SurgicalNews

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ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

GLOBAL HEALTH

RACS supports gastroenterology training across Pacific Islands

RACS COUNCIL

Meet our newest Councillors Dr Maxine Ronald and Dr Christine Lai

SETTING SIGHTS ON THE STARS

Dr Lisa Brown on studying aerospace medicine

"We are not a team because we work together. We are a team because we trust, respect and care for each other,"

Vala Afshar

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Highlights from June RACS Council week

Dr Maxine Ronald being welcomed to RACS Council with Māori Welcoming Ceremony during Council Week

June Council was a full week for all Councillors. It began on the Monday with the second of our off-site strategy days to develop the 2019 to 2021 Strategic Plan. This was facilitated by Simon Longstaff AO, Executive Director of the Ethics Centre and provided Councillors with a different perspective to look at our Purpose, Vision and the Pillars that underpin our direction and activity. The third and final strategy meeting will be prior to October Council.

A wide range of other topics were also discussed including governance, advocacy, corporate social responsibility, sustainability, healthcare outcomes and we also welcomed two new Councillors.

The Advocacy Board, formed by the amalgamation of the Board of Regional Chairs and the Governance and Advocacy Committee, met for the first time during June Council week. It represents the importance of advocacy across the full breadth of RACS and the importance of the regional voice at Council.

RACS has been an active advocate and supporter of community health initiatives for several decades. One of the issues that we strongly advocate for is Aboriginal and Torres Strait Islander ear health. The continuing prevalence of ear disease and hearing loss in Australia's Aboriginal and Torres Strait Islander populations is a clear barrier to closing the gap priorities. RACS has, through the Indigenous Health Committee and the Reconciliation Action Plan, advocated for the need for a nationally consistent approach to monitoring and addressing the unacceptably high rate of ear disease in Aboriginal and Torres Strait Islander communities.

RACS has held meetings with the Hon Greg Hunt MP, Federal Minister for Health and the Hon Ken Wyatt AM MP, Minister for Indigenous Health and Aged Care and other key government stakeholders, championed by Aborignal Fellow, Associate Professor Kelvin Kong. It is imperative that the health outcomes of indigenous communities are improved and there is a real need for leadership in this area as more immediate action is necessary.

RACS strongly supports the development of both a service delivery and research road map on indigenous ear health and will endeavour to secure funding from the Medical Research Futures Fund (MRFF). Council expressed its very strong commitment to assist with providing resources for this to progress.

We were fortunate to have the National Rural Health Commissioner, Professor Paul Worley, with us during Council Week as we discussed the challenges facing rural communities and their access to surgical care. A rural workforce summit with key Australian federal and jurisdictional representatives will be held on 15 September, with Professor Worley as a guest speaker.

The RACS Council also discussed the issue of excessive fees and out-of-pocket costs. It was agreed that Council will review current positions and information on Education and Informed Financial Consent (IFC): improve promotion, continue with advocacy efforts, and develop relevant information for patients to be made available in GP rooms. We will also continue to apply sanctions where appropriate and encourage adherence to the RACS Code of Conduct. It is important that we continue working with Specialty Societies and government to ensure that our patients are well informed about their rights.

Sustainability in terms of both the environment and the healthcare system was also on our agenda. RACS recently joined OraTaio: the New Zealand Climate and Health Council's Joint Call for Action that is looking at how it can reduce the impact that surgical practice has on the environment. The Joint Call for Action is already supported by 18 of New Zealand's most prestigious health professional organisations. We will continue to explore the issues that involve sustainability and surgical practice further and look at how we can take a leadership role in this area.

After a successful Annual Scientific Congress in May we are now busy planning ahead for next year's event in Bangkok, Thailand and have also started looking at future events.

I also visited China with CEO Mary Harney and Ken Loi, NSW Regional Chair this month. In addition to attending the Chinese College of Surgeons (CCS) 11th Annual Meeting in Beijing, we held meetings with the executive of the Chinese Medical Doctors Association (CMDA), representatives of the CCS, Austrade and with conference venues in both Beijing and Shanghai. These broad ranging discussions provided an initial understanding of the relationships required to possibly run a scientific congress in China and provided a broader understanding of the Chinese healthcare system. Further work will need to be undertaken to test the feasibility of potentially running an ASC in China, possibly in 2022.

The month of June saw 18 RACS Fellows receive Queen's Birthday Honours for their services to medicine. I was delighted that one of our own Councillors, Professor David Fletcher, received a Member of the Order of Australia (AM). Congratulations to them all!

We also welcomed 11 new Fellows to RACS. I am reminded of the powerful pledge we make as Fellows, so I urge our new colleagues to always act in the best interests of their patients and to continue improving their knowledge and skills. I wish them every success in their future endeavours.

The RACS Council extends another warm welcome to new Councillors, Dr Christine Lai and Dr Maxine Ronald. Christine is a general, Breast and Endocrine surgeon from South Australia and is also the current Chair of the Women in Surgery Section. Maxine is a general surgeon from New Zealand and our first Māori Councillor. We are fortunate to have these two impressive young surgeons as members of the RACS Council.

Mr John Batten
President

Advocacy it's in our DNA

Dr Kelvin Kong taking part in the Ear Health For Life program

'The leading ADVOCATE for surgical standards, education and professionalism in Australia and New Zealand.' This is RACS' mission statement and should underpin all of the activities we undertake for our Fellows, Trainees and IMGs as well as for the community we serve.

Our College has a proud tradition of advocacy, particularly in the fields of road trauma and alcohol related harm, and we have taken a lead in the Building Respect, Improving Patient Safety program.

Our earlier agreed advocacy priorities for 2018 are:

- Implementing cultural change against discrimination, bullying and sexual harassment - with a focus on gender diversity;
- Surgeon's health – particularly as it relates to burnout and mental wellbeing;
- Sustainability of healthcare, with regards to fees and the Choosing Wisely movement;
- Aboriginal and Torres Straits Islander and Māori health;
- Maldistribution of Workforce;
- Trauma, and
- Alcohol related harm.

Furthermore, there is the important work done in the domains of global health and education and the activities of the Australian states, territories and New Zealand (STANZ), as well as all of the good work done by our colleagues in the specialty societies.

In April there was an advocacy workshop conducted at RACS, with representatives from all of the specialties, New Zealand and all of the states. It identified 25 areas for advocacy, including those listed above, and an overarching RACS advocacy strategy was discussed, that ensures that messages get to the right places.

Two key additional areas that participants felt strongly about were identified – promotion of the FRACS brand to both members and to the community (as well as protection of the title 'surgeon') and renewed work with hospitals and jurisdictions around flexible training, Trainee working conditions and transfer of Trainee leave entitlements.

At the RACS Council meeting in February this year, formal presentations from New Zealand, Northern Territory, Queensland and Western Australia were made. Other regions will be represented later in the year. It was agreed that all of the STANZ should play a more central role and have a more visible presence during the meetings that take place in the lead up to Council meetings. In addition, a need for greater engagement with our specialty societies was identified, and to be more responsive to the issues that concern them most.

Therefore, I am pleased to announce that the Governance and Advocacy Committee (GAC) of RACS has been dissolved and replaced with the Advocacy Board. Membership will include the STANZ chairs as well as the Chair of the Rural Section and specialty representatives. The Board had its first face-to-face meeting in June, and will meet three times a year in the week of the full Council meeting.

At its first meeting, the outcomes of the advocacy workshop held in April were discussed, with the following priorities recommended:

- Equitable access to surgery and healthcare continuum; including maldistribution/rural health;
- Workforce (flexible training, selection, education, standards, member wellbeing and distribution);
- Sustainability in healthcare/private health insurance/ fees – and the need to educate the public about the cost of healthcare and out-of-pocket costs;
- Public perceptions of surgeons and surgery/protection of surgery title – FRACS brand;
- Aboriginal and Torres Strait Islander and Māori health

  - Increasing Aboriginal and Torres Strait Islander and Māori specialists

  - Aboriginal and Torres Strait Islander ear health, and
- Trauma.

In addition, the Board will commence a project on surgeon wellbeing, with the development of a comprehensive wellbeing framework including safe hours for surgeons and Trainees, and broaden the scope of our Sustainability in Surgery work to include the effects of climate change on healthcare.

As part of this new approach to advocacy, we are seeking to form partnerships with the specialty societies and engage the expertise of STANZ members so that we can work together on particular issues that the different groups have a special interest in. I would encourage any Fellow, Trainee or IMG who would like to be involved in any of these areas to get in touch with me. I am excited to be involved at the beginning of this broader remit for RACS in the advocacy arena and would welcome involvement from all members as we progress these issues.

Ms Cathy Ferguson
Vice President

Dr Lawrence Malisano

AOA aims to become world leader in training, research and diversity

The Australian Orthopaedic Association (AOA) is rolling out a transformational agenda designed to make Australia a leader in orthopaedic surgery, training and research, diversity and the ethics that underpin the specialty.

After years of research, workshops, academic collaborations and membership surveys, the AOA has now completed the overhaul of its curriculum to streamline training including leading assessment and technology changes, establishing an Ethical Framework, a Diversity Strategic Plan and a Research Strategic Plan.

Each element is designed to enhance the skills and professionalism of orthopaedic surgeons to the benefit of the Australian community under the overarching professional purpose of restoring and advancing the wonder of movement.

Three years ahead of schedule, AOA21, an ambitious education and training initiative launched in 2014 focussing on the improvement of patient care through the delivery of evidence-based 21st Century orthopaedic surgical education and training, is being implemented throughout Australia. The initiative has already led to encouraging improvements in Trainee pass rates across the country.

The Diversity Strategic Plan has set aspirational goals to have women comprise 30 per cent female applicants for training by 2021 and 30 per cent of Trainees by 2021, while the Research Plan has established academic hubs to help Fellows and Trainees attain their research goals.

Fellows, Trainees, educators and examiners now have a clearer understanding of their roles and responsibilities and the knowledge they must have, which has not previously been articulated with the full endorsement of the AOA.

The AOA has also part funded a world-first pilot project to build on the information gathered through the National Joint Replacement Registry which is expected to lead advancements in registries across medical specialties.

The project, called Patient Reported Outcome Measures (PROM), will gather and analyse patient data before surgery and will run for the next two years beginning in July.

All questions to be put to patients have been devised by orthopaedic surgical leaders from the International Consortium of Orthopaedic Registries and designed to overcome the inherent difficulties associated with pain perception and patient expectation.

President of the AOA Dr Lawrence Malisano said all the work conducted to establish AOA21 and the new strategies was aimed at making orthopaedic surgery a dynamic, transparent, modern specialty capable of leading the world.

He said AOA21 laid out core competencies that Trainees need at various levels of their training, followed by understandings of more specialised procedures, while surgical educators also now have clear guidelines on the skills and knowledge they need to transfer.

He said the changes have been enthusiastically

received by Trainees.

"This year is the first year of the full implementation of AOA21 and we have already seen a dramatic improvement in pass rates across the country," Dr Malisano said.

> "We have stratified what Trainees need to know and when they need to know it, we have standardised the educational modules taught through Bone School so that each state is teaching the same material at the same time and we have put in place practices to help identify Trainees who require assistance."

"In the past this has been developed on an *ad hoc* basis so these changes represent a major culture shift in our expectations of both Trainees and educators."

Dr Malisano said that the American Orthopaedic Association's Council of Residency Directors has already shown keen interest in the new curriculum as well as the new Diversity Strategic Plan.

He said that the Diversity Plan was designed around the primary pillars of culture and leadership, flexibility and advocacy and engagement.

Specific aims of the plan include:

- to remove barriers to diversity and create an enabling environment;
- to mentor and support women into leadership roles;
- to encourage diverse representation on all panels at AOA state and national meetings; and
- to promote flexibility and work-life balance.

Dr Malisano said the AOA was committed to raising the number of women accepted into orthopaedic training from the current rate of 12 per cent.

"We understand that this rate is low but we are putting in place a variety of measures designed to attract more women into orthopaedic surgery," he said.

"Selections are already underway for next year and we have ensured that each interview panel in each state has at least one female member, we have standardised questions to remove any unintentional gender bias and we are addressing perceptions that orthopaedics does not welcome women.

"Following the lead of RACS, we are also providing child care facilities at our Annual Scientific Meeting to be held in October and we are actively encouraging more scientific presentations from women and greater diversity on all panels.

"We have a lot to do if we are to meet our aspirations of having 30 per cent female applicants by 2021 and 30 per cent female Trainees by 2021 but I believe we can do it."

Dr Malisano said the Ethical Framework, which came into effect last year, listed the core values of orthopaedic surgery as integrity, respect, quality, empathy, teamwork, service and stewardship.

Dr Malisano participating in the "helium stick challenge", designed to test teamwork and communication skills, at a Young Leaders' Forum.

He said these values would be incorporated into all training, with some educational modules now mandatory for educators and Trainees.

"We need to espouse these values primarily for the good of our patients and the Australian community but also if we are to become leaders within medicine," he said.

"It is difficult to change a culture within an organisation and while there has been some push-back we are determined to promote these values across all committees, sub-specialty groups and training within our specialty."

Dr Malisano said the Research Strategic Plan had been designed to help Trainees meet their mandated research requirements and to promote a life-long learning culture within orthopaedic surgery.

He said the AOA had established a Network of Orthopaedic Academic Departments (NOADs) to help Fellows and Trainees conduct internationally recognised research.

The NOADs will act as contact points for those wishing to conduct research and will help them get their work off the ground by assisting with grant applications or in developing collaborations.

Finally, Dr Malisano said the AOA Board has decided to further support the diverse activities of Orthopaedic Outreach, the international aid division of the AOA.

He said that at a time of great need but with limited funding, it has been decided that aid work supported by the AOA and donors would, over the next few years, focus on teaching and training surgeons in Myanmar, Papua New Guinea and Vietnam.

With Karen Murphy
Surgical News journalist

Meet our newest Councillors

Dr Maxine Ronald

Dr Maxine Ronald is one of RACS' newest Councillors. A general surgeon specialising in oncoplastic breast surgery, Maxine is also a strong champion for health equity for Māori and Aboriginal and Torres Strait Islanders and is the Deputy Chair of RACS' Indigenous Health Committee. Living in Whangarei in New Zealand's sunny north with her partner and two daughters, Lola and Ava, Maxine caught up with *Surgical News* to talk about health equity, work life balance, and surfing.

Kia ora Maxine, thanks for joining us. An easy question to begin with – what led you to a career in surgery?

I had always loved anatomy, both when I was a physiotherapist before medical school and then when I was actually studying medicine. I was really fortunate in my third year to be involved in a project that was looking at liver anatomy, and had the opportunity to go to theatre with an Auckland surgeon, Dr Jonathan Koea. I really enjoyed meeting and talking to the patient beforehand, but the first incision blew my mind. I decided pretty much on the spot that I was going to be a surgeon. Jonathan has also been an amazing role model and mentor since then.

What do you enjoy most about being a surgeon?

Earlier in my career I would have probably said that I enjoyed the technical side of things the most, and taking satisfaction from when an operation really comes together nicely. Now though I think I enjoy connecting with patients the most. I do a lot of cancer work, and part of that is talking to patients about their diagnosis. Surgery is only a small part of cancer treatment, but I feel that by doing the best I can and creating those relationships, I can help patients and their whanau, (Māori extended family) through this really difficult time.

I also really enjoy the people I work with. My colleagues are awesome – inspiring, interesting and talented. It is a great privilege to work with a dedicated team that is committed to helping patients and to striving for positive outcomes.

What are you most proud of?

It's something that most surgeons end up doing, but I think getting my FRACS was a huge accomplishment! I am really grateful to my family for all of their support on that journey.

Since I have been a consultant I have realised how much confidence having the FRACS qualification

Dr Maxine Ronald with her two daughters, Lola and Ava.

provides. When you first start working as a consultant it can feel nerve wracking, but having a FRACS, you soon realise that you have actually trained to a really high standard, and that makes you appreciate the qualification more, and the standing it gives you.

Is there anything you want to achieve on the RACS Council?

I think my one key goal would be to see all the surgical specialties include an equity focus in their training programs and a genuine desire to address health inequity in whatever their surgical field is. I think it is vital that all current and future Trainees include this as part of their core clinical skill base, and that Fellows appreciate why this is important.

And now for the non-surgical questions! How do you like to spend your free time?

The answer is probably an awful lot of Netflix at the moment! We are also really fortunate to live close to the beach so I have been trying to get back into surfing and paddle boarding.

