ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 18 NO 4 MAY 2017

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The College of Surgeons of Australia and New Zealand

Foundation for Surgery

Passion. Skill. Legacy.

Pledge-A-Procedure

May/June 2017

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Surgical News Editor: Greg Meyer

Valuing our College Connections

JOHN BATTEN
President

It is truly an honour and privilege to be elected by your College Council to the position of President of this great college.

The Royal Australasian College of Surgeons (RACS) is a highly respected institution with a long and proud history of training generations of surgeons to a world-renowned standard. The FRACS brand is held in high regard globally and is synonymous with the community expectation of a well-rounded professional. Those who aspire to this brand need to rise to the high standards of service, integrity, compassion, collaboration and respect that define the College values in the interest of the public we serve.

To maintain those high standards, we need to be well connected: to our Fellows, our Trainees, IMGs, our patients and our domestic and international college partners. The health of our connections will determine the success or otherwise in all that we do.

As a College, all our connections need to remain open, transparent, two way and respectful. These connections are vast, diverse and frequently challenging, but vitally important for the relevance, and advocacy necessary to maintain the vision clearly outlined in the RACS Strategic Plan: *Leading surgical performance, professionalism and improving patient care*. Our modern College functions in the contemporary digital environment. Connecting our broad array of stakeholders effectively via the web and well managed social media platforms, e-committees, e-portfolios, e-commerce and e-learning will ensure that the two-way dialogue necessary to maintain the best interests of Fellows, trainees, IMGs, and the patients we treat, is first and foremost.

Our professional reach is considerable and can appear challenging and complex.

RACS has a training program across nine specialties, with 13 training programs, all managed and delivered by Fellows of this College, albeit with varying degrees of autonomy. Actively connecting with our specialty societies through partnering agreements ensures that the foundation platforms of standards, principles-based policies and governance are in place with total accountability. The Australian Medical Council requires this for our selection, training and assessment programs to be accredited and approved.

RACS is undergoing its third full accreditation in the last 17 years. The first accreditation, a voluntary undertaking, was welcomed even then as an exceptional opportunity for quality improvement and quality assurance activity. The accreditation process is now mandatory, but the opportunity to review and refine our quality improvement and quality assurance agenda is ongoing.

To uphold the standard of the RACS brand, we welcome and require independent confirmation that we have kept pace with the constantly changing surgical education environment. We need to know that our connections with the specialty societies are robust and transparent. We must meaningfully acknowledge our Indigenous peoples and action their rights to health equity and equality. We have a duty of care to patients, IMGs, Trainees and Fellows, to ensure that work places for training and surgical services are positive environments where respect and patient safety is paramount. We need to be confident that the public knows that when they seek acute or elective surgical services, that those services will be available on demand and of a high standard.

Genuinely connecting and collaborating with all of the stakeholders necessary to cement a positive accreditation cycle, reaffirms RACS investment in its brand. These stakeholder connections are so important to help Fellows, who fall behind or below the high standards that we define in our Code of Conduct, to be remediated and given appropriate support and mentoring to re-establish those standards. These connections will also inform and guide our engagement in the conversations about the revalidation models and methodologies presently being evaluated for medical practitioners in this country.

Connecting effectively with Government is critical if we are to inform appropriate and timely advocacy for funding priorities for surgical patients, based on sustainable, evidence-based interventions. Elected government officials need the guidance and wisdom of the surgical profession, through RACS, to appropriately prioritise the finite health budget.

Our Trainees represent our future. Trained under RACS-accredited oversight by specialty societies, loyalties can be sometimes confused. The RACS Trainee two-way dialogue has never been more important. Meaningfully connecting Trainees with the RACS facilitates, listening and mutual awareness. This means having a grounded appreciation of issues at the coalface and being able to respond appropriately and efficiently. For Trainees, connecting effectively with RACS enhances their understanding of the larger activities of the College, not just as the gate keeper of the FRACS post-nominal and the prestige and responsibilities that come with it, but to see their College as an open door, encouraging and enabling them to participate and contribute meaningfully to the profession.

Our largest stakeholder group are our Fellows. 7000+ in number, we all aspire to practice our discipline to the highest standard, in a professional manner with the welfare of our patients as our number one priority. Connecting with our diverse stakeholder group, RACS works to maintain the environment where these aspirations can be realised. We have a very broad offering of participation opportunities for Fellows to excel, not only as patient-centred surgeons with technical expertise, but also as collaborators, teachers, managers, health advocates, philanthropists and researchers. I encourage all Trainees and Fellows to explore these opportunities.

The year ahead will undoubtedly deliver its challenges and I will do my utmost to represent your interests in these conversations.

In accepting this role, I pay tribute to my colleague Phil Truskett, our President over the last 12 months. Phil has been a relentless advocate for promoting positive confidence in the profession by mandating a culture of respect in the surgical workforce. He has been a key partner and architect of the many initiatives, including the Diversity and Inclusion plan, and campaigns that have evolved from the *Building Respect and Improving Patient Safety Action Plan* initiative. His efforts have been tireless and evidence of this commitment speaks clearly for all to see.

I thank him for his enormous, selfless contribution to RACS over the last nine years, particular the last 12 months as your President.

I now look forward to this role, fully understanding the enormous shoes that I need to fill. I hope to catch up with you all at the ASC in Adelaide in early May this year.

Regards
John Batten

Walking together

CATHY FERGUSON
Vice President

As I take on the role of Vice President of our College, I am proud to also take on a formal role with the Foundation for Surgery, the philanthropic arm of RACS. I am a long term supporter of the Foundation for Surgery and am constantly inspired by the positive impacts achieved in our communities. Most of all, I am very proud to know that surgeons have not only achieved so much within their own careers but have also proven to be great philanthropists in supporting the Foundation for Surgery and its important work.

In today's world, the Foundation for Surgery is needed more than ever to meet the increasing and changing health needs of communities. The Foundation for Surgery is striving to ensure quality surgical care in our communities. To achieve this, the Foundation for Surgery supports three main areas:

- Global Health,
- Aboriginal, Torres Strait Islander and Māori Health
- Research.

As many of you know, over the past 35 years the Foundation for Surgery has helped fund some of the most exciting research conducted in Australia and New Zealand. Thanks to your support of the Foundation, thousands of people have benefitted from these activities facilitated by RACS. Over the past year alone, together we have supported:

- Over **10,584** patients from developing Asia-Pacific countries receiving critical specialist consultations
- Over **2,526 life-changing procedures** delivered in these Asia-Pacific countries
- The delivery of **23 skills courses** and specialist training workshops in the Asia-Pacific
- **Indigenous medical students** in Australia and New Zealand including one Aboriginal medical student and five Māori doctors to attend the ASC in Brisbane

- **38 scholarships and grants enabling groundbreaking research** in cardiothoracic surgery, laparoscopy and robotic technology, healthcare rationing, colonic surgery, haemorrhage control and many other areas of critical research to promote access to enhanced levels of early detection, surgical care, recovery and overall improved patient outcomes.

However, there is still much to be done.

As an Otolaryngologist, I am particularly enthusiastic about all areas of ENT practice. As a result, I continue to be concerned by the unacceptably high rates of Otitis Media affecting our Māori, Aboriginal and Torres Strait Islander communities. It is estimated that more than 90% of young Aboriginal children have hearing-aid-level deafness for much of the year. Imagine the profound long-term effects on communication, learning and education, employment and long-term social and economic disadvantage.

These statistics stagger me. We can all do numerous things to help address this, but one critical thing we can do as surgeons, is invest in and support aspiring Aboriginal, Torres Strait Islander and Māori surgeons.

As we approach the end of the financial year in Australia, I would encourage you to **Pledge-a-Procedure** – that is, make a tax-deductible donation of the proceeds from just one of your most common major operations before 30 June 2017. If you are not a practising surgeon, giving a one-off donation will make a significant difference. This is my way of asking you to walk alongside our Indigenous young people who are looking to make powerful, positive changes for our communities.

I thank our New Zealand colleagues who have already made their pledged donations in support of Māori Health, before the end of the New Zealand financial year on 31 March. Thank you for your generosity and kindness. Thanks to you, thus far $19,524 has been donated to support our aspiring Māori surgeons. It's now your turn Australia, Pledge-a-Procedure today.

Unlike other charities, 100% of all donations assist in addressing critical surgical needs and your support achieves its maximum impact in the community. All costs for administering the Foundation for Surgery are provided for by the RACS, so that every dollar of your precious donation can go where it is needed most.

All donations over $10 are eligible and welcome 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 Foundation's thanks.

Donating is very simple: please go to www.surgeons.org/foundation/ to donate and gain an immediate tax receipt or complete and return the form that will be sent to you this month. This simple act will have an enormous impact supporting young aspiring Indigenous surgeons.

I urge you to make a tax-deductible donation to support our Foundation for Surgery's major fundraising campaign and **Pledge-a-Procedure** before 30 June 2017.
Let's walk together, toward a better future.

Please donate today.

Foundation for Surgery
Passion. Skill. Legacy.

World's smallest surviving baby

A baby girl born in Germany 16 months ago and weighing little more than an orange is being hailed as the world's smallest surviving premature baby. At birth she weighed 226 grams and her foot was about the length of an adult fingernail. She was fed by doctors using a cotton bud soaked in sugar water and even survived abdominal surgery at a weight of 340 grams. Baby Emilia was born by Caesarean section in the 26th week of pregnancy in a hospital in the western German city of Witten. According to media reports, the survival of the baby was only possible thanks to the joint effort of paediatricians, gynaecologists and paediatric surgeons.
Visit: http://www.msn.com/en-au/news/world/worlds-smallest-surviving-baby-born-weighing-only-8-ounces-and-with-feet-the-size-of-a-fingernail/ar-AAiFJRb

Microscope-in-a-needle licensed for commercialisation

The University of Western Australia (UWA) is celebrating 60 years of its Medical School, with the release of the 'microscope-in-a-needle'. This award-winning invention, developed by a team of UWA researchers, has been licensed this year so that it can be developed and commercialised for use by surgeons. The optical imaging tool will help surgeons avoid blood vessels during surgery and help surgeons deliver better treatment and minimise surgery costs.
Visit: http://www.news.uwa.edu.au/201702149390/microscope-needle-licensed-commercialisation

Keyhole surgery best option for women needing hysterectomies, study finds

A study conducted by the University of Queensland has concluded that women who had keyhole surgery had slightly higher survival rates than those women who had a total abdominal hysterectomy. A total of 760 patients and 27 surgeons from 21 cancer centres throughout Australia, New Zealand and Hong Kong were examined, the results of which showed that adopting minimally invasive surgery would reduce the development of severe surgical complications, hospital stay time and expenditure.
Visit: http://www.abc.net.au/news/2017-03-29/study-finds-keyhole-surgery-best-for-hysterectomies/8394582

Miniature mechanical nanofish set to explore the Human Body

Engineers at the University of California in San Diego have created a gold and nickel fish 1/100th the size of a grain of sand that could soon carry drugs to specific areas of the body, be used for invasive surgeries, and even single cell manipulation.

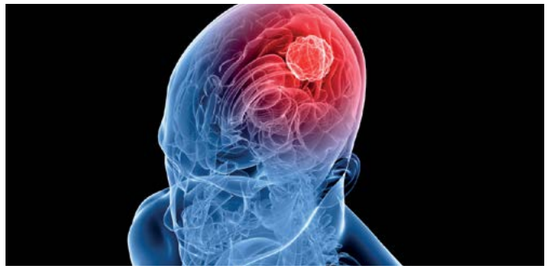
The nanofish is made of gold and nickel parts fitted together by silver hinges, according to *The New Scientist* magazine. An oscillating magnetic field is applied to make the nickel parts move from side to side, in turn swinging the head and tail allowing it to 'swim' in a specific direction.

Justin Gooding of the University of New South Wales is reported to have told The New Scientist that active transport has recently begun to be explored and this work shows that active transport particles can be made smaller and faster.

One issue with the nanofish that isn't quite clear yet is how they will leave the body after use, but word is that the team is trying to create a biodegradable version.

Toward glow-in-the-dark tumors with a new fluorescent probe

Imagine if cancer was fluorescent. Surgeons could see the cancer cells clearly and be absolutely sure they have removed every part of a tumor. This is exactly what is being developed at the Michigan Technological University. A probe that can cling to enzyme-coated antibodies and make then glow under fluorescent light could be the next solution to making a surgeon's work that little bit easier.
Visit: http://oncologynews.com.au/toward-glow-in-the-dark-tumours-new-fluorescent-probe-could-light-up-cancer/



Microbubbles to reduce unnecessary biopsies

An innovation using tiny microbubbles could reduce unnecessary surgeries in women suspected of having breast or ovarian cancer. The microbubbles, that bind to malignant tumours, make them visible to ultrasound imaging. Up until now, the bubbles couldn't latch onto blood vessels of cancer in patients, but researchers from Stanford University have designed the bubbles to bind to a receptor called KDR, which is found on tumour blood vessels, but not in healthy tissue. Lead author Dr Jürgen Willmann said that distinguishing between benign and malignant tumours will save millions of patients from biopsies they don't need.
Visit: http://www.bioportfolio.com/news/article/3104119/Microbubbles-help-identify-malignant-tumours.html

RACS farewells CEO, David Hillis

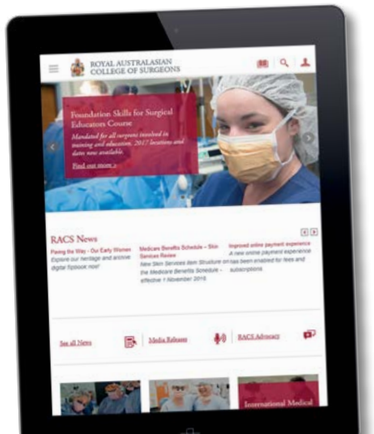
After a remarkable 13 years, Associate Professor David Hillis has resigned from his role at the Royal Australasian College of Surgeons.

Having worked in general and family practice in the LaTrobe Valley, followed by a number of leadership positions at the Peter MacCallum Cancer Centre, Peninsula Health, Western Health and St Vincent's Health, A/Prof Hillis joined RACS in 2003.

A/Prof Hillis certainly made his mark on RACS, and among many achievements, was pivotal in leading the College's response to the ACCC's inquiries about its role in the provision of specialist medical training, and in responding to issues of bullying and harassment. He was also responsible for paving the path to accreditation by the Australian Medical Council.

RACS President, Mr Phil Truskett AM, paid tribute to the leadership and many achievements that A/Prof Hillis made during his tenure at RACS.

"On behalf of all RACS Council, the Fellows and staff, we acknowledge the drive, dedication and tenacity of A/Prof Hillis in leading RACS through a period of unparalleled growth and change."



"Many of the initiatives and programs that have now reached fruition and are embedded within RACS are as a result of David's vision based on his deep understanding of the health sector, and the needs of RACS Fellows and stakeholders" he said.

A/Prof Hillis was responsible for the development of professionalism in surgical education in Australia and New Zealand and particularly the commitment of the College in building a culture of respect in surgery.

He led the Digital College transformation – including online CPD, account management, electronic payment facilities and online examinations, and he helped established the JDocs Framework, aligned to the RACS nine surgical competencies, to assist junior doctors aspiring to a career in surgery.

A/Prof Hillis was also instrumental in the development of the mobile audit and logbook tool (MALT) that provides electronic access to enable audit as well as progress in training.

A/Prof Hillis was awarded an honorary RACS Fellowship in 2013 in recognition of his service to the College. RACS Vice President, Professor Spencer Beasley said the College wished A/Prof Hillis well in the next stage of his professional career and thanked him for his dedicated service to RACS.

Goal 1:

Build a culture of respect and collaboration in surgical practice and education

Goal 2:

Respect the rich history of the surgical profession, advance the culture of surgical practice so there is no place for discrimination, bullying and sexual harassment (DBSH)

Goal 3:

Build and foster relationships of trust, confidence and cooperation on DBSH issues with employers, governments and their agencies in all jurisdictions

Goal 4:

Embrace diversity and foster gender equity

RACS goals for Respect

In November 2015, the Royal Australasian College of Surgeons (RACS) launched its *Action Plan: Building Respect, Improving Patient Safety* to address the issue of discrimination, bullying and sexual harassment (DBSH) in the surgical workplace.

During 2016, the connection between DBSH and patient safety became clearer, with increasing evidence to confirm this. RACS has committed to change because SET Trainees and IMGs deserve to learn in a safe environment.

It has become more evident that the problems of DBSH extend well beyond surgery and affect the entire health sector. Therefore, RACS has engaged with a broad range of organisations including hospitals, medical schools, health departments and other health jurisdictions to gain their commitment so we can all work together. Other specialist medical colleges are also partnering with us, to collaborate towards achieving this common goal.

The *Lets Operate With Respect* campaign has given focus to our work. You would have noticed that many surgeons have allowed RACS to use their faces on our campaign posters. They and their colleagues have taken a strong stand for the campaign.

We all need to lead the way wherever we work; to advocate for change, stand up to unacceptable behaviour and demonstrate what it really looks like to operate with respect. We can talk the talk but let's walk the walk.

Images (from left): Professor Julian A Smith and Dr Claire Campbell wearing the BRIPS surgical caps

Goal 5:

Increase transparency, independent scrutiny and external accountability in College activities

Goal 6:

Improve the capability of all surgeons involved in surgical education to provide effective surgical education based on the principles of respect, transparency and professionalism

Goal 7:

Train all Fellows, Trainees and International Medical Graduates to build and consolidate professionalism including:

- fostering respect and good behaviour
- understanding DBSH: legal obligations and liabilities
- 'calling it out'/not walking past bad behaviour
- resilience in maintaining professional behaviour.

Goal 8

Revise and strengthen RACS complaints management process, increasing external scrutiny and demonstrating best practice complaints management that is transparent, robust and fair

In 2016 many agencies across the health sector recognised that the time had come to deal more effectively with discrimination, bullying and sexual harassment. As well as the 14 agreements we signed with a range of organisations, RACS worked hard during the year to raise awareness of these problems and support change through partnership. This included making a submission to the Senate community affairs reference committee on medical complaints.

