SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 18 NO 6 JULY 2017

Cultural Competence

Highlights from NZ symposium

RACS & Global Health

RACS releases new Global Health Strategic Plan 2017-2021

Cowlishaw Symposium

The Kenneth Fitzpatrick Russell Lecture 2016

SURGICAL NEWS July 2017 Vol 18 No 6

The College of Surgeons of Australia and New Zealand

I have to wash my hands many times each day at work. I find it helpful to imagine that I am washing away any stress as I wash my hands.

\- Dr H

Speak to a RACS Support Program consultant to debrief and process some of the challenges, stressors and concerns that are faced by Surgeons, Surgical Trainees and International Medical Graduates.

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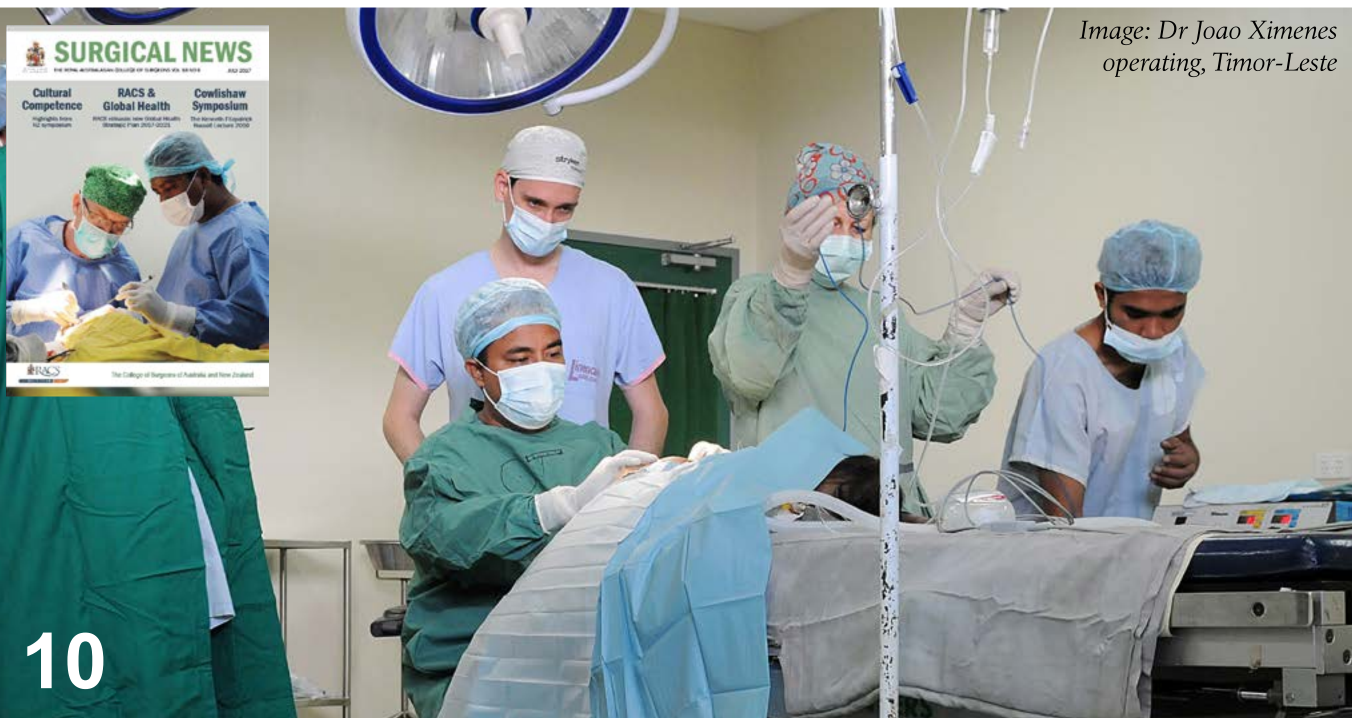

Image: Dr Joao Ximenes operating, Timor-Leste

FEATURE: GLOBAL HEALTH – RACS releases its new Global Health Strategic Plan 2017-2021

DISASTER RESPONSE REGISTRY
The history and the handover

CULTURAL COMPETENCE SYMPOSIUM, WELLINGTON
Medical Council of New Zealand partners with Te ORA, (Māori Medical Practitioners Association)

COWLISHAW SYMPOSIUM
The Kenneth Fitzpatrick Russell Lecture 2016

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COVER: Dr Mark Moore (left), Dr Joao Ximenes (right), Timor-Leste. Photographer is Ellen Smith.

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The Quality Improvement Agenda of RACS Training Programs

JOHN BATTEN
President

As many of you may be aware, RACS is currently undergoing accreditation of its surgical training programs by the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ).

Accreditation is a process by which the quality of an education program or institution is judged by an external organisation against a set of agreed standards.

The great value of accreditation is as a stimulus for self-assessment, growth and development of the training entity, namely a quality improvement process. Accreditation also attests to the quality of the program for regulatory purposes, i.e. recognition of the medical programs for the purpose of medical registration of graduates, and as such is also a quality assurance process.

While initially accreditation was a voluntary process with participation agreed to by the medical colleges as evidence of their commitment to quality, it is now mandatory. The accrediting bodies in both countries that oversee RACS bi-national programs are different but both inherently seek quality outcomes for patients through their accreditation and standard setting processes.

In the assessment of RACS training programs in 2017, the accreditation was undertaken by a joint AMC and MCNZ assessment team, the AMC and MCNZ making separate accreditation decisions, but the two councils working together to align their processes. The AMC lead the accreditation processes, but the team had two New Zealand members who, in addition to contributing to the team's overall assessment, took the lead in reviewing any specific New Zealand requirements.

RACS has a long history of accreditation. RACS was one of the first colleges to volunteer to be accredited, initially being accredited by the MCNZ in 1998. The AMC accreditation process for specialist programs and continuing professional development programs began in 2002. The AMC first assessed RACS in 2002, accrediting RACS for a period of six years, until July 2008.

The last full accreditation was in 2007, at the same time as RACS introduced the new Surgical Education and Training (SET) program. RACS and the SET program was granted accreditation until December 2011, subject to a follow up assessment in 2008 to confirm that the SET program had been implemented as planned and confirming the accreditation period.

In 2011, RACS submitted a comprehensive report for extension of accreditation. The AMC found that RACS met all of the standards and extended the accreditation for a further six years, until December 2017.

This is only the 3rd full re-accreditation in 17 years.

There are 10 agreed upon standards which the RACS program is assessed against, each of which has several criteria underpinning them. The standards were revised in 2015 with 25 substantive changes. There was an enhanced focus on trainee wellbeing and patient safety, additions across the 5 standards on indigenous health and revised CPD and IMG assessment standards (9 and 10).

The 10 standards are below:

1. The context of education and training
2. Organisational purpose and outcomes of specialists training and education
3. The specialists medical training and education framework (curriculum)
4. Teaching and learning methods
5. Assessment of learning
6. Monitoring and evaluation
7. Trainee (including trainee wellbeing, selection and appeals)
8. Implementing the program (including supervision/ supervisors and accreditation of training posts)
9. Continuing Medical Education
10. International Medical Graduates

The AMC standards are used to assess whether a program of study and its provider, provide graduates with the knowledge, skills, and professional attributes necessary to practice the profession (National Law). It must take account of community expectation, consult widely about the content of standards, and take into account contemporary international standards and statements e.g. CanMeds; WHO/WFME guidelines.

The purpose of RACS providing a detailed submission addressing the 10 AMC standards is to reflect on a critical analysis of our performance since the last accreditation: what is different since the last submission; articulate any plans for the future; and identify our strengths, challenges and processes for addressing emergent situations in health education and training.

Providing a response to each criterion under each of the standards in the submission required a considered, collaborative response from our training partners who deliver the programs in each of the speciality disciplines. Our training programs in the nine specialities have varying degrees of autonomy, complexity and devolution, but all are overseen by principle based policies to allow flexibility in the delivery of the programs by the 12 speciality training boards, and the AOA Federal Training Board

The AMC designed and undertook a program of hospital site visits to meet trainees and supervisors and observe the educational work of the training boards and RACS, including meetings with hospital CEOs, allied health personnel and Directors of Surgery.

The visits included meeting groups and committees that contribute to the delivery of SET. To gain an understanding of regional context, the team met with relevant health department jurisdictions, representatives of the major education boards and committees, Indigenous Health Committee, RACSTA, Younger Fellows, Women in Surgery and community representatives, all with the aim of verifying and triangulating information and resources. This included observing the fellowship examination and the RACS Annual Scientific Congress.

The AMC will present its preliminary findings to June Council, with the final report due in August. The report is delivered as feedback against each criterion under each standard with commentary, and either a **commendation** indicating an initiative that will be recommended to other colleges; a **recommendation** to enhance a program of activity or if substantive deficiencies are identified, **conditions** that are required to be met in a time frame by the training institution, with planned review for compliance.

We anticipate several recommendations and a few commendations, but maybe a few conditions. Either way the exercise is one of quality improvement and confirmation of the quality of the program RACS delivers through its specialty societies.

I would like to express my sincere thanks for the enormous work done over the last 6 months in the preparation of the submission led by Kathleen Hickey and her department; for the coordination of the fellows time in the discussions with the AMC accreditation team; and for the specialty society representatives who provided input to the submission and generously gave their time with the team during the assessment process.

The RACS Voice on Advocacy

CATHY FERGUSON
Vice President

Since assuming the role of Vice President and being exposed to the volume of RACS advocacy submissions, letters and responses, I can say with confidence that our College is taking informed and principled positions on issues of public health at both state and national levels.

The College's policy and advocacy activities support the leadership role of surgeons, both collectively and individually, in influencing a broad range of factors that impact upon the health and wellbeing of patients and the broader community, and the healthcare that they receive.

So far this year we have responded to or made submissions on more than 30 crucial issues such as the harmful use and misuse of alcohol via our response to the National Health and Medical Research Council, the Senate Enquiry into the effects of red tape on the sale, supply and taxation of alcohol, the DFAT Foreign Policy White Paper on the importance of health among Australia's geographical neighbours, and in response to the issue of universal access to safe, affordable surgical and anaesthesia care.

At a state level we have provided comment on issues such as the Review of the *Liquor Reform Act* in Victoria, the performance of the Queensland Health Ombudsman's functions, the Model Scopes of Clinical Practice Project in New South Wales, the Quad Bikes Safety Issues Paper in Tasmania and Patient Access to Medicinal Cannabis in South Australia.

The national and state elections also provide us with a range of opportunities to quiz the various political parties about where they stand on the key health issues such as maintaining high quality and timely access to healthcare, recognising the burden of trauma on the healthcare system, reducing alcohol-related harm and increasing the commitment to Indigenous health. This year we identified what we believed to be the five key focus areas in advance of the 2017 Western Australian Election. We are now in preparation mode for elections in New Zealand and Queensland.

In my neck of the woods, RACS has had input this year into a number of consultations in New Zealand. This has included submissions on Health Workforce New Zealand's proposed investment approach to the post-entry training of New Zealand's health workforce, the Health Quality and Safety Commission's proposed national recognition and response system for deteriorating patients, Medical Council of New Zealand's document on strengthening recertification for vocationally registered doctors and the Ministry of Health's proposed model of care for vascular service. RACS also responded to the Perioperative Mortality Review Committee on its proposed recommendations for its 2017 Annual Report.

RACS strives to ensure the highest standard of safe and comprehensive surgical care to the community through excellence in surgical education, training, professional development and support. Championing professionalism and standards across surgery and working proactively with government on advocacy issues are firmly in the spotlight of our RACS vision and strategic objectives.

Our Regional Chairs and their committees maintain relevance at a local level and act as conduits to and from Council on important advocacy issues. They provide the main interface between the thousands of Fellows, Trainees and IMGs that the College represents, and it's Council.

The ability to access the resources and knowledge of our regional committees and the New Zealand National Board is highly valued by Council and there is no question that they add incredible value to our advocacy efforts.

We always endeavour to not only draw on local knowledge but specialty knowledge as well. The mutual sharing of positions and contributing to each other's submissions is now a common exercise between the surgical specialty societies and RACS. Internally, we work across departments and divisions including RACS Research & Evaluation, Professional Standards, Fellowship Services, Trauma, Rural Section, and Indigenous Health Committee.

The RACS policy and communication officers across Australia and New Zealand are also crucial to our work in this space – they are committed to helping RACS monitor and influence how health policy is developed, formulated, implemented and evaluated in Australia and New Zealand. Together with the Regional Managers, they provide significant input into the quality and depth of our submissions.

In this way RACS has become an authoritative source and a valued partner of key stakeholders and a key influencer of government policy and legislation on behalf of its members.

Over the remainder of this year we will continue to advocate on issues that are important to us, such as Building Respect and Improving Patient Safety (BRIPS), sustainability of healthcare, Indigenous health, quad bike safety and influencing alcohol policy.

If you would like to share your thoughts on how we as a College can strategically and actively engage with key stakeholders and reinforce our reputation as the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand, I would be very keen to hear from you.

RACS Advocacy 2017

As the leading advocate for surgical standards, professionalism in surgery and surgical education in Australia and New Zealand, RACS is committed to taking informed and principled positions on issues of public health and matters that impact patient care and surgical standards.

Recent submissions from RACS include:

Responding to the **NZ Quality and Safety Commission's Proposed national recognition and response system.** In general, RACS would support the introduction of a universal Early Warning Scoring (EWS) system and documentation process to all DHBs and private hospitals across New Zealand. The universal introduction would be more acceptable than having different systems and documents in different facilities.

Responding to the Commonwealth Government's proposed changes to the **Health Practitioner Regulation National Law (National Law)**. RACS supports the proposed reforms to address the inadequacies of the penalties under the National Law, in light of the recent worrying cases of individuals holding themselves out as health practitioners when they are not registered under the National Law.

Responding to the **Tasmanian Government's Role Delineation Framework regarding Paediatric Surgery Guidelines.**

To view these and other submissions in full, please visit the RACS website http://www.surgeons.org/media/college-advocacy/

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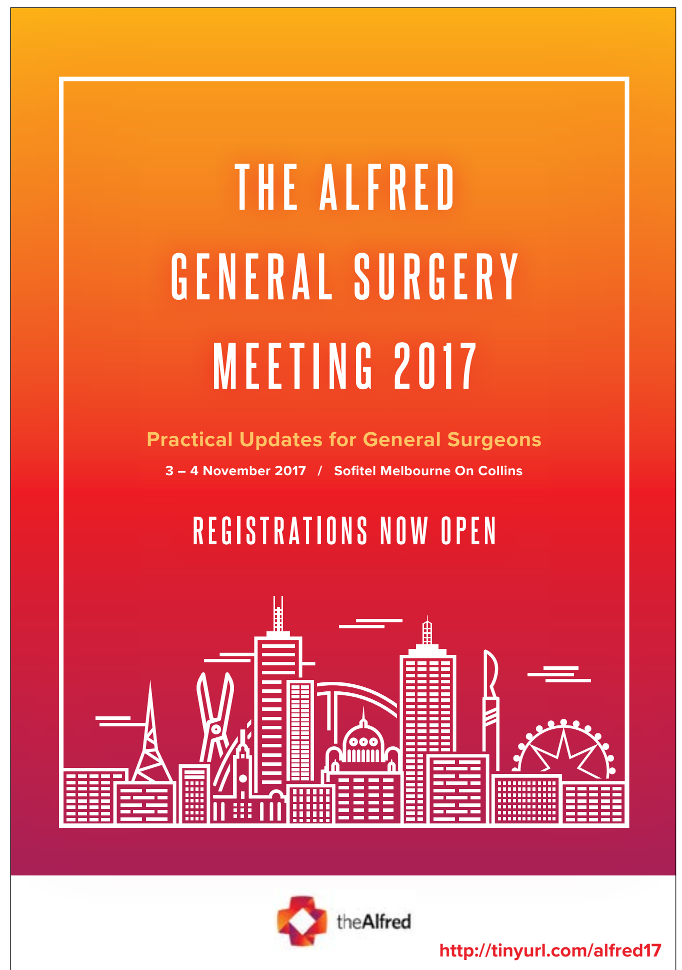
Milestones: a time to reflect and a time to plan

DR BB-G-LOVED

Last month Dr Wrinkle reached a milestone age and came, quite responsibly, to seek my opinion on fitness for continuing to work. Milestones are opportunities to reflect either on how far you have come or how far you want to go. When you are walking they probably mean something every kilometre; when you are driving a great distance, it is probably only the 100km marks that are encouraging measures of progress; when it's a journey usually a little short of 100 like life, then the there's at least some cause for celebration every 10 years.

Decades past, 60 seemed old and most working people expected to retire at 65. Now few doctors do, even if by the seventh decade their practice has changed from what it was. In the 1970's 60 seemed old to the now aging baby boomer generation then in their twenties and thirties. In the USA there are now 240,000 physicians aged over 65, quadruple the number there were in 1975, the year the Vietnam war ended. For Australians, 1975 was also the year the Australian Open witnessed joint Australian tennis champions - Evonne Goolagong beat Martina Navratilova and John Newcombe defeated Jimmy Connors! The All Blacks yet again beat the touring Scots and Irish.



Today, many senior surgeons, some now well beyond their 60's, have managed to redefine their roles and stay in the workforce. RACS had 6002 active surgeons in 2016, 1629 (27%) of whom were aged 60 or over. Their motivation includes quality of life from remaining active, securing their financial futures after the GFC, still having dependent children, or insufficient non-professional interests to be occupied in retirement.

Our medical boards and councils warn us that doctors in their last few years of practice are at greater risk of error. Some countries retire their physicians at 65. Others suggest ageing doctors and surgeons should be singled out for competency assessment. Those against cite horror at such 'ageism', as shouldn't all doctors, regardless of their age and experience, be willing to regularly submit their professional skills, decision making and patient outcomes to clinical audit/peer review and be willing to undertake multi-source feedback? These offer opportunities to improve quality by encouraging reflection and providing feedback on performance. Guidelines on best practice change every few years as the evidence for what is best accumulates through registries, large data sets and research. That's not to say you change what already works well, but some heroic treatments of the past such as the vagotomies of the 1960's & 70's are now seldom indicated.

Senior doctors, like all doctors including yours truly, need to practice according to the professional standards expected today, and not necessarily as they have always done. Many standards don't change but in the context of today's world some behaviours that clinicians 'got away with' in the past are no longer acceptable.

Most surgeons will change their scope of practice and take on different roles during their careers. For example, senior surgeons have many opportunities for leadership within their hospitals and profession. To lead one must have vision, must be always improving, be an inspiring role model, and willing to help those more junior to develop their careers. There is a great need for clinician engagement in our health systems. Indeed clinical governance, safety and quality are impossible without it.

Wrinkle had a recent prescription for spectacles, hearing was passable, and was physically fit. Any medical conditions were being treated and controlled. Yes, there were creaking joints with a bit of crepitus, and scars from previous surgery, but no cognitive or other impairments. Competent and fit to practice assuming peers agree.

Wrinkle also needs to plan how to transition to retirement perhaps with the help of the Surgical Career Transitions Guide (http://surgicaltransitions.surgeons.org/). Retirement is no longer about particular numbers on your birthday card - that would be ageist - but 60 and 65 are certainly milestones that should alert the birthday girl or boy to a different terrain approaching in the journey of life. Happy birthday Dr Wrinkle, congratulations ...... and watch out for the future!

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Surgery: The Neglected Stepchild of Global Health

RACS releases its new Global Health Strategic Plan 2017-2021, *Surgical News* features some important projects happening in our region

MS ANNETTE HOLIAN
Chair, External Affairs

On a Monday morning a few months ago, surgeons strided around a striated carpet, reaching for coffees, handshakes with old friends, and tethered black chairs, to come together and partake in the RACS Annual Scientific Congress Global Health Symposium, convened by Assoc. Prof. Suren Krishnan, FRACS. Darting around like a morning city pushbike courier, and eventually ending up behind the lectern, a rather young man began his presentation, "Surgery: The Neglected Stepchild of Global Health".

With eyes peering out through that gap that exists between the brow and the frame of one's glasses, Professor Mark Shrime, an ENT Surgeon from Harvard Medical School's Program in Global Surgery and Social Change began his keynote lecture on how surgery has unfortunately, and often, been left out of Global Health. Echoed throughout the symposium in presentations by RACS Fellows, the key message was understood, 5 billion people around the world do not have access to safe, affordable, and timely surgery.

Such a message slowly begins to permeate to policy makers and donors, coupled with astounding figures like the global burden of surgical disease exceeds that of HIV, malaria, and tuberculosis combined; and global health actors are becoming increasingly aware that global health is global surgery, and Fellows of RACS are leading the way. As the newly-elected Chair of External Affairs, I attended the 70th World Health Assembly of the WHO in Geneva, bringing the maxim from the Asia-Pacific that surgery can be affordable and accessible, and is intrinsic to Global Health, and that our region is pioneering the collection of national surgical metrics in order to inform national health plans.

This year, RACS releases its new Global Health Strategic Plan 2017-2021 with a vision that safe surgical and anaesthetic care is available and accessible to everyone. Since the early 1990's, RACS has been working across the Asia-Pacific, witnessing a shift from charitable service delivery to partnership with Ministries of Health and universities in surgical education, training, workforce development, and clinical governance. Under the new strategic plan, RACS Global Health activities work towards three strategic objectives: (i) surgical and anaesthesia care is included in national health plans, (ii) workforce development is supported by training and continuing professional development activities, and (iii) strong partnerships are forged with international surgical bodies and partners across the Asia-Pacific.

At the global level, RACS activities align with Sustainable Development Goal (SDG) Number 3 to "ensure healthy lives and promote well-being for all at all ages". At the national level, RACS collaborates with in-country governments and partners to develop sustainable health systems and processes for our primary stakeholders – the local communities, to access safe and affordable surgical care.

In this issue of Surgical News, I welcome you to #RACSGlobalHealth and invite you to read stories from our colleagues and counterparts in Australia, New Zealand, and across the region, highlighting our work contributing towards a world where safe surgical and anaesthetic care is available and accessible to everyone. ▶

5 billion people around the world do not have access to safe, affordable, and timely surgery.

Dr Mark Moore (left), Dr Joao Ximenes (right), Timor-Leste. Photographer is Ellen Smith.

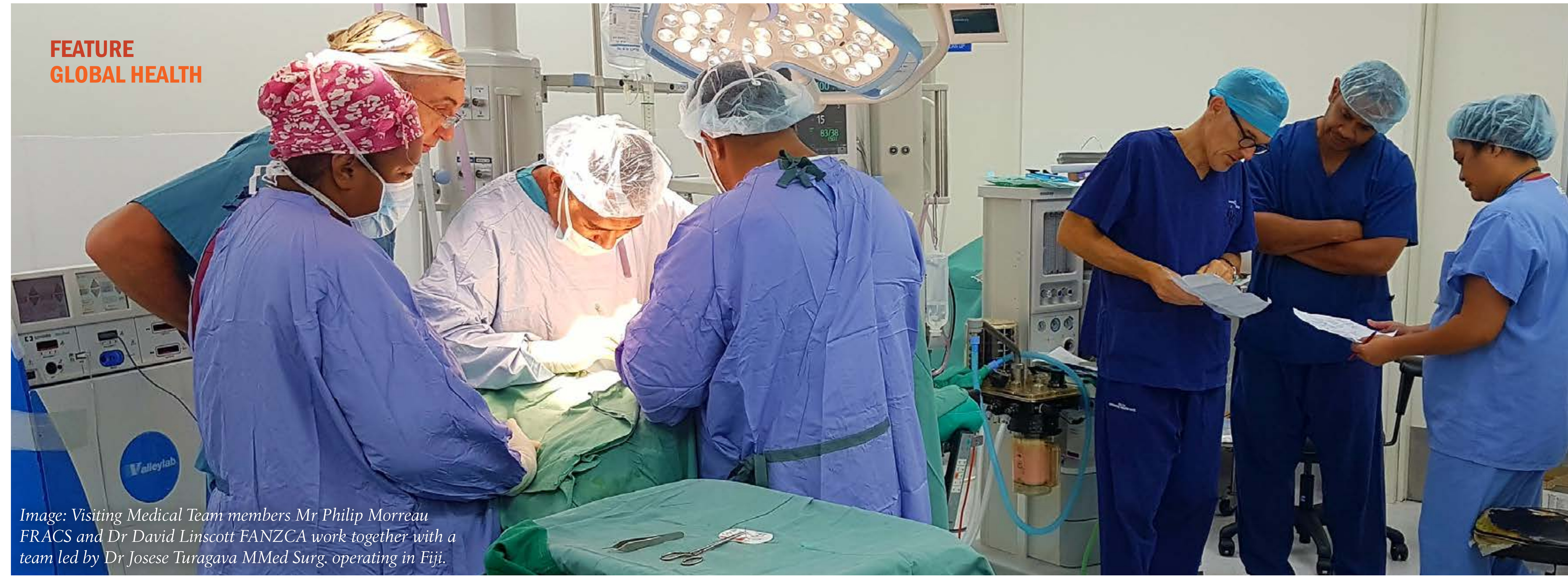

Image: Visiting Medical Team members Mr Philip Morreau FRACS and Dr David Linscott FANZCA work together with a team led by Dr Josese Turagava MMed Surg. operating in Fiji.