> "I think my one key goal would be to see all the surgical specialties include an equity focus in their training programs and a genuine desire to address health inequity in whatever their surgical field is. I think it is vital that all current and future Trainees include this as part of their core clinical skill base, and that Fellows appreciate why this is important."

Is there any skill you would like to learn?

I would like to be able to surf properly!

If you could have dinner with two people who would you choose?

The actor Dwayne "The Rock" Johnson and – this is probably really clichéd – Nelson Mandela… and we would be eating Japanese.

If you weren't a surgeon what other career would you have chosen?

I really wanted to be a writer or an artist when I was in high school, and in university I also really loved Māori political studies. Still not too late for a career change I guess!

What is your greatest achievement?

This might not be the answer you would expect, but switching my Fellowship training so that I could make sure that I had more time with my eldest daughter. At one point I was barely seeing her and it was really having an impact on our relationship. I had to make some hard changes, but getting that work-life balance right has been absolutely worth it.

And to end with – what does a perfect day look like to you?

Maybe sleeping in past 6:30am without having a child wake me up? After that though, it is definitely a day at the beach, and having someone look after the kids so that my partner and I can go surfing together. Followed by a barbeque and a few piña coladas with friends in the evening… that sounds like a pretty perfect day to me!

Interview by Calum Barrett
Communications and Policy Officer, RACS.

Meet our newest Councillors

Dr Christine Lai

Dr Christine Lai with her husband Daniel Harris and their children, Matthew and Lauren.

For as long as she can remember, Christine Lai liked the idea of becoming a doctor, and particularly a surgeon. But there were moments when she could have easily been deterred.

"You're a woman and you're Chinese, there is no way you'll get into the surgical training program," a registrar said to her when she was a medical student in the mid 1990s.

The warning seemed well intentioned. At the time, the surgical workforce in Adelaide where she lived was fairly monocultural and the registrar who worked in a different medical specialty was from an Asian family. He thought it would be an uphill battle for her, she says. But Dr Lai chose to pursue her dream job anyway.

"I wanted to do surgery so much that I didn't believe him. My attitude was I'll keep applying and see what happens."

Her determination paid off, and as it turned out, any concern about discrimination did not materialise. Dr Lai got into the general surgery program the first year she applied.

Thirteen years on, the breast and endocrine surgeon has reached new heights; over the past year she has been appointed chair of the Women in Surgery group, and elected to RACS Council.

Colleagues who know her well have never doubted her potential for leadership.

"Christine will be an amazing councillor - she has a passion for surgery, a strong work ethic, high sense of fairness and an incredible eye for detail," said David Walsh, a general, breast and endocrine surgeon who has known Dr Lai since she was a first year resident.

"She is a wonderful role model to all surgeons and is an illustration of the fact that women shouldn't accept compromises."

As she works with RACS to meet its ambitious diversity targets, Dr Lai wants to promote surgery as a great career for women. While only 12 per cent of active consultant surgeons in Australia and New Zealand are female, Dr Lai says such statistics should not deter young female doctors from pursuing the specialty.

By the end of 2017, women made up 29 per cent of Trainees, 20 per cent of new Fellows, and 32 per cent of RACS Councillors.

In addition to social media campaigns, the Women in Surgery group is now looking at ways to reduce unconscious bias that might exist among male dominated panels that interview students and Trainees.

Dr Lai wants to increase the visibility of female surgeons for students and junior doctors curious about the specialty so they can quash negative stereotypes. She says the perception that surgery is more gruelling than other medical specialties or requires a particularly tough personality is an unhelpful fallacy. So too is the idea that you can't balance family with a surgical career.

Having raised two children after becoming a Fellow, Dr Lai says it is not easy to juggle work and family, but with RACS policies allowing women to take time off from training to care for children, it is not necessarily harder than maintaining any other career with parenthood.

Christine and her family at Singapore Zoo.

"I always have multiple balls in the air, but I wouldn't change it for the world," she says on speaker phone while ferrying her daughter to swimming.

Dr Lai did not know any female consultants when she was considering surgery as a junior doctor, but female surgical Trainees made her believe it was achievable. With this in mind, she and other volunteers are now proactively attending medical student society gatherings to talk to young women about the realities of the profession.

"You cannot be what you cannot see," she says. "I feel honoured to be chair of the Women in Surgery group… If we're going to make progress, now is the time"

When Dr Lai is not working on council tasks or sharing parenting duties with her emergency physician husband, she is a consultant at The Queen Elizabeth Hospital in Adelaide where she teaches medical students and supervises training for general surgery. She also works privately at the Western Community Hospital and the Calvary Hospital network.

"I enjoy teaching students. It's great to see their knowledge expand, particularly the fourth year students who might come to us when they don't know much about surgery," she says.

"I'm now old enough that I've seen some of my students become surgeons… It's so wonderful to see them at RACS meetings. They come up to you with 'new Fellow' on their lanyard. It's fantastic to see them achieve their goal."

Outside of work, Dr Lai is an amateur photographer, a hobby that sometimes has her sneaking out of conferences when the light is favourable to photograph iconic sites. She recently enjoyed photographing the Marina Bay Sands hotel on a holiday in Singapore and was proud of her persistence to capture the rare blood moon earlier this year.

"It required a lot of patience and the right conditions - a bit like surgery!"

With Julia Medew
Surgical News journalist

RACS supports gastroenterology training across Pacific Islands

Scores of surgeons and physicians across the Pacific have gained vital training in endoscopy, colonoscopy and gastroscopy through a collaboration between RACS and the Australian and New Zealand Gastroenterology International Training Association (ANZGITA).

More than 70 volunteers have given their time and skills to provide training over the past 11 years through intensive month-long courses at the Colonial War Memorial Hospital (CWMH) in Suva, Fiji, with the support and guidance of the World Gastroenterology Organisation (WGO).

Surgeons, physicians and nurses have been trained at the WGO Training Centre located at the hospital, in the provision of safe endoscopy, skill development in gastroscopy and colonoscopy and education in gastrointestinal medicine.

Such skills are vital in a region where people suffer more advanced gastrointestinal diseases that are seen less often in Australia and New Zealand, such as advanced malignancy, ulcer disease and infection colitis.

RACS has provided support to the program through the Australian government funded Pacific Islands Program (PIP) and has recently collaborated with partners to provide outreach in-country training in Samoa with plans to provide training in Tonga.

Victorian gastroenterologist Associate Professor Chris Hair is an ANZGITA board member and director and South Pacific Programs lead and has assisted in designing and providing training programs in Fiji, Solomon Islands, Samoa and Timor Leste for the last nine years.

A member of the WGO, Chris first provided training in Fiji in 2010 and is a co-director of the WGO Training Centre alongside fellow co-directors Professor Jioji Malani, Dr Mai Ling Perman and Professor Finlay Macrae.

Chris said he was drawn toward offering his skills to the program after learning that many treatable conditions were unable to be managed in the Pacific Islands due to either a lack of equipment or expertise in endoscopy.

He said he wanted to transfer gastroenterology skills to surgeons and physicians working in Pacific Island nations who had identified a great need of it and said the skills transfer had already saved lives.

Dr Chris Hair

“Traditional pathways for patients with gastrointestinal disease have only really included palliative surgery or supportive medicines for advanced diseases,” Chris said.

“If a patient had a bleeding stomach ulcer, it could have meant bleeding to death or an emergency laparotomy, rather than a quick endoscopic treatment and early discharge from hospital.

“I recall a 29 kilogram woman from the north side of Fiji who swallowed a caustic agent which burnt out and scarred her oesophagus.

"She came to the WGO training centre, where we taught the local team how to dilate with an endoscope and after a session or two, the team was able to provide independent endoscopic guided dilations to the woman and a year later she was a healthy 70 kilograms.

"Without this training, she would have either died from malnutrition or needed some form of palliative surgery to restore function.

"This program has always been about health professionals from all around the Pacific coming to Suva and then going back to their own countries such as Tonga, Timor Leste, Samoa, Solomon Islands, Micronesia, Vanuatu, the Cook Islands and Kiribati.

> "Now, rather than offering only very limited treatment options for advanced disease presentations, those who have been through the training program are better able to detect and treat many GI problems early, so that patients receive more timely, and potentially life-saving surgeries, or prevent unnecessary ones."

Dr Hair said since the start of the ANZGITA training program which began in Suva, more work had been done to provide in-country training to surgeons and physicians in other Pacific Island nations.

He said the first outreach program concept developed after he met with members of a charitable foundation working in the Solomon Islands, a meeting facilitated by former RACS President Professor David Watters and ANZGITA Board Chair Professor Finlay Macrae.

Since then, outreach gastroenterology training has been provided in Honiara and Samoa with the support of RACS and the Australian government, and work is now underway to expand the outreach program.

Dr Hair said that due to the training offered in Fiji and outreach support, there are now three surgeons and two physicians currently conducting competent and safe endoscopy at the National Referral Hospital in Honiara.

A champion of the local training program in Suva is Dr Mai Ling Perman, a local physician at Colonial War Memorial Hospital, Suva. Dr Perman was one of the original 'graduates' who received training in the WGO centre in the early days.

Dr Perman has since led the program from Suva, and been influential in delivering local endoscopy skill training to others, as well as important outreach support to nations including Vanautu, Kiribati, Palau, Tonga and recently Marshall Islands.

"In recognising outreach success to the Solomon Islands, and the greater need and benefit to reach out to other nations in their own country, PIP is collaborating with ANZGITA on a much broader

Dr Chris Hair (left)

scale to support endoscopy sustainability across the countries," Chris said.

"Samoan surgeons and physicians have been receiving training at CWMH through the WGO program for several years and PIP helped to support our training in Samoa in 2017 and 2018.

"That work has seen the strong recovery of competent and safe endoscopy, teaching in GI medicine, skills such as variceal banding and ulcer treatment and leadership support.

"A similar PIP program is planned for Tonga in the near future which shows how well the collaboration between RACS and ANZGITA is developing.

"Many of the Trainees are in the midst of their postgraduate studies in medicine or surgery and now they have ongoing opportunity to train in endoscopy outside the program month at CWMH."

Chris said ANZGITA was also developing strong philanthropic links with endoscopy-associated industries to support education and training in the Pacific.

He said three providers of endoscopes in Australia had donated equipment free of charge and had helped maintain sterile, hygienic equipment at the teaching sites.

Although he works as a gastroenterologist with Epworth Private Hospital and Barwon Health in Geelong, has teaching commitments at Deakin University and is married with three young sons, Dr Hair remains committed to expanding the training offered across the Pacific.

"I hope that we will continue to develop the outreach program to provide support in Tonga, Micronesia and collaborate with colleagues in Fiji to support endoscopy in Lautoka and Labasa as well as Suva," he said.

"I'd also like to collaborate with ANZGITA members to develop the passion within New Zealand to reach across to our eastern sites such as Samoa, the Cook Islands and Kiribati and work on the development of links with Hawaii and Japan to support the northern states such as the Marshall Islands and Palau.

"There is no end date to this work because if and when there is sustained safe, hygienic and maintainable practice around endoscopy by trained health professionals, there will still be a need to maintain quality education and skill development support."

Visit **www.anzgita.org** for more information.

Gabrielle Forman
Communications and Policy Officer, RACS.

Plastic Surgeon's painting chosen as finalist in portrait prize

She appears the epitome of calm, her head tilted back, her eyes closed with her hands draped loosely across her body on a chair that supports her slight frame.

Her lovely face is haloed by her trade-mark hijab.

She is Islamic academic and commentator Susan Carland and she is the subject of Plastic Surgeon Andrew Greensmith's second portrait to be chosen as a finalist in Australia's preeminent portraiture competition, the Archibald Prize.

Last year, Dr Greensmith also made the finals with his portrait of 102 year old Eileen Kramer, a former ballerina believed to be the world's oldest working choreographer, poet, artist and costume designer.

The former head of the Department of Craniofacial Surgery at the Royal Children's Hospital in Melbourne, Dr Greensmith co-headed the team that successfully separated conjoined twins Trishna and Krishna in an operation that captured global attention and delight in 2009.

Now with a private practice at the Cabrini Hospital, the Avenue and the Stonington Day Surgery Clinic, he conducts a broad range of reconstructive and aesthetic surgery and has a particular interest in functional and aesthetic rhinoplasty.

A self-taught artist, Dr Greensmith has only recently returned to his childhood passion for painting and has established his practice to allow him time each week

Still life Moroccan pottery 2014 (oil on linen)

The Serenity of Susan Carland 2018 (oil and walnut alkyd on wooden panel) Finalist Archibald Portrait Prize 2018

either at his easel or learning more about art through books, videos and exhibitions.

Speaking to *Surgical News*, he said he made the decision to leave public practice at the Royal Children's Hospital in 2015 in part so that he could carve out time for his artistic endeavours.

"It was impossible to immerse myself in a creative mindset with a combined public and private practice, so I had to make the choice," he said.

"Now I've designed my practice to allow for up to two days a week to devote to painting and I feel extremely lucky for that.

"Sometimes, when I'm with other artists I feel like an imposter because I don't have the pressure to earn income from painting.

"Instead, I am more interested in art as a way of living, not a means to make a living and I'm very fortunate to be in that position."

Dr Greensmith, who was born and raised in New Zealand, said his early interest in both plastic surgery and art combined when he chanced as a young boy upon a book illustrating before and after images of cleft lip and palate repair surgery.

"It was a strange book for a young kid to like, but I was struck by the difference surgeons could make to children born with facial deformities and I wanted to become a facial reconstructive surgeon even from my teen years.

"I didn't gravitate naturally to medicine though, and began my university studies learning art and history before swapping to medicine which always made me feel a bit of an outsider.

> "The combination of art and surgery is wonderful. As a surgeon you learn to see, you know what to look for, you understand the shape and form of the human body and the face, you see skin tones and curves and shadows."

"This knowledge is a huge advantage to a novice painter and I often think that while I have had to learn how to paint, other artists have had to learn their anatomy."

Describing his artistic work as contemporary realism, Dr Greensmith said he began his studies in portraiture through painting family members before he approached Eileen Kramer in 2016.

He flew to Sydney to meet her, took photographs and made sketches and then returned to his home in Melbourne to work upon canvas.

He said he approached her after reading of her extraordinary life as a dancer with the avant-garde Bodenwieser Ballet in Sydney and her peripatetic life as an artist working in India, Paris, London and New York through most of the 20th century.

He also decided to ask Dr Carland to sit for him after reading a magazine feature which described her work, her life and her determination to dismantle the preconceptions and prejudices faced by many Muslims in Australia.

Skull study 2014 (charcoal on cotton paper)

Portrait on my son 2017 (oil on linen) semi finalist Moran Art Prize 2017

She agreed to sit for him and again Dr Greensmith spent a day taking photographs and making sketches to take back home to work from.

After two months of painstaking effort, the portrait was finished and formally titled 'The Serenity of Susan Carland.'

“I saw an article about her and was impressed with her courage and resolve,” Dr Greensmith said.

“She faces a daily onslaught of hate, yet she continues to progress Muslim women’s rights despite criticism from within and outside Islam.

“I wanted to capture that calm resolve and placed her in a generous space to convey this lonely isolation yet in a reflective pose to capture her serenity.

“Drapery of all sorts, particularly on the female head, has appealed to painters like Vermeer, Sargent and Sorolla through time and Susan’s hijab, so much a part of her identity, is integral to the piece and was a new challenge to paint.”

While Dr Greensmith did not win the prestigious art prize this year, he said he was honoured to be selected as a finalist for a second time, with his work to go on tour around the country alongside paintings by some of Australia’s leading artists.

He said he now felt that between his work as a surgeon and the time he could spend at the easel, he had finally found the perfect work/life balance.

“I absolutely love performing surgery and often yearn to get back to it even after a few weeks of family holiday time, but painting fulfils a different part of my psyche or spirit,” he said.

“Being a surgeon has made me a better painter through my understanding of anatomy and becoming a painter has made me a better surgeon simply because I am happier.

“I’m constantly learning as an artist and trying to gain confidence and I sometimes feel a bit like I did as a surgical Trainee.

“In the future, I’d like to become looser in my style but that can be a bit of a challenge for people like us surgeons.”

