ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 18 NO 9 OCTOBER 2017

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COVER: Dr Areta Samuelu and Mr M John Clifford FRACS (from left to right) performing an open bone-patellar tendon-bone ACL reconstruction (PHOTOGRAPHY: Dr Ferraby Ling).

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Surgical News Editor: RACS CEO

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PRESIDENT'S PERSPECTIVE

Healthcare for all

RACS President reports on the 54th Medical Symposium of the Medical Society of Papua New Guinea: *Access to Safe and Affordable Surgery and Anaesthesia.*

JOHN BATTEN
President

As your president, I had the privilege of attending the 54th Medical Symposium of the Medical Society of Papua New Guinea in Port Moresby. This is a meeting of all medical disciplines in Papua New Guinea. The theme of the meeting was "Access to Safe and Affordable Surgery and Anaesthesia." This is probably the first time anywhere that a multi-disciplinary national medical group has come together to discuss this important issue and together explore how it relates to global health and, more specifically, to Papua New Guinea.

Also attending this meeting were the President of the Australian and New Zealand College of Anaesthetists (ANZCA), Professor David Scott, and the President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), Professor Stephen Robson. Our presence strongly supported and reinforced the importance of access to safe and affordable surgery and anaesthesia in Papua New Guinea and globally. This was further reinforced by the presence of Professor David Watters, past RACS President and past Professor of Surgery in Papua New Guinea.

As you will be aware, Global Health advocacy is one of RACS' strategic directions and RACS has been very active in this space.

In 2015, several important milestones were reached in Global Health, and more specifically, Global Surgery.

- In May 2015, the 68th World Health Assembly (WHA) in Geneva adopted Resolution 68.15 which placed Emergency and Essential Surgical Care and Anaesthesia on the global platform as a key component of Universal Health Coverage. Surgery, nor the burden of surgical disease, had not been mentioned in the Millennium Goals on global health and wellbeing, and this was the first time that surgery had been recognised as an essential part of universal health coverage. This landmark decision was a result of sustained surgical advocacy and lobbying, with the resolution put forward by Zambia and co-sponsored by Australia.
- In August 2015, the Lancet Commission on Global Surgery published its landmark paper highlighting the current global situation and proposed 2030 targets. It provided evidence and solutions on access to safe surgery and anaesthesia. The Commission suggested six surgical indicators be collected to provide data to quantify the problem in each country and provide information to objectively advocate for appropriate resources by respective health bureaucracies.
- At the United Nations Sustainable Development Summit in September 2015, the 2030 Agenda for Sustainable Development was adopted, outlining the 17 Global Goals, of which Goal #3 relates specifically to health – to *"ensure healthy lives and promote well-being for all at all ages"*.

RACS advocated for the collection of the six indicators data in Australia and New Zealand and worked with, supported and encouraged our Pacific Island partners in the Pacific Island Program to collect the same data. These 13 Low and Middle Income Countries (LMIC) have done a commendable job in data collection allowing an objective assessment of their current status to inform a national health plan for each country.

Health systems around the world have begun to pilot the collection of the first four of the six surgical indicators, which has led to the 6 Surgical Indicators being incorporated into the World Bank – World Development Indicators dataset.

In May this year, at the 70th WHA, following further global surgical advocacy, Decision Point 70.22 was adopted, which requested continued data collection for the 2030 Agenda for Sustainable Development, including **the strengthening of emergency and essential surgical care and anaesthesia as a component of universal health coverage.** Further, the new World Health Organisation (WHO) Director General, Dr Tedros Ad-Hanom, in response to correspondence from RACS, committed that in his capacity, he would: *"work in consultation with Member States to build national capacity for surgical care to implement WHA68.15, and importantly, measure performance of the initiative"*. This makes the collection of these health metrics increasingly important to inform progress, identify and address areas of further work.

My visit to PNG reinforced the importance of many of these landmark initiatives.

Papua New Guinea as our closest neighbour, has had a long association with Australia, being, up until 1975, a territory of Australia. It is a developing LMIC with a population of eight million, an anticipated population of 30 million by 2030, and a very young demographic, of which 80 to 85 per cent live in rural and remote areas, making the logistics of health care delivery extremely difficult.

Some key facts about surgery in PNG:

- Access to a capable acute surgical care facility within 2 hrs (the first Lancet metric) is available to less than 20 per cent of its population, compared with 99 per cent of our population. Surgical volume (the second Lancet metric) is one of the lowest in the Pacific at 1264 per 100,000 population, compared with our 10,156, and the number of Surgeon Obstetrician Anaesthetist (SOA) providers (the 3rd Lancet metric), is 2.3 per 100,000 population compared with our 64. This is clearly in stark contrast to the Australian setting.
- Papua New Guinea has a total of 82 surgeons and substantially fewer anaesthetists. The country is divided into 22 provinces, each with a provincial hospital; all but one province currently has a resident surgeon. There are 3 major health facilities or tertiary treatment centres. Medical training is undertaken at the University of Papua New Guinea based in Port Moresby and surgical training at the major tertiary facilities.
- The perioperative mortality rate (the 4th Lancet metric, is 0.5 deaths in hospital per 100,000 procedures) and the maternal and infant mortality rates remain high.

One can appreciate the dimensions of the task before the medical profession and the health ministry in Papua New Guinea to deliver access to safe, affordable surgery and anaesthetic care to their population.

Further, the proportion of the global burden due to surgical disease is expected to rise progressively over the next few decades as the control and eradication of communicable diseases continues around the world with trauma, musculoskeletal disorders and neoplasm becoming increasingly the major causes of annual GDP loss in LMIC. The final two Lancet metrics are financial protection indicators of percentage of the population at risk of impoverishing or catastrophic expenses to obtain surgery.

The meeting attempted to analyse the surgical training needs in Papua New Guinea and resolved to lobby for a stand-alone university for health sciences, increase training places for surgeons, and establish an electronic information data base including the collection of the 6 Lancet indicator metrics.

To achieve improvement in any of these indicators, PNG will need assistance and guidance from RACS. The three Presidents met with Department of Foreign Affairs and Trade (DFAT) representatives, Christine Sturrock and Benedict David to discuss re-establishing a relationship to assist in governance, curriculum development, safety and standards in training. A further meeting with the secretary of the Department of Health, Pascoe Kase, and the President of the Medical Society of Papua New Guinea, Professor Nakapi Tefuarani and DFAT will result in a concept paper exploring how RACS might assist.

I feel we, as a high income country with a mature health system, national training programs for medicine, surgery and anaesthesia, almost universal equitable access to care when needed, need to assist by providing guidance and support to our nearest neighbour as they develop their national health plans to provide access to safe and affordable surgery and anaesthesia to their population. RACS will review the concept paper and continue the dialogue with Papua New Guinea in health advocacy.

It was a privilege to attend this meeting as your President.

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Bringing joy to the world

CATHY FERGUSON
Vice President

Yes, Christmas is fast approaching – I have already been wished a Merry Christmas by one of my patients who I will not see again until next year! Discussions are occurring about the on-call roster over Christmas and January, and soon the rush of patients needing urgent appointments before the end of the year will begin.

While the lead up to Christmas is traditionally a very busy time for all surgeons, it is also a time when we start to reflect on the year that has passed and remember that many are far less fortunate. At this time of the year, I encourage you to take a moment and consider donating to the Foundation for Surgery, either via your subscription payment or online at www.surgeons.org/foundation/. Your compassionate donation will help ensure that children, families and communities within our region and across Australia and New Zealand have access to safe and quality surgery when they need it most.

This year it has been overwhelming to see people's generosity and energy towards the Foundation for Surgery, particularly the Pledge-a-Procedure campaign dedicated to Indigenous health. As Jacklyn, one of our recent Maori ASC Award winners said, "If the goal is equity in health outcomes for Indigenous people, achieving equity in the surgical workforce is a huge step towards this". Thank you all for your support. Very special thanks also to our Gold and Silver donors who greatly assisted in this year's success.

> *"Unlike other charities, no overhead or administration fees are deducted from donations"*

I am a long term supporter of the Foundation for Surgery and am continually inspired by the positive impacts achieved in our communities through all its programs. In particular, I have an enormous sense of pride that surgeons are proving to be great philanthropists in supporting the Foundation. It is through your extraordinary support, as Fellows of our College, that the Foundation for Surgery has achieved so much in global health, indigenous health and research for more than 35 years.

Thanks to you, the Foundation for Surgery is working to help here at home and within our region. The Foundation has enabled RACS, through our Fellows, to be a key player in delivering much needed surgical care in the Asia-Pacific region as well as supporting aspiring Aboriginal and Torres Strait Islander and Maori surgeons and funding ground-breaking research that promotes greater surgical care for all.

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100% of your donation assists in addressing critical surgical need

However, it continues to stagger me that five billion people currently do not have access to safe, affordable surgical care when they need it.

This year as you renew your subscription, I urge you to consider a one-off donation to support the Foundation for Surgery to help ensure children, families and communities access safe and quality critical care when they need it most.

Thus far, this year alone, over 8,043 patients from developing countries in the Asia-Pacific region have received specialist consultations from our Fellows. More than, 2,000 patients have had life changing surgery and over 120 health workers have been trained, thanks to your generous support. Four Aboriginal medical students and four Maori doctors were supported to undertake specialised professional development opportunities, and there was significant long-term planning for achieving better health outcomes for Aboriginal and Torres Strait Islander and Maori communities. In addition, more than 47 scholarships were awarded to Fellows and Trainees to support pioneering research resulting in better patient care, as well as research into the early detection and treatment of many cancers, disorders and diseases to assist all people to live their healthiest lives. We need your help to continue and expand these essential activities.

As you know, the Foundation for Surgery relies on donations and bequests to continue to support disadvantaged communities as well as supporting research that improves surgical outcomes for all. **Unlike other charities, no overhead or administration fees are deducted from donations** so that 100% of your donation can achieve its maximum impact in the community.

*Last month we introduced you to the **1927 Society**, the bequest program named after the year our College was founded, and this is a good time to consider leaving a bequest to assist the Foundation in its endeavours. Jessica can assist you in any enquiries you may have about this process. This simple act will bring joy to the world this festive season and support our Foundation for Surgery to help ensure quality surgical care when it's needed most.*

Please donate today
1. when you pay your annual subscription fee, or
2. online at www.surgeons.org/foundation/
Alternatively, if you would like to make a more substantial personal contribution to the Foundation for Surgery's work, please contact Jessica Redwood, Manager, Foundation for Surgery, on ph: +61 3 9249 1110.

The Coeliac Axis

Going against the Grain

DR BB-G-LOVED

Dee Cue consulted me last month suffering from low energy, intermittent headaches, bloating and joint pains. She is a time-challenged surgeon, normally preferring to struggle through the personal, parental and professional challenges of life without my help. However, her adolescent son, Axel, woke up one morning with a rash around his mouth, it was somewhat herpetic like in appearance, and the boy was down on energy. I ran the usual battery of standard bloods on both of them. Those tests were negative so I did what I usually do, I recommended trying dietary exclusion, one foodstuff at a time - gluten, dairy and salicylates in that order.

The coeliac axis describes a spectrum of intolerance to gluten and its constituent proteins, gliadin and glutenin. Coeliac disease which affects 1.5 per cent of the population (1.2 per cent in men and 1.9 per cent in women) is diagnosed by villous atrophy on duodenal biopsy, taken when consuming gluten. The classical enteropathy-induced malabsorption may be associated with failure to thrive or poor growth in children, but can present in adult life with a whole range of severity. Anti-gliadin IgA or IgG antibodies to tissue transglutaminase (tTG and/or IgA EMA) will be positive (sensitivity and specificity 95 per cent). Only about half of those who suffer have actually been diagnosed. 90 per cent have the HLA (Human Leucocyte Antigen) haplotype DQ2 and a further 5 per cent DQ8.

I usually find that patients like Dee Cue and Axel who justify a diagnosis of coeliac disease may still improve on a gluten free diet. It is sometimes more pragmatic to try exclusion of gluten for some weeks than refer for endoscopy. Dietary exclusion will benefit other conditions in the coeliac axis – wheat allergy (1 per cent) and non-coeliac gluten (or wheat) sensitivity (3-6 per cent).

Wheat allergy affects adults and children, and can be diagnosed by serum specific IgE testing, skin prick testing, patch testing or oral challenge. The specificity, sensitivity and diagnostic accuracy of these tests is variable. In children who test positive to an oral challenge, only about a quarter will have an immediate reaction, the others have a delayed response over some hours or the following day. Other allergic conditions of the axis include Baker's asthma and Baker's rhinitis, in reaction to inhaling wheat, and conditions that have been recognised since Roman times.

Non-coeliac gluten sensitivity (NCGS) is diagnosed after excluding coeliac disease, wheat allergy, and a trial of avoiding gluten. The symptoms vary from abdominal pain, bloating, and altered bowel habit to being foggy in the head, fatigue, joint pains, paraesthesia, rash or depression. About 50 per cent of sufferers have the coeliac HLA-DQ2 and DQ8 genotypes.

There are two other gluten related conditions in the axis: dermatitis herpetiformis (chronic blistering rash with IgA deposits in the skin) and gluten ataxia responsible for about 30-40 per cent of idiopathic sporadic ataxias.

Dee Cue and Axel were negative for anti-gliadin antibodies. Dee insisted on checking their HLA genotype - both were DQ2. They undertook a six week trial of a gluten free diet. Axel's school and athletic performance picked up immediately. He was his old self again! Dee also was surprised at how much better she felt.

Gluten helps dough rise, provides consistency and is palatable. It is found in wheat, barley and rye and thus in flour, pasta and couscous. We have no idea why the incidence of these conditions is rising but they are. Perhaps it is the immunogenicity of the wheat proteins favoured for commercial productivity of the grains. Farmed wheat was introduced to the human diet 10,000 years ago, though strains rich in gluten content only in the last 500 years. I am not suggesting a paleo diet but older strains of wheat such as einkorn and emmer may be better tolerated than the current *Tricitum aestivum*.

Fortunately, for those in the coeliac axis, most restaurants now offer gluten free options. There is a wide range of gluten free products in food stores - just watch out for those with added sugar. Dee Cue is not alone. RACS has over 7000 members, thus about 100 with coeliac disease, 70 with wheat allergy, and over 200 with NCGS. Half may not know it but would be healthier going against the grain.

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A fully functioning hospital... in a tent

RACS Trauma Verification works alongside the Australian Defence Force

Trauma Verification Site Review Team and ADF Team

Dust, wind, unique fauna, working in the elements and having limited access to modern medical necessities are facts of life that you might encounter when working in a hospital environment in a third world country. But these are the conditions that staff of the Australian Army's 2nd General Health Battalion (2GHB) face, working in a deployed military hospital.

Recognising the Royal Australasian College of Surgeons (RACS) Trauma Verification Program as the leading mechanism for quality improvement and accreditation in trauma in Australia and New Zealand, and valuing potential benefits of external review, the Australian Defence Force (ADF) invited the multidisciplinary team from the RACS Trauma Verification Program to undertake a site review of 2GHB when deployed to Shoalwater Bay in Queensland during the Talisman Sabre Exercise in July this year.

The Talisman Sabre exercise is a biennial combined Australian and United States training activity, designed to train our respective military forces in planning and conducting Combined Task Force operations to improve the combat readiness and interoperability between our respective forces.

Supported by RACS, the College of Intensive Care Medicine, the Australian and New Zealand College of Anaesthetists, the Australasian Trauma Society and the Australasian College of Emergency Medicine, the Trauma Verification Program's site review assists hospitals in analysing trauma systems of care and benchmarking services against international standards.

From the perspective of 2GHB, major goals were to fill any gaps between current and ideal practice, benchmark against Australian civilian standards, assist wider Defence understanding of capability by showing equivalence to a particular type of Australian civilian hospital, and help Defence understand what might be required to generate a larger (Role 3) hospital should that be desired.

This was the first time a military hospital had undergone this process, and so was a significant milestone not only for the ADF but for the Trauma Verification Program.

A site review covers the patient's journey from pre-hospital through to discharge and rehabilitation, and identifies ▶

Images (opposite): Trauma teams work together in the Emergency Room.
Clockwise from top: Trauma Verification Team are shown around by Military personnel; Aerial shots of 2GHB as deployed on Exercise Talisman Sabre 2017; Hospex Exercise - MASCAS patient's followed as review team observe care of the trauma patient in deployed hospital; Surgeon-General Australian Defence Force meets Military and Civilian trauma team members - Bushmaster Ambulance used in the field.

strengths and weaknesses of the hospital's trauma service. Trauma verification is applicable to major and non-major trauma services Australasia-wide, but the difference this time was that 2GHB is required to construct temporary hospitals that are deployed only during times of actual or simulated combat, peacekeeping or disaster relief.

The 2GHB team completed the standard pre-review RACS Trauma Verification questionnaire, highlighting areas in which the deployed environment placed constraints on capability. This included the analysis of equipment used, processes and systems in place and the staff employed to manage the service. While the full range of medical and surgical care is potentially required, the major focus of the entire hospital is usually on trauma.

'real' casualties (only 6 surgical operations under general anaesthesia were performed during the exercise), the assessment relied on observing the treatment of simulated casualties as well as inspection of patient records from the ADF hospital currently deployed in Iraq.

"Despite being in a hospital in a tent, some were no doubt surprised at the available infrastructure including digital radiology, a pathology lab with molecular diagnostics and blood bank capability, emergency physician-led resuscitation bays and Australian standard-compliant operating theatres and CSSD," Michael said.

Captain Bob Eccleston said that he particularly enjoyed facilitating the trauma verification group's understanding of the military environment.

> *"Despite being in a hospital in a tent, some were no doubt surprised at the available infrastructure including digital radiology, a pathology lab with molecular diagnostics and blood bank capability, emergency physician-led resuscitation bays and Australian standard-compliant operating theatres and CSSD." – Colonel Michael Reade.*

The Program is overseen by the RACS Trauma Committee and the Trauma Verification sub-committee. All team members undergo specific training and mentorship prior to a verification visit, and the verification process culminates with a comprehensive report which is ultimately owned by the site that has undergone verification.

The report enables the hospital to identify areas of improvement, measure and assess their progress, and develop new and innovative ways of doing things.

The task of assembling all of the required information and identifying capability gaps fell to Captain Bob Eccleston, a Regular Army FRACGP and now anaesthetic registrar in the ADF's full-time Medical Specialist Program.

2GHB Director of Clinical Services, Colonel Michael Reade, said that Captain Eccleston worked tirelessly to translate understanding of the hospital's capability into RACS nomenclature.

"He worked with many unit members to enhance Clinical Practice Guidelines, tailored to the austere environment of a hospital where, among other limitations, there is no CT scanning, and evacuation can be both prolonged and hazardous.

"As well as having to contend with dusty stretchers for beds, portable toilets and the occasional snake, the Trauma Verification Team was asked to understand the unique characteristics of hospital care in the operational military environment.

"The tented hospital had been built only the week before, with clinical teams of Regular and Reserve staff still forming and defining individual roles. As there were fortunately few

"From discussions about pre-hospital retrieval with Warrant Officer Travica dressed in patrol order with armour, webbing and weapon, to inspecting the unique (and cramped) environment in the back of an armoured Bushmaster Ambulance, there was a great deal of interest in the unique aspects of providing care in a military environment," he said.

Retired Trauma and General Surgeon of the Royal Brisbane and Women's Hospital, Associate Professor Cliff Pollard was deployed to 2GHB as a member of the Trauma Verification Program Committee, and said that he found the exercise to be both unique and rewarding.

"The commitment to provide the highest standards of care to wounded and injured service personnel was demonstrated at every level from the Commanding Officer to the individual soldiers in the Battalion. This commitment is without a doubt reinforced by the ADF's decision to allow an external professional body to examine in detail their structure, procedures and policies, and to facilitate that inspection without reserve," Cliff said.

Chair of the Trauma Verification sub-Committee, Trish McDougall said that she has never been involved with a review where the hospital hasn't come away having learnt something new.

"The ADF review was a unique opportunity for highly experienced trauma clinicians to observe clinical standards available to injured military personnel during a field exercise. The recommendations made will provide guidance that can be utilised by the ADF to enhance the trauma systems currently in place and help deliver the best possible patient outcomes", she said.

