ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 17 NO 09 OCTOBER 2016

ASC 2017 Call for Abstracts inside

Suffrage, surgery
and the First World War

Indigenous Scholarship Program
RACS supporting Indigenous doctors

RACS LET'S OPERATE WITH RESPECT

The College of Surgeons of Australia and New Zealand

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An Operation at the Military Hospital, Endell Street Military Hospital.
Artist: Francis Dodd, Image from The Imperial War Museum

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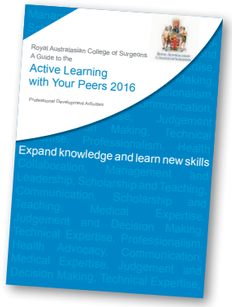
PROFESSIONAL DEVELOPMENT

Workshops & Activities

Online registration form is available now (login required).
Inside the 'Active Learning with Your Peers 2016' booklet are professional development activities enabling you to acquire new skills and knowledge and reflect on how to apply them in today's dynamic world.



Foundation Skills for Surgical Educators Course

16 October 2016 – Christchurch, New Zealand
19 October 2016 – Christchurch, New Zealand
29 October 2016 – Adelaide, SA, Australia
6 November 2016 – Cairns, QLD, Australia
12 November 2016 – Coffs Harbour, NSW, Australia
1 December 2016 – Adelaide, SA, Australia
5 December 2016 – Melbourne, VIC, Australia

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

Keeping Trainees on Track (KToT)

26 November 2016, Sydney, NSW, Australia

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

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

Supervisors and Trainers for SET (SAT SET)

26 November 2016, Sydney, NSW, Australia

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

Academy Forum 'What It Takes to Take the Lead'

10 November 2016 – Melbourne, VIC, Australia

The Academy Forum will feature preeminent thought leaders discussing progressive topics in medical education. Attendees will enjoy a three-course meal and drinks whilst workshopping questions at their tables and engaging in a Q&A session with the panel of experts. Confirmation of speakers will be announced and posted on the website.

For registration and information on fees, please visit: *https://www.surgeons.org/for-health-professionals/academy-of-surgical-educators/courses-and-events/#Forum*

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Bioethics Forum 'Bioethical Framework Implementation in Clinical Practice'

22 October 2016 – Sydney, NSW, Australia

The Forum will stimulate robust bioethical discussions amongst surgeons.

The 2016 Forum has a broad clinical emphasis to reveal current medical, surgical and hospital practice and to bring into focus innovations in medicine, nursing, pain relief and surgery that continue to evolve. For registration and information on fees, please visit: *http://www.surgeons.org/for-health-professionals/register-courses-events/professional-development/bioethical-framework-implementation-in-clinical-practice-forum/*

CLEAR Course for Consultants

11 – 12 November 2016 – CL138 The Park Hyatt Melbourne

This Fellows-only course runs over two days and concentrates on topics including: running a journal club, supervision of Trainee research and application of evidence in practice. Participants enhance their epidemiology and research skills with fellow peers and mentors.
Fee A$1,530.00 (incl. GST)

Writing Medico Legal Reports

15 November – Sydney, NSW, Australia

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

http://www.surgeons.org/for-health-professionals/register-courses-events/professional-development/writing-medico-legal-reports/

PROFESSIONAL DEVELOPMENT WORKSHOP DATES

October – December 2016

ACT
2 December 2016
Clinical Decision Making, Canberra

NSW
22 October 2016
Bioethics Forum, Sydney
12 November 2016
Foundation Skills for Surgical Educators, Coffs Harbour
15 November 2016
Writing Medico Legal Reports, Sydney
26 November 2016
Keeping Trainees on Track, Sydney
26 November 2016
SAT SET Course, Sydney

NZ
16 October 2016
Foundation Skills for Surgical Educators, Christchurch
19 October 2016
Foundation Skills for Surgical Educators, Christchurch
20 October 2016
Surgical Teachers Course, Hanmer Springs

SA
29 October 2016
Foundation Skills for Surgical Educators, Adelaide
11 November 2016
Process Communication Model: Seminar 1, Adelaide
1 December 2016
Foundation Skills for Surgical Educators, Adelaide

QLD
7 October 2016
Foundation Skills for Surgical Educators, Logan
6 November 2016
Foundation Skills for Surgical Educators, Cairns

VIC
10 November 2016
Academy Forum, Melbourne
11 – 12 November 2016
CLEAR Course for Consultants, CL138 The Park Hyatt Melbourne
25 November 2016
Non-Technical Skills for Surgeons, Melbourne
5 December 2016
Foundation Skills for Surgical Educators, Melbourne

Contact the Professional Development Department

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

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20 years reflected in the changes for CPD

Continuing professional development (CPD) is compulsory for registration in Australia and New Zealand

PHILIP TRUSKETT
President

I remember clearly the mid-1990s and the start of 'the change'. Why then? Well, there were a number of things. I remember the outrage that accompanied the publication of the interim report from the Taskforce on Quality in Australian Health Care. The findings of the taskforce headed by Dr Ross Wilson were questioned and analysed from many angles. It certainly highlighted the importance of the systems that support the delivery of clinical care as well as the standards of the individual practitioner. It seemed such a contested issue. However, the reports and the issues kept on being identified and profiled. Fellows of the College will recognise many of them. The Shipman enquiry highlighted how a mass murderer could masquerade as a caring general practitioner. The Bristol Infirmary enquiry demonstrated that all hospital surgical services needed to be open to audit, review and ongoing questioning. Our ability to assure ourselves that things were 'as good as they can be' was clearly based more on a desire to be seen in a positive light than on auditable facts.

The United Kingdom endeavours around revalidation started in the 1990s. It is the process by which doctors in the UK demonstrate that their knowledge and skills remain up to date and that they are fit to practise in their chosen field and are able to provide a good level of care.

The United Kingdom was not alone. Australia has had its share of reviews and failings of systems and individuals, be it King Edward Hospital, Bundaberg Hospital, Canberra Hospital or more recently Djerriwarrh.

It is no wonder that the profession progressed issues relating to ongoing professional standards, professional development and peer review. Whilst being streamlined there have also been ongoing attempts to ensure it is more robust and more certain to ensure that standards are being maintained throughout a professional career. Continuing professional development (CPD) is compulsory for registration in both Australia and New Zealand. And rightly so, in many ways it should have happened a lot earlier.

There has been substantial discussion over the past five years as to the shape that our CPD programs or revalidation or recertification should take. The Medical Board of Australia has encouraged this discussion and looked extensively at models across the world. RACS has been critical of the now very bureaucratic approach to revalidation that has evolved in the United Kingdom. It needs substantial support from the NHS system. We have also been critical of the compulsory re-examination process that has developed in the USA. As a surgeon's career develops their scope of practise may evolve to be very different from what a standard examination process would cover. How do you define the questions that must be asked? At an assessment level one of the true 'Gordian knots'.

The discussion paper released by the Medical Board and on which it is now consulting focuses on two parts: firstly strengthening CPD so that it is evidence based in its approach to ensure practice improvement and improved patient healthcare; secondly that at-risk and poorly performing practitioners need to be identified and appropriate performance monitoring and where necessary remediation is provided.

The discussion paper, available on the Medical Board web-site provides a high quality analysis and perspective on approaching these issues. In particular it highlights the difference in monitoring performance when a medical practitioner is involved continually with an organisation with defined and good quality clinical governance structures and where a medical practitioner practices outside that. There is detail about what makes a professional development activity of high quality. Certainly the passive attendance at conferences needs to be questioned and the more interactive workshop approach needs to be strongly supported. One of the more contentious areas will be the definition of the at risk groups for poor clinical performance. At the moment this needs serious attention to ensure there is appropriate focus on groups where risk is at a substantial level.

RACS encourages all Fellows to be involved in the consultation process that is occurring on-line and across Australia. The RACS position is clear and has been developed as one of the leaders in CPD over the past twenty years. Our profession needs to proudly grasp the responsibility of self-regulation, CPD and revalidation. The program needs to be robust and meaningful. It should include:

1. An educational and CPD program built on an understanding of the individual surgeon's strengths and weaknesses. We need to have a plan to identify our weaknesses and address them.

2. The CPD program needs to be of substantial educational value. Collegiate networking at conferences is always of value but conferences need more than lecture attendance and listening to didactic presentations. Multiple forms of engagement and learning are critical.

3. Surgeons need to obtain meaningful feedback from their work colleagues. Whether this is a multi-source feedback process or alternative approach is evolving. However surgeons need to ensure that they seek feedback. And listen to it and improve their practice.

4. RACS believes in the mandatory review of all procedural deaths. We have been able to achieve a nationally consistent approach in Australia and a comparable mechanism in New Zealand.

5. RACS strongly believes in peer-based morbidity reviews within the actual scope of surgical practice undertaken by the surgeon. This is an area where substantial improvement is required and a far better approach to Morbidity and Mortality meetings or Multi-disciplinary meetings achieved.

6. So how do we deal with those at risk? Revalidation is not just 'polishing all the apples'. We need to understand the apples that are there. The evidence is now irrefutable that with age, ones cognitive and technical skills decline. Also it is in the more senior age group that their type of practice may see them under less scrutiny by clinical governance structures of hospitals or they may decide to spend some time as locums in a number of hospitals. Certainly there is both an age and type of practice where closer scrutiny of knowledge and skills becomes more important. There is also clear evidence from the Medical Board and from the Medical Defence Organisations that medical practitioners have greater risk of complaints with every complaint made. Being a 'frequent flyer' in this group is a high risk.

   At the moment RACS verifies about seven percent of surgeons each year to ensure the program is appropriately completed. If there are concerns of performance then this becomes an annual verification. It appears appropriate for those within a designated high risk group that a more detailed verification process was routinely in place.

Not all surgeons will agree with the position of the College. Many will recall the years before the 1990s where our patients and the community trusted the medical profession to 'do the right thing'. What has been demonstrated time and time again across the world, is that does not provide enough reassurance for the government, the politicians and the public.

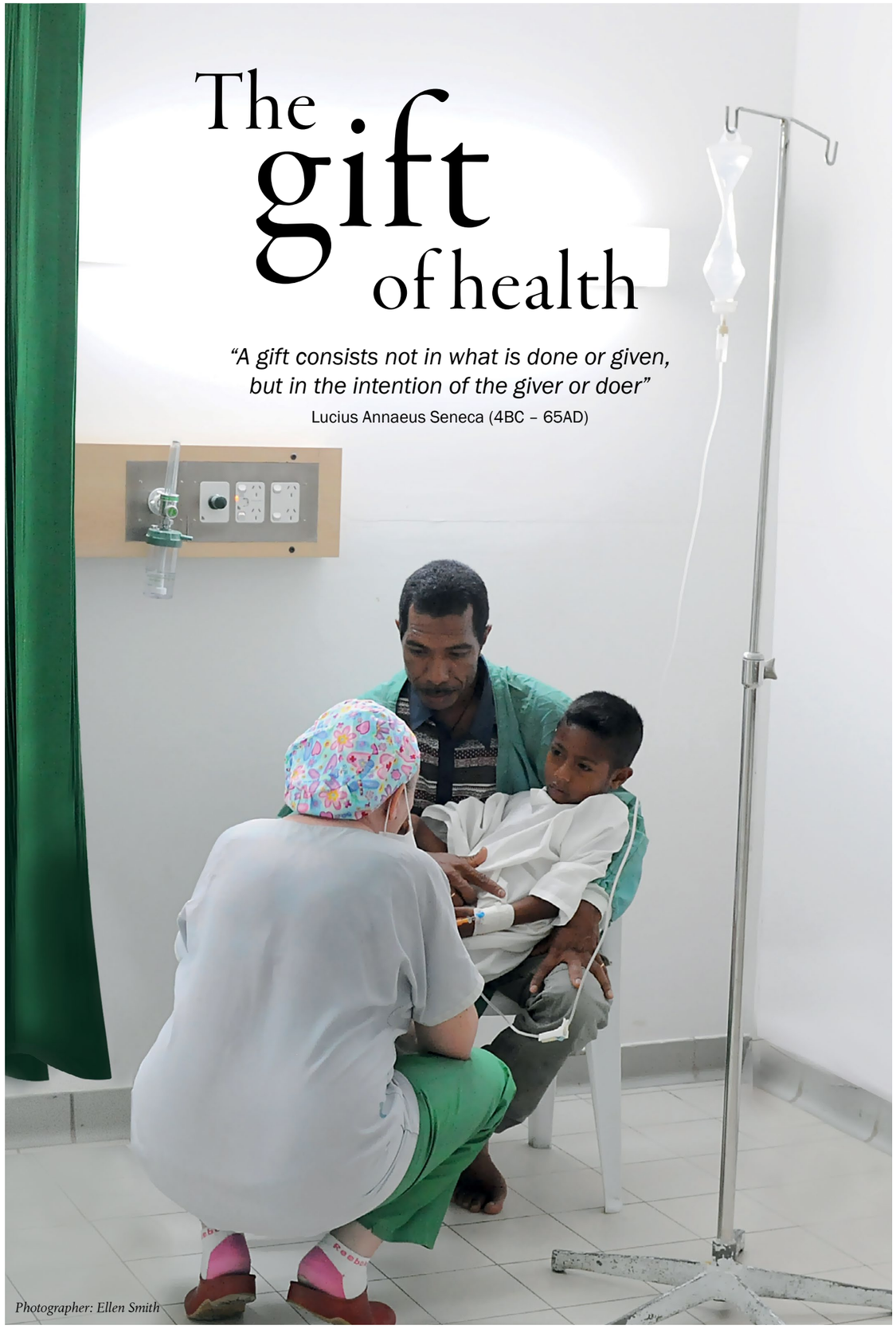
In this case, RACS believes that the program identified by the Medical Board is going in the correct direction; it needs both our support and our very active involvement as the detail gets sorted. Our professionalism demands no less.

I encourage your involvement with the consultation that is currently being undertaken. Please direct comments to the Medical Board's consultative forums as well as myself at **college.president@surgeons.org**

The gift of health

"A gift consists not in what is done or given, but in the intention of the giver or doer"

Lucius Annaeus Seneca (4BC – 65AD)



Photographer: Ellen Smith

PROFESSOR SPENCER BEASLEY
Vice President

We are at that time of the year when we are about to be bombarded with the sound of Christmas carols in our shopping malls and supermarkets as a reminder of the proximity of the festive season, the season of giving. It may be that this is the time when we should also reflect on our own fortunate lives, and to remember that there are many whose situation is far less fortunate than ours. It may also be the moment when you may decide to donate to the Foundation for Surgery, either via your subscription payment or online at www.surgeons.org/foundation/. Contributing to the Foundation is an effective way to help children, families and communities within our broader region (South Pacific and South East Asia) and across Australia and New Zealand gain better access to the precious gift of health when they need it most.

As Vice President, I have an enormous sense of pride that surgeons not only have achieved so much in their own careers but also have proven to be great philanthropists in supporting the activities of 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 over 35 years.

We must remember that worldwide, five billion people do not have access to safe, affordable surgical care when required. The Foundation for Surgery is well positioned to help in our region. In addition, it can support the Lancet Commission on Global Surgery's vision of universal access to safe, timely, affordable surgical and anaesthesia care. The Foundation for Surgery has enabled RACS through us as Fellows, to be a key player in delivering much needed surgical care in the Asia-Pacific region. Closer to home it has fostered Aboriginal and Torres Strait Islander and Maori surgeons and supported ground-breaking research that promotes greater surgical care for those at a disadvantage. However, there is still a lot to be done.

This year, as you renew your subscription, I would encourage you to consider a one-off donation to support the Foundation for Surgery. In doing so, remember you are helping the more remote and underprivileged children, families and communities get improved access to timely, safe and high quality critical care, irrespective of their circumstances or where they live.

Thanks to your support, in the last five years alone, our Foundation for Surgery has supported:

- More than 55,128 patients in developing countries in the Asia-Pacific to receive specialist consultations and procedures
- 32 Aboriginal and Torres Strait Islander and Maori medical students from Australia and New Zealand to undertake specialised educational workshops
- Over 180 research scholarships and grants resulting in ground-breaking research to increase the quality of patient care and assist people to live their healthiest lives

This year alone, over 5675 patients from developing countries in the Asia-Pacific region have received specialist consultations from our Fellows, 1373 patients have had surgery and over 100 health workers, many of them surgeons, have been trained thanks to your generous support. Fourteen Aboriginal, Torres Strait Islander and Maori medical students and doctors undertook specialised educational workshops and there was significant long-term planning for achieving better health outcomes for Aboriginal and Torres Strait Islander and Maori communities through the RACS Reconciliation and the RACS Māori Health Action Plans. On top of this over 40 scholarships were awarded to Fellows and Trainees to support research to achieve better patient care, including preventative care, such as research into the early detection and treatment of malignancy. But we need your ongoing help to continue and expand these activities.

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

The Foundation for Surgery relies on donations and bequests. Unlike other charities, no overhead or administration fees are deducted from donations: 100 per cent of your donation goes to the activities of the Foundation, so you can be confident that your donation achieves its maximum impact in the communities to which it is directed. Please donate now.

PLEASE DONATE TODAY

1. when you pay your annual subscription fee, or
2. online at www.surgeons.org/foundation/

This simple act will support our Foundation for Surgery to give the gift of health to those who need it most, when they need it most.

Foundation for Surgery
Passion. Skill. Legacy.

Surgeons sign pledge board in a show of Respect

Metro South Health

16 September 2016

Dear Doctor

On the 28th July 2016 I signed a Memorandum of Understanding (MOU) with the Royal Australasian College of Surgeons on behalf of Metro South Hospital and Health Service and with the support of our surgical leaders across the Service. The MOU is a commitment from the Health Service and RACS to implement the action plan, *'Building Respect, Improving Patient Safety'*. An excerpt from that MOU is attached. We're working closely with RACS, through our MOU. This gives us a platform to share ideas, education and training. I would like to encourage your involvement through the following.

