



SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 18 NO 5

JUNE 2017

ASC 2017

In a New Yorker
state of mind

ICOSET 2017

Rethinking Surgical Training:
Highlights & Reflections



LET'S OPERATE WITH RESPECT

The College of Surgeons of Australia and New Zealand



A dream is just a dream. A goal is a dream with a plan and a deadline. – *Harvey Mackay*

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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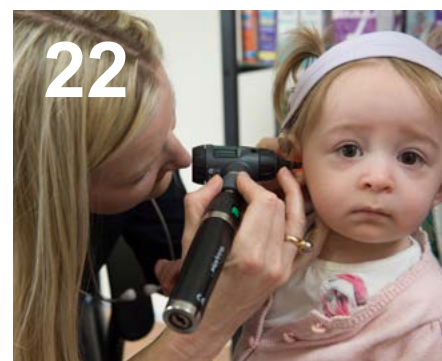
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COVER: RACS accepts the New Yorker Cover Challenge. From top-left: Dr Donna Egbeare, Dr Janne Bingham, Dr Christine Lai and Dr Deborah Amott.

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The ASC – Highlights and Reflections



JOHN BATTEN
President

Autumn has delivered a wealth of opportunities for Fellows and Trainees to advance their understanding of the full range of surgical competencies, and to be brought up to date with the emerging challenges that put both our profession and society in general on notice.

Taking centre stage was the Adelaide 2017 ASC, wonderfully and seamlessly delivered by Peter Subramanian and David Walsh and their team of 30 section leaders. This ASC proved to be the most successful in the history of such meetings held in this beautiful capital city. The attendance was a record 1768 delegates with just under 2000 registrants with our industry partners. Adelaide delivered a scintillating scientific program, superbly matched by brilliant weather, amazing wine and wonderfully warm fellowship.

The Theme of the ASC, *Safety and Sustainability – The Future of Surgery* challenged us all to consider our individual and collective responsibilities when it comes to rationally assessing and evaluating the explosion of new and enticing technologies as well as the place of some surgical procedures where the evidence fails to objectively support improved patient outcomes. The local, national and international faculty enriched the meeting by giving a broad global perspective of this subject for us all to consider.

Balancing evidence-based medicine, equity and affordability against the seductive, yet potentially disruptive thinking and practice of horizon technology, was explored in many of the plenary sessions and conference presentations. This is a responsibility of each member of our profession and can only be done by the profession in the best interests of safe and effective outcomes for the patient in the face of the unsustainable rise in health care costs in our country and internationally.

Robotics and Nano-technology promise much, but rigorous evaluation and transparent auditing are essential, if we are to occupy the forefront of science, and at the same time, retain

our credibility and integrity as a profession, in the best interests of our patients.

I had the privilege of attending the Younger Fellows Forum in the Adelaide Hills just prior to the ASC. Over two stimulating days, themed *Leading Surgeons*, our surgeons of the future shared their ideas, concerns and possible solutions with members of the current executive. Sharing their ideas and witnessing such talent and commitment gives us all great hope and optimism that the future of the profession is in great hands.

A highlight of the meeting was the attention given to RACS leadership in continuing to consolidate our work in calling out discrimination, bullying and sexual harassment (DBSH). There was wide agreement that DBSH is not restricted to surgery and is sadly seen in all health sectors and in all work places. A concerted effort from all Fellows, whether as supervisors or trainers, from Trainees, and particularly health jurisdictions to ensure patient safety through the provision of supported and non-toxic work environments with a quality and safety agenda, is required. RACS has opened the conversation and is leading the way to an improved culture of inclusion, equity and diversity.

There was also the call to improve both the supervisors and trainers capacity to deliver constructive feedback and the Trainees capacity to receive it in good faith and take appropriate action. Increasing concerns were expressed that DBSH must not become the default strategy for aggrieved trainers or Trainees. Our work must and will continue in this important field.

This was reinforced in the ICOSSET meeting of surgical educators run just prior to the ASC, which discussed and debated the processes of selection, surgical training and assessment around the world and the transition to Competency Based Medical Education. Although predominantly attended by Medical Educators; medical students, prevocational junior doctors and SET Trainees were also in attendance, clearly interested in the advances in this field that will affect their future.

Another highlight was the work progressed through RACS in Indigenous Health care delivery and training. David Murray brought together an enlightening program that challenged us and ranged from an overview of excess representation of ear disease, trauma and cancer in Indigenous populations, to the extraordinary benefits of traditional healers, in helping Indigenous patients manage contemporary illnesses.

Sadly, we are yet to achieve Indigenous population parity in acceptance into our Australian Medical Schools. On the surgical specialty front, our Cardiothoracic and ENT Training Boards are to be congratulated in recognising the value that

Indigenous Trainees bring to our understanding of diversity by enabling training pathways for eligible indigenous specialist Trainees. I sincerely hope that our larger training boards follow. Our New Zealand counterparts have clearly led the way, with Māori doctors graduating at population parity from 2016, and we have much to learn from their programs of undergraduate and postgraduate support and mentoring.

Looking ahead to RACS ASC 2018 in Sydney, Adelaide has set us an agenda to work towards. This meeting is co-badged with the American College of Surgeons and The Australian and New Zealand College of Anaesthetists and is themed *Reflecting on what really matters*.

Our priorities for 2017-2018 include building the very best relationships possible with our specialty societies. Through consensus and collective strength, as united surgeons with a common purpose, we can facilitate safe, quality patient care. We all share the same vision and together this vision is more likely to be realised.

We will promote surgical research and audit, work towards a sustained and sustainable workforce and advocate globally, sharing our expertise and support to resource poor neighbours in areas of need or conflict. This will enable us to genuinely demonstrate our professionalism.

As the ASC is a time of changeover of the Council leadership, I would like, on behalf of all the fellowship, to thank Phil Truscott, for his unsurpassed commitment to RACS not only during his term as President, and on Council,

but for the many decades preceding. Phil has been a great mentor for many of us, old and new. His even temperament, his gentle humour, his wise counsel, and his exceptional common sense, as well as liberal advice on matters gastronomic and viticultural, have guided us through great times of professional advancement, embracing educational, cultural and governance challenges.

There have been some rocky times, but Phil has managed them with patience, kindness and the necessary exactitude of good process. I thank him on your behalf.



Image: Past President Mr Phil Truscott AM and Current President Mr John Batten.

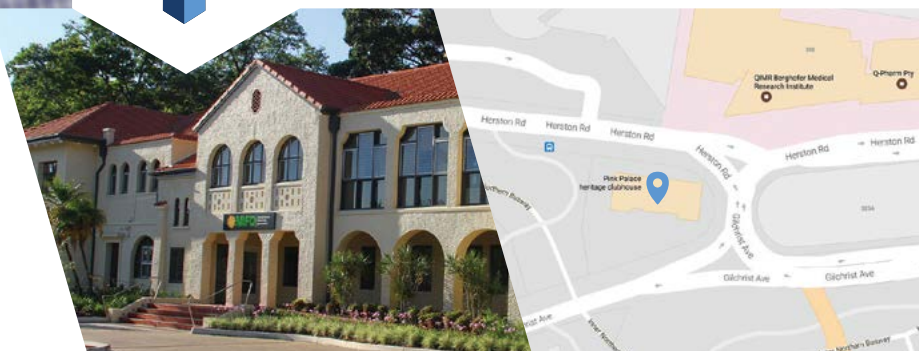


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CATHY FERGUSON
Vice President

This year the College's regions are hosting a fantastic array of local Annual Scientific Meetings (ASMs). From Perth to Palm Cove and across to Wellington – the quality of the programs and the locations are outstanding.

As part of the Vice President's portfolio, I am pleased to promote these events, which take place in the second half of the year and provide a perfect opportunity for Fellows to meet somewhat closer to home than the ASC normally allows. Typically, they include a variety of high quality presentations relevant to all surgeons, irrespective of specialty. Participants gain CPD points and have an opportunity to network with colleagues, often in pleasant surroundings.

The RACS office in your jurisdiction is where the event comes together. The regional staff, committee chairs and local conveners put in a lot of work to organise them: accepting and sorting through abstracts, lining up speakers of interest, and finding sponsorship. I wish to thank them for their efforts.

The regional ASMs and events attract not only Fellows but also a large number of SET Trainees, International Medical Graduates, junior doctors and medical students. These events provide an avenue for the next generation of surgeons to present papers, compete for awards and prizes and seek mentors. The prestigious Louis Barnett Prize (NZ) and the Neville Davis Prize (Qld) are each worth \$2,500.

Abstracts for these meetings are now open for oral and poster presentations. I would encourage Trainees in

particular to submit their abstracts to their local ASM early on.

The month of August sees three regional ASMs:-

- 17-18 August, Wellington, New Zealand
- 18-20 August, Palm Cove, Queensland
- 25 August, Perth, Western Australia (combined WA/SA/NT)

The New Zealand ASM is often held in Queenstown, however, a change in scenery this year brings us to the Te Papa Museum in my beautiful home town Wellington where an interesting cast of international and local speakers will present on the various aspects of future proofing surgery and healthcare.

Key speakers this year include Professor Taylor Riall - Professor of Surgery - University of Arizona. Dr Riall is known for her work on comparative effectiveness (research comparing different treatments to understand the right treatment, for the right patient, in the right setting) and patient-centred cancer and general surgery outcomes. We will also hear from Dr Forbes McGain - Anaesthetist and intensive care physician at Western Health, Melbourne. Dr McGain created the PVC Recovery in Hospitals Program which collects high-grade, clear plastic hospital items, such as used facemasks, oxygen tubing and irrigation bags. Through this initiative Western Health has slashed its plastic waste and more than 24 hospitals in the Asia Pacific



Image: QLD ASM 2016, presentation of awards



Image: ACT ASM, 2016

region have adopted the PVC recycling program.


The Queensland ASM is combining with the RACS Surgical Directors Section Leadership Forum this year to explore 'Whither the 21st Century Surgeon? The Challenge of Adaptation to Change – Advancing Technologies, Clinical Governance and Leadership, Payment for Outcomes and Role Delegation.' One session sure to be of interest focuses on advances in artificial intelligence, robotics, molecular genetics and 3D printing.

This year's 'Tri-state' meeting for WA, SA and NT will be in Perth with a focus on Trauma – When Disaster Strikes. International speaker, Dr Yoram Kluger, founder and director of the Rabin Trauma Center at Tel Aviv Medical Centre will be one of the presenters. He is recognized worldwide for his research on medical preparedness and medical infrastructure management in mass casualty situations. The Henry Windsor Lecture will be given by Professor Alexander Heriot, director of Cancer Surgery at the Peter MacCallum Cancer Centre.

The Tasmanian ASM will have a local focus this year, 'Surgery in One State, One Health System, Better Outcomes' with the health minister, shadow minister and CEO of Tasmanian Health Service, David Alcorn all speaking.

Geelong will host the Victorian ASM this year (20-21 October) with the theme of 'Safety in Surgery.' The conference will discuss how registries and audits can improve practice, and explore the topical and contentious


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debate around what kinds of complex surgery should be done by generalists versus specialist units. Keynote speakers:

- Stephen Duckett, who authored the highly influential report on health safety in Victoria; and
- Stephen Bolsin, who has been at the forefront of advocacy for surgical audit and safety both locally and internationally.

The ACT ASM will be 4 November at the ANU Medical School. The theme developed this year by convener, Rebecca Read, is 'Systems of Care: Collaboration and Care.'

NSW dedicates the month of November to 'Surgeons' Month' with various events targeting a range of stakeholders from medical students to retired surgeons. I would encourage NSW Fellows who are able to attend and support these events to do so.

I look forward to seeing many of you at the meetings I am able to attend. I would encourage you all to support your local ASMs. Even if your regional meeting is 'not so local' this year - traveling to a different location may still provide just that bit of inspiration you need!



Smartphone app developed to manage drinking

A Smartphone app developed in America called 'Step Away' is now being trialled for use in New Zealand to determine whether it can reduce the frequency of alcohol abuse in Auckland. The app, which took four years to develop, leads users through coping mechanisms, monitors drinking behaviours, identifies 'triggers' and provides weekly reports tracking progress in kicking the habit. Researchers are collaborating with the US team to develop something that works in New Zealand. Health research Council Executive Prof Kate McPherson said that the cost of alcohol related harm in New Zealand was around \$5.3 billion per year and that the app would potentially fill a treatment gap in the country.

Visit: <https://www.fmhs.auckland.ac.nz/en/faculty/about/news-and-events/news/2017/3/29/smartphone-app-developed-to-manage-drinking.html>

Pointing the figure at prostate cancer

PSA screening has led to soaring rates of over-diagnosis, unnecessary biopsies and harmful over-treatment according to a recent article in the Central Western Daily newspaper. For every 1000 men aged 55-65 who had annual PSA tests, a report has shown that 87 would have a false positive result after an invasive biopsy, and 28 would experience side-effects including impotence and incontinence. According to the article just two men would have been saved from death as a result of screening. The story went on to suggest that the US Preventative Taskforce was about to recommend against PSA screening altogether, until new draft guidelines were put forward that recommended doctors inform men aged 55-69 of the potential benefits and harms of PSA screening and offer them the opportunity to discuss these before screening.

Visit: <http://www.centralwesterndaily.com.au/story/4599135/american-doctors-warning-for-australian-men/>

Scientists determine a child's normal face shape over time

A 3D imaging technique that provides facial averages is being developed by the Murdoch Children's Research Institute and overseas collaborators. According to an article in the Sunday Times the averages will help to determine a child's face shape at different ages and predict its growth and growth abnormalities. The project, which aims to take the guesswork out of surgical practice, will help

surgeons to better design operations and has the potential to be used to predict how a missing person might look years later or to pinpoint the age of someone who may not have a birth certificate.

Visit: <http://www.perthnow.com.au/news/3d-technology-could-help-surgeons-when-operating-on-kids-faces/news-story/adc94101e24f341775278b715ffcf70f>

Robots used in surgical first for women's health

Gynaecological robotic assisted surgery for endometriosis and hysterectomy is now being performed for the first time in regional Australia at the St. Andrew's Toowoomba Hospital. The South Burnett Times said the procedure, which is less invasive and allows surgeons to operate in the difficult-to-access pelvis area, provides unmatched accuracy and precision. Benefits for patients include less pain, faster recovery, reduced scarring and less risk of infection. According to the article St. Andrew's Toowoomba Hospital was also the first to offer robotic assisted surgery for the treatment of prostate cancer.

Visit: <http://www.southburnettimes.com.au/news/robots-used-surgical-first-womens-health/3168068/>



Simple act of hand washing the best first defence against infection

According to a story in the Age newspaper it's the simplest method of infection control, it's practically free and if it were always practised, it could save more than 1500 lives a year in this country – it's hand washing. The article referred to the latest audit by Hand Hygiene Australia, which found that doctors were only washing their hands around 80 per cent of the time before conducting a procedure, and even less often afterwards. The newspaper said that the worst compliance rates were reported in overwhelmed emergency departments, where overworked staff were making life-and-death decisions.

Visit: <http://www.theage.com.au/comment/the-age-editorial/simple-act-of-hand-washing-the-best-first-defence-against-infection-20170416-gvlvyl.html>



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Another one bites the dust the ASC 2017 Wrap



Image: President Phil Truskett and Dr Nadia Wise FRACS

It has been six years since the RACS Annual Scientific Congress (ASC) was last held in Adelaide, and upon arrival it was clear for all to see that the city had undergone somewhat of a transformation since the last visit. The convention centre, where the conference was held, had added a second stage, with a third stage nearing completion. The venue backs on to the banks of the River Torrens, where a new footbridge leads to the redeveloped Adelaide Oval - a venue at which many memorable section dinners were held.

But perhaps as medical professionals the most interesting of all developments was the new medical precinct that stands directly to the west of the Convention Centre. The precinct includes the new Royal Adelaide Hospital, the South Australian Health and Medical Research Institute, and two new high rise medical research facilities belonging to the Universities of Adelaide and South Australia.

All in all the city of Adelaide proved to be the perfect venue for the conference with its picturesque setting,

agreeable weather and many great hotels and restaurants within close proximity of the venue. It was a great achievement that 2,152 attendees gathered at the Congress (including associates and industry), to make it one of best attended conferences yet.

The highlights of the week were numerous and some of the memorable moments are detailed below.

Scientific Program

One of the biggest drawcards of the ASC has always been the unique gathering of Fellows, Trainees, International Medical Graduates (IMGs), with presenters from all over the globe covering a plethora of specialties and subspecialties. This year was no exception, providing the perfect environment for delegates to interact and learn from one another. The program was divided in to 30 different sections, involving 880 presentations and 267 published e-posters. Amongst the presentations were the



Images (From left): Justine Peterson (New Zealand Manager) receiving Honorary Fellowship; Margaret Rode (Manager, President's Office and Council) and Ian Burke, (former Director, Resources Division) being presented with the RACS Medal.



daily plenary sessions, various key note speakers and several memorial lectures.

Safe and Sustainable – the Future of Surgery was the theme for the week and this was reflected throughout the presentations. We live in a time where significant scrutiny is placed on the value of individual surgical procedures in an attempt to rationalise the money spent on our health system. At the same time, technological advancement and developments in surgical practice are continuous and surgeons are regularly challenged to justify both the cost of adopting new technologies and the validity of maintaining existing practices. The current situation has created many questions about what the future of surgery will look like, and how we can balance the many challenges and opportunities that face us in a manner that is both safe and sustainable.