Images (Clockwise from top-left): Hospital staff prepare the hospital for incoming patients – main corridor of the hospital; Radiology department onsite of the deployed hospital; Army surgical team discusses work being done at 2GHB with the Verification Team; Living onsite at the deployed hospital – staff quarters and mess in foreground with hospital in the background; Ambulance not made for comfort but rather protection from blast and ballistic munitions and mobility over rough terrain; Lieutenant Colonel Louise Martin thanks the Surgeon General - AVM Tracy Smart for attending meeting with Trauma Verification team.

2GHB Personnel involved:
Lieutenant Colonel Louise Martin – Commanding Officer
Colonel Michael Reade – Director of Clinical Services
Lieutenant Colonel Jamie Phillips – Senior Medical Officer
Captain Bob Eccleston – General Duties Medical Officer
Warrant Officer Class One Virginia Morris – Regimental Sergeant Major
Lieutenant Colonel Nerida McManus – Director of Clinical Governance and Training

Trauma Verification Site Review Team involved:
Associate Prof. Arthas Flabouris – Intensivist, Royal Adelaide Hospital
Prof. Mark Fitzgerald – Director of Trauma Services, the Alfred Hospital; Director, National Trauma Research Institute
Ms Annette Holian – Orthopaedic and Trauma Surgeon, Royal Darwin Hospital
Associate Prof. Cliff Pollard – General and Trauma Surgeon (retired), Metro North HHS Board Member; Royal Brisbane and Women's Hospital
Erica Caldwell – Trauma Clinical Nurse Consultant
Rosalind Wendt – RACS Trauma Program Coordinator, RN, EM

SOCIAL MEDIA

Using Facebook for your practice?

Did you know you can 'turn off' different settings on your Facebook page?

As we move further into the digital age, we're seeing more businesses utilising social media more than ever before.

No longer is it enough to have a website, phone number and email as a method of contact, we now expect a Facebook page that includes some basic information.

However, these additional platforms can take time and effort to create, generate content and monitor.

If you do have the time and resources or having a Facebook page for your business fits in with your strategic plan, then we encourage you to explore the settings and functions on offer to you.

Facebook pages offer many settings and eLearning resources such as Facebook Blueprint to assist you to customise the page to suit your needs.

It's worth noting the majority of our RACS community is wary of having a Facebook page (or social media platform of any kind) because of the perceived lack of privacy and strict guidelines surgeons must adhere to.

For example, surgeons are not allowed to actively promote or market their business in ways such as publishing positive reviews. If you have a Facebook page for your practice, you can simply 'turn off' the reviews section without anyone ever knowing it was there.

Within the general settings of a Facebook business page, you can easily disable or enable functions such as private messaging, visitor posts, recommendations, profanity filters or ban specific words, tagging abilities and even country restrictions.

If you wish to step-up your knowledge, Facebook Blueprint is *"a global training and certification program about marketing on Facebook. It is a series of free, self-paced online courses and learning paths you can take to learn more about marketing on Facebook."*

For further information about Facebook Blueprint eLearning, visit the website: https://www.facebook.com/blueprint/

Alternatively, you are welcome to contact our RACS social media team member, Aubrey Hamlett for additional social media support and resources.

– Aubrey Hamlett
Digital Media & Internal Communications Coordinator
Communications & Advocacy

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

RACS Advocacy 2017

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

Recent submissions from RACS include:

NT 'Towards Zero' Road Safety Action Plan

Last month RACS responded to the Northern Territory 'Towards Zero' Road Safety Action Plan.

The National Road Safety Strategy 2011-2020 (NRSS), to which the Northern Territory Government is a signatory, analyses road safety risks in terms of the elements of the Safe Systems Approach to Road Safety and makes strong recommendations as to how individual components of these major elements can contribute to reductions in fatalities and serious injuries. The comprehensive discussion paper that has been developed by the Northern Territory Government appears to reflect this mindset. We hope that this will lead to meaningful policy development and promote a safer driving culture, and most importantly save lives.

RACS' response to the Northern Territory 'Towards Zero' Road Safety Action Plan is divided in to the following six sections as per the discussion paper:

1. Alcohol and Drugs
2. Seatbelts and Child Restraints
3. Speed and Driving Conditions
4. Roads and Roadsides
5. Vulnerable Road Users
6. Other Key Actions

SA Pathology Proposed Operational Configuration and Workforce Model

RACS' main concern with the proposed reconfiguration of pathology services under the SA Pathology Proposed Operational Configuration and Workforce Model, is the reliance the new model places on the Enterprise Patient Administration System (EPAS).

The desire to move towards an electronic based model is understandable; however any system reliant on technology involves inherent risk. Inevitably at some point technical difficulties will occur. In a health setting where even minor glitches can lead to catastrophic outcomes, it is crucial that these risks are mitigated, and disruptions are prevented wherever possible.

Since it was first introduced to South Australian hospitals in 2013, RACS and a number of other medical organisations have repeatedly expressed serious concern with the reliability and functionality of the EPAS system. We have previously raised these concerns directly with the Health Minister following a number of system glitches and technical outages. Despite the intention to roll-out EPAS across the state's hospital network, it looks unlikely that the system will be functional at the new Royal Adelaide Hospital for some time after the facility opens.

Therefore, the reconfiguration of services must not occur until it can be guaranteed that the systems are robust, compatible and able to cope with the demands that will be placed upon them. It is essential that if the state's pathology services are to be 'modernised' that the supporting infrastructure is thoroughly stress tested and proper contingency plans are readily available, regularly reviewed, and clearly communicated to those affected by the changes.

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

RACS advocacy

In July and August several meetings were held with Commonwealth Ministers and departmental staff to discuss the College's position on sustainability of the healthcare sector, road safety and the need for a nationally-consistent approach to improve hearing health among Aboriginal and Torres Strait Islander children.

RACS Councillors Lawrie Malisano and Chris Perry, along with Chair of the Australian Society of Otolaryngology Head and Neck Surgery Indigenous Committee Kelvin Kong and A/CEO John Biviano met with Minister for Health Greg Hunt and Minister for Indigenous Health Ken Wyatt on August 16 in Canberra.

Several other meetings were held with the Shadow Minister for Health Catherine King, Commonwealth Member for Lingiari Warren Snowdon and Member for Newcastle Sharon Claydon, the Department of Prime Minister and Cabinet, the Department of Health, the Australian Medical Association and the Consumers' Health Forum of Australia.

Surgical fees and transparency

The Minister for Health is interested in financial and geographic barriers to accessing surgery, workforce distribution and how to provide greater transparency to patients on surgical outcomes and fees. The College is in the process of preparing a context paper and recommendations on how this might be approached, which will be considered at the October Council meeting.

RACS and other colleges are coming under increasing pressure from consumer groups in Australia to provide or encourage a simple platform for the public to view and compare specialist fees.

The work that RACS has begun with Medibank on surgical variation is an important step in the journey towards increased transparency of fees and outcomes.

Commonwealth road safety inquiry

The Commonwealth Minister for Infrastructure and Transport Darren Chester has invited RACS Trauma Chair John Crozier to co-chair an Inquiry into the National Road Safety Strategy 2011-20, along with Associate Professor Jeremy Woolley, Director of the Centre for Automotive Safety Research at the University of Adelaide.

RACS has already made significant in-roads to quantify the impact of serious injury from road accidents by advocating for $450,000 over three years to continue the work of the Australian Trauma Registry. The Registry released a Consolidated Report (January 2013-June 2015) in June this year which analysed 18,268 serious injuries over the 30 month period. Nearly half of these (44%) were road-related.

The road safety inquiry Terms of Reference are to:

- Identify the key factors involved in the road crash death and serious injury trends.
- Review the effectiveness of the National Road Safety Strategy 2011-2020 and supporting 2015-17 Action Plan; with particular reference to the increase in deaths and serious injuries from road crashes over the last two years.
- Identify issues and priorities for consideration in development of the next road safety strategy and action plan.
- Advise on how to improve coordination and use of the capacity and contributions of all partners involved in road safety.

Several stakeholder roundtables have been or will soon be held before the co-chairs provide a report to the Commonwealth Government in October for consideration at the Transport and Infrastructure Council and Road Safety Ministers meetings in November 2017.

– Amy Kimber
ACT Regional Manager, Commonwealth Advocacy

2018
RACS Diary

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Agreement for national approach to improve hearing health

DAVID MURRAY
Chair, Indigenous Health Committee

Closing the Gap is a government strategy that aims to reduce disadvantage among Aboriginal and Torres Strait Islander people with respect to life expectancy, child mortality, access to early childhood education, educational achievement, and employment outcomes. It is a formal commitment made by all Australian governments to achieve Aboriginal and Torres Strait Islander health equality by 2030.

However, ear disease among the Aboriginal and Torres Strait Islander community directly impacts on the ability to achieve several of the Closing the Gap targets related to education and employment.

Hearing health is central to an individual's ability to participate in society, acquire language and cognition skills, and ear disease is a barrier to the realisation of educational achievement, employment and general wellbeing.

Indigenous children in Australia have the highest prevalence of Chronic Suppurative Otitis Media in the world, a condition that can lead to significant hearing loss which in turn directly contributes to the cycle of disadvantage.

Tackling this issue head on, ear disease experts including surgeons, audiologists, paediatricians, researchers and Aboriginal medical service workers met last month to discuss a national approach to high rates of ear disease among Aboriginal and Torres Strait Islander people.

President of the Australian Society of Otolaryngology Head of Neck Surgery Chris Perry says disadvantage is being compounded by a 'pandemic of deafness' among Australia's first people.

"What we have is a national emergency. If children can't hear, they can't learn. They may become truants, leave school early, and then be stuck with no job or income. It may lead to substance abuse problems, or jail," Assoc. Prof. Perry said.

"Its impact on Australia's commitment to halve the gap in reading, writing and numeracy achievements for children, Year 12 attainment rates, and employment outcomes can no longer be ignored.

"Billions of dollars are being spent on *Closing the Gap* programs."

A new report from the Australian Parliament Standing Committee on Health, Aged Care and Sport released in September also highlights the need for a nationally consistent approach.

The report, *Still Waiting To Be Heard*, estimates that hearing loss costs Australia $33 billion each year and that the level of hearing loss among Aboriginal and Torres Strait Islander children is at crisis point.

"In 2017, we are still unable to monitor the national prevalence of ear disease, its geographic distribution, screening rates, wait times between referrals or whether timely and appropriate treatments are being delivered," A/Prof Perry said.

"We know that in 2014-15 the proportion of Indigenous children with ear/hearing problems was still 2.9 times the rate for non-Indigenous children, but this data is self-reported, collected infrequently, and does not identify areas of need."

A/Prof Perry reinforced that Aboriginal and Torres Strait Islander leaders and organisations must be supported by Government to address the issue. RACS will continue to advocate strongly in this area to ensure the recommendations for a national approach including the formation of a taskforce are realised.

For more information on *Closing the Gap* visit: http://closingthegap.pmc.gov.au/

– with Amy Kimber, Manager, Commonwealth Advocacy

EarHealthForLife

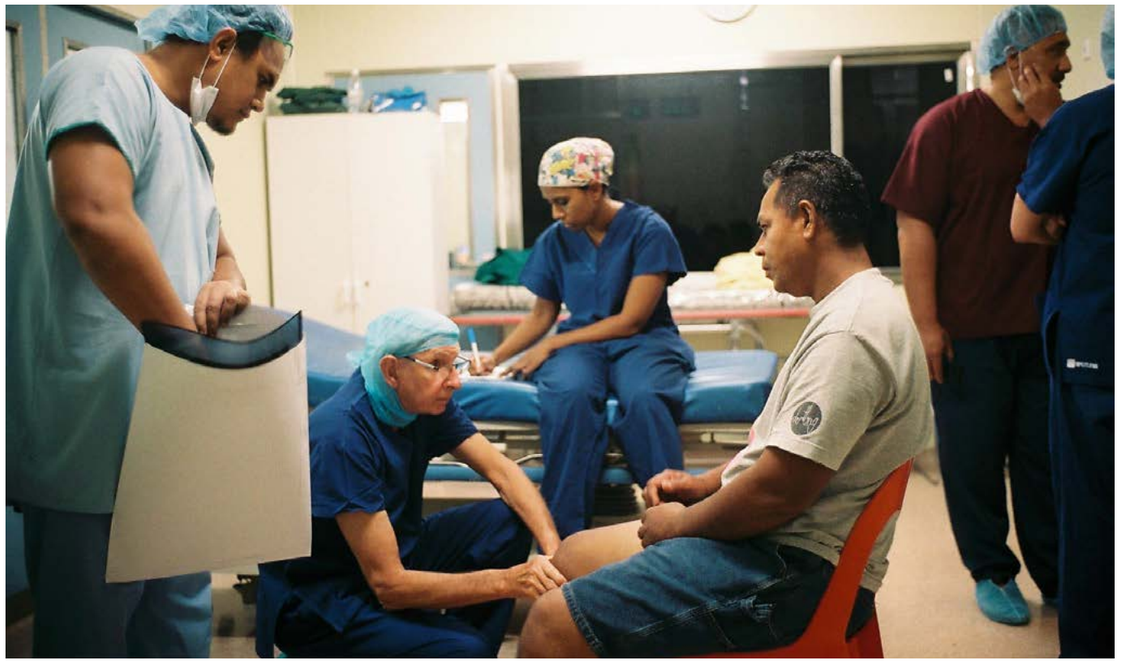
Surgery's Silent Achievers: A Photo Essay

LOCATION: Apia, Samoa | PHOTOGRAPHY: Dr Ferraby Ling

MR KIKI MAOATE FRACS
Project Director

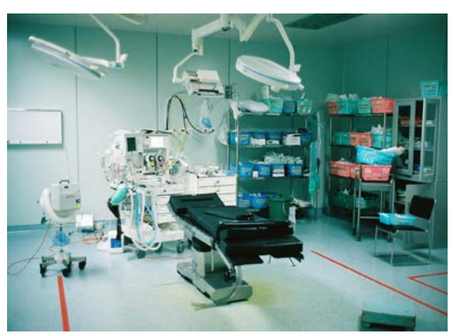
Amidst a small city locale of the tropics, Samoan surgeons are the silent achievers. With only a handful of surgeons, there is no true specialisation, and Samoan surgeons have to be prepared to make difficult decisions on complex cases, covering a wide range of pathologies.

Mr John Clifford FRACS and Mr Robert Pianta FRACS, orthopaedic surgeons from Western Health, Victoria, are two respected colleagues, and two close friends. Over the last few years they have worked together to support their colleagues in Samoa to improve orthopaedic services. Contributions are not just made in surgery however, but also in anaesthesia through team member Dr Julie Chan FANZCA, and nursing with Ms Katy Sue and Ms Lynne Moloney from Royal Melbourne Hospital. This year, the trip was joined by orthopaedic registrar, Dr Ferraby Ling, and his camera using Kodak film. Dr Ling has a passion for capturing the essence of a moment on film, and shares with us the people that make up the Australian Government funded RACS Pacific Islands Program (PIP). ▶



Images (Clockwise from opposite page):

Lifetime friends *Mr John Clifford FRACS (left) and Mr Robert Pianta FRACS (right);*
Two Peers *Mr Robert Pianta (left) and Dr Naseri Aitaoto (centre);*
Courageous yet humble *Orthopaedic trainee Dr Naseri Aitaoto stands in-theatre at the Tupua Tamasese Mea'ole Hospital;*
Care until nightfall *Mr Robert Pianta FRACS (kneeling) and Dr Dharsh Musiienko (seated on bed);*
Orthopaedic Team *Led by Mr John Clifford (foreground) with (from left to right) Dr Julie Chan, Ms Lynne Moloney, Dr Alex Beath, Dr Dharsh Musiienko, Ms Katy Sue, and Mr Robert Pianta FRACS (absent: Dr Ferraby Ling).*



Images (Clockwise from top): **Studying Sonographic Anatomy** Dr Areta Samuelu, Dr Lamour Hansell, Dr Naseri Aitaoto, Dr Julie Chan (from left to right); **Scrub Nurse** Mr Junior Aperaamo; **Operating Theatre** Tupua Tamasese Meaole Hospital; **Navigating the Navicular** Mr Robert Pianta (left) and Dr Naseri Aitaoto (right); **A Gentle Touch** - Dr Areta Samuelu with Mr John Clifford (background). *Centre Image:* **Photographer** Dr Ferraby Ling.

Are You OK?

RICHARD LANDER
Executive Director for Surgical Affairs (NZ)

Every two years, RACS conducts a Surgical Workforce Census, which provides the College with vital information regarding the factors that affect surgeons in their day to day work. The regular collection of this data is important as it builds a picture of the challenges facing the surgical workforce in Australasia, and helps the College identify areas in which it needs to advocate and educate.

The results of the 2016 Surgical Workforce Census have recently been published and are now available under 'Workforce and Activities Reports' on the College website.[1]

The Census provides data on subjects such as Fellows' work hours, public and private sector employment, pro bono work and future work intentions. It also provides data on Fellows' health and the causes of stress, the topic of which I wish to highlight in this column.

We owe it to our patients to look after ourselves. If we don't maintain our physical and mental health, then we cannot provide the best possible care to those that we have dedicated our lives to helping on a day to day basis. When we spend so much time focusing on ensuring the welfare of others, it is easy to get lost in our busy schedules and overlook the importance of, or be unable to find time to, maintain our own wellbeing.

Because it can be difficult to objectively and honestly assess one's own health, the RACS position paper on *Providing care to yourself, family members or those close to you* recommends that Fellows have their own general practitioner or other relevant medical practitioner.[2] According to the 2016 census, only 36 per cent of Fellows reported that they had visited a GP in the last two years for a routine check-up, with another 25 per cent having visiting only because it was necessitated by ill-health. Disturbingly, 10 per cent of Fellows reported that they perform regular health checks on themselves rather than visit a GP. 29 per cent had neither visited a general practitioner nor had any form of health check.

Some of the more telling statistics in Census' section on *Work-Life Balance and Health* relates to Fellows' self-rated stress levels in the workplace. By quite some margin, and not surprisingly, administrative regulation and administrative processes were reported as being the top two causes of stress respectively, with around 20 per cent of Fellows reporting this stress to be either high or extreme. Stress and inappropriate responses to stress can increase the risk of being accused of bullying and discrimination or even litigation.

A small majority of Fellows (56.1 per cent) reported that they had not experienced any mental health issues in the last two years. However, of the 42.7 per cent who had experienced stress or mental health issues during this time, very few (only 7.6 per cent) reported that they had actually sought professional assistance. 1.2 per cent of respondents elected not to disclose.

If you are not okay and under stress, seek advice from a family member, peer or a trusted mentor. Mindfulness and exercise can be appropriate distractors from the stress of work and daily life. If you see a colleague under stress; ask, listen, encourage action and then check back in on them at an appropriate time.

RACS has a number of resources available to Fellows, Trainees and IMGs who need support. Both myself as the Executive Director of Surgical Affairs in New Zealand, and my Australian counterpart Dr John Quinn, are available to provide confidential support or advice to anyone who needs it.

In addition, Fellows, Trainees and IMGs have access to confidential counselling for any personal or work-related issues through Converge International, with RACS covering the costs for up to four sessions per year. Counselling can be in person, over the phone, or via skype. Converge can be contacted via phone on 1300 687 327 in Australia, or 0800 666 367 in New Zealand.

Workplace sources of Fellows' self-rated stress levels

1 http://www.surgeons.org/media/25115898/2017-02-23_2016-surgical-workforce-census-full-report_final.pdf
2 https://www.surgeons.org/media/312926/2017-02-23_ pos_fes-pst-034_providing_care_to_yourself_family_members_or_those_close_to_you.pdf

Unique research could lead to improved outcomes for OAC patients

Oesophageal cancer is fast becoming a leading men's health issue, according to General Surgery trainee and PhD candidate Dr Steven Due (pictured, left).

Now rising at a faster rate than any other malignancy, oesophageal adenocarcinoma (OAC) has become the sixth most common cause of cancer death around the world, causes an estimated 407,000 deaths per year and has five-year survival rates languishing at a dismal 15 per cent even for patients who receive treatment.

The fact that the disease effects men at eight times the rate of women has been known for some time but now Dr Due and a team of researchers and surgeons at the Flinders University Upper GI Disease Laboratory are working to understand the reasons behind the disparity with the ultimate aim of finding new treatment options.

Dr Due has spent the past four years testing the hypothesis that oestrogen receptor (ER) signalling networks may play a role in combating OAC with funding support provided by the RACS through the Foundation for Surgery's Richard Jepson Research Scholarship and the Eric Bishop Scholarship.

