, outpatient clinic, infection control, general medicine, obstetrics and gynaecology, cardiology and cardio vascular, and orthopaedics. We were given an informative tour of the hospital where it was interesting to hear that approximately 55 per cent of the arthroplasty surgery performed required further surgery.

The next day we travelled to Dhulikhel University Hospital for the two day symposium where we presented to the Nepalese orthopaedic surgeons and registrars. My colleagues presented on ‘Preoperative Arthroplasty Clinic’ and ‘Pre/Per/Post-operative Management and Rehabilitation’ and I presented on RACS guidelines on how to conduct constructive mortality and morbidity meetings.

After lunch we went on a tour through the hospital, which was built in 1981 and became a University Hospital in 1997. It has 380 beds with six operating theatres. The theatre used for orthopaedics is the only theatre that has laminal flow, and the nurses showing us around told us that when doing the arthroplasties the staff use disposable gowns and drapes, which are not used in the other theatres.

Following the symposium we attended a trauma conference at the Medciti Hospital, where it was interesting to hear that the Kathmandu Ambulance service has only three ambulances, and the majority of trauma is from road accidents, with 55 per cent of patients arriving at the hospital via taxi.

The next day we headed out to a rural camp where we joined an education session prepared by one of the outreach nurses to twenty of the local women who administer first aid and health education to the villagers. We presented each of the women with a first aid kit and some little Australian novelties.

Another highlight of the trip was our visit to Pokhara, where we embarked on a steep trek across a small 25km part of the Ammapurna Trail, before visiting the Pokhara Hospital of Academy of Health Science. This was an eye-opening experience as we were escorted around this very busy, overcrowded hospital, by one of the local orthopaedic registrars. It really makes one appreciate how lucky we are in Australia and New Zealand.

A typical ward in a Nepalese Hospital

I would like to thank Dr Shrestha for inviting me to join this wonderful group on its inaugural trip to Nepal. It was a wonderful experience that I will not forget, and I am sure under his guidance the orthopaedic teams will assist with the quality of life of many Nepalese people in the future.

Interview by Mark Morgan,
Communications and Policy Officer, RACS

RACS President John Batten and 2018 Rural Surgeons Award winner Dr Bill Taine

Rural Health Award for New Zealand orthopaedic surgeon

Orthopaedic surgeon and RACS Fellow, Dr Bill Taine was presented with the Rural Health Award at the 2018 New Zealand Annual Surgeons Meeting in Queenstown, in recognition of his contributions toward rural health. Described as quietly spoken, Dr Taine was commended for his dedication to providing excellent care to patients in the South Canterbury district on New Zealand's South Island for over 30 years.

The Rural Surgeons' Award acknowledges significant contributions to surgery in rural settings in New Zealand and Australia. The Award is given to a rural surgeon who has made a significant and enduring impact on their community through the development of a high standard of surgery, education and training.

Dr Taine didn't expect the honour and said it was "a bit overwhelming" to be recognised for his work by his surgical peers and by RACS.

"I am very honoured, especially when you think of all the other people in [regional] centres who are doing a lot of work. It's quite overwhelming," he said.

Dr Taine graduated from Otago University Medical School in 1977, before specialising in orthopaedics and gaining his Fellowship. He started working at South Canterbury's Timaru Public Hospital in 1986, a relatively small orthopaedic service that he was instrumental in growing.

"Working in a rural area has its challenges, but the broad range of experiences keeps work interesting. When working in a rural area, you not only get to know your patients, but also their place in the community," he said. Dr Taine believes this aspect has helped him to become part of that community, often being recognised in the street.

"Surgeons working in rural areas also often have to be a jack-of-all-trades, ready to contend with whatever challenges come through the door."

Dr Taine was instrumental in preparing Bidwill Trust Hospital, a local private hospital, to handle major cases and throughout his time with the South Canterbury District Health Board, numerous house officers worked under him and developed a love for orthopaedics. These house officers have since gone on to become orthopaedic consultants themselves.

By 2008 he took a break from full-time clinical practice and started to work part-time for the Accident Compensation Corporation (ACC) as a medical adviser. As his work with the ACC increased, Dr Taine began to work full-time for the ACC as their Chief Medical Officer.

Following the first initial set-up of the Small Centres Meeting of the New Zealand Orthopaedic Association (NZOA) in 2006, Dr Taine went on to become the first representative of the Small Centres on the NZOA, a position he fulfilled for two and a half years.

RACS President John Batten presented Dr Taine with his award. "The provision of surgical services to non-metropolitan areas is an important focus for RACS, and we aim to assist in the provision of surgical care of the highest standard to the people in regional, rural and remote areas across Australia and New Zealand," said Mr Batten.

"Congratulations to Dr Bill Taine on a well-deserved award in recognition of his efforts towards providing exceptional service to the people of South Canterbury over many decades," he added.