Convocation and Opening Night Presentations

As always the opening night Convocation was a great opportunity to welcome many new members as Fellows of RACS and to wish them well in the next phase of their journey. President (at the time) Mr Phil Truskett, shared with the audience that he only practiced around 11 percent of the original techniques ►



Images (Clockwise from top-left): Natalie Pink, Justin Cain and Natasha Martin; Opening the ASC; Dr Cathy Ferguson being presented the Sir Louis Barnett Medal; ASC 2017 Convenors Mr David Walsh and Mr Peter Subramaniam; Mingling on opening night; New Fellows, Martin Mcleod and Shehnarz Salindera; Lindy Moffat (Manager of Conferences and Events) and Arthur Richardson (ASC 2018 Convener); New Fellows of RACS.



that he learnt in his surgical training. This was a good reminder to all that the learning process as surgeons never stops and it is incumbent upon all to maintain their skills, embrace change and always be willing to learn and adapt. A number of outstanding Fellows and friends of the College were recognised throughout the proceedings, with several worthy recipients receiving awards and commendations for their contributions to surgery.

The Syme Oration

The Syme Oration is the most senior address on the RACS annual calendar, and was delivered by the Governor of South Australia, his Excellency the Honourable Hieu Van Le AC (pictured, below). His Excellency is reportedly the first Vietnamese person in the world to be appointed to a Vice-Regal position. He migrated to Australia as a refugee in a fishing boat in 1977. He recounted that at the time how he was warmly embraced in Australian society, and in turn he embraced the Australian culture and way of life. His address focused on the importance of providing high quality and accessible health care to all Australians, and the valuable contribution that refugees and other migrants could make to our society.



Images (Clockwise from top-left): RACS Stand in the Exhibition Hall; Ngarrindjeri Elder Major Sumner gave Welcome to Country; ASC audience x 2.



Indigenous Breakfast

One of the key RACS priorities is a commitment to improving the health outcomes of our Indigenous populations in Australia and Aotearora /New Zealand. Wednesday's Indigenous Health breakfast was the perfect way to begin the day's Indigenous Health program. It was announced at the breakfast that Mr Phil Truskett had been appointed as a patron of Australian Indigenous Doctors Association, a role to which he will be perfectly suited.

The RACS Aboriginal and Torres Strait Islander Health Medal was presented to Dr David Cronin in recognition of his extensive contribution to Aboriginal health, particularly his strong advocacy and efforts to reduce the burden of ear disease among children. Associate Professor Ian Campbell was awarded the RACS Māori Health Medal for his long contribution to Māori health, including his extensive research into the health disparities of Māori women suffering from breast cancer, and in recognition of his role as a founding member of the Waikato Breast Cancer Research Trust. ►



Images (Above, from top): (L-R) Mr David Murray (Chair, Indigenous Health), Dr Nathan Joseph (Chair, TeORA-Māori Medical Practitioners), Cheyenne Heka (ASC award recipient), Professor Kingsley Faulkner; Assoc Prof Ian Campbell receiving RACS IH medal; Panel Members: Dr Nathan Joseph (TeORA), Dr John Mutu-Grigg (IHC-NZ), Dr Su Mei Hoh (TRGEN-VIC), Dr James Johnston (TROHN-NZ), Dr Kali Hayward (AIDA) and Meshlin Khouri (Johnson & Johnson Medical Devices).



Images (Above): Fancy dress fun at the Younger Fellows Dinner.

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**MEDICAL AND
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Images (Clockwise from top-left): Dr Amanda Cuss, Dr Christine Mouat and Dr Jasmina Kevric; Women in Surgery breakfast; Women in Surgery attendees with our past and present President Phil Truskett and John Batten.

Women In Surgery Breakfast

The Women in Surgery breakfast provided an opportunity to celebrate success and promote a focus on leadership, role modelling training and advocacy. A key RACS focus is to expand the number of women in surgical training and to ensure that training programs are structured to be inclusive. Attendees at the breakfast also discussed respect, diversity and surgical culture, including what RACS had done to promote greater gender diversity and inclusiveness.

President's Lecture



The President's lecture was delivered by Professor Ian Harris (pictured, left), a distinguished surgeon and researcher. Professor Harris delivered a thought-provoking lecture titled *Surgery Value Proposition*. The lecture challenged many existing surgical procedures, questioning the evidence behind their effectiveness and whether they should continue to be performed. His engaging presentation sparked debate

amongst audience members and was also covered widely across the media.

Annual Dinner

The penultimate dinner event was a memorable one. While delegates ate, the entertainment was provided by Opera South Australia. The Presidency of the College was handed over to Mr John Batten who praised Phil Truskett for his charitable nature and professionalism not only in his time as RACS President, but also his extensive service as a RACS Councillor.

Despite the conference coinciding with Federal Budget week in Australia, and hundreds of media journalists striking, the broader media showed strong interest in the event. Requests for interviews flowed in and many articles were written and strongly supported with a highly interactive social media presence from the 28 media releases generated for the ASC.

The general feedback received was that the ASC was a resounding success, with the lessons learned being easily transferable to future events. ASC Convenor Peter Subramanian and the Scientific Convener David Walsh (pictured, right) did a mammoth job overseeing a highly engaging and entertaining program, with the exceptional support of RACS staff and ASC management.

As we bid farewell to Adelaide, work is already well underway to ensure that the 87th ASC in Sydney is every bit as successful.



Images (Clockwise from top-left): Past and present President Mr Phil Truskett AM and Mr John Batten; Dr David Cronin, Deborah Quinn, Lyndell Cronin and Dr John Quinn AM; ASC Dinner; ASC Convenor Peter Subramanian and the Scientific Convenor David Walsh; ASC delegates.



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Social Media at #RACS17



The Annual Scientific Congress this year brought together surgical Twitterati from all around the country for a week of tweeting, Instagramming and Facebooking about the latest developments in the surgical sphere. The wealth of knowledge presented at the ASC was incredible, with the social media space reflecting the busy schedule of seminars, talks, lectures, plenaries concurrently on a range of topics and fields of expertise. The Adelaide Convention Centre was buzzing with activity, as was the #RACS17 Twitter feed.

The #RACS17 hashtag served as a hub of great discussion and collegial spirit for the conference, including live tweeting from the numerous sessions, discussions on key controversial topics, highlighting interesting slides and data, and curating the congress as a whole. Delegates took to Twitter to share their key points and take-aways from the array of expert speakers, debating some of the finer points of surgical technique and best practice.

The Twitter wall took centre stage in front of the Exhibition Hall, a four by four screen scrolling through a curated list of the most engaging tweets throughout the ASC. The wall served as a platform for dialogue, reminders of the upcoming keynotes and pertinent sessions, in

addition to snippets from lighter social activities and goings on, such as photos from the 70s themed Younger Fellows section dinner.

#RACS17 engaged more than 690 delegates, producing over 3,700 tweets and 7.6 million impressions over the week – quite an impressive turn out. Chatter is still going strong about some of the most impactful presentations!

During the ASC program, the Communications & Advocacy Manager, Greg Meyer and Digital Media Coordinator (otherwise known as @RACSurgeons), SJ Matthews conducted presentation on Media in the 21st Century, covering the ever-changing landscape of traditional media and the merge into digital, social and interactive communities as a source of news and communications. The discussion was lively, covering the medico-legal issues of social media, the potential blurring of professional and personal arenas, and how organisational policies could impact on social media use and misuse.

Social media is constantly evolving, and with it, policies and protocols are struggling to keep up. Many Fellows expressed interest in learning more in further training sessions. If you are interested, individual social media training is available to Fellows by contacting SJ Matthews on sj.matthews@surgeons.org.



RACS accepts *the New Yorker* Cover Challenge

The New Yorker OR Cover Challenge – or #NYerORCoverChallenge – on Twitter began with the New Yorker release of an animated cover called “Operating Theatre” by the French artist Malika Favre, featuring four women surgeons. The now iconic image is from the patient’s perspective, showing the four female faces hovering above, masked with gloved hands poised and ready to begin the procedure.

The cover became a viral sensation after Dr Susan Pitt, a US endocrine surgeon issued the challenge to her colleagues to reproduce the image, particularly to highlight women and people from underrepresented racial backgrounds in surgery. The #NYerORCoverChallenge fit perfectly with another campaign #ILookLikeASurgeon, which was started

to represent the diversity in the surgical profession, and hence the hashtags were used in unison.

Hundreds of surgeons from around the world have responded to the call and posted their photos online. From Saudi Arabia to the UK to Algeria, female surgeons and surgeons of colour have contributed to an amazing show of solidarity; to ensure minorities within surgery are visible and represented and hopefully encouraging a whole new generation of surgeons from a wide variety of backgrounds to join their ranks.

Our very own female surgeons banded together at the Annual Scientific Congress to show their strength in numbers and add their faces to the #NYerORCoverChallenge movement.

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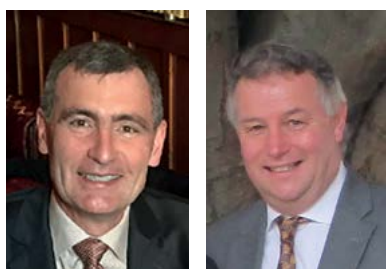
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Rethinking Surgical Training



ASSOC. PROF. STEPHEN TOBIN
ICOSSET Convener

PROF. PETER ANDERSON
ICOSSET Convener

The 6th International Conference on Surgical Education and Training (ICOSSET) was held at Adelaide Convention Centre from 7 – 8 May 2017. The ICOSSET brought together 26 presenters from around the globe, attended by over 120 delegates representing Australia, New Zealand, Canada, United Kingdom and United States of America. With a significant social media presence, the hashtag #ICOSSET17 generated over 500 posts across the two days.

The aim of the ICOSSET is to share global developments and innovative approaches in surgical education through interactive sessions and debates. This year, the conference provided a special opportunity to meet and network with surgeons, leaders in surgical education and policy makers from different jurisdictions.

Session 1: Outcomes of Surgical Training

Assoc Prof Stephen Tobin, Dean of Education RACS and ICOSSET convener, opened the conference with his presentation *The Community Need and the College Views*, emphasising that the community expects a surgeon to be safe and clinically proficient. Both Prof Oscar Traynor (Royal College of Surgeons Ireland - RCSI) and Mr Craig Mcillhenny (Royal College of Surgeons Edinburgh – RSCEdin) touched on the Greenway report, about its recommendation for generalisation. However, both cautioned the audience that the Greenway report was more of a systemic medical training report rather than a surgical training report. Prof Torben Schroeder (Union Européenne des Médecins Spécialistes – UEMS) then spoke on Denmark healthcare setting envisioning that certification is the norm around procedures rather than specialities. Dr Ken Harris (Royal College of Physicians and Surgeons Canada – RCPSC) highlighted that training would need to be redesigned to focus on outcomes and that generalism should not be disregarded. Dr Ajit Sachdeva (American College of Surgeons – ACS) then presented on the transition to being ‘an interdependent surgeon’ via a pre-recorded presentation. In closing off the presentations for the morning, Dr Mary

Theophilus FRACS and Dr Rhiannon Bousounis FRACS gave their perspectives on their surgical career and support needed for younger Fellows.

Session 2: Preparation for Surgical Training (Residency)

Prof Peter Anderson, ICOSSET convener introduced the next session by giving the audience a brief glimpse of the presentations ahead. Each College represented at the conference then gave an update on aspects of surgical training in their country.

A debate between Prof Humphrey Scott (Royal College of Surgeons England – RCSEng) and Prof Richard Reznick (Queens University Department of Surgery – Canada) on post-medical school/ pre-surgical training resident years being necessary before entering surgical training programs added an extra flavour to the session. After many rebuttals from both parties, Dr Reznick (against the topic) emerged as the winner of the debate, following a vote from the delegates.

Session 3: Selection for Surgical Training

Dr Ken Harris, RCPSC, chaired the afternoon session and introduced Dr Brian Dunkin from the Houston Methodist Institute for Technology, Innovation and Education (MITIE) as the keynote speaker. Dr Dunkin presented



the lessons learned from selection in the USA and concluded that there is no evidence-base for standard selection approaches there. He also highlighted the Situational Judgement Test and even how it is utilised by Starbucks to assess whether the potential employee has the necessary skills and personality traits to be a barista, store manager, etc. The delegates were then divided into 5 groups, and they were encouraged to design their ideal SET selection method. The 5 groups then presented the outcome of their discussions:

- Evidence of suitable prevocational work, possibly involving JDocs;
 - Prerequisites and GSSE attended;
 - Structured CV worth a small component of the system;
 - Authentic work-based reports, multisource feedback in style, to inform 'references'. These should be realistic and referees honest and possibly accountable;
 - Interviews of multiple mini interview style, with some community input;
 - Some support for situation judgement tests and personality profiles;
 - Evaluation of recent approaches.
- The day then ended with an optional dinner for faculty and delegates at the National Wine Centre.

Session 4: In-Training Assessments

The second day started with Assoc Prof Stephen Tobin chairing Group 1's presentations. The first presentation was by Prof Lars Konge (UEMS) on Denmark embarking on a nationwide project in implementing technical aspects (simulations) in surgical training. Prof Oscar Traynor then spoke on the usage of smartphone app by RCSI to support surgical trainers. Prof Debra Nestel (University of Melbourne) touched on how high quality simulation-based education and well-designed assessments can support learning.

Prof Peter Anderson chaired Group 2's presentations with Prof Elizabeth Molloy (University of Melbourne) kicking off the series of presentations. She emphasised

that rethinking of feedback was needed but this would require work from both learner and teacher, as feedback should be considered an ongoing process. Mr McIlhenny then pointed out that work-based assessment needed judgement as well. However, humans are subjected to cognitive bias and should need to be aware of that.

Dr Teodor Grantcharov and Dr Mitchell Goldenberg (University of Toronto) were up next with their presentation highlighting their current work in setting outcome-based standards in surgical performance. In determining this, two key questions were posed to the delegates; 'Can we determine standards based on clinically important outcomes?' and 'Should competency be the outcome, or should patient safety be the outcome instead?' Prof Richard Reznick ended the session by updating the delegates on the Queen's University journey in transforming 29 programs to CBME model.

Session 5: Free Papers

Delegates had the opportunity to present a free paper during this session. Below is the list of free papers presented at ICOSSET:

- The AOA Smartphone Feedback App: Does the "in-the moment" Mobile Enhanced Learning Encourage Effective Feedback for Surgeons? by Dr Ian Incoll
- Where the Surgical Blackbox is at? By Dr Teodor Grantcharov (Pre-recorded Presentation)
- Trauma and Orthopaedic Competency in the UK by Dr Simon Fleming
- The Value of Leadership Forum for Younger Fellows by Dr Ian Incoll
- Developing and Delivering a Regional Simulation Programme in Surgery by Prof Alan Horgan
- Golden Scalpel Games by Dr Michael Su and Assoc Prof Kerin Fielding
- Identifying Technical Procedures in Vascular Surgery for Simulation-Based Training – A Nation-Wide Needs Assessment by Prof Lars Konge.

Session 6: Issues Going Forward

Incoming RACS President, Mr John Batten gave his views on how he saw SET in the future - in 5-10 years' time.

The premise is that the graduating surgeon (just certified) should fit in or have a clearly defined work role as the new surgeon. He stressed that outcomes of SET were a core business of RACS. Prof Oscar Traynor then spoke on the online professionalism module launched in RCSI and its focus on relationships in the series of modules. This resource will be available as open access.

Assoc Prof Stephen Tobin updated the delegates on the RACS Action Plan, its progress from 2016-2017 and the critical lessons learned. Mr Simon Fleming inspired the crowd by declaring that Trainees can indeed lead the way in culture change with its 'Hammer It Out' campaign, launched by British Orthopaedic Trainees Association. This campaign led to several spin-offs by other specialties, such as 'Cut It Out' by General Surgery and 'Knock It Out' by Anaesthesiology.

Prof Ian Symonds as Dean of Medicine, University of Adelaide ended the series of presentations by giving his vision of better integration of clinical sciences, clinical placement and simulation as a Dean in surgical training. He also stressed the importance of increased focus on professional skills and patient safety.



The conveners then ended the conference by encouraging participants to attend ICOSSET 2019, from March 21-22 in Edinburgh and obtaining their feedback on what they would like to see at the next conference. Evaluation of this 2017 conference by survey has been commenced.

Until then, see you in Edinburgh!

Images (Clockwise from far-left): ICOSSET in full-swing; ICOSSET speakers, Dr Brian Dunkin (USA), Dr Robert McCusker (Australia), Dr Simon Fleming (England); Assoc Prof Stephen Tobin kicking off ICOSSET 2017.

Towards Cultural Competence



DAVID MURRAY

Chair, Indigenous Health Committee

Towards Cultural Competence for RACS was the theme for this year's Indigenous Health program at the 2017 ASC; providing an opportunity for delegates to spend time reflecting, learning and discussing Aboriginal, Torres Strait Islander and Māori health. The program featured an opportunity to celebrate achievements, visit a local Aboriginal Medical Service, consider some of the latest research in Indigenous health, learn more about traditional healing unique to Central Australian communities, and gain insights into culturally safe practice.



Aboriginal Medical Service Visit

This year's site visit was to Nunkuwarrin Yunti of South Australia, one of 150 organisations in Australia providing a primary health care service initiated, operated and managed by the local Aboriginal communities it serves. Nunkuwarrin Yunti means 'Working Together – Doing Right Together' and the centre takes pride in its holistic approach to health care

which is respectful of local culture and responsive to health and wellbeing needs defined by the community. Centre staff shared insights of their patients' experiences of hospital care and interaction with specialists, including surgeons.