RACS leadership on dealing with discrimination, bullying and sexual harassment was recognised by the:

- Victorian Auditor General's Office, which referenced RACS leadership and research in their paper on Bullying in the Health Sector http://www.audit.vic.gov.au/publications/20160323-Bullying/20160323-Bullying.pdf
- Appointment of RACS Vice President, Spencer Beasley, as one of the Australasian leaders across business, government and universities who had come together to establish a Male Champions of Change (MCC) group focused on gender equality in science, technology, engineering and maths (STEM). http://malechampionsofchange.com/australian-leaders-tackle-gender-inequality-in-stem/
- Auckland District Health Board of the RACS Let's Operate With Respect campaign, in its 'Speak Out' initiative

2016 complaints data:

- There was a 25% increase in complaint enquiries lodged in 2016 compared with 2015, with 125 complaint enquiries registered during the year. This expected increase reflects increased awareness of the RACS complaints framework.
- 85 of all matters registered were resolved and closed in 2016
- of these 85 matters closed in 2016, 56% were enquiries
- 77% of enquiries made in 2016 related to unacceptable behaviours (DBSH), mostly bullying
- 25% of enquiries progressed to complaints
- 67% of complaints related to unacceptable behaviours (DBSH).

This graph demonstrates the steady increase in the number of enquiries and complaints registered (orange) and the corresponding number of matters resolved and closed (blue) in 2016. Complaints were made by Fellows, the public, IMGs and trainees.

Here are some posters from one of our MOU partners, Metro South Health, who have profiled their local surgeons committed to building a culture of respect. http://www.surgeons.org/about-respect/stories-and-news/partnering-for-change/

Images (from left): Professor David Watters and Dr Jane Fox; Dr Joseph Thomas.

What really makes my day after FSSE is when surgeons come by and thank the facilitators, telling me "...I was really sceptical about coming but I've really learnt a lot and now I'm looking forward to going back and trying it out"

- Debbie Paltridge, RACS Principal Educator

Image (from left): Mr Matthew Alexander, Dr Jane Fox, Mr Graham Starkey, Mr Bruce Mann

BUILDING RESPECT,
IMPROVING PATIENT SAFETY

FSSE – Training in the Principles of Adult Learning

Mandated training is about supporting supervisors and trainers in their roles

ASSOC. PROF. STEPHEN TOBIN
Dean of Education

The Foundation Skills for Surgical Educators (FSSE) is a valuable course for all clinical assessors, supervisors and surgeons who teach and train. The course covers learning principles, teaching in the workplace, and feedback and assessment within the SET program - to assist surgeons in their role as teachers to enhance the learning of SET trainees.

FSSE was developed and piloted over 2014-2015, with the involvement of medical education consultants and the RACS Dean of Education, Assoc. Prof Stephen Tobin in response to requests received for training in the principles of adult learning.

In my first year as Dean, there were multiple requests from surgical colleagues about '...a snappy one day course about surgical education that would also be delivered across the two countries on a regional basis ...not just Melbourne and Sydney...'

RACS Principal Educator Debbie Paltridge, has taught on multiple courses since 2015. Her experience has shown that the course provides new insights for participants.

"What really makes the day after FSSE is when surgeons come by and thank me and the other facilitators, telling me I was really sceptical about coming but I've really learnt a lot and I am looking forward to going back and trying it out," she said.

The Expert Advisory Group's report on bullying, discrimination and sexual harassment also clearly reported the need for training in the skills of being a surgical educator.

Supervisor's technical skills were not questioned, but lack of teaching skills and ignorance of contemporary adult education models was seen as a direct contributor to bad behaviour in general and bullying in particular. There are reports that many teachers teach the way they were taught, using humiliation and bullying. (From EAG report, page 8.)

This is described in the Building Respect, Improving Patient Safety Action Plan as Goal 6: improve the capability of all surgeons involved in surgical education to provide effective surgical education based on the principles of respect, transparency and professionalism.

The Foundation Skills for Surgical Educators course is now part of the Let's Operate With Respect campaign, and is mandatory training for all clinical assessors, surgical supervisors, and surgeons who teach and train.

Just over a year ago, RACS President Mr Phil Truskett launched the campaign to stamp out discrimination, bullying and sexual harassment. There is a lot of work underway already, including an updated complaints process and roll-out of a new Diversity and Inclusion Plan, revised Code of Conduct and revised policies and procedures. Our efforts are continuing because the problems are real – cultural change and improved skills and behaviours leading to resolution will take some time.

There has been progress - the momentum and support to stamp out discrimination, bullying and sexual harassment is growing. Other educational resources developed by RACS include the Operate With Respect on-line module (mandated for all Fellows and Trainees) and the advanced one day Operate With Respect course .

Completion of the Operate With Respect (OWR) module is a mandatory component of CPD. Launched in July 2016, to date 50 per cent of fellows, Trainees and IMGs have now completed the 45 minute module. The Operate With Respect Course (1 day) is now available and provides advanced training in skills to recognise and address unacceptable behaviours. It is required of supervisors, members of major RACS Committees and Boards and those in leadership positions such as surgical directors.

Almost 40 FSSE courses have already been run this year, training more than 250 surgeons, and a further 80 courses are planned for the remainder of the year. There is opportunity for you to complete the course at multiple venues, in both metropolitan and regional hospitals. Don't delay registration if you are required to complete the course by the end of 2017.

Access to FSSE registration or the on-line OWR module is via your portfolio. The advanced OWR course was made available in April 2017.

Sitting down with John Batten

Orthopaedic Surgeon, family man and new RACS President

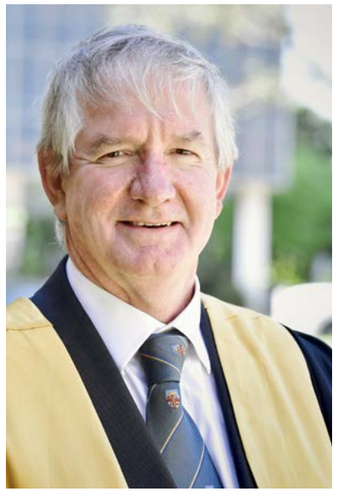
Amid the mayhem of council meetings and countless requests for his time, John Batten was kind enough to spare a few minutes to talk with us about his role at the Royal Australasian College of Surgeons and his new position as RACS President.

"I'm really looking forward to my term as RACS President. Being elected as the 47th RACS president last month was a great honour," he said.

Mr Batten said that this was a great time to undertake this role.

"RACS has a lot going on. I'm particularly committed to maintaining and nurturing mutually supportive relationships with our societies. That's very important. How we relate to societies is crucial. We need much more two-way dialogue and a dedication towards how we collaborate and partner with societies."

Elaborating on the Building Respect and Improving Patient Safety (BRIPS) Action Plan, Mr Batten shared his thoughts about how he thought the culture of bullying and harassment would change in the future.



"The BRIPS Action Plan is an ongoing commitment and I will be working hard to ensure that its objectives are built into our culture.

"Bullying and harassment at any level, be it peer to peer, across craft groups or disciplines, or trainer to Trainee, can never be acceptable and we recognise that. We cannot put our patient's safety at risk by accepting this behaviour. This program allows us to build respect for one another for the purpose of improving overall outcomes.

Dr Batten said that the BRIPS Action Plan had been very active and effective, and as a result, other groups had felt empowered to introduce the same policies.

"A number of other organisations have now signed agreements with RACS to commit to this important change," he said.

It may have been a shock to some, but Mr Batten is positive about the media exposure received when the bullying and harassment issue was first raised.

"Yes, the media has put us on notice, and the campaign was made public. But now the public needs to see the results so we can regain their trust. Without respect and with disharmony, the public, and our patients will suffer" he said.

Mr Batten hasn't always lived in Tasmania, but Launceston changed his life and that is where he stayed, having decided to move 'overseas' with his wife in 1985.

"I was born in Melbourne, and schooled in Melbourne. But I was accepted into Advanced Training in Orthopaedics, which involved a year in Tasmania, as a country rotation. I never intended to go regional," he said.

"My wife is a physician, and we were both lucky enough to secure a training post in Launceston at that time. I found the training to be of a very high standard; it was very collegiate, and they embraced us."

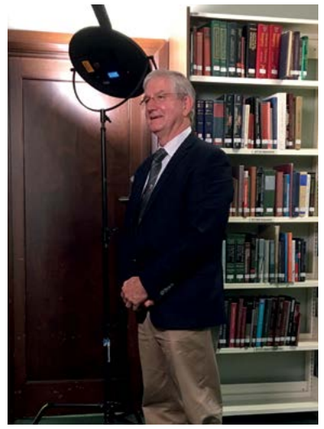
Mr Batten said that he maintained contact with his Tasmanian colleagues and mentors who followed the couple's progress once they had finished that training year and had returned to Melbourne.

"We kept in touch and made some great friendships, so when I decided to broaden my horizons to work in general orthopaedics, my wife and I decided to return to the more rural setting of Launceston. The quality of life is just a little bit different there," he said.

Mr Batten worked at St Vincent's Hospital, Royal Children's Hospital and the Austin Hospital on rotation when he returned to Melbourne, but said that he analysed his training and planned post-Fellowship training in hand surgery, arthroplasty and paediatrics.

"I also worked overseas for a time at the Royal Infirmary and the Princess Margaret Rose Children's Orthopaedic Hospital in Edinburgh.

"There were many other options but we decided to go back to Launceston where paediatrics required extra manpower, so my fellowship focus was Paediatric Orthopaedics.



Mr Batten is definite about the value of having a career direction and emphasised the importance of young Trainees taking the time to decide where they wanted to go, ensuring they had a focus and a plan to add to their training that would benefit the communities that they hoped to return to and serve.

"Most surgeons who are brought up in a system where they are trained by a senior, feel inspired and aspire to do the same. It's important that surgeons contribute in this way and continue to provide that modelling. I enjoy teaching students because they see things differently, they are challenging and insightful and you learn so much from them".

With a number of other commitments and a family, Mr Batten recently closed his private practice after 32 years. "I have always practiced in both the public and private sectors. I decided to close my private practice because I had a lot of other commitments including my work as Chair to the Clinical Advisory Group for the Department of Health, and my work with RACS. I just seemed to be away too often. I have the utmost respect for my patients and felt that in order to provide them with the best care I needed to be more available."

Quoted recently in *The Examiner Newspaper* as having an interest in 'all things mechanical' some may have questioned whether he'd ever considered engineering as a career choice.

"Actually, my father was an Engineer and my mother was a Nurse. I always had an interest in mechanics so you could say that I have specialised in the mechanics of the body. I enjoy my cars as a hobby and also have an interest in the mechanisms of clocks and watches. It just suits the way my mind works," he said.

On a more personal note, Mr Batten said that all three of his grown-up children had followed their own career paths.

"My three sons have all taken different directions, none in medicine. They were interested in other fields of interest and other opportunities. My oldest son is an Accountant, my second son is a Teacher and my youngest is a Builder who is in the process of getting his pilot's licence. I am also fortunate to have four beautiful grandchildren."

Let's Talk Teamwork

Multi-Professional Team Briefings in W.A. Operating Theatres

Days in operating theatres are busy. Many things need to fall into place for a surgical list to go smoothly. Whether a surgical list runs well can depend on everyone in theatre working together, having a good idea of what is planned for the day and what is expected of them. This can be difficult as people with various professional backgrounds, holding different skills and insights, need to work together in theatre to deliver excellent patient care. More frequent use of non-permanent staff such as agency nurses, lists rotating between different theatres, less stable team compositions increase this issue. The 'core' teams are less stable and teams can't rely as much on past experience working together.

Good communication between different professional groups is key for good clinical practice. Research and tools developed around communication and teamwork in the operating theatre so far focus on particular professions working in theatre, such as anaesthetists (e.g. ANTS rating system; Fletcher et al, 2003, surgeons NOTS; Yule et al, 2006, or scrub nurses SPLINTS; Mitchell et al, 2013). What these tools do not address directly is how different professional groups work together and communicate effectively.

Communication in Western Australian Operating Theatres

As part of an ongoing research project funded by the Western Australian Department of Health, researchers from the University of Western Australia (UWA) have engaged with operating theatre staff to get insights into their day-to-day experiences. A survey of 149 medical staff working in theatres in major hospitals in Western Australia, including surgeons, technicians, nurses and anaesthetists showed that communication breakdowns are relatively common with most staff experiencing these sometimes (47%) or often (37%) – See table 1. Similarly, foreseeable delays were reported by most surveyed theatre staff as occurring sometimes (60%) or often (24%).

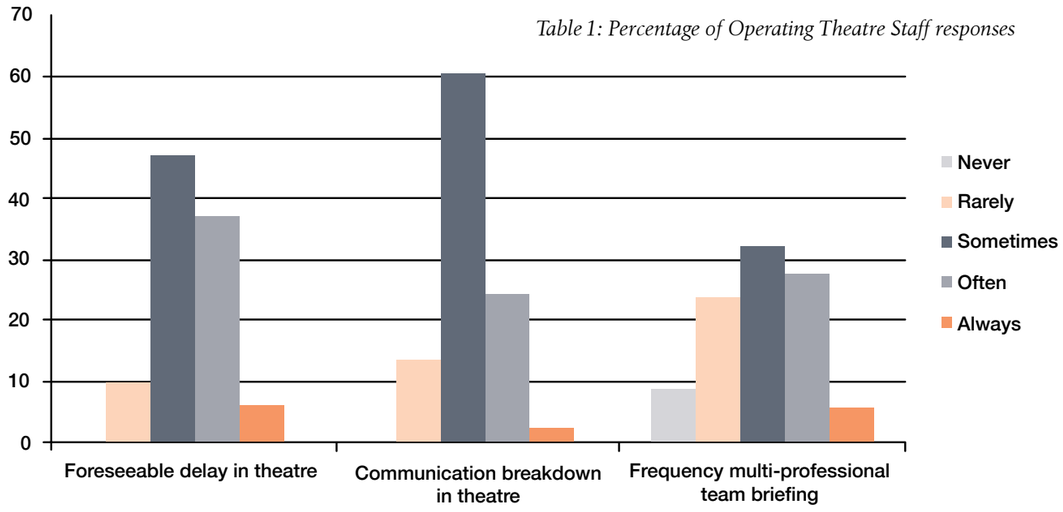
Given that communication failures may not be immediately noticeable, they may not be instantly addressed and can lead to issues later on. Good communication and active information sharing can turn the variety in skills, knowledge and awareness into a strength.

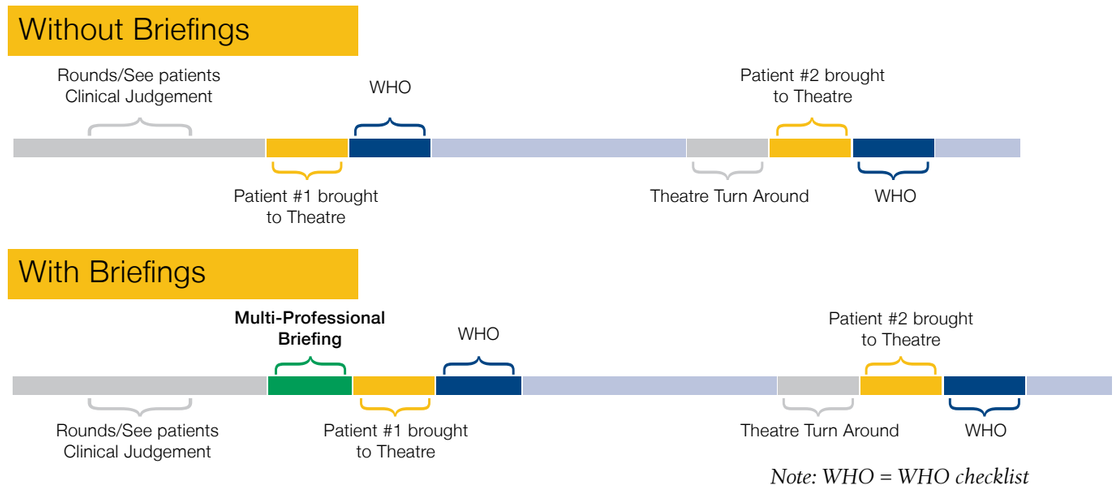
A key finding of research into team communication is that team members tend to spend more time sharing information that everyone in the team is already aware of and less on the information unique to each individual (Stasser & Titus, 1985). Yet, it is these information pieces that can make or break smooth progress and patient safety in operating theatres. Unique information will be very common in theatre where different professions with different responsibilities and backgrounds collaborate. In operating theatre settings, surgeons and anaesthetists are particularly likely to have relevant unique information about patients, such as allergies, as they see them before the surgical list. Nurses are in tune with the on-goings in theatre and also hold valuable knowledge of instrumentation and hospital resources.

Sharing information is not only beneficial for how the work progresses. Studies have shown that teams that more readily share information are also happier at work, as they enjoy each other's company and trust each other more (Beal, Cohen, Burke & McLendon, 2003).

A busy day in theatre does not necessarily provide the time and space to actively share information. One option however is to create a moment in which all staff working in theatre come together to talk about the tasks that lie ahead. In Western Australia, several hospitals are now engaging in an initiative to introduce multi-professional team briefings in operating theatres, guided by researchers from the UWA. These briefings are an opportunity to share information between all the individuals working in a theatre that day.

Table 1: Percentage of Operating Theatre Staff responses





Note: WHO = WHO checklist

Multi-Professional Team Briefings – A Platform for Communication

Multi-professional briefings are short 3-5 minute meetings before the start of operating lists (Carpini et al, 2015). Preliminary results show that these minutes are worth investing as teams who engage in team briefings will more than make up this time.

Team briefings complement the WHO checklist as their focus is on the entire list, not individual patients. They are intended to be a conversation that occurs between staff members before the first patient is brought in.

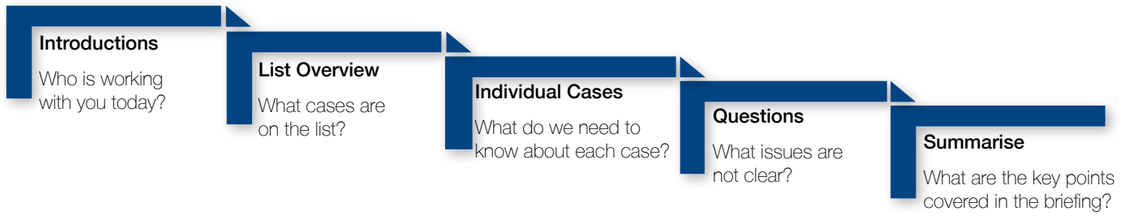
Briefings are designed to facilitate teamwork, and support theatre efficiency and safety. The briefings include all professional groups working in operating theatres (i.e. surgeons, anaesthetists, nurses, and technicians). They can be initiated and led by any staff member.

Why and how briefings work:

Briefings operate on two levels: information sharing and opening up communication.