> *"Given the safety and tolerability of Tamoxifen as an adjuvant treatment in breast cancer, our findings raise the possibility of a real clinical advance for OAC patients which is enormously exciting."*

In unique research, he has found ERs in both human tissue specimens of OAC and in OAC cell culture models, and has also demonstrated that OAC cell culture models respond to treatment with the breast cancer drug Tamoxifen.

He has also confirmed that the cytotoxic effect of the drug not only compares well with current chemotherapy agents used to treat OAC in the *in vitro* laboratory setting but also augments their own cytotoxic activity.

"Few malignancies carry as grave a prognosis as OAC," Dr Due said.

"It has a mortality rate of 85 per cent and less than 30 per cent of patients present with operable disease.

"Most patients require chemotherapy, either in the neoadjuvant, definitive or palliative setting so identifying a novel therapeutic agent to augment existing treatment regimens would have great value."

Describing his research into the use of a breast cancer drug to treat a male disease as an "idea out of left field", Dr Due said his findings were greatly encouraging.

He said he had assessed the cytotoxic potential of the two major metabolites of Tamoxifen – 4-hydroxytamoxifen and endoxifen – in a panel of six oesophageal and two breast cancer cell lines and found both metabolites to be effective.

He said he had also conducted analysis comparing ER expression patterns to treatment response and had earmarked specific ER*a* and ER*b* molecular isoforms as being relevant in mediating the response to treatment.

"Oestrogen receptors are widely expressed in normal and abnormal human tissue with ER*a* expressed in breast, ovary, uterus, bone, kidney, adipose tissue and liver while ER*b* is distributed throughout the cardiovascular and central nervous system as well as ovary, prostate, colon and kidney," Dr Due said.

"Together they regulate many aspects of cell growth and death and interact with multiple oncogenic signalling pathways which make them of key interest to medical scientists working in many fields around the world.

"We wanted to understand the biological role they play in OAC so these receptors were further investigated in a series of experiments to assess cancer cell proliferation and caspase-mediated apoptosis. It turns out that Tamoxifen metabolites have the potential to both slow the growth of cancer cells and induce apoptosis in OAC cells cultured in the lab."

Dr Due said he had also investigated the cytotoxic effects of Tamoxifen in combination with the conventional chemotherapy agents used to treat OAC which are cisplatin and 5-FU.

"Tamoxifen was found to significantly enhance the effectiveness of both of these conventional agents, with the combination of all three agents showing greater activity than any single agent or two-agent combination," he said.

"This means that the addition of Tamoxifen creates an effect that is greater than the sum of the parts involved and means that adding it to conventional regimes may not only be feasible but greatly beneficial.

"We have also developed a unique preclinical model in which endoscopic biopsies from real-life patients are kept alive in our laboratory in order to investigate treatment options. The findings so far confirm that Tamoxifen metabolites are also effective in this preclinical model.

"Given the safety and tolerability of Tamoxifen as an adjuvant treatment in breast cancer, our findings raise the possibility of a real clinical advance for OAC patients, which is enormously exciting."

Dr Due is undertaking his PhD under the supervision of Professor David Watson, Head of Flinders University Department of Surgery and Dr Damian Hussey, Head of Flinders University Upper GI Research Laboratory.

He received the Richard Jepson Scholarship in 2014 which supported the first three years of his research and the Eric Bishop Scholarship in 2017 which allowed him to finalise laboratory experiments and write up his thesis.

He said that while the results of his laboratory work were promising, a multi-centre Phase 2 clinical trial would be needed to determine if the results could be replicated in the more complex, multifactorial environment of human disease. The Upper GI community is well-connected nationwide and Dr Due is hopeful that interstate colleagues would be willing to participate in such a clinical trial.

He described his research as being both intellectually stimulating and professionally rewarding and thanked the College for the support it provided.

"The Flinders University Upper GI Disease Laboratory involves very close collaboration between surgeons and scientists which leads to great synergies of thought," Dr Due said.

"The surgeons help to ensure that the research is clinically relevant, they can provide biopsies straight from theatre and bring new treatments to the clinical setting. The scientists develop systems to keep cancer tissues alive, perform experiments and develop the technology needed to conduct them, and constantly refine methodology. It's a mutually beneficial environment.

"This work is quite unique and is based on a novel idea that came about because of the expertise we have here which allowed the laboratory to get some blue sky funding to begin this research.

"We can say at this stage that Tamoxifen does lend itself well to being incorporated into current chemotherapy regimens for OAC, it seems to increase the effectiveness of other agents currently in use and it would be terrific if it helps us treat OAC patients who suffer greatly from this disease."

A SET 3 Trainee, Dr Due has also maintained his clinical skills throughout his PhD research conducting on-call emergency general surgery at Flinders Medical Centre and assisting on private lists. He said he hoped to specialise as an Upper GI Surgeon and become an academic surgeon/scientist.

"Completing a PhD changes your thinking," he said. "You ask more questions about everything you do, both in theatre and in the clinic, which I think helps to refine your surgical practice.

"My ultimate aim is to become an academic Upper GI Surgeon because I think surgeon/scientists can do a great deal of good in the public health setting, they conduct fascinating research, they strive to continually refine surgical practice, and they teach the next generation of surgeons to do their very best for the patients they treat." *– With Karen Murphy*

Career Highlights

2017 – RACS Foundation for Surgery Eric Bishop Scholarship

2017 – Australia and New Zealand Gastro-Oesophageal Surgery Association (ANZGOSA) Glyn Jamieson Research Prize

2016 – RP Jepson Medal, RACS SA, NT and WA Joint Annual Scientific Meeting

2016 – Flinders University Faculty Student Publication Prize

2016 – ANZGOSA Travelling Scholarship to attend international meeting in Singapore

2015 – Flinders Centre for Innovation in Cancer Small Grants award

2014 – RACS Surgical Research Society Prize

2014 – RACS Foundation for Surgery Richard Jepson Research Scholarship

The silent epidemic of chronic pain after surgery

Education in pain management for all surgeons could reduce the prevalence of chronic post-surgical pain, may help drive the development of new techniques and limit the number of ineffective pain-reducing surgical procedures, according to Neurosurgeon Associate Professor Andrew Zacest.

Assoc. Prof. Zacest FRACS (pictured, below) is Chair of the College's Pain Medicine Section, a Fellow of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists (ANZCA), a Consultant Neurosurgeon at the Royal Adelaide Hospital and Clinical Associate Professor of Neurosurgery at the University of Adelaide.

One of the first Neurosurgical trainees in Australia to be awarded a Pain Fellowship through ANZCA,Assoc. Prof. Zacest has become a leader in the Australian contribution to *The Global Year Against Pain After Surgery,* an initiative of the International Association for the Study of Pain (IASP) as part of the Declaration of Montreal.

Speaking at the end of the year-long campaign, Assoc. Prof. Zacest said post-operative pain continued to affect 10-80 per cent of patients undergoing surgery with a smaller number developing chronic pain after surgery (CPAS) in what is now being described as a 'silent' epidemic.

Assoc. Prof. Zacest said there was a crisis in the knowledge of surgeons about pain and pain management and that further training would make surgeons better informed about pain after surgery, identify risk factors predictive of CPAS, employ individualised and multidisciplinary strategies to treat CPAS which would improve patient outcomes and reduce health costs.

He said the causes behind the crisis included:

- The increasing numbers of patients with chronic pain being referred to surgeons for treatment;
- The lack of education about pain and pain management and the consequences;
- The paucity of high-quality evidence for pain relieving procedures; and
- The potential for conflicts of interest between industry and surgeons.

"I think this has now become one of the biggest issues facing our profession and mandatory training in pain and post-operative pain management must be introduced if we are to deal with it," Assoc. Prof. Zacest said.

"The Faculty of Pain Medicine has launched a range of on-line pain education modules to educate health professionals and the Education Faculty of RACS is taking a strong interest in this work. I believe that if such training were to be made mandatory, better management of pain would become central to a surgeon's practice and career.

"It doesn't need to be onerous or expensive training but it is vital and must be made mandatory so that no surgeon can receive their Fellowship unless they understand the basic principles of pain and its management, which is an inescapable component of all surgery."

Assoc. Prof. Zacest said that while studies had shown that pain management can and should be personalised, many surgeons were not familiar with the potential factors contributing to variability of pain experiences after surgery.

He said these included genetic and gender differences in nociception, intensity and duration of preoperative pain, pre-existing chronic pain and pain medications particularly opioid therapy, psychological factors including anxiety, patient expectations of perioperative pain, catastrophizing and coping ability, intraoperative factors including nerve injury and surgical technique and post-operative pain.

If surgeons had a better understanding of such factors, they would be better able to identify those patients likely to gain the most benefit from pain relieving surgery and those with a higher risk of post-operative pain, he said.

"These issues affect every specialty of surgery," Assoc. Prof. Zacest said.

"There have been questions raised about the efficacy of a number of procedures regularly conducted such as arthroscopic knee surgery and spinal fusion surgery and health insurers are now looking at some of these elective procedures because there is growing evidence that patients are either no better or can be left worse off after surgery than before.

"Lack of knowledge and interest in pain and pain education is widespread across medicine, not just in surgery, but our patients need it to become a central aspect of all medical specialties.

"Chronic post-surgical pain has been increasingly recognised and studied for almost 20 years since researchers looked at the composition of patients attending chronic pain clinics and identified trauma and surgery as being risk factors for chronic pain.

"Anaesthetists and pain specialists have been the early leaders in this field but it is time for the rest of the medical community to catch up not only to limit unnecessary suffering but to help reduce the massive economic costs associated with chronic pain."

Assoc. Prof. Zacest said the Faculty of Pain Medicine was now working with a number of Colleges to provide educational materials about pain education and management.

He said it was of crucial importance that GPs, in particular, be provided with better pain management education given that they manage most patients with chronic pain in the community and said more money should be spent on funding multidisciplinary pain management teams to assist all doctors in managing patients with chronic pain.

The Global Year Against Pain After Surgery was designed to raise awareness concerning post-surgical pain management in health-care professionals, government leaders and the patients who face surgery.

Leading pain researchers said at the launch in January this year that most post-surgical pain was the result of nerve damage and was identified by symptoms of neuropathic pain such as burning pain, shooting pain, numbness and changes to physical sensation or sensitivity to temperature or touch.

They also said that there was a strong link between the severity of pain in the first ten days after surgery and the development of long-term pain, making adequate pain relief immediately after surgery critical to preventing ongoing pain.

As part of the global effort to reduce unnecessary pain, the Pain Medicine Section of the College designed a program at this year's ASC that included other surgical specialty groups including General Surgery, Breast, Orthopaedic and Craniofacial surgery and featured key note lectures on the pathophysiology of post-operative pain and neuromodulation for post-operative pain.

Choosing Wisely Australia, an initiative of NPS Medicine Wise to advise the public on unnecessary tests, procedure or treatments, has also acknowledged the potential for post-operative pain following elective surgery. One of the recommendations advises surgeons to carefully consider performing repair surgery for minimally symptomatic or asymptomatic inguinal hernias given that 10 per cent of such patients can go on to develop chronic pain with two per cent suffering severe pain.

> *"The best way forward will be through improving pain education of surgeons, performing studies to establish the efficacy of the pain-relieving procedures we perform and maintaining transparency in our dealings with industry and our patients."*

Assoc. Prof. Zacest said that while one of the most gratifying aspects of surgical practice was being able to relieve a patient's pain, more research and education was required to ensure that no patient seeking pain relief through surgery was left worse off.

"The best way forward will be through improving pain education of surgeons, performing studies to establish the efficacy of the pain-relieving procedures we perform and maintaining transparency in our dealings with industry and our patients," he said.

"We should be leaders in this field but if we do not accept this responsibility, others will make the decisions for us.

"Finally, the IASP Declaration of Montreal asserting the right of a patient to good pain treatment, behoves physicians and surgeons who perform procedures on patients to make good pain management the highest priority in the treatment of patients."

– With Karen Murphy

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Future Proofing Surgical Practice

In a change of scenery from past years, New Zealand's 2017 Annual Surgical Meeting, Surgery 2017, swapped the mountains of Queenstown for the harbour of Wellington. The theme of Surgery 2017 was *Future Proofing Surgical Practice* and was held on the waterfront at New Zealand's national museum Te Papa. Despite the capital's notorious wind initially disrupting flights into the city, the event was an excellent two days of engaging presentations as attendees considered the challenges and opportunities facing the future of their practice and surgical care. This was punctuated by a welcome function at Te Papa, followed by the conference Dinner at the outstanding *Te Wharewaka*, located right beside the harbour.

Panel discussion on the future of surgery in NZ, the USA and Australia

Surgery 2017 featured a fantastic International Speaker in Professor Taylor Riall, Acting Chair of the Department of Surgery at the University of Arizona, who gave three outstanding presentations. These included opening the first day with a talk on the effect that technology, regulation and extensive subspecialisation was having on surgical training and practice in the USA. Professor Riall also presented on the impact of personalising medicine to the patient and spoke on the importance of maintaining a work-life balance as a surgeon, drawing on her experience as a professional life coach.

The future orientated theme of Surgery 2017 lent itself to a varied and interesting programme, which was highlighted by the diverse range of subjects discussed over the course of the meeting. This included sessions on the future of surgery and training in the USA, Australia and NZ, health equity, cultural competence and unconscious bias, and methods to improve teamwork and performance.

There was also a session on climate change titled *Environmental Challenges and Opportunities*. Climate scientist Dr James Renwick provided an excellent, albeit unsettling, overview of climate change, its causes and the consequences of our current trajectory. This was followed by Professor Alistair Woodward speaking on climate change as a health issue, including the proliferation of tropical diseases, its impact on food supplies and the results of social disruption. The news was not all negative however, Professor Philippa Howden-Chapman presented on the impact that good urban design can have on promoting health; and anaesthetist Dr Forbes McGain spoke on the many initiatives that clinicians at Western Health in Melbourne have implemented to help reduce waste and their carbon footprint.

The meeting concluded with a valuable session on *Resilience and Wellbeing* which had a strong focus on the importance of maintaining one's own health while practicing medicine. This message was reinforced with a humorous but thought-provoking presentation from Plastic & Reconstructive Surgeon Dylan James who spoke on his personal experiences as a patient in the health system. Excellent talks were also given by past-Chair of the New Zealand Medical Association, Dr Stephen Child, on the health of the doctor, and intensivist Dr Carl Horsley on building team resilience. Surgery 2017 was concluded with a final presentation by Professor Taylor Riall, a highly beneficial talk on the role that mindfulness and emotional intelligence plays in surgeon well-being and optimal performance.

Looking ahead to next year, Surgery 2018 will be returning to Queenstown on 9 and 10 August. We hope to see you there!

– Calum Barrett, Policy & Communications Officer
New Zealand National Office

Dr Jaclyn Aramoana presenting on the recruitment and retention of Māori doctors into surgical careers

When Disaster Strikes

MR DIETER WEBER
FRACS, Convener

On Friday 25 August approximately 100 Fellows, Trainees, IMG's and Associates from Western Australia, South Australia and the Northern Territory gathered in Perth for the Tristate Annual Scientific Meeting. The conference was split into four sessions which were all centred on the theme *When Disaster Strikes*.

The event provided an excellent opportunity to listen to the perspectives of colleagues from interstate, and share experiences of working in different hospital environments. While each jurisdiction has their own unique characteristics, it was clear from the presentations that there are also many similarities.

Image (above): Mr Weber and Professor Kluger

As an example, Western Australia, South Australia and the Northern Territory are Australia's three most sparsely populated regions. Outside of the major urban centres, hospitals and retrieval assets are scarce, which provides a significant challenge for authorities and health professionals when things go wrong.

In the opening sessions presenters from each of the jurisdictions provided an insight into the challenges involved in responding to a disaster situation under these conditions, what strategies they have in place to mitigate the inherent risks, and what advice they can offer to their peers based on previous experiences. This also included perspectives from the Australian military provided by Dr Anton Chambers, Australian Army Reserves Medical Officer (Captain) and WA Orthopaedic Registrar.

This was accompanied by an overview of the important role that RACS plays in disaster management at a binational level, with the morning session featuring Professor Yoram Kluger, international key note speaker from Israel, who delivered a presentation on what it takes to make an operating system ready for mass casualties.

Professor Kluger shared his experience as the founder and director of the Rabin Trauma Center at Tel Aviv Medical Center. He was the first in Israel to establish a dedicated hospitalisation centre for patients with multiple injuries and is recognised worldwide for his research on medical preparedness and medical infrastructure management in mass casualty situations.

Sessions two and three of the program focussed on 'Data Defining Surgeons' and 'Logistic s- Skills, Team Management and Others.' Both these sessions featured many high quality presenters, including Professor Alexander (Sandy) Herriot, Melbourne colorectal surgeon and Director of Cancer at the Peter MacCallum Cancer Centre, who delivered the Henry Windsor Lecture. Professor Herriot's presentation focussed on his experience in establishing a colorectal database and his role as Chairman of the Binational Colorectal Cancer Audit.

The day's program concluded with a session concentrating on 'Surgeons and Disasters' with three highly engaging presentations from Mr Michael Levitt on 'How I deal with it', a perspective from psychiatrist Dr Simon Byrne on 'How I *should* deal with it' and 'RACS Support and Systems' by Dr Stephanie Chetrit.

The session was a good reminder to us all that we are not robots. Unfortunately surgical complications are a reality of the profession that we all must face from time to time. Dealing with these situations can be very difficult and emotionally draining. Perhaps a reflection of how relevant the final session was to all, was that despite the meeting concluding at 5.15pm on a Friday afternoon, many of the attendees remained behind to continue an impromptu out of session panel discussion on the topic.

That night the annual meeting dinner was held at the Old Brewery, where retired Fellow, Professor John Hall, delivered the Hanrahan Oration. His presentation on 'Alexander Collie' had clearly been very well researched, and he provided the audience with a fascinating historical account of one of Australia's most famous colonial surgeons.

All in all the day was an enormous success and I would like to thank the organising committee, the presenters, the staff and everyone who attended for their contribution.

Preparation is already under way for the 2018 Tristate ASM which will be held in Alice Springs with combined sessions from Rural and Indigenous Health. We look forward to seeing you there!

Image (below): Professor Kluger presenting

Great leaders reach out for support

MR DAVID LOVE
Chair, Victorian Regional Committee

As this year presses on, RACS continues with its program of eradicating bullying behaviour. There are now several courses to improve our interaction with the resident and registrar cohort. It is important that all surgeons partake in these courses and register for these educational opportunities as soon as possible. The aims of these courses are high. We are trying to make sure the next generation of surgeons are as highly trained as they can be as well as ensuring their safe and healthy passage through the training programs. Doctors already incur a great many physical and mental health issues which are not going to improve if we do not fix the health of our trainees. As such I encourage all those who have not registered to do so.

With the myriad of changes happening across the profession and at national and state levels it is now more important than ever that surgeons, across all specialties, step-up to the leadership roles they need to assume. In speaking of leadership roles I'm not referring to heads of department or directors, I'm speaking to all surgeons at all stages of their careers. We are, like it or not, leaders in the health profession regardless of whether we are in formal management positions. Every surgeon can, and should, be an effective leader.

The main motivation for leadership in healthcare is the protection of our patients and therefore good leadership is a key theme in not only improving our workplaces but in improving patient safety.

It is well recognised that continual exposure to bullying can cause psychological and physical harms in people and also adversely affects patient outcomes. As a profession we have made a commitment to improving workplace culture and strong communication and collaboration with healthcare teams, colleagues, RACS and others is vital to achieving this.

Good leadership is no easy task but in healthcare it is vital. It is incumbent on all of us to ensure we live up to this challenge.

Following on from that, I would also encourage all surgeons to look at their own work life balance. It is the time of the year when we tend to hit our stride as far as work is concerned. It may have been some months since you last took a break or holiday. Work can become overwhelming and sometimes we forget to stop and look around. It is important for our own health and wellbeing to do this.

Finally, as we head toward the end of the year there are many things to look forward to. Recent Trainees have completed their exams and are looking forward to starting work as consultant surgeons in 2018. This is always a daunting time. For the first time we are left to make our own decisions about the treatment of patients without the backup of a "boss". For most, this is simply a logical extension of the training we have had. There are always cases that are tricky and will not follow the usual pattern. As such, remember that there are always colleagues to help us though these times. It may be a simple conversation or even asking a senior colleague to help with a tough case. I certainly know that getting help from colleagues with tough cases is not a failure but a chance to improve our own skills. It makes the operation a lot less stressful, lessens the intra-operative decision making burden and improves the outcome for the patient. Good leaders recognise not just their own strengths but also the areas where they need support. Great leaders reach out and ask for that support when needed. So remember that surgery is a team game and if you think you need help, ask for it. Most surgeons are actually honoured to be asked for your help.