Karen Murphy
Surgical News journalist

#crazysocks4docs

Dee and Ed were always so competent, cheerful, resourceful, paid great attention to detail and ensured their unit patients did well. It seemed to them life was only work. Home late, they had no enthusiasm for social life, slept poorly and, unrecognised by any of their colleagues, Dee and Ed had stopped feeling any sense of pride or achievement at work, it only felt like a chore. They were depressed and, during lonely weekends not on call, Dee brooded about how life was not delivering what she had hoped for. She became extremely cynical, negative and so unhappy she quit her training. Ed became quieter, more withdrawn and then one day the team woke up to the news that Ed had taken his own life. No one had seen it coming. In retrospect there had been signs such as uncharacteristic errors, taking on tasks without delivering, outbursts of anger and frustration. His team, his colleagues and the health system had failed to recognise his depression and he did not feel safe to talk about it.

Doctors do have mental health problems and doctors are often afraid to let others know this. There is a fear that being vulnerable will not result in respect and will compromise their professional and personal reputations. Surgeons find this particularly hard to be open about, and they are particularly prone because surgery attracts those who are perfectionist, obsessive about detail, willing to work hard, and usually enjoy good job satisfaction. But some experience life in surgery as akin to running faster and faster on a hamster wheel until there is no energy left and bang the collapse! Life and career fall apart.

The medical and surgical workplace continues to be stressful and toxic. The evidence from reported surveys is that this is increasingly so. According to *beyond blue* the rates of mental illness among doctors and surgeons are high and higher than the normal working population. At this year's Annual Scientific Congress (ASC) @EricLevi brought an elephant onto the stage, to remind his audience that mental health is the issue that no one wants to discuss but everyone can see. There he cited evidence that 21 per cent of doctors reported having been diagnosed or treated for depression, 24.8 per cent had contemplated suicide in the past, with 2 per cent having attempted it. #crazysocks4docs Day on 1 June was enthusiastically supported across Australia and New Zealand in recognition that doctors really do suffer mental health issues and should not feel ashamed to say so.

Getting down to the science, burn-out is measured on the Maslach Burnout Inventory (MBI) Scale with three subscales: Emotional exhaustion, Depersonalization and Reduced Personal Accomplishment. Reported rates are in the order of 47.5 per cent emotional exhaustion, 45.8 per cent high cynicism and 17.6 per cent low professional efficacy. In the United States, surgical residents' emotional exhaustion was most commonly experienced (69 per cent), with reduced personal accomplishment only by 14 per cent. Yet 44 per cent had still considered quitting their job. About 40 per cent of US surgeons meet the criteria for burn-out, with 30 per cent screening positive for depression. High achieving, perfectionism, and conscientious behaviours makes one more prone to mental illness. Female gender, neuroticism (emotional sensitivity) and younger age have also been reported to make one more susceptible.

Avoid negative responses such as cynicism, avoiding family and friends because you are vulnerable and ashamed, or turning to alcohol and drugs.

The ASC was themed 'Reflecting on what really matters' and featured topics on mindfulness including making time to be self-aware, aware of the present situation, aware of priorities and aware of others. It asked us to focus on gratitude, being positive, accept people for who they are, let go of expectations, and relinquish some control.

I like @PeninsulaHealth and @smartlikemum's launch of #crazysocks4docs saying "This is not a game of Survivor. Our strength is in working together to leave no man or woman behind".

Resilience is a dynamic, evolving process of positive attitudes and effective strategies. Invest in yourself, integrating and balancing the four domains of life - self, family, work and community. Exercise, meditation, hobbies, holidays or simply relaxing with a good non-medical book are all methods of building resilience. Talk about how you feel with trusted friends. If you feel burned out, or depressed, know you are not alone.

If the information in this article raises any issues for you or someone you care about, please contact Lifeline 131114 (24 hours) or beyondblue 1300 22 4636 for confidential advice and support.

DR BB-G-LOVED

Victimisation

Things you need to know

In 'dictionary land' victimisation is defined as unwarranted singling out that results in unfair treatment, exploitation or persecution. It relates to hurtful actions that disadvantage people and in-turn make people victims.

In everyday colloquial 'have-a-chat land', people tend to interact in a way that reflects the dictionary definition of victimisation while demonstrating an understanding of what it would be like to be in the shoes of the affected person.

As we head to work and find ourselves in 'medical administration, employment and training land' things change somewhat. Contextually our understanding of victimisation needs to adjust, becoming better informed and more sophisticated given the explicit use of the word in various statutes relevant to work and training environments.

It is significant that RACS over recent years has articulated repeatedly that persons making complaints about discrimination, bullying and sexual harassment should not experience victimisation. Unpacking what the RACS statement means on the ground, to ensure a consistent and comprehensive picture of its breadth and depth is important.

Firstly, it must be stated that this RACS position on victimisation is firm. Underpinned by obligations housed in various state, territory and national pieces of legislation, the message is clear for all in Australia and New Zealand.

So in 'medical administration, employment and training land' victimisation means subjecting, or threatening to subject, a person to some form of detriment, disadvantage or punishment because they have made a complaint about discrimination, bullying or sexual harassment. The complaint in question could have been made (or there is a plan to make it) either internally or to an external agency.

Victimisation also means subjecting, or threatening to subject a person to some form of detriment, disadvantage or punishment because information or documents were provided to an internal investigation or to an external agency, or because a person helped a complainant or acted as a support person, or because of attendance at an external conciliation. Again victimisation rules can apply if one has planned to do such things and it becomes known and there are consequences.

Victimisation also covers subjecting, or threatening to subject a person to some form of detriment, disadvantage or punishment because the person refused to do something that would amount to discrimination, bullying, sexual harassment or victimisation. A recent example is a security officer who was told by his manager to deny people of a particular religious faith access to the venue. The security officer did not follow the instruction, rather he allowed all who were sober and in attire that met the dress code into the venue. When his employment was terminated he made a complaint of victimisation.

Understanding detriment in employment and training environments is the key to a solid picture of the breadth and depth of victimisation. When detriment is done or threatened, there is proof of victimisation. Detriment can mean loss, damage, disadvantage, unfair treatment, reprisal, retaliation, payback or injury. It must be tangible to form proof of victimisation.

There are many examples of detriment. It can be played out in relation to terms and conditions of employment, leave allocation, rostering, career development, training opportunities, reduced shifts, purposeful undermining of professional reputation, the severing of professional networks, denial of acting roles, job realignment, demotion, it can be financial, forced moves, delayed moves, termination, non-renewal of contract, removal of clients, it could be bullying or calculated isolation.

Of important note, is the fact that when a victimisation complaint is made, it is an independent and separate action. That means a pregnancy discrimination complaint and a victimisation complaint could be made about the same person, by the same person. Or the victim and her witness could both make individual victimisation complaints about the same person due to punishment and reduced shifts. Further they could make separate complaints about their own individual managers if both managers took retaliative action.

Given that a victimisation complaint is distinctly independent it could be the case that the victimisation complaint continues when an original racial harassment complaint fails, or if for example a sexual harassment complaint is withdrawn. If a witness intending to supply material in an investigation, did not do so, but had been victimised when it became known that they had planned to do so, the victimisation complaint is still a legitimate complaint worthy of investigation, irrespective of whether it is made internally or lodged externally.

Mindful that you can still be victimised if the original complaint is rejected, dropped or can't be substantiated, it is worthwhile thinking through the following scenarios.

- A nurse made a race discrimination complaint about another nurse and applied for a transfer. A deliberate delay in organising the transfer was found to be a detriment. The discrimination complaint and the victimisation complaint were made about two different people in the organisation.
- A manager told his employee that he had a week to withdraw the complaint he made to an external commission, or he'd experience a loss of overtime. A complaint of victimisation was made about the manager and the original complaint made about a peer continued.
- A medical professional alleged that a particular client sexually harassed her while she performed her duties. The employer offered her less shifts after she made the complaint. A victimisation complaint against the employer followed.
- Not allowed to return from maternity leave to a substantive position on a job-share or part-time basis, a woman claimed that the job provided on return was a demotion. An internal grievance led to bullying by a senior manager. A victimisation complaint about the senior manager was progressed. The matters of gender and pregnancy discrimination were handled separately.

The New Zealand State Services Commission provides an additional point to consider when dealing with victimisation – that workplace policies should articulate that any form of retaliation against those who make a genuine complaint is unacceptable. The Commission goes on to quote a policy that reminds us all that it is not only complainants and their witnesses and support people in the mix. Respondents and their witnesses and support people also have rights. The policy stated - 'Care will be taken during the investigation ... and afterwards, to prevent any disadvantage to the complainant. Care will also be taken to protect the position of the person against whom the complaint was made and any other parties involved in case the complaint is found to be unwarranted.'

It would be remiss not to point out that even if the complaint is found to be warranted that respondents and their witnesses and support people have workplace rights. There should be no victimisation of anyone!

There have been many scenarios in workplaces where people are affronted that peers support and act as witnesses for respondents, particularly when complaints are upheld. Unfortunately human nature being what it is means that there are times where work teams divide and as a result plans that amount to nothing short of professional warfare are mapped. This never ends well.

In short, proper process progressed by those accordingly tasked, is what we all need to promote and support. There is no place for victimisation or for that matter any vigilante activities in relation to the complainant, the respondent, or any other parties who may be involved. So it is not okay for the colleagues of the alleged perpetrator to start making questionable phone calls to the complainant's witnesses. Similarly the friends of the alleged perpetrator should not be targeted and treated poorly by the friends of the complainant.

Concluding, it is worthy of highlighting the complex and expansive nature of victimisation via this case heard by the New Zealand Human Rights Review Tribunal. Victimisation was found, given that an employer had refused to re-hire an employee because his partner, who worked for the same employer, had made a complaint of discrimination about the employer's actions.

Undoubtedly RACS will continue to inform people that persons making complaints about discrimination, bullying and sexual harassment should not experience victimisation.

Note: This article is not legal advice. If legal advice is required, an employment law specialist should be consulted with reference to the specific circumstances and country of residence.

Susan Halliday
Australian Government Defence Abuse Response Taskforce (DART) 2012-2016 and former Commissioner with the Australian Human Rights Commission

Surgical Trainee sets her sights on the stars

General Surgery Trainee and PhD candidate Dr Lisa Brown has become the first New Zealander to study aerospace medicine via a combined course provided by NASA and the University of Texas.

Dr Brown received the only scholarship awarded to any candidate to complete the course and spent time in 2015 at NASA's Johnson Space Center and the Neutral Buoyancy Laboratory to advance her understanding of aerospace medicine through familiarisation of conditions on the International Space Station.

In recent years she has also worked as a Research Fellow in aerospace medicine at Oxford University, UK, and completed an internship at the German Aerospace Centre in conjunction with the European Astronaut Centre at the European Space Agency.

Last year, she attended the Bellagio II Aerospace Medicine Summit in Italy to present her research on aerospace medicine and how it affects human health both in space and on the ground.

And this year, she received the RACS Hugh Johnston Travel Grant to further develop her PhD research into percutaneous drains to determine how they function in microgravity.

Dr Brown, a SET 4 General Surgical Registrar at North Shore Hospital in Auckland, began her research career looking at the high failure rates of percutaneous drains in the treatment of necrotising pancreatitis and abscesses.

In collaboration with surgeons and engineers at the University of Auckland and designers at Victoria University in Wellington, she helped formulate a new drainage system that they hope will decrease those high failure rates.

Now she has combined her interest in surgery and space medicine to design experiments to see how the percutaneous drainage designs will operate in microgravity.

She said any advances made in this field would not only help patients with abscesses on Earth, but also help doctors manage astronauts who develop acute medical conditions, such as appendicitis or cholecystitis, while travelling in space.

> "The microgravity environment is more hostile than that on Earth due to factors such as a change in surface tension of fluids, the lack of gravitational fluid flow and changes that occur in intra-abdominal and intra thoracic pressure."

"Percutaneous drains are the agreed first-line treatment for surgical conditions containing abscess formation within the aviation and microgravity environment," Dr Brown said.

"However, testing of currently available drains at ground level show they are prone to failure, with studies confirming up to a 60 per cent failure rate, most commonly caused by drain blockage.

"The microgravity environment is more hostile than that on Earth due to factors such as a change in surface tension of fluids, the lack of gravitational fluid flow and changes that occur in intra-abdominal and intra thoracic pressure.

Dr Lisa Brown at NASA's Johnson Space Center

Dr Lisa Brown with a NASA Extravehicular Mobility Unit or Spacesuit

"My PhD research identified attributes in currently available percutaneous drains which slowed flow and caused blockage and our research team then came up with new designs which were prototyped through 3D modelling.

"The travel grant provided by RACS will cover the costs of travel and accommodation so that I can be close by while we test these drain prototypes in the microgravity environment, in collaboration with aerospace companies overseas."

Dr Brown said she hoped to conduct experiments later this year using a ballistic material pre-designed cavity containing fluid at similar viscosity to that of abscess fluid. She said the tests would measure fluid outflow over time during parabolic flights that created a microgravitational environment.

She said that developing a drainage system that operates effectively in such a challenging physical environment would allow doctors on Earth to manage astronauts with acute medical conditions without the need for heavy and cumbersome equipment.

"Astronauts now routinely spend a year on the International Space Station, the planned mission to Mars will take at least three years and the increasing commercialisation of space travel means more people outside Earth's atmosphere," she said.

"In the past, people who were going to hostile and isolated environments like Antarctica were often asked to undergo certain prophylactic surgeries to avoid any medical complications but that is generally no longer recommended.

"These drainage systems, then, could be key because they are small and effective but they need to be reliable."

Dr Brown said she first became interested in aviation and astrophysics as a child, an interest that flowered in the footsteps of her grandfather who was the first Māori jet pilot in the Royal Australian Airforce.

She was drawn to surgery as a junior doctor and has since expanded her research into aerospace medicine with the full support of her PhD supervisors Professor John Windsor, Associate Professor Anthony Phillips and Dr Jiwon Hong.

In recent years she has presented research on:

- the role of genomic information in astronaut selection, retention and assignment at the 2018 Aerospace Medicine Association (AsMA) Annual Conference in Dallas, USA;
- the use of percutaneous drains in microgravity at the 2017 AsMA Annual Conference in Denver; and
- a case series of pulmonary hypertension in airline passengers at the 2016 AsMA Annual Conference in Florida, USA.

This year, Dr Brown was elected the student/resident representative for the Space Medicine Association.

She is the current co-head of the Aerospace Medicine Students and Residents Association International Outreach Committee and a member of the New Zealand Aviation Medicine Society Board.

Dr Brown said it was an exciting time to be involved in aerospace medicine.

"We have Rocket Lab in New Zealand which is creating a new space industry here while Australia has just recently received funding to set up its own space agency," she said.

"There is so much to be discovered in this field, not only in terms of exploring planets or planetary systems, but also in terms of developing our understanding of how the human body adapts to hostile or alien environments and how we can best treat people so far from home."

Dr Brown thanked RACS and its Fellows for the support shown to her.

The Hugh Johnston Travel Grant arose from a bequest from the late Eugenie Johnston in memory of her late husband. It was established by the Foundation for Surgery to assist needy and deserving Fellows and SET Trainees to take time away from clinical positions to gain specialist knowledge and expertise overseas to benefit the surgical profession and the community.

ACADEMIC HIGHLIGHTS

- 2018 RACS Hugh Johnston Travel Grant
- 2016 Louis Barnett Surgical Research Training Prize
- 2016 Jeffrey R. Davis International Aerospace Medicine Award
- 2015 Royal Aeronautical Society Student Medicine Award
- 2012 RACS Foundation for Surgery Research Scholarship for PhD research into accelerating liquefaction of pancreatic necrosis.

Karen Murphy
Surgical News journalist

Loosening gun laws could risk lives says Chair of Tasmanian Committee

Norm Legg, a project supervisor with a local security firm, holds an Armalite rifle during the 1996 gun buyback (Getty Images/AFP)

More Australians could be at risk of gun related violence if the Tasmanian government proceeds with plans to loosen gun control laws, according to the Chair of the RACS Tasmanian Committee, Dr David Penn.

Dr Penn said the Government was considering proposals to make it easier for people to access pump action shot guns and self-loading rifles.

He said the plans included:

- allowing greater access to Category C weapons for farmers, sporting shooters and licence holders;
- allowing Category C gun holders to use silencers;
- to double the duration that gun licenses can be held from five to ten years; and
- to remove a provision which sees weapons removed from owners for breaches of gun storage laws.

He said such changes contravened the spirit of the National Firearms Agreement (NFA) and subsequent legislation put in place to control access to such weapons in the wake of the horrific Port Arthur gun massacre in 1996.

Dr Penn said he was concerned that the Government was also considering a protocol for carriage of firearms in vehicles and a review of gun laws for weapons with a military appearance.

