SurgicalNews

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ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

GOING THE DISTANCE

An International Medical Graduate's journey to FRACS

#I LOOK LIKE A SURGEON

Challenging bullying and discrimination in surgery

PAEDIATRIC SURGERY ASSOCIATION

Set to expand its role and presence

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Starting on a solid foundation

I was honoured to take up the position of President of the College in May during the RACS 2019 Annual Scientific Congress (ASC), with Mr Richard Perry assuming the position of Vice President. I would like to acknowledge past President Mr John Batten and past Vice President Dr Cathy Ferguson for the outstanding leadership, humility and grace they demonstrated during their tenure. I am sure we will be calling on them for advice and support as we settle into our new roles.

I am also fortunate to have started on a high note riding on the wave of positive feedback received about the RACS 2019 ASC. Many participants told us the program was of an exceptional quality and they found it to be a useful educational experience offering them many networking opportunities.

After the ASC, I went to China with John Biviano, our new Chief Executive Officer, to visit the Chinese College of Surgeons (CCS) meeting held in Beijing. The Chinese presented me with an Honorary Fellowship to their College during an opening ceremony that was reminiscent of the Australian Logies Awards. Since its establishment 12 years ago, the CCS has experienced tremendous growth in its membership. It has approximately 400,000 surgeons servicing 1.5 billion citizens through 20,000 hospitals. It was evident that there were some potential opportunities for RACS to collaborate with the CCS, particularly in the provision of surgical training as well as sharing our expertise in ethical and professional standards.

I was heartened to see the professionalism and care exhibited by our surgeons and indeed all health workers during the sad and tragic Christchurch shootings in March. They truly lived up to our Code of Conduct, demonstrating compassion and placing their patients' interests first. Many of our Fellows, Trainees and international medical graduates (IMGs) worked tirelessly at hospitals in Christchurch caring for the people who were injured and their families. I commend Dr James McKay who was the on-call trauma surgeon at Christchurch Hospital and RACS Executive Director Surgical Affairs, Mr Richard Lander, for sharing their expertise with the New Zealand government and adding their voice to the call for new gun laws in the country. More recently, we saw much attention focused on inappropriate out of pocket fees being charged by surgeons with patients seeking crowdfunding or re-mortgaging their houses to access surgical treatment.

While it is important to note that most surgeons do the right thing by their patients, we know there are some operators who charge fees that are inappropriate to the circumstances, exploiting their needs and placing the patient and their family in additional stress both financially and emotionally.

This behavior is unprofessional and in breach of the RACS Code of Conduct which seeks to ensure full disclosure and transparency in all aspects of surgical financial consent. All surgeons have a duty to advise their patients that urgent, acute or cancer-related surgery can be timely dealt with in the public system.

All surgeons have a duty to advise their patients that urgent, acute or cancer-related surgery can be dealt with in a timely manner in the public system.

These are just some of the challenges and opportunities that we as a College have to address. I am fortunate that I have the support of an able and committed Council and dedicated staff at RACS.

Many of you will be aware that we recently appointed John Biviano as the new Chief Executive Officer. John brings more than 35 years of invaluable experience in the health sector to RACS, having worked in hospitals, in government departments and the Australian and New Zealand College of Anaesthetists. Councillors are confident that the skills and vision John brings to the role will enable a strong and considered future for the organisation. We are all very much looking forward to working with him on this path.

John has been working with his executive leadership team and the broader RACS team to improve services to Fellows, Trainees and IMGs. In support of lifelong learning for surgeons, our education portfolio recently regrouped into three departments: Training Services, Education Services and Research and Innovation.

Under Professor Julian Archer, Executive General Manager of Education, the Education portfolio's renewed strategic intent will see RACS focus on strengthening our model of educational delivery in partnership with the Specialty Societies, developing greater links with leading universities to bolster our capacity for surgical education research, and reviewing and fortifying governance and policy across the College.

I look forward to working with all of you and with the staff at RACS under the leadership of new CEO John Biviano to continue improving surgical standards and professionalism and to continue to foster trusting relationships with our numerous membership societies.

Mr Tony Sparnon
President

Surgical Research Fellowship

Master of Philosophy or PhD research program (Hepato-Biliary cancer)

Expressions of Interest

The Northern Upper GI Surgery Unit (Royal North Shore Hospital and North Shore Private Hospital, Sydney) is offering a funded full-time research position in HPB surgery for a 12-month period, with a view to extension. This is open to candidates currently enrolled in a surgical training program or who have just completed surgical training. The candidate must have Australian citizenship and hold current registration with AHPRA.

This is a time-limited research experience providing exposure to both clinical and laboratory research. It is an ideal opportunity to be supervised and mentored by experienced researchers and clinicians. Candidates will have an opportunity to prepare and submit manuscripts for peer-reviewed publication. Enrolment in the Master of Philosophy program is for 2 years, with a possibility of converting to a PhD degree if desired. (https://sydney.edu.au/courses/courses/pr/master-of-philosophy-medicine.html)

The ideal candidate should be a Royal Australasian College of Surgeons surgical Trainee SET 3 or above or be a new Fellow within the first two years following award of their FRACS. More junior candidates who are not yet on the program will also be considered depending on their application. Candidates should demonstrate an interest and experience in some form of research, as well as an ability for self-directed project management. Successful applicants can expect substantial stipend support for the first year of candidature as well as opportunities for surgical assisting, with the expectation to apply for competitive grants and scholarships going forward.

The Northern HPB unit has a proven track record of strong clinical and laboratory research and benefits from a large prospectively maintained liver resection database, a large liver tumour biobank, and strong affiliations with basic scientists in the RNSH Kolling Institute.

Research program opportunities include (but are not limited to):

- Investigating molecular features of colorectal liver metastasis
  - (whole exome sequencing, nanostring gene expression profiling and proteomic expression analysis)
- Identifying early and prognostic biomarkers in liver cancers
- Investigating tumour-stroma interactions in primary and secondary liver cancers

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THE UNIVERSITY OF SYDNEY
NSW GOVERNMENT Health Northern Sydney Local Health District
RNSH SERT Institute

The way forward for the RACS complaints process

"My resident has told me Dr X is a real bully. It's been going on for years. Everyone knows it. The College has got to do something!"

– Anonymous complainant

The complaint is made. Where do the responsibilities and accountabilities lie?

In 2015, RACS established the Building Respect, Improving Patient Safety initiative, which outlined how RACS would counter unacceptable behaviours in surgical practice and training.

In April 2019 we conducted an evaluation of the actions taken by RACS so far. The findings showed that the College's activities were positively received and strongly supported by Fellows, Trainees and International Medical Graduates (IMGs).

The evaluation findings also confirmed that RACS is leading the way in developing a model for the introduction of respectful behaviours, with other colleges and organisations turning to RACS for policy advice and education programs. However, the College's complaints process was not perceived as safe by a substantial number of Trainees.

In June 2019, RACS Council reviewed the complaints process at a workshop. Experience with the complaints process highlighted the limited powers and options available to RACS to pursue a complaint. Consider the complaint described at the beginning of this article. There is an alleged perpetrator but the victim is anonymous. It is hearsay. It implies a long-standing issue which nobody has taken responsibility to address. It implies an abdication of responsibility. And it indicates a failure of leadership. There is nowhere for RACS to go with a complaint like this. Yet this complaint is made with the expectation that some consequence will ensue and that it will be made public.

What steps can be taken?

RACS has limited powers available to address poor behaviour. A Trainee can be moved to another unit or hospital or a unit can be disaccredited for training. A Fellow in breach of the RACS Code of Conduct can be censured. The ultimate sanction is removal of Fellowship. For RACS to invoke an effective sanction, the level of evidence required must match that required in a court of law – the Fellow who is subject to the complaint has the right to procedural fairness and natural justice, and to appeal to the Court if they disagree with the sanction. Without the ability to enter the workplace and undertake a full investigation, the chance of RACS acquiring the evidence to apply a meaningful sanction is low.

The real power to investigate and act on unprofessional behaviour is vested in the employer and the regulator. RACS is working more closely with both to improve the effectiveness of the complaints system. RACS has already signed memoranda of understanding and letters of intent with a number of hospitals and jurisdictions to enable information sharing and to encourage them to take responsibility for the safety of their working environments. RACS is also working more closely with the regulators such as the Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Council of New Zealand, to better facilitate complaint notifications.

Education and behaviour

Prevention is a more effective long-term strategy. The vast majority of surgeons and Trainees are good, well-motivated individuals. A simple complaint should serve as an invitation for dialogue. To change the culture that leads to escalated complaints we need to look more closely at behaviour.

The surgical workplace introduces a range of differential power relationships, some of which influence career progression. The psychology of transactional analysis[1] casts behaviour into the ego states of "child', "adult" and "parent". Berne says that "adult" behaviour assumes responsibility and ownership of their attitudes and behaviour while "child" behaviour is free and irresponsible and "parent" is critical or nurturing. Everyone exhibits all three behaviours from time to time. When attempted "adult" to "adult" communication receives a "parent" or "child" response, destructive interactions can result.

There is a place for behavioural education and training to enhance self-awareness and better equip surgeons and Trainees for the hierarchical, time-poor, ambition driven surgical environment. It is pleasing to note that the

majority of Fellows have completed the Operating with Respect online course, and those involved with Trainees or with RACS committees have completed the face-to-face course. These programs equip surgeons with the skills to moderate their behaviour in times of stress, and where necessary, to respectfully address unprofessional conduct in their colleagues. In this way, the principles of Operating with Respect can permeate hospital environments. RACS programs such as Surgeons as Leaders in Everyday Practice and RACS' Human Factors and Advanced Feedback modules introduce some behavioural psychology, to complement the broad skillset of the contemporary surgeon.

Moving forward

RACS will continue to support those who have been subjected to poor behaviour – to bullying, discrimination, or sexual harassment – and Trainees should feel safe to contact the RACS Hotline.

As RACS takes a more nuanced approach for individuals, initial focus is on a discussion or restorative mediation. The Vanderbilt program has shown that the majority of surgeons against whom a complaint has been made change their behaviour when alerted to the problem. RACS will also liaise more closely with the regulators and employers to encourage them to be more responsive to complaints, and will facilitate referral of issues to the employer or regulator when appropriate.

Conclusion

We strongly believe that everyone has the right to a safe working environment, where respectful behaviour encourages positive outcomes for individuals, colleagues and patients. RACS remains committed to addressing complaints and supporting Fellows, Trainees and IMGs to find the best possible resolution.

It's been proven that workplaces that foster an inclusive, diverse and respectful environment in surgery and practice achieve better patient outcomes. As the College continues to advocate for respect, the tools, education and resources we provide create a platform to minimise and manage disrespectful behaviour.

Partnerships with hospitals, regulators and specialty societies are clearly crucial to progress. It is important that we understand our respective roles and agree on how we can best work together to address behavioural issues effectively and create a respectful culture.

1 Berne, Eric. *Games People Play: The Psychology fo Human Relationships.* New York: Grove Press, 1964. Print.

Mr Richard Perry
Vice President

Advocating for improved health outcomes for Aboriginal and Torres Strait Islander peoples

NAIDOC week was held across Australia in July to celebrate the history, culture and achievements of Aboriginal and Torres Strait Islander peoples. NAIDOC originally stood for 'National Aborigines and Islanders Day Observance Committee' with the acronym now used for the week itself. Following the theme 'Voice, Treaty Truth', this year's focus was working together as Australians for a shared future.

Australia is one of few liberal democracies in the world that does not have a treaty or formal acknowledgment or arrangement with its Indigenous peoples. The New Zealand government respects the Treaty of Waitangi and places an important role on government policy and the relationship between Māori and non-Māori New Zealanders.

RACS has a commitment to Reconciliation in Australia that includes acknowledging Aboriginal and Torres Strait Islanders as the first inhabitants, traditional owners and custodians of Australia. We strongly believe that the surgical community should demonstrate leadership and advocate for improved healthcare outcomes for Indigenous peoples.

This commitment has been formalised in the RACS Reconciliation Action Plan for a number of years and has been acknowledged in our 2019 Strategic Plan as a business-critical endeavour across our strategic pillars. Our priorities are: to ensure the surgical workforce is culturally safe; increase the number of Indigenous surgeons; and advocate Close the Gap in health outcomes.

Our voice as an advocate in this space has been very strong; we have made a significant impact.

Following consistent advocacy from the College in partnership with the Australian Society of Otolaryngology Head & Neck Surgery this year, the Minister for Health Mr Greg Hunt announced $160 million for Indigenous health research, including ending avoidable deafness as one of its flagship priorities.

This impact was made possible by the commitment of surgeons to improving healthcare outcomes of Aboriginal and Torres Strait Islander peoples. It is an incredible testament to the importance of your work and something of which you should all be proud.

Special acknowledgement is extended to the work of Maxine Ronald, Kelvin Kong and the members of RACS Indigenous Health Committee. They have provided invaluable guidance in the development of RACS strategies around Indigenous health and their drive and commitment has raised the profile of Indigenous Health within the College.

CEO John Biviano officially launched our NAIDOC week activities speaking to staff on the importance of RACS commitment in advocating for improved health outcomes for Indigenous peoples. Educational resources were provided across College offices for staff who were also offered cultural awareness and safety seminars over the course of the week.

RACS Indigenous Health Committee overseas the implementation for the Reconciliation Action Plan, Māori Health Action Plan and the College's strategic commitments in Indigenous Health. We encourage all Fellows to learn more about the College's work across Australia and New Zealand in supporting Aboriginal, Torres Strait Islander and Māori Health. For more information, please search Indigenous Health on the RACS website.

IMAGE (left): RACS Staff engrossed in Aboriginal Australia Amazing Facts & Inventions poster set

Dr David Murray
Deputy Chair,
Indigenous Health Committee

Mr John Batten's portrait unveiled

RACS Past president John Batten was recognised at the June Council Dinner for his contribution to the College with the unveiling of his portrait, painted by plastic surgeon and Archibald Prize finalist, Dr Andrew Greensmith.

It is a long-standing tradition for College presidents to be honoured with a portrait, with 48 having been commissioned since the first was painted circa 1926.

Dr Greensmith has twice been a finalist in the nation's Archibald Prize with two consecutive portrait entries. The first was of 102-year old former ballerina Eileen Kramer in 2017, with the second being of academic and commentator Susan Carland, which now hangs in the Art Gallery of New South Wales.

Mr Batten said he read of Dr Greensmith's painting accomplishments in *Surgical News* (as featured in August 2018) and in the latter half of 2018, approached him to paint the presidential portrait.

"Andrew was at the time immersed in his third (2019) Archibald entry and was concerned about his time commitments. After kind consideration, he indicated that he drew great pleasure and was happiest when painting, and graciously accepted my offer – to my great honour," said Mr Batten.

"I am very proud that a Fellow of our College – a portrait painter of renown – did agree to paint my portrait and celebrate the art of portraiture, displaying the hidden talent within our Fellowship"

IMAGE (left): Past president Mr John Batten being presented a certificate of outstanding service by President Mr Tony Sparnon.

"I am very proud that a Fellow of our College – a portrait painter of renown – did agree to paint my portrait and celebrate the art of portraiture, displaying the hidden talent within our Fellowship," Mr Batten added.

Dr Greensmith (right), a self-taught artist, was former head of the Department of Craniofacial Surgery at the Royal Children's Hospital in Melbourne and has only recently made the choice to split his time between the studio and private practice.

The portrait will hang in the College's Council room where all immediate past presidents' portraits hang. The originals of all College portraits are kept in Melbourne with most hanging in the often-frequented Council, Hughes and President's meeting rooms. Copies are made for a president's home regional office and due to limited display space, some are held in storage.

Fellows, family and guests are welcome to view the portraits by arrangement through Geoff Down, RACS museum.

RACS is delighted to welcome Mr Batten as the incoming Chair, Foundation for Surgery, as he continues his longstanding contribution to the College in increasing access to safe and quality surgical care.

NSW Trainee on track to become first Aboriginal orthopaedic surgeon

While a severe knee injury spelled the end to his burgeoning AFL career, it also acted to steer Dr Anthony Murray (pictured, left) towards a new future as an orthopaedic surgeon.

The 2017 recipient of the RACS Aboriginal and Torres Strait Islander Surgical Education and Training (SET) Trainee Scholarship, Dr Murray is now expected to become the first Aboriginal orthopaedic surgeon in Australia when he completes his training in 2021.

Yet making history is nothing new for the Murray family, as Dr Murray is the brother of Dr David Murray who recently became the first Aboriginal general surgeon in the country.

Speaking to *Surgical News*, Dr Murray described the $20,000 funding attached to the Aboriginal and Torres Strait Island Trainee Scholarship as "life-changing".

He said he had used the money both to pay for additional training courses through the College and the Australian Orthopaedic Association (AOA) and to help cover some of the costs incurred by a trip to London to present research at the Royal College of Surgeons.

His research, *Microbial cell counts after surgical skin preparation – a randomised control trial*, was presented to the British Society for Surgery of the Hand Annual Scientific Meeting.

"It felt like great timing and very significant to receive this scholarship," Dr Murray said.

"It genuinely made a substantial impact on my life and training as a surgeon and I felt incredibly fortunate to have the opportunity to present research at such an historic institution as the Royal College of Surgeons, particularly as an Aboriginal doctor."

Dr Murray is currently working at the Hunter New England Health District and is an examiner, lecturer and anatomy tutor attached to the University of Newcastle School of Medicine.

He has a keen interest in upper limb surgery and orthopaedic trauma surgery and has current research interests focused on developing surgical education models designed to teach orthopaedic trauma surgical skills in a way that is best retained by junior doctors.

Dr Murray was drawn to orthopaedic surgery because of the variety of procedures and patients involved and the opportunity it provided to change the lives of the injured or impaired.