Information sharing during briefings clarifies expectations. By sharing information teams build shared understanding that will help reduce ambiguity and make everyone's role in theatre clearer. Ensuring that everyone is aware of what will be needed during the procedures is for example, likely to save time looking for the right equipment and having it at hand at the right moment. Such issues can easily add up to delays contributing to patient cancelations.

Opening up communication channels between professional groups can change how teams work together. Starting the day with a team briefing indicates how the team solves problems. A constructive briefing sets the tone for the day. It establishes a collaborative team environment where open communication and teamwork is valued and emphasized. This can help with speaking up as well as general coordination later during the list. ▶



How to Brief - A Content Guide

Typical briefings consist of five steps to facilitate efficient exchange of information as well as a free flowing conversation (Carpini et al, 2015).

Step 1: Introductions
Introductions of team members' names and roles familiarise staff with each other. This step clarifies everyone's roles and builds a team spirit. Even though this item is included on the WHO list, it is not often considered.
Step 2: List Overview
The list overview focuses on the number of cases, the list duration, and turn-around strategies. This step provides everyone with an idea of what kind of work to expect.
Step 3: Individual Cases
The case review provides specific information on each case. It clarifies roles, potential complications, equipment requirements, and team member level of experience with procedures. Based on the individual case review, changes to the list order that will enhance workflow can be identified before the first patient is called.
Step 4: Questions
Questions are then welcomed by all staff members to clarify any issues.
Step 5: Summarise
Summarising any changes that were made to the list order and any notable issues reminds the team of key issues that have been discussed.

How to Brief - A Style Guide

Tone and (body) language convey meaning in addition to the actual content that is transferred. Be mindful of how messages are conveyed during a briefing. Do they show respect for fellow colleagues? Are the messages inclusive?

- Tip: Use "we" instead of "I" during briefings – research on pilot language shows that inclusive language is linked to performance (Sexton & Helmreich, 2000).

Listening is also important for briefings to be successful. Listening does not just happen (like hearing). Active listening using both verbal and non-verbal messages such as maintaining eye contact, nodding, and encouraging others to continue by nodding, can be key.

- Tip: stand in a circle so that everyone can see each other.

Open ended questions can open up conversations. Briefings are not meant to be another checklist that teams go through by ticking boxes. Open ended questions can stimulate free flowing conversations.

- Tip: direct some of your open questions (but not all) at specific individuals to engage those with relevant knowledge to actively participate.

If you do not practice briefings regularly, give it a go! In hospitals where briefings are currently not common practice, you may face logistical challenges in getting everyone into the theatre before the first patient arrives. One strategy would be to agree on a particular time and inform staff of your intention to conduct a briefing beforehand. It might take a couple of tries to establish this as a regular practice, but it is worthwhile to not give up. Taking a pause and getting everyone on the same page before a busy day in theatre starts shows that you care about working together. The research team at the UWA are in the process of systematically analysing the impact of briefings in more detail. However preliminary results suggest that your rewards are likely to be enhanced efficiency, more staff satisfaction at work, and improved patient outcomes.

To share your experience around briefings and for more information about the UWA research team's work, please visit: nontechnicalskills.org or contact Laura Fruhen at laura.fruhen@uwa.edu.au.

– The piece was written by Laura Fruhen (PhD, Research Fellow) together with Joseph Carpini (PhD Student), and Prof Sharon Parker (Australian Research Council Laureate Fellow, Professor of Organizational Behavior), University of Western Australia's Business School.

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The CAPLE Project

Creating a Positive Learning Environment

A negative learning environment can have a lasting impact on both students and teachers. From doubts about career choices to stress and long term mental health issues such as depression, the harmful effects of a negative learning environment are significant and well documented. Impacts are not limited to students and teachers - they can also have a negative effect on the patient and clinical services.

A pilot project recently trialled by the University of Otago in conjunction with the Otago Polytech School of Nursing is experimenting with new ways to create positive learning environments by moving towards a more respectful and harmonious way of teaching and learning. Titled "Creating a Positive Learning Environment", or CAPLE for short, the project aims to work with clinical staff to develop and evaluate ways to improve teaching and learning within their specific clinical environments.

Associate Professor Lynley Anderson, of the University of Otago's Bioethics Centre and Chair of the Health Research Council Ethics Committee, is one of a team of researchers engaged with the project first trialled at the Dunedin Public Hospital late last year. Over the course of two months, participants at a surgical unit took part in a number of multidisciplinary workshops tailored to provide attendees with tools and techniques particular to creating positive learning environments within their own clinical setting.

"We know that mistreatment is a big issue between medical students and medical staff, as well as between nursing students and nursing staff, and that this is a global issue. However, these concerns frequently cross disciplinary boundaries. Rather than specifically target an individual causing a problem, the aim of the CAPLE project is to create a respectful and positive learning environment in the entire department, so that everybody's skill level can go up."

The content of the CAPLE project was strongly influenced by what worked and what didn't as identified within the international literature. Local students also provided data about their experience, and 12 staff (6 doctors, and 6 nurses as participants) in the clinical area informed the project of the needs within the department. This allowed the workshops to provide evidence-based interventions according to the needs of the participants' particular work environments, such as offering students effective feedback under time or pressure. During the project, these participants kept in constant contact with the researchers, as well as being asked to keep journals to reflect on their own behaviour. As the project progressed, the participants eventually became researchers themselves.

"The literature strongly suggests that most people who are identified as bullies lack self-awareness. I think most people want to be good teachers, but for whatever reason, whether it be constraints on resources and time, stress, or just being unaware of their behaviour, are unable to create a good learning environment."

Researchers:

Associate Professor Lynley Anderson, University of Otago
Dr Althea Blakey, University of Otago
Dr Kelby Smith-Han, University of Otago
Emma Collins, Otago Polytechnic
Professor Tim Wilkinson, University of Otago Christchurch
Elizabeth Berryman, Student representative, University of Otago

Aboriginal doctor set on career as rural General Surgeon

Aboriginal medical graduate Dr Claudia Paul has a dream. First she would like to become a General and Trauma Surgeon and then establish a mobile clinic that will travel to regional and remote communities to treat and manage Aboriginal patients in their own communities.

Having graduated last year from the University of Adelaide, Dr Paul is now working as an intern at the Hunter New England Local Health District in Newcastle. She said she first became attracted to the idea of pursuing a career in surgery after completing a rural surgery rotation at Port Augusta, South Australia, in 2014.

Since then she has completed other rural and remote placements at Whyalla, Broken Hill and Bourke, as well as undertaking surgical electives in Vietnam and the UK.

Last year Claudia was awarded the Aboriginal and Torres Strait Islander ASC Foundation for Surgery Scholarship to help fund her attendance at the Annual Scientific Congress held in Brisbane. Claudia was also selected to receive the 2017 Career Enhancement Scholarship for Aboriginal and Torres Strait Islander Junior Doctors.

"It was during my first clinical year that I did a rural surgical term and I loved the idea of becoming a rural General Surgeon," she said.

"I particularly like the idea of both creating connections and relationships with patients while having the skills to fix problems and improve their quality of life. I also like the great variety of work that General Surgeons perform."

"My dream job is to work as a general surgeon in rural and remote Australia, working in communities where it is otherwise difficult to access surgical services."

"Indigenous communities suffer high rates of heart disease and diabetes so I would expect that working in such an environment would mean treating diabetic manifestations, undertaking vascular surgery, treating chronic and acute wounds and skin infections."

Dr Paul thanked RACS for its support and said she found attending last year's ASC to be of great value and is looking forward to attending the upcoming ASC to be held this year in Adelaide.

Now planning to undertake a Masters of Traumatology, she said she was particularly impressed with the variety and depth of the research presented by Australian and New Zealand Fellows and surgical trainees.

"I really enjoyed attending the ASC last year and hearing the PhD research being conducted around the country. A huge range of subjects are being explored, many of which lie far outside the operating theatre," she said.

"A group of us also had the opportunity to meet Associate Professor Kelvin Kong, who does such wonderful work within the Indigenous community, and discuss our ambitions with him, which was very inspiring."

During the course of her medical studies, Dr Paul said she had received great encouragement to pursue a career in surgery, particularly from General Surgeon Dr John Groome whom she met while completing a surgical elective in the UK.

She is also a member of, and has received great support from the Australian Indigenous Doctor's Association (AIDA) and will also attend this year's AIDA conference.

She said she plans to use the funds attached to the 2017 Career Enhancement Scholarship to assist with covering the cost of completing a critical literature evaluation and research course as well as resources needed to begin a Masters of Traumatology.

> *My dream job is to work as a general surgeon in rural and remote Australia, working in communities where it is otherwise difficult to access surgical services*

Professor Kingsley Faulkner, Chair of the Foundation for Surgery, spoke to Surgical News regarding the introduction of the RACS Career Enhancement Scholarships in 2017. "The Foundation for Surgery has the privilege to support determined Aboriginal and Torres Strait Islander students and doctors, like Claudia. There are numerous health inequities in our country, but one critical thing we can do to address these, as surgeons, is invest in and support aspiring Indigenous surgeons".

Dr Paul encouraged other Indigenous students to consider a career in medicine and surgery and said that the more Indigenous surgeons there were, the better the treatment that could be offered to Indigenous patients.

"There is a gap in knowledge between people in medicine and Indigenous culture. I think the main cause of that gap is that relevant knowledge isn't filtering through while students are being trained," she said.

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"Most medical and surgical training takes place in major metropolitan centres while most Indigenous patients live in regional, rural or remote communities, so I believe that if we can increase the number of Indigenous students in medicine - the more that gap in understanding can be closed."

Dr Paul said that while setting out to complete her medical degree had at first appeared a huge task, requiring a move from Broken Hill to Adelaide and adjusting to being far from her family and friends, it allowed her to quickly become independent and learn to manage her time so she could keep up her sporting interest in basketball.

She said she had first considered pursuing a career that combined her interest in sport and exercise by becoming a physiotherapist, until she decided instead on a career in medicine and surgery in particular.

Yet, while she plans to apply for a place in the General Surgery training scheme in 2019, she is still basking in the glow of having graduated from medical school.

"I remember my final exams were a very overwhelming moment for me and my family," she said.

"It has taken a little while for it to sink in that I have finally finished medical school. It does take a bit of getting used to, going to university for so long, then adjusting to not having any exams looming and then awaiting that first letter in the post with the word 'doctor' printed on it.

"Even getting this far has taken a lot of hard work but it's worth it. If you're passionate about medicine and willing to work hard, then the opportunities are there. I would encourage any young Indigenous student considering medicine to **go for it** because it is a highly rewarding career."

– With Karen Murphy

Images (from left):

Dr Claudia Paul attending a suturing workshop facilitated by The Australasian College of Dermatologists at the AIDA 2016 conference; Dr Claudia Paul (left) attending a suturing workshop together with Mr Ian Lee (right) facilitated by The Australasian College of Dermatologists at the AIDA 2016 conference. Dr Dana Slape (middle) was one of the workshop facilitators.

Images by Brad Newton Photography. Copyright AIDA.

Sexual Harassment – Is it a Grey Area?

SUSAN HALLIDAY

In the world that we live, what offends one person will not necessarily offend another. There is no more topical example than sexual harassment. *It's a grey area* is often the response that people call upon when summarising a situation and looking for an answer. Indeed it is not always immediately black and white when we look on from a distance because we are individuals and our life experiences differ. However no matter what the scenario, it should be clear that it is the nature and the impact of the behaviour or environment that is assessed when sexual harassment is raised as an issue. Intent and motive of the offending party are irrelevant.

Following on from the article in last month's Surgical News where the concept of sexual harassment was unpacked, a selection of examples of conduct that people did not identify as sexual harassment when they first surfaced in medical and science related environments, may well provide some food for thought.

With over three decades of interaction with those accused of sexual harassment, witnesses, and people who found themselves offended, humiliated and intimidated by conduct of a sexual nature, it's clear that we need to take the time to understand the issue from the shoes of the affected party, have a good grasp of the case law and apply the reasonable person's test. There is also a need to be ever mindful that everyone has a right to feel comfortable and safe at work, in education and training environments, and when accessing goods and services.

That said, I recall a receptionist from a medical environment who was troubled by the dot point on her position description that stated *other duties as required*. The issue surfaced when it evolved that some of those *other duties* included the need to field a number of personal calls and in turn lie to both the spouse and the girlfriend of one of the specialists she worked for. Given the circumstances, the nature of the deceit required of the receptionist, and the content of certain messages that she was required to pass on over the phone, to the total shock of the specialist in question, there was a finding of sexual harassment. The finding also struck one of his colleagues as, and I quote, "a new age dilemma" given it was considered the receptionist should simply do as she was asked and mind her own business. It must be pointed out that the receptionist had not anointed herself as the monitor of monogamy and the keeper of morals. Rather she found herself in a very uncomfortable situation at work, feeling sexually harassed due to the part she was being required to play, the sexual connotations and the content of the messages that were to be passed *on as part of her job*.

Then there were the workplace discussions in a medical science related environment between three employees in a tearoom. Details about a particular Sydney Mardi Gras after-party were shared at length, resulting in a number of offended people, and a complaint about a sexually permeated environment. The tearoom was considered a common area by staff. The conversation amongst the three over the period of a week returned regularly to physical activity that took place in front of those attending the after-party. Graphic discussion about individual sexual experiences took place and personal questions were posed to others in the tearoom who were clearly not engaged in the conversation. Unfortunately the manager who reviewed the complaint told staff who had complained

- "it's morning tea so people can talk about what they want" and
- "people can easily leave the tearoom if they don't like the conversation... think about it this way, it's like being able to change the channel if you don't like what's on SBS!" and
- "they weren't talking about illegal behaviour."

Wrong on all three counts given the circumstances, and the fact that it was a workplace! The manager found himself in a spot of further bother when the complaint leapfrogged to the CEO with some additional wording that indicated the manager had excused the inappropriate and offensive conduct failing to recognise the tearoom should be comfortable for all, and additionally that people believed the manager had given approval for people to be sexually harassed.

There was also a medical organisation that argued the unwanted physical contact of a sexual nature was not conduct that formed part of the perpetrator's job description or responsibilities, hence the organisation, and the senior medical practitioner who was present at the time, had no accountability.... Wrong !

A slightly more complex situation saw a senior executive's partner who sexually harassed a new male graduate when she attended the Christmas party with the senior executive, send the hospital in question into a spin. Witnessed by others, the behaviour which proved to be distressing for the new graduate was not addressed by the hospital as the relevant medically trained manager considered absolutely nothing could be done unless a written complaint from the new graduate was lodged with the hospital.... Wrong !

A hospital employee weighing up decisions about future study options asked an established doctor for advice. Invited to the doctor's home to discuss the various options in detail over a meal (away from the hospital and nosey colleagues) the employee feels dizzy and asks to lie down. Sexually assaulted, a urine test reveals benzodiazepine. This may well be categorised as criminal conduct, but it is also work-related sexual harassment – one process does not cancel out the other.

A young secondee from the corporate environment starts at a regional clinic. Non work- related material including several pictures of a spouse in a bikini in various poses are displayed and can be seen when attending the office in question. When the appropriateness of the material is questioned on several levels including organisational reputation, client responses and discomfort of staff, the answer provided at the regional level is that the photos were in the environment before the secondee arrived, and it's his wife.... Really ?

While I'd be keen to forget about it, I remember well a number of people participating in a heated debate about the need to prevent the use of gender aligned pet names given to women entering the medical profession. Viewed by some who were vexed at the time, as an "over reaction" and "political correctness" there were people involved in the discussion who had never been burdened by gender aligned pet names and associated stereotyping. It's fair to say they just didn't get it. Some of the names and descriptors in question amounted to sexual harassment. For the record, the term sweetheart is not appropriate when a Trainee (be they male or female) has a first name and a surname.

The view that sexual harassment is quarantined to conduct that has men as perpetrators and women as victims needs to shed its stereotypical coat. Sexual harassment is perpetrated by males and females against people of the same sex and the opposite sex. Sexual orientation is irrelevant.

Moving beyond the fields of medical and scientific endeavour the following examples offer some additional insights into different forms of sexual harassment. The fact is that sexual harassment does not discriminate ... people across all walks of life, as well as different professions and vocations are vulnerable; as are people of all ages, genders, beliefs and backgrounds.

Dream job in tow, and a strong mutual attraction between employee and boss leads to a covert relationship. The boss is married. A work-related pregnancy results accompanied by an ultimatum – terminate the pregnancy or lose your job.

A senior school student is sexually harassed due to his father's gender re-assignment surgery. In receipt of derogatory social media messages with sexual connotations, and insufficient support from key relevant organisations, the student anxious and fearing for his safety removes himself from school to cope.

A male employee was taunted by male co-workers who told others he was gay and a paedophile. The verbal attacks increased and a co-worker simulated sexual intercourse with him in front of others. A psychological injury resulted.

A French national is asked by a new client in an Australian business meeting whether it's true that many French women are unfaithful to their husbands. The client compliments her on her looks and fitness and suggested a drink after work. Feeling awkward but not wanting to offend the woman notes she leaves work early to pick up children, so unfortunately drinks are not possible. The next day she asks her manager's advice on how to handle the client. Her manager laughs and tells her not to worry adding that the client loves the ladies and she should be flattered that he finds her attractive. Far from the correct response the manager has actually condoned the conduct.

A male is shopping and when trying clothes on the sales assistant touches him inappropriately and propositions him. The offer is declined with the male wondering what he said or did that could have given the sales assistant the impression he may have been interested. This is a typical response from a victim.

The rental market seems flooded with interested parties and it's been hard to secure a place. Inspecting a good apartment the potential renter chats to the agent who suggests a coffee to help with the necessary application. Over coffee there's an offer to pull some strings with the landlord assuming there'll be a sexual favour in return.

In the world that we live education is essential. It provides a platform to call out unacceptable behaviour in an informed way and to understand the breadth and depth of conduct that can amount to sexual harassment in the twenty-first century.

While being held accountable for sexual harassment may be a new experience for some, sexual harassment is certainly not "a new age dilemma." Indeed I recall hearing my first cautions about behaviour that came to be known as sexual harassment in the late 1960's from my mother who was a nurse. Her words of wisdom that set me on a path of no return - "knowledge is power...."

NOTE

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

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

Legal issues for medical audits in Australia

MICHAEL GORTON AM
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Audit (whether self-audit or in groups) is a welcome quality assurance activity - to monitor and improve medical competence, and to inform the debate on medical standards.

