ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SURGICAL NEWS

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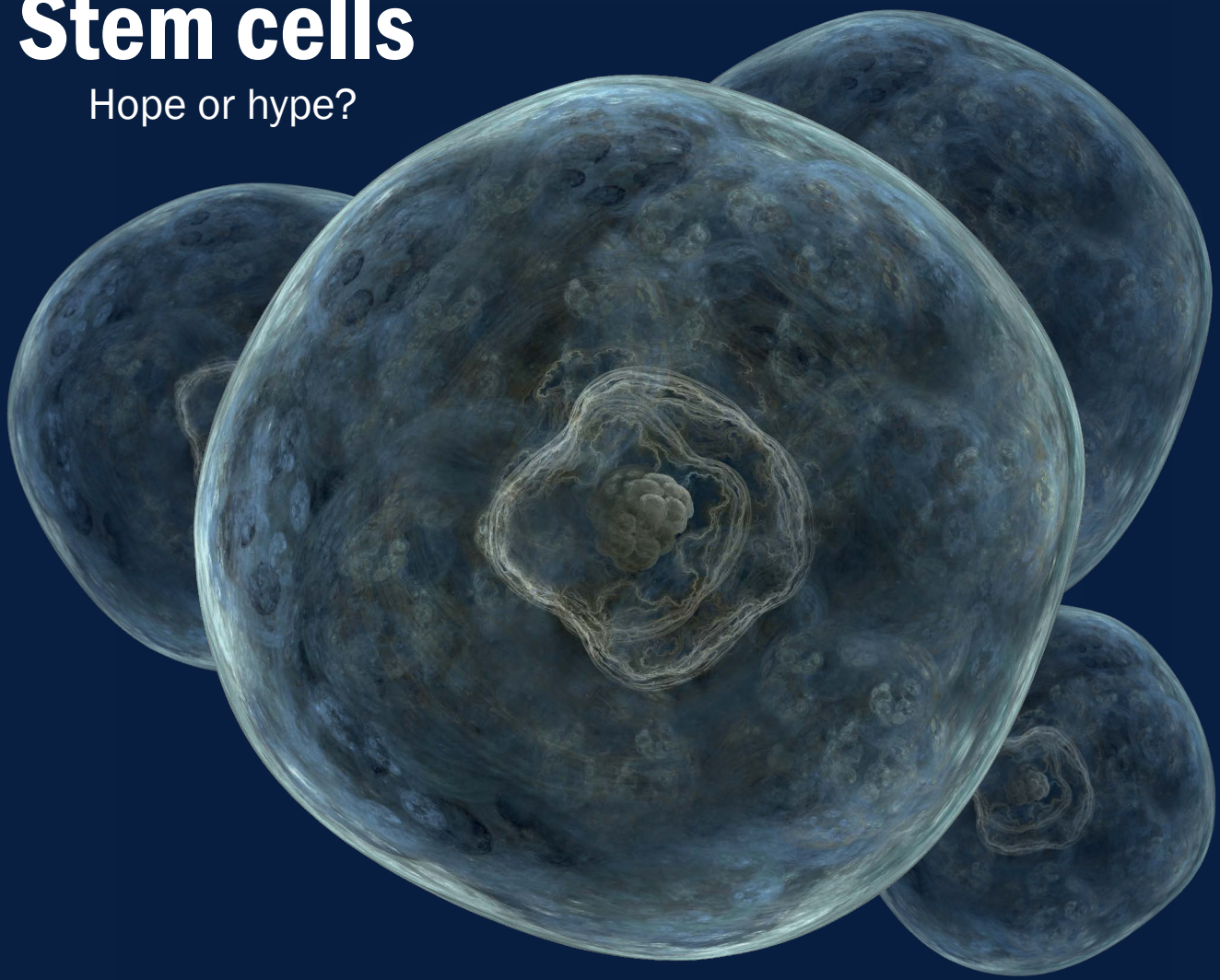
Surgery & Stem cells

Hope or hype?



RACS & respect

14 Respect agreements signed last year

Talking transformation

From the 2016 Pacific Region Indigenous Doctors Congress

Trauma registry funded

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RACS LET'S OPERATE WITH RESPECT

The College of Surgeons of Australia and New Zealand

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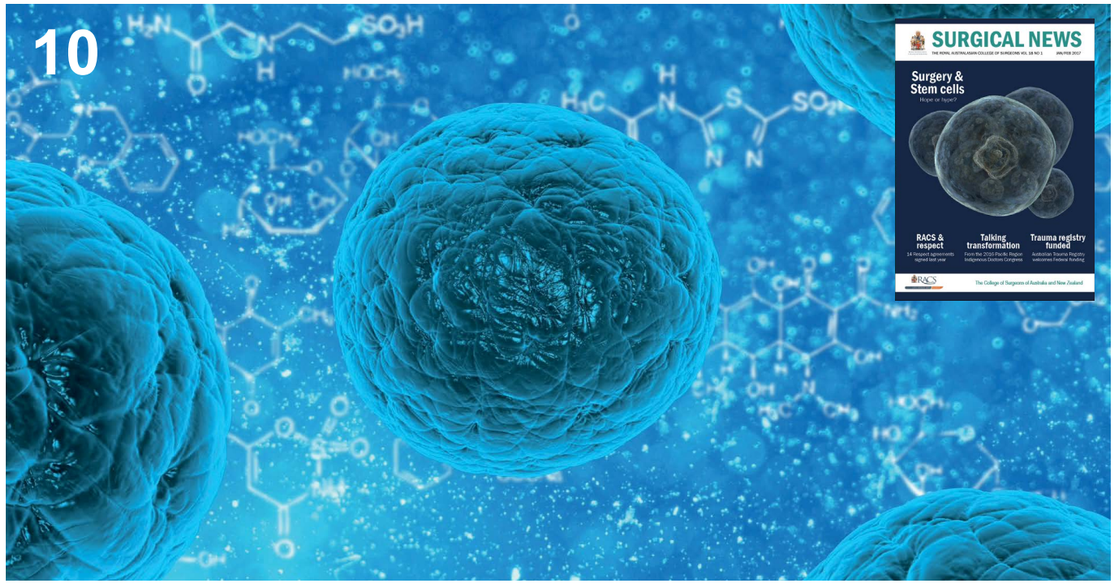

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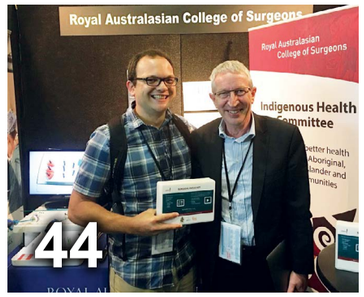

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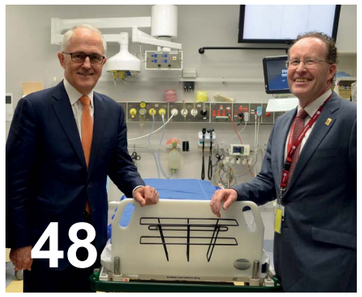

AUSTRALIAN TRAUMA REGISTRY
Australian Trauma Registry welcomes Federal funding

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Deliberate Practice & Constructive Feedback

PHILIP TRUSKETT AM
President

It is now more than 25 years since Anders Ericsson, psychologist at Florida State University, and his colleagues, did their pivotal study on violinists at the famous Music Academy of West Berlin - a highly competitive academy that only took the best students. Their intention was to try and define the factors that produced the expertise of this highly select group of talented musicians. They asked the Professor of Violin to define three groups of students. The first was those who he expected would become world-renowned soloists; the second was who would be highly accomplished and as violinists in the world's great orchestras; the third to identify those who would be proficient but would never make renowned performers? They would make their living as music teachers, music journalist or from other activities in the classical music industry.

Apparently the learned Professor had no trouble identifying the three groups and produced the lists. Ericsson and his team then extensively studied the backgrounds of the members of groups to that point in their career. They found that their bios were very similar with a strong commitment to music, and the violin in particular, from an early age. There was only one startling factor that separated each group; apparently an unexpected finding. It was the length of time spent in 'deliberate practice'. At the age of 20, those who were to be virtuosi and renowned soloists had spent 10,000 hours; those destined to be orchestral violinists of leading orchestras of the world had spent 8,000 hours and those who would not make the performance groups had spent 6,000 hours. Within these many hours of practice, the first group was the most likely to have set themselves improvement goals, pushed themselves to practice at the edge of or outside their comfort zone. As a result their practice was made more productive and efficient.

When I first heard of this notion I was a little incredulous. I realised that I had spent well over 10,000 hours behind the wheel of my car and I was no Jackie Stewart; even though I would love to be, on so many levels. The key of course is the issue of 'deliberate practice'. Although I do get helpful suggestions from my wife from time to time about my driving, my experience is not considered to be deliberate practice according to Ericsson.

Ericsson has defined two components to deliberate practice. The first component is that you must exert a sustained effort on what you don't do well. It is about pushing yourself to the next level and this may not always be comfortable. Many will fall back to doing what they feel is easy, a bit like my driving. Fit for purpose but not always, according to my wife. Time spent but not progressive. The other component is that you must have a coach to provide you with the constructive feedback to both review your efforts and help direct your practice. To give you the confidence to set your goals and help you achieve them. You must be told what you are not doing 'well' and be given the encouragement to do better.

What is the point of all this?

From some of the feedback I have been hearing, some supervisors and surgeons who teach Trainees are feeling a bit shell shocked. RACS has been going through a difficult time over the past few years with the public perception that we surgeons are a 'bullying' community. I fear that some supervisors and trainers are now very reluctant to give constructive feedback about how to improve to their Trainees for fear that it might be considered 'bullying' behaviour. We are all committed to a competency-based training program - this is about observing our Trainees at work, with supervision as appropriate, for quality patient outcomes. To sustain this we must provide frequent constructive feedback to our Trainees in order for them to progress. We cannot ignore or 'pass' poor performance in any of the nine competencies. Surgery requires technical expertise and much more. We owe it to our Trainees and the community we serve to give appropriate feedback, so that we can promote 'deliberate' practice.

There are a number of structured ways to provide constructive feedback designed to be receptive to the learner. These models of feedback are discussed and practised in the Foundation Skills for Surgical Educators course (FSSE) as well as all our skills instructors courses (EMST, CRiSP and TIPS). The FSSE course is expected to be completed by all supervisors and trainers by the end of 2017. It is a one day course facilitated by a medical educator and surgeons trained as faculty. It is a very interactive course and most enjoyable. The evaluations reported across 2016 have been very positive. It is free of charge and quite portable and can be brought to your hospital or a society meeting if a group wishes to do it together. A number of 20 participants is ideal and there are similar courses available. If you have done such a course, an exemption can be granted but even so, I would still recommend the course to all. Outcomes of the course and criteria for exemption can be found on the RACS website.

But back to feed back.

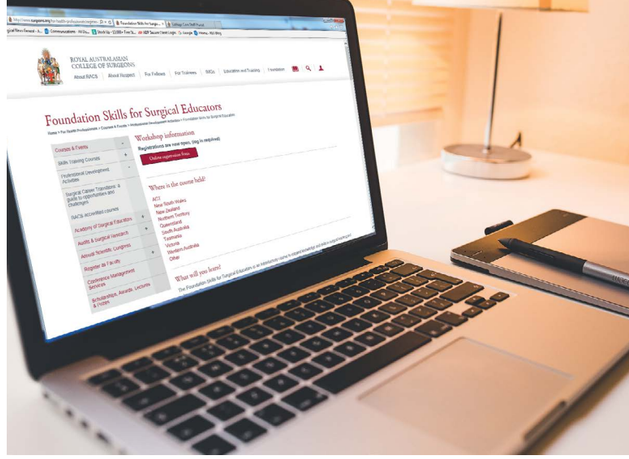
It's not just how you do it; it is where and when. The timing should be as close to the observed task as possible. The feedback may be perceived as 'positive' or 'negative'. You should also be aware of the environment in which the feedback is given. It is usually best in a private non-threatening environment. If there are to be significant constructive components about the need to improve these may be perceived as 'negative'. Consider also your frame of mind and that of the Trainee. Immediately after a complicated operation, a poor patient outcome, or even a dispute; a later time might be more appropriate. Limit wide sweeping feedback like 'You're doing fine' as this can be encouraging but is not really constructive and not related to the clinical tasks you may have observed.

The Pendleton feedback method has been around since 1984. Some describe the structure to be a little rigid but in reality, with practice, you can mould it into a format that suits you. Its major value is that it does allow good components of the performance to be recognised. Its danger is that if too much emphasis is placed on the good, the constructive component may be lost.

The Pendleton method is a stepwise construct:

1. Check the learner is ready for feedback.
2. Let the learner express how they feel and make comments on the task or activity for which they are about to be assessed.
3. The learner is asked to state what went well.
4. The observer states what went well and why.
5. The learner is asked to state what could be improved.
6. The observer discusses what could be improved and how to achieve this.
7. An action plan is then constructed together by the learner and the observer.

When the learner is asked to respond as to how they are feeling in step 2, try to avoid a long discourse on what went 'badly', but don't cut them off too quickly. Rigidity is apparent when the learner is immediately cut short by the observer and told to focus on the good. This is not necessary. Let them get it off their chest and just actively listen for a



while and when the outpouring stops say something like 'I want to get back to that'. Then say something like 'but it wasn't all bad, was there anything you were happy with?' Then move on through the algorithm. Being a little more flexible and permissive at the start will enhance the rapport and make the learner more receptive. Remember that it is a two way process with an opportunity for both the Trainee and trainer to reflect.

Another useful technique involves the 'basic assumption'. The basic assumption, simply put, is that the person you are observing is intelligent and everything they have done has been for a reason. Once the assumption is made, you can be curious. From a curious stance you can say; 'I noticed you did this…., I am sure you had a reason for doing it that way. Can you tell me about it?' It is amazing what can come from this form of inquiry. They usually do have a reason, which you can discuss, or had not realised they were doing whatever it was you observed. Either outcome sets up an opportunity for rich non-threatening feedback. Curiosity will stop you saying 'What the hell were you thinking? which will undoubtedly be considered aggressive.

We must do whatever ever we can to support our SET training program. To do this we are obliged as trainers to encourage 'deliberate practice' in our Trainees. This is across all of their work and described by the nine RACS Competencies. To achieve this we must give constructive feedback that includes recognition of the good, but more importantly, a constructive plan to improve that which needs attention.

The holiday is over

But have we all got a job to return to?

PROFESSOR SPENCER BEASLEY
Vice President

Christmas has come and gone, and hard on its heels, so has the New Year. Most of us have enjoyed a few weeks of summer holidays with family and friends, and have now returned to work - but oh, how quickly the relaxation of our break seems to have receded into the distant past! Yet we must not forget that the festive season and summer holidays did give us a chance to recharge our batteries and reflect on the year now gone, as well as allowing us the space to give some thought to the year ahead.

How easy is it then for us to take for granted the certainty of having our busy practice to return to? I expect that few of us will have given much thought to the plight of many new Fellows who do not have that same luxury. We should be aware that the uncertainty of future employment, or of a satisfactory surgical appointment, weighs heavily over an increasing number of our bright new colleagues. And this is a problem that is of concern to our College.

Recently, the Younger Fellows committee raised its concerns to Council. It has been pointed out that Fellows are often encouraged to gain additional training in sub-specialty (read: super-specialty) areas in the expectation of a position in a large metropolitan tertiary hospital, only to find when the time comes the hospital has neither the inclination or resources to oblige. There is either no position available or the position is not adequately resourced, with woefully inadequate theatre time and little administrative or collegial support. Sometimes, at least from the perception of those who find themselves in this frustrating situation, the problem seems to stem in part from a lack of surgical succession planning. More senior surgeons sometimes keep their cards very close to their chest when it comes to declaring their retirement intentions, further compromising the ability of a department to plan ahead its future staffing needs. The sessional allocations are just not available, and the hospital is too inflexible to accept the financial risk of timely appointments.

If we leave the major centres and head for the country the situation is quite different. For many provincial hospitals, it remains a real struggle to attract quality surgical staff. New surgeons who have invested several years acquiring very specific skills may see a provincial hospital appointment as a retrograde career move, and are concerned that they will not get the opportunity to practice in those areas in which they have devoted their last few years acquiring expertise. Moreover, they fear the isolation, and their scope of practice may be at variance to what the provincial centre actually needs. (That may be a concern to the recipient hospital as well!) There is a mismatch between the skills of the new Fellow and the skills required by the rural hospital. Why has this happened?

Let us go back a step to SET training itself: in some specialties more than others, the scope of surgery to which SET trainees are exposed increasingly does not correlate well with what they are likely to need to be proficient in post-Fellowship. Even for the metropolitan surgeon, the spectrum of referrals and operative expertise required in the private sector is quite different from that of the public hospitals in which they received their training. The differences between metropolitan and rural areas may be even greater.

So how can we improve the attractiveness of being a surgeon in a provincial hospital and provide better support for the rural surgeon?

Actually, there are many things that we can do. First, the specialty training boards need to recognise this is a real issue for surgery in Australia and New Zealand and be prepared to make substantial changes to the training programs. The focus must be on ensuring the SET training program prepares surgeons to best meet the community needs in their specialty. This may require some significant changes to the configuration of the training programs. For example, there could be more frequent rotations through rural or provincial centres (where the Trainees not only gain valuable exposure to the benefits of rural practice, but also gain experience in the scope of surgery required to support them). To achieve this, the boards could easily create more rural accredited training posts - and in doing so, acknowledge their true value, and not insist on expecting them to provide the same (limited) range of exposure as is offered in many specialised tertiary centres.

Established surgeons could also take their regional responsibilities more seriously. Granted, it is more convenient for a surgeon to work at a single location, and expect all patients to come there for treatment. But a counter view is that very specialised surgeons should be providing for all those in their drainage region in a way that is the most convenient and easiest for the patients (incorporates the principles of 'equity of access' and 'patient focussed' and providing treatment as close to the patient's home and support as possible). This must be done in a way that supports the rural surgeons who will have to be intimately involved in the service. A metropolitan surgeon who criticises the management provided by rural surgeons without having made genuine attempts to support them is unacceptable.

Surgeons with subspecialist skills working in major city hospitals have a responsibility to do everything they can to support the highest level of care for all patients in their drainage region, including those in the more remote areas. This may involve the inconvenience (time, money and comfort) of providing a regular outreach service to those more remote regions, and working very collaboratively with the rural surgeons there to develop safe and appropriate clinical guidelines for triage, immediate management and referral. It also means developing a close rapport and working closely with rural surgeons to upskill and support them as they share responsibility for the care of the more complex or specialised cases, often in the absence of some of the resources routinely available in the larger centres. If this became the norm, I suspect many new Fellows would be more inclined to accept a rural or provincial appointment: they would feel better supported and valued, and would still be able to provide some of the highly specialised care for which they received training.

Maldistribution of the surgical workforce is a major issue for both countries, and is one that our College needs to address effectively in those areas where it has influence; otherwise, as we have seen already, the response of other health jurisdictions occasionally produces less than ideal outcomes for our profession or the quality of surgical care.

Federal Medical Research Plan

With almost two in three Australian adults and one in four children overweight or obese, two-thirds of Australians over the age of 50 with poor bone density, and one in six Australians with chronic back pain, the recent release of the Medical Research Future Fund (MRFF) Strategy sets out the roadmap for addressing some of our biggest health issues.

That is the verdict from the medical research community and Research Australia, the organisation behind the virtual doubling of health (NHMRC) funding in 2000, and again in 2005.

"As the organisation that has been championing health and medical research for the last 15 years, we can tell you the MRFF is a real game changer," said Research Australia Chair, Dr Christine Bennett.

CEO of Research Australia, Nadia Levin said the MRFF Strategy's vision of a health system informed by quality research is exactly what's needed.

Research Australia welcomed the Strategy's acknowledgement of the foundational work that must be done to set the future direction for the MRFF.

Support for Aboriginal and Torres Strait Islander people facing the challenge of lung cancer

Cancer Australia has launched My Lung Cancer Pathway: a guide for Aboriginal and Torres Strait Islander people with lung cancer and their families.

The guide provides culturally appropriate information for Aboriginal and Torres Strait Islander people diagnosed with lung cancer and their families to help them navigate the lung cancer pathway and improve understanding of:

- what a lung cancer diagnosis means
- what treatment options are available
- how to look after themselves during and after treatment
- palliative care and getting their affairs in order
- where to find supportive information for family and friends.

The guide will also be a valuable resource for those involved in the care of Aboriginal and Torres Strait Islander people undergoing treatment for lung cancer across community and clinical settings. My Lung Cancer Pathway can be downloaded from the Cancer Australia website.

Making the connection - the Industrial Internet of Things

A 5G cellular network that supports the trillions of interconnected devices predicted to be in use in the coming few years is being designed by telecommunications specialists at the University of Sydney. The 5G network will be dedicated to supporting the "Industrial internet of Things" (IIoT).

Professor Branka Vucetic, Director of the Centre for Telecommunications Excellence, School of Electrical and Information Engineering, says the dramatic rise in connected devices now referred to as "Internet of Things" for individual users or "Industrial Internet of Things" for corporate use will see a thousand-fold increase in mobile traffic.

The IIoT is currently in its infancy but to date Professor Vucetic's team has been involved in exciting pilot projects and research test-beds for trialling new technologies, in multiple vertical applications.

"In the New Year our researchers will be focussed on developing the new framework and models, algorithms and technologies for the next generation of the wireless cellular 5G.

"We are also refining the requirements for the ultra-high reliability needed for machine-to-machine communications particularly within an industrial setting.

"Medical procedures are now being performed using robotic technologies. It allows doctors to perform complex procedures with precision and control. The surgeon is not in the theatre. In the future they may not need to be in the same country."

New probe may improve breast cancer surgery outcomes

South Australian scientists have developed a new tool that could help surgeons in the fight against breast cancer. University of Adelaide researchers have developed an optical fibre probe that distinguishes breast cancer tissue from normal tissue.

It has the potential to help surgeons be more precise in surgery as well as prevent follow up surgery. The probe works by detecting the difference in the pH between the two types of tissues.

Chaos, impotence and market pressures:

THE STEM CELL STORY

PROFESSOR GUY MADDERN
Surgical Director of Research and Evaluation incorporating ASERNIP-S

Stem cells treatments have come a long way since the first bone marrow transplant was performed in the 1960s. Many specialities including surgery are turning to stem cell treatments to improve therapeutic outcomes. However, this enthusiasm raises the questions: Is the use of stem cells in surgery safe and effective? What issues should surgeons be aware of?

In order to look into this issue a team from Research & Evaluation incorporating ASERNIP-S reviewed evidence for the use of stem cells treatment in surgery across the nine surgical Specialties. Ongoing clinical trials from Australia and New Zealand were identified. Stem cell treatment centres in Australia and New Zealand, and the range of treatments they provide were also assessed.

Currently, bone marrow transplantation is a recognised therapy for treatment of blood, metabolic and autoimmune diseases, and for cancers. In Australia, these services are reimbursed through Medicare (MBS item 13760). Beyond these recognised stem cell treatments the application of stem cells is broadening rapidly for a variety of diseases and conditions.

What are stem cells?

The human body is made up of over 200 different kinds of specialist cells – all of which originate from stem cells. Stem cells are characterised by their ability to both differentiate and proliferate. In theory, they are capable of developing into any cell type, and are essential in maintaining tissue and organ health. These characteristics make stem cells a potential treatment to assist organ and tissue repair after invasive procedures such as surgery.

Human stem cells are categorised in many ways. Based on their potency or ability to differentiate, stem cells are defined by two main groups, they are; multipotent stem cells (also called adult tissue-specific or somatic stem cells); and, pluripotent stem cells.

Multipotent stem cells are limited in their potential to differentiate and are restricted to one of the germ layers (endoderm, mesoderm, or ectoderm) or adult cell lineages such as skin, muscle, brain, heart, eye, lung, pancreas, liver, intestine and bone marrow. In contrast, pluripotent stem cells have the potential to grow into any type of cell in the body. Examples are embryonic stem cells; however, their use in clinical and research settings is still the subject of significant and ongoing ethical debate.

Adult stem cells have been the cell of choice when researching and developing stem cell treatments. Treatments have utilised cells from two main origins, these being the haematopoietic and mesenchyme tissues. Adult bone marrow, peripheral blood and umbilical cord blood are sources of haematopoietic stem cells. Bone marrow stroma, adipose tissue, umbilical cord blood and the placenta are sources of mesenchymal stem cells. Irrespective of stem cell type or tissue origin, stem cell treatment is based either on recipient-derived cells (autologous) or from a separate donor (allogeneic).