He described the proposals as a major public health issue that risked decades of national cooperation designed to keep Australians safe from gun violence.

He said legislation that restricted access to firearms had led to a 75 per cent decrease in private gun ownership between 1988 and 2005 and that since the NFA legislation came into effect, more than one million privately owned firearms had been seized, surrendered and destroyed.

Any watering down of the legislation would risk the hard-won protections put in place to keep Australians safe from gun violence.

In July, Dr Penn wrote to Tasmania's Premier, Mr Will Hodgman MP, urging him not to proceed with the plans.

In the letter, he wrote that in the 18 years prior to the introduction of the NFA gun laws, there had been 13 fatal mass shootings in Australia, with 104 victims killed, with only one mass shooting in Western Australia occurring since.

He told the Premier that the statistics proved that Australia's gun control laws were one of the country's most successful public health measures and the envy of many countries.

He also informed the Premier that RACS had a particular affinity with the victims of the Port Arthur massacre.

"It was fortunate that a RACS course – Early Management of Severe Trauma (EMST) – had just been held in Hobart days before the massacre and the health professionals at the Hobart Hospital, who received the injured patients from Port Arthur, were grateful to have received such recent and relevant training in caring for trauma patients," he wrote.

"We live in a society free from alarming gun violence statistics, which is the envy of others, and we are grateful to live peacefully without constantly fearing for the safety of our lives – and our children's lives.

> "It has been 22 years since the Port Arthur massacre (and) if our gun control laws loosen, we will not just go back 22 years, but the lives lost will tragically have been in vain."

The letter to the Tasmanian Premier was also co-signed by Dr Girish Pande, the Immediate Past Chair of the RACS Tasmanian Committee.

Karen Murphy
Surgical News journalist

CPD Reflective Practice

RACS introduced a Reflective Practice category into the College's CPD Program in 2017. The introduction of this category is consistent with the direction the Medical Board of Australia (MBA) is taking in the development of it's Professional Performance Framework and also the principles outlined by the Council of Medical Colleges in New Zealand and supported by the Medical Council of New Zealand (MCNZ).

All Fellows were required to complete the Operating with Respect eLearning module last year, to obtain compliance with the reflective practice requirement. From 2018, Fellows can choose from a variety of activities that promote reflection, respectful behaviours and cultural competence including:

- Development of a structured learning plan (including self-reflection);
- Multisource feedback;
- Surgical or clinical attachment to a peer (including clear learning objectives and self-reflection);
- Completion of cultural competency training;
- Participation in a structured mentoring program;
- Patient feedback survey (including action plan);
- Recipient of a structured practice visit (including evaluation and action plan), and
- Participation in a practice visit (as a visitor).

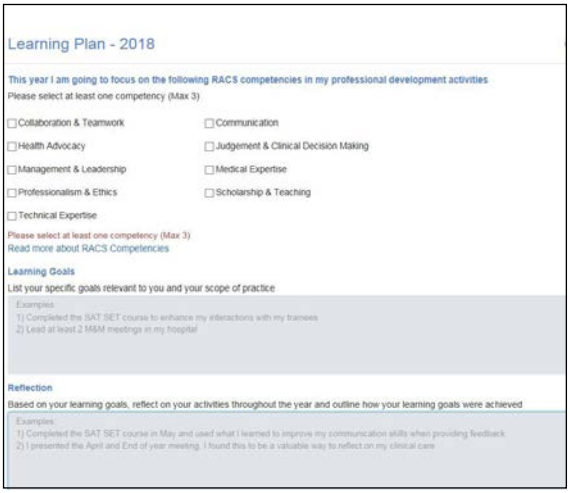
To support Fellows in meeting these requirements, RACS offers access to a number of these activities free of charge to Fellows.

Learning Plan

Fellows participating in the RACS CPD Program and using CPD Online can access an online Learning Plan tool. The tool is based on the RACS surgical competencies and asks Fellows to identify in which competencies they would like to undertake activities to improve their practice. At the end of the year, Fellows are asked to reflect on the activities they have undertaken during the year and whether this has resulted in improvement to their practice. Once complete, the activity is automatically credited towards a Fellow's reflective practice requirement.

The Learning Plan can be accessed from your Portfolio by clicking on My CPD.

For further information, please contact the CPD Team at cpd.college@surgeons.org



Screenshot of the Learning Plan which can be accessed on My CPD

Multisource Feedback (MSF)

RACS has a limited number of multisource feedback assessments available to Fellows, including the option of incorporating patient feedback. The assessment is based on the RACS surgical competencies and is administered via an independent external agency that has extensive experience in MSF including working with the General Medical Council (GMC) in the United Kingdom (UK), the Australian Health Practitioner Regulation Agency (AHPRA) and other specialist medical colleges. The assessments are available to all Fellows (including those participating in other approved CPD programs). For more information, please contact the Professional Standards Department at professional.standards@surgeons.org.

Dr Bruce Hall
Chair, Professional Standards

2017 Fellowship Survey

Having your say - results and action

2017 Fellowship Survey: results and action

Thank you for your participation in the 2017 Fellowship Survey. The survey was conducted to gauge your views and ensure that RACS activities meet the needs of Fellows. RACS Council has discussed the survey results and the responses required in a number of areas. The survey will serve as a source of information for strategic planning, identifying strengths, improvements and challenges for surgery over the next five years.

Peer support

Seventy per cent of Fellows said that they would use a peer support program if they were making or subject to a complaint. RACS has actioned this feedback by training a group of Peer Supporters to provide confidential support and by launching a Peer Support Program available for RACS members who make a complaint or who are required to respond to a complaint being reviewed by RACS. Support is focused on listening, checking on a colleague's wellbeing and encouraging access to professional counselling and support services.

Surgical education and training

More than three-quarters of respondents involved with the Surgical Education and Training (SET) Program were satisfied with the delivery of surgical education and training. Areas for improvement identified were the selection process, managing underperformance, the role of RACS versus Specialty Societies, Trainee pressures and costs, and recognition of supervisors and skills course educators.

A selection workshop was held in April 2018 to review the findings of studies into SET outcomes and selection. This workshop was an opportunity for RACS and the specialties to constructively review and discuss selection practices. There was agreement to develop new selection initiatives for piloting as a way forward.

Communication

Fax Mentis was ranked as your first preference to receive communication about RACS news and upcoming events, but Fellows wanted to see this offered less regularly. As a result of this feedback Fax Mentis is now released fortnightly rather than weekly.

RACS services

There were high satisfaction levels for most of the RACS online services including the website, online payments, and updating CPD and member details via the RACS Portfolio. As consistently reported for all past Fellowship Surveys, Fellows continue to feel strong satisfaction for the RACS Library services.

More than 80 per cent of Fellows were able to often or always locate the appropriate RACS staff member to assist them. This is a good result; however there is more work to be done to improve our customer service. RACS CEO Mary Harney is championing an organisation-wide project to improve service across the organisation.

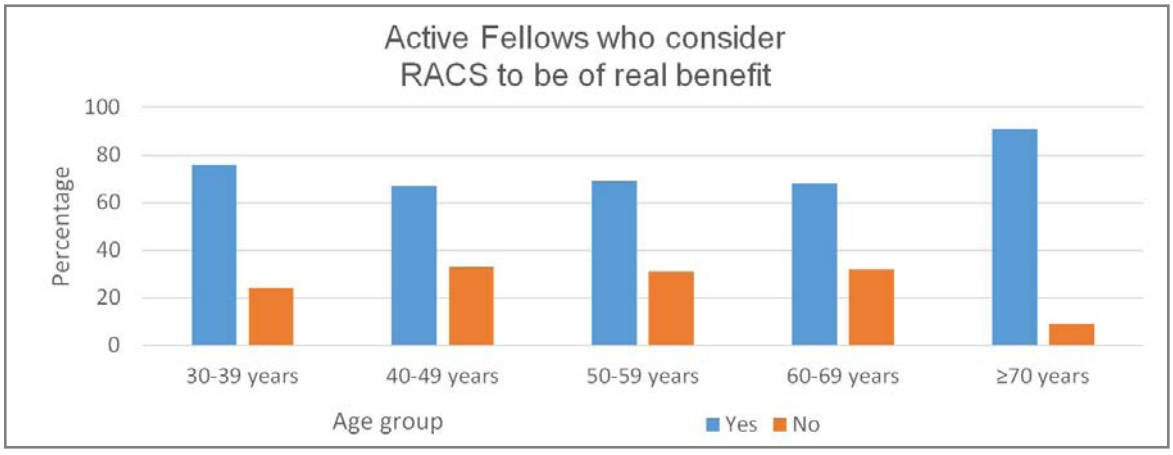
Building Respect and Improving Patient Safety

Almost two-thirds of Fellows were satisfied or very satisfied with the way RACS has been advocating on the issue of bullying and harassment. Implementing the Building Respect and Improving Patient Safety Action Plan is a key priority, with almost all Fellows completing the Operating with Respect eLearning module. The focus is now on supervisors and educators attending the Operating with Respect Workshop which has a practical focus on managing and preventing discrimination, bullying and harassment as well as a range of other actions to achieve cultural change.

Role and value of RACS

Overall, Fellows are satisfied with the role of RACS and services provided, although some declines in satisfaction have been noted when compared to the 2015 Fellowship Survey. Eighty-two percent of respondents are satisfied with the role of RACS and the services provided – a decrease from 91 per cent in 2015.

Seventy-two percent of respondents considered RACS to be of real benefit to them as a Fellow – a decrease from 79 per cent recorded in 2015. Benefits highlighted



Satisfaction with RACS

82% of Fellows are satisfied with the role of RACS and services

72% of Fellows consider RACS to be of real benefit to them

80% of Fellows are able to often or always locate or contact an appropriate RACS staff member

by Fellows included RACS acting as an umbrella to represent surgery, maintaining surgical standards and providing a quality SET Program.

Next steps

I will be reporting on our strengths, areas for improvement and ongoing challenges identified by Fellows in the next edition of *Surgical News*.

I would like to take this opportunity to thank you again for participating in the survey. The survey has provided valuable feedback and gives RACS Council confidence that decisions and plans for the future reflect the views of Fellows.

The Fellowship Survey is open to all active and retired Fellows, and was conducted online with a response rate of 20.4 per cent (n=1403). We have observed a decline in the number of Fellows participating in the survey since the first Fellowship Survey in 2006. Engaging the Fellowship to 'have your say' remains an ongoing priority.

The 2017 Fellowship Survey Report is available at www.surgeons.org

Ruth Bollard
Chair,
Fellowship Services Committee

ASC Bangkok 2019

The Complete Surgeon: Backing the future

Planning is well underway for this exciting meeting. The team based in Wellington with assistance from our surgical colleagues around New Zealand, and the excellent administrative support from the Wellington office and Melbourne ASC staff, have made for some great progress.

Four plenary sessions have been organised to explore issues relevant to us all. The opening plenary on Tuesday, titled 'Generalism', will explore issues such as surgery in smaller centres, education for generalists (as compared to sub or super-specialised) practice and training surgeons to work across/with all centres and interconnected services.

Wednesday's plenary on 'Global Health' will focus on the essential emergency surgical care initiative and speakers include experts from the World Health Organisation (WHO). Thursday's plenary on 'Diversity' will explore issues such as gender, indigenous or other ethnic diversity, cultural competence and bias. Finally, Friday's plenary on 'Future Horizons' will discuss developments and research that could influence the direction of surgery.

Recognising the potential difficulties of planning an off-shore meeting we have endeavoured, where possible, to collaborate between sections.

A great example of this is going to be SUPER Thursday. This will combine women in surgery, education, surgical directors, medicolegal and colorectal.

We plan to also explore Social Media, Diversity, the promotion of women in leadership roles and unconscious bias.

By looking creatively at the programme, and with clever utilisation of invited speakers, we aim to deliver more content to a wider audience.

I hope that you have put your pin in the map and blocked out the calendar for what is shaping up to be an excellent meeting.

And remember to factor in your post conference tours or vacation. It would be a shame not to take advantage of the proximity of South East Asia and the great tours we'll be offering through Thailand, Cambodia, Laos and Myanmar.

On behalf of the executive and the section convenors I strongly recommend this Annual Scientific Congress to you.

Looking forward to seeing you all in Bangkok.

Nigel Willis
ASC 2019 Convener, FRACS

Telehealth in the rural setting

Dr John North, FRACS
Rural Surgeons Series

Dr John North

It would be difficult to classify John North as a 'rural' surgeon, regardless of how loosely you defined the term. Although he has always been involved in or had an interest in outreach services, for the majority of his life he has lived and operated as an orthopaedic surgeon out of Brisbane.

But through his involvement in *Telehealth* services over the past decade, John and his colleague orthopaedic surgeon, Dr Greg Nutting, (together with the nursing and administrative team at Mount Isa and in the Telehealth centre team at Princess Alexandra Hospital in Brisbane) have been instrumental in ensuring that the residents of Mount Isa, and its surrounds, have regular access to high quality health care within their own community.

The results have been enormously beneficial for the large mining town of approximately 25,000 residents. A recent study highlighted a saving of approximately $400,000 per year to the health system, and a significant reduction in patient transfers to Townsville Hospital (the nearest major hospital which is located approximately 900 kilometres away).

The journey began when John provided some consultancy services via Skype. Although these consultations were only very basic, he was encouraged by the initial results, and from the outset there were many obvious benefits.

In 2012, the Princess Alexandra Hospital (PAH) officially commenced fracture clinics with Mount Isa Hospital (MIH) via a newly developed facility. The facility incorporates six sound proof rooms, each with appropriate technology to effectively run the clinics.

An initial analysis of the service highlighted a noticeable 'failure to attend' rate, however, once it became clearly understood that a specialist clinician in Brisbane would be in attendance, that rate reduced significantly.

John acknowledges that there are some obvious disadvantages with not being physically present at the same location as the patient, and highlights the critical role of having a primary care support person in attendance.

"There are some things you can't examine without having physical contact with the patient, but Telehealth is not just a consultant to patient exercise; it is consultant to primary care consultant as well," John said.

"Whenever we conduct clinics, I am accompanied in the rooms at PAH by a radiographer, while in Mount Isa Hospital a local clinician is present with the patient. Having the doctor or nurse there with the patient minimizes the apprehension they might be feeling about the service.

"The quality of the images and the audio are excellent. Everything is clearly visible on the screens and the x-rays are all on hand to bring up whenever you need, thanks to the radiographer. We can easily show the patient and practitioner at the other site the films and explain the issues. This is very useful when parents ask about fractures and possibilities for their children.

> "Effectively the doctor, nurse or physiotherapist at the other end becomes our hands, and partly our eyes. I am able to talk them through the process, and if you watch carefully you can see exactly what is happening during the distant interaction between patient and practitioner."

While John notes the significant financial savings generated by the services, he is equally buoyant about many of the other benefits that have also been derived.

"It has been an incredibly cost effective exercise for patients that would otherwise be travelling to Brisbane or Townsville to access our services. It also removes the sometimes stressful elements of travel, particularly for parents who can just take their kids to the local hospital without having to cover those vast distances.

"But not only this, it has turned out to be a tremendous learning opportunity for everyone involved. For instance normally in outpatient clinics radiographers only see the x-rays, but they never get to listen in on the consultations and hear what the consultant and/or registrars have to say to one another or the patient.

"Then there are the clinicians at the other end. They all get the chance to be part of the consultations and have that exposure, which they would otherwise rarely get. James Cook University send medical students to Mount Isa all the time, so there is that student teaching/learning aspect as well.

"This communication and conversation is great for the patients and their support people, who often get a much greater understanding of what the fracture type is, and why it might need to stay in plaster or to develop a change in the management plan.

"And lastly, from my own perspective, we get to see so many amazing types of pathology and a much more varied caseload that we don't get to see in Brisbane."

As Telehealth has evolved, the complexity of the cases has also broadened. PAH has the capacity to hold clinics with smaller rural hospitals upon request. For many remote practitioners this has broken down the many barriers that often isolate them from fellow medical professionals.

"Telehealth has opened communication lines between our hospital and some of the GPs who relieve in small rural towns, Indigenous communities and many other hard to reach places. There is now an openness to communicate, and remote practitioners know that they can SMS us x-rays, or give us a call if there is anything they want to discuss.

"Most of the time we can quickly identify the problem, provide them immediate treatment advice and then arrange a follow-up appointment at the fracture clinic later in the week. If a transfer is required, we can often facilitate this with a phone call or two.