It is important that doctors are encouraged to participate in these activities, given the benefits for the individual, and the profession as a whole.

Whilst the profession generally is in favour of open and positive participation in quality assurance activities, some may be discouraged for fear that:

- information generated by the activity may be used in medical negligence litigation;
- disclosure of the information may cause embarrassment or adverse impact on their practice;
- legal action may arise from third party review of other practices.

Many doctors will be concerned that information obtained during the audit, particularly identifying information, may be adverse to the doctor and his or her practice. Additionally, care should be taken to avoid patient identifying information. Even information which identified particular hospitals, if adverse, would be a matter of some concern. Accordingly, surgeons will be reassured if some privilege or confidentiality applies to the process.

Qualified Privilege

There are various statutory schemes available to provide protection to medical professionals for protection of information obtained through audit and quality assurance activities.

The Commonwealth Qualified Privilege Scheme is established under sections dealing with quality assurance and confidentiality in the *Health Insurance Act 1973 (Cth)*.

The **RACS Audit of Surgical Mortality** is registered under this Scheme.

Quality assurance projects, medical audits and credentialling processes can be registered under the Scheme. Application is made to the Minister for Health for a declaration in relation to the activity or project.

Once an activity is declared under the legislation, all participants must comply with the confidentiality requirements contained in the legislation. This means that any person (including a participant) who acquires information which identifies individuals or entities, which is information known solely as a result of participation in the activity, must not disclose or make a record of that information. A breach of the confidentiality provisions is a criminal offence to which sanctions apply.

The information cannot be disclosed in court, unless it involves a serious criminal offence, and then only with the specific written approval of the Minister.

Registration under the Commonwealth legislation provides two important protections:

- Confidentiality of information that identifies individuals or entities, which is known as a result of participation in the activity or project.
- Protection from civil proceedings for members of committees that assess or evaluate the quality of health services provided by others (Credentialling activities).

States and Territories also have legislation to provide protection for quality assurance activities. However, the legislation in some States does not provide as strong protection as the Commonwealth legislation and, in some cases, information thought to have been protected by State legislation has been ordered to be produced publicly by courts and tribunals. The legislation in some States is similar to the Federal legislation and, accordingly, the choice of registration (either under State or Federal law) will vary from state to state.

I believe that registration under the Commonwealth legislation affords professionals, and doctors in particular, with adequate and strong protection of confidentiality and removes the fear of unprotected disclosure of adverse identifying information.

In New Zealand, an application can be made for recognition as a Quality Assurance Activity under the New Zealand Health Practitioners Competence Assurance Act 2003 (PART 3 - Compliance, Fitness to Practise and Quality Assurance). This is often done through an application by the local district health board.

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Patient Confidentiality

Some activities, including medical audit, might necessarily involve the disclosure of patient identifying information.

Patient confidentiality is, of course, a general duty attaching to all medical professionals.

Identifying patient information and patient records should not be used without patient consent.

In many circumstances, in hospitals, consent is given as part of the general hospital consent form, signed by all patients on admission.

However, in the context of private practice, patient consent should be sought for all release or use of patient identifying information or patient records for quality assurance, medical audit, or research purposes.

The material below in relation to privacy legislation also deals with these issues.

Privacy Laws

Recent legislative changes dealing with privacy issues impact on the way audit, credentialling and medical research is conducted in Australia.

The *Commonwealth's Privacy Act* (2001) and regulates the way that information is collected, used and protected. It particularly restricts disclosure.

Private sector organisations are required to comply with a set of privacy principles (National Privacy Principles - NPP) that set a base line standard for the protection of personal information. Reference has been made in other articles to requirements under Privacy legislation.

The NZ Privacy Act (1993) and Health Information Privacy Code (1994) also define a number of similar principles governing the collection, use, accuracy, storage and disclosure of health information relating to individuals. Additionally, health agencies are not permitted to assign a unique identifier to an individual unless this is necessary for the efficient functioning of the agency.

The National Privacy Principles should also be borne in mind:-

- reasonable steps must be taken to ensure that, where health information has been collected without consent, it is de-identified before it is disclosed;
- reasonable steps must be taken to protect personal information from mis-use, loss, unauthorised access, modification or disclosure;
- reasonable steps must be taken to destroy and de-identify personal information when no longer required;
- reasonable steps must be taken to let any person who asks, to be advised of the personal information held, for what purpose, and how the information is collected, held and used.

Other Legislation

State based legislation does, in the main, reflect the same requirements. For example, in Victoria, the *Health Records Act 2001* establishes its own health privacy principles (HPP), which similarly govern the collection, use, disclosure and handling of health information. The Health Complaints Commissioner in Victoria has also issued statutory guidelines on research reflecting similar requirements to those under the Federal legislation:

- research must be in the public interest if it is not practicable to seek consent from patients;
- research information should be de-identified as much as possible;
- research should be reviewed by a Human Research Ethics Committee.

This article from Michael Gorton was in response to a request for more information from a RACS Fellow. If you have a burning medico-legal question then please send it in to surgical.news@surgeons.org and we will do our best to respond to it. – Ed.

Image: Patients waiting for eye consultations in Sumba, Eastern Indonesia (Photographer: Ellen Smith)

Across the Asia-Pacific with Global Health

PHILL CARSON
Chair, Global Health

Over five billion people lack access to safe, affordable and timely surgical and anaesthesia care. RACS Global Health is working across the Asia-Pacific to help change this. This year's World Health Day campaign was 'Depression: let's talk', with the World Health Organisation raising depression as being the leading cause of ill health and disability worldwide. The Pacific Islands Program (PIP) is taking a holistic approach to health in the Solomon Islands, working in collaboration with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) to find a way forward in the delivery of a psychiatry clinical visit and working toward community-orientated mental health services. Mental health was identified as a top health priority at the 9th Meeting of Ministers of Health for the Pacific Island Countries in Honiara, Solomon Islands, in June 2011. Ministers agreed that mental health issues, if not addressed appropriately and immediately, will continue to grow, with a significant adverse impact on health and socioeconomic development.

Australia Timor-Leste Program of Assistance for Secondary Services (ATLASS II)

Project Director: Professor Glenn Guest FRACS

The *Australia Timor-Leste Program of Assistance for Secondary Services – Phase II* (ATLASS II) is a health workforce development program funded by the Australian Government Department of Foreign Affairs and Trade and managed by RACS. The program is currently the only provider of postgraduate medical education and training in Timor-Leste. Through the delivery of postgraduate training in Family Medicine, Anaesthesia, Paediatrics, Surgery, Obstetrics and Gynaecology, Emergency Medicine, Ophthalmology and Internal Medicine, 98 Timorese doctors have received training in critical skills relevant to the Timorese context, and are now placed in medical facilities across Timor-Leste. These graduates are strengthening the national health workforce– particularly in rural and remote areas where access to quality health care is often scarce.

In December 2016, 11 Timorese doctors successfully completed an ATLASS II Postgraduate Diploma in Surgery, Anaesthesia or Paediatrics. With the exception of two trainees, these doctors have been with ATLASS II since 2014, when they enrolled in the Family Medicine Program Year 1 training. The successful completion of their diploma training is a culmination of two and a half years of hard work, determination and dedication, and the RACS Timor-Leste program is immensely proud of their achievements. In May of this year, these doctors will formally graduate from the National University of Timor-Leste.

2017 is set to be an exciting year for the program. In addition to the graduation of trainees from the National University ATLASS II is also looking forward to enrolling new cohorts of doctors across the Foundation Year and Postgraduate Diploma programs. Of particular importance, the Postgraduate Diploma in Internal Medicine will be delivered for the first time. The RACS Timor-Leste team is excited that the program is able to respond to the Timorese Ministry of Health's priorities for the health sector as well as deliver multiple training programs.

East Timor Eye Program (ETEP)

Project Director: Assoc. Prof Nitin Verma AM, Companion of the College

The East Timor Eye Program kicked off its outreach program in Manatuto in January this year, performing 120 eye health consultations and 39 operations. Following on from the Manatuto visit, in late February the team travelled to Los Palos, a small town approximately 250 kilometres east of Dili with a population of around 18,000. The response to this five-day visit was overwhelming: more than 400 patients were screened and 64 life-changing surgeries were performed. It was one of the busiest outreach visits ever undertaken in Los Palos. Of the 64 operations performed, 62 were to treat cataracts – the leading cause of preventable blindness in Timor-Leste.

Along with the local eye care nurse Jhonjino and the resident outreach team from the Department of Ophthalmology, RACS ophthalmologist Dr Manoj Sharma, Timorese Ophthalmology Registrar Dr Bernadete Pereira and Swiss Ophthalmology Fellow Dr David Brunner also accompanied the outreach team to Los Palos. Over the coming 10 months, the Department of Ophthalmology will deliver a further 11 outreach visits across Timor-Leste. With limited eye-health services available in the districts, a poorly functioning referral system and limited transportation options to the nation's capital, these outreach services - made possible through ETEP with funding from the Lions SightFirst program, are the only source of eye care services for many communities outside of Dili. To find out more about the East Timor Eye Program visit: **etep.org.au**

Pacific Islands Program (PIP)

Project Director: Mr Teariki (Kiki) Maoate FRACS ONZM

The Pacific Islands Program (PIP) has been synonymous with RACS Global Health since it was launched in 1995. Funded by the Australian Government through the Department of Foreign Affairs and Trade (DFAT), the past twenty years has seen more than 600 volunteer medical teams visit 11 Pacific Island Countries, providing over 60,000 consultations and 16,000 procedures.

In 2016, RACS entered into a new 5-year grant agreement with DFAT to extend the program until 2021, activities now covering all specialised clinical services including but not limited to surgery, anaesthesia, cardiology, nursing, radiology, nephrology, psychiatry and more. Key to this has been strengthening ties with other Australian, New Zealand, and Pacific Island specialist associations and colleges; where in 2016 the first All-Specialist-Colleges Global Health Meeting was held, bringing together leading clinical organisations to discuss approaches to harmonising activities in Global Health across the region.

A key component of the new program looks at strengthening regional tertiary education institutions for specialised clinical services, and partners in the program include Fiji National University and the Pacific Community. Additionally, activities aim to strengthen workforce planning, the continuing professional development of clinicians, and the systems and structures that support their function throughout the Pacific. 2017 has already proven to be a productive and energetic year for the program, with more than 25 clinical teams organised for visits throughout 2017.

More people die each year from lack of access to emergency and essential surgical care than do from HIV, TB, and malaria combined. It is estimated that by 2030, the lost financial output across the globe from death and disability due to continued poor access to safe and affordable surgery could total USD $12.3 trillion, reducing annual Gross Domestic Product (GDP) growth in low and middle income countries by as much as two per cent. Such programs like the Pacific Islands Program are key to tackling these issues, experienced by many of our neighbouring countries.

Overall, RACS Global Health looks forward to this new era of the Pacific Islands Program, where a comprehensive approach to specialised clinical services

Image: East Timor Eye Program consultation (Photographer: Ellen Smith)

seeks to facilitate change across all levels, from the individual level of the clinician, to the systems level of regional coordination and networking.

Myanmar

Project Director: Dr James Kong FRACS

In partnership with the Myanmar Medical Association, Ministry of Health and University of Medicine, RACS Global Health continues to support Emergency Medicine and Primary Trauma Care (PTC) training in Myanmar, responding to needs identified by the Myanmar Ministry of Health for medical capacity-building. The national PTC leadership group is effectively managing PTC training in Myanmar under the mentorship of an international faculty. It is anticipated that the establishment of a national PTC Foundation in the next three years will be the final step in the transition of PTC training in Myanmar, which will culminate to local ownership and independence.

RACS Global Health is also working with the Myanmar Surgical and Orthopaedic Societies to deliver surgical and non-technical skills training, to develop local capacity in key areas of patient care including critical care, infection control and quality assurance. In March 2016, a team of four volunteer instructors delivered a Surgical Skills training program in Yangon and Mandalay. This was the fourth Surgical Skills Program delivered in Myanmar, however the first to extend beyond Yangon to Mandalay.

Asia Paediatric Surgical Education Project (APSEP)

Project Director: Assoc. Prof Chris Kimber FRACS

The Asia Paediatric Surgical Education Project (APSEP) aims to improve health outcomes for children in South-East Asia, by training national health staff to provide improved paediatric surgery to their communities, and by promoting the development of sustainable, regional professional networks.

In 2016, five Cambodian and Vietnamese specialists developed leadership, technical and patient management skills and gained in-depth understanding of advanced hospital and patient management systems during hospital attachments in Australia. Since completing this training, these specialists have successfully led their surgical teams to implement changes to their clinical practice and approach to patient management in their home hospitals. Reports indicate that these changes have led to improved patient outcomes in their respective hospital, and that the specialists have passed on their new skills to colleagues.

In addition, 215 Southeast Asian health personnel received specialist paediatric training through targeted skills courses and clinical on-the- job training, 154 Cambodian children with disorders of sexual development

Image: Paediatric clinical visit, Timor-Leste (Photographer: Ellen Smith)

Image: Anaesthetist, Dr Timothy Webb, with a patient at Colonial War Memorial Hospital, Fiji (Photographer: Darren James)

received a consultation by the Monash Children's Hospital International (MCHI) and RACS visiting specialists and local doctors in training. Angkor Hospital for Children Management and MCHI-RACS worked together to define a clear scope of surgical capability for hospital staff, with a future focus on safer implementation of core skills and reduction of complex surgical conditions being treated.

In 2017, the APSEP will support health outcomes for children through improved knowledge and skill sets of national surgeons; development of loco-regional clinical networks, training and education and development of culturally specific approaches to management of paediatric surgical diseases; and improved health outcomes for children with complex congenital disorders.

Sumba Eye Program (SEP)

Project Director: Dr Mark Ellis FRACS AM

The Sumba Eye Program, established in 2007, is targeted at delivering eye care services to the people of Sumba and building the capacity of the local and regional health staff to provide effective eye care for the community in Nusa Tenggara Timur (NTT), Eastern Indonesia.

In 2016, the Australian team delivered two clinical and training visits in collaboration with the Sumba Foundation and regional ophthalmologists from Hassanuddin University, Sulawesi to promote skills transfer and capacity building. The purpose of the visit was to work alongside and mentor two Sumbanese eye care nurses in an effort to help establish a sustainable local infrastructure for eye care in Sumba. The nurses have demonstrated increased competency and confidence identifying pathology, refracting and the appropriate provision of spectacles.

In 2017, the Australian team will continue to support the health needs of the people of Sumba. As part of support and development of capacity of local health staff in Sumba, two Sumba Eye Care nurses visited Melbourne and Sydney in March this year. The nurses visited various sites and observed various techniques for the refraction and detection of common eye diseases. They are now back in Sumba transferring the skills learnt to their local community.

Global Health at the ASC

The Global Health Program at the RACS 86th Annual Scientific Congress in Adelaide this year is set to be an exciting one, convened by Assoc. Prof Suren Krishnan FRACS with visiting keynote speakers Dr Mark Shrime, Research Director, at the Harvard Program in Global Surgery and Social Change and Professor Rajat Gyaneshwar, Founder of the Viseisei Sai Health Centre in Fiji.

For further details visit asc.surgeons.org and join the conversation using **#RACSGlobalHealth** on Twitter.

#RACSGlobalHealth

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

19/05/2017	Wollongong	NSW
20/05/2017	Sydney	NSW
22/05/2017	Sydney	NSW
26/05/2017	Brisbane	QLD
27/05/2017	New Plymouth	NZ
27/05/2017	Brisbane	QLD
31/05/2017	Gold Coast	QLD
2/06/2017	Melbourne	VIC
16/06/2017	Traralgon	VIC
17/06/2017	Brisbane	QLD
23/06/2017	Sydney	NSW
24/06/2017	Christchurch	NZ
27/06/2017	Wellington	NZ
30/06/2017	Melbourne	VIC
8/07/2017	Sydney	NSW
9/07/2017	Hawaii	USA
21/07/2017	Wagga Wagga	NSW
22/07/2017	Sydney	NSW
29/07/2017	Shepparton	VIC

The Foundation Skills for Surgical Educators is an introductory course to expand knowledge and skills in surgical teaching and education. The aim of the course is to establish a basic standard expected of RACS surgical educators and will further knowledge in teaching and learning concepts. Participants will look at how these concepts can be applied into their own teaching context and will have the opportunity to reflect on their own personal strengths and weaknesses as an educator. With the release of the RACS Action Plan: Building Respect and Improving Patient Safety, the Foundation Skills for Surgical Educators course is now **mandatory** for Surgeons who are involved in the training and assessment of RACS SET Trainees.

Breaking Bad News

3/06/2017	Melbourne	VIC

Delivering distressing news can be challenging for all involved; patients, family and clinicians alike. 'Breaking Bad News' is a four hour evidence-based workshop in which facilitators will guide you through 'real-life' scenarios with a trained actor. You'll learn effective communication techniques and be able to practise them in a safe environment.

SAT SET Course

27/05/2017	Brisbane	QLD
3/06/2017	Sydney	NSW

The Supervisors and Trainers for Surgical Education and Training (SAT SET) course aims to enable supervisors and trainers to effectively fulfil the responsibilities of their important roles, under the new Surgical Education and Training (SET) program. This free 3 hour workshop assists Supervisors and Trainers to understand their roles and responsibilities, including legal issues around assessment. It explores strategies which focus on the performance improvement of trainees, introducing the concept of work-based training and two work based assessment tools; the Mini-Clinical Evaluation Exercise (Mini CEX) and Directly Observed Procedural Skills (DOPS).

Keeping Trainees on Track

27/05/2017	Brisbane	QLD
3/06/2017	Sydney	NSW

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

This free 3 hour course is aimed at College Fellows who provide supervision and training SET Trainees. During the course, participants will have the opportunity to explore how to set up effective start of term meetings, diagnosing and supporting Trainees in four different areas of Trainee difficulty, effective principles of delivering negative feedback and how to overcome barriers when holding difficult but necessary conversations.

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

2/06/2017	Melbourne	VIC

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

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

Clinical Decision Making

23/06/2017	Christchurch	NZ

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

Friday, 7 July 2017	Auckland	NZ

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.