He said he received great support from the College and senior surgeons and listed his mentors as Professor Zsolt Balogh, the Director of Trauma at the John Hunter Hospital and Professor of Traumatology at the University of Newcastle, and Dr Ed Bateman, an upper limb reconstructive surgeon.

"When I had my knee injury, I had to spend quite a bit of time with orthopaedic surgeons and registrars and I found the work involved in treating musculoskeletal injuries fascinating so I think I just had a natural calling towards orthopaedics," Dr Murray said.

"In recent years I've focused my research interests around hand surgery but having done a few rotations now and having completed the CCrISP course, I've found that I'm also drawn to orthopaedic trauma surgery because it really can change lives.

"To be called to treat someone who's got a debilitating disease or what you think may be unsalvageable injuries and then to see them after a few weeks walk out the door is incredible."

"(The Scholarship) genuinely made a substantial impact on my life and training as a surgeon… I felt incredibly fortunate to have the opportunity to present research at such an historic institution as the Royal College of Surgeons, particularly as an Aboriginal doctor."

Dr Murray has been a member of the Australian Indigenous Doctors' Association (AIDA) since he became a medical student and in those early days made long trips up the Queensland coast speaking to Indigenous students at schools along the way encouraging them to consider a career in health and medicine.

Now he has a dream to establish and coordinate an outreach service to provide surgical care by Indigenous surgeons for Indigenous patients across all specialties for people in regional and remote communities.

"While I don't believe there will ever be parity of Indigenous people in surgery as compared to the population, my hope is that one day we might reach a level where we have an Indigenous surgeon in each specialty so that if there is a need for cultural awareness and sensitivity that need can be met," he said.

"I'd love to think that if an Indigenous patient needed Upper GI surgery, for instance, there'd be an Indigenous surgeon available to provide it.

"I don't plan to establish an outreach service from scratch because there are many organisations who do great work in this space and there's no need to reinvent the wheel.

"Yet there are gaps in the provision of surgical services for Indigenous people living in remote communities so my aim, after I complete my training, is to create a network of surgeons willing to give their time and skills to those patients who often miss out on surgical care because of cultural issues or geographical isolation.

"Some Indigenous people find the western health model overwhelming and isolating and sometimes refuse treatment, yet if we find the time to describe what we can do, how the surgery will reduce pain or increase function and our expectations of the results going forward, they are more willing to receive the treatment they need."

The RACS Aboriginal and Torres Strait Islander SET Trainee Scholarship is funded by Johnson & Johnson Medical Devices and is designed to help Indigenous doctors become surgeons.

Johnson & Johnson is proud to partner with RACS to offer scholarships for Aboriginal and Torres Strait Islander and Māori Trainee surgeons. We are committed to working together to support and increase the number of Indigenous surgeons in both Australia and New Zealand. I extend my congratulations to Dr Murray for winning this scholarship and wish him well as he completes his Traineeship and becomes the first Aboriginal orthopaedic surgeon," said Sue Martin, Managing Director, Johnson & Johnson Medical Devices.

Dr Murray thanked the College and Johnson & Johnson Medical Devices for the Aboriginal and Torres Strait Islander Scholarship and support given to him during his surgical training.

He said he had a keen interest in upper limb surgery and hoped to undertake a Fellowship in microsurgery or replant surgery in Australia or overseas before returning to Newcastle as a consultant.

Career highlights

2018: Research Published in the European Journal of Hand Surgery on the *effect of nail polish on bacterial counts after surgical skin preparation.*

2017: Recipient of the RACS Aboriginal and Torres Strait Islander Trainee Scholarship.

2016: Research presentation to the British Society for Surgery of the Hand Annual Scientific Meeting, Royal College of Surgeons, London.

2015: Research presentation to the Annual Scientific Meeting NSW Hand Surgery Association on *radiation exposure to seated hand surgeons.*

With Karen Murphy
Surgical News Journalist

Paediatric surgery association set to expand its role and presence

Newly elected president of the Australian and New Zealand Association of Paediatric Surgeons plans to enhance digital presence to provide more services to members

The recently elected president of the Australian and New Zealand Association of Paediatric Surgeons (ANZAPS), Dr Guy Henry (pictured), plans to expand both the presence and purpose of the association to benefit its members and the children of Australasia.

Dr Henry became president in March having previously served as treasurer and secretary of ANZAPS. He is a member of the College's Board of Paediatric Surgery and served for 11 years on the RACS Court of Examiners for paediatric surgery before retiring from the position earlier this year.

Based at Sydney Children's Hospital, Dr Henry obtained his general surgical Fellowship in 1994 before taking up a Paediatric Trauma Fellowship at the Children's National Medical Center, Washington DC. He received his paediatric surgical Fellowship in 1997.

Speaking to *Surgical News,* Dr Henry said that ANZAPS had a key role to play in advocating for children and supporting research collaborations as well as developing reaccreditation programs and providing Continuing Professional Development (CPD) resources to its members.

Dr Henry said that as the smallest of the specialties, the craft group had been restricted in its aspirations in the past by limited finances and the small pool of surgeons available to provide volunteer services. He is now hoping to circumvent those limitations by expanding ANZAPS digital presence to enhance communication and collaboration between members, promote paediatric surgical research, support rural and regional surgeons and advocate for children's health and safety. The first step is to develop a more significant website.

Dr Henry also aims to develop closer relationships with international paediatric associations such as those in the US, UK and Canada, as a way to access and share resources, develop research collaborations and provide training Fellowships.

> "Paediatric surgery represents only two per cent of Australia and New Zealand's surgical population and as such the role of ANZAPS has been limited by our small numbers but my hope as President is to create a digital presence that will allow us to better support all paediatric surgeons."

"Paediatric surgery represents only two per cent of Australia and New Zealand's surgical population and as such the role of ANZAPS has been limited by our small numbers but my hope as President is to create a digital presence that will allow us to better support all paediatric surgeons," Dr Henry said.

"We hope to create a database that will allow paediatric surgeons to better connect with each other while also allowing surgeons from other specialties or other countries to connect with us to optimise the surgical care of children.

"We would also like to provide members with details of international meetings and research that may be of interest, set up a bi-national audit of paediatric surgical outcomes and create links between paediatric surgical researchers."

Did you know?

Paediatric surgeons treat and manage children aged up to 16 years in most cases. They commonly deal with general paediatric, paediatric urology, non-cardio thoracic surgery and oncological surgery for children. They are also involved in the antenatal management of congenital structural abnormalities and neonatal surgery. Their most common work is known within the craft as groinology (circumcisions, hernias and undescended testes) but they also commonly treat rare conditions in newborns and conduct organ transplants. Of the 114 paediatric surgeons currently working in Australia and New Zealand, 40 per cent are women, with the number of female Trainees rising to 65 per cent.

Dr Henry explained he also wanted ANZAPS to develop recredentialling protocols and programs, provide CPD resources and offer independent auditing services to paediatric surgeons working in smaller units who may find it otherwise hard to achieve this. He is currently in discussions with RACS to expand the secretarial services funded by ANZAPS but provided by the College to assist in the expansion of the association's role and vision.

'We want to offer more to members to keep them informed of matters that affect them and to promote the crucial role they play in the surgical management and care of children so they feel proud to be members of our craft group," Dr Henry said.

"ANZAPS also has a crucial role to play in recredentialling and I believe our members will be best served if we take the lead and develop policies and programs to assist all paediatric surgeons to meet any proposed requirements going forward."

With only 100 paediatric surgeons spread across Australia and New Zealand, Dr Henry said it was important for the specialty to create strong links with other surgeons – both from different specialties and around the world – if it was to best represent the craft group and advocate for children's surgical services.

He said he would like to have a closer relationship between ANZAPS and the RACS Trauma Committee to collaborate on children's safety campaigns and for the association to have a more active role in supporting the College's paediatric outreach visits to Pacific Island nations.

Dr Henry also plans to develop stronger ties between the association and other surgeons who treat children such as rural and regional general surgeons and for ANZAPS to develop a larger role in the provision of paediatric outreach services.

"ANZAPS also has the potential to help build collaborations between hospitals conducting ongoing paediatric research along with the ability to provide more significant numbers in various studies.

"We could help paediatric surgical researchers to better connect with surgeons so they can expand their research across hospital facilities and conduct multi-centre research and trials," he said.

Dr Henry also believes ANZAPS has a role in helping in the training of rural and remote surgeons.

"Most of the large children's hospitals in our major cities could offer Paediatric Fellowships for general surgeons who plan to work in regional or rural settings but there is also scope for us to arrange short visits for regional surgeons who wish to expand their paediatric surgical skills at our major urban centres."

With Karen Murphy
Surgical News Journalist

Challenging stereotypes – #ILookLikeASurgeon

When Dr Heather Logghe finished her second year of surgical training, she was left with a sense of frustration about the added barriers that she witnessed being faced by those who did not fit the typical stereotype of what a surgeon is perceived to be.

After discussing her experiences with friends and colleagues, she soon discovered that many shared the same frustrations. Having witnessed the success of the hashtag #iLookLikeanEngineer, Heather authored the blog post *#ILookLikeASurgeon. Tweet it. Own it: Be the Role Model You Always Wanted But Never Had.*

She then tweeted the blog post using the hashtag #ILookLikeASurgeon, and with that a movement was born.

Four years since its inception the hashtag has now had more than 200,000 tweets, reached more than one hundred million people and made over a billion impressions. But despite its seemingly instant success, the initial stages of the campaign were not without dedicated hard work from Dr Logghe and her colleagues.

"In the initial days, I was retweeting for 18 to 22 hours a day. Perhaps some tweets happen and go viral on their own, but this one took a lot of effort not just from me but from others, including Drs Kathryn Hughes and Marissa Boeck, who were retweeting and reaching out to encourage others to contribute.

"We realised we had the microphone for a brief moment, so we had to ask ourselves exactly what we wanted to happen. It was a combination of reacting to the opportunity and strategising on the go," Dr Logghe said.

The intent of the campaign was to highlight the many faces that make up surgery and to promote the diversity amongst the profession, particularly in relation to gender, race and ethnicity. Women and men from all backgrounds were encouraged to share photos of themselves.

Eventually, thousands of surgeons and surgical Trainees were adding to the conversation and uploading photos of themselves to the social media site. This included pictures in the operating theatre, with colleagues, at home, with family, and in various settings in their personal lives.

"It gave people a new perspective of what it looks like to be a surgeon, as opposed to what was traditionally portrayed. In our CVs we have the bullet points highlighted and almost try to gloss over the spaces where life happens. I think people may feel they are a little bit alone in their unique path, but I think often perhaps the unique path is a lot more common than they realise.

"For example, I heard from a few young black women who had never come across a black female orthopaedic surgeon and wondered if they existed. They were literally making comments like 'this hashtag gives me life,'" Dr Logghe said.

Not long after the hashtag went viral, a broader conversation about discrimination, bullying and sexual harassment (DBSH) in surgery and healthcare emerged, largely driven by the work of the RACS Expert Advisory Group (EAG) in 2015.

At the time, Heather was aware of the work being done in Australia and New Zealand. She identified it as one of the factors that helped motivate her to keep pursuing the hashtag.

"I was so impressed by everything I looked at in the EAG report. RACS did everything in their power to get that information. They didn't try to ask questions in a way that would hide the reality and that was really unprecedented.

"There seemed to be this belief, which is still quite prevalent, that if DBSH was such a problem then people would have reported it. But that overlooks the stress, the financial impacts, and the emotional turmoil and vulnerability of going through the complaints process. This idea that you can make a complaint and then it will all be fine is a long way from reality.

"I definitely congratulate RACS on all they have done to promote diversity to this point. I really think they have been world leaders in addressing DBSH in surgery. Now is the time to focus on what we do with all that data and begin focusing on the next steps which are to listen to the advisors and the advice of the people that experienced those issues. We need to ensure that the people in positions of power are speaking for everybody who is affected."

Prior to her surgical training, Heather completed her undergraduate studies in psychology with a focus on women's studies. She has long been interested in the link between popular culture and discrimination and how in the worst cases it can lead to sexual violence.

Her background in psychology has helped her to gain additional perspective on the important role that education and awareness play on influencing human behaviour.

"Implicit bias is part of human nature. For most of us, gender roles have been ingrained from birth and continue in our education and other cultural influences. Often, cultural expectations of gendered behaviour hurt us all.

"Just one very small example is a line from one of America's most popular musical songs (*Tell me More* from the musical Grease) which says, 'did she put up a fight?' What exactly are we trying to say there?

"People aren't 100 per cent good or bad. There is a lot of conditioning and expectation about what we now realise is inappropriate, makes people feel uncomfortable and can be damaging. It isn't about blaming anyone for that culture, it is more about highlighting the problems with it and focusing on equity moving forward.

"I think if people sometimes were to get the feedback that their behaviour was making others feel uncomfortable they would usually be quite surprised and often would be open to changing.

"One of my favourite quotes is 'the standard you walk past is the standard you accept.' It is so true. If nobody says anything then you never get that feedback, and things perpetuate over time and become conditioned," Dr Logghe said.

Since the hashtag took off, Dr Logghe has become renowned as a trailblazer in the use of social media in surgery and is now an internationally sought-after speaker. She was recently an invited guest at the RACS 2019 Annual Scientific Congress where she headlined the first all day Women in Surgery Section program.

Reflecting on the last four years Heather said that the #ILookLikeASurgeon campaign had not only changed her life, but also demonstrated the effectiveness of social media in highlighting issues of inequality and developing a groundswell for change.

"It has given me a position that I otherwise wouldn't have had. I wouldn't have been able to make the presentations that I did at the ASC, nor would I have met so many amazing colleagues from across the globe, shared stories and developed such great support networks. It has been surreal and a privilege.

"There is no set way for how social media should be done and it definitely poses challenges for bigger organisations. But I wouldn't underestimate the potential for cultural change that it offers. There is a lot of power that comes with having such a strong following, and a lot of responsibility.

"For me that responsibility has been a little overwhelming at times, but I think inherently the success of the hashtag has been the motivation, the validation and the inspiration that I needed to keep talking about these issues and most importantly to continue my training.

"What is really significant about social media use is the way that it has up-ended traditional hierarchies and traditional paths to influence. That has pros and cons for surgery which is based a lot around tradition. This evolution has been both exciting and uncomfortable at times.

"I don't think things happen for a reason, but I think we can make reasons out of things that happen. I have had a tremendous opportunity to be part of a growing momentum for change and I feel like that has and will continue to create a more inclusive culture, and ultimately be for the betterment of our profession."

Dr Heather Logghe was a guest speaker at the Women in Surgery Section program at RACS 2019 Annual Scientific Meeting in Bangkok. She is currently a surgical research fellow at Thomas Jefferson University Hospital in Philadelphia, examining the role of social media surgical education, research dissemination and patient care.

– With Mark Morgan, Communications and Advocacy, South Australia

Correction

The 'Women in Surgery's Super Thursday a success' article in *Surgical News* (March/April) named Dr Jane Strang as convener of the ASC Women in Surgery Section program and omitted mention of Dr Aleksandra Popadich and her significant contribution as co-convener.

The leadership keynote speech (attributed to Dr Christine Lai) was given by leadership development specialist Ms Suzi McAlpine with Dr Christine Lai as Chair.

The RACS Women in Surgery Section also wishes to acknowledge Macquarie Bank as sponsor of the all-day program.

Going the distance

An International Medical Graduate's challenging journey rewarded with FRACS and orthopaedic practice in Melbourne and Bendigo

Dr Vera Sallen, the first female orthopaedic consultant appointed to work at one of Europe's leading orthopaedic teaching hospitals – the University Hospital Balgrist in Zurich – has since become one of the first women to obtain a FRACS in orthopaedic surgery as an International Medical Graduate (IMG).

Born in Germany in a small town near Cologne, Dr Sallen did her medical training at the historic Ludwig-Maximilians-Universität in Munich.

She completed her orthopaedic and trauma training at the Uniklinik Balgrist, a 200-bed specialist orthopaedic centre attached to the University of Zurich in Switzerland, working under the supervision and mentorship of renowned upper limb surgeon Professor Christian Gerber.

In the following years, Dr Sallen went on to complete Fellowships in upper limb, hand and microsurgery in Paris and finalised her doctoral thesis in the surgical management of rheumatoid arthritis of the shoulder joint through the University of Hamburg, Germany.

Wanting more exposure to orthopaedic trauma, Dr Sallen then successfully applied for an 18-month Fellowship at the Alfred Hospital in Melbourne, a decision that changed her life after she met her future husband there.

Now, she is a mother of two and has a combined general orthopaedic public and private practice based in Bendigo in regional Victoria and a private practice focused on lower limb arthroplasty and upper limb surgery in Melbourne.

Speaking to *Surgical News*, Dr Sallen said it had been a difficult decision to move to Australia permanently given that it required walking away from her qualifications, returning to supervised surgery and sitting an exam in a foreign language.

However, being bilingual made it the easier option for the family though a stressful experience for her.

"While most International Medical Graduates (IMGs) understand the need for the rigorous processes and requirements asked of us as surgeons wanting to work in Australia, it can be daunting," Dr Sallen said.

"We feel like we're caught up between the different organisations involved – the Australian Medical Council (AMC), the College of Surgeons and the Australian Health Practitioner Regulation Agency (AHPRA) – and sometimes there can be communication breakdowns between them which can be difficult to resolve.

"However, I was extremely lucky to be offered a position at Bendigo Health which gave me the broad exposure to a range of orthopaedic procedures necessary to pass

the FRACS exam and particularly fortunate to gain the support, mentorship and supervision of Mr Dugal James."

Now Dr Sallen is a member of the Australian Orthopaedic Association (AOA) and sits on the IMG Committee, sharing her different perspective on the broader IMG pathway.

She believes more could be done to support IMGs as they strive to meet the necessary requirements to allow them to work in Australia.