"We can't always treat the patient entirely via Telehealth, however, what we can do is diagnose any sinister pathology early, and then begin discussing treatment options and plans while the patient is still in their community.

"For example, we recently saw a patient with advanced stages of melanoma with brain metastases who had a fall. We looked at his x-rays and confirmed what appeared to be a fracture with suspected malignancy that had spread to the bone.

"The patient lived on a very remote property, so you begin to ask yourself- what on earth do you do with such an isolated patient with all of these things wrong with him? The answer is communication.

"You have to communicate with the oncologist, the orthopaedic surgeon and the various other medical professionals involved in care. You must also communicate with his primary carer, who in this case was his wife, and with the local hospital to ensure that all the paper work for transfer is completed without any unnecessary hold ups.

"Obviously for this patient and his family it was always going to be a difficult process, but there are so many things that the Telehealth process can do early (before the patient had even had to travel), which can make their lives that much easier.

"It took a lot longer than the average consultation, but it would have been much more complex without this service. Regardless, we are there for patient care and not for patient length of consultation."

As John continues to promote the use of Telehealth, he has been heartened by initiatives such as the inaugural Telehealth Awareness Week, which was held in Western Australia recently. He is hopeful that the technology will be expanded to incorporate more rural hospitals across the country, and begin to form an increasing part of national rural health policy.

"It is amazing what you can do, where you can go, and how much use you can be to these communities. As is the case with most things in medicine, communication is key, and Telehealth opened up a whole line of service that otherwise would not have existed. I am committed to Telehealth and I will always be a passionate advocate for it."

Dr John North will be presenting at the SA, WA and NT Annual Scientific Meeting, being held from 23-25 August 2018 in Alice Springs. You can register online at https://surgeons.eventsair.com/nt-sa-wa-asm-2018/registration/Site/Register.

Interview by Mark Morgan, Communications and Policy Officer, RACS

Welcome to the new SET Trainees for 2019

RACS Surgical Education and Training (SET) selection interviews have just been completed and by the time you've read this the results of the selection process will have been sent out. Getting accepted onto the SET program is a momentous occasion that puts an end to the inherent uncertainty of being an unaccredited registrar. However, the pathway through SET can be somewhat daunting at the beginning.

The Royal Australasian College of Surgeons Trainees' Association (RACSTA) will host the SET Induction Conference for new Trainees in Melbourne on Saturday 27 October 2018. This annual one day conference welcomes new Trainees and provides advice to help them make the most of their surgical training. Topics will focus on the evolution of SET towards competency-based training, professional and personal wellbeing, getting the most out of feedback, as well as panel discussions including research, women in surgery, rural surgery and flexible training. The conference will conclude with a dinner at a local restaurant (location to be confirmed).

This year our invited speakers include:

- Mr John Batten, Orthopaedic surgeon from Launceston and current RACS President;
- Miss Ruth Bollard, Breast/Endocrine surgeon from Ballarat, current RACS Councilor, the immediate past Chair of the Women in Surgery Committee, and current Board member of the Rural Surgery Hub (Ballarat);
- Associate Professor Stephen Tobin, Colorectal/ Breast surgeon from Ballarat and current RACS Dean of Education;
- Mr Adrian Anthony, Upper Gastrointestinal surgeon from Adelaide, current Chair of the RACS Board of Surgical Education and Training, and a member of the Foundation Skills for Surgical Educators faculty;
- Mr Eric Levi, Otolaryngology, Head and Neck surgeon from Victoria who has a special interest in the mental wellbeing of doctors;
- Dr Christine Cuthbertson, General Surgeon practicing in the areas of colorectal, rural, breast and endocrine surgery from Victoria.

Dr Ben Chan

The induction conference this year will also include a half day haemostasis workshop, sponsored by Johnson&Johnson at no extra cost to participants. This hands-on workshop will include tutorials on coagulation as well as an opportunity to use various haemostatic agents. It will be held the day after the conference (Sunday 28 October 2018).

Last year's conference was a great success and RACSTA is committed to keeping this strong tradition going. It is an engaging forum where new Trainees glean valuable advice from both Fellows and senior Trainees and get a running start into their new careers as tomorrows surgeons.

For more information see:

https://www.surgeons.org/becoming-a-surgeon/surgical-education-training/racsta/trainee-induction-workshop/ or contact racsta@surgeons.org

Dr Benjamin Chan
RACSTA Executive

John Corboy Medal

The John Corboy Medal, a distinguished award for surgical Trainees commemorates Dr John Corboy's (1969-2007) achievements and recognises exceptional service by other Trainees.

The John Corboy Medal is awarded annually to a Trainee who demonstrates the characteristics for which John was admired.

The award is made to a candidate who shows some or all of the following qualities:

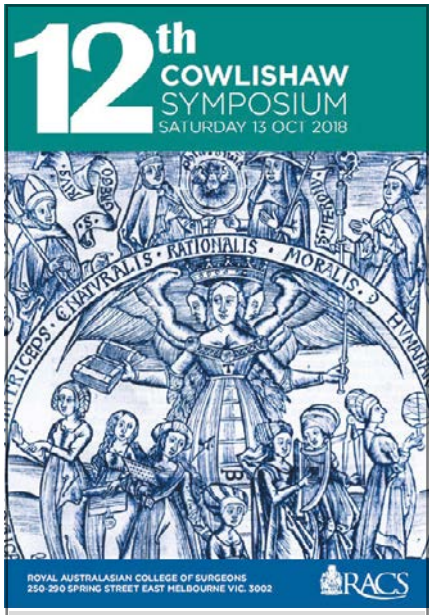
- Outstanding leadership
- Selfless service
- Tenacity
- Service to Trainees of the College

These qualities must be demonstrated in either the performance of his or her duties, service to the surgical community, the manner of and approach to the fulfilment of their surgical training and/or by their commitment to and involvement with the community of surgical Trainees.

Nominations for the 2019 award close on 31 August 2018 and should be emailed to racsta@surgeons.org. For more information see https://www.surgeons.org/becoming-a-surgeon/surgical-education-training/racsta/

Past recipients of the John Corboy Medal

2018 – Kimberly Aikins
2017 – Genevieve Gibbons
2016 – Grant Fraser-Kirk
2014 – Gregory O'Grady
2013 – Ruth Blackham
2011 – Brandon Adams
2010 – Matthew Peters



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

Transparency of surgical fees

In recent meetings, the Australian Minister for Health, Hon Greg Hunt, has asked RACS for recommendations on how to improve transparency for patients on fees and surgical outcomes.

The 28 May televised *ABC Four Corners* report titled 'Mind the gap' sparked an influx of emails to our President. Some Fellows want RACS to advocate for the appropriateness of the Australian Medical Association (AMA) Schedule of Fees, which unlike the Medicare Benefits Schedule, has kept pace with the cost of providing healthcare services. As a professional body there are limitations on what RACS can do and it is clear that RACS cannot prescribe or mandate any schedule of fees.

Full disclosure and transparency within the doctor-patient relationship is essential. It is a professional responsibility for all surgeons to obtain Informed Financial Consent from their private patients, ensuring clear communication.

On 12 June the President attended an Out-of-Pocket and Fee Transparency Roundtable hosted by the Consumers Health Forum of Australia (CHF), the University of Melbourne and Medibank, and facilitated by Norman Swan.

Roundtable participants acknowledged that healthcare reimbursement exists in a complex regulatory environment that is not necessarily user friendly or easily understood by consumers. While the vast majority of healthcare in Australia (88.1 per cent) is provided at no direct cost to the patient and a further 6.9 per cent of services have a known-gap charge of less than $500, more needs to be done to improve patients' understanding of potential out-of-pocket costs.

The CHF's 'Out of Pocket Pain' study found that one in six of the 1,200 survey respondents reported costs having a significant impact on their lives, with some charged tens of thousands of dollars in out-of-pocket costs and some having to draw down on their superannuation. Of the 62 per cent who responded to this question, more than a third of respondents said that no one involved in their treatment had discussed the possibility that they may face significant out-of-pocket costs.

In 47 per cent of cases, specialists had discussed costs.

The CHF report notes that many consumers support the establishment of an independent and authoritative website, which consumers can access to ascertain the fees and charges of individual specialists and allied health professionals.

RACS continues to be well engaged with government on this issue and is represented on the Ministerial Advisory Committee on Out-of-Pocket Costs, chaired by the Chief Medical Officer Brendan Murphy.

There is concern about the legal implications of price fixing and the fact that a public listing of fees is almost certain to have the unintended consequence of inflating fees. The AMA Private Health Insurance Report Card 2018 states that publishing the fees for every doctor and every procedure would be impractical, and potentially unhelpful, because out-of-pocket costs are determined by a range of factors including MBS billing practices, private health coverage and benefits, the episode of care and the patient's geographic location.

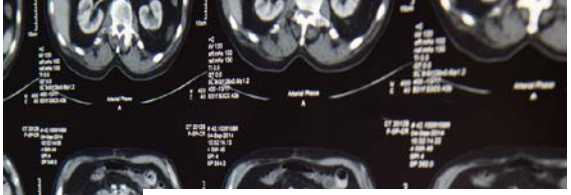
The Medibank collaboration on surgical variance is ongoing and these reports are designed to anonymously show a practitioner where they are located among their peers on fees and outcomes.

Risk adjustments are encouraged as some practitioners perform complex procedures or work in more remote regions, which will affect costs.

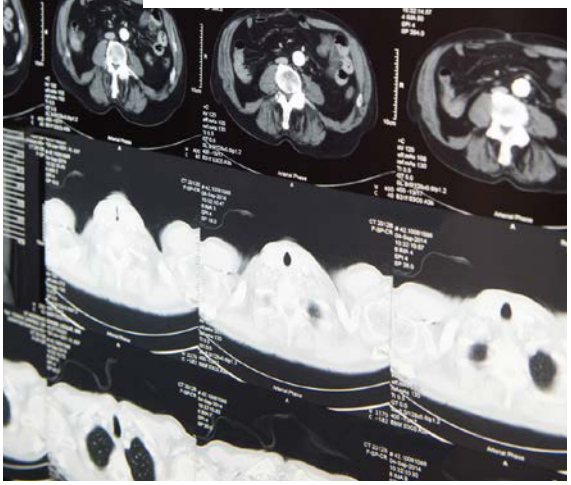
During the most recent Council week, the RACS Advocacy Board agreed to work on revising all RACS position papers, including the guide on informed financial consent, and to look at new patient information resources. Engagement with the surgical speciality societies will be at the centre of this work.

RACS will continue to work with the Australian Government and other key organisations such as the AMA and CHF to improve transparency of surgical fees.

Amy Kimber
Regional Manager ACT and Commonwealth Advocacy, RACS.



The wind of change



West of the Nullarbor, the safety and quality agenda is gathering pace. This is also occurring elsewhere. All the recommendations in Dr Stephen Duckett's report, 'Targeting Zero',[1] were accepted by the Victorian government and led to the establishment of Safer Care Victoria. Although there was no trigger event, the Western Australia (WA) Department of Health subsequently commissioned its own review by Professor Hugo Mascie-Taylor, which included similar recommendations.[2] A central tenet of both reports was the timely capture of high quality data and the active involvement of hospitals and clinicians. Both reports made reference to their state's Audit of Surgical Mortality.

However, Australia has nothing that comes close to the American College of Surgeons National Surgical Quality Improvement Program and the National Health Service Healthcare Quality Improvement Partnership. Many countries have national hip fracture audits that have collected data for over twenty years. By contrast, the Australian Hip Fracture Registry has only just received funding. In only four years, the National Emergency Laparotomy Audit in England and Wales demonstrated improved outcomes and cost savings in a very high risk group and has had its funding extended for another five years.

There is no reason why Australia cannot do better. The Australian Orthopaedic Association National Joint Registry is an outstanding example of how a relatively small investment now will recover its costs many times over in the future. Whatever the cost of preventing accidents, it is nearly always cheaper than paying for them later.

RACS has made a significant contribution with its guidelines for the conduct of effective Mortality and Morbidity meetings. This has attracted considerable interest from the WA Department of Health, which has asked its hospitals to address the recommendations. Clinicians are clear that the 'gold' standard is the only acceptable standard. Surgical societies are increasingly making participation in their own audits a condition for membership.

The next step is to make the changes required to achieve these goals. Hospital credentialing committees must take a greater interest in all aspects of what they approve. This includes confirmation of annual returns of Continuing Professional Development (CPD) documents (including participation in specialty audits), and attendance at hospital safety and quality meetings. Data quality is paramount. These committees may also need to employ data managers.

The holy grail of using routinely collected administrative data to measure clinical outcomes remains a dream. Although financial institutions can seamlessly link data through a common Application Programming Interface and can share data across the world, hospitals separated by a car park cannot even share a haemoglobin level. Some New South Wales hospitals are introducing a National Surgical Quality Improvement Program with highly trained independent data managers at its core. Such staffing is expensive, and it remains to be seen how this will progress.

The profession must accept its obligations. No matter how good the data collection, it will be of no value if clinicians do not use it. So, meaningful participation in Mortality and Morbidity meetings is essential. RACS promotes its CPD programme as central to the maintenance of standards; while processes have been developed to deal with those who ignore their obligations. Both RACS and its societies need to continue to take a robust approach to those Fellows who do not participate in CPD and audit activities.

To address the issues of data collection, data protection and sharing of outcomes for improvement in healthcare services, RACS has invited Dr Stephen Duckett to chair a workshop, to which the country's health departments and others are invited to explore and agree on common ground. The aim is to reach a mutually acceptable position that balances the demands of the health departments and hospitals with the obligations that can be expected of a surgeon, and how to do this with the openness and transparency now demanded.

There is every reason to believe scrutiny of clinical activities in Australia is likely to increase, and RACS will need to demonstrate it is seriously engaged in open and transparent safety and quality activities.

1. Department of Health and Human Services. Targeting zero: supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care. The Report of the Review of Hospital Safety and Quality Assurance in Victoria: Department of Health and Human Services; 2016 [Cited 2018, 15 June]. Available from: https://www2.health.vic.gov.au/about/publications/researchandreports/report-of-the-review-of-hospital-safety-and-quality-assurance-in-victoria

2. Department of Health. Review of Safety and Quality in the WA health system – a strategy for continuous improvement: Government of Western Australia, Department of Health, 2017 [Cited 2018, 15 June]. Available from: https://www2.health.wa.gov.au/Improving-WA-Health/Safety-and-quality-review

Mr James Aitken
Clinical Director WAASM

Members of the Australian Defence Force and Dr John Crozier

ADF and RACS mark first Australian Defence Force Trauma Verification review

Members of RACS Council Executive, RACS CEO and officers from the Australian Defence Force (ADF) marked an impressive milestone in the history of the Trauma Verification program and its partnership with the ADF on 1 June this year. RACS President Mr John Batten presented a plaque to Lieutenant Colonel Paul Manuel to acknowledge the review of the 2nd General Health Battalion (2GHB) at Shoalwater Bay which was the first time an ADF deployed hospital had undertaken a Trauma Verification review. The President commended the ADF for the insight and courage to have its tent hospital benchmarked against international standards using the RACS Trauma Verification program. In turn, Lieutenant Colonel Paul Manuel presented the President with a framed photograph of the hospital and military regalia. The photograph is being housed in meeting room 2 on level 2 at RACS, Melbourne.

The RACS Trauma Verification Program is a benchmarking process that assists hospitals to improve their standard of care for trauma patients. The program commenced in 2000 and has reviewed trauma services within 39 hospitals across Australia and New Zealand over the past 18 years. In contrast to the usual sanitised, purpose-built, predictable environment of a hospital, the conditions for the ADF review were vastly different – dust, wind, native fauna, camp beds and rations – as well as being part of a simulated war exercise! Trauma care has much to learn from the work conducted in the military setting and, as in all lessons from the defence force, the advances in trauma care aid the broader community that we serve.

For more information on the review see October 2017's *Surgical News* or contact trauma.verification@surgeons.org

Gabrielle Forman
Communications and Policy Officer, RACS.