By increasing our collegial interaction, either through regular meetings, or operating together we will increase our ability to operate with respect and improve the healthcare of all of our patients, our families and ourselves.

Congratulations Mr Peter Byrne

On 18 August Mr Peter Byrne, was presented with an Outstanding Service to the Community Award in a surprise ceremony by RACS, in recognition of his long and distinguished career. Mr Byrne, who now resides in Wirrabara in country South Australia, was lured to the RACS Adelaide Office by his partner Robyn, on the pretext that he was to attend an art exhibition.

Instead Mr Byrne was stunned to find family, former colleagues, and old army mates (many of whom had travelled from interstate and overseas), all gathered to celebrate his service to the community.

"I felt totally overwhelmed by the whole thing. It was completely unexpected and I am very humbled in regards to it. It is incredibly generous of the College to give me this award" Mr Byrne said.

The award was presented by Dr Phil Worley, Deputy Chair of the RACS South Australian Regional Committee.

"The Outstanding Service to the Community Award recognises a surgeon with a dedicated history of distinguished service to surgery in their local community, without whom the standard of surgical care in that community would have been less than society expects" Dr Worley said.

Upon gaining his RACS Fellowship in 1975, Mr Byrne quickly developed a reputation as a gifted and dedicated surgeon. Over his long career Mr Byrne helped to improve the lives of thousands of patients, and was highly regarded as a fine surgical teacher who provided guidance to many generations of young Trainees.

However, it has not only been his surgical abilities that endeared Mr Byrne to the community that he served. He became involved in the military from a young age, and provided almost half a century's worth of dedicated service.

His military career included serving as a Major in Vietnam, and also as a United Nations Military Surgeon is East Timor. Among his many accolades, he was appointed as a Member of the Order of Australia (Military Division) in 1992, and between 1990 and 1993 he served as an Honorary Surgeon to the Governor General. His remarkable military career culminated in being promoted to full colonel.

Further examples of his contributions are found in his active involvement as a member of the RSL, as well as his service to 'Exercise Trojan's Trek', an organisation which provides psychological rehabilitation and support to ex-service personnel.

Mr Byrne has also had a long involvement in sports medicine, particularly as a medical officer for teams in the South Australian National Football League for nearly 20 years. He has previously been Medical Officer for the South Australian Cricket Association which involved care of the Australian Cricket Team at the Adelaide Oval. His interest in local rural sport continues with his support of his local football team.

Dr Worley, himself a former colleague of Mr Byrne, concluded the formal presentation by saying that it was an honour to be able to present the award to such a deserving recipient.

"I count myself fortunate to have known Colonel Peter Dudley Byrne and to have had a surgical career that has overlapped with his. He is a fine embodiment of that oft overused term, 'legend.' As a role model, it would be hard to find better.

"His selfless dedication, loyalty, integrity and service to both his profession and his community, all delivered with an infectious, positive attitude and sense of humour, more than stamp him as a worthy recipient of this award."

– Mark Morgan,
Policy and Communications Officer, SA/WA/NT

Images (from top): Dr Phil Worley and Mr Byrne with the award; Mr Byrne was joined by his family at the event.

To err is surgeon

DR SHRIKKANTH RANGARAJAN
RACSTA

"David is a surgical Trainee. He does not get tired. He does not make mistakes. David is a robot. He is programmed to do his job without error. He is able to process complex algorithms with ease and calculate the outcome for each combination and permutation available in a given scenario, all within seconds. David will pursue the course of action that will result in zero harm, or the least possible harm, to the patient. David will not suffer from stress, fatigue, lack of knowledge, or lack of experience. He will be neither timid nor too proud to call for help. His decisions will be sound, his communication clear, his actions predictable. At the operating table, his movements will be precise and efficient, he will not get frustrated or anxious when things are not as they should be. David is not human. David is a robot."

Human factors are the social and personal skills, such as communication and decision making, which complement our technical skills. They influence how we perform in our jobs, and are especially relevant in high stakes industries, where the result of errors could be loss of human life. The airline industry is one example. The medical industry, especially the surgical division, is another. As surgical Trainees, and future leaders in health care, we need to understand these human factors, how they influence patient outcomes, and how we can change our practice and the systems we work in, to minimise risk to patients.

I recently had the opportunity to attend a four-day seminar hosted in Sydney by the Academy for Emerging Leaders in Patient Safety (AELPS). This was a replication of the long standing program held in Telluride, Colorado, and focussed on understanding human factors, how they apply in the health industry and, how we can improve health systems to combat error, and importantly, how to engage relevant stakeholders on this front. Out of 30 attendees from all walks of healthcare around Australia, I was the only one from the surgical industry, which was unfortunate because a large focus of the seminar was surgical error and the various factors involved. I strongly encourage surgical Trainees, or indeed any member within the surgical fraternity, to attend the seminar. It is well worth it, directly relevant, and fully funded scholarships are available.

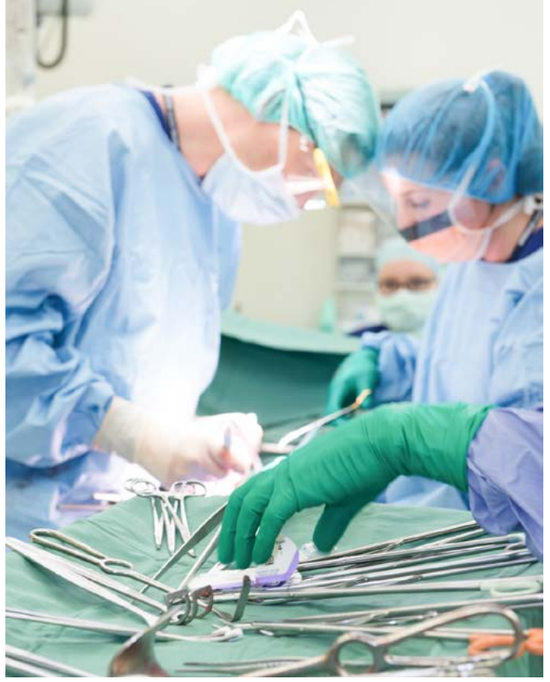
What is often misunderstood in the patient safety discussion is that there is more than one victim in any given scenario. The obvious one is the patient, or their family members, who have suffered loss due to an error made by the treating team. The other is often a member, or members, of the treating team involved. As a surgical Trainee, I have made various errors along the way, none without concrete lessons learnt. I trust I am not alone. I ask you to remember a time when you made an error that resulted in an adverse patient outcome, no matter how big or small. If you can't think of one, either your memory is failing or your time in surgery has been short. Or maybe you too are a robot, like David. In any case, think about how you felt, and how you were made to feel. What were the human factors that led to the error, and how might the system be changed to prevent the same error from recurring?

The airline industry has a long history of studying human factors, and engineering their systems to minimise exposure to risk from the same. A great example was the US Airways Flight 1549 landing in the Hudson River after a bird-strike resulted in dual engine failure. This was chronicled quite accurately (and very entertainingly) in the recent movie titled *Scully* (Tom Hanks) which I would plug as a good introduction to the study of human factors.

I have been lucky enough to have fantastic mentors over the years whom I have been able to rely on to get me through the lows of being on the wrong side of a clinical error (there is no right side obviously). That is not always the case, and the blame culture that is still very much rife in surgery often leads to belittling some individuals, and covering up mistakes to protect others. None need reminding of the deleterious mental and physical effects these actions can have, especially on junior staff, and numerous cases purporting devastating outcomes have made their way into the media in recent months and years.

When mistakes are made we should focus on the opportunity presented to engineer systems and minimise risk exposure, rather than engage in censure and suppression.

We are not robots. Indeed, to err is surgeon.



RACS Trainees' Association

INDUCTION CONFERENCE 2017

This conference has been specifically designed to meet the needs of newly selected SET Trainees. You will be oriented by RACS staff and senior Trainees, and receive insights from RACS leaders, with plenty of time to meet and socialise with your new colleagues. New Trainees will leave this conference equipped with the knowledge and confidence to succeed in surgical training.

Please join us in Melbourne on 11 November for the 2017 Induction Conference for new Trainees.

Date, Time and Venue Time
11 November 2017
Conference registration from 9.30am
Royal Australasian College of Surgeons
250-290 Spring Street, East Melbourne, VIC, 3002

Social Function
The conference will conclude with a tour of the RACS Building and an evening function

Further Information
Contact the RACSTA Executive Officer
racsta@surgeons.org or +61 3 9276 7490

Selfie app BiliScreen could help users detect early signs of pancreatic cancer

They say the eyes are the window to the soul, but perhaps they are also the gateway to the body. Researchers in Washington have recently devised a way to detect pancreatic cancer by 'snapping a selfie' using a 3D light box and smartphone app. The new yet simple technology detects raised levels of bilirubin in the white part of the eye before it's visible to humans, which could drastically improve survival rates for pancreatic cancer, which are currently less than 10 per cent, due to late detection. Pancreatic cancer is often diagnosed too late. A study of 70 people found the app and a 3D light box was able to correctly identify cases of concern nearly 90 per cent of the time when compared with blood tests. Researchers hope it would make testing for the disease much more accessible for the public.

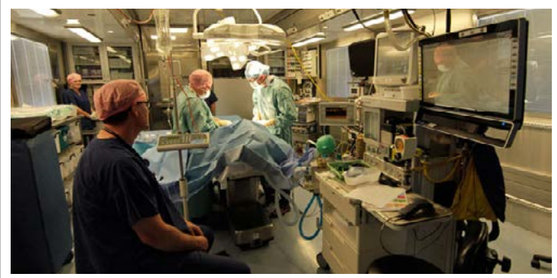
http://www.news.com.au/technology/science/human-body/selfie-app-biliscreen-could-help-users-detect-early-signs-of-pancreatic-cancer/news-story/c6c22405a9ed3f6ac934308dac554213

Image: University of Washington

Mobile surgical unit treats its 1000th patient

A mobile clinic established in Taumarunui, New Zealand in April 2002 has just provided its 1000th procedure, confirming that the service is of great value to the rural community. The service has come about as a result of many rural New Zealand towns losing surgery facilities for their residents. The country's only surgical bus has since treated hundreds of people providing access to surgical procedures not otherwise available in their towns. It visits 23 rural towns during a five-week cycle, stopping in each place for a day. Previously people of the area had to travel to Waikato Hospital in Hamilton, 160 kilometres away. The surgical bus, fondly named 'Edith' provides endoscopies, colonoscopies, ophthalmology, gynaecology, general surgery, and dental services.

http://www.stuff.co.nz/national/health/96012891/mobile-surgical-unit-treats-its-1000th-taumarunui-patient



THE ALFRED

GENERAL SURGERY MEETING 2017

Practical Updates for General Surgeons

3 – 4 November 2017 / Sofitel Melbourne On Collins

REGISTRATIONS NOW OPEN

theAlfred

http://tinyurl.com/alfred17

ATCSA 2017
MELBOURNE

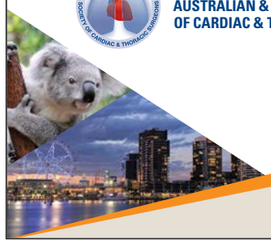
SAVE THE DATE

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

16 - 19 NOVEMBER 2017

MELBOURNE CONVENTION AND EXHIBITION CENTRE, AUSTRALIA

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



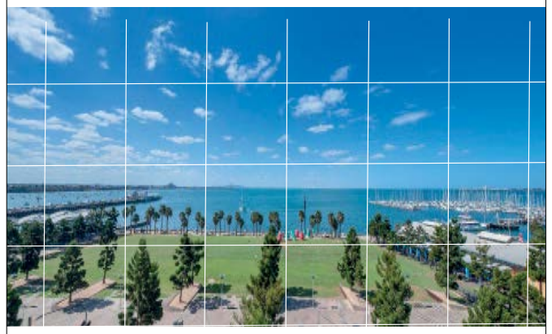
E: atcsa2017@surgeons.org
T: +61 3 9276 7406

www.atcsa2017.com

59th Victorian Annual Surgical Meeting

"Safety in Surgery"
Novotel Geelong

21, 22 October 2017



REGISTER ONLINE:
www.tinyurl.com/ VicASM17

PROVISIONALPROGRAM:
www.tinyurl.com/VicASM17Program

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Contact RACS Victorian Regional Office
T: +61 3 9249 1254 | E: college.vic@surgeons.org

#VicASM17
www.surgeons.org/222042.aspx

CR17

6TH COMBINED AUSTRALIA AND NEW ZEALAND COLORECTAL SURGICAL MEETING 2017

(SPRING CME AND SYDNEY COLORECTAL SURGICAL MEETING)

FRIDAY 17 – SATURDAY 18 NOVEMBER
SHANGRI-LA HOTEL
SYDNEY

Register online:
www.cssanz.org/events/cme-2017

Registration Enquiries:
E: Colorectal.SM@surgeons.org
T: +61 3 9249 1139

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS RACS CSSANZ

RACS ACT ANNUAL SCIENTIFIC MEETING

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Systems of Care: Collaboration and Innovation
4 November 2017
ANU Medical School, The Canberra Hospital, ACT

Convener: Dr Rebecca Read, FRACS

Invited Speakers:
Mr James Kong FRCS, FRACS, FHKAM, FCSHK - The University of Hong Kong

Mr John Batten
FRACS - RACS President

Mr Grant Christey
FRACS - Director of Trauma
Waikato District Health Board, NZ

Professor Imogen Mitchell
PhD, FRCP, FRACP, FCICM - Dean,
ANU Medical School

Register online www.tinyurl.com/ACTASM17

RACS ACT Regional Office
T: +61 2 6285 4023 • E: college.act@surgeons.org

#CanberraASM17

ACADEMY OF SURGICAL EDUCATORS
Royal Australasian College of Surgeons

Academy Forum
Building Leadership, Improving Patient Safety

Thursday 2 November 2017
Amora Hotel Jamison Sydney

Guest Speakers & Topics

'Leadership in Healthcare Teams'
Prof Larry Marlow
(Adjunct Professor, UTS Centre for Research in Learning & Change)

'Involving Surgeons in Systems Improvement - Educate the Young and Regulate the Old?'
Dr Sarah Dalton
(Clinical Lead, Agency for Clinical Innovation)

To register or for more info,
contact ase@surgeons.org or 03 9249 1111

$120 (members of the Academy)
$155 (non-members of the Academy)
(Fee includes 3-course dinner, beverages and presentations)

This evening is in conjunction with the RACS NSW's Surgeons Month

Proudly sponsored by COVIDIEN

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

2017 South Australian Dinner & Anstey Giles Lecture

Friday 20 October, 2017

Botanic Gardens Restaurant
Plane Tree Drive, Adelaide

Pre-Dinner Drinks to commence at 6.30pm for 7.00pm

Anstey Giles Lecture
Guest speaker: Katie Sarah
Title: "Aiming high: A Journey to Everest"

The 2017 South Australian Sir Henry Newland recipient Associate Professor Mohan Rao will be awarded during the dinner.
Cost: $140.00 per person
Dress: Lounge Suit
RSVP: 16 October, 2017

In 2007 Katie came to within 400m of the summit of Mount Everest on her first ever high-altitude climb. A successful summit was prevented partly by a badly healed broken ankle.

After gaining more climbing experience, she returned to Mt Everest in 2010. This was a successful bid, becoming the first South Australian (and sixth Australian) woman to summit Everest.

Online registration now available via this link
https://surgeons.eventsair.com/saad17/onlinebooking

Royal Australasian College of Surgeons
PO Box 44, North Adelaide SA 5006
Telephone: 08 8239 1000 **Email:** college.sa@surgeons.org
Website: www.surgeons.org

REGIONAL MEETINGS UPDATE

59th Victorian Annual Surgical Meeting

Dates: 20 - 21 October 2017
Venue: Novotel, Geelong

Safety in Surgery

Find out more:
T: +61 3 9249 1188 • E: college.vic@surgeons.org
W: www.surgeons.org/about/regions/victoria

ACT Annual Scientific Meeting

Date: 4 November 2017
Venue: Australian National University, Medical School, Canberra

Systems of care: collaboration and innovation

Submit an abstract online www.tinyurl.com/actabs17

Find out more:
T: +61 2 6285 4023 • E: college.act@surgeons.org
W: www.surgeons.org/about/regions/australian-capital-territory

Workshops 2017

Online registration form is available now (login required)

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

Mandatory courses

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

By the end of 2017

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

By the end of 2018

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

Foundation Skills for Surgical Educators Course

5 November	Melbourne	VIC
19 November	Sydney	NSW
20 November	Sydney	NSW
25 November	Orange	NSW
1 December	Melbourne	VIC
2 December	Melbourne	VIC
3 December	Sydney	NSW
4 December	Sydney	NSW
9 December	Sydney	NSW
11 December	Sydney	NSW
12 December	Sydney	NSW
14 December	Brisbane	QLD
16 December	Sydney	NSW

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.

Academy of Surgical Educators Forum

2 November	Sydney	NSW

The Academy Forum evening features a preeminent thought leaders discussing progressive topics in medical education, accompanied by a 3-course meal. Attendees discuss questions at their tables and engage in a Q&A session with the panel of experts. The upcoming Academy Forum 'Building Leadership, Improving Patient Safety' will be in Sydney on 2 November 2017, featuring Prof Larry Marlow and Dr Sarah Dalton. For more information and to register, visit http://www.surgeons.org/for-health-professionals/academy-of-surgical-educators/courses-and-events/

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

Breaking Bad News

11 November	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. This educational program is proudly supported by Cancer Council Victoria.

Non-Technical Skills for Surgeons (NOTSS)

24 November	Sydney	NSW

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

Surgeons as Leaders in Everyday Practice

24 - 25 November	Melbourne	VIC

The 'Surgeons as Leaders in Everyday Practice' course is the first leadership course designed to meet the needs of the practising surgeon. Using an evidence-based model, the materials and principles in the course are applicable to Fellows, International Medical Graduates and Trainees. The aim of this course is to enhance the leadership skills within the context of surgeons. The vision is to offer a suite of educational resources related to leadership and surgeons. Using everyday examples, the course explores the role a surgeon has as a leader. Guided discussions promote insight where surgeons can enhance their leadership.

This course complements work being undertaken by the College in the Building Respect, Improving Patient Safety (BRIPS) Action Plan by empowering surgeons with skills to understand culture and influence change in their workplaces and the profession.

The course is based around four modules:

- Understanding leadership
- Understanding yourself
- Communication
- Leading teams

Clinical Decision Making

1 December	Brisbane	QLD

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.

Younger Fellows Forum (YFF) - 2018

4 – 6 May 2018	NSW

The Younger Fellows Forum is held annually prior to the Annual Scientific Congress (ASC) of the Royal Australasian College of Surgeons. The Forum is a professional retreat of RACS Younger Fellows (a Younger Fellow is a surgeon who has obtained their fellowship within the last 10 years). In addition, there are three international Younger Fellows; one each from the College of Surgeons of Hong Kong and Thailand, as well as a representative from the US Association of Academic Surgery (AAS). The forum offers a unique opportunity for a group of Fellows to share ideas and experiences and debate issues that affect their professional and personal lives.

Applications for 2018 are now open via an online nomination form until 30 November 2017. Nominations will be reviewed by the convenors of the forum, and the successful applicants will be informed and confirmed by December 2017. Please note the forum is limited to 20 places.

For more information phone +61 3 9249 1106, email PDactivities@surgeons.org or visit our website https://www.surgeons.org/181074.aspx.