For therapies based on haematopoietic stem cells, the cells are either collected from the peripheral blood after mobilisation from the bone marrow using growth factors, or less commonly directly from the bone marrow. In contrast, mesenchymal stem cell-based treatment protocols rely on the isolation of stem cells in the laboratory following their harvesting from source tissue. However, due to the low numbers of stem cells in adult tissues, there is usually a need to expand their numbers to achieve cell numbers suitable for therapeutic use.

Which stem cell treatments are available in Australia and New Zealand?

For many years, patients who were interested in stem cell treatments travelled overseas in what is termed 'stem cell tourism' to receive their therapy. However, in recent years there have been a growing number of health practitioners and clinics offering these treatments in Australia and New Zealand. It has been suggested that as many as 60 clinics in Australia are offering stem cell treatment for various diseases and conditions. Although Ireland, Singapore, the Cayman Islands and the Bahamas have more clinics per capita than Australia, Australia has a greater number of stem cell clinics per capita than the USA.

Web searches identified 16 stem cell clinics in Australia and seven from New Zealand, which were advertising their services online. Treatments are offered across a range of indications across all surgical specialties.

Stem cell treatments for degenerative bone diseases (e.g. osteoarthritis degenerative disc disease, tendinopathies), sports injuries (bone, joint, tendon and cartilage injuries) and chronic pain (joint or back pain) were commonly treated within Australian and New Zealand stem cell treatment centres. Cosmetic and anti-ageing procedures also involved stem cell treatments. Less commonly advertised stem cell treatments were for Parkinson's disease, multiple sclerosis, autism, Alzheimer's disease, dementia or urological conditions.

The most common source of stem cells was adipose-derived stem cells (ASC) harvested following abdominal liposuction. Bone marrow-derived stem cells (BMSC) treatments are offered by some clinics for osteoarthritis and tendinopathies, although normally these conditions are treated using ASC by most centres. Some centres were not clear as to the stem cell source they use for treatments.

From a review of the websites and the information they provide about their services there is a large amount of variability in the methods used to provide the therapies. This is particularly the case for stem cell isolation and manipulation. In general, treatment centres process stem cells within a few hours (same day processing) on the day of treatment. Some centres offer two schedules of cell preparation: same day or multi-week cell processing. The longer timeline would allow for cell growth to increase cell numbers. Usually very little detail is provided as to how cell processing is done.

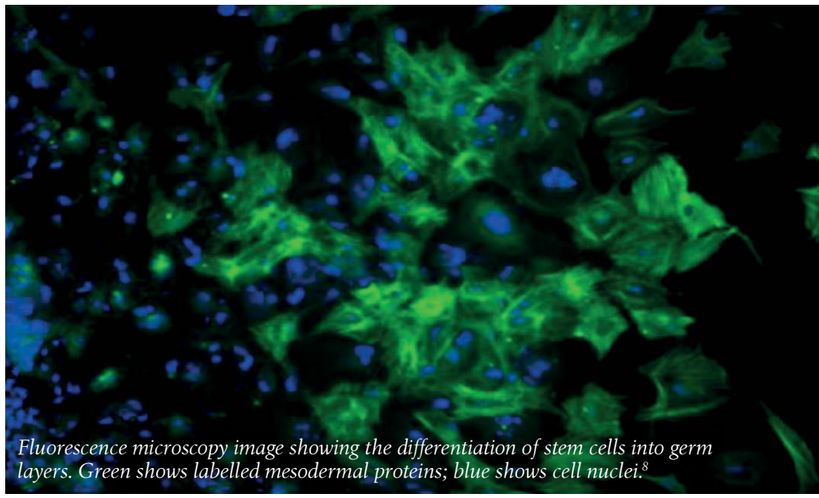
Treatments are expensive, costing from A$9,000 to $60,000 per treatment. As these services are not reimbursed by Australian or New Zealand governments (e.g. MBS in Australia), or by private health insurance, this cost is paid by the patient.

Patients with severe diseases and conditions, especially when previous treatment options have provided little benefit, may consider unproven stem cell treatments. These patients are often vulnerable, having tried and failed many other alternative treatments. Usually they are not referred to stem cell treatment by the specialist who treated their condition. Instead, patients are self-directed after reading an advertisement or article. Previous treatment recipient testimonials are used by clinics to support benefits of a treatment (anecdotal evidence) while no robust scientific evidence is provided to support safety or efficacy. The use of testimonials in this manner may breach the Australian Health Practitioner Regulation Agency Code of Conduct for clinicians, which does not allow using patients' testimonials to promote treatments. Often patients decide to proceed with these treatments without seeking clarification or a second opinion.

For the average patient there is a significant degree of ambiguity in whether the stem cell treatments are proven, experimental, or part of a registered clinical trial. The National Health and Medical Research Council provides clear information to patients regarding stem cell treatments that includes which stem cell treatments are proven, and highlights information pertinent to participating in a clinical trial.[1]

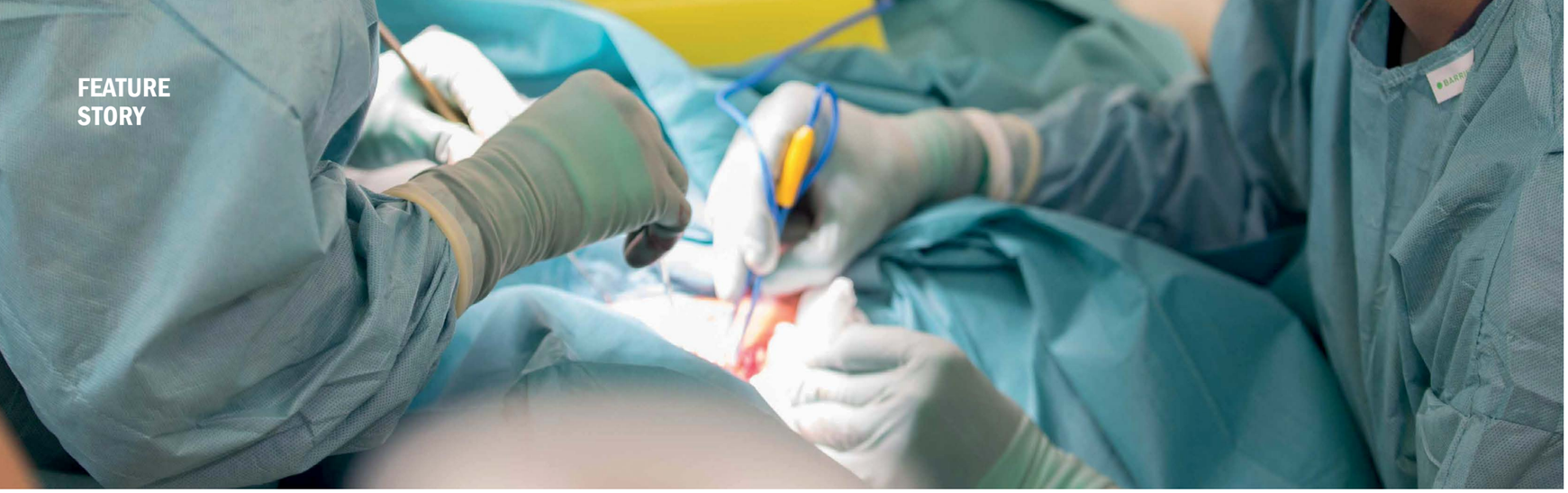
Regardless of whether there is any 'proven' efficacy or not, many may ask the question that surely there is little harm in providing the patient with their own cells? An example of the potential risks posed by stem cell therapy, and concerns regarding how well patients are informed prior to consent to stem cell therapy were recently highlighted in the findings of a NSW coroner.

In July 2016, the NSW deputy coroner found that a 75-year-old ▶



Fluorescence microscopy image showing the differentiation of stem cells into germ layers. Green shows labelled mesodermal proteins; blue shows cell nuclei.[8]

> *Although the technology is moving quickly and there is huge potential in the use of stem cells, many questions remain regarding their use.*



woman died from uncontrolled blood loss following a liposuction procedure to source ASC. This intervention to treat Alzheimer's disease was considered experimental. The coroner found that the cosmetic surgeon's performance was poor and resulted in the woman's death. In his report, the coroner commented that the treatment 'has some of the troubling hallmarks of 'quack' medicine: desperate patients, pseudo-science and large amounts of money being charged for unproven therapies". The coroner recommended that the Therapeutic Goods Administration (TGA) and the NSW Ministry of Health "consider how best to manage and regulate the provision of 'experimental' or 'innovative' medical or surgical procedures that have not yet been approved following clinical trials or other recognised peer-reviewed evaluation processes."[2]

Clearly, these stem cell treatments (for harvesting, cell preparation and subsequent injection) need to be provided in appropriate facilities. However, from the information provided by the majority of local clinics, it is uncertain whether the stem cell procedures are provided in appropriately accredited surgical facilities, and if all cell manipulations are undertaken in accredited laboratories where there are appropriate quality control standards. It appears some treatments are provided in an office-based environment, which in certain instances is not regulated. In a similar manner, the location of cell processing is often not clear, but should be undertaken in an appropriately accredited laboratory.

As recommended by the National Stem Cell Foundation of Australia and Stem Cells Australia:

"Any manipulation of cells, even if they come from you, carries risk of infection and other complications. They should be prepared in an accredited laboratory, where there are exacting quality control standards independently verified, or using a device that has been approved by regulators such as the TGA (page 12)".[3]

Who regulates stem cell treatments in Australia and New Zealand?

So why are these unproven and potentially dangerous therapies allowed to happen on our patch? Put simply, regulatory issues for the oversight of stem cell treatments remain a problem both locally and internationally due to the complexity of the cells themselves, and the variety of ways in which they can be used and manipulated.

Within Australia, the TGA is responsible for the regulation of all medical products, including human cells and tissues, which include certain stem cell treatments. The Australian Regulatory Guidelines for Biologicals outline the legal arrangements in Australia for the supply and use of human cell and tissue-based therapeutic goods. Certain stem cell treatments that require processing, such as haematopoietic stem cells transplant for disorders of the blood and immune system, fall under the oversight of, and are approved by, the TGA.

However, many autologous stem cell treatments are not regulated by the TGA. These treatments would be considered 'medical practice' and are excluded from regulation under the Therapeutic Goods (Excluded Goods) Order No. 1 of 2011.[4] The definition of excluded treatments is "human cells that are collected, processed and returned to the same patient, in a single course of treatment while under the clinical care and supervision of a registered medical practitioner." However, all other stem cell therapeutic products of human origin not covered by this exclusion would be regulated as biologicals by the TGA under the Australian Regulatory Guidelines for Biologicals. Therefore, there is a loophole in the regulations.

The TGA has noted that an increased number of autologous stem cell treatments are proliferating within Australia and that these products are of unproven safety and efficacy and are often provided to patients at a high cost. Given this situation, the TGA is undertaking a review of current oversight, and is considering whether the current regulatory model needs to change.

The New Zealand environment is similar to the Australian one, with the government currently working on a new and comprehensive regulatory regime to regulate therapeutic products in New Zealand, which will replace the Medicines Act 1981, and its Regulations. Medsafe (the New Zealand Medicines and Medical Devices Safety Authority) is the body responsible for regulation of medicines and medical devices. Certain stem cell products have been approved in New Zealand by Medsafe. Clinics providing autologous stem cell treatments claim that these procedures fall under the category of physicians' practice of medicine, under which the physician and patient are free to consider their chosen course of treatment. This involves minimal manipulation of the patient's own cells.

The proliferation of unproven stem cell treatments over recent years has placed a focus on regulatory agencies to provide clear direction. From a regulatory perspective, stem cells provide difficulties for all jurisdictions due to the novel manner of this therapy and the fact that stem cells do not fit into current frameworks. These problems have led to the exploitation of loopholes, and the provision of services without clear regulatory oversight or other guidance.

It is clear that authorities are moving towards clearer and more explicit guidance around regulation of stem cell products. With increasing cooperation between regulatory agencies, governments, researchers, practitioners and industry, improvements should be seen. However, this may take some time to come to fruition.

Is there robust scientific evidence for stem cell treatments in surgery?

Bearing in mind the problems associated with stem cell therapy, a key focus of the research was to investigate what published evidence is available regarding the use of stem cells in surgery. A literature review identified 69 systematic reviews and 10 additional comparative studies regarding stem cell treatments in surgery.

All of the scientific literature identified through PubMed and Embase searches were grouped into three categories depending on the maturity of evidence base for each stem cell treatment.

We defined the categories as:

- Category A – This reflects that multiple randomised controlled trials (RCTs) are available, and their outcomes suggest superior or non-inferior safety and efficacy of the stem cell treatment for a given disease or condition compared with standard treatment. Their safety and efficacy is likely assessed by systematic reviews.
- Category B – This reflects that comparative studies with inconclusive safety or efficacy outcomes of the stem cell treatment for a given disease or condition compared with standard treatment are available. Their safety or efficacy is currently unproven or uncertain.
- Category C – This reflects that no comparative evidence on safety and efficacy of the stem cell treatment compared with standard therapy is available. These treatments are still in the process of evaluation through early, animal or pre-clinical trials.

Category A evidence was only available for Cardiothoracic Surgery. Seven of the 11 systematic reviews assessed 23 RCTs involving 1,255 participants who received intramyocardial transplantation of autologous BMSC for ischemic heart disease and congestive heart failure. These evidence syntheses provide a view of between trial consistency in outcomes, and indicate that for those indications the use of stem cells seems safe and effective.

The largest volume of evidence was for orthopaedic use; however, the evidence base for all orthopaedic indications remains unproven or investigational. Even across RCTs for orthopaedic indications, there is heterogeneity across the methods used. There is overlap of certain indications, particularly across the specialties of Orthopaedic Surgery, and Plastic and Reconstructive Surgery. Certain novel uses of stem cells are relevant ▶

across specialties, particularly in the field of tissue and organ bioengineering, although they are currently limited to laboratory trials.

In contrast, five surgical specialities had category B evidence as the highest evidence category - these included General Surgery, Neurosurgery, Orthopaedic Surgery, Urology and Vascular Surgery. Based on the characteristic of category B the evidence is considered equivocal and the use of stem cell treatments unproven.

For the three remaining specialties (Otolaryngology Head and Neck Surgery, Paediatric Surgery and Plastic and Reconstructive Surgery), the evidence base was limited to category C. This indicates that there is little or no comparative evidence, and the use of stem cells is considered experimental.

The published evidence-base, demonstrates a large variability across a number of domains. Cell-based therapies vary depending on the origin of the stem cells, their manipulation and their intended use. In terms of the sources of stem cells, this report identified that (autologous) ASC and BMSC are commonly used for treatments. ASC is most commonly collected by liposuction from abdomen adipose tissue. Bone marrow is harvested from the posterior iliac crest. However, the stem cells density and dose for each treatment varied so the ideal dose for each treatment is unknown.

The lack of standardisation between published stem cell trials and other research studies in terms of isolation, manipulation and expansion protocols makes comparison between studies difficult.

What does it mean for surgeons and their patients?

Unfortunately, stem cells are not an established or recognised intervention for surgical practice. There remain a concerning amount of unknowns. None of the stem cell treatments provided in the private clinics in Australia and New Zealand had proven evidence for safety and effectiveness. As such, surgeons should not feel pressured to undertake these novel procedures simply because they are aware of others who are providing them. Unproven stem cell treatments risk harming patients and also bring risk to the clinicians themselves. Such treatments should be discouraged. A number of professional organisations including the Australian Rheumatology Association[5], Australian College of Sports and Exercise Physicians[6] and Motor Neurone Disease Australia[7] raise concerns about patient safety, absence of unequivocal evidence regarding safety or efficacy of these treatments, and lack of knowledge in terms of many aspects of stem cells and their function.

Although the technology is moving quickly and there is huge potential in the use of stem cells, many questions remain regarding their use.

Uncertain components include the matching of cell source and type to specific diseases /conditions, the need to expand stem cells following harvesting and the impact of laboratory processing on stem cell function as well as the cell density required to affect tissue repair. Important questions include:

- What is the best source of stem cells?
- How should stem cells be manipulated and expanded?
- For each indication, what is the appropriate density or dose of stem cells?
- For each indication, what is the mechanism of action in vivo and how do stem cells impact local tissue and biological processes?
- Are there negative consequences in the long-term?

However, the good news is that high-quality research is underway both locally and around the world. At the time of the review 34 ongoing clinical trials registered with the Australian and New Zealand Clinical Trials Registry (ANZCTR) were identified. Continuing research was uncovered in the ANZCTR for five of the surgical specialities; these being Cardiothoracic Surgery, General Surgery, Neurosurgery, Orthopaedic Surgery and Urology. Close to 70 per cent of the ongoing clinical trials in the ANZCTR are assessing stem cell treatments for orthopaedics. Collectively this indicates greater research interest in stem cell treatments by surgeons in this craft group. In contrast, it appears the speciality of Otolaryngology Head and Neck Surgery is least impacted by stem cell treatments and researched for its potential.

> *"Treatments are expensive, costing from A$9,000 to $60,000 per treatment. As these services are not reimbursed by Australian or New Zealand governments ... this cost is paid by the patient"*

The upcoming TGA review is highly anticipated and should provide much needed clarity around the use of stem cells in Australia. In the meantime the evidence vacuum suggests that we should all take care, whether from the perspective of a patient or a surgeon, and wait and see what the future will bring.

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Innovation & Health technology Assessments

PROFESSOR GUY MADDERN
Surgical Director of Research and Evaluation incorporating ASERNIP-S

In 2016 ASERNIP-S completed a total of 16 Technology Briefs and Technology Brief Updates for the Health Policy Advisory Committee on Technology (HealthPACT). As a sub-committee of the Australian Health Ministers' Advisory Council, HealthPACT functions as the reviewing body for substantial new technologies seeking entry to the Australian health care system.

The completed Briefs covered a range of technologies, such as ablative therapies for cancer, novel radioactive tracers for imaging, to retinal prostheses. Interestingly, they have also included reviews of surgical practice such as CT for appendectomy, 'Enhanced Recovery After Surgery' (ERAS) practices, and 'Retrograde Endovascular Balloon Occlusion of the Aorta' (REBOA).

> *"... the concept of innovation is as expansive as the technologies that arise from its application."*

As a consequence of this work the Research & Evaluation/ ASERNIP-S team has gained unique insights into contemporary innovations in health technology. Such innovations are exemplified by the current activities occurring within the field of vascular technologies. Stent technology continues to evolve ever onwards, from self-expanding, to self-expanding drug eluting, to the newer bioresorbable stents. Although none of these types of technologies are new per se, the range of device frames (cobalt-chromium, platinum-chromium, and now biodegradable polymer) and their combination with a range of drugs (Everolimus, Sirolimus, Paclitaxel) is driving the multiplication of new technologies. Even a crude search of the National Clinical Trials website results in the identification of 500 trials for vascular stents, and 63 vascular scaffolds. It is however likely that this last result will increase markedly as the FDA recently approved a bioresorbable vascular scaffold for coronary artery disease.

Vascular scaffolds and stents are one area of innovation, however valve replacement technologies are evolving at a similar pace. For mitral valve repair, innovation has developed valves that include their own anchors, that self-position or which have improved conformity properties. The multitude of device designs is complemented by the expansion in technologies allowing alternate approaches for their placement. Devices enabling transfemoral or transapical approaches are bolstering the cardiologists armamentarium. Additionally, mitral valve replacement is not the only option; devices that repair, replace or augment the functioning of chordae are now emerging with increased frequency.

There are new technologies, but there are also current technologies being used for new indications. This is exemplified by the August 2016 decision of the Food and Drug Administration to allow a transcather aortic valve to now be used in patients at intermediate (rather than immediate) risk. This allowance demonstrates the willingness of authorities to look at existing technologies in innovative ways.

These examples illustrate that the concept of innovation is as expansive as the technologies that arise from its application. Innovation is the development of wholly new technologies such as the use of new metals and polymers as well as their combination with different drugs. It is identifying new approaches for the use of old technologies. It is also the perception of new populations for an existing device.

Although innovation helps to drive the healthcare system it is paramount to be implemented in a safe and effective manner, so I am pleased to note that the team has already commenced on HealthPACT Briefs for 2017.

For further information please see:
https://www.health.qld.gov.au/healthpact

Meet the Awardees


ASSOC. PROF. STEPHEN TOBIN Dean of Education
DR SALLY LANGLEY Chair, Professional Development

In November 2016, the Academy of Surgical Educators (ASE) presented the Educator of Merit and Educator of Commitment awards to our surgical educators. These awards acknowledge and recognise the dedication and excellence of our surgical educators. Some of the awardees will be featured over the next few editions of *Surgical News*. Here's the Part 1 of the snapshots.

Feature on Jane Strang
Educator of Merit: Supervisor/ Clinical Assessor of the Year (New Zealand)

Jane has been a RACS Fellow since 2007, in General Surgery specialty practising in Nelson, New Zealand. She was also awarded The Sumner Award in 2016 (awarded by New Zealand Association of General Surgeons, as voted for by the Trainees in General Surgery)

What inspired you to pursue surgical education?
I have had an interest in teaching since I was a medical student; passing on knowledge is a very enjoyable part of my career. This was probably influenced by both my parents being involved in education, music and mathematics. I started by helping overseas medical graduates with their studies to be able to practise in NZ, enjoyed implementing practical sessions for medical students/ house surgeons to learn suture techniques, and became a clinical lecturer for Otago University as a basic surgical Trainee and this continued as an advanced Trainee and into current practice. I enjoy being the supervisor for Trainee interns (final year medical students) in General Surgery and helping them in the transition from student to practising hospital doctor. I like to think of different ways I can encourage junior doctors who have an interest in surgery, and to help with career planning and progression with advanced Trainees as well as trying to give them the building blocks for preparation for Part 2 examinations. My interest in surgical education was also helped by having inspiring role models in some of my senior colleagues and consultants during my training.

In your opinion, what does the future of RACS Surgical Education look like?
Difficult to answer! RACS surgical education is a very broad area. There is the development of the surgical training programme, the new SET programme. Part of implementation of any redevelopment of the training programme will involve assessment to ensure the 4 SET years are sufficient for what the Trainees need to practise safely. Then there are all the courses that RACS provides e.g. ASSET, CCrISP and EMST. Then there is assessment of Trainees including the pilot for the Entrustable Professional Activities (EPA) and Procedural Based Assessment (PBA), which I am participating in also, the attempt to move toward competency-based rather than number-based training for Trainees, simulation training may become more available with advances in technology and reduction in costs of that technology so that it can be provided in many centres throughout Australia and NZ, not just large teaching centres. I would personally like to see more dedicated part-time training positions in Australia and NZ available for Trainees who need or want to reduce the hours worked for a defined period of their training.

What advice do you have for health professionals who are passionate about surgical education?
There are opportunities everywhere to improve the education of health professionals including medical students, junior doctors, advanced Trainees and our peers. Get involved where you can in areas that interest you, don't be timid about implementing different ideas within your hospital or workplace, if something doesn't work well you can adapt it as you go. Ask for feedback from those you are working with and take the time to listen to that.

How do you feel receiving the ASE Educator of Merit award?
I actually cried out with shock (and happiness as I felt very honoured) to be honest when I received the email advising of the ASE Educator of Merit. I was at work in the operating theatre when I opened the email and everyone asked me what was wrong! I have never thought of myself as an academic surgeon though I would aspire to be. Attending the meeting in Melbourne was invaluable as I realise there is 'more' to academia than research and publishing papers, something in which I have limited experience. I was pleased to see education is equally important in the term academia.


Jane Strang receiving her award and Bruce Stewart

Feature on Bruce Stewart
Educator of Commitment

Bruce has been a RACS Fellow since 1996, in General Surgery specialty practising in Ballarat, Victoria.

What inspired you to pursue surgical education?
I was inspired to do my bit for surgical education to repay what I felt was an enormous gift of knowledge imparted on me by my many surgical mentors, in particular Noel Sherson from the Royal Melbourne hospital, Jack Mackay from St Vincent's, and Russell Stitz from Royal Brisbane. Their example of patience and commitment to their Trainees' education was outstanding and I hoped to have the same impact on the next generation of surgeons. I am not sure that I have had quite the same impact but I think my country town of Ballarat is a popular Trainee destination and still provides good solid, undiluted surgical experience for the advanced Trainees.