Best research paper prizes

Awarded at the 2018 RACS Annual Scientific Congress

General Surgery Dr Ahmed Barazanchi - *Mortality after emergency laparotomy – systematic review of risk factors*

Surgical Education Mr Dennis King - *Supervisors' assessment of operative competence of urology Trainees: A framework of factors and behaviours influencing decisions*

Paediatric Surgery Dr Kiera Roberts - *Radiation exposure in infants with oesophageal atresia and tracheo-oesophageal fistula*

Endocrine Surgery Miss Lauren Jin Suk Joo - *A RET-related microRNA, miR-153-3p, acts as a tumor suppressor in medullary thyroid carcinoma via S6K signaling*

Paediatric Surgery Dr Liam Quinn - *Paediatric surgical services in remote northern Australia: an integrated model of care*

Endocrine Surgery Dr Man-Shun Wong - *Apparent low-risk differentiated thyroid cancers are under-treated with initial thyroid lobectomies only*

Pain Medicine Dr Paul Verrills - *Investigating the Efficacy of High Frequency Spinal Cord Stimulation at 10 kHz for Treating Chronic Abdominal Pain: Interim results from a multicentre feasibility study*

Vascular Surgery Dr Suk Cheng - *Restenosis after carotid endarterectomy: comparison of three surgical techniques and usage of intraoperative shunts*

Head & Neck Surgery Dr Thi Pham - *Emergency surgical airway simulation model: monitoring Trainee stress response and performance outcome in a live sheep model*

2018 Victoria ASM

Trauma Surgery in 2018 - The Contemporary Surgical Management of Severe Trauma.

19 – 20 October 2018 | Royal Children's Hospital | Melbourne

The Royal Children's Hospital, Melbourne. Photo by John Gollings

On behalf of the RACS Victorian Regional Committee, it gives us great pleasure in formally inviting you to the 2018 Annual Scientific Meeting: Trauma Surgery in 2018- The Contemporary Surgical Management of Severe Trauma, to be held on Saturday 20 October 2018 in the Ella Latham Auditorium, Royal Children's Hospital, Melbourne.

In collaboration with the three major trauma centres and our regional surgical partners across Victoria, the one-day program will bring together surgeons from across the state and provide a practical update on the management of severe trauma.

In recognition of the role that all hospitals play in the Victorian State Trauma Service, the meeting will cover core issues facing surgeons who participate in on-call rosters from Wodonga to Geelong, Warrnambool to Traralgon, and the major health care networks of metropolitan Melbourne in between.

To help deliver the program, we are very fortunate to welcome a line-up of presenters from across the state who are recognised as leaders in their field. They represent the spectrum of surgical specialties and reflect the multi-disciplinary nature of trauma surgery.

We are also privileged to have the involvement of our anaesthetic and interventional radiology colleagues with whom best practice management would not be possible.

Topics to be discussed include chest decompression and thoracotomy, laparotomy and the management of haemorrhage, paediatric resuscitation, pelvic bleeding, vascular injury, limb salvage, craniotomy and burns.

As the most livable city, Melbourne has something for everyone. The Royal Children's Hospital is located at the entrance to the CBD, and within walking distance or a short tram ride to many of the city's famous attractions. From shopping to eating, or the zoo to the museum, your family will enjoy the opportunity to experience Melbourne in spring.

We look forward to seeing you in Melbourne in October.

To register online visit www.tinyurl.com/VicASM18

Convenors: Ms Kate Martin, Alfred Health; Professor Rodney Judson, Royal Melbourne Hospital; Associate Professor Warwick Teague, Royal Children's Hospital

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)

17 August 2018	Christchurch	NZ
17 August 2018	Melbourne	VIC
25 August 2018	Brisbane	QLD
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
20 October 2018	Adelaide	SA
28 October 2018	Perth	WA
2 November 2018	Brisbane	QLD
4 November 2018	Sydney	NSW
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)

23 August 2018	Melbourne	VIC
1 September 2018	Wellington	NZ
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

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
23 October 2018	Melbourne	VIC

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)

11 August 2018	Brisbane	QLD

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

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.

SAT SET course

8 September 2018	Brisbane	QLD

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

Keeping Trainees on Track

8 September 2018	Brisbane	QLD

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

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

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.

Process Communication Model Seminar 2

14 -16 September 2018	Sydney	NSW

This advanced three day program allows you to build on and deepen your knowledge while practicing the skills you learned during PCM Seminar 1. You will learn more about understanding your own reactions under distress, recognising distress in others, understanding your own behaviour and making communication happen. PCM enables you to listen to what has been said, while at the same time being aware of how it has been said. At times we are preoccupied with concentrating on what is said, formulating our own reply and focussing solely on the contents of the conversation. To communicate effectively, we need to focus on the communication channels others are using and to recognise when they are in distress. ►

Note: In order to participate in PCM Seminar 2, registrants must have attended and be familiar with the content of PCM Seminar 1.

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.

Academy Forum

8 November 2018	Sydney	NSW

The Academy of Surgical Educators hosts the Academy Forum, an evening to acknowledge and celebrate the surgical educators and the leaders among us.

www.surgeons.org/AcademyForum

PROFESSIONAL DEVELOPMENT WORKSHOP
DATES: August - November 2018

ACT		
Surgeons as Leaders in Everyday Practice	10-11 Aug	Canberra
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
Academy Forum	8 Nov	Sydney
Non-Technical Skills for Surgeons	23 Nov	Sydney
NZ		
Foundation Skills for Surgical Educators	17 Aug	Christchurch
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		
Safer Australian Surgical Teamwork	4 Aug	Brisbane
Foundation Skills for Surgical Educators	25 Aug	Brisbane
SAT SET Course	8 Sep	Brisbane
Keeping Trainees on Track	8 Sep	Brisbane
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		
Foundation Skills for Surgical Educators	17 Aug	Melbourne
Clinical Decision Making	15 Sep	Melbourne
Foundation Skills for Surgical Educators	6 Oct	Melbourne
Academy of Surgical Educators Studio Sessions	23 Oct	Melbourne
Foundation Skills for Surgical Educators	1 Dec	Melbourne
TAS		
Academy of Surgical Educators Studio Sessions	14 Aug	Hobart
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
Foundation Skills for Surgical Educators	20 Oct	Adelaide
Non-Technical Skills for Surgeons	26 Oct	Adelaide
Process Communication Model Seminar 1	16-18 Nov	Adelaide
Clinical Decision Making	30 Nov	Adelaide

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
SEPTEMBER - NOVEMBER 2018 | *Available courses

ASSET	
Friday, 12 October – Saturday, 13 October	Brisbane
Friday, 19 October – Saturday, 20 October	Melbourne
Friday, 26 October – Saturday, 27 October	Sydney
Friday, 26 October – Saturday, 27 October	Auckland
CCrISP	
Thursday, 6 September – Saturday, 8 September	Auckland
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, 14 September – Saturday, 15 September	Melbourne
Friday, 19 October – Saturday, 20 October	Brisbane
Friday, 2 November – Saturday, 3 November	Adelaide
Friday, 23 November – Saturday, 24 November	Auckland
EMST	
Friday, 14 September – Sunday, 16 September	Sydney
Saturday, 21 September – Sunday, 23 September	Sydney
Friday, 5 October – Sunday, 7 October	Brisbane
Thursday, 11 October – Saturday, 13 October	Perth
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, 9 November – Sunday, 11 November	Wellington
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
TIPS	
Friday, 16 November – Sunday, 18 November	Melbourne
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

RACS recognises highest achievers

Professor Spencer Beasley, ONZM

Immediate past Vice-President, Professor Spencer Beasley has been made an Officer of the New Zealand Order of Merit for his service to paediatrics in this year's New Zealand Queen's Birthday Honours. The honour is a well-deserved recognition of Professor Beasley's long-standing dedication to the advancement of paediatrics and surgery in New Zealand.

Among the many accolades in the Honour's citation, Spencer is lauded for his instrumental role in establishing specialist paediatric surgical services for New Zealand's South Island more than 20 years ago. During the last two decades this service has grown into a four surgeon unit based in Christchurch which offers outreach clinics and operating lists in all of the regional centres, which provides essential and equitable access to quality paediatric services in the South Island.

"The focus has always been to configure the service in a way that provides the highest standard of care, as close to where the children live as possible"

"to ensure equity of access, and the least disruption and expense to families" Professor Beasley says.

Professor Beasley is a well-known and regarded RACS Fellow and has had a long history of involvement with the College, rounding off a full nine years on the College's Council as the immediate past Vice-President in 2016. Before being elected to Council, he held, at different times, all of the executive positions in paediatric surgery. Over two decades he has had a tremendous influence on surgical training through roles as Chair of the Board of Surgical Education and Training (SET), Chair of the Court of Examiners, Senior Examiner for Paediatric Surgery, deputy Censor-in-Chief, and Chair of the Board of Paediatric Surgery.

With a strong passion for surgical training, education and research, Spencer is currently the President of the New Zealand Society of Paediatric Surgeons and former President of the Australia and New Zealand Association of Paediatric Surgeons. Spencer is a former Trustee of the Rainbow Children's Trust, current Trustee of Children's Cancer Research Trust, and a member of the Pacific Association of Paediatric Surgeons Board of Governors. He is also a member of the Male Champions of Change Science, Technology, Engineering and Maths (STEM) group, made up of senior leaders who are committed to achieving gender equality and greater diversity in their organisations and fields.

In recognition of his outstanding service, Spencer was awarded the RACS Colin McRae Medal in 2017. His earlier RACS awards include the GJ Royal Memorial Medal (1993), the John Mitchell Crouch Fellowship (2001), the Sir Alan Newton medal for contribution to surgical education (2015), and the Peter Jones Memorial Medal (2016).

On the award of his ONZM, Spencer was quick to point out that his achievements were possible only because of the enormous support and encouragement he has received from many people, but particularly his family and colleagues.

"Without their understanding and assistance, little of what I have done could have been possible," he said.

Professor David Fletcher, Head of Department General Surgery at Fiona Stanley Hospital WA, has recently been appointed Member of the Order of Australia (AM) for significant service to medicine in the field of gastrointestinal surgery as a clinician, educator, researcher, and leader in health service delivery in this year's Queen's Birthday Honours.

Professor David Fletcher, AM

Professor Fletcher graduated with an MBBS from the University of West Australia in 1970. He gained his General Surgical Fellowship from the Royal Australasian College of Surgeons in 1974, and completed his Upper G.I./Endoscopy training at Royal Post Graduate Medical School and Hammersmith Hospital in London from 1978-1980. He began research in Gut Endocrinology for which he was subsequently awarded Doctorate of Medicine, University of Melbourne.

Professor Fletcher took up the role of Associate Professor of Surgery at the Austin Hospital from 1980-94 where he was a member of the Victorian Liver Transplant team and involved in introducing Laparoscopic Surgery to Australia and New Zealand. At the time he was Chair Upper GI Group, RACS and for the purpose of defining training and credentialing requirements for all disciplines, established and was elected Chair Endo-surgery Group, RACS. He is a former President of the Surgical Research Society Australasia.

Since 1994, Professor Fletcher has been Professor of Surgery at the University of West Australia, during which time he also became Director of Surgical Services at Fremantle Hospital from 1996-2014. He was also Chair of the Fremantle Hospital Clinical Staff Association from 2011-2015.

Professor Fletcher was instrumental within the National Institute for Clinical Studies (N.I.C.S.) of which he was a member from 2000-2005, and assisted in closing the gap between current and best practice.

Member of the Reid Committee planning group for WA Health Care, Professor Fletcher was involved in the development of the new West Australian tertiary Fiona Stanley Hospital and South Metropolitan service provision. He is now Head of General Surgery, Lead Surgeon and inaugural President of the Fiona Stanley Hospital Clinical Staff Association, a role he has undertaken since 2015.

Professor Fletcher was awarded Honorary Life Membership of the Society of American Gastrointestinal Endoscopic Surgeons in 1998 for his role in the development of laparoscopic surgery and an Excellence award in Surgical Education WA in 2015 (founding member Academy of Surgical Educators).

In 2015 Professor Fletcher was elected Councillor of RACS. He is inaugural Chair of the Surgical Directors Section. Appointed in 2016, Professor Fletcher is a member of the Medical Services Advisory Committee, and the Classifications Clinical Advisory Group of the Independent Health Pricing Authority.

When asked what the appointment means to him, a very humble Professor Fletcher said he felt greatly honoured.

"I have always endeavoured to do what is best for the community and profession. I am honoured to think that in some of my colleagues going to the trouble of nominating me for this award, they consider maybe I have made a contribution."

Gabrielle Forman
Communications and Policy Officer, RACS.

‘Appendicitis’ What’s the point?

John William Keys Parkinson reported the first case of appendicitis, in English, in the *Transactions of the Medical and Chirurgical Society of London in 1812*. This was the first case in which perforation was recognised as the cause of death. Parkinson was the son of James Parkinson, of Parkinson’s disease/paralysis *agitans*, fame.

It was not until 1886 when Reginald Heber Fitz, a graduate of Harvard College and Professor of Pathological Anatomy at Harvard suggested the name ‘appendicitis’, in his article, ‘Perforating Inflammation of the Vermiform Appendix; with Special Reference to its Early Diagnosis and Treatment’, published in the *Transactions of the Association of American Physicians*.

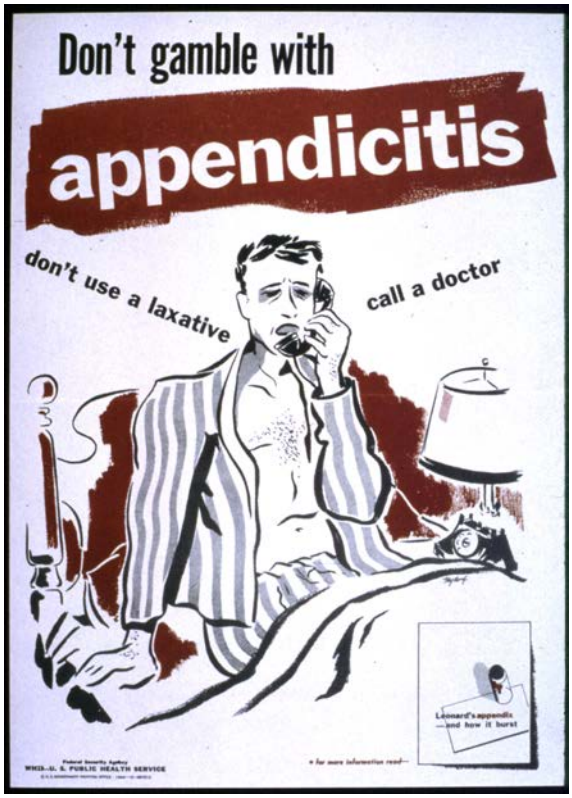
Much of his important article is dedicated to attempting to clarify the difference between typhlitis, perityphlitis and paratyphlitis; Fitz stated, ‘any attempt at explaining the various results of an inflammation of the appendix must necessarily be preceded by a statement of the peculiarities it may present with respect to structure and position’.

‘In considering the symptoms of appendicitis, it is to be noted that attacks of inflammation frequently occur without giving rise to any characteristic symptoms, and often without a suggestion of any distinct malady’.

Fitz concludes his article with the following statements: ‘The vital importance of the early recognition of perforating appendicitis is unmistakable. Its diagnosis, in most cases, is comparatively easy. Its eventual treatment by laparotomy is generally indispensable. Urgent symptoms demand immediate exposure of the perforated appendix, after recovery from the shock, and its treatment according to surgical principles. If delay seems warranted, the resulting abscess, as a rule intraperitoneal, should be incised as soon as it becomes evident’.

Charles McBurney gained his BA and MA at Harvard University before graduating MD from the College of Physicians and Surgeons, New York City in 1870. A formal bibliography of his writings lists 114 papers incorporating a wide range of subjects including glioma of cerebellum, osteosarcoma of the jaw, use of rubber gloves in operative surgery (1898) and excision of a spina bifida.

Posterity has rewarded McBurney by attaching his name to one of the most common signs of the disease, appendicitis, a point of tenderness in the right lower abdominal quadrant.



US Public Health Poster 1941-45

In November 1889, Charles McBurney read his paper, ‘Experience with Early Operative Interference in Cases of Disease of the Vermiform Appendix’, before the New York Surgical Society.

McBurney noted, ‘the fact that inflammatory affections of the vermiform appendix give rise to a considerable number of the so-called pericecal inflammations is now accepted in every part of the medical and surgical world, although one still reads of perityphlitis and paratyphlitis. Certainly, all of these terms are misleading, inasmuch as each of them, when used without explanation, implies that the particular disease to which it refers, is a disease by itself, and fundamentally different from the others’.

‘I must therefore prefer to use the term inflammation of the appendix, or appendicitis, and give up, once and for all, the terms perityphlitis and paratyphlitis, as misleading and not valuable except in explanation of secondary pathological processes’.