PROFESSIONAL DEVELOPMENT WORKSHOP DATES

November – December 2017

NSW		
Academy Forum	2/11/2017	Sydney
Process Communication Model	17/11/2017	Sydney
Foundation Skills for Surgical Educators	19/11/2017	Sydney
Foundation Skills for Surgical Educators	20/11/2017	Sydney
Non-Technical Skills for Surgeons	24/11/2017	Sydney
Foundation Skills for Surgical Educators	25/11/2017	Orange
Foundation Skills for Surgical Educators	3/12/2017	Sydney
Foundation Skills for Surgical Educators	4/12/2017	Sydney
Foundation Skills for Surgical Educators	9/12/2017	Sydney
Foundation Skills for Surgical Educators	11/12/2017	Sydney
Foundation Skills for Surgical Educators	12/12/2017	Sydney
Foundation Skills for Surgical Educators	16/12/2017	Sydney
NZ		
Process Communication Model: Seminar 1	20-22/10/2017	Auckland
QLD		
Foundation Skills for Surgical Educators	14/12/17	Brisbane
VIC		
Foundation Skills for Surgical Educators	5/11/2017	Melbourne
Comm Skills for Cancer Clinicians	11/11/2017	Melbourne
Surgeons as Leaders in Everyday Practice	24-25/ 11/2017	Melbourne
Foundation Skills for Surgical Educators	1/12/2017	Melbourne
Foundation Skills for Surgical Educators	2/12/2017	Melbourne
WA		
Surgical Teachers Course	19-21/10/2017	Mandurah

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

New Senior Instructors

JONATHAN SERPELL
Chair of Prevocational and Skills Education Committee

The Prevocational and Skills Education Committee congratulate the following RACS Skills Course Faculty on becoming Senior Instructors in 2017. In particular, acknowledging the multidisciplinary practitioners who teach on RACS skills courses.

To become a RACS Senior Instructor faculty teach on over 10 courses over a period of four or more years.

ASSET: Australian and New Zealand Surgical Skills Education and Training Course

Dr Bernard Cheung FRACS, General Surgery
Mr John Dunn FRACS, General Surgery
Mr John Fisher FRACS, General Surgery
Mr Charles Flanc FRACS, Vascular Surgery
Mr Walter Flapper FRACS, Plastic & Reconstructive Surgery
Dr Susan Gan FRACS, General Surgery
Mr Paul Goodman FRACS, General Surgery
Mr Dennis Gyomber FRACS, Urology
Mr Tamer Kahil FRACS, Orthopaedic Surgery
Mr Chitrakanti Kapadia FRACS, General Surgery
Mr Andrew Kennedy-Smith FRACS, Urology
Mr Richard Maxwell FRACS, Plastic & Reconstructive Surgery
Mr Niyaz Naqash FRACS, General Surgery
Mr Phillip Nathaniel FRACS, General Surgery
Dr John North FRACS, Orthopaedic Surgery
Dr Daniel Novakovic FRACS, Otolaryngology Head & Neck
Dr Carissa Phillips FRACS, General Surgery
Mr Peter Pohlner FRACS, Cardiothoracic Surgery
Mr Robert Pucius FRACS, General Surgery
Dr Yasantha Rajapakse FRACS, Plastic & Reconstructive Surgery
Miss Amanda Robertson FRACS, General Surgery
Dr Arnold Seglenieks FRACS, General Surgery
Assoc Prof David Storey FRACS, General Surgery
Mr Siew-Piau Tan FRACS, Orthopaedic Surgery

CCrISP®: Care of the Critically Ill Surgical Patient Course

Dr Janine Arnold, FRACS General Surgery
Dr Waleed Aty, FRACS Cardiothoracic Surgery
Mr Kelepi Cama, FRACS Paediatric Surgery
Mr Michael Chin, FRACS Orthopaedic Surgery
Dr Christopher Flynn Anaesthesia
Mr Mark Hamilton, FRACS Vascular Surgery
Mr Paul Hollington, FRACS General Surgery
Mr Chitrakanti Kapadia, FRACS General Surgery
Dr Nicos Kokotsis Emergency Medicine
Dr Miranda Lam Physician
Dr David Mackrill, FRACS General Surgery
Dr Sze-Lin Peng, FRACS General Surgery
Dr Sudarsanam Raman, General Surgery
Dr James Smyth, Emergency Medicine
Dr Desmond Soares FRACS, Orthopaedic Surgery
Dr Shyamala Sriram, Intensive Care
Dr Anthony Stevenson, General Practice
Dr Jeannette Ting FRACS, Plastic & Reconstructive Surgery
Dr Ravi Tiwary, Anaesthesia
Mr Sathyajith Koottayi, Intensive Care
Dr Jenny Wagener FRACS, General Surgery
Dr Aileen Yen FRACS, General Surgery

EMST: Early Management of Severe Trauma Course

Dr Kyle Bender, General Surgery
Dr Melinda Berry, Emergency Medicine
Dr Timothy Crozier, Intensive Care
Dr Kamala Das FRACS, General Surgery
Dr Rohit D'Costa, Intensive Care
Dr Michael Dinh, Emergency Medicine
Dr Kieron Gorman, Intensive Care
Dr Megan Gray, Anaesthesia
Mr Simon Harper FRACS, General Surgery
Dr Babak Hedayati, Anaesthesia
Dr Razaq Ibuowo, Emergency Medicine
Dr Anita Jacombs, General Surgery
Dr David Levy, Emergency Medicine
Dr Alistair Murray, Emergency Medicine
Dr Charles Pilgrim FRACS, General Surgery
Dr Sivagnanavel Senthuran, Intensive Care
Mr Braad Sowman FRACS, Orthopaedic Surgery
Dr Matthew Spotswood, Emergency Medicine
Dr John Sutherland, Emergency Medicine
Dr Sarah Whitelaw, Emergency Medicine
Dr Ian Wilson, General Practice

TIPS: Training in Professional Skills Course

Prof Deborah Bailey FRACS, Paediatric Surgery
Dr Paul Bowe, Emergency Medicine
Dr Erica Jacobson FRACS, Neurosurgery
Dr David Sainsbury, Anaesthesia

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*

November - December 2017

CCrISP	
Wednesday, 1 November – Friday, 3 November	Dunedin
Friday, 10 November – Sunday, 12 November	Adelaide
Friday, 8 December – Sunday, 10 December	Melbourne
CLEAR	
Friday, 24 November – Saturday, 25 November	Auckland
EMST	
Friday, 3 November – Sunday, 5 November	Wellington
Friday, 3 November – Sunday, 5 November	Wagga Wagga
Friday, 3 November – Sunday, 5 November	Brisbane
Friday, 17 November – Sunday, 19 November	Dunedin
Friday, 17 November – Sunday, 19 November	Brisbane
Friday, 24 November – Sunday, 26 November	Wellington
Friday, 1 December – Sunday 3 December	Sydney
Friday, 1 December – Sunday 3 December	Melbourne
TIPS	
Friday, 17 November – Saturday, 18 November	Auckland

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Annual Joint Academic Meetings

Adelaide Health and Medical Sciences Building,
North Terrace, South Australia

Thursday 9 - Friday 10 November 2017

DAY ONE- SECTION OF ACADEMIC SURGERY MEETING

The Mid-career course will be held in the morning covering thought provoking topics on progressing an academic career, followed by two concurrent work shops on “Being a surgeon scientist” and “Breaking barriers to academic surgery” in the afternoon.

The day will conclude a stimulating debate: *Academic surgeons are multitaskers* vs *Academic surgeons need focus*.

Thursday evening - Section of Academic Surgery dinner at Jolleys Boathouse Restaurant. An opportunity to network with colleagues and create new connections.

DAY TWO - SURGICAL RESEARCH SOCIETY MEETING

Presentations:

High quality researchers will present on a wide range of topics

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

Both days are open to: Medical students, pre-vocational doctors, SET Trainees, Fellows and anyone with an interest in academic surgery

Online registration is NOW OPEN
ABSTRACT SUBMISSION CLOSES FRIDAY 29 SEPTEMBER
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Royal Australasian College of Surgeons | Section of ACADEMIC SURGERY | SURGICAL RESEARCH Society

2017 Fellowship Survey – Have Your Say

RUTH BOLLARD
Chair, Fellowship Services Committee

The 2017 Fellowship Survey launches this month. This is your chance to have your say and influence the future planning of RACS.

All active and retired Fellows will receive an email invitation to participate in the ten minute online survey. The 2017 Fellowship Survey is a fantastic opportunity to help shape the future direction of RACS by identifying areas for improvement, strengths and the potential path Fellows wish their College to take in the coming years.

RACS would like to hear from all Fellows about satisfaction and feedback on:

- surgical standards and education
- advocacy issues
- preferred communication modes
- service delivery and your customer service experience
- CPD Program
- professional development opportunities including the ASC
- online services
- strengths and improvements, and
- the challenges facing the surgical profession over the next five years.

I encourage all Fellows to take the time to complete the survey in October, so that we can ensure RACS meets the needs of the Fellowship and that our strategic priorities are shaped by Fellows.

RACS
LET'S OPERATE WITH RESPECT

Operating With Respect

eLearning Module completion at 60%

A majority of RACS Fellows has now completed the *Operating With Respect* eLearning module, and feedback continues to demonstrate that it is beneficial.

Those who haven't yet completed the training have until December 31, 2017.

As of early September, 2017, 60% of Fellows had completed the module. Region by region, the strongest showing is from the Northern Territory at 86% completion. NSW, by comparison, stood at 56%, although population is obviously a factor.

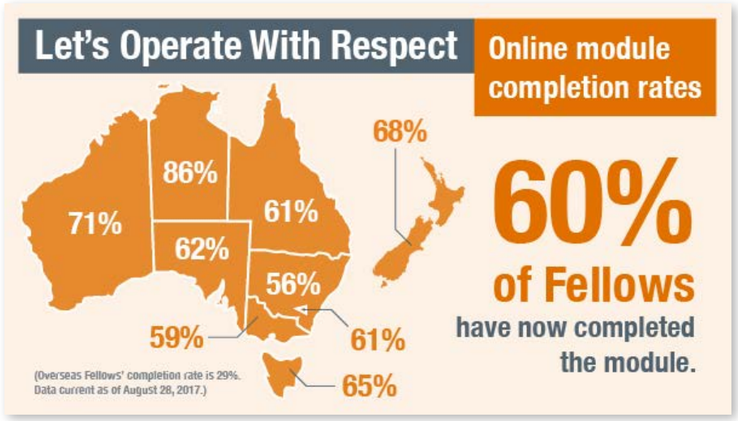
Operating With Respect demonstrates what unacceptable behaviour in the workplace looks like and provides practical strategies to help address it.

It is a key part of the *Let's Operate With Respect* campaign, through which RACS is fostering respect and improving patient safety across the surgical profession.

The module takes only 45 minutes to complete, and can be accessed via the RACS portfolio.

It is mandatory for all Fellows, Trainees and IMGs and is a CPD requirement for 2017.

Participant feedback has demonstrated that a vast majority of those who have completed the eLearning module have found it to be useful, engaging and relevant.



An anonymous survey of 286 surgeons, completed immediately after they had completed the module, saw strong themes emerge:

- Respondents repeatedly agreed that the module was easy to locate and access, and that the online delivery method was an effective way to learn about its subject matter;
- 96% of respondents said there was a good balance between the module's various components, including written material, video clips, reflective prompts, review questions and links to further resources.

When asked about the usability of the module, feedback was also predominately positive. Comments include "very realistic", "This is a great tool for us to learn about *Operating With Respect*" and "Excellent resource. I hope it has the intended impact."

Some specific comments:

- "This was an excellent module. One of the best I have ever seen. And has taught an important subject very well."
- "I actually appreciated a refresher course in this area. All too often we become focused on the technical aspects and forget our behaviour, and its influence on others."
- "Ironically, I was being bullied while doing module between cases. The consultant viewed what I was doing and promptly stopped the behaviour – thanks."

There was some criticism of the module, and that primarily came from those seeking more searching and open-ended questions to better address the complex issues at play.

The good news is that this audience is catered for. The *Operating With Respect* face-to-face course builds on the online module and provides advanced training in recognising, managing and preventing discrimination, bullying and sexual harassment. That course enables participants to develop skills in respectful behaviour and practice strategies in responding to unacceptable behaviour.

With just over three months left in the year, there's still time to complete the *Operating With Respect* eModule. Act now to complete your CPD requirements, and to engage with RACS' campaign to build respect and improve patient safety in our profession.

Visit www.surgeons.org/about-respect to complete the eModule today.

"TOUGH LOVE TEACHING JUST DOESN'T HAVE A PLACE IN OUR INDUSTRY ANYMORE."

Dr Rick Jiang, Vascular Fellow, Monash Health

COMPLETE YOUR MANDATORY TRAINING

OPERATING WITH RESPECT (E-LEARNING)

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

Mandatory for all Fellows.

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RACS
LET'S OPERATE WITH RESPECT

Find out more: www.surgeons.org/respect

Congratulations!

MS JUSTINE PETERSON
Honorary Fellowship

Born in Levin, Justine attended school there and in Auckland. She completed a BA in Anthropology at Otago University and then an MA in Sociology - Applied: Social Work at Canterbury University. Justine entered the workforce in 1978 as a Psychiatric Social Worker at Cherry Farm, north of Dunedin. Three years later, she moved to Wellington securing a position as social worker for a community mental health service. Acquiring management skills by completing a Diploma in Health Services Management through Massey University, Justine was appointed to a supervisory role in the Social Work and Community Mental Heath services of the Wellington Area Health Board in 1984 and later into management roles in the Mental Health Service.

In 1994, Justine applied for and was appointed manager of the College's New Zealand office. The appointments committee at that time obviously appreciated that her grounding in management, social work and psychiatric services ensured a sound basis to work with surgeons and oversee their interests. In this role, Justine has worked tirelessly in the support of surgeons and the College in the provision of surgical care in New Zealand. Over more than two decades she has been instrumental in the maintenance of very good and mutually valued working relationships between the College and the bodies representing the nine surgical specialties. Of equal importance, she has been central in the development of excellent links between the College and many of the key health institutions in New Zealand including the Ministry of Health, the Health and Disability Commission, the Medical Council of New Zealand, and the Health, Quality and Safety Commission.

Justine has acquired an extensive breadth and wealth of knowledge of both RACS and health affairs in New Zealand, the Pacific Islands and Australia and this has been of great value for individual Fellows and the College. She has been extremely supportive of New Zealand National Board chairs, successive EDSAs, New Zealand Councillors, Fellows, Trainees and IMGs as well as the staff in the New Zealand office. Always calm, friendly and positive, a keen follower of sport and with a love of a good coffee in the morning, Justine readily establishes good relationships with all. She has maintained a positive, productive work environment within the office, despite more difficult circumstances recently when relocation of the NZ Office premises on two occasions corresponded with a periods of staff shortages.

In her role as Manager of the New Zealand office since 1994, Justine has fulfilled her responsibilities to RACS with distinction and is the focal point in New Zealand for the provision of College services to Fellows, Trainees and many others. Through her commitment to the College in all its spheres of activity, and frequently placing the demands of her work ahead of personal desires, Justine has earned the unrivalled respect and support of her staff, Board members and the New Zealand Fellowship.

Justine Peterson is an outstanding servant of the College and has contributed significantly to the development of surgical services in New Zealand - she is a most worthy recipient of Fellowship of the Royal Australasian College of Surgeons.

Citation kindly provided by Mr Richard Lander FRACS.
Image: Ms Justine Peterson with Past President Mr Phil Truskett AM.

Academic Gown Donation

The College would like to acknowledge Mrs Janice Rayner, wife of the late Mr George Rayner, for generously donating his academic gown.

The College maintains a small reserve of academic gowns for use by convocating Fellows and at graduation ceremonies. If you have an academic gown taking up space in your wardrobe and it is superfluous to your requirements, the College would be pleased to receive it to add to our reserve. We will acknowledge your donation and place your name on the gown if you approve.

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

Case Note Review

Remote area trauma

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

A middle-aged person was found unconscious following a fall down a flight of stairs and an ambulance was immediately called. The first-recorded observation by the ambulance crew was shortly after 11pm. The patient's Glasgow Coma Scale (GCS) was three with a dilated but reactive left pupil and a dilated but reactive right pupil. Initial oxygen saturations were 86%. The next observation was three minutes later. Oxygen saturation was then 97%. The right pupil had been normal and reactive. The left pupil remained dilated but still reactive. The ambulance report documented an abrasion to the forehead and a laceration to the occipital region, indicative of two blows to the head. During the next 15 minutes GCS improved to six, though subsequent recordings showed a GCS of three once more.

The patient was taken to the local rural hospital and admitted shortly after midnight. The last observation recorded by ambulance personnel was shortly before this time, with a GCS of three and with a dilated but reactive left pupil. The admission notes reported that in the early hours of the morning, the patient was intermittently demonstrating some spontaneous eye opening but clearly had a right hemiplegia. The patient was intermittently bradycardic to 45 beats per minute. A lateral x-ray of the cervical spine did not demonstrate any fracture or dislocation. There was no skull fracture. An indwelling catheter was inserted.

There were only four more observations on the local hospital neurological observation sheet. These took place between 01:30 hours to 03:00 hours where there was a fluctuating GCS but no record of pupillary or motor responses. Two of the recordings indicate incomprehensible sounds. Another two comments indicate spontaneous eye opening and attempts at speech. No further medical notes were written. Discussion with the clinical coordinator led to the decision to evacuate the patient to a major regional hospital with intensive care facilities and a neurosurgeon.

The Royal Flying Doctor Service (RFDS) first made contact with the patient just before 4am at the local rural hospital and departed for the major regional hospital around 7am. During that time, active measures were taken to resuscitate the patient. There were comments that while in hospital the patient had a conscious state fluctuating GCS 6-10 (However, no documentation to support this was found in the medical record). Oxygen saturations were deteriorating. Right-sided air entry was deteriorating. A right intercostal catheter (ICC) was inserted and a large volume of air was released with significant improvement in respiratory function. No air entry was heard on the left side ten minutes after ICC insertion and a left ICC was inserted, again with a large volume of air released. There was a significant improvement in oxygenation. GCS remained three.

Following insertion of ICC and with intubation and ventilation, blood pressure of 210/120 mmHg was recorded with a pulse of 60 beats per minute. There was some improvement in the observations over the following 15 minutes but no improvement in the GCS.

The first record of fixed dilated pupils was just after 8am while in transit with the RFDS. The admission to intensive care unit (ICU) at the major regional hospital was reported at just before 11am. A computed tomography (CT) scan at that hospital demonstrated a small acute subdural haematoma with midline shift, some subarachnoid blood and bilateral frontal haemorrhagic contusions. There was evidence of severe diffuse brain swelling. CT angiogram demonstrated poor flow in the right middle cerebral artery with possibly no flow in the posterior circulation. The patient's pupils remained fixed and dilated with GCS at three.

After neurosurgical consultation, it was considered that the patient had sustained an irretrievable head injury and after discussion with the relatives, no active treatment was provided. Brain death was confirmed and the patient was pronounced dead later that afternoon.

Assessor's comment:

It is clear that hypoxia and hypercarbia played a very significant role in this patient's demise and this was a fatal combination with a brain injury that involved bilateral haemorrhagic contusions and swelling. There were many features of the management, mostly to do with communication issues, which might have been improved. Would best-practice management have altered the outcome?

Assessment of this case was hampered by poor record keeping. Observations were sparse and infrequent. The time delay from injury to the arrival of the retrieval team was lengthy but probably unavoidable. The retrieval team corrected the major complicating factors quickly. This did improve the patient's medical state but made no impact on the final outcome.

There is no suggestion made in the notes that mannitol could have been used in an attempt to provide some relief of raised intracranial pressure throughout the transport period. Likewise, there was no suggestion that perhaps the patient could have been intubated and ventilated earlier. However, the downside is that it may have impacted adversely on the pneumothoraces.

Ideally, early involvement of a neurosurgeon might have been able to provide other advice to the local treating doctor during the hours before the arrival of the retrieval team. Education in the management of head injuries in remote areas needs to be an ongoing project. This is one aspect of patient management which has been well defined with clear-cut guidelines. Telephone support should never be overlooked in the management of head injuries.

Law Report

"Medical college did not discriminate"

MICHAEL GORTON AM
Principal, Russell Kennedy Lawyers

A trainee with "exam phobia" asked a medical college to grant fellowship without having to sit final exams. The college refused, but offered ways to accommodate his disability. The trainee lost his claim of discrimination against the college.

In *Sklavos v Australasian College of Dermatologists* the Court upheld an earlier decision that the college did not directly or indirectly, discriminate by requiring the trainee to sit a final written and clinical examination.

The Court found that the college's assessment method, which was based on an examination was a reasonable method to assess the knowledge of practitioners. Any other finding would have had significant consequences.

To be registered as a dermatologist in Australia, a medical practitioner must pass the college's final written and clinical examinations. The trainee suffered a psychiatric disorder, a phobia of sitting examinations, and believed that he should be excused from the written and clinical examination.

He alleged that the college engaged in disability discrimination and that the college could have made a reasonable adjustment of assessment, for instance workplace-based assessment, or modified examinations.