"Clearly, surgical posts with a broad range of pathologies are more valuable when preparing for the Fellowship examination, but appropriate support and supervision is also necessary as each IMG may have had a different subspecialty focus," Dr Sallen said.
"Going through this process in Australia definitely slows down career progression for many IMGs, particularly if they come as junior consultants which is a very important time in every surgeon's career.

"You're in the prime of your surgical life as a junior consultant, a time when you're learning, teaching, networking with colleagues, travelling and presenting and conducting research but you must focus and direct your energy toward achieving the necessary requirements.

"Often IMG posts are in regional areas which can also make participation in study groups and attendance at bone school difficult."

To overcome this, Dr Sallen would like to see a greater focus placed upon matching IMGs with senior Fellows

willing to act as mentors and assistance given to IMGs to help them navigate the regulatory requirements asked of them.

Having received her FRACS in 2017 upon her second attempt, Dr Sallen is now enjoying her life as a consultant orthopaedic surgeon in Victoria.

She works four days every fortnight in Bendigo managing a wide variety of procedures from treating farm accidents to conducting joint replacements, covers a weekend on-call trauma roster every eight weeks and spends the rest of her time focusing on her private practice in Melbourne.

She said that while she had been drawn to orthopaedic surgery early in her medical studies and had travelled widely to complete her training, she had never imagined working as an orthopaedic surgeon in Australia.

"I like the mechanical way of thinking that we do as orthopaedic surgeons and I like being hands-on but more than anything I love orthopaedic surgery because it is a beautiful thing to restore function and reduce the pain suffered by many of our patients," she said.

> "I also really enjoy working in Australia because I have broadened my surgical skill set and now perform a wider range of procedures than I did in Europe… It was a difficult journey to get here as a surgeon, but I don't regret it for a minute."

"I also really enjoy working in Australia because I have broadened my surgical skill set and now perform a wider range of procedures than I did in Europe, where surgical units are usually more subspecialised.

"It was a difficult journey to get here as a surgeon, but I don't regret it for a minute."

With Karen Murphy
Surgical News Journalist

Surgical burnout – from the academic to the personal

Recent articles and commentary on surgical stress, anxiety and burnout are to be welcomed.[1,2,3] As a senior surgeon who has been through many stressful situations without support it is especially welcome.

At the time of my training and practice in the 1990s stress was considered part and parcel of being a surgeon. There are now many research articles discussing surgical stress and its effects, there is also scope to share personal experiences, the intensity of affect which cannot be underestimated, the descriptions of which may have potential benefit for both Trainee and qualified surgeons. This is an attempt to start a more personalised discussion, based on the academic foundation that has now been established.

A surgical mentor once said that complications would occur, but part of being a great surgeon was not letting that get to you. The lesson back then was really that part of surgical training was to develop a thick skin and hide any sensitivity. Amongst Trainees at that time we knew surgery was looking for strong-minded individuals who were decision-makers. To say that that worked well would be to endorse the non-caring aspect. However this era was about surviving stressful situations without the current understanding of how to handle stress. Hiding sensitivity became almost an art in itself, represented by one colleague who had left an abdominal pack inside a patient. When asked whether it gave him sleepless nights he replied, "No that's what you have medical defence insurance for". That deflective approach has been endorsed in surgery unofficially until recently.

We now know that for many, stress was internalised, not deflected, causing not only personality change but potentially suicidal behaviour.[4] While there are many factors related to the 50 per cent burnout rate amongst Trainees, one of the positive developments has been identifying issues and discussing them.[5] The value of discussion, particularly interactive, cannot be underestimated. More can be done, and I base this partly on my own experience as well as recent evidence.

Surviving a terrorist attack which threatened my future in surgery, I applied the 'surgical principle' related to stress – not to internalise it and to get on with life and surgery. I only realised that such an approach was totally inadequate when others remarked on apparent personality changes, anger reactions to minor provocation, the disappearance of happiness in family interactions, corruption of otherwise accurate decision-making, all now commonly recognised as manifestations of stress.[5, 6] At that time Post Traumatic Stress Disorder was not adequately explained, nor how to deal with it. Salvation in terms of the overwhelming stressful reaction was therefore serendipitous; I started writing about had happened.

One major stressor in surgery is litigation. For a young surgeon without the old reflective hide it can be as devastating as personal trauma. Early in my surgical career I was sued over an inguinal wound infection.

The exchange of lawyer's letters suggesting I was incompetent permeated my subconscious, despite being told by my counsel that this was all part of a legal game to achieve a settlement. The nightmare finally went away. Independent expert international opinion attributed the infection to mismanagement by the microbiologist consulted. My lawyer then advised a $60,000 settlement to make the case go away. Noting my indignation, she said, "Up to you. If you want to appear in the local newspaper and suffer the consequences to your practice, then we will fight it." I didn't fancy that and we settled.

For this type of rabid legal character assassination, surgical Trainees need to be given real life scenarios; directed by colleagues and antagonistic lawyers, (although I can't imagine any doing it pro bono which may limit the interaction). This could be further developed with a closed password access online forum for surgeons to be able to support colleagues through their own experiences, particularly in litigation.[7] Surgeons who have been through personal trauma and who are at ease talking about it could volunteer to be online mentors notified by email when a colleague registers on the online forum. One of the things that I found most helpful later in my surgical career was being able to talk to colleagues about situations that arose in surgery, and have their advice on how not only they dealt with complications and any potential litigation, but also the stress.

In summary the greater understanding that surgery is showing off factors causing stress and burnout, could be further expanded through personal support and intervention, potentially diminishing burnout even further. In addition, the availability/oversight of professional colleagues trained in dealing with stress and anxiety, monitoring and providing feedback and where necessary advising on treatment, would be desirable. To have an online forum available immediately when the trauma happens, potentially may lessen the impact on Trainees and young surgeons and provide another avenue for research.

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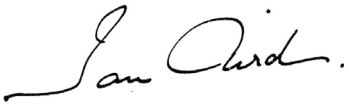
Dr Paul Anderson
FRACS
– With Dr Jordan Anderson M.B.Ch.B

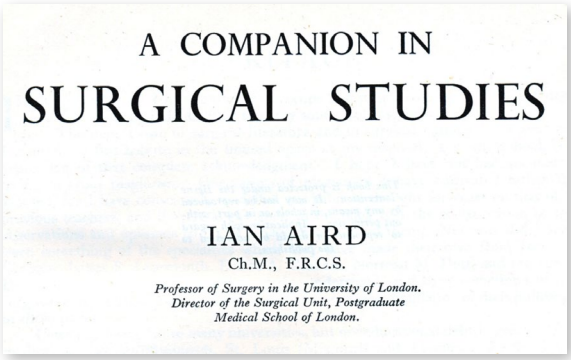
Visit the Surgeons Wellbeing page on the RACS website for information and resources on topics including practising self-care; looking after your health; coping strategies and peer support. – Ed.



Ian Aird (1905-1962)

M.B., Ch.B. Edinburgh 1928; Ch.M. 1935; F.R.C.S.Ed. 1930; F.R.C.S. 1946; Hon. F.A.C.S. 1957.

The GJ Royal Memorial Lecture honours the memory of Geoffrey James Royal FRACS (1939-1991) who occupied senior positions at the Geelong hospital over 20 years, including Supervisor of Surgical Training. A brilliant and persuasive tutor, Geoff brought to the attention of his registrars, Ian Aird's monumental book, *A Companion in Surgical Studies*.


A COMPANION IN
SURGICAL STUDIES

IAN AIRD
Ch.M., F.R.C.S.
Professor of Surgery in the University of London.
Director of the Surgical Unit, Postgraduate
Medical School of London.

First appearing in June 1949, and by year's end running into a second printing, *The Practitioner* considered the work, "a masterpiece of clear exposition by an author of remarkable breadth of view". *The Lancet* noted, "surgeons will hasten to get a copy of the book which will always remain a monument of erudition".

Ian Aird was born in Edinburgh on 4 July 1905, the son of William Aird and Jean Elizabeth Binnie: he was educated at George Watson's College and the University of Edinburgh where he obtained the Thomson Scholarship, Wightman Prize and Annandale Gold Medal.

In 1935 he was appointed surgeon to the Royal Hospital for Sick Children in Edinburgh and assistant surgeon to the Royal Infirmary. During the period between these appointments and the beginning of the war in 1939 he acquired a great reputation as a teacher of surgery.

In WWII he joined the Royal Army Medical Corps rising to the rank of Lieutenant-Colonel and being twice mentioned in dispatches. Most of his service was in the North African campaign where he pioneered a mobile surgical unit. He was briefly a prisoner of war during that campaign, receiving praise from both the Germans and Italians for treating their wounded, once, in the presence of Erwin Rommel, the 'Desert Fox'.

Returning to Scotland in 1944, he was appointed assistant surgeon to the Professorial Unit in Edinburgh and Deputy Director of the Wilkie Surgical Laboratories. In 1946 he was appointed Professor of Surgery, University of London, and Director of Surgical Studies, Postgraduate Medical School of London, Hammersmith Hospital.

His first assistant was Maurice Ewing who in 1955 was appointed Foundation Professor in Surgery at the University of Melbourne: Professor Vernon Marshall in his obituary of Ewing noted that, "he was Aird's right hand and they formed a powerful duo".

Aird was a man of outstanding academic achievement and phenomenal industry; he was an ideal director of a research unit and an inspiration to those working with him: he served on the Court of Examiners and the Council of the Royal College of Surgeons of England.

Regarding the omission of diagrams from his 1,060 page *magnum opus*, Aird would grin: "I meant this as a bible – and the Bible does not have any pictures", adding, "there is no doubt that the commonest type of memory is that which relies on visual impressions, yet too close a dependence on visual memory enchains the intellect; the highest faculty of the intellect and the finest medium for communication is language."

"The title of this book has been chosen to avoid any suggestion that it is a manual or textbook designed to teach the reader how to conduct a surgical practice or to perform operations.

"The surgical student's illustration is the living patient and his blackboard is the operation wound. A doctor not widely read cannot collect clinical data from a patient, much less interpret and collate them.

"So too when the surgical apprentice assists at an operation. The steps of that operation are chosen by his principal from many alternatives, and to understand a technique the assistant must not only know its details but be familiar with its alternatives and appreciate the reasons for its choice.

Images (Clockwise from top-left): *A Companion in Surgical Studies*, Frontis; Aird's mobile operating tent; Lt.-Colonel Aird in the Western Desert.

Image (right): Ian Aird, 1958.

"The list of references is not intended to be exhaustive. I have tried to predigest the written work of others by the enzymes of a personal experience admittedly limited."

Ian Aird also authored an interesting tome entitled *'The Making of a Surgeon'*, published in 1961, commencing the first chapter, entitled *'Necessary Training'*, with these words:

> In this book I am going to be mainly concerned with a description of the training that must be undertaken by anyone who elects to follow surgery as a career and the kind of life he can expect when he has qualified as a surgeon, but I must say something also of the motives that lead at least some men to surgery as a profession.
>
> I suppose that at no time have men taken up surgery as a profession purely for financial gain. The surgeon who came late to dinner has never existed. I mean the one who excused himself to his host by saying that he had been called in emergency to the South Coast to perform an urgent operation.
>
> *How interesting,'* said his host, *'what did you operate for?'*
>
> *'One hundred and eighty-three pounds, seven shillings and tenpence.'*
>
> *'No no,'* went on the host, *'I mean what did the patient have?'*
>
> *'One hundred and eighty-three pounds, seven shillings and tenpence.'*

Aird devoted much of this work to his concern about the stability or otherwise of marriages during surgical training: "As recently as 30 years ago I heard the late Sir Henry Wade say, on learning of a young fellow in his 30s getting married, *'knife before wife'*, or to one of his assistants who showed signs of an attachment, *'A young surgeon should keep his affections in cold storage.'* "

In 1953 he achieved notoriety for an operation to separate Siamese twins from Nigeria, this publicity tended to obscure his much more solid and important surgical achievements, such as the development of the heart-lung machine and of organ transplantation.

Many of Aird's papers on surgical subjects were published in the *British Medical Journal.* His department carried out research on the perfusion of isolated human organs, resulting in a mechanical heart-lung being described in 1953; a year later, his paper, "Assisted Circulation by Pump-oxygenator during Operative Dilatation of the Aortic Valve in Man" was published.

He was also much interested in the relationship between blood groups and lesions of the alimentary tract, specifically cancer of the stomach and peptic ulceration.

On the morning of Monday 17 September 1962, Ian Aird had not appeared in the hospital: on the door of the Professor's flat was pinned a hand-written notice, 'Please do not disturb-Ian Aird'.

Later that day his Resident Surgical Officer opened the unlocked door and saw the figure of Aird sitting up in his bed with his glasses on his nose, reading a book on his lap. The Professor was dead.

The Bible on his knees was open at Ecclesiastes:

'To everything there is a season, and a time to every purpose under the heaven…'

A book was also found on Aird's deathbed in which he had written:

> 'To the Hammersmith Coroner:
>
> I have taken a fairly substantial dose of barbiturates. I have never taken a drug before in my life.
>
> I have passed my apogee. My skill is going and I am in deep despair. I find myself immersed in unmitigated gloom.
>
> Although I am a sincere and practising Christian, I cannot continue. I have burnt myself out.'
>
> There is too much to do. I cannot write my book again.
>
> My department has produced the electronic control of patients in operating theatres, done the first intra-cardiac operations, transplanted the first kidney homografts in Britain, shown the connection between blood groups and disease, and there has been no distinction given to us….
>
> Ian Aird'

His biographer concluded:

'Aird did not value titles or bits of ribbon, but why did he have to fight for money?

Why did he meet such active discouragement in medical circles?

These were the things which both baffled and angered him.'

Ian Aird had married in 1936.

His wife, son and daughter were left, mystified, as were his countless colleagues and students.

His Obituary in the British Medical Journal noted, his *'sudden death removes from us one of the outstanding surgeons of his time.'*

Mr Peter F. Burke
FRACS

Retired surgeon continues to support new generations of Fellows

Retired colorectal surgeon, Mr Brian Morgan AM (pictured right), made many significant contributions to surgery during the course of his long career as a surgeon and teacher at the Royal Prince Alfred (RPA) Hospital in Sydney.

The first resident at RPA to obtain a Fellowship in general surgery, Mr Morgan spent two years expanding his skills in the UK.

In 1969 he introduced colonoscopy into surgical practice in Australia. This procedure transformed the detection, treatment and cure rates of colorectal cancer.

Over subsequent years, he became a leader in the development of day surgery which created huge savings across the health system and worked to understand and meet surgical workforce demands while maintaining surgical standards.

Mr Morgan served on the College Council from 1979 – 1990 during which time he held a number of senior positions including Censor in Chief and Vice President and was later elected to the College's Court of Honour for his services to the profession.

In 1992, he was awarded an Honorary Master of Surgery Degree by the University of Sydney in recognition of his commitment to the teaching and training of junior doctors. The following year he became a Member of the Order of Australia for services to surgery and surgical education.

He also became one of the few Australian surgeons to be made an Honorary Fellow of the American Society of Colon and Rectal Surgeon.

Yet although long retired, Mr Morgan's contribution to surgery did not finish when he put down his scalpel and took off his scrubs for the final time.

Instead, he chose to continue to support new generations of surgeons through his funding of a perpetual Fellowship designed to expand the skills and broaden the experience of young surgeons.

The Morgan Travelling Fellowship helps fund younger surgeons in the first five years of receiving their FRACS who wish to travel overseas to gain clinical experience or to conduct research.

First awarded in 2008, the Fellowship has so far supported 20 Fellows across specialties to gain vital international exposure. Many of them have gone on to become leaders in their field.

Some of these include:

- Dr Nathan Lawrentschuk (2009) who used the funds to support a Urologic Oncology Fellowship through the University of Toronto, Canada.
- Dr Ben Dixon (2011) who worked at the University Health Network in Toronto conducting research into the integration of new technologies in theatre such as 3D visualisation displays including augmented reality and virtual views.
- Dr Elizabeth Hodge (2014) who took up a Fellowship through the National Centre for Airway Reconstruction in the UK which enabled her to participate in more than 20 open airway reconstructive procedures.
- Dr Timothy Lording (2015) who completed a Fellowship in Orthopaedic Sports Medicine in Ontario, Canada, where he completed more than 10 research papers and book chapters on various aspects of sports knee surgery and arthroplasty.

Legacy Funds

Each of us finds different ways to make our mark on the world. A Legacy Fund through the Foundation for Surgery is an extraordinary gift that will always be remembered.

There are two very special ways you can transform lives and advance your specialty or area of passion. You can:

- **Establish a named perpetual scholarship,** as Mr Morgan has done, so that you can see the results of your philanthropy in your lifetime; or
- **Leave a bequest,** of any size, in your will and improve the lives of others into the future.

This 'Include a Charity' month, we invite you to consider your legacy. Please contact Jessica Redwood, Manager, Foundation for Surgery at foundation@surgeons.org or call +61 3 9249 1110 today.

Speaking to *Surgical News*, Mr Morgan said he had established the Travelling Fellowship to give young surgeons exposure to new techniques and different health systems along with the opportunity to develop international networks and conduct research.

He said that because he wanted the scholarship to be available in perpetuity, he had begun giving money to the College some years before the corpus of funds was sufficient to pay for the Fellowship from interest earned and the income from investments as managed by the Foundation for Surgery.

"This was a good approach because it meant that I could start donating early, contributing what I could afford while receiving tax deductions for my donations.

"Over time the fund has grown considerably, through compound interest and earnings on investments, and now we can support two Fellowships a year which is extremely pleasing."

Photo taken at the Foundation for Surgery Thank you Dinner, Sydney. From left: Mr Paul Mirabelle, Dr Chantel Thornton, Dr Glen Guerra and Mr Brian Morgan

Mr Morgan said he had chosen to fund a travelling Fellowship because he had found his time in the UK of great value in helping him gain considerable experience and he wanted to help give other young surgeons the same opportunity.