Large Ocean States: The Pacific Islands Program

MR KIKI MAOATE
Project Director

There is nothing small about these island states, when countries like Kiribati stretch over an area of the Pacific as large as the United States of America. There is nothing small about a surgeon single-handedly covering all operations for a population of 100,000 people (in Australia, there is one surgeon per 5,000). There is nothing small about the gap in life expectancy, which for someone on Nauru can be more than 15 years less than the average Australian. For over 20 years, RACS Global Health has been working with large ocean states in order to address some of the above challenges when it comes to timely, affordable, and safe surgery.

The Pacific Islands Program (PIP), supported by the Australian Government, has come a long way since it was established over 20 years ago. In 1995 the focus of PIP was almost exclusively clinical service delivery; whereas now activities focus on workforce planning, continuing professional development, and clinical governance. Under this new phase of the PIP (2016 – 2021) service delivery is no longer the primary objective. All our Visiting Medical Teams (VMTs) have specific training objectives for each national counterpart, whether it's a surgeon, nurse, or pathologist, with the aim of supporting clinical governance, workforce and leadership development. Under this new phase of the PIP, the Program works more closely with Pacific Island Ministries of Health (MoH), facilitating their ownership of the PIP goals for their state. PIP supports their evidence-based identification and prioritisation of needs, plans, and goals.

"Every year there has been a clear increase in the local capability for surgery in Vanuatu. Surgeons who started as trainees are now highly capable surgeons functioning safely and effectively in their own right. My operative role has changed from demonstrating surgery to a relatively inexperienced surgeon…to being the assistant watching increasingly capable local surgeons demonstrate my redundancy."
Professor Spencer Beasley (Paediatric Surgeon, FRACS)

A key to the successes of PIP has been the strong and close relationships held between RACS Fellows and national counterparts in Pacific island countries, with some surgeons having worked together for more than 10 years. PIP volunteers and their national counterparts both express great respect and admiration for each other, and communicate throughout the year to share professional knowledge and exchange medical opinions on complex cases.

"My 'on-island' peers are keen to progress nursing standards and education. It works both ways, as the two senior nurses in Vila are my mentors and help me understand Island culture, and how to get a job done the "island way". Telling the local staff what to do is not a very bright thing to do."
Mr Paul van Nynanten (Nurse)

"It takes a few visits to establish rapport with the national staff - to build trust, and I think that it is beneficial to have the same teams go over a number of years to establish strong relationships."
Mr John Tuffley (Orthopaedic Surgeon, FRACS)

However, there are also a lot of challenges that PIP, our volunteers, and national counterparts encounter, such as the lack of resources in terms of medical equipment, limited infrastructure, and the remoteness of the outer islands.

"Access to healthcare on the outer islands remains a crucial issue, with some islands only having professional medical staff visit every 4 to 8 years. Resources are extremely low and national health professionals often cannot apply the skills they have learned from PIP volunteers due to a lack of appropriate equipment and amenities."
Dr Sheanna Maine (Orthopaedic Surgeon, FRACS)

The role of the PIP will be to act increasingly as a facilitator between national MoH, health professionals, and regional bodies to identify gaps in healthcare delivery, and to assist in the development of workforce planning and clinical governance.

PIP is no longer about the number of cases VMTs see, or the number of procedures they perform. We now have to ask ourselves how we can support governance at the clinical level, and also at the higher organisational level.

Here at RACS, not just within the Pacific Islands Program, but across all our Global Health programs, we have been incredibly inspired to see these strong relationships between volunteers and national counterparts develop over time. We would like to express our gratitude and appreciation to all our volunteers for their passion, determination and commitment over the years. PIP and RACS Global Health could not exist without you. ▶

"I always wanted to help overseas but could not because of other commitments....

Now I can contribute to improving health in our region by donating to RACS Global Health and the Foundation for Surgery"
Dr Glenn McCulloch

Donate today at
www.surgeons.org/donations/

Image: Sara Hudson

15 years on in Timor-Leste

PROFESSOR GLENN GUEST
Program Director

After 400 years of Portuguese rule and 24 years of Indonesian occupation, Timor-Leste finally gained independence in 2002.The withdrawal of the Indonesian military was destructive, leaving behind a disrupted and rattled healthcare system. The majority of the skilled workforce fled the country with medical equipment abandoned in a state of complete disrepair.

Since independence, the nation has rebuilt a comprehensive health service, from what was essentially a blank canvas. In the early 2000s, a RACS scoping mission found a medical workforce of only 20 Timorese doctors servicing an estimated population of 700,000. At the time, there were also no recognised postgraduate education institutions or universities.

> *Over the years, 188 doctors have enrolled in one of RACS' postgraduate diplomas.*

Today, Timor-Leste is home to over 1.2 million people. Health outcomes remain poor with approximately 52.9 per cent of people living on or below the poverty line and one in 12 children dying before the age of five from poor neonatal health and preventable diseases.

The RACS Timor-Leste program, funded by Australian Aid began with just a surgeon and an anaesthetist, eagle eyed in their focus on the delivery of essential surgical care at the national hospital in the capital city of Dili. Visiting RACS surgical teams also regularly delivered services in the district hospitals, looking after families and communities who would have otherwise gone without access to life-saving procedures.

Between 2005 to 2011, some extraordinary Timorese doctors received scholarships for specialist training overseas. From 2012 until now the *Australia Timor-Leste Program of Assistance* in Secondary Services (ATLASS II) program provides in-country postgraduate training of junior doctors across a variety of clinical specialties, with the support of Timorese specialists who are lucky enough to have finally returned home from their intensive training abroad.

Today, Postgraduate Diplomas are available in Surgery, Anaesthesia, Paediatrics, Ophthalmology, Family Medicine, Internal Medicine, Obstetrics and Gynaecology and a Masters of Medicine in Paediatrics, all delivered from the National Hospital in partnership with the Ministry of Health of Timor-Leste and the National University. Over the years, 188 doctors have enrolled in one of the RACS' postgraduate diplomas.

RACS has worked closely with Timorese specialists to fine tune their skills as medical educators leading the national hospital to be an effective teaching hospital and a national university, positioned to deliver a bright future in postgraduate medical education.

In late May 2017, 26 doctors formally graduated from Timor-Leste's National University, pictured above.

The majority of these doctors will return to work in district hospitals and health centres across the country, where their skills and knowledge will be truly invaluable to their fellow Timorese.

In the 15 years since gaining independence, giant steps have been made towards a nationally-led healthcare service. The current generation of Timorese doctors are not only taking up the task of delivering clinical care under challenging conditions, but are involved in mentoring and teaching the next generation of Timorese doctors; every inch closer to the creation of a truly independent healthcare service – a far cry from the broken system found in the early 2000s. ▶

Images: Ellen Smith

EXPRESSIONS OF INTEREST

Hepato-Pancreato-Biliary (HPB) PhD Research Program (Liver and Pancreas)

The HPB Unit at Royal North Shore Hospital, Sydney is offering two full-time positions for enrolment in the Doctor of Philosophy (Medicine) program at the University of Sydney commencing in 2018.

Candidates should be accredited as an RACS trainee SET 3 or above (up to and including new Fellows in the first two years following completion of their fellowship). They should demonstrate interest in research and an ability to work independently. Financial support is available for the first year with ample opportunities for additional income from surgical assisting. Candidates will be expected to apply for competitive grants and scholarships thereafter.

The Northern HPB Unit of the University of Sydney is made up of three consultants and has a full-time data manager. The unit has a strong academic track record including securing over $421k in research funding over the last five years; supervision of two PhD candidates, three Masters of Surgery candidates & five MD research projects; and publication of 52 papers in peer reviewed journals. There are also large prospectively maintained liver and pancreatic clinico-pathological research databases. The unit has close affiliations with the Cancer Surgery and Metabolism Research Group and the Bill Walsh Cancer Research Foundation.

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

Liver:

- Investigating tumour-stroma interactions in colorectal liver metastases
- Investigating tumour-stroma interactions in HCC and/or cholangiocarcinoma
- Prognostic biomarkers in liver malignancies
- Pre-clinical modelling of liver malignancies
- Quality of life after resection of malignant liver tumours
- Impact of biological agents on outcome following resection of colorectal liver metastases

Pancreas:

- Prognostic biomarkers in pancreatic cancer – IHC, proteomics, metabolomics
- Role of pancreatitis in adverse outcomes following pancreatic surgery
- Neo-adjuvant chemotherapy in resectable pancreatic cancer
- Nutrition and quality of life in pancreatic cancer
- Immune therapy in pancreatic cancer

Contact:
Professor Thomas J Hugh (Liver) – tom.hugh@sydney.edu.au
Dr. Anubhav Mittal (Pancreas) – anubhav.mittal@sydney.edu.au

Upskilling in Papua, Indonesia

Training Papuan doctors in Jayapura, Indonesia to become self-sufficient in essential trauma management and basic surgical skills

ANNETTE HOLIAN
Chair, External Affairs

Dr Freddy Goo, a young Papuan doctor, travelled from Dogiyai Regency, Papua by foot for three hours, then by boat, then by plane to attend trauma training in the Papuan capital of Jayapura.

He would do it all over again for the opportunity to gain the knowledge and skills to improve patient's survival rates in the remote region, where he works under challenging conditions every day.

Basic surgical skills

Many other Papuan doctors like Dr Goo made their way to Jayapura, the capital city of the Special Region of Papua in Indonesia from 17 – 26 of March 2017 to attend urgently-needed training programs designed to upskill provincial doctors to become self-sufficient in basic surgical skills and essential trauma management. RACS Global Health was there to support the request of the Papua group from RSUD Jayapura (the regional general hospital of the Papua Province) in collaboration with the Association of Indonesian Surgeons and the College of Surgeons Indonesia, to witness the record turnout.

This milestone training event attracted 17 experienced instructors from Jakarta, Bali, Makassar (Sulawesi) and Ambon (Maluku), and the organisers were able to run two trauma skill and management training courses for a total of 65 participants, and two Basic Surgical Skills courses for 100 young doctors stationed at health centres throughout Papua, West Papua and Maluku. Additionally, 30 new instructors were certified in a trauma management instructor course, enabling a way forward for training and transfer of skills within the region. This was phenomenal by Papuan standards as such training in other parts of Indonesia would normally only attract 2 to 3 Papuan doctors each time, due to the high costs of the training and travelling.

Thanks to Australian Aid, RACS supported the mobilisation of visiting faculty, materials needed for surgical skills practice and adult and paediatric manikins to use for ongoing training needs. This helped to defray costs tremendously for the participants, bringing the fee down to half what they would normally have to pay, plus the added advantage of not having to pay to travel out of their province.

Like Dr Goo, many young doctors were grateful for the opportunity to attend the trauma management and basic surgical skills training in Jayapura. Dr Charlie from Jayapura, who attained the highest score during the first trauma training course, appreciated the more affordable cost. He explained, that for new doctors the cost of travel and fees to attend the same training in Bali or Jakarta would typically cost up to five times their monthly salary.

Dr Putu Ayu, a female surgeon from Timika who became a new instructor was very pleased to receive the instructor training. She looks forward to training many more young doctors to treat patients and increase survival rates in outlying areas. They will be able to better prepare and stabilise patients for medical evacuation as many have to travel at least eight to 12 hours by boat to receive proper medical care and treatment. Dr Ayu said that the knowledge and practice gained from the course will help their skills, confidence and prioritising of treatment, with Dr Ayu and her team often treating casualties of tribal skirmishes. She looks forward to more training programs in the Papua region and the opportunity to learn from experienced instructors.

Immediately following the success of the course and with the enthusiastic new instructors, the organising committee has planned for the next trauma training program to be run in Sorong, West Papua this month, by the new instructors supported by a small faculty of senior instructors.

An Essential Pain Management course has also been scheduled for late July and an Emergency Management for Severe Burns course has been scheduled for September 2017 in Jayapura with 75 participants already signed up. RACS will work with the College of Surgeons Indonesia and the Australian and New Zealand Burns Association to support this important activity.

– Story and photo contributed by Veronica Verghese

Trauma Training

MOSES goes to Myanmar

ASSOC. PROFESSOR MICHAEL HOLLANDS
Past President RACS

With a population of nearly 60 million in a country the size of France, Myanmar with its rich and diverse culture is making great strides in ensuring access to health care for all. RACS is playing a substantial role in developing and supporting this transition to sustainable national health structures.

Close to eight years ago, Management of Surgical Emergencies (MOSES) a non-technical skills course was developed by six RACS Fellows, with General Surgeons Australia (GSA) further funding and overseeing its progress. MOSES was rolled out in 2010, since then, nearly 300 general surgical trainees have successfully completed the course. MOSES, with its non-technical emphasis, seemed a perfect fit for the Myanmar program, given the focus on technical skills normally covered in the ASSET course.

In February 2017, two back-to-back MOSES courses were delivered, providing essential training to 32 national doctors, mostly junior consultant surgeons.

MOSES course attendees with instructors

The day before teaching started, we took a train ride around the suburbs of Yangon, the former capital. The circular loop ride has become one of "the things to do" in Yangon and encouraged us to take a closer look at the city. In a sense, the loop ride delivers an anthropological glimpse of how people live in Myanmar, providing the perfect backdrop for the days to come.

All too often with international travel, it becomes easy to stay in a comfortable hotel; travel to and from a hospital or university in a mini-van through the streets, day in and day out – missing the finer details that lie within the mosaic of a big city, and departing without gaining a true insight.

Teaching is not all hard work; courses in Myanmar invariably begin on the first day with a filling bowl of Mohinga, an enticing fish soup! The visiting MOSES team got into the spirit by wearing the local dress, the longyi, a garment much like a sarong for the day. Teaching in a new environment is always a challenge, however most surgeons in Myanmar are enthusiastic

in their participation and have a great working knowledge of English.

Under the direction of Professor Thien (Stephen) Lwin, a further 12 national MOSES instructors have been trained. The course consists of a series of lectures on subjects such as error, decision making, patient assessment, post-operative complications and ends with a lecture on '*what is surgical wisdom?*' The lectures are complemented by group discussions using real life cases with Myanmar-based faculty preparing cases in advance, to ensure that the context of the course remains relevant. RACS has received excellent feedback from the MOSES courses.

Over the years, RACS in collaboration with the Australian College of Emergency Medicine and the International Federation of Emergency Medicine, has helped bring emergency management training to Myanmar. Between 2012 - 2015, 24 successful candidates have been awarded a Diploma of Emergency Medicine. In 2016, a Masters of Emergency Medicine Program began, steered by the very same Diploma qualifiers. With support from the Foundation for Surgery, courses including ASSET and EMST were introduced, and funding was provided for a Myanmar Scholarship Program, closely modelled on the successful Weary Dunlop Boon Pong Exchange Fellowship. Primary Trauma Care courses are now run in Mandalay and Naypyidaw as well as in Yangon by national faculty.

This work would not be possible without the invaluable input of the Director of the Myanmar Program, Dr James Kong FRACS, and champions such as Professor Zaw Wai Soe. Special thanks to General Surgeons Australia for helping bring MOSES to Myanmar, and Sally Erickson (Events Manager & Communications Officer of GSA) who organised the course.

Mission Accomplished on disaster response registry

2004 Indian Ocean earthquake and tsunami 230,000 – 280,000 dead and more missing

As news of the destruction caused by the Boxing Day Tsunami filtered out into the wider region and calls for help went unanswered in empty offices across Australia, it became very clear very quickly that Australia needed a more robust disaster response system.

Yet in the absence of rapid government action, RACS stepped in to fill the gap by gathering and maintaining a list of surgeons willing to respond to a disaster.

Register of Surgeons willing to assist

RACS first established the Disaster Preparedness subcommittee in 2005 which worked under the umbrella of the Trauma Committee and the stewardship of the inaugural Chair Mr Rob Atkinson. The Committee put out the call to Fellows who may be willing to assist and then established a database detailing the skills and experience of those who responded.

Around 170 Fellows, Trainees and IMGs from both Australia and New Zealand answered the call.

Each year, an updated list of surgeons prepared to assist was sent from RACS to the Chief Medical Officer of Australia and the Chief Health Officers of each State and Territory so that rapid assistance could be provided by the right people from the appropriate locations in times of disaster.

Last year, after more than a decade of providing that service to the people of Australia and the wider Asia Pacific Region, RACS was able to disband the committee and hand over responsibility for the register to the respective State Governments and the National Critical Care and Trauma Response Centre (NCCTRC) located in Darwin.

NCCTRC Disaster Response Training

Announced following the 2002 Bali bombings when many victims were flown to Darwin for critical care and established in 2005, the NCCTRC provides a local disaster response capability and world-leading disaster response training.

The NCCTRC has so far coordinated the support provided to the Solomon Islands following an outbreak of dengue fever, to the Philippines following the devastating Typhoon Haiyan and most recently to the people of Vanuatu in the aftermath of Cyclone Pam in 2015.

The NCCTRC coordinates a four-day course which enables both Australia and New Zealand to provide the services of some of the most rigorously trained surgeons, anaesthetists and perioperative nurses in the world in times of disaster.

Since 2010, the centre has provided that training – both for surgeons and other medical team members - through the Australian Medical Assistance Team (AUSMAT) course and the New Zealand Medical Assistance Team (NZMAT) course.

So far, 700 people have been through the training including allied health, emergency services and logistics personnel.

Teams of surgeons, anaesthetists and perioperative nurses have now been trained from each State jurisdiction in Australia and the NCCTRC training has become the formal pathway for surgeons wishing to offer their services in times of catastrophe.

So rigorous and highly regarded is it, that Australia recently became the fifth country in the world to be classified and verified by the World Health Organisation for field hospital deployment in times of disaster alongside China, Russia, Japan and Israel.

> *"We have 6000 Fellows in Australia and New Zealand and we all know there have been times of disaster when a surgeon with skills and courage being in place and prepared to step forward has made an enormous difference to the lives of injured people."*

RACS Councillor and past Chair of the Disaster Preparedness Subcommittee, Dr Annette Holian was instrumental in developing that training through her position as Deputy Director of Trauma at the NCCTRC which she held from 2011 to 2015.

A Group Captain in the RAAF and an Orthopaedic and Trauma Surgeon, Dr Holian is also the Chair of the RACS Military Section and has served on a number of international military and aid missions, including in Afghanistan.

Currently she divides her time between her surgical practice based at the Royal Darwin Hospital and her home in Melbourne and in 2015 spent time in Geneva working for the International Committee of the Red Cross developing and writing the comprehensive *Field Guide on the Management of Limb Injuries in Disasters and Conflicts.*

A new era

Dr Holian said the transfer of responsibility for providing information on surgeons willing to assist in times of disaster from RACS to State jurisdictions and the NCCTRC represented a milestone in Australia's disaster response capabilities.

"I am proud to be one of the very few Chairs in RACS' history to close a committee because its work has been done," Dr Holian said.

"We made the switch last year because after five years of providing NCCTRC training each state by then had six surgeons, anaesthetists and perioperative staff who had all been fully trained.

"Now, no-one can be deployed by the Federal Government in times of disaster if they haven't done this AUSMAT training, a straight-forward system which provides both quality assurance and rapid response."

Role for FRACS

The inaugural Chair of RACS Disaster Preparedness Subcommittee, Mr Rob Atkinson is a trauma and orthopaedic surgeon with a long and distinguished career in the Army having reached the rank of Brigadier in 1998.

Through decades of service to the ADF, Mr Atkinson served in the Vietnam War and the Gulf War, on peacekeeping missions in Rwanda and East Timor and provided medical aid in the aftermath of the Aceh and Samoa tsunamis of 2004 and 2009.

He said that while he was delighted that Australia now had such a robust disaster response system in place and that the Committee he established was no longer needed, he believed it was vital that all Fellows felt that their skills were valuable in times of catastrophe.

"We have 6000 Fellows in Australia and New Zealand and we all know there have been times of disaster when a surgeon with skills and courage being in place and prepared to step forward has made an enormous difference to the lives of injured people," Mr Atkinson said.

"The training provided by the NCCTRC is vital because the core surgeons who receive this training and who know how to operate in an austere environment can share their knowledge with others.

"However, every disaster is different and we need all surgeons to be willing to help, particularly in local situations, if they have the appropriate skills.

"I see the NCCTRC-trained surgeons as the tip of the spear – particularly in terms of responding to international disasters - with the entire RACS Fellowship as representing the rest of the spear."

The Chair of the RACS Trauma Committee, Dr John Crozier, thanked all Fellows who had offered their services in times of disasters.

He also particularly praised the "tenacity, fidelity and endurance" of Ms Lyn Journeaux, the Executive Officer of the RACS' Trauma Committee, for the administrative support she provided to maintain the database.

Fellows wishing to continue to offer their assistance at times of a disaster should contact their jurisdictional health departments and seek AUSMAT/NZMAT training http://www.nationaltraumacentre.nt.gov.au

– With Karen Murphy

Images (from far-left): Devastation in Banda Aceh; Mr Rob Atkinson operating on Tsunami victims; Peter Riddell and Robert Atkinson in Banda Aceh; Supplies arriving.

Achievements of the Committee

2005	RACS Disaster Preparedness subcommittee established in the wake of the 2004 Indian Ocean earthquake & tsunami
2005	The Committee sets up a register of Fellows willing to respond in times of disaster
2006	Personal equipment list prepared to advise surgeons deploying to a disaster area *http://www.surgeons.org/member-services/interest-groups-sections/trauma/disaster-preparedness/*
2012	Wound Management Poster prepared and presented at Global Burden of Surgical Disease Symposium at RACS. This set of guidelines, produced by RACS, steers first responders and health care personnel through the initial management of wounds to prevent infection and further tissue loss *http://www.surgeons.org/media/20877684/april_2014_sn_management_of_contaminated_wounds_in_disasters.pdf*
2014	Disaster Preparedness becomes a standing item on the Trauma Committee agenda
2015	Disaster Preparedness Subcommittee disbanded
2016	RACS register of surgeons willing to assist at times of a disaster discontinued
2017	Fellows notified that those wishing to continue to offer their assistance at times of a disaster should contact their jurisdictional health departments and seek AUSMAT/NZMAT training http://www.nationaltraumacentre.nt.gov.au

ASC Syme Oration

His Excellency, the Governor of South Australia, the Honourable Hieu Van Le AC opened the ASC and here is his speech.

I acknowledge the traditional custodians of this land, the Kaurna people, and I pay my respects to their spiritual relationship to the country. I am pleased to be with you at this congress.