Dr Taine says that one lesson he has carried with him over his career was to be respectful of other people's opinions and be open minded when it comes to dealing with some of the issues and attitudes you come across in boardrooms, committees and institutions.

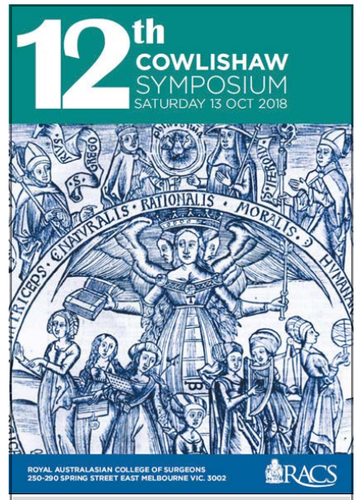
On the clinical side, Dr Taine says it is important to give your patients plenty of time to tell you what is bothering them. He said it does not take much time to listen to your patients and that listening to patients as well as the staff around you is always a good idea.

Dr Taine recommends considering doing a "house surgeon year" in a provincial centre for those interested in working outside metropolitan areas.

"I did my years in Dunedin and then Invercargill and it showed me the benefits of being in a provincial centre. There are a lot of advantages in the metropolitan areas, and you've got to work to organise some of those things in a small centre, but it's a very fulfilling place to work," said Dr Taine.

Dr Taine believes he has been fortunate to have a long and successful career, and he currently volunteers his time with the hospice movement. This has proved interesting and rewarding for him, and he believes there is plenty of work in the community for everyone to assist with. He plans to remain active in the community.

Agron Dauti
Digital Media & Internal Communications Coordinator, RACS



PROGRAMME
13 October 2018
9:30 am - 5pm

Session 1
The 14th Kenneth Fitzpatrick Russell Memorial Lecture:
1783 - Anatomy of a Duel
Associate Professor Susan Neuhaus

Dieffenbach – The 'Father of Plastic Surgery'
Mr Robert Pearce

Session 2
The Fabric of Vesalius – 16th Century networking and a paradigm shift in surgical anatomy
Mr David Grayson

A female surgeon of the early 17th Century: Marie Colinet (1560-1640) of Berne
Professor David Watters

Session 3
'Sir Benjamin Collins Brodie- physiologist, surgeon, philosopher and administrator: His role in transforming surgery from a handicraft to a science'.
Mr Peter Burke

Le mort or la mort: The origins and cultural context of the Danse Macabre, with specific reference to Hans Holbein's sixteenth century woodcuts.
Elizabeth Milford

Session 4
The Decline and Fall of the Roman Empire
Mr Graham Stewart

Bibliographical Observations
Mr Geoffrey Down

Leading the way in surgical education

With its vision to be the leading advocate for surgical standards, education and professionalism in Australia and New Zealand, RACS has always had a focus on improving the knowledge and skills of its surgical educators.

The Academy of Surgical Educators (ASE) was formed to continually improve the level of surgical education delivered by Fellows to Trainees. Since its inception in 2014, the ASE has led the charge to 'foster excellence in surgical education' in the surgical community.

The Academy has over 800 members from a broad range of societies and regions, to support, enhance and recognise excellence within surgical education. Members regularly meet at specialised conferences and meetings, apply for scholarships and research support and attend master classes or post graduate study. ASE Membership is a privilege and applications are open to Fellows, Trainees and non-surgeons who wish to increase their capacity to deliver excellent surgical education. It provides a chance to be part of a highly knowledgeable community of practice, undertake regular online learning supported by targeted quality resources, attend face-to-face courses and sessions at the Annual Scientific Congress (ASC) surgical education and educational master class programs.

There are many courses and events that the Academy organises to support the community of practice including the Educator Studio Sessions which occur at a range of venues around Australia and New Zealand. The sessions occur each month and provide members with a chance to learn about and reflect upon current research and have included a range of relevant presenters including Professor Spencer Beasley who spoke about the unconscious biases in selection for training. These discussions prompted an open constructive debate among those present about the challenges facing situations of bias and methods of dealing with it.

Many ASE members decide to extend their training in surgical education via the graduate programs offered through the University of Melbourne including the Graduate Certificate, Graduate Diploma and Masters in Surgical Education. The collaboration between the ASE and the University of Melbourne culminates in the Victorian Showcase of Educational Research in the Health Professions. This meeting will occur in November 2018 and brings together EXCITE University of Melbourne Master of Clinical Education, HealthPEER Monash University Master of Health Professional Education and RACS / University of Melbourne Master in Surgical Education to discuss optimising and improving upon surgical education.

The Academy supports research into surgical education best practice via the Academy of Surgical Educators Education Research Scholarship. Each year, $10,000 is awarded to conduct research into the efficacy of existing surgical education or innovation of new surgical education practices.