- Do the RACS e-learning module *Operating with respect* on discrimination, bullying and sexual harassment
- Do the Foundation Skills for Surgical educators(FSSE) course, offered on 7 October at Logan Hospital and other sites available at the RACS website, to strengthen your skills as an educator
- Become Faculty for the FSSE, to help provide the training to your peers and colleagues
- Be a local face of our '*Let's Operate with respect*' campaign – we are profiling our own surgeons to be in posters around our health services (contact Emma Morton, Digital Manager Metro South Health on 3156 4904)
- Use the cobranded Metro South/ *Let's operate with respect* email signature block on your work email (access the logo and instructions from the intranet here http://qheps.health.qld.gov.au/metrosouth/comms/racs-signature.htm
- Use the cobranded logo and presentation templates (accessible on the intranet) in your presentations about surgery, especially in surgical grand rounds
- Call it out if you see unacceptable behaviours (the e-learning module suggests ways you can do this)
- Think about the link between respectful teams and improved patient outcomes
- Tell us what you've done to help build respect and improve patient safety in surgery – contact Emma Morton as above so we can share stories
- Tell us what else we can do – we want to hear good ideas that will raise awareness of these issues and help build a safe and respectful culture at Metro South.
- Reflect on your own behaviour

We are committed to solving this problem and supporting all members of our workforce and I encourage you to join us.

Yours sincerely

Dr Susan O'Dwyer
Executive Director Medical Services
Metro South Health

Queensland Government | Metro South Health | RACS LET'S OPERATE WITH RESPECT

Surgeons at Logan Hospital will sign a pledge board committing to stamp out bullying, discrimination and sexual harassment as part of a new effort by Metro South Health and the Royal Australasian College of Surgeons to enhance the surgical workplace and improve patient safety.

RACS Vice President Spencer Beasley said hospital wards, operating theatres and outpatients were areas where surgical education and health service employment overlapped.

"Research shows that bad behaviour has a negative impact on the whole team and not just the people at which it's directed.

"This partnership is about ensuring improvements in patient safety by improving work environments,'" Mr Beasley said.

Logan Hospital Director of Surgery Dr Brian McGowan welcomed the initiative and said Logan Hospital was proud to roll out the College Action Plan on Building Respect and Improving Patient Safety (BRIPS).

"This signature board is a visible and tangible commitment of the surgeons of Logan Hospital to the goals of the College and Queensland Health in this endeavour," Dr McGowan said.

Metro South Health Executive Director Medical Services Dr Susan O'Dwyer said Metro South Health strongly believed every employee had the right to work in an environment free from any form of bullying, sexual harassment and discrimination.

She said as an organisation, Metro South Health had taken a leadership role to ensure the principles which promoted a workplace free from harassment were integrated into everyday practice.

"We believe that a safe and supportive work environment not only benefits our staff, but also delivers better outcomes for our patients."

Metro South Health also sent a letter to all Metro South Hospital and Health Service surgeons encouraging their involvement in and commitment to solving the problem and supporting all members of the workforce help build a safe and respectful culture.

"Our partnership with RACS will strengthen the existing supportive culture within our surgical teams and provide a solid framework to promptly address any issues if they occur," Dr O'Dwyer said.

For more information visit www.surgeons.org/media/media-releases

Image: General Surgeon Dr Ming Ho with General Surgeon and Deputy Director of Surgery Logan Hospital Dr Peter Wysocki

Shrimp on the BBQ

Lord of the Manor?

THE BARONESS

Well, it was not a BBQ. It was not with the flare of the Chinese wok tried at our last banquet. Indeed the gathering was away from our usual gathering place: we were dining out at an esteemed restaurant on the North Shore. The gathering of my friends and University colleagues had moved distinctly up-market. As you know they have gone in a variety of directions. Law, religion, finances and even surgery: an eclectic group. My surgeon friend felt relaxed. He had recommended the restaurant from his last outing with a pharmaceutical company. Just discovered, he had said, but I was not so sure, as the maître d' seemed to know him so well. However, the prawns had been guaranteed to be superb.

I eyed the tempura style king prawns keenly. There is a special way that the batter should be prepared. This restaurant kept the water cold and sparkling as it was mixed with the flour and other ingredients. It is important to keep it cold to ensure the batter is fluffy and light. Then the oil should be sesame oil for the most outstanding taste. My other favourite is tea seed oil. At the correct temperature and time, you have a so slightly undercooked delight. And so it was with the rocket pear parmesan salad and the exquisite dipping sauces. Perfect.

Obviously not a shrimp on a BBQ. But an exquisite meal accompanied by a Provence Rosé. Crisp and slightly dry it was almost a white wine rather than a Rosé. A Cotes de Provence La Londe 2013. Inspired choice. The pharmaceutical company really knew the places to go.

I was discreetly trying to order a second serve when the conversation turned to the plight of my dearest friend. He was there trying to maintain some decorum when I knew he would be choking. At our last gathering we had reflected on his sudden prosperity. His elderly father had passed 'to the other side' (as they say) and had left a substantial estate of which he was the only beneficiary. After University he had such a bohemian and wandering lifestyle he had hardly an asset to his name. He had entertained us all in how he was going to enjoy such a substantial change to being a 'lord of a manor'. He had reflected that his ex-partner, separated many years before would have gone 'green with envy'. Knowing the difficulties from the past, most of us had said little. The separation had been messy and may not have actually ever been resolved except for different directions and the passage of time.

Green with envy was not the way it was being explained around the tempura and the Rosé. Indigestion if not choking was a real life hazard. Explain *Ordway & Ordway* [2012] FMCAfam 624 was the gasp. I paled as it is a case that has created much comment in the legal press. An ex-wife was given permission by the courts to bring a property settlement claim against her ex-husband, some 26 years after their divorce. And in making a property settlement, the Court looked at the asset pool as at the date of trial and not as at the date of separation. There was a remarkable similarity in the number of years with the potential 'lord of the manor'. There had been a divorce and even new relationships, but no formal property settlement.

I knew from ongoing advice to my clients, that all divorce proceedings are not always followed by a formal property settlement and vice versa. It may be that the additional expense of filing consent orders for a property settlement can be too much or that sometimes clients are comfortable with an informal agreement reached with their ex…Surely there is some trust left!!

When it comes to money, I was now hearing, through prawns, parmesan salad and Rosé that there can be no honour and only other factors.

I nodded wisely. As my family law practitioners know, after long separations the value and content of the parties' property pool will change. And although there are time limits for parties to commence property proceedings, there are also exceptions to those time limits. Without a doubt, it is far better to get that sorted early, recorded in writing and embodied into an order from the courts or in a financial agreement. What are the legal words for better safe than sorry?

Legal material contributed by Daniel Kaufman, Special Counsel in the Family and Relationship Law Department at Lander & Rogers.

Data and privacy

New Poll – Australians say Yes to sharing personal data if privacy is protected

Over 90 per cent of Australians would be willing to share their de-identified medical data if it went towards research purposes. This is just one of the important findings from a Roy Morgan Research poll conducted on behalf of Research Australia as part of their annual national *Australia Speaks* study.

Research Australia is an alliance of members and supporters advocating for health and medical research and according to their CEO Nadia Levin the Australian health system has not effectively supported the collection and use of health data for research purposes in the past.

"What we are saying is that the privacy considerations and other barriers can be overcome with enormous benefits as a result," Nadia Level said.

"Around 4.1 million Australians currently have a My Health Record and we need to increase that number so that researchers can access de-identified data and put it to work to find new cures.

"Right now there are trials underway in the Blue Mountains and North Queensland of an opt-out rather than opt-in system for My Health records, and that holds great promise for researchers and for improving the health of all Australians.

"If we make better use of our Australian data to understand our own health needs, we can develop solutions that lead to new and better drugs and therapies for ourselves. The logical next step is taking home-grown innovation to international markets.

"Put another way, there is a very real possibility that the mining boom of the future could come from mining our own health data.

"It is encouraging to see significant levels of support for data sharing as we continue along the My Health journey," the Research Australia CEO said.

"Whilst privacy has been raised as an issue in e-health, this data shows that if data can be protected and is used to improve the health system, Australians support it," she said.

"This is absolutely doable – we can protect privacy and at the same time mine the data to improve our health system."

The poll also showed that the community is increasingly turning to technology to improve health outcomes, and is willing to share that information with medical researchers.

According to the poll, one in five Australians (19 per cent) say they use an activity tracking device like a fitbit™ daily or nearly daily to track their activity.

And three quarters of regular device users would share the data if they could not be individually identified.

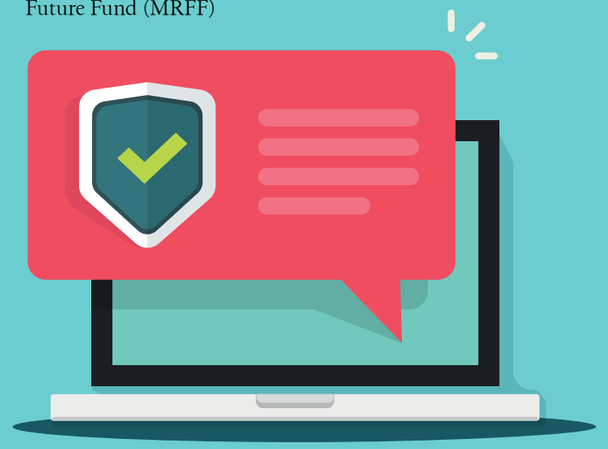
The poll also showed patients used the internet as an additional medical information source, and were open to being referred to reliable sites from doctors.

- 89 per cent of Australians reported consulting a doctor in the last 12 months, and 73 per cent of this group had used the internet to find out more about something their doctor had told them.
- The age group most likely to do this was 25-34 year olds (82 per cent), but even 69 per cent of those aged 65 and over had used the internet in this way.
- Just over one fifth (21 per cent) reported that their doctor had suggested a website where they could find more information, but only one in 10 had asked a doctor to suggest a website.
- Despite these relatively low numbers, three quarters (77 per cent) reported that they would find it helpful if a doctor suggested a website they could visit.
- 87 per cent of Australians support the Federal Government's investment in the Medical Research Future Fund (MRFF)

According to the research:

- 79 per cent of Australians would be willing to share their data if it went towards advancing medical research;
- 74 per cent would support it being used to improve patient care; and
- 60 per cent supported health officials using it to track diseases.

Ms Levin said that with a broader update of My Health records, we will see more data available and less reliance on paper records – all part of a contemporary society that uses accessible and available technology to achieve the best possible outcomes



RACS Multi-Source Feedback (MSF) Tool

RACS is excited to announce the launch of the new online tool

DR LAWRIE MALISANO
Chair, Professional Standards

RACS is excited to announce the launch of the new online Multi-Source Feedback tool.
The electronic Multi-Source Feedback (MSF) tool is a purpose-built resource to support the process of assessing performance against the nine RACS Surgical Competencies. The RACS Competencies form an integral component of surgical training.

The launch of the new Continuing Professional Development Program (CPD) in 2017 will integrate CPD and the surgical competencies in a meaningful process and will promote lifelong learning.

Multi-Source Feedback using a structured framework reflecting the surgical competencies. Other activities that can be completed in this category are; Recipient of a structured Practice Visit by a peer with evaluation and action plan and Participation in a Practice Visit (as a visitor).

In 2017, to achieve CPD compliance all Fellows, International Medical Graduates and Trainees must complete the RACS 'Operating with Respect' eLearning module available via the RACS website – completion of other activities in this category will be also populated in your CPD record.

An integral component of the MSF process is the self-assessment, where you rate yourself and reflect on your own skills prior to receiving feedback from others. This also provides a chance to familiarise yourself with the questions on which your colleagues rate you.

There are no set criteria in determining the colleagues who will rate you however you are encouraged to engage with a range of reviewers. These reviewers may include RACS Fellows and Trainees, other registered health practitioners (e.g. Anaesthetists, Physicians, Nurses, Ward Staff, Allied Health Professionals and other professional colleagues (e.g. Health Service Managers, Administrative or Practice Staff).

At the completion of the assessment by both you and your nominated colleagues you will receive an outcome report. It is important that you have support particularly once the report is available. We encourage you to identify a trusted peer to discuss all aspects of the outcome report. This person should also assist you to identify your strengths and any developmental needs. Your trusted peer may also work with you to develop potential future goals as well as a personal and professional development plan

In 2017, to achieve CPD compliance all Fellows, International Medical Graduates and Trainees must complete the RACS 'Operating with Respect' eLearning module available via the RACS website – completion of other activities in this category will be also populated in your CPD record.

The new 2017 CPD program includes a new category – Reflective Practice. To achieve annual compliance, CPD participants are required to complete at least one activity from this particular category. The RACS program offers a range of activities to support this requirement, including a new online Learning Plan, Patient Feedback Survey or

If you would like further information on the MSF please contact the Professional Standards Department +61 3 9249 1282 or Professional.Standards@Surgeons.org

2016 CPD

2016 Continuing Professional Development due 28 February

DR LAWRIE MALISANO
Chair, Professional Standards

The end of the year is rapidly approaching and it is time to start considering if you have completed adequate Continuing Professional Development (CPD) activities to achieve your annual compliance. If you do need to complete additional activities, a list of RACS and RACS-approved activities is available in the Education Events tab within the RACS Portfolio.

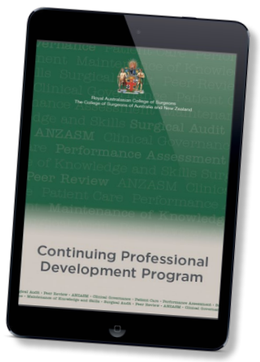
I encourage you to log on to your Portfolio to populate activities you completed in 2016. When accessing your Portfolio, please check that your personal contact details are correct and update if required. Please ensure your Practice Type is correct as this may affect your annual CPD activity requirements.

Throughout 2016, RACS has continued to expand the activities that are auto-populated into your CPD record. These include RACS activities: ASC, Professional Development and Education activities and RACS approved activities. We have also recently incorporated RACS Supervisors and Examiners activities. This information has been populated on your behalf and removes the administrative burden.

RACS will soon commence issuing CPD compliance reminders; this communication includes supporting documentation to assist you with the process and notification to those who have been selected to verify their 2016 CPD.

After completing your CPD Online, please remember to select 'Finalise my CPD' to ensure your annual Statement of Completion is promptly issued to you.

If you require any assistance with your CPD requirements please contact the Professional Standards Department on + 61 3 9249 1282 or email CPD.College@Surgeons.org



Expression of Interest

ASC Coordinator

(0.3 FTE, 10.5 hours / week)

The RACS Annual Scientific Congress is the largest regular meeting of surgeons in the Southern Hemisphere and is recognised internationally as the key educational event that brings surgeons of all disciplines together. It is at the forefront of educational and professional development activities.

The current ASC Coordinator, Mr Roger Wale FRACS is retiring. Expressions of interest are invited for this pivotal position that supports our ASC activities. Working closely with the Conference and Events Department of the College and the Committees supporting the ASC, the role is critical to ensure the ASC delivers outstanding opportunities for all of our Fellows, Trainees and International Medical Graduates.

Remuneration will be at the appropriate senior specialist level (pro-rata).

Potential applicants may contact the current Coordinator at roger.wale@surgeons.org or the Director, Daliah Moss at daliah.moss@surgeons.org
Phone 03 92491276

Surgical Fellowship - Breast and Endocrine

We are pleased to announce the continuation of the Fellowship in Breast, Endocrine and Melanoma Surgery at both **John Flynn Private Hospital and The Tweed Hospital** for a one year period commencing January 2017. This fellowship offers an outstanding opportunity for training in Oncoplastic Breast Surgery, Endocrine and Complex Melanoma and Soft Tissue Tumour Surgery, with a substantial clinical workload in operating sessions, post-op ward care, breast clinics and weekly multi-disciplinary meetings.

Applicants are expected to participate in a 1 in 3 on-call Fellows roster at Tweed Hospital sharing general surgical on-call duties with 2 other fellows in Upper GI and Colorectal. There are 8 General Surgeons at the Tweed/John Flynn Hospitals and is staffed by a full complement of Advanced Trainees in General Surgery. Expectations are that you will be involved in teaching supervising and mentoring at this level.

Applicants should hold a FRACS; be eligible for registration with AHPRA and NSW Medical Board; have recently completed advanced training in general surgery. This position involves working with 3 specialist surgeons and will assist with private surgical operations. You will be encouraged to participate in clinical programs, initiate research, and oversee the Breast Outpatient and Breast Screening Assessment Clinics.

To learn more about this great opportunity contact **Dr Nic Crampton** (07) 5536 8855 or email manager@drcrampton.com.au

TO APPLY please email your current CV to Kylie Woods, HR Manager, John Flynn Private Hospital at woodsk@ramsayhealth.com.au.

Public Announcements

Drowning in the sound waves

PROFESSOR GRUMPY

There is one thing that really annoys me and it is public announcements. I am sure you know what I mean – announcements in railway stations, airports, hospitals, public buildings, shops, etc. They seem to employ someone with speech that is not clear, or if it is clear it is masked by an electronic means. Did he/she say the flight to (word unclear) will be leaving in 10 minutes or an hour and 10 minutes from gate thirty or thirteen? Was that an announcement that asked for Mrs. Budgen or Mr. Curmudgeon to go to theatre ten or to go to Peter Wren.

I often catch an airport bus in Melbourne and the driver has a set patter that he or she trots out at speed. After about a dozen repetitions I have learned what it is. Stop one for Jetstar, Virgin and Tiger. Stop two for Qantas. Dead easy! I do not need to know exactly how to get to Jetstar as there are signs but what I do need to know (but have never been told by the driver) is that it is a cut lunch and water bottle from the Qantas lounge to the Jetstar gates. This curmudgeon doesn't do water bottle distances any more.

Whilst at the airport I have often wondered how a person not fluent in English copes with an announcement in rapid Australian with a few slang words thrown in. "OK layies and genmen, we will be a few mos late so have a spot of brekky and we will give youse a shout when all is hunky dory". I could of course comment about the vagaries of the New Zealand accent and idiom but that is another story.

If the announcement is bad news the language is often altered or softened to make it seem better. "We are encountering a slight operational problem and the flight will be delayed for a few minutes" really means "the plane is not working and we will be at least two hours before we get a replacement".

Even supermarkets are a source of annoying announcements. "It is only three shopping days to Christmas so check out our specials in aisle six". I know it is only three shopping days to Christmas, which is why I am panicking and desperately trying to get to the toy section in aisle six but can't because of the crowd. At least shops do not seem to have the annoying spruikers any longer. I am sure many will recall the lady of a certain age who was demonstrating some product whilst talking into a portable PA system that inevitably screeched and squawked (or maybe that was her natural voice). The product was dubious and the claims outrageous. Perhaps it is that this curmudgeon does not frequent those sorts of shops anymore.