Visiting a local Indigenous organisation like Nunkuwarrin Yunti is a privilege as it presents Indigenous health in a real life local setting. Importantly it allows us as surgeons to reflect on what RACS Fellows can do locally to improve the Aboriginal patient's journey through mainstream services to maximise the health outcomes for the individual and the community.

Scientific Program

The Indigenous Health scientific program featured a range of engaging presentations that examined the disparities in health between Indigenous and non-Indigenous peoples, and also those that explored what is meant by culturally safe practice.

The keynote address, Toward Cultural Competence for RACS set the scene for a series of presentations examining and discussing cultural issues relevant to care of the Indigenous patient by front-line Aboriginal health professionals. A highlight of the afternoon's program was an extended session focused on Traditional Aspects of Healing – facilitated by Mrs Debbie Watson, a Ngangkari Healer who is a founding member and the current director of the Nnangu Ngankari Tjutaku Aboriginal Corporation (ANTAC).

Supporting Future Aboriginal, Torres Strait Islander and Māori Surgeons

Seven Aboriginal and Māori medical students and junior doctors received ASC Foundation of Surgery Awards and a Career Enhancement Scholarship at the Indigenous Health Breakfast. The awards supported the recipients to attend the ASC, participate in workshops, meet with RACS Fellows and Trainees and gain insight into options for a career in surgery and the associated training pathways.

Dr David Cronin and Associate Professor Ian Campbell were awarded at the breakfast for their contributions to Aboriginal, Torres Strait Islander and Māori health (details page 13). The breakfast also featured an outstanding panel discussion on the topic *Towards Equity in Surgery*. Panellists discussed RACS Aboriginal and Torres Strait Islander SET Training initiative, cultural competency and safety, the importance of partnerships and RACS Indigenous Health scholarship program supported by the Foundation

for Surgery and Johnson and Johnson Medical Devices. Dr James Johnston an inaugural winner of the RACS SET Training Scholarship spoke about the importance of these scholarships both for his own training and research but also to inspire the next generation of Aboriginal, Torres Strait Islander and Māori doctors hoping to pursue a career in surgery.

If you weren't able to attend these excellent sessions but would like to learn more, video recordings of the

ASC Indigenous health sessions are now available to all Fellows, Trainees and IMGs as part of the RACS Virtual Congress <https://asc.surgeons.org/>

Images (From far-left): Delegates attend Nunkuwarrin Yunti Medical Service; President Phil Truskett and Dr Chris Perry Presenting the RACS Aboriginal and Torres Strait Islander Health Medal; (L-R) Cheyenne Heka, Lance Buckthought, Claudia Paul, Justin Cain, Natalie Pink, Nathan Joseph, Kali Hayward, Moea Nimmo, Natasha Martin, Kingsley Faulkner, David Murray.



RACS Aboriginal and Torres Strait Island SET Trainee One Year Scholarship

Due to availability in funding, applications for this scholarship have been re-opened. This scholarship was established by the RACS Indigenous Health Committee to support Trainees who identify as Aboriginal and/or Torres Strait Islander, and could be used to cover one or more of the following:

- SET registration fees
- SET course fees
- SET examination fees
- Research projects
- Mentoring Programs
- Travel, accommodation and registration fees to attend conferences
- Other relevant professional development activities

Who can apply

SET Trainees of any year who identify as being Aboriginal or Torres Strait Islander. Scholars are eligible to re-apply observing the advertised application deadlines and formats in competition with all applications.

Conditions

To be eligible for the Scholarship an applicant needs to fulfil the eligibility requirements for membership of the Australian Indigenous Doctors' Association (AIDA). Details can be found on www.aida.org.com.au/membership/eligibility/.

All scholarships are conditional upon the applicant being a permanent resident or citizen of Australia or New Zealand.

For further information and to apply, please go to the RACS scholarship website at www.surgeons.org/scholarships or directly to Research Scholarship web page.

Value

\$20,000

Tenure

One scholarship year commencing in January 2018

Closing Date for Applications

Applicants will be notified in December 2017

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Contact

Scholarship Program Co-ordinator
 Royal Australasian College of Surgeons
 199 Ward Street
 North Adelaide SA 5006 Australia
 Telephone: +61 8 8219 0900
 Fax: +61 8 8219 0999
 Email: scholarships@surgeons.org

**Worth
 \$20,000**

The closing date for applications for this award is 31 August 2017

Surgery in Children



DR LAWRIE MALISANO
Chair, Professional Standards

RACS recognises the importance of surgical services to meet the specific needs of children at the ages and stages of life. To reinforce this, RACS in collaboration with the Australian and New Zealand Association of Paediatric Surgeons, General Surgeons Australia and Urological Society of Australia and New Zealand, have developed the Surgery in Children Position Paper. The position paper has been created to empower regional and metropolitan centers across Australia and New Zealand to safely treat some paediatric conditions.

The focus must always be on ensuring the paediatric patient is not subject to adverse health outcomes

RACS encourages all regional and rural surgeons to be adequately trained to assess and treat children within their community. The focus must always be on ensuring the paediatric patient is not subject to adverse health outcomes including when transfer could potentially result in detrimental outcomes. In some cases it may be that surgery

should be performed locally, such as the acute scrotum in a geographically isolated patient.

There are a range of common procedures within the paediatric age group where perioperative care and admission needs differ in comparison to adult patients. Low complexity or non-paediatric specific conditions such as appendicitis can and should be treated appropriately for the child's age, condition and local health capability at the closest institution to their home.

The table below provides a clear guideline regarding age and surgery underpinning the principles set out in the Surgery in Children Position Paper.

To ensure the best patient outcomes, regional and rural surgeons must be able to provide predictable and evidence based care. RACS also encourages the following measures:

- Ensure communication between health care providers is accurate, and places the safety of the child as paramount
- Hospitals develop transfer guidelines
- Specialist paediatric surgical outreach teams
- Develop transition plans for older children with complex surgical conditions
- Support accreditation pathways for adult sub-specialists to attend and consult upon children in the paediatric environment
- Treat older children and adolescents presenting with non-paediatric surgical conditions in an adult facility.

While surgery in children is provided by all nine of the RACS surgical specialties, the principles of the position paper are primarily focused on the interface between Specialist General and Paediatric Surgeons, presenting the largest area of overlap. Paediatric neurosurgery, cardiothoracic surgery and other complex surgery such as major congenital reconstructive, neonatal and oncology requiring specialist paediatric surgical and multidisciplinary teams should continue to be performed in tertiary paediatric facilities.

The Surgery in Children Position Paper is available from the RACS website. If you have any questions or feedback regarding the position paper please contact the Professional Standards Department on +61 3 9249 1292 or ProfessionalStandards@surgeons.org

< 2 years	Elective surgery (and emergency surgery if possible) in children's specific facility or by surgical specialists and perioperative team with appropriate paediatric training and scope
2 – 8 years	Elective surgery and acute/emergency surgery locally if facility and procedural expertise has been supported with paediatric resources (medical paediatric, anaesthetic, and perioperative staff) and paediatric surgical up-skilling, training, or outreach
8–12 years	Low complexity surgery performed locally depending on ability to support appropriate perioperative care
> 12 years	Non paediatric specific, low complexity conditions (elective and acute/emergency) – general surgical facilities and staff



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May/June 2017

All donations over \$10 are eligible to join the Aboriginal and Torres Strait Islander Health Network, receive email updates and contribute to the work RACS is doing in this area. You will also receive a Network pin with the our thanks.

Protecting the long-term viability of private health insurance



DR LAWRIE MALISANO
Chair, Professional Standards

The increasing costs of health services in Australia pose a significant challenge to governments and the health sector. The system is under pressure from a range of factors including the burden of chronic disease, population changes, workforce distribution and costs associated with technological advances.

In 2014-2015 Australia's health expenditure was \$161.6 billion, with health representing 10 per cent of the country's Gross Domestic Product for the first time.¹

Private health coverage makes up a significant portion of this expenditure. As at 30 June 2015, 11.3 million Australians were covered by hospital treatment cover (47.4 per cent of the population) and 13.3 million Australians had some form of general treatment cover (55.8 per cent of the population).² This was subsidised with \$5.8 billion in Commonwealth funding via the Private Health Insurance Rebate.

RACS recognises the important contribution of the private sector in the financing and delivery of health services under the Medicare framework. In 2013-2014, public hospitals provided approximately 29 elective admissions involving surgery per 1,000 population and private hospitals provided approximately 57 per 1,000.³

A significant shift away from the private sector would increase pressure on governments to provide those services and likely increase waiting times for elective surgery to the disadvantage of patients. The long term viability of the private health model in Australia will also decline if health insurance premiums continue to rise above CPI and wages growth. The industry weighted average premium increase in 2017 is 4.84 per cent, with the cumulative average increase in premiums totalling 33.47 per cent since 2012.⁴

RACS has been working with the Commonwealth

Government and other stakeholders⁵ to:

- simplify and improve transparency in insurance packages
- develop standard definitions for medical procedures across all insurers
- provide advice on regulation
- improve value for rural and remote consumers
- educate the surgical workforce about clinical variation including fees.⁶

RACS supports assisting consumers to gain a better understanding of rebates associated with their policy and recommends discontinuing exclusionary policies, which leave patients vulnerable to significant out of pocket or upfront costs

Discussions about out of pocket costs are often associated with the fees charged by hospitals and medical practitioners. RACS has taken the position that extortionate fees are exploitive and unethical. A series of documents have been developed that outline our position including Excessive Fees⁷, Informed Consent⁸ and Informed Financial Consent.⁹ RACS has also prepared a patient information sheet,¹⁰ which encourages patients to take an active role in discussions with their surgeon about all available treatment options, full disclosure and transparency of fees as early as possible in the patient-doctor relationship and a second opinion on recommended treatments and fees where patients are concerned.

At a systemic level, purchasing or contracting arrangements between private health insurers and hospitals can significantly impact upon out of pocket costs or cost variation, and continue to remain opaque to patients and medical practitioners. For example, prostheses prices in the Australian private hospital setting are amongst the highest in the world, with estimates indicating that prostheses benefit payments comprise 14 per cent of total reimbursements by private health insurers - totalling \$1.9 billion in 2014-15.¹¹

Beyond discussions about the role of private health insurance in the Australian healthcare sector, there are a number of other initiatives underway that can support patients in making more informed decisions about their healthcare and improve affordability. RACS has been actively involved in the Choosing Wisely Australia and New Zealand campaigns, which aim to improve the quality of healthcare by eliminating unnecessary and sometimes harmful tests, treatments, and procedures.¹²

We have also worked collaboratively with Medibank to establish a series of Surgical Variance Reports, which aim to address the paucity of available information to surgeons on

indicators such as the median length of patient stay, rates of readmission or admission to an intensive care unit (ICU), and prices charged for services, for different procedures within their speciality, and particularly in the private sector.

RACS supports the principle of universal and sustainable healthcare provision across all communities in Australia and New Zealand and acknowledges the important contribution the private sector makes in the financing and delivery of health services under the Medicare framework in Australia.

Strategies to reduce growing out of pocket costs including exclusionary policies that offer little or no value to consumers must be addressed. A consistent approach to the use of quality indicators for performance, supported by a rigorous evidence base and subject to regular review would also benefit the ongoing quality improvement of the healthcare sector.

A version of this article was first published in the Consumers Health Forum of Australia journal *Health Voices*.

- 1 Australian Institute of Health and Welfare, Health Expenditure Australia, October 2016.
- 2 <http://www.health.gov.au/internet/main/publishing.nsf/Content/PHIconsultations2015-16>
- 3 Australian Institute of Health and Welfare, Surgery in Australia's Hospitals, March 2015.
- 4 <http://www.health.gov.au/internet/main/publishing.nsf/content/privatehealth-average-premium-round>
- 5 <http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac>
- 6 <http://www.surgeons.org/policies-publications/publications/surgical-variance-reports/>
- 7 http://www.surgeons.org/media/20023066/2014-10-30_pos_fes-pst-036_excessive_fees.pdf
- 8 http://www.surgeons.org/media/312206/2014-08-29_pos_fes-pst-042_informed_consent.pdf
- 9 http://www.surgeons.org/media/312174/2014-08-29_pos_fes-pst-041_informed_financial_consent.pdf
- 10 http://www.surgeons.org/media/21660272/2015-04-29_surgeons_fees.pdf
- 11 Private Healthcare Association Australia, Private patients paying too much for medical implants and surgical supplies, February 2016
- 12 <http://www.choosingwisely.org.au/home>



The release of the Medical Workforce Plan for Queensland



DR BRIAN MCGOWAN
Chair, Queensland State Committee

It is with much pleasure that I take the opportunity to write this article after recently taking over the role of Chair of the Queensland State Committee. A major role for the State Committee is to interact with the local Health Department and the key issues are generally waiting list management and workforce.

To its credit the Queensland Government has recently released its Medical Practitioner Workforce Plan for Queensland. After widespread consultation in 2016 the plan is envisaged to support medicine through to 2026. Within the plan is a scheme promoted by the previous Chair in Queensland Professor Owen Ung; its detail is below and is taken from the plan, which is available at <https://www.health.qld.gov.au/system-governance/strategic-direction/plans/medical-practitioner-workforce-plan-for-queensland>

There are increasing numbers of doctors who are currently progressing towards specialisation in an environment where access to Fellowships (i.e. pre - consultant positions) is becoming increasingly competitive. There are also opportunities to develop well supported Fellowship positions across Queensland to attract, support, develop and transition recently qualified specialists to regional and rural communities.

A structured pilot program of supported placement for new Fellows in regional, rural and remote settings (Fellowship Transition Scheme). This will be facilitated by an initial placement in a metropolitan setting, followed by regional/ rural placement with access to formalised peer networks and ongoing training and education opportunities.

Developing our future surgeons is a key role that needs to be performed by all Fellows. You do this through your training role in the Hospital setting and in the work we do for Training Boards and the College. However this role should not end when the Registrar passes the Fellowship exam. As a group we should continue to mentor them and present them with opportunities to develop their skills and further their careers. Increasingly concerns are being raised by younger Fellows that there are not enough positions available in the Public Hospital system for them to progress their careers.

With a finite health dollar it is difficult to create these positions. So to get them we need to gain efficiencies elsewhere. These efficiencies can be gained in our Operating Theatres as alluded to by the Queensland Auditor General's report of 2016 at <https://www.qao.qld.gov.au/reports-parliament/queensland-public-hospital-operating-theatre-efficiency>.

The other issues which arise in every workforce discussion are:

- The mix in each hospital and unit of VMO and SMO staff
- Maldistribution of the workforce
- Area of need.

There are some specialty units in Metropolitan areas that are heavily reliant on a VMO workforce and there are many Regional areas that have an almost exclusive SMO workforce. Potentially neither of these situations is ideal. The regional areas advertise positions almost exclusively for an SMO and we have advised the Chief Health Officer in discussions on the workforce plan that it is a model that to date has failed to resolve the acknowledged maldistribution of the workforce towards the south east corner of the state. This advertising approach often leads to the declaration of Area of Need and the positions are filled by International Medical Graduates; this is often a very lengthy process which does not always resolve the gaps that have been left by departing staff.

Directors of Surgery have a key role to perform in workforce discussions as they also do in the areas of Governance, Leadership and developing a Sustainable health system. Issues such as:

- Building respect, improving patient safety (BRIPS)

- Futile Surgery
- M&M meetings
- Clinical governance
- Outpatient and surgical waiting lists.

RACS has a Section of Surgical Directors that you can view at the following link: <https://www.surgeons.org/member-services/interest-groups-sections/surgical-directors/>

This section will be combining with the Queensland Regional Committee for a combined ASM 2017 at the Pullman Sea Temple Resort Palm Cove from 18-20 August 2017 where many of these issues will be discussed.

Local media reports that we may see an election in Queensland sometime in the second half of 2017 though it is not officially due until early 2018. RACS has been privileged to have had many meetings with the Director General and Chief Health Officer over the past 2 ½ years although the Minister Cameron Dick has not been as available as his predecessor Lawrence Springborg.

The Queensland Regional Committee will again put together an election statement which it will send to the major parties seeking a response. It is likely issues we will cover include:

- Surgical and Outpatient waiting lists - add balancing elective surgery capacity to match the recent increased specialist outpatient activity
- Medical Practitioner Workforce Plan for Queensland
- Quad Bike deaths, manufacturing standards and laws
- Alcohol Laws

- The position of Chair of the Medical Board - we are very supportive of multidisciplinary and consumer representation on the board but we strongly recommend a Medical Board is chaired by a Medical Practitioner
- Complaints and the role of OHO, Medical Board and AHPRA
- Public Hospital positions for Younger Fellows.

If you have an issue related to surgical services or standards that you would like raised please contact me through Chair.Qld@surgeons.org.

Please may I ask you to fulfil your obligations as Fellows, Trainees and IMGs in relation to the Operating with Respect modules and Courses. If you work with RACS Trainees you will need to be aware of the Foundation Skills for Surgical Educators Course and Operating with Respect Face to Face courses which you will need to complete. The details are on the RACS website at <http://www.surgeons.org/about-respect/>.

I would like to thank outgoing Chair Professor Owen Ung for his work over the past two years and wish him well as he moves onto his new role as a College Councillor. I look forward to representing the surgeons of Queensland and advocating for their and our patients interests.

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Surgery and Leadership

Surgical News speaks to Sally Langley, Chair, Professional Development



Coming from a family background in nursing and surgery, and with an interest in craft and working with her hands, it's no surprise that Sally Langley entered into the world of medicine, specialising in plastic and reconstructive surgery.