The 2017 Surgical Educators Education Research Scholarship recipient was Dr David Lam who investigated the Development of Ambidexterity in Laparoscopic Surgery throughout 2018 and will present his findings

Professor Spencer Beasley at the Wellington studio session in May

Professor Mark Smithers at the Brisbane studio session in July

at the end of the year. In addition to the Scholarship, the ASE also supports excellence in surgical education across Australia and New Zealand at the ASE Academy Awards held once a year which identify exceptional contributions to surgical education. Nominations for 2018 have closed and the winners will be announced at the Academy of Surgical Educators Forum in Sydney in November.

The ASE Forum occurs once a year and provides a chance for Academy members to come together and improve collaboration and compare and reflect upon current surgical education topics. The 2017 ASE Forum meeting held in Sydney included a broad range of talks presented by Dr Sally Langley FRACS, Associate Professor Stephen Tobin FRACS, and Professor Larry Marlow who discussed leadership in healthcare teams, as well as Dr Sarah Dalton who presented on involving surgeons in systems improvement.

The Academy supports the RACS nine competencies and recognises the importance of using a structured framework to guide supervisors, Trainees and Trainee boards.

There are many great things occurring in the ASE and we are always looking for like-minded people to join the group and become involved in supporting, organising, and collaborating with their peers. The ASE will continue to grow and evolve as a group and it needs a dedicated group of members to lead this process.

In the future the ASE will continue to respond to the changing educational landscape and be at the forefront of surgical education standards. We are member focussed and we should represent the membership by providing an opportunity to share and expand the surgical education community. The Academy has come a long way since its inception in 2014. We are certainly on our way in developing Surgical Education as a community of practice.

If you'd like any more information about the Academy please contact ase@surgeons.org or follow us on twitter @SurgEdAcademy.

Dr Sally Langley
Chair, Academy of Surgical Educators

Assoc. Professor Stephen Tobin
Dean of Education

With Dr Alison Drechsler Education Coordinator and Rob Di Leva, Professional Development Manager, RACS.

RESEARCH PROJECT

HOW EFFECTIVE IS THE OPERATING WITH RESPECT TRAINING AT REDUCING BULLYING IN SURGICAL PRACTICE?

Participate in this research to help find out.

WHAT DOES THE RESEARCH INVOLVE?

1. You will be asked to complete an **online questionnaire**. Which includes the NAQ-R (Negative Acts Questionnaire Revised) before and six months following the Operating with Respect Training.
   TIME REQUIRED?
   Approximately 15 minutes on each occasion.
2. There will also be an opportunity to participate in a **phone interview** that will explore your experience of workplace behaviour in greater detail prior to and six months following the OWR training.
   TIME REQUIRED?
   Approximately 1 hour at a convenient time to you.

WHO IS BEING TARGETED?

If you have **not yet** participated in the OWR training but are scheduled to do so later in 2018, you are ideally placed to assist with this research.

WHAT IS REQUIRED?

Quick, online questionnaire, Plus optional, follow up phone interview

The NAQ-R is a well-recognised, standardized tool used for research into workplace bullying.

This research is being conducted by LaTrobe University (Ethics Number HEC18308) and is independent of the Royal Australasian College of Surgeons (RACS). RACS are assisting with recruitment of participants by promoting the research to Fellows.

LA TROBE UNIVERSITY

INTERESTED?

Contact: Paul Gretton-Watson
82041187@students.latrobe.edu.au or mobile +61 (0)410 415 319

Email reminders about the research will be sent out prior to future OWR training events

Courses for every stage of your career

Online registration form *is now available (login required).*

Inside 'Active Learning with Your Peers 2018' 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.

Mandatory courses

With the release of the RACS 'Action Plan: Building Respect and Improving Patient Safety', the following courses are mandated for Fellows in the following groups:

- Foundation Skills for Surgical Educators course: Mandatory for SET Surgical Supervisors, Surgeons in the clinical environment who teach or train SET Trainees, IMG Clinical Assessors, Research supervisors, Education Board members, Board of Surgical Education and Training and Specialty Training Boards members.
- Operating with Respect one-day course: Mandatory for SET Supervisors, IMG Clinical Assessors and major RACS Committees.

Foundation Skills for Surgical Educators course (FSSE)

15 September 2018	Sydney	NSW
20 September 2018	Orange	NSW
22 September 2018	Adelaide	SA
29 September 2018	Sydney	NSW
6 October 2018	Melbourne	VIC
14 October 2018	Brisbane	QLD
16 October 2018	Queenstown	NZ
28 October 2018	Perth	WA
1 November 2018	Adelaide	SA
3 November 2018	Brisbane	QLD
4 November 2018	Sydney	NSW
1 December 2018	Melbourne	VIC
2 December 2018	Canberra	ACT
8 December 2018	Auckland	NZ
1 December 2018	Melbourne	VIC
2 December 2018	Canberra	ACT
8 December 2018	Auckland	NZ

FSSE is an introductory course to expand knowledge and skills in surgical teaching and education. The aim of the course is to establish a basic standard expected of RACS surgical educators and will further knowledge in teaching and learning concepts. Participants will look at how these concepts can be applied into their own teaching context and will have the opportunity to reflect on their own personal strengths and weaknesses as an educator.