First let me acknowledge all of the new Fellows of the College, whom we are here to celebrate today. It goes without saying that becoming a surgeon is one of the most challenging career paths anyone can take. Achieving Fellowship of the College has required incredible passion, skill, dedication and hard work. My sincere congratulations to you all on reaching this important milestone in your professional career.

Ladies and gentlemen, I thank the organisation for its kind invitation to be here and to deliver this year's Syme Oration. Today I would like to speak with you on the role of some aspects of access to health services in our society, in particular, for migrants and refugees.

I have first-hand knowledge of the experiences of new arrivals in Australia when it comes to navigating the health care system. If you have heard my personal story, you may know that my wife and I arrived in Darwin Harbor as refugees on a leaky boat in 1977. Years later, I worked extensively with culturally diverse communities through my membership of the South Australian Multicultural and Ethnic Commission. At that time, amongst many other areas of activities, I was deeply engaged in facilitating and promoting collaboration with government and community groups in policy, planning and consultations to improve migrant and refugee access to health care.

Successive waves of immigration from Europe, Asia and elsewhere over the last 220 years, along with an indigenous people's presence of some 50,000 years, have made modern Australia one of the most successful multicultural countries in the world. Australia's society is linguistically and culturally diverse, consisting of about 3 per cent of Australians of indigenous origin, while 97 per cent have settled or are descendants of settlers over the past 220 years.

Since 1945, 7 million people have migrated to Australia. Australians collectively speak well over 200 languages and identify with more than 270 ancestries. Our cultural diversity in Australia is increasing. Last year, the proportion of Australians who were born overseas hit its highest point in over 120 years, with 28 per cent of Australia's population born overseas. Those born in the United Kingdom and Europe have been decreasing but those born in east, central or southern Asia have been increasing over the past 10 years. To date, over 48 per cent, nearly 1 in 2 Australians, were born overseas or have at least one parent who was born overseas – an incredible statistic! In addition, more than one quarter of our population speaks a language other than English at home.

We have worked hard, and generally with much success, at fusing an astounding variety of cultures, ethnicities and languages into a diverse but harmonious Australian society.

One of the most important challenges we have faced along the way is to ease people's transition into a new culture that is, in many cases, markedly different – indeed, quite alien – from all they have known in the past. By this, I mean opening up access to all kind of services, housing, educational and job opportunities and health care. In the process, of course, service providers have as much to learn about migrants as migrants have to learn about their new environment. I need to say, at this point, that when I use the term "migrants", it includes refugees and all other humanitarian arrivals.

Migration and resettlement require physical and cultural adaptation, changes to social support systems, shifts in social status and a host of other changes, all of which might impact significantly on the health of a migrant. As we all know, providing health care within a culturally diverse setting is a complex and intricate process.

Health issues touch the core of the individual and collective human experience, and migrants who have insufficient command of the English language have particular challenges accessing Australian health services.

The key issues that impact health care in this situation are: lack of knowledge about available services, language differences, and varying cultural attitudes, beliefs and practices around health and their interaction with the wider community. Until the late 20th century, no concerted effort had been made to gather an epidemiological profile of Australia's migrant communities.

The epidemiological and social research that commenced in Australia in the early 1990s began to build health profiles of entire culturally and linguistically diverse communities: we were starting to find "what ailed them", and we were identifying patterns of morbidity across entire sectors of the population.

By that time, too, we had addressed at least some of the issues that had impeded migrant access to health care — most importantly, considerable focus had been placed upon the challenges of language and communication, with the setting up of government-funded interpreting and translating services being provided to public health services and even to doctors in private practice.

When migrants arrive with insufficient English skills, they can often be reluctant presenting themselves to the general practitioner or the hospital emergency department because they are aware they may have language difficulties. This can affect diagnostic interviews too, for patients who may answer 'yes' to questions, do so to avoid further dialogue or disguise poor comprehension. In many circumstances, a response "yes" might mean that they are acknowledging what you are saying but does not mean they agree with you.

In Australia, the concepts of "patient autonomy" and "patient rights and responsibilities" have been around for at least 20 years, and probably more. There is substantial emphasis placed on these concepts: patients can request a doctor or nurse of a particular sex or request greater privacy.

In addition, patients have every right to request an interpreter and are encouraged to do so. In many situations, an interpreter is just as important to both the health professional and his or her patient, as each needs to understand the other. It is likely that non-English speaking migrants do feel less empowered and are unwilling to make their wishes known, particularly if it is a complaint!

Some migrants can be less confident to ask questions, and they are reticent to do so because they may perceive a class difference with healthcare professionals and ascribe to them a high status that, in their countries of origin and cultures, puts such people far above mere patients who do not have the same education.

All these things can reduce compliance with treatment regimes and can even discourage further visits, thus combining to worsen the health outcomes of new arrivals.

In areas such as the treatment of mental health or survivors of torture and trauma, these concerns are compounded manifold.

Over the last 25 years especially, many of the key service-delivery elements of health care for migrants, such as the language services and cross-cultural communication I mentioned earlier, along with ethno-specific marketing and organisational operations, which contribute to accessibility of care, are now much better understood and are well applied across health agencies.

There has to be continuing research about the health status of each new intake of migrants, and the findings have to translate into policies, strategies and appropriate service programs.

We have come a long way in providing appropriate health care for migrants, although supporting refugees requires more effort still.

We have learnt from our previous shortcomings: by conducting research, we applied proper analytical rigor to that research and we built appropriate and effective services and methodologies to deal with the unique challenges confronting culturally and linguistically diverse communities.

At the same time we are addressing issues of health care for migrant communities across a wide spectrum of conditions, such as emerging patterns of morbidity, generational variations in health status, age relevant issues – from the very old to the very young – and the effects of adjustment and acculturation on health.

Legions of medical and allied health professionals have participated in research and continue to do so but, more importantly, they have driven the momentum to action, finding the best way to deal with the particular set of challenges imposed on individual and collective health by cultural diversity.

Image: Honourable Hieu Van Le AC with Past President Mr Phil Truskett AM

A number of appropriate, targeted health services, programs and networks have been established across Australia to cater for the specific needs of migrants and refugees, including mental health networks.

However, notwithstanding the challenges and innovations I spoke of earlier, it ultimately falls to you and your skills as medical practitioners, your commitment to the humanitarian basis of medicine and your compassion as fellow humans to help migrants and refugees to Australia overcome the barriers they face, obtain an adequate standard of healthcare and start a new life in a new land.

Ladies and gentlemen, in many respects I am a typical refugee. A very lucky one, yes, but upon my arrival I had the same hopes and dreams as all migrants who arrive on our shore seeking to live in a free country - to build a better life and a better future for themselves and their children.

If you are a refugee or migrant on your way to Australia, this is what you may expect to happen here: you find a place to live, you learn to navigate a range of public systems, including the health system, you undertake education and training to equip yourself with skills, find a job or run a business, and you work hard to build a meaningful and fulfilling life. Then after a while, you take on a vice-regal role and the College of Surgeons asks you to deliver a prestigious address!

When it works, it works well: with the right support and care, all migrants become people who are able to realize their full potential and who in turn contribute back to the society which ultimately helps to make our country a much better place for all of us.

As medical practitioners you hold a very important role in supporting us, and our children, to get to where we are headed – which, often, is in the direction of our dreams.

I hope you will have a productive conference and a wonderful time in Adelaide.

Thank you.

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It's time to Particip8

PROF. PETER ANDERSON
Convenor, Surgical Education Stream, ASC

ELIZABETH BERRYMAN
Medical Student

A feasibility study of a smartphone App called Particip8 has shown it is an effective means of recording the wellbeing of medical students and increases self-awareness of wellbeing and mental health.

The research project titled, "Daily Collection of Self-Reflected Wellbeing (SRW) scores via a smartphone App in clinical medical students: A feasibility study," was presented by Elizabeth Berryman in the Surgical Education Stream at the Royal Australasian College of Surgeons, Annual Scientific Congress, in Adelaide on 10 May 2017.

A 2013 Australian national mental health survey of doctors and medical students reported higher rates of psychological distress than the general population. Twenty per cent had thoughts of suicide in the previous 12 months. The New Zealand Medical Students' Association (NZMSA) performed a survey of their members in 2015 which revealed that 54 per cent of students had experienced bullying or sexual harassment while on clinical placement (1). It was in response to this data that prompted the study.

A smartphone App was developed by two senior University of Otago medical students, Elizabeth Berryman (5th year) and Daniel Leonard (4th Year) in an attempt to evaluate the feasibility of collecting daily SRW scores and to identify any correlations between clinical experiences and wellbeing.

A total of 29 University of Otago medical students based on clinical placements at the Dunedin School of Medicine were enlisted to trial the App over 31 days during October 2016. The App also collected participant demographic data (gender, ethnicity, age and training year) and used an adapted version of the New Zealand WHO-5 Wellbeing Index to assess daily wellbeing reflections.

Despite being a feasibility study with a smaller sample size of 29 participants, the data collected revealed statistically significant associations between wellbeing and clinical experiences on a day to day basis. In addition, the qualitative focus groups revealed rich data about the relationship between student experiences and daily wellbeing.

Tuesdays were rated as the days of lowest overall wellbeing (2.91/5.00 p=0.003) and Saturday were rated the highest (3.51/5.00). Unsurprisingly, days off had higher wellbeing scores than days attending placements.

There were clear differences of wellbeing scores between students assigned to different specialities for their clinical placement. General Practice scored highest of all specialties (4.02 out of 5.00 p<0.001) followed by "Other" (ED, ICU, Public Health) (3.78/5.00) and Surgery (3.13/5.00). The lowest scores were reported by students undertaking lecture based whole class learning (2.63/5.00), Psychological Medicine (2.63/5.00) and Women's and Children's Health (2.51/5.00).

The study also looked at day to day clinical experiences and effects on wellbeing.

Five incidents of bullying or harassment were reported by participants during the study, and these incidences showed to have a significantly negative effect on wellbeing. Surprisingly, this was not the greatest detrimental effect on wellbeing scores. 'Receiving feedback that was not constructive or helpful' had a greater impact than bullying or harassment; dropping the wellbeing score on average for

Medical Students Elizabeth Berryman and Daniel Leonard

that day by 20 per cent (p<0.001). The next largest wellbeing decrease was, 'Felt like I didn't learn anything', followed by, 'Stress or worry about something outside of medical

Experience	Not experienced	1 or more days	Difference	
Felt confident about my knowledge or skills	3.02	3.59	+0.57	p<0.001
Engaged in a hobby, sport or social activity	2.92	3.45	+0.53	p<0.001
Received feedback that was constructive or helpful	3.05	3.57	+0.52	p<0.001
Felt I learnt something new	2.96	3.41	+0.45	p<0.001
Felt like I helped someone	3.05	3.45	+0.40	p<0.001
Worried about exams	3.37	2.74	- 0.63	p=0.001
Felt I was treated unfairly	3.19	2.53	- 0.66	p=0.016
Stress or worry about something outside of medical training	3.29	2.62	- 0.67	p<0.001
Felt I didn't learn anything	3.28	2.34	- 0.94	p<0.001
Felt like I was bullied or harassed	3.41	2.33	- 1.08	p=0.005
Received feedback that was not constructive or helpful	3.21	2.03	- 1.18	p<0.001

Table 1. Effect of clinical experiences on wellbeing scores

training' and 'Felt like I was treated unfairly' (Table 1).

Experiences logged which increased wellbeing scores, were 'Felt confident about my knowledge or skills', 'Engaged in a hobby, sport or social activity,' and 'Received feedback that was constructive or helpful (p<0001).'

Students on Dunedin based placement were 2.4 times as likely to receive constructive feedback compared to their colleagues based outside of Dunedin (p=0.04). Students on placements away from Dunedin were 2.1 times as likely to experience stress or worry (p=0.009) possibly due to being isolated or away from their usual support networks.

Māori students were 1.22 times as likely to engage in sports, social activities or hobbies than NZ European students (p=0.009), and 2.27 times as likely compared to non-NZ European students.

Those who logged three days of low wellbeing scores sparked a safety feature on the App which alerted them to the fact and suggested places to get some help. During the study 41.7 per cent of all participants received the safety pop-up message at some stage during the study period. This large number is a concern because the WHO-5 Wellbeing Index used in this App has a sensitivity of 0.93 and a specificity of 0.83 in the detection of depression (2).

When asked if they did seek support, most participants said that they talked to a trusted person and a few went to student health services. None went to a University Dean.

The study revealed that the use of the App increased self-awareness by 20 per cent. A fourth year medical student said in a qualitative focus group interview:

"Sometimes it is hard to know that you are actually quite stressed out."

The team is now working on an updated App and adding extra functions, including the ability to journal reflections – something that over half of participants said they would find useful.

After taking part in the study, more than 90 per cent of students said that a measure of their own wellness was useful,75 per cent said that they would be happy for their data to be reported back to faculty and 95 per cent said that they would be happy for anonymous data to be reported back to faculty.

A future study is now being designed in association of the Creating Positive Learning Environments (CAPLE) research group at the University of Otago (3).

The proposed study would increase the number of students and introduce another location. There has been so much interest in this idea of self-reflection via an App that the study may also be widened to include hospital staff, not just medical students.

For further information, please contact Elizabeth Berryman (Berel235@student.otago.ac.nz) or Daniel Leonard (Leoda391@student.otago.ac.nz).

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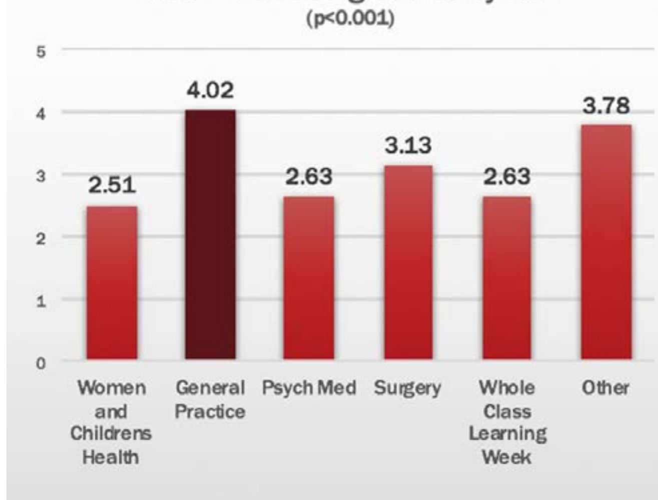


Table 2. Mean Well-Being Scores by Run (p<0.001)

Journal more popular than ever

The exponential growth in the downloading of articles published in the ANZ Journal of Surgery from 50,000 in 2002 to 250,000 in 2016 proves the quality and depth of surgical research in Australia and New Zealand, according to the Editor-in-Chief Professor John Harris, AM.

Professor Harris said that last year alone, downloads of journal articles via the online library increased by 20 per cent compared to an average increase across other academic journals produced by the same publisher of only 14 per cent.

He also said that not only were more international surgeons and academics downloading articles from the journal, more were submitting articles for publication.

The latest publishing report to the Editorial Board shows that last year 23 per cent of journal articles were downloaded in the US, 17 per cent in Europe, 9 per cent in China, 23 per cent in Australia and New Zealand with 28 per cent accessed by surgeons and scientists from other global regions. During the same period, surgeons and academics from a record number of countries submitted articles to the journal, including China, Denmark, Germany, Hong Kong, India, Ireland, Singapore, Poland, the UK and the US.

Currently the journal receives more than 1200 submitted articles each year. Professor Harris said that the average acceptance rate of 27 per cent for original papers submitted for publication ensured the quality of the research and rigour of the peer review process. He also said that such rigour was not only vital in an era of predatory and false scientific publishing, it was increasingly being valued by the international research community.

"In recent years our advertising position has improved, sales of the Journal have increased and the cost to RACS has decreased which is a wonderful result for all involved."

"While there is a trend in Australia and New Zealand to publish research in international specialist publications, it is clear that the Journal has gained its own considerable international reach based on quality research and review," Professor Harris said.

"It has become a vehicle that allows us to take Australian and New Zealand surgical research out into the broader international community, work which is gaining increased interest and regard.

"I believe that many surgeons and researchers from other countries have come to appreciate that Australasian research is conducted and presented honestly and reliably and underpinned by transparent funding streams.

"The journal has developed a very good reputation which is particularly important in an age of predatory publishing which can be a trap for young surgeons who are so keen to be published that they become vulnerable to scams that end up costing not only their money but their reputations.

"Published research that is rigorously assessed also plays a crucial role in ensuring that developments in all surgical specialties and changes made to clinical practice are introduced safely and based on sound scientific methodology."

Professor Harris said the ANZ Journal of Surgery has an Impact Factor (IF) of 1.513, an index measure which calculates the importance or rank of a journal by calculating the number of times its articles are cited.

"The IF is a complex metric but I've taken the pragmatic view that if we continue to publish good work in a timely fashion, the IF will take care of itself," Professor Harris said.

Professor Harris said the College Council had approved an additional 150 pages for the web-site version of the journal for issues published in 2017/2018 which should ease the back-log of papers awaiting publication and allow for greater flexibility in fast-tracking appropriate papers.

"Digital expansion means that selected articles can now be published on-line but not in hard copy, resulting in faster publication for authors who will still have a PubMed citable reference and an entry in the Journal's hard copy table of contents," he said. "This hybrid model means we are well positioned to make the most of our digital platform, it puts downward pressure on costs and speeds up publication times which should be of particular benefit to younger surgeons who are waiting for their work to be published so they can cite their research for the purposes of applying for surgical positions or further research funding.

"In recent years our advertising position has improved, sales of the Journal have increased and the cost to RACS has decreased which is a wonderful result for all involved."

Professor Harris, now an Emeritus Professor at the University of Sydney, took up the position as Editor-in-Chief in 2012.

In recognition of his eminent career as a leader in Vascular Surgery, he received the RACS' prestigious ESR Hughes Medal for distinguished contributions to surgery in 2012 and the Outstanding Service Award, NSW Regional Committee of the RACS, in 2013.

A Distinguished Fellow of the Society for Vascular Surgery in North America and an Honorary Member of the Society for Vascular Surgery for Great Britain and Ireland, Professor Harris was made a member of the Order of Australia in 2007 for advances in vascular surgery, vascular ultrasound, medical education and public health administration.

Professor Harris thanked members of the Editorial Board for their support. "I am extremely grateful for the selfless contribution made by the board members, most of which is routine but some of which is occasionally testing, in working to ensure a high-quality journal while looking after the interests of our authors, the College and our publishers," he said.

– With Karen Murphy

Conference Success in Hangzhou, China

The 9th Sino-Australia/New Zealand (RACS) Conference on Surgical Oncology

MICHELLE THOMAS
FRACS

In October, James Moore, Ben Thomson, Marcos Perini, Craig Lynch, and I, led by Bruce Waxman, had the great privilege of presenting at the Sino-Australia/New Zealand (RACS) Conference on Surgical Oncology at the Sir Run Run Shaw Hospital (SRRSH) in Hangzhou, China. This series of meetings was established in 2000 and alternates biennially between China and Australia. It is co-ordinated by Gordon Low and sponsored by Project China of the College and the Cancer Centre of the Sun Yat-Sen University, Guangzhou, China. The Cancer Centre was represented by Pan Zhi-zhong and Chen Gong at this Conference. The Convener was Liang Xiao of the SRRAH. Speakers from the host hospital included Cai Xiujun, Peng Shuyou, Fang Yujin, Liang Xiao, Ding Peirong, Wang Xianfa and Song Zhangfa.

This year's ninth conference was held in Hangzhou, a beautiful city with a rich history. It is best known for its large picturesque West Lake situated in the middle of the City. The meeting was organised through the Run Run Shaw Hospital, which was jointly established 20 years ago by the Zhejiang Provincial Government and Sir Run Run Shaw, a famous movie entrepreneur and philanthropist in China and the Western Pacific region. It has an ongoing association with the Loma Linda University Health Institution in California.

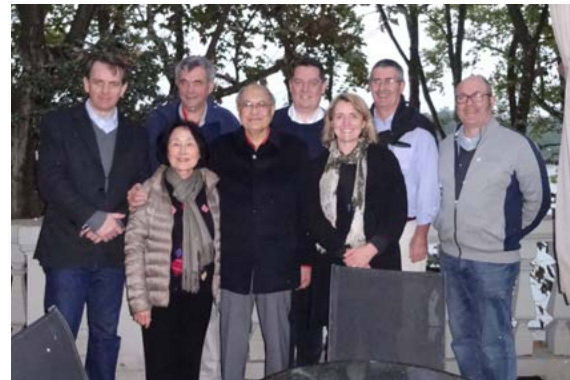
We took a tour of the hospital the day before the conference. With 3000 beds over two sites, the volume of surgery is impressive, improved further by the rapid shift of ventilated patients to recovery for extubation, minimising turnaround time. In the emergency department, there was an "IV" section where patients can attend and request IV fluid, no doctor needed. Care for 80 per cent of patients is covered by government insurance. Beyond this, there are VIP areas where one can pay for more convenient service and even a VVIP area. Even so, the costs are modest; a CT in this area is around A$30. Patients self refer to outpatients, either pre-booking or turning up on the day and booking at kiosks. Apparently only around 10 per cent get the wrong specialty.

The conference was held in the new Hangzhou International Conference Centre which had just hosted the G20 Summit four months ago. (We were obviously on par with that!). It was a huge facility - rooms fit to house 747s. Despite Ben's confident leading, we were frequently lost. The talks were translated prior to the meeting so the slides were in Chinese and English. The meeting covered a mixture of hepatobiliary surgery, colorectal surgery, oncology and basic science. The liver surgeons learnt new techniques and the cancer research was impressive. There was an MDT case discussion for the afternoon, the first case translating as a patient with abdominal pain relieved by "anal exhaust". I think I may adopt this term.

The hospitality was exceptional and a junior doctor or medical student was allocated to each Australian attendee. This was much appreciated as English is not widely spoken and it would otherwise have been difficult to negotiate the city. The hospital provided all accommodation and meals which were Chinese feasts. Notable amongst the dishes was duck's tongue and fish stomach soup. (Less recommended is the fermented tofu - a very challenging odour even for a colorectal surgeon).

Throughout our stay we had the pleasure of the company of Rosie and Gordon Low who established Project China. We appreciated their insights into the Chinese culture and letting us know what we were eating (though sometimes after the fact!). We finished our time in Hangzhou by attending the light show over the West Lake. A spectacular performance of innovation with a cast of hundreds from the choreographer of the Beijing Olympics opening ceremony.

We left China with a greater understanding of the Country, new medical insights, new friends and potential collaborations for the future. I would strongly encourage anyone who has the opportunity to attend one of these meetings in the future to do so. The next meeting will most likely be held in Adelaide in 2018 before returning to China in 2020.



Images (from left):
1) Professor Bruce Waxman and Liang Xiao (Convenor), Sir Run Run Shaw Hospital (SRRSH).
2) Back row from left: Marcos Perini, Bruce Waxman, Ben Thomson, James Moore, Craig Lynch. Front row from left: Rosie Low, Gordon Low and Michelle Thomas.

Setting a course – the surgeons behind RACS' mandatory training

Adrian Anthony discusses the process that went into creating the *Let's Operate with Respect* training courses

ADRIAN ANTHONY
Chair, Education Reference Group

Adrian Anthony, a Consultant Surgeon with the Queen Elizabeth Hospital's UGI Unit in Adelaide, has been an integral part of RACS' work to implement the *Building Respect, Improving Patient Safety (BRIPS)* Action Plan.

A RACS Fellow, he is Chair of the BRIPS Education Reference Group, the *Operating with Respect* committee and the Board of Surgical Education and Training (BSET).

Through his role with the Education Reference Group, he led the creation of the training courses now offered through the College.

"Our aim was to develop educational activities that not only met the needs of the Action Plan, but that Fellows, Trainees and IMGs would engage with," he said.

The Education Reference Group was made up of surgeons, non-surgical specialists, Trainees and IMGs. They drew on the subject matter expertise of surgeons and clinicians, educators and staff experienced in developing educational and professional development programs.