President of the New Zealand Association of Plastic Surgeons (NZAPS), member of the Australian and New Zealand Head & Neck Society (ANZHNS) and the Australian and New Zealand Burn Association (ANZBA), Dr Langley took some time out to talk with RACS about her thoughts on BRIPS, her role as Chair, Professional Development with the RACS Council and what she thinks are the most important issues for RACS right now.

What have you enjoyed most about the role as RACS Councillor?

I think it is a combination of extending my knowledge and working with excellent people who are highly competent. I have enjoyed the governance work and I have greatly valued the experience of attending the Australian Institute of Company Directors (AICD) course.

What does the role of Chair, Professional Development entail?

I have had to become fully aware of the portfolio of Professional Development, which also includes the Academy of Surgical Educators (ASE). Early on I read all the recent agendas and minutes of the meetings to better understand the spectrum of professional development activities and how they have evolved and changed.

The previous Chair, Professional Development, Prof Spencer Beasley, has been a great source of direction and a wonderful role model. I need to know the full description of each course, its history, and the staff and Fellows associated with the courses.

There are a couple of new courses and *Leadership in Everyday Practice* under development. It has been very educational for me to be part of the development of the Leadership course alongside such highly experienced colleagues as Prof Beasley, Prof Stephen Tobin and RACS staff, John Biviano (Acting CEO), Kyleigh Smith and others.

I am very impressed with the development and structure of the ASE which is delivering many aspects of surgical education, led by Prof Tobin and managed very well by Grace Chan.

My father was a GP with a surgical interest (his practice was in our house) and my mother was a charge nurse of a men's surgical ward before having our family. They were very supportive of me.

What RACS issues are most important to you?

Education of surgeons to a high standard is extremely important. Development of SET selection, training, curriculum, assessment and feedback is very important and has its challenges.

Better training for our supervisors and trainers is of high importance and the FSSE course is a step towards that. I have been involved with the Fellowship examination for 11 years now and I am a strong advocate for this exit examination and for the rigour associated with the Court of Examiners.

Care of IMGs through their pathways to Fellowship can be a challenge for RACS.

What are your thoughts about the Building respect, improving patient safety (BRIPS) campaign?

This is a very important issue that has seen RACS as a leader in developing an action plan to move forward. Our focus is to make sure that the care of our patients is excellent and that our Trainees, IMGs and Fellows are educated well and work in a safe workplace. These problems are not experienced by surgeons alone but by all medical and professional groups.



Why did you choose plastic and reconstructive surgery?

My natural interests are in doing craft projects and manual activities either on my own or with others e.g. playing music. My father was a GP with a surgical interest (his practice was in our house) and my mother was a charge nurse of a men's surgical ward before having our family. They were very supportive of me.

As a student my medical interests were broad but included paediatric, syndromes, cancer but I was more interested in procedural medicine. I managed to get some good jobs with interested surgeons and I was allowed by registrars and surgeons to do a lot of operations either under supervision or by myself at a very junior level. That is not possible now.

After doing some general surgery, ENT surgery and orthopaedics I was also exposed to plastic surgery where all my interests came together. My specialty is strongly procedural, cares for males and females of all ages, and includes some of the most complex operations possible.

I love the creative aspect of plastic surgery. I was fortunate to start plastic and reconstructive surgery training at Middlemore Hospital in Auckland for two years, and then two years back in my home town of Christchurch before developing my skills overseas. I had the great privilege of working at the Christine Kleinert Institute in Louisville, Kentucky doing hand and microsurgery, and then I went on to The Radcliffe Infirmary in Oxford, UK doing craniofacial, head and neck and a whole range of plastic surgery.

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

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: 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: 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

www.surgeons.org/about/regions/western-australia

RACS SA Regional Office

T: +61 8 8239 1000 • E: college.sa@surgeons.org

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

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

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

Find out more:

T: +61 2 6285 4023 • E: college.act@surgeons.org

www.surgeons.org/about/regions/australian-capital-territory



Workshops 2017

Online registration form is available now (login required)

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

Foundation Skills for Surgical Educators Course

16/06/2017	Traralgon	VIC
17/06/2017	Brisbane	QLD
19/06/2017	Wellington	NZ
23/06/2017	Sydney	NSW
23/06/2017	Ballarat	VIC
24/06/2017	Christchurch	NZ
30/06/2017	Melbourne	VIC
8/07/2017	Sydney	NSW
9/07/2017	Hawaii	USA
14/07/2017	Mackay	QLD
17/07/2017	Melbourne	VIC
20/07/2017	Perth	WA
21/07/2017	Wagga Wagga	NSW
22/07/2017	Sydney	NSW
29/07/2017	Shepparton	VIC
4/08/2017	Sydney	NSW
4/08/2017	Adelaide	SA
7/08/2017	Queenstown	NZ
7/08/2017	Sydney	NSW
7/08/2017	Clayton	VIC
11/08/2017	Melbourne	VIC
16/08/2017	Wellington	NZ
18/08/2017	Palm Cove	QLD
19/08/2017	Melbourne	VIC
19/08/2017	Sydney	NSW

24/08/2017	Perth	WA
26/08/2017	Gosford	NSW
29/08/2017	Adelaide	SA

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 have the opportunity to explore how these concepts can be applied into their own teaching context and reflect on their own personal strengths and weaknesses as an educator. With the release of the RACS Action Plan: Building Respect and Improving Patient Safety, the Foundation Skills for Surgical Educators course is now **mandatory** for Surgeons who are involved in the training and assessment of RACS SET Trainees.

Clinical Decision Making

23/06/2017	Christchurch	NZ
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This four hour workshop is designed to enhance a participant's understanding of their decision making process and that of their trainees and colleagues. The workshop will provide a roadmap, or algorithm, of how the surgeon forms a decision. This algorithm illustrates the attributes of expert clinical decision making and was developed as a means to address poor clinical decision making processes, particularly as a guide for the supervisor dealing with a struggling trainee or as a self improvement exercise.

Operating with Respect course

7/07/2017	Auckland	NZ
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24/08/2017	Perth	WA
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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.

With the release of the RACS Action Plan: Building Respect and Improving Patient Safety, the Foundation Skills for Surgical Educators course is now mandatory for SET Supervisors, IMG Clinical Assessors and major RACS Committees.

Surgical Teachers Course

20 – 22/7/2017	Yarra Glen	VIC
19 – 21/10/2017	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.

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

2/09/2017	Sydney	NSW
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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 2017	Brisbane	QLD
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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 2017	Brisbane	QLD
6 October 2017	Auckland	NZ
24 November 2017	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.

Process Communication Model Refresher (PCM)

24 September 2017	Melbourne	VIC
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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.

Process Communication Model Seminar 1 (PCM)

20 – 22 October 2017	Auckland	NZ
17 – 19 November 2017	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.

PROFESSIONAL DEVELOPMENT WORKSHOP DATES

June – August 2017

NSW		
Foundation Skills for Surgical Educators	23/06/2017	Sydney
Foundation Skills for Surgical Educators	8/07/2017	Sydney
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	19/08/2017	Sydney
Foundation Skills for Surgical Educators	26/08/2017	Gosford
NZ		
Foundation Skills for Surgical Educators	19/06/2017	Wellington
Clinical Decision Making	23/06/2017	Christchurch
Foundation Skills for Surgical Educators	24/06/2017	Christchurch
Keeping Trainees on Track	1/07/2017	Wellington
SAT SET Course	1/07/2017	Wellington
Operating with Respect (OWR)	7/07/2017	Auckland
Foundation Skills for Surgical Educators	7/08/2017	Queenstown
Foundation Skills for Surgical Educators	16/08/2017	Wellington
QLD		
Foundation Skills for Surgical Educators	17/06/2017	Brisbane
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
SA		
Foundation Skills for Surgical Educators	4/08/2017	Adelaide
Foundation Skills for Surgical Educators	29/08/2017	Adelaide
USA		
Foundation Skills for Surgical Educators	9/07/2017	Hawaii
VIC		
Foundation Skills for Surgical Educators	16/06/2017	Traralgon
Foundation Skills for Surgical Educators	23/06/2017	Ballarat
Foundation Skills for Surgical Educators	30/06/2017	Melbourne
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
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



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.

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 unlearned bad academic habits
Self awareness and avoiding burnout
#Ilooklikeanacademic surgeon

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-career 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 opens in June

Contact Details

E: academic.surgery@surgeons.org

T: +61 8 8219 0900



Section of
ACADEMIC
SURGERY

SURGICAL
RESEARCH
Society

Medtronic



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*

July – August 2017

ASSET

Friday, 4 August – Saturday 5, August	Adelaide
Thursday, 10 August – Friday, 11 August	Perth
Friday, 25 August – Saturday, 26 August	Brisbane

CCrISP

Friday, 14 July – Sunday, 16 July	Brisbane
Friday, 21 July – Sunday, 23 July	Adelaide
Friday, 25 August – Sunday, 27 August	Brisbane

CLEAR

Friday, 28 July – Saturday, 29 July	Perth
Friday, 18 August – Saturday, 19 August	Auckland

EMST

Friday, 21 July – Sunday, 23 July	Melbourne
Friday, 21 July – Sunday, 23 July	Perth
Friday, 28 July – Sunday, 30 July	Brisbane
Friday, 4 August – Sunday, 6 August	Sydney
Friday, 11 August – Sunday, 13 August	Melbourne
Friday, 18 August – Sunday, 20 August	Brisbane
Friday, 18 August – Sunday, 20 August	Perth
Friday, 25 August – Sunday, 27 August	Sydney
Friday, 25 August – Sunday, 27 August	Melbourne

TIPS

Thursday, 13 July – Friday, 14 July	Brisbane
Friday, 4 August – Saturday, 5 August	Melbourne



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

*Course dates were available at the time of publishing

CR17

COMBINED AUSTRALIA AND NEW ZEALAND COLORECTAL SURGICAL MEETING 2017

(SPRING CME AND SYDNEY COLORECTAL SURGICAL MEETING)

FRIDAY 17 – SATURDAY 18 NOVEMBER
SHANGRI-LA HOTEL
SYDNEY



ROYAL AUSTRALASIAN COLLEGE OF SURGEONS



CSSANZ
COLORECTAL SURGICAL SOCIETY
OF AUSTRALIA AND NEW ZEALAND



Further Information
Colorectal.SM@surgeons.org
T: +61 3 9276 7406

ANZHNCS ASM 2017

AUSTRALIAN AND NEW ZEALAND HEAD & NECK CANCER SOCIETY 19TH ANNUAL SCIENTIFIC MEETING

12 – 14 October 2017
Brisbane Convention & Exhibition Centre
Brisbane, Australia



AUSTRALIAN AND NEW ZEALAND
HEAD & NECK
CANCER SOCIETY

Abstract submissions & registration now open

Meeting Organisers
Conferences & Events Management
Royal Australasian College of Surgeons

W: www.anzhnca.org
T: +61 3 9249 1139
E: anzhnca.asm@surgeons.org

2017

Neurosurgical Society of Australasia Annual Scientific Meeting



Adelaide 2017

Wednesday 30 August to
Friday 1 September 2017

Adelaide Convention Centre
Adelaide, Australia

www.nsa.org.au



Early bird registration closes 1 July 2017

SAVE THE DATE



ATCSA 2017 MELBOURNE

27TH ANNUAL CONGRESS OF THE ASSOCIATION OF THORACIC AND CARDIOVASCULAR SURGEONS OF ASIA

16 - 19 NOVEMBER 2017
MELBOURNE CONVENTION AND EXHIBITION CENTRE, AUSTRALIA



PROUDLY HOSTED BY
AUSTRALIAN & NEW ZEALAND SOCIETY
OF CARDIAC & THORACIC SURGEONS



E: atcsa2017@surgeons.org
T: +61 3 9276 7406

www.atcsa2017.com

RACS WA, SA & NT Annual Scientific Meeting 2017

25 August, Pan Pacific Hotel, Perth, Western Australia

MR DIETER WEBER Convener 2017

The Joint RACS WA, SA, NT Annual Scientific Meeting (ASM) is almost upon us, and we have another comprehensive and engaging program in store. The theme for this year's meeting is 'Trauma Management: When Disaster Strikes.' The key topics discussed will be RACS role in disaster management, understanding and defining data in surgery, training and simulation in Trauma, and complications in surgery relating to trauma.

As always the ASM provides a forum for us to support our Trainees and colleagues across other disciplines and celebrate the achievements of our peers. We are delighted to have two highly respected speakers attending this year. Our Keynote Speaker is **Professor Yoram Kluger** from Israel, while the Henry Windsor Visiting Lectureship has been awarded to **Professor Alexander Heriot**.

Professor Kluger is the Director of the division of general surgery and the medical director of the pancreatic surgery service at Rambam Health Care Campus. He is a clinical Associate Professor at the Ruth & Bruce Rappaport Faculty of Medicine of the Technion-Israel Institute of Technology. As well as this, he was recently appointed Chairman of the Department of Surgery at the Faculty of Medicine.

He was also the founder and director of the Rabin Trauma Center at Tel Aviv Medical Center and the first in Israel to establish a dedicated hospitalisation centre for patients with multiple injuries. He is recognised worldwide for his

research on medical preparedness and medical infrastructure management in mass casualty situations. Professor Kluger's main interests are surgical oncology and trauma surgery. He holds a position on the board of the World Society of Emergency Surgery and is the Israeli delegate to the European Society for Emergency Surgery and Trauma.

Professor Heriot is a Consultant Colorectal Surgeon and is the director of Cancer Surgery at Peter MacCallum Cancer Centre in Melbourne. He qualified from Cambridge University and completed general surgery training in the UK. Professor Heriot is a Clinical Professorial Fellow at the University of Melbourne and was awarded the John Mitchell Crouch fellowship by RACS for 2016. He was previously Chairman of the Research Support Committee for the Colorectal Surgical Society of Australia and New Zealand (CSSANZ) and is a member of the Australasian Training Board in Colorectal Surgery (TBCRS). He is the Chairman of the Binational Colorectal Cancer Audit.

We look forward to welcoming these two excellent speakers to Perth, as well as our many other presenters over the ASM. Registrations are currently open via the RACS website. For more information please feel free to contact the Western Australian Office via phone +61 8 6389 8600 or college.wa@surgeons.org

This educational activity has been approved in the RACS CPD Program. **Registrants can claim 7 CPD points** in Maintenance of Knowledge and Skills. As part of the ASM a Foundation Skills for Surgical Educator, and an Operating With Respect Course will be held separately on 24 August.

We look forward to welcoming you to Perth.



Five lessons from the Building Respect, Improving Patient Safety Training

Mr Kareem Marwan, General and Colorectal Surgeon at Knox Private Hospital, shares his five top learnings from the Building Respect training.



MR KAREEM MARWAN
General and Colorectal Surgeon

As a surgeon and a trainer, I've valued the opportunity to complete two training courses as part of the *Let's Operate with Respect* campaign to build respect and increase patient safety in surgery.

The courses are:

- 1) The *Operating with Respect* Online Module, which provides knowledge and understanding of unacceptable behaviours so they can be recognised when they occur. It's delivered online, takes 45 minutes and is a mandatory part of CPD requirements for 2017.
- 2) *The Foundations Skills for Surgical Educators (FSSE)* course, that gives expanded knowledge and skills in surgical teaching and education techniques. It's delivered face-to-face and is mandatory for all who teach or train SET trainees or supervise IMGs.

I've taken some key learnings from these courses, including those below, and would recommend them to all surgeons.

1. It is everyone's responsibility to report unacceptable behaviour

We all have a responsibility to report unacceptable behaviour in the workplace, no matter our title. The *Operating with Respect* online module provides a great overview of the way bullying, discrimination and sexual harassment has impacted our profession, and shows clearly why we need to keep working to address it. From our position as leaders, surgeons have a responsibility to lead the charge.

2. We must respect everyone around us

From our Trainees, to nurses, to registrars and first and foremost, our patients, we must show them respect. Historically, our work culture has been as surgeons, ordering others around and taking a hierarchical approach to the workplace. The *Operating with Respect* course teaches us we

must all come together and work cohesively. We all have the right to a workplace free of discrimination, bullying and sexual harassment.

3. As teachers, we need to give constructive and effective feedback

It's easy for Trainees or IMGs to feel intimidated. They look up to surgeons and can feel vulnerable in the learning environment. At the same time however, they need to fulfil certain criteria in the training program, so it's important they receive timely, honest and tactful feedback on their performance. If feedback is withheld or conveyed in a belittling manner, it can be destructive, so we need to ensure feedback is constructive and helpful. Trainees or IMGs should never be made to feel threatened or unsafe in the workplace.

It's important to set aside time for providing feedback to your Trainees as close to the direct observation of practice as possible. We have a responsibility to our Trainees to mentor them.

4. Effective communication is crucial for patient safety

Two-way communication needs to be effective to care for the patient. The Trainee is there to learn and if they don't know what they're doing wrong, they have no way of improving. If a Trainee is doing something right, provide them with positive reinforcement. We cannot do our work without the support of our team, so be direct and specific. By creating a respectful workplace, we create an environment where everyone is comfortable to speak up and create a dialogue and that leads to better patient outcomes.

5. We're on a journey

As teachers, we must remember that we are all human and we do have weak and vulnerable moments. High standards of behaviour, in and out of theatre, are expected of us as surgeons. That means showing respect and calling out unacceptable behaviour.

The *Let's Operate with Respect* campaign offers the opportunity for us to work together to ensure all of us – consultant surgeons, Trainees and International Medical Graduates – are working as a team, driving the best in patient outcomes.

Complete mandatory training now. Find out more at: surgeons.org/about-respect



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.