However there is something of interest about spruikers that has caught my attention. The word is an Australianism. It is not from 17th century England or derived from mediaeval German but dinky die, fair dinkum Australian. I wonder in the interests of national prestige – we should resurrect them. Is there a potential new career for a curmudgeon?

Dear Professor,

It may seem somewhat oxymoronic, but I get great pleasure from your grumpy curmudgeon corners.
Haven't we all thought about the lovely words in a lovely church, or synagogue, said about the lovely departed (died) soul.
Talking of synagogues, I am reminded of the Yiddish Proverb – "If the rich could hire other people to die for them, the poor could make a wonderful living".
Your latest on dying (from the July edition – Ed.), I read with interest! How many times will "Letters to the Editor" insist on this stupidity? It seems just a little sop to the original authors before crucifying them.
Finally about death and dying Woody Allen captured most folks sentiments when he said that – "I'm not afraid of dying – I just don't want to be there when it happens!"

Thank you once again for your undying humour.

Yours, Bruce M Rigg

Extremely Healthy or Unhealthy Extremes?

DR BB-G-LOVED

We should all try to eat healthily and make time to exercise but there are some who take it to extremes. Such persons can develop an unhealthy obsession with being healthy. Two patients in my practice, quite unrelated to each other in any sense other than their pathology, are Ann T Oxi-Dense and Conn Sum Kayl. Each displays an unhealthy pre-occupation with healthy superfoods, such as chia seeds, goji berries and spirulina.

Ann T's breakfast is a green "superfood" smoothie en route to her early morning gym class. She's slim, fit, anxious and, were she to admit it, miserable. She will not eat normal meals, nibbles nuts, stresses about her health, counts every calorie and makes excuses not to go out to restaurants because there she will have no control of what she might consume. She greets people at the gym and at work but she is socially isolated. I've nothing against smoothies, nor going to the gym. The one can be energy-boosting and the other promotes fitness and burns calories. But the end result should be better, not worse, health. Her bloods show she is deficient in iron, vitamin D and B12. Her self-esteem has become dependent on how she eats and her perception of how healthy it is.

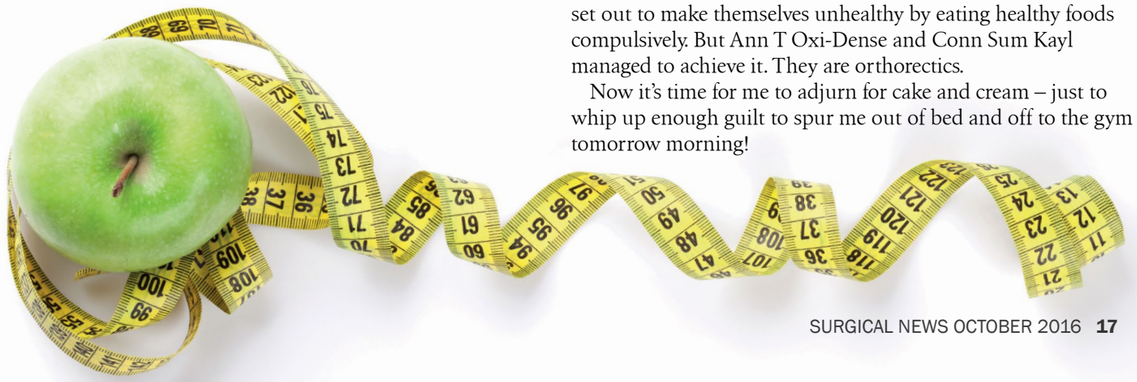
Conn Sum Kayl is strictly into raw. He's got a bad family history of heart disease including early deaths due to cardiac events. In response he has de-grain'd, disdaining what can't be picked, plucked or shot, regressing to an ancestral 'Paleo' past. He spurns cooked or processed food, survives on fruit, nuts, berries, vegetables, seeds believing he needs every enzyme still active in the raw for vitality and longevity. He had indigestion so I persuaded him to have a gastroscopy, which found quite severe gastritis – quite possibly because he just won't eat normally and guzzles nuts, seeds and berries to stave off the unpleasant feelings of starvation. He has swallowed raw foods whole – hook, line and sinker. It's proving quite challenging to unhook him – he's not only not unhealthy, but his gastritis is probably due to his dietary habits. He eats alone, and though he has a family he avoids eating with them. It's not the pepper that gets cracked at home, it's Conn.

Both Ann T and Conn suffer from orthorexia nervosa. The condition was first described 20 years ago by Dr Steven Bratman who diagnosed himself. "All I could think about was food. But even when I became aware that my scrabbling in the dirt after raw vegetables and wild plants had become an obsession, I found it terribly difficult to free myself. I had been seduced by righteous eating."

'Ortho' means straight, right or proper and 'rexia' alludes to the eating/appetite of anorexia. Orthorexia nervosa is a parallel and overlapping condition with obsessive compulsive disorder (OCD) and anorexia nervosa (AN). Though not listed in the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5) it aptly describes some patients who make themselves unhealthy by an obsessed adherence to a healthy lifestyle, such that they feel guilty even were they to enjoy a rare treat. There are 40 papers listed in pubmed, published in Appetite, Eating Disorder and Neuropsychiatric journals. One clinical review describes it as "a pathological obsession with proper nutrition that is characterised by a restrictive diet, ritualized patterns of eating, and rigid avoidance of foods believed to be unhealthy or impure." As yet, there are no reliable tools (questionnaires) to measure the condition. The ORTO-15 appears to over-diagnose, particularly in young Turkish doctors. However the characteristic features include a preoccupation with food quality, unrealistic food beliefs, desire to maximise health, perfectionism, cognitive rigidity, limited insight, guilt over food transgressions, ritualized food preparation, some of which are also features of OCD or AN. Fitspiration and Dietary apps or Social Media may further compound the problem.

You would expect that no one in their right mind would set out to make themselves unhealthy by eating healthy foods compulsively. But Ann T Oxi-Dense and Conn Sum Kayl managed to achieve it. They are orthorectics.

Now it's time for me to adjurn for cake and cream – just to whip up enough guilt to spur me out of bed and off to the gym tomorrow morning!



Discrimination against international medical graduates:

Wang v Australian Capital Territory

Wang v Australian Capital Territory[1] ("**Wang**") concerns the discriminatory treatment of international medical graduates in applications for internships in Australian Capital Territory (**ACT**) hospitals. The decision is of note to Australian medical colleges[2]

MICHAELGORTON AM
Principal, Russell Kennedy Lawyers

Background

Dr Qinlin Wang is a Chinese-born, and trained, doctor with Australian citizenship. Dr Wang completed the necessary Australian Medical Council examinations for recognition of his Chinese medical qualification in 2011. He then applied for an internship position at Canberra Hospital to commence in 2014. Such an internship is an essential requirement for any international medical graduate in order to qualify for registration as a medical practitioner in Australia.

The respondent, the Australian Capital Territory (**ACT**), is responsible for running the internship programs for ACT hospitals. In 2014 the respondent implemented a new Ministerial 'internship policy' (**the Policy**) that prioritised applicants for internships in ACT hospitals into eight categories. The first priority category was for ANU Medical School Graduates, followed by graduates of other Australian Universities. Overseas trained doctors were relegated to the last priority category. Resultantly, there was no real possibility of Dr Wang, or any other overseas trained doctor, obtaining an internship at the Canberra Hospital.

Dr Wang brought a claim against ACT for direct and indirect discrimination under section 8 of the *Discrimination Act 1991* (ACT).

Findings

The *Discrimination Act 1991* (ACT) (**DA**) prohibits discrimination on the grounds of certain attributes, including race. This is extended to discrimination based on a characteristic that people with a certain attribute generally have.[3] It was agreed that it is generally the case that medical graduates obtained their degrees in their country of origin. Therefore, distinguishing applicants on where they obtained their medical degree amounted to distinguishing applicants on their race.

The Policy was found to be discriminatory due to the intention to distinguish between people of Australian 'national origin' and those that are not[4] and the ACT was therefore found guilty of direct and indirect discrimination over its internship selection policy. Dr Wang was awarded $40,000 compensation for having suffered "*considerable anxiety, embarrassment and humiliation*[5] as a result of the discriminatory conduct and is to be considered on his merits for the next internship intake. The consideration of Dr Wang's merits must be free of assumptions to the effect that all ANU graduates would be superior candidates to the applicant on their merits just by reason of the fact that they are recent ANU graduates.[6]

Jurisdiction

Similar issues have been the subject of decisions of courts and tribunals throughout Australia in the context of differently worded discrimination statutes. As noted by the court in Wang, these differences in wording are of significance.[7]

For example, the case of *Australian Medical Council v Wilson & Ors*[8] (**"Wilson"**) concerned a quota system imposed by the Australian Medical Council (**AMC**) on overseas trained doctors. The policy sought to accredit the first 200 candidates on the AMC examination. Dr Siddiqui, an Australian citizen who obtained his medical qualification in India, did not rate in the first 200 for his exams and was thus not accredited. Dr Siddiqui unsuccessfully challenged the policy under the *Racial Discrimination Act 1975* (Cth) (**RDA**).

The RDA does not contain an extended definition of 'characteristic' or 'attribute' as appears in the DA. Sackville J took the view that unless the policy criteria explicitly mentioned national origin, as opposed to 'overseas trained', then no discrimination had occurred.[9] The Tribunal in *Wang* distinguished *Wilson*, based on differences in legislation.[10]

Implications for Australian Medical Colleges

The decision of *Wang* should be noted by the Australian medical colleges. While the case focused on international medical graduates applying for Australian internships, there may be flow-on effects for applicants seeking fellowships with an Australian medical college.

The decision is consistent with the recent push from the Expert Advisory Group,[11] endorsed by the Medical Board of Australia (**MBA**) and Australian Health Practitioner Regulation Agency (**AHPRA**), for action across the health sector to end discrimination, bullying and sexual harassment. Specifically, the Expert Advisory Group report included reference to specialist international medical graduate assessment and encouraged specialist medical colleges to ensure transparency and accountability in their assessment of international medical graduates and ensure these processes are free from discrimination, bullying and sexual harassment.[12]

Wang demonstrates that differentiating criteria which is not expressly discriminatory may act as a "proxy" for discriminatory criteria regardless of whether it is intentional or not.[413] Therefore, the colleges should be aware that even where discrimination is not intended, if an application or selection process distinguishes applicants based on a factor which by implication 'generally' brings into play an "attribute" or "characteristic" noted in relevant discrimination legislation, the process or criteria may be considered discriminatory.

Given the history of the case, it is likely to be appealed. The Colleges should be aware of any appeal, and in the meantime, ensure all processes relating to applications and the review of applications from international medical graduates for a specific medical college are free from discrimination.[14]

1 [2016] ACAT 17.
2 Including, the Royal Australasian College of Surgeons, the Australasian College of Emergency Medicine, the Royal Australasian College of General Practitioners, the Royal Australasian College of Physicians, etc.
3 *Discrimination Act 1991* (ACT), s7(2)(a).
4 [2016] ACAT 71 at [222].
5 [2016] ACAT 71 at [273].
6 See [2016] ACAT 71 at [268] and [269].
7 [2016] ACAT 71 at [16].
8 [1996] FCA 1616.
9 See [2016] ACAT 71 at [198].
10 [2016] ACAT 71 at [186].
11 Established by the Royal Australasian College of Surgeons.
12 Medical Board of Australia, 'Medical Board and AHPRA endorse EAG call for action' (10 Sep 2015) online athttp://www.medicalboard.gov.au/News/2015-09-10-media-statement.aspx.
13 [2016] ACT 71 at [233].
14 [2016] ACT 71 at [229].

Suffrage, surgery and the First World War

SUSAN NEUHAUS
CSC, FRACS

In 1914 *Kitchener's 100* medical officers marched off to war wearing the uniforms of the Australian Imperial Forces. The experience of women doctors was quite different. Universally rebuffed, many were given advice that their skills would be more useful knitting for the troops than attending the medical needs of soldiers.

Nonetheless, approximately 20 Australian female doctors saw active war service during WWI. Denied the uniform of the AIF they instead donned the grey woolen skirts, stout shoes and tartan lapels of the Scottish Women's Hospitals (SWH), suitably armed with revolvers.

These women, like others that served with our Allies, have received little recognition. Their story is not well known partly because history has preferenced male heroism, 'official histories' have overlooked their service and the name SWH inherently implies that the women were Scottish.

This article explores the association between women's suffrage, surgery and the First World War with a particular focus on the role of the SHW and the surgical exploits of Dr. Mary de Garis.


Artist: Francis Dodd / Image from The Imperial War Museum

Deeds not words

In the 1900s women doctors had been educated in an environment of military feminism and activist politics.

Many professional women supported militant suffrage organisations such as the Women's Social and Political Unions (WSPU) and *Mrs. Pankhurt's Army* of vigilante feminists. Dr. Louisa Garrett Anderson (daughter of the first female doctor in Britain) was amongst high-profile supporters and spent a month in prison for breaking a window during a demonstration.

Paradoxically, war provided the impetus to suspend their more radical suffrage activities and instead, seize an opportunity to prove their worth in an archetypal male environment.

In England, Dr. Louisa Anderson and her friend and colleague Dr. Flora Murray were determined, despite fierce opposition, to carve out a role for women in military medicine.

What resulted was a series of fully functioning war hospitals, staffed almost exclusively by women and funded by private donations. In Britain, female run hospitals did have a precedent, although not in a military context. Workhouse hospitals for women and children and care for the poor was largely met by the suffrage societies such as the National Union of Women's Suffrage Society (NUSS).

The first of the 'women's hospitals', set up within four weeks of the declaration of war, in the Hôtel Claridge in Paris, accepted patients arriving directly from the Front. Having demonstrated that women possessed the stamina and discipline for war surgery and the capacity to manage and administer a hospital, further 'voluntary hospitals' were opened. Of these Endell St Military Hospital in London was the largest and was accepted by the War Office as an official military hospital. It remained operational from 1915 to1919 and treated over 26, 000 patients. Australian doctors who served on its all-female staff included surgeons Dr. Vera Scantlebury and Dr. Elizabeth Hamilton-Browne, and doctors Rachel Champion, Emma Buckley and Eleanor Bourne.

Scottish Women's Hospitals (SWH)

The largest and best known of all the voluntary hospitals during WWI, were the so-called *Scottish Women's Hospitals* (SWH) run exclusively by women and established by Dr. Elise Inglis a Scottish doctor and campaigner for women's rights.


Dr. Mary C. De Garis


Women of Royaumont Hospital

The name SWH was chosen to deliberately play down their suffrage associations, but has unfortunately led to a misunderstanding of their role and the women who served in them. During the war the SWH provided over 14 hospitals; some as fixed facilities, others mobile field hospitals under canvas.

The SWH at Royaumont Abbey, north of Paris, operated continuously through the war. Australian Dr. Elsie Dalyell worked there undertaking pioneering research into the use of anti-sera for gas gangrene. A monument in the grounds marks the limit of the German offensive in 1914. An Australian volunteer orderly, Miss Millicent Armstrong served at one of Royaumont's forward outposts and was awarded the Croix de Guerre, France's highest honour for her bravery in rescuing wounded soldiers while under fire from advancing German forces.

America Unit No.1

America Unit No1 was a mobile and tented hospital established on the now largely forgotten Eastern Front in Serbia. Despite its name, given because it was funded largely by donations from the United States, America Unit No 1 was a decidedly 'Anzac' affair. Australian women who served there included Dr. Agnes Bennett (its original commanding officer and surgeon), Dr. Laura Hope (who subsequently became a prisoner of war) and Dr. Lilian Violet Cooper, later the only woman included on the Foundation Roll of Fellows of the Royal Australasian College of Surgeons, as well as Dr. Mary de Garis and Dr. Jessie Scott of New Zealand.

Other notable Australian women who served with the unit included Olive King an ambulance driver and the author Miles Franklin who worked as a volunteer cook. Australian nurses included Caroline Reid, Florence Grylls, Mary Stirling and Robina Ross. Sister Agnes Kerr died during her service from the effects of malaria.

The work undertaken by this unit, under harsh war conditions was nothing short of extraordinary. That it was run entirely by women, armed with determination and revolvers was a testament to their resourcefulness and Australian female leadership.

Mary de Garis

Mary de Garis was the second woman to graduate from the University of Melbourne as a Doctor of Medicine in 1907. When Britain declared war on Germany, she was working in rural practice in Tibooburra, NSW. Two weeks previously she had become engaged to Colin Thompson. Colin enlisted into the 27th Bn and survived Gallipoli but was killed in action on August 4 1916 at Pozieres, in the single day of greatest loss of Australian life.

In December that year, struggling with her grief, Mary enlisted into the SWH. She served in Serbia for 19 months between February 1917 and October 1918.

A diminutive figure, Mary was physically fit, with a flair for languages and organisational skill.

In her first months with the unit Mary was sent to relieve Dr. Cooper at Dobraveni; a forward dressing station undertaking battlefield surgery – within range of the guns, on a desperate 3rd Serbian army. There were 40 beds under canvas, a makeshift operating theatre in a shed and patients arrived on mules via rough mountain tracks. Water and supplies had to be carted from two miles away. ▶

Due to the bitter wintery conditions, surgery whenever possible was deferred to the afternoon, as surgical fluids froze through the night. The women operated in gloves, fur coats and sheepskin vests, performing amputations and immediate wound-stabilising surgery prior to transferring casualties to the main tented hospital 20 km further down the mountain at Ostrovo.

In September of 1917 Dr. Bennett was forced to resign due to severe bouts of malaria and Mary de Garis, 10 years her junior, was appointed as successor, taking over the running of the main camp hospital at Ostrovo. Mary found command challenging but, despite her relative youth, she was confident, decisive and able to lead in a stressful environment with uncompromising authority.

The scope and nature of the work changed throughout the war but records indicate the majority of surgical cases undertaken at Ostrovo were amputations or surgery for bomb or bullet wounds and compound fractures. Mary recorded the variety of cases they encountered:

… five patients in my ward – two Serbs (one plating of a leg, the other a wound of the hand), one Frenchman (operated for appendicitis), a Turk (with both eyeballs excised and injury to the hand), and a Canadian (both of whose hips had been dislocated).