He said that while the College chose the recipients, he received written reports made by all Morgan Travelling Fellows detailing their achievements and the advances made during their time away from Australia.

"Some of these surgeons have done remarkable things for patients in Australia and New Zealand which is the most rewarding aspect of the whole endeavour," Mr Morgan said.

"Many also make lifelong friends through having a chance to develop networks around the world. They also get to experience different cultures and attitudes and health systems while learning new surgical skills and conducting research designed to advance their surgical specialty.

"While Australia and New Zealand provide some of the best surgical training in the world, we can still feel the tyranny of distance. The Travelling Fellowship is designed to help give young surgeons access to the wider surgical world for the benefit of patients and the surgical profession."

"While Australia and New Zealand provide some of the best surgical training in the world, we can still feel the tyranny of distance and the Travelling Fellowship is designed to help give young surgeons access to the wider surgical world for the benefit of patients and the surgical profession.

"I have always found it an honour to help these dedicated and determined young surgeons and I would encourage other Fellows to consider setting up a similar scholarship fund.

"It's a great way of staying connected to the broader Fellowship and it doesn't require a huge injection of money, you just have to establish a fund that grows over time through the good management of the Foundation for Surgery."

Karen Murphy
Surgical News Journalist

Microscope donation supports ENT health in Tonga

The Brisbane Tongan Community has expressed their gratitude for the recent donation of a Zeiss microscope to the Kingdom of Tonga's Vaiola Hospital, replacing the hospital's existing hardware which dated back to the 1960s.

The initiative was coordinated as part of RACS Pacific Islands Program (PIP) by Associate Professor Bernard Whitfield, Director ENT at Logan Hospital and ENT Specialty Coordinator, together with Brisbane-based Fellows.

Founded in 1995, PIP strengthens specialised clinical services, clinical governance, specialist education, training, and workforce development across the Pacific Region. Activities are funded by the Department of Foreign Affairs and Trade (DFAT) with all RACS Fellows and clinicians participating in PIP trips donating their time. The program is implemented in collaboration with the Pacific community, Ministries of Health, specialist colleges and associations, and delivery partners.

The initiative forms part of the broader support provided to health services in Tonga through the PIP. Outreach work to understand the prevalence of hearing problems amongst children and improve referral to specialist services has also been undertaken by a team of Tongan and Australian specialists this year. The delivery of ENT surgical services through the provision of a visiting medical team is scheduled for the second half of the year.

> "There is a dire need for essential medical equipment that fits the purpose of our Pacific neighbours… RACS is supporting progress such as this through cooperation between the Pacific Islands Program and PENTAG (Pacific Ear, Nose, Throat & Audiology Group)"

Associate Professor Whitfield explained, "There is a dire need for essential medical equipment that fits the purpose of our Pacific neighbours.

"The installation of such specialist ENT equipment should be replicated across other Pacific nations. RACS is supporting progress such as this through cooperation between the Pacific Islands Program and PENTAG (Pacific Ear, Nose, Throat & Audiology Group).

"We donated the 'baby version' of this microscope to Kiribati last August and their ear clinic was fully fitted out by the College and DFAT at the end of November.

IMAGE (from left): ENT Specialist Dr Leiukamea Saafi with the Zeiss microscope; Acting High Commissioner Rhona Mcphee, ENT specialist Dr Sepiuta Lopati, ENT nurse Loleta Mafi, Director of Health Tonga MOH Dr Siale Akauola, ENT Specialist Dr Leiukamea Saafi and Associate Professor Bernard Whitfield.

"This microscope will be hugely beneficial to our colleagues providing care to their patients in Tonga," Associate Professor Whitfield added.

The microscope was donated by Metro South Hospital and Health Service, with a delegation of Brisbane Tongan Community committee members consulting on the initiative.

Brisbane Tongan Community President Reverend Maile Molitika said the microscope will help improve health services offered by Tonga's Department of Health.

"The Brisbane Tongan Community are grateful to Professor Whitfield and the Pacific Island Project of the Royal Australasian College of Surgeons for their generosity and willingness to assist Vaiola Hospital – as this will truly benefit the people of the Kingdom of Tonga," Reverend Molitika said.

Tongan ENT specialist Dr Sepiuta Lopati said the microscope will enable ear surgeries including their most common minor procedures: myringotomy and grommets insertion; and mastoidectomy – clearing infection before it spreads to the brain and causes brain abscess, meningitis or nerve palsy. Other procedures to be carried out with the new microscope include micro inspection, myringoplasty and microlaryngoscopy.

Associate Professor Whitfield recently travelled to Tonga to conduct training on the Zeiss microscope at Vaiola Hospital, in consultation with Dr Lopati and fellow ENT specialist Dr Leiukamea Saafi.

Annette Holian
Chair, External Affairs

– With Sarah O'Brien, Surgical News team

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Supporting Myanmar surgeons through education and training

As part of RACS Global Health commitment, the RACS ASSET (Australia and New Zealand Surgical Skills Education and Training) team – consisting of Mr Richard Perry, Dr James Kong, Dr Christine Castle, Mr Warren Hargreaves and Dr Robert Davies – conducted its ninth surgical workforce capacity building mission to Myanmar this past February.

Since the new millennium, Myanmar has been progressively opening (albeit in fits and starts) to rejoin the international medical community. With this change, "injury" was recognised among the medical community beyond the orthopaedic trauma surgeons, as the leading cause for morbidity and the fastest growing cause of mortality.

The devastation of the lower Ayeyarwaddy by Cyclone Nargis in 2008 led to discussions between key members of the Myanmar Orthopaedic Society (Professors Kyaw Myint Naing and Myint Thaung), the Myanmar Medical Association and RACS Global Health Director, Myanmar, Dr James Kong (a Myanmar born RACS Fellow based in Hong Kong). The result was the inauguration of the Primary Trauma Care – a skills training program for low resourced communities which critically also provides a train-the-trainer component.

The success of the Primary Trauma Care program led, in 2011, to an appraisal of the approach to Emergency Care with the full support of the then Minister of Health Professor Pe Thet Khin and his Ministry. Professor Zaw Wai Soe (Orthopaedic Surgical Leader and now Rector of University of Medicine 1) and Dr Kong focussed on the comprehensive development of Emergency Medicine – a new specialty in Myanmar. RACS, under the leadership of Dr Kong, provided significant input into this expedited capacity building program. Teaching basic surgical skills – ASSET – was one of its core components.

The experienced team of RACS ASSET leaders first visited Myanmar to help teach basic surgical skills to the Emergency Physician Trainees. After 2012, at the request of the Myanmar leadership, the ASSET program expanded and has now delivered skills, instructor and directors' courses to more than 540 students, 250 instructors and 40 surgical leaders. This program has now extended beyond Emergency Medicine to cover the gamut of surgery, orthopaedics, obstetrics and gynaecology – all areas where competent basic surgical skills is core.

IMAGES (From top): Participants learning instrument handling; Faculty and participants group shot.

The Myanmar surgical workforce has now grown in numbers and the skills and foundations of a surgical teaching culture have been established. With the help of the ASSET team, Professor Moe Moe Tin, Head of Surgery at University of Medicine 2 in Yangon, has achieved a self-sufficient faculty of surgical skills instructors within her department.

While numbers have increased over these years, there is still a gross under-supply of surgeons and specialists to adequately meet the health needs of the people. Some 300 orthopaedic surgeons, 400 general surgeons and an estimated 200 anaesthetists and 200 obstetrician/

Foundation for Surgery
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IMAGE (L-R):
Mr Richard Perry,
Dr Christine Castle,
Dr James Kong,
Mr Warren Hargreaves
and Dr Robert Davies

gynaecologists serve a population of around 65 million people.

Overwhelmed with the clinical workload, Myanmar surgeons have insufficient time for teaching. However, Mandalay surgical leaders are also encouraging their surgeons to acquire teaching skills and have mandated the Surgical Skills ASSET Myanmar course (SSAM) for all post-graduate Surgical Masters Trainees. The Rector of the University of Medicine Mandalay, Professor Khin Maung Lwin, and the Professor of Surgery and President of the Myanmar Surgical Association, Professor Shein Myint, are enthusiastic supporters and regular visitors to the courses in Mandalay.

Today, the SSAM course is a stable program based on the RACS ASSET course and adapted for Myanmar conditions and needs. The program has been established through the collaborative efforts of the RACS ASSET team and local surgeons. Feedback from instructors and participants has led to notable improvements including raised interactivity, using common language and introducing new segments that support the practice of questioning and feedback.

“There is growing recognition in Myanmar that skills such as teaching and communication are important aspects of surgical practice”

Mr Richard Perry, RACS Vice President and ASSET team member, said “There is growing recognition that skills such as teaching and communication are important aspects of surgical practice.”

He attributes the success of the program to a variety of factors.

“Foremost among them is the indispensable contribution of Dr James Kong. As program director for Myanmar, his role includes facilitation of relationships, in-country liaison, and conduct of sections of the course, particularly the debriefings, in Myanmar language.

“Stability of the team is also important, allowing the development of relationships and the building of trust with surgeons in Myanmar. The flexibility of the team in adapting to local requirements, which sometimes change at short notice, has been outstanding.

“The surgical skills training program has now matured to a point where it is an excellent model that could be introduced anywhere in the developing world,” Mr Perry said.

With Sarah O’Brien, Surgical News team

Article based upon the Myanmar project report, March 2019, written by Mr Richard Perry

Myanmar participants’ feedback to the teaching culture survey

I want to be a better teacher
Around 60% were ‘extremely’ and ‘very’ interested, 40% ‘somewhat’ interested

To be a good surgeon I must be a good teacher
Around 60% agreed either ‘very strongly’ or ‘strongly’, around 40% ‘agreed’

Teaching is an essential skill for surgeons
All either ‘strongly agreed’ or ‘agreed’

Most Myanmar surgeons have excellent surgical skills
Nearly 70% responded ‘most’, just under 30% responded ‘some’

I prefer to see patients and operate than teach surgical skills courses
Around 60% ‘agreed strongly’ or ‘agreed’, just over 25% were neutral and nearly 15% ‘disagreed strongly’ or ‘slightly’

Training new surgeons is a valuable use of my time
Over 50% agreed ‘very strongly’ or ‘strongly’, just over 40% ‘agreed’

Life on Mars?

What do KMC, Manchuria and life on Mars have in common? This was a question at a parents' school trivia night recently, a trivia night that ended a lot less dramatically than the one featured in the HBO series *Big Little Lies.* I must confess I was stumped by the question, despite already knowing that KMC stands for 'Kombucha Multimicrobial Community'.

The community in question is not a spiritual retreat on a mushroom patch in Manchuria, but describes an abundance of microbes thriving in flavoured, fermented cold black or green tea. The microbes form a symbiotic culture of bacteria and yeasts (SCOBY), including acetic bacteria such as *Gluconacetobacter xylinus* and the osmophilic yeast, *Saccharomyces cerevisiae.* Our table at the trivia night was outdone by one with an astrophysicist, aware of the Biology and Mars Experiment (BIOMEX), which found that the KMC is even able to survive in a Mars-like atmosphere.

Kombucha is made by adding KMC to tea and sugar and allowing it to ferment. My reason for sharing this trivia is that I am increasingly being asked by patients whether kombucha is good for their health. It is at least rich in antioxidants, polyphenols and the KMC is likely to be beneficial in populating their microbiome. Recent in vivo experiments have suggested, it prevents obese mice from developing hepatic steatosis and liver damage (rats and mice), yet there have been intermittent case reports of toxicity including fatalities, some of which may be due to contamination of home preparation (including lead poisoning from brewing in a ceramic pot). However, kombucha may rarely be associated with lactic acidosis, hepatic toxicity or bacterial translocation and sepsis in the immunosuppressed.

Despite these case reports consumption is rising rapidly as any visit to a foodstore will tell you. The global kombucha market exceeds $1billion. The low alcohol content escapes taxation and the popularity of the drink is spurred on by its flavours (citrus, apple, coconut, herbs, flowers and/or berries) and by its possible health benefits. For those seeking an investment opportunity, various market researchers are betting on an expanding kombucha industry given the growing population, increased yields, improved logistics and global supply chain (Orbis/Inkwood Research).

And now back to the claims of health benefits for which there is little or no evidence: arthritis, cancer, degenerative diseases and ageing have all been suggested. These conditions will certainly benefit from antioxidants and polyphenols, and cardiovascular conditions may improve due to better lipid metabolism. A recent systematic review (2019) identified 310 articles though unfortunately there are no registered clinical trials. One uncontrolled study in 24 subjects aged 45-55 found normalised blood glucose levels in non-insulin dependent diabetics. A 2015 field study on cattle found kombucha spraying protected against foot and mouth disease virus.

So what do I tell my patients when they raise the kombucha question? I say it's been around for over 2000 years. It's been commercially available since the 1990s. I inform them that black and green tea are healthy, the kombucha alcohol content is low (0.5-1.3%), its polyphenols and microbes are likely to be beneficial. It is to be regarded as 'not harmful' if consumed by 'healthy' individuals at less than 4 oz (120ml) per day. I suggest they ask where the kombucha comes from as there is a risk of low pH brews leaching heavy metals from containers, and they should avoid drinking highly acidic kombucha. Pregnancy, immunosuppression, chronic pulmonary and chronic renal disease are contraindications.

In considering the case reports of toxic effects of kombucha, we should remember people have long suffered from other fermented products such as kimchi and sauerkraut as well, never mind the high alcohol (10-15 per cent) containing Fijian kava, Filipino basi (sugar cane), Korean makgeolli (rice) and many other national home-brews.

Though the evidence for the beneficial health effects of probiotics is building, evidence for Kombucha benefits in humans is lacking. It is surprising that despite the growth of the industry it is largely studies in rats, mice and outer space that appear in searches of the literature. Kombucha is probably not usually harmful, but there is certainly no evidence it is particularly healthy, though it is probably healthier than many of my favourite, much higher alcoholic tipples. However, for those hoping to make the first trip to Mars, it is likely some of the Kombucha microbial community will survive even when humans do not.

DR BB-G-LOVED

Case note review

Poor preoperative processes

Summary

A male in his late 70s was an elective admission for lower urinary tract endoscopic surgery.

It was noted that he would require an optical urethrotomy and probable further prostatic resection.

The hospital notes do not give a clear indication of the severity of urinary symptoms. Reference is made to a urinary tract ultrasound which does seem to be a major basis for the decision to undertake endoscopic surgery.

Six years prior, the patient had had a prostatic resection. It required an admission of eight days because of postoperative cardiorespiratory issues.

Importantly, he had a significant history of ischaemic cardiac disease and was on multiple medications for this problem. Medications included: anticoagulants, antihypertensives and a diuretic.

The medical records indicate the referring GP was desirous that his patient be reviewed medically but no record of any preoperative review was found. The patient was admitted and found to have not ceased his anticoagulant therapy so surgery was postponed.

The endoscopic surgery proceeded uneventfully, and it was planned for the patient to be discharged on the second postoperative day. Prior to the discharge, he had a sudden cardiac event from which he did not make a recovery despite admission to the coronary care unit.

Considerations

1. The preoperative management of the patient's known medical problems.

Despite the long history of cardiac problems and the unusually long admission following his previous prostatic resection, the hospital records do not suggest there was enough consideration of the likely cardiac risks in undertaking the urological procedure. Consideration needs to be given as to whether there was enough consultation with the medical team who had been caring for the patient for many years.

2. The cessation of his usual medication during the postoperative period.

There was a failure to continue the patient's normally prescribed medication during the postoperative period. While his anticoagulant therapy may have been deliberately withheld, the remainder of his medication was withheld without any obvious reason. This may have been an unintended sequence of events. I note the reviewing pharmacist pointed out the lack of supply of the normally prescribed medication but there is no evidence there was any response from the medical staff caring for the patient.

Comments

The real issue in the management of this patient is the preoperative assessment. Was it appropriate to undertake the endoscopic surgery given the history and the complications following a previous prostatic resection?

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

Disclaimer: Please note that these cases are edited from ANZASM first - or second-line assessments that have been generated by expert surgeons in the field.

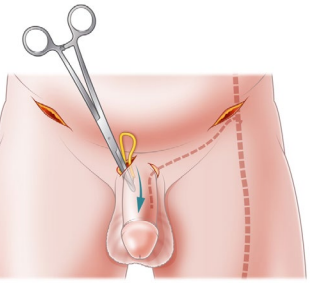
A new approach to restoring sexual function

I had been caring for patients diagnosed with prostate cancer for over ten years when Professor Chris Coombs approached me regarding a potential new procedure to restore sexual function post radical prostatectomy. We had shared a number of patients at the same hospitals and I was aware of his position as the head of the plastic surgery unit at the Royal Children's Hospital and his work using end-to-side nerve grafting to treat peripheral nerve injuries and facial nerve palsy.

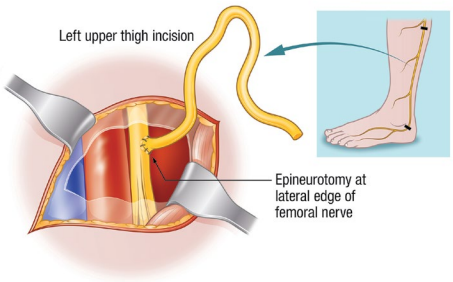
As a urologist treating prostate cancer, the focus is very much on curative management and survival rates. If a patient is diagnosed in the early stages of the disease survival rates are usually high. Quality of life issues are addressed as needed in the recovery phase. Patients are counselled that it is uncommon to experience incontinence, however, erectile function recovery is unpredictable – despite nerve sparing techniques and the use of penile rehabilitation including medications, injections and vacuum devices – and the treatments are limited.