Reginald Heber Fitz

Importantly, he continued: 'The exact locality of the greatest sensitiveness to pressure has seemed to me to be usually one of importance. Whatever may be the position of the healthy appendix as found in the dead-house, and I am well aware, that its position when uninflamed varies greatly, I have found in all of my operations that it lay, whether thickened, shortened, or adherent, very close to its point of attachment to the cecum. This, of course, must, in early stages of the disease, determine the seat of greatest pain on pressure'.

'And I believe that in every case the seat of greatest pain, determined by the pressure of one finger, has been very exactly between an inch and a half and 2 inches from the anterior spinous process of the ilium on a straight line drawn from that process to the umbilicus. This may appear to be an affectation of accuracy, but, so far as my experience goes, the observation is correct'.

It has been argued that pain on pressure at McBurney's point is explained by reflexly irritated nerve endings of the eleventh and twelfth dorsal segments on the anterior abdominal wall. The same nerve segment is always irritated so that the point remains fixed no matter in which direction the diseased appendix may extend.

Across the Atlantic, Frederick Treves, the English authority on appendicitis begged to differ: in the Cavendish Lecture at Hammersmith Town Hall in 1902, just a few days before he operated on Edward VII for an appendiceal abscess, Treves observed; 'I want to deal with one solitary point, the so-called McBurney's point. Tenderness at this magic spot has become a sort of talisman; it is an inspired sign, it is some sort of religious stigma, it is the touchstone of the disease'.


Charles McBurney

'I need not remind you where this spot is but let me say what is said of it. It is said to be always present in every case of appendicitis, it is said to be not present in other troubles met within the abdomen. It is said to indicate the seat of the disease, it is said by some to indicate the position of the diseased appendix. The very great majority of all cases of appendicitis get well spontaneously; operation during an acute attack of appendicitis is attended with great risk to life'.

It is ironic that Treves continued to advocate the 'interval' operation, 16 years after Fitz had demonstrated the necessity for immediate surgery. At the close of 1900, when Treves' daughter Hetty was 18, she was stricken with an abdominal pain, but Treves did not suspect appendicitis. Hetty became feverish and belatedly her father realised that she had developed advanced peritonitis; when it was already too late, Treves decided to operate on his own daughter and at the eleventh hour he called in two surgical colleagues, who refused to take any responsibility for the case, pointing out that if he could not save her, no one could! He failed.

Peter F. Burke
FRACS

The gold-headed cane

William MacMichael. The Cowlishaw Symposium 2014

The Arms of Anthony Askew

In his catalogue of Historical Books in the Library of the Royal Australasian College of Surgeons, Professor Kenneth Russell noted, The Gold-Headed Cane written by William MacMichael, and published in London in 1827, *"is a series of biographical accounts of John Radcliffe, Richard Mead, Anthony Askew, William Pitcairn and Matthew Baillie, who successively owned the cane"*.

The book is written as if the cane itself is speaking, which allows the cane to embellish events, and to describe them lightly as a story, without demanding the accuracy and detail needed for an historical record.

The cane notes, *"of my early state and separate condition I have no recollection whatever: and it may reasonably enough be supposed, that it was not until after the acquisition of my head that I became conscious of existence, and capable of observation"*.

The author, William MacMichael was born at Bridgnorth, Shropshire on November 30, 1783: he was the fourth of the nine children born to William and Susannah MacMichael.

In 1800 he was awarded an exhibition to Christ Church Oxford and took his BA in 1805, his MA in 1807 and his BM in 1808. In 1811 he was elected a Radcliffe Travelling Fellow of University College, Oxford; receiving £300 a year for 10 years and was required to spend five of those years in medical study abroad.

MacMichael travelled widely visiting Greece, Bulgaria, Rumania, Russia, and Turkey, inter alia, and in 1816 he returned to England to take his DM at Oxford: owing to the failure of his bankers, he then remained in medical practice. In London he had many friends and was elected FRS in 1817 at the age of 34 and FRCP in September 1818.

His background of classical learning, foreign travel and love of books enabled him not only to write well, but also to practise medicine well: his first book, *A Journey from Moscow to Constantinople*, was published in 1819.

MacMichael's friendship with Sir Henry Halford PRCP led to his becoming Censor of the Royal College of Physicians in 1820 and, from 1824 until 1829, Registrar. His association with the RCP, coupled with his Radcliffe Fellowship, no doubt fuelled his desire to record the extraordinary story of the gold-headed cane which was, and remains, a treasured possession of the RCP, after it was presented to that College by the widow of the fifth and last owner, Matthew Baillie, in 1824.

The physician's cane was their only article of uniform, and no good doctor of the 18th Century could be seen in public or visit a patient without it. As a rule, its heavy gold or silver top was designed to carry a vinaigrette or pomander, which would be held to the nose when attending a sick person.

What is interesting, is that John Radcliffe's cane has a solid handle, and is not a 'doctor's' cane in the traditional sense; the Arms of the five owners are engraved on the gold head.

Its choice by Radcliffe might have been a conscious effort to distance himself from the traditional handle which had become associated with quackery: nowhere is this better illustrated than in William Hogarth's 'Arms of the Undertakers', published in 1736 with the motto, *"et plurima mortis imago" / 'and many are the faces of death'*.

The caricature is presented as a mock coat of arms; the lower half of the image shows a 'consultation' of eleven doctors, all heavily caricatured and bewigged, sniffing at their pomander topped canes, to dispel the stench of death, and a central figure demonstrating the use of a urinal.

MacMichael succeeds brilliantly in conveying the quality of the 18th Century physician: the intimate and friendly way in which the cane records details of consultations and conversations makes for delightful reading.

Following the First edition of 1827, a Second edition was published in 1828 with additional material, and later in 1884, a Third edition was published with further chapters provided by William Munk, of 'Munk's Roll' fame.

The Second edition, with an index, was republished in New York in 1915, with an introduction by Sir William Osler.

William Hogarth's 'The Company of Undertakers', 1736.

Osler regarded the book as a memorial of the life and labours of its first owner, John Radcliffe: where and when Radcliffe obtained the celebrated cane is unknown, however there is probably no name in our profession with which are associated so many benefactions.

The cane observed: *"Though it could not be said that our house was ever a melancholy one, yet still the home of a bachelor is occasionally but a dull and stupid residence"*.

Osler considered, the account of Mead was the best in the volume: *'It is a pity that he did not hand over his wonderful collections to the College of Physicians. Now the bibliophile turns the pages of the printed catalogue of his books, which took 27 days to sell, and mourns that the treasures of his lifetime should have been dispersed. 6,592 items, Oriental, Greek and Latin MSS'.*

William MacMichael

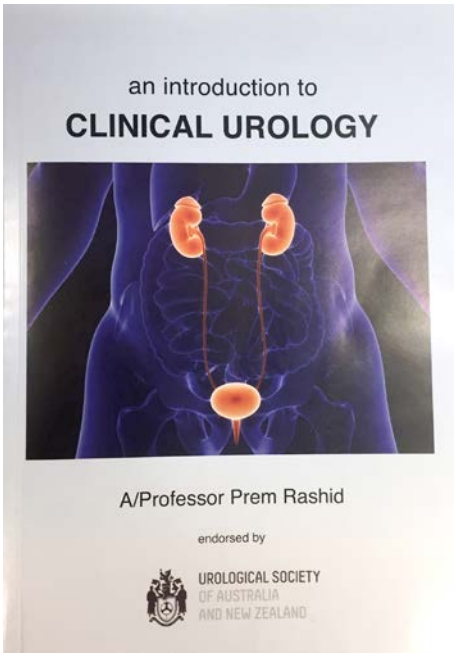
Concerning the next possessor of the cane, Anthony Askew, Osler's memory lingered in connection with the famous *'Bibliotheca Askeviana'*, the priceless treasures of which, were dispersed in 1775, through a twenty day sale.

Matthew Baillie, in many ways the most distinguished possessor of the cane, John and William Hunter's nephew, developed a close combination of pathology with clinical medicine; Munk's Roll noted: *"he possessed a perfect conception of his subject, and imparted it with the utmost plainness and perspicuity to his hearers"*.

The cane closed with the following lament: *"when I was deposited in a corner closet of the Library, on the 24th June 1825, the day before the opening of the new College of Physicians, with the observation that I was no longer to be carried about, but to be kept amongst other reliques of that learned body, it was impossible to avoid secretly lamenting the obscurity which was henceforth to be my lot"*.

Peter F. Burke
FRACS

Donations to the library collection



An Introduction to Clinical Urology by Associate Professor Prem Rashid

This book is a timely addition to Urological teaching resources in Australia and New Zealand. Associate Professor Rashid and colleagues have written a concise and practical guide aimed primarily at medical students. I believe it will also be of great use to interns and junior residents in their day-to-day work. The format and electronic companion allows rapid and easy access to common urological conditions seen in day-to-day practice in Australia and New Zealand.

The promotion of urological health for the benefit of the community is a core goal of the Urological Society of Australia and New Zealand (USANZ). An educated and supported medical workforce ultimately serves our community better through prompt recognition of urological conditions and their appropriate management.

Associate Professor Stephen Tobin RACS Dean of Education has also provided a review of the book as follows:

It gives me great pleasure to have been able to review Associate Professor Prem Rashid's textbook about Urology for medical students. Surgery has been reduced in terms of depth of study and time allocations in some medical school curricula. The case for a suitable text that covers Urology for medical students, not all of whom will have extensive exposure to the specialty, seems to be demonstrated.

Apart from his career as a practising Urologist, Associate Professor Prem Rashid has an extensive background in medical and surgical education, including Urology. He has chaired the RACS Board of Urology and had substantive roles within USANZ. He supervises urology Trainees, junior doctors, medical students and mentored colleagues. He is thus eminently suited to be the author of this book, which has been openly reviewed by a number of his Urology colleagues.

Donated by the author.

Endorsed by the Urological Society of Australia and New Zealand. Much of the content of the book is available online at: http://uro101.com/

Lecture Notes on Pancreatitis by Ali Ibrahim Yahya

The idea of centring a book on pancreatitis came to the author's mind after working as a general surgeon at his hospital over a period of 27 years after his return from Britain, where he finished his postgraduate training and received his Fellowship from the Royal College of Surgeons, Edinburgh. It covers topics of pancreatitis including pathology, clinical presentation, investigations and treatment; recommended for surgical residents and Fellows.

Dr Safaa Alsarrage writes in the books' foreword:

"…acute pancreatitis is very much related to the presence of gallstones in the Middle East. Having such a high prevalence of gallstones and its complications gave the author of this book the opportunity to understand and manage this condition efficiently and intelligently."

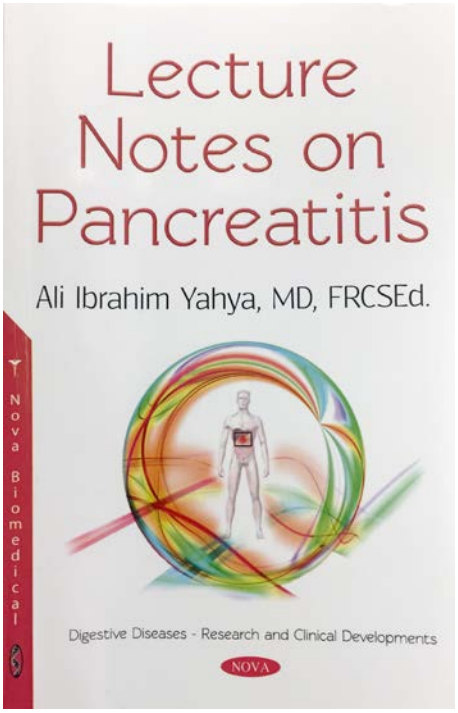
Chapters in the book include anatomy, pathology, systemic effects, investigation, scoring and treatment as well as different and rare types of the disease.

Donated by the author.

My Inestimable Friend: An Account of the Life of Rear-Admiral William Brown (1764-1814) by Alastair R. Brown

Review by Warren Reed reproduced with permission

This finely produced 416-page hardcover book is a tribute by a retired Sydney surgeon to his great-great-grandfather, an illustrious British forebear who was one



of Lord Nelson's trusted naval colleagues. Most family histories of this description inevitably glide into that well-known orbit of hagiography.

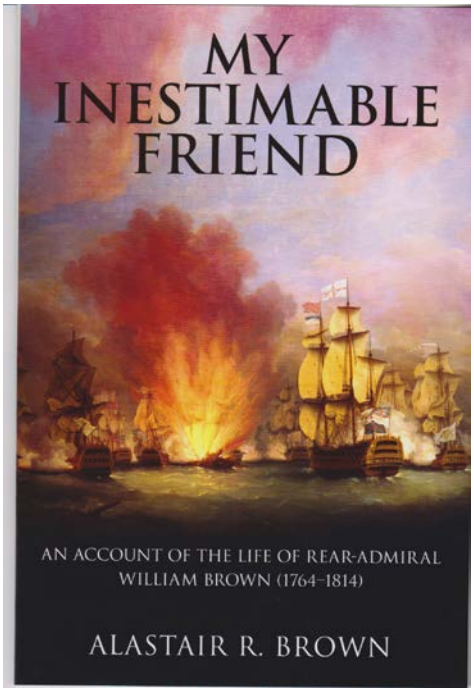
Dr Alastair Brown's biography, however, is in a different league entirely. His meticulous research, carried out during long stints in The National Archives in Kew, the National Maritime Museum in Greenwich, the Birmingham Record Office, the British Library, the British Newspaper Library and the Mitchell Library in Sydney, ventures far beyond mere family papers. Contemporary official documents tell the story of William Brown's life from midshipman to admiral, as seen through the eyes of his peers and seniors. His is a fascinating story.

We know that truth is often stranger than fiction and in *My Inestimable Friend* we are witness to the odd twists and turns that the life of an officer could evince in the Royal Navy of the late 18th Century. This biography takes us through the varied issues and challenges that William Brown had to contend with as an individual cog in a massive Admiralty machine. It was a highly effective and efficient system that coordinated the activities of fleets of ships around the globe. Through the smooth chronological sequence that is the backbone and strength of this book the reader can easily identify with William Brown's human qualities.

Keeping a fighting ship in a state of readiness had as much to do with water, food, livestock supplies, and rum and rope as it did with regular gunnery drills at sea amid the acrid smell of black powder. A naval vessel was a complex and sophisticated machine whose captain had to strike a delicate and constant balance between the human factor, discipline and tactics on the one hand and that of weather, a ship's manoeuvrability, luck, and opportunity on the other.

It is often said that when ships were made of wood, men were made of steel. This biography shows why that was so. Naval officers of William Brown's era weren't confronted by just hostile engagements at sea. They were often blighted by tropical diseases, the sudden inactivity of peacetime and the boredom of languishing on land on half-pay or on a shore-posting. Long periods of separation from family were commonplace. Brown grappled with all of these and shone as much as a major dockyard administrator as he did when in charge of a three-decker man-o'war and the fleet it was part of.

The title of the book is taken from a letter of condolence to Brown's family from Lord St. Vincent, retired Admiral of the Fleet and in his eightieth year, on learning of William Brown's death from yellow fever in 1814 in Jamaica, where he was Commander-in-Chief.



For naval history buffs, *My Inestimable Friend* is a rare gem, though its detailed annotations and reference guides may test the patience of the general reader. But it is raw history at its best and brings to mind the declaration of William Faulkner, a renowned American novelist, that, "The past is never dead; it's not even past."

Warren Reed is a former intelligence officer with the Australian Secret Intelligence Service (ASIS) who was trained by MI6 in London and served in Asia and the Middle East. He has a longstanding interest in naval history and is the author of numerous books.

Donated by the author.

Fellowship exam

Challenging the myth

In my role as RACS Principal Medical Educator, I recently had the privilege of attending the RACS Fellowship Exam (FEX) in Auckland, NZ. While teaching more than 80 Foundation Skills for Surgical Educator courses (FSSE), I had been regaled by many Fellows on their beliefs of how to prepare their Trainee or International Medical Graduate (IMG) for the gruelling experience of the FEX, often based on their own experience.

Was this high stakes assessment unchanged from the often harrowing experience they still remember?

I attended the Examiner Training Course which prepares novice examiners for their role. Attention was paid to ensuring the reliability and validity of the FEX, and implementation of best practice in assessment. The discussion focussed on how to support Trainees and IMGs through the FEX. Presented by experienced senior examiners, the inherent stress created by such an examination was acknowledged. The importance of minimising the candidates' stress was explained as an important aspect of examining and supporting the candidates' ability for optimal performance. So far so good!