Women operating Ostrovo

Gas gangrene was a constant threat and, unlike their colleagues at the SWH sister hospital at Royaumont, they did not have access to gas gangrene antiserum. Like many surgeons at the time, they struggled to find a balance between radical debridement or amputation and conservative management. Mary's own notes recalled:

Bomb wounds of the hands were frequent, and though very destructive and dirty, it was wonderful how conservative treatment repaid one. Hopeless looking fingers and hands would be saved – so much that now in civilian practice, I would ask my patient which he wanted, a speedy healing by sacrifice, or a slow recovery, but with more of hand and fingers saved.

Suffrage, recognition and the right to vote

Following the war, any thought that the British or Australian Army would relent and allow women doctors to serve was ill-founded and pleas for women doctors to be allowed commissions fell on deaf ears.

The SWH were authorised by the British government and, in accordance with internationally accepted rules of war, placed entirely at the disposal of Britain's allies. And yet, despite their exceptional service their efforts were not included in the Official Histories and the women who served were denied recognition or pensions.

Neither did their deeds progress the suffrage agenda. Whilst women in Australia received suffrage in 1902, it was not until the Equal Franchise Act of 1928 that women in Britain over 21 were able to vote and women finally achieved the same voting rights as men.

Towards the end of her service Mary de Garis, along with Drs Jessie Scott, Agnes Bennett, Lilian Cooper and Miss Josephine Bedford who ran the ambulance cars, were each awarded the Serbian Medal of St Sava.

Their service however remains largely invisible and unrecognised within Australia.

References:

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Australia's female military surgeons of World War I. Neuhaus SJ ANZ J Surg 2013

Nefri performing an eye examination on a Sumbanese patient

Sumba Eye Program

RACS interview with Nefriana Buta Rade (Nefri), Sumbanese Eye Care Nurse

Sumba is an Indonesian island in the disadvantaged province of Nusa Tenggara Timur (NTT) that has limited local access to ophthalmology, optometry and specialist eye care services. Eye disease and refractive error remain largely untreated in the province and many people continue to live with avoidable vision impairment.

The Royal Australasian College of Surgeons (RACS)-managed Sumba Eye Program (the Program), founded by Ophthalmologist Dr Mark Ellis FRACS and Optometrists Peter Stewart and Peter Lewis, recruited two Sumbanese residents and has been supporting their training in eye health care and refraction since 2013. The Program, which has provided over 9,000 consultations and performed 1,400 life changing operations for the Sumbanese community since 2007, conducts biannual visits to the island to train and mentor the national eye care workers and provide specialist eye services for the population. With an initial focus on service provision, over time the Program has increased its focus on teaching and training of Indonesian health personnel in an effort to help establish a sustainable local infrastructure for eye care in Sumba. The eye care workers are employed by RACS partner organisation, the Sumba Foundation, a local non-government organisation.

During the Program visit to Sumba in August 2016, the RACS team sat down with one of the eye care workers, Nefriana Buta Rade or 'Nefri' as she is fondly known, to talk about her experience as an eye care nurse in Sumba.

What made you want to learn about eye care? What are your professional interests/passions?

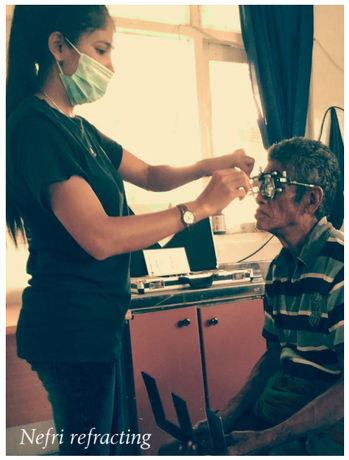
My interest in eye care started years ago when I observed that an increasing number of people in Sumba do not have access to medical facilities and this includes eye care services. There were increasing numbers of locals with eye problems who are just not able to get help. This is due to the economic situation and living conditions in Sumba where most are from the rural villages and do not have a consistent source of income. They live on bare necessities and are not able to afford basic health checks or medical care. The lack of access to medical facilities is the root cause for the increasing eye problems in Sumba. I would estimate that close to 50 per cent of the population is affected by eye problems such as cataracts, which are most common.

You completed a training attachment at the John Fawcett Foundation in Bali with funding support from the RACS Sumba Eye Program over three years ago and have been working as an Eye Care Nurse with the Sumba Foundation since then. What has changed for you now that you are an experienced eye care nurse?

Before becoming involved with the Sumba Eye Program, I didn't have any nursing training. Previously I worked in Public Health as an administrator. I feel blessed to have been given the opportunity to be trained as an eye care nurse, pursue a career in eye care and contribute to improving eye health care in my community. Since completing the training, I am able to diagnose and detect different eye problems in patients, report the different issues and provide interim solutions for some of the patients while waiting for specialist help. There is a sense of fulfilment being able to help the people of Sumba with their visual problems.

Have you been involved in training your colleagues at the Sumba Foundation in eye care? What can you teach them from your experiences?

I am able to help my colleagues when they are doing preliminary eye checks on patients. I can confidently guide them to check the various conditions when doing the initial screening and help them to better understand the situation as well as providing an appropriate solution for the problem.


Nefri refracting


Nefri and Sumba Eye Program Optometrist Peter Stewart


A typical village in Sumba

What is the most important contribution you can make as an experienced eye care nurse in Sumba?

Early detection of some of the major eye issues is important for patients during the early stages before the problem worsens. With the experience I gained over the years, this has allowed me to provide accurate clinical advice and refer them appropriately when the RACS Sumba Eye Program team visits to get the specialist help they need.

How has the Sumba Eye Program helped you over the last three years?

The Program has helped me a lot over the last three years. It is an ongoing learning experience but the Sumba Eye Program has helped my career development in health care for which I am really thankful. I can now confidently detect certain eye issues like retina problems or glaucoma, which previously I never thought of doing. The Program has certainly assisted me to become a more accomplished and experienced eye care nurse. I am able to put in practice what I have learnt and help my people access medical services especially in eye care.

What is your vision for eye care and/or health care in Sumba?

There isn't much I can do to change the living conditions of the people of Sumba. Most of them are farmers and this has been their livelihood and way of life for a long time. But I would like to see a fully functional eye clinic based in Sumba and a growing number of trained eye care nurses. This will help in facilitating the mobile eye screenings and reach out to more people in the various parts of Sumba. In time, I hope there will be a decrease in eye problems especially amongst children as they are the future generation of Sumba.

The Sumba Eye Program is supported by the Royal Australasian College of Surgeons, with funding kindly provided by Optometry Giving Sight, Rotary Clubs of Glenferrie and Kew, The Sumba Foundation, Kabo Lawyers, Watiga & Co., the Wilkinson Foundation and private donors.

If you would like to donate to the Program, please contact the Foundation for Surgery on +61 3 9249 1110 or Email: jessica.redwood@surgeons.org

Royal Australasian College of Surgeons
Foundation for Surgery
Passion. Skill. Legacy.
Sumba Eye Program
OPTOMETRYGIVINGSIGHT
Transforming lives through the gift of vision

Updates from the SA, WA & NT ASM

New Buildings, New Systems, the New Surgeons – The theme of the recent combined SA, WA & NT Annual Scientific Meeting

DAVID WALTERS
SA Regional Chair

With Perth's Fiona Stanley recently opened, the new Royal Adelaide Hospital (nRAH) nearing completion, and the NT Government's plans to build Palmerston Regional Hospital 'New Buildings, New Systems, the New Surgeons – Surviving Change" was the perfect theme for the SA, WA & NT Annual Scientific Meeting (ASM) on 25-26 August, in Adelaide's Crowne Plaza.

Mr James Moore opened proceedings with an update to delegates on the progress of the new Royal Adelaide Hospital (nRAH). The hospital promises to deliver world class health care facilities to South Australians but its construction has not been without controversy. After several delays and disputes between the Government and contractors an official opening date has yet to be announced. Mr Moore was followed by Professor David Fletcher and Professor Marianne Vonau, who shared their first hand experiences of living through the construction of the Fiona Stanley and Gold Coast Hospitals. The clear message from all three presenters was that proper engagement and consultation with senior clinicians was vital throughout the process. This is something the Gold Coast Hospital managed to do relatively well, however Fiona Stanley has left many clinicians feeling disgruntled by the process.

The opening session set the scene for an engaging two days where surgeons discussed how new systems, techniques and technologies had the potential to revolutionise the way they operate, but also could become a hindrance if not implemented properly. Presentations included Professor Guy Maddern on *New Surgical Systems: Affordable and Essential*, Professor Suren Krishnan on *Robotics – Platforms for the Next Generation* and Professor Dieter W Hutmacher on *3D Printing in Medicine*.

Among the new technologies discussed were the Da Vinci Robot in urology and also the recent addition of a hybrid operating theatre at the Royal Darwin Hospital. Both of these topics are of particular interest to South Australian surgeons, as currently neither is available in the South Australian public health system, nor have they been provisioned for in the initial build of the nRAH.

RACS President Mr Phil Truskett, and Vice President, Professor Spencer Beasley both attended the meeting and spoke of the importance of professionalism in surgery. Their frank, yet positive assessment provided an interesting perspective as to where they saw the future of the College and surgery heading in Australia and New Zealand.

A number of local events were also held in conjunction with this year's ASM. Dr Gill Hicks, double amputee as a result of the 2005 London Terrorism Bombings, delivered the Anstey Giles Lecture at the Friday night dinner. Her inspirational account of survival and resilience captivated audience members, and epitomised the notion of adjusting to change. Her speech was followed by the presentation of the Sir Henry Newland Award to Professor Glyn Jamieson AM. The award recognises Professor Jamieson's long and distinguished career and his outstanding service to surgery in South Australia.

Also awarded during the ASM were the Justin Miller Prize and the RP Jepson Medal. The Justin Miller Prize was won by Dr Sophie Plagakis, Urological Trainee for her presentation *Age and BMI do not Effect Continence Outcome Following Robot Assisted Laparoscopic Radial Prostatectomy*. While the RP Jepson Medal was awarded to Dr Steven Due, General Surgical Trainee for his presentation on *Anticancer Properties with Acute Cholecysistis following the Introduction of an Acute Surgical Unit Model of Care*.

The jam-packed two day program was a big success. Congratulations to the WA, SA and NT Regional Offices for all their hard work. We look forward to seeing everyone at next year's ASM on 25 and 26 August 2017 in Perth!

What is RACSTA?

The voice of the Trainee

DR RACHEL CARE
RACSTA Communications Representative

When I began my surgical training I had little knowledge of how the Royal Australasian College of Surgeons (RACS) worked, or how I as a Trainee fitted in. As I have progressed through my training I have become involved in RACS activities, initially as the New Zealand otolaryngology Trainee representative, and then by becoming involved in RACSTA.

RACSTA is the Royal Australasian College of Surgeons Trainees Association; we are the Trainees representative body to the College. We give Trainees a voice within the College and aim to improve surgical training for everyone. One of our major roles is representing Trainees at training and regional meetings and on committees within RACS, where we advocate for trainees and protect their interests, as well as providing an avenue of communication between Trainees and RACS for either specific or general issues.

> *We advocate for Trainees and protect their interests*

There are currently 27 elected RACSTA board members, consisting of the Executive Committee, the Regional Representatives, and the Specialty Representatives. The Specialty Representatives are those Trainees who have been elected by Trainees as their Trainee Representatives. The Regional Representation are either elected representatives from each region or from the Specialty Representatives. We also have several Co-Opted Board members.

The Executive Committee is made up of the Chair, the Immediate Past Chair and a number of portfolios. These are:
Education: ensuring excellence in surgical education, focusing on the curriculum and facilitating the RACSTA End-of-Term Survey of Trainees.
Training: focusing on matters relating to the training environment and curricular pathways.
Support and Advocacy: advocating for the health and wellbeing of Trainees and being the contact for complaints or concerns with bullying, discrimination, or sexual harassment.
Communications: managing internal and external communication matters including coordinating input into Surgical News, social media and RACSTA brand management.

You may have noticed – and hopefully completed – the End-of-Term Survey of Trainees that we release every six months; perhaps you wonder what we do with this information? In order to make all responses non-identifiable, we have been collecting data for five years and we are in the process of collating all of this information. Once we have done this analysis you should see information being released relating to the findings, so please watch this space! We would encourage all Trainees to complete the survey each term, as the more Trainees perspectives we can gather, the richer the data we can present back to RACS.

RACS Trainees automatically become members of RACSTA once their registration for the SET program is complete. If you would like more information about RACSTA, or need our help or support with any issue, our RACSTA Executive Officer, Zoe Husband, can help you or put you into contact with the appropriate committee member. Do not hesitate to contact her at racsta@surgeons.org.

Image: Dr Rhea Liang

Ready, SET, Go

Dr Rhea Liang conducts study into reasons why some women choose to leave surgery

The surgical axiom *"timely and simple interventions prevent further deterioration"* may apply equally to Trainees at risk of leaving surgery as it does to the risks facing critically ill surgical patients, according to General and Breast Surgeon Dr Rhea Liang.

Dr Liang has conducted the first in-depth qualitative study into the reasons why women choose to leave the SET program as part of a Master of Surgical Education at the University of Melbourne.

With women leaving the training program at twice the rate of men, Dr Liang said solutions must be found to stem the exodus if RACS was to reduce the disparity in the gender distribution of consultant surgeons.

She found that the over-riding reason women decided to leave surgical training lay in the cumulative effects of the sacrifices required to conform to surgical culture and complete training.

She said these sacrifices also affected men in surgery, with the exception of those relating to childbirth, and that any changes that helped retain women would be of benefit to all Trainees.

She said the findings of her research also indicated that it was time for the profession to move away from the historical concept of a surgeon as a senior military officer to one of a surgeon as collaborative team member.

Through a series of detailed interviews with 12 women, who represented five out of the nine specialty streams, Dr Liang found that reasons for leaving the SET program included:

- Long working hours, fatigue and sleep deprivation
- Unpredictable lifestyle in which there was no control over being relocated
- Lack of primary operating experience
- Bullying, sexism/discrimination, genderised behaviour and the lack of independent and specific avenues to address such behaviours
- Inaccessibility of leave without judgement
- Impact of pregnancy, childbirth and childrearing duties
- Lack of role models and support.

Dr Liang is the Clinical Lead for Breast Services at the Gold Coast Hospital and Health Services in Queensland, a member of the Academy of Surgical Educators, a CCrISP Course Director, a Surgical Teachers Course convenor, and a member of the RACS Building Respect: Improving Patient Safety Education Reference Group.

She said she set out to find why women chose to leave the SET program when they had already succeeded in a very competitive entry process in which they often out-performed their male colleagues.

> *"A lot of really good work is going on now at RACS by a number of committees but we don't need to wait for College policies to be finalised or for grand gestures to be made because my research indicates that small gestures can make a very big difference."*

She said while most of the findings confirmed the results of limited research conducted in the US and UK, an unexpected finding was that interventions specifically designed for women in surgery may have unintended adverse consequences.

"The women interviewed indicated a concern that gender-specific interventions can actually exaggerate the 'otherness' of women in surgery and that it may act to inhibit male mentorship, teaching and support while exacerbating genderised behaviour," Dr Liang said.

"This tells us that any intervention should be designed to benefit all trainees because these issues affect all young doctors going through the SET program and creating a culture of 'secret women's business' has no value or validity within surgical training.

"The interviews also indicated that the factors affecting the final decision to leave were additive but that the final impetus may be relatively small and usually occurs within the first 18 months of entering the SET program.

"Therefore I believe that small interventions may be preventive such as putting Trainees in contact with an independent mentor, providing them with protected meetings with the Director of Training during each rotation, offering early positive feedback and providing reasonable access to leave without judgement."

Dr Liang was supported in her research through the RACS Ian and Ruth Gough Surgical Education Scholarship, which she received last year.

She said she chose to investigate this aspect of surgical training because she had twice comes close to leaving training, the first time when she became a mother and the second time after being bullied.

She said increasing access for part-time training placements could make a significant difference to both male and female Trainees while hospitals could play a role by providing on-site childcare, which is relatively common in the US.

She praised the College for the work undertaken in the past year to address issues of discrimination, bullying and sexual harassment and said that while the culture was changing, there was still much to be done.

"A lot of really good work is going on now at RACS by a number of committees but we don't need to wait for College policies to be finalised or for grand gestures to be made because my research indicates that small gestures can make a very big difference," Dr Liang said.

"We can look out for each other, we can offer to take someone's shift if their child is sick and we can stand up against sexist or bullying behaviour when we see it."

Dr Liang said that other medical specialties such as Obstetrics and Gynaecology, Psychiatry and Anaesthesia had found a way to address some of these issues raised in her research, proving that it could be done if there was sufficient will.

"Changes that could make a difference simply require the political will and a shift in our thinking of who we are and who we should be as surgeons," she said.

"We need to think more holistically about what we want of surgeons and about how we see ourselves and move away from the old stereotype of a surgeon as some sort of a army major leading his troops.

"This will take time however, as all cultural change does, because for many years people were selected for surgical training precisely because they fitted this ideal.

"Yet separate research indicates that patients want us to be more like normal human beings, in that we have humility and compassion and can communicate well while still having excellent skills and good judgement.

"Other medical specialists want us to be human beings, hospital staff want us to be human beings and we should want that for ourselves as well.

"We should see ourselves as people who work hard but also people who can fall in love, have children and who have the same highs and lows in life as everyone else.

"Ultimately, I believe we could reduce the number of Trainees leaving the SET Program simply by supporting each other better, particularly our junior colleagues."

CAREER HIGHLIGHTS

2015: Inaugural recipient of the John Collins Educational Research Development Prize

2015: RACS Ian and Ruth Gough Surgical Education Scholarship

2014: Massey Scholar (Postgraduate Scholarship) from Massey University, New Zealand

2012: Inaugural recipient of the Outstanding Achievement Award, Massey University.

– With Karen Murphy

BUILDING RESPECT
IMPROVING PATIENT SAFETY

Was that harassment?