LET'S OPERATE WITH RESPECT

Find out more: www.surgeons.org/respect

Being an expert witness



MICHAEL GORTON AM
Principal, Russell Kennedy Lawyers

Many doctors will already have experienced the thrill of acting as an expert witness in court or tribunal proceedings. Most doctors will already have been engaged to prepare medical reports in relation to patients, or on a referral basis. These reports are often undertaken in circumstances where their conclusions will affect the outcome of litigation or legal process.

Particularly with the increase in personal injuries litigation, medico-legal reports are an important part of the evidence presented to support or diminish a plaintiff's case.

Where a doctor has examined a patient, or where the doctor has supplied a medical report, he or she may be called to give evidence in relation to his or her observations in the examination, or the comments made in the report.

The doctor is an expert witness, because of the special skills and knowledge of the doctor in relation to the medical condition of the patient. Doctors should remember, however, that they are giving expert evidence as to the 'medical' condition of the patient, not the financial condition of the patient, not necessarily the demeanour of the patient, the doctor's views on MediCare or WorkCover, or other political issues! Information supplied by the doctor should be relevant to the medical issues only.

Accordingly, doctors should ensure that their reports or evidence in court is:

- *accurate*
- *fair and impartial*
- *clear, concise and as unambiguous as possible*
- *within the specialty or medical skill or knowledge of the doctor, or his or her expertise*
- *relevant to the medical issues involved.*

In preparing a medico-legal report:-

- 1 Stick to the facts as you know them. Check the medical records and other documents and don't rely on memory.
- 2 Clearly identify the patient, the condition, the treatment and other relevant information involved in the care of the patient.

- 3 Avoid jargon, abbreviations and medical terms which would not be obvious to a lay person.
- 4 Be clear when you are expressing an opinion, rather than referring to a fact.
- 5 Keep your opinions to within your medical expertise and speciality. Avoid extravagant claims, or stating opinions that go beyond your expert medical knowledge.

Always ensure that the patient has consented to the preparation of the report. In many cases this would be evident from the fact that the patient or patient's file has been referred to you for this purpose.

Always remember that the report is likely to be used in litigation, and you will be required to substantiate the contents of your report, including your opinions, under oath.

The doctor is asked to assist the court to provide an objective view of the medical situation in relation to the patient. The doctor may be assisting the court to determine the nature of the injury or ailment of the patient, the nature of the damage which the patient has suffered, the prognosis for recovery, and other relevant matters.

In relation to court and tribunal processes, normally the doctor would be issued with a subpoena, requiring the doctor to attend at court at a particular time. Arrangements may be made with the solicitors involved to defer the time for attendance, but doctors should remember that a subpoena is an order from the court to attend, and failure to attend could be a contempt of court.

In giving evidence, the party calling the doctor will conduct the 'examination in chief'. These are the preliminary questions of the doctor to explain the facts and expert opinions of the doctor in relation to the issues at hand. The 'opposition' solicitors will also have an opportunity to 'cross examine' to challenge the evidence and views of the doctor.

Doctors should therefore remain objective at all times. Doctors should 'stick to the facts'. The doctors' 'expert' opinion should be based on factual and objective grounds.

If the doctor cannot remember all that has occurred, he or she is allowed to review their notes or the medical report to assist in recollection.

If the doctor does not understand a question, he or she should ask to have it clarified.

Obviously court processes can be frustrating, time consuming and protracted. The court process may have little regard for the timetable and scheduling of the doctor's practice.

Nonetheless, expert opinion from medical practitioners is an important part of the legal process. Good, clear, credible evidence of a doctor can 'make or break' many legal cases.

If a doctor is in doubt as to whether they must answer a subpoena, or concerned about the nature of the evidence which they are to give, the concerns can be discussed with their MDO representative, or their own legal adviser.

Do Gnu Methylate?

DR BB-G-LOVED

My lack of knowledge about methylation and our need to methylate was revealed by running annual blood tests on Dr Devol Gnu, one of my g-nicer patients. Devol Gnu has g-tended to have a low serum B12 for optimum neurological health [best above 250pmol/L] though folate levels have always been good. Given low-ish B12s are significantly associated with cognitive impairment over time, I had requested serum homocysteine, which was raised (22umol/L; normal 3.7-14umol/L). I was discussing the g-latest set of results when Dr Devol Gnu asked me to check MTHFR gene status. Would the MTHFR genotype affect methylation ability? Would this affect Devol Gnu's general health, wellbeing or ageing?

So back to organic chemistry basics: Methyl groups consist of one carbon and three hydrogen atoms whilst methylation is the addition of a CH₃ group to another molecule. Our nucleic acids, body proteins, neurotransmitters, antioxidants and immune systems depend on such methylation. Without adequate methylation we tire, wear out and fail to repair across a number of different systems.

A recent Family Physician Review explains that MTHFR stands for methylene-tetrahydrofolate reductase, an enzyme that converts 5,10 methylene tetrahydrofolate into 5-methyltetrahydrofolate. Genetic mutations on chromosome 1 reduce enzyme capacity so less folate is bio-available. Current tests focus on two of the many polymorphisms or mutations: C677T and A128C [If you can remember these codes at the end of this article you don't have cognitive impairment!]. MTHFR is a hot 21st century topic, though for surgery it is more relevant to a surgeon's health rather than their practice. A pubmed search on MTHFR will yield

over 6000 articles, some 10 per cent of which are reviews, and there are 200-odd clinical trials (some very odd), but some in really high impact journals.

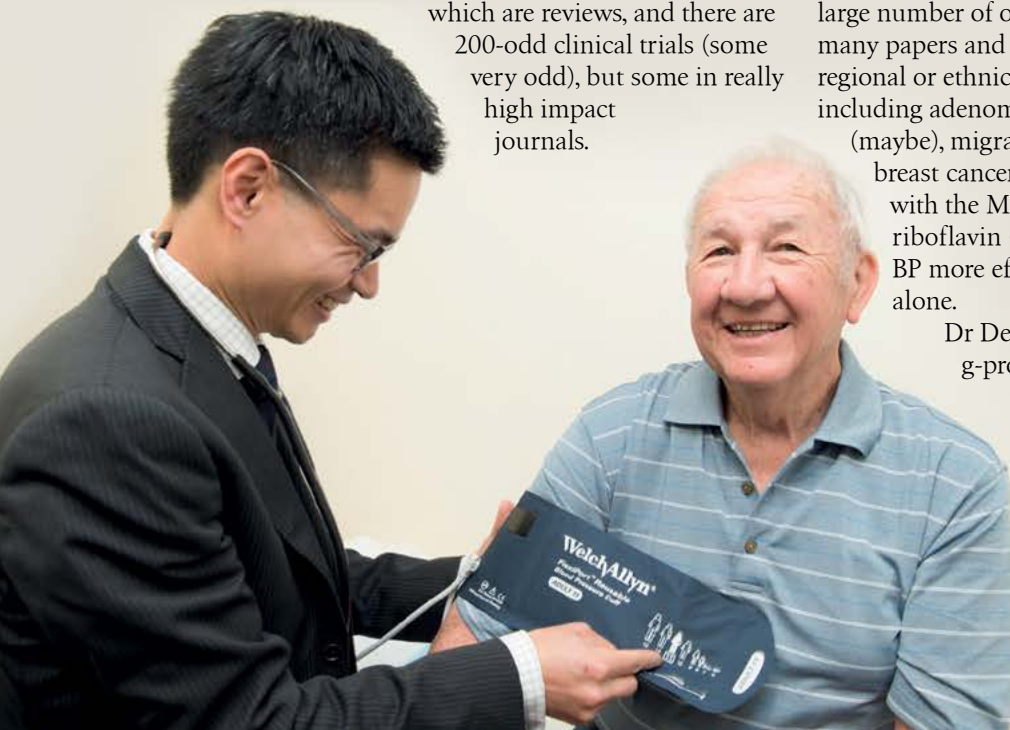
Homocysteine is a by-product of the amino acid, methionine, which instead of being excreted in the urine can be recycled by methylation back to methionine or the antioxidant, glutathione, but the process depends on vitamins B12, B6 (pyridoxine) and B9 (folate) as well as MTHFR enzyme. Deficiency of any of these three B vitamins, results in the accumulation of homocysteine. Raised levels may be associated with cognitive impairment, lack of ability to metabolise toxins or heavy metals, reduced anti-oxidant activity (glutathione), less neurotransmitters and poor inflammatory response. The recycling and methyl group availability is therefore fundamental to mitochondrial function, blood and immune cells, and general well being.

Elevated homocysteine levels have been associated with cardiovascular disease and CVD mortality, hypertension, increased aortic diameter [and aneurysm], myocardial infarction and stroke. Pregnant women are more likely to suffer pre-eclampsia and its complications or have a child with a neural tube defect (hence folic acid supplementation in women planning to reproduce).

The most common MTHFR mutation is MTHFR C677T, the prevalence of which varies with ethnicity. In the USA 20-40 per cent of the Caucasian and Hispanic populations are heterozygous (reduced enzyme function to 65 per cent of normal), though it is less common in African Americans (1-2 per cent). In both the USA and Australia 8-20 per cent of the population are homozygous with only 30 per cent of MTHFR enzyme function. The other mutation, A1298C affects 7-12 per cent of North American, European and Australian populations though is less common in Hispanics and Asians (1-4 per cent).

The consequence of having a MTHFR mutation include hypertension, cardiovascular disease, DVT/PE, pregnancy induced hypertension and its complications, though in countries where food is fortified by folic acid, probably only in individuals whose homocysteine levels are raised. A large number of other conditions have been studied in the many papers and reviews previously mentioned that report regional or ethnic associations [not the same as causality] including adenomatous polyps (probably), gastric cancer (maybe), migraine (some association) with aura, and breast cancer (probably not). Hypertensive individuals with the MTHFR 677TT genotype, benefit also from riboflavin (B2) supplementation, which can decrease BP more effectively than antihypertensive drugs alone.

Dr Devol Gnu is, g-like many of my patients, g-prone to hypertension. Best to reduce homocysteine levels to normal so I said, "G-lets do the MTHFR gene test (\$30-90 depending on the lab) but g-lets be careful in interpreting it." I g-hope readers will excuse my Flanders and Swann, or check You-tube for "I'm a Gnu".





Earle Page FRACS: truant surgeon

Sir Earle Page. (1880-1961)

**PETER F BURKE
FRACS**

Earle Christmas Grafton Page was born at Grafton on August 8, 1880, the fifth of 11 children. His father was London-born Charles Page, blacksmith and coachbuilder and his mother, Johanna, was born in Melbourne.

His family had held civic office intermittently at Grafton since 1860; Earle's grandfather opened the first primary school in northern New South Wales and his father was responsible for establishing the first secondary school north of Maitland.

Page traced his interest in the medical profession to a family incident when his mother accidentally sustained a steel foreign body in one of her eyes: treatment was unavailable in Grafton and she made the long return journey to Sydney, many times, in a vain attempt to save its sight.

Encouraged by his mother, Page excelled at Grafton Public School before winning scholarships to Sydney High School and the University of Sydney graduating from Medicine at the top of his final year in 1901, aged 21.

He was offered a position at the Royal Prince Alfred Hospital, spending his first year as a house surgeon and was then invited to remain as pathologist: Page noted, "soon after I assumed the position three people died of rare diseases on the same day and post-mortems were called for".

In those days rubber gloves were not used and the pathologist smeared his arms with vaseline up to the elbows: the first case was that of peritonitis following bowel perforation after typhoid: cellulitis soon involved Page's

upper limbs and he recalled that his death was anticipated within three days, such that all his friends, and the 'honorarys' came to bid farewell and to sympathise on the sudden termination of his young career.

The assistant superintendent then made stab incisions in Earle's arms "in forty places"; fomenters were applied for three days and he recovered! Page thereby gained an enduring philosophy, and, losing all fear of death, made certain to do as much in each remaining day as he could.

His hospital appointment was terminated and after recovering, he commenced as a junior partner in

a medical practice at Grafton and was soon performing many daring and successful operations. Sydney colleagues judged him among the best surgeons of his generation and his practice soon spread far along the coast and inland: his bowel anastomotic techniques were perfected weekly with the intestines of a fresh pig!

He built a modern private hospital with all aseptic and antiseptic accessories, even equipping it with an x-ray plant equipped with batteries. He had one of the first cars in northern New South Wales and in 1908 purchased a 20 hp 'Itala', the first to reach Australia, and had a body built at Grafton by his father such that it could be used as an ambulance to carry sick patients, long before there were any ambulances in the country.

He served in the First World War sailing to Egypt in February 1916 with the Army Medical Corps. He became bored with the slackness of medical work and Sir Neville Howse V.C. allowed him to spend a couple of weeks visiting the Aswan Dam which had just been completed: Page learnt a lot about irrigation from the British engineers, furthering his interest in water conservation.

Later he served as a surgical specialist in the Australian casualty clearing stations on the French Front: when heavy fighting was going on, dealing with as many as 900 cases a day.

He returned and became Mayor of South Grafton with many ideas; his obvious ability and tireless enthusiasm won him supporters and finally the Federal Country Party was formed and Page became Party leader in April 1921.

In politics, he displayed the ruthless precision and timing that had made him a first-class surgeon and businessman.

Stanley Melbourne Bruce in 1923 established a coalition government with Earle Page as the Deputy Prime Minister.



TRUANT SURGEON

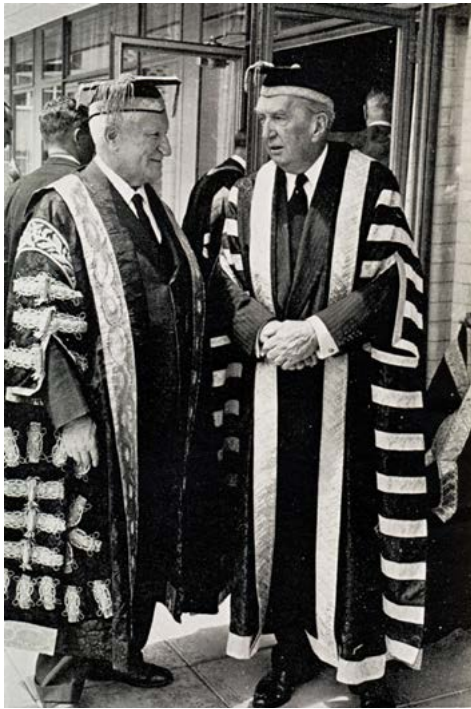
*The Inside Story of
Forty Years of Australian Political Life*

by

SIR EARLE PAGE

P.C., G.C.M.G., C.H., M.B., Ch.M., F.R.A.C.S.,
F.R.C.S. (Hon.), D.Sc. (Hon.), M.P.

A copy of Truant Surgeon can be found at the RACS Library – Ed.



In his first speech to Parliament in March, the new Prime Minister laid out his policies including the establishment of the National Capital: this was unfinished business from 1913, a result of the 1914-1918 war.

Building Canberra and transferring the seat of government from Melbourne in 1927 was a major task for the new Bruce-Page government: as

government income expanded, Page reduced Federal land tax and income tax.

Page recalled in his autobiography that both Neville Howse and he, "assisted in bringing into being the Royal Australasian College of Surgeons, which held its inaugural meeting in Canberra in March 1928, when we both became foundation members."

The new College of Surgeons of Australasia was offered a site in Canberra, however fears were expressed that any building there might become a 'white elephant' and ultimately Melbourne was chosen as the geographical centre of the south-eastern Australian seaboard.

In 1931 Page negotiated a pre-election pact with Joe Lyons and the 1934 election once more gave the Country Party the balance of power when Lyons was forced to accept a coalition. On Lyon's death in April 1939, Page became caretaker Prime Minister for 19 days until the United Australian Party elected a new leader, Robert Menzies.

Page was 5 feet 8 ½ inches (174cm) tall, blue eyed, with a shock of wavy brown hair; robust, possessing the delicate hands of a surgeon and the brawny forearms of a blacksmith.

He rode a horse and played a daily hard game of tennis until he was over 80, playing it, as he did politics, with scant regard for the rules. He habitually punctuated his speech with the refrain "you see, you see" and would assume agreement and be on to the next point before the listener could get a word in.

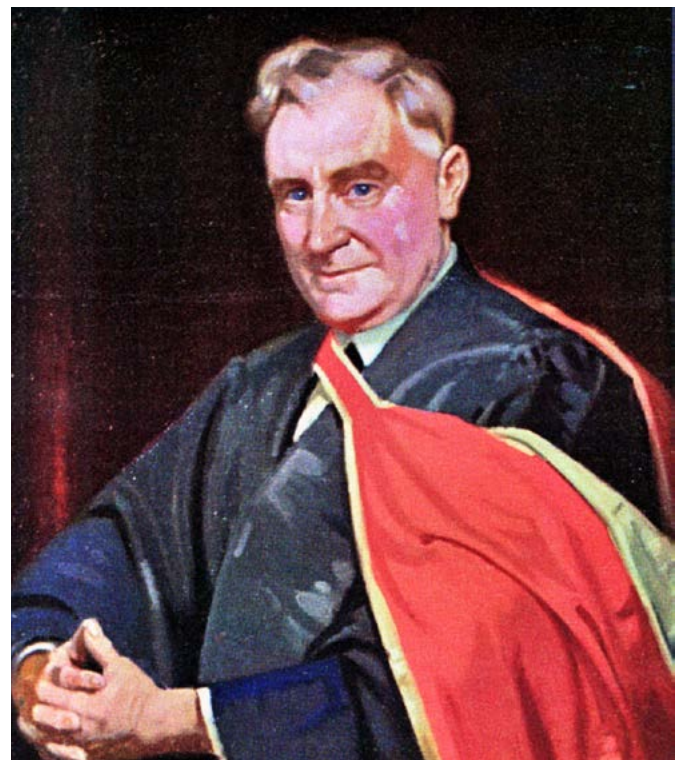
He married Ethel in 1906 and the union produced a

daughter and four sons; Ethel died in 1958 after a marriage of some 52 years, and Page married his secretary in 1959, not long before he lost his life to cancer in December 1961, and his parliamentary seat, after forty years.