Operating with Respect course (OWR)

14 September 2018	Adelaide	SA
29 September 2018	Canberra	ACT
12 October 2018	Sydney	NSW
13 October 2018	Sydney	NSW
16 October 2018	Queenstown	NZ
13 October 2018	Sydney	NSW
16 October 2018	Queenstown	NZ

The OWR course provides advanced training in recognising, managing and preventing discrimination, bullying and sexual harassment. The aim of this course is to equip surgeons with the ability to self-regulate behaviour in the workplace and to moderate the behaviour of colleagues, in order to build respect and strengthen patient safety.

Academy of Surgical Educators Studio Sessions

11 September 2018	Canberra	ACT

Each month, the Academy of Surgical Educators presents a comprehensive schedule of education events curated to support surgical educators.

The Educator Studio Sessions are presented around Australia and New Zealand and deliver topics relevant to the importance of surgical education and help to raise the profile of educators. They provide insight, a platform for discussions and an opportunity to learn from experts.

All sessions are also simulcast via webinar. Register here: www.surgeons.org/studiosessions

Safer Australian Surgical Teamwork (SAST)

24 November 2018	Perth	WA

SAST is a combined workshop for surgeons, anaesthetists and scrub practitioners. 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). These frameworks can help participants develop the knowledge and skills to improve their performance in the operating theatre in relation to communication/teamwork, decision making, task management/leadership and situational awareness. The program looks at the relationship between human factors and safer surgical practice and explores team dynamics. Facilitators will lead participants through a series of interactive exercises to help reflect on performance and that of the operative team.

Surgeons as Leaders in Everyday Practice

21-22 September 2018	Auckland	NZ
23-24 November 2018	Melbourne	VIC

Surgeons as Leaders in Everyday Practice is a one and a half day program which looks at the development of both the individual and clinical teams' leadership capabilities. It will concentrate on leadership styles, emotional intelligence, values and communication and how they all influence their capacity to lead others to enhance patient outcomes. It will form part of a leadership journey sharing and gaining valuable experiences and tools to implement in the own workplace. All meals, accommodation and educational expenses are included in the registration fee. The evening session will involve an inspirational leadership speaker.

Combined Meeting of AOA/RACS/AMLC includes AMA Guidelines: Difficult Cases

7-8 September 2018	Melbourne	VIC

This meeting includes:

- Clinical updates on micro-invasive surgery, on elbows – particularly the stiff
- Elbow, on surgery for arthritis of the ankle, foot surgery, and on degenerative and post traumatic conditions
- Risk management in bariatric surgery
- Robotic surgery
- Medico-legal matters such as 'operating on the futile case'
- Current litigation presentations by indemnity providers
- Expert evidence
- Pain Management including opiate overload and Complex Regional Pain Syndrome
- Difficult cases assessed under AMA 4th, 5th and 6th Editions

External registration through AOA.

Process Communication Model Seminar 1

12 -14 October 2018	Perth	WA
16 -18 November 2018	Adelaide	SA

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

Before the Introductory PCM course each participant is required to complete a diagnostic questionnaire which forms the basis of an individualised report about their preferred communication style.

Partners are encouraged to register.

Clinical Decision Making

15 September 2018	Melbourne	VIC
30 November 2018	Adelaide	SA

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

Non-Technical Skills for Surgeons (NOTSS)

22 September 2018	QLD	Brisbane
5 October 2018	NZ	Auckland
23 November 2018	NSW	Sydney

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.

Bioethics Forum

27 October 2018	Sydney	NSW

RACS Medico Legal Section presents the Bioethics Forum to stimulate robust bioethical discussions amongst surgeons. The Forum has a broad clinical emphasis to reveal current medical, surgical and hospital practice and to bring into focus innovations in medicine, nursing, pain relief and surgery that continue to evolve. Topics include Medicinal Cannaboids, Euthanasia Debate - Patient's rights to die, Futile case - Collaborating Hospitals of Surgical Mortality on Mortality Rate, Complaints handling in bioethical disputes, Advanced directives, Guardianship and Power of Attorney, Off-field behaviour by professionals and Conflict of Interest, Financial disclosure e.g. when a surgeon has been involved in the development of an implantable device, End of life issues and Healthcare proxy. The target group for this forum is Fellows, IMGs, Trainees and other interested participants.