Surgical Teachers Course

Thursday 20 - Saturday 22 July 2017	Yarra Valley	VIC

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

Process Communication Model Refresher (PCM)

Friday,1 September 2017	Melbourne	VIC

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

Non-Technical Skills for Surgeons (NOTSS)

Friday, 22 September 2017	Brisbane	QLD

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 Seminar 1 (PCM)

Friday 20 – Sunday 22 October 2017	Auckland	NZ
Friday 17 – Sunday 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

May – July 2017

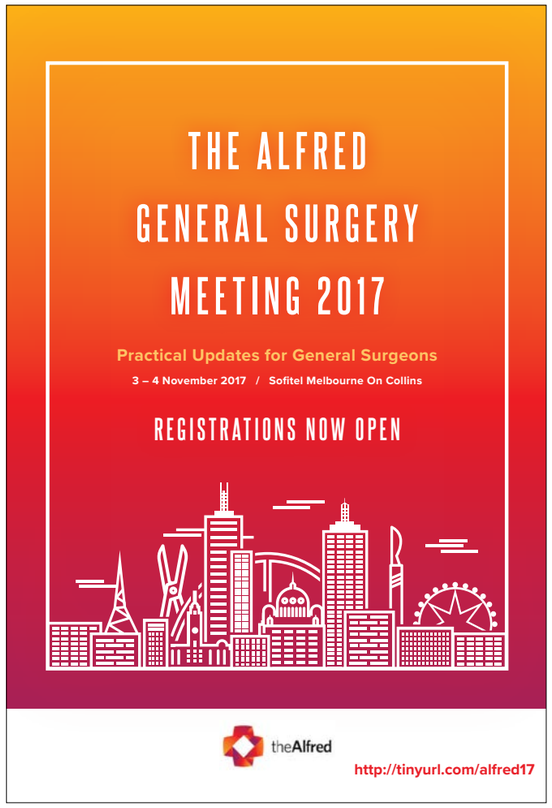
NSW		
Foundation Skills for Surgical Educators	19/05/2017	Wollongong
Foundation Skills for Surgical Educators	20/05/2017	Sydney
Foundation Skills for Surgical Educators	22/05/2017	Sydney
Keeping Trainees on Track	3/06/2017	Sydney
SAT SET Course	3/06/2017	Sydney
Foundation Skills for Surgical Educators Faculty Training Day	4/06/2017	Sydney
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
NZ		
Foundation Skills for Surgical Educators	27/05/2017	New Plymouth
Clinical Decision Making	23/06/2017	Christchurch
Foundation Skills for Surgical Educators	24/06/2017	Christchurch
Foundation Skills for Surgical Educators	27/06/2017	Wellington
Operating with Respect (OWR)	7/07/2017	Auckland
QLD		
Foundation Skills for Surgical Educators	26/05/2017	Brisbane
Foundation Skills for Surgical Educators	27/05/2017	Brisbane
Keeping Trainees on Track	27/05/2017	Brisbane
SAT SET Course	27/05/2017	Brisbane
Foundation Skills for Surgical Educators	31/05/2017	Gold Coast
Foundation Skills for Surgical Educators	17/06/2017	Brisbane
VIC		
Foundation Skills for Surgical Educators	13/05/2017	Melbourne
Foundation Skills for Surgical Educators	2/06/2017	Melbourne
National Simulation Health Ed Training Program (NHET Sim) S5, S6 modules	2/06/2017	Melbourne
Breaking Bad News	3/06/2017	Melbourne
Foundation Skills for Surgical Educators	16/06/2017	Traralgon
Facilitator Skills for Surgeons	24/06/2017	Melbourne
Foundation Skills for Surgical Educators	30/06/2017	Melbourne
Foundation Skills for Surgical Educators	29/07/2017	Shepparton
USA		
Foundation Skills for Surgical Educators	9/07/2017	Hawaii

Contact the Professional Development Department

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

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

WORKSHOPS • ACTIVITIES • EVENTS



THE AUSTRALIAN MEDICO LEGAL COLLEGE

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Annual Combined Meeting

Australian Orthopaedic Association Medico-Legal Society
Royal Australasian College of Surgeons Medico Legal Section
The Australian Medico Legal College

Friday 1 & Saturday 2 September 2017
Sheraton on the Park
Sydney

Incorporating the AMA Impairment Guidelines 4th and 5th Edition: Difficult Cases workshop on the Saturday morning

For details please contact Alison Fallon, Conference Secretariat
alison.fallon@aoa.org.au
or see the website:
http://medico-legal.aoa.org.au

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*

June – July 2017

ASSET	
Friday, 23 June 2017 – Saturday, 24 June 2017	Wellington
CCrISP	
Thursday, 8 June 2017 – Saturday, 10 June 2017	Auckland
Friday, 16 June 2017 – Sunday, 18 June 2017	Sydney
Friday, 23 June 2017 – Sunday, 25 June 2017	Bendigo
Friday, 14 July 2017 – Sunday, 16 July 2017	Brisbane
Friday, 21 July 2017 – Sunday, 23 July 2017	Adelaide
CLEAR	
Friday, 30 June 2017 – Saturday, 1 July 2017	Sydney
Friday, 28 July 2017 – Saturday, 29 July 2017	Perth
EMST	
Friday, 19 May 2017 – Sunday, 21 May 2017	Brisbane
Friday, 19 May 2017 – Sunday, 21 May 2017	Melbourne
Friday, 19 May 2017 – Sunday, 21 May 2017	Auckland
Thursday, 25 May 2017 – Saturday, 27 May 2017	Perth
Friday, 26 May 2017 – Sunday, 28 May 2017	Sydney
Friday, 26 May 2017 – Sunday, 28 May 2017	Adelaide
Friday, 2 June 2017 – Sunday, 4 June 2017	Sydney
Friday, 2 June 2017 – Sunday, 4 June 2017	Brisbane
Friday, 16 June 2017 – Sunday, 18 June 2017	Sydney
Friday, 16 June 2017 – Sunday, 17 June 2017	Auckland
Friday, 23 June 2017 – Sunday, 25 June 2017	Sydney
Friday, 23 June 2017 – Sunday, 25 June 2017	Melbourne
Friday, 30 June 2017 – Sunday, 2 July 2017	Hobart
Friday, 30 June 2017 – Sunday, 2 July 2017	Auckland
TIPS	
Friday, 19 May 2017 – Saturday, 20 May 2017	Melbourne
Friday, 16 June 2017 – Saturday, 17 June 2017	Auckland

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*

WORKSHOPS • ACTIVITIES • EVENTS

Program Highlights 2017

Annual Joint Academic Meetings

Thursday 9 - Friday 10 November
Adelaide, South Australia

DAY ONE - SECTION OF ACADEMIC SURGERY MEETING

Presentations

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

Concurrent Workshops

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

Short Debates

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

DAY TWO - SURGICAL RESEARCH SOCIETY MEETING

Invited Guest Speakers

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

Presentations of Original Research

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

Registration opens in May
Contact Details
E: academic.surgery@surgeons.org
T: +61 8 8219 0900

Royal Australasian College of Surgeons | Section of Academic Surgery | Surgical Research Society | Medtronic

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

Tri-Nation Alliance

Building Respect and Leading Change

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

The Tri-Nation Alliance met in Melbourne from 7 to 10 March. The four days were hosted by the Australia and New Zealand College of Anaesthetists (ANZCA) in association with the other participating colleges, namely the Royal Australasian College of Physicians (RACP), the Royal College of Physicians and Surgeons of Canada (RCPSC), Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Royal Australasian College of Surgeons (RACS).

The business meeting was held on the 7th March.

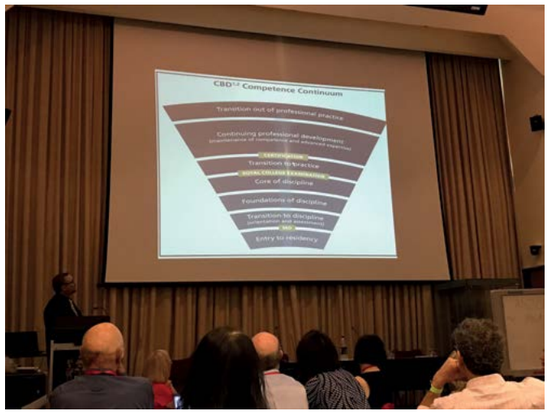
CBME, EPAs and CB-CPD Workshop

Dr Craig Campbell set the scene for the day by illustrating CBME, the challenges experienced and lessons learned. Dr Jason Frank presented an overview of the history, development and principles of CBME and pointed to the issues with implementations. He referenced EPAs as well as CanMEDS 2015. Each college then gave their take on where they are with the implementation of CBME. For RACS, Assoc Prof Stephen Tobin presented on the JDocs framework development, the use of key clinical tasks as multi-competencies assessments akin to EPAs, and the portfolio and mobility platform involved with JDocs.

For Session 2 'Evaluation of and Challenges within CBME, EPAs and Vocational Training', Prof Jonathan Fryer from Northwestern Medicine, USA spoke on practical/ change issues in implementing performance measurement tools in the workplace.

In Session 3 'Exploring the Concept of CB-CPD throughout a Career in Practice', Dr Craig Campbell developed the theme of competency-based Continuing Professional Development (CPD) clearly. Following that, participants were divided into 3 groups to discuss the different issues related to competency-based CPD. All groups then reported back with their findings.

In the last session 'Research Opportunities across the Tri-nation Alliance', multiple good ideas were discussed. This was a good platform for all the Colleges to come together and leverage on the mutual expertise in pursuing research opportunities.



Dr Jason Frank, RCPSC illustrating the competence continuum at the CBME, EPAs and CB-CPD workshop

Health & Wellbeing of Indigenous Peoples Workshop

This was an extensive, thought-provoking workshop ably facilitated by Assoc Prof Papaarangi Reid, Auckland and Assoc Prof Gregory Phillips, Melbourne. Dr Kali Hayward (Australia), Dr Curtis Walker (New Zealand) and Dr Thomas Dignan (Canada) shared their perspectives on the impact of colonisation and the challenges faced by Indigenous doctors and patients. The 'colonisation' concept was thoughtfully developed and it set the scene for the rest of the day.

After morning tea, the focus was on growing the Indigenous workforce. Discussions were centred on the barriers Indigenous medical students/Trainees face and strategies that colleges can take to support them and grow their numbers. On this note, the colleges agree that there needs to be equity (support for those coming from a lesser base), and not just equality (merit-based selection).

In the 'Embedding cultural competency and safety for the Indigenous health' session, it was discussed that there has been much activity in cultural safety training. However, little evaluation has been done to demonstrate the effectiveness of this training. It is also important to incorporate cultural competency for all, and not just the trainers/ supervisors.

Dr Kali Hayward, AIDA speaking at the Health & Wellbeing of Indigenous Peoples workshop

International Medical Symposium

The International Medical Symposium with the theme 'Leading Change' was held at the Arts Centre, Melbourne. As it was open to the wider community, approximately 220 delegates attended the IMS.

In the first session, Assoc Prof Stephen Tobin started by framing the concepts of future and culture from societal and medical perspectives. Prof Spencer Beasley built on this with a comprehensive review of the College's Action Plan and progress until now. Dr Victoria Atkinson as CMO of St Vincent's Health Australia, touched on Vanderbilt principles and explained how St Vincent's plans the 'Ethos' system will progress.

In the next session on 'Leading Change in Indigenous Healthcare', Dr Thomas Dignan, a Seneca physician from Canada framed the future of Indigenous health and healthcare, specifically in Canada. Dr Kali Hayward, President of the Australian Indigenous Doctors Association (AIDA) painted a picture on cultural safety as it is the best pathway towards achieving safe colleges and strengthening the indigenous specialist medical workforce. Dr Curtis Walker, member of the Medical Council of New Zealand then spoke on safe practice and the importance of building cultural competency.

After lunch, the focus was on 'Leading Change in Medical Education and Technology'. Prof Jonathan Fryer was the afternoon plenary speaker. In his presentation, he made a point on autonomy driving people in learning. There is a need to identify EPAs (numbers must be manageable) and workplace performance assessment needs to be real-time and not retrospective. To add on, instead of periodic assessments, there needs to be multiple assessments from multiple assessors. Prof Elizabeth Molloy then touched on enhancing feedback in professional practice. In her presentation, she pointed out that feedback needs to be designed in, rather than a retrospective activity. Prof Ian Symonds, Dean of Medicine, University of Adelaide then ended the session with his talk on transforming health education and the intertwining of the past, present and future of medical education.

The last session of the day was on 'Leading Change in Systems and Practice'. Dr Margaret Aimer from Ko Awatea Centre for Health System Innovation and Improvement started off by framing the future of medical systems and practice. Assoc Prof Grant Phelps then presented on the importance of networking clinicians for the excellence of patient care. Prof David Story touched along the same vein as he shared about his experience as an anaesthetist and the teamwork of the entire team in the operating theatre, i.e. 'inter-professional practice' and how it enhances perioperative care. Prof Jeffrey Braithwaite, from Macquarie University and the Foundation Director Australian Institute of Health Innovation then gave the closing plenary on implementation science and the advancing of healthcare systems. He gave an interesting equation, in which the success of implementation is the factor of evidence, context and facilitation.

The three-day educational program was beneficial for all attendees. The recordings from the International Medical Symposium will be made available on the Academy of Surgical Educators' website. Please take the opportunity to review the recordings as the IMS day is unique in the Australian and New Zealand medical conference calendars.

Prof Spencer Beasley presenting on the progress of the Building Respect, Improving Patient Safety RACS Action Plan

RACS D'Extinguished Surgical Club Meeting

Friday 16th of June 2017

A meeting of the D'EXTINGUISHED SURGICAL CLUB under the Chairmanship of Mr Cas McIness will be held on Friday the 16th of June 2017.
With a luncheon at the RACV Club
501 Bourke Street at 12.30pm.

Image: Brian Collopy presenting his Surgical History Lecture on James Beaney with a champagne touch; April 2017.

This will be followed by a Surgical History presentation by Mr Miclos Pohl OAM on the topic

Billroth and Brahms,
A blend of surgery and music

This eminent 19th century surgeon was a close confidant of Johanes Brahms, the composer who used to get Billroth the violinist to edit and even advise on various musical compositions.

Mr Pohl, (Founder of the Australian and European Doctor's Orchestra) visited 'Billroth' at the Berlin Medical Institute in 2013 and his experiences there will be part of his presentation.

Invitation to this meeting is extended to all Fellows.
Limited places available.

Please confirm attendance via email:
felix@felixbehan.com.au

Morbidity and Mortality meetings: an evidence-based review

Thorough reporting and review of episodes of care identifies opportunities for all to understand patient outcomes and improve future care.

ASSOC. PROF. STEPHEN TOBIN Dean of Education
DR LAWRENCE MALISANO Chair, Professional Standards

Morbidity and Mortality (M&M) meetings provide important opportunities for healthcare professionals to share and learn. Thorough reporting and review of episodes of care identifies opportunities for all to understand patient outcomes and improve future care. However, the structure of these meetings, the way they are conducted, and what is taken from them differs from between hospitals.

In early 2016, RACS Research and Evaluation, incorporating ASERNIP-S performed an evidence-based review of the factors that enable and/or disable M&M meetings in order for the College to provide guidance as to their conduct.

A two-stage project was undertaken; the first examined the peer-reviewed literature to produce a summary of the factors affecting M&M meetings. In this first stage, three biomedical databases, clinical practice guideline clearinghouses and other literature sources were searched. Of the included studies, the majority were observational (n=21), with only two non-randomised comparative trials, and one randomised controlled trial, identified. A review of this information identified enabling factors such as structured meeting formats, structured case identification and presentation, and a systems-focus. Similarly, frequently identified limiting factors included the absence of key personnel from meetings, logistics and heterogeneity in case evaluation.

In order to translate these research findings into a practical direction for the College, the second stage of the project developed these findings into a guideline summary document. This document defines what constitutes an M&M meeting: it highlights the importance of M&M meetings to surgical education and improving clinical practice; and, identifies the factors that enable or limit the effective conduct of M&M meetings.

To ensure the practicality of this report, the enabling factors (n=18) were listed a simple table and grouped under three main headings: Format, Conduct, and Outcomes. Then, based on the frequency of these factors in the literature along with expert clinician feedback, these factors were used to develop three standards of M&M meetings. The bronze standard included those factors that should be present in all M&M meetings, the silver added other factors that would improve all meetings, lastly, the gold standard included all of the enabling factors identified.

For any Surgical department, the conduct of M&M meetings is contingent on local factors so these standards should be thought of as a means to guide and enhance future meetings. We and the other members involved in this guideline believe that these results could also be used to inform College policy on these meetings.

Finally, we are also pleased to note that Associate Professor Stephen Tobin will be presenting this research at the College's Annual Scientific Congress (ASC) meeting in early May. To those reading the early online version of this article, and who are attending the Congress, please come to this session; any feedback you are able to provide would be greatly appreciated as it will certainly add to and strengthen our understanding of this important area.

Should you require further information please contact:
professional.standards@surgeons.org

National Reconciliation Week

DAVID MURRAY
Chair,
Indigenous Health Committee

This year marks 50 years since the 1967 Referendum, an event that marked the end of formal constitutional discrimination against Aboriginal and Torres Strait Islander people and began a new era in race relations in Australia. On 27 May 1967 a Federal referendum was held to decide on two proposals. The second question was to determine whether two references in the Australian Constitution, which discriminated against Aboriginal people, should be removed.

The sections of the Constitution under scrutiny were:

51. The Parliament shall, subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect to:- ... (xxvi) The people of any race, other than the aboriginal people in any State, for whom it is necessary to make special laws.

127. In reckoning the numbers of the people of the Commonwealth, or of a State or other part of the Commonwealth, aboriginal natives should not be counted.

Section 51 gave the federal government the power to make laws to cover anyone in Australia, except Aboriginal people. As Attwood and Markus describe, this clause was originally structured in this way to enable parliament to discriminate against racial groups such as the Pacific Islander Kanaka labourers in Queensland. The words 'other than the aboriginal race in any State' were intended to exempt Aboriginal people from this type of discrimination.

As a result of this clause the federal government had largely divested law making and Indigenous affairs to the states, where there were a diffuse range of approaches. Referendum supporters argued that if the federal government could enact legislation governing Aboriginal affairs, such uniformity would benefit Aboriginal people.

The removal of Section 127 was more pointed. The significance of that clause had been to disenfranchise Aboriginal people from recognition and citizenship of their own country. The support for removal of the words '... other than the aboriginal people in any State...' in section 51(xxvi) and the whole of section 127 was in part owing to the success of the widespread campaign for Aboriginal Civil rights that occurred during the 1960s.

As a result of the political climate, this referendum saw the highest YES vote ever recorded in a Federal referendum, with 90.77 per cent voting for change.