On the morning of the exam I was surprised at how nervous I was. Anyone would think that I was sitting the exam but my nerves were for the Trainees and IMGs. I remembered the comments I had heard from FSSE participants. The need to prepare candidates for the 'grilling' they would get at the FEX, the strong feeling that they needed to be 'put on the spot', ensure they were used to 'rapid fire' questioning and the need to 'toughen them up', if they were to be successful at the FEX. So my expectation was to witness this 'grilling', almost a rite of passage, first hand.

This is not what I observed. I was very impressed at how hard the examiners worked to put the candidates at ease before each component of the exam. Prior to entering the room examiners used phrases such as 'think of this as a conversation with a colleague', and 'take your time and feel free to ask for clarification if you are not clear what we are asking'. On entering the room, the viva commenced and far from a 'grilling', I observed examiners actively trying to get the best out of the candidate in a supportive and collegial manner. Questioning was not 'rapid fire', nor was it harsh. Instead examiners used strategies to explore the candidate's clinical reasoning and provided additional questions to redirect them if they got off track. The examiners' body language was non-threatening and overall it was obvious they were doing everything possible to put the candidate at ease and get the best out of them.

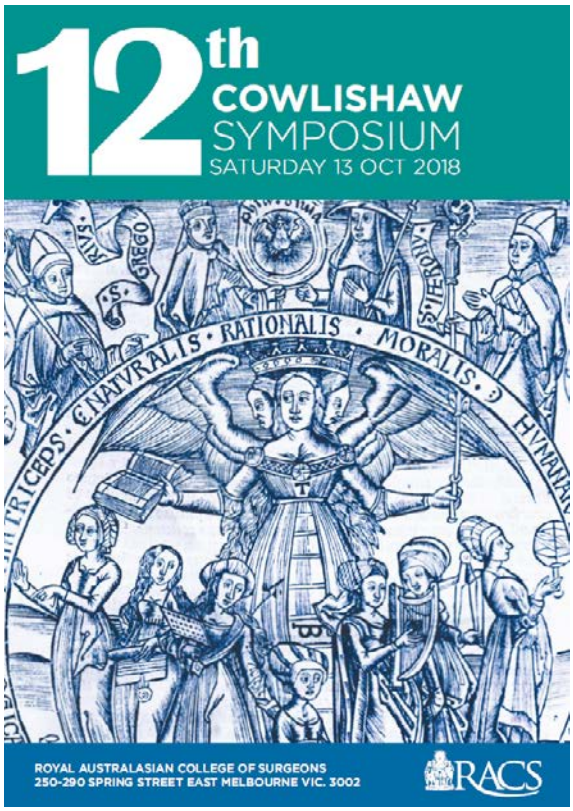
So why was my experience so different to that which had been described to me? Has the FEX changed from when these supervisors sat their final exam? Does the stress of sitting a high stakes exit exam cloud your impression of the experience? Does the memory get worse the further you are away from your exam? The answer to all of these questions may very well be 'yes', but either way I think we need to challenge the perception of the FEX as an experience to survive! There will always be stress associated with this exam but Trainees and IMGs need to be aware that the examiners are not trying to 'trick them', trap them into making a mistake, or make them weak at the knees so they will fail. The examiners are committed to upholding the standards of the profession at the same time ensuring those who sit the exam have every opportunity to demonstrate their competence in a supportive environment. I would like to thank the examiners for their efforts and commend them on the way they conducted themselves. I would also like to see the myth of the FEX challenged so that a new perception is realised which is reflective of the reality.

Deb Partridge
Principal Medical Educator, RACS

Cowlishaw Symposium 2018

Saturday 13 October 2018

Leslie Cowlishaw (1877-1943)



The Cowlishaw Collection is the collection of historical volumes held by the Royal Australasian College of Surgeons. The collection was created through the efforts of two men: Leslie Cowlishaw and Kenneth F. Russell.

Doctor Leslie Cowlishaw (1877-1943) was a bibliophile who became an honorary lecturer in medical history at the University of Sydney and the first honorary librarian for the Royal Australasian College of Physicians (RACP). His will gave the RACP first option on his collection but for financial reasons this offer was rejected. It was Kenneth F. Russell (1911-1987) who convinced RACS to acquire the collection, which he then spent a great deal of time protecting and cataloguing.

The Cowlishaw Collection was originally housed in the Gordon Craig Library but now resides in the Council Room at RACS. Robert Gordon Craig (1870-1931) was one of RACS' founders, and bequeathed £60,000 to RACS for education and research. In his honour, the RACS library is named after him.

The Cowlishaw Collection contains more than 2,000 volumes of outstanding quality. There are eight incunabula (books printed before 1501), including Guy de Chauliac's Cyrurgia, Venice, 1499. Hippocrates is presented in eighteen editions, Galen in five editions, and Celsus in twenty-one, starting with the 1493 printing. Vesalius's 1555 edition of De humani corporis fabrica, and Pare's 1568 edition of Tractie de la Peste are also included in the collection, along with many English books from the sixteenth and seventeenth centuries.

The Cowlishaw Symposium promotes the collection and is held every second even year. The next meeting on 13 October this year will see presenters choose a book(s) from the collection to underpin a presentation on an aspect of surgical history.

The first Cowlishaw Symposium was held in 1996 and has been a popular event in the RACS calendar since that time.

For further information and to register for the Symposium and dinner visit the RACS website:

https://www.surgeons.org/about/college-history/collections/

The Cowlishaw Symposium will be held at:
Royal Australasian College of Surgeons
250-290 Spring Street
East Melbourne Vic. 3002

Richard Lander
FRACS

The RACS Military Surgery Section

Encouraging interest in the care of the injured in service and the universal support to the veteran communities of New Zealand and Australia

A Military Surgery Section was first proposed in 1980 by RACS Fellow Sir Edward Hughes, however it did not become a reality until 1989 (as the Section of Military Medicine) when it had 21 foundation members. Its first visitor was invited to the 1994 Annual Scientific Congress (ASC). From these beginnings, the Section has grown to 101 members and runs a successful ASC program.

The Section aims to:

- promote the study of military surgery, foster interest in present and past surgical and anaesthetic practice in this field, and encourage interest in care of the injured in Service;
- maintain close association with the Archives and Library Committees, to ensure that RACS' historical material in this field is used to the best advantage of all Fellows;
- encourage Fellows and Trainees to enlist in the Defence Forces of our two countries, and supply high quality surgical care to our Defence Force personnel;
- develop productive relationships with all surgical specialties, particularly trauma surgery and surgical outreach, and
- foster universal support to the veteran communities of New Zealand and Australia.

Convener Dr Mary Langcake is to be congratulated on an excellent program at the Sydney ASC. Visitors were Dr M. Margaret Knudson (USA), Mr Thomas Scotland (UK) and Air Vice Marshall Tracy Smart (Australia). Sessions included "Lessons from trauma surgery in austere environments", "That was then, this is now – one hundred years of military surgery" (combined with: Surgical History), and "Being a good neighbour – the role of reserve military personnel in regional development".

Dr Rhys Thomas from Wales has accepted an invitation to be the 2019 ASC visitor. Dr Thomas is an anaesthetist and a former colonel in the British Parachute Regiment who served in Afghanistan.

Ms Annette Holian, Chair, Military Surgery Section at Shrine of Remembrance in Melbourne with SoR CEO Mr Dean Lee.

This ANZAC Day, the Section had good reason to be proud of two of its members:

Retired Colonel Susan Neuhaus CSC delivered the Commemorative Address at the Australian War Memorial service. The theme of her address was 'inclusion'. We are all beneficiaries of the two million Australians who wore the uniform of this country in war and the more

Susan Neuhaus CSC ANZAC Day 2018 (credit Australian War Memorial)

than 102,000 whose names are inscribed in the Roll of Honour, whether or not we have a direct link to them, or are Australians by birth or choice.

In Melbourne, I became the first woman still serving in the Australian Defence Forces to address the Dawn Service at the Shrine of Remembrance. I called for better community support for returned service people, and urged Australians to connect with current veterans and listen to their inspiring stories. I encouraged all to stand up for what they believe in, and strive to explore the limits of their potential and help others to achieve theirs. I urged the community to speak up for those who have no voice and to raise their children, especially their girls to be brave.

Membership of the Military Surgery Section is open to all RACS Fellows, Trainees and IMGs, and new members are welcome. You don't have to be a current or former member of the Defence Forces to join the Section. Members of the New Zealand Medical Assistance Team (NZMAT) may find it of interest, and Trainees are particularly encouraged to get involved.

Please email military@surgeons.org if you would like to become a part of this important Section.

Annette Holian
Chair, External Affairs

with Janet Devlin, Administrative Officer, Fellowship Services, RACS

Foundation for Surgery
Passion. Skill. Legacy.

The Foundation for Surgery and the D'Extinguished Surgeons warmly invites you

12 noon
Friday 21 September

Lecture:
"Hamilton Russell – The man, his music, his medicine, and his friend, Percy Grainger, the maestro."

This lecture will be delivered by
Mr Barry Elliott RFD FRACS

RACV City Club,
501 Bourke St,
Melbourne
VIC 3000.

Lunch will be served after the lecture.

Guests welcome.
Please feel free to bring colleagues, friends and family.

Thanks to the D'Extinguished Surgeons, who raised over $1,700 from the last function in support of the Foundation for Surgery.

RSVP
foundation@surgeons.org
by Friday 14 September.

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

IN MEMORIAM

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

Richard Cowdery (NSW)
Neville Way (WA)
Donald Simpson (SA)
James Rohrsheim (NSW)
Brian Williams (NZ)
Herbet Rawson (NZ)
Piratla Viswanatham (USA)

Informing RACS

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

ACT: college.act@surgeons.org
NSW: college.nsw@surgeons.org
NZ: college.nz@surgeons.org
QLD: college.qld@surgeons.org
SA: college.sa@surgeons.org
TAS: college.tas@surgeons.org
VIC: college.vic@surgeons.org
WA: college.wa@surgeons.org
NT: college.nt@surgeons.org

PREPARATION FOR PRACTICE WORKSHOP

MELBOURNE 22-23 SEPTEMBER 2018

BUILDING BLOCKS FOR STARTING OUT IN PRIVATE PRACTICE

This two day workshop will provide surgeons, final year trainees and practice managers with information and practical skills to set up and manage private practice.

LEARN ABOUT:

- Issues involved in setting up private practice.
- Practical strategies and tools for practice operations.
- How to develop a practice framework and improve practice performance
- Managing practice staff, staff contracts and employment relations

CPD FOR FELLOWS

This educational activity has been approved in the RACS CPD Program. Fellows who participate can claim one point per hour in Maintenance of Knowledge and Skills.

Venue:
RACS - Melbourne
250-290 Spring Street
Melbourne East, 3002

Contact:
Victorian Regional Office
P 9249 1254
E: College.vic@surgeons.org

RACS ACT ANNUAL SCIENTIFIC MEETING

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

The role of surgeons in health advocacy
27 October 2018
ANU Medical School, The Canberra Hospital, Garran

Co-conveners:
Dr Justin Pik, FRACS
Dr Timothy Makeham, FRACS

Invited speakers:
Mr Ahmad Aly, President, Australian & New Zealand Metabolic and Obesity Surgery Society

Dr Catherine Ferguson, Vice President, FRACS

Professor Jeffrey Rosenfeld
Senior Neurosurgeon Alfred Hospital,
AC, OBE, FRACS

Ms Meegan Fitzharris
ACT Minister for Health

Register online www.tinyurl.com/ACTASM18
Submit an abstract www.tinyurl.com/actabs18

RACS ACT Office
T: +61 2 6285 4023 • E: college.act@surgeons.org
#CanberraASM18

Program highlights 2018

Annual Joint Academic Meetings

Thursday 8 - Friday 9 November 2018
University of Technology Sydney, UTS 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

Medtronic

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

DAY TWO – SURGICAL RESEARCH SOCIETY MEETING

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

Presentation of original research by surgeons/trainees/students/scientists

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

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

Registration is now open

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

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A very special thanks to all those who have donated to the **Pledge-a-Procedure** campaign in June and showed their support for our younger Fellows – The future of surgical care.

Every donation during this campaign makes an incredible difference.

"Travel grants are the stepping stone for younger Fellows"
– Pecky De Silva, Younger Fellow

If you would like to support our younger Fellows, please donate to the Pledge-a-Procedure Younger Fellows Campaign today

Donate online at www.surgeons.org/donations/ to gain an immediate tax receipt.

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Ms Julia Farrell
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Dr Susan Adams
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ANZ Society of Cardiac & Thoracic Surgeons
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100% of your donation assists in addressing critical surgical need

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

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www.surgeons.org/memberbenefits

July might be over but the tax return season is just beginning for many and it is the perfect time to save on your insurance policies.

Get a quote through your RACS benefits program and compare how switching could benefit you.

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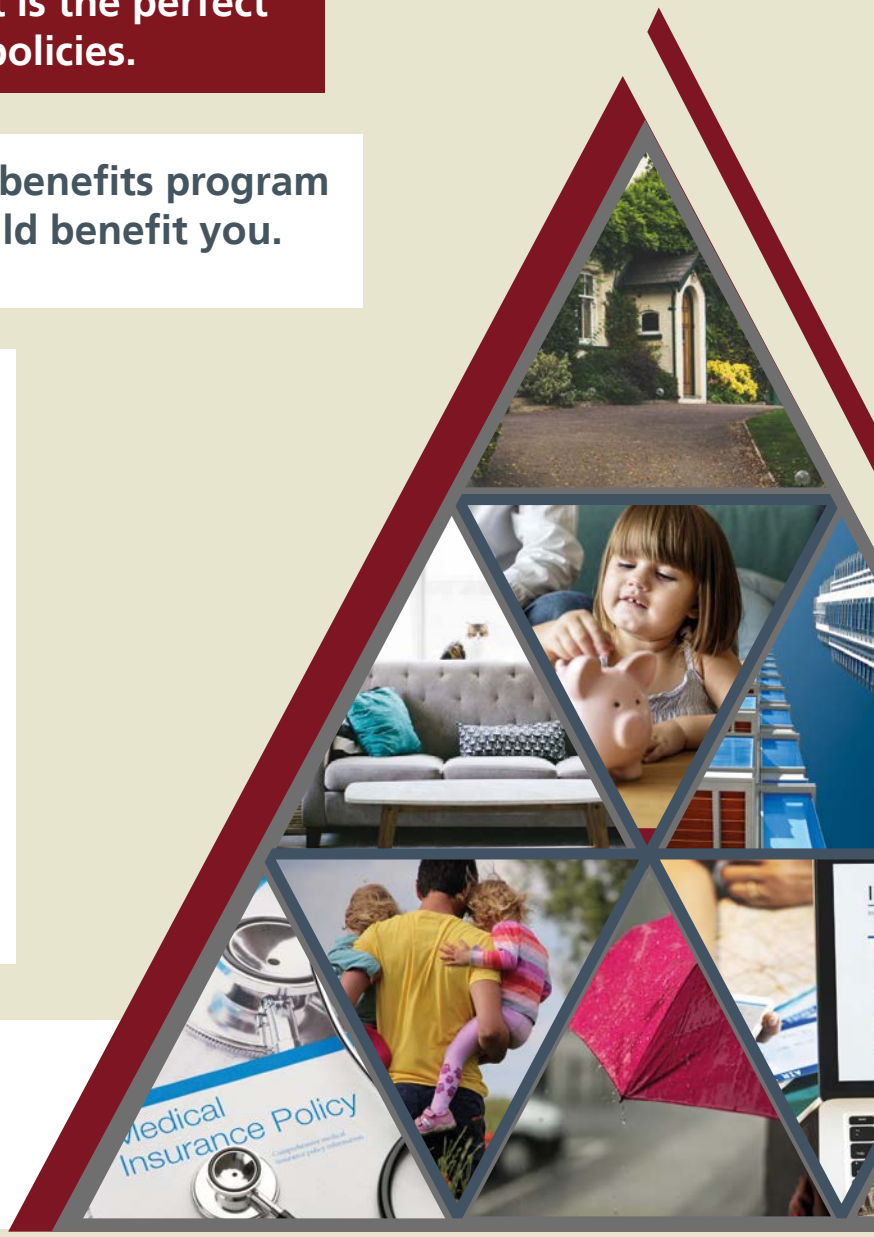
- Travel Insurance
- Critical Illness
- Key Person
- Professional Indemnity
- Home & Contents
- Car Insurance
- Landlord Insurance
- Prestige Home & Contents



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