His honours were many having been appointed to the Privy Council in 1929, made a GCMG in 1938, a Companion of Honour and installed as first Chancellor of the University of New England with the award of an honorary Doctorate of Science.

While Page was on service in England in January 1942, the Council of the Royal College of Surgeons conferred an Honorary Fellowship upon him. The award was made partly because of his services to surgery and partly because of the honour he 'brought to our profession by his distinguished career as a statesman'.

In reply, Earle Page noted his deep appreciation of this honour stating, "*Though I have had a varied life, at heart I am only a truant surgeon. Surgical training is most valuable for political life. The most needed and least common thing in politics is diagnosis before treatment. Too often political treatment is empirical. A huge poultice is clapped on the cancer to hide it from the public, instead of doing a complete excision. The next most important thing needed in politics which our life and training teach is quick decision and immediate action on the decision. With this combination of early diagnosis, quick decision and immediate action, half the political and international troubles would never arise*".



Images (Clockwise from top-left): Earle Page; Two Chancellors: Lord Bruce, first Chancellor of the Australian National University, and Sir Earle Page, first Chancellor of the University of New England; Portrait, Australian Parliament House, Historic Memorials Collection; Discussing malaria problems at an Australian General Hospital, New Guinea, WW2; Truant Surgeon frontispiece; Meszaros medallion.



Margarita Philosophica Nova

The 16th century encyclopaedia of knowledge

GEOFF DOWN
RACS CURATOR

The Royal Australasian College of Surgeons acquired Leslie Cowlshaw's collection of rare and historic medical books late in 1943, through an inspired piece of executive decision-making by then President (Sir) Alan Newton, and quick work by John Laidley, Chair of the New South Wales Regional Committee, and Kenneth Russell.

The collection is not focussed solely on surgery, or even on medicine. Cowlshaw's broad view of the history and development of medicine, and its place in society, meant that his collection covered an expansive range of subjects, including philosophy, history, biography, science and the occult.

Of those books that are not specifically medical in nature, the *Margarita Philosophica Nova* is among the most important. It is in fact an encyclopaedia, containing more or less the sum total of human knowledge as it was in the early years of the 16th century. Its importance to medicine lies in its illustrations, among which are some of the earliest depictions of the thoracic and abdominal organs (Image 4), and the oldest schematic representation of the human eye (Image 3), in a printed book.

The title translates as "New Pearl of Philosophy", and the first edition is said to have been printed at Heidelberg in 1496. It was the work of Gregorius Reisch (c.1467-1525), Prior of the Charterhouse of St John the Baptist near Freiburg-im-Breisgau, and Confessor to the Emperor Maximilian I. It was an extremely popular publication, and went through a number of editions in a very few years. Its format is catechetical, ie the student asks a question, which the master then answers.

The College's copy is the edition published on 31 March 1508 in Strasbourg by Johann Grüninger. It has been rebaked, but retains its authentic leather-covered oak boards, finely

decorated with stamped roses, fleurs-de-lis, and other plants. The leather straps and brass clasps which once held it closed are however long gone.

The text is comprehensively illustrated with original woodcuts. The artists of these handsome illustrations are unknown, and are referred to simply as "MW" and "Master DS". They were contemporaries of the great engraver and woodcut designer Albrecht Dürer, and while clearly not taught by him, have nevertheless fallen under his pervasive influence.

The margins of many pages have been copiously annotated in at least two different hands (Image 2).

Most important is the representation of *Philosophia* (Image 1). She is shown standing in the middle of a circle, surrounded by the seven Liberal Arts. She has three faces, looking into the past, the present and the future, above which hovers a crown. The three faces give her the character of *prudentia*, and the crown symbolizes victory over ignorance. She holds a book, representing knowledge, and a staff, representing authority. She has wings, like an angel or a *nikē* (victory) figure. The Liberal Arts are represented as female figures holding an attribute, and their names are inscribed around the circle. Logic gestures, Rhetoric holds a scroll, and Grammar holds a grammatical table. Arithmetic holds an abacus, Music a harp (with a lute lying at her feet), Geometry a pair of compasses, and Astronomy an armillary sphere. In the corners below are two figures. The one on the left is Aristotle, representing *philosophia naturalis*, and on the right Seneca, representing *philosophia moralis*. Above the circle are the four Doctors of the Church, Saints Augustine, Gregory the Great, Jerome and Ambrose. In the top centre is the Dove of the Holy Spirit, here labelled *philosophia divina*.

This great work was intended to guide the reader towards wisdom and enlightenment. Anyone who read this book and learned its lessons could stride out into the 16th century, secure in the knowledge that there was nothing more to know. If only it were that simple today!



Image 2

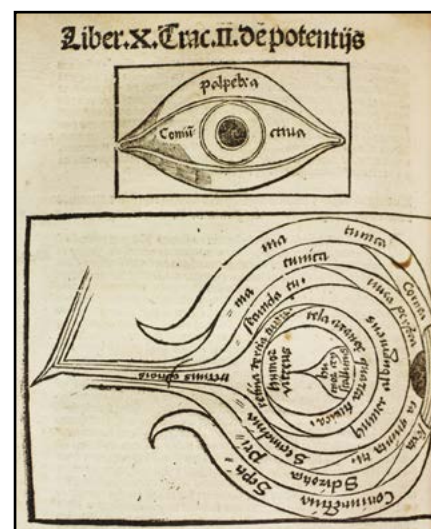


Image 3

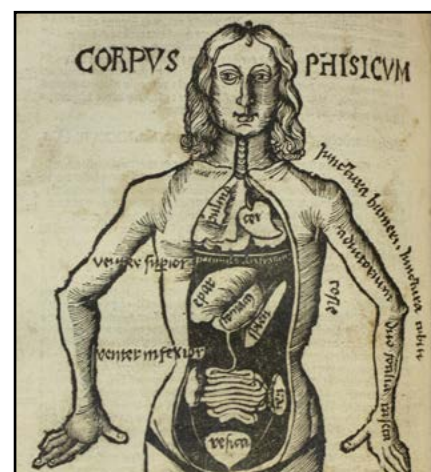


Image 4

Image 1: (Opposite page)

Case Note Review

Haemorrhage post-prostatectomy associated with chronic myelocytic leukaemia



PROFESSOR GUY MADDERN

Surgical Director of Research and Evaluation
incorporating ASERNIP-S

Case summary

An elderly patient had been catheterised for urinary retention for a month and was admitted electively for a transurethral resection of the prostate (TURP). The patient had known chronic myelocytic leukaemia (CML) but there was no documentation of the date of diagnosis or any known thrombocytopenia. However after a cystoscopy, litholapaxy and bladder neck incision several years prior, the patient suffered an unconscious collapse and cardiac arrest secondary to massive haematuria, requiring blood transfusion and fresh frozen plasma (FFP). There was no mention of the CML or thrombocytopenia in the discharge letter at the time.

Thrombocytopenia was noted in the pre-admission clinic and a preoperative platelet transfusion was planned. The patient was admitted to hospital the day before surgery. A duty haematologist was contacted and advice given to transfuse a unit of platelets prior to surgery.

The following day the patient received the platelet transfusion then underwent a TURP. There was no mention of anything untoward in the operation note. The urine was described as being dark rose on return to the ward and then in the early hours, went into clot retention

and became hypotensive. The patient was given Gelofusin, transfused and returned to theatre later in the morning. At cystoscopy, the clots were evacuated and the only bleeding site was a resected area in the bladder. The patient was taken to Intensive Care Unit (ICU) while still intubated and ventilated, where he received a large number of units of blood, a couple of units of FFP and a couple of units of platelets. A few days later the patient was transferred back to the ward with a catheter and irrigation. The catheter was removed several days later but the patient failed to void adequately and was recatheterised the next day. Irrigation was started again because of dark haematuria and clots. Bleeding continued and that evening the patient was noted to be anaemic and hypotensive. After further discussion with a haematologist, blood was transfused but platelets were not given.

The patient continued to bleed and required bladder washouts. The patient remained hypotensive and tachycardic until suffering a cardiac arrest. The patient was resuscitated, intubated and ventilated and transferred to ICU, but died soon afterwards.

Assessor's Comment

This patient had a very significant complication with the previous urological procedure, namely a cardiac arrest from profound haemorrhage related to CML with thrombocytopenia. This led to an extra-careful preparation for this potentially life-threatening surgery. There should have been very active involvement by the haematologists both pre- and postoperatively. If this was unavailable at this hospital, perhaps the surgery should have been performed at a more central location. It appears likely that there was inadequate platelet function, despite at times a platelet count that was above the usual recommended threshold for platelet transfusion. The management appears to have been very reactive rather than proactive and the patient probably should have been monitored in the high dependency unit or ICU for longer, or returned earlier when the situation deteriorated.



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Cancer researchers find Achilles Heel in mutant gene



General surgery Trainee Dr David Liu has identified a specific vulnerability in cancers harbouring mutations in the master tumour suppressor gene known as p53 which has the potential to fundamentally shift the focus of molecular cancer research.

Widely known as the ‘guardian of the genome’, p53 is involved in correcting genetic defects and maintaining genomic stability. It has been known for some time that p53 is mutated in the majority of cancers, and this commonly results in chemo-resistance and poor patient outcomes.

Working on a PhD investigating molecular therapies to treat oesophageal adenocarcinoma (OAC), Dr Liu and the research team at the Peter MacCallum Cancer Centre discovered that mutant p53 predisposes cancer cells to oxidative damage, a weakness that could be used to kill such cells.

“An effective therapeutic strategy to target mutant p53 tumours is widely considered the holy grail of cancer medicine,” Dr Liu said.

“Our discovery that mutant p53 protein predisposes cancer cells to oxidative damage meant that we found an ‘Achilles heel’ that could be exploited.

“We found that mutant p53 directly suppressed key defence mechanisms in cells that protects them against the damage caused by reactive oxygen species (ROS). We discovered a way to selectively kill mutant p53 cancer cells with ROS and we believe this represents a paradigm shift in how we can treat cancers with mutant p53.

“Our findings have now been confirmed by datasets from the Broad Institute of MIT and Harvard and The Cancer Genome Atlas, all of which suggest the same result.”

Dr Liu said of equal excitement was the fact that drugs currently prescribed for other medical conditions and

therefore already deemed safe for human use could be adapted to target the vulnerability.

He said a liver cancer drug currently used to treat inflammatory bowel disease had the potential to be repurposed to deliver ROS to kill mutant p53 cancer cells and that the team are now in the process of screening thousands of compounds to see which achieved the best outcomes.

Dr Liu said the discovery, now in the process of being patented with intellectual property protection, did not arise as a singular ‘Eureka’ moment, but emerged after years of painstaking research into molecular therapies to treat OAC, the most rapidly rising solid malignancy in Western society.

That increase has been directly linked to the mechanics of obesity which predisposes to oesophageal reflux and Barrett’s metaplasia, a necessary precursor of OAC.

The incidence of OAC has risen a staggering 600 per cent in the past three decades and despite advances in diagnostics, surgical care, radiotherapy and chemotherapy, the outcomes for OAC patients remain poor with an overall five year survival rate of less than 20 per cent.

One reason for this is that researchers have been hampered in their ability to find molecular therapies for the disease because of a lack of representative animal models in which to test novel therapies.

In 2013 and with RACS funding support, Dr Liu set out to overcome this problem by helping to build a tumour bank and working with scientists to create mouse xenograft models that replicated the histology, cell surface markers, oncogenic signatures and response to chemotherapy of the majority of OAC tumours.

Then, in collaboration with researchers at the Karolinska Institute, Sweden, the research team tested the efficacy of a drug, known as APR-246, and demonstrated potent anti-tumour efficacy in these novel animal models. APR-246 is a first-in-class compound that reactivates normal protein activity of mutant p53.

Dr Liu said that based on these results, a Phase II multicentre clinical trial of APR-246 will commence this year in Victoria for patients with advanced OAC.

As the third arm of his PhD, Dr Liu then turned his attention to studying oxidative stress pathways to selectively kill mutant p53 cancer cells.

“The discovery of the weakness in mutant p53 was very exciting but it didn’t just arrive as a light-bulb moment but emerged after years of work,” Dr Liu said.

“Only now, when I look back do I appreciate how lucky we were to find the connection and we are all very excited about this work and where it might lead.”

Dr Liu has submitted his PhD thesis and has already



Images (from left): With supervisors Wayne Phillips and Nick Clemons; VCCC award ceremony

published his research in prestigious international journals including *Nature Communications*, *Gut*, *Oncotarget*, *Discovery Medicine* and the *Annals of Surgical Oncology*.

His work has also been presented at numerous national and international conferences including the annual meeting of the American Association for Cancer Research held in New Orleans, 2016, at Digestive Diseases Week in Washington DC, 2015. He was also invited to give a symposium in Holland in late 2016.

He conducted his research under the supervision of Professor Wayne Phillips, a cellular and molecular biologist at the Peter MacCallum Cancer Centre and University of Melbourne, Dr Nicholas Clemons, a senior scientist, and Upper GI surgeon Mr Cuong Duong.

Dr Liu said that his research findings were achieved through national collaborations between the Victorian Comprehensive Cancer Centre, the Austin Hospital, Flinders University, the Queensland Institute of Medical Research and St Vincent's Institute of Applied Medical Research in Sydney.

His team also partnered with the Karolinska Institute, the Edinburgh Cancer Research UK Centre and the Academic Medical Centre in Amsterdam.

Throughout his PhD, Dr Liu has received strong support from RACS and was the recipient of the Foundation for Surgery Reg Worcester Research Fellowship (2013), the Foundation for Surgery John Loewenthal Research Fellowship (2014) and the Foundation for Surgery Eric Bishop Research Scholarship (2015).

Now as a SET3 Trainee, Dr Liu said he hoped to specialise in Upper GI surgery and maintain a strong academic focus throughout his surgical career.

– With Karen Murphy

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ACADEMIC HIGHLIGHTS

- 2016:** Excellence in Cancer Research Prize: Victorian Comprehensive Cancer Centre and the Picchi Foundation
- 2016:** Harold Mitchell Travel Fellowship: Harold Mitchell Foundation
- 2015:** RACS Eric Bishop Research Scholarship
- 2015:** RJ Thomas Research Prize: Peter MacCallum Cancer Centre
- 2015:** Cancer Therapeutics Scholarship: Cancer Therapeutics CRC
- 2014:** New Investigator Grant: Peter MacCallum Cancer Foundation
- 2014:** Foundation for Surgery John Loewenthal Research Fellowship
- 2014:** Robert J Thomas Award in Surgical Oncology: RACS
- 2013 & 2014:** Surgical Research Society Travel Grants
- 2013:** Foundation for Surgery Reg Worcester Research Fellowship
- 2013:** John Ham Medal: General Surgeons Australia
- 2013:** DCAS Scholarship: General Surgeons Australia/ RACS
- 2012:** Postgraduate Medical Research Scholarship: NHMRC

Solution may lie at the fingertips of surgeons



Biomedical engineers, surgeons and scientists in WA are developing a 3D-printed thimble-sized device that could be placed within a surgeon's glove to allow them to detect microscopic traces of tumour tissue which are currently inadequately detected using palpation or current clinical imaging modalities.

Using micro-elastography, the device is known as the 'smart-glove' and is the first time in the world the technology has been designed to measure and quantify the stiffness

of tissue as a marker for the presence of microscopic tumour cells.

If successful, the glove will give surgeons an enhanced means of palpation to determine if all tumour cells have been removed via excision through simply running their finger around the cavity.

The fibre-optic-based technology will then alert the surgeon to the possible presence of remaining tumour cells while also providing magnified images on a near-by screen.

The device is being developed through the University of WA, the Harry Perkins Institute of Medical Research in Perth and the pathology department at Fiona Stanley Hospital.

Biomedical engineer and laboratory head Dr Brendan Kennedy is leading the research in close collaboration with Professor of Surgical Oncology Christobel Saunders to ensure the technology is both reliable and practical for use in theatre.

Dr Kennedy said he began thinking about the possible use of compression optical coherence elastography (OCE) in theatre almost a decade ago but seriously turned his attention to the development of a device five years ago after discussions with Professor Saunders and other breast cancer surgeons searching for a way to reduce the need for repeat surgeries.

He said that since then, the research team had first implemented a bench-top prototype, conducting clinical studies on more than 100 tissue specimens, then designed a hand held device and were now in the process of miniaturising the technology so that it can be fitted into the finger tip of a surgical glove.

"We believe that probing and measuring the mechanical properties of tissue on the micro-scale can aid in the

identification of diseased tissue which can then be used to guide medical procedures such as the excision of breast tumours," Dr Kennedy said.

"We are now at the stage where the hand-held probe is ready for trial while at the same time we will be analysing the use of the 'smart glove' in the laboratory and designing different types of feedback that will be of the most use to surgeons including visual, audio or tactile reactions to the presence of rigid tissue.

"This is a fascinating project which has brought together the skills and knowledge of biomedical engineers, clinicians, surgeons and pathologists.