PROFESSIONAL DEVELOPMENT WORKSHOP
DATES: August - November 2018

ACT		
Academy of Surgical Educators Studio Session	11 Sep	Canberra
Foundation Skills for Surgical Educators	2 Dec	Canberra
NSW		
Process Communication Model Seminar 2	14 -16 Sep	Sydney
Foundation Skills for Surgical Educators	15 Sep	Sydney
Foundation Skills for Surgical Educators	20 Sep	Orange
Foundation Skills for Surgical Educators	29 Sep	Sydney
Bioethics Forum	27 Oct	Sydney
Foundation Skills for Surgical Educators	4 Nov	Sydney
Non-Technical Skills for Surgeons	23 Nov	Sydney
NZ		
Surgeons as Leaders in Everyday Practice	21-22 Sep	Auckland
Foundation Skills for Surgical Educators	16 Oct	Queenstown
Non-Technical Skills for Surgeons	5 Oct	Auckland
Foundation Skills for Surgical Educators	8 Dec	Auckland
QLD		
Non-Technical Skills for Surgeons	22 Sep	Brisbane
Foundation Skills for Surgical Educators	14 Oct	Brisbane
Foundation Skills for Surgical Educators	3 Nov	Brisbane
VIC		
Clinical Decision Making	15 Sep	Melbourne
Foundation Skills for Surgical Educators	6 Oct	Melbourne
Academy of Surgical Educators Studio Sessions	23 Oct	Melbourne
Surgeons as Leaders in Everyday Practice	23-24 Nov	Melbourne
Foundation Skills for Surgical Educators	1 Dec	Melbourne
WA		
Process Communication Model Seminar 1	12-14 Oct	Perth
Foundation Skills for Surgical Educators	28 Oct	Perth
SA		
Foundation Skills for Surgical Educators	22 Sep	Adelaide
Process Communication Model Seminar 1	16-18 Nov	Adelaide
Foundation Skills for Surgical Educators	1 Nov	Adelaide
Non-Technical Skills for Surgeons	26 Oct	Adelaide
Clinical Decision Making	30 Nov	Adelaide

RACS Post Op podcasts

Latest episodes

Check out the interviews with some of the most inspiring and forward-thinking industry professionals.

Gun violence as a health issue: strict gun control is necessary to minimise mass shootings

How telehealth is helping patients in remote regions

Tackling ear infections in remote indigenous regions of Australia

Developed by RACS the Post Op Podcasts feature extended interviews on the latest research across the medical industry as well as practical advice that surgeons can implement in their practices, such as insights on financial management, wealth creation, legal and tax advice and economic forecasts.

You can subscribe to the fortnightly RACS Post Op Podcasts on Apple's iTunes or, for those with other smartphone models, on Stitcher.

Listen on iTunes
Search 'RACS Post Op' in the Podcast app on iPhone or in iTunes on desktop

Listen on Stitcher
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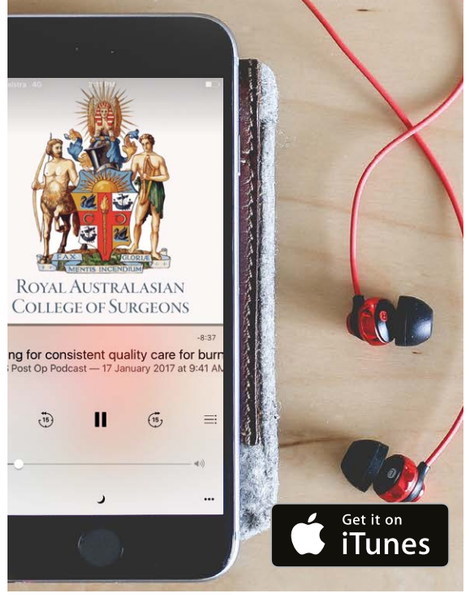


Register online

For future course dates or to register for any of the courses detailed above, please visit
https://www.surgeons.org/for-health-professionals/register-courses-events/
Contact the Professional Development Department on +61 3 9249 1122 or email **PDactivities@surgeons.org**

Skills training courses 2018

RACS offers a range of skills training courses to eligible medical graduates that are supported by volunteer faculty across a range of medical disciplines. Eligible candidates are able to enrol online for RACS Skills courses.

ASSET: Australian and New Zealand Surgical Skills Education and Training

ASSET teaches an educational package of generic surgical skills with an emphasis on small group teaching, intensive hands-on practice of basic skills, individual tuition, personal feedback to participants and the performance of practical procedures.

EMST: Early Management of Severe Trauma

EMST Edition 10 has launched! EMST teaches the management of injury victims in the first hour or two following injury, emphasising a systematic clinical approach. It has been tailored from the Advanced Trauma Life Support (ATLS®) course of the American College of Surgeons. The course is designed for all doctors who are involved in the early treatment of serious injuries in urban or rural areas, whether or not sophisticated emergency facilities are available.

CCrISP®: Care of the Critically Ill Surgical Patient

CCrISP Edition 4 has launched! RACS has officially launched Edition 4 of the Care of the Critically Ill Surgical Patient (CCrISP®) course across Australia and New Zealand. The CCrISP® Committee has extensively reviewed materials provided by the Royal College of Surgeons of England (RCS) - resulting in an engaging new program which is highly reflective of current Australian and New Zealand clinical practice and standards in management of critically ill patients.