Mr Anthony said his role was to bring a surgeon's perspective and context to the education. It was important for the group to ensure the educational outcomes were informed by evidence and best practice.

This approach positions the training courses to be relevant to practising surgeons – **they've been developed by surgeons, for surgeons**.

These training courses and the *Let's Operate with Respect* campaign are helping address a part of surgical culture that, if left unchecked, undermines everything surgeons do to safely care for their patients.

"I'd definitely encourage my colleagues to complete the training. It's about creating greater awareness and understanding of a problem that we have largely normalised and been de-sensitised to," Mr Anthony said.

"The training helps us to better self-regulate our behaviour during the stressful and challenging times in our daily practice and to support our colleagues in moderating their behaviour in those situations.

"It also helps us to be resilient, individually and as a profession, in how we respond to the demands of caring for patients, supervising trainees and interacting with each other."

Patients expect surgeons to be proficient across all competencies, Mr Anthony said.

"I invite my colleagues to be open-minded and apply our attributes as adaptable people to learn the skills necessary to make us not only medical and technical experts, but experts in our professional behaviours," he said.

"Of course surgeons don't always agree with each other – we hold a healthy diversity of views and opinions.

"We do, however, share a common value: to act in the best interest of our patients and to be collegiate to each other in training and working."

For Mr Anthony, he'll be staying actively involved with the *Let's Operate with Respect* campaign and committees, facilitating on courses and further developing and reviewing them.

"I'll be continuing to learn how to best engage Fellows in changing our culture, and promoting respectful interactions in my workplace."

Learn more about *Lets Operate with Respect* training and register today at surgeons.org/about-respect

Three courses available now:

- The **Operating with Respect** online module that demonstrates what unacceptable behaviour in the workplace looks like and provides practical strategies to help address it. The course takes 45-minutes to complete and is a 2017 CPD requirement.
- The **Foundation Skills for Surgical Educators (FSSE)** course, a one-day session for surgical educators to expand knowledge and skills in surgical teaching and education. It is mandatory for those who teach or train SET trainees or supervise IMGs by end of 2017, and;
- The **Operating with Respect** one-day course, providing advanced training in how to tackle discrimination, bullying and sexual harassment. It is mandatory for the leadership and supervisor group: surgical supervisors, IMG clinical assessors and members of speciality training boards and major committees by the end of 2018.

HAVE YOU COMPLETED YOUR CPD REQUIREMENTS FOR 2017?

OPERATING WITH RESPECT (E-LEARNING)

Improve your knowledge and understanding of unacceptable behaviours, which will enable you to recognise when they occur.

Mandatory for all Fellows.

FOUNDATION SKILLS FOR SURGICAL EDUCATORS (FSSE)

Introductory course for surgical educators to expand knowledge and skills in surgical teaching and education.

Mandatory if you teach or train SET trainees or supervise IMGs.

Find out more: www.surgeons.org/respect

SUCCESSFUL SCHOLAR

Effects of colonic surgery highlighted in breakthrough study

Disturbed gut motility following colonic surgery could be partly caused by hyperactivity rather than hypomotility as has been thought for decades, according to New Zealand Colorectal Surgeon and researcher Associate Professor Greg O'Grady.

The recipient of the James Ramsay Research Grant for 2017 and the RACS Foundation for Surgery Small Projects award, A/P O'Grady has conducted ground breaking research with the Auckland Colorectal Research Group and through his joint appointment as the leader of the Surgical Engineering Laboratory at the Auckland Bioengineering Institute.

Using fibre-optic High Resolution Manometry, a technique invented in Australia and now led out of South Australia, students from the Institute and members of the Auckland Colorectal Research Group have measured colonic activity both in healthy subjects and those who have had colon surgery, presenting their findings at the Annual Scientific Meeting of the American Society of Colorectal Surgeons.

Together with Professor Ian Bissett, PhD student Dr. Anthony Lin, and Flinders University partners, he has already used the new technology to reveal a new type of colonic activity that propagates backwards in the distal colon which the team have termed the "rectosigmoid brake".

A General and Colorectal Surgeon at the Auckland City Hospital with an appointment at the University of Auckland, A/P O'Grady has also led research to develop new ways to visualise the Manometry data so that the results are clear and intuitive to clinicians.

"Manometry measures pressure waves that arise when the colon contracts. The device we are using allows us to piece these individual pressure waves together into sequences to determine motor patterns in the gut," he said.

"This fibre optic device is revolutionary because each pressure measurement is converted into a light signal that is conveyed down a specific frequency in the fibre-optic cable.

"This means that the catheter can be made very long, with a large number of sensors, without increasing the size of the cable or reducing the flexibility of the device.

"Adding a large number of sensors to previous devices was relatively impractical and as a result the complexity of colonic motility and many other important patterns occurring in the gut have been overlooked.

"But this technology allows us to see events with greater clarity such as the new type of activity that we have termed the 'rectosigmoid brake' which we hypothesise plays a key role in normal continence.

"We are now investigating whether the rectosigmoid brake may play a role in common surgical problems such as faecal incontinence and its treatment with sacral neuromodulation, anterior resection syndrome and post-operative colonic ileus."

Most significantly, research conducted together with Professor Bissett and led by PhD student Dr. Ryash Vather has shown that post surgery gut dysfunction could be partly caused by hyperactivity of the colon rather than hypomotility, a finding that could fundamentally change understandings of the workings of the gut.

In research part-funded by RACS, the team used fibre-optic manometry to measure gut activity throughout the pre, intra and post-operative periods in the left colon and rectum of patients undergoing right hemicolectomy, with comparisons to healthy controls.

Motor events were characterised by pattern, frequency, direction, velocity, amplitude and distance propagated.

Yet instead of finding that disturbed gut motility was caused by quiescence as was commonly assumed, the team found the opposite was occurring and that distal gut motility instead became markedly hyperactive during colonic surgery, dominated by cyclic motor patterns.

A/P O'Grady said the finding – made by PhD candidate Ryash Vather under the supervision of himself and Professor Ian Bissett - was so new and unexpected the team was now conducting extensive further research in a bid to understand it.

"This is a very new finding and we are still seeking to understand the drivers behind it," he said.

"The next step, which is being supported by the James Ramsay Research Grant, is to investigate how this new finding correlates with recovery of bowel function in patients because we hypothesise that this hyperactive motility is slowing down patient recovery.

"We believe that while pre-operative anxiety seems to set off the colonic motility, it does so at a fairly low level so it seems to be the stimulus of surgery that puts the colon into a hyperactive state.

"Because the finding is so new we don't yet know the underlying physiology and we are currently setting up a range of additional studies to understand these drivers. The fibre-optic technology from our South Australian collaborators is the essential component that will allow us to advance this research."

A/P O'Grady said another key step would be to establish a robust animal model to allow investigators to research the underlying mechanisms behind the hyperactivity so they can investigate drug therapies, and then to translate that knowledge into improved surgical practice and post-operative care.

He said that any advances in the field which could improve gut function post surgery had the potential to save health systems millions of dollars, with ileus estimated to cost the US health system around $1 billion each year.

Another problem being investigated by the team is "Anterior Resection Syndrome", involving poor long-term bowel function after distal colorectal resections. He said that while the cost of chronic impairment of colonic function was unknown, many such patients required ongoing medical contact, chronic use of gut medications and, in severe cases, the implantation of neuromodulation devices to reduce symptoms of urgency and faecal incontinence.

"For far too long impaired gut function after surgery has been viewed as an 'unpredictable and inevitable nuisance' that must be tolerated by patients," he said.

"However, we believe that new technologies can allow us to vastly improve our understanding of the gut and our current research track suggests that we are presenting something that is altogether new with the potential for translational relevance.

"Colorectal surgery is a field that is undergoing a great rate of change, driven fundamentally by technology and scientific curiosity.

"In terms of colonic motility, however, the field had become quite stale and we were relying on antiquated research devices and principles. But now we have new technologies - including high-resolution electrical gut mapping, fibre-optic high-resolution manometry and 'electroceuticals' such as sacral neuromodulation - entirely new avenues of research are opening up leading to new diagnostic and therapeutic opportunities."

The James Ramsay Research Grant was established through donations made by Mr James Ramsay, AO, and subsequently through the generosity of Mrs Diana Ramsay, AO. The fund was established to recognise the contribution to surgery made by Sir John Ramsay, a co-founder of the RACS upon its formation in 1927.

– With Karen Murphy

Academic Highlights and Major Grants Received

2017: The RACS' James Ramsay Research Grant

2016: University of Auckland Vice Chancellor's Research Excellence Medal

2016: NZ Health Research Council Project Grant for Translational Advances in Faecal Incontinence and Anterior Resection Syndrome

2015: US National Institutes of Health Grant for the development of an implantable wireless system to study gastric neurophysiology

2015: Award for Emerging Researcher Prize for Outstanding Early Career Research from the Physiological Society of New Zealand

2016: Foundation for Surgery Small Project Grant

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Juggling Health with Training

RACSTA Board

Recently the health of our doctors has been highlighted in recent mainstream media articles, with a particular focus on fatigue, depression and stress, and how this ultimately affects levels of patient care. The recent suicide of our medical colleague Dr Andrew Bryant and the open and candid letter written shortly afterwards by his wife further highlighted the issue of doctors' health among our profession. In this issue of Surgical News two very brave trainees have shared their experiences managing health and stress during their training and how it has affected them. RACS is grateful for their time and honesty in providing us with their story.

Depression in Training

When I was asked to write this article about my experience of depression and training I felt quite motivated to share my experiences with you.

Not because I think I have all of the answers. I don't! But because when I was going through surgical training I was unaware of anyone who may have had similar issues before me. I knew the stats; 20% of doctors suffer from depression and the percentage is even higher for medical students. Two of my med school classmates took their lives,but I had never heard of any other surgeon with similar problems.

I was diagnosed with anxiety and depression in my early twenties. I remember feeling like an imposter in my second year of medical school. Initially the symptoms were low mood, anxiety, and constant fatigue despite nine to ten hours of sleep. Gradually a feeling of hopelessness set in and occasionally, suicidal thoughts. Eventually I tried to quit Medical School. The Dean offered me as much time off as I needed and suggested a visit to the GP. I only took three days off in the end, started my anti-depressant medication and just battled on. I have mostly remained on medication ever since.

This article was meant to be about how depression affected my training, but it also goes the other way.

The 'imposter' syndrome (as I call it) and depression have persisted. In some ways it drove me to work harder and make the most of every training opportunity - I got through training and exams without a hitch. But it has also been incredibly tiring, second-guessing and double-checking everything I do, and has put significant strain on my relationships.

I met my husband around the time I started surgical training. Over the next five years I was moved around the country and we spent many years apart as a result.

The distance away from loved ones allowed me to be selfish and focus on my training, but has also meant that I have not had a support network at hand.

I stopped medication twice during training. Both times I was exercising, happy and relaxed. Without any family or medical advice, I rapidly weaned myself off medication, but a few weeks later the downward spiral started again. The second time, I had just moved from one city to another and was working in a busy department. I'd passed my fellowship exam, bought and sold a house and was getting married. I was hoping to start trying for a baby and had read the latest research on anti-depressants in pregnancy and the slight increase in risk of foetal defects. But of course I ignored the bit that mentioned the benefits to maternal welfare and bonding with a baby. I knew for anyone else that all of this going on would be a stressful time, but in my mind "it's just what you do during training, everyone else does it". In fact my mantra when things got tough was "suck it up".

So the spiral set in, but this time it was worse. I had debilitating panic attacks that breathing exercises and positive self-talk could not change. Whenever I got behind the wheel of my car I would daydream about driving off a cliff. I called into work sick for the first few days, saw my GP and restarted the meds. I made it back to work for the rest of the week. But the following week I was no better, I arranged a meeting with the Head of Department and hospital management. I really didn't want to tell anyone. I had managed to keep it a secret throughout my training, but at the same time I didn't want to keep calling in sick at the last minute and stuffing my colleagues and patients around.

I don't know why I was so worried. The reassurance and support I got from the Head of Department and management was amazing. They allowed me to take as much time off as I needed and asked if there were any contributing factors at work that they could change. I still didn't disclose it to many of my fellow registrars, but those who I did tell were really supportive.

This time it took a lot longer to get back on track. Exercise, healthy food, sleep, avoiding alcohol and cognitive behavioural therapy all helped.

I know my depression will be a lifelong battle. I love my job as a surgeon and although the pressures and stress contribute to my symptoms, I wouldn't have it any other way. But I also know that I'm not going to push myself to be the next professor or world-leading expert as the stakes for me are too high.

I still have good days/weeks and bad ones. I have to pace myself. My husband, family and the few colleagues in the know continue to be an amazing support.

Brain Haemorrhage in Training

I am never sick - well of course I get the usual coughs and colds but being a surgical Trainee I battle through and get on with it. I knew that something was wrong almost immediately. I had been at a conference and my right hand and forearm felt like they didn't belong to me anymore. I ignored it at first as many of us do, assuming it would resolve and rationalising it with numerous presumed diagnoses. The following week I had trouble knot tying in theatre then suffered a couple of dizzy episodes with right arm numbness. Given my right hand was the key to my future career I decided to get it checked out. I asked a medical colleague to do a neurological examination and saw a GP - neither could find anything wrong.

A few days later, at the hospital, I felt the familiar numbness spreading up my arm and then I had a seizure. On coming round from my post ictal state the gravity of the situation dawned on me - something serious was going on - then I had another seizure. There was some difficultly interpreting my CT result so I was admitted for an MRI, I did not enjoy the experience of being on the other side. The results were in, the neurology team thought it might be a tumour that had bled, maybe a metastatic melanoma, cue round 2 of tests and coming to terms with the fact that I might have a terminal illness. During this period of time my colleagues we amazing, from the neurology and neurosurgery teams looking after me to my department and training supervisor. They told me to forget about work and concentrate on getting better.

More tests and a second opinion ensued and a definite diagnosis could not be reached, I had to wait a month for a repeat MRI once the haemorrhage had improved to see if there was an underlying tumour. This time was so stressful for me, my husband and my family all waiting to find out if I had a death sentence. In this time however my thoughts returned to work and training. I had spent so much of my life working towards my career as a surgeon and it represented such a constant in my life that I missed it, I missed the structure it gave my days and the mental stimulation. After two weeks off I was cleared by my neurologist to return on restricted duties, and it was just the distraction I needed to take my mind off what was happening.

My follow up demonstrated haemorrhage only and no tumour which was of course fantastic but also represented the stresses of training setting in. I was told by my training committee that I had taken the maximum amount of time off, and if I took any more I would fail the run. I had to travel for my follow up and ended up having my husband drive back overnight through hell and literally high water to get back for work the following day. I felt angry, having put so much of my life into surgical training, moving around, living separately from my husband and it seemed all of the compromises were coming from me but one extra day off and six months of training disappears. I have since learnt that in these situations the training board usually reviews the situation and may accredit the run in special circumstances - this is not clear from the training regulations or widely known even by training supervisors.

Following this I was well, I stopped my anticonvulsants and returned to normal duties. Follow up MRIs demonstrated resolution of the haemorrhage and I had no ongoing neurological sequelae. The biggest difficulty from a training perspective though was not being able to drive for 12 months but the hospital provided alternative transport arrangements. I dismissed my illness as a blip and put it to the back of my mind but as I prepared for my Fellowship exam the sensory symptoms began to return transiently. I was diagnosed with sensory seizures and told that my risk of a further grand mal seizure was significant. Anticonvulsants were restarted; I am off driving again for 6-12 months and back on restricted duties at work. Now I have to accept I have to manage a lifelong chronic illness, balance this with my training, my family and studying for my Fellowship exam.

Prior to this experience the thought of any disruption to my training or study would have been devastating. It has taught me that there are more important things in my life than training, namely my health and my family. It has also highlighted that the training committees could do better. I have highlighted my personal situation to them with the hope it will help someone in the future but we all need to speak up when we have problems. Maybe I won't pass my exam the first time, maybe my training will be extended but every day I wake up, I see my baby smile, I spend time with my family and I am healthy enough to do my job and help my patients, for this I am lucky and I am thankful.

If you have a health concern please see your GP, alternatively you can seek help from these services:

RACS Support Program with Converge International: http://www.surgeons.org/member-services/college-resources/racs-support-program/

Doctors Health Advisory Service: http://www.dhas.org.au/contact/contact-dhas-in-other-states-territories-and-new-zealand.html

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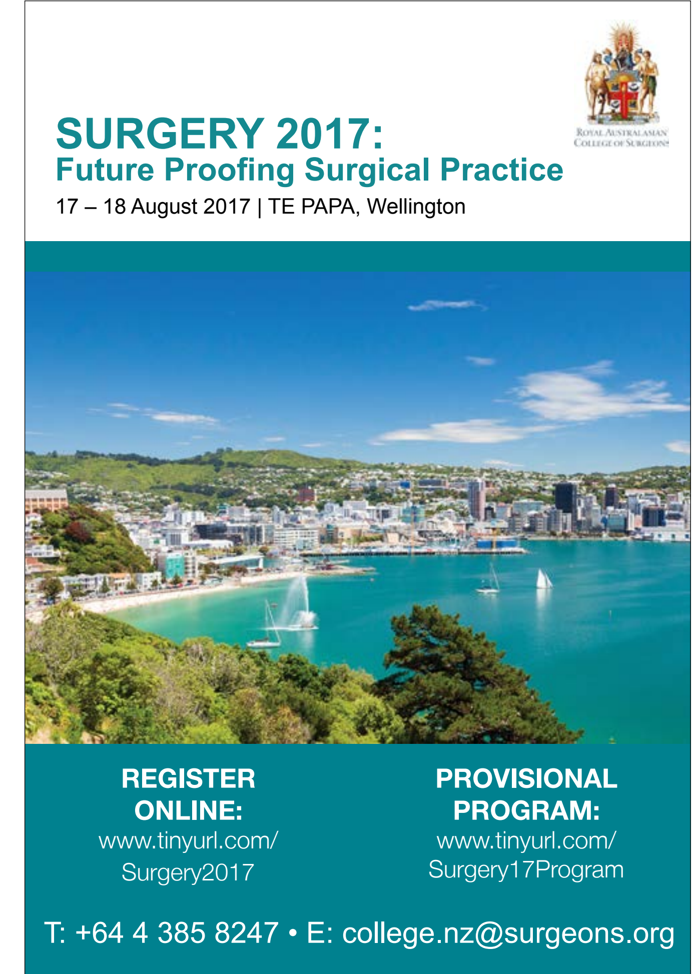


REGIONAL MEETINGS UPDATE

Surgery 2017: Future Proofing Surgical Practice

Date: 17 –18 August 2017
Venue: TE PAPA, Wellington, New Zealand
In addition, the NZ Surgical Pioneers session will be held the day before on Wednesday 16 August from 1:00pm-6:30pm.
Find out more:
T: +64 4 385 8247 • E: college.nz@surgeons.org
W: www.surgeons.org/about/regions/new-zealand

2017 RACS Combined Queensland Annual State Meeting & Surgical Directors Section Leadership Forum

Date: 18 – 20 August 2017
Venue: Pullman Palm Cove Sea Temple Resort & Spa, Palm Cove
Whither the 21st Century Surgeon? The Challenge of Adaptation to Change – Advancing Technologies, Clinical Governance and Leadership, Payment for Outcomes, Role Delegation
For additional information regarding the ASM:
David Watson
T: +61 7 3249 2900 • E: college.qld@surgeons.org
W: www.surgeons.org/about/regions/queensland/
For enquiries regarding the Surgical Directors Section:
Kylie Mahoney
T: +61 3 9276 7494 • E: surgical.directors@surgeons.org
W: www.surgeons.org/member-services/interest-groups-sections/surgical-directors/

WA, NT & SA Annual Scientific Meeting

Dates: 25 August 2017
Venue: Pan Pacific Hotel, Perth
Trauma: When Disaster Strikes
A foundation course will be offered on the 24 August.
Find out more:
RACS WA Regional Office
T: +61 8 6389 8600 • E: college.wa@surgeons.org
W: www.surgeons.org/about/regions/western-australia
RACS SA Regional Office
T: +61 8 8239 1000 • E: college.sa@surgeons.org
W: www.surgeons.org/about/regions/south-australia

83rd TAS Annual Scientific Meeting

Date: 22 - 23 September 2017
Venue: The Old Woolstore Apartment Hotel, Hobart
Surgery in One State, One Health System, Better Outcomes
A foundation course will be offered on the 22 September.
Find out more:
E: college.tas@surgeons.org
W: www.surgeons.org/about/regions/tasmania

59th Victorian Annual Surgical Meeting

Dates: 20 - 21 October 2017
Venue: Novotel, Geelong
Safety in Surgery
Find out more:
T: +61 3 9249 1188 • E: college.vic@surgeons.org
W: www.surgeons.org/about/regions/victoria

ACT Annual Scientific Meeting

Date: 4 November 2017
Venue: Australian National University, Medical School, Canberra
Systems of care: collaboration and innovation
Submit an abstract online www.tinyurl.com/actabs17
Find out more:
T: +61 2 6285 4023 • E: college.act@surgeons.org
W: www.surgeons.org/about/regions/australian-capital-territory

WORKSHOPS • ACTIVITIES • EVENTS

Workshops 2017

Online registration form is available now (login required)

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

Mandatory courses

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

By the end of 2017

Foundation Skills for Surgical Educators course: Mandatory for surgeons involved in the training and assessment of SET Trainees

By the end of 2018

Operating with Respect one-day course: Mandatory for SET Supervisors, IMG Clinical Assessors and major RACS Committees

Foundation Skills for Surgical Educators Course

20 July	Perth	WA
21 July	Wagga Wagga	NSW
22 July	Sydney	NSW
29 July	Shepparton	VIC
04 August	Sydney	NSW
04 August	Adelaide	SA
07 August	Queenstown	NZ
07 August	Sydney	NSW
07 August	Clayton	VIC
11 August	Melbourne	VIC
16 August	Wellington	NZ
18 August	Palm Cove	QLD
19 August	Melbourne	VIC
24 August	Perth	WA
26 August	Gosford	NSW
29 August	Adelaide	SA
02 September	Darwin	NT
02 September	Rockhampton	QLD
15 September	Melbourne	VIC
15 September	Perth	WA
22 September	Hobart	TAS
22 September	Adelaide	SA
28 September	Canberra	ACT

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

Operating with Respect course

24 August	Perth	WA
8 September	Brisbane	QLD

The Operating with Respect 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.

AMA Impairment Guidelines 4th & 5th Edition: Difficult Cases

2 September	Sydney	NSW

The American Medical Association (AMA) Impairment Guidelines inform medico legal practitioners as to the level of impairment suffered by patients and assist with their decision as to the suitability of a patient's return to work. While the guidelines are extensive, they sometimes do not account for unusual or difficult cases that arise from time to time. This morning workshop provides surgeons involved in the management of medico legal cases with a forum to discuss their difficult cases, the problems they encountered and the steps they applied to satisfactorily resolve the issues faced. This workshop is part of the AOA/RACS/AMLC Combined Meeting (to attend the Combined Meeting, register through AOA http://medico-legal.aoa.org.au/).

Writing Medico Legal Reports

12 September	Brisbane	QLD

This evening workshop helps you to gain greater insight into the issues relating to providing expert opinion and translates the understanding into the preparation of high quality reports. It also explores the lawyer/expert relationship and the role of an advocate. You can learn how to produce objective, well-structured and comprehensive reports that communicate effectively to the reader. This ability is one of the most important roles of an expert adviser.

Non-Technical Skills for Surgeons (NOTSS)

22 September	Brisbane	QLD
6 October	Auckland	NZ
24 November	Sydney	NSW

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

SAT SET Course

9 September	Melbourne	VIC
23 September	Adelaide	SA

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 3 hour workshop assists Supervisors and Trainers to understand their roles and responsibilities, including legal issues around assessment. It explores strategies which focus on the performance improvement of trainees, introducing the concept of work-based training and two work based assessment tools; the Mini-Clinical Evaluation Exercise (Mini CEX) and Directly Observed Procedural Skills (DOPS).