In your opinion, what does the future of RACS Surgical Education look like?
The future of education is a difficult issue that the College will have to face. The facts of life are that advanced surgical training no longer equips a Trainee for consultant surgical practice if it ever did. Experience has been diluted by the explosion of surgical Fellows on most subspecialty teaching units and by safe hours rostering and generation XYZ attitudes to after-hours commitments. I believe there will need to be an expansion in simulation models and more rigorous assessment of manual dexterity and surgical ability throughout the training program as time alone no longer confers the necessary experience. I also believe each unit needs to have dedicated Trainee lists and time needs to be allocated to teaching of basic surgical techniques in a more structured fashion.

What advice do you have for health professionals who are passionate about surgical education?
Surgical education is an undervalued resource and is mostly done on a pro-bono basis by consultant surgeons with variable enthusiasm. It is a hugely rewarding and invigorating part of surgical practice and I pride myself on learning something new from each Trainee on our unit as it is clearly a two-way street. I think we have to think laterally and develop more innovative education techniques to make up for the dramatically reduced surgical experience to which Trainees are currently exposed. As long as we are inspired by our teachers the future will be bright.

How do you feel receiving the ASE Educator of Commitment award?
I think the ASE awards are a nice way of recognising people who have given generously of their time over a long period in the pursuit of improving the surgical education of the next generation.

Celebrating the significance of surgical scholarships

PROFESSOR DAVID SCOTT
Chair, Scholarships Evaluation and Monitoring Committee

The Scholarships Evaluation and Monitoring Committee (SEMC) was tasked with analysing the benefits of the Royal Australasian College of Surgery (RACS) research and travel scholarship program. The current findings from this ongoing project are now published in the ANZ Journal of Surgery,[1,2] and summarised below.

The RACS Foundation for Surgery, established over 30 years ago, raises funds for the research Scholarship Program. This program aims to encourage Surgical Trainees and Fellows to pursue their interest in academia by conducting surgery-related research that answers relevant questions that can benefit patients. Over the past five years, RACS has awarded over $9 million to scholars through the research Scholarship Program.

In order to identify the key outcomes of RACS scholars' research, a survey was distributed to Trainees and Fellows who received a scholarship/Fellowship between 2007 and 2011. A total of 66 scholars were surveyed, with 41 responses, giving a response rate of 62 per cent.

The survey results demonstrated a high number of scholars (over 70 per cent) had performed further independent research, and almost half of the respondents had received a non-RACS grant, following the scholarship-funded period. Approximately three-quarters of the scholars indicated that they supervised the research of junior medical staff following the completion of the scholarship funded research. Furthermore, over 75 per cent of the scholars used the funds to undertake a higher degree.

The findings of this evaluation demonstrates that the RACS Scholarship Program has very successfully supported many Trainees and Fellows to undertake further research, and in so doing make a significant contribution to the surgical research literature. It is key to note that a significant proportion of scholars achieving higher degrees as a consequence.

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2. Smith JA. Benefits of the Royal Australasian College of Surgeons Scholarship Program Highlighted. ANZ J. Surg. 2016; 86: 855.

SUCCESSFUL SCHOLAR

Driving cancer research through RACS grant

The 2016 recipient of the John Mitchell Crouch (JMC) Fellowship, Professor Alexander Heriot (pictured below), has used part of the attached funding to extend his world-leading translational research into new treatments for complex lower gastrointestinal cancers and peritoneal disease.

Image: Professor Alexander Heriot

The Director of Cancer Surgery at the Peter MacCallum Cancer Centre (PMCC), Professor Heriot was awarded the College's most prestigious Fellowship in recognition not only of his work to improve the outcomes of patients with complex colorectal disease but also for his support of junior surgeons undertaking higher degrees within his research program.

Since taking up his position in 2006, Professor Heriot helped establish the laparoscopic and robotic colorectal surgery program, set up a tertiary and quaternary multidisciplinary referral service for patients with advanced pelvic cancer and developed one of only five units in Australia to provide surgical management of peritoneal cancer.

His commitment to treating the most complex lower gastrointestinal disease has resulted in a four-fold increase in throughput with patients now referred to his unit from across Victoria, other parts of Australia and abroad.

Throughout all of this work, Professor Heriot has also supervised and supported 14 surgeons through Masters, Doctorate and PhD research programs through interdepartmental collaborations with medical oncology, radiation oncology, and the Research Division at the PMCC and the University of Melbourne.

His research program covers a range of areas and tumour types which at present includes:

- Identifying novel therapeutic targets through genomics and assessment using human xenografts for the treatment of anal cancer;
- Identifying tumoural immunological markers of response and outcome to neoadjuvant chemoradiotherapy in the treatment of rectal cancer;
- Exploring the impact of the peritoneal environment on the risk of developing peritoneal disease; and
- Evaluating the thromboembolic risk during neoadjuvant therapy and surgery and conducting molecular profiling of predictors of that increased risk.

Professor Heriot said that while colorectal cancer remained the second most common cause of cancer death there were limited funds available to research rarer cancer types which made the funds attached to the JMC Fellowship greatly appreciated.

He said he used some money to further research into anal cancer, which he said receives little public attention or support, while also funding a junior surgeon to tackle unexplored aspects of peritoneal disease.

"There is currently a great deal of work being done on the development of cancer vaccines and immunotherapy which boost the body's ability to recognise and fight certain cancer tumours but the focus of this research has largely been in the possible treatment of melanoma and lung cancer," Professor Heriot said.

"We are now investigating whether this approach might be useful in the treatment of anal cancer because while there are over 300 new cases per year in Australia we can still only offer patients the same treatment as we offered 40 years ago and 30 per cent of such patients still do not survive beyond five years.

"We are now in the process of using biopsies of such tumours to grow them in the lab to determine if we can find biomarkers which predict response and resistance to adjuvant therapies while also looking to identify novel pathways for targeted therapies.

"I have used some of the JMC money to extend this work into rectal cancer and have supported a research Fellow to initiate new fields of research into peritoneal cancer.

"One of the most important and rewarding aspects of receiving the JMC Fellowship is that it provides the funds to allow research into totally unexplored realms which stands in stark contrast to most grants which are tied to data and predicted outcomes.

"This untied money, then, allows us to conduct research which may generate that data which in turn could allow us to apply for other grants, so that the JMC Fellowship creates a snowball effect that begins with basic curiosity, develops into basic science with the end result, hopefully, being improvements in clinical care."

Professor Heriot said that aside from his clinical and research responsibilities, he took great enjoyment in supporting the next generation of surgical scientists.

He said the young surgeons working in his research program were in the national colorectal training program and had been embedded into various laboratories across PMCC.

"The focus of our translational research has been to build a bridge between the bench and the bedside and these young surgeons are that bridge and I get great intellectual stimulation in supporting their endeavours because they are doing some amazing work," he said.

"I think it's extremely important for surgery to retain primacy in the treatment of cancer and for surgeons to take the lead in these new fields of research.

"We are the first to see cancer patients upon referral, we are the first to diagnose the disease, and predominantly surgery is the primary therapy. Hence, it is essential that we lead this biomedical research because we understand the physiology of cancer, the surgical options for treatment and the likely outcomes."

Professor Heriot completed his general surgical training in London and undertook specialist colorectal Fellowships at St Vincent's Hospital in Melbourne, St Mark's Hospital, London, and the Cleveland Clinic in the US.

He said he was asked by his mentor in Australia, Professor Jack Mackay, to return following his time in Melbourne and that he found the opportunity to build a world class colorectal surgical program while conducting cutting-edge translational research too marvellous to resist.

Professor Heriot is a former Chair of the Research Support Committee for the Colorectal Surgical Society of Australia and New Zealand (CSSANZ), is a board member of the Australasian Training Board in Colorectal Surgery and is the Chair of the Operations Committee of the Binational Colorectal Cancer Audit.

He has published more than 145 peer reviewed papers, multiple book chapters and a book on lower gastrointestinal disease and is the current Director of the Lower Gastrointestinal Tumour Stream at the Victorian Comprehensive Cancer Centre (VCCC).

He said that the recent move by the PMCC into a new state-of-the-art facility in Parkville, Melbourne, as a member of the Victorian Comprehensive Cancer Centre, provided significant opportunities for advances and collaborations in cancer care and research.

"One of the most rewarding aspects of working at the PMCC is that it has world-class laboratories on site with more than 500 laboratory researchers working alongside us in the surgical units," he said.

"Our collaborations with the VCCC also offer enormous opportunity and there is no question that we are now providing clinical care and conducting research that compares to that provided or conducted at the premier centres in the world."

Professor Heriot described being selected to receive the JMC Fellowship as an unexpected honour and privilege.

"To be considered in the same field as other recipients of the JMC Fellowship is both humbling and a great honour and I thank the College and Fellows for their support."

The John Mitchell Crouch Fellowship is the premier research award of the RACS and commemorates an outstanding Fellow of the College who died as a young man. The award is made to an individual who is deemed by the College Council to be making an outstanding contribution to the advancement of Surgery.

- With Karen Murphy

CAREER HIGHLIGHTS – GRANTS & AWARDS

2017: Supervisor of the recipient of the RACS Foundation for Surgery Small Project Grant for research into peritoneal malignancy

2016:

- Colorectal Surgical Society of Australia and New Zealand (CSSANZ) Foundation Grant for research investigating immune markers to predict response and the role of Immunotherapy in neoadjuvant rectal cancer treatment.
- CSSANZ Foundation Grant for research into personalising treatments for patients with metastatic colorectal cancer
- Victorian Cancer Agency grant to advance research into the shared care of colorectal cancer survivors
- RACS John Mitchell Crouch Fellowship

2015: Bricker Prize, Society of Pelvic Surgeons

2013: Recipient of the RACS Hugh Johnston ANZ Chapter of the American College of Surgeons (ACS) Travelling Fellowship where he attended and participated in the ACS Annual Clinical Congress in Washington DC, USA.

2010: NHMRC grant to fund research into predicting the response to chemoradiotherapy in patients with advanced rectal cancer.

Your College, Your Council

Surgical News talks to incoming councillor Owen Ung

Queensland Surgeon Owen Ung will soon join the College Council following the elections held in October last year.

Professor Ung was elected to the Council by the general Fellowship out of a record number of candidates and will take up his position at the Annual General Meeting to be held in Adelaide in May.

PROFESSOR OWEN UNG

Owen Ung is a General Surgeon with an interest in Breast and Endocrine surgery, the Chairman of the RACS Queensland Regional Committee and a RACS Court Examiner. He has a number of local subspecialty societal memberships and is also on the executive of Breast Surgery International.

Currently the Head of the Breast Endocrine Unit at the Royal Brisbane and Women's Hospital (RBWH), Professor Ung is also a VMO at Breast Screen Queensland, the Wesley Private Hospital, St Andrews War Memorial Hospital and is also a Professor of Surgery at the University of Queensland (UQ) Medical School.

His current research interests include axillary staging in breast cancer, theranostics and targeted imaging, breast reconstruction with tissue-engineered constructs and breast cancer outcomes including a collaborative Trans Tasman study.

Originally from Brisbane, Professor Ung worked at the Westmead Hospital in Sydney for many years commencing as a Fellow and Surgical Superintendent and later as Clinical Director of the Breast Cancer Institute (BCI) and Director of the Department of General Surgery. He made his mark at the renowned BCI and helped establish one of the early Acute Surgical Units (ASU) when such models were being explored.

He relocated back to Brisbane in 2009 with his wife and four children to create a better work/life balance and to get away from the Sydney traffic that was consuming ever more of his time.

Since arriving in Brisbane, Professor Ung has enthusiastically provided clinical leadership to the breast/endocrine surgical unit, modernising surgical approaches, cultivating clinical research and helping to establish a similar ASU by tapping into his Westmead experience. He established another busy private practice and joined the academic surgical unit of the UQ medical school.

Professor Ung divides his time outside his hospital duties between his academic appointment and corporate positions that include serving as a board member of MIGA Medical Indemnity Organisation, the Specialist Services Medical Group and more recently the RBWH Foundation.

A member of the RACS International Scholarship Committee, he has mentored a number of surgeons from across South East Asia, particularly those funded to visit Australia through the Weary Dunlop Boon Pong Scholarship, and recently, via a reverse scholarship, was able to visit former Fellows at their hospitals in Thailand.

He said that some of the most challenging surgery he had performed was operating on large goitres in Moshi, Tanzania, but that his busy professional program at home made such volunteer international work sporadic.

Professor Ung said he was surprised and delighted to have been elected to Council and hoped he could make a contribution to the College through the experience gained from his varied professional life of private and public practice, surgical and RACS leadership, corporate and public appointments, academic research and surgical teaching.

Describing himself as 'moderate but politically aware', he listed four major issues confronting RACS that he felt needed to be addressed.

They are: the budgetary constraints facing the health system; public perceptions of surgeons; the need to train and accommodate a growing number of medical students, and the evolution of surgery into the future.

He said that while the College had a proud history in advocating for changes to improve public health outcomes, it also had a potentially important role to play in public health policy by adding its voice to the debate surrounding Medicare payments and private health insurance.

"I'm a strong supporter of both public and private health systems and see this dual system as one of the great strengths of the Australian health system," Professor Ung said.

"It works not just for patients around the country, it allows us as surgeons to develop our own private practices while keeping great expertise in public hospitals and universities and it is this symbiotic combination of public and private work, teaching and academic research which creates the rich fabric of our professional lives.

"However, the biggest problem with public health is that it is constantly held hostage to the election cycle which means the root causes of problems are never addressed and I think we need an independent body established at the national level that has the power to set strategies and allocate funding so that public health is no longer vulnerable to the politics of the day.

"The problem with the private system is the growth of junk or unaffordable policies and the constant price rises that are rarely or poorly explained, both of which cause people to drop their cover which inevitably places more pressure on the public system.

> *"The biggest problem with public health is that it is constantly held hostage to the election cycle which, means the root causes of problems are never addressed and I think we need an independent body established at the national level that has the power to set strategies and allocate funding so that public health is no longer vulnerable to the politics of the day."*

"I think RACS could have a part to play in all these issues and while we have had success in public health issues like alcohol and obesity these are issues that are somewhat more controversial both within the community and the Fellowship of the College."

Professor Ung said he believed the College could be more visible and more involved in the debate around the Medicare payment freeze and that nuanced policy positions to address the problem of rising patient gap payments were also important.

"The Medicare Freeze is a very important issue because this policy does not just temporarily adjust payments for a year or two, it resets the costings going forward and I think we need to get involved in these issues at a political level," he said.

Professor Ung said he also believed more could be done to educate the public about the work done by surgeons to overcome negative public perceptions and explain how much time and effort surgeons gave back to the community in teaching, advocacy and research.

"I don't think the public understand the intricacies of how we work and are remunerated and how often we adjust fees to accommodate our patients' circumstances or perform various pro-bono activities," he said.

"We are professionals - not elitists - and if the public purse had to pay for the teaching and training our Fellows generously find additional time to provide, provision of surgical services into the future would be unaffordable.

"These are not complaints. We do this work because we want to and most of us love our time in the operating theatre. Yes, there may be a very small proportion of surgeons who rort the system, just as in any profession, but the vast majority of us do our best for our patients and we have to work out how to explain this to the public."

Professor Ung also said work needed to get started now to deal with the challenges presented by science and technology that could fundamentally alter the role of the surgeon in the future.

"Technology will replace many things done by surgeons and specialists now, while scientific advances could obviate the need for surgery in treating many conditions and diseases and we have to prepare for that," he said.

"Some of my research, for instance, is focussed on finding better targeted therapies for breast cancer, which will mean there will be less need for surgery and that will affect many of us going forward."

Professor Ung said he felt humbled and greatly surprised by his election to the RACS Council.

"I nearly fell off my chair when the President rang me with the news because there were 28 people applying for the new positions so I had no expectation of being elected at all," he said.

"I am greatly looking forward to this role. Visiting specialists in private practice may not have the time to get involved in senior College roles, which means their voices may not get heard, so I am proud to represent other VMOs at this level.

"We are also blessed, as a profession, to have some fantastic, thoughtful people on council."

With Karen Murphy

Beware the Disgruntled Patient!

A recent case in New South Wales in September 2016 demonstrates the length to which a disgruntled patient may sometimes go.

MICHAEL GORTON AM
Principal, Russell Kennedy Lawyers

In this case, a patient of an orthopaedic surgeon suffered an adverse outcome following a hip arthroscopy in 2010. The patient lodged a complaint with the Health Care Complaints Commission in NSW which was dismissed. The patient remained unsatisfied, and on a number of occasions threatened the surgeon and created a defamatory website in the surgeon's name. The patient subsequently pleaded guilty to a charge of intimidation. He was sentenced to four months imprisonment suspended, as he entered into a good behaviour bond. An apprehended violence order was also granted, which included a condition that the patient would not create any other defamatory website.

In August 2016 the surgeon discovered a new website with a similar domain name, as before, registered to a different owner. The Court inferred that the site still related to the patient.

The new website was highly defamatory and whilst the patient might have argued that the comments were based in truth, the Court concluded that any defence to that extent would not be successful. The Court also concluded that the new website was very similar to the surgeon's professional website, and therefore the surgeon would suffer damage as more patients were likely to read the defamatory material.

The Court concluded that the website was defamatory and an injunction should be granted to prevent it being active. The Court also concluded that the new website was a breach of the apprehended violence order as previously granted by the Courts.

In determining an injunction application, the Courts must balance the competing interests of free speech, against the commercial effects of defamatory information being published.

The Court granted the injunction and the new website was taken down.

This was obviously a particularly vexing issue for the surgeon, having to deal with a patient fixated on what might had been a poor outcome, but not necessarily the negligence of a surgeon. Of course, in handling any complaints, doctors should be prepared to explain a poor or adverse outcome, without necessarily any admission of negligence. In many cases, there are risks involved in the surgery, and a perfect result is not guaranteed. This goes to the information provided to the patient ahead of the surgery, explaining to the patient the risks of the surgery and the potential for an imperfect result. Surgeons cannot guarantee a perfect result in all cases.

In addition, after an adverse outcome, good practice would be to explain the reason for the adverse outcome, the issues involved, and any corrective action that can be taken. This is particularly where there is no suggestion of negligence, but where the patients' disappointment may be understandable. Good communication before a procedure, and good communication after an adverse event, are very good ways of dealing with patient disappointment and anxiety. Good communication is also a good defence to the potential for legal threat and claim.

This case is an extreme case of patient disappointment, where actions have been taken by the patient which needed Court intervention. Hopefully, most doctors do not have to resort to these extraordinary measures.

That's Not Bullying!

SUSAN HALLIDAY

The term bullying is currently used in our workplaces to describe a surplus of situations and behaviours. In fact, the term is sometimes used in a colloquial sense –if not loosely – to describe a multitude of feelings and experiences that don't amount to bullying as determined by the various legislative frameworks that shape our employment policies and govern our workplace modus operandi.

Misuse of the term bullying, or bandying it about due to frustration or personal discomfort, has unfortunately had some negative consequences over the past decade. Two classic examples are when a person is required to provide an independent medical report prior to resuming work, and when a person faces a firm discussion about poor performance. The conversations that follow with colleagues in certain circumstances will position the individual with responsibility, power and authority as a bully. In addition to potentially undermining workplace responses to genuine cases, a level of cynicism about *bullying* has evolved over recent years. Further, a significant level of reluctance on the part of some supervisors, managers and accountable senior practitioners has emerged when faced with progressing 'the hard' workplace discussion, given the perceived personal risk of a bullying complaint.

> *Everyone in the workplace, no matter what their role or employment status, should be clear that bullying is repeated unreasonable behaviour directed towards an individual or a group that creates a risk to physical or mental health and safety.*

There is a need in our workplaces to be proactive and pre-emptive about workplace education as people need a good understanding of what is, and what is not, workplace bullying. Tensions in the workplace can arise from time to time. Personality clashes, a one-off instance of insensitivity, and those different views about how the world (or the workplace) should be run, can result in a level of frustration and highlight key differences of opinion. Low level workplace conflict that does not create a risk to health and safety is not bullying. Further there will always be people we need to work with professionally that we'd choose not to barbeque with in the non-work environment because we simply don't like them, their attitude or how they approach their responsibilities.

Over recent times some have run with the line 'if you feel bullied, then you've been bullied' but that is not how it works. There are criterion that underpin, and tangible behavioural experiences that shape the definition of workplace bullying. There will be times where people beach an organisation's code of conduct or act in a manner contrary to the stated values of the organisation, to the detriment of others; but the circumstances will not necessarily amount to workplace bullying despite a need for remedial or disciplinary action.

In general terms reasonable management action carried out in a reasonable manner does not constitute bullying. Hence genuine performance management, providing direction on how work is to be done, following established equitable processes, merit based decision making and progressing procedurally fair and reasonable disciplinary action, will not amount to bullying. There will be those who blatantly disagree with an outcome, a few noses out of joint due to a personal sense of importance and entitlement, misinformed views about the person *next in line* should be getting the job, those who feel professionally wounded and formal complaints that workplace treatment has been unjust. When such an offended, angry, upset or aggrieved person heads down the bullying pathway, in the vast majority of situations, the cul-de-sac looms.

More specifically reasonable management action (assuming the delivery is appropriate and professional) can include detailed discussions about poor work performance and unacceptable behaviour that affects colleagues and patients (both inside and outside of work), constructive negative feedback, as well as documenting workplace discussions and warnings. It is also reasonable to directly ask a person to perform the duties in keeping with the breadth and depth of their job and the priorities of the organisation, as well as alter duties or allocate new duties as required due to restructuring or peak periods. A decision not to provide a promotion based on an employee's capability or lack thereof is reasonable management action, as is legitimate action taken to transfer, retrench or terminate a contract. Adhering to lawful injury and illness processes, including requesting a person provide an independent medical or psychological report are reasonable management actions.

It is worthy of note that reasonable management actions can be considered bullying if they are misrepresented with the aim of targeting a particular person repeatedly, or if primarily and purposefully used to systematically intimidate, humiliate, undermine, isolate, demean, victimise or threaten an individual or a group.

In today's workplace a person is entitled to state and press their position, just as a supervisor, manager or senior practitioner is entitled to disagree and make a final management or medical decision. When opinions and experience differ, it is legitimate for a supervisor, manager or senior practitioner to end a discussion by asserting their seniority and management prerogative in a civil and professionally astute manner. Given that the delivery of all information needs to be professional, there are times when insensitive, aggressive and sarcastic delivery let some, otherwise exceptional people, down badly. Needless to say both timing and the proximity of others are important factors to consider when providing negative feedback. An aggressive or punitive management style that repeatedly impacts negatively on an individual or a group, placing physical and mental health and safety at risk, can amount to workplace bullying.

Everyone in the workplace, no matter what their role or employment status, should be clear that bullying is repeated unreasonable behaviour directed towards an individual or a group that creates a risk to physical or mental health and safety. It is behaviour that results in the affected person feeling intimidated, humiliated, undermined, isolated, demeaned, victimised or threatened. While bullying can be physical, verbal, written or psychological, it is not always intentional. That said there does not need to be intent, or a motive for behaviour to amount to bullying.

The repeated unreasonable behaviour does not have to be the same behaviour. It can be a series of different experiences that have a similar negative impact placing health and safety at risk. Bullying can also be the misuse of power due to position, status, professional or social standing, physical attributes, gender or race. It can also equate to the abuse of a system of work or a condition of employment, in order to repeatedly target a person or group in a negative way.

The following types of behaviour, where repeated or occurring as part of a pattern are unfortunately experienced in many workplaces, and do amount to bullying:

- verbal abuse, inappropriate name calling, yelling and swearing
- deriding a person or giving instruction for someone else to do so
- interference or sabotage of work or personal belongings
- initiation practices, pranks, and mocking personal characteristics
- standover tactics, making threats and throwing objects or equipment
- repeatedly assigning meaningless tasks unrelated to the job
- teasing, sarcasm, personal and professional insults
- withholding information vital for effective work performance
- requiring someone to do a task without the essential training
- psychological harassment
- setting someone up in a purposeful way to fail
- constant and unwarranted criticism in public or private
- cyberbullying and inappropriate targeted use of social media to degrade
- malicious gossip and the spreading of rumours and innuendo
- the purposeful undermining of an individual's reputation
- repeated unwarranted threats to terminate employment
- using a system of work, such as a roster or the allocation of overtime to punish, penalise or otherwise cause detriment.

There are no excuses. Everyone has a responsibility to engage in a positive and productive manner mindful of what bullying is, and is not.

TO BE CONTINUED...

The March 2017 edition of Surgical News will feature a follow-up article focusing on direct approaches that can be utilised when people believe they are being bullied.