In late 2014 Professor Coombs had just returned from a microsurgery conference in the United States and had detoured to Brazil to observe Professor Fausto Viterbo performing a new approach to restore erectile function. At that stage Professor Viterbo had performed forty such operations with a success rate of 60 per cent. The concepts were quite foreign to me initially having had only limited training in microsurgery. To utilise "spare parts" and to "hijack" the function of nearby nerves sounded bizarre. I was given a number of references that brought me up to date with microsurgical concepts that I was surprised to find had been first described in the early 1900s.

Reviewing Professor Viterbo's patient outcomes, I found that his patients had tolerated the procedure well. They had undertaken the nerve grafting procedure two years post radical prostatectomy, at a time when the chances of spontaneous recovery of their erectile function was low. Based on these results we agreed to perform sural nerve grafting on five patients. All patients were closely assessed in terms of tolerability and recovery over a two year period. We applied for and were granted ethics approval for a retrospective analysis of our patients who underwent this procedure.



The procedure involves harvesting the sural nerves from the lower limbs. This can be done in a minimally invasive way via small incisions. The sural nerve is then grafted onto particular branches of the femoral nerve as it passes just below the inguinal ligament, in an end-to-side manner. The grafts are then passed subcutaneously to the corpora cavernosa. It is believed that as new fibres regenerate out of the donor femoral nerve and grow along the sural nerve graft, they provide a source of acetylcholine restoring erectile function.



We faced several challenges along the way. The first patient's partner was diagnosed with motor neurone disease three months after his surgery. Other patients have had relationship break downs or been affected by other conditions that impact their ability to recover such as diabetes and depression. Our second patient showed signs of recovery at six months and was medication-independent by fifteen months. Six of the first eight non-nerve sparing patients returned to erectile function when usually the probability of recovery is low.

To have our work recognised in *European Urology* this year is gratifying. Our first cohort showed a return to sexual function in 71 per cent of cases with 94 per cent demonstrating significant improvement in quality of life measures. These men were very grateful. The challenge now is to better understand why not all patients were able to recover. There is also potential to apply the procedure to other iatrogenic causes of erectile dysfunction such as anterior resection for recto-sigmoid cancer, transurethral resection of the prostate (TURP) and cystectomy.

Dr David Dangerfield
Urologist, FRACS

– with Professor Christopher Coombs

Putting teamwork essentials into practice

Based on an article by RACS New Zealand National Board Chair, Nicola Hill and Daniel Fisher, ANZJSurg June 2019

Collaboration and teamwork is one of RACS nine core competencies. This competency describes the need for surgeons to work with other health professionals in treatment selection and patient care, minimise inter-professional conflict and demonstrate a respectful attitude towards colleagues.

Collaboration and teamwork are evident in our daily workplaces with multidisciplinary care and use of team communication tools in the operating theatre. Focusing on surgical team communication, the importance of briefing and team training programs is being increasingly appreciated. Structured debriefing both in routine practice and after serious events is becoming more prominent and is likely to be a future focus for surgical safety.

Theatre teams are often an ad hoc grouping, so briefing can help establish a common goal and promote teamwork. Preoperative briefing involves communication between all members of a theatre team, and comprises introductions by name and role, and review of the planned theatre session, with relevant considerations. It has not traditionally been routine practice, but there is high-quality evidence for its role in improving teamwork and surgical outcomes.

After reviewing a large case series, Wolf et al concluded that medical team training, including briefing, significantly improved operating room team function and decreased delays. Improved teamwork has implications not only for patient safety, but also for job satisfaction and sick leave taken. The main concern about implementing the briefing process is adding complexity and delay to already extensive theatre processes. However, at Johns Hopkins, standardised two minute briefings were found to reduce unexpected delays by almost one third.

At the conclusion of an operation a short review process (during wound closure, for example) provides an opportunity to reflect on the positive and negative events that occurred while it is still fresh in the minds of the team members. This can help identify and address any issues regarding equipment or any process issues. A goal of any good surgical team is to minimise mistakes, and debriefing has demonstrated a reduction in communication difficulties which are a key cause of error in surgery. Debriefing has also been shown to reduce adverse events and to promote enhanced technical function in surgery.

Both briefing and debriefing are formal tools we can use to improve teamwork and collaboration in the perioperative setting. Simulation and other team training workshops are an opportunity to practise these communications tools in a safe environment.

Dr Nicola Hill
Chair, New Zealand National Board

– with Philippa Lagan, Policy and Communications, New Zealand

June 2019 RACSTA Board Meeting

On Saturday 29 June 2019 the Royal Australasian College of Surgeons Trainees' Association (RACSTA) held one of its thrice-yearly board meetings at RACS Melbourne. RACSTA works within the College to represent and advocate for Trainees. Through the College, RACSTA is also able to advocate at state and federal government level for matters that affect surgical Trainees and, consequently other Trainee medical doctors.

The June RACSTA Board meeting included representatives from most surgical specialties and regions, with the RACS Council room at nearly full capacity. In addition, the Board warmly welcomed RACS' new President Mr Anthony Sparnon and Chief Executive Officer Mr John Biviano. This was a wonderful opportunity to highlight Trainee priorities and give our new leaders a thorough cross-examination!

Key issues relating to training were discussed including:

Building Respect and Improving Patient Safety (BRIPS)
RACSTA continues to support the BRIPS campaign and is excited to be working with the 'Operating With Respect' team to develop a Trainee course. RACS clearly recognises the importance of increasing Trainee engagement.

RACSTA Survey
The end of term survey is a great way to gather information from Trainees in order to improve conditions in training. Areas discussed include increasing flexible training opportunities, regulating on-call hours and ensuring outpatient clinic exposure. The Board also discussed ways to better utilise the data while ensuring anonymity is maintained.

2019 RACSTA Induction Conference
The team has put together an excellent itinerary for the annual induction conference to be held on 26 October 2019 in Melbourne. Please encourage your successful SET applicants to attend.

Clinical Trials Network of Australia and New Zealand (CTANZ)
RACSTA recognises the importance of research in training and discussed how we can work together with CTANZ to maximise Trainee involvement.

Interstate leave entitlements
Loss of leave entitlements when moving between rotations can be extremely detrimental for Trainees and their families. RACSTA continues to work through various avenues to achieve recognition of leave between states. There has been excellent support from several RACS boards and specialty training boards.

RACSTA brings together voices, ideas and opinions from all surgical specialties and jurisdictions for collegiate discussion and action. The RACSTA Board members are all Trainees who devote their precious spare time, often juggling family commitments, to improve training conditions. I feel very fortunate to have the opportunity to lead this impressive group of emerging surgical leaders.

For more information see:
www.surgeons.org/trainees/trainee-association-racsta
or contact racsta@surgeons.org

Dr Imogen Ibbett
Chair, RACSTA

The 2020 John Corboy Medal Applications closing soon

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

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

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

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

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

Nominations for the 2020 award close on Friday 30 August 2019.

For more information, please search 'John Corboy Medal' on the RACS website.

For a nomination form, please email racsta@surgeons.org

Past recipients of the John Corby Medal

2019 – Ruth Mitchell
2018 – Kimberly Aikins
2017 – Genevieve Gibbons
2016 – Grant Fraser-Kirk
2014 – Gregory O'Grady
2013 – Ruth Blackham
2011 – Brandon Adams
2010 – Matthew Peters

Social media: a virtual reality of 21st century surgical practice

Medical practitioners, including surgeons, are more connected than ever before. A 2014 survey of Australian doctors found that nearly 75 per cent of those surveyed used some form of social media, usually for an hour a day[1]. A more recent survey of healthcare professionals in a Texas hospital placed this figure at nearly 90 per cent[2]. Facebook seems to be the most popular platform.

Many people use a variety of platforms, and these form different categories with different functions[3].

Facebook is the most popular social networking service in the world, and the most frequently utilised by medical practitioners. Approximately 60 per cent of doctors have a Facebook account[1]. As of March 2019, there are 2.38 billion monthly active users on Facebook and the company employs approximately 37,700 full time employees[4]. Facebook is an excellent resource for keeping in touch with family and friends, sharing content, and engaging in robust discussion with special interest groups. I personally enjoy the Facebook group, *Medical Mums and Mums to Be (Australia/NZ)* where over 8,000 members, all medical parents, discuss topics from workplace issues to choosing high chairs. There are multiple break-out groups, including my favourite, *Learning to Adult successfully (sometimes)* – an often light-hearted and occasionally cynical group, where our tendencies to not manage in our lives outside work are celebrated with humour and solidarity.

LinkedIn serves as a professional networking tool, with many features in common with Facebook. It has a niche role in providing a more professional platform. It is full of cultivated head shots for profile pictures, high quality articles from reputable sources, and sports a slick and business-like interface. Connecting with a new colleague after a chance meeting at a conference is easy, and it doesn't feel like each party is sharing their personal life, as Facebook sometimes may. For this reason, LinkedIn is the professional social networking choice of many doctors.

Twitter is best described as a "microblogging" site, where ideas and musings are restricted to 280 characters[3]. It popularised the "hash tag" – a codified way of grouping discussions on a particular topic in a single chain of "tweets". As demonstrated by the recent RACS ASC in Bangkok, Twitter has the ability to take a concise message to a wide audience. There are many excellent examples of surgeon Twitter users, including @LiangRhea, @DrEricLevi, and @drruthmitchell. They use the platform to share news, spread ideas, and further their mission of advocacy.

Social media does have its risks and downsides:

- Practitioners must ensure that content they post online conforms to ethical and professional standards, including patient confidentiality.
- Use of social media may open up unwanted interactions with patients outside of the workplace (such as patients requesting to be "friends" with their care provider).
- Social media opens avenues for patients to respond negatively to their doctor in a public forum. This can be stressful and/or damaging to a practitioner and their reputation.

Yet for all of these downsides, social media provides extraordinary opportunities to connect, disseminate reliable information, and encourage continuing professional development and learning – indeed #FOAMEd (Free Open Access Medical Education) can be rewarding, enlightening and of great value to us all.

Social media is here to stay. As practitioners, it is up to us to decide how we will best use it to augment our mission and professional brand.

For more information on use of social media in the professional setting, please see the following resources:

www.medicalboard.gov.au/Codes-Guidelines-Policies/Social-media-policy.aspx

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2. Ventola CL. Social media and health care professionals: benefits, risks, and best practices. *P T*. 2014;39(7):491–520.
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Dr Charles Jenkinson
RACSTA

News round-up

Surgical Skills workshops in the ACT

RACS ACT's first cadaveric dissection course, held in May this year, proved a great success with everyone expressing their excitement at having such a course held locally.

The course was offered as part of the RACS accredited ACT Surgical Skills workshop, which has taken place biannually for the last four years. Established in the ACT to build on the ASSET skills course, the Surgical Skills workshop provides Trainees and junior doctors with ongoing, hands-on training and mentoring opportunities in a non-clinical setting.

The workshop has previously included training in laparoscopic and open surgical skills, as well as non-technical workshops such as sessions on informed consent, breaking bad news and conflict resolution for junior Trainees. To help ensure relevancy of course content and rectify any Trainee identified learning deficiencies, a Trainee co-convenes the workshop. This involvement also encourages Trainees to be educators of the future. Local surgeons have enthusiastically supported the workshops and generously donate their time and expertise to ensure an optimum trainer to Trainee ratio.

Our first surgical dissection cadaveric course focused on operative anatomy and common abdominal operations. Nicole Rodrigues was the Trainee co-convenor with Siva Gananadha, Ram Ganesalingam and Janaka Balasooriya as faculty. This offered both junior and senior Trainees small group hands-on training on surgical exposure, operative anatomy and general abdominal operations, giving them the opportunity to hone in on critical steps and obtain tips from faculty on how to perform procedures they may not have had exposure to in daily practice.

The course was offered at a nominal cost thanks to the support of various organisations including Medtronic, Johnson and Johnson and Stryker. The workshop was held at the excellent facility at the Australian National University anatomy laboratory with their support,

as well as that of ACT Health who provided the equipment. We were pleased to receive excellent feedback from the Trainees and unaccredited registrars who expressed their enthusiasm to participate in more of such workshops.

Moving forward, we would look to include the other subspecialty groups to maximise the use of the cadavers and enhance the training of all surgical Trainees rotating into the ACT.

Assoc. Prof. Sivakumar Gananadha
Dr Nicole Rodrigues

Surgical Oncology conference and RACS ASM – South Australia

On 5 September the Sino-Australia/New Zealand Surgical Oncology conference will be held at the Royal Adelaide Hospital. This will be the tenth instalment of the conference since 2000, which rotates in venue between China, and Australia and New Zealand.

The aim is to provide a platform for academic exchange and friendship between surgeons of the three countries. This year's conference will explore the differences and similarities between Chinese and Western surgical cultures in the treatment of GI malignancy. Over the course of the day, experts from Australasia and China will present on the latest in treatment of upper GI cancers, colorectal cancers and liver metastases, followed by a panel discussion of cases.

The conference precedes the RACS State Annual Scientific Meeting (ASM) to be held in Port Lincoln on 6 and 7 September – *Robots in Surgery: Tsunami or the next wave?* For those wishing to go on to the ASM, arrangements will be made for transport from Royal Adelaide Hospital to the airport in time to fly to Port Lincoln for the welcome function on the Thursday evening.

For further information, please see the RACS South Australia web page.

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https://surgeons.eventsair.com/qasm-seminar-2019/delreg

2019 RACSTA Induction Conference

The Royal Australasian College of Surgeons Trainees' Association (RACSTA) will host the tenth RACSTA Induction Conference for SET1 Trainees in Melbourne on Saturday 26 October 2019.

The annual one-day conference welcomes incoming Trainees to both RACS and the Surgical Education and Training (SET) program, focuses on preparation for their coming years in the SET program, and provides advice to help them make the most out of their surgical training.

Informative and interactive sessions are held across the day, with breaks allowing time to socialise with new colleagues and visit sponsor exhibitors. The conference concludes with a tour of the RACS building and an evening function.

Session topics will cover 'Tips to help you succeed, including an interactive session on feedback', 'Your wellbeing and your surgical career', 'Diversity in surgical practice' and a panel discussion on hypothetical situations including interruption to training, flexible training, Trainees in trouble, women in surgery, parenthood and training, rural and global surgery, and recent Fellowship experience.

This year's invited speakers include a number of prestigious and well renowned RACS Fellows, invited guests and members of the RACSTA Board.

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

For more information, visit:
surgeons.org/trainees/trainee-association-racsta/racsta-induction-conference or contact racsta@surgeons.org

Dr Charles Jenkinson
Convener, 2019 RACSTA Induction Conference

SURGICAL SNIP

Free app helps carers keep track of medicines

New features in the free NPS MedicineWise (National Prescribing Service) mobile app help carers who look after one or more people to keep details of everyone they care for in the one app.

Building on its core functions of storing lists of medicines, scheduling reminders, and tracking when medicines are taken, carers and patients can now share this information between multiple carers. This way, all carers can be sure that no medicine has been forgotten or given twice.

The new carers functionality of the NPS MedicineWise app has been funded by Family and Community Services (FACS) New South Wales. NPS MedicineWise is a not-for-profit organisation that receives funding from the Australian Government Department of Health. The MedicineWise app can be downloaded from preferred app stores.

– nps.org.au

Queensland State Conference and Surgical Directors Leadership Forum

Both the Queensland State Committee and RACS Surgical Directors Section have always striven to present programs that are relevant and strategic for all specialities, surgeons and aspiring surgeons. This has resulted in the second combined Leadership Forum of these two groups. From 12-14 July, surgeons and medical professionals from across Australia and New Zealand enjoyed a mid-winter break, as they joined their Queensland colleagues on the Gold Coast.

This year the theme of the "Seven (st)ages of a surgeon" started with a State-wide Surgical Service Forum in collaboration with Queensland Health, as well as research paper competitions and an evening welcome reception. This was followed by the two-day conference program, which consisted of 31 presentations spread across seven sessions.

As the theme suggests, the program covered everything from the medical and intern years right through academic, philanthropic and directorship career pathways; to the transition to retirement. There were numerous highlights spread across the three days. These included:

- A keynote presentation from senior principal scientist in the field of strategic foresight at the Commonwealth Scientific and Industrial Research Organisation (CSIRO), Dr Stefan Hajkowicz. Dr Hajkowicz is widely published in international research literature and is a member of the OECD and the World Economic Forum. His presentation 'Global megatrends and implications for healthcare and the practice of surgery' was particularly relevant as he is currently leading a project for Queensland Health in strategic approaches to deal with sustainability to health and surgical delivery, in response to economic and digital disruptors.
- An update from RACS Vice President, Mr Richard Perry, who discussed the important role RACS plays in ensuring surgical competency and professionalism.
- Dr Gary Nielsen presenting on introducing the AOA21 competency-based training.
- A strong focus on flexible working pathways and doctors' health, featuring presentations on burnout, resilience and lived experience with several different flexible training models. Following panel-led debate the delegates strongly supported the development of 1) "tool-boxes" to support surgical departments' successful development of part-time posts that support competency progression and 2) Training Board flexible training portfolio holders.
- The "great debate" – with medicolegal expert Claire Bassingthwaighte, Vice President Richard Perry and Queensland Health Deputy Director-General John Wakefield providing thoughtful insight into the challenge of who is accountable for professionalism and competency assessment.
- A quality field of registrants for the various paper competitions. Congratulations to the prize winners; Dr Andrew Morton, who won the Queensland RACS Papers Prize, and to Dr Aaditya Narendra who won the Neville Davis Prize.
- Congratulations also to the winners of the examination prizes; Dr Matthew Cheng who won the Clinical Committee Prize, and to Dr William McSweeney who won the Gordon Gordon-Taylor Prize.
- Inspirational presentations were shared by the award winners. Dr Barry O'Loughlin, Surgical Department Head, Royal Brisbane and Women's Hospital, previous RACS councillor and Fellowship examiner gave the David Theile Lecture. Dr Neil Wetzig was honoured for his work in teaching and surgery both in Queensland and in the Congo. Associate Professor Fred Leditschke received the RACS Outstanding Service Award for his dedication to Child Restraint Education & Safe Travel (CREST) and Queensland Trauma committees.