The Original Decision

The primary judge accepted that the trainee's phobia was a disability under the *Disability Discrimination Act 1992 (Cth)* (**"DDA"**). The disorder was a specific phobia which was provoked by the college assessing his capacity to be a dermatologist. Initially, the specific phobia was a fear of sitting the college's final examinations but by the time of trial, the specific phobia had extended to a fear of any assessment by the college.

In 2011 the trainee provided the college with a report from a consultant psychiatrist stating that he had a phobia which would have a disabling effect on his capacity and performance when participating in written and oral components of the college's examination. As a result, he requested that the college admit him as a Fellow without him passing the college's final written and clinical examination.

The college considered the request and declined it. The college would consider any reasonable request made by him for special conditions in the examinations under the college's special consideration policy. Despite this, the trainee decided that he was unable to sit the examinations.

Dr Sklavos commenced proceedings and alleged that the college had contravened the DDA by not accommodating for his disability. He pursued a number of causes of action against the college, including the college's failure to make reasonable adjustments, which amounted to either direct or indirect unlawful discrimination under the DDA. The claims were dismissed by the trial judge.

The Appeal

The trainee appealed the original decision and contended that the college had breached the DDA by:

- failing to make reasonable adjustments to the method of addressing his eligibility for fellowship, amounting to direct discrimination; and
- requiring that as a condition of eligibility for election as a Fellow he pass the college's examination, amounting to indirect discrimination.

He also submitted that he had suffered financial loss as a direct consequence of the college's alleged contraventions of the DDA.

Findings

The Court found that nothing the college did was because of Dr Sklavos's disability. The Court found that the college's requirement that all trainees sit and pass exams applied generally and therefore, Dr Sklavos did not receive less favourable treatment than one of his peers. As such, because the exam requirements were not imposed due to the doctor's disability, there was no direct discrimination.

The parties agreed that the college imposed a condition upon the Dr Sklavos that he needed to pass in order to be admitted as a Fellow and that due to his disability, he could not comply with this condition. Consequently, the requirement had the effect of disadvantaging people with the doctor's disability. However, the examination requirement would not be indirect discrimination, if it was reasonable in the circumstances.

The Court considered the challenges the college would have encountered if they had provided an alternative assessment. The Court considered:

- the training and assessment practices that ensure that only medical practitioners who are "safe to practise" dermatology are accredited;
- the impracticality of an alternative assessment method; and
- the effect this outcome would have on the trainee. However, this adverse impact was balanced against two other factors. First, that the trainee was still able to practise with a focus on skin conditions. Secondly, he had performed poorly in his prior clinical exams and demonstrated an inability to interact well with the college. The Court found that this provided some indication as to the probability of his success if a substitute assessment had been provided.

As a result, the Court upheld that the college's assessment method was appropriate. Whether an alternative mode of assessment may have been possible, for example workplace-based assessments, it did not detract from the reasonableness of the examination requirement, given the appropriateness of that requirement to assess practitioners.

Thus, the trainee had not been treated less favourably than a person without the disability in the circumstances and the proposed adjustment of an alternative assessment method would impose an unjustifiable hardship on the college.

Key Principles

In considering whether a condition or requirement is reasonable, the fact that an alternative option may be available will not necessarily mean that the requirement or condition imposed is unreasonable.

When assessing reasonableness, the volume of work, effort and time involved in implementing reasonable adjustments and the likelihood of the aggrieved person being able to comply with those adjustments will be considered.

Although a failure to make reasonable adjustments for a person with a disability is relevant to the assessment of both direct and indirect discrimination, direct discrimination relates to the treatment of the aggrieved person and indirect discrimination relates to the impact of particular conduct.

Practical Implications

Colleges need to be aware of the obligation to make reasonable adjustments for persons with a disability. When determining whether adjustments are reasonable, colleges should consider all of the circumstances, including the adverse impact on the employee.

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"Convivia", illustration to *Margarita Philosophica Nova* by Gregorius Reisch, Straßburg 1508.

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RACS

Research opportunities for medical students at SAASM

Medical students working with the South Australian Audit of Surgical Mortality (SAASM)

MR GLENN MCCULLOCH
Chair, South Australian Audit of Surgical Mortality (SAASM)

The Australian and New Zealand Audits of Surgical Mortality (ANZASM) now holds comprehensive data on approximately 40,000 audited surgical deaths, offering a valuable resource for research to improve quality and safety in surgery. The South Australian Audit of Surgical Mortality (SAASM) has been collaborating with medical students on research projects using the national data. This allows the audit to disseminate important findings and feed back key learnings and also provides an opportunity for the students to gain valuable research skills. The students and their research work are profiled below. We welcome expressions of interest from other students and Fellows who would like to undertake research.

Charles Jones

Research area:
Factors associated with low risk surgical deaths

I am currently a 5th year medical student at the University of Adelaide. From early on in life, I had a passion for science. In particular, I found the physiology of the human body fascinating, and found my passion in medical research when I enrolled in medicine. Whilst undertaking an Honours of Medical Sciences, my enthusiasm for research was confirmed, and I resolved to become involved in any available research projects whilst completing my medical degree. I approached the ANZASM hoping to participate in the important research they undertake. Through this work with the SAASM, I have acquired important research skills, met many fascinating people and confirmed my intention to pursue a future career in medical research. Recently, I have been involved in a study investigating surgical deaths identified as low risk. My manuscript has been submitted for publication.

Aashray Gupta

Research area:
Potentially avoidable issues in surgical mortality

My name is Aashray Gupta, I am a 5th year medical student at the University of Adelaide. I have a keen interest in surgery, to which I have had some great exposure during my undergraduate studies, as a future career pathway. During my pre-clinical studies, I became involved with surgical research under Professor Guy Maddern and have been working on a number of projects since. These include work with the SAASM (described below) and the Department of Surgery at the Queen Elizabeth Hospital. Some of this work has been published in the ANZ Journal of Surgery, and I also presented at the 2017 Annual Scientific Congress of the Royal Australasian College of Surgeons (RACS). The SAASM Clinical Director Mr Glenn McCulloch directly supervised my projects at the SAASM and he has been an invaluable mentor for me. I hope the skills I have gained in research during my undergraduate years will provide a strong foundation for a career in academic surgery in the future.

My research with the SAASM involved thematic analysis of potentially avoidable issues in surgical mortality in Australia (excluding New South Wales) from 2009 to 2015. Our work has covered three surgical specialties: Neurosurgery[1,2,4], Urology[2,4] and Vascular Surgery[1,2,3,4]. The basic findings are likely to be applicable to other specialties. The key findings for Neurosurgery[1] were:

- Avoidable contributors to mortality occurred most frequently at the preoperative stage, most commonly relating to inadequate assessment and delays.
- Specific issues included delay in diagnosis, misdiagnosis, inappropriate treatment and inappropriate inter-hospital transfers.
- There were 68 cases identified in which assessors raised concerns about delay in diagnosis. The majority of these delays were attributed not to surgeons but to other hospital departments or clinicians, hospital management or general practitioners.
- Of the cases with delay in diagnosis, the most common specific issues were that emergency departments failed to recognise symptoms and undertake appropriate investigations and/or transfer the patient to neurosurgical care.
- Failure of communication was the second most frequently occurring avoidable issue, identified across the spectrum of neurosurgical care, most commonly at the points of documentation, communication between teams and clinical handover.

Sean Davis

Research areas:
Mortality rates associated with oesophagectomy and pancreaticoduodenectomy.
Mortality rates associated with bariatric surgery

I am a 5th year medical student from the University of Adelaide. I was first exposed to research after undertaking a 4 week research elective in my 4th year of University under Professor Guy Maddern. I have a keen interest in surgery and thought this would provide a good opportunity to gain some academic experience while still completing my university degree. I gained great insight into the process involved with research and publication and after completing the University project requirements I was able to continue working with the team to put together a manuscript for submission.

Perioperative mortality following oesophagectomy and pancreaticoduodenectomy in Australia has recently been accepted for publication in the World Journal of Surgery[5]. This study analysed all Australian oesophagectomy and pancreaticoduodenectomy procedures performed from 2005 to 2013. The key findings are:

- The overall pancreaticoduodenectomy perioperative mortality rate across this period was found to be 3.0%. This rate is equivalent to the pancreaticoduodenectomy 30 day mortality documented in the United States (3.0%) and lower than reports from Japan (3.3%) and the Netherlands (5.1%). There was evidence of a reduction in perioperative mortality rate during the study period.
- The overall oesophagectomy perioperative mortality rate across the period was found to be 3.5%. This rate is higher than the 1.6% and 1.9% 30 day mortality documented in the United Kingdom and Sweden, however, it is lower than reports from Denmark (4.6%) and France (6.3%). No improvement in perioperative mortality rate occurred throughout the study period for this procedure.
- A statistically significant difference in pancreaticoduodenectomy preoperative mortality rates was found between the states and territories.

A second article, *Perioperative mortality following bariatric surgery in Australia*, is currently in progress. This study involved an analysis of all Australian bariatric surgery performed from 2005 to 2013. The key findings are:

- During the study period, 39 deaths occurred nationally, with an overall average perioperative mortality ratio (POMR) of 0.03%. The national annual POMR showed an apparent improvement across the study period falling from 0.07% (05/06) to 0.02% (12/13). The average national POMR compares well internationally. It is lower than the 0.11% in-hospital mortality reported in the United Kingdom, while the 0.14% 30 day mortality rate documented in the United States is more than 4 times Australia's.
- 82.1% of procedures were primary procedures, associated with a perioperative mortality rate of 0.03%. 17.9% of procedures were secondary procedures, associated with a perioperative mortality rate of 0.06%.

1 Gupta AK, Stewart SK, Cottell K, McCulloch GAJ, Babidge W, Maddern GJ. Potentially avoidable issues in neurosurgical mortality cases in Australia: identification and improvements. *ANZ Journal of Surgery*, (2017); 87(1-2): 86–91 [DOI: 10.1111/ans.13542]
2 Gupta A, Stewart S, Cottell K, McCulloch G, Miller J, Li R, Fitridge R, Babidge W, Maddern G. Potentially avoidable issues in Surgical mortality: Findings of a national audit. RACS 86th Annual Scientific Congress. Adelaide, Australia, May 8-12, 2017. Conference proceedings: *ANZ Journal of Surgery* (2017); 87(S1): 98 [DOI: 10.1111/ans.14003]
3 Gupta A, Li R, Stewart S, Cottell K, McCulloch G, Fitridge R, Babidge W, Maddern G. Potentially avoidable issues in Vascular Surgery mortality cases in Australia: identification and improvements. RACS 86th Annual Scientific Congress. Adelaide, Australia, May 8-12, 2017. Conference proceedings: *ANZ Journal of Surgery* (2017); 87(S1): 147-148 [DOI: 10.1111/ans.14013]
4 Gupta A, Stewart S, Cottell K, McCulloch G, Miller J, Li R, Fitridge R, Babidge W, Maddern G. Decreasing surgical mortality: A national audit of three specialties. Australasian Students' Surgical Conference. Adelaide, Australia, May 5-7, 2017.
5 Davis SS, Babidge WJ, Kiermeier A, Aitken RJ, & Maddern GJ. Perioperative Mortality Following Oesophagectomy and Pancreaticoduodenectomy in Australia. *World Journal of Surgery*, (2017); 1-7. [DOI: 10.1007/s00268-017-4204-3]

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ENT Surgeon honoured and humbled to receive medal

The recipient of this year's RACS Aboriginal and Torres Strait Islander Health Medal is believed to have visited and treated children in Indigenous communities on more occasions and for longer periods than any other Fellow of the College.

Dr David Cronin, an ENT Surgeon from Queensland, has been involved in and led numerous surgical team visits to Indigenous communities since 1982 and was contracted in 2007 to provide clinical and operative services to Indigenous children under the Federal Government's Northern Territory Intervention.

Over the years, Dr Cronin has participated in more than 30 visits to Indigenous communities across Queensland through the successful *Deadly Ears* program and he has presented a number of lectures on Aboriginal Ear Disease at Australian ENT meetings, local teaching sessions to Aboriginal Health workers and at international conferences.

Working under the umbrella of the Federal Government's Intervention program, he has operated on children across the Northern Territory, in Nhulunbuy, Tennant Creek, Katherine and Alice Springs, while conducting clinics at some of the most remote areas in Australia including in Yuendumu, Mt. Liebig, Pine Creek, Milingimbi, Maningrida, Ramingining, Elcho Island, Gapuwiyak and Yirkalla.

Dr Cronin was the Head of the ENT Department at the Gold Coast Hospital, and Senior Lecturer at Griffith University Medical School as well as Assistant Professor at the Bond University School of Health Sciences.

A VMO at the Gold Coast Hospital since 1983, Dr Cronin had a private ENT practice at the Pindara Private Hospital and in 2015 he received the Australian Society of Otolaryngology Head and Neck Surgery Medal for Outstanding Contribution to the Specialty.

Dr Cronin said he had been initially attracted to life as an ENT surgeon while he was a General Practitioner working alongside ENT surgeons at a clinic specialising in the clinical examination of scuba-diving trainees and treating the effects of scuba-diving on the ears and sinuses.

He gave up his General Practice in Queensland in 1977, began his surgical training in England in that year, and obtained the FRCS in 1979 and the FRACS in 1983.

He said he had never set out to make a particular contribution to the field of Indigenous ear health, but rather that the problem was so endemic and severe it was impossible to avoid as a Queensland ENT surgeon.

"The loss of hearing caused by chronic ear infections in Aboriginal kids is an absolute tragedy," Dr Cronin said.

"We know that 100 per cent of Indigenous children will have an ear infection before they are three months of age and how those infections are treated can have life-long consequences.

"If children can't hear well they tend to drop out of school, get into trouble and many end up in the criminal justice system or self-harming simply because they didn't have access to clean water, nutrition, appropriate hygiene or timely medical care.

"I just started working with different groups involved in the field, particularly the *Deadly Ears* program, because I had the skills and the time to help and felt that I should."

Dr Cronin estimated that he had done about 50 trips to Indigenous communities across Queensland and the Northern Territory and said he had greatly enjoyed the opportunity to work with dedicated team members as well as the chance to see parts of the country rarely visited by most Australians.

"On most of these trips I'd fly to the destination as a member of a team which usually comprised of two surgeons, two anaesthetists, six nurses and two audiologists," he said.

"In most of these places there are no theatre facilities so we'd cart along 350kg of gear.

"We'd consult for two days then we'd operate for two days. I greatly enjoyed these trips particularly those run through *Deadly Ears* as they are incredibly well organised and supported.

"Then when I was asked to provide surgical services for the Intervention, I was based out of Alice Springs, Katherine, Fitzroy Crossing and Tennant Creek. These trips were not as well organised and it was difficult to build the trust required to turn things around because of a degree of resentment, partly caused by the Intervention itself."

Dr Cronin said that when he started this work, more than 50 per cent of Indigenous children had perforated tympanic membranes, a situation caused by what he described as the "Ds" - dirt, dust, diet, "durries", deprivation, dogs, density of living and disempowerment.

He said that while progress in some communities has been slow, others have shown a remarkable turnaround such as the near absence of ear disease in Bamaga, a small town located 40km from the Northern tip of Cape York in Queensland.

"We used to go up there and operate on 20 kids a day but there is virtually no endemic ear disease to be found there now which is greatly encouraging," Dr Cronin said.

"Thursday Island in the Torres Strait is also a success story, with great improvements made through collaboration between Indigenous leaders, elders, community members and health care professionals.

"Still, other communities, particularly those without access to clean running water, are not doing so well and more needs to be done so that the whole cycle of despair that can be triggered by hearing loss can be broken in the early years of a child's life.

"We all want to close the gap and see members of the Indigenous community enjoy the benefits that the rest of us enjoy."

Dr Cronin said that even though he was approaching retirement, he had great confidence in the willingness of younger Fellows to continue to work with Indigenous communities to improve the health and well-being of children.

He said throughout his career, registrars had shown a keen interest in participating in ENT team visits across Queensland and the Northern Territory and that their contribution was only limited by the fact that there were just 13 ENT registrars in Queensland and 27 trips to be done yearly.

Dr Cronin thanked RACS for the honour of being selected to receive the Aboriginal and Torres Strait Islander Health Medal.

"I can think of far more deserving surgeons than I to have been chosen, but I was surprised, humbled, and honoured to receive it," he said.

The RACS Aboriginal and Torres Strait Islander Health Medal is designed to acknowledge the great work done by Fellows in Indigenous health care and advocacy, acknowledge that Aboriginal and Torres Strait Islander people have common yet distinct health needs that require specific responses, and is bestowed in recognition of an individual's contribution by the entire RACS Fellowship.

– With Karen Murphy

2017 Medal recipient David Cronin (Aus)

RACS Aboriginal and Torres Strait Islander Health Medal and RACS Māori Health Medal

CALL FOR 2018 NOMINATIONS

The RACS Aboriginal and Torres Strait Islander Health Medal and the RACS Māori Health Medal are awarded annually to acknowledge significant contributions to Indigenous Health in Australia and New Zealand.

Criteria for Awards

The awards are made to Fellows who have demonstrated excellence through leadership, practice, advocacy, community engagement, education or research of lasting and significant contribution to Aboriginal and Torres Strait Islander Health or Māori Health.

Eligibility

The Awards are open to all Fellows and the nomination may come from any individual Fellow, surgical society regional committee, the Indigenous Health Committee, or the Aboriginal, Torres Strait Islander or Māori community in Australia or New Zealand.

Nominations

Nominations shall be made in writing to the Chair of the Indigenous Health Committee. The nomination shall contain a CV, details of how the nominee meets the criteria for the award, and a 250 word citation.

Closing date for nominations is 5:00pm Wednesday 31 January 2018

For more information, please visit the RACS Aboriginal and Torres Strait Islander Health Medal web pages and the RACS Maori Health Medal or contact the Indigenous Health Committee Secretariat on +61 3 9276 7407 or by email melanie.thiedeman@surgeons.org

NZ leader in breast cancer research honoured by RACS

Māori women have the highest incidence of breast cancer of any ethnic group in the world and tend to contract the disease at a younger age yet the biological drivers behind the statistics remain a mystery, according to **Associate Professor Ian Campbell.**

Assoc. Prof. Campbell (pictured, left), an academic Breast General Surgeon from the Waikato Clinical Campus, University of Auckland, has spent almost 25 years conducting research aimed at improving outcomes for New Zealand women. In the last 10 years, and in particular with Professor Ross Lawrenson, Dr Nina Scott and team, he has focused on Māori and Pacific Island women who suffer twice the mortality rates from breast cancer compared with women of European descent.

This year he was awarded the RACS' Māori Health Medal in recognition of his work and decades - long dedication to research aimed both at understanding the causes behind the disparities and designing screening and treatment protocols to improve survival rates and standards of care.

Assoc. Prof Campbell is the Chair of the NZ Breast Cancer Working Group, which has developed the Standards of Service Provision for Patients with Breast Cancer in NZ. He is a member of the Breast SurgANZ Breast Audit Evidence and Performance Subcommittee, which has published work on outcomes for Māori and Pacific women and variations in presentation and tumour biology by ethnicity. He is Chair of the Waikato Breast Cancer Research Trust, which has funded, together with the NZ Breast Cancer Foundation, the Waikato Breast Cancer Register – the resource that has enabled a significant amount of his work on outcomes for Māori women.

A founding Executive Member of Breast Surgeons of Australia and New Zealand, he is also the lead surgeon for Breast Screen Midland (BSM), and is the BSM Representative on the Breast Screen Aotearoa Surgeons Unidisciplinary Group. He also chaired the management of the Early Breast Cancer Guidelines, launched at the National Māori Cancer Forum in 2009.

Assoc. Prof. Campbell said valuable research conducted through the RACS' Breast SurgANZ Quality Audit and confirmed by Dr Sanjeewa Seneviratne's PhD research showed:

- A more than 60 per cent higher mortality rate in Māori and Pacific Island women with breast cancer compared with women of European descent;
- Later stage at presentation, younger age at diagnosis and higher rates of deprivation;
- Differences in breast cancer biology by ethnicity including more ductal than lobular cancers, fewer triple negative cancers, more HER2 positive cancers in Māori and Pacific Island women and more lymphovascular invasion in Pacific Island women.

Assoc. Prof. Campbell has published on clinical outcomes and health disparities for Māori and Pacific Island women with breast cancer and differences in tumour biology.