NOTE – This article is not legal advice. If legal advice concerning workplace bullying is required, an employment law specialist should be consulted with reference to the specific circumstances.

SUSAN HALLIDAY – Australian Government's Defence Abuse Response Taskforce (DART) 2012-2016 and former Commissioner with the Australian Human Rights Commission.

21 December 2016
Dear Mr Truskett,
President, Royal Australasian College of Surgeons

RE: LET'S OPERATE WITH RESPECT

Thank you for your letter of 6 December 2016.

I have misgivings about the direction the College is taking on this and a number of similar sociological issues.

I have been in surgical practise for 45 years including 25 in a major teaching hospital. I was head of our State specialty training committee for a number of years. I cannot recall a single episode of what any reasonable person could construe as bullying, harassment or lack of "respect'.

This personal experience leads me to question why the College is spending time and money on these matters. Surely they are "motherhood" issues and in my view their very enunciation is a mistake only likely to draw the unhelpful attention of the media.

If the College does receive a complaint surely it can be dealt with using College networks on a case by case basis.

Respect for others is an axiom we are all taught from childhood. To compel Fellows to take a 45 minute re-fresher course in respect is, frankly, insulting.

Just what are driving these issues? I fear they are a sop to the so called progressive views of the far left of politics. They are reminiscent of the school bullying programme in Victoria which has now been exposed as a cover for gender politics.

Please concentrate on the core educational and fellowship roles of the College and reconsider these behavioural matters that I consider not only un-necessary but damaging to the public perception of the College.

Yours sincerely,

Daniel Hains FRACS
[email address withheld]

PS: Please pass this letter on to the Surgical News Editor as I wish to gauge the views of other Fellows on this matter.

OFFICE OF THE PRESIDENT

22 December 2016
Dear Mr Hains,

RE: Let's Operate with Respect

Thank you for your letter of 21 December 2016. I am very pleased to hear that in your 45 years of practice you have never witnessed a single episode of 'what could construe as bullying, harassment or lack of 'respect'.' You also express concern that our campaign 'Let's Operate With Respect' will draw "unhelpful attention of the media."

Our experience to date has been the opposite. For some years, the College had recognised that discrimination, bullying and sexual harassment (DBSH) were problems in our profession and had developed courses such as Training in Professional Skills (TIPS) and Non-Technical Skills for Surgeons (NOTTS) to address these issues. In March 2015, when we were in the national media spotlight about these problems, it became clear that we had not done enough. As you may know, we established an Expert Advisory Group (EAG) to examine the extent of discrimination, bullying and sexual harassment in surgery, and advise us on how best to manage them. The results of the EAG research were damning and I would like to quote from the EAG report:

> Nearly 50% of College Fellows, Trainees and International Medical Graduates report being subjected to discrimination, bullying or sexual harassment. It is inconceivable that anyone finds this acceptable or contests the seriousness and spread of these problems.
>
> The status quo will not serve the future. Individually and collectively, College Fellows must recognise and commit to closing the gap between how it has been, and how it must become.

The EAG report is published in full on the College website at http://www.surgeons.org/media/22086656/EAG-Report-to-RACS-FINAL-28-September-2015-.pdf

Discrimination, bullying and sexual harassment are serious problems in our profession and our commitment to addressing them is detailed in our Action Plan: Building Respect, Improving Patient Safety, which is also published on our website. We have a large program of work in place to support cultural change and leadership, strengthen surgical education and improve complaints management. The mandatory participation of fellows in core education programs is a cornerstone of this work.

During 2016, we have been congratulated for our leadership on this important cultural issue and the College's approach is widely regarded as a benchmark in the sector. As a Fellow of the College I am very proud of the work we are doing to respond to these problems and lead the health sector in building a culture of respect. As President, I feel privileged to be able to play a part in this initiative.

I sincerely hope that in the near future, all surgeons, trainees, health care workers and patients have the same experience you have enjoyed over the past 45 years and have access to a safe working environment free of discrimination, bullying and sexual harassment.

I will of course pass on your letter to the Editor of Surgical News.

Yours sincerely,

Mr Philip Truskett AM
President
college.president@surgeons.org

RACS
LET'S OPERATE WITH RESPECT

ANZASM 2015
National Report Executive Summary

PROFESSOR GUY MADDERN
Surgical Director of Research and Evaluation
incorporating ASERNIP-S

The Australian and New Zealand Audit of Surgical Mortality (ANZASM) programme has been operational for over 12 years beginning in Western Australia. It has been operating nationally, with all states and territories contributing since 2010.

The principal aims of the audit are to inform, educate, facilitate change and improve quality of practice within surgery. The primary mechanism is peer review of all deaths associated with surgical care. The audit process is designed to highlight system and process errors and to identify trends in surgical mortality. It is intended as an educational rather than a punitive process.

The ANZASM is managed by the Research Audit and Academic Surgery Division of the Royal Australasian College of Surgeons (RACS). The ANZASM oversees the implementation and standardisation of each regional audit to ensure consistency in audit processes and governance structure across all jurisdictions. The individual regional audits are funded by their departments of health. The RACS provides infrastructure support and oversight to the project. The ANZASM receives protection under the Commonwealth Qualified Privilege Scheme, part VC of the Health Insurance Act 1973 (gazetted 25 July 2016).

Each region produces its own Annual Report. In addition, since 2009, the ANZASM has been producing a national report based on combined regional data. The national database contains several thousand cases, which provide the opportunity to analyse mortality trends and potentially identify areas for improving patient care. From this important initiatives are now becoming realised over time as more data is becoming available. The ANZASM is in a good position to utilise the extensive information learned to promote safer health care practices. Below is the executive summary from the 7th ANZASM 2015 National Report. Key highlights from the report include:

- The proportion of cases with adverse events has remained relatively static (3.6% in 2012 compared to 3.4% in 2015).
- The most common issues experienced were delays related to the transfer (10.6%), inappropriateness of transfer (5.6%) and insufficient clinical documentation (4.3%).
- In the majority of instances those patients expected to benefit from critical care support did receive it. The review process suggested that 7% of patients who did not receive treatment in a critical care unit would most likely have benefited from it.
- Fluid balance in the surgical patient is an ongoing challenge; however the report highlights improvements are being made in some regions.
- The audit revealed that patients admitted as surgical emergencies have a greater risk of falling while in hospital. All health professionals should increase their awareness of this risk to improve the quality and safety of patient care.
- Participation in the audit has increased significantly over time, and from 2017, the Australian Orthopaedic Association will make it compulsory for its members to partake.

The full report is available at http://www.surgeons.org/media/24853564/2016-11-22_rpt_anzasm_national_report_2015.pdf

The National Surgical Mortality Audit is an important part of clinical governance for surgeons in Australia. It is also a process which is largely under our own control, but in order to maintain this, we need to be able to show that we have a robust process in place. Moving forward I would encourage all surgeons to complete their mortality case forms as accurately as possible to ensure that we can maintain and improve the standard of the process well into the future.

RACS can be rightly proud of these important initiatives in collaboration with the jurisdictions. The diversity of medical professionals participating in this process significantly enhances the quality of information and has highlighted the need for improvement in various aspects of patient care.
Thank you for your ongoing support.

Cycling Flanders & the Somme

Annette, Martin at Annette's great uncle's grave

ANNETTE HOLIAN
FRACS

MARTIN RICHARDSON
FRACS

Annette Holian, Martin and Don Richardson and Lindy Moffat ticked one off the bucket list in September 2016, and cycled the World War I battlefields in France and Flanders where Australians and New Zealanders fought so bravely 100 years ago. Their guide was Tom Scotland, the ASC 2015 Surgical History Visitor and renowned military and surgical historian.

"We were a 'peloton' of four Scots and 4 Australians, complete with bagpipes filling the evening sky in the French country-side," said Annette.

Two days were spent cycling around Ypres, following in the footsteps of Australian and New Zealand soldiers where, on 20 September 1917, men of the 1st and 2nd Divisions spearheaded successful attacks during the Battle of the Menin Road, sustaining 5,000 casualties, one of whom was Martin and Don`s grandfather.

The group cycled past Polygon Wood, which was captured by the 5th Division on 26 September 1917, and up to Broodseinde Ridge where the Australian 1st, 2nd and 3rd Divisions and the New Zealand Division formed the main thrust of attack at the Battle of Broodseinde on 4 October 1917, it was now time to reflect. Annette was particularly moved as she cycled alongside a field, with red poppies starting to sprout, where a relative, Pvte James Bennett Stephens, who fought with the 3rd Division, was killed. His body was never found and he is commemorated on the Menin Gate.

Visiting the lovely town of Passchendaele in brilliant sunshine, where Australians and New Zealanders had fought and died in appalling conditions at the First Battle of Passchendaele on 12 October 1917, Martin said that it was impossible to imagine those famous iconic Frank Hurley photos showing the town completely obliterated.

Then it was onto the Somme, stopping at places of importance *en route*, including Fromelles. On the night of 19 July 1916, inexperienced men of the Australian 5th Division and British 61st Division went into battle against strong defensive positions of a numerically superior enemy well equipped with machine guns, which resulted in a catastrophic 5,553 Australian casualties for no gain. From there the group visited the Australian National Memorial at Villers Bretonneux, where 10,773 Australian soldiers are commemorated who died in France and have no known grave. Then Le Hamel, where on 4 July 1918, Lieutenant General Monash, now in command of the Australian Corps, led a successful joint American-Australian attack using artillery, tanks and air power to protect the infantry. Australians under Monash went on to perform magnificent feats at the Battle of Amiens on 8 August, the Battle of Mont St. Quentin on 30 August and the Hindenburg Line on 29 September.

Two days cycling around the Somme followed, where it became obvious that the Somme is quite hilly! Annette said that Pozières, which is indelibly linked with Australia, was a highlight.

"Pozières was captured by the Australian 1st Division on 22 July 1916, and the Windmill by the 2nd Division on 4 August", she said. "There were 17,000 Australian casualties around this little village. Soil from the Pozières battlefield is scattered in the Tomb of the Unknown

Don, Annette, Martin, Lindy arrive at Pozieres

Australian Soldier at the Australian War Memorial in Canberra.

"Mouquet Farm, which was repeatedly attacked by Australians at enormous cost in August 1916, and the Thiepval Memorial to the Missing were highlights, as were the preserved trenches at Beaumont-Hamel, and eating lunch in the famous Sunken Road where the 1st Battalion Lancashire Fusiliers nervously waited to go into battle on 1 July 1916".

The group cycled onto Serre 3 Cemetery at Sheffield Park, marking the northern most part of the battlefield.

Lindy made a pilgrimage to the grave of second cousin Richard Moffat, killed in action in 1918, aged 19. No-one from Australia had ever visited his grave. Lindy said that it was hard to fight back the tears when Annette made a similar visit to the grave of Hedley Howard Thomas, her great uncle, who died 10 July 1918, a stretcher-bearer shot by a sniper whilst tending the wounds of an injured soldier near Hazebrouck.

On the return journey, the group met George Sutherland, 95 year old retired head gardener of Lijssenthoek Cemetery near Ypres and still cycling around his village. George's father Walter was a gardener at Lijssenthoek before him. During the Great War, Walter worked as a medical orderly in Canadian Casualty Clearing Station 3 where Martin and Don`s grandfather was taken with a gunshot wound to the foot on 20 September 1917. He said that he may have even met him.

It was poignant for the medical staff who served in the Middle East Area of Operations to look back at a past war and learn how a hospital could manage such large volumes of injured soldiers passing through their doors. A strongly recommended site for medical staff visiting the Western Front.

In Annette's words "*for me it was rewarding to see the beautiful green countryside bathed in sunlight, hay rolls in the fields awaiting collection and families living a normal life. Having served in Afghanistan a few times I can only hope that one day people might be touring there remembering the past and giving thanks for freedom of travel and the right to live free of the hazards of war*".

2017 – The Year Ahead

Welcome to the New Trainees

DR RACHEL CARE
Communications Representative, RACSTA

Firstly 'Happy New Year' for 2017, the RACSTA board hopes you have all had an enjoyable holiday period and managed to spend some time with family and friends enjoying the festivities. The beginning of the year is not only a time to set New Year Resolutions but also to reflect on the year past and plan for the year ahead.

Welcome to the new Trainees at the beginning of their surgical training, this can be challenging time taking the step up to a training position and learning to balance new responsibilities. It is also a time when the most junior and senior Trainees are looking forward to the upcoming Part 1 and Part 2 exams – good luck to all of those taking exams this year! With these added pressures in place you may want to know where you can get advice, advocacy and support. In this first instance for any training issues you can speak with your Specialty Representative; they sit on your Training Board and are able to represent any training issue you may have. They are also a useful source of information for any changes in the examination process and can provide you with support for other issues if required.

The Specialty Representatives are part of our RACSTA Board and can also raise any training related issues at our meetings; these issues can then be escalated via us throughout RACS. It is our job to represent you so we are always happy to hear from you with any issues. If for any reason you wish to contact us directly we have a dedicated Support and Advocacy role within our Executive; just contact Zoe Husband (Executive Officer) on +61 3 9276 7490 or racsta@surgeons.org and she will put you in touch with the appropriate person.

Last year the Board worked closely with RACS in developing the Building Respect and Improving Patient Safety action plan. More recently we have been working closely with the New Zealand Resident Doctors Association regarding the strike action currently taking place. Looking forward the RACSTA Board will be busy this year analysing your survey results over the past five years. Watch this space and you should see these soon.

All the best for an exciting year ahead.

Workshops 2017

Online registration form is available now (login required)

Inside 'Active Learning with Your Peers 2017' booklet are professional development activities enabling you to acquire new skills and knowledge and reflect on how to apply them in today's dynamic world.

Foundation Skills for Surgical Educators Course

Monday, 20 February 2017	Melbourne	VIC
Thursday, 23 February 2017	Canberra	ACT
Friday, 24 February 2017	Hastings	NZ
Saturday, 25 February 2017	Canberra	ACT
Friday, 3 March 2017	Melbourne	VIC
Saturday, 4 March 2017	Wangaratta	VIC
Saturday, 11 March 2017	Newcastle	NSW
Saturday, 18 March 2017	Brisbane	QLD
Tuesday, 21 March 2017	Adelaide	SA
Friday, 24 March 2017	Palmerston North	NZ
Saturday, 1 April 2017	Hobart	TAS
Saturday, 1 April 2017	Port Macquarie	NSW
Monday, 3 April 2017	Clayton	VIC
Monday, 3 April 2017	Perth	WA
Friday, 7 April 2017	Sydney	NSW
Friday, 21 April 2017	Melbourne	VIC
Saturday, 29 April 2017	Geelong	VIC

The Foundation Skills for Surgical Educators 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. With the release of the RACS Action Plan: Building Respect and Improving Patient Safety, the Foundation Skills for Surgical Educators course is now **mandatory** for Surgeons who are involved in the training and assessment of RACS SET Trainees.

Responding to Emotions in Cancer

Saturday, 25 February 2017	Melbourne	VIC

Effectively responding to a patient's emotional cues in cancer is an essential clinical skill for acknowledging the patient experience and building rapport. This evidence-based experiential course will provide health professionals with the skills and learning opportunities for responding to emotional cues by using a defined series of skills and framework to enhance communication with patients and families. This educational program is proudly supported by Cancer Council Victoria.

International Medical Symposium

Friday, 10 March 2017	Melbourne	VIC

The Royal Australasian College of Physicians (RACP), the Royal College of Physicians and Surgeons of Canada (RCPSC), the Royal Australian & New Zealand College of Psychiatrists (RANZCP), the Australian & New Zealand College of Anaesthetists (ANZCA) and the Royal Australasian College of Surgeons (RACS) are pleased to host the 2017 International Medical Symposium: Leading Change.

Comcare: Difficult Cases

Tuesday, 21 March 2017	Sydney	NSW

The Comcare Guide to the Assessment of the Degree of Impairment informs medico legal practitioners as to the level of impairment suffered by patients. This assists with determining their patients' suitability to return to work. While the guidelines are extensive, they sometimes do not account for unusual or difficult cases. This evening workshop provides surgeons involved in the management of medico legal cases with a forum to discuss their difficult cases, the problems they encountered and the strategies employed to solve them. Cases will be circulated beforehand. This workshop complements the accredited Comcare Guideline Training Courses. Please note: Each attendee needs to bring with them a copy of the Comcare Guide 2nd Edition. This educational program is proudly supported by eReports.

Non-Technical Skills for Surgeons (NOTSS)

Friday, 24 March 2017	Melbourne	VIC

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

National Health Education and Training in Simulation (NHET-Sim)

Friday, 31 March 2017	Melbourne	VIC

The NHET-Sim Program is a nationwide training program for healthcare professionals aimed at improving clinical training capacity. NHET-Sim offers a training program for healthcare educators and clinicians from all health professions. The curriculum has been developed and reviewed by leaders in the simulation field across Australia and internationally.

Surgical Teachers Course

Thursday 16 – Saturday 18 March 2017	Hunter Valley	NSW

The Surgical Teachers course builds upon the concepts and skills developed in the SAT SET and KTOT courses. The most substantial of the RACS' suite of faculty education courses, this new course replaces the previous STC course which was developed and delivered over the period 1999-2011. The course is given over 2+ days and covers adult learning, teaching skills, feedback and assessment as applicable to the clinical surgical workplace.

PROFESSIONAL DEVELOPMENT WORKSHOP DATES

February – April 2017

ACT		
Foundation Skills for Surgical Educators	Thursday, 23 February 2017	Canberra
Foundation Skills for Surgical Educators	Saturday, 25 February 2017	Canberra
NSW		
Comcare: Difficult Cases	Tuesday, 21 March 2017	Sydney
Foundation Skills for Surgical Educators	Saturday, 11 March 2017	Newcastle
Surgical Teachers Course	Thursday 16 - Saturday 18 March 2017	Hunter Valley
Foundation Skills for Surgical Educators	Saturday, 1 April 2017	Port Macquarie
Foundation Skills for Surgical Educators	Friday, 7 April 2017	Sydney
NZ		
Foundation Skills for Surgical Educators	Friday, 24 February 2017	Hastings
Foundation Skills for Surgical Educators	Friday, 24 March 2017	Palmerston North
QLD		
Foundation Skills for Surgical Educators	Saturday, 18 March 2017	Brisbane
SA		
Foundation Skills for Surgical Educators	Tuesday, 21 March 2017	Adelaide
TAS		
Foundation Skills for Surgical Educators	Saturday, 1 April 2017	Hobart
VIC		
Responding to Emotions in Cancer	Saturday, 25 February 2017	Melbourne
Foundation Skills for Surgical Educators	Saturday, 4 March 2017	Wangaratta
International Medical Symposium	Friday, 10 March 2017	Melbourne
NHET-Sim	Friday, 31 March 2017	Melbourne
Non-Technical Skills for Surgeons	Friday, 24 March 2017	Melbourne
Foundation Skills for Surgical Educators	Monday, 3 April 2017	Clayton
Foundation Skills for Surgical Educators	Friday, 21 April 2017	Melbourne
Foundation Skills for Surgical Educators	Saturday, 29 April 2017	Geelong
WA		
Foundation Skills for Surgical Educators	Monday, 3 April 2017	Perth

Contact the Professional Development Department

Phone on +61 3 9249 1106 | email **PDactivities@surgeons.org** | visit **www.surgeons.org**

Please contact the Professional Development Department on +61 3 9249 1106, PDactivities@surgeons.org or visit the website at www.surgeons.org and follow the links from the Homepage to Activities.

WORKSHOPS • ACTIVITIES • EVENTS

Annual Scientific Congress
Adelaide 8-12 May 2017

PETER SUBRAMANIAM
ASC 2017 Convener

DAVID WALSH
ASC 2017 Scientific Convener

The phenomenon of health system reform is not unique to Adelaide, South Australia or indeed, Australia. The same questions are being posed to surgeons operating in the USA (with likely changes to the *Affordable Health Care Act* under a new USA administration), the UK (with its monolithic National Health System, multiple commissioning authorities and NICE guidelines) and other jurisdictions with different models of service provision and funding.

The main plenary sessions of ASC 2017 will provide an opportunity to gain insight into how surgery has coped or changed in the era of major healthcare transformation. With sessions on sustainability of surgery, safety of surgery and the safe surgeon, we look at how surgeons have responded to the challenges of healthcare reform.

The plenary sessions and scientific sessions are now finalised, the section dinners are booked and the session chairs appointed - all is ready for the 86th Annual Scientific Congress to be held at the Adelaide Convention Centre situated alongside the Torrens River.

Your Provisional Program booklet showcases the program that has been arranged by the Scientific Committee of ASC 2017. As accommodation in Adelaide is in demand at this time of year, we strongly encourage you to visit the Congress website http://asc.surgeons.org now to register and reserve your room.

The Convocation Ceremony and Welcome Reception are on Monday 8 May, 2016 at 5.00pm at the Adelaide Convention Centre.

In keeping with the theme *Safe and Sustainable - the Future of Surgery?* the section conveners have devised sessions to challenge attending surgeons with the often uncomfortable debate of surgical costs versus benefits and the reassuring data of new surgical approaches and techniques with improved patient outcomes. We commend them for their creativity and their dedication to making each section of the meeting as interesting and engaging as possible while addressing the theme of the Congress.

A feature that continues this year is the Council Plenary, which will address current topics affecting all surgeons. The President's Lecture will be delivered by Professor Ian Harris and the title will be *Surgery as a value proposition*.

The Provisional Program booklet, also available online at asc.surgeons.org details session information, some of which are highlighted below. Other session details will be featured in future editions of *Surgical News*.

Medico-Legal Program
Paul Carney and Cindy Molloy have arranged a comprehensive program in all matters legal. The highlight of this program will be the attendance of Senator Nick Xenophon who will bring us up to speed with Commonwealth thoughts on these matters on Friday 12 May.

Senior Surgeons
John North has again arranged an excellent program covering issues that should be of interest to all surgeons. Sessions such as *Improving processes for safety and quality in future surgeons* and *Volume and outcome in the rural setting*, both of which should challenge all of us.

Pain Medicine
Andrew Zacest has arranged a comprehensive program covering interesting aspects of pain.
The session on *Painful challenges in general surgery* will be of interest to all surgeons in a general surgical or subspecialty practice, and the *Chronic pain after breast surgery* session to surgeons whose area of interest is mainly breast surgery.

Quality and Safety
Glenn McCulloch has arranged an extensive program starting with a review of Australasian quality programs covering difficult topics such as *The decision to operate in high risk patients*, *Quality and safety in pain treatments* and *Surgical site infection – a continuing issue or a vanquished foe?*. Professor Mary Hawn will deliver a keynote lecture on *Surgical re-admissions: What are the Drivers?* and Dr Sally Roberts will address the issue of antimicrobial stewardship in her keynote lecture.

Colorectal Surgery
Elizabeth Murphy has arranged a comprehensive program with three distinguished visitors; Professor John Monson, Associate Professor Sonia Ramamoorthy and Associate Professor Andrew Stevenson, who will cover a breadth of colorectal surgery topics including a focus on new trans-anal approaches to rectal tumours including TEM and Ta-TME and the role of the robot in colon and rectal surgery. Difficult areas of pelvic floor disorders and endometriosis will also be addressed.

We trust you will join us in Adelaide.

Register now through the Congress website asc.surgeons.org

All Hands On Deck!

Australian Hand Surgery Society AGM 2017 1-4 March 2017

RICHARD PERRY
Chair, Fellowship Services

The Australian Hand Surgery Society (AHSS) is pleased to welcome Dr James Higgins (pictured, right) to its 2017 AGM. Dr Higgins serves as the chief in the Curtis National Hand Center. He completed his undergraduate studies at Williams College and received his medical degree from the University of Rochester School of Medicine and Dentistry. He completed his residency in plastic and reconstructive surgery at the University of Rochester and a hand surgery fellowship at the Curtis National Hand Center at Union Memorial Hospital.

Dr Higgins is a member of the academic faculty at Johns Hopkins University, Georgetown University and University of Pennsylvania. He sub-specialises in upper extremity microvascular surgery. His clinical and research interests include vascularised bone reconstruction of extremity nonunions, functioning muscle reconstruction of the upper limb, toe transfer digital reconstruction, complex reconstruction of upper extremity trauma and vaso-occlusive disease of the hand. He directs the microsurgical didactic lecture and anatomy program and the Hand Center's biannual flap course.

As the guest professor of the Australian Hand Surgery Society, Dr Higgins will present work on micro vascular soft tissue and bone reconstruction of the hand and upper limb and will demonstrate his technique on vascularised bone graft at a cadaver lab to be held at RACS.