Delegates participated in lively discussions and shared many laughs along the way. The meeting provided an opportunity to reflect on the common experiences faced by all attendees, regardless of which stage they were at in their career, and network towards practical solutions facing provision of high standard surgical services into the future.

The discussions, begun at the Queensland Health and Surgical Directors forum on the Friday and continued by Professor Richard Murray (Dean of James Cook Medical School), Mr Phil Truskett (previous RACS President) and by Dr Roxanne Wu (Cairns Head of Surgery) on the Sunday, concerned the need for "generalist" trained surgeons in all specialities to providing acute surgery and rural surgery of Australia, provide much fodder for a future theme for Queensland forums.

The organising committee would like to thank everyone who made the event such a big success, and we look forward to welcoming you back in two years' time for the next instalment.

Professor Deborah Bailey
Chair

Forum feedback

"I enjoyed the diverse presentations, having read the provisional program, which whet our appetites to attend and hear the speakers, having traversed the journey ourselves"

Senior surgeon

"Very empowering and productive and I feel optimistic for the future!"

Trainee

"I never thought the talks would be like this - so inspiring for our future"

Medical student

"We need to debrief so we can work more closely together"

Queensland Health senior executive.

"I could have listened to Stefan Hajkowicz all morning… opens your perspective"

RACS councillor

IMAGES: **(1)** Neville Davis Prize winner Dr Aaditya Narendra and our gold sponsor Avant's QLD State Manager Michael Carr **(2)** Prof Deborah Bailey, the conference's Honoured Guest Dr Neil Wetzig and his wife Gwen Wetzig receiving his RACS Honoured Guest plaque **(3)** Queensland RACS Papers Prize winner Dr Andrew Morton and RACS Vice President Dr Richard Perry **(4)** Session 2 – The Registrar Years: Prof Deborah Bailey, Dr Adelene Houlton, Dr Jo-Lyn McKenzie, Dr Jill O'Donnell, Dr Emily Olive and Dr Gary Nielsen **(5)** Clinical Committee Prize winner Dr Matthew Cheng **(6)** Gordon Gordon-Taylor Prize winner Dr William McSweeney **(7)** Dr Barry O'Loughlin receives the David Theile medal from Prof David Theile (Snr) **(8)** Dr Matthew Hope, Chair of the Queensland Trauma Committee presented the RACS Outstanding Service award to retired Fellow, paediatric surgeon Assoc Prof Fred Leditschke **(9)** Saturday evening dinner.

News from the Trauma Committee

2019 Trauma Symposium

On Wednesday 13 November the RACS Trauma Committee is hosting 'Pedestrians – staying safe' at RACS Melbourne. Convener Dr Valerie Malka, Director of Trauma Liverpool Hospital, has planned a comprehensive program with road engineers, researchers, surgeons, pedestrian advocates and city designers speaking on this important challenge to our community. Topics include alcohol, distraction, scooters, speed, hospital trauma care, tips to stay safe, education, law enforcement and vehicle design.

Damian McMahon fundraising dinner will be held Wednesday 13 November – immediately after the symposium. All are welcome to join the Trauma Committee at Charcoal Lane, Gertrude Street, Fitzroy.

The Trauma Committee annual meeting will then be held on Thursday 14 November 2019 at RACS Melbourne. The Road Trauma Advisory, Trauma Quality Improvement, Definitive Surgical Trauma Care and Trauma Verification subcommittees will meet in the morning before the main Trauma Committee.

Road safety

The Victorian Transport Accident Commission (TAC) held a road safety summit in Melbourne in May to address the rising road toll this year in Victoria – road deaths have nearly doubled compared to last year. Dr Christian Kenfield, Chair RACS Victorian Trauma Committee, addressed the audience about the types of injuries that are sustained from high-speed collisions. The Australasian College of Road Safety Victorian chapter also held a forum to address science and road safety. Guest speaker Johan Strandroth, a civil engineer from Sweden, presented on the development of Victoria's next Road Safety Strategy. The forum provided an opportunity to create better roads for our communities, gain valuable industry insights and improve knowledge on current and future road safety strategy.

E-Scooters

The collection of data from injuries with E-Scooters presented in three Brisbane emergency departments enabled a rapid change of legislation and recommendations regarding helmet wearing, numbers of people riding each scooter and alcohol use. Trauma Committee members Matthew Hope and Kirsten Vallmuur are commended for their efficient, prompt and important work identifying the challenges that E-Scooters present to the community.

Quad Bikes

The dangers of quad bikes, especially with children, was tragically highlighted when two children were killed on the one day in separate quad bike crashes in Tasmania and Western Australia. There is a need to continue strongly advocating for banning of quad bike use by the under 16 age group. The NSW Coroner, following the death of a seven year old in New South Wales, has recommended that adults who allow underage children to ride adult-sized quad bikes face criminal charges.

Trauma Verification

This multidisciplinary process assures that participating hospitals maintain international standards in the care of injured patients. Every state in Australia has now received a Trauma Verification visit with the review of Royal Hobart Hospital in February/March. The calendar for 2019 is full – book now to confirm your place for 2020. Discussions have begun around a review of the Queensland Trauma System in 2021 and an enquiry has been received about Trauma Verification of a Saudi Arabian hospital. The Trauma Verification Subcommittee is holding a one-day workshop in Melbourne on Friday 15 November to update the standard requirements for hospitals managing injured patients.

Statements of support

These have been prepared for two quality assurance programs – the Australian Trauma Registry and the Trauma Verification program. This follows the publication in 2018 of the Report into the National Road Safety Strategy Inquiry which identified Trauma Verification as having an integral role in improving trauma outcomes in Australasia and the Australian Trauma Registry as a platform for benchmarking trauma care and delivering service improvements to minimise preventable deaths and disability. The statements of support will be used to advocate for improved care of injured patients in Australasia.

All enquiries – trauma@surgeons.org

Dr John Crozier
Chair, Trauma Committee

RACS Australian policy updates

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Important Australian submissions from November 2018 to June 2019

During any year, the RACS Australian Policy and Standards team is always engaged with various Australian Commonwealth requests for submissions. As often as possible we canvass the views of our Fellows from various sources including the Rural Surgical Section, surgical specialty societies and associations, and States, Territory and New Zealand committees. Below are summaries of some of the more recent and important public consultations in which RACS has participated.

Mandatory Reporting Queensland Health Practitioner National Law November 2018

In collaboration with the RACS Queensland State Committee, a submission was written and sent to the *Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018 Mandatory Reporting in Queensland*. These new laws will be rolled out into other states and territories during 2019 to 2020, except for Western Australia. In WA exemptions from any rigid form of mandatory reporting exists in that a treating practitioner can determine risk of substantial harm by a second health practitioner based upon their own discretionary clinical expertise.

RACS supports these exemptions in principle and provided a critical review of the Queensland amendments which focuses on the immediacy to report those practitioners who are placing the public at a 'substantial risk of harm.' However, RACS expressed concerns for the re-evaluation on the meaning to 'impairment' in that not all forms of 'impairment' will necessarily constitute a risk. There is also the potential for a newly created sense of urgency for the treating practitioner to report as compounded by the doubling of penalties for a 'second health practitioner allegedly holding out' from seeking help. RACS warns that the new regime may create these additional strains on our profession.

Cancer Council Australia Informed Financial Consent February 2019

The Cancer Council Australia, Breast Cancer Network Australia, CanTeen and Prostate Cancer Foundation of Australia asked for RACS feedback on their draft document; 'Standard for informed financial consent.' RACS examined this document in detail and made comments with emphasis made to the following key points; that Australian doctors have a legal obligation to warn patients of any risks in their treatment in conjunction with the case of *Rogers v Whitaker* (1993) and that Australian doctors can also set their own service fees which is an implied right under the Australian Constitution's s51(xxiiiA) within the meaning of 'civil conscription.'

Furthermore, RACS argues that a comprehensive informed financial consent document and process will help streamline the communication between a patient and a doctor regarding costs and fees relating to a procedure. RACS has been very active in this realm and supports other key healthcare stakeholders to do the same. The responsibility for fee transparency is a shared one between patients, medical practitioners, hospitals and private health insurers alike.

Consultation paper on Victorian Strengthening Rural Generalist Training Plan May 2019

In collaboration with the RACS Victorian State Committee and RACS Rural Surgical Section, a response was lodged to the consultation on Strengthening the Rural Generalist Training Plan. If this plan is implemented, it may reduce the number of contact points RACS needs to work with in Victoria on extended skills in surgery for GPs.

While the measurable outcomes still appear to be relatively vague, RACS found it encouraging to see references to the following; stability of employment, flexibility about the employment process and increased responsibility and accountability to health services. In addition, RACS expressively stated that we welcome the opportunity to be involved in surgical training for GPs in specific extended scopes of practice, for example the curriculum for Advanced Specialised Training Rural Generalist Surgery. RACS warns that the main risk for residents and the community is that health services may tend to recruit according to budget and rosters rather than community needs or long-term accountability for a sustainable medical workforce.

Dr Sally Langley
Chair, Professional Development and Standards Board

With Chesney O'Donnell, Manager, Policy and Standards
Elaine Tieu, Policy Officer, Policy and Standards
Cathy Phillips, Rural Surgery Section Officer, Policy and Standards

Academic gown donation

RACS would like to acknowledge **Mr Sudhindra Rao,** for generously donating his academic gown to the College.

RACS preserves a small reserve of academic gowns for use by Convocating Fellows and at graduation ceremonies at the College. If you no longer have use for your gown, RACS would be grateful to add to our reserve. We can acknowledge your donation and place your name on the gown if you approve.

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

A bi-national Trainee-led research collaborative in Paediatric Surgery

Two years ago, the Clinical Trials Network of Australia New Zealand (CTANZ) meeting at the RACS Annual Scientific Congress (ASC) in Adelaide sparked considerable interest amongst the paediatric surgical Trainees and consultants present at this inaugural event. In particular, Trainees were inspired to implement a collaborative, Trainee-led approach to improve the quality of research in paediatric surgery.

Along with the support of CTANZ and surgical specialty lead, Associate Professor Sebastian King, much work has been put into establishing "Australia and New Zealand Surgery in Children Registrar's Association for Trials" (ANZSCRAFT), a bi-national, Trainee-led, research collaborative. Initial interest has continued to grow, Trainee leads have been chosen, governance has been established and projects have been started and presented.

Research in paediatric surgery poses many challenges. Firstly, the relatively low incidence of certain congenital anomalies and pathologies means that patient numbers are often small. Secondly, the follow-up required to ascertain long-term effects is often decades long, meaning cause and effect are sometimes based on out-dated data or practices. Frustratingly, this has traditionally led to low quality research that relies predominantly on retrospective case series.

Likewise, training in paediatric surgery poses unique challenges for collaborative research. As the Paediatric Surgery Trainee group is small, with approximately 30 currently active Trainees and with training centres spanning multiple states in Australia and New Zealand, our Trainees more often than not find themselves to be the only Trainee working at a centre, or even in a state, often for extended periods of time. This has posed a challenge for initiating new collaborations, with meetings often conducted by teleconference across significant time zone differences.

However, it is exactly for these reasons that collaborative research is vital to paediatric surgery and our Trainee group (both pre-SET and SET) is perfectly positioned to lead this research in Australia and New Zealand. The current group represents 23 different centres across two countries. In addition, the group is experienced and highly motivated – in a recent survey of active paediatric surgery SET Trainees, 70 per cent had already published as first authors, with 90 per cent currently involved in research projects. The twin factors of bi-national access to patients and established research experience allows ANZSCRAFT to understand the needs of paediatric surgery research in Australia and New Zealand, as well as conduct research that has the ability to inform practice.

ANZSCRAFT's focus to date has been the establishment of a sustainable network that is able to both serve the Trainees, as well as contribute meaningfully to the profession. With a governance model that is both sustainable and truly Trainee-led, the infrastructure is in place for data collection to begin.

A survey of all paediatric surgeons in Australia and New Zealand is currently being conducted to assess the variability in the management of thoracic empyema in children. The aim is to understand the regional differences that exist and use this to direct research that will ultimately inform practice. In addition, the ANZSCRAFT network has been involved as part of a larger global collaborative – Global PaedSurg – a multi-centre prospective cohort study looking at the management and outcomes of congenital anomalies in low, middle and high-income countries.

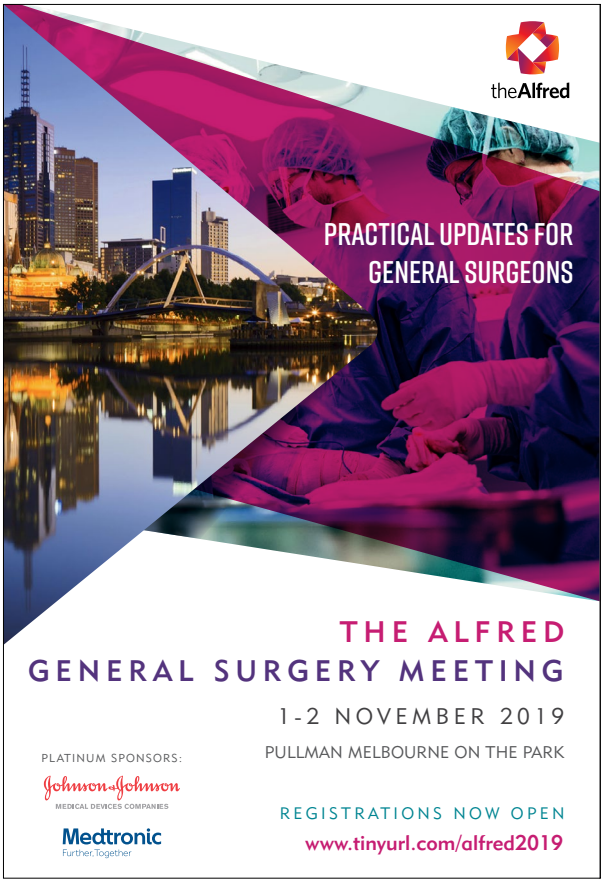
The RACS Annual Scientific Congress is one of only two annual meetings that provides paediatric surgery Trainees the opportunity to meet and engage. The creation of ANZSCRAFT has encouraged ongoing academic engagement among a motivated and tight-knit group to allow for better national evidence-based practice in Paediatric Surgery.

For further information, please contact CTANZ@surgeons.org

Dr Damir Ljuhar, Dr Ela Hyland, Dr Jessica Rayner
ANZSCRAFT Executive Team

IMAGES (L-R) Group photo; Damir presenting.

The Alfred General Surgery Meeting 2019



The Department of General Surgery at The Alfred Hospital, Melbourne, is once again holding The Alfred General Surgery Meeting from Friday 1 November to Saturday 2 November 2019 at Pullman Melbourne on the Park. The major theme for this biennial meeting is Practical Updates for General Surgeons, targeting General Surgeons and Trainees with a wide range of surgical interests. The meeting highlights major issues and problems, current and future standards of care, practical tips and surgical technique.

We are pleased to welcome our keynote speakers – Associate Professor Amir Ghaferi, Professor Peter Sagar and Mr Jon Shenfine.

Bariatric surgeon, Associate Professor Amir Ghaferi, is the current Surgeon-in-Chief of the University of Michigan Hospital Operating Rooms and Founding Director of the Bariatric Surgery Program at Ann Arbor VA Healthcare System. Associate Professor Ghaferi has a strong interest in improving the safety and quality of bariatric surgery and as such his research focuses on understanding the relationship of organisational systems and design to quality and efficiency, with the ultimate goal of designing interventions to improve care locally, regionally and nationally.

Professor Peter Sagar is currently a consultant surgeon at Leeds Teaching Hospitals and the Professor of Colorectal Surgery at the University of Leeds. During his time at St James' University Hospital, Leeds, Professor Sagar actively developed laparoscopic surgery as well as a tertiary practice in advanced and recurrent colorectal cancer.

Mr Jon Shenfine is a consultant surgeon at Flinders Medical Centre, specialising in upper GI surgery and surgical oncology. He is a Fellow of both RACS and RCS and holds an international reputation for research and teaching in upper GI surgery and in the management of Boerhaave's syndrome.

The meeting has been scheduled to enable delegates to go on to enjoy the long weekend. There are five sessions on the Friday and three on the Saturday morning, inclusive of breakfast sessions on both mornings which are proudly supported by our two platinum sponsors – Johnson & Johnson and Medtronic. These include a Meet the Professors session on Friday morning and a Fundamental Techniques in Bariatric Surgery session on the Saturday morning.

Session one relates to major issues and includes; key manoeuvres in acute oesophageal and bariatric leaks, major traumatic bleeding from the pelvis, new concepts and algorithms relating to acute severe pancreatitis and essentials of an emergency Hartmann's procedure.

The second session focuses on meeting current and future standards of care in relation to public reporting in the UK, breast cancer, thyroid cancer and the future of robotics as it relates to upper GI and colorectal surgery.

The first session after lunch includes what surgeons should be doing to help tackle obesity and sugary drinks, techniques in advanced endoscopy, essential considerations in peri-operative medicine, major advances in immunotherapy and hormonal therapy for gastrointestinal malignancies and melanoma and interpreting the CT for severe abdominal trauma when decision making is urgent.

The final session on the Friday is all about major challenges and learning from mistakes, which includes preventing complications in thyroid surgery, embracing clinical registries, umbilical hernia repair, how surgeons can work together to improve outcomes and mistakes to only make once in surgery. On the Friday evening, a welcome reception will follow the conclusion of the presentations at Pullman Melbourne on the Park.

On the Saturday morning the first session after breakfast is on surgical technique and deals with topics relating to the difficult malignant pelvis, reconstructing complex abdominal wall hernias, tips and tricks for laparoscopic anastomosis, retroperitoneoscopic adrenalectomy and mastectomy to facilitate reconstruction options.