What changed after the referendum?

One of the government's first acts under its new power was to establish the Council for Aboriginal Affairs. The Council brought Ministers from all states and territories together so they could discuss issues related to Aboriginal and Torres Strait Islander peoples and recommend actions to the Australian Government.

The Referendum also paved the way for the enactment of a number of important pieces of legislation, including the Aboriginal and Torres Strait Islanders (Queensland Discriminatory Laws) Act 1975; the Aboriginal Councils and Associations Act 1976; the Aboriginal Land Rights (Northern Territory) Act 1976; the Council for Aboriginal Reconciliation Act 1991; and, in response to the land rights cases of the 1990s, the Native Title Act 1993.

However, the Referendum did not end discrimination. For example, Aboriginal and Torres Strait Islander peoples did not receive equal wages as a result of the referendum; this right was granted through a different process.

A Lasting Symbol

Addressing these longstanding constitutional inequalities, and the resultant change in the relationship between government and Aboriginal and Torres Strait Islander peoples, has given the 1967 Referendum longstanding significance for all Australians. One of the most important outcomes of the Referendum was to demonstrate how Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians can work together to improve policy, systems, and ultimately realise reconciliation.

Through its Reconciliation Action Plan RACS is involved in the ongoing work of achieving equity in health outcomes for all Australians. More information on National Reconciliation Week available at www.reconciliation.org.au.

Further Reading

'The 1967 Referendum - Race, Power and the Australian Constitution'
by Bain Attwood and Andrew Markus

Closing the Gap – Progress & Challenges

DAVID MURRAY
Chair, Indigenous Health Committee

On 14 February 2017 the Commonwealth Government released the 10th Closing the Gap report in Canberra. The report highlighted areas where there had been successes and gains in measures associated with the social determinants of health. The report also made it clear that in many areas Australia is not on track to meet the set targets.

Closing the Gap was developed in response to the call of the social justice report 2005 and the Close the Gap social justice campaign. In March 2008, Australian governments and Aboriginal and Torres Strait Islander people agreed 'to work together to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by the year 2030' when they signed the Indigenous health equality summit statement of intent. It is a formal commitment made by all Australian governments to achieve Aboriginal and Torres Strait Islander health equality within 25 years.

The closing the gap report shows how we, as a nation, are meeting our responsibilities in improving outcomes for our First Australians. The Closing the Gap targets address the areas of health, education and employment, and provide an important snapshot of where progress is being made and where further efforts are needed.

Challenges

According to the report "The target to close the gap in life expectancy by 2030 is not on track based on data since the 2006 baseline. Over the longer term, the total Indigenous mortality rate declined by 15 per cent between 1998 and 2015, with the largest decline from circulatory disease (the leading cause of Indigenous deaths). However, the Indigenous mortality rate from cancer (the second leading cause of death) is rising and the gap is widening. The recent declines in smoking rates will contribute to improvements in health outcomes into the future."

In response to these challenges the federal government is evaluating the way that it works with Aboriginal and Torres Strait Islander people. At the Close the Gap day event Prime Minster Turnball emphasised that relationships between Government and Aboriginal people are entering a new period:

"We are building a new way of working together with Indigenous leaders and their communities to create local solutions—putting Aboriginal and Torres Strait Islander people at the centre of decision-making in their regions"

The report also states, "The importance of culture cannot be underestimated in working to close the gap. The connection to land, family and culture is fundamental to the well-being of Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander cultures are the world's oldest continuous cultures – they have stood the test of time."

Medical Colleges

In this environment medical colleges are uniquely placed to provide leadership. RACS in particular is increasingly advocating for preventative health measures and for a better recognition of the root causes of morbidity and mortality in Australia. Through the Indigenous Health Committee RACS is aiming to increase the number of Aboriginal and Torres Strait Islander people in the workforce, improve the cultural safety of our Fellows, IMGs and Trainees and support Aboriginal health organisations to provide effective care to their communities. Together these initiatives are powerful ways in which we can practically address the gap in healthcare.

RACS is demonstrating through its initiatives that the way forward is through partnerships and strong relationships. Both Indigenous and non-Indigenous people working together is essential to realising better health outcomes for all Australians.

The Ear Health For Life campaign being overseen by the Indigenous Health Committee (profiled in the March Surgical News) is one critical way in which RACS is working closely with stakeholders to Close the Gap. Through recognition of the critical influence of Ear disease on achieving all the Close the Gap targets, RACS in partnership with ASOHNS aims to make ear health a Close the Gap priority and encourage the development of an integrated national strategy to addressing ear health among Aboriginal and Torres Strait Islander peoples across Australia.

Choosing the best model of care for hernia surgery

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

The Surgical Variance Report: General Surgery that was released in May last year highlighted substantial variation between surgeons in the rate of day hernia repair. Medibank engaged RACS Research and Evaluation, incorporating ASERNIP-S to undertake research and produce a report which provides guidance for best practice in Australian private hospitals. This report identified that between 70 to 80 per cent is an appropriate rate for same day hernia repair in Australian private hospitals, compared with the current rate of 20 per cent (Figure 1).

A range of approaches were taken, including review of the published evidence on day hernia repair and the use of a Working Group to provide feedback and advice.

Although it is of varying quality, there is a great deal of evidence reporting that same-day surgery for repair of inguinal, femoral and umbilical hernia is safe and effective. Not surprisingly as it is most common of these procedures, the evidence base is greatest for inguinal hernia. Additionally, Australian and international guidelines recommend day surgery for most patients undergoing inguinal hernia repair surgery, providing that surgical infrastructure is available to assess and select patients and that suitable aftercare can be given. Clinical practice guidelines and published data from a range of countries are consistent in reporting that an appropriate rate of same-day hernia repair is 70 to 80 per cent of all hernia repair surgery.

Of course, some patients are not suitable for same-day hernia repair (for example those who are elderly, overweight, or undergoing bilateral surgery) and these patients should stay in hospital for a period deemed suitable by the surgeon. There seems no reason why the majority of patients outside of this group cannot undergo hernia repair as a same-day procedure.

Day surgery in general is a multifaceted topic, and many influential factors are external to clinical issues. Hospital management, financial incentives, social factors, facilities and staffing are all important aspects to determine the ease of access to, and success of, day surgery. While barriers for day surgery exist in all of these areas, the interaction between patients, healthcare providers and patients and the community remains the greatest one.

It was concluded that 70 to 80 per cent of hernia repair patients can be safely released home on the same day. Although a change in our clinical practice and current culture may take some time and effort, a shift could be made by enhancing the patient-doctor communication and education to increase patients' satisfaction, ameliorating staffing and facilities to match resources for day surgery, and creating supportive communities and policies. The acceptance and promotion of day surgery requires a holistic approach from a range of financial, institutional, societal and individual efforts.

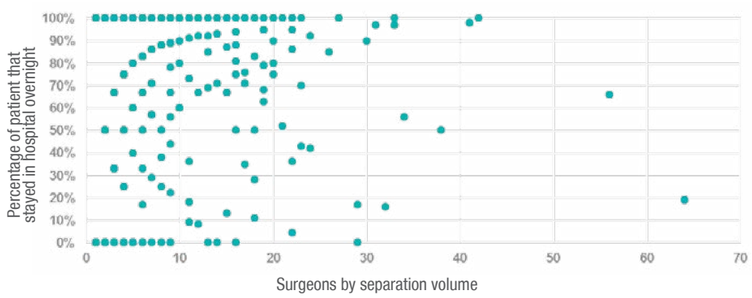
The report highlights that day hernia repair is appropriate for most patients; is good practice for the surgeon; is efficient for the hospital and benefits the payer. Surgeons are encouraged to reflect on their practice and work with their private hospital to identify ways to move Australian private hospital day hernia rates from the current 20 per cent to the 70 to 80 per cent recommended in the report.

Working Group:

- Professor Guy Maddern (Surgical Director RACS Research and Evaluation)
- Mr Alex Karatassas (General Surgeon)
- Professor David Watters (General Surgeon)
- Professor David Fletcher (General Surgeon)
- A/Prof Wendy Babidge (RACS Research, Audit and Academic Surgery Director)
- Dr David Rankin (Medibank Clinical Director)
- Dr Stephen Bunker (Medibank Clinical Research Advisor)

For further information please visit: http://www.surgeons.org/policies-publications/publications/surgical-variance-reports/, www.surgeons.org/HTA or contact college.asernip@surgeons.org The final report will be published on these websites at the end of May.

Figure 1: In Australia, 80 per cent of all hernia repair procedures have one night or longer stay in hospital.



Go Dairy, Full cream ahead

DR BB-G-LOVED

Tubby and Chewbar came for review following their New Year's resolution to lose body fat, reduce their waistlines, improve blood pressure and dyslipidaemia. Both had overstepped the BMI >30kg/m2 zone and were somewhat disappointed with how they'd let their lifestyles slip.

I am pleased to report that each has lost about three kgs. They asked me about dairy intake. They were both wary of dairy, despite neither being lactose intolerant. Tubby in particular had tended to be impressed with 'low fat' labelling on foods and so succumbed to the commonly held, but mistaken, belief that avoiding obesity was about avoiding fats.

So is dairy safe and what dairy products should we consume for good metabolic health outcomes? Recent [2016] systematic reviews and meta-analyses have found an inverse relationship between intake of dairy foods and type 2 diabetes. There is moderate evidence for an inverse association with stroke, metabolic syndrome. Studies of dairy consumption show either favourable or neutral effects on hypertension and cardiovascular disease.

A study of metabolic health and dairy intake has just been reported from Ireland (www.iuna.net) in the prestigious Nature Nutrition and Diabetes journal. Perhaps surprisingly, greater dairy intake was highly significantly associated with a lower body mass index, reduced percentage body fat, waist circumference and waist to hip ratio (P<0.001). Dairy consumers were divided into three patterns – whole milk, 'butter and cream' or reduced fat milks and yoghurt cluster. The pattern of dairy consumption did not influence Fasting Triglycerides, HDL or LDL cholesterols. Serum insulin was reduced, and insulin sensitivity (something good) was increased in higher dairy intake groups.

Despite 60 per cent of fats in dairy fat being saturated, dairy food consumption improves metabolic health, improves lipid profiles and glycaemic responses, has a reduced risk of type 2 diabetes and lowers systolic and diastolic blood pressure.

Low fat yoghurts often have sugar surreptitiously slipped in for taste, low-fat may mean high sugar content. Interestingly although the Irish who consumed reduced-fat milks and yoghurt were more likely to have the highest scores on a Healthy Eating Index, they had higher triglycerides and total cholesterol. So they were not gaining all the metabolic benefits of trying to eat healthily due to their consumption of low-fat carbs. It is often sugar and carbohydrates that drive dyslipidaemia.

Even butter, which suffered a bad press for many years, has been found 'not guilty'. Nine cohort studies [but no randomized clinical trials] encompassing over 600,000 participants in 15 countries and 6.5m combined years of follow up found butter consumption had no significant association with any cardiovascular disease, coronary heart disease, diabetes or stroke. And to think how often many of us chose marge!

For those of you with Celtic ancestry, the Irish study should let you enjoy moderate butter and cream with a clear conscience, all washed down with a good glass of milk. My clinical notes recorded Tubby and Chewbar had even attended their first review appointment in March on St Patrick's Day. But their improved anthropometrics were much more than just the luck of Irish!

Dairy products with kilojoules, protein, fat and cholesterol content

Product	Vol or weight	KJ	Protein	Total Fats	Sat Fats	MonoFats	Chol	Sugars
Medium latte	1 cup	845	11g	11g	7g	0	0	15g
Whole milk	250ml	703	8g	10 g	6g	0	0	12g
Skim milk	250ml	354	8g	0	0	0	5mg	12g
Lite milk	250ml	481	8g	4g	2g	0	0	13g
2% fat milk	250ml	539	9g	5g	3g	1g	21mg	13g
Soy milk	250ml	442	6g	4g	1g	1g	0	8g
Almond milk	250ml	167	1g	4g	0	2g	0	0
Thickened cream	20 ml	293	0g	7g	5g	0	0	1g
Yogurt	100g	255	3g	3g	2g	1g	13mg	5g
Cheddar	50g	849	12g	17g	10g	4g	51mg	0
Gouda	50g	745	12g	14g	9g	4g	57mg	1g
Camembert	50g	628	19g	12g	8g	4g	36mg	0
Brie	50g	699	10g	14g	9g	4g	50mg	0
Feta	50g	552	7g	11g	7g	2g	45mg	2g

Source: http://www.myfitnesspal.com/food/calorie-chart-nutrition-facts
Note that most cheeses contain between 600-900mg sodium and 60-190mg potassium per 100g. Polyunsaturated fats in the above dairy products tend to be below 1g per quantity shown with the exception of full cream milk (2g/250ml). 250ml Cow's milk provides about a third of daily calcium requirements.

RACS online Learning Plan

The online Learning Plan enables Fellows to plan their learning in line with the specific competencies they may want or need to develop

DR LAWRIE MALISANO
Chair, Professional Standards

In 2017, RACS is pleased to launch the online Learning Plan, which continues to expand on the tools and resources available to support you in the completion of the annual Continuing Professional Development (CPD) program requirements.

Developed around the RACS Surgical Competencies that specify the abilities required of a surgeon to practice effectively within a defined scope and context, the online Learning Plan enables Fellows to plan their learning in line with the specific competencies they may want or need to develop.

The model of personal learning planning bears much resemblance to the process of managing strategic change and indeed clinical audit. The key points throughout all of these are: What is the current situation? How could it be improved? How can this be achieved? What will it look like when we get there?[1]

Creating a learning plan using the RACS tool is a simple four step process

- Select the competencies to focus your learning in the CPD year ahead
- List your specific learning goals, relevant to the selected competency
- Save your learning plan
- At a later date, return to reflect on your learning goals

Activities entered into CPD online will automatically populate into your learning plan, with competencies that match those initially selected in the development of your plan. Your reflection is based on your initial learning goals and provides the opportunity to consider how or if your learning goals were achieved.

Once all three fields in the learning plan have been populated, finalising the plan will also automatically populate the activity 'Completion of a structured learning plan' in the Reflective Practice, category 4. A finalised Learning Plan can also be exported as a PDF, should a copy be required for your own personal reference.

In 2017, all Fellows, Trainees and International Medical Graduates are required to complete the RACS Operating with Respect eLearning module, which fulfils your Reflective Practice CPD requirement for the 2017 year.

In future years, the learning plan forms one of the range of options available to complete your annual requirements in this category. Completion of a Reflective Practice (category 4) activity annually is a mandatory requirement across all the CPD program practice types.

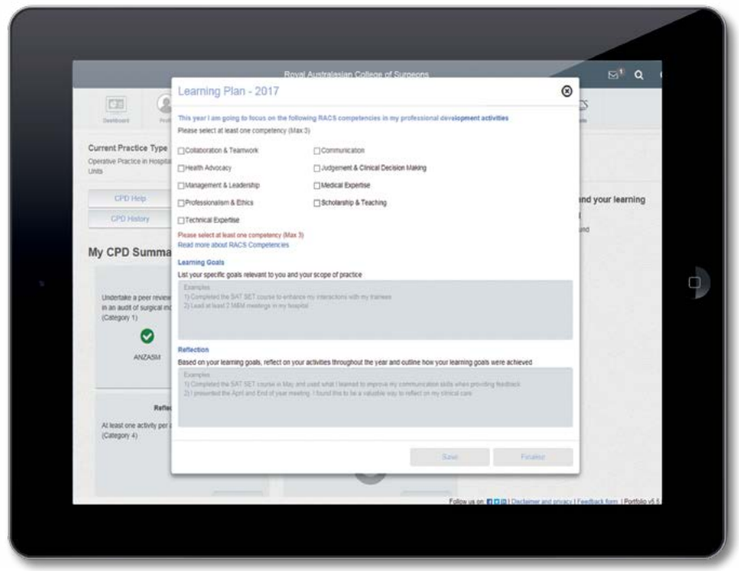
Key Functions of our Online Learning Plan:

- No duplication of information
- Focus on RACS competencies
- Auto population of activities
- Completion of a learning plan automatically populates into your CPD
- The learning plan provides examples to assist you with population

The Learning Plan is available from My CPD within the RACS Portfolio.

I encourage you to establish your learning plan early in the year to assist you achieve your learning goals.

If you require any assistance with your CPD or would like to provide any feedback on the program or the learning plan please contact the RACS Professional Standards Department on +61 3 9249 1292 or Professional.Standards@surgeons.org



1 Maggie Challis (2000) AMEE Medical Education Guide No. 19: Personal learning plans, Medical Teacher, 22:3, 225-236, DOI: 10.1080/01421590050006160 http://www.tandfonline.com/doi/pdf/10.1080/01421590050006160?needAccess=true

Case Note Review

Team decisions needed in complex cholecystitis case.

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

Case summary

This patient was admitted as an emergency with sepsis (possibly cholangitis) secondary to common bile duct (CBD) stones. There was a long history of symptoms from suspected gallstones which had been diagnosed by ultrasound. The patient was admitted on a Friday evening under the care of another surgeon and the initial plan was to treat with antibiotics and perform an endoscopic retrograde cannulation of pancreatic duct (ERCP) on the following Monday.

On the Saturday morning, a third surgeon decided that the patient should proceed to theatre over the weekend and an attempted laparoscopic cholecystectomy was performed on the Sunday afternoon. It soon became apparent that this would be impossible and the procedure was converted to open. This initial procedure was commenced by a Fellow who soon called in the admitting surgeon. The gallbladder was encased in dense adhesions and it proved impossible to adequately dissect out the gallbladder and remove it. The gallbladder was opened and stones extracted and a cholangiogram was performed via a tube inserted into the gallbladder. This confirmed drainage into the CBD and the presence of stones in the CBD without obstruction of bile flow into the duodenum.

The operating surgeon was inexperienced in this situation and sought telephone advice from two other colleagues. Consequently the surgeon abandoned attempts to remove the gallbladder and inserted a tube into this to act as a cholecystostomy, and also placed a drain adjacent to the gall bladder and closed the patient.

Postoperative course was difficult due to inadequate analgesia with a deterioration in respiratory function due to atelectasis and hospital acquired pneumonia. There was persistent leak of bile via the adjacent drain so plans were made to proceed with ERCP and clearance of the CBD. This was performed 8 days after the initial procedure.

During the ERCP, the patient developed severe cardiovascular instability due to runs of supra-ventricular tachycardia. It proved impossible to clear the CBD but it was possible to insert a stent beyond the stones to facilitate bile drainage into the duodenum.