The AHSS is grateful to RACS for its support of Dr Higgins through the RACS Visitor Program.

New Zealand Association of General Surgeons

Annual Scientific Meeting, 25th & 26th March 2017, Palmerston North Convention Centre

RICHARD PERRY
Chair, Fellowship Services

The NZAGS is pleased to welcome Mr Simon Patterson Brown to its 2017 ASM and grateful to RACS for their support.

Simon Patterson Brown is a world renowned upper gastro-intestinal surgeon who has published extensively in this field and headed one of the foremost upper gastro-intestinal surgical units in the UK. He has been actively involved in numerous surgical Royal College and UK Medical Council affairs related to specialist training, assessment and mentoring, and surgical safety, amongst a wide variety of activities. He brings a wealth of technical, clinical and non-clinical experience and knowledge to our meeting. The NZAGS looks forward to this opportunity to strengthen the collegial bond between New Zealand and UK surgeons particularly as our newest appointed surgical consultant is currently completing post-fellowship training in upper gastrointestinal surgery within Simon Patterson Brown's department.

Simon Patterson Brown will give the following presentations:

Management of giant hiatus hernias

The incidence of giant hiatus hernias with intra-thoracic gastric volvulus is on the increase associated with patients living longer and better methods of detection. However the decision to operate remains difficult due to the increased age of the patients and their co-morbidity. This presentation will discuss indications for surgery, different surgical approaches and the controversial role of mesh repair.

Current standards for anti-reflux surgery

Laparoscopic anti-reflux surgery is now the standard treatment for symptomatic gastro-oesophageal disease refractory to medical therapy, although the best procedure remains controversial. This presentation will examine the current evidence for various techniques and their long-term success with regard to complications and control of reflux.

The role of Human Factors and non-technical skills in improving surgical outcomes

It is now well recognised that surgical excellence alone does not guarantee a good outcome and that Human factors play a major role in success or failure. Individual and team non-technical skills are as important as technical proficiency. This presentation will discuss the role of Human factors and non-technical skills in surgery and how team training can improve outcomes.

Complications of upper GI surgery

Major upper gastro-intestinal surgery for both benign and malignant conditions is associated with a significant potential morbidity and mortality. While the complication rate between hospitals is similar, it is those units that recognise problems early and thereby rescue patients that have the better results. This involves a high level of care, before surgery with regard to careful and accurate decision-making, good technical ability during surgery and close attention to detail and early recognition and intervention of post-operative problems. This presentation will focus on the key areas which make the difference between success and failure.

RACS Visitor Grant Program for Visitors in 2018

RICHARD PERRY
Chair, Fellowship Services

RACS is committed to excellence in surgical education and practice and recognises that Fellows within sub-specialties and other groups wish to enhance their annual scientific meetings by inviting visitors of note from Australia, New Zealand and internationally. RACS supports these initiatives through the RACS Visitor Grant Program.

Eligible groups are invited to apply for funding towards the cost of travel, accommodation and registration for the visiting speaker(s) to their 2018 annual scientific meetings. Applications are open to any recognised society or association of Surgeons.

Applications for meetings in 2018 open on 1 February 2017 and close on 20 March 2017.

For more information please see the website or contact Paul Cargill, Manager, Fellowship Services on +61 3 9276 7415.

John Buckingham Travelling Fellowship

2016 American College of Surgeons (ACS) Annual Congress - John Buckingham Travelling Fellowship Scholarship

RICHARD PERRY
Chair, Fellowship Services

DR CHRISTINE GOH
FRACS

As the successful recipient of John Buckingham Traveling Scholarship, I travelled to Washington DC to attend the American College of Surgeons (ACS) Annual Congress. As a current cardiothoracic Trainee, the travel was to promote international exchange of information concerning surgical science, practice, and education, as well as to establish friendships with my USA counterparts.

Dr Christine Goh (R) with delegates, 2016 ACS Annual Congress

It was my first time attending the ACS congress. No doubt it was a large calibre meeting. Despite this it was very well organised. I attended the Resident and Associate Society (RAS) focus meeting on the Sunday where all the residents came together to address current surgical training and practice issues. The committees of the RAS-ACS welcomed me, along with other international scholars.

On the first day of the meeting, I attended the presidential address as well as the John Gibbon Jr Lecture. John Gibbon was a cardiothoracic surgeon, who pioneered the cardiopulmonary bypass machine and established the first successful open heart surgery in an 18-year-old girl with an atrial septal defect in 1953. John Mayer, who was the past president of Society of Thoracic Surgery, delivered the prestigious lecture. Dr. Mayer described optimal self-regulation and explained the importance of recognising the dual roles surgeons play as healers of the sick and members of a profession. He also described the important mindset in surgical training. He emphasised Seattle Seahawks coach Pete Caroll's pyramid – to have a belief system, always compete, and that practice is everything. After such a grand first day, the rest of the meeting was packed with various interesting lectures.

Apart from the academic side of things, I attended a medical student night where the Trainees meet the medical students where they had the chance to learn first-hand information on surgical training. I was impressed with the emphasis on promoting surgical career among the students. I think this is something we could improve on and I would encourage such a program at our upcoming RACS meeting.

In summary I want to thank RACS for the opportunity to attend this meeting. It was not only academically enriching, but also an exceptional opportunity to meet international counterparts, from a social and educational point of view.

The late John Buckingham was a well-loved specialist breast cancer surgeon who pioneered the sentinel node mapping technique. He contributed significantly to BreastScreen Australia and was also highly regarded in the international arena. In recognition of his great love of teaching, the John Buckingham Travelling Scholarship has been established to encourage international exchange of information concerning surgical science, practice and education. It also aims to establish professional and academic collaborations and friendships amongst Trainees.

http://www.surgeons.org/member-services/scholarships-awards-lectures-prizes/research-and-travel-scholarships/john-buckingham-travelling-fellowship/

76th ASM for 80 year old AOA

RICHARD PERRY
Chair, Fellowship Services

DR ANDREAS LOEFLER
FRACS, AOA Past President

This year marks the 80th Birthday of the Australian Orthopaedic Association (AOA). Every five years the AOA has a combined meeting with our New Zealand colleagues. It was fortuitous, that we could celebrate our anniversary with our friends and fellow member of RACS.

The theme of the meeting: Ethics and Professionalism is one of the core competencies of RACS, of the new AOA 21 Training program, and indeed of the practice of medicine. The main plenary session took a good look at surgeons, like a 360 appraisal. We had an ethicist, a lawyer, a theatre manager, a trainee, and insurance advisor, and a medical educationalist speak on various aspects of what we do. It is important to articulate right and wrong, even if much of what we say is preaching to the converted. The session was well attended and caused much discussion, as it was meant to do.

AOA had two RACS sponsored visiting speakers at the ASM and is grateful for RACS support. Jan Verhaar is Professor and Chair of the Department of Orthopaedics at the Erasmus University Medical Centre in Rotterdam, the Netherlands. Jan is the current President of the European federation of Orthopaedics and Traumatology, or EFORT, of which AOA is an Associate Scientific member. Jan was one of the keynote speakers on Ethics and Professionalism and how our European colleagues tackle the challenges to practicing the right way. Professor Verhaar was also one of the key speakers at the EFORT Symposium on Shortening Length of Stay, which is a challenge to all in surgery.

The second RACS funded speaker was Dr Jason Frank, who is Director of Specialty education, Strategy and Standards at the Royal College of Physicians and Surgeons in Canada. Jason is well known to AOA. He is one of the architects of AOA 21, our new training program. Jason was another keynote speaker on how to teach Ethics and Professionalism. Jason also took part in several workshops and addressed the trainees at the registrar conference, held just before the ASM.

Robert Pozzi, an orthopaedic surgeon in Cairns, was the local convenor. Robert did an excellent job. Together with Alison Fallon, our conference organiser, both the scientific and social functions were perfect. And fortunately, our Vice President, Spencer Beasley, was able to bolster the numbers from New Zealand.

The meeting was in Cairns and attracted a total of 1295 registrants. Whilst this sounds fantastic, one has to remember that registrants include guests, industry and accompanying persons. It is quite common to show off with the total number, a bit like bragging with one's gross income, but the net is a little disappointing. We had 402 Australian and 57 New Zealand surgeons and a total of 72 Trainees from both countries. Still, it was a vibrant congress.

Cairns proved to be a great venue. The weather and the relaxed atmosphere added to the vigour of scientific discussion. We had eight guest speakers, nine international speakers, and 16 international presidents. On the occasion of our 80th Anniversary, AOA launched a new history book, a tie, and travelling road show of what we do in orthopaedics. Cairns allowed me to pass the jewel of office to my friend Ian Incoll, the current President of AOA.

Images: Dr Jason Frank and Professor Jan Verhaar

The Scientific Secretaries, Ian Harris from the AOA and Michael Barnes from the NZOA, put together a wonderful program covering all subspecialty interests in orthopaedics. One innovation was a plenary session on: *Three Most Important Recent Papers in my Specialty That Have Changed Orthopaedic Practice*. Not surprisingly, there was standing room only. It was a great success and will be repeated.

New Zealand Association of Plastic Surgeons Annual Scientific Meeting 2016

RICHARD PERRY
Chair, Fellowship Services

The New Zealand Association of Plastic Surgeons held its Annual Scientific Meeting 2016 in Queenstown in July and welcomed two international guest speakers: Paul Smith, Hand and Plastic Surgeon from the UK and New Zealand born Simon Talbot, Director, Upper Extremity Transplant Program, Harvard Medical School.

Dr Simon Talbot is an academic plastic surgeon from Boston, Massachusetts, with an attending appointment at Brigham and Women's Hospital (BWH). He is also an Assistant Professor of Surgery at Harvard Medical School (HMS).

Simon opened the event with a presentation on face and hand transplantation at BWH, and made another presentation on *The 2013 Boston Marathon bombings - Lessons Learned*. He also addressed delegates for a second day with a session on perineal reconstruction.

Dr Talbot's time is divided between clinical patient care, teaching, and research. His clinical focus is on hand and microsurgical reconstructive surgery, and he is also the Director of Upper Extremity Transplantation at BWH. As an educator he supervises up to 27 plastic surgical trainees annually, and is the director of the HMS plastic surgery clerkship. He is actively involved in numerous research projects including strategies to improve nerve regeneration in the extremities using bioengineering technologies; microsurgical device development; and outcomes research related to upper extremity transplantation. He is funded by both the National Institutes of Health and US Department of Defense.

Dr Talbot's attendance was supported by the Royal Australasian College of Surgeons Visitor Program Funding and NZAPS thanks RACS for its generous and continued support.

NZAPS was fortunate to have another overseas speaker at the ASM - Paul Smith

His main interests have centred around Dupuytren's contracture and congenital hand surgery. In the latter sphere he has treated over 200 radial club hands and undertaken over 140 pollicisations as well as looking after eight mirror hands.

Paul delivered two excellent presentations during the day on *Dupuytrens disease* and the *Revision of the Blauth Classification*.

Mr Smith's attendance was supported by the Manchester Trust and NZAPS thanks the Trust for its generous support.

The 2016 Annual Scientific meeting was the largest to date, with over 80 attendees from New Zealand and overseas. Members found it an excellent opportunity to meet with colleagues. Next year's meeting has been planned for the 4th to 6th August 2017 in Queenstown.

Developing a Career and Skills in Academic Surgery Course

Adelaide Convention Centre, South Australia, Australia
Monday 8 May 2017, 7:00am - 4:00pm

Keynote Speaker:
Professor Mary Hawn
Chair, Department of Surgery,
Stanford University, Palo Alto, California, USA

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

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

2016 comments:
"Equally as good as previous years. Very well structured"

"Brilliant opportunity to gain insight into academic surgery"

Association for Academic Surgery and international invited speakers:

Karl Bilimoria
Northwestern University, Illinois, USA

Ankush Gosain
Children's Foundation Research Institute, Tennessee, USA

Amir Ghaferi
University of Michigan, Michigan, USA

Eugene Kim
Children's Hospital Los Angeles, California, USA

Rebecca Sippel
University of Wisconsin, Wisconsin, USA

Tracy Wang
Medical College of Wisconsin, Wisconsin, USA

Australasian Faculty:
For the list of Australasian faculty, please visit www.tinyurl.com/DCAS2017

DCAS course participation
Cost: $220.00 per person incl. GST
Register online: www.tinyurl.com/DCAS2017
There are fifteen complimentary spaces available for interested medical students. Medical students should register their interest to attend by emailing dcas@surgeons.org.

Further information:
Conferences and Events Management
Royal Australasian College of Surgeons

T: +61 3 9249 1260
F: +61 3 9276 7431
E: dcas@surgeons.org

NOTE: New RACS Fellows presenting for convocation in 2017 will be required to marshal at 3:45pm for the Convocation Ceremony.

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

Information correct at time of printing, subject to change without notice.

General Surgery Trainees who attend the RACS Developing a Career and Skills in Academic Surgery course may, upon proof of attendance submitted to: board@generalsurgeons.com.au, count this course towards one of the four compulsory GSA Trainees' Days.

Provisional Program

6:45am	Registration Desk Open	
7:15am	Welcome	
7:20am	Introduction	Marc Gladman / Amir Ghaferi
7:30am - 9:30am	**Session 1: A Career in Academic Surgery**	**Chairs: Richard Hanney / Amir Ghaferi**
7:30am	What is an academic and why every surgeon can and should be one	John Windsor
7:50am	The research cycle	Marc Gladman
8:10am	Clinical research	Guy Maddern
8:30am	Education / simulation research	Rebecca Sippel
8:50am	Translational Research	Klaus-Martin Schulte
9:10am	Discussion	
9:30am	**Morning Tea**	
10:00am - 10:20am	**Hot Topic In Academic Surgery**	
10:00am	Introduction	Marc Gladman
10:02am	Challenges of Optimizing Surgical Training – The FIRST Trial	Karl Bilimoria
10:20am - 11:30am	**Session 2: Ensuring Academic Output**	**Chairs: Marc Gladman / Mary Hawn**
10:20am	Writing an abstract	Amir Ghaferi
10:40am	Writing and submitting a manuscript	Tracy Wang
11:00am	Presenting at a scientific meeting	Eugene Kim
11:20am	Discussion	
11:30am - 12:15pm	**Keynote**	
11:30am	Introduction	Amir Ghaferi
11:35am	The Art of Success: Learning from Failure	Mary Hawn
12:15pm	**Lunch**	
1:10pm - 2:40pm	**Session 3: Concurrent Academic Workshops**	
1:10pm - 2:40pm	**Workshop 1: Early Career Development**	**Chairs: Eugene Kim / Yishay Orr**
	What can I do as a:	
	Medical Student	Andrew MacCormick
	Junior Doctor	Peter Pockney
	SET Trainee	Julie Howle
	Fellow	Jonathan Karpelowsky
	Consultant	Sebastian King
1:10pm - 2:40pm	**Workshop 2: Higher degrees – which one?**	**Chairs: Karl Bilimoria / Christine Lai**
	The doctorate the ultimate higher degree?	Greg O Grady
	Masters by coursework	Cherry Koh
	Masters by research	Ian Bissett
	Overseas experience – when, what and why	Alexander Heriot
1:10pm - 2:40pm	**Workshop 3: Practicalities of Research**	**Chairs: Henry Pleass / Tracy Wang**
	Building a career pathway: opportunites, obstacles and getting past them	Ankush Gosain
	Assembling the team and establishing collaborations	Julian Smith
	Randomised clinical trials	Andrew Hill
	Funding opportunities	David Watson
2:40pm	**Afternoon Tea**	
3:00pm - 4:00pm	**Session 4: Sustainability in Academic Surgery**	**Chairs: James Lee / Rebecca Sippel**
3:00pm	Academic surgery in private practice	Henry Woo
3:20pm	TBC	TBC
3:40pm	Standing on the shoulders of giants	Glyn Jamieson
4:00pm	Discussion and close	Marc Gladman / Amir Ghaferi

Presented by:

AAS Association for Academic Surgery

Royal Australasian College of Surgeons
Section of Academic Surgery

Proudly sponsored by:

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MEDICAL DEVICES COMPANIES

The Annual Joint Academic Meetings

PROFESSOR ANDREW HILL
Chair, Surgical Research Society

PROFESSOR GUY MADDERN
Surgical Director of Research and Evaluation incorporating ASERNIP-S

The RACS November Academic Meetings were held in Melbourne on Thursday 10 to Friday 11 November. A highlight-filled two-day event, the meetings attracted interest from senior academic surgeons, surgical trainees, junior doctors and medical students.

The Section of Academic Surgery (SAS) meeting held on Thursday incorporated the Mid- Career Course, with presentations on the topic of *Leadership, Innovation and Academic Advancement*. The afternoon session focused on the principles of research from building a research team to the requirements for applying to key funding bodies. This well-received meeting targeted surgeons in the mid-to-late stage of their academic career and provided the attendees with thought-provoking discussions.

The Surgical Research Society (SRS) meeting held on the Friday was an opportunity for medical students, Trainees and junior Fellows to present their novel surgery-related research. The SRS meeting offers five awards for the most outstanding presentations.

Dr Joseph Kong was awarded the Young Investigator award for his presentation on *Developing an organoid immune assay for immunotherapy*. This prestigious award funds attendance at the Academic Surgical Congress in the United States, February 2018.

The Developing a Career and Skills in Academic Surgery (DCAS) Award funds travel, accommodation and registration to the DCAS course held in May prior to the RACS Annual Scientific Congress (ASC). Dr Su Kah Go was the recipient of this award for presenting *Donor-specific cell-free DNA as a non-invasive marker of organ rejection after liver transplantation: A pilot study*.

The Travel Grants, funding surgical research-related travel, were awarded to; Dr Bruce Su'a who presented *Peritoneal cytokine levels can predict anastomotic leakage on the first postoperative day; Dr Merran Holmes presented A potential modifier gene in familial adenomatous polyposis*; Miss Pikli Balabyal presented *Geospatial variability of breast cancer according to age - The Royal Prince Alfred experience* and Dr Andre Joshi presented *Patient derived metastatic prostate cancer deposits for the development of actionable personalised cell lines*.

Professor Andrew Hill presenting Dr Joseph Kong with the most prestigious Young Investigator Award

Attendees were also treated to presentations by two prestigious international guest speakers; Dr David Hackam, from Johns Hopkins Children's Centre, who discussed a surgical journey of necrotizing enterocolitis in premature infants and Dr Daniel Abbot, from the University of Wisconsin who presented his research on the hospital resource characteristics associated with improved surgical performance. Our international guests were awarded a RACS plaque to thank them for their considerable contribution to the meetings. Professor Andrew Hill also received one for the Jepson Lecture on *Mentoring through research*.

The evaluation forms from the meetings suggested the registrants found the two-day meeting valuable and inspiring. The 2017 Annual Joint Academic meetings will be held in Adelaide on 9-10 November. We look forward to another successful meeting. If you would like any information on this meeting please contact **academic.surgery@surgeons.org**

Well orchestrated medical musicans

The halls of the University of Tasmania's School of Medicine hummed with the strains of Brahms and Rachmaninoff in October thanks to a group of musical students and staff who have created the state's first medical orchestra.

The Tasmanian Medical Orchestra (TMO) was established in 2014 as the first ensemble open to staff and students of the University of Tasmania's Schools of Medicine, Paramedicine, Pharmacy, Nursing and Medical Research along with staff from the Royal Hobart Hospital.

Dr Mary Self, a General Surgeon and an accomplished violist, brought together interested musicians with the assistance of students Corrine Teh and Jeremy Yang. It now comprises 25 players and includes string, brass, reed and wind sections with piano accompaniment when required.

Dr Self began her surgical training in Queensland before moving to Tasmania where she received her Fellowship before completing a Breast Cancer Surgical Fellowship at Westmead Hospital in Sydney. She then travelled to Ireland to take up a lectureship at University College Dublin and a Breast Surgery placement.

Since then she has completed a Masters in Applied Ethics and is a member of the Tasmanian Committee of RACS and Chair of the RACS Critical Literature Evaluation and Research (CLEAR) course committee.

Currently she works out of the Royal Hobart Hospital and is a senior lecturer in the School of Medicine at UTAS.

A keen musician, Dr Self plays with the Australian Doctor's Orchestra, the Hobart Chamber Orchestra and the Derwent Symphony Orchestra and is a member of a number of informal chamber music ensembles.

She said the idea for the orchestra arose after she received support from the then Head of the School of Medicine and after encouraging some musical students to participate who, in turn, contacted others..

"In early 2014 we got a small group to play in the foyer for Orientation Day to raise awareness and attract newcomers and slowly we have grown from an original group of 15," Dr Self said.

"There were a number of students who hadn't had the opportunity to play their instruments since they left secondary school and they were enthusiastic about polishing their skills again and performing together because there is something wonderful about playing music with other people.

"There were also quite a few parents who were very pleased to see their children pull out their instruments from the top cupboard and give them a dust and a tune up after forking out the money to buy them and for tuition."

From that early beginning, the TMO has now performed at a number of University functions, including award and appreciation ceremonies, a concert at the main Medical School lecture hall and cocktail receptions.

The first conductor for the TMO was esteemed French Horn player Greg Stephens who is a member of the Tasmanian Symphony Orchestra and a teacher at the Tasmanian Conservatorium of Music.

Dr Self said the TMO was thrilled to have such professional support, given that Mr Stephens has conducted the Tasmanian, Adelaide, Queensland and Melbourne Symphony Orchestras and the Auckland Philharmonia Orchestra.

"We were very fortunate to have Greg Stephens as our inaugural conductor for the first two years and he helped get us off the ground," she said.

"He helped give us confidence, given that many people hadn't played their instruments for some time, and when we first began to play in public we were very low key but Greg was patient and supportive and helped us improve substantially."

Recently becoming a father, Mr Stephens has handed the baton to new conductor Melfred Lijauco also from the Tasmanian Conservatorium of Music.

Dr Self said that while a number of UTAS staff members had been in the original group, the students had now taken ownership and that she and another lecturer continued to play with the orchestra to act in a liaison role between faculty and students.

She said the TMO performance in October will feature the slow movement of Brahms Third Symphony and a Hungarian Dance, Vocalise by Rachmaninoff and a medley from the film *Pirates of the Caribbean*.

Dr Self said she believed Tasmania was the last Australian state to have its own medical orchestra and praised the students for their skills and dedication.

Since the TMO has formed, two students have played with the Australian Doctors Orchestra and two others played in the inaugural Australian Medical Students' Orchestra performance, held in Melbourne in July.

"This has been a satisfying project to be part of because it's not only wonderful to play beautiful music it's lovely to hear people say how much they enjoy playing in a group setting and getting to know other people," Dr Self said.

"It is commonly known that many medical students have a strong interest in music and I believe providing an opportunity to play helps them shift their minds away from study so that hopefully they come back to their work refreshed and invigorated.

"I also think playing and practising music can be a form of mindfulness while performing can deliver a great sense of personal and communal fulfilment."

With Karen Murphy

Images (Clockwise from top-left): Corinne Teh and Callum Jarvis (medical students), Violinists absorbed in the music, Rehearsing with Greg Stephens conducting

Young doctors reap benefits from skills workshop

DR PHILIP CHIA
Surgical Trainee

The Australian Capital Territory continues to grow as a surgical education hub with the local RACS Committee initiating a surgical skills workshop that it hopes to run on a biannual basis.

The first pilot held in September 2016 gave junior doctors and Trainees the opportunity to practice surgical skills including suturing, knot tying, laparoscopic skills and vascular and bowel anastomosis.

The workshop's curriculum also included a session on informed consent and was developed with input from RACS ACT Chair Sivakumar Gananadha, younger Fellow Ram Ganesalingam, myself, JDocs program manager Jacky Heath and ACT Regional Manager Amy Kimber.

We were lucky enough to have eight consultants give up their time on a Saturday to teach the group. This allowed us to run the workshop at no cost to participants, and provided a relaxed learning environment.

The day was split into introductory and advanced streams to cater for varying levels of experience and was able to accommodate 25 junior doctors and general surgical Trainees.

Feedback from the day indicated participants thought it was an excellent opportunity to practice their skills and that more regular workshops would be beneficial. The benefits of the day were also recognised by the local obstetrician and gynaecologists who attended the session and have adapted the curriculum for O&G Trainees.

We plan to run our second workshop in March and will extend the informed consent session as a separate module before the workshop as we've recognised this as a vital area of junior registrars' early training. We hope the program will continue to improve and in time hopefully involve other craft groups.

We are happy to share our teaching model with other training hubs if there is interest running a similar training session in other locations.