SUSAN HALLIDAY
Australian Defence Abuse Taskforce 2012-2016 and former Commissioner with the Australian Human Rights Commission

Harassment is a word that we hear often. Used to refer to different types of behaviour it usually describes unsolicited and unwanted behaviour of concern in social, employment, and education and training environments. Sometimes the word surfaces during the provision of goods and the delivery of services. That said, the phrase *it's such a grey area* will commonly be heard in the same sentence as the word harassment.

For those who feel harassed, it is important to clearly describe the behaviour of concern and to articulate the resultant negative impacts. It's also important, in the first instance, to scope appropriate verbal and written responses that will make it clear that you want the behaviour to stop.

For those who ponder the grey area, further clarity may be gained by asking yourself if the unsolicited behaviour of concern was experienced by a member of your family what your response would be. When reflecting it may be advantageous to remember that everyone has the right to feel comfortable and safe, and that it is generally the expectation of employers and customers that work, training and service delivery environments, should be fair and productive as opposed to unreasonable and destructive.

The Oxford Dictionary defines harassment as aggressive pressure or intimidation, and the Merriam-Webster Dictionary refers to harassment as the act of making unwelcome intrusions upon another. Dictionary.com says harassment is the act or an instance of disturbing, pestering or troubling behaviour. Helpful as these are when unpacking and detailing what may have been experienced, in reality the onus rests with each of us to be aware of the established definition of harassment that's directly relevant to the workplace. This definition has been with us for well over three decades; indeed it is older than many of the people whose rights it exists to protect.

Harassment is a form of discrimination

Harassment is a form of discrimination, and the anti-discrimination legislation that governs workplaces makes it clear that it is unlawful to treat a person less favourably on the basis of a protected attribute. Protected attributes can include, but are not limited to, a person's sex, race, pregnancy, parental status, disability, religion, sexual orientation, gender identity, marital status, family responsibilities, and age. There are several ways to treat a person less favourably, including harassing a person. As a form of discrimination 'harassment' including sexual harassment is generally defined as unwelcome conduct that causes offense, humiliation or intimidation that a reasonable person would anticipate would offend, humiliate or intimidate.

The situation is relevant for the person being harassed, and in some instances other individuals who are within the vicinity and in turn also impacted. An example of this is a work environment that is sexually permeated due to banter of a provocative nature, or a culture that is sexually hostile. Both situations could amount to sexual harassment for all those exposed to the conduct, given they were required to be in the environment to complete their duties.

A single incident can amount to harassment

It is crucial to understand that a single incident linked to, or based on, one of the legally protected attributes can constitute harassment. More readily seen in cases of race, religion, disability and sexual harassment, it is astounding how many people run the line – *but it only happened once* – to excuse or mollify their conduct. This is somewhat akin to being caught without your seatbelt on, and saying – *but it's only happened once, Officer*.

While the Officer may believe you, a single incident is an incident, and there are consequences because everyone in the driving community knows that it is a requirement to do the right thing and wear a seatbelt. The comparison continues given that everyone in the employment community should know that they need to do the right thing and not harass colleagues or persons to whom they deliver services. For the sake of labouring the point that none of this is new information it's noted that by 1973 seatbelts for adults were compulsory across Australia and New Zealand, and it was around the same time New Zealand in 1971 and Australia in 1974, introduced their first pieces of anti-discrimination legislation.

Decades on there is heightened awareness. However, in general conversation people regularly refer to bullying and harassment simultaneously. Unfortunately colloquial language where the interchange of words fails to reflect established definitions and specific circumstances, can cause confusion. It is important to note that the established definition of workplace bullying is repeated, unreasonable behaviour that places physical and mental health and safety at risk. It is behaviour that can result in recipients feeling threatened, intimidated, undermined or victimised. Unless the behaviour in question is based on one of the protected attributes it won't amount to harassment as covered (in various ways) by discrimination laws.

Multiple means are used to harass

Harassment can be blatant, subtle or covert. It can be written, verbal, photo image based, physical contact, gestures or the display of objects. As for delivery, it can be face-to-face, in one's presence, behind one's back, via social media, a phone call or a text message. It may be the result of notes left on a locker or a windscreen, or sent by mail. Add the arrival of inappropriate gifts, or someone mimicking your accent or mocking your speech impediment, and there's an abundance of things people do and say, based on the protected attributes, that cause detriment and can amount to harassment, given they offend, humiliate and intimidate.

Despite the diverse array of arguments put forward by offending parties, both intent and motive should be viewed as irrelevant. It is the nature and impact of the conduct of concern that is assessed by the individual experiencing it and those applying the reasonable persons' test.

You must act if there is a body of knowledge

People often experience harassment because others have failed to engage with dignity and respect; there are also situations where conduct is deliberate and purposeful, and sadly at times nothing short of predetermined and calculated. In this day and age we all have a responsibility to speak up when we witness or experience harassment; it should be as automatic as telling your passenger to buckle up that seatbelt. Once we have knowledge, we have knowledge. From that point on, to do nothing to improve the situation is to condone the conduct.

There are many ways to speak up. Some individuals may be comfortable to raise their concerns with the offending person directly. For others the best way forward will be to seek help from a trusted colleague or complaints specialist. At the point in time where supervisors, managers, practice partners, employers, directors and HR specialists have knowledge, they have an immediate role to play, ensuring all reasonable steps are taken to address the issue of concern and importantly prevent any future conduct as well as any form of victimisation or reprisal.

To do nothing will always be the wrong choice. To act in a way that is insufficient and tardy is also problematic. This situation was summed up many years ago in 2003 by the NSW Administrative Decisions Tribunal in a sexual harassment determination involving the Richmond Club Pty. Here the employer was found to be vicariously liable for the actions of an employee involved in sexual harassment. The Tribunal was also clear that although the Club had correctly responded to a formal complaint dismissing the harasser, it lacked adequate procedures for prevention, and more specifically that managers had not acted when *they had knowledge* prior to a formal complaint being made. The point was made that the lack of action effectively "allowed and permitted" the sexual harassment to continue given there was "relevant prior knowledge" about the "usual behaviour" of the offending party. The Tribunal made it clear that the managers with a body of knowledge who didn't intervene to stop the conduct gave the harasser a "virtual green light to continue."

There are no excuses, and everyone has a role to play and action to pursue when there is knowledge about unacceptable behaviour - be it harassment or the failure to wear a seatbelt.

To be continued

The final 2016 edition of *Surgical News* will house a follow-up article that focuses on direct approaches that can be utilised with offending parties, by those who consider they have experienced harassment.

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

Image: Danny Sims, CEO Ramsay Australia and RACS President Philip Truskett

Showing Respect

Ramsay Health Care and the Royal Australasian College of Surgeons (RACS) have signed a Memorandum of Understanding (MoU), as part of an agreement to build respect among staff and doctors and improve patient safety in surgery.

Ramsay Health Care (Ramsay) is a global health care group with 223 hospitals. It was founded in Sydney in 1964 and today operates facilities and treats over 1 million patients each year in Australia.

RACS President Philip Truskett said Ramsay Health Care was the latest in what he hoped would be a strong line of leading health organisations in Australia and New Zealand to commit to dealing more effectively with discrimination, bullying and sexual harassment (DBSH) in the surgical workplace.

"The list of early adopters is growing faster than we had imagined, with Ramsay Health joining Monash Health, St Vincent's Health and Metro South Health in Queensland in committing to the respect campaign and there are many more on the way keen to participate," Mr Truskett said.

Ramsay Health Care has over 2,500 surgeons working across its facilities in Australia and some of its hospitals have a significant role in training the future medical workforce.

"Ramsay is committed to ensuring that all our doctors and, in particular, our Doctor Trainees and Junior Surgeons work in an environment that is respectful and free from any bullying or harassment," said Danny Sims, CEO Ramsay Australia.

"As the largest private hospital group in Australia, we have a leadership role to play in ensuring that the principles that underlie a positive work environment are free from bullying or harassment. A safe and supportive work environment not only benefits our staff, but also delivers better outcomes for our patients," he said.

Mr Sims said the Company was already progressing the rollout of the Vanderbilt program, a program that promotes professional accountability, through its hospitals.

This MoU commits both organisations to a shared vision that will provide high quality training, education and experience in the practice of surgery. This commitment is underpinned by the shared values of integrity and respect.

Specific initiatives include:

- Aligning or developing policies and processes to the extent possible to deal with DBSH using the 'Vanderbilt Principles' as a foundation (See appendix two in the RACS Action Plan: Building Respect, Improving Patient Safety); MEDIA RELEASE

- Ensuring that complaints about discrimination, bullying and sexual harassment involving Trainees, International Medical Graduates or College Fellows working in Ramsay hospitals are managed fairly and expeditiously and that the outcomes of complaints are shared within an agreed framework

- Ensuring that surgical supervisors have the necessary skills and attributes and are supported to provide training, assessment, feedback and support to Trainees and International Medical Graduates in matters related to DBSH; and sharing information and resources for training programs to address DBSH Collaborating with employers to build respect in surgery is one of RACS' core commitments in its Action Plan: Building Respect, Improving Patient Safety.

The Action Plan is the cornerstone of RACS' response to the recommendations of the 2015 Expert Advisory Group into DBSH in the practice of surgery.

In May 2016, RACS launched Let's Operate With Respect – a campaign to help deal effectively with discrimination, bullying and sexual harassment in surgery. RACS has also published a dedicated new section of its website, About Respect.

Obstetricians and Gynaecologists join with Surgeons to build Respect

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the Royal Australasian College of Surgeons (RACS) have signed a Letter of Agreement in a show of collaboration toward building respect in the medical workplace and eliminating discrimination, bullying and sexual harassment (DBSH). RACS President Phil Truskett said it was a shared commitment to providing high quality training and a safe shared working environment to our respective Trainees, Fellows and International Medical Graduates. RANZCOG President Prof Michael Permezel said that RACS was to be commended for the leadership it had shown in promptly and determinedly taking steps to address this very important issue. The Letter of Agreement is underpinned by the shared objective of ensuring patient safety and delivery of quality frontline services and the parties have agreed to support each other, share information and resources, collaborate on programs to deal with the issues and work together to provide better training, assessment, feedback and support, free of DBSH.

- Mutually support each other in activities that promote respect, and counter DBSH.
- Share information and resources regarding the education and training available in relation to DBSH.
- Enable use of educational resources developed by either college on a case by case basis
- Collaborate on the development of programs and processes to deal with DBSH in the health sector.
- Foster greater diversity within each other's specialty and share relevant information
- Work together to provide training, assessment, feedback and support to Trainees and IMGs free of DBSH.

Image: RANZCOG President Prof Michael Permezel and RACS President Philip Truskett

NZ RACS advocacy pays Smokefree dividends

On 8 September the Smokefree Standardised Packaging Bill passed its third and final reading in the New Zealand Government by 108 votes to 13. The Bill will soon pass into law and will require all cigarette and tobacco products in New Zealand to have brown/green coloured packaging, enlarged health warnings and tobacco company marketing imagery removed. Australia adopted similar legislation as a world first in 2012.

New Zealand's plain packaging Bill was initially introduced back in 2013, but sat largely idol for several years pending the outcome of legal challenges to Australia's own plain packaging regime. RACS has been active in advocating for this important legislation in New Zealand over the past few years and is pleased to see that it will now be passed into law.

In New Zealand, roughly 13 people die prematurely every day from smoking related illnesses. To combat this, the New Zealand Government has set a goal for a Smokefree Aotearoa New Zealand by 2025, which aims to have a smoking prevalence of less than 5 per cent. Tobacco plain packaging will play a crucial role in helping New Zealand meet this target, as it will further limit the influence of tobacco advertising and branding.

NT Open Speed zones gone by the end of 2016

On the back of a dedicated advocacy campaign launch by RACS and supported by the Royal Australasian College of Physicians (RACP) and the Australian College of Emergency Medicine (ACEM) the new Northern Territory Labor Government has confirmed in a statement that it will scrap open speed zones across the Territory and replace them with 130kph limits by the end of the year. In an NT media statement Labor said it had been consistent and transparent for a number of years that its policy was to remove open speed limits based on advice from surgeons, doctors, nurses and police who agree that open limits should not exist.

First NZ Respect agreement with RACS

The Royal Australasian College of Surgeons (RACS) and the University of Otago Medical School have signed a landmark Letter of Agreement, aimed at building respect and improving patient safety in surgery and strengthening the education of medical students.

This is the first agreement signed between RACS and a university, and the first New Zealand collaboration formed under the Action Plan: Building Respect, Improving Patient Safety. The collaboration between RACS and the University of Otago Medical School paves the way for a continuous focus on respect as a cornerstone of professionalism, from medical school to specialist surgical training.

RACS Vice President Professor Spencer Beasley said collaborating together would assist in ensuring the next generation of surgeons come from a learning environment that is supportive, promotes greater participation of women in surgery and is free from discrimination, bullying and sexual harassment (DBSH).

Professor Peter Crampton, Pro-Vice Chancellor Health Sciences and Dean of the University of Otago Medical School said that the Otago Medical School was committed to actively addressing bullying and harassment. "I am very happy to partner with RACS in this endeavour - we have developed a comprehensive set of policies to assist us.

This Agreement commits both organisations to a shared vision that will provide high quality training, education and experience in the practice of surgery. This commitment is underpinned by the shared values of integrity and respect.

Changes to eTOC service

System improvements will make research easier and more comprehensive

The RACS Library's eTOC Service has been in operation since the beginning of 2015. Almost 600 RACS Fellows, Trainees, IMGs and staff are now signed on to receive alerts that are sent directly to an email inbox. Once opened, it is an easy step to click on the links for each article within the email and to access the full-text, which can then be read, printed or saved. Each set of eTOCs contains a selection of journals related to that specialty, sub-specialty or special interest. Around 90 journals are now included and subscribing can assist in keeping up-to-date regarding the latest articles published online.

How often eTOCs are received will depend on whether the e-journals included within each collection are monthly, bi-monthly, quarterly, etc. To date around 650 individual email alerts have been delivered to subscribers.

Currently eTOC sets are available for the following:

- Cardiothoracic Surgery
- General Surgery – Colorectal Surgery
- General Surgery – Gastric & Oesophageal Surgery
- Neurosurgery
- Orthopaedic Surgery
- Otolaryngology Head and Neck Surgery
- Paediatric Surgery
- Plastic and Reconstructive Surgery
- Urology
- Vascular Surgery
- Medical Education.

The next stage will be to move onto other sub-specialties within General Surgery and Orthopaedics. The sign-on form is available at: http://eepurl.com/-dUCH

Recently, *The ANZ Journal of Surgery* was also made available as a stand-alone eTOC, for those who wish to receive notification, via an eTOC, of the latest issue's content as well as the "Early View Articles" published online before print. The ANZJS sign-on form is available at: http://eepurl.com/cbCNB5

The Read by QxMD app is also available as an alternative means to receive alerts. Unlike the eTOC service, using the app allows for personal customisation in the selection of journals for which alerts are received. Keyword alerts are also available.

ANZ 'Organ Recital' in Cairns

Australian and New Zealand Society of Cardiac and Thoracic Surgeons (ANZSCTS) Annual Scientific Meeting (ASM), 6-9 November 2016, Cairns Convention Centre, Cairns, Queensland

RICHARD PERRY
Chair, Fellowship Services

The ANZSCTS is delighted to welcome Professor David Taggart to its 2016 ASM.

David Taggart is currently Professor of Cardiovascular Surgery at the University of Oxford. He qualified from Glasgow University in 1981 and in 1989 was awarded an MD with Honours for studies on the effects of hypothermia on the metabolic response to cardiac surgery. He subsequently trained as the Senior Registrar at the Royal Brompton Hospital under Professor Yacoub and Mr Lincoln.

Professor David Taggart

In 1995 he was appointed consultant cardiac surgeon at the John Radcliffe hospital in Oxford where he obtained a PhD (from Strathclyde) for studies of the inflammatory response during cardiac surgery. In 2004 he was appointed Professor of Cardiovascular Surgery at the University of Oxford.

His main interests are coronary revascularization, arterial grafts and off pump surgery. He has authored over 150 peer reviewed scientific papers and is the PI of the ART trial – one of the largest surgical trials ever conducted (a randomized trial of 3000 CABG patients to single or bilateral IMA grafts during CABG).

He was President of the Society for Cardiothoracic Surgery of GB and Ireland (April 2010-April 2012), Chairman of the European Society of Cardiology Cardiovascular Surgery Working Group, a member of the Adult Domain of the European Association for Cardiothoracic Surgery and a member of the AATS and STS. He was recently appointed as the lead for Cardiothoracic Surgery in the UK by the Royal College of Surgeons of England.

Professor Taggart will be presenting the following topics at the ANZSCTS ASM:

Sunday 6 November 2016
1:30pm – 2:00pm
Case 1: Coronary Challenges (Advanced Trainees Day)
Monday 7 November 2016
2:30pm – 2:50pm
Scientific Session 3: Coronary Artery Surgery – Evolution or back to the future?
Arterial grafting – When, why and how to do it. When and how do I use vein?
(Main Program)
Wednesday 9 November 2016
7.00am to 8.00am
Masterclass Session: MiraQ technology from Medistim

The ANZSCTS is grateful to RACS for funding Professor Taggart through the RACS Visitor Program.

For further information regarding the ANZSCTS ASM, please visit: www.anzsctsasm.com

2016 Surgical Leader Forum

Is FRACS Enough to be a Leader?

RICHARD PERRY
Chair, Fellowship Services

The Surgical Directors Section is hosting a Surgical Leaders Forum 25 – 26 November 2016 as part of Surgeons' Month in New South Wales. The Forum will be held at the Amora Hotel, Sydney with the theme 'Is FRACS enough to be a Leader?'

The Forum is a unique opportunity for Directors of Surgery, Heads of Departments and surgeons with leadership aspirations to come together for professional development and forum discussion on issues that affect surgical leaders.

Commencing on Friday 25 November with a social dinner, Dr Brian McGowan, Deputy Chair, RACS Queensland Regional Committee and Director of Surgery, Logan Hospital, will provide the keynote presentation on his reflections on leadership. Partners are welcome.