The closing session for the meeting includes key considerations with elective and emergency hiatus hernias, managing perforated colonic diverticulum, para-stomal hernia and a lively discussion on intra-operative problems of gall bladder surgery.

The Alfred General Surgery Meeting on Practical Updates should appeal to general surgeons in all areas and in all sub specialties.

We look forward to your attendance at the meeting.

Professor Jonathan Serpell,
Convener,
The Alfred General Surgery Meeting 2019

LET'S OPERATE WITH RESPECT

Building Respect Evaluation: RACS leading the way

Independent scrutiny has endorsed the work RACS has done to build respect in surgery and recognised our commitment to doing it.

An evaluation of our implementation of the *Action Plan: Building Respect, Improving Patient Safety* found the College is now a leading institution that has acknowledged the problems of discrimination, bullying and sexual harassment and made a serious commitment to addressing them.

The evaluation report found the implementation of the Action Plan has been successful, overwhelmingly supported by members and well delivered. RACS is now seen to be in step with public opinion and broader societal shifts.

The evaluation report found a 'remarkably high' level of support among Fellows, Trainees and IMGs for the College's commitment to dealing with discrimination, bullying and sexual harassment in surgery. It also recognised there were 'pockets of resistance' and that 'a significant cohort of members is resistant to change'.

"RACS is leading the way in developing a model for introduction of respectful behaviours, with other colleges and organisations turning to the College for policy advice and education programs," the report found.

The evaluation report identified RACS education program and the visibility of RACS *Let's operate with respect* campaign as significant and successful elements of the Building Respect work. It found that one of the key strengths of the Action Plan has been highlighting the evidence linking behaviour to patient safety in its messaging and call to action. The report identified complaints management as an ongoing challenge.

The evaluation was based on a comprehensive evaluation framework designed to help RACS assess the reach and impact of our work over the short, medium and long term, and specifically after three, five and ten years.

The 2019 evaluation examined whether we have done what we set out to do in the 2016 Action Plan. Future evaluations will assess the impact of our work.

The evaluation involved a systematic process led by external consultants and backed by a Project Reference Group. It included a survey open to all Fellows, Trainees and International Medical Graduates, qualitative interviews and analysis of other data sources. Using the Action Plan's planned outcomes as a base, key evaluation questions and appropriate indicators and data sources were identified.

The evaluation was designed to make sure our work to build respect in surgery is targeted and effective. Results of the evaluation will inform future work and shape our priorities as we continue our efforts to build respect in surgery.

RACS recognises that meeting the eight goals set in the RACS *Action Plan: Building Respect, Improving Patient Safety* will take a sustained effort over many years. Since 2015, successive RACS Councils have pledged support to maintain this commitment and build a culture of respect in our profession.

Mr Richard Perry
Vice President

RACS launches new-look website

The new RACS website was launched successfully on Tuesday 16 July.

Shaped by member feedback, the new website along with an improved search function, provides a better user experience and improved usability. New information architecture that makes it easier to find and access information.

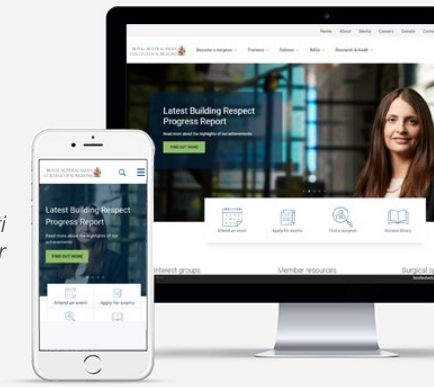
The site has a new menu that helps point users to key information, tools and resources. The homepage also features a set of icons to quickly direct you to events, exams, guides and more.

Other features include a clean, mobile-first approach that presents well across multiple devices, and an improved College calendar function that allows users to filter events by region, specialty and event type.

Many of the improvements you see on the website have resulted from Fellow, Trainee and IMG feedback. We would like to take thank you for your assistance throughout the project and remind you that you can continue to provide feedback.

Help inform the future of the website by sharing your thoughts using the "Help us improve" button on the right-hand side of the page. For further information about the website project, contact college.webadmin@surgeons.org

– With Agron Dauti
Digital Communications Coordinator



Pledge-a-Procedure campaign a great success thanks to the generosity of donors

Incredibly generous, active, retired and honorary Fellows, Trainees and friends across Australia and New Zealand have helped achieve an outstanding result during the 2019 Pledge-a-Procedure campaign.

Thanks to you, over **$205,000** has been raised. This is more than double our target goal and an increase of 98 per cent on last year. What a truly fantastic effort.

This means more children, like baby Aldo and his family (pictured), along with communities across Timor-Leste, will be able to sustainably access safe, quality surgical care when they need it most. The significance of this impact cannot be understated. Thank you.

Through your profession and your support for the Foundation for Surgery, you change lives. You save lives, and you ensure that those who most need care, get it. As Timorese specialists prepare to take the reins of our largest lifesaving health program, your support leaves a legacy of better healthcare for those who desperately need it. Your generosity has ensured that our Timor-Leste health program will continue to change and save lives long after our teams have returned home.

If you wish to share in this work or make a further contribution to equip the next generation of Timorese specialists in meeting the critical health needs of their communities, there is still time. You can donate online now at surgeons.org/foundation-for-surgery.

– Jessica Redwood
Manager, Foundation for Surgery

Surgical ethics and surgical fees

OPUS LVIII (58)

The pleasure of listening to French romantic music can be inspirational and as a consequence it had an effect on me recently. When the French Can-Can music by Offenbach came across the airways recently to commemorate his birthdate (20 June, 1819) it stimulated me to put pen to paper. I was at the time perusing an article in the Fairfax Press on the Banking Royal Commission. A Dr Laker, Chairman of Prudential Regulation Authority, was quoted as saying "the free market economy and pursuit of self-interest had not created a moral market in financial services". This topic surely has some relevance today in the present surgical climate regarding the controversy of *surgical fees*.

Surgical governance must embrace the principles of continuing education. It is conducted under the auspices of RACS while focusing predominately on clinical practice. Individual personalities contribute, but education must be based on a sound financial footing. Yes, education is expensive.

The ethics in surgical practice have their genesis in our teachers participating in the public domain. We must acknowledge this as a basis of gaining continuing education coupled with surgical experience. While the public health system has taught us to be competent surgeons, aren't we encouraged to contribute back to the very system that taught us fundamentals?

I read also in the press recently about a person called Mr Dalio, a co-founder of one of the world's largest financial Hedge Funds, explaining the background of his financial success. He touched on the relevance of ideas, innovations, inventiveness and insight in the corporate world. Any new strategy that comes across the boardroom table is there for open discussion amongst the protagonists and antagonists. The commercial aspects of this has similarities to the peer review system we adopt in all medical publications.

In the public system, the excellence of ongoing treatment is coupled with academic departments doing investigative research. This leads to peer review published material and this is irreplaceable, from the point of view of overall clinical advancement. Yet sometimes the editors get it wrong like the retracted *Lancet* article, published about the controversy of Autism and immunisation. This was based on fabricated science. Even at a commercial level, (like the kodak story) mistakes occur.

Kodak was one of the original companies in the Dow 100 Index in the 1890s. In recent times, Kodak had designed and developed the digital camera but at a board meeting in 1977 the statement was made that "nothing will replace film". Kodak relinquished their patents but subsequently suffered enormous financial loss. Thus the prerequisite of a second opinion is an essential in both academic treatment and on the commercial front.

I commenced my public hospital commitments at Western General and later at Peter MacCallum Cancer Institute in the mid-70s, having returned after three years of Reconstructive Surgical training in London. I retired from the public health system in 2014. The reconstructive techniques developed over my career have benefitted many cases and the Keystone concept became the basis of many peer reviewed articles and book publications. Professor Bob Thomas in the Academic Surgery Department at the Western General, was also editor of *ANZ Journal of Surgery* at the time. He supported my Keystone concept in reconstruction and I am grateful for his editorial suggestions to improve my authorship.

The Keystone is also useful in handling compound fractures of the lower limb which would otherwise have led to amputation as the patient's co-morbidities precluded microsurgical techniques. The same principles applied in the Head and Neck Cancer Service at the Peter MacCallum Cancer Institute. This technique is particularly useful in the elderly, with a shorter operating time, and a far more acceptable aesthetic appearance than can be achieved by using microsurgical flaps, and the procedures are relatively pain free.

I was speaking to Michael Denton recently about his new idea in Vascular Surgical reconstruction – he was formerly in charge of Vascular Surgery at St Vincent's Hospital. He pioneered the technique in the development of endo-stenting of abdominal aneurysms – this could only have happened in the public system.

All our cases were publicly presented at RACS meetings with an open forum discussion and the subsequent acceptance of the technique with evidence of peer review publications, locally and internationally. As the College acknowledges, the public system is indispensable for ongoing teaching and research, to provide the best clinical care.

Regarding fees, some of us in our collegiate domain may become the victims of adverse publicity on this topic and become "tarred with the same brush." I recently experienced one such tirade because of my surgical background and the exorbidant fees charged by some. But in the present circumstances, nothing has been said about the altruistic commitment of many surgeons treating the disadvantaged in many parts of the world.

The Interplast story is interesting – it was a dominant focus in the life of the late Don Marshall. Interplast, under the College umbrella supply the surgical needs of many extending from the Pacific to the Sub-Continent. Don was still actively involved almost to the end – and such a great contribution he made to the welfare of others. What a dénouement.

And when flying to Brisbane recently for the funeral of the late Sam Mellick (pictured, left), I could not help reminiscing about his dedication to his surgical craft. In those final months of his life he was still communicating with me and his staff would continue to read current vascular journals to him even at his eleventh hour. He would offer advice to all and sundry who wished to tap into his experiences. What a *dévouement* – devotion – to his craft, RACS and the public system.

John Quinn mentioned in the eulogy at Sam's funeral that Sam had, on many an occasion, visited De Bakey who was another world expert on vascular reconstruction. Earle Brown from New Zealand recently told me of a general surgeon at the Mount Sinai Hospital New York by the name of Rodulph Nissen. He repaired Einstein's aneurysm successfully wrapping it in cellophane which lasted from 1948 to his terminal phase. Sam, in his final weeks before parting, told me a sequel to this Einstein story. The aneurysm was regarded as inoperable by his advisors at Princeton. When De Bakey heard of his predicament, he offered to fly up from Houston to solve the problem. Einstein's response was simple. As he was reconciled about his forthcoming demise, refusing surgery, he said "I have had a successful life and I will now go in peace" – a story lost if Sam had not recounted it to me in those final weeks before he died. His mind was still as sharp as ever right to the end.

As Jonathan Swift said, "Vision is the art of seeing things invisible" – almost a summary of Sam's contribution to surgery. Whereas Abraham Lincoln is noted for his quote: *"It is not the days in your life, it is the life in your days"* – Sam seems to have captured both aspects implied in this adage written on the Lincoln memorial. À bientôt Sam – my first surgical tutor.

Assoc. Professor Felix Behan
FRACS

DON MARSHALL BOOK LAUNCH

Footprints on the sands of time
(an autobiography with supplementary annecdotes and references)

Presentations by Mr John Hanrahan (former PRACS), Professor Vernon Marshall and Mr John Anstee

Profits from book sales will be donated to the Foundation for Surgery

26 September 5-7pm

RACS Melbourne Office
250 - 290 Spring Street,
East Melbourne VIC 3002

Catering provided

Please RSVP to
foundation@surgeons.org by 13 September

Foundation for Surgery
Passion. Skill. Legacy.

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

12 noon
Friday 20 September

Lecture:
'Surgeons and their music'

This lecture will be delivered by
Dr Kate Robson

RACS Melbourne Office
250 - 290 Spring Street,
East Melbourne VIC 3002

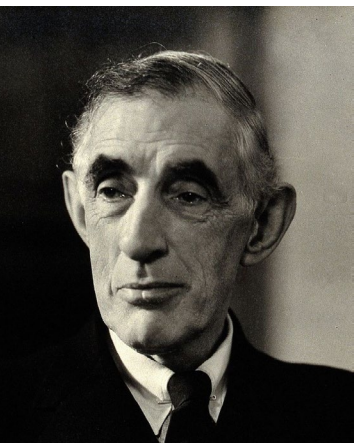
Lunch will be followed by the presentation.

Attendance by donation to the Foundation for Surgery.

RSVP
Please RSVP to foundation@surgeons.org at your earliest convenience to avoid disappointment as places are strictly limited

Historic furniture at RACS

The Huntercombe Manor Set



In the foyer to the Council Room at Spring Street, Melbourne, sit three pieces of old English furniture: a refectory table, an armoire or cupboard and a Welsh dresser. These were donated to the College in 1962 by Mrs Alice Grey Turner, widow of the eminent British surgeon George Grey Turner FRCS (1877-1951).

The table is the most important of this group. It dates from the reign of King Charles I (1625-49). Made of oak, the table measures 234cm long, 83cm wide and stands 77cm high. Three heavy planks join lengthwise to make the 4cm thick top which has darkened and warped over time, and carries marks and indentations that testify to its life through three or more centuries. The top rests on a frame supported by four sturdy columnar legs and a deep skirt carved with continuous arcading, known as "nulling". A foot-rail joins the legs together near the floor – its nicks and gouges are said to have been made by the swords of the gentlemen as they sat at table.

The oak armoire or cupboard was once thought to be Jacobean, but expert opinion indicates that the vine-like decoration along the top front dates it to the reign of Charles II (1660-85).

The dresser, called "Welsh" because of the importance of this type of furniture in North Wales, is in two pieces, with drawers in the lower part and open shelves in the upper section. In the 18th century the dresser became a significant way of displaying a family's best chinaware. This one dates from the 18th century, but is made up of two disparate pieces. Mrs Grey Turner declared that the china had always been on the dresser, so she included the china with the donation. Most of the dishes are willow pattern, but no two are exactly the same.

George and Alice Grey Turner came to Australia in 1937 at the invitation of the College to open the refurbished Prince Henry's Hospital, which was to be RACS' teaching hospital – that came to an end when WWII broke out. At the time Grey Turner was Director of the British Postgraduate Medical School at Hammersmith Hospital and Professor of Surgery in the University of London. Although he achieved little public acclaim, he was greatly respected and honoured within the profession. In recognition of his services he was elected Hon. FRACS in 1937, and he formed a bond of affection with the College.

Born and educated in the north of England, Grey Turner built up a large and highly successful practice in Newcastle-on-Tyne but had to move south in order to fulfil his duties in London. He and his family acquired Huntercombe Manor, a large historic house near Taplow in Buckinghamshire. This house, begun in the 13th century, was famous for its four hectares of extensive gardens, created by the noted Victorian children's author Eleanor Vere Boyle (1825-1916) who lived there during the latter part of the 19th century. The house was substantially altered in the 19th century, but the mediæval hall which forms its core is still largely intact.

George Grey Turner died suddenly at Huntercombe Manor on 24 August 1951. Alice lived on in the house until her own death some 12 years later. Shortly before her death she made a return trip to Australia and visited the College where she was shown around by (Sir) Benjamin Rank. On the upper landing she remarked on how bare the upstairs was, and suggested the area might benefit from some appropriate furniture which she

IMAGES (clockwise from top-left): George Grey Turner 1947 (credit: Wikipedia); Armoire, late 17th century; Welsh dresser, 18th century, with chinaware; Table, mid 17th century.

IMAGES: The Great Hall at Huntercombe Manor 1949 (credit: *Country Life*)

could donate to the College. This very generous offer was accepted, and following her death, the three pieces of furniture and the chinaware arrived from England.

It was Mrs Grey Turner's wish that the pieces be kept together, and they still stand near each other outside the Council Room.

– Geoff Down
RACS Museum

SURGICAL SNIP

Fat cell discovery could help combat obesity-related health issues

Researchers have discovered differences in fat cells that could potentially identify people predisposed to metabolic diseases such as diabetes and fatty liver disease.

The world-first discovery also identified 'fast burning' fat cells that if unlocked might help people lose weight. About 70 per cent of Australians are overweight or obese, which has been linked to metabolic disease risk. The University of Melbourne research found that an individual's level of risk might depend upon the type of fat they store.

Recently published in *Cell Reports*, the study took samples from human volunteers and discovered three specific subtypes of precursor cells that went on to become fat cells.

Senior author Matthew Watt, Head of Physiology in the University of Melbourne's School of Biomedical Sciences, said the results indicated that the makeup of these cells in a person's body could help to determine their health.

Professor Watt said if treatments were developed to 'switch off' the fat releasing cells and 'switch on' the fat burning cells developed, they could help prevent some illnesses and be less invasive than bariatric surgery. He also emphasised that a healthy lifestyle is also important.

"The discovery is important because it tells us that not all fat cells are the same and that by understanding the fat subtypes in a human, we might be able to predict their future metabolic health," Professor Watt said. While the results indicated certain cell subtypes might increase risk of metabolic disease, Professor Watt said a clinical trial was now needed to accurately answer that question.

– about.unimelb.edu.au/newsroom

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

Mandatory courses

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

- Foundation Skills for Surgical Educators Course: mandatory for SET surgical supervisors, surgeons in the clinical environment who teach or train SET Trainees, IMG supervisors, research supervisors, Education board members, Board of Surgical Education and Training and Specialty Training boards members.
- Operating with Respect one-day course: Mandatory for SET supervisors, IMG supervisors and major RACS committees.