In 2013 he was made an Officer of the New Zealand Order of Merit for services to breast cancer and breast cancer research.

He said he became involved in researching the outcomes of Māori women with breast cancer because the Waikato region of NZ has the largest population of Māori in NZ and that the disparity in outcomes was startling even at the beginning of his research career.

He said it had been clear even from the early 1990's that one of the main challenges in overcoming the difference in mortality rates lay in enabling more Māori and Pacific Island women to undergo breast cancer screening.

However, he said despite the overall difference in mortality rates, recent research had shown that Māori and Pacific Island women who have breast cancer detected early by screening have excellent outcomes, every bit as good as women of European descent with breast cancer.

"These findings are extremely reassuring and we are working very hard to get that message out to Māori and Pacific Island women," Assoc. Prof. Campbell said.

"Earlier stage at diagnosis is where we have shown we can make major improvements in outcomes. Our research tells us that half the increased death rate in Māori and Pacific Island women is due to later stage at diagnosis, whereas the biological differences in cancers we see in the different ethnic cohorts - although interesting - have only a relatively small effect.

"It means that even though we don't know why Māori and Pacific Island women tend to contract the disease earlier or why their tumours show some biological differences from those of women of European descent, we can still treat it effectively if we find it early.

"In the early days of the Waikato Pilot Breast Screening Programme, only 25 per cent of eligible Māori and Pacific Island women were participating. The National Screening Program has worked hard to develop strategies to improve the engagement between health services and Māori and Pacific Island women, with coverage now up to 60 per cent.

"That work, in turn, led to the development of more culturally appropriate health care services and education campaigns and a commitment to recruit more Māori and Pacific Medical and Health Practitioners to help us create better connections between our health system and Māori and Pacific Island communities.

"We now know that getting Māori and Pacific Island women into the screening process is key, and that when cancer screening is applied to a population where late stage at diagnosis is common, it can have a much greater impact than when applied to a healthy, wealthy European population."

Assoc. Prof. Campbell said some of the barriers to Māori and Pacific Island women having mammograms and presenting earlier included access issues like distance to travel, time off work and cost, traditional attitudes toward health and well-being, fear of an unfamiliar environment and the diagnosis of cancer, and previous bad experiences of the health system.

Together with Prof. Lawrenson and the team, Assoc. Prof. Campbell has been the recipient of an Health Research Council grant to try to drill down into these issues and develop strategies for improvement.

He said screening vans were now regularly visiting traditional Māori communal meeting areas and smaller towns across NZ with culturally appropriate education campaigns launched to encourage participation.

He said that Māori and Pacific Island women comprised about 15 per cent of his clinical workload and that he very much enjoyed working with these women and their whanau.

"They have a great sense of humour, they are very stoic people and they are very appreciative of good, culturally appropriate health care," he said.

Assoc. Prof. Campbell said he was greatly humbled to receive the Māori Health Medal and thanked RACS for the honour and the support provided to breast cancer research in NZ.

He also wished to acknowledge the contribution made by his research partners Prof. Lawrenson, Professor of Population Health at the National Institute of Demographic and Economic Analysis, and Māori Research Partner Dr Nina Scott, Senior Lecturer at the University of Auckland, Public Health Physician, Te Puna Oranga, and Dr Sanjeewa Seneviratne, PhD student, and other team members.

"We have become far more culturally aware in the health environment over recent years and that is leading to improved outcomes for some Māori and Pacific Island women," he said.

"Yet while we have succeeded in reducing mortality rates in Māori women over the last decade, we have not reduced these as much as we have for non-Māori women so the disparity is widening and we still have a long way to go."

The RACS' Māori Health Medal is bestowed to honour an individual's contribution to the field of Māori health, in acknowledgement that this unique group has common yet distinct health needs requiring locally specific responses, and to inspire and encourage new engagement by Fellows of the College in efforts to deliver better health outcomes for Māori communities.

– With Karen Murphy

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Access to safe, affordable surgery and anaesthesia in Papua New Guinea

PROFESSOR DAVID WATTERS
RACS Past President

The Papua New Guinea (PNG) Medical Society held its 53rd Medical Symposium in Port Moresby from 3-6 September 2017. The RACS President usually attends and this year was no exception with Mr John Batten presenting a keynote address. PNG's Chief Surgeon, Osborne Liko, and Chief Anaesthetist, Duncan Dobunaba, hosted this year's Symposium in the nation's capital on *Access to safe, affordable surgery and anaesthesia in PNG*, having made a successful bid to host it at last year's meeting. In 2016, the meeting's theme was the *Global Burden of Disease*, held in Alotau, Milne Bay Province, and attended by Immediate Past President, Mr Phil Truskett.

What made this year's meeting special was its focus on how PNG would respond to the World Health Assembly resolution 68/15: *Strengthening Emergency and Essential Surgical Care and Anaesthesia as a Component of Universal Health Coverage*, to improve access to surgery and anaesthesia within PNG. This was the first Symposium organised by the Surgeons and Anaesthetists of Papua New Guinea and they chose their cross-cutting theme to align with the 2015 Lancet Commission of Global Surgery. The Symposium had keynote addresses from two Lancet Commission authors, Dr Mark Shrime who was also the Global Surgery visitor to this year's Annual Scientific Congress in Adelaide, and Past RACS President Prof. David Watters.

The meeting was opened by the Prime Minister, the Hon. Peter O'Neil who kindly delayed his attendance at the Pacific Islands (Leaders) Forum to do so. The Hon. Sir Puka Temu, Minister of Health and HIV/AIDS, a Physician, attended the entire opening plenary.

The opening plenary began with David Watters, a former Professor of Surgery at the University of Papua New Guinea (1992-2000), presenting the key messages of the Lancet Commission of Global Surgery (illustrated, right), the imperative to scale up surgical and anaesthesia services, and the six metrics by which to measure success (Table 2).

Dr Mark Shrime reviewed the past, present and three College Presidents spoke

Keynote speakers to PNG Medical Symposium. L to R: President of RANZCOG, Stephen Robson; Dr Mark Shrime (Lancet Commission, Global Surgery and Social Change, Harvard Medical School); President of RACS, John Batten and President of ANZCA, David Scott. (Photo: Rocky Roe).

The Five Key Messages of the Lancet Commission of Global Surgery

5 BILLION

Lack access to safe, affordable surgical and anaesthesia care when needed. Access is dependent on Timeliness, Capability, Capacity, Safety and Affordability

143 MILLION

Additional procedures are needed annually to fill unmet need. 312m global surgical procedures but only a small proportion (6%) in the world's poorest countries

33 MILLION

Face catastrophic expense after surgical care annually and a further 48mil face impoverishment as a result of the need for surgery

INVESTMENT

In surgical and anaesthesia care saves lives, is cost-effective, affordable, and promotes economic growth. Failure to invest in a scale up of emergency and essential care will result in significant GDP losses due to premature death, treatable disability, and correctable deformity

SURGERY + ANAESTHESIA CARE

Are an indivisible, indispensable part of health care without which universal health coverage cannot be achieved

L to R: Chief Surgeon of PNG, Dr Osborne Liko; A/Prof. Ikau Kevau (Academic Head of Surgery in PNG), Prof. David Watters; former Chief Surgeon of PNG, Polapoi Chalau and Chief Surgeon of Tonga and President of Pacific Islands Surgical Association, Lord Viliami Tangi FRACS. Both David Watters and Polapoi Chalau were awarded the rare honour of Life Membership of the PNG Medical Society. (Photo: Noah Tapaua)

on Informing Health Policy through evidence derived from the six surgical indicators (President John Batten), College Standards making Anaesthesia safer (President David Scott of Australian and New Zealand College of Anaesthetists), Challenges to Obstetrics and Gynaecology Care in the Pacific (President Stephen Robson of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists). The Tongan surgical indicators were by Lord Viliami Tangi FRACS, Chief Surgeon of Tonga, and President of the Pacific Islands Association of Surgeons (PISA).

The session closed with Noah Tapaua who presented the current status of surgical metrics in PNG (Table 3 – Australia, New Zealand and PNG). The meeting continued with plenary sessions on the Surgical, Anaesthesia, Obstetric (SAO) workforce, access to surgery in rural areas, cost effective interventions and the finance and economics of how PNG can scale up global surgery and anaesthesia throughout the country, engaging 22 Provincial Hospitals and 22 Provincial Health Authorities as well as the National Ministry of Health. The Association of Surgeons of PNG meeting had contributions on surgical metrics from many of the Provinces. Dr Michael Cooper (Sydney and Anaesthesia representative on RACS Global Health) spoke on safe surgery and anaesthesia for children, the Chief Surgeon spoke on the surgical workforce, and the Chief Anaesthetist on the anaesthesia workforce including ASOs.

The Symposium passed a resolution on improving access to safe surgery and anaesthesia in Papua New Guinea and called upon each Province to report surgical metrics and develop health plans that address access, workforce, surgical volume and reporting of the Perioperative Mortality Rate (POMR).

	Global Surgical Indicator	Description	Target by 2030
1	Access to Timely Essential Surgery for Bellwether Procedures: Caesarean Section, Laparotomy, and open long bone fracture management	Percentage of population that can access within 2 hours a facility capable of performing the 3 Bellwether Procedures	80% of population
2	Surgeon, Anaesthetist and Obstetrician (SAO)Density	Number of physician SAO proceduralists per 100,000 population	100% countries with 20 SAO/100,000
3	Surgical Volume	Total number of surgical cases in an operating room per 100,000 population	5000/100,000 100% by 2030 (80% by 2020)
4	Perioperative Mortality Rate (POMR)	Percentage deaths occurring after any surgical procedure before discharge from hospital	100% by 2030 tracking POMR 80% by 2020
5	Risk of Catastrophic Expenditure due need for surgical care	Direct out of pocket costs from surgical care exceeding 10% of annual income or 40% remaining after subtraction of food and housing accounted for	100% protection
6	Risk of Impoverishment due to surgical care	Direct out of pocket costs driving family/household income below poverty line of US$1.25/day	100% protection

Table 2: Surgical Metrics Recommended by Lancet Commission of Global Surgery and now adopted within the World Health Organisation's 100 Core Health Indicators and/or World Bank Health Development Index.

Country	Population	Access to Bellwethers (%)	Workforce SAO/100,000	Surgical Volume/100,000	POMR (%)
PNG	7,500,000	20	2.3	1264	0.5
New Zealand	4,452,300	90	43	5308	0.43
Australia	23,946,300	98.85	63.9	10,156	0.19

SAO = Surgeon, Anaesthesia, Obstetric medical workforce. POMR = Perioperative Mortality Rate. PNG = Papua New Guinea. PNG data collected by Noah Tapaua, New Zealand by Leona Wilson and Australia by Glenn Guest.

Table 3: Surgical Metrics in Papua New Guinea


OPUS L (50)

The Foundations of Surgery

Recollections of surgical personalities that have made lasting contributions to our legacy – a panegyric on Sam Mellick

FELIX BEHAN
Victorian Fellow

Recently I returned to the University of Queensland Art Museum which houses my father's art collection of over 100 pieces from the Colonial days to the modern era. Initially it was donated to the Stuartholme Convent and Duchesne University College but thanks to Zelman Cowan, the then Vice Chancellor, it was suggested they all go under the management of University Art Museum. I was meeting with Campbell Gray, and the University Vice Chancellor Iain Watson to discuss ongoing gallery matters and future exhibitions and curatorial care.

On that morning in late July, I left near freezing temperatures in fog-bound Melbourne on the 6am flight to arrive in Brisbane's ambient temperature of 25°. On this particular visit later I contacted Prof. Sam Mellick, my first lecturer in Clinical Anatomy and Operative Surgery at the University of Queensland. I continue to be impressed by his mental sharpness in recalling events and names which have since faded into my own amnesic degeneration.

Sam's clear recollections were characteristic of his teaching style which always created interest. He is also a wordsmith calling himself an *opsimath* or slow learner. He then used the word *thaumaturgy*, which he says means 'when a little magic may almost appear like a miracle'. We may have all experienced such episodes in our careers of doing the impossible or seeming to perform miracles. Once when working at Lorne Hospital, I remember when an emergency Ring Finger Avulsion Injury arrived. I transferred the patient to the Western Hospital completing the procedure later that afternoon. I managed the microsurgical feat by avoiding microsurgical vein grafts over the PIPJ using a *venous island conduit flap* which extended comfortably over the PIPJ. The procedure was published in the British Journal of Hand Surgery in the 90's. When I saw the patient some months later on his bread truck, he said "Doc, it's perfect, thank you." In view of the circumstances this is the closest thing I have experienced in relation to a miracle. It should not have worked!

Visiting Sam at his Ascot home that afternoon I was able to enjoy the cool relaxing breezes off the Glass House Mountains and Moreton Bay, both visible through the veranda trellis. Tea and fruit cake was served as Sam continued to recount memories of his surgical experiences. It was quite remarkable that Gordon Clunie's name surfaced (of the Scottish tradition). Sam recalled how he entertained him and his family on their arrival from snowbound Edinburgh to the heat wave in Brisbane. Having been appointed to the Department of Surgery at the University of Queensland, Sam was offering some welcoming hospitality. Subsequently Gordon was elected to the Chair of Surgery at the University of Melbourne to follow Professor Maurice Ewing who came from the Hammersmith. As a little aside I must mention the story of my own FRCS exam in London. Felix Eastcott, a Canadian, internationally famous for his carotid-endarterectomy procedures, took me for my viva. He opened the batting by saying 'I see you have an Australian Fellowship, let's dispense with the trivialities, more importantly Son, how is Maurice Ewing getting on in the Antipodes?' Yes, I managed to pass my exam.


Royal College of Surgeons, London.

During our conversation Sam touched on some points of interest characterising a good surgeon – "do the best for your patients, contribute to the public system to expand experience that will complement your teaching, always base decisions on clinical evidence and avoid being driven by the dictates of the dollar – a disintegrator".

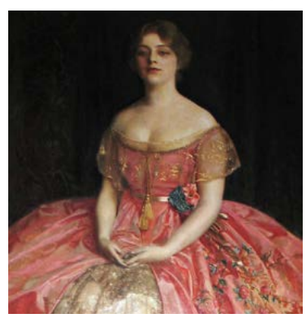
Gordon's talents in general and transplant surgery were legion. He was also a strong political force. He subsequently became Editor of the *ANZ Journal of Surgery* teaching me the basics of surgical publications. I presented him my findings during my initial experiences with Island Flap Reconstruction in the Head and Neck, seeking his advice. His crisp response was simply, "Felix, if you've got something new to say get off your derriere and get into print", adding "If you publish locally you own the concept". Publishing internationally invites plagiarism if the idea is good. Let's not forget Tom Robins's experience of a rejected paper on Breast Reconstruction: it was subsequently presented at an American Plastic Surgery Meeting in Boston by one of the Reviewers. At question time Tom let fly quite amazingly in his keen Scottish brogue with stentorian blast of what he thought of this scientific transgression; even Benny Rank was there to congratulate him.

As a vascular surgeon, Sam, a nonagenarian, had a close association with DeBakey who lived to almost 100. His vascular expertise from thrombo-endarterectomies in 1953 before Eastcote's 1975 publication, and his aortocoronary bypass of 1964 before Favaloro's 1975 publication, were discussed. Quoting from a book of *The Classics of Vascular Surgery* edited by Charles Rob, he then recounted how he gave a lecture in his honour at the *Uniformed Services University of Health Sciences* in Washington in 2004 - really a memorial as the great man had just died. He recounted the snippet where he needed a piece of fabric to repair an aortic aneurysmal defect, cutting a piece from his cotton shirt, sterilising it and repairing the defect.

My first exposure to vascular surgery was the DeBakey forceps used by the late Bob Shannon in Brisbane who also taught me another DeBakey trick of teasing the adventitia off the open lumen of the vessel facilitating the glide of the vascular suture. In Melbourne I continued this technique at the micro level. When doing a partial hand re-plantation in the late 70's the successful outcome appeared in *The Age* newspaper as was the trend in those days. The Head of Microsurgery at St. Vincent's Hospital, the late Bernard O'Brien disapprovingly, contacted the hospital administration to have all the major microsurgical cases transferred to his unit in future. Later, when Geoffrey Durham Smith was doing a total forearm re-plantation with his meticulous technique (having just returned from the Kleinert Unit in Louisville), the administration (arriving at 9am) tried to cancel the procedure but the anaesthetic had already commenced. Yes, the replant was perfect.

Sam's recollections of DeBakey's study and desk are noteworthy. With his rollercoaster chair he would migrate from portal 1 -for clinical notes, portal 2 - International publications, portal 3 - research material and portal 4 - local and international correspondence. After a frugal breakfast (*fruit petit dejeuner*) he was off to the hospital. His intuitive ideas blossomed in his early career even *inventing* a cardiac pump for open heart surgery that is still in use today (earning royalties still). Thus, he shows those characteristics of great surgeons: with technical aptitude but **Instinctively Innovative while Intuitively Inventive** – he was an ideas man.

When the afternoon breeze cooled and Sam asked for his jumper, we moved into his study, where I saw the wedding party photograph featuring Gordon Gordon-Taylor. Sam's wife was one of his secretaries at the Royal College of Surgeons, London (RCS).



Images: (L) Sir Gordon Gordon-Taylor by James Gunn 1960; (R) Lady Gordon-Taylor by F. Cadogan Cowper 1922.

Gordon-Taylor was another product of the Scottish School of Surgery from Aberdeen, of WW1 fame with a Fellowship in 1906 and was Wartime Vice President from 1941-43. With umpteen Hunterians he was also a visiting examiner in Australia for the English college in 1931 and 1934. He regarded the Australasian College of Surgeons as his second spiritual home and his second family. He bequeathed the portrait of his wife Lady Gordon Gordon-Taylor painted by Cadogan-Cowper to the RACS Portrait Collection where it is on open display (illustrated below).

More historical snippets: A thoracic surgeon, Morgan Windsor returning from the Hammersmith in 1950's introduced the principle of phrenic nerve avulsions at the Royal Brisbane Hospital (RBH) in the management of tuberculosis. Sam's public hospital commitment meant he would do up to 6 of these procedures every Monday morning. When later doing the FRCS exam, Sam impressed the examiners with his expert knowledge of this technique passing with flying colours. Sam recalls on another tack an English surgeon doing a Hunterian Presentation of 137 cases of skin malignancy over a lifetime. Sam remarked that on the Head and Neck unit at the RBH with Trevor Harris they would see over 100 every outpatient clinic.

On returning from England in 1960, to become the Vascular Surgeon at the Princess Alexandra Hospital in Brisbane, then Head of Unit in 1968, Chairman of Surgery from 1978-81, Snr Lecturer in operative surgery and surgical anatomy for 11 years and with clinical tutorships in surgery from 1955-85. Sam became a RACS Councillor in 1969, Chairman of the Board of Examiners 1980-83, Sensor in Chief from 1983-86 then becoming Snr Vice President from 1987-89. Internationally he had affiliations with the American Colleges of Surgeons, The Royal College of Surgeons of Ireland as an Examiner and eventually President of the International Society of the Cardiovascular Surgeons in 1993.

I must conclude with a little story about mechanical aptitude and his Sam's 1935 Cadillac La Salle convertible. It was bought by his father for £5 in the depression years in Innisfail, North QLD. The car was parked under a tree for 20 years before Sam one day tickled the carburettor, changed the points and plugs, adjusted the distributor making it spring to life before the blue rings of smoke cleared the exhaust (of leaves). It was not dissimilar to the concourse model illustrated below valued today at $300,000+. And he said "Felix, if only I'd kept it". This completes an edited paean on Sam Mellick and his contributions to surgery.

Pregnancy Pathways and Reasonable Adjustments

SUSAN HALLIDAY

Writing about pregnancy and potential pregnancy for the medical fraternity may seem fraught with danger when your own professional expertise resides far from medicine. That said I often stand on common ground with medical practitioners explaining to employers, and education and training entities, that pregnancy is not a disability. Sadly however, pointing out that pregnancy should be viewed in work and training environments as a normal healthy physical condition, is something that many of us still have to do regularly. Three decades after legislative frameworks were introduced into Australia and New Zealand there remains a limited understanding of the rights of pregnant and potentially pregnant women in work and training environments.

While comforted by the united front shared with medical practitioners and that grass-roots cases have established that women have the right to work and train while pregnant, there is still no time to rest. Given the examples of pregnancy and potential pregnancy discrimination that continue to surface and the long and short term disadvantages for women, focusing our attention on knowledge growth is important. This is particularly so given that examples of less favourable treatment and indirect discrimination come to light in many professional fields, including medicine.