"It's exciting in that we are not just measuring pressure and resistance; we are providing quantification of the stiffness of tissue which is unique in the world. Importantly, this means that our measurements should be more accurate and repeatable than related technologies."

Dr Kennedy said he hoped to be able to trial the 'smart glove' technology in theatre next year and that while it now had a small cable running from the finger tip probe to an imaging machine, he believed the device could be made wireless in the future.

In addition to Dr Kennedy, Professor Saunders and leading pathologist Dr Bruce Latham, the current research team comprises four biomedical engineering researchers, eight Masters and PhD students and two clinical researchers to co-ordinate with the other specialties involved.

Dr Kennedy said that while the device could have broad applications, the research team had decided to focus on breast cancer surgery because of the burden of disease and high rates of repeat surgery required to remove all tumour cells.

"Professor Saunders' leadership and advice regarding this research has been fantastic," he said.

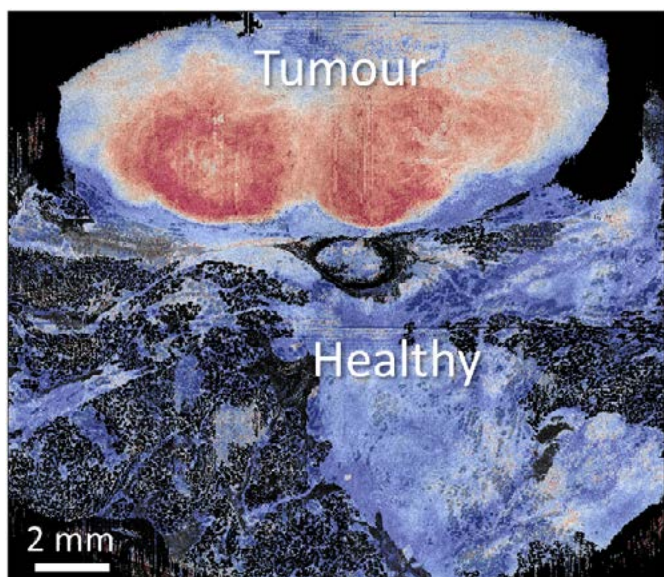
"She mentioned once how much she wished she had a magic wand that she could wave around a cavity to ensure that no tumour cells were left behind and that got me thinking.

"Then the close clinical and research links we developed allowed us to begin to best address the problem.

"We are developing compression OCE as a platform technology and believe it will be useful in treating vascular and lung disease while we are also in discussions with neurosurgeons.

"Basically, we believe the device will be useful at any time when a medical examination is conducted which requires palpation because it super-charges the sense of touch."

Professor Saunders said she had been involved in trialling



optical techniques to examine breast cancers and margins since 2002 in collaboration with Professor David Sampson at UWA in a bid to reduce repeat surgeries.

She said that up to 30 per cent of women need re-excision for involved margins because current imaging technology had limitations in the ability to accurately localise tumours that were impalpable for surgery.

She said that while OCE had the potential to improve tumour margin assessment and reduce re-excisions, it had to be practical for surgeons to use.

“We need not so much to assess tumour margins as assess residual disease and that means assessing the surgical cavity at a microscopic scale,” Professor Saunders said.

“However, the technology needs to be easily interpretable by the surgeon in real time, it needs to be ergonomic, it needs to be quick, it needs to be high resolution and it needs to be accurate.

“We need to be able to determine exactly how much tissue to remove at surgery and how much to leave behind in ONE operation so that we can achieve the best cosmetic as well as the best oncological outcome for the patient.

“We are now getting very close to using this technology to detect with accuracy microscopic tumour and if we can then miniaturise the probe into a glove without inhibiting the surgeon’s manual dexterity we could have a solution that could reduce repeat surgeries.”

Professor Saunders said the potential of the ‘smart glove’ technology proved the importance of breaking down research and specialist silos.

“Undertaking clinical research in collaboration with other disciplines often leads to novel and fruitful outcomes which improve our care and solve clinical problems and our work with the biomedical researchers on this device is a fabulous example of this,” she said.

“We hope this technology, in conjunction with other innovations we are trialling, could reduce breast surgery re-operation rates to less than ten per cent.”

– Karen Murphy

Images (from left): The glove; A micro-elastography image of invasive ductal carcinoma.

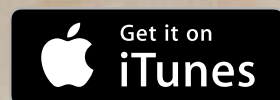
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Dr Janne Bingham under the IMG spotlight



If you had asked Janne Bingham ten years ago how she saw the next decade panning out, she probably would have given you a very different answer to the story that was to follow. Born and bred in Belfast, Janne had just given birth to a baby girl and was nearing completion of her surgical training.

But after a combination of spontaneous decisions, mixed with a little bit of luck and a lot of hard work, she now finds herself settled more than 16,000

kilometres away in Adelaide. And she couldn't be happier.

The adventure began in 2009, when Janne and her Fellow Northern Ireland Trainees were encouraged to consider spending a year abroad, and experience the inner workings of another country's health system.

"A colleague who had been a Fellow in the Royal Adelaide Breast and Endocrine Unit and thoroughly enjoyed it, suggested that I consider it as he thought I would be a good fit. At that stage my daughter was only two and half and in order to support me, my husband Paul took a 'career break' from his teaching job," Janne said.

"It was strictly for a year and we had no intention of making it anything more than that. But during that year we both fell in love with the place."

"We found there was just so much we liked about Adelaide. We really enjoyed all of the festivals throughout the year and the cultural side of things. There are also so many beautiful places close to where we lived, like the Adelaide hills, the wine regions and the beaches. Because the weather is so nice here compared to where we had come from, we were able to get out there and enjoy it."

After her year in Adelaide, Janne returned to a consultant job in Belfast where she remained for three years. However, her curiosity had been sparked, and throughout that time she maintained contact with her former colleagues in Adelaide.

"I said tongue in cheek that if a job ever came up to keep me in mind, but I never really thought that it would happen. One day out of the blue a former colleague contacted me about a job that was going and encouraged me to apply for it.

"Paul and I talked about it and decided that we weren't thoroughly enjoying where we were. Maybe it was a mid-life crisis (laughs), but we just decided to go for it and if I got the job then great, but if not then at least we had tried. I was just as surprised as anyone when I was successful."

While Janne had achieved her goal, it soon became apparent that the hard work was only just beginning.

"I have to say the IMG process was difficult. I wouldn't lie to anyone by telling them that it is anything otherwise. There was a lot of paper work involved initially, which was followed

by two years of supervised practice, which involved frequent reporting and assessments."

"It was an involved process and I suppose a little bit stressful and tedious. A lot hinges on those two years and you certainly feel like your life is in limbo and your skills are being questioned. However, I understand why the requirements exist and I think the process is as fair as it can be, considering the nature what people are applying for."

Since migrating permanently to Australia Janne has become a shining example of the excellent contribution that IMGs can make to our society. She has quickly developed a reputation as a dedicated and highly respected surgeon who is popular amongst her colleagues and patients alike.

She has also shown a willingness to become involved in RACS activities through her participation in various training courses, and in 2016 she was elected to the South Australian Regional Committee.

She joined the committee at a particularly interesting time, owing to the South Australian Government's ambitious and controversial Transforming Health agenda, which affects almost every medical professional in the South Australian Health system and has divided opinion.

"I haven't been on many committees like the SA Regional Committee that are multi-specialty. At this stage I am still finding my way a little bit and learning about the system, but I think it's fascinating because there are issues that are similar to all of us regardless of our specialty."

"I think the committee represents a very important group and has a big advocacy role to play. Whilst we are mindful of the financial side of things that constrain governments, our priority must always be our patients. It is hugely important to ensure that structural changes do not impact upon the quality of care that we are able to provide."

Despite being a very different life to the one she envisaged ten years ago, Janne has no regrets about her decision to migrate to Australia.

"I would never have imagined that during my training I would end up in Australia. It is just by those small chances and opportunities along the way that our path changed. I have a long running joke with another colleague who migrated here as well, that if we weren't surgeons we would probably work for the tourism board because we love it here so much."

Her advice to others is that the process of moving to Australia is not an easy one, but if they have a goal to do so, then it is one worth pursuing and persevering with.

"When I look back on it, it doesn't seem like an awful lot. Whereas at the time it (the IMG process) felt like it was never going to end. I think being an organised person really helped me to keep on top of things."

"I can't speak for everyone as the skills assessment process will be different depending on their background, but from my perspective I would say go for it to anyone considering moving here."

Can I assist?

A rewarding transition to retirement



RANDAL WILLIAMS
FRACS, FRCS (Eng)

There is no mandated retirement age for Australian surgeons. Some may continue beyond optimal retirement age because of factors such as income, work satisfaction and personal fulfillment, however transitioning into retirement as a **surgical assistant** may provide some of these benefits with less demands and stress.

The only prerequisites are good health, a desire to remain involved, and an ability to adapt to the secondary role.

Since closing my general surgical practice in 2015 I have worked as a surgical first assistant in private hospitals in Adelaide. Perspectives from semi-retired surgeons who assisted me in the latter years of my practice helped me make the decision to do this.

Transitioning to retirement as an assistant allows you to maintain Australian Health Practitioner Regulation Agency (AHPRA) registration, control your choice of work and work load, minimise stress and ongoing responsibilities, and keep up with advances in the profession.

The positives for me have been keeping physically and mentally active, maintaining a professional identity, staying in contact with peers, and working with a new generation of surgeons and theatre staff.

You can work in your own specialty or venture beyond. I chose general surgery and its subspecialties, with occasional vascular, plastics and urology lists. I also found assisting with caesarian sections enjoyable.

I began accepting most assist requests within my parameters and then fine-tuned this according to my experience. Emergency cases, accepted selectively, were found to be interesting and satisfying, and where my experience was helpful at times.

Benefits of the surgeon first assistant

- Familiarity with theatres and technologies
- Expert assistance - 'educated hands'
- Experience / intuition
- Automatic 'second opinions'
- Enhanced extrication from difficult situations
- Mentoring and support for younger colleagues
- Minimal overheads: transport, smartphone, computer, medical indemnity insurance (much reduced), and professional subscriptions.

There may also be opportunities to teach students who have been seconded to private hospitals, and there are opportunities to observe judgment, skill and competence – a potential revalidation tool.

A senior surgeon assisting a junior colleague may increase the efficacy and safety of the procedure. My approach has been to offer advice only when asked for it or if it is clearly needed. Quiet words of encouragement during a difficult procedure can be helpful.

It has been enlightening to observe different surgical practices and new techniques, and to 'see how others do it'. I find myself frequently looking up unfamiliar topics and anatomy. I also have been able to keep up with medical news and politics via the interesting conversations which take place in operating theatres and tea rooms!

Some of the practicalities you should consider before taking on a surgical assistant role include getting a thorough medical check including vaccinations with your GP, registering with a surgical assistant service to manage bookings and billing and joining the Australian Association of Medical Surgical Assistants (AAMSA), which is an advocate, and a source of news and developments.

Tips

- Try assisting while winding down practice to ensure it is 'for you'
- Adopt qualities that you valued in your own assistants and aim to be a positive influence in theatre
- Keep workloads within your physical and mental capabilities
- Be patient - every surgeon does things a bit differently and delegates variably. It can take time to gain proficiency assisting with unfamiliar or complex procedures
- Ultimately, work with surgeons and hospitals you are comfortable with.

It's important to recognise that even though you have taken on a surgical assistant role, that there will still be physical demands, particularly on your back and feet. There still may be long or late cases which can be tiring and some bookings may be delayed. So wear comfortable, easy-change clothes and footwear. You no longer need a coat and necktie! Work on maintaining good health (watch theatre tea room 'snacking'), and continue to take regular breaks and attend conferences. Double-check your bookings - most of us have gone to the wrong hospital at least once, and if you're ever unsure of what to say use the 'co-pilot' analogy when explaining the new role to family and friends.

Finally, you must know when to stop. Assisting can be an enjoyable and rewarding transition to retirement but you must be honest in yourself and to others about your physical/cognitive capabilities, and be open to evidence of decline in function. Always seek objective opinion if you're ever in doubt and if you're no longer enjoying it, remember that it is always better to stop on your own terms.

If I could have taken 'time out' to assist colleagues for a period in mid-practice I believe I would have expanded my knowledge and horizons and returned a better surgeon.



International surgical community unites in Australia to save a young Indian girl

A team of surgeons at Monash Children's Hospital have conducted life-changing surgery on a toddler with complex abnormalities caused by 'soaking up' the lower anatomy of a twin sister in utero in a procedure that captured the imagination of people around the world.

The child, from Bangladesh, was born with a third leg attached to the back of her pelvis, no genitalia or anal opening but with two rectums, two vaginas, two uteruses and two sets of anal muscles.

Within days of her birth, Bangladeshi surgeons removed most of her third leg and created stomas to allow her to expel waste yet still the child experienced chronic infections and became severely malnourished.

However, while local surgeons felt unable to undertake the

complex reconstructive surgery required to help the child, representatives of the Children First Foundation believed she could be treated if she could be brought to Australia.

The charity approached the surgical team at Monash Children's Hospital and Associate Professor Chris Kimber, head of Paediatric Urology

and Paediatric Surgery, began discussions with her local doctors to gain a better understanding of her anatomy and condition.

Then, over the course of the following months he consulted international leaders in a bid to map out a surgical treatment plan.

These experts included Mr Mark Levitt, an international leader in Paediatric Colorectal Surgery from Columbus, Ohio; Professor Pierre Yves Mure, an expert in Uro-Genital Malformation from France; and Professor Phillip Ransley, former head of Paediatric Urology at Great Ormond Street Hospital, London.

In Australia, Assoc Prof Kimber also collaborated with Dr Justin Kelly AO, former head of Surgery at the Royal Children's Hospital in Melbourne and Dr Peter Borzi, senior surgeon at the Lady Cilento Hospital in Brisbane.

After months of discussions, the Monash Children's Hospital team told the charity they believed they could help although they were unsure if they could achieve total continence.

Even so, Choity and her mother Mrs Shima Khatunto were flown to Melbourne mid last year to stay on a farm outside the city so the toddler could gain weight and strength and undergo a series of tests, scans and endoscopic examinations.

Finally, in November last year after the team had devised a detailed surgical plan, Choity was brought into the hospital to undergo a seven-hour operation conducted by a six member surgical team led by Assoc Prof Kimber and Dr Juan Bortagary.

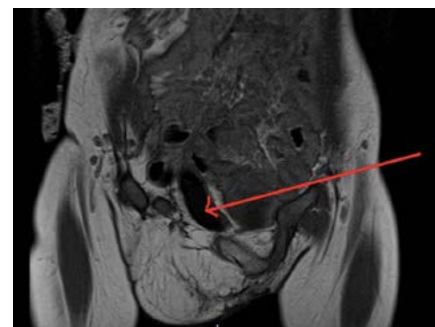
Other team members included surgeons from Myanmar, Bhutan, Vietnam and Fiji, some of whom are Rowan Nicks and RACS International Scholars.

Speaking to *Surgical News*, Assoc Prof Kimber said the team first began by removing the remainder of the leg from the pelvic cavity along with unwanted tissue while retaining attached muscles for use in other reconstructive procedures.

After this was done, the team began to electrically stimulate muscles in the pelvis to determine which were useful and were stunned to find that Choity had two sets of anal muscles which had never been seen before.

The discovery sent the team back to the white board to better





understand how they could use the extra muscles and over the next five hours they conducted a laparoscopic high cloacal repair, a urogenital sinus mobilisation, a laparoscopic pull through for a high anorectal malformation, a complex pelvis reconstruction with local flaps and an endoscopic rectal resection.

Assoc Prof Kimber said that during the first surgery they were able to move the urinary tract while the stoma was reversed three months later after further surgery to expand her anus.

"We really were not confident that we could achieve complete continence but that was our goal because we wanted to give her a chance to live in her local community and not be at risk of death from sudden infection," he said.

"The first good sign was finding that her spine was normal and that her nerves were functional but while we thought we could remove the remainder of the leg and divert the urinary stream, which was attached to the second rectum, we thought that achieving total continence would be unlikely.

"However, we redesigned her rectum and constructed an anus and she had all the anatomy inside that we needed so no foreign tissue was required to complete the reconstruction. She is on no medication and requires no physical therapy, which is a tremendous outcome."

Assoc Prof Kimber said that while some media outlets had described

Choity's surgery as the first of its kind conducted anywhere in the world, this was a somewhat of a misleading interpretation of the procedures undertaken.

He said the key to the success of her treatment lay in the collaborations formed with her local doctors, the relationship formed with her parents, the consultation with international experts and the careful and detailed planning that occurred over five months before she was brought into theatre.

"Children like Choity are very rare with few children ever born like this anywhere in the world so they represent a real challenge because we've got no pathway to follow," he said.

"However, all the procedures that we did have been done before, they just had to be designed in a step-by-step process that would allow us to first understand the unique anatomy presented and then reconstruct it.

"In the weeks leading up to her surgery, I was fortunate to be hosting Professor Phillip Ransley at my home in Melbourne and we spent many evenings discussing different approaches.

"Little Choity is now back home in her village, running around and playing and back under the care of her local doctors, which is a wonderful outcome given that she and her parents were overwhelmed by her needs and ostracised by their community before

we were able to treat her."

Assoc Prof Kimber said that while he was delighted with the outcome of the surgery, he stressed that although the Monash Children's Hospital had a robust international aid program, 95 per cent of its focus was on providing surgical training across South East Asia with only six to eight complex individual pro bono surgeries conducted each year.