Keeping Trainees on Track

9 September	Newcastle	NSW
23 September	Adelaide	SA

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 3 hour course is aimed at College Fellows who provide supervision and training 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.

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

22 September	Melbourne	VIC

The NHET-Sim Program is a nationwide training program for healthcare professionals aimed at improving clinical training capacity and consists of e learning modules on simulation-based education. NHET-Sim is funded by the Australian Government. The project, being undertaken in partnership with Monash University, offers a training program for healthcare educators and clinicians from all health professions. The curriculum has been developed and reviewed by leaders in the simulation field across Australia and internationally.

The e-learning component of the NHET-Sim Program takes approximately 12 hours to complete. Registrations are already open for the last of 2017 NHET-Sim course. (log in required).

Process Communication Model Refresher (PCM)

24 September	Melbourne	VIC

Participants will refresh the skills learnt during an earlier attended Process Communication Model workshop. A needs assessment is done at the beginning and the workshop then addresses any issues of interest. This way the course program will be adapted to each participant's needs. Participants will have the opportunity to practice the parts they consider most relevant to them. Note: In order to participate in PCM Refresher, registrants must have attended and be familiar with the content of PCM Seminar 1.

Surgical Teachers Course

19 – 21 October	Mandurah	WA

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

Process Communication Model Seminar 1 (PCM)

20 – 22 October	Auckland	NZ
17 – 19 November	Sydney	NSW

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

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

Clinical Consultation Skills Education Retreat

Cancer Council Victoria and Deakin University's Centre for Organisational Change in Person-Centred Healthcare are pleased to present a Clinical Consultation Skills Education Retreat for oncology clinicians, 9-11 October at RACV Torquay Resort. This three day immersive residential education program will offer tailored, small group learning with other oncology clinicians, delivered by expert facilitators in a luxury environment away from workplace demands.

For more information please visit https://www.cancervic.org.au/clinical-consultation-skills-for-oncology-clinicians-three-day-retreat or register your interest education@cancervic.org.au

PROFESSIONAL DEVELOPMENT WORKSHOP DATES

July – September 2017

NSW		
Foundation Skills for Surgical Educators	21/07/2017	Wagga Wagga
Foundation Skills for Surgical Educators	22/07/2017	Sydney
Foundation Skills for Surgical Educators	4/08/2017	Sydney
Foundation Skills for Surgical Educators	7/08/2017	Sydney
Foundation Skills for Surgical Educators	26/08/2017	Gosford
Supervisors & Trainers for SET	9/09/2017	Newcastle
Keeping Trainees on Track	9/09/2017	Newcastle
NZ		
Foundation Skills for Surgical Educators	7/08/2017	Queenstown
Foundation Skills for Surgical Educators	16/08/2017	Wellington
QLD		
Foundation Skills for Surgical Educators	14/07/2017	Mackay
Process Communication Model: Seminar 2	21-23/7/2017	Brisbane
Foundation Skills for Surgical Educators	18/08/2017	Palm Cove
Foundation Skills for Surgical Educators	2/09/2017	Rockhampton
Operating with Respect (OWR)	8/09/2017	Brisbane
SA		
Foundation Skills for Surgical Educators	4/08/2017	Adelaide
Foundation Skills for Surgical Educators	29/08/2017	Adelaide
Foundation Skills for Surgical Educators	22/09/2017	Adelaide
Supervisors & Trainers for SET	23/09/2017	Adelaide
Keeping Trainees on Track	23/09/2017	Adelaide
VIC		
Foundation Skills for Surgical Educators	17/07/2017	Melbourne
Surgical Teachers Course	20-22/07/2017	Yarra Glen
Foundation Skills for Surgical Educators	29/07/2017	Shepparton
Foundation Skills for Surgical Educators	7/08/2017	Clayton
Foundation Skills for Surgical Educators	11/08/2017	Melbourne
Foundation Skills for Surgical Educators	19/08/2017	Melbourne
Foundation Skills for Surgical Educators	15/09/2017	Melbourne
National Health Education & Training in Simulation	22/09/2017	Melbourne
WA		
Foundation Skills for Surgical Educators	20/07/2017	Perth
Foundation Skills for Surgical Educators	24/08/2017	Perth
Operating with Respect (OWR)	24/08/2017	Perth
Foundation Skills for Surgical Educators	15/09/2017	Perth
TAS		
Foundation Skills for Surgical Educators	22/09/2017	Hobart
ACT		
Foundation Skills for Surgical Educators	28/09/2017	Canberra

Contact the Professional Development Department

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

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

Global sponsorship of the Professional Development programming is proudly provided by Avant Mutual Group, Bongiorno National Network and Applied Medical.

WORKSHOPS • ACTIVITIES • EVENTS

Update from the Skills Lab

PROFESSOR JONATHAN SERPELL
Chair, Prevocational and Skills Education

2017 sees fourteen years of operation of the RACS Skills and Education Centre (SEC) Melbourne. Located on levels one and two of the east wing of the RACS head office in Melbourne, SEC hosts many workshops and meetings.

A typical recent event involved a pre-workshop prior to the Australian Hand Surgery Society ASM in March this year. This interactive dissection workshop was held in the Skills Laboratory utilising cadaver specimens and involved using tissue transfer to teach the technique of vascularised free flaps from tissue based on the inferior genicular artery in the knee to transpose to resurface the scaphoid bone in the wrist.

The Skills Lab located on level one is a flexible area with eight workstations and a demonstrator station which are able to handle human anatomy specimens and other wet specimens, and is set up with water, suction, and compressed air. This area is typically used for activities such as cadaver workshops, basic surgical skills training, laparoscopic suturing practice, and endoscopy simulation.

A recent significant audio-visual upgrade has enabled high quality live video streaming of activities in the Skills Lab to be viewed in the adjacent lecture room by an audience of up to sixty people.

The SEC is also regularly utilised for Early Management of Severe Trauma (EMST), Australian and New Zealand Surgical Skills Education and Training (ASSET), and Care of the Critically Ill Surgical Patient (CCrISP) courses.

There is an increasing focus on simulation with use of mannequins and laparoscopic and endoscopy trainers.

The Skills and Education Centre very much embodies core business of RACS, whilst also providing the level two training area which can accommodate up to two hundred people in theatre style and the Hughes Room which can accommodate up to one hundred and ten people. There are a number of other break-out rooms.

The Skills and Education Centre is available seven days a week and is significantly utilised. For example, over the past twelve months, apart from SEC room bookings by RACS staff, Fellows and Trainees, there were over six hundred and thirty room bookings for external clients for meetings attended by over twenty-four thousand people. Last year there were ninety events in the Skills Lab of which sixty-six were surgical training workshops. 2017 will see the continuation of a program of renewal of equipment to keep the Skills Lab state-of-the-art, including endoscopy towers, electrosurgical generators and audiovisual equipment.

The SEC still has a new feel and is an ideal venue and one which RACS is keen to continue developing as the default site for skills courses. SEC staff are available to assist with ordering catering and servicing events. For meal breaks, there is availability of the central outdoor garden space, which is ideal in appropriate weather.

The SEC is fortunate in having superb staff including Centre Manager David Lawrence and Event Services Manager Luke Jordan who coordinates all room bookings. To talk to David about how the SEC can help you organise a surgical workshop, or to contact Luke about booking a meeting room, send an email to skills.centre@surgeons.org or call 03 9249 1261.

Skills and Education Centre
Royal Australasian College of Surgeons
250-290 Spring Street
East Melbourne VIC 3002 Australia
Telephone: +61 3 9249 1261 • Fax: +61 3 9276 7459
Email: skills.centre@surgeons.org

Skills Training Courses 2017

RACS offers a range of skills training courses to eligible medical graduates that are supported by volunteer faculty across a range of medical disciplines.

Eligible candidates are able to enrol online for RACS Skills courses.

ASSET: Australian and New Zealand Surgical Skills Education and Training

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

EMST: Early Management of Severe Trauma

EMST 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

The CCrISP® course assists doctors in developing simple, useful skills for managing critically ill patients, and promotes the coordination of multidisciplinary care where appropriate. The course encourages trainees to adopt a system of assessment to avoid errors and omissions, and uses relevant clinical scenarios to reinforce the objectives.

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 the medical literature and decision analysis and cost effectiveness studies.

TIPS: Training in Professional Skills

TIPS teaches patient-centred communication and team-oriented non-technical skills in a clinical context. 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.

AVAILABLE SKILLS TRAINING WORKSHOP DATES*
August — September 2017

Dates	Location
ASSET	
Thursday, 10 August 2017 – Friday, 11 August	Perth
Friday, 25 August 2017 – Saturday, 26 August	Brisbane
Friday, 1 September 2017 – Saturday, 2 September	Auckland
Friday, 8 September 2017 – Saturday, 9 September	Sydney
CCrISP	
Friday, 25 August 2017 – Sunday, 27 August	Brisbane
Monday, 1 September 2017 – Wednesday, 3 September	Melbourne
Friday, 15 September 2017 – Sunday, 17 September	Perth
Friday, 15 September 2017 – Sunday, 17 September	Sydney
Thursday, 21 September 2017 – Saturday 23 September	Auckland
CLEAR	
Friday, 18 August 2017 – Saturday, 19 August	Auckland
Friday, 8 September 2017 – Saturday, 9 September	Melbourne
Friday, 22 September 2017 – Saturday, 23 September	Sydney
EMST	
Friday, 4 August 2017 – Sunday, 6 August	Sydney
Friday, 11 August 2017 – Sunday, 13 August	Melbourne
Friday, 18 August 2017 – Sunday, 20 August	Brisbane
Friday, 18 August 2017 – Sunday, 20 August	Perth
Friday, 25 August 2017 – Sunday, 27 August	Sydney
Friday, 25 August 2017 – Sunday, 27 August	Melbourne
Friday, 1 September 2017 – Sunday, 3 September	Brisbane
Friday, 8 September 2017 – Sunday, 10 September	Melbourne
Friday, 15 September 2017 – Sunday, 17 September	Adelaide
Thursday, 21 September, 2017 – Saturday, 23 September	Darwin
Friday, 22 September 2017 – Sunday 24 September	Melbourne
TIPS	
Friday, 4 August 2017 – Saturday, 5 August	Melbourne
Friday, 8 September 2017 – Saturday, 9 September	Sydney

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

**Courses available at the time of publishing*

WORKSHOPS • ACTIVITIES • EVENTS

Program Highlights 2017

Annual Joint Academic Meetings

Thursday 9 - Friday 10 November
Adelaide, South Australia

DAY ONE - SECTION OF ACADEMIC SURGERY MEETING

Presentations

How I approach challenging conversations
How I unlearnt bad academic habits
Self awareness and avoiding burnout
#Ilooklikeanacademicsurgeon

Concurrent Workshops

1. Concept to reality
2. Write like a pro
3. Clinical Trials Network

Short Debates

1. Full-time (HDR) research vs after hours projects (debate between trainees)
2. Independent researcher vs research group (debate between department heads)
3. Focussed academia vs academic generalist (debate between mid-careeer academics)
4. Academics should embrace social media vs social media has no place in academia

DAY TWO - SURGICAL RESEARCH SOCIETY MEETING

Invited Guest Speakers

Society of University Surgeons Guest Speaker - Dr Sharon Weber,University of Wisconsin, WI
Association of Academic Surgeons Guest Speaker - Dr Sam Wang, University of Texas, TX
Jepson Lecturer - Professor Robert Fitridge, University of Adelaide, SA

Presentations of Original Research

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

Registration open soon
Contact Details
E: academic.surgery@surgeons.org
T: +61 8 8219 0900

SURGICAL RESEARCH Society

Medtronic

Understanding cultural influences on health

MAXINE RONALD
Deputy Chair, Indigenous Health Committee

The Medical Council of New Zealand (MCNZ) in partnership with Te ORA, the Māori Medical Practitioners Association, held a symposium on Cultural competence, partnership & health equity on 1 June in Wellington.

The day was opened with a *Mihi Whakatau* (a welcoming speech) from Professor of Māori and Indigenous Research at the Eastern Institute of Technology David Tipene, which emphasised that the day was an opportunity to set aside dedicated time to discuss Māori health and the pathway to better outcomes. Mr Andrew Connolly FRACS, MCNZ Chair, strongly emphasised how important it is to understand the fundamental connection between a patient's cultural background and their experience of the health system and medical care. We must be patient focused.

As part of the day's program, RACS was one of three medical colleges invited to speak on its progress towards addressing Māori health inequity. Members of the College's Māori Health Advisory Group, Professor Pat Alley, myself and Dr Ben Cribb presented on the development and progress of the RACS Māori Health Action Plan. The RACS delegates also spoke on the challenges faced by Māori surgeons and the positive effect that more Māori surgeons will have on Māori health outcomes.

Other highlights of the symposium included Public Health Physician Professor Rhys Jones giving an engaging and powerful presentation on unconscious bias and how it can have a pervasive effect on how we treat other people. Dr Jones further highlighted how unconscious bias can lead us to make assumptions and stereotype others into groups. This stereotyping can lead us to provide a lesser standard of care and even potentially discriminate against patients because we have not considered their individual needs.

The old medical adage 'we treat all our patients the same' is woefully inadequate in caring for the diverse populations that we work with across Australia and New Zealand. The care that we provide to our patients should be a combination of knowledge, skills and attitudes – including the basic consideration that a patient's ethnicity may affect their understanding and experience. In order to confront and address our biases, Prof Jones concluded, we should consider a range of 'de-biasing' strategies – training, intergroup contact, acknowledging the perspectives of others and avoiding bias-reinforcing exposure.

Members from organisations across the country were challenged to consider their structures, systems and processes – and to ask whether they have a comprehensive strategy to promote equity, Māori health and leadership. Immediate past Chair of Te ORA, Dr David Jansen, suggested that organisations needed to implement 'systematic monitoring and assessment of equity'. Importantly, the more that systems reduce the cognitive load on doctors and provide opportunities for reflection and training, the more health practitioners will be prepared to work with a diversity of patients. The focus must be on equity based quality improvement.

The day concluded with brainstorming ideas about how we can build upon the progress made and take the next steps towards cultural change. As Medical Colleges we are leading the way through our Indigenous health action plans, but the significant challenge as we move forward will be to progress from cultural competence to cultural proficiency. Into the future we need to evaluate our own biases and teach our young surgeons and trainees the skills they need to reflect on culture so that they may treat all their patients in culturally sensitive ways.

Image (from left): RACS delegates brainstorming progress on the Māori Health Action Plan; Maxine Ronald and Ben Cribb.

Fellowship Survey – How has your voice improved RACS?

RUTH BOLLARD
Chair, Fellowship Services Committee

Next month all Fellows will have an opportunity to help shape the future direction of RACS by participating in the 2017 Fellowship Survey. The survey will seek feedback from Fellows to identify areas for improvement, strengths and the potential path members wish to see our College take in the coming years.

The Fellowship Survey was last conducted in 2015, and was open to all active and retired Fellows. A response rate of 31 per cent was achieved. Importantly, Fellows who participated in the survey were a representative sample of the broader Fellowship in terms of specialty practiced, regions, age and gender.

How was Fellow feedback used?

RACS Council received comprehensive reporting on the results of the 2015 Fellowship Survey to assist with identifying key issues and areas for improvement. Feedback also contributed to the RACS Strategic and Business Plans ensuring Fellows have a direct influence on the strategic direction of the College.

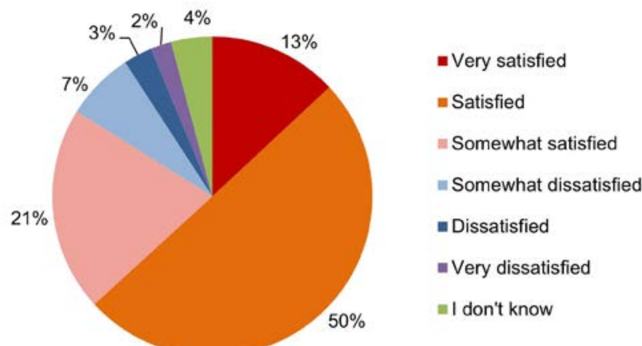
How satisfied are members?

In 2015 the majority of active Fellows indicated that they were 'satisfied' or 'very satisfied' with the College overall (76%), an increase from 2010 results (68%). Almost 80 per cent of Fellows considered RACS to be of real benefit to them as a Fellow, an increase from 76 per cent in 2010.

Core Activities

Delivery of Surgical Education and Training

In 2015 Fellows were asked to evaluate RACS' delivery of surgical education and training. Approximately 84 per cent of Fellows gave a 'somewhat satisfied' rating or higher and almost 12 per cent of Fellows gave a 'somewhat dissatisfied' rating or lower. Feedback highlighted issues such as selection process, managing trainee underperformance and recognition of supervisors and educators as areas that require review.

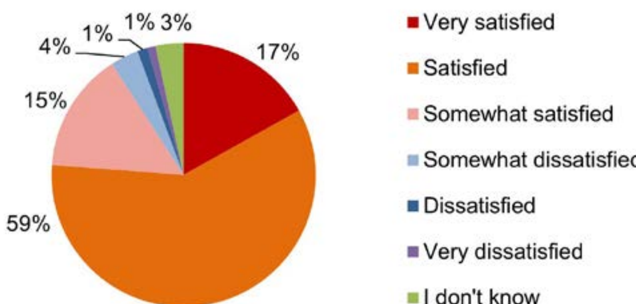


RACS has introduced JDocs, a competency framework to help guide and prepare junior doctor's career development during the early prevocational years. The program provides a range of learning and assessment resources to assist with readiness for formal surgical training.

More than 1100 trainers and surgical supervisors have now participated in the Foundation Skills for Surgical Educators course. This covers the standards expected of RACS surgical educators with a focus on assessment and feedback skills. The national selection process, SET curricula and ensuring natural justice for complaints and appeals are functions that are regularly reviewed. Recognising the pro-bono contribution of supervisors and educators remains an ongoing priority.

Surgical Standards Policies and Guidelines

Fellows were asked about satisfaction with professional standards guidelines and policies to support surgeons in everyday practice. Just over 90 per cent of Fellows gave a 'somewhat satisfied' rating or higher. When asked how RACS can improve the professional standards guidelines and policies, the most commonly received responses were to ensure guidelines and policies are enforced and to improve access to standards documentation.



RACS has achieved 99.9 per cent Continuing Professional Development (CPD) Program compliance in 2016, ensuring Fellows meet professional standards, including surgical audit and peer review. A range of position papers and standards have been published or reviewed, including the recently revised Code of Conduct. Improved access to guidelines and policies was achieved as part of the RACS ePortfolio project (single login and personalised access to lifelong learning, professional development and assessment systems via the RACS website).

I will be reporting on more results from the Fellowship Survey and how RACS has responded to feedback in the next edition to *Surgical News*. The areas will include professional development offerings, advocacy, communication and customer service.

I encourage all Fellows to participate in the survey in August 2017 to help shape the future of RACS.

2017 RACS Fellowship Survey

How can we better support Fellows?
What can RACS improve on?
What are our future challenges?

Have your say on RACS priorities and future direction by participating in the 2017 Fellowship Survey.

Look out for your invitation to participate in your inbox this August.

Further information:
e: Fellowship.Survey@surgeons.org
t: +61 3 9276 7494

Starting out in social media?

Facebook, Twitter, Snapchat, Instagram, YouTube, Wordpress. If you're new to the social media space, it can all seem a bit daunting. Choosing which social media channel to start with depends on what you are trying to achieve. Is it professional or personal? How much time do you have to keep it updated? Do you want to give yourself a passive presence and listen, or do you want to have regular long discussions about the latest developments in your field?

To start with, Facebook might be the best social media platform if you are not overly social media savvy. Facebook is used by a wide variety of people for their personal and professional profiles. You create an account for yourself as an individual, and from that profile, you can create a business page for your clinic or rooms. A warning: if you create an account under a business name, Facebook can and will shut it down, as accounts are meant to be a personal profile of an individual, not a collective or a business.

Once you have both an account for yourself and a business page set up, you can connect with others you know by adding them as a 'friend', and then start adding posts or updates. The updates can be up to 2,000 characters (as opposed to Twitter's measly 140), and can include a link and a photo if you want to make the post more noticeable. Others can 'like', 'react' with an emoji, comment, or share the post with their friends.

Keep in mind when writing for your Facebook business page, that your updates will be jumbled in amongst updates from their family and friends: photos of their friend's latest holiday, their newest addition to the family, their pets, a link they might have found interesting or funny, or even where and what they had for lunch that day. You are speaking to them in their lounge rooms, not in an office, so while a professional tone is expected, try to be more conversational and you may find more people will respond to your updates.

For more information about Facebook and how to set up an account, please contact RACS' Digital Media Coordinator, SJ Matthews at sj.matthews@surgeons.org

ARTICLE OF INTEREST

Australian Breast Device Registry keeping Australian women safe

Poly implant prothese (PIP) breast implants were recalled in 2010 after it was discovered that non-medical grade silicone was associated with increased rupture rates. At that time, a pre existing Breast Implant Registry (BIR) captured only 3.4 per cent of the implants used in over 6,000 potentially affected women. This unsettling discovery led to the realisation that the BIR's reach was far too limited to determine just how many women had been affected.

Following a senate enquiry in 2012 into the use of medical devices, it was recommended that a more reliable and accurate data capture method be introduced nationally to ensure the ongoing safety of Australian women who have undergone surgery for the implant or explant of a breast device.

In 2015 the BIR, a voluntary, patient funded registry was replaced by the Australian Breast Device Registry (ABDR), a Commonwealth Government funded initiative that records information on all procedures involving a breast device. The new Registry was the initiative of the Australian Society of Plastic Surgeons and the Australasian Foundation for Plastic Surgery which provided initial funding and lobbied Government for further financial backing.. Now led by Monash University, the ABDR aims to identify and report on possible trends and complications that may arise from implant procedures. The registry has the capacity to track long term safety and performance of devices as well as patient health outcomes. The 'opt-out' approach also ensures a higher data capture rate and close to full population coverage.

Total number of patients:
16,000
Contributing surgeons: 320
Contributing sites: 180
**at time of print*

Today an estimated 20,000 Australians annually receive implantable breast devices for breast augmentation or reconstruction. Less than one per cent of participants have opted-out of the ABDR, which represents data from more than 16,000 patients, and more than 300 participating surgeons from all three craft groups - Plastic and Reconstructive, General Breast and Cosmetic surgery - contributing to the registry.

The ABDR uses a quick and simple double-sided tick-box form to collect the data at the time of the operation, at no cost to the patient.

As the roll-out of the ABDR continues nationally, the database will mature to accurately and objectively reflect breast device surgery in Australia, including the influence of tissue expanders and acellular dermal matrices on outcomes and contribute to a greater understanding of Anaplastic Large Cell Lymphoma (ALCL).

Melbourne-based Plastic and Reconstructive Surgeon Dr Jeremy Richardson, specialising in a range of reconstructive and aesthetic breast, facial and skin procedures, has been participating in the registry since 2016.

"Patients appreciate the peace of mind that is provided when they know their device is being tracked and monitored."

"The registry keeps a record and helps facilitate a rapid turn-around for contacting patients in the event of a device recall," he said.

As a national registry, the ABDR provides greater representation of the population, and data collected from surgeons is consistent, standardised and reproducible. Patients are followed up and reports will be generated by Monash University which acts as an independent third party.

Dr Jeremy Richardson

Dr Ingrid Hopper

> "The registry tells us what we are actually doing and not just what we think is going on"

"The registry tells us what we are actually doing and not just what we think is going on," Dr Richardson said.

With standardisation and amplification of data, once unanswerable questions can now be answered:

What is the life-span of breast implants? Is there a difference between the performance of devices inserted for cosmetic or reconstructive purposes? What is the impact of the surface coating of the device?