Images (From top): RACS Pre-Vocational & Online Education Manager Jacky Heath (L) and ACT junior doctors practice their laparoscopic skills; Practicing hand sewn bowel anastomoses

RACS Respect Resonates Across 2016

14 RACS Respect agreements signed last year and more in the pipeline for 2017

In 2016 RACS was congratulated for its leadership on the very important issue of discrimination, bullying and sexual harassment (DBSH) in the practice of surgery and the milestones it had achieved around building respect and improving patient safety.

Throughout the course of the year RACS signed eight memorandums of understanding, four letters or statements of Intent and two letters of agreement on the subject of operating with respect. Five of those occurred in the last two months of 2016.

On 24 November 2016 RACS signed agreements (pictured below) with Nelson Marlborough Health and the New Zealand Private Hospitals Association, agreeing to work together to ensure that surgical supervisors have the necessary skills and attributes and are supported to provide training, assessment, feedback and support to Trainees and International Medical Graduates free of DBSH.

RACS Vice-President Professor Spencer Beasley said that bullying had been a real problem for the surgical profession, as it had been across the health sector, but now was the time to build a culture of respect and improve patient safety.

"We know that if we can improve the culture of medicine, and surgery in particular, we can expect better patient outcomes. This is a powerful reason why we wish to work together with this initiative," Prof Beasley said.

Back in Australia a few days earlier a Statement of Intent aimed at building respect and improving patient safety in surgery was signed between RACS and Royal Brisbane Women's Hospital (RBWH).

The agreement, a collaboration under the RACS 2015 Action Plan: Building Respect, Improving Patient Safety, committed both organisations to a shared vision to provide high quality training, education and experience in the practice of surgery.

President Phill Truskett said that RACS and RBWH were firm believers in the rights of all healthcare professionals to a safe training and work environment where they can realise their full potential.

On Wednesday 14 December a Memorandum of Understanding (MoU) was signed with the Murrumbidgee Local Health District (MLHD) in Wagga Wagga (pictured below) with MLHD saying that the agreement would strengthen the hospital's initiatives to improve patient safety and overall workplace culture.

The following day the Australian and New Zealand College of Anaesthetists (ANZCA) signed a Letter of Agreement (pictured below) with RACS confirming a collaborative approach toward building respect in the medical workplace and DBSH.

RACS President Philip Truskett said research had shown that bad behaviour had a negative impact on the whole team and not just the people at which it was directed. He said that this agreement was an important step towards improving patient safety and work environments.

Discrimination, bullying and sexual harassment are serious problems in our profession and our commitment to addressing them is detailed in our Action Plan: Building Respect, Improving Patient Safety, which is also published on the RACS website.

We have a large program of work in place to support cultural change and leadership, strengthen surgical education and improve complaints management and this will continue strongly in 2017. The mandatory participation of fellows in core education programs is a cornerstone of this work.

Memorandums of Understanding

1. Monash Health (VIC)
2. St Vincent's Health Australia
3. Metro South Health (Qld)
4. Ramsay Health Care (does not include sharing re complaints)
5. Gold Coast Health
6. Nelson-Marlborough DHB (NZ)
7. Murrumbidgee LHD (NSW)
8. NZ Private Surgical Hospitals Association

Letter or Statement of Intent

1. University of Otago Medical School
2. Queensland Health
3. NSW Health (statement of agreed principles – including w/other colleges)
4. Royal Brisbane & Women's Hospital

Letter of Agreement

1. RANZCOG
2. ANZCA

Dear Doctor

On the 28th July 2016 I signed a Memorandum of Understanding (MOU) with the Royal Australasian College of Surgeons on behalf of Metro South Hospital and Health Service and with the support of our surgical leaders across the Service. The MOU is a commitment from the Health Service and RACS to implement the action plan, '*Building Respect, Improving Patient Safety*'. We're working closely with RACS, through our MOU. This gives us a platform to share ideas, education and training. I would like to encourage your involvement through the following.

- Do the RACS e-learning module *Operating with respect* on discrimination, bullying and sexual harassment
- Do the Foundation Skills for Surgical educators(FSSE) course, offered on 7 October at Logan Hospital and other sites available at the RACS website, to strengthen your skills as an educator
- Become Faculty for the FSSE, to help provide the training to your peers and colleagues
- Be a local face of our '*Let's Operate with respect*' campaign – we are profiling our own surgeons to be in posters around our health services (contact Emma Morton, Digital Manager Metro South Health on 3156 4904)
- Use the cobranded Metro South/*Let's operate with respect* email signature block on your work email (access the logo and instructions from the intranet)
- Use the cobranded logo and presentation template (accessible on the intranet) in your presentations about surgery, especially in surgical grand rounds
- Call it out if you see unacceptable behaviours (the e-learning module suggests ways you can do this)
- Think about the link between respectful teams and improved patient outcomes
- Tell us what you've done to help build respect and improve patient safety in surgery – contact Emma Morton as above so we can share stories
- Tell us what else we can do – we want to hear good ideas that will raise awareness of these issues and help build a safe and respectful culture at Metro South.
- Reflect on your own behaviour

We are committed to solving this problem and supporting all members of our workforce and I encourage you to join us.

Yours sincerely,

Dr Susan O'Dwyer
Executive Director Medical Services
Metro South Health

Queensland Government | Metro South Health | RACS LET'S OPERATE WITH RESPECT

Talking about Transformation

From the 2016 Pacific Region Indigenous Doctors Congress

RICHARD LANDER
Executive Director for Surgical Affairs (NZ)

The 8th biennial Pacific Region Indigenous Doctors Congress (PRIDoC) was held between 27 November and 1 December 2016 in Auckland, New Zealand. The delegation consisted of a range of clinicians, researchers and educators from across the Pacific – including representatives from Australia, New Zealand, Canada, Taiwan and Hawaii.

The congress, *Talking about Transformation*, provided a space for Indigenous doctors, medical students, health professionals, health researchers and medical educators to share and discuss the ideas, actions and evidence that are transforming Indigenous health in the Pacific region. The diverse range of attendees were representative of a broad scope of personal, medical and academic discourse, with each national delegation bringing their own stories and perspectives on the health of their own Indigenous people.

Over the four days of the congress, keynotes and sessions focused on exploring the collective shared experiences of Indigenous peoples across the globe, research and best practice in medical education and Trainee support, and how to affect real change in individual practice and the healthcare system.

Although PRIDoC included delegates from a diverse range of Indigenous cultures and healthcare systems, some clear themes emerged over of the course of the week. The most predominant theme was the on-going challenge posed by institutional and personal racism (sometimes euphemistically referred to as 'unconscious bias') within health systems across all countries. The subsequent impact that discrimination has on Indigenous identity, confidence and progress within the health profession was also described in detail and strategies to address this proposed.

The importance of building culturally safe workplaces and education providers, and for health services to consider designing models of care outside the mainstream was consistently emphasised across the sessions. Crucially, it was also acknowledged that transformation in the health sector required leadership not just from Indigenous champions, but from non-Indigenous too.

The busy conference programme included keynote addresses from an outstanding line-up of speakers. These presenters included the Hon. Dame Tariana Turia, former Member of New Zealand's Parliament and Co-Leader of the Māori Party; Dr Camara Jones, the Immediate Past President of the American Public Health Association; Moana Jackson, renowned Māori lawyer and Director of the Māori Legal Service; and Professor Linda Tuhiwai Smith, Pro Vice-Chancellor Māori at the University of Waikato.

The social calendar for PRIDoC was also a highlight of the week, with the Cultural Evening providing an opportunity for each nation's contingent to share their indigenous songs and dance with attendees. Each group's performance was exceptional, but it was hard to ignore the haka performed by the 100 strong Māori delegates. PRIDoC was also capped off with the superb Conference Dinner, held on the top floor of the Auckland War Memorial Museum which boasts stunning 360 degree views of the Auckland skyline. Both evenings provided a valuable opportunity to strengthen existing partnerships and make new friendships.

As Gold sponsors of the event RACS had a strong presence, with four staff members on site for the whole congress, including the Executive Director for Surgical Affairs (New Zealand) Richard Lander. Members of the College's Māori Health Steering Group, as well as the Chair of the New Zealand National Board, were also able to attend parts of the event, including the RACS sponsored lunch. This presence provided many valuable opportunities for indigenous medical students and junior doctors to connect with Fellows and discuss the challenges, rewards, and pathways toward a career in surgery.

> *"Transformation in the health sector requires leadership not just from indigenous champions, but from non-indigenous too."*

During the scheduled breaks between presentations, the RACS booth was frequented by high foot traffic and was the subject of considerable interest amongst many delegates. Alongside material promoting SET selection, JDOCs, and Indigenous Scholarships, the mobile laparoscopy trainer proved a very popular attraction to those wanting to test their coordination and try their hand at some basic laparoscopic skills. As well as attracting curious on-lookers to the booth, the trainer served as an effective icebreaker and prompted many further lines of enquiry into surgery as a career.

The Congress was a key learning and networking event for all attendees working towards the development and refinement of Indigenous healthcare strategies. The Congress themes reinforced the important work that RACS is undertaking in its Indigenous Health Action Plans, Reconciliation Action Plan and *Operate with Respect* campaign. The congress also served as a reminder that there is still a tremendous amount of work ahead.

Images (From far-left): EDSA NZ Richard Lander and the recipient of a surgical skills kit; Keynote address from the Hon Dame Tariana Turia; Prospective surgeons try their hand at the mobile laparoscopy machine

NZ specialists still fighting to improve health care in Vietnam

Despite recently losing their NZAid funding, a small group of NZ surgeons and specialists have continued to provide assistance to colleagues in Vietnam in honour of the bond forged in the tumult of the now largely-discredited Vietnam War.

The New Zealand Civilian Surgical Team and the New Zealand Services Medical Team, based in the Binh Dinh province of central Vietnam from 1963 to 1975, distinguished themselves from other international medical units by their willingness to treat everyone in need – including sick and injured citizens and soldiers on both sides of the conflict.

That equity, justice and care created such lasting trust and friendship that when international relations resumed in 1990 – after years of Vietnam being isolated by the world – a small group of New Zealand doctors returned to the region to find a population desperate for health care, equipment and training.

Dr Viet with the visiting team at the Rehabilitation Hospital

Upon their return home, they set up the NZ Vietnam Health Trust which, for the past two decades has funded educational visits by NZ specialist teams to the province as well as return educational visits to NZ by Vietnamese surgeons.

In particular, the Trust works with surgeons and specialists in the regional cities of Quy Nhon and Bong Son providing Orthopaedic and Paediatric programmes at the Binh Dinh General Hospital, Rehabilitation Hospital and at the Quy Hoa National Leprosy Dermatology Hospital.

Over the course of their collaboration, visiting NZ surgeons have witnessed great advances in the health services provided. Major hospitals have either been redeveloped or newly built, modern equipment has become accessible, training has greatly improved and surgery has progressed from basic to advanced procedures.

Some of those advances have been enhanced through the support provided by the NZ surgeons, anaesthetists, specialists and specialist nurses who helped their Vietnamese colleagues to design modern, efficient surgical suites, ICU bays, out-patient clinics and in-patient wards.

Mr John Dunbar from Dunedin, an Orthopaedic surgeon with a Paediatric subspecialty, is one of a group of NZ Orthopaedic Surgeons – that includes Mr Allan Panting and Mr Simon McMahon and General Surgeon Mr David Morris - to visit the province frequently over the past 20 years.

His last visit was in June 2016 when he spent two weeks at the Rehabilitation Hospital, a facility dedicated to orthopaedic medicine which performs up to 50 orthopaedic surgeries per week.

He said the NZ group of Fellows helped train local surgeons in advanced orthopaedic procedures while also helping them manage a number of paediatric orthopaedic conditions including muscle contractures, burns injuries and the effects of cerebral palsy.

He also said that surgeons in Vietnam continued to see a disproportionate number of children suffering congenital deformities such as missing parts of limbs believed to be caused by the lingering effects of Agent Orange, mal-union or non-union of bones after fracture and congenital dislocation of the hip.

Mr Dunbar said that the Trust had also sponsored nine surgeons to visit NZ in recent years including the Director of the Rehabilitation Hospital, Dr Phan Canh Cuong, who wanted to see how modern hospitals were designed and managed.

Through the work of the Trust, which is now largely self-funded by the surgeons and specialists, there is a now little piece of New Zealand in a province of Vietnam.

"Dr Cuong wanted to see how our hospitals operated, the layout of the wards, theatres, laboratories and out-patient clinics while his hospital was in the process of being rebuilt," Mr Dunbar said.

"Now, I feel quite at home when I visit because the operating theatres there have been roughly designed on the layout of the Nelson Hospital.

"These visits by Vietnamese surgeons to NZ were designed to show the local guys the direction they could go in, what's possible and what's necessary to provide the best possible care, not just for surgical patients but for paediatric patients and those undergoing physiotherapy.


Ward round at Quy Hoa Hospital, Qui Nhon


Operation in progress at Rehabilitation Hospital. Anything new creates interest!

"Some of the new guys coming through in Vietnam are very skilled and very good at arthroscopic work but the main issue relating to surgical skills there is that they are so variable.

"In NZ and Australia, all surgeons must attain certain standards to become a Fellow of the College and then maintain those standards to retain Fellowship yet there is no such system or oversight there.

"They also don't travel much and most don't speak English well enough to travel without an interpreter which is also why they appreciate the chance to spend time here and learn from us when we are there."

> *"Through the work of the Trust, which is now largely self-funded by the surgeons and specialists, there is a now little piece of New Zealand in a province of Vietnam."*

Mr Dunbar, who is learning Vietnamese, said that in the absence of Government funding, surgeons and specialists were self-funding their trips but that the Trust was now in the process of seeking contributions from the central Vietnamese Government given the country's continuing economic development.

He said the Trust had also sought to raise funds from private and corporate sponsors to fund a visit to NZ by Vietnamese physiotherapists while it was also keen to help Vietnam build its trauma services.

"It was disappointing to lose NZAid funding but the historical connection meant that we didn't want to walk away and now the work of the Trust depends on the enthusiasm of the people behind it," Mr Dunbar said.

"There is a need for the program to continue because although Vietnam is rapidly advancing, every time we go there we see things that could be improved, particularly outside the major centres where health care and trauma care is pretty rudimentary.

"If we had the funds, we could concentrate on helping our colleagues design adequate trauma systems because they really want some formal training and we would love some of the younger NZ Fellows to go there and run trauma courses."

Speaking to *Surgical News*, Dr Cuong, the Director of the Rehabilitation Hospital, said local surgeons had benefited significantly from the relationships developed with NZ surgeons.

He said the Vietnamese surgeons who had spent time in NZ had become more confident and capable in performing orthopaedic surgeries on paediatric patients, knee arthroscopic surgeries, knee joint arthroplasty, hip hemiarthroplasty and ACL and PCL reconstructions.

Such is his enthusiasm for the work done by the Trust, Dr Cuong said he would even like to see junior doctors from NZ complete their orthopaedic electives at the Rehabilitation Hospital and he thanked the NZ surgeons, specialists, physiotherapists, anaesthetists and nurses for the assistance provided.

"NZ specialists still have a lot more to (offer) us in our development in both managerial and technical skills such as open shoulder and arthroscopic surgeries, rheumatoid arthritis and osteoarthritis management and treatment, total hip replacement and ankle surgeries and in the treatment of traumatic spinal injuries," Dr Cuong said.

"We would also appreciate further training for our local anaesthetists and physiotherapists and to have NZ specialists run seminars and conferences in both Quy Nhon and NZ which we could attend."

The Chairman of the NZ Vietnam Health Trust, Paediatrician Dr Johan Morreau, said that since the Trust was established, it had funded visits by multiple different specialty groups including Neonatal, Obstetric, Orthopaedic, Ophthalmology, Anaesthetic, Laboratory and General Surgery teams and others.

He said that while key health indicators such as infant mortality had improved in line with economic development and that a number of countries still visited Vietnam to provide specialist services, few provide the much-needed training and mentorship provided by the NZ medical teams.

He said that every visit to Vietnam by NZ team members was based around a busy schedule of training through Grand Rounds, lectures, surgeries and workshops as well as "by-the-bedside" discussions.

"Our attention to safety, infection control, care protocols and communication with families can be a real eye opener to our very capable Vietnamese colleagues who then develop and progress their own approaches," Dr Morreau said.


Visiting team at Rehabilitation Hospital (left to right): Ms Jane Dickison, Physiotherapist; Mr Simon McMahon, Orthopaedic Surgeon; Dr Vo Van Viet, Vice Director and Orthopaedic Surgeon; Mr John Dunbar, Orthopaedic Surgeon.

"We have also contributed significantly to workforce planning and new hospital building plans to achieve the best possible care arrangements adapted to local circumstance."

"If we had the funds we could quadruple the educational work of the NZ Vietnam Health Trust in Binh Dinh. We have the systems, the relationships, the support of the central government and we have the specialists willing to go."

For more information or to donate please visit nzvnhealth.org

With Karen Murphy

Hard work pays off with funding win for ATR

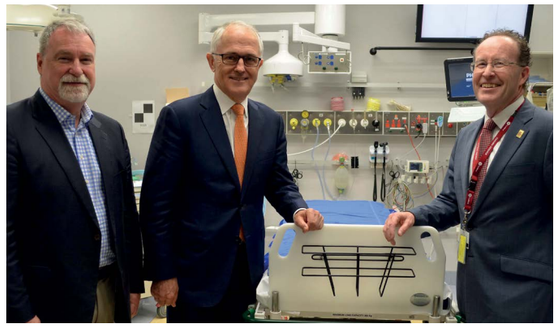
After years spent searching for funds, establishing integrated data sets, liaising with Federal and State health agencies and lobbying for support, Australian trauma experts have finally won dedicated Federal Government funding for the Australian Trauma Registry (ATR).

In December last year, Prime Minister Malcolm Turnbull visited the Alfred Hospital in Melbourne – accompanied by both the Federal Health Minister and the Minister for Infrastructure and Transport – to announce a $450,000 grant to support the registry over the next three years.

This funding will complement total in-kind contributions of $1.85 million from the 27 designated trauma centres across Australia along with a $50,000 grant from the Alfred Foundation and bio-statistical support from Monash University's Department of Epidemiology and Preventative Medicine.

The Royal Australasian College of Surgeons welcomed the news with great pleasure given that the ATR was initiated more than 15 years ago under the leadership of Queensland Surgeon Associate Professor Cliff Pollard through a joint endeavour by the RACS Trauma Committee and the University of Queensland (UQ).

During the past year, RACS worked closely with the National Trauma Research Institute and the Bureau of Infrastructure, Transport and Regional Economics to develop a statistical framework for the ATR.



Prof Andrew Way, Chief Executive of Alfred Health, Prime Minister Malcolm Turnbull and The Alfred's Director of Trauma Services and the National Trauma Research Institute, Prof Mark Fitzgerald. Images courtesy of The Alfred Hospital

Trauma surgeons and specialists also addressed the Road Safety Senate Committee hearings in May last year to urge the case for dedicated Federal support for the ATR which eventually became the top funding priority identified by the committee.

While the ATR will track all major injuries in Australia – including road trauma, major falls, interpersonal violence, gunshot wounds and stabbings – it is expected to have significant impact on understanding and reducing the harm caused by road accidents.

For every fatality in Australia, there are 27 hospital admissions and 10 survivors with lifelong injury resulting from road trauma with costs estimated to be around $27 billion each year.

The new funding will pay for the employment of a dedicated analyst and administrative staff which will allow the ATR to build capacity not only in identifying accident trends and trouble spots but increase quality assurance by allowing trauma centres to compare patient treatment plans and outcomes.

The new funding will also allow the ATR to be used to create timely reports to Federal and state governments and other stake-holders as a resource in the formulation of national health policy.

The registry, which has operated for the past two years through funding from the National Critical Care and Trauma Response Centre in Darwin, is currently co-ordinated by the National Trauma Research Institute.

Currently the ATR:

- Collects relevant information on patients with an Injury Severity Score greater than 12 across the full spectrum of traumatic injury;
- Identifies sub-groups of patients and areas of trauma care that may need greater attention and support;
- Provides a more detailed picture of the variability in trauma care across the country;
- Identifies centres of excellence which can then share their systems and protocols with other hospitals;
- Develops and validates measures of trauma performance to improve efficiency.

The Chair of the RACS Trauma Committee, Sydney vascular and trauma surgeon Dr John Crozier, praised the Federal Government's commitment to fund the ATR, describing it as a significant step towards injury prevention and trauma system quality improvement across Australia.

Dr Crozier said that in Australia the bulk of trauma comprised blunt injuries, with 50 per cent caused by road injury accidents and 40 per cent caused by falls, work related injury and interpersonal violence, while stabbing and gunshot wounds do not exceed ten per cent.

He said the greatest benefits of an enhanced registry included the ability to provide stakeholders with almost "real-time" whole-of-Australia injury statistics, including detailed analyses of the causes of injury, location of accidents, types of injuries sustained and patient outcomes including mortality, morbidity and in-hospital recovery rates.

A further critical additional benefit will be from the linkage of the "geoplot" of the incident to the subsequent injury dataset, information which will help support injury prevention efforts and improve trauma outcomes.

Dr Crozier also said that the enhanced ATR will become a vital tool in assessing the quality of care provided by trauma centres across the country while providing stake-holders with the data and analysis to underpin the formulation of evidence-based public health policy.

"Having the ATR adequately funded will provide a snapshot of trauma on a national level close to real time, in contrast to most current data analysis and publication which is, on average, five years post-event," he said.

"Currently, in Australia 1400 deaths and more than 32,500 serious injuries from road crashes occur each year. With our current methods of data acquisition and analysis, we can't identify effects of policy or system changes - including reduced speed limits or road improvements – until years after they are implemented.

"In most states in Australia there has been a significant uptick in road crash deaths in the last six months.

"Enhanced ATR data, with more timely data entry and analysis, will facilitate accelerated Safe System policy development and implementation to help curb this national annual tragedy."

Dr Crozier particularly acknowledged Associate Professor Cliff Pollard for his tenacity and endurance in designing and promoting the Australian national trauma registry.

He said that Professor Mark Fitzgerald, the current Director of the National Trauma Research Institute, Ms Kate Curtis, Co-Director of the ATR, Mr Nathan Farrow and Mr Meng Tuck Mok had all been pivotal in establishing the ATR.

He also praised the efforts of Professor Russell Gruen, inaugural Director of the ATR, for his unstinting efforts to build co-operation and establish matching protocols and data sets between all 27 trauma centres around Australia.

Professor Daryl Wall, Professor Danny Cass and Associate Professor Peter Danne, former Chairs of the RACS Trauma Committee, and the recently deceased Dr Damian McMahon, also played vital leadership roles in stewarding the ATR.

Professor Cass and Mr Garry Grossbard had alerted a Senate Committee into Aspects of Road Safety about the utility of the ATR while Dr Ailene Fitzgerald advocated for the ATR in subsequent hearings in the ACT Parliament House last year.

Dr Crozier said that while it had taken years to produce the first fully integrated Trauma Registry in 2014, the Federal funding would help ensure its longevity and usefulness.

"Two years ago we didn't think there would be any government funding," he said.

"This Federal contribution of $450,000 will therefore be of great benefit. The fact that the PM personally announced this funding, while present in the Alfred Hospital late last year, accompanied by the Minister for Health and the Minister for Infrastructure and Transport, represents very significant support for this endeavour.

"Now it is up to all the stakeholders involved in trauma medicine to support the ATR so that we can use this information to develop timely, detailed reports that can be readily accessed by state and federal government agencies so that it becomes a vital resource in the development of injury reduction and trauma system quality improvement policy."

Now retired from surgery, Associate Professor Cliff Pollard chaired a sub-committee of the RACS Trauma Committee in the late 1990s tasked with developing a national trauma registry.

That work evolved into the creation of the National Trauma Registry Consortium – a collaborative initiative of the RACS, the Centre of National Research on Disability and Rehabilitation Medicine (CONROD) at UQ, the Australasian Trauma Society and the NSW Institute of Trauma and Injury Management - which produced its first report in 2002.

After so many years working with colleagues in trauma medicine to secure funding for the registry – particularly Professor Nicholas Bellamy, the then Director of CONROD - Associate Professor Pollard expressed great satisfaction with the Federal Government funding.

"We tried for years to secure funding for this from health organisations, insurers and state and federal agencies with surgeons, physicians and anaesthetists travelling the country asking people for support without much luck so this funding is a testament to the hard work of many, many people," Associate Professor Pollard said.