The day long program on Saturday 26 November will cover a range of leadership topics. Participants will be invited to complete a leadership inventory and receive their individual results as part of a session on personal leadership styles with Professor Spencer Beasley, RACS Vice President. Dr Sarah Dalton, Clinical Lead for the New South Wales Agency for Clinical Innovation will present on Leading Through Change and Professor Deborah Bailey, Clinical Director at the Gold Coast Hospital will run a case study session on Managing Disruptive Behaviours. Dr Peter Dohrmann, Director of the Neuroscience Clinical Institute at Epworth HealthCare and former RACS Clinical Director, IMG Assessments will present on Engaging and Building Clinical Teams and Professor Jeff Braithwaite, Director of the Centre for Healthcare Resilience and Implementation Science, Macquarie University will speak on The Influence of Leadership on Quality and Safety.

The afternoon will also include an open forum facilitated by Professor David Fletcher, Chair of the Surgical Directors Section. Participants will have the opportunity to contribute to discussion on the concerns and issues that affect surgical leaders and how the RACS can support leaders.

Registration includes dinner on 25 November 2016. Overnight king accommodation is available at the Amora Hotel. To register for the Forum and for more information about the program, please contact the Surgical Directors Section Secretariat on +61 3 9276 7494 or email SurgicalDirectors@surgeons.org.

Rural Surgery Fellowships – Extending our Horizons

DR SALLY BUTCHERS
Chair, Rural Surgery

Since its first offering in 2014, the Rural Surgery Fellowship for Provincial Surgeons has been awarded to six rural surgeons, from specialty backgrounds as diverse as Vascular, Ear Nose and Throat (ENT) and General Surgery. The Fellowship's purpose is to support the upskilling of surgeons practising outside the metropolitan centres of Australia and New Zealand. The specialty mix of previous recipients reflects the make-up of the rural surgical workforce. Approximately 28 per cent of Australian and 29 per cent of New Zealand respondents to the RACS Surgical Workforce Census in 2014 reported that they practiced in a rural or regional area. Almost 40 per cent of Urologists and approximately 30 per cent of General surgeons, Orthopaedic surgeons and Otolaryngologists indicated they practiced surgery in a rural or regional area. (http://www.surgeons.org/media/21893722/2015-06-05_rpt_-2014_census.pdf)

What activities has the Rural Surgery Fellowship funded in the past?

Neil Meulman, a General Surgeon from rural NSW, undertook Oncoplastic Breast Surgery courses in Europe. While the courses confirmed a lot of his current practice they also made him aware of a great range of possibilities that he is enthusiastic to offer to the patients in his community.

"The beauty of a lot of oncoplastic surgery is that it is technique rather than equipment-based and hence is less likely to be met with financial obstruction when introduced into a regional hospital. Like a lot of countries around the world there are financial considerations to most new medical developments."

Jonathan Golledge, a Vascular surgeon from regional Queensland, visited leading US research centres to increase his knowledge regarding vascular research, surgery and diseases that can be disseminated through research and clinical practice within a regional centre.

"The Vanderbilt University Medical Centre is a truly integrated research and clinical health service facility. This appeared unique by Australian standards in integrating research and clinical facilities and scientists and health care professional within the same centre. The set-up seemed a great template for Australian hospitals interested in becoming an academic centre."

Niall McConchie is an ENT surgeon from rural Victoria. The Fellowship enabled him to attend endoscopy ear surgery courses in Boston and Glasgow – courses in a relatively new area to ENT surgery. In the long term endoscopy will allow for better results for the patient in terms of less invasive procedures and a change of thinking regarding the disease process of the middle ear with an emphasis on improving the function of the middle ear to eradicate disease.

"Overall, the courses have enabled me to significantly change my clinical practice and I think have improved both myself and, more importantly, the results that I can obtain for my patients in giving a more up to date and exemplary surgical management plan."

Neil Kling, a General Surgeon, from WA, attended the Surgical Training for the Austere Environment course run by the Royal College of Surgeons. In spite of working in a high trauma environment in South Africa, followed by 12 years as a regional surgeon in WA, Neil felt he lacked preparation (especially obstetrics and gynaecology) to work in more austere locations.

"Having spent some time working in conflict areas of South Sudan and now in Afghanistan, I can say that this course was undeniably the best preparation available for working in an austere environment."

The Rural Surgery Section (RSS) represents the interests of surgeons in working in rural Australia and New Zealand. Membership of the RSS is free and open to all Fellows with a stake or interest in this area. Increased cross-specialty representation and engagement in the Section is encouraged and welcomed.

Applications for Rural Surgery Fellowships in 2017 are now open, and Fellows are encouraged to visit the Rural Surgery website for more information http://www.surgeons.org/member-services/interest-groups-sections/rural-surgery/.

Congratulations Dr Primal Singh

2016 Mark Killingback Colon and Rectal Surgery Section Prize Winner

As the recipient of the 2015 Mark Killingback Prize I was fortunate to attend The American Society of Colon and Rectal Surgeons Annual Scientific Meeting held in Los Angeles in May 4, 2016. This is the largest scientific meeting in North America devoted exclusively to colorectal surgery and was attended by over 1,700 surgeons from around the world.

As part of this prize, I was privileged to present my research paper 'Randomised controlled trial of perioperative simvastatin therapy in major colorectal surgery' as a podium presentation. This was well received and it was great to meet American Trainees and discuss research and differences in surgical training between our countries.

The conference had outstanding scientific sessions, including updates on core topics such as diverticulitis, benign anorectal conditions, inflammatory bowel disease and rectal cancer. I found these extremely useful as a Surgical Trainee and also particularly enjoyed the debate sessions on extended thromboprophylaxis, mechanical bowel preparation, and management of distal rectal cancer.

Some take home messages included: a single dose of prophylactic antibiotics in elective colorectal surgery is better than multiple doses for 24 hours, that the therapeutic/biologic effect of anti-TNF agents can significantly exceed their half-lives suggesting elective surgery should be delayed at least 6 to 12 weeks, anterolateral thigh flap for closure of perineal wounds and novel intraoperative methods for testing perfusion to anastomoses

This conference was a thoroughly enjoyable and rewarding experience and I would like to thank RACS for this wonderful opportunity.

2017 Rural Surgery Fellowship for Provincial Surgeons

Call for Applications

The Rural Surgery Section (RSS) Committee is offering up to three travelling grants to assist provincial surgeons who wish to spend time away from their practice to travel and develop existing skills or acquire new skills in a field of benefit to the surgeon, the College and the community.

Each Fellowship will be valued to a maximum of AUD$10,000 (incl. GST) and is to be expended in the 2017 calendar year.

Eligibility criteria

The applicant must be a rural or remote based Fellow in Australia or New Zealand whose practice post code is non-metropolitan. At the time of submitting their application the Fellow must be a permanent resident or citizen of Australia or New Zealand, or an International Medical Graduate accepted into the College as a Trainee.

Application Process, Selection and Reporting

Applicants are required to submit an application form with specific details of the planned trip and visit.

Selection will be dependent on:

- the abilities and experience of the candidate
- the extent to which the proposed activity will enhance surgical or clinical skills
- the merit of the proposed travel plan
- and the potential benefits to the individual and/or other surgeons from the travel
- current membership of the Rural Surgery Section
- preference for secured structured visits / appointments to established units over less structured proposals.

Fellowship recipients will be expected to provide a written report on their experience and present a brief descriptive paper at the annual conference of the Provincial Surgeons of Australia (PSA)

Full details of the Fellowship and application process are available on the RACS website at Rural Surgery Fellowship for Provincial Surgeons or by contacting the Rural Surgery Section Secretariat by email rural@surgeons.org or by telephone on +61 3 9276 7409

Applications close 5.00 pm Friday 27 January 2017

Western Medicine

Outlining challenges and overcoming obstacles in Western Australia

MR STEPHEN HONEYBUL
WA Chair

I have now been in the role of Chair of the Western Australian Regional Committee of the Royal Australasian College of Surgeons for 15 months. It has been my privilege to be in this position and to advocate on issues of importance to WA surgeons in partnership with my fellow committee members. Whilst preparing this article I looked back at previous issues and read with considerable interest the article by my previous Chairman, Rob Love. In his commentary he describes the difficulties that have been encountered when introducing new technologies, specifically those encountered with the commissioning of Fiona Stanley Hospital. This was back in 2012 and the planned opening was to be in October of that year. As we all know this was further delayed and the subsequent opening has not been without some difficulty.

There is no doubt that many aspects of the hospital's development are to be celebrated and this is a testament to the commitment of the hard working and diligent staff. However, as Head of Department of the relatively small neurosurgical service working at the "grass roots" level, I have been able to witness first hand some of the difficulties encountered. I believe these should be aired in public, not so much as a complaint, but rather so we can learn from our mistakes. This is especially pertinent given that there are a number of similar high profile projects being undertaken in South Australia and Queensland.

One of the major problems has been the somewhat overly ambitious nature of the whole project, which set itself to fall even before the doors had opened. There is little doubt that the building itself is excellently engineered and the technology available is cutting edge. However, all too often commentators were proclaiming that this was going to be the flagship hospital in Australia within two to three years. A more realistic approach would have been to slowly develop the facility with a view to gradually increasing the complexity of procedures performed, and to develop the type of environment in which multidisciplinary teams could be fostered over a number of years.

What has actually occurred is fragmentation of surgical services such that heads of department have limited ability to lead and develop their services. The financial downturn had led to widespread uncertainty amongst staff, many of whom have had their positions terminated. The freeze on recruitment has also led to considerable difficulties in obtaining anaesthetic cover for elective surgical lists, such that many have had to be cancelled at short notice. At the recent WA, SA and NT Annual Scientific Meeting David Fletcher gave an excellent talk about the difficulties encountered. As a leader in our field he not only outlined the problems but also suggested some of the possible solutions. The most compelling issue has been the lack of engagement of senior clinicians and there are now moves afoot to correct this issue.

When I was training, the head of department was someone who was seen as a mentor to whom you would go for advice and guidance regarding surgical performance, research and career planning. As a Trainee within a neurosurgical department, I would expect my seniors to be involved in RACS activities such as Trainee seminars, College examinations and Trainee supervisory board membership. I also expected the hospital executive to be supportive of these activities. I myself have been a member of the SET Neurosurgical Board, and I am currently an examiner for the Fellowship of the Neurosurgical Society of Australasia. I take pride in fulfilling these duties, which I feel to be paramount to the ongoing development of my specialty, and the practice of surgery in general throughout Australia.

However, in recent years all my dealings with hospital administration at any of the tertiary hospitals within Western Australia has revolved solely around money. I have been to numerous so-called 'dashboard meetings' with executive co-directors and financial consultants, and been asked to explain or justify variances in targets achieved. All too often when I ask how the data has been obtained I am met with blank stares and my colleagues and I frequently come away from these meetings with a feeling that little has been achieved. I completely understand that within the healthcare provision we all have fiscal responsibility, but this should not replace our role as surgical leaders. This lesson has been learnt in the United Kingdom where considerable effort is now being directed to reducing the bureaucratic framework within the National Health Service as it is becoming increasingly obvious that this limits creativity and slows down progress.

I would suggest that this is precisely the reason why Fiona Stanley Hospital is struggling. I accept money is limited, but would contend that the role of surgical leaders is not to count dollars but to develop their service within the confines of their budget. This can be determined by the hospital executive who in turn would expect a return on that budget in terms of clinical performance. Clinical outcome must be seen as the driving force rather than dollars spent. This must be our focus in the following years.

I actually think this will occur and although this may have been a relatively negative discussion, I am optimistic regarding the future of healthcare provision in Western Australia. Chairing the WA Regional Committee has exposed me to many aspects of our public healthcare service. I have always been impressed by the hardworking and dedicated nature of my colleagues across all aspects of medical, nursing and ancillary staff. I think the recent appointment of David Russell-Weisz as Director General was positive, and although he has a difficult task ahead, I can think of no one better to guide us in the following years. I look forward to providing any support that is required.

Wishing you all the best in health and surgery.

2016 Medal recipient Francis Lannigan (Aus)

Aboriginal, Torres Strait Islander and Māori

Scholarship Program

RACS is supporting Indigenous doctors by providing opportunities to undertake surgical-related education and training

DAVID MURRAY
Chair, Indigenous Health Committee

Increasing the representation of Aboriginal, Torres Strait Islander and Māori doctors in the surgical workforce is a RACS priority. The Reconciliation Action Plan and the Maori Health Action Plan acknowledge that support for new graduates and final year medical students with an interest in surgery is desirable, as this is the time when decisions regarding career pathways are being considered and professional development plans are being drawn up. Providing opportunities for 'aspiring' surgeons to undertake surgical-related education, skills training and research will strengthen career portfolios and importantly lead to mentoring and support networks, to help inform and aid career choices.

RACS has been working to determine appropriate pathways to identify and support prospective Aboriginal, Torres Strait Islander and Māori Surgical Trainees. Since 2010 awards have been offered to Aboriginal, Torres Strait Islander and Māori final year medical students, junior and resident doctors to participate in the educational and scientific program of the Annual Scientific Congress (ASC).

In 2012 the first travel bursary was awarded to an Aboriginal medical student to allow their participation in the surgical skills workshop convened annually by the Victorian Regional Committee. Held at the Skills Lab in Melbourne, these popular workshops showcase a selection of surgical specialties, with hands-on stations staffed by enthusiastic consultant surgeons, registrars, and industry sponsors.

In 2017 the Indigenous Health Committee, in conjunction with the Foundation for Surgery, will be offering a suite of new Aboriginal, Torres Strait Islander and Māori scholarships. In addition to Awards for attendance at ASC 2017, a new scholarship program focused on career enhancement for junior and resident doctors and a new scholarship program for medical students has been launched.

The career enhancement scholarships for junior (resident) doctors will support activities that align with the RACS JDocs Framework. JDocs describes the many tasks, skills and behaviours that should be achieved by doctors at defined early post graduate year levels and will assist in their development towards a career in surgery and other proceduralist careers.

The career enhancement scholarships for medical students will support activities that benefit the final year of undergraduate medicine, such as the VRO surgical skills workshop, attendance or presentation at a medical, surgical or Indigenous health conference, or the undertaking of surgical-related research projects.

For full details of the new career enhancement scholarship programs, ASC awards and to read the reports from previous ASC and VRO surgical workshop attendees, please visit the Indigenous Health webpage at http://www.surgeons.org/member-services/interest-groups-sections/indigenous-health/

Feedback from recipients

Annual Scientific Congress

Dr Zanazir Alexander: "To be able to attend the conference at such a junior stage in my career was invaluable, as it helped to clarify my own pathway forward and enabled supportive networks to be established with Fellows of the college and other RACS staff."

Claudia Paul: "Many of us came away from the conference thinking: wow, they're people, just like you and I, which I believe resonates a level of achievement that we can aspire to, regardless of previous disadvantage or hardship. It removed a lot of self-doubt I had held, especially as a medical student. I am more confident in addressing senior colleagues and consultants, which is something I found quite difficult in the past."

Kersandra Begley: "I felt very welcomed into the ASC environment, and each person I met was happy to impart advice on what they had learnt throughout their careers. This was a major strength of attending the ASC. The ranges of life experiences shared by each individual were so varied and strong, it helped dismantle some of the stereotypes about surgeons portrayed within medical school. The ASC allowed me to filter out some of the misinformation that I had been told before about lifestyle and surgery."

Dr Joshua Knudsen: "It was often the sessions I hadn't planned on going to that were the most interesting. With an interest in Orthopaedics I found the masterclasses great with plenty of practical opportunities. Dinners and Breakfasts were not only tasty but led to the opportunity to meet the people whom I had heard so much about."

Surgical Workshops

Anika Tiplady : "What excites me is the many paths that are open to me in the future. Which one I travel down I have absolutely no idea, but attending the VRO workshop certainly made a couple of those paths a little more interesting."

Anika Tiplady: "Often as a student, it is difficult in the busy hospital environment to connect with trainee registrars, and sometimes a feeling of embarrassment is also felt when asking questions as a surgical career seems so far away. This workshop provided this opportunity in a relaxed environment and I really appreciated that. They answered my questions, gave me some advice and were pretty down-to-earth people, which fit with my outlook."

Sarah Bormann: "Attending the clinical skills workshop has allowed me to believe that actually it is okay to want to be a surgeon and that a surgery career is possible no matter where you have come from."

Natasha Martin: "A key point I noted was, when considering a specialty make sure you enjoy the common procedures."

Image (Clockwise from top-left): Dr. Lincoln Nicholls and Foundation Chair Kingsley Faulkner; Foundation for Surgery Aboriginal, Torres Strait Islander and Māori award recipients; Assoc. Prof. Edward Wilkes; VRO surgical skills workshop.

A spirit of Reconciliation & Co-operation

Strengthening Partnerships Australian Indigenous Doctors' Association 2016

PHILIP TRUSKETT
President

From September 14-17 I was proud to represent RACS at the Australian Indigenous Doctors' Association (AIDA) 2016 Symposium in Cairns. RACS maintains a strong collaborative relationship with AIDA going back a number of years. This year, as part of the launch of our Reconciliation Action Plan, we recommitted to expanding this relationship. RACS was a gold sponsor of the event for the second year running and acknowledged by AIDA for demonstrating leadership in our support of Aboriginal and Torres Strait Islander medical students, doctors and specialists.

Promoting RACS approach to equity

As part of the formal proceedings I presented during a plenary session on RACS' Reconciliation Action Plan. Immediately prior to my presentation Professor Martin Nakata, Pro-Vice Chancellor, Indigenous Education and Strategy from James Cook University in Townsville spoke passionately about the need to address the gap faced by many Aboriginal and Torres Strait Islander medical students, before they enter medical school and not just during undergraduate training. This message was particularly resonant as it is consistent with the approach being undertaken by RACS as outlined in our current Reconciliation Action Plan. His very strong message was that Indigenous students should not be set up to fail. He has recently moved from UNSW where he held a similar role. At UNSW he doubled the degree completion rate by Aboriginal, Torres Strait Islander and Māori students. He has a lot to teach us.

RACS is committed to an equity approach and providing the appropriate support for success. Following Professor Nakata I presented on RACS commitment to provide support for Aboriginal and Torres Strait Islander medical students and those in the prevocational space to meet the standards required for surgical training and support them to succeed. For 2017, the RACS Foundation for Surgery is supporting 12 Career Enhancement Scholarships (see page 42-43 for additional details) open to Aboriginal, Torres Strait Islander and Māori final year medical students and prevocational doctors. The purpose is to support them in gaining the knowledge and skills required for successful entry into surgical training. To my knowledge RACS is the only medical college in Australasia that is formally recognising this gap and offering this type of support for Aboriginal, Torres Strait Islander and Māori doctors and medical students.