The patient was transferred to the intensive care unit (ICU), ventilated and subsequently developed marked elevation of liver function tests (thought to be ischaemic in origin and reflecting multi-organ failure). The patient also developed renal failure requiring large doses of inotropes and deteriorating gas exchange.

Initial improvement in haemodynamic status was short-lived and was returned to the operating theatre with suspected bile peritonitis due to an uncontrolled bile leak. This was confirmed at laparotomy where it was also confirmed that the biliary stent was on view in the base of the gallbladder confirming the presence of a large cholecyst-choledochal fistula. By this time the patient was requiring massive doses of inotropes, had a very labile blood pressure and, despite surgical control of the bile leak and return to ICU, died of septic complications related to bile peritonitis.

Clinical lessons

One must question the decision made to perform a laparoscopic cholecystectomy on Sunday in a case of cholangitis with sepsis due to CBD stones in which there was a clear plan for an ERCP on the following day. The consultant making this decision should have also considered the complexity of the case and the fact that there was no specialist hepato-biliary cover available and should have communicated with an experienced surgeon rather than making a major decision regarding the care of a complex case in isolation.

Dear Professor Maddern,

I read your review of the death of an elderly patient following treatment for a fracture of the patella in the *Surgical News*. As always the facts expressed are fair and balanced.

My question relates to use of prophylaxis for DVT and PE. I am not aware of any evidence that current DVT prophylaxis makes any difference to death from PE. George SIkorski's MD thesis showed (about 20 yrs ago) that prohylaxis seems to postpone the PE by about a week after the usual timing of 10-14 days.

If it doesn't help the patient, why are we doing this?

I am aware that there is a decrease in incidence of DVT, and the complications such as post phlebitic syndrome and ulceration. However, this has not translated into a corresponding decrease in the incidence of fatal PE.

My impressions from 30 yrs as a doctor (20 as an orthopaedic surgeon) is the I am seeing fewer deaths from PE than I did when I was an intern. I do not have hard data to back this up however.

Emerik Trinajstic, Orthopaedic Surgeon

PS: I do use calf/foot pumps immediately post op (until they stop bleeding) and then clexane for my patients. Amounts and regimes are altered according to risk stratification. Whenever I see a severe bruising or a painful haematoma which sometimes results, I again ask 'why are we doing this?'

Dear Editor,

I would appreciate some clarification with respect to the Case Note Review written by Prof Maddern, published within the Jan/Feb 2017 edition of *Surgical News*.

Is this article recommending that a "very elderly" patient, after a fall from a height greater than the second story of a building, sustaining multiple injuries including significant head trauma with facial fractures, is most appropriately managed with low molecular weight heparin (LMWH) within 48-72 hours of injury and patellar fracture surgery?

I note the expressed "great concern" that the treating consultant involved "even in hindsight" considered mechanical thrombo-prophylaxis alone as appropriate in the initial management of this patient.

In order to "prevent similar errors occurring in the future" please clarify the evidence supporting of the early use of LMWH in this particular scenario, with specific reference to both benefit and risk.

Regards,
A/Prof Patrick Weinrauch

These two Letters to the Editor are referring to a Case Note Review published in the Jan/Feb issue of Surgical News (page 54). It can be read online here: https://www.surgeons.org/flipbook3d/Digital/SurgicalNewsJanFeb2017/index.html

A response to the queries raised in these letters can be found below. – Ed.

Venous Thromboembolism in Orthopaedic Trauma

PROFESSOR ROB FITRIDGE
Professor of Vascular Surgery at the University of Adelaide and Head of Vascular Surgery at The Queen Elizabeth Hospital

Venous thromboembolism (VTE) remains a significant cause of morbidity and mortality following trauma. As Dr Trinajstic points out, there is no data to guide clinicians in many specific clinical situations, including this one.

There are 2 specific key issues relevant to this case: Firstly the lower extremity (patellar) fracture which required tension band repair, and secondly the requirement for leg immobilisation in a knee brace. Further to these issues, the traumatic aetiology and older age of the patient also increase the risk of VTE.

A recent Cochrane review of 6 RCTs found an incidence of VTE ranging from 4.3 to 40% in patients who had a lower extremity injury which had been immobilised in a cast or brace for at least one week, when not given prophylaxis. The incidence was significantly lowered with the use of low molecular weight heparin (LMWH) during immobilisation. This was consistent between groups operated and not operated on, as well as patients with and without fractures. The review also noted that the incidence of **major** bleeding events was rare (0.3%)[1].

In a recent review in Orthopedic Clinics of North America (2016), Whiting and Jahangir pointed out that the presence of VTE (either DVT or PE) nearly doubled the mortality rate following major trauma (and amongst those patients who developed a PE, the mortality rate was 25.7%). This review felt that the literature did not support the use of unfractionated heparin in orthopaedic trauma[2].

Both mechanical and chemical prophylaxis reduces the incidence of VTE following trauma. Nonetheless, prophylaxis does not eliminate the incidence of VTE. Stannard et al found a 13.4% incidence of DVT in trauma (11.3% proximal DVT) associated with the use of LMWH and 8.7% with the use of LMWH and foot pumps (2.9% proximal). Pulmonary embolism occurred in 2.1% of the LMWH only group and none in the LMWH plus foot pumps[3].

Whilst the above is all indirect evidence, the approach mentioned by Dr Trinajstic of early commencement of foot (or calf) pumps and adding in LMWH when bleeding risk is reduced, would seem a good approach. Continuing mechanical and pharmacological prophylaxis for a minimum of 14 days whenever possible would seem the best approach on currently available evidence.

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3. Stannard JP, Lopez-Ben RR, Volgas DA et al. Prophylaxis against deep-vein thrombosis following trauma: a prospective, randomized comparison of mechanical and pharmacological prophylaxis. *J. Bone Joint Surg* Series A. 2006;88:261-266.

NZ Fellowship will allow SA Head and Neck surgeon to turn heads

Otolaryngologist Head and Neck Surgeon Mr Sam Boase spent 12 months from June 2015 undertaking a Head and Neck Surgery Fellowship at the Auckland City Hospital with funding support provided by the prestigious Margorie Hooper Travelling Scholarship.

Working under the supervision and mentorship of Mr John Chaplin, Mr Nick McIvor and Mr Mark Izzard, Mr Boase spent the year at New Zealand's largest public hospital and clinical research facility expanding and refining his skills in head and neck surgical oncology and reconstruction.

Mr Boase, now back in his home state of South Australia, has a broad public and private practice that spans a massive geographical area stretching from the Adelaide Hills to Broken Hill. The majority of his work is conducted at the Royal Adelaide Hospital and the Flinders Medical Centre and he also provides ENT services to the Maari Ma Health Aboriginal Corporation.

He is an Associate Clinical Lecturer at the University of Adelaide, having completed his PhD research in sinus surgery in 2011, and has presented his research findings both in Australia and abroad. He has also had a number of papers published in international journals on the causes of, and surgical treatments for, chronic rhinosinusitis.

However, Mr Boase said the time spent in New Zealand allowed him to pursue his passion for advancing head and neck surgical oncology and reconstruction.

He said the enormous case-load of complex cases treated at the Auckland City Hospital had allowed him to gain particular expertise in ablative and reconstructive surgical oncology of the head and neck including microvascular reconstruction and thyroid and parathyroid surgery including airway resection and reconstruction.

"Reconstruction of the head and neck is challenging due to the variety of tissues whose structural deficiencies must be corrected," Mr Boase said.

"As we seek to improve our patient's outcomes from treatment for head and neck cancer, it is necessary to improve the reconstruction of surgical defects so as to mimic as closely as possible the native tissues.

"Additionally, improvements in tumour resection techniques are essential if we are to maintain as much function as possible.

"This requires a comprehensive understanding of the function of the anatomical subsites of the head and neck as well as how these can be altered by tumours and treatment modalities, including surgery and radiotherapy.

"During my time in New Zealand, the main reconstruction procedures conducted were free flaps – including free fibula, free forearm, free rectus and free scapula – for bone and soft tissue reconstruction.

"The great benefit of learning from experts in this field was understanding how to tailor the reconstruction to maximise function, and having the opportunity to observe outcomes through long-term follow-up of patients."

Mr Boase described the Fellowship as being unique in that the Otolaryngology Head and Neck Department at the Auckland City Hospital was one of the few in the region to offer patients a holistic surgical approach where a single Head and Neck team provided both ablative and reconstructive care.

He said that central to this approach was the Auckland Regional Head and Neck Multidisciplinary Meeting, a team approach that gave him the opportunity to understand the subtleties of the relationship between tumour removal and reconstruction.

"One of the most impressive aspects of my Fellowship experience was immersing myself in and running that meeting which I consider to be the benchmark of Head and Neck multidisciplinary teams," Mr Boase said.

"A half day was set aside per week which, while requiring significant commitment from all clinical staff, improved patient outcomes and their experience.

"A one-stop approach for patients meant one visit for discussions with all involved staff including consultations on surgical planning including both ablative and reconstructive surgery, anaesthesia, radiotherapy and chemotherapy, a dental review, and meetings with dieticians, speech pathologists and social workers while cancer care nurse specialists helped guide the patients and their families through the process.

"As I became familiar with the process I realised it was the optimal way to manage complex Head and Neck cancer patients and I hope to incorporate many of these processes into our Head and Neck Multidisciplinary teams in South Australia."

Mr Boase said he was grateful for the support provided to him to undertake the Fellowship.

"Many past recipients of this Margorie Hooper Scholarship have progressed to become clinical and academic leaders in their field and I hope to follow a similar path in Head and Neck surgical oncology," he said.

"My work - and the work of the Head and Neck units in Adelaide - continues to evolve and has certainly been altered by my experience in Auckland, even though we do not currently have the local resources required to replicate the protocols and procedures followed by the multidisciplinary teams in Auckland.

"However, we do now have a greater focus on holistic cancer treatment which has been enhanced by my experience in New Zealand and that of some of my colleagues in Adelaide who have done similar Fellowships abroad."

The great benefit of learning from experts in this field was understanding how to tailor the reconstruction to maximise function, and having the opportunity to observe outcomes through long-term follow-up of patients.

The Travelling Scholarship is funded through a bequest from the late Margorie Hooper of South Australia. It was established to enable the recipient to reside temporarily outside South Australia in order to undertake postgraduate studies or for surgeons to travel overseas to learn a new surgical skill for the benefit of the community of South Australia.

– With Karen Murphy

QASM – ten years & counting!

DR JOHN NORTH
QASM Clinical Director

In May 2017, the Queensland Audit of Surgical Mortality (QASM) reaches a significant milestone. The QASM has now been collecting and analysing data for Queensland surgeons for 10 years.

During that time nearly 10,000 cases have been submitted to the QASM from public and private hospitals across Queensland. All of those cases have been comprehensively assessed by surgical peers at the *first-line assessment* level. Approximately 10 per cent of cases have needed to be assessed at the *second-line assessment* level. This has resulted in over 1,000 second-line assessment reports.

Queensland surgeons are to be congratulated and thanked for their constant support of and participation in the QASM. For example, the return rate for individual surgical case forms is 94 per cent. This excellent return rate equates to a robust database that allows greater insight to potential areas for surgical care improvement in Queensland.

The QASM would also like to thank the Queensland Department of Health for their ongoing financial support and guidance. The QASM contributes data to the Australian and New Zealand Audits of Surgical Mortality (ANZASM) database enabling valuable national monitoring and reporting to occur. The ANZASM's support has been integral to the QASM's development since 2007.

Since inception, the QASM has had two Clinical Directors. Dr Jon Cohen established a solid foundation for the QASM and worked closely with a tremendous project team to raise the profile of the audit throughout Queensland. Dr John North, the current Clinical Director, continues to work closely with the project team in delivering professional audit services to all Queensland surgeons and hospitals.

In 2010, the QASM was honoured to collaborate in the creation of the Northern Territory Audit of Surgical Mortality (NTASM). Proudly, the QASM continues to successfully manage the NTASM from its Queensland-based office in Brisbane. Dr John Treacy (NTASM Chair) and his Northern Territory team work closely and collaboratively with the QASM team. The NTASM Report (2010 to 2016) is available at www.surgeons.org/NTASM.

The core QASM project team have been together for 10 years. In recent years, Dr Peter Wysocki and Dr Michael Donovan have kindly volunteered to convene QASM's annual education seminars. Dr Wysocki has also been part of the QASM scientific publishing team.

The QASM has published ten scientific papers in peer-reviewed journals and nine annual reports. To view all QASM publications visit www.surgeons.org/QASM.

Along with the QASM's annual seminar, *Lessons from the Audit* is another valuable education tool. This booklet of theme-based case studies is produced twice a year and circulated widely in the Queensland surgical community. All 17 volumes are available on the QASM website.

Importantly after ten years, a snapshot of QASM data reveals that surgery in Queensland is safe and when comparing the total number of patients who had surgery, the number of surgical patients who die, is low.

At this significant milestone in the QASM's development, Dr John North (QASM Clinical Director) and Therese Rey-Conde (QASM manager) seek and welcome any feedback from Queensland-based surgeons on the audit and related reporting processes. Feedback can be emailed to QASM@surgeons.org

QASM would also like to thank The Royal Australasian College of Surgeons for its ever-present support.

Ten years and counting...

Image: Standing – Dr John North; Seated L to R – Sonya Faint, Kyrsty Webb, Jenny Allen, Therese Rey-Conde, Candice Postin

SAVE THE DATE
QASM's annual free one-day education seminar
Date: Friday 10 November 2017
Title: *Captain of the ship? A surgeon's role in safety and quality.*
Guest speaker: Mr John Batten (College President)
Venue: Gold Coast University Hospital (Southport, QLD).

WA Regional Update

As I near the end of my position of Chair of the Western Australian Regional Committee of the Royal Australasian College of Surgeons I look back at the past two years and wonder where the time went and what has been achieved.

MR STEPHEN HONEYBUL
Chair WA State Committee

I have learnt one thing during this time, it's that things don't happen quickly in the world of hospital administration. If I were to pass on one piece of advice to my successor, it would be to learn to take a deep breath, be patient and embrace some of the difficult issues that require consideration.

As surgeons, we are trained to think quickly and expediently, especially for those of us involved in the acute specialties. A large acute subdural in a young person requires immediate attention. The patient needs to be intubated, ventilated and taken to theatre immediately, with limited time for discussion. This is something every neurosurgeon is trained to do and I feel very comfortable in this environment.

Fast forward a few years and I am seated in an office being presented with dashboards that present numerous graphs detailing the degree to which our department, or an individual consultant, has achieved or not achieved various targets. All too often when I ask how or who set such targets I am met by blank stares or told that it is set against a national benchmark. Coding is also another issue that continues to be a source of frustration. For example, if a person is confused on admission the advice from administration is to enter the term delirium in the notes, as this will place the person into a high illness severity cavity and the hospital will be able to claim more funding. This is correct in some ways but fails to recognise that delirium is by definition an acute confusional state and is not always the correct diagnosis.

I would have to say that this sort of data presentation and interpretation was a source of significant frustration when I first became involved with hospital administration, but I now recognise it to be part of modern medicine that cannot be ignored.

Looking through the recent bulletin of the Royal College of Surgeons of England there is considerable emphasis amongst the various articles on finance and resources. Discussions range from the lack of hospital beds, endemic and unsustainable financial problems within two thirds of hospital trusts, and the gender pay gap. I accept that the management of hospital finance represents an area of limited interest amongst surgeons, especially those involved in research and academic medicine. However, if we do involve ourselves in these issues then our interests will not be represented and ultimately patient care will suffer. In addition, Western Australia is facing its own particular issues given the downturn in the economy and the enormous budget deficit that needs to be addressed. There is in many ways an ethical imperative to ensure that increasingly scarce healthcare resources are allocated fairly and equitably.

What I have learnt as Chair of RACS WA and as a head of department, is that being involved and attempting to address some of these issues requires adaptation of the surgical mentality. A single meeting is never enough. If there is one thing I am sure about (other than death and taxes) it's that I will not get to the end of my career and say 'I wish I had gone to more meetings after work.' However, engagement is required on a regular basis if some of these issues are going to be addressed. From my perspective, I no longer try and squeeze meeting in between surgical cases or between clinics but schedule times that are suitable for me on a sustainable basis. I believe surgeons must become engaged otherwise decisions will be made that will not always be within our best interests. We need look no further than our colleagues in the National Health Service to see the level of frustration that can occur if we fail.

Wishing you all the best in health and surgery.

Victorian Urologist advances the field of Andrology

The first Victorian Fellow to complete an international Fellowship in Andrology, sexual and reproductive medicine, prosthetics and male infertility has now created his own Fellowship to teach other Urologists similar skills.

Victorian Urological and Prosthetic Surgeon Mr Darren Katz, in collaboration with his senior colleague Mr Christopher Love, has established the first Andrology Surgical Fellowship in Australia, a position currently held by Israeli urologist Dr Ohad Shoshany.

Dr Shoshany had completed a 12 month infertility fellowship in Chicago, but wanted to undertake the inaugural fellowship with Mr Katz and Mr Love to broaden his experience in prosthetic urology as well as further enhance his microsurgical skills.

Since Mr Katz has returned from his year-long Fellowship at the prestigious Memorial Sloan-Kettering Cancer Center and the New York Presbyterian Hospital/Weill Cornell Medical Centre, he has worked to improve the surgical treatment and management of erectile and voiding dysfunction, Peyronie's disease and male infertility.

In 2011, Mr Katz was awarded the Ian and Ruth Gough Surgical Education Scholarship as well as the Australian Urological Foundation Travel Grant when he was accepted into this overseas Fellowship position.

He has collaborated on a new technique for penile implant surgery, improved microsurgical techniques for harvesting sperm and started one of Victoria's first Andrology clinics at a major public hospital.

Mr Katz said he had received great support from other Urologists upon his return from the USA and approximately 15 per cent of his private patients are referred to him by fellow Urologists. He said that he feels privileged and humbled when he receives these referrals from his colleagues who request his sub-specialty expertise in managing patients.

He said the surgical treatments and management of male sexual health and infertility issues were gradually catching up with a demand that has been largely over-looked, particularly in the public health system.

"Unfortunately in the past the surgical management of such issues as infertility, erectile dysfunction or certain penile disorders has not been a major part of our training as Urologists because most urological training takes place in public hospitals and these conditions rarely make it through the outpatient waiting list, let alone onto an operating list!" he said.