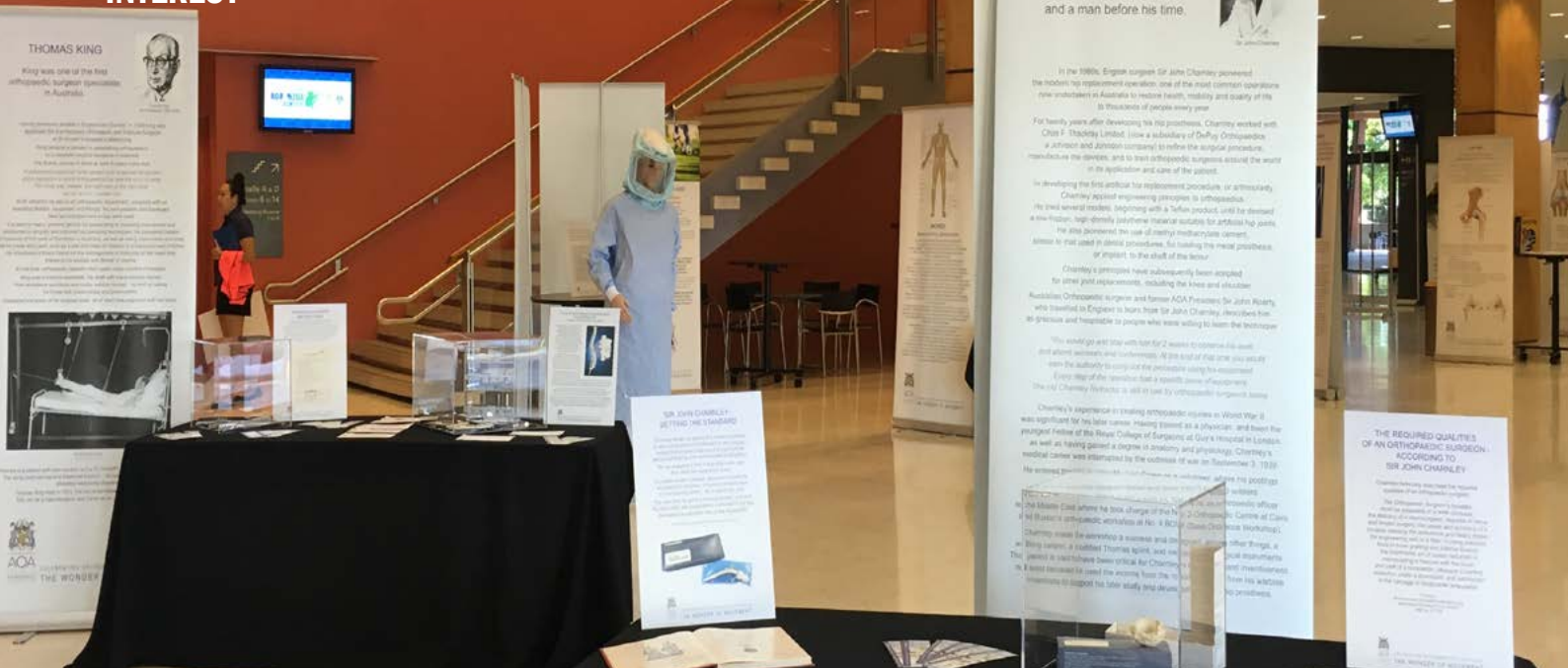
The key, he said, was finding children with conditions that could be treated in Australia that would allow them to live well in their home environment.

"These procedures are all conducted on weekends, they are funded through stand-alone foundations and they are selected after consultations with local specialists from the child's community by a hospital committee before we even consider applying for a visa or seeking extra theatre time," he said.

Children First Foundation is a Melbourne based not-for-profit charity whose mission is to transform the lives of children in need by providing them with excellent medical care regardless of where they are born.

— With Karen Murphy

Image (Clockwise from top-left): Choity today; During the operation; Choity, pre op Xray; MRI showing second rectum anterior to bladder; Shima, Choity and Associate Professor Chris Kimber.



Orthopaedic exhibition a hit – make no bones about it!

A travelling exhibition designed by the Australian Orthopaedic Association (AOA) to mark last year's 80th anniversary of Orthopaedic Surgery in Australia has proved so popular that schools, hospitals and public facilities across the country have applied to host it.

Called *The Wonder of Movement*, the exhibition was developed to showcase the history and progress of orthopaedic surgery and the contribution it makes to the wellbeing and health of the Australian community.

Based on a modular format designed to accommodate a variety of exhibition spaces and locations, the exhibition display items and topics covered include:

- A full-sized skeleton and surgeon mannequin
- A copy of a hieroglyph from ancient Egypt explaining how to treat bone fractures
- Orthopaedics in Wartime
- The evolution of Joint Replacement Surgery - with many hip and knee replacement samples
- Safe Sport for Kids – Youth Sports Injury Prevention Program
- A light-box and x-rays
- Robots and technology in contemporary orthopaedic surgery.

Since its launch in Cairns in October 2016, the Exhibition has been displayed in hospitals in metropolitan and regional NSW, at the Epworth Hospital in Melbourne and in the regional city of Bendigo, Victoria.

Throughout this year it will be displayed at venues across Queensland, then across Western Australia and later in the year it will be hosted by the Adelaide Lord Mayor and Mayoress.

AOA President and Dean of Education Dr Ian Incoll said that with more than 1.1 million orthopaedic joint replacements and tens of millions of procedures undertaken throughout Australia's hospital networks since 1999, it was time to celebrate the specialty that heals the sick and injured while helping thousands of Australians to regain their mobility.

He said the demand for the exhibition had been overwhelming and that he believed the exhibition would remain on the road for many years.

"I think this positive reaction to the exhibition is driven by the fact that orthopaedic conditions affect almost every family at some stage and cover the whole spectrum of life," he said.

"The exhibition was therefore designed for the community in order to educate them about the hundreds of orthopaedic procedures performed in more than 300 Australian hospitals every day.

"Orthopaedic surgeons use both surgical and nonsurgical means to treat spine diseases, sports injuries, degenerative diseases, infections, tumours, musculoskeletal trauma and congenital disorders.

"We also wanted the exhibition to celebrate the quality of work conducted in Australia because Australian Orthopaedic surgeons rank very highly in global terms while Australia has some of the best joint replacement outcomes in the world, as evidenced by our AOA National Joint Replacement Registry (AOANJRR) results.

"AOA members include world-class research scientists, highly sought-after international speakers and leaders in military healthcare, while we are also developing innovative educational initiatives such as our 21st century training program, AOA21 and Safe Sport for Kids."

Dr Incoll said the data collected by the AOANJRR since 1999, which captures 100 per cent of procedures performed, had proven to be of great value with an independent review estimating it had saved the Australian healthcare system more than \$600 million by decreasing the need for revision surgery.

He said the quality of the data collected meant that AOA surgeons could make informed choices and that underperforming prostheses were quickly identified and avoided.

“As an example, the AOANJRR was the first in the world to identify problems with the ASR hip replacement system and some estimates have suggested that more than 5,000 patients were saved from receiving this faulty implant. This also saved money for the healthcare system and unnecessary suffering for patients,” Dr Incoll said.

“Total Hip and Knee Replacement revision rates are falling in Australia, in contrast to a gradual rise in other developed nations, which is largely due to the evidence the registry provides to inform both surgeons and patients of their choice of prosthesis.”

Dr Incoll also praised the work being conducted by academic surgeons with research teams across Australia now working to prevent surgical site infections, regenerate bone, enhance understandings of the biomechanics of fracture healing and optimise the treatment of wrist fractures in the elderly.

He said that since the AOA was formed in 1936, Australian orthopaedic surgeons had led the world in wartime surgery, the treatment of club foot, in their advocacy of the compulsory use of seat belts, in the design and development of orthopaedic surgical equipment and stabilisation devices and the treatment of sports injuries including new practises in knee Arthroplasty procedures.

“We have also made great advances in orthopaedic oncology and genetics, notably in reconstruction surgery for soft tissue tumours as well as for bone tumours and our academic surgeons are now in the forefront of research in regrowing cartilage and using customised 3D printed implants and 3D scaffolding networks,” he said.

Dr Incoll said that although the exhibition was primarily funded by the AOA, initial funds had been provided by J&J/DePuy Synthes and Stryker. He thanked them for their support, along with all the AOA staff and surgeons who had contributed to its creation.

“The response we have received to the exhibition so far has been extremely positive and demand for it has greatly exceeded my expectations,” he said.

“We are proud of our achievements and we hope the exhibition might also open up the eyes of young people to a future career as an orthopaedic surgeon.”

– With Karen Murphy



Surgeons in Conflict

There is a new display in the walkway at Head Office. Surgeons in Conflict examines the role of surgeons in Korea, Vietnam, East Timor and Afghanistan. It also looks at current surgical projects in SE Asia.



Respect is a two-way street

RACS & Barwon Health sign an agreement to address bullying

Barwon Health is a leading Australian health care provider with services ranging from hospital, rehabilitation, elderly care, community health centres and mental health services. Founded in 1998, Barwon Health is among the largest comprehensive regional health services in Australia and also one of the country's largest regional employers. Its facilities include University Hospital, Geelong, the McKellar Centre, and five community service centres in Victoria, located in Corio, Belmont, Newcomb, Torquay, and Anglesea.

Earlier this month in Geelong it became the latest Australian health provider to sign a Memorandum of Understanding (MoU) with RACS aimed at building respect and improving patient safety in surgery.

The MoU commits both organisations to collaborate on the development of programs and processes to deal with discrimination, bullying and sexual harassment (DBSH) across the workplace, in surgery and in the health sector, generally.

The MoU is underpinned by both groups' shared values of respect and compassion.

The agreement outlines a shared commitment to effective collaboration and information sharing between the parties to facilitate quality specialist medical training in a safe environment, and one that is free from DBSH. Such an environment contributes to high standards of care, and timely access to care for consumers.

RACS and Barwon Health also commit to work together to ensure that surgical supervisors have the necessary

skills and attributes and are supported to provide training, assessment, feedback and support to Trainees and IMGs free of discrimination, bullying and sexual harassment.

The MOU provides the framework for a shared understanding of the relationship between the parties, which enables specialist medical training at Barwon Health, and responds to the need for a clear and mutual understanding of the roles and responsibilities of the parties.

RACS President Phil Truskett said both groups would work cooperatively together on these issues, and exchange information and take appropriate action wherever possible.

"Our role is to determine and maintain standards for the respective disciplines and provide national oversight and consistency for the training and education of medical specialists in those disciplines," Mr Truskett said.

Barwon Health Chair of the Board Dr John Stekelenberg said the agreement would strengthen initiatives to improve patient safety and enrich overall workplace culture.

"Our role is to provide accredited training places and employ medical specialist Trainees and Supervisors.

"Barwon Health will also provide overall support to specialist Trainees, and facilitate integration between training settings to ensure consistent regional health service delivery and quality learning experiences," Dr Stekelenberg said.

In May 2016, RACS launched Let's Operate with Respect – a campaign to help deal effectively with DBSH in surgery. Further information can be found on a dedicated new section on the RACS website called About Respect.



Images (From left): Prof David Watters, surgical registrar Yit Leang, surgical registrar Gausihi Sivarajah, RACS past-president Mr Phil Truskett AM; Mr Phil Truskett AM and Dr John Stekelenburg, Chair of the Barwon Health Board.

Safe Working Hours and Surgical Training



DR BEN CHAN
OHNS (NZ) Representative, RACSTA

What are safe working hours? This question has been the topic of much debate in New Zealand recently. After a series of strikes, the New Zealand Resident Doctors Association (NZRDA) negotiated a new contract that defined maximum consecutive working days for all junior doctors. With this new contract, junior doctors will work no more than 10 consecutive days or 4 consecutive nights and after this, 2 full days must be rostered off. In real world terms this means that if a Trainee worked 8 weekends and 3 weeks of night shifts in a year, they would now be required to have 25 extra days rostered off on top of annual leave. This will have an obvious impact on surgical training.

RACS released a position paper in 2013 regarding working hours and surgical training. It gave an excellent summary of studies that have looked into the effect of restricted working hours. They identified key issues with restricting working hours and rostered weekdays off based on training and safety:

Training:

- Loss of training opportunities including formal teaching sessions, multidisciplinary team meetings, and grand rounds
- Imbalance in operating case load mix with more acute minor operating and fewer complex major cases which are invariably done 'in hours'
- Loss of routine contact with surgical supervisors.

Safety

- Decreased continuity of care with an increased number of handovers required

- Consultant fatigue as restricting hours means that more junior staff will be required to fill out a roster. This will result in supervising consultants needing to provide more support overnight which will affect their ability to work the next day.

The European Working Time Directive (EWTD) was the first restricted hours roster introduced to surgical Trainees in 1998. In a series of follow up studies it was found that the majority of UK surgical Trainees felt that their training had deteriorated with the EWTD. Furthermore, they felt that their work/life balance had also deteriorated even though they were working less hours.

Based on international data, the position paper proposed that the ideal working week for surgical Trainees would be 65 hours (60 hours clinical plus 5 hours for handover and teaching). This took into account the balance between maintaining surgical skills as well as ensuring patient safety by minimising fatigue. Restricting hours to a 38 hour week would require extending training by 2 years to make up for the loss of surgical experience. The full paper is available on the RACS website and is well worth reading.

Safe working hours is a critical component to ensure patient safety but a blanket restriction of working hours is too broad an approach. The technical component of surgical training requires exposure, repetition, and real time feedback. Any roster that enforces weekdays off will take away from this and diminish training. It will be interesting to see the impact that this new roster will have on surgical training in New Zealand. Whatever the outcome, surgical training must evolve with the changing times. Discussions need to continue at all levels to develop realistic ways of identifying and reducing fatigue whilst maintaining training standards.



RACSTA
Your Trainees' Association



IN MEMORIAM

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

Terence Brumm (QLD)
Nikolas Kosanovic (VIC)
Rodney Laing (NSW)
Robert Loh (Singapore)
Dean Mackie (SA)
Robert Smith (NSW)

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

Informing the College

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

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

In Memoriam

RACS is now publishing abridged Obituaries in Surgical News.

We reproduce the first two paragraphs of the obituary. The full versions can be found on the RACS website at:

www.surgeons.org/member-services/in-memoriam/

Brian Thomas Shearman Otolaryngologist

29 June 1930 - 18 January 2017

It is with great sadness we announce the passing of Brian Thomas Shearman MB BS (Hons), DLO, FRACS, (1930 - 2017).

Brian grew up at Lindfield, was dux of Shore School and graduated with honours from Sydney University where he was awarded the Robin May Prize. Starting his ENT training at Sydney Hospital, he then undertook an otology fellowship in Detroit in the United States. He returned to ENT practice in northern Sydney retiring in 1997 to pursue other interests. One of his lifelong passions was music. Being an accomplished amateur violinist, he enjoyed his many opportunities to play in varied groups including the Doctors' Orchestra up until his death.

The Brian Shearman Memorial Fund has been established to celebrate his life and will be used to pay for an additional Scholarship in the NSW Doctors Orchestra Sydney Eisteddfod Instrumental Scholarships (16 - 25 years) from 2017 and into the future.

Robert Andrews Leggatt Urological Surgeon

18 July 1930 - 16 June 2016

Mr Robert Leggatt was born in 1930. He was educated at the Geelong College where he was actively involved in everything. He represented the school in the first football and cricket teams and won the long jump in the

combined public schools athletic competition. His school career culminated as "The Very Model of a Modern Major General" in the school production of the "Pirates of Penzance".

He commenced his medical course at the Mildura Branch of Melbourne University in 1949 before moving to Ormond College and graduated MBBS in 1954. He spent two years as a resident medical officer at Prince Henry's Hospital Melbourne, and in 1957 he proceeded to London with a letter of introduction to Sir Gordon Gordon Taylor.

He quickly passed the first part of the fellowship examination, gained further surgical experience in SHO and registrar positions at the Miller Hospital Greenwich, Epping, and Bedford gaining his Edinburgh fellowship in early 1960. He then worked as Registrar to the Urological unit at the Edgware District Hospital.

Thank You

A very special thanks to all those who have donated to the

Pledge-a-Procedure campaign

and showed their support for aspiring Indigenous surgeons.

We still have a long way to go to meet our goal, so please donate before
30 June at www.surgeons.org/donations/

Every donation during this campaign makes an incredible difference and supports aspiring Indigenous surgeons make a positive impact in their and all our communities. Let's walk together today.



Our sincere thanks to these incredible donors who supported the Foundation for Surgery in **April**:

Gold (\$10,000+)

Dr Katherine Edyvane Lions Recycle for Sight Australia Inc Prof David Scott

Silver (\$1,000 - \$10,000)

Australian and New Zealand Association
of Paediatric Surgeons

Clifford Craig Foundation
Rotary Club of Kew

Bronze (Up to \$1,000)

Mr Peter Anderson	Dr Eric Donaldson	Dr Roger Grigg	Dr John Mutu-Grigg	Mr Simon Tratt
Mr Edward Barui	Mr Roger Fasken	Mr Ross Harrington	Mr Brendan Rice	Ms Janina Tucker
Mr Russell Blakelock	Mr Neil Gannon	Mr Timothy Jansen	Mr John Sheehy	Mr Masashi Ura
Dr Michele Campbell	Mr Richard Sampson Genest	Mr Harry Learoyd	Mr Bruce Shelton	Prof David Whiteman
Mr Glen Crimmins	Mr Wayne Greensill	Dr David Morrissey	Mr Charles Tran	Mr Gerard Wilkinson

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

To find out more, please join us at www.surgeons.org/foundation



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Dr Neelam Bhardwaj
Avant member

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