Engaging workshops

I was joined by RACSTA representative Dr Tom Arthur and together we ran a heavily over-subscribed laparoscopic skills workshop on the second day of the meeting. Participants enjoyed the opportunity to spend time hands on with the FLS trainers and run through basic exercises. Rotating time on the trainers amongst small groups offered an opportunity to speak with delegates about their goals and the possible surgical training and career options open to them in the future. I would also like to thank Paul Cargill for his logistic preparation and setting up of 6 laparoscopy stations in record time.

Following the skills workshop Dr Arthur, Jacky Heath, RACS Manager of Prevocational and Online education and I participated in a two hour AIDA session entitled "Growing our Fellows", with representatives from other colleges. The session offered AIDA medical students and junior doctors an opportunity to rotate around the room and put questions to college representatives. It provided particularly interesting insight into the rumours and misconceptions about specialist training circulating through medical schools and an opportunity to provide up to date information. RACS has been collecting data on Aboriginal and Torres Strait Islander applicants to surgical training and working hard to learn more about why potential applicants may not apply.

Images (Clockwise from top left); President Truskett presenting RACS Reconciliation Action Plan; students practising laparoscopic techniques; President Truskett with previous Foundation ASC award winners-presented with their painted stethoscope; President Truskett Presents AIDA 2016 Associate Member Award

AIDA 2016 Awards – Acknowledgement of our growing partnership

As part of the formal proceedings each year AIDA presents three awards to its members who have demonstrated an outstanding contribution to Aboriginal and Torres Strait Islander health. The awards were designated into three categories, associate member, student member and AIDA member. This year I was honoured to be asked to present

> *"RACS is committed to an equity approach and providing the appropriate support for success"*

the awards in partnership with AIDA President Dr Kali Hayward. This was the first time a partner organisation has been invited to participate in AIDA's awards ceremony and I was truly humbled to be offered an opportunity to contribute and for this formal recognition of RACS efforts and partnership.

Foundation for Surgery
Passion. Skill. Legacy.

Congratulating Foundation for Surgery ASC Award winners on their continued success

The Foundation for Surgery's generous support for Aboriginal, Torres Strait Islander and Māori medical students and prevocational doctors has offered a number of opportunities for those with an interest in surgery to attend our major scientific meeting, learn more about RACS and the surgical specialties and engage with Fellows, Trainees and IMGs. This year I was able to congratulate two former 2015 Foundation for Surgery ASC medical student award winners Dr. Mitchell Sutton and Dr. Artiene Tatian on their successful completion of medical school and their transition into the workforce. AIDA acknowledges its medical school graduates by awarding stethoscopes hand painted with an Aboriginal design. Upon completion of a specialty fellowship AIDA members are awarded a second beautifully framed painted stethoscope. This is a special occasion for Aboriginal and Torres Strait Islander doctors to be acknowledged by their peers. Continuing to engage with and encourage these talented young doctors and demonstrate RACS ongoing support for their achievements was truly a highlight of the meeting.

Upper GI Vic surgeons throw their weight behind new bariatric research

Providing a high-volume Bariatric service in the public health system is safe, cost-efficient and effective, according to new research conducted by Victorian Upper GI surgeons.

The research analysed the surgical and health outcomes following 1453 Bariatric procedures and showed the surgery achieved a reduction both in weight and co-morbidities for super obese patients while the service itself provided vital high-volume bariatric training for Upper GI registrars and Fellows.

It was conducted by surgeons from the Alfred Hospital in Melbourne – the only public hospital in Australia to offer such a high-volume Bariatric service – who tracked patients over six years from 2007 including follow-up data to 2014.

It showed that patients lost up to 20 kilograms in the first year after surgery with weight loss continuing over the six years of follow up, with high patient compliance rates indicated, along with significant reductions in the rates and severity of co-morbidities such as diabetes and sleep-apnoea.

The lead author of the research, Upper GI surgeon Mr Paul Burton, conducted the study with part-funding support provided through the RACS Foundation for Surgery Research Scholarships.

It follows his PhD research into the physiology and pathophysiology of adjustable gastric banding, which showed that the procedure works by switching off appetite rather than mechanically restricting food intake.

Mr Burton said that there was now no doubt that Bariatric surgery was the single most effective treatment for obese patients and that it could and should be offered within the public health system.

He also thanked RACS for its support over many years and called for greater research funding to be made available by government agencies to help drive developments in the field to maximise public health benefits.

"Obesity is a key public health issue and surgery is the only effective treatment and yet there remains a critical lack of funding support for research into this field either through ignorance as to how obesity works as a disease or through lingering stigma towards obese patients," Mr Burton said.

"There is no question now that Bariatric surgery is not only the most effective intervention there is, it also provides a net health cost benefit by reducing the need for medications and medical devices, reducing hospital admissions and increasing employment.

"The cost-benefit ratio of Bariatric interventions is heavily skewed toward the benefit side of the ledger and yet Bariatric surgery research does not attract the funding it deserves from the broader health research community.

"There is enormous potential to further refine Bariatric procedures but we need the Government and the NHMRC to support surgical research so that we can provide those benefits to the Australian community."

The research, published earlier this year in the *Australia and New Zealand Journal of Surgery,* followed the outcomes of all Bariatric procedures conducted at the Alfred Hospital when it agreed to fund a high-volume service to address growing patient demand in 2007.

The patients were on average super-obese and predominantly female with most receiving LAP BAND surgery, which required an average length of stay of just over one day.

More than 400 of the procedures were performed by Upper GI Trainees or registrars.

The head of the Upper GI and General Surgery Unit at the Alfred Hospital and senior researcher of the study, Associate Professor Peter Nottle, said that such training was vital and should be offered at large public teaching hospitals across Australia.

> *"Previous studies have also shown that reducing obesity has similar public health effects as reducing smoking, alcohol-related harm and road trauma and that Bariatric surgery is the most cost-effective intervention we can provide to improve the health of obese patients"*
>
> *- Co-author of the research report Professor Wendy Brown from Monash University and the Alfred Hospital's Upper GI Unit.*

He said the Alfred Hospital's Upper GI Unit was now performing between 300-350 Bariatric procedures each year, which both improved the quality of life for patients while providing the only high-volume Bariatric surgical training in the public health system in Australia.

He said that training involved pre-operative assessments and post-operative care while the surgery itself involved a number of procedures including LAP BAND surgery, sleeve gastrectomy and Roux-en-Y gastric bypass.

He praised the Alfred Hospital management for supporting the service and its willingness to provide extra theatre and out-patient resources and said that each state in Australia should offer such a Bariatric service in at least one major public hospital.

"This aspect of Upper GI training is not widely available in the public system and yet our registrars and younger Fellows need to know both how to conduct the procedures and also understand what has been done in the past when treating return patients," A/Prof Nottle said.

"It is also important to remember that obesity is predominantly a disease of disadvantage, which means that many patients may not be able to afford treatment in a private setting.

"Yet there still seems to be a reluctance to fund such services in the public system because of the stigma attached to obese patients, Bariatric surgery and the surgeons who perform it.

"Yet obesity is a chronic illness that needs to be treated and can be treated and we need the resources in our public teaching hospitals to train the surgeons capable of treating it.

"However, the greatest resources should go into preventing childhood obesity because once someone puts on substantial excess weight it is very hard to get rid of it without surgical intervention."

Co-author of the research report Professor Wendy Brown from Monash University and the Alfred Hospital's Upper GI Unit said the findings into the quality and safety of the Bariatric surgical program were reassuring given the complex cohort of patients treated.

She said that while standard assessments of obesity included a BMI greater than 35 with two co-morbidities, the patients treated at the Alfred had an average BMI of 50 with four co-morbidities including diabetes, sleep apnoea, hypertension and hypercholesterolemia.

The majority of patients who were treated by the service during the time of the study were required to undergo a full health assessment by their GP, attend a health information seminar and complete an on-line modular healthy eating and exercise education program before surgery.

The study found that of the 1453 Bariatric procedures performed, there was an unplanned ICU admission rate of less than one per cent, no deaths, high patient satisfaction ratings and a greater loss of weight in those who undertook the pre-surgery educational program.

Professor Brown said that while 17,000 Bariatric procedures were conducted in Australia each year, less than 10 per cent were performed in the public health system where most surgical training was provided.

She said the Upper GI team at the Alfred Hospital set out to determine if they could achieve optimal results in a high-volume, public hospital training environment and that the results proved it could be done.

"We know that obese patients need only lose 15 per cent of their body weight to achieve improved health outcomes and this was achieved in the majority of our patients," Professor Brown said.

"Previous studies have also shown that reducing obesity has similar public health effects as reducing smoking, alcohol-related harm and road trauma and that Bariatric surgery is the most cost-effective intervention we can provide to improve the health of obese patients.

"The Victorian Government should be congratulated for taking the lead in funding Bariatric surgery within the public health system at a time when there is still great misunderstanding about the physiology of obesity as a chronic illness.

"This study also indicates that hospitals in particular can benefit from this surgery by treating high resource-use patients who require frequent admissions due to the diseases associated with obesity."

- With Karen Murphy

Congratulations!

Associate Professor Norman Eizenberg

Honorary Fellowship

The Council of the Royal Australasian College of Surgeons admits from time to time distinguished surgeons, scientists and other persons to Honorary Fellowship of the College in recognition of their contributions to Surgery, Surgeons and the College. The purpose of the award is to recognise significant work of eminent individuals in any field of endeavour.

The Council of the Royal Australasian College of Surgeons admits from time to time distinguished surgeons, scientists and other persons to Honorary Fellowship of the College in recognition of their contributions to Surgery, Surgeons and the College. The purpose of the award is to recognise significant work of eminent individuals in any field of endeavour.

Norman Eizenberg graduated in medicine from the University of Melbourne and is currently Associate Professor in the Centre for Human Anatomy Education, Department of Anatomy and Developmental Biology at Monash University as well as Head of Clinical Teaching in the Melbourne Clinical School at The University of Notre Dame. He is a distinguished academic with nearly 40 years' experience teaching medical students and surgical trainees. At Melbourne University Norman rose through the ranks from Demonstrator, Lecturer and then Senior Lecturer where he coordinated the teaching of anatomy to medical students and contributed to major Faculty revisions of the medical curriculum. He joined the staff at Monash in 2009 and Notre Dame in 2016. His major areas of research are medical education and the surgical significance of anatomical variations.

His association with this College dates from 1976 when he gained top marks in the Part 1 Fellowship examination. Norman has been a key coordinator of the GSSE program and a senior examiner on the Anatomy Discipline Committee of the College. He is also a long standing contributor to basic sciences for the Royal Australasian College of Dental Surgeons and an anatomy examiner for the College of Radiology.

Norman is the project leader of the widely acclaimed, multimedia, e-learning program Anatomedia Online, which comprehensively explores anatomy from multiple perspectives providing flexibility and interactivity for the student to "construct" the human body by systems and regions or "deconstruct" the body, by dissection and imaging. This provides surgical trainees, with limited resources and heavy clinical commitments, the opportunity to study online in their own time and place of choice. Associate Professor Eizenberg is a cofounder of the very successful, dissection-based postgraduate Diploma in Surgical Anatomy offered by Melbourne University in association with the College. He is a founding member of the Australian and New Zealand Association of Clinical Anatomists (ANZACA).

Norm Eizenberg is an outstanding teacher with a strong commitment to our College and a worthy recipient of an Honorary Fellowship of this College.

Citation kindly provided by Mr Richard Wong She FRACS and Mr Lubomyr Lemech FRACS

Associate Professor Norman Eizenberg (left)

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:

2016

Robin Gilmore, New Zealand Fellow

Tom Taylor, NSW Fellow

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

Informing the College

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

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

While RACS accepts and reproduces obituaries provided, we cannot ensure the accuracy of the information provided and therefore take no responsibility for any inaccuracies or omissions that may occur.

Over 50 and riding a quad bike? You're at risk.

DR. JOHN GRAHAM
FRACS

Some years ago, in this journal, I recounted my experience with a quad bike rollover. Spraying herbicide near dark on the side of a creek, a strap securing the spray tank snapped and the bike rolled, throwing me into the creek bed. The bike rolled over me and amazingly landed on its wheels, tank and rider intact. Others have not been so lucky and the statistics have not improved since then.

Deaths among men in their 50s and 60s from quad bike incidents are unfortunately not isolated. A study by the Australian Centre for Agricultural Health & Safety examining 610 on-farm fatalities between 2001 and 2015 found that nearly half of all people killed in on-farm non-intentional incidents were aged over 50. Of those, more than 90 per cent were male. Farm vehicles and machinery were responsible for almost two thirds of the fatalities, with quads alone involved in 85 cases.

Children under 16 don't have the mental capacity to make safe decisions on such an inherently unstable vehicle, and they don't have the body mass to ride it safely

Older farmers are at increased risk of injury due to the normal processes of ageing. These include reduced strength, flexibility and balance, issues with sight, hearing and memory, and the possible influences of some medications. While older farmers may be involved in fewer incidents, if they are injured, they are more likely to die.

This year alone there have been eight reported fatalities in Australia. Of the older cohort, a farmer in his late 60s died on his Pomborneit East farm in Victoria in June. A month earlier, prominent lawyer Ross Ray was killed and found pinned under a quad bike at his hobby farm in Merrijig near Mansfield on a Sunday afternoon. Four other men aged 53-88 have been killed in NSW and Queensland. These deaths are tragic, and could be prevented with more 'fit-for-purpose' vehicles.

The situation is similar in New Zealand, where quad bikes are also used extensively within agriculture. On average five people are killed each year, and 850 injured, although last year nine people were killed.

While it's important that older farmers continue to be actively involved in work, the benefits need to be balanced with personal safety. If you're over 50 and still riding a quad bike, consider switching to a more stable vehicle such as a side by side. I did – and I now have a very versatile vehicle that will do everything I need on the farm and is much safer to drive. And I can take passengers out to see the cows in relative comfort and safety.

Associate Professor Warwick Teague

Tasmanian Coronial Inquest

Earlier this year, the Tasmanian Coroner decided to hold an inquest into the deaths of seven quad bike riders across the state between 2012 and 2015. Victorian paediatric surgeon Warwick Teague was the lead author of a RACS written submission to the inquest, which recommends:

1. Development and adoption of a suitable standard for quad bike helmets designed for off-road riding and compulsory use for all riders.
2. Adoption of all available strategies to prevent children under 16 years from riding quad bikes of any size or specification.
3. Compulsory quad bike handling training for all new quad bike owners, and employees whose work involves quad bikes.
4. An Australasian New Quad Bike Assessment Program similar to the ANCAP safety rating system for cars.
5. Industry-partnered development and implementation of an Australian standard for quad bikes, and consideration of more demanding safety requirements for workplace quad bikes.

A/Prof Teague will represent RACS at the inquest hearings, if required, due to begin in early October.

For many years, surgeons have been strong advocates for legislative change to support the prevention of quad bike injuries and deaths, particularly in children. In the last 15 years in Australia, 52 boys and girls under the age of 18 have died in quad bike incidents. Forty of those deaths were children under 16 years, and five deaths occurred on 'child'-sized quad bikes.

In New Zealand, the most recent tragedy in August involved a five year old boy who drowned in a creek after the child-sized quad bike he was riding, rolled and pinned him underwater at a property in Kumeu, West Auckland.

"Children under 16 don't have the mental capacity to make safe decisions on such an inherently unstable vehicle, and they don't have the body mass to ride it safely," A/Prof Teague says.

"In the past ten years we have seen literally hundreds of children arriving at hospitals in Victoria with quad bike injuries. When we look at those with major injuries, apart from the ones that die at the scene and never get to any hospital, as many as 40 per cent end up with an ongoing disability.

"The current laws and recommendations are not doing enough. We know from the introduction of 'Sean's law' in Massachusetts how effective strong laws can be in preventing deaths.

"Sean's law refers to legislation passed in Massachusetts in 2010, which introduced a variety of quad bike safety measures, including a ban on children under 14 using quad bikes.

"We must do more to ensure Australian and New Zealand children reach their next birthday."

- Special thanks to Tony Lower for research provided

Case Note Review

Who is managing this patient?

PROFESSOR GUY MADDERN
Surgical Director of Research and Evaluation

Clinical Details:

This elderly patient was admitted for an elective percutaneous nephrolithotomy for a large left staghorn calculus. The patient was known to have had a large renal calculus since 2005 on that side but had been lost to follow-up. He re-presented to the Urology outpatients with a history of recent 'flank pain' and lower urinary tract symptoms. Further investigation also demonstrated a bladder stone.

The patient subsequently underwent an uncomplicated transurethral prostatectomy (TURP) and removal of a bladder stone. The patient was then scheduled for a left percutaneous nephrolithotomy (PCNL). There was no identifiable medical contraindication for this planned operation. He had well-controlled hypertension, gastro-oesophageal reflux disease (GORD) and moderate but asymptomatic mitral valve regurgitation. The patient's medications included fish oil (which was presumed ceased).

Intraoperatively, despite an earlier successful placement of a guide wire, significant difficulty was encountered gaining percutaneous access to the collecting system. Tract dilatation was performed, but access failed despite three attempts. The procedure was appropriately abandoned and there seemed to be no obvious problem. The anaesthetic was completed mid-morning and the patient arrived in recovery within fifteen minutes. The patient was kept in the recovery for over an hour. Observations in recovery were normal and the patient appeared stable.

The patient was then transferred to the surgical ward. A drop of blood pressure (to 95/60 mmHg) was noted on arrival and an hour later 70/40 mmHg was recorded and the urology resident was notified. Intravenous (IV) normal saline (300 mLs) was given and the plan was to review the patient in 30 minutes. Blood pressure (BP) rose to 90/50 mmHg but the patient was not reviewed for over two hours when the resident was again called. BP then was 80/60 mmHg. Haematuria was noted and the patient complained of left flank pain.