CLEAR: Critical Literature Evaluation and Research

CLEAR is designed to provide surgeons with the tools to undertake critical appraisal of surgical literature and to assist surgeons in the conduct of clinical trials. Topics covered include: Guide to clinical epidemiology, Framing clinical questions, Randomised controlled trial, non-randomised and uncontrolled studies, Evidence based surgery, Diagnostic and screening tests, Statistical significance, Searching medical literature and decision analysis and Cost effectiveness studies.

TIPS: Training in Professional Skills

TIPS is a unique course designed to teach surgeons-in-training core skills in patient-centred communication and teamwork, with the aim to improve patient care. Through simulation participants address issues and events that occur in the clinical and operating theatre environment that require skills in communication, teamwork, crisis resource management and leadership.

SKILLS TRAINING COURSE DATES
OCTOBER - DECEMBER 2018 | *Available courses

ASSET	
Friday, 26 October – Saturday, 27 October	Sydney
Friday, 26 October – Saturday, 27 October	Auckland
CCrISP	
Friday, 19 October – Sunday, 21 October	Melbourne
Friday, 26 October – Sunday, 28 October	Brisbane
Friday, 31 October – Sunday, 2 November	Dunedin
Friday, 2 November – Sunday, 4 November	Adelaide
Friday, 16 November – Sunday, 18 November	Sydney
Friday, 23 November – Sunday, 25 November	Melbourne
CLEAR	
Friday, 19 October – Saturday, 20 October	Brisbane
Friday, 2 November – Saturday, 3 November	Adelaide
Friday, 23 November – Saturday, 24 November	Auckland
EMST	
Friday, 19 October – Sunday, 21 October	Auckland
Friday, 19 October – Sunday, 21 October	Sydney
Friday, 26 October – Sunday, 28 October	Canberra
Friday, 26 October – Sunday, 28 October	Adelaide
Friday, 2 November – Sunday, 4 November	Brisbane
Friday, 2 November – Sunday, 4 November	Sydney
Friday, 9 November – Sunday, 11 November	Melbourne
Friday, 16 November – Sunday, 18 November	Sydney
Friday, 23 November – Sunday, 25 November	Brisbane
Friday, 23 November – Sunday, 25 November	Adelaide
Friday, 30 November – Sunday, 2 December	Melbourne
Friday, 7 December – Sunday, 9 December	Sydney
TIPS	
Friday, 23 November – Sunday, 25 November	Auckland

**Courses available at the time of publishing*

Contact the Skills Training Department

Email: skills.courses@surgeons.org • Visit: www.surgeons.org click on Education and Training then select Skills Training courses.
ASSET: +61 3 9249 1227 asset@surgeons.org • **CCrISP:** +61 3 9276 7421 ccrisp@surgeons.org • **CLEAR:** +61 3 9276 7450 clear@surgeons.org
EMST: +61 3 9249 1145 emst@surgeons.org • **TIPS:** +61 3 9276 7419 tips@surgeons.org • **OWR:** +61 3 9276 7486 owr@surgeons.org

A case note review

Necrotising fasciitis of lower limb in patient with type 2 diabetes and cardiac impairment

This middle-aged man was admitted to a major metropolitan hospital as an emergency with necrotising fasciitis of the left lower limb. He had a six-week history of an ulcer over the Achilles tendon, and had received a course of ciprofloxacin for pseudomonas in the ulcer.

Intercurrent health problems included type 2 diabetes mellitus, dilated cardiomyopathy (ejection fraction 35%) with atrial fibrillation, mild renal impairment (glomerular filtration rate (GFR) 53-63 mL/min)* and obesity. Previous surgical history included pacemaker insertion.

Necrotising fasciitis was diagnosed within 24 hours of admission and he underwent emergency extensive debridement of the left lower limb, with a re-look operation the following day. He required inotrope support and remained in the intensive care unit (ICU) following debridement. Steadily improving, he was discharged to the ward five days following admission with ongoing vacuum-assisted closure (VAC) dressing to the left leg.

Enterococcus, Streptococcus and Candida albicans were cultured from the left leg. The wound was reviewed in the operating theatre two days later and was noted to be clean with no new areas of sepsis. No further debridement was required.

One week later the patient was transferred to the plastic surgery service of another hospital.

The white cell count was normal and the wound clean and granulating, but there was residual fluid overload with significant peripheral oedema and a low albumin level.

The patient underwent split skin grafting to the left leg several days after admission. Ten days later, debridement of exposed tendons on the lateral leg was performed, but with the exception of those areas the graft had taken. The first stage of a bipedicled flap was performed a week later to cover the residual ungrafted area.

The second stage of the flap, scheduled for six days after the first, was cancelled as the patient developed candida septicaemia from an ascending urinary tract infection. He was admitted to the ICU for one week with septic shock, respiratory failure and left ventricular dysfunction. He also developed a deep vein thrombosis in his arm from the peripherally inserted central (venous) (PICC) catheter. Candida was cultured from the skin and urine.