"We now have tremendous technological capabilities compared to those available when I began working on this - even to the point where we can provide GPS data on accident hotspots – which will allow health authorities to better understand issues of prevention, quality of trauma care and the full economic costs of traumatic injury in Australia.

"This funding will allow the ATR to become a resource to help drive public health and safety policy and quality assurance and I believe lives will be saved because of this work within years."

- With Karen Murphy

Other recent highlights from the Trauma Committee include …

- **July 2016 Launch of the TAC humanoid 'Graham'** created a media storm - http://www.meetgraham.com.au/ 'Graham' is specifically designed to withstand road trauma.
- **September 2016 - Australasian College of Road Safety Conference ACT** – RACS hosted session 'The Real Cost of Trauma' including P.A.R.T.Y. (Prevent Alcohol and Risk-Related Trauma in Youth), dangers of quad bikes, driver distraction and the Australian Trauma Registry.
- **November 2106 - Combined Queensland ASM/ Trauma Registries symposium** – a great success - the theme "Trauma – we're all engaged" hit the spot with partnerships forged and links created.
- **21 November 2016 - Cessation of NT Open Speeds** – great work from NT team surgical and advocacy team.
- **National Road Safety Partnership Program (NRSPP)** a continuing important partnership which included RACS support on videos about driver distraction and safe use of mobiles in vehicles.
- **Trauma Verification 'Benchmarking Trauma Care'** - The Australasian Trauma Verification Program has gone from strength to strength. Trauma Verification is becoming recognised as an essential tool for trauma centres in the improvement of care of the injured.
- **Trauma Advocacy Plan** – was prepared to prioritise and focus on trauma advocacy issues
  - Promote trauma as a significant public health issue
  - Improve trauma care and resourcing
  - Improve road safety
  - Reduce alcohol-related harm
  - Prevention of falls in the elderly
  - Reduce death and disability from quad bike accidents
  - Support firearm safety standards
  - Ongoing funding for the P.A.R.T.Y. programs
- **Save the Date 2017 RACS Trauma Week**
  - 15 November: Trauma workshop 'Trauma Verification – its role in improving patient care'.

ARTICLE OF INTEREST

Breast surgery in Australia and New Zealand

The Breast QualityAudit and the history of Specialist Breast Surgical Practice in Australia and New Zealand

MR JAMES KOLLIAS
FRACS
Founding President of BreastSurgANZ

Historically, a general surgery Fellowship awarded by the Royal Australasian College of Surgeons (RACS) was sufficient for a surgeon to perform breast cancer surgery. Some surgeons undertook variable and unregulated post-fellowship training towards breast subspecialisation but this was by no means uniform. There were very few designated Fellowships in breast surgery in Australia and New Zealand. Some surgeons sought post-fellowship breast surgical experience overseas, preferably in international centres of excellence. It was the discretionary viewpoint of individual surgeons and hospital credentialing committees/employers to ensure that the skill set required for breast surgical practice were obtained.

For many years, the Breast Section of the Royal Australasian College of Surgeons acted as the 'voice' for breast surgical practice. The Breast Section managed enquiries made to the College in relation to standards of care and for the credentialing of breast surgical practice. The RACS Breast Section comprised surgeons representing all Australian states and territories and a New Zealand representative with the principal aim of developing an educational program for the Annual Scientific Congress of the College. Representatives would be selected for working parties conducted by Cancer Australia (previously the National Breast and Ovarian Cancer Centre) to provide information to professionals and consumers about best current clinical practice in breast disease. Breast surgeons representing the RACS Breast Section were also involved in important clinical and research activities with the Clinical Oncology Society of Australia (COSA) and the ANZ Breast Cancer Trials Group.

The History of the Breast Quality Audit

The need for a national audit of breast cancer surgery was outlined in 1995 by the House of Representatives Standing Committee on Community Affairs. It was recommended that the Royal Australasian College of Surgeons establish a compulsory form of accreditation and audit of general surgeons performing breast cancer surgery. This coincided with the inaugural audit activities of BreastScreen Australia. In 1998, a one-year pilot study using a trial dataset initiated in South Australia and Tasmania through the RACS Breast Section was performed in collaboration with the National Breast and Ovarian Cancer Centre. The main objectives at the time were to create a standardised and centralised breast cancer database of surgical activity in Australia and New Zealand, to collate data for research purposes, and to allow surgeons to compare their own surgical practices with those of their peers.

Over the following years, changes were made to the dataset and a governance structure was developed to include a multidisciplinary steering committee. Funding was obtained from various sources. Qualified privilege was awarded by the Federal government, acknowledging the Breast Quality Audit (BQA) as a quality assurance activity in connection with the provision of health services to protect information from disclosure and to protect surgeons involved in the activity from civil liability. A secure online data entry system was established for data collection, which allowed surgeons to view their individual practice summaries and compare their results for certain clinical criteria with national figures.

The BQA, managed by Asernip-S, accepted voluntary data submissions by breast surgeons, capturing approximately 70 per cent of all breast cancers treated in Australia and New Zealand. The BQA is currently the largest repository of breast cancer data in the southern hemisphere, having captured over 150,000 breast cancer episodes since its inception.

Other benefits of the BQA include:

1. Assessing Management Trends in Breast Cancer

The data relating to breast cancer management has now accrued over a 15-year period, which can ascertain management trends over time. Recent examples include management trends for ductal carcinoma in situ (DCIS), immediate breast reconstruction and surgery for the axilla.

2. Promoting the Uptake of Evidence-Based Medicine

One of the great strengths of the BQA is the capacity to determine whether best current practice is being performed based on current clinical evidence and National recommended guidelines. Examples of this include the uptake of sentinel node biopsy, Herceptin use for HER2 positive breast cancer and the referral of high-risk cases for post-mastectomy radiotherapy

Current BreastSurgANZ Council members

3. Research

The high-quality and large size of the BQA dataset has permitted the publication of over 30 scientific manuscripts in refereed journals including survival data for women living in rural and remote areas, areas of differing socioeconomic status and those treated by surgeons with variable breast cancer annual caseloads. More recent publications have focused on differing survival prospects for Maori and South Pacific Island women treated for breast cancer in New Zealand. The BQA has identified gaps in breast cancer care where improvements are necessary. The Audit has worked closely with Cancer Australia in relation to the various projects and publications.

4. Ensuring Quality of Surgical Practice and Benchmarking

In 2005, the BQA moved a step further in ensuring the quality of surgical breast practice. Clearly defined Key Performance Indicators were introduced to implement benchmarks with which surgeons should comply. The BQA could then implement improvements in surgeons' performance. An Outliers process (termed the Standards Assessment Process) was developed and ratified by the Royal Australasian College of Surgeons and Breast Section members. In order to produce this document, legal advice was sought and confirmed.

The BQA is recognised as a quality National Registry, abiding by the majority of suggested operating principles for national Clinical Quality Registries issued by the Australian Commission on Safety and Quality in Health Care, listed online at http://www.registries.org.au. The BQA was one of only six national registries chosen to test and validate the proposed principles, and remains in contact with the Commission, providing expert advice on good practice registry systems and procedures.

The Formation of the Breast Surgeons Society of Australia and New Zealand (BreastSurgANZ)

Due to the impact of the BQA and advances in subspecialisation made by breast surgeons, the RACS Breast Section executive approached the Royal Australasian College of Surgeons Council with a request that membership to the Breast Section be stratified according to surgeons who contribute to the BQA. In 2007, the Breast Section Executive recommended that breast surgeons contributing to the audit be acknowledged as full members of the section. Other lower categories were recommended including associate membership and honorary membership. A reply was received on 15/12/2007 from the RACS Professional Development and Standards Division stating that the application for differential membership for the Breast Section was not permitted under the Constitution of the College. A College ruling stipulates that a fellow can self nominate for a College section that can provide an educational experience. As such, financial fellows may not be excluded from membership of any section. It was recommended that if the Breast Section wished to distinguish specialist breast surgeons from other members of the College that some consideration be given to the formation of an independent society.

In February 2008, surgeons representing the Breast Section met in Melbourne to propose the formation of a specialist breast surgeons' society and to formulate a Constitution. Following much deliberation and various interventions by


Photograph of Assoc. Prof. Andrew Spillane (current BreastSurgANZ president), Assoc. Prof. Christopher Pyke (Immediate Past-President BreastSurgANZ) and Mr James Kollias (Founding President BreastSurgANZ)

legal advisers, a Constitution was finalised and ratified by the RACS Breast Section executive and Breast Section general members. The business name "Breast Surgeons of Australia and New Zealand" (BreastSurgANZ) was confirmed. BreastSurgANZ was recognised as an income tax exempt (ITE) organisation by the Australian Taxation Office under the "health promotion charity" category. Deductable Gift Recipient (DGR) status was also obtained. ▶

BreastSurgANZ was announced at the Royal Australasian College of Surgeons Annual Scientific Congress (ASC) in Perth in May 2010. The Society now boasts over 290 full members who contribute to the BQA. The Society is committed to improving patient care through teaching, research, and the development of evidence-based strategies. Individual members' surgical performance and outcomes are continuously monitored through assessment via the BQA. The governance structure includes four subcommittees relating to Surgical Education and Training (providing direct input to RACS and General Surgeons Australia for breast curriculum development), Post-fellowship Training, the Breast Quality Audit and Oncoplastic Training. In recent years, BreastSurgANZ has conducted workshops in Breast Ultrasound and Oncoplastic Surgery aimed at Trainees and Fellows, but which also attracted junior (and not so junior) consultant surgeons. The BreastSurgANZ website is well established and includes the current membership and a 'find a breast surgeon' section. The website has a link with the BQA website. BreastSurgANZ has forged close working relationships with other national breast cancer stakeholders such as Cancer Australia, the Clinical Oncology Society of Australia (COSA), ANZ Breast Cancer Trials Group, Australasian Society of Breast Diseases and Breast Cancer Network Australia. In May 2011, BreastSurgANZ signed a Memorandum of Understanding with the Association of Breast Surgery (United Kingdom) with the aim of forging relationships in areas of clinical research, technical advancement and training.

Disbanding of the RACS Breast Section

An online poll of Section members was conducted from 11 – 25 August 2014 to determine whether the RACS Breast Section should disband. This followed a vote to disband at the 2014 Annual Business Meeting, on the grounds that BreastSurgANZ (the Society) had taken over all former Section functions. The Breast Section was unable to form a new Committee following the call for nominations in February 2014. The results of the online poll confirmed that 82 per cent of RACS Breast Section members agreed with the proposition that the RACS Breast Section be disbanded. This decision was ratified by the RACS Professional Development and Standards Board Executive, and the Section was officially disbanded. BreastSurgANZ will continue to work with RACS on the ASC program and other matters of common interest, and to provide educational opportunities to surgeons interested in breast disease who wish to attend the ASC or any other BreastSurgANZ educational event. The archives of the *RACS Section of Breast Surgery* will be accessible via the College.

For further information about BreastSurgANZ, please visit the website www.breastsurganz.com.

RACS support of the audit was originally through ASERNIP-S, whereby the system was gradually enhanced and became web-based. More recently the Morbidity Audits department of the RAAS Division has managed the system on behalf of BreastSurgANZ

Snapchat?

Surgeons across the world have been making big news with the revelation that they are broadcasting operations via Snapchat in an effort to maximise reach and access to surgical education. But what is Snapchat?

Whether you have heard of it or not – the once outsider app is taking on and matching established social media giants. Marketers are intrigued and teenagers are hooked.

Snapchat has morphed since launching in 2011 but the core of its functionality remains unchanged. It is essentially a social media app that allows users to send photos and videos to contacts which will self-destruct seconds after being viewed. There are now also filter and broadcast functions.

It is transient and ephemeral – allowing a short glimpse into a moment in time. The point is not to linger or analyse but rather share an experience and move on. And in the age of short attention spans it has captured our shifting attention. There are more than 150 million active users and it racks up a whopping 10 billion video views each and every day!

And if anything is emblematic of the evolving state of mobile marketing, it's Snapchat. More and more people are interacting with brands and public entities through the platform. And beyond this it is now making and breaking news. Young people, Snapchats core demographic, are increasingly reporting higher consumption rates of news and current affairs through the app.

It is predicted that 2017 will also be the year Snap Inc. moves toward an initial public offering – a move generating much buzz and speculation in the industry. So Snapchat is not going anywhere anytime soon – which leaves us with the exciting potential of reaching more people than ever and exploring broadened options for information sharing and education.

New Year's Resolution

Slow burn your body fat

DR BB-G-LOVED

Tubby and Chewbar were at my first consulting session in January, both in despair at their waistlines and weight gain. Their Body Mass Index (BMI) had edged into the Class 1 obese zone (30-34.9 kg/m2) whereas previously they had been rising ignominiously through the ranks of the overweight (25-29kg/m2). They had had a stressful and busy year like many of us. Their cholesterol levels and blood pressure were threateningly high, and therefore prone to Type 2 diabetes, cardiovascular disease and Alzheimer's disease. They were afraid – and quite rightly so! I was sympathetic but it was also my responsibility to persuade them to do something about it, and more than just prescribing statins and anti-hypertensives which would be of less benefit than changing their lifestyles.

I wonder how many readers have made a resolution to either lose weight or reduce body fat? Perhaps by the time this article has been published you will already be tempted to abandon your laudable resolve. Yet could this year be your year for change? Or will you let that belly grow?

This article is one of a mini-series that will give advice on breakfast, lunch and dinner together with the implications of the menu on your size, shape and substance. I share my clinical experience as to what has worked in practice, interwoven with evidence from published research.

For good health you should combine a change in diet with exercise. If you don't find it easy to schedule regular exercise into your routine, consider hiring a personal trainer. You can probably afford it, and you will enjoy an excellent return on your investment in later life by maintaining health, never mind saving out-of-pocket expenses for prescriptions. Exercise alone may not result in you losing weight, but rather improve your body composition, building more muscle and burning fat. However, exercise also in its own right will improve glucose metabolism, hyperlipidaemia, metabolic syndrome, and lowers cardiovascular mortality.

To lose weight you need to eat and drink less. First be determined to follow the 2015 WHO guideline on sugar intake for adults and children (http://www.who.int/nutrition/publications/guidelines/sugars_intake/en/) and consume less than 10 per cent of energy intake as free sugars, i.e. generally less than the equivalent of 10-12 teaspoons of sugar (4g per teaspoon) per day. WHO defines free sugars as *monosaccharides and disaccharides added to foods and beverages by the manufacturer, cook or consumer, and sugars naturally present in honey, syrups, fruit juices and fruit juice concentrates*. A moderate reduction in the calorific value of your daily food of some 400-500kcals per day in combination with exercise and/or training will result in a leaner YOU.

When athletes reduce carbohydrates (pasta, bread, rice, alcohol, fruit, soft drinks) even further to around 50g/day) they must do this in conjunction with increasing their protein and 'healthy fat' intake (meat, fish, green vegetables, olive oil, water). This accelerates their body composition changes over those achieved by mere calorie reduction. The protein intake prevents hunger, builds muscular strength and improves performance. So for a speedier change combine a low carbohydrate diet with a protein intake of 1.7-3.3g/kg/day. Healthy fats include omega-3s, olive oil, avocado and coconut oil.

A slimmer trimmer YOU will be lighter (good for arthritic-prone joints), less insulin-resistant, better lipid profiled with improved blood pressure and strength. There's no need to go to unhealthy extremes and those of you prone to obsessive compulsive behaviour please note my column on orthorexia (Healthy Eating or Unhealthy Extremes? Surgical News, October 2016). Also be aware that today's surgeons never learned much about these topics in medical school.

Now that the 'season to be merry' has passed, leaving many of us somewhat heavier like the unfortunate Tubby and Chewbar, 'tis the year to become slimmer and trimmer. Should you want to monitor progress you can weigh yourself weekly, though meaningful change will take a few weeks. However, your lipid profiles, glucose homeostasis and blood pressure will be improving steadily as you go. Measuring your body composition (see below) on a Dual Energy x-ray absorptiometry (DEXA) scan might seem extreme and over obsessive. However, if you are serious and disciplined I would predict that by the time of your ASC in May, you'll be looking and feeling good – as will Tubby and Chewbar!

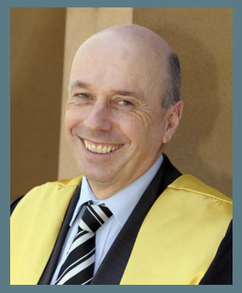
Women(Age)	21-40	41-60	61-80	Men (Age)	21-40	41-60	61-80
Essential	8-12	8-12	8-12	Essential	3-5	3-5	3-5
Thin/Athletic	13-20	13-22	13-23	Thin/Athletic	6-7	6-10	6-12
Recommended	21-32	23-33	24-35	Recommended	8-19	11-21	13-24
Overweight	33-38	34-39	36-41	Overweight	20-24	22-27	25-29
Obese	>=39	>=40	>=42	Obese	>=25	>=28	>=30

Percentage Body Fat Classification (can be measured using Dexa) by gender and age

Source: Gallagher D. Am J Clin Nutr. 2000 Sep;72(3):694-701 and American College of Sports Medicine

Case Note Review

DVT prophylaxis may not have been adequate



PROFESSOR GUY MADDERN
Surgical Director of Research and Evaluation
incorporating ASERNIP-S

Case Summary:

A very elderly patient who was living alone and medically well, presented with a closed fracture of the left patella and right zygoma, and a forehead laceration, following a 4-metre fall. Initially taken to a regional hospital for assessment and management, the patient was transferred to a metropolitan teaching hospital on the same day. The patient was assessed at the teaching hospital shortly after dawn on the following day and underwent surgery six hours later. A modified tension band technique was used for internal fixation of the patella fracture.

The postoperative recovery was uncomplicated and the patient was transferred to another metropolitan hospital for rehabilitation two days later. Heparin 5000 units was commenced in the evening of the day the patient was transferred for rehabilitation. The patient was to be immobilised in a hinged knee brace for six weeks, with the range of motion progressively increased. The patient was allowed to full weight-bear despite the immobilisation of the knee, and it is reasonable to assume that the patient was not confined to bed while in the rehabilitation ward.

The patient made an uncomplicated recovery over the next two and a half weeks. However, on the day of discharge the patient underwent a sudden deterioration and resuscitation was unsuccessful. The coroner's postmortem revealed the cause of death to be underlying bilateral pulmonary emboli.

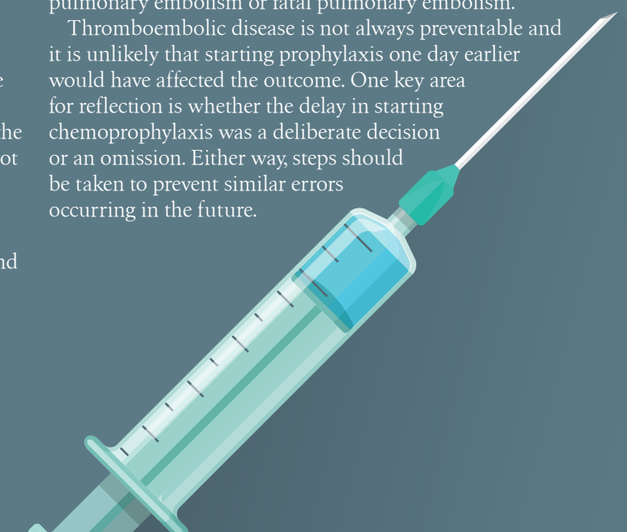
Assessor's Comment:

There are two issues to consider, the first relating to the timing of heparin administration and the second to the anticoagulant administered. This patient had multiple risk factors for thromboembolism, including significant trauma and the immobilisation of the knee in a brace with locked extension. The patient was also elderly, and the incidence of venous thromboembolism rises with each decade for patients over the age of 40.

The patient missed one to one-and-a-half days of chemoprophylaxis. In a trauma situation it would be reasonable to withhold heparin prior to surgery, and for a period of time after the procedure, to allow haemostasis to be achieved. However, heparin was not started until the patient reached the rehabilitation ward. There is no evidence of chemoprophylaxis being considered or an alternative measure used, with the exception of thromboembolism-deterrent stockings. Of great concern is that even in hindsight the consultant believed that the use of the stockings alone was adequate prophylaxis.

The second issue to consider is the use of unfractionated heparin rather than low molecular weight heparin (LMWH). While the evidence for using chemoprophylaxis is based on decreasing deep vein thrombosis (DVT) rates, not pulmonary embolus rates, there is substantial evidence that LMWH is more effective in preventing DVT in hip replacement and hip fracture patients. However, there is a lack of reliable data in relation to the use of LMWH for lower limb trauma or immobilisation. There is also no evidence that LMWH decreases the rate of either pulmonary embolism or fatal pulmonary embolism.

Thromboembolic disease is not always preventable and it is unlikely that starting prophylaxis one day earlier would have affected the outcome. One key area for reflection is whether the delay in starting chemoprophylaxis was a deliberate decision or an omission. Either way, steps should be taken to prevent similar errors occurring in the future.



Dear Editor,

After reading the article in Surgical News Nov/Dec 2016, I felt that I must write and comment.

I believe that there are a number of points that need to be made in relation to this article:

1. The first thing is that this article raises the question of responsibility. It is the responsibility of the surgeon who performed the procedure and the Consultant in charge whose name appears above the patient's bed to supervise post-operative care. At no stage are we informed as to whether a consultant or registrar performed the procedure. Whoever it was, it is clearly the responsibility of the Consultant to have been informed. We must ask why that is the case. Does the Consultant not play a role in post operative management? Do the members of the junior staff feel that they have to manage themselves? Surely, those days have gone.
2. The patient "was diagnosed with clot retention shortly after returning from the operating room". How shortly? The urology resident "attempted to wash out the clots but realised this was incomplete". At this stage the registrar and Consultant should have been notified and the patient returned to the operating room. The size and type of catheter is irrelevant as it would have been the one that the patient received in the operating room.
3. Clearly, nothing was done by the Consultant and registrar as "nursing notes indicated ongoing pain consistent with clot retention well into the next day".
4. "There appeared to be an idea that catheter traction alone would solve the problem." Catheter traction only works when applied at the end of the procedure for venous bleeding and will not stop arterial bleeding. This requires a return to the operating room and cautery.
5. The patient "was then transferred to another ward". Why? Was the patient not in a Urology ward where the staff should have experience and equipment to deal with this problem? If not, why is elective surgery being carried out on patients who are not admitted to the parent ward?
6. "In the days that followed..." How many? There should be no question of "days that followed" as this patient should have been returned to the operating room, the clots evacuated and haemostasis achieved.
7. In the Clinical Lessons section, I believe that there is not enough emphasis on point 1. above and while Professor Maddern has attempted to give some guidance, it would appear to me that this patient lost sufficient blood to warrant transfusion although no mention of actually doing any blood tests is made. The chest pain is likely to have occurred as a result of blood loss which, in my experience is not increased by the use of aspirin.
8. In my opinion, this case is a failure at senior level rather that any other and that point should be made rather than instructions on clot evacuation which can be carried out with the usual 22Ch catheter inserted at the end of a TURP if needed.

I write this on a background of over 30 years' experience in Urology, having performed more than 5,500 TURPs with over 1,000 carried out as day surgery cases.

Yours sincerely,

Neil S. I. Gordon
MBBS (Melb.) FRCS (Glasg.)
FRCSEd. FRACS FICS.

The article Mr Gordon refers to can be found online on page 42: https://www.surgeons.org/flipbook3d/Digital/SurgicalNewsNovDec2016/index.html –Ed.

Dear Dr. Gordon,

Thank you for your letter regarding the article in Surgical News. In replying may I make three general points:

- The greater part of the text of the article consists of comments from the second-line assessor – the views are not from my pen, although I agree with them.
- Some clinical details are not published in the interest of de-identification.
- ANZASM does not have access to the case notes and consequently the details that you seek are not available to us. The case notes were available to the assessor.

Although the term 'clinical leadership' has not been used I think that the failings would be classified as failings of clinical leadership, namely:

1. Inadequate case note records including no consultant entries.
2. An apparent lack of supervision by either the operating or supervising surgeon.
3. A lack of knowledge of the best means of treating clot retention, or a lack of instruction of junior staff on this issue.

In this regard we are in accord. It may be of interest to you to know that we are preparing a journal article looking at the question of clinical leadership as revealed by the over 40,000 cases in the ANZASM data base.