The patient was given 500mL of normal saline over the next hour. Investigations included full blood examination), electrolytes and liver function tests, and coagulation studies and group and save blood for transfusion was initiated. A large IV cannula was inserted. Hb was recorded as 120gm/mL. The platelet count was normal. No radiological, investigations were arranged. BP was 130/70mmHg one hour after the bloods were taken but shortly thereafter dropped to 60/40 mmHg. The patient became increasingly drowsy and an "arrest code" was called. Transfer to the intensive care unit was prompt and the urology registrar was called. Persistent retroperitoneal bleeding was thought to be the diagnosis and surgical intervention was planned. Repeat Hb was then noted to be 70 gm/mL and despite transfusion and resuscitation, the patient remained unstable. Two hours later, the patient suffered a refractory ventricular fibrillation and died.

Comments:

Was the decision to operate a reasonable one? The decision to operate on this patient was not an issue as the patient was symptomatic with left loin pain. The choice of surgery, a PCNL, was also not an issue as there was good cortical preservation of that kidney despite the presence of a large staghorn calculus. One may argue the role of differential renal function in determining the choice of treatment (nephrectomy versus PCNL). It is well documented, however, that the kidney function is likely to improve if stone clearance can be achieved.

Was the postoperative complication recognised in a reasonable time? The delay in diagnosis of a significant retroperitoneal bleed is a significant issue. Considering the difficulty in this percutaneous approach and the failure to access the collecting system despite puncture tract dilatation, the issue of renal parenchymal trauma with significant retroperitoneal bleeding should have been considered. Immediate radiological investigation should have been arranged to confirm the possible diagnosis. This would then expedite urgent appropriate management.

Who was managing this patient? The patient was seen by the urology resident on the ward for their hypotensive episode. Inexperience, mixed with uncertainty about the possible causes of this significant hypotensive episode, led to a failure to notify a more senior colleague. The urology registrar and consultant were not notified until late in the event.

The systemic failure may perhaps have been avoided if there was appropriate education of the junior medical and nursing staff about the possible complications of a 'failed' PCNL. Clear communication in postoperative instructions/orders should have been written by the consultant drawing attention to the high risk of postoperative bleeding and encouraging early discussion of any concerns at the consultant surgeon level.

Program Overview

Correct at time of printing (September 2016). May be subject to change.

	Monday 8 May 2017	Tuesday 9 May 2017	Wednesday 10 May 2017	Thursday 11 May 2017	Friday 12 May 2017
Breakfast Session 7:00am – 8:20am	Pre-Congress Workshop Program Transplantation Surgery Program Global Health Program	Masterclasses	Masterclasses	Masterclasses	Masterclasses
Session 1 8:30am – 10:00am		Opening Plenary	Scientific Sessions	Scientific Sessions	Scientific Sessions
10:00am – 10:30am		Morning Tea with the Industry	Morning Tea with the Industry	Morning Tea with the Industry	Morning Tea with the Industry
Session 2 10:30am – 12noon		Scientific Sessions	Plenary Session	Plenary Session	Plenary Session
12noon – 12:30pm		Keynote and Named Lectures	Keynote and Named Lectures	The President's Lecture	Keynote and Named Lectures
12:30pm – 1:30pm		Lunch with the Industry	Lunch with the Industry	Lunch with the Industry	Lunch with the Industry
1:30pm – 2:00pm		Keynote and Named Lectures	Keynote and Named Lectures	Keynote and Named Lectures	Keynote and Named Lectures
Session 3 2:00pm – 3:30pm		Scientific Sessions	Scientific Sessions	Scientific Sessions	Scientific Sessions
3:30pm – 4:00pm		Afternoon Tea with the Industry	Afternoon Tea with the Industry	Afternoon Tea with the Industry	Afternoon Tea with the Industry
Session 4 4:00pm – 5:30pm		Scientific Sessions	Scientific Sessions	Scientific Sessions	Scientific Sessions
Evening Functions 7:00pm – 11:00pm	Convocation Ceremony 5:00pm – 6:30pm Welcome Reception 6:30pm – 7:30pm	Section Dinners	Section Dinners	Congress Dinner	

ABSTRACT SUBMISSION

ABSTRACT SUBMISSION WILL BE ENTIRELY BY ELECTRONIC MEANS.

This is accessed from the Annual Scientific Congress website **asc.surgeons.org** by clicking on Abstract Submission.

Several points require emphasis:

1. Authors of research papers who wish to have their abstracts considered for inclusion in the scientific programs at the Annual Scientific Congress must submit their abstract electronically via the Congress website having regard to the closing dates in the call for abstracts, the provisional program and on the abstract submission site. **Abstracts submitted after the closing date will not be considered.**
2. The title should be brief and explicit.
3. Research papers should follow the format: Purpose, Methodology, Results and Conclusion.
4. Non-scientific papers, e.g. Education, History, Military, Medico-Legal, may understandably depart from the above.
5. Excluding title, authors (full given first name and family name) and institution, the abstract must not exceed 1750 characters and spaces (approximately 250 words). In MS Word, this count can be determined from the 'Review' menu. Any references must be included in this allowance. If you exceed this limit, the excess text will NOT appear in the abstract book.
6. Abbreviations should be used only for common terms. For uncommon terms, the abbreviation should be given in brackets after the first full use of the word.
7. Presentations (slide and video) will only have electronic PowerPoint support. Audio visual instructions will be available in the Congress provisional program and will be included in correspondence sent to all successful authors.
8. Authors submitting research papers have a choice of two specialities under which their abstract can be considered. Submissions are invited to any of the specialties or special interest groups participating in the program except cross-discipline.
9. A 50-word CV is required from each presenter to facilitate their introduction by the Chair.
10. The timing (presentation and discussion) of all papers is at the discretion of each Section Convener. Notification of the timing of presentations will appear in correspondence sent to all successful authors.
11. Tables, diagrams, graphs, etc CANNOT be accepted in the abstract submission. This is due to the limitations of the computer software program.
12. Authors must be registrants at the Congress to present and for their abstract to appear in the publications, on the website or the Virtual Congress.
13. Please ensure that you indicate on the abstract submission site whether you wish to be considered for:

SECTION PRIZE

- Bariatric Surgery (Trainees)
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- Cardiothoracic Surgery (Trainees)
- Colorectal Surgery (Mark Killingback Prize for Younger Fellows & Trainees)
- Craniomaxillofacial Surgery (Trainees)
- Endocrine Surgery (Tom Reeve Prize - Trainees)
- General Surgery (Trainees)
- Global Health (Trainees)
- Head and Neck Surgery (Trainees)
- Hepatobiliary Surgery (Trainees)
- Military Surgery (Trainees)
- Orthopaedic Surgery (Trainees)
- Paediatric Surgery (Trainees)
- Pain Medicine (Trainees)
- Quality and Safety in Surgical Practice
- Rural Surgery (Trainees)
- Surgical Education
- Surgical History (Trainees)
- Surgical Oncology (Trainees)
- Transplantation Surgery (Trainees)
- Trauma Surgery (Damian McMahon Prize for Trainees)
- Upper GI Surgery (Trainees)
- Vascular Surgery (Trainees)

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SCIENTIFIC POSTERS

All posters will be presented electronically during the Congress and will be available for viewing on plasma screens in the industry exhibition. Posters will be placed on the Virtual Congress in addition to the abstract.

IMPORTANT DATES

Abstract Submission opens
October 2016

Closure of Abstract
29 January 2017

Closure of Early Registration
17 March 2017

RACS ASC Section Conveners and Visitors

Correct at time of printing (September 2016). May be subject to change.

SECTION	CONVENERS	RACS VISITORS	COUNTRY
Bariatric Surgery	Jacob Chisholm	Assoc Prof Matthew Kroh	USA
Breast Surgery	Robert Whitfield	Prof Judy Boughey Prof Sarkis Meterissian	USA CANADA
Cardiothoracic Surgery	Fabiano Farto Viana Michael Worthington	Prof Nasser Altorki Dr Jeswant Dillon	USA MALAYSIA
Colorectal Surgery	Elizabeth Murphy	Prof John Monson Assoc Prof Sonia Ramamoorthy Assoc Prof Andrew Stevenson	USA USA AUSTRALIA
Craniomaxillofacial Surgery	Walter Flapper	Dr Anil Madaree	SOUTH AFRICA
Endocrine Surgery	Christine Lai	Assoc Prof Rory Clifton-Bligh Assoc Prof Robert Parkyn Assoc Prof Tracy Wang Dr Michael Yeh	AUSTRALIA AUSTRALIA USA USA
General Surgery	Adrian Anthony	Prof Jacques Belghiti Ms Meron Pitcher	FRANCE AUSTRALIA
Global Health	Suren Krishnan	Prof Rajat Gyaneshwar Prof Mark Shrime	FIJI USA
Head & Neck Surgery	John-Charles Hodge	Dr David Goldstein	CANADA
HPB Surgery	John Chen	Prof Pierce Chow Prof Charles Vollmer	SINGAPORE USA
Indigenous Health	David Murray		
Medico Legal	Paul Carney Cindy Molloy	Dr Katrina Hutchinson Dr Vinay Rane Prof Wendy Rogers	AUSTRALIA AUSTRALIA AUSTRALIA
Military Surgery	Anthony Chambers	Colonel Jeffrey Bailey	USA
Orthopaedic Surgery	Mark Rickman	Prof Justin Cobb	UK
Paediatric Surgery	Day Way Goh	Prof Paolo De Coppi Dr Eugene Kim	UK USA
Pain Medicine	Andrew Zacest	Mr Nikunj Patel	UK
Quality and Safety	Glenn McCulloch	Prof Mary Hawn Dr Sally Roberts	USA NEW ZEALAND
Rural Surgery	Matthias Wichmann	Prof O James Garden	UK
Senior Surgeon Program	John North	Mr David Davidson Prof Guy Maddern	AUSTRALIA AUSTRALIA
Surgical Directors Program	Rob Padbury	Prof Jeffrey Braithwaite	AUSTRALIA
Surgical Education	Peter Anderson	Prof Pamela Andreatta	USA
Surgical History	Brian Brophy	Dr Simon Chaplin	UK
Surgical Oncology	David Gyorki Robert Whitfield	Dr Sandra Wong Dr Karl Bilimoria	USA USA
Trainees Association	George Balalis Rob McCusker		
Transplantation Surgery	Eu Ling Neo	Mr Darius Mirza	UK
Trauma Surgery	Christopher Dobbins	Mr Peter Bautz	AUSTRALIA
Upper GI Surgery	Tim Bright	Assistant Prof Amir Ghaferi Prof Giovanni Zaninotto	USA UK
Vascular Surgery	Michael Herbert	Prof Ian Loftus	UK
Women in Surgery	Melissa Bochner Kate Drummond	Dr Rebecca Sippel	USA
Younger Fellows	Christine Lai Peter Shin		

SA and the ASC

The South Australian Audit of Perioperative Mortality and the 2017 Annual Scientific Conference

MR GLENN MCCULLOCH
SAAPM Chair

The 2017 Annual Scientific Congress (ASC) of the Royal Australasian College of Surgeons (RACS) will be held in Adelaide from May 8-12. The Quality and Safety Section will be organised by the South Australian Audit of Perioperative Mortality (SAAPM). The program for the meeting is well advanced and covers many areas other than audits of surgical mortality. Naturally such a section would not be complete without a presentation on what has been achieved by the Australian and New Zealand Audits of Surgical Mortality (ANZASM). In New Zealand this is operated under the guidance of the Health Quality and Safety Commission New Zealand as the Peri-operative Mortality Review Committee (POMRC). The 2015 POMRC report can be accessed at *https://www.hqsc.govt.nz/assets/POMRC/Publications/POMRC-fourth-report-Jun-2015.pdf*

Dr Cathy Ferguson, the current Chair of the RACS Professional Development and Standards Board, will be speaking at the 2017 ASC on the POMRC and its differences from the ANZASM. If you want to hear more, come to the Quality and Safety session on May 10 2017.

The session will also highlight other important audit programs and registries that are conducted by the RACS or by other surgical associations. Surgeons often know little of events outside their specialty so the program at this ASC will be a chance to learn about the Morbidity Audit and Logbook Tool (MALT) (Mr Adrian Anthony, Adelaide), the Australian Safety and Efficacy Register of New Interventional Procedures - Surgical (ASERNIP-S) (Professor Guy Maddern, Adelaide) and the Australian Orthopaedic Association National Joint Replacement Registry (Mr Graham Mercer, Adelaide).

There will also be a session in which all speakers are asked the same question – "What has the [ABC] audit achieved?" ABC in this instance represents the Australasian Vascular Audit, the Australian and New Zealand Society of Cardiac and Thoracic Surgeons Cardiac Surgery Database (Professor Julian Smith, Melbourne), the ANZ Gastric and Oesophageal Surgical Society Audit (Mr Andrew MacCormick, Auckland), the Bariatric Surgery Registry (Professor Wendy Brown, Melbourne), the BreastSurgANZ Quality Audit (Mr David Walters, Adelaide) and the Bi-national Colorectal Cancer Audit (BCCA) (Professor Alexander Heriot, Melbourne). With such a diversity of topics and speakers it will be hard not to learn something new.

There will also be a session in which the decision to operate on high risk patients will be considered from the point of view of an anaesthetist, a perioperative physician, an intensivist and an ethicist. As surgeons, the decision **not** operate is often harder than the decision to operate.

One of the visitors is Dr Sally Roberts, an infectious disease specialist from Auckland who will speak on 'Antimicrobial stewardship and surgery'. In association with Dr Roberts, there will be a symposium entitled 'Surgical site Infection – a continuing issue or a vanquished foe?' which will feature contributions from the specialties of Colorectal Surgery and Orthopaedic Surgery.

We are fortunate to also have several North American surgeons who will be attending the Developing a Career in Academic Surgery meeting which precedes the ASC. Some have expertise in Quality and Safety issues and have agreed to contribute to our program. These speakers will include:

- Mary Hawn, Stanford, California, USA ('Implementation of an early warning system to reduce in-hospital mortality')
- Karl Bilimoria, NW University, Chicago, Il, USA ('Does NSQIP make surgery safer for patients?')
- Amir Gheferi, Ann Arbor, Michigan, USA ('Failure to rescue – is it a failure in need of rescue?')

So, do plan to come to Adelaide in May 2017 and learn a lot about Quality and Safety.

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The surgical team at Labasa Hospital, Fiji

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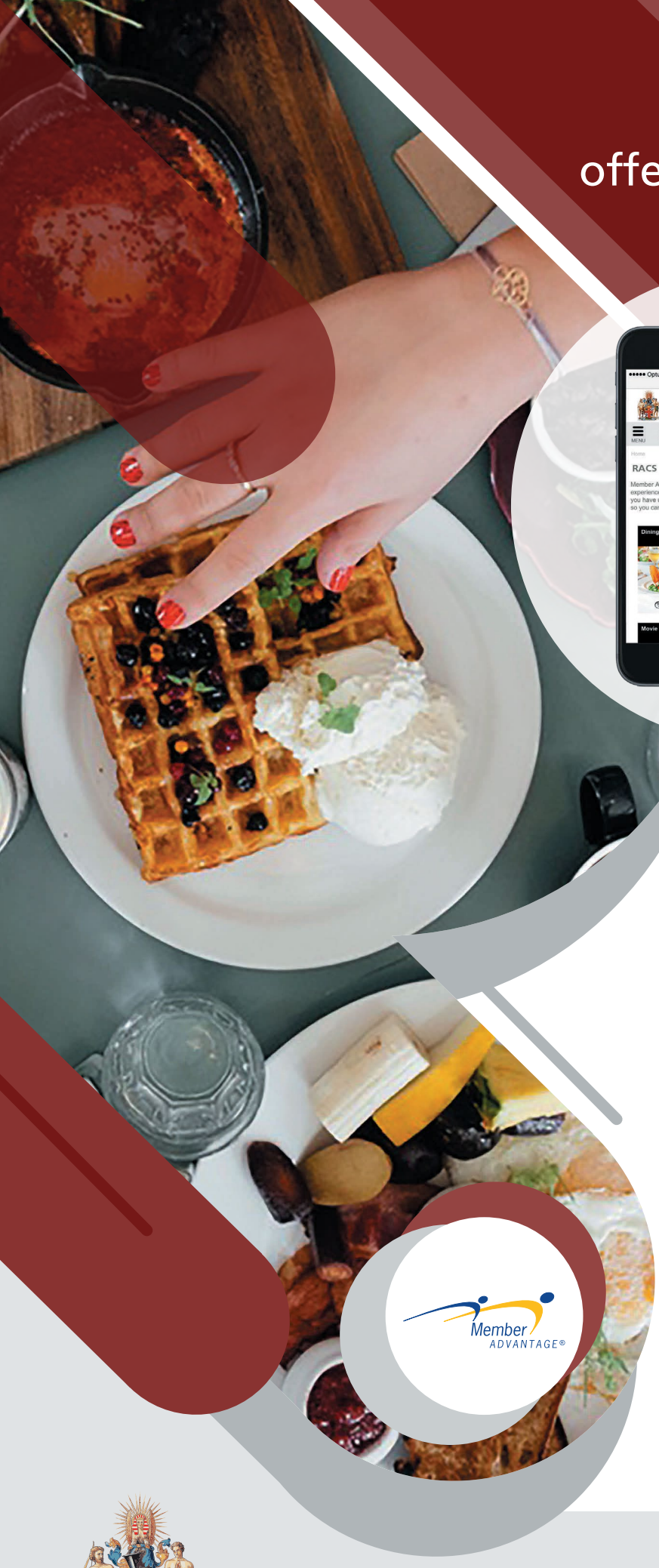

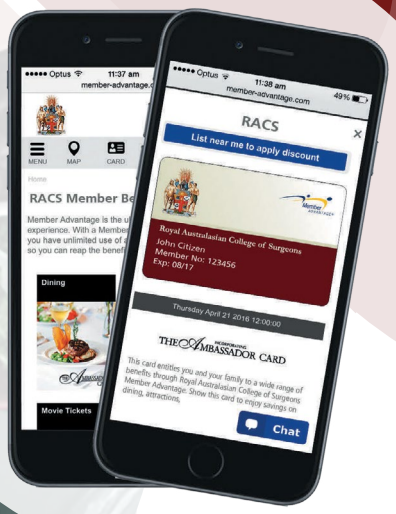

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