Ten days after ICU discharge the second stage of the flap was completed under local anaesthesia (unfit for general anaesthesia due to reduced ejection fraction and general deconditioning). On the ward over the next two and a half weeks he received dressings to the residual leg defect and general supportive treatment but did not substantially improve.

The patient was readmitted to the ICU due to Pseudomonas septicaemia, with Pseudomonas cultured from the PICC line and peripheral blood cultures. A septic arthritis of the right knee became apparent, and washout and synovial biopsy were performed. Pseudomonas was cultured from joint fluid.

By this time, ten weeks after the initial admission, the patient was profoundly deconditioned, septic and uraemic with very low cardiac output (ejection fraction 15%). Above knee amputation was proposed but was declined by the patient. He was discharged from the ICU after ten days and referred to the palliative care team. He died three weeks later.

COMMENT

The initial management of this patient with extensive debridement and antibiotics was appropriate. He made a good initial recovery and was fit for skin grafting when transferred. The possibility of amputation was raised at the first debridement, but the improvement following the procedure was clearly sufficient to make limb salvage a viable proposition.

Until the flap was performed there was no indication that the patient was deteriorating. The split skin grafting was largely successful; the flap was indicated for the areas of tendon that had become exposed. Shortly after the flap was performed he developed candida septicaemia, the source of which was likely a urinary tract infection (although candida was cultured from the wound and it is likely that this was the source of the urinary candida). During this period he appears to have been too unwell for anaesthesia, although this may have been the optimal time for amputation.

The patient's condition plateaued following the second stage of the flap, and the subsequent development of pseudomonas septicaemia with peripheral dissemination was another major setback. The source of the pseudomonas was again most likely the leg wound.

The decision for amputation was made very late in the admission and amputating at this stage would probably not have affected the final outcome. In any event, the patient refused amputation and may well have done so even if it had been offered earlier. It should be noted that Gentamicin was prescribed for this patient in the presence of deteriorating renal function. Although it does not appear to have compromised renal function any further, it was contraindicated.

This patient had an ulcer over his Achilles tendon for six weeks prior to the development of necrotising fasciitis. Such ulcers often overlie a necrotic Achilles tendon extending proximally and are portals of entry for bacteria. Identifying the risk and treating this ulcer earlier, both aggressively and surgically, would have provided the patient with the best chance of avoiding necrotising fasciitis, which may have a high mortality rate.

This case highlights the need for regular surveillance of all diabetic patients for foot problems, as well as education for diabetes patients and health care providers alike in the importance of foot care and early attention to lesions.

*NR >60 mL/min/1.73m^2; RCPA; https://kidney.org.au/cms_uploads/docs/estimated-glomerular-filtration-rate-egfr.pdf; accessed 06.08.2018

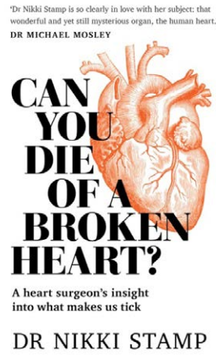
Professor Guy Maddern
Surgical Director of Research and Evaluation incorporating ASERNIP-s

Donations to the library collection

Can You Die of a Broken Heart? by Dr Nikki Stamp FRACS

When actress Debbie Reynolds died a day after her beloved daughter Carrie Fisher, the world diagnosed it as "heartbreak" but what's the evidence? Does emotional upheaval affect the heart? Can love or chocolate really heal our heart problems? Why do we know so much about heart attacks in men when they are more fatal in women? Dr Nikki Stamp's book is a heart surgeon's insight into "what makes us tick." Rich with anecdotes and insights for maintaining heart health, this title comes from a uniquely-positioned young specialist.

Dr Nikki Stamp is one of only a handful of female heart and lung surgeons in Australia. A RACS Fellow, Nikki has trained in some of the country's busiest hospitals, and has a strong desire to change the way we think about health.



The author takes us into the operating theatre, explaining what she sees in patients with heart complications and how a life-saving transplant works. She fell in love with the heart as a child and continues to be fascinated by its workings and the whole-of-life experiences that affect it.

Chapters include *Depression: can a heart be blue? Transplants and mechanical hearts, The medical mysteries of a women's heart,* and *Can love heal?*

Donated by the author.

Eight Decades of Philippine Surgery by The Philippine College of Surgeons Board of Regents

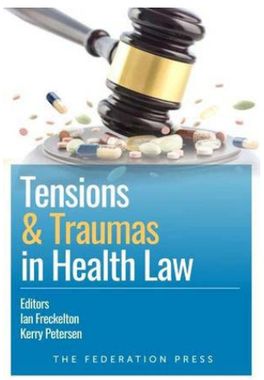
Philippine College of Surgeons

From the book's foreword: This book is a documentary opus chronicling the 80-year odyssey of the organisation. It is a written salute to the men and women who contributed to the success of the Philippine College of Surgeons (PCS) which commenced in 1936. This labour of love involved a lot of searching and researching to validate and authenticate the facts and figures contained within it. With these came the investments of time, talent, treasure and technology. The composition exacted a lot of patience and painstaking work by the team to weave together recently discovered gems in the organisation's journey to excellence. Guided by the common aspirations bequeathed by the founders and those who followed after them, this body of work demonstrates the resiliency and determination of the PCS to rise above the challenges and changes brought before it. The authors hope that it will inspire the next generation of surgeons.