> *Unfortunately in the past the surgical management of such issues as infertility, erectile dysfunction or certain penile disorders has not been a major part of our training as Urologists because most urological training takes place in public hospitals and these conditions rarely make it through the outpatient waiting list, let alone onto an operating list!*

"That means that some men have suffered for years from conditions that can actually be treated."

To overcome this deficit, Mr Katz spends a considerable amount of time attending conferences, giving presentations and coordinating workshops to explain the developments that have been made in the field, as well as new procedures and new thinking around men's sexual health and fertility.

Together with Mr Love, they developed the Minimally-Invasive No Touch (MINT) technique for penile implant surgery. Mr Katz said research had now shown that their technique has an infection rate of less than 1 per cent, compared to around 5 per cent indicated in most other series not using this technique.

"Using the MINT technique, the entire three-piece implant can be inserted via a single 3cm incision hidden just below the pubic bone with patients discharged after just one night in hospital," he said.

"We have presented our MINT technique at the National Urological Conference (USANZ) and internationally at the American Urological Association Conference, in China at the World Meeting in Sexual Medicine, and at the Sexual Medicine Society of North America.

"We have also had several visiting Urologists from Australia and abroad who have come to Melbourne to observe how this procedure is performed."

Mr Katz and Mr Love are also investigating the use of Low Intensity Shock Wave Lithotripsy for the treatment of mild to moderate arteriogenic erectile dysfunction.

Now in the process of running a small trial through their clinic in Melbourne, the procedure works by applying sound waves to the penis over a six week course of treatment with evidence suggesting that it recruits stem cells and initiates angiogenesis to improve blood flow.

However, over and above all the technical developments that have been made in the field of Andrology, Mr Katz said the most exciting local developments have been made in the field of male infertility management. He said that while research showed that about 50 per cent of infertility in couples trying to conceive involved a male factor, most infertile couples were managed by gynecologists with the focus first placed upon the woman before the man's fertility was investigated.

"I have seen women being put through multiple investigations before their male partners are even brought in for basic tests," Mr Katz said.

"However, while making changes to established practices in any field of medicine or surgery is very difficult, over the last few years I have made a concerted effort to engage with the IVF fertility specialists through speaking at conferences, registrar training weekends and face-to-face meetings.

"I try to explain the importance of early engagement with a Urologist who has an interest in male infertility and microsurgery when dealing with an infertile couple and these specialists are now seeing the tangible positive outcomes for couples when utilising such interdisciplinary collaboration.

"There is now a well-established interdisciplinary referral network in Victoria, not previously present, which I believe has truly advanced the management of male infertility in this state.

"At times I have spent up to four hours in the operating room searching for viable sperm in patients who were previously told that there was no hope, but then nine months later I receive a thank-you card and a picture of a newborn and that is hugely rewarding."

– With Karen Murphy

Mentors without Borders

DR PHILIP CHIA
Education Portfolio, RACSTA

Surgery can prove a pretty stressful place from time to time; most of my life is spent on surgery. I've certainly had my moments in the last year where I've needed my surgical mentors to guide me through training and impart the wisdom of their years. In that sense I've been lucky, having had the opportunity to train in one location for an extended period I've been able to establish truly valuable relationships with my surgical mentors. They put me back on course when I would lose my way and they have fostered my development as a Trainee surgeon. Surgery has proven a great environment in that sense. Essentially we are practicing to be surgeons in the professional sphere and when it comes to mentoring in this environment our senior colleagues are usually there for us. But it left me wondering who mentors me in the rest of my life? Who are my mentors in life outside the borders of surgery?

Outside of surgery my mentors help shape and guide my life. They provide support and advice with a perspective uninformed about the idiosyncrasies of the hospital; they guide me on matters that are beyond the reach of just 'reading more'.

My family are my closest and most frequent mentors, they have shaped my moral compass more than any other influence. But more than that my brother has always been there to teach me the seemingly simple things in life; like how to fix my car or how to invest. My brother helps me live an adult life.

During my first degree I had a job at a small coin and stamp shop. It was a family business and I would do odd jobs. On reflection this where I developed my work ethic. The owner took me under his wing and over the many years I worked there I was given more responsibility, he would have me man his stalls at the coin fair and purchase stock for the store. Buying a rare coin for the store would require a detailed assessment of year, grade, mint mark and variations. This is where I learnt the value of precision and efficiency.

My school friends are still my closest. These are the ones who keep me grounded. They don't really care what I do day to day because I am their same mate that I was in high school. These are the guys I call on a long drive to keep the time ticking. They keep my perspective on life realistic and we talk about our relationships and our life goals. Every few years we travel together and they provide an escape where surgery doesn't carry the same weight.

Surgical mentors don't have to stay within the borders of surgery either. My closest surgical mentor for the last 10 years recently took me to his new property to show me around. We walked for a few hours and discussed plans to build here and harvest over there. We discussed water security and vineculture, cars, travel and family. Over the hours on that afternoon surgery didn't even get a mention. In that way I feel lucky to have found mentors for life within my profession.

Surgery can dominate the life of a trainee. So much of our time is spent practicing the science and art. As such we value our mentors, treasuring their advice. Life doesn't always get the same recognition as something you must learn, but I can't help feeling I lack experience at life and its my life mentors that help get me through.

I think it's worth a moment to reflect on the mentors we might have beyond surgery, if only to recognise their contribution. They are often your family and friends, but as my career has progressed I have been lucky to find life mentors within the borders of surgery as well.

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS | RACSTA Your Trainees' Association

Library collection update

The following new e-books are now included in the collection and available after login to the RACS website. Alternatively, scan the QR codes for each to link to the items online

Plastic and reconstructive surgery: approaches and techniques

Editor(s): Ross D. Farhadieh, Neil W. Bulstrode, Sabrina Cugno

This specialty continues to evolve as new techniques open up new possibilities for the surgeon. In this book (co-edited by a RACS Fellow, Ross Farhadieh), contemporary approaches are explained and demonstrated to allow Trainees and experienced surgeons alike to understand and assimilate best practice.

Containing over 300 colour figures demonstrating surgical practice, an international cast of leading surgeons show the paths to effective plastic surgery technique and outcomes. They cover all the major bases including:

- Integument
- Pediatric Plastic Surgery
- Head and Neck Reconstruction
- The Breast
- Trunk, Lower Limb and Sarcomas
- Upper Limb and Hand Surgery.

Available on the Wiley e-book platform

E-books new to ClinicalKey

Atlas of Laparoscopic and Robotic Urologic Surgery

Bishoff, Jay. 3rd ed.

http://ezproxy.surgeons.org/login?url=https://www.clinicalkey.com.au/dura/browse/bookChapter/3-s2.0-C20140050174

Much has changed in the 10 years since the last edition of this work because of the collective efforts of those surgeons around the globe who are seeking ways to contribute to iterations that progressively make surgery safer, less invasive, and more successful. In addition, modern times have called for a focus on making surgical approaches cost effective. All these were the impetus for a third edition of this text.

The role of minimally invasive surgery has continued to expand over the past decade. This text recognises this reality through new and updated chapters. Indeed, most extirpative and reconstructive urologic procedures are now performed through keyhole incisions. Facilitating this trend has been the application of da Vinci surgical approaches to surgery. As such, specific sections and chapters have been added in recognition of this phenomenon.

Principles of Hand Surgery and Therapy

Trumble, Thomas. 3rd ed.

http://ezproxy.surgeons.org/login?url=https://www.clinicalkey.com.au/dura/browse/bookChapter/3-s2.0-C20140036684

The goal of this book is to draw upon the collective insights of the community of hand surgeons and hand therapists to provide the best recommendations for surgery and rehabilitation to expertly and safely care for patients.

Ideal for hand surgeons, Trainees in a hand surgery rotation, and therapists interested in a review of surgical principles, this 3rd Edition, by Drs. Thomas E. Trumble, Ghazi M. Rayan, Mark E. Baratz, Jeffrey E. Budoff, and David J. Slutsky, aims to be a practical source of essential, up-to-date information in this specialised area.

New editions of e-books recently added to ClinicalKey:

Insall & Scott Surgery of the Knee (Scott, W. Norman) 6th ed.

Operative Techniques: Hand and Wrist Surgery (Chung, Kevin) 3rd ed.

Hinman's Atlas of Urologic Surgery (Smith, Joseph) 4th ed.

The Art of Reprimand & the Edicts of Wise Old Owls

OPUS XLVI

FELIX BEHAN
Victorian Fellow

This story, not gossip nor rumour, had its origin in an event in late 2016 in the pre-Christmas period when my personal assistant, arriving early, went across to the University for an early morning coffee. On her return she noticed a somewhat distressed person outside Melba Hall on Royal Parade crying her eyes out. In an empathetic manner, reflecting her personality, my assistant asked whether she could be of any assistance, mindful of the Shakespearean quote from Macbeth about the *milk of human kindness*.

The story transpired that the lady worked as a theatre nurse at a major nearby teaching hospital. She had been the victim of verbal abuse by a surgeon. The episode left her visibly distressed some hours later. *Where is the duty of care?*

I now quote from the flyer of the January/February 2017 edition of *Surgical News:*
We all rely on our surgical teams. When we show them respect, we bring out their best performance. How prescient - how portentious - drafting this story yet again (in the Proustian manner) on the Ides of March.

We all improve with a friendly reprimand not a vindictive verbal outburst, which sometimes reflects ominously on the guilty personality. The characteristics of a surgeon are legion and would fill textbooks of psychology. We generally find the better ones are able to restrain their obsessive compulsive disorders (verbal tirades) while those lacking in these qualities may create conflict. Such sequelae may be devastating and usually ends up in the hands of HR departments.

This episode led me to recount how the art of constructive criticism is part of any teaching process, particularly in surgery.

When I was at the memorial service for Scotty McLeish last year Rodney Judson mentioned amongst other attributes how Scotty's personality could educate the inexperienced into a level of competence that created a friend for life rather than the enemy entreched.

Let us not forget the famous Gandhi quote 'you can't shake hands with a clenched fist'. Yes I have seen the clenched fist episode in the hospital corridor in my junior days - thankfully ending peacefully.

I defer again to my colleague Don Marshall whom you know I quote regularly. I have never heard him reprimand anyone during our surgical association now extending back almost fifty years. His recollections are *exemplary* and he is a fountain of knowledge on surgical vignettes. We are compiling these into a book of recollections titled *Letters from Spring Street (Alistair Cooke style)*. Don told me how his father gently educated him at the age of six in the art of smoking. He was attending his sister's wedding in the late 1940s and everyone smoked. Most films of that era featured smoking and I recall the soft rolling articulation of Humphrey Bogart, with cigarette in hand, speaking to Ingrid Bergman in *Casablanca* uttering: 'Play it again Sam'. Don asked his father if he could likewise have a cigarette as both his elder brothers Vernon and Bob were smoking. His father's clever response was 'Of course you can son but on one condition - you must finish the cigarette' – not in a didactic way, nor dictatorial, nor a demanding style but in a conciliatory, concessional and even condescending manner. Don recalled how he spent the following hours in the toilet 'enjoying' his emetic experience. Needless to say he has not smoked since. He remarked on the value of his father's sapience – and *the wise old owl had spoken*.

This brings me to additional points about constructive criticism and their outcomes. We all enjoy the educational experience associated with the *apprenticeship system* in surgical training. One can do umpteen courses and read umpteen textbooks but there is nothing like the 'captain on the flight deck' proceding to show you the tricks of the trade including the pitfalls reflecting that superior experience. Few can match Sir Rodney Smith, President of the RCS in his famous statement in the 70s – and I again quote 'I am a self-taught surgeon with a great respect for his master'. Don Marshall in his retirement phase reflects this in paint - his artworks are masterful – without tutoring, reflecting an intrinsic talent. Simon Laurie said recently of these pictures that Don paints like a Piguinet (see illustration below). Don's painting of translucent water is of extreme quality if not masterful. I will include his images in

a subsequent story.

My father's educational expertise style during our golfing afternoons helped me to appreciate the *principles of life*. We played sometimes up to three times a week discussing between shots a whole range of topics. I learned that one does not get angry even when one swings a golf club otherwise the ball ends up in the rough. Thus the principles of life became indelibly imprinted and when I was part of the University golf team it was obvious that those with the most relaxed swing would be the winners. Likewise it applies in surgery. In my early training days at PANCH I was assisting in a Millard cleft lip repair with a senior surgeon from the Royal Children's Hospital who assessed (I suppose) my level of competence was below average. After his second courteous reprimand for my poor performance I discreetly (and timidly) offered him the Iris scissors to show me his way deferring to his superior skills. It worked wonders - I metamorphosed into an improved surgical Fellow and he became a friend forever.

When reprimand is deficient and *anger* supervenes the consequences may be tragic. In my early Hand Surgery days in Brisbane a recent junior consultant found the theatre equipment somewhat deficient. In frustration he threw the hand drill across the theatre breaking it and some theatre tiles. The following day he was summoned to appear before the Superintendant of the hospital. The conversation reportedly was 'Your services are dispensable whereas my theatre staff are irreplaceable. I am inviting you to resign'. One can recall the quote from Horace 'Anger is short madness'. Or as Eleanor Roosevelt said 'Anger is missing one simple letter (d) anger'. If one can be patient, the dust will settle and never forget the prudent person hides his anger. The French say when you are experiencing such an episode – *'tournez votre langue sept fois'* (turn your tongue seven times). Let us not forget that anyone who angers you, conquers you – more words of wisdom from these *wise old owls*. In synopsis - target the problem not the person.

As Don Marshall observed, this Powerful owl located in his neighbour's yard in Ivanhoe.

fig.1 Figure 1

Social media as a teaching and learning tool

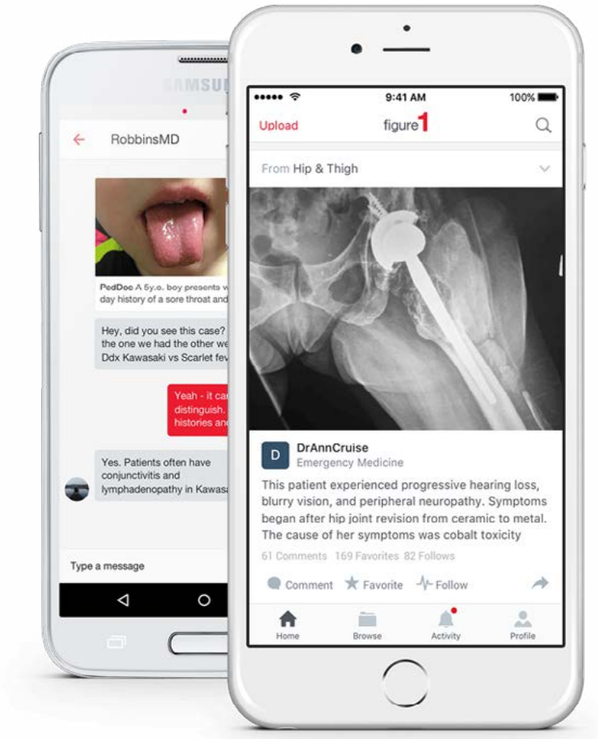
Described as 'Instagram for doctors', the Figure 1 app is an interesting concept for both learning opportunities and consulting colleagues. Figure 1 is an image-based social media service for the medical profession, with built-in tools to de-identify the photos to preserve patient privacy.

Once you download the app, you can scroll through photos of scans, x-rays, or patient photos showing a condition of interest to your relevant field. Some health professionals use it to discuss a diagnosis with colleagues for an unusual presentation; others use it as a teaching tool to quiz Trainees, or illustrate a technique or treatment. Some posts are fascinating extreme injuries or conditions.

You can follow a particular field, i.e. cardiothoracic surgery, a user who might post interesting content, or browse the latest images. On a post you are able to favourite the image, comment, ask or answer questions, and get notifications for that particular conversation thread.

Figure 1 is available on both iTunes and Google Play.

If you have any social media questions, feel free to send to Sarah-Jane Matthews, RACS Digital Media Coordinator (Sarah-Jane.Matthews@surgeons.org).



ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

IN MEMORIAM

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

Anthony Hugh Taylor Hodgkinson (NSW)

William Lennon (NSW)

John Garland Lester (NZ)

William Thomas Sugars (QLD)

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

Informing the College

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

ACT: college.act@surgeons.org
NSW: college.nsw@surgeons.org
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Congratulations!

Professor Michael Grigg FRACS

Induction into Membership of the Court of Honour

Members of the Court of Honour are chosen from those who show continuing personal interest in the College. The Court exists both to honour its members and to provide advice to Council.

Professor Michael Grigg was the 44th President of our College, and the first Specialty Elected Councillor to become President. He is a vascular surgeon, Professor of Surgery at Monash University, and the Director of Surgery at Eastern Health.

A graduate of Monash University Medical School and training at the Alfred Hospital, he gained his Fellowship in 1984, before further experience in vascular surgery in Hull and St Mary's, London. He returned to Victoria to a substantive appointment as Senior Lecturer at the Alfred Hospital, before being promoted to his current position at Box Hill Hospital and Eastern Health in 1998.

He has contributed substantially to health care in Victoria and more widely. He was a Member (2000 - 2008) and Chair (2006 - 2008) of the Ministerial Advisory Committee for Surgical Services in Victoria (MACSS) and also the Expert Panel for the Council of Australian Governments, 2011 - 2015.

He is a champion of professionalism in surgery. He is a strong advocate for the ongoing role of the medical colleges, and the challenges that must be faced in the future to ensure good surgical practice meets the community's expectations and preserves the professional autonomy.

During his nine years on College Council, his portfolios included Chair of Professional Standards, Chair of the Professional Development and Standards Board (PDSB) and Vice President before becoming the 44th President. He was the leading author of the 2nd edition of the RACS Code of Conduct (2011-2012) and a co-author of the College Pledge.

As a Councillor of our College, Michael also had an alias – the poison'd chalice of Professor U R Kidding in *Surgical News*. Professor U R Kidding blended Shakespeare with the reflections of a mature, definitely ageing, Director of Surgery. U for Ulysses, and R for Reginald, and No was short for his medical school nickname Number (September 2009).

In his alias as Professor U R Kidding, he entertained the Fellowship for four years in *Surgical News*. This included Shakespearean quotes such as "Therefore, since brevity is the soul of wit. And tediousness the limbs and outward flourishes, I will be brief."

Nothing about Michael Grigg is brief - indeed his service to this College has been extensive and sustained.

Citation kindly provided by Professor David Watters OBE, FRACS

Image (from left): Professor Grigg and Professor Watters

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