Regards,

Professor Guy Maddern
Chair, ANZASM

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:

2016

John Critchley (VIC)
Anand Dixit (NSW)
Leon Gillam (NSW)
Thomas Taylor (NSW)
Etika S Vudiniabola (Fiji)

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

Informing the College

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

ACT: 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

In Memoriam

RACS is now publishing abridged Obituaries in Surgical News.
We reproduce the first two paragraphs of the obituary. The full versions can be found on the RACS website at:
www.surgeons.org/member-services/in-memoriam/

Emeritus Professor Gordon James Aitken Clunie General Surgeon

28 March 1932 – 26 September 2016

Gordon Clunie was a pre-eminent figure in the surgical life of Australia, New Zealand and the Pacific. Born in Fiji, he received his primary school education in Suva and secondary schooling at first in Hamilton New Zealand and later in Edinburgh. He studied medicine at the University of Edinburgh, graduating in 1956 and trained in surgery in Edinburgh and Newcastle-Upon-Tyne. He was awarded Surgical Fellowships of the College of Surgeons of Edinburgh (1963) and England (1964). Sir Michael Woodruff was the leading surgical figure at the Royal Infirmary in Edinburgh at the time and Gordon joined his Department of Surgery as Senior Registrar and Lecturer in 1964.

In 1963 the world's first successful kidney transplants took place from a cadaveric donor at the Brigham and Women`s Hospital, Boston. This success was due in large part to the new immunosuppressive drug combination of prednisone and azathioprine. At that time in Edinburgh Sir Michael Woodruff was developing a different immunosuppressive approach using anti lymphocyte serum. Gordon was in the right place at the right time to participate in these exciting developments.

Peter Court Grayson FRACS Orthopaedic Surgeon

2 May 1923 – 18 February 2016

Peter was born in New Plymouth, the eldest child of Henry James Grayson, and Minnie Thorburn Court. He had a sister, Pamela, and brother, Garth. Following their father's appointment as assistant general manager of the Standard Insurance Company, the family moved to Dunedin when Peter was five years old. Living next to the Balmacewan Golf Course, and with keen golfing parents, Peter was soon caddying for a fee of one shilling and three pence (equivalent to $15). He commenced school at Maori Hill Primary School and at the age of 11 was enrolled at nearby John McGlashan College, where he was made junior dux at the end of his two years there. Peter then attended Otago Boys High School 1937-41, where he became a prefect and captained the 1st cricket XI in his final two years at school. Deciding on medicine as a career, and being aware of the costs involved, Peter secured a Lizzie Rathbone Scholarship as the student from Otago or Southland obtaining the highest marks in English and History in the national scholarship examination.

Peter gained entry to the Otago Medical School in 1942, completing his MB ChB in 1948. During his time at university he continued to participate in both cricket and golf being awarded a University Blue for golf. In common with many others, he was called up for home service and for three years found himself doing regular camps with the Royal New Zealand Army Medical Corps. During this period, on a blind date, he met a beautifully dressed physiotherapy student, Marjorie (Mardi) Holiday, and soon after they were married. Rick and Tim were born in the ensuing few years.

Terence Charles Morgan Urologist

9 February 1943 – 17 August 2016

Terence Charles Morgan was born in Melbourne to Patricia Ann and Eric William (Mick) Morgan on 9 February 1943. In 1951 the family moved to Hobart. Terry went to St Virgil's where he was very successful academically becoming dux of the school and head prefect 2 years in a row. He became lifelong friends with fellow students Tony Dowd, Terry Busch, Garth Cobern, Peter Shanahan and Barry Woods.

He excelled at sports representing St Virgil's in football and cross country but particularly swimming going on to win the Tasmanian backstroke championship and in 1962 he represented Tasmania in the national water polo championship.

Thomas Kinman Fardon Taylor Orthopaedic Surgeon

6 August 1932 – 4 September 2016

Few if any have had as great an impact on Australian orthopaedic surgery as Tom Taylor. 'TKFT' was born in Sydney in 1932, the son of Dr Charles and Mrs Dot Taylor of Bondi. In 1941, when invasion by the Japanese appeared possible, Tom's education (on a scholarship at Sydney Grammar School) was interrupted by a prolonged stay with family in Adelong. Tom subsequently studied medicine at the University of Sydney, graduating with honours in 1955 and also being awarded a University Blue for boxing.

Following two years of residency at Royal Prince Alfred Hospital Tom took himself to Edinburgh, where he spent a year demonstrating in anatomy and a further two years as an orthopaedic registrar in the Royal Infirmary and Princess Margaret Rose Hospital, working with J.I.P. James. During that time he obtained fellowships of the Royal Colleges of Surgeons of England and Edinburgh. In 1960 he moved to the Radcliffe Infirmary at Oxford. He held a Nuffield Dominions Fellowship in orthopaedic surgery at Oxford for four years, working with Prof J. Trueta. He was awarded a D.Phil. (Oxon) for a thesis on "Some Aspects of Structure, Growth and Degeneration of the Intervertebral Disc", and gave a Hunterian Lecture on this topic to the Royal College of Surgeons. His work involved the then new technique of X-ray crystallography.

'TKF'

A Personal Reflection

Professor Tom Taylor, Professor of Orthopaedic Surgery of the University of Sydney at Royal North Shore Hospital was giving orthopaedic lectures when we first encountered him as students. Two slides stood out; one that said "No Blood No Bone", that is without vascularisation, bone formation would not occur and bony union of avascular bone could not repair. The other slide; Cancellous Bone 'doesn't jump gaps', that is to say, fracture management of tubular bone without cortical apposition, endosteal union does not occur unless there is bridging with cancellous bone. The inference was that there was benefit to cortico-cancellous bone grafting. It was back at clinical school at Royal North Shore Hospital where we as Registrars became aware of his wealth of knowledge in both adult and paediatric spinal surgery and his considerable expertise in spinal injury. He, with John Grant, neurosurgeon and John Yeo, Director of the Royal North Shore Spinal Injury Unit, provided a formidable spinal service in northern Sydney.

In the orthopaedic rotation training program, Tom and Sydney Nade ran enthusiastic orthopaedic seminars with the Registrars on Tuesday afternoons. Tom asked us to think on our feet, especially for conservative management including plasters and spicas as well as detachable bracing, lumbosacral binders, splints, Milwaukee and Somi braces as well as a systematic approach in interpreting x-rays and CT scans.

In my final year of orthopaedic rotation as Professorial and Senior Orthopaedic Registrar at Royal North Shore Hospital, I had the pleasure of working with Tom for six months to attend both general and orthopaedic and spinal clinics as well as manage spinal injuries and adult and corrective surgery for scoliosis and kyphosis and adult spinal surgery. When doing lumbar surgery in adults, Tom's dictum was to explore both lower levels so that diagnostic disc protrusions were not missed and wrong level surgery was avoided. The 'wake up' test, when doing scoliotic surgery, is now replaced with evoked sensory potential and neurological monitoring. Tom encouraged his Registrars to produce papers such as bony metastases from thyroid cancer, the limbus vertebra and Supraclavicular nerve entrapment and clavicular fractures, to mention a few.

Following the Fellowship exam, Tom instructed me to celebrate with spouse at the 'Pavilion on the Park', when he was having to cover me that night. The phone rang during the first course saying he had been rung to do a Colles fracture. I had to gracefully decline as I had already some celebratory bubbles and suggested he contact Sham Desphande, the other Registrar, and he confirmed Tom had given me the night off. He then relieved Tom of the need to go in to reduce the fracture.

Tom was known for his enthusiasm for SpineCare and the Bone and Joint Decade as well as his research projects led by Peter Ghosh and Michael Ryan. His retirement after 23 years as Professor of Orthopaedic Surgery at Royal North Shore Hospital was marked by a refectory dinner at Sydney University to which I sent an acrylic model of a lumbar fusion – symbolising his ability to see clearly through spinal problems and a neck tie from the Friends of Grammar Rugby that showed a golden ball going over the black dot, reflecting his ability to continually kick goals in spinal research.

His last address was at the AOA (NSW) Meeting in which he made an impassioned plea for anatomical dissection to be returned to the Medical Faculties in Sydney. He would be pleased to know that the most common elective now chosen by those doing the BSc(Med) is Anatomy.

Tom's dictum often expressed was 'it's got to be right'. It was a pity that Tom was not born a Frenchman in that, when leaving the operating theatre while we did wound closing, he was first to partake of the croissants and would often refer to the famous French provincial spinal surgeons Dubosset and Cottrell. He was fond of using the expression 'plus ca change, plus fait la meme chose'. In his extensive orthopaedic career, what he meant was that while some things change, the more things remain the same. He was always offering more than 'un soup con' of advice in orthopaedic matters.

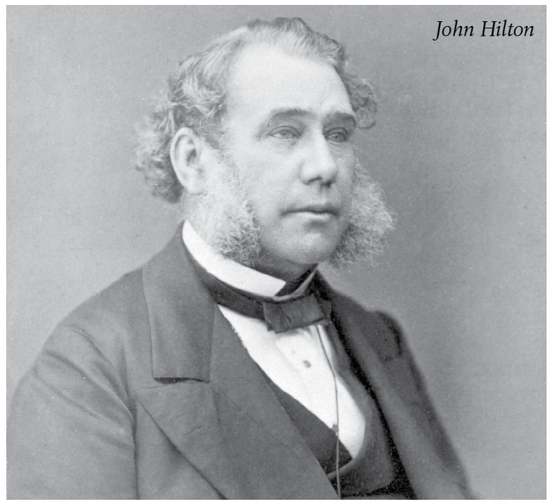
Au revoir Tom, may we meet again in the great Orthopaedic Clinic in the sky.

– Mr. Drew Dixon

John Hilton: Anatomist and Surgeon

John Hilton (1805-1878) FRS 1839 FRCS 1843

PETER F BURKE
FRACS


John Hilton

John Hilton was born at Sible Hedingham in Essex in 1805, the first son of John and Hannah Hilton: the family ultimately consisted of two sons and two daughters.

He was educated at Chelmsford and attended school in Boulogne before becoming a medical student at Guy's Hospital in 1824, 31 years after the death of John Hunter; however, Hunterian teaching survived with both Henry Cline and Astley Cooper having been his pupils.

Hilton devoted himself so assiduously to the dissecting room that he was known as 'Anatomical John' and in 1828 was appointed Demonstrator in Anatomy: when not dissecting or teaching he was making post-mortem examinations and after 16 years of this work he gained an unrivalled knowledge of the anatomy of the human body and had become a first-rate teacher and lecturer.

His dissections were modelled in wax by the genius, Joseph Towne who having been appointed at age 17, spent 53 years with the Anatomy Department at Guy's; many of Towne's superb models remain in the Gordon Museum of Guy's Hospital.

Hilton was elected Assistant Surgeon to Guy's Hospital in 1844 having the distinction of being the first surgeon at one of the large London hospitals who was appointed without having served an apprenticeship either to the hospital or to one of its surgeons.

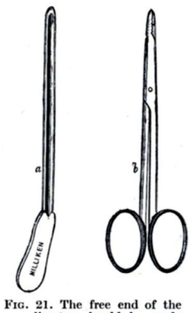


FIG. 21. The free end of the director should be made blunt and rounded; the last quarter of an inch of the groove ought to be increasingly shallow, until it emerges upon the rounded end of the director. The end of the closed blades of the forceps should be of a size adapted to run easily in the groove of the director.
a, Director. *b*, Dressing forceps.

Abscess drainage

In 1849 he became Senior Surgeon and this was a difficult time as he had always been an anatomist and had never had charge of beds: although without the experience of the older surgeons, the exactness of his anatomical knowledge made for a proficient operator.

He was chosen as a life member of the Council of the Royal College of Surgeons in 1854 and was elected President in 1867, the same year in which he delivered the Hunterian Oration on '*Sympathy*', or, what we would nowadays term, 'referred pain'.

Hilton concluded with the words, '*his conscious love of truth, for truth's own sake, called out in Hunter the high-minded indifference of the philosopher to the petty assaults of ignorance*'.

In 1871 he was appointed Surgeon Extraordinary to Queen Victoria.

John Hilton ultimately died of gastric cancer in 1878. Of his family, we only know, 'He married twice and his children survived him'.

His claim to remembrance rests upon his essay, '*On the Influence of Mechanical and Physiological Rest in the Treatment of Accidents and Surgical Diseases and the Diagnostic Value of Pain*': which was delivered as the '*Arris and Gale*' lectures, at the RCS in 1860, 1861 and 1862, and later published as '*Rest and Pain*.'

Frederic Wood Jones commented in, '*The principles of anatomy as seen in the Hand*', that Hilton's epic work '*should be read by every medical student once at least during his study of anatomy, once again during his practical work in the wards, and afterwards as often as possible during his career as a medical practitioner*'.

Hilton came to appreciate that when a joint was inflamed the nerves were stimulated and not only gave referred pain to the skin over the joint but also caused the muscles controlling the joint to go into a spasm, thereby protecting the joint from further injury; so fundamental was the importance of this observation that it is now known as *Hilton's Law*; because of this work and in recognition of his original observations on the anatomy of the laryngeal nerves, he was made a Fellow of the Royal Society at the age of 34.

Hilton then turned his attention to the distribution of arterial trunks, again seeking a teleological explanation: thus the internal maxillary became the '*artery of mastication*'; it was designed and laid down to supply all the parts concerned with the jaw and the muscles which moved it: the middle meningeal branch, far from proving his thesis to be wrong, proved its truth, for it supplied the temporal area of the skull, the origin of the temporalis muscle.

On the same basis he explained the distribution of the branches of the subclavian arteries as being '*respiratory vessels*', designed to supply muscles and bones concerned in the act of respiration.

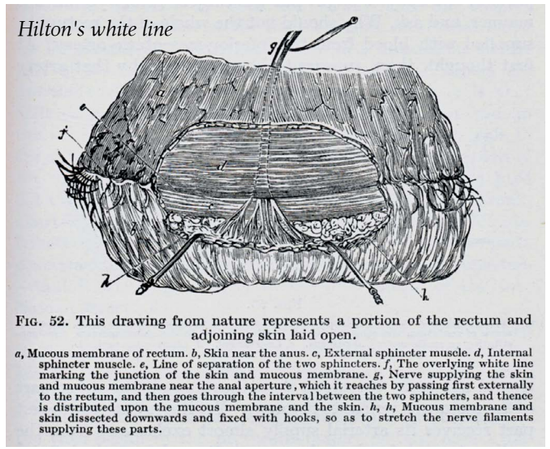
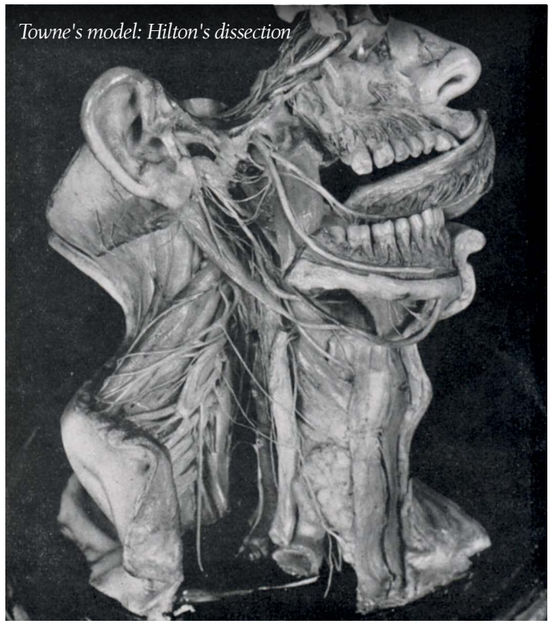

Hilton's white line

FIG. 52. This drawing from nature represents a portion of the rectum and adjoining skin laid open.
a, Mucous membrane of rectum. *b*, Skin near the anus. *c*, External sphincter muscle. *d*, Internal sphincter muscle. *e*, Line of separation of the two sphincters. *f*, The overlying white line marking the junction of the skin and mucous membrane. *g*, Nerve supplying the skin and mucous membrane near the anal aperture, which it reaches by passing first externally to the rectum, and then goes through the interval between the two sphincters, and thence is distributed upon the mucous membrane and the skin. *h*, *h*, Mucous membrane and skin dissected downwards and fixed with hooks, so as to stretch the nerve filaments supplying these parts.

Hilton's 'white line' was described thus; 'Here is another drawing which to my mind is of great interest, because it exhibits one of the important landmarks capable of guiding the surgeon in his operations. If you ask a surgeon, Where are you going to cut to divide the sphincter of the rectum? Have you any lines to direct you? I think this figure will answer the purpose'.

'Why do surgeons open abscesses'? Providing examples in many anatomical situations, Hilton spoke of some surgeons saying with rash confidence, 'plunge in a knife': 'it is a grand term, not a courageous plunge for the surgeon but perhaps a fatal stab to the patient'.

Hilton discusses a deep axillary abscess, cutting the skin with a lancet below pectoralis major 'at that part we can meet with no large blood vessel, then push a grooved director upwards into the swelling; take a blunt, not a sharp, instrument such as a pair of dressing forceps and run the closed blades along the groove in the director into the swelling, then opening the blades'.


Towne's model: Hilton's dissection

He performed many post-mortem examinations and developed interests in hydrocephalus, spina bifida and head injuries. He performed the post-mortem examination on Sir Astley Cooper, John Hunter's pupil, in 1841 who, *inter alia*, sought a reason for his never being able to sleep whilst lying on his left side!

He was a confirmed teleologist and tried to prove that anatomical distribution was due to design rather than to development.

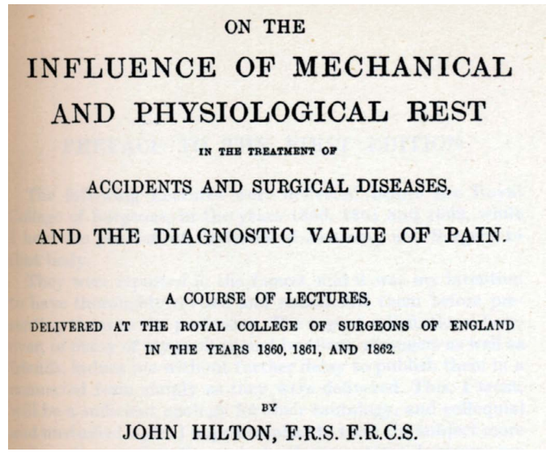
It was said that no one looking at Hilton would have taken him for a great surgeon: he appeared much more like a prosperous City man. Short, rather stout and plodding in his walk; he was no easy master to serve and his caustic tongue was feared and resented. Hilton drove himself hard and insisted on hard work from those who served him: he disliked circumlocution and the use of polysyllabic pseudoscientific terms.

On one occasion while walking up the stairs to his wards, followed by his firm, a dresser started to whistle. Hilton stopped the procession on the landing and, with biting sarcasm, invited the firm to wait for the musician, who was then put at the head of the procession, with the remark, '*The band, gentlemen, always goes in front*'.

Hilton made no startling new discovery and he cannot share the heights of surgical fame attained by Hunter, Billroth or Halsted; however, he taught that nature was inscrutably wise and that she was the supreme healer and that interference by man must be directed only to assisting nature.

When today we see a surgeon in Moynihan's phrase, 'caressing tissues', we can but feel that such an attitude derives from the teaching of Hilton, with his insistence upon 'Rest', his understanding of the significance of 'Pain'.

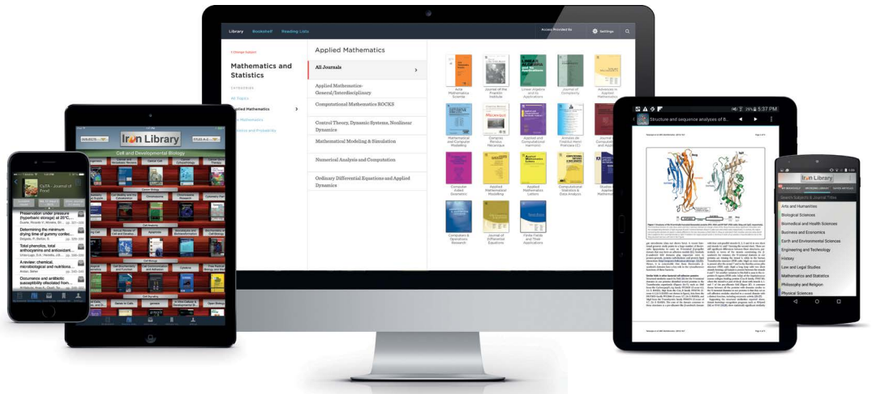
Hilton concluded his 18 lectures with these words, '*Pain the monitor, and Rest the cure, are starting points for contemplation which should ever be present to the mind of the surgeon in reference to his treatment. Feeling that I have, at most, advanced but one short step towards the object of every scientific surgeon, I trust I have not spoken presumptuously*'.


ON THE
INFLUENCE OF MECHANICAL AND PHYSIOLOGICAL REST
IN THE TREATMENT OF
ACCIDENTS AND SURGICAL DISEASES,
AND THE DIAGNOSTIC VALUE OF PAIN.
A COURSE OF LECTURES,
DELIVERED AT THE ROYAL COLLEGE OF SURGEONS OF ENGLAND
IN THE YEARS 1860, 1861, AND 1862.
BY
JOHN HILTON, F.R.S. F.R.C.S.

Frontispiece, 'Rest and Pain'

New Library Online Resources

Two great new library resources are available in 2017. The *ProQuest Health Research Premium Collection* adds hundreds of extra e-journal titles while *BrowZine* makes accessing your favourite e-journals from your mobile device or desktop so much simpler and easier.



ProQuest

After receiving positive feedback during a recent trial, extra ProQuest databases with extensive full-text are now available:

- *Health Research Premium Collection* and its subsets:
  - *Health Management Database*
  - *Public Health Database*
  - *Family Health Database*
  - *Psychology Database*

This resource covers a wide variety of valuable content. The Collection provides a broad collection of journals, evidence-based resources and full-text dissertations.

As well as access to the individual e-journals, topic searching and ongoing alerting across all the content is also available. The new material is also searchable from within *Summon* (a tool which searches across all of the RACS Library's online content).

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Setting up BrowZine is very simple. When you open the app, a list of libraries will appear; select "Royal Australasian College of Surgeons". Enter your RACS website login details. Browse e-journals by subject or search for journal titles by name and add them to your bookshelf. Adding them to your personal bookshelf makes it very easy to return to them. Accessing journal back issues is also much simpler and more straightforward.

Please email Library staff college.library@surgeons.org or phone +61 3 9249 1271 with any issues or questions about either of these great new resources.

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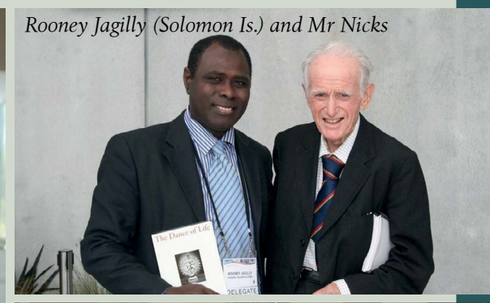
2018 Rowan Nicks **AWARDS**

Dr Vuthy Chhoeurn (Cambodia) with patient



Rooney Jagilly (Solomon Is.) and Mr Nicks

Win Win Kyaw (Myanmar) operating

- **2018 Rowan Nicks Pacific Islands Scholarship**
- **2018 Rowan Nicks International Scholarship**
- **2018 Rowan Nicks Australia and New Zealand Exchange Fellowship**

The Royal Australasian College of Surgeons invites suitable applicants for the 2018 Rowan Nicks Scholarships and Fellowships. These are the most prestigious of the College's International Awards and are directed at qualified surgeons who are destined to become leaders in their home countries.

Rowan Nicks International and Pacific Islands Scholarships

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

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

Applications for the International Scholarship are open to citizens of Bangladesh, Bhutan, Cambodia, Indonesia, Laos, Mongolia, Myanmar, Nepal and Vietnam.

Applications for the Pacific Islands Scholarship are open to citizens of the Cook Islands, Fiji, Kiribati, Federated States of Micronesia, Marshall Islands, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu or Vanuatu.

Selection will primarily be based on merit, with applicants providing an essential service in remote areas, without opportunities for institutional support or educational facilities, being given earnest consideration.

Rowan Nicks Australia and New Zealand Fellowship

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

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

Value

The value of the Scholarships and Fellowships is up to AU$50,000 for a 12 month attachment, depending on the funding situation of the candidate and provided sufficient funds are available, including support to attend the Annual Scientific Congress of the College, if the Scholar is in country at the time of the Congress.

Further Information

Application forms with the full criteria and submission instructions will be available from the RACS website from December 2016: www.surgeons.org

Closing date: Monday 5 June, 2017. Applicants will be notified of the outcome of their application by 31 October 2017.

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

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