Dr Richardson said that, "The earlier BIR had a cumbersome data collection process and the cost to the patient was a disincentive for participation. The ABDR has made the administrative processes much easier to manage."

"By contributing to the registry I am contributing to the development of a rich, robust data resource that will help identify complications and improve patient safety".

Monash University ABDR Project Lead, Dr Ingrid Hopper, said that the ABDR is on track to identify trends and complications associated with breast implants, tissue expanders and acellular dermal matrices, for the benefit of surgeons and patients.

"All surgeons want optimal health outcomes for their patients."

"The registry creates a feedback loop between surgical intervention and patient health outcomes and reports on device performance," she said.

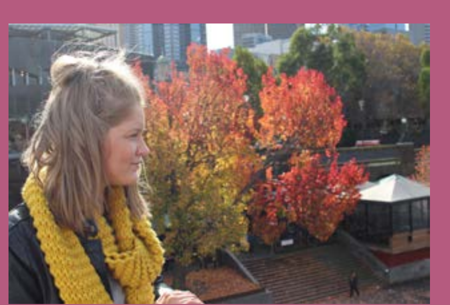
The ABDR will aggregate the data for national, regional and site reports, with surgeons having the option to view their individual outcomes against the national aggregate.

"No surgeon will have access to another surgeon's individual report," Dr Hopper said.

With the release of the ABDR Annual Report later this year, Dr Hopper is keen to encourage all surgeons not already participating in the registry to do so.

"We encourage all surgeons involved in breast implant surgery, including those who only explant devices, to contribute to the ABDR. This will benefit their clinical practice and ultimately their patients' health."

Current Clinical Craft Group Representatives and Clinical Leads on the ABDR: Prof Rod Cooter (FRACS), A/Prof Elisabeth Elder (FRACS) and A/Prof Colin Moore (FRACS). A/Prof Chris Pyke (FRACS) provided past representation of general breast surgeons.



My name is Tahni and I'm 24 years old. I made the decision to have breast augmentation in 2016.

Despite some of the horror stories I'd already heard and read, I knew I was in safe hands and that all of my information would be stored for the future.

My surgeon discussed the registry with me prior to the procedure taking place. I didn't have a problem with providing my private information as I knew that if there had been any new research or if there were any complications with the implants down the track then I could be easily contacted.

For me, this surgery was a positive life changing decision. I knew there were risks involved, which were explained thoroughly to me, but I also felt confident knowing that the registry's primary objective is to keep women safe. I'm very lucky – my mum is a nurse and has spoken to me about the importance of research. Whilst I can move on with my life, it is reassuring to know that constant research is being done in the background to ensure that the implants do not negatively affect my health.

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Age is not relevant

SUSAN HALLIDAY

The only thing that is standard about ageing is that everyone is doing it!

While society, the media and employment environments mercilessly foster age based stereotypes, the reality is that employees, consultants and contractors no matter their age, have a right to be treated in a non-discriminatory and professionally respectful manner.

Protection and redress mechanisms exist in various employment laws and workplace policies. So if 'age' is directly or indirectly the cause of less favourable or untoward differential treatment and your rights have been compromised, then a process to scrutinise the matter can be commenced.

Those who fuel stereotypes that undermine older professionals, and others who spruik generic decline in capability and commercial disadvantage on the basis of age, need to rethink such commentary and reflect on their ethics. Considering personal accountability in relation to the frameworks that extend protection in relation to 'age' may also be wise. A go-to list could cover anti-discrimination and equal employment opportunity (merit principle) legislation, relevant human rights and industrial relations frameworks, workplace bullying and defamation.

These scenarios do not escape the world of medicine. While colleagues may not be aware that they hold and promote age-based stereotypes, those who bear the brunt of aged based assumptions and comments are well aware of the negative impacts and associated reputational damage. Often feeling the need to articulate disdain and disappointment privately, affected parties, just like their younger colleagues who cause the problem, have the right to expect fair and respectful treatment on the basis of merit.

To be clear, it is 'age discrimination' when a person is treated less favourably than another person in a similar situation, because of their age. Indirect age discrimination can result when there is a rule, policy, practice or procedure that appears neutral or the same for everyone, but has an unfair effect on people of a particular age. Harassing a person on the basis of age, causing offense, humiliation or intimidation, can be a form of discrimination.

> *"The need to work through 'age' related issues and simultaneously dispel some derogatory stereotypes is important as our populations in Australia and New Zealand age"*

A 2015 study conducted by the Australian Human Rights Commission entitled the *National Prevalence Survey of Age Discrimination in the Workplace* spoke to employers and colleagues being harsher when assessing the skills of older people. Further, in relation to older people, it surfaced that employers and colleagues commonly held negative perceptions about skill sets and older people's ability to learn with some 44 per cent of participants reporting that they had experienced this type of age discriminatory behaviour. Yet across Australia and New Zealand society reaps the benefits of the contributions made by many older professionals, be they providing service in the areas of law, medicine, science, education, research, customer service, hospitality, construction, or accounting, to name just a few examples.

Interestingly, when concerns and complaints associated with age surface, people talk about their psychological impacts, a diminishing sense of self worth, and at times the purposeful undermining of professional reputations and expertise in order that someone else may benefit. Examples of recent cases involved 'professionals' referring to colleagues as being *past it*, *old hat*, *a has-been*, and *last century*. A number of targeted comments such as a person having a *traditional skill-set*, or a *less contemporary* or *out-dated* approach also come to mind.

When they speak up, affected parties express their experiences in various ways. Some talk about bullying. Indeed when a person is victimised due to their reputation being repeatedly undermined it may well amount to bullying. If we think about the situation in colloquial terms, the reference to being *white anted* sums up the experience for many whose competitors use 'age' when seeking to damage a reputation.

Others who speak up consider defamation options. The one thing that jumps out here is that negative commentary seems to find its way into social media, which of course means it is public; dare I say published. It is this type of evidence that has greatly increased defamation case loads and successful complainant outcomes over recent years.

The need to work through 'age' related issues and simultaneously dispel some derogatory stereotypes is important as our populations in Australia and New Zealand age. Drawing upon the ageless contributions of Sir David Attenborough is one way to make a pertinent point or two from the outset of such a discussion.

Statistics that reflect demographic realities are always helpful. Encouraging people to think about the fact that the number of people in Australia aged 65 and over has more than tripled in the past fifty years, gets the ball rolling. Add to that the ninefold increase in the number of people aged 85, and the penny drops! Currently in Australia more than 15 per cent of the population is over 65. The over 65 age group in New Zealand has doubled over the last 35 years, and sits at just under 15 per cent.

People over 65 continue to work and have much to contribute. Yet to this very day the barriers prevail. It is in the best interests of all for us to move beyond the recent findings of Professor Carol Kulik in a University of South Australia study on 'stereotype threats' which demonstrated that age stereotypes were notoriously persistent in organisations with mature-age employees commonly perceived to be less productive than their younger counterparts, lacking initiative, disinterested in learning or developing, and resistant to change.

We all have a level of ownership of this challenge. So next time someone offers up an ageist comment or suggests someone is not utilised due to age, take it personally, speak up and push back. Ultimately ageism slights us all.

NOTE

This article is not legal advice. If legal advice about age discrimination, bullying or defamation is required, an employment law or defamation law specialist should be consulted with reference to the specific circumstances.

SUSAN HALLIDAY

Australian Government's Defence Abuse Response Taskforce (DART) 2012-16 and former Commissioner with the Australian Human Rights Commission.

Review of complaints to the Medical board of Australia & AHPRA

MICHAEL GORTON AM
Principal,
Russell Kennedy Lawyers

The National Scheme for complaints against health practitioners has now been in place since June 2010. A recent research study has analysed some of the outcomes in relation to complaint handling through the Medical Board and AHPRA with some interesting results.

The study 'Outcomes of notifications to health practitioner boards: a retrospective study' (Spittal et al, 2 December 2016, BMC Medicine) has analysed data from notifications/complaints lodged with AHPRA over 24 months and the actions taken against registered health practitioners in numerous professions.

The study serves to give relevant and current information in relation to outcomes of notifications and complaints, identify some of the causes for complaints, and may assist work towards prevention or avoidance of complaints in the future.

According to the study the highest notification rate was in relation to dentists, followed by doctors. The lowest rate of notifications is in relation to nurses and midwives.

According to the Annual Report of the Medical Board of Australia 2015/16, there were 107,000 registered medical practitioners, an increase of 4 per cent on the previous year and in respect of which 3,100 notifications or complaints were lodged. In the same period 2,700 notifications against medical practitioners were closed.

The overall rate of notifications for all registered health practitioners was 6.3 per 1,000 practitioners.

A third of all complaints were lodged by patients or relatives, and a further third by State Health Complaints Commissioners. Employers only counted for 9.5 per cent of complaints, and complaints made by fellow practitioners were 13 per cent. However, interestingly, notifications from employers most often led to restrictive action being taken in relation to a health practitioner.

Complaints related to concerns about the performance of a practitioner in 38 per cent of complaints; 31.5 per cent related to conduct of a practitioner; and 5 per cent related to concerns about the health of a practitioner.

While 10 per cent of closed notifications resulted in restrictive action being applied to a health practitioner, only 0.3 per cent resulted in removal from practice. The most common outcome involved the imposition of some formal condition on a practitioner's registration.

Approximately a third of complaints were resolved within three months and the median time to close matters was nine months. The research study indicated that the longer the matter took to resolve, the more likely that some restrictive action would be imposed as a result.

It was more likely that some restrictive action would be imposed where a notification was made in relation to a health impairment of a practitioner, in relation to an allegation of unlawful prescribing or use of medication or an allegation of violation of sexual boundaries.

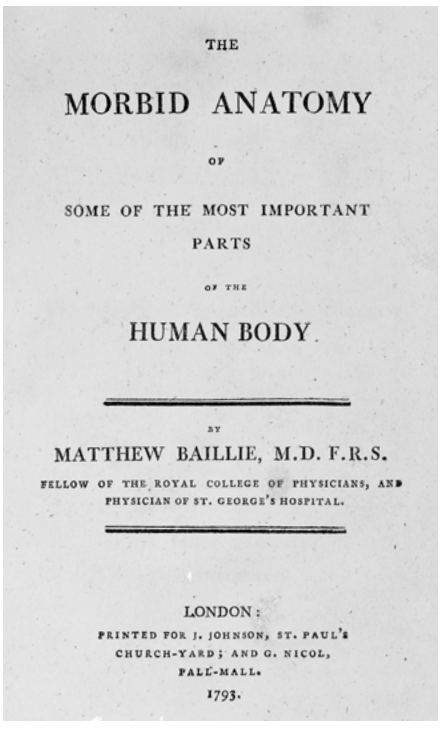
If a notification is made by an employer or colleague, there is a higher rate of restrictive action being applied, than where a complaint is made by a patient or relative.

Although doctors had a relatively high rate of notification, the likelihood of being subject to a restriction on practice was lower than for nurses, psychologists and other health practitioners.

Notifications against male practitioners (while more were made) were no more likely to result in a restrictive condition being opposed than for female practitioners.

While more notifications were received for older practitioners, there was no corresponding increase in respective actions being applied to their registration.

Both the research study, and the AHPRA Annual Report, are good sources of information in relation to the regulation, registration and complaint handling actions of the National Scheme in Australia. As more data is collected, this information will be a good source of information in relation to the conduct of and complaints against health practitioners in Australia.


THE
MORBID ANATOMY
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SOME OF THE MOST IMPORTANT
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BY
MATTHEW BAILLIE, M.D. F.R.S.
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1793.

Matthew Baillie, portrait

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FASCICULUS I.
COMPREHENDING
THE CHIEF MORBID APPEARANCES OF THE HEART,
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Matthew Baillie's 'Morbid Anatomy', its sequel, and, the Melbourne 'connexion'.

The Kenneth Fitzpatrick Russell Lecture 2016

MR PETER F BURKE
Speciality Editor-Surgical History: ANZ JSurg

The first Kenneth Fitzpatrick Russell Memorial lecture, *'Kenneth Russell-Medical Historian, Matthew Baillie's Atlas of Engravings and Samuel Johnson's Lung'*, was delivered in 1991 by Prof Harold Attwood.

The 2016 lecture was based on *'The Morbid Anatomy of some of the most important parts of the Human Body'*, written by Matthew Baillie in 1794 and subsequently supplemented with the issue of 10 Fascicules containing copper plate engravings of pathological specimens, which could be used either separately, or in addition to Baillie's original work.

It should be noted that the engravings illustrating pathological changes were made from a series of original, commissioned drawings: those drawings were the work at *'one guinea each'* of William Clift, amanuensis to John Hunter and first Conservator of the Hunterian Collection at the English College of Surgeons.

Specific to the memory of Kenneth Russell is the fact that he discovered, in a flooded basement at the University of Melbourne, a copy of the 1803 First Edition of the combined fascicules, and to his astonishment, realised that many of the engravings had been removed and replaced by the artist himself, William Clift, with his original drawings!

This lecture dealt with the author, Matthew Baillie, his original non-illustrated work, his association through William Hunter with William Clift, and his engagement of Clift, to subsequently produce the drawings for reproduction in the ten fascicules of illustrated morbid anatomy, published over four years until 1802.

Matthew Baillie was born in Lanarkshire, Scotland, in 1761, the son of Dorothea Hunter, sister of William and John. Matthew's father died in 1779 and Dorothea sent her son to live with his uncle, William in London. William was a bachelor and addressing the question of why he never married, stated, *"a man cannot have two loves, and my first and only love is to teach"*.

From 1779 Baillie studied at Oxford University gaining all appropriate degrees to enable practice as a physician and in his vacations worked with Hunter in London. In 1783 William Hunter died, and the following year, Baillie assumed responsibility for his anatomical lectures.

In 1793 Matthew Baillie published *'The Morbid Anatomy of some of the most important parts of the Human Body'*. Essentially these 'parts' comprised the solid organs or viscera enclosed in the cranial cavity, the thorax, the abdominal cavity and pelvis; there were 24 chapters, commencing with the pericardium, heart and lungs, through to the brain and its membranes. There was no reference to the upper or lower limbs.

In 1799, Baillie tentatively published the first two fascicules of, *'A Series of Engravings accompanied with Explanations, which are intended to illustrate The Morbid Anatomy of some of the most important parts of the Human Body'*.

Reproduced here we see the frontispiece of each of the two first editions in 1793 and 1799: the unfortunate replication of wording for these two titles has unsurprisingly led to much subsequent confusion, as will be referred to.

In Munk's Roll of the Royal College of Physicians, Baillie's obituary noted: *'as a teacher he succeeded in the highest degree: his demonstrations were remarkable for their clearness and precision: he possessed a perfect conception of his subject, and imparted it with the utmost plainness and perspicuity to his hearers. He continued to lecture until 1799'*.

FIG 2

B. The strictured part, where the cavity is so narrow as just to admit a goose-quill to pass through it. At the upper part of the stricture ulceration is very observable.
C. A part of the rectum under the stricture, free from disease.
From Dr. Hunter's Museum.

Until his death in 1823 Baillie conducted a most successful specialist medical practice and had no time for further publications, working 16 hours a day and earning a stated £10,000 per year. He was appointed physician extraordinary to George III.

However, owing to the redundant nomenclature he employed for his two separate works on morbid anatomy, confusion has subsequently ensued.

The well-known resource of medical historians, *'The Medical Bibliography'* of Garrison and Morton, correctly lists the two volumes of morbid anatomy and engravings as separate items but refers to the un-illustrated original volume with the words: *'the work is well written and notable for its fine illustrations on copperplates, the work of William Clift'*.

In a 'definitive' work entitled, *'The Influence of Matthew Baillie's Morbid Anatomy', biography, evaluation and reprint,* Prof Alvin Rodin of the University of Texas provided an incorrect list of the editions of Baillie's works.

In the October 1982 edition of *'Medical History'*, published by the Wellcome Institute for the History of Medicine, an article entitled *'The editions and translations of Dr Matthew Baillie's Morbid Anatomy'*, by Franco Crainz, set out to finally clarify the situation.

The already somewhat complex situation was further compounded by the intrusion of James Wardrop (1782-1869), one of the original 300 Fellows of the reconstituted Royal College of Surgeons of England in 1843. His biographer in Plarr's, *'Lives of the Fellows of the RCS', noted, inter alia, 'James Wardrop possessed great abilities and was an original thinker and actor. As a lecturer, he was somewhat tame and discursive, and like Robert Liston he was not a good lecturer'.*

The Cowlishaw Collection has Wardrop's 1825 edition of Baillie's 'Morbid Anatomy', which includes his presumptuous addition of *'Preliminary Observations on Diseased Structures'.* In his 1833 edition, also held in the Cowlishaw, Wardrop noted, *'It is considerably enlarged and I hope more correct than the former'.*

The 2016 Russell lecture then considered Baillie's *'Series of Engravings'*, published between December 1799 and October 1802: they were collated as a first edition in 1803 and there was one final second edition published in 1812. RACS does not hold a copy of either of these editions, nor any of the 10 fascicules.

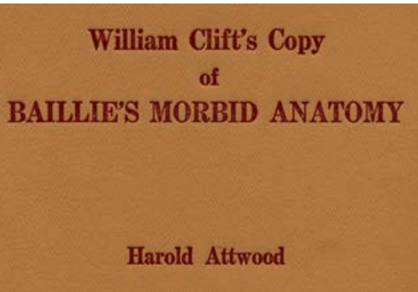
Matthew Baillie in an 'advertisement' stated: *"No work has been published in this, nor, I believe, in any other country, in which the principal Morbid Changes of Structure, affecting the most important parts of the Human Body, have, as far as they admit of it, been illustrated by a regular Series of Engravings. I propose to publish two fascicules as a trial of the public's opinion the first of which comprehends the chief diseases of the Heart and of the Aorta near its origin, and the second, the chief diseases of the Lungs'.*

William Clift, who had worked with John Hunter during the latter part of his life, prepared 73 of the 74 drawings which subsequently were converted into engravings to enable multiple reproductions of the illustrations in printed form.

Kenneth Russell's discovery in the Melbourne University basement confirmed not only that this was William Clift's personal copy of the complete series of engravings, but also, that Clift had meticulously replaced 48 of the engravings with his original drawings. It subsequently transpired that the Royal College of Physicians in London holds a further 25 of

Clift's original drawings for 'Morbid Anatomy'.

Subsequently, due in large part to the endeavours of Harold Attwood, Melbourne University Press published



in 1986, a hand bound, limited-edition of 520 copies, reprint of the series of engravings "which are intended to illustrate", *'The Morbid Anatomy of the Human Body'*; where possible, the engravings are replaced with high-quality photographs of Clift's original drawings held both at Melbourne University and the RCP.

The Australasian College holds a copy of this most significant facsimile.

Images (clockwise from top-left): William Clift's original drawing of a rectal cancer from John Hunter's Museum: inserted in place of its engraving: note, margin of attachment; William Clift drawn by his son; Prospectus cover for Clift's Copy of Morbid Anatomy.

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Urgency of endoscopic retrograde cholangiopancreatography can be important, but not in this case

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

Case summary:

An elderly smoker with asthma was seen in emergency in the early afternoon with a one day history of epigastric pain radiating to the back. The patient was tachycardic but afebrile and the emergency department assessment was of sepsis secondary to pancreatitis or cholecystitis. A surgical opinion was requested.

An hour later the temperature was 39°C, white cell count (WCC) of 18,000, a raised lipase and abnormal liver function tests (bilirubin 51). Over the next six hours the patient was resuscitated but remained febrile, tachycardic and the blood pressure labile. In the early evening a general surgeon assessed the patient and noted the cholangitis and plans for computed tomography (CT), endoscopic retrograde cholangiopancreatography (ERCP) and the intensive care unit (ICU). There is a note indicating discussions were held with a radiologist who declined a CT and suggested ultrasound the next morning. Following prepresentations by a consultant surgeon a CT was eventually performed and reported large gallstone with cholecystitis, pancreatitis with peripancreatic oedema and a 9 mm common bile duct (CBD) but no obvious CBD stone. Later that night the gastroenterology registrar suggested 12 hours of intravenous (IV) antibiotics followed by ERCP. Sometime after this the patient was admitted to the ICU.

The following morning the patient underwent ERCP. The procedure was difficult due to oedema and swelling, and cannulation of the CBD was impossible. Pus was seen extruding from the papilla and a knife papillotomy was performed. It was suggested repeat ERCP or surgery should be considered. *Escherichia coli* was identified on blood cultures and was sensitive to Tazocin, which the patient was already receiving.

Over the next four days the patient's condition improved with antibiotics and ICU support, although ventilation was difficult due to a left pleural effusion. Liver function tests and inflammatory markers improved and a further ERCP was deemed unnecessary.

On the eighth day following admission the patient developed fresh per rectum bleeding. The patient was haemodynamically stable (Hb 92 g/L) and IV pantoprazole was commenced. Later that day there was a further bleed and surgical review suggested it was a diverticular bleed. The patient was transfused two units of blood. On the ninth day the nurse documented melena, however the patient remained haemodynamically stable, was off all inotropes and the haemoglobin (Hb) remained stable.

On the 10th day the respiratory condition deteriorated, the patient became hypotensive and the inflammatory markers increased. The Hb was 62 g/L and WCC 32,000. A further CT reported cholecystitis, peripancreatic oedema and bilateral basal consolidation. Bronchial aspirate grew *Escherichia coli*. Inotropic support was restarted and requirements increased during the next few hours. Following discussion with ICU, surgery, gastroenterology and the patient's family it was decided to cap treatment. Support was withdrawn on the 11th day after admission where the patient subsequently passed away.

Comment:

For patients presenting with septic shock the 'Surviving Sepsis Campaign' [1] urges source control within six hours of presentation. In this case, consideration was given to the timing of ERCP and it was suggested that the delay in performing ERCP may have contributed to the poor outcome. A single-blinded cohort study of 250 subjects with moderate to severe ascending cholangitis who underwent ERCP or pancreaticobiliary duct showed hospital mortality was less when biliary drainage was performed within 11 hours of admission, compared with more than 42 hours after admission.[2] There was no difference between 11 hours and 24 hours after admission in this study. I do not believe there is any evidence to state that an earlier ERCP would have altered the outcome in this case.

1 Dellinger RP, Levy MM, Carlet JM, Bion J, Parker MM, Jaeschke R, et al. International Surviving Sepsis Campaign Guidelines Committee; Surviving Sepsis Campaign: international guidelines for management of severe sepsis and septic shock: 2008. *Crit Care Med*. 2008;36:296-327.

2 Mok SRS, Mannino CL, Malin J, Drew ME, Henry P, Shivaprasad P, et al. Does the urgency of ERCP/PBD impact mortality and disease related complications in ascending cholangitis? *J Interv Gastroenterol*. 2012 Oct-Dec; 2(4):161-167.

The nRAH brings the future to Adelaide

DAVID WALTERS
South Australian Regional Chair

After 10 years of debate South Australian surgeons are about to embark on a new era when Australia's most technologically advanced and expensive hospital opens on September 5 this year. The new Royal Adelaide Hospital or "nRAH" will replace the venerable institution at the eastern end of North Terrace with its evolved patchwork of buildings ranging from historic neo-classical to tired mid-century brutalism.

The hospital opens during a period of state-wide health reform. *Transforming Health*, has seen the realignment of services, downgrading of facilities, future closure of hospitals and the rollout of a much-criticised electronic medical records system. Into this environment the monolithic, gleaming new hospital enters the fray. Designed for a 100-year life and to remain functional through a 1 in 500 year earthquake, this survivability was perhaps best illustrated by the empty nRAH awash with light as the rest of the state was plunged into darkness during last year's extreme weather event.

The new RAH will form the centrepiece of the state's $3.6 billion cluster of health and life sciences institutions called Adelaide Biomed City. This precinct will eventually host between 10,000 and 15,000 people and include university teaching and research facilities. The architecturally applauded SAHMRI (South Australia Health and Medical Research Institute) building is closely applied to the new RAH and will soon be joined by SAHMRI 2 housing Australia's first $80 million proton therapy unit for targeting inoperable tumours.