Donated by Alejandro Dizon MD (current President of The Philippine College of Surgeons).

Tensions and Traumas in Health Law 2017 Editors Ian Freckelton and Kerry Petersen

The soft-covered book of 787 pages is multi-authored by acknowledged authorities in a wide variety of health law topics. It provides an up-to-date authority in a number of fast-moving areas of health law. Each chapter (and indeed each page) features footnotes for further study. There is an extensive "select bibliography" at the end of the book.



In a book which provides essential reading for experts in various medical fields – particularly in Australia and New Zealand, it is a necessary acquisition for any medical professional library.

Review by Tony Buzzard FRACS

Sections in the book include: *Human Rights Issues, Ethico-Legal Issues, Global Health Issues, Consent Issues, Privacy and Confidentiality Issues, Reproductive Technology Issues, Health Research Issues, Death and Dying Issues, Legal Liability Issues and Reform and Regulatory Issues.*

Further reviews available at: https://bit.ly/2AJdw5s

Donated by the publishers (The Federation Press).

Celebrating a century

In 2027, the Royal Australasian College of Surgeons (RACS) will celebrate a major milestone – the one hundred year anniversary of its creation. The founders of the College in 1927 were combating entrenched biases against its establishment – from the Australian and the New Zealand branches of the British Medical Association, from general practitioners who undertook a substantial amount of surgery and from surgeons who practiced without any postgraduate surgical qualifications. And of course, the founders were ploughing a new field – RACS was the first medical college to be established in our two countries. While they had the models of the long-established United Kingdom colleges and the American College, from an antipodean perspective they confronted a blank sheet.

It would be forgivable to believe that against such forces, our founders perhaps gave little thought to the College existing 100 years later. Despite all this, they laid the foundations for the highly successful College that it has become and held in high regard by its sister Colleges around the world.

The Heritage and Archives Committee has been asked by the RACS Council to promote the forthcoming event, to provide suggestions as to how should our centenary celebrations take shape and to canvas suggestions from Fellows and Trainees as to what RACS might do to provide one or more enduring centennial artefacts.

The Heritage and Archives Committee is of the view that nine years from the centennial year is not too soon to be collecting options and suggestions from the fellowship.

The Heritage and Archives Committee has already recommended that the 2027 Annual Scientific Congress be held in Melbourne and that the College itself plays a central part in the meeting. However, the Committee expects there will be centennial events happening throughout 2027. The Committee has also proposed that the redeveloped West Wing of the College be named the Centennial Wing, irrespective of its actual completion date.

Other proposals generated from the Committee include the updating of the history of RACS to bring *'The Mantle of Surgery'* up to 2027 or for RACS to commission an entirely new history – either would necessitate several years of research by the author or authors. Should RACS commission a 'Lives of the Fellows'? Should RACS commission a Centenary tie and scarf?

Suggestions and proposals are therefore requested from you, both Fellows and Trainees. Such suggestions could represent our history as well as our diversity. The Heritage and Archives Committee will aggregate these (where there is common ground among proposals) and provide these to Council for its final decision.

Please give the centenary careful thought and email your suggestions to the Chair of the Heritage and Archive Committee at RACS.2027@surgeons.org

Campbell Miles
Chair, Heritage and Archives Commitee

Academic gown donation

RACS would like to acknowledge **Mrs Nellie Benjamin** for generously donating Professor Bruce Benjamin's academic gown to the College.

RACS maintains a small reserve of academic gowns for use by Convocating Fellows and at graduation ceremonies at the College. If you have an academic gown taking up space in your wardrobe and it is superfluous to your requirements, RACS would be pleased to receive it to add to our reserve. We will acknowledge your donations and place your name on the gown if you approve.

If you would like to donate your gown to RACS, please contact the Conference and Events Department on +61 3 9249 1248. Alternatively you could mail the gown to Ms Ally Chen c/o Conferences and Events Department, Royal Australasian College of Surgeons, 250-290 Spring St, EAST MELBOURNE, VIC 3002

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Thank you!

A very special thanks to all those who have donated to the **Pledge-a-Procedure campaign** and showed their support for ensuring the future of surgical care during July.

Every donation during this campaign makes an incredible difference.

All costs for the Foundation for Surgery are provided for by the College so that 100% of your donation can achieve its maximum benefit to the community.

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Mr Gordon Pickard

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Mr John Taylor

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