Foundation Skills for Surgical Educators course (FSSE)

10 August 2019	Melbourne	VIC
19 August 2019	Sydney	NSW
24 August 2019	Hobart	TAS
25 August 2019	Sydney	NSW
30 August 2019	Hamilton	NZ
06 September 2019	Melbourne	VIC
13 September 2019	Canberra	ACT
13 September 2019	Auckland	NZ (Trainees only)
14 September 2019	Brisbane	QLD
20 September 2019	Christchurch	NZ

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

Operating with Respect course (OWR)

07 September 2019	Gold Coast	QLD

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

Academy of Surgical Educators Studio Sessions

20 August 2019	Wellington	NZ

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

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

All sessions are also simulcast via webinar. To register, please visit www.surgeons.org/studiosessions

Surgeons as Leaders in Everyday Practice

Friday 16 to Saturday 17 August	Wellington	NZ
Friday 30 to Saturday 31 August	Adelaide	SA

Surgeons as leaders in everyday practice is a one and a half day program that looks at the development of both the individual and clinical teams leadership capabilities. It concentrates on leadership styles, emotional intelligence, values and communication and how they all influence their capacity to lead others to enhance patient outcomes. The program forms part of a leadership journey sharing and gaining valuable experiences and tools to implement in the workplace.

Safer Surgical Teamwork (SST)

Friday 23 August 2019	Brisbane	QLD

Safer Surgical Teamwork (previously known as Safer Australian Surgical Teamwork – SAST) is a combined workshop for surgeons, anaesthetists and scrub practitioners. The workshop focuses on non-technical skills that can enhance performance and teamwork in the operating theatre thus improving patient safety. These skills are explored using three frameworks developed by The University of Aberdeen, Royal College of Surgeons of Edinburgh and the National Health Service – Non-Technical Skills for Surgeons (NOTSS), Anaesthetists Non-Technical Skills (ANTS) and Scrub Practitioners' List of Intra-operative Non-Technical Skills (SPLINTS). These frameworks can help participants develop the knowledge and skills to improve their performance in the operating theatre in relation to communication/teamwork, decision making, task management/ leadership and situational awareness. The program looks at the relationship between human factors and safer surgical practice and explores team dynamics.

Process Communication Model Seminar 2

Friday 13 to Sunday 15 September	Melbourne	VIC

This advanced three day program allows you to build on and deepen your knowledge while practising the skills you learned during Process Communication Model (PCM) Seminar 1. You will learn more about understanding your own reactions under distress, recognising distress in others, understanding your own behaviour and making communication happen.

PCM enables you to listen to what has been said, while at the same time being aware of how it has been said. At times we are preoccupied with concentrating on what is said, formulating our own reply and focusing solely on the contents of the conversation. To communicate effectively, we need to focus on the communication channels others are using and to recognise when they are in distress.

Clinical Decision Making

Saturday 21 September	Melbourne	VIC

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

SAT SET Course

Tuesday 20 August 2019	Auckland	NZ

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

Keeping Trainees on Track

Tuesday 20 August	Auckland	NZ

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

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

Non-Technical Skills for Surgeons (NOTSS)

Friday 27 September 2019	Brisbane	QLD

This workshop focuses on the non-technical skills that underpin safer operative surgery. It explores a behaviour rating system developed by the Royal College of Surgeons of Edinburgh that 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 that of your colleagues.

Please contact the Professional Development Department on: +61 3 9276 7440, PDactivities@surgeons.org or visit the website at surgeons.org and follow the links from the homepage to activities.

PROFESSIONAL DEVELOPMENT WORKSHOP
DATES: August – September 2019

ACT		
Foundation Skills for Surgical Educators	13 September	Canberra
NSW		
Foundation Skills for Surgical Educators	19 August	Sydney
Foundation Skills for Surgical Educators	25 August	Sydney
NZ		
Surgeons as Leaders in Everyday Practice	16-17 August	Wellington
Academy of Surgical Educators Studio Sessions	20 August	Wellington
Keeping Trainees on Track	20 August	Auckland
Supervisors and Trainers for SET – SAT SET	20 August	Auckland
Foundation Skills for Surgical Educators	30 August	Hamilton
Foundation Skills for Surgical Educators	20 September	Christchurch
VIC		
Academy of Surgical Educators Studio Sessions	07 August	Melbourne
Foundation Skills for Surgical Educators	10 August	Melbourne
Foundation Skills for Surgical Educators	06 September	Melbourne
Process Communication Model Seminar 2	13 September	Melbourne
Clinical Decision Making	21 September	Melbourne
WA		
Non-Technical Skills for Surgeons	9 August	Perth
SA		
Surgeons as Leaders in Everyday Practice	30-31 August	Adelaide
QLD		
Safer Surgical Teamwork	23 August	Brisbane
Cominbed Meeting of AOA	7 September	Gold Coast
Foundation Skills for Surgical Educators	14 September	Brisbane
Non-Technical Skills for Surgeons	27 September	Brisbane
TAS		
Foundation Skills for Surgical Educators	24 August	Hobart

Register online

For more information phone **+61 3 9276 7440**, email **PDactivities@surgeons.org**
or visit our website **surgeons.org** and search Professional Development

Skills Training courses

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

ASSET: Australian and New Zealand Surgical Skills Education and Training

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

EMST: Early Management of Severe Trauma

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

CCrISP®: Care of the Critically Ill Surgical Patient

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

CLEAR: Critical Literature Evaluation and Research

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

TIPS: Training in Professional Skills

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

Contact the Skills Training Department

Email | skills.courses@surgeons.org
Visit | www.surgeons.org - Click on Education and Training then select Skills Training courses

SKILLS TRAINING COURSE DATES
AUGUST - NOVEMBER 2019 | *Available courses

ASSET	www.surgeons.org/asset
Friday, 23 August – Saturday, 24 August	Brisbane
Friday, 13 September – Saturday, 14 September	Sydney
Friday, 11 October – Saturday, 12 October	Brisbane
Friday, 18 October – Saturday, 19 October	Melbourne
Friday, 8 November – Saturday, 9 November	Auckland
Friday, 15 November – Saturday, 16 November	Melbourne
Friday, 29 November – Saturday, 30 November	Sydney
CCrISP	**www.surgeons.org/ccrisp**
Friday, 30 August – Saturday, 1 September	Brisbane
Thursday, 5 September – Saturday, 6 September	Auckland
Friday, 6 September – Sunday, 8 September	Sydney
Wednesday, 30 October – Friday, 1 November	Dunedin
Friday, 1 November – Sunday, 3 November	Sydney
Friday, 8 November – Sunday, 10 November	Adelaide
Friday, 15 November – Sunday, 17 November	Brisbane
CLEAR	**www.surgeons.org/clear**
Friday, 20 September – Saturday, 21September	Sydney
Friday, 18 October – Saturday, 19 October	Melbourne
Friday, 8 November – Saturday, 9 November 201	Wellington
EMST	**www.surgeons.org/emst**
Friday, 6 September – Sunday, 8 September	Adelaide
Friday, 13 September – Sunday, 15 September	Brisbane
Friday, 20 September – Sunday, 22 September	Wagga Wagga
Friday, 18 October – Sunday, 20 October	Perth
Friday, 18 October – Sunday, 20 October	Sydney
Friday, 18 October – Sunday, 20 October	Auckland
Friday, 25 October – Sunday, 27 October	Gold Coast
Friday, 25 October – Sunday, 27 October	Canberra
Friday, 1 November – Sunday, 3 November	Sydney
Friday, 1 November – Sunday, 3 November	Brisbane
Friday, 8 November – Sunday, 3 November	Wellington
Friday, 15 November – Sunday, 3 November	Melbourne
Friday, 15 November – Sunday, 3 November	Sydney
Friday, 22 November – Sunday, 3 November	Brisbane
Friday, 22 November – Sunday, 3 November	Adelaide
Friday, 29 November – Sunday, 3 November	Melbourne
TIPS	**www.surgeons.org/tips**
Friday, 13 September – Saturday, 14 September	Melbourne
Saturday, 19 October – Sunday, 20 October	Sydney
Friday, 15 November – Saturday, 16 November	Melbourne
Friday, 22 November – Saturday, 23 November	Auckland

**Courses available at the time of publishing*

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

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PREPARATION FOR PRACTICE MELBOURNE WORKSHOP

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LEARN ABOUT:

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

CPD FOR FELLOWS

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

VENUE

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

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

https://www.surgeons.org/about/racs-offices/victoria/

In memoriam

RACS publishes abridged obituaries in *Surgical News*.
We reproduce the opening paragraphs of the obituary. Full versions can be found on the RACS website.

Herbert Dick Rawson FRCS(Ed) FRACS

General and Vascular Surgeon
26 April 1924 – 23 June 2018

Dick was born at the family home in Kilbirnie, Wellington, to Jack, a general practitioner, and Gladys. He was the second of four children – Evelyn, Beatrice and Bruce. Dick commenced school at Eastern Hutt School and, successfully completing a proficiency examination, gained entry to Wellesley College. When he was 12 years old his father died suddenly leaving Gladys to raise the family. As a consequence of his father's death, and on a hardship scholarship, Dick was sent as a boarder to Christ's College in Christchurch for some male influence. While bullying of junior boarders was the norm at that time, Dick's musical talents became evident as he commenced playing the piano and participated in the Chapel Choir. He was a very capable gymnast becoming a member of the Gym-eight.

Strongly influenced by his father's choice of career and sister Evelyn's commencing medical training, Dick gained entry to Otago University Medical School in 1942. During this time the family lived in Dunedin and Dick was strongly motivated to study to avoid being enlisted for the army. However, there was time to enjoy participation with the University Dramatic Society. Sadly, Evelyn died in a horse accident during her final year at medical school.

Full obituary can be read at https://www.surgeons.org/about-racs/about-the-college-of-surgeons/in-memoriam/herbert-rawson

William Owen Sawtell Phillipps FRCS(Ed) FRACS

General Surgeon
31 August 1926 – 11 June 2018

William Owen Sawtell (known as Bill) Phillipps was born in Wellington to William John Phillipps, an Ethnologist at the Dominion Museum, and Esther (née Waldie), who was a graduate of Wellington Girls College. Bill commenced his education at Khandallah School and then went to Wellington College, where he excelled academically and at athletics. With an ear for music, Bill learned to play the piano and was a singer in the Anglican Boys Choir.

Although his father thought Bill might like to take up a career in accounting, being very proficient at mathematics, he chose medicine instead. He was admitted to Otago Medical School, graduating MB ChB in 1950. During his time in Dunedin he was University table tennis champion for several years and was awarded a University Blue. After spending a year as an Anatomy Demonstrator, Bill worked as a House Surgeon at Wellington Hospital, meeting Patricia Martin, a trained nurse. They married in 1952 and moved to Rotorua Hospital for one year. In 1954, after working briefly as a locum for general practices in the North Island, Bill and Pat travelled to England where Bill took up a position as a senior house officer at Kingston on Thames. In 1956 he moved to a similar position at Carshalton Children's Hospital, spending two years there and gaining his FRCSEd. Bill was a surgical registrar at South Devon and East Cornwall Hospital, Plymouth during the years1958-9 and at Southend General Hospital in 1960.

Full obituary can be read at https://www.surgeons.org/about-racs/about-the-college-of-surgeons/in-memoriam/william-phillipps

Stuart Taylor

Urologist
25 September 1934 – 16 April 2019

Stuart Taylor was born in Braidwood, NSW and had a carefree childhood growing up as a country boy, attending Braidwood Primary School (often on horseback).

He attended Sydney Church of England Grammar School as a boarder, having an enjoyable and successful school life and matriculated in 1952. He was accepted into Medicine at Sydney University in 1953 and lived in St. Andrew's College graduating in 1958.

After an initial stint as a Registrar and Assistant Superintendent at St. George Hospital Sydney, he was awarded a Nuffield Scholarship and went to the U.K. in 1961. After periods of work as a Medical Officer in the Australian Migration Mission in Spain (1962) and the 8th US Army Medical Corp in Germany (1962-1964) he returned to England in 1966 where he obtained his Fellowships from the Royal College of Surgeons Edinburgh and later England. He then underwent Paediatric Urology Training at St. Phillips and Great Ormond Street and was a Registrar at St Peters Hospital and Institute of Urology in London in 1967. In 1968 Stuart was a Senior Registrar (working alongside Peter. O. Maher) at the Western General Hospital (Newcastle-upon-Tyne).

Full obituary can be read at https://www.surgeons.org/about-racs/about-the-college-of-surgeons/in-memoriam/stuart-taylor

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

IN MEMORIAM

Our condolences to the family, friends and colleagues of the following Fellows whose deaths have been recently notified.

2019

Sam Mellick (QLD)

Stuart Taylor (NSW)

Informing RACS

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

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

Selim (Sam) Abraham Mellick CBE MBBS FRCS FRACS FACS FRCSI (Hon)

Vascular surgeon and past RACS Vice President

1925 – 2019

Selim Mellick, universally known as Sam, was a legendary surgeon.

He was born in Innisfail in north Queensland and was Dux of both his local primary school and his high school the All Souls School in Charters Towers. He graduated from the University of Queensland with first class honours in medicine and surgery in 1948.

Sam travelled to England to work and study and obtained the Fellowship of the Royal College of Surgeons in 1953. In 1954 he married Patricia (Pat) Bulmer and they had two daughters, Sally Ann and Alice Amanda (Mandy).

Returning to Australia he was appointed as a Visiting Surgeon to the newly opened South Brisbane Hospital (later the Princess Alexandra Hospital), where he worked for 30 years of his distinguished career. He was Chairman of the Princess Alexandra Hospital Society from 1964 to 1968.

Sam was initially a general surgeon but the surgical group recognised the need for someone to specialise in vascular surgery and he was chosen for that role. He was an influential pioneer in the developing specialty of Vascular surgery and was appointed as a Vascular Surgeon from 1961. He headed the specialty group as Senior Vascular Surgeon until his mandatory retirement at the age of 60 in 1985. The unit was named in his honour as the Sam Mellick Vascular Unit. After that he worked in private practice at the Holy Spirit Hospital.

Sam's contributions to vascular surgery in Brisbane and indeed worldwide were enormous. In that era, ruptured abdominal aortic aneurysm was a feared and usually fatal event.

Surgery was extremely challenging and techniques were being developed to manage the pathology. The ruptured aorta need to be replaced with a new artery and commercial grafts were not yet available. Sam's wife Pat prepared grafts from synthetic terylene material on her home sewing machine and these were used successfully. Sam led improvements that over time reduced the mortality from around 80 per cent down to 30 per cent in cases of rupture and also led to classification and criteria for operating prophylactically before rupture occurred, resulting in much improved overall survival. Sam delivered a Hunterian Professorship Oration to the Royal College of Surgeons of England in 1981 in which he described the results, from the unit he headed, of 1166 femoro-popliteal bypass grafts over that first 20 year period. Sam was an excellent surgical technician and one of his peers described him as "stitch perfect".

Sam had a long and distinguished association with the Royal Australasian College of Surgeons, obtaining his Fellowship in 1960. He was an enthusiastic and knowledgeable teacher of students and surgical trainees. He was the Founding Chairman of the RACS Section of Vascular Surgery in 1972, serving for four years as Chairman and then continuing as a member. He was a member of the Editorial Board of the Australian and New Zealand Journal of Surgery 1989-1996.

He was a member of the FRACS Part 1 Board of Examiners from 1969 to 1983, being Chairman for the last three years. He was a member of RACS Council from 1977 to 1989, Censor in Chief from 1983 to 1986 and Senior Vice President from 1987 to 1989. After retirement from Council he was made a life member of the RACS Court of Honour.

His involvement at a high level of international professional organisations was remarkable. He was a Fellow of the American College of Surgeons, Chairman of its Australian and New Zealand Chapter from 1987 to 1982 and served two terms as a governor between 1986 and 1992.

He was a member of the International Society for Cardiovascular Surgery from 1977, President of its Australian and New Zealand Chapter from 1989 to 1991 and President of the International Society from 1991 to 1993.

Sam was a consultant vascular surgeon to the No.1 military hospital in Brisbane from 1965 and in 1968 led a civilian surgical team in South Vietnam during the war. Among his many non-medical affliations he was a Chairman of the Marriage Guidance Council of Queensland, member of Council of St John's College at the University of Queensland, Founding Chairman of the St. John's College Foundation, Founding President of the Medical Alumni Association of the University of Queensland and Founding President of the State Library of Queensland Society.

Sam received many honours throughout his career. The most prestigious was Commander of the Most Excellent Order of the British Empire (CBE) in 1980. Other notable honours were visiting Professorships in England, Ireland, USA, France and New Zealand. The Australian and New Zealand Society for Vascular Surgery named its travelling fellowship in his honour, the ANZSVS Sam Mellick Travel Fellowship, and Sam presented the inaugural award in 2012. He was a tutor in surgical anatomy at the University of Queensland and later was awarded the title of Honorary Professor.

Sam's presence was always positive. He seemed to be eternally optimistic and when meeting him and enquiring how he was he would say "marvellous" or "strong". He had no problems finding an operating theatre to work in (even when staff was apparently in short supply for other surgeons) and was enthusiastically supported by nursing staff and assistants. In an era when some surgeons behaved somewhat autocratically Sam was a wonderful teacher, mentor and role model. He leaves an outstanding legacy as a master surgeon.

Obituary kindly provided by Professor Ian Gough AM

Foundation for Surgery

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Mr John Baker
Dr Graeme Barber
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Mr John Binks
Mr Robert Black
Mr Andris Blokmanis
Mr Laszlo Borbely
Mr Peter Brady
Ms Michele Brennan
Ms Megan Bridger-Darling
Miss Ingra Bringmann
Dr Mary Brooksbank
Mr Peter Brown
Ms Belinda Brown
Mr William Bye
Mr Peter Byrne
Assoc Prof Richard Cade
Mrs Ingeborg Cairns
Mr Lawrence Carroll
Mr Anthony Cass
Stephany Chamieh
Dr Mun Khin Chan
Mr David Chapman
Mr John Chen
Dr Janice Cheng
Dr Bernard Cheung
Dr Soo-Huat Choo
Mr William Clark
Mr Robert Claxton
Mr Harvey Coates
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