There has been a lot of hype surrounding the nRAH but whether or not you believe it is the "third most expensive building in the world"; it certainly will be an impressive edifice. The light filled single rooms; courtyard gardens, public art installations and food courts will surely wow the public. Moving through the cavernous spaces visitors will feel they have entered a 4-star hotel or an international airport. Approaching a "digital way-finding kiosk" they will obtain a specific map to assist navigating the 250,000 square metres of building. An important facility when you consider each of the 10 floors has the equivalent area of two football ovals. "Electronic appointment kiosks" will register outpatients with the swipe of a Medicare Card and reserve an appointment. Outpatients will be encouraged to wander the "retail precinct" or courtyards while awaiting a text message notification of their appointment. Inpatients will have access to a Wi-Fi nurse call system and be able order a meal or in-room entertainment through their bedside electronic device. In the background "Automated Guided Vehicles" will robotically transport linen, waste, meals and supplies throughout the hospital.

This is all very impressive but what can surgeons expect from the new Royal Adelaide Hospital? What does a "Super-site" for major emergencies and complex multi-trauma in South Australia look like?

Despite extensive consultation much of the detail surrounding the surgical service delivery is just starting to emerge. What we do know is that 36, of the potential 40, state-of-the-art "Technical Suites" will initially be commissioned. An often-promised Hybrid suite potentially retrofitted later. A typical theatre will have its expansive 65 square metre floor space uncluttered using the Maquet Satellite Ceiling Mount System. A hydra of pendants will project from a single point including automated shadow free LED lighting, picture-in-picture capable monitors to display critical radiological images and cameras for teaching or streaming of video elsewhere. Sixty ICU beds will receive patients and the Emergency Department complete with up to 70 treatment areas will be twenty five per cent larger. Controversially, there will be no robotic surgical system, with public robotic work still contracted to the private sector.

With a great deal of space given over to the inpatient and visitor experience there is a concern that Outpatient and Clinical Research areas may suffer. South Australia has a long tradition of using public hospital outpatients for surgical teaching and training. Chronically underfunded and over attended outpatient clinics are in the scope for rationalisation. This may account for why the 78 consulting rooms may appear comparatively cramped. It remains to be seen how a complex, emotive encounter with a patient, family members, a clinic nurse and students is conducted in these confines. In addition, how all the existing clinics will fit into the nRAH remains a dilemma administrators continue to grapple with. Outpatient clinics are well situated however, and will occupy the same level as medical imaging, pharmacy and pathology for ease of access.

The move to South Australia's largest infrastructure project will involve one of the most challenging periods for the state's health system. Decanting the Royal Adelaide Hospital during the "ramp down" and the 800-bed nRAH "ramp up" will be a multifaceted logistical exercise impacting the entire health system. It is anticipated that additional stressors will be imposed on front-line clinicians and nursing staff during this time.

Putting aside the longstanding arguments surrounding the economics of the structure and how it integrates into a stretched system, clinicians are perhaps anxious and excited in equal measure. One would hope that after the initial dislocation South Australian surgical services must ultimately benefit from this massive investment in acute care infrastructure.

Choosing Wisely New Zealand

RICHARD LANDER
Executive Director for Surgical Affairs (NZ)

In 2015, RACS established its Sustainability in Healthcare Committee with a focus on the long-term provision of high quality healthcare that is affordable and financially sustainable. As part of realising this, RACS has been actively engaged with Choosing Wisely initiatives on both sides of the Tasman, first in Australia, and more recently in New Zealand.

Choosing Wisely recognises that the capability of the public health sector to meet the healthcare needs of every individual is ultimately limited by finite resources. It is therefore important that the resources that are available are used effectively and not on tests, procedures or interventions which are of low or no value to patients.

Currently underway in 16 countries including Canada, the USA and the UK, the aim of the Choosing Wisely campaigns is to encourage health professionals and patients to work together to improve the quality of care that is delivered by limiting low-value practices and interventions. In New Zealand, the campaign is being run by the Council of Medical Colleges in partnership with the Ministry of Health, Health Quality & Safety Commission and Consumer New Zealand. It has quickly gathered support from many other health sector groups, including RACS.

Led by clinicians, Choosing Wisely is centred on helping patients make good choices regarding their care and focuses on areas where clear evidence shows that a test, treatment or procedure provides little or no benefit, or of low efficacy.

There are a number of factors which could contribute to health professionals ordering such services for their patients. These include the patient's expectations, a lack of consultation time, overall uncertainty and fear of missing a diagnosis or malpractice concerns, reimbursement incentives, the way health professionals were taught, or a desire to avoid the challenge of telling a patient they do not need a specific test or procedure.

Choosing Wisely New Zealand aims to limit these practices by encouraging patients to ask their health professionals these four questions:

- Do I really need to have this test treatment or procedure?
- What are the risks?
- Are there simpler, safer options?
- What happens if I do nothing?

By having these conversations, patients are empowered to make informed and evidence based choices regarding their own treatment.

Choosing Wisely New Zealand needs clinicians to develop specialty specific lists of tests, treatments and procedures that their specialty considers provide little or no benefit, and which clinicians and consumers should at least discuss before proceeding. As part of its commitment to the Australian campaign, RACS has already worked with General Surgeons Australia and the Australian Society of Otolaryngology Head and Neck Surgery to develop specialty lists.

RACS encourages New Zealand Fellows to work together and identify tests, interventions and surgical procedures in particular, which are of low value to New Zealand patients. By working together with the specialty societies, it is hoped that New Zealand surgeons can contribute a number of comprehensive lists specific to the Choosing Wisely New Zealand campaign.

For more information, visit the Choosing Wisely New Zealand website at www.choosingwisely.org.nz.

Robotic "snake" a game changer for ENT

A group of ENT surgeons in South Australia is now using a state-of-the-art "snake-like" robotic system that allows them to treat complex throat cancers as they would a simple tonsillectomy.

The first of its kind in the Southern Hemisphere, the Medrobotic Flexible Robotic system is now being used at the Memorial Hospital in Adelaide and was introduced earlier this year by leaders in ENT robotic surgery Dr John-Charles Hodge (pictured, above) and Professor Suren Krishnan.

Dr Hodge conducted the first ENT procedure using the new robotic system in January this year. A further seven procedures have since been conducted by the team.

A pioneer in the introduction of the DaVinci Robotic System for ENT procedures, Dr Hodge described the Medrobotic Flexible system as an "absolute game changer" for the specialty of Otolaryngology Head and Neck Surgery.

Worth about $1 million, the robot consists of a high definition 3D camera attached to a singular flexible serpentine-shaped arm that allows surgeons to navigate nonlinear anatomical regions in the head and neck.

> *"Not many people think of Adelaide as a world leader in medicine but we are only the eighth unit in the world to be using this system. We are providing world leading care and world class training."*

Dr Hodge said the benefits of this particular robotic system are centred on its flexible single port technology which allows access to previously inaccessible locations such as the larynx and nasophyranx. He said that since it had been developed for the ENT market the instruments were delicate enough for the confined spaces in which they are used, facilitated by high definition 3D optics. Ease of transportation between theatres had also maximised its accessibility for multiple surgeons.

Robotic operating systems in ENT had allowed surgeons to reduce operative times for malignant oropharyngeal tumours from 12 hours to three hours, with shorter hospital stays, less pain and morbidity and improved functional outcomes when compared to traditional open techniques.

The system was also proving its worth in multi-level sleep surgery and was being trialled for laryngology procedures, he said.

"When we operate in the mouth we always confront line-of-sight and access limitations and in the past the difficulties we confronted in accessing and excising these tumours with open procedures contributed to abysmal functional outcomes for oropharyngeal cancers," Dr Hodge said.

"In the days before robotics, patients with such tumours often had to endure an open neck dissection and reconstruction that could take up to 12 hours, be in hospital for weeks and then have to go through toxic adjuvant therapy.

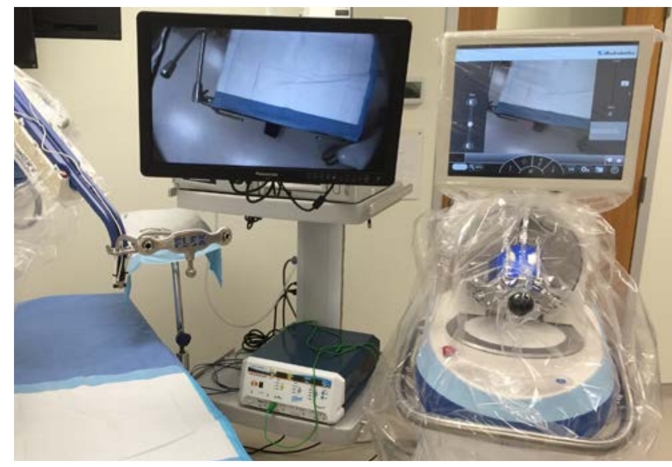
"Up to 30 per cent of these patients never effectively swallowed again. This led to the development of non-surgical treatment protocols which still left ten per cent of patients unable to swallow. Robotic technology has led to the pendulum swinging back in favour of trans-oral surgical protocols for these patients, with the goal being the de-intensification of adjuvant toxic treatment such as radiation treatment and chemotherapy. The severe swallowing dysfunction following these robotic protocols is now very low.

"More recently we have seen the emergence of HPV related oropharyngeal tumours and have found that the DaVinci robotic system was particularly useful in treating these. Lacking the field cancerisation of smoking related cancers and hence the issues with second primaries, the overall survival rates with treatment are much higher in a younger age group. The importance of good functional outcomes following oncological success is much more important as a result, given the four times higher survival rates.

"However, that system requires having three instruments in the mouth – one camera and two instruments - and that triangulation of instruments is limited by the aperture of the mouth and therefore limits distal access. This issue is circumvented by the new Medrobotic Flexible system as it has only one endoscopic camera arm that is articulated like a snake. Two flexible instruments fit down sleeves alongside the camera port.

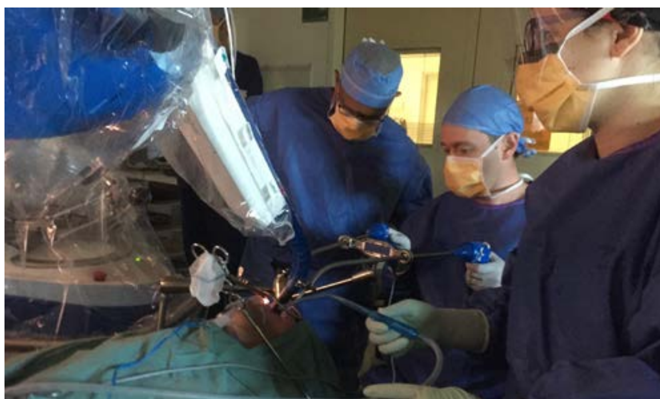
"This advantageous technology means more patients have their tumours accessible for trans-oral excision. With favourable pathology the patient may not even need any adjuvant treatment with uni-modality surgery sufficient. This allows a return to work within a few weeks rather than six to nine months required off work with chemoradiation protocols.

"It's an absolute game changer for our specialty and an amazing piece of kit."



Images (from left): Professor Suren Krishnan and Dr John-Charles Hodge; the Medrobotic Flexible Robotic system.

Dr Hodge completed his basic surgical training in the UK before immigrating to Perth to undertake advanced ENT training and received his FRACS in 2007.



He completed a further two years of specialist training focusing on Head and Neck cancer, snoring and obstructive sleep apnoea surgery and diseases of the salivary glands and thyroid. His robotic accreditation was undertaken in the US at the University of Pennsylvania under Professor Greg Weinstein.

Currently the Chairman of RACS Head and Neck Section, Dr Hodge works out of the Royal Adelaide Hospital, St Andrew's Private Hospital and the Memorial Hospital.

He trained in the use of the Medrobotic Flexible system in Boston under the supervision of Professor Umamaheswar Duvvuri, a global leader in ENT surgical robotics at the University of Pittsburgh's Centre for Advanced Robotics Training.

He has also presented on this new technology, delivering the keynote robotic speech at the Australian Society of Otolaryngology Head and Neck Surgery in March this year.

Dr Hodge said that Professor Duvvuri would be visiting Australia in November to lead a unique cadaveric training course using the new robotic system for ENT surgeons at the South Australian Health and Medical Research Institute at Gilles Plains.

He thanked the leadership team at the Memorial Hospital for having the vision to fund the purchase of the system and said that it meant that Australian surgeons no longer had to travel halfway around the world for training which would benefit patients across the country.

He said that the establishment of a training centre in Adelaide meant that training of other surgeons had become much easier. With both Prof Krishnan and Dr Hodge accredited in this new technology, Dr Andrew Foreman and Dr Michael Switajewski have now had their first cases proctored while Dr Guy Rees and Dr Sam Boase will also soon be on board.

"Not many people think of Adelaide as a world leader in medicine but we are only the eighth unit in the world to be using this system. We are providing world leading care and world class training," Dr Hodge said.

"The reality is that any Head and Neck surgeon with serious professional intent needs to have robotic surgery as part of their clinical armamentarium. The issue currently with the DaVinci system is its lack of accessibility to ENT surgeons.

"The mobility and portability of the Medrobotic system means that in one hospital it can be used in any theatre, on any surgeons list throughout the day. It has a quick setup time and also provides an excellent view for other theatre staff and requires no assistant.

"This technology will continue to improve with cameras further miniaturised which will allow us to access even smaller anatomical areas. Competition in the market will only fuel more exciting future developments with the next technological advancement for the Medrobotic system likely to be roboticized instruments."

Dr Hodge said that while the Medrobotic Flexible Robotic system was now only available to treat private patients, he hoped to find the funding in the future to allow for a public patient list, such as exists for Royal Adelaide Hospital patients treated at St Andrew's private hospital with the DaVinci robot.

– With Karen Murphy

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Linking Billroth & Brahms
The Surgery & Music Analogue

OPUS XLVII

FELIX BEHAN
Victorian Fellow

Plato once said over two millennia ago: *'Music is a moral law, it gives soul to the universe; and wings to the mind with flights of the imagination adding charm and gaiety to life'*. In the modern era one cannot but enjoy the opulence of Offenbach's Gaîté Parisienne and its melodic flavours linking rhythm, melody, harmony and then Schubert's Trout.

Music and surgery share common traits where the technical refinements of the musician emulate the surgical style. This was the association Billroth had with Brahms. Their interaction became the basis of their friendship because music and surgery share a common analogue of timing and technique.

My surgical life has evolved around my work mellowed by musical interludes. It helps to balance the mind in a busy career even at home, often to my wife's chagrin.

In *Surgical News,* tales of surgical reflection are the basis of these reminiscences. These texts need constant review to make them more readable; that is, before the e*ditorial red pen* plays its part.

Repeat drafting is an attempt to achieve refinement, a trait that characterised that 19th Century Literary Master, Marcel Proust. In Paris I would often pass his house, near rue Malesherbes off the rue Haussman, by Garnier's edifice, the Paris Opera and the boutique shops of Galerie Layfayette in 8th Arrondissiment. Don Marshall mentioned recently that his brother, Vernon was slowly absorbing that famous Proust volume: À La Recherché du temps perdu – a memory trail *"In Search of Lost Time"*. One of the classics of the 20th century they say warrants a position in any important library between Shakespeare and The Bible. Proust captures his childhood memories and adult experiences over 4,022 pages reflecting the society of the day from the Ritz downwards. He was a perfectionist who reworked his texts endlessly.

My first draft on Billroth, began in late January 2017, on Australia Day when the ABC FM announcer mentioned incidentally that Billroth was not only a friend of Brahms, and an eminent surgeon but also a plastic surgeon. This ignited my imagination about this music-loving personality who was to become the Father Figure of modern day surgery.

With Billroth's death on 6 February 1894 I commenced **my second draft** on that anniversary day. I needed some historical information and phoned my former surgical mentor in Brisbane, Brian Courtice, then in his 96th year. He had become an expert in surgical history with a large number of Billroth's tomes. In the 1960s he introduced me to the art of general surgery in my early phase of surgical development at the Royal Brisbane Hospital (RBH). His unit was the most prized for all budding surgeons. John Graff, his contemporary said to me recently that Brian Courtice was one of the most competent and accomplished general surgeons. His abdominal wound closure technique produced outstanding results, a trick he learnt from one of his own mentors, George Brandis. This continuous nylon eversion suture achieved dermal apposition with epidermal seal. I have modified this in a plastic surgical manner with periodic loops applying it universally including the face. My Registrars in Melbourne over the years, call it the 'Behan Suture" – but I was merely "standing on the shoulders of a giant" to quote Newton.

Don Marshall reminded me recently of his earlier experiences at the RMH. He was one of the few to gain his Primary FRACS in his first year of graduation with Gabriel Kune and Ken Myers. The three plum jobs at the RMH - Plastic Surgery, Thoracic Surgery and Neurosurgery – were theirs for the asking. Don, working with John Hayward, recalled his famous statement: *"Sister give me what I need, not what I ask for"* in any tight situation. Once in Papua New Guinea (PNG) Don was operating with John in the New Guinea Highlands doing a Patent Ductus via a thoracic exposure. All hell broke loose when the Artery Clip slipped off its connection. Blood gushed everywhere. John's surgical dexterity of using sutures to retract and elevate the open margins of the wound of the vessel, sequentially achieved haemostasis. Don's assistance gained John Haywood's admiration who then invited him to follow a career in Thoracic Surgery (which he almost did). On another tack about surgical dexterity and presti-digitation Oliver Beahrs from the Mayo Clinic was visiting Australia at the RBH in the late 60's. He was closing a difficult abdomo-perineal resection before the staple era. Somebody incidentally remarked that his technique was *magical*. He explained that his part time hobby on weekends was doing conjuring tricks for his grandchildren.

My career in Plastic Surgery commenced when I wrote to Benny Rank in Melbourne during my Courtice term asking his advice for training in Plastic Surgery and in his positive response he said simply "Get your Primary FRACS and join us at the Victorian Plastic Surgery Unit (VPSU). This I managed.

In those regular conversations we had, Brian would reminisce about his overseas experiences, from studying the Fellowship in 1947 at the Royal College of Surgeons at Lincoln's Inns Fields, being freely tutored by Raymond Last at the College, then with Dickson Wright of the Middlesex Hospital, before joining him in private practice after their NHS commitments. Let us not forget that Dickson Wright helped to re-awaken the importance of a Carpel Tunnel Syndrome release initially published by Learmonth in 1933. However from the clinical experience of Russell Brain of Queen Square Dickson Wright published his series of Carpal Tunnel release in the BMJ in 1947. This Neurological link to Queen's Square may explain why many Neurosurgical Lists commence with a Carpal Tunnel release.

Images: State Library of Victoria

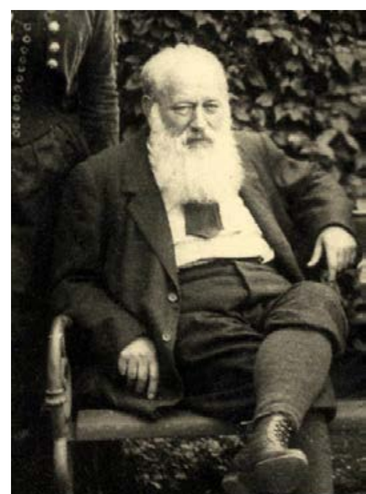
Johannes Brahms

Brian's retiring occupation was his medical library and filing documents there while enjoying the social exchange and love with Judy, his wife of 60 years. On many occasions, when I phoned he would be out raking the garden leaves in his Indooroopilly home indicating that he was still physically active. Judy incidentally, on reviewing my draft could not help remarking about Brian's interest in Proust.

In his last bundle of correspondence about Billroth - I repeat, the Father of Modern Day Surgery, Brian could recount his life story as a doctor from 1853-1860. Being a slow learner he eventually became apprenticed to Carl Langenbech of "L" retractor fame. His text book of *General Surgical Pathology and Therapeutics* of 1863 is a classic. He even introduced Mortality and Morbidity meetings where all complications were openly discussed. Now Quality Assurance assessments have adopted this same principle and Brian Collopy has been the one to carry on this mantle academically.

Billroth's 'firsts' in surgery are documented in Brian's correspondence – esophagectomy in 1871 presumably mobilising the cardia to achieve anastomosis; the first laryngectomy in 1873, and most famously the first gastrectomy in 1881, presumably under chloroform and cocaine. Brian could still recall the details of a Billroth I procedure attached to the duodenum and a Billroth II to the jejunum. These general surgical principles I knew for my Fellowship exams in 1970 but now lost in the mists of time. I did my last appendix at PANCH at 1970 with John Upjohn and when recounting this rewarding phase to Benny Rank at the VPSU, his response was cryptic, "Son, you now realise that the Plastic Surgeon is someone who has completed their training"

Now let's turn the page to focus finally on Brahms, whose musical importance in the 19th Century is not insignificant and some say the last of the great Romantic Composers. He was a close friend of Billroth in Zurich before both moved to Vienna. The amateur violinist played like a professional and even Brahms would seek his advice in various musical compositions before publication and trial rehearsals. Our modern day protégé Miklos (Miky) Pohl, of Hungarian background, coming to Australia at 6 years of age becoming a Plastic Surgeon in Sydney, Hobart and London and then established the Australian and European Doctors' Orchestra. He plucks the strings of a violin like a Paganini while operating as a Plastic Surgeon with the same dexterous refinement.



Dr Theodor Billroth

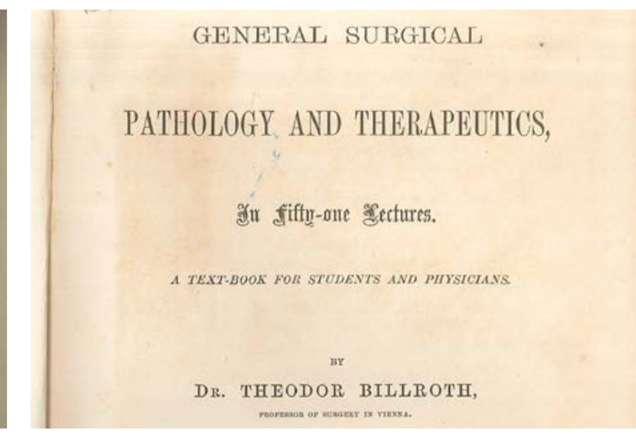
Draft III in this Billroth reminiscence is significant. I was in the middle of collating these items into a readable text when the sad news came through that Brian's parting on 21 March 2017 appeared in the Death Notice of the Courier Mail in Brisbane. Perhaps these were the last letters he wrote and I will propose they should be part of the memorabilia of the Cowlishaw Collection with its bibliotheca (library) documents.

In finale, this leaves only one thing for me to say by way of conclusion. I quote from the elegiac poem of Catullus of 50BC:

Vale Atque Vale - Hail and Farewell.

This sums up my feelings about this great surgical mind, my mentor and I must recall the words of Mark Smithers who recently said to me – "Brian was a Surgeon's Surgeon"..

Miklos Pohl – the surgical violinist at the Berlin Science Museum embracing Billroth (in marble of course).


GENERAL SURGICAL

PATHOLOGY AND THERAPEUTICS,

In Fifty-one Lectures.

A TEXT-BOOK FOR STUDENTS AND PHYSICIANS.

BY

DR. THEODOR BILLROTH,

PROFESSOR OF SURGERY IN VIENNA.

A copy of Billroth's General Surgical Pathology and Therapeutics can be found at the RACS Library.