Cases of pregnancy discrimination I have worked on could readily be described as destructive, blatant, calculated, traumatic, subversive and covert. Officially however the conduct amounts to direct or indirect discrimination, or pregnancy based harassment.

Legislative frameworks are clear that pregnancy refers to the time when a woman is carrying a baby, as well as physical characteristics of pregnancy such as having nausea, a large abdomen and tiredness. Pregnancy discrimination can also include women who are perceived as likely to become, or want to become pregnant, for example, where a woman expresses an interest in having children or is assumed or currently known to be utilising IVF services.

During a recent recruitment process, discrimination based on *potential pregnancy* occurred when a consultant engaged by a medical employer slipped in a few family related 'casual questions' under the auspice of small talk at the reception desk. The candidate was on a short list of three and feeling nervous. A suitably qualified woman of child-bearing age, she answered the 'casual questions' politely despite feeling a little uneasy. Ultimately, the candidate challenged the actual employer about not being offered the role some weeks later. Hearing about the 'casual questions' asked prior to the formal interview, the employer pleaded ignorance, spoke about the organisation's equal opportunity policy and pointed the finger at the recruiter.

At the time attempting to leap quite some distance from the incident, the employer in front of the candidate showed a failure to understand the concept of joint accountability. Additionally there seemed to be little interest in the responsibility to ensure that the employer's agent - the recruiter - was aware of their legal obligations when engaging in recruitment and selection.

Not long after, albeit under what appeared to be guilt related sentiment, the recruitment consultant when challenged said that the medical employer had requested a certain *type* of person. It was becoming very clear that irrelevant personal characteristics and stereotypical assumptions may well have been in the way of a merit based process and the fair treatment that the applicant was entitled to assume would be forthcoming.

As the onus rests with the employer and their agent to demonstrate that they acted in good faith in line with employment law, the ending was text-book! The concerns of the candidate were validated. All up it was an expensive exercise on many levels. We would be naïve if we didn't believe that there is a list of recruitment consultants happy to engage in unscrupulous conduct and discriminatory sorting of candidates.

It is direct discrimination when a woman is treated less favourably because she is pregnant or has the potential to be pregnant. Indirect pregnancy and potential pregnancy discrimination occurs when a condition, requirement or practice disadvantages a pregnant or potentially pregnant woman. In such cases decisions, requirements, practices and conditions that seem neutral and fair to everyone, have an adverse effect on a pregnant or potentially pregnant woman for no *good reason*.

Over the last three decades people with decision making power and influence have articulated their *good reasons*. But alas, once unpacked, the *good reasons* generally present as personal bias, insufficient knowledge, or the personal preferences of an irrelevant party. Stereotypical views and assumptions, historical practices, out-dated policies and industrial agreements that contain clauses that conflict with employment laws also feature when people table their *good reasons*. Generally the 'good reasons' are flawed and lead to 'bad decisions' that cannot be defended.

When people raise concerns, situations can be resolved. However, when women are pregnant and working and relying on training opportunities they are vulnerable, cautious and often worried about their return to work. It is a time when they are reluctant to speak up, or challenge a system or individuals in stable positions who will potentially be making decisions about their futures. Employers and training entities need to come to terms with the fact that the onus rests with them to do the right thing in the first place.

Decisions that fall well short of what is required often include a failure to understand and apply *reasonable adjustments* in work and training environments. Employers, trainers and training entities are required to make reasonable adjustments for medical reasons when necessary. Reasonable adjustments exist to ensure equivalency of work and training experience, as well as to ensure the health and safety of the pregnant woman. It is about equitable safe treatment – not identical treatment for all. Different stages of pregnancy may require different adjustments; some women require no adjustments. Every pregnancy has to be considered on its own merits and discussions should include the woman and her medical practitioner.

Some attempt blanket rules - all pregnant employees and trainees will do X or Y. That never ends well. An adjustment may mean things are done differently, or within different timeframes. Consideration, timely communication and treating an individual with dignity and respect will usually ensure an appropriate journey.

There are people who personally disagree with these professional obligations. That does not provide a license to compromise the rights of others. It has been the case for decades that treating a pregnant person differently to accommodate her work and training needs is a requirement and the pregnant person's right, if that is the way to ensure the pregnant woman can continue on, under the same conditions as other employees and persons being trained. A failure to reasonably accommodate the needs of a pregnant worker will often amount to discrimination and individuals who fail to act or oversee flawed decisions have accountability – personally and professionally.

Seating, temporary transfers, and flexible work and training hours are all considered appropriate reasonable adjustments. If a pregnant woman is more productive or physically comfortable at certain times of the day (e.g. after mid-morning when the nausea has passed) it is deemed reasonable to arrange for her to work different shifts or to make up the hours. Change should be progressed in consultation with the woman in a way that does not compromise her conditions of work, pay or training options.

Transfer to another department where physical duties may be lighter or safer, and the opportunity to eat and drink frequently would be deemed reasonable accommodation. Appropriate uniforms, temporary car spaces, frequent toilet breaks, working from home and flexible work locations all qualify as reasonable accommodation.

Ask "is the pregnant person suffering any form of detriment – long or short term – because of action or lack of action?" Detriment has a broad meaning; it may equate to financial loss or a loss of benefit, inability to partake in certain activities, limited opportunities for training or professional development, inequitable opportunities to take on an acting role, being labelled, people referring to the pregnancy when it is not relevant, or actually being touched. Don't be surprised if you see a pregnant person mirroring unwanted physical contact and the original offender looking shocked that there is a hand rubbing *their* stomach.

Relevant legislation was introduced prior to the birth of those currently giving birth. In New Zealand the *Human Rights Act*, the *Employment Relations Act* and the *Parental Leave and Employment Protection Act* with 2016 amendments should be consulted.

Australia's *Sex Discrimination Act* became law in 1984 despite the argument that it would 'rot the fabric of our society!' State and territory anti-discrimination laws also protect women from pregnancy and potential pregnancy discrimination. Add the *Fair Work Act* and a plethora of industrial agreements and the pathways forward are clear, albeit in some places yet to be fully understood and walked.

NOTE

This article is not legal advice. If legal advice 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.

Foundation for Surgery

Passion. Skill. Legacy.

The ultimate gift to advance surgical care

PROFESSOR KINGSLEY FAULKNER
Chair, Foundation for Surgery

The health and well-being of future generations depends on the research we do now. For over 30 years, the Foundation for Surgery has helped fund some of the most exciting research conducted in Australia and New Zealand.

But there still have a long way to go and it will take more than just one lifetime.

Bequest - of any size - make an extraordinary difference, change lives and advance your area of passion or speciality forever. Three inspiring surgeons share their stories and what bequests mean to them.

Prof Bennett

One of the architects of the Foundation for Surgery, Professor Richard Bennett, is also one of its most generous benefactors.

Having established the Foundation in 1980, Professor Bennett and his wife Enid have funded the Surgeons International Award since 1989. Professor Bennett has also made provisions in his Will for an on-going bequest.

Over the course of a distinguished career, Professor Bennett became the inaugural University of Melbourne Professor of Surgery at St Vincent's Hospital, edited the ANZ Journal of Surgery for 15 years, served the College as Treasurer and Vice-President, and in 1986 received the Hugh Devine Medal – the highest honour that RACS can bestow upon a Fellow during their lifetime.

Since its establishment, the Foundation for Surgery has become one of RACS' most successful initiatives and stands as a testament to Professor Bennett's vision and commitment to the profession of surgery and the provision of world-class surgical care.

It has helped the training of hundreds of surgeons across the Asia Pacific region, increased surgical capacity in some of the world's poorest regions, supported young and established academic surgeons in their critical research and boosted education at home, including within Indigenous communities in both Australia and New Zealand.

Professor Bennett, who retired in 1990, said he worked with others to set up the Foundation for Surgery to expand the College's role in education, provide opportunities for surgical research, to attract international leaders in surgery to attend Australasian meetings and to provide assistance to surgeons from neighbouring countries.

"At the time we set up the Foundation there was a great need for RACS to provide a more expansive surgical education program," he said.

"We were very good at training junior surgeons up until they received their Fellowship but we didn't have an active post-graduate education program or Continuing Professional Development program and we didn't fund research projects.

"We were falling behind other first world countries in terms of scientific research and lagging behind in the educational programs provided by other Surgical Colleges so it was clear we had to do better.

"We needed to find a way to fund research and post-graduate training, while I also thought we needed to fund international leaders across all surgical specialties to travel to our meetings as a way of promoting scientific exchange as a central aspect of modern surgery.

"It was also important to me that the RACS assist our rural and remote surgeons and also surgeons from less affluent countries because at that time we had no active international aid program.

"It was a shock to many Fellows in 1980 when we asked them to contribute to the Foundation, but they soon understood its importance and value to the profession and many have become very generous benefactors."

Professor Bennett said part of the success of the Foundation for Surgery lay in its beginnings when every Fellow was asked for a dedicated subscription. That pool of money was then able to earn sufficient interest to begin funding various programs.

He said that Fellows across all specialties not only became both contributors and potential recipients of the funds but that RACS was then in a position to request donations from the broader community because the Foundation had the clear support of the Fellowship.

"At the beginning, we approached a large number of companies and we were often successful in our search for funds because we could show that the initiative had both the financial and philosophical support of the Fellowship," Professor Bennett said.

"As extra funds came in we were then able to offer a broad range of Scholarships and Fellowships which not only benefited the recipients but also their patients in Australasia and the wider region."

Describing the work of RACS as "very close to my heart", Professor Bennett said he had made a decision to leave a bequest in his Will some time ago as a way to continue to support surgical research.

"I decided to leave some funds for research as a way to assist future generations of surgeons and their patients," he said.

"One of the great beauties of surgery is that those who conduct research then go on to teach others thereby creating on-going benefits both to the profession and the people of Australia and New Zealand."

Professor Bennett said the Foundation for Surgery was almost unrecognisable now from its humble beginnings and praised the leadership provided by the Chair of the Foundation, Professor Kingsley Faulkner.

"The growth and development of the Foundation, particularly in the services and education it now provides to surgeons across the Asia Pacific region, has been of huge importance and Fellows should be very proud of it," he said

"Supporting younger surgeons in their research endeavours also enables senior surgeons to gain access to their skills and enthusiasm, while the support provided creates great good will across the entire Fellowship.

"I'd encourage Fellows to think seriously about leaving a bequest to the College because it provides a great sense of satisfaction knowing that you are giving something back. Leaving a bequest will ensure you are helping RACS to maintain its important programs of aid to developing countries while also maintaining essential educational programs and research opportunities at home."

(Continued over page)

The Late Prof Walker

Having had a life-long interest in medical education and a passionate love of surgery, Professor Philip Walker continues to contribute to the profession through a series of generous bequests following his death in 2014.

One of Australia's most highly respected and warmly regarded surgeons, Professor Walker was a renowned academic Vascular surgeon who was instrumental in the early development and clinical application of aortic stent graft technology, endovascular techniques for the management of complicated aortic dissection and spiral CT angiography.

A pioneer in minimally invasive surgery, Professor Walker held tenure at the University of Queensland (UQ) Department of Surgery, was Head of the Department of Vascular Surgery at Royal Brisbane Hospital, Director of the Vascular Laboratory at the Royal Brisbane and Women's Hospital and Chair of the Vascular Surgery Department.

Although still greatly missed, his dedication to medical education and surgical research live on through a number of perpetual endowments including a bequest to the Foundation for Surgery.

In his Will, Professor Walker donated $250,000 to the Foundation to establish and maintain the Professor Philip Walker RACS Vascular Surgery Research Scholarship Fund to provide financial support to RACS trainees undertaking postgraduate research related to vascular surgical disease.

A man of great generosity, Professor Walker also provided bequests to:

- UQ School of Medicine supporting research and an annual lectureship in ethics;
- The Australian and New Zealand Society for Vascular Surgery (ANZSVS) to help medical students cover the costs of attending the ANZSVS Annual Scientific Meeting; and
- Royal Brisbane and Women's Hospital Foundation to support research.

His sister and Executor of his Will, Ms Laurie Walker, described her brother as a passionate advocate for academic research and surgical education.

She said that while Professor Walker was highly regarded within his beloved profession of surgery, he was so modest that it was only after his death that she learnt that he had been praised for his surgical skills by heart transplantation pioneer Dr Norman Shumway during his Fellowship at Stanford University in the United States.

"I was told that Norm Shumway acclaimed him as having the best surgical hands in North America at the time he was there and many people considered him to be a brilliant surgeon," Ms Walker said.

"Yet, while he could have spent his life in private practice he loved teaching and research and supporting medical students and surgical trainees.

"He had some time to think about his Will before his death and I think it reflects our beautiful brother's desire to nurture and support the entire profession of surgery with a particular focus on Vascular surgery," she said.

Ms Walker described her family as being "a medical fraternity". She said her father had been a Urologist and that Professor Walker had spent his career surrounded by members of both his immediate and extended family who are also surgeons, physicians, nurses and allied health professionals.

"Philip was one of eight children and our parents made it clear that they would do everything possible to provide us with a good education and then it was up to us to make our way in the world.

"That belief in the value of education has carried through for all of us – and no more so than for Philip who dedicated his life to it.

"He was a wonderful man, brother and surgeon and his Will demonstrates his deep altruistic desire to give others the opportunity to achieve their goals in medicine generally and surgery in particular."

Ms Walker said the College had been sensitive to the wishes of her brother as outlined in his Will and to those of the family. The process of establishing the RACS scholarship fund had been straightforward.

She encouraged other prospective donors to consider the Foundation given the impact such bequests can have.

"I would urge others wanting to donate to get expert advice so that their generosity can make the most difference to the most people over time," she said.

Ms Walker said the extended Walker clan took great comfort in having Professor Walker's contributions to medicine honoured through the scholarships and said in the future they looked forward to hearing about the progress and contributions made by the junior doctors who benefited from his generosity.

> *"He was a wonderful man, brother and surgeon and his Will demonstrates his deep altruistic desire to give others the opportunity to achieve their goals in medicine generally and surgery in particular."*

Prof O'Leary

One of Australia's most internationally renowned surgeon/scientists, Professor Stephen O'Leary, described the funding provided by the Foundation for Surgery to young surgeons as being of pivotal importance to the profession and to scientific advances made within surgery.

A former recipient of the College's most prestigious funded Fellowship, the John Mitchell Crouch (JMC) Fellowship, Professor O'Leary currently holds the William Gibson Chair of Otolaryngology at the University of Melbourne and is one of only a score of medical researchers in Australia to be a NHMRC Practitioner Fellow.

He said that while senior academic surgeons helped put Australasian surgery on the international map, it was Foundation for Surgery funding for junior surgeons that helped kick start such careers.

"If you want to end up as a surgeon/scientist you have to decide years before arriving here and you have to work extremely hard to receive the recognition you need to attract the funding required to pursue your work," he said.

"Therefore, funding junior surgeons at the outset of the career, as they are finding their field of interest, is crucial.

"Any surgeon or surgical trainee who has done PhD research has been trained in analytical thinking, writing, communication, public speaking, presentation and intellectual debate which provides a great benefit not just to their careers but to medicine in general and surgery in particular.

"They learn the skills that allow them to either continue down the research path or to take up leadership positions within their specialty or hospital.

"The Foundation for Surgery has a core mission of supporting junior surgeons and that support is crucial."

Professor O'Leary is internationally regarded for his clinical and research activities in ear disease, hearing and balance and particularly for his contribution to cochlear implantation.

His primary translational research is the protection of the inner ear during cochlear implant surgery to enable implant recipients to maintain the hearing in the ear that receives the cochlear prosthesis.

Recently, he has developed a system that allows surgeons to test the patient's hearing even during the surgical implantation procedure.

He was awarded the JMC Fellowship in 2009 - which is funded by an extraordinary bequest made to the Foundation for Surgery – and has since been awarded a number of international awards and Fellowships for his research.

"It is rather amazing how the JMC Fellowship funding helps because so many of the research grants are so tightly tied down that you often don't get the chance to say: 'I just want to push this button and see what happens next' which many scientists long to do," he said.

"The JMC is very highly regarded within the medical research community and receiving it helps attract further support because most funding organisations look for evidence of excellence. The JMC Fellowship means that you have been recognised as having something valuable to contribute to science and surgery."

Bequests like the JMC give junior surgeons that critical support and increase surgical knowledge in its entirety.

The Foundation for Surgery is incredibly grateful for the compassionate support it receives through donations and bequests.
If you would like more information about including a gift to the Foundation for Surgery in your Will or joining the 1927 Society, please call +61 3 9249 1110 or email foundation@surgeons.org.

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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:

John Royston Crellin (VIC)
Aiyadurai Sundar Prakash (VIC)
Norman Stokoe (UK)

2016
Anthony Tynan (NSW)

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

Informing the College

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

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

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

John Keith Henderson, AO
Neurosurgeon

1923 - 2017

John Keith Henderson, universally known as Keith was born and raised in Perth WA. In 1940 he came east to study medicine at the University of Melbourne. He graduated the end of 1945 and started as a resident medical officer at St Vincent's Hospital Melbourne, spending two years as Frank Morgan's registrar in the neurosurgical unit before travelling to the UK in November 1950 with his newly acquired wife Pixie Doyle. They remained devoted to each other for the next 65 years.

It was during his time at St Vincent's he came under the influence of Arthur Schuller, the Austrian Jewish refugee radiologist who arrived in Melbourne in 1940. Schuller did much of the early work in neuroradiology and was an urbane, witty and brilliant clinician. The next four years were spent in Oxford as a neurosurgical trainee in the professorial department, initially under the direction of the Adelaide neurosurgeon, Sir Hugh Cairns who was succeeded by Joe Pennybacker after Cairn's untimely death. The intellectual and cultural life of Oxford were a revelation and remained an abiding memory for the rest of his life.

Norman Leslie Stokoe
Ophthalmologist

17 May 1923 - 23 August 2017

Norman Leslie Stokoe, eminent ophthalmologist who practised in Edinburgh, Fife and the Borders

Norman Leslie Stokoe, MB, ChB, (Edinburgh, 1945), Dip Ophthalm (RCS, h London, 1958), Fellow of the Royal College of Surgeons (Edinburgh, 1953), Fellow of the Royal Australasian College of Surgeons (Melbourne, 1958), Fellow of the Royal College of Ophthalmologists. Born: 17 May, 1923. Died 23 August 2017, aged 94.

Norman Leslie Stokoe (always known as Leslie) was born in Edinburgh in 1923. The son of William Norman Stokoe and Annie Barbour (Henderson) Stokoe, he was the second of four children and extremely proud of his Edinburgh upbringing and education, being a graduate of Watson's College and Edinburgh University.

Anthony (Tony) Peter Tynan
Urologist

23 March 1940 - 21 November 2016

Tony was the fourth child in a family of five of Patrick and Madeline Tynan, an Irish Catholic working class family living in Kogarah. He was educated locally first at St Patrick's and then at Marist Brothers High School. He was a good student and always dreamed of becoming a doctor. His Dad, a truck driver for Tooth's Brewery could not afford the University fees but was fortunate to obtain a Commonwealth Scholarship and entered the faculty of medicine at Sydney University in 1957. He was the first person in his family to go to University. He was conscientious student and even got through 4th year despite his Mother's passing after a motor vehicle accident.

He was a student at St Vincent's Hospital but was appointed a Junior Resident Medical Officer at the Mater Hospital. To supplement his income he did GP locums and a stint with the Royal Flying Doctor Service during his senior year. It was at the Mater that he met Margaret O'Grady (Maggie), who he married and promptly left for England. He obtained both the Edinburgh and English Fellowships of the College of Surgeons and worked as a Surgical Registrar in Birmingham. In 1968 he returned to Australia working his way as a ship's surgeon with Maggie and their two children, Damien and Cait, and took umbrage at the fact that most of the passengers were "Ten Pound Poms". Back in Australia he obtained his Fellowship with the Royal Australasian College of Surgeons.

Thank you for your extraordinary compassion and generous support to the Foundation for Surgery.
Thanks to you many more children, families and communities have access to quality surgical care when they need it most.

Every donation makes an incredible difference throughout Australia, New Zealand and the Asia Pacific Region.

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

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Gill Family Foundation
Prof Sir Peter Morris
Mr Peter Skillington
St Stephens Anglican Church
Dr Andrew Tosolini

Bronze (Up to $1,000)

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

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

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