SNIPPETS AND SILHOUETTES

VASM's mission to achieve Target Zero

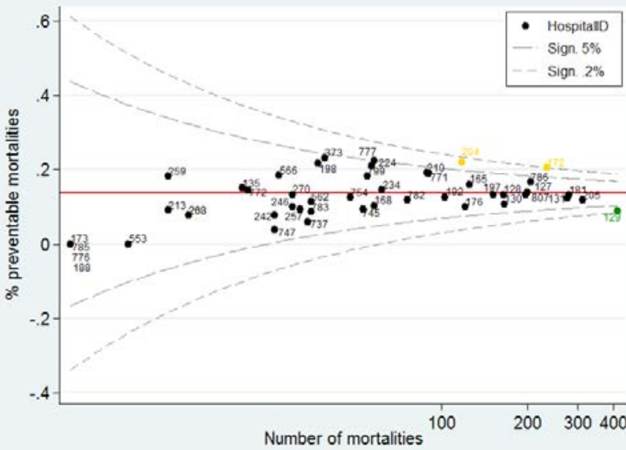
BARRY BEILES
VASM Clinical Director

The Victorian Audit of Surgical Mortality (VASM) is part of the Australian and New Zealand Audit of Surgical Mortality (ANZASM), a national network of regionally-based audits of surgical mortality that aims to ensure the highest standard of safe and comprehensive surgical care. The Audits of Surgical Mortality (ASM) monitor trends in mortalities and clinical management outcomes.

The Targeting Zero report (formerly known as the Duckett review) which was released on 14 October 2016, assessed the department's systems for all in-hospital care in both the public and private sectors. This can be accessed via https://www2.health.vic.gov.au/about/publications/researchandreports/report-of-the-review-of-hospital-safety-and-quality-assurance-in-victoria. Implementation of the Target Zero review recommendations aim to produce improvements in identified areas of deficiencies, and the VASM has been identified to play an important role in the revised Safer Care Victoria structure.

The VASM has recently released its ninth Annual Report. In this report the VASM presents the outcomes of the review of 3,984 deaths from 1 July 2012 to 30 June 2016. In the current VASM Annual Report, trends relating to clinical risk management show overall improvements in some key areas of patient surgical care.

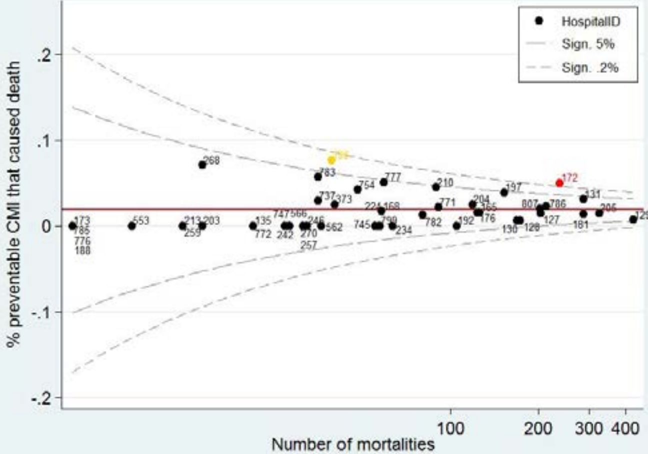
Figure 1: Cases where the death was considered potentially preventable (flag 0.2% and 5% significant contours above Victorian average 13.7%).



Note: Potentially preventable mortality outcomes only collected in Victoria. Cases have been selected as those which assessors (the highest level assessor per case) deemed to probably or definitely cause the death of the patient. Hospitals with less than 5 cases have been excluded. This report groups all hospitals irrespective of their size and does not take into consideration surgical specialties or procedure types. Risk adjustment is not relevant for preventable issues as determined by the assessor, as these are independent of case-mix and demographics.

- greater than three standard deviations above the Victorian mean of cases with preventable outcomes, warrants further investigation.
- greater than two and less than three standard deviations above the Victorian mean of cases with preventable outcomes, may warrant further investigation.
- greater than two standard deviations below the Victorian mean of cases with preventable outcomes, appears not to warrant investigation.
- greater than three standard deviations below the Victorian mean of cases with preventable outcomes, appears not to warrant investigation.
- within two standard deviations of the Victorian mean of cases with preventable outcomes, appears not to warrant investigation.

Figure 2: Cases with potentially preventable clinical management issues (flag 0.2% and 5% significant contours above national average 14%).



Note: Preventable clinical management issues data point collected nationally. CMI: Clinical management issues.
Cases have been selected as those which assessors (the highest level assessor per case) deemed to probably or definitely cause the death of the patient. Hospitals with less than 5 cases have been excluded. This report groups all hospitals irrespective of their size and does not take into consideration surgical specialties or procedure types. Risk adjustment is not relevant for preventable issues as determined by the assessor as these are independent of case-mix and demographics.

- greater than three standard deviations above the national mean of cases with a preventable CMI, warrants further investigation.
- greater than two and less than three standard deviations above the national mean of cases with a preventable CMI, may warrant further investigation.
- greater than two standard deviations below the national mean of cases with a preventable CMI, appears not to warrant investigation.
- greater than three standard deviations below the national mean of cases with a preventable CMI, appears not to warrant investigation.
- within two standard deviations of the national mean of cases with a preventable CMI, appears not to warrant investigation.

Along with other jurisdictions and through peer review process, the VASM has identified the following clinical management issues as ongoing areas for improvement:

- delay in diagnosis and treatment, including better detection and management of the deteriorating patient,
- poor communication between health professionals, especially for coordination of patient care, and
- decision to operate rather than palliate.

The recurring errors in clinical management issues are driving the VASM to refocus on its educational role in disseminating lessons learned to clinicians, and using its publications to drive further improvements.

The VASM released the first series of the national individualised Hospital Clinical Governance Reports in 2014, and the most recent series was disseminated in December 2016.

A new VASM publication, the Hospital Surgical Performance Summary Report, will enable a comparison of hospitals in terms of potentially preventable mortalities and preventable clinical management issues that contributed to death. Included in this report are funnel plots; a visual tool to investigate bias in meta-analysis. These have been modified to present an easily visualised graph for comparing hospital health outcome performance. They are scatter plots of the adverse outcome estimated from individual studies expressed as a percentage (y-axis), against a measure of study size (x-axis). On the scatter plot, 95% (2SD) and 99% (3SD) confidence limits are superimposed.

The funnel plot is based on the precision in the estimation of the underlying treatment effect increasing as the sample size of component studies increases. This is why the smaller sized samples have wider confidence intervals. For this reason they have been selected as the methodology for the VASM data instead of a table approach. Figure 1 and 2 are a sample of how these performance tools will be presented.

There is a subtle but important difference in preventability of management issues that might be responsible for the death of a patient as opposed to issues identified in a mortality case identified as potentially preventable, therefore the traffic lights shown in the figure legends for hospital performance might vary for each of these criteria.

These reports will assist the VASM audit, RACS, Safer Care Victoria from the Department of Health and Human Services and hospitals to develop strategies to address preventable errors and clinical management issues. These reports are to be used in combination with other comprehensive clinical performance data sets and supplementary performance reports to monitor and improve patient safety in Victoria.

To read more about VASM's findings visit: www.surgeons.org/VASM

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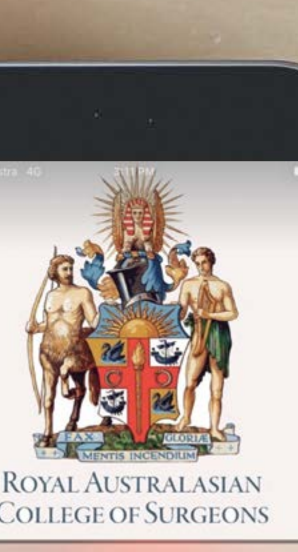


Advances in Neurosurgery during WWI

The legacy of Dr Harvey Cushing

PROFESSOR JEFFREY V. ROSENFELD AM, OBE
FRACS
Major General. Former Surgeon General-Reserves, Australian Defence Force

I write this article in Iraq whilst I am deployed with the Australian Defence Force. I am proud to wear the uniform of the Australian Army and serve in the Royal Australian Army Medical Corps. I am privileged to be working in a US Combat Support Hospital with its talented and committed hospital staff. Being here is a stark reminder of all the Australian and New Zealand men and women who have gone to war before me. I was privileged to attend a poignant and moving Anzac Dawn Service followed by a 'gunfire breakfast' here on base. US and Canadian troops joined the Aussies and New Zealanders. We remembered the deaths of the young Australian soldiers who served in the Middle East and Afghanistan over the last decade or so as their names were read out. All their names are also displayed on their individual plaques at Camp Baird, the Australian Middle East Headquarters. Corporal Cameron Baird was an Australian soldier who won the Medal of Gallantry and the Victoria Cross in Afghanistan and was killed in action 22 June 2013.

Neurosurgery was not a distinct surgical sub-specialty in 1914. General military surgeons treated the penetrating head and spine wounds. Sir Victor Horsley (1857-1916), a pioneer of neurosurgery and a consultant surgeon in Egypt at this time, was critical of the chaotic medical services and the shortage of nurses. He complained that the public in the UK were being kept in a 'fool's paradise' and did not know what was going on. He also stated to his wife that 'Anyone would suppose it was the wounded's own fault they got injured'.[1]

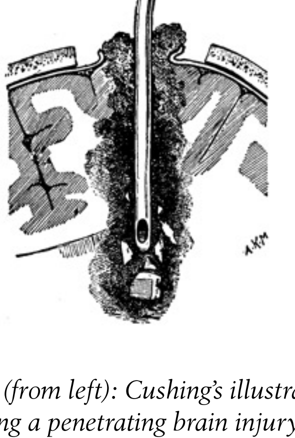
The Base or General Hospitals in WWI had x-ray machines, and better anaesthesia and instruments than the Casualty Clearing Stations - casualties from the battle front were first received in these units. Radiographs were first used in the field in the US War with Spain in 1898 and plain radiographs were available in the Australian General Hospital (AGH) on Lemnos.

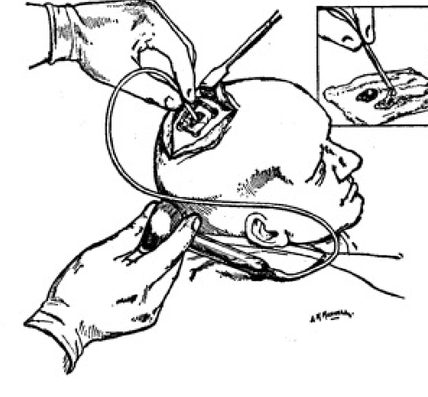
Military health care provision during the Gallipoli Campaign was marred by poor leadership, gross underestimates by the planners of likely casualties, inadequate provision of medical resources both on the Gallipoli beaches and at the destinations for evacuation, unsanitary conditions resulting in dysentery outbreaks, poor diet, inadequate shelter, and loss of medical personnel due to enemy fire.[1] Turkish gunners would have killed many Australian soldiers due to penetrating head wounds. For those who survived the head wounding, shell dressings were applied by the Medics. Many casualties were brought, often over the back of mules guided by Medics such as Private John Simpson Kirkpatrick, to the Casualty Clearing Stations on the beaches. Casualties were then evacuated by transport ships to Mudros on Lemnos island and Alexandria, Egypt. In the first ten days after the April landings, 16,000 sick and wounded men arrived at Alexandria.[1] Soldiers with more superficial shrapnel wounds, compound fractures of the skull, tangential bullet wounds and concussion were most likely to reach the care of the military surgeons at this time. More severe grades of neurotrauma due to penetrating craniocerebral bullet wounds would have had a high mortality. Delayed sepsis also killed many. The head was vulnerable to injury in the trench warfare of WWI. Steel helmets were introduced by the French in 1915 - these offered some protection from shrapnel injury but not rifle bullets. The Germans followed with *der Stahlhelm.*[2]

Image: Dr. Harvey Cushing dressed in US Army Uniform serving on the Western Front in WWI.

The American surgeon, Dr. Harvey Cushing (1869-1939) served on the Western Front in WWI and had a profound influence on the management of penetrating craniocerebral head injury. He was a principal figure in the development of neurosurgery as a specialty and is regarded as the father of modern neurosurgery. He classified head injury and was a pioneer in 'mission rehearsal' by setting up a military hospital in Boston before deployment. He developed surgical techniques of craniectomy, cerebral debridement, techniques of haemostasis in neurosurgery and dural closure. He used local anaesthesia for most cases, with or without morphine supplement.

Cushing brought neurosurgery closer to the frontline and developed the 'all or nothing rule'. He stated that a delay of 2 to 3 days to get to specialist was better than recovering from an incomplete procedure before transportation. We no longer follow this rule because current military practice is to bring the neurosurgeons forward in Combat Support Hospitals (NATO Role 3) and transportation times with aeromedical evacuation are much shorter. Over a 3 month period in 2017, Cushing and his team operated on 133 soldiers with a brain wounds. Cushing was able to reduce the mortality of penetrating brain injury from 78 per cent to 28.8 per cent which was in the pre-antibiotics and pre-diathermy era!





Images (from left): Cushing's illustration of the rubber catheter technique for debriding a penetrating brain injury; The Catheter is attached to a bulb for suction and fragments of bone, metal and blood clot are progressively extracted.

There is still a high mortality for gunshot wounds to the head. Aarabi et al recently reported that of 786 patients with gunshot wounds to the head, 712 (91 per cent) died and only 74 (9 per cent) completed acute care in trauma centres.[3]

Cushing also described subtemporal decompression for the intracranial complications associated with bursting fractures of the skull in 1908. He advocated *en bloc* removal of involved bone, aggressive débridement of the brain and extraction of bone fragments.[4,5] Both Cushing and Horrax emphasized additional peri-operative procedures including shaving the scalp, patient positioning and overall aseptic technique. Cushing also advocated water-tight closure of the scalp, a procedure which was not universally practiced during WWI.

WW Keen (1837-1932) performed surgery in American Civil War and published 'The treatment of war wounds' in 1917 at age 79 years. He endorsed Cushing's teachings. Keen and Cushing's principles included the use of muscle for haemostasis (Horseley's technique), dural closure, cranial decompression, siting surgical incisions away from the bullet or shrapnel entry wounds and the extraction of foreign bodies from the brain albeit within limits. Many of Cushing and Keen's principles are still followed today. Cushing also kept a detailed diary of his experiences which is still today is interesting to read.[6]

Cushing did not have an unblemished service record. It would appear that he was not easily able to follow military orders and was almost sent home for insubordination. It could also be argued that Cushing also did not adequately acknowledge his forebears in terms of the management of penetrating brain injury. There was already published experience from the Boer war and by the French and Germans in WWI which would have influenced Cushing.[7]

Australian surgeons serving during the Gallipoli Campaign were treating head, spine and peripheral nerve injuries. Australian surgeons such as Henry J Newland, James A Dick, Piero FB Fiaschi, and Henry A Powell all went from Gallipoli to serve in Australian Military Hospitals in France.[8] Fiaschi, became a pioneer in the use of saline for hypovolaemic shock whilst in France.[8] These Australian surgeons would have been directly influenced by Cushing who visited the 1st Australian General Hospital in France later in 1917. Cushing already had an influence on the practice of neurosurgery before WWI. Newland had visited Harvey Cushing at Johns Hopkins Hospital in Baltimore before WWI and would have been influenced by Cushing following this visit.[8] Interestingly, Newland later became President of the Royal Australasian College of Surgeons (1929-35). A 6 week neurosurgical course for 230 American military surgeons developed during WWI. The civilian neurosurgical training system in the USA evolved from this course.[9]

In the Iraq and Afghanistan wars of the 1990s to the present there has been an increasing use of more powerful bombs with soldiers frequently being close to the epicentre of the blast, either mounted in vehicles or dismounted on patrol. The basic science and pathophysiology of blast and penetrating injuries is better understood than previous wars. There has been increased survival from these severe blast injuries because of immediate resuscitation by skilled combat medics in the field, rapid evacuation to far-forward combat support hospitals for further resuscitation and initial wound surgery and early evacuation to in-theater advanced field hospitals where neurosurgery and other specialty surgery is performed. More extensive craniofacial injuries due to bomb blast were also being encountered by military neurosurgeons. A more aggressive approach to the head and neck injury and the other extensive injuries is required to save lives and obtain the best outcomes.[10]

As you read this article I invite you to reflect on the courage and sacrifice of all the Australians and New Zealanders who have placed themselves in harm's way in arduous and dangerous conditions overseas to protect Australia and New Zealand from our enemies and help to preserve the freedoms we enjoy today and often take for granted. May we also remember all those brave souls who paid the ultimate sacrifice in past wars. Lest we forget!

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IN MEMORIAM

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

Donald Cam (NSW)
Solomon Levitt (WA)
John Reimer (NSW)
James McKinnon Watts (SA)

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

Informing the College

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

ACT: college.act@surgeons.org
NSW: college.nsw@surgeons.org
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In Memoriam

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

James Russell Fergusson Downie General Surgeon

1932 - 2017

James Russell Fergusson Downie (Jim) was born on 5 November, 1932 to George and Gertrude Downie at St Georges Hospital, Kew. He spent his childhood in Auburn attending school firstly at Auburn South Primary School, then Gardenvale, the Melbourne High School where he matriculated with distinction. This led to his study of medicine at the University of Melbourne. He is remembered as being a very high achiever there.

In 1956 he married Betty Ashton and in 1961, Jim gained his Fellowship of the Royal Australasian College of Surgeons. He then travelled to England with Betty and young son Paul, working as ship's doctor to enable him to undertake further studies and qualify for admission to the Royal College of Surgeons of England. On return to Australia, Jim began his work at the Austin and for a time also at Prince Henry's and Repatriation Hospitals and a second son, Peter was born.

William (Bruce) Conolly Orthopaedic Surgeon

1 February 1935 - 21 February 2017

An impressive funeral was held in Sydney on 6 March, in the city's oldest Anglican church, St James, for a special doctor who had found a new calling late in life helping disabled people in Myanmar.

Associate Professor Bruce Conolly was the driving force behind Sydney University Hospital's world-renowned "Hand Unit", the first of its kind in Australia, and for which he was awarded a Member of the Order of Australia (AM) in 1994. After his notional retirement from medical practice in 2013, Bruce Conolly and his wife Dr Joyce Conolly, set up the Myanmar Australia Conolly Foundation as a humanitarian organisation with the aim of improving medical education in Myanmar. Although they had both worked in a number of countries, they only made this special commitment for Myanmar.

Solomon Levitt General Surgeon

1927 - 2017

It is with great sadness that we acknowledge the passing of well-known and highly regarded Sir Charles Gairdner Hospital (SCGH) clinician Mr Sol Levitt on 16 February 2017.

As the first General Surgeon appointed to SCGH after its commencement as a General Hospital in 1958, Mr Levitt was an outstanding clinician and mentor to many of Perth's surgeons.

Following his graduation from the University of Adelaide Medical School, Mr Levitt began a career in surgery and while working in London at St Mark's Hospital, he developed a career-long interest in Familial Adenomatous Polyposis (FAP) and later established Australia's first FAP Registry in Perth.

James McKinnon Watts General Surgeon

27 August 1932 - 19 May 2017

Jim Watts was born in Bendigo, Victoria. Following primary schooling in country Victoria he attended Geelong College where he excelled and graduated as dux of his class in 1950. He went to the University of Melbourne where he graduated MBBS in 1956. His residency years were at the Royal Melbourne Hospital where initially he became interested in specializing in medicine. However appendicitis intervened at the time those selections were made and surgery it became. He was appointed surgical registrar at the Alfred Hospital in Melbourne and was awarded the distinction of FRACS in General Surgery in 1962.

Jim had an interest in clinical research from the outset and in 1962 to 1964 worked in the Department of Surgery headed by John Goligher in Leeds UK. He held the positions of Surgical Research Fellow and then Lecturer in Surgery.

RACS Complaints Snapshot

RICHARD PERRY
Chair, Professional Development and Standards Board

Quarter 1, 2017

RACS has invested in a centralised complaint database for the recording and management of complaints. All complaints are referred to the Manager, Complaints Resolution for registration, assessment, triage and assigning to the appropriate person for action. Actions taken in the management of complaints are recorded. The dedicated database serves as a repository for all complaints. De-identified data is collated and relevant systemic trends are reported to inform continuous improvement initiatives. A summary of complaint metrics for 2016 has been published in the *Building Respect, Improving Patient Safety* (BRIPS) progress report. Surgical News will now feature a quarterly complaints snapshot.

There has been a 25 per cent increase in the rate of reports received in 2017 to date when compared with 2016. This is likely a reflection of increased awareness of the RACS complaints framework.

Source of Complaints 2017

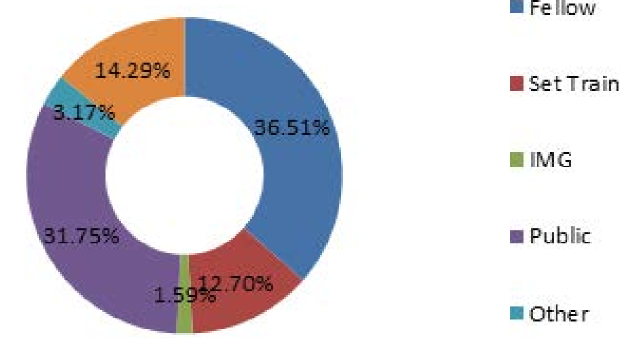
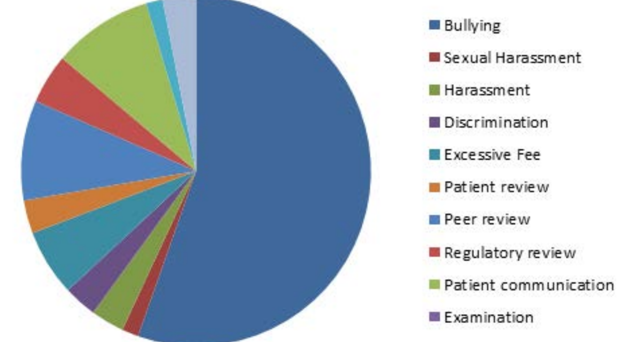


Chart 1: demonstrates the distribution of complaints received by source.

Gender distribution analysis indicates that the vast majority of reports received were from males; not a surprising result given the gender distribution across the profession. This may progressively alter with a greater focus on diversity.

Complaint themes are broadly divided into two categories - Professional Standards; and Education, Training and Assessment. Bullying remains the prevailing complaint theme and no surgical specialty has been immune from complaints.

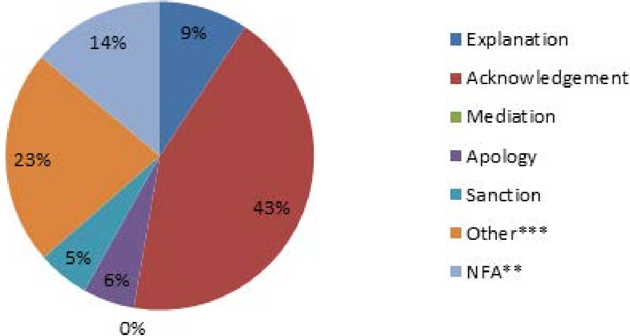
Distribution of reports 2017



65 complaint reports were recorded in the first quarter of 2017.

Less than a third of these progressed to formal complaints. Many reports have been resolved with registration and acknowledgement of the issues raised, explanation or an apology. Less than 5 per cent of substantiated complaints have resulted in a level 1 sanction under the RACS Sanctions Policy.

Outcome of all closed reports to date



This chart reflects all closed reports Jan 2016 – April 2017

Less than 10 per cent of all reports received have been from anonymous complainants. However many complainants continue to report confidentially preferring to have their concern registered but not progressed with the respondent.

What's next?

The foundations have been established and in 2017 we will continue to fine tune our processes, monitor and report on complaint trends. RACS anticipates the number of complaints received will continue to grow as awareness and confidence in the confidentiality of our complaints framework grows providing our membership and the public the confidence to call out unacceptable behaviours.

We thank you for your continued support of the *Building Respect, Improving Patient Safety* Action Plan.

Our sincere thanks to these incredible bronze donors for their kindness and generosity in supporting the Foundation for Surgery at the Annual Scientific Congress

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Professor Peter Gilling CNZM FRACS

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