SurgicalNews

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ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Our health + wellbeing

WELLBEING

Reaching out to end burnout

VASCULAR SURGERY

Tradition and technology

RACS TRAUMA SYMPOSIUM

Pedestrians – staying safe

NOVEMBER ANNUAL ACADEMIC SURGERY CONFERENCE-

incorporating the Surgical Research Society of Australasia

Held in conjunction with the Academy of Surgical Educators Forum

THURSDAY 7 – FRIDAY 8 NOVEMBER 2019

Venue: RACS, Hughes Room, Melbourne

DAY ONE – SECTION OF ACADEMIC SURGERY CONFERENCE

Highlights and topics

Academic Surgeons – who are we?

The Surgeon Scientist	Presenter: Winthrop Professor Fiona Wood
The Surgeon – Teacher and Advocate	Presenter: Mr Eric Levi

Career Development

Fostering Junior academics: mentoring and sponsorship for a successful Academic Unit	Presenter: Associate Professor Sebastian King
Running meetings, building collaborations and influencing units	Presenter: Mr Jason Chuen

Academic Surgeons Today

Representing a minority group in Academia	Presenter: Associate Professor Kerin Fielding
Junior Doctors: Research and higher degrees from a JMO point of view	Presenter: Mr William Ridley

DAY TWO – SURGICAL RESEARCH SOCIETY OF AUSTRALASIA CONFERENCE

An opportunity to present your original surgical research. Prestigious and highly sought-after prizes awarded to fund attendance at international and national conferences, along with travel grants.

Guest speaker: Dr Taylor Riall, Professor, Chief, General Surgery and Surgical Oncology, University of Arizona, USA

Topic: Implementing a Resident Well-being program; Outcomes and Lessons Learned

Guest speaker: Dr Kristalyn Gallagher, University of North Carolina at Chapel Hill, Surgical Oncology, North Carolina, USA

Topic: A National Survey of Sexual Harassment Among Surgeons

Guest Speaker - Jepson Lecture: Professor Jeffrey Rosenfeld, Professor of Surgery at The Alfred

Topic: Forging a career in academic surgery: Advice for surgical academics of the future.

Proudly sponsored by Medtronic

Click HERE to REGISTER and for more information
Registration is free to attend Day One
and only $100 for Section of Academic Members
and $120 for non members for Day Two of the Conference

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President's perspective

It has been a busy few months for us with several annual scientific meetings taking place in Australia and New Zealand along with the implementation of various advocacy initiatives.

I would like to commend the NSW Government for its recent decision to formally recognise the parental leave entitlements for surgical Trainees returning to NSW after completing a rotation of their training elsewhere in Australia or New Zealand.

RACS has been a long-term advocate for the portability of Trainees' parental leave entitlements. Many of the smaller surgical specialties require interstate and even trans-Tasman moves for broad exposure during surgical training. At present, New Zealand and each state and territory have separate policies determining eligibility for paid parental leave, mostly requiring 12 months' continuous service in that jurisdiction. This means that if these Trainees have to move interstate while pregnant, they may no longer be eligible for paid parental leave. This issue is one of many factors identified about surgical training that discourage women choosing surgery as a career and also affects men taking parental leave.

The NSW decision is a good sign of progress being made on this issue and RACS will continue to advocate for formal leave recognition arrangements across Australia and New Zealand.

I also wish to congratulate our colleagues for their hard work in support of the Northern Territory Government's new *Liquor Licensing Act*, which has taken a comprehensive approach. RACS has a long track record of advocating for a minimum price on alcohol across Australia and supports evidence-based measures. It is pleasing to see such enactment as surgeons are confronted first-hand with the devastating consequences of alcohol related trauma. We also know from our audits of surgical mortality that hepatic issues and alcohol misuse are much higher per capita in the Northern Territory compared to similar audit reports in other jurisdictions.

We have also continued to support advocacy efforts on road safety thanks to the work of many staff and Fellows such as Dr John Crozier. The number of deaths and serious injuries on Australian roads remains unacceptably high. Road trauma crisis demands real leadership, close collaboration and smarter data. We need a collective response and action to halt the silent annual epidemic of road crash deaths and serious injuries. We have expressed our support of the proposals in the Australian Automobile Association report *Reviving Road Safety, Federal Priorities to Reduce Crashes and Save Lives.*

We have had various events taking place around Australia and New Zealand focusing on promoting education and networking opportunities for our Fellows, Trainees and International Medical Graduates. These events, which include annual scientific meetings and preparation for practice, are important activities in our annual calendar.

IMAGES (l-r): Tri-State Annual Scientific Meeting, Mr Mark Livesey QC, Professor Guy Maddern and Dr Christine Lai; Dr Phil Worley presented Dr Sathish Paramasivan with the 2019 RP Jepson Medal for best research paper.

The first event took place in New Zealand in early August where surgeons discussed the future of surgery, surgical funding and the surgical workforce. This is a critical issue for colleges around the world, as we have to contend with an increasingly ageing population and workforce, a fact that will give us some significant challenges in the near future.

We also held a scientific meeting in August in my home state, South Australia, with surgeons from South Australia, Western Australia and the Northern Territory meeting in Port Lincoln to discuss technological advancements and what they mean for surgery. The conference provided a unique opportunity to explore what the future of surgical technology might look like and analyse what could be learnt from the implementation of past innovations. It was pleasing to see the South Australian Minister for Health and Wellbeing, Honourable Stephen Wade, attend the conference and dinner and speak on the topic of 'Securing a technologically advanced surgical workforce for South Australia'.

Well done to our staff, Fellows, Trainees and International Medical Graduates who supported and attended the various events.

IMAGE: New Zealand Annual Scientific Meeting, Mr Russell Blakelock, Professor Ian Civil and Mr Tony Sparnon.

Despite these positive gains, we continue to see ongoing media coverage on the issues of surgeons' fees and inappropriate behaviour in the surgical workplace. We encourage anyone with a concern to contact their employer, RACS, the Australian Health Practitioner Regulation Agency or the Medical Council of New Zealand.

RACS' Code of Conduct requires Fellows to behave in a respectful manner to patients, families, colleagues and staff at all times. Inappropriate behaviour such as bullying and sexual harassment is unacceptable in the workplace and research suggests it can increase the risk of complications for patients in a healthcare setting.

Since 2015, RACS' *Building Respect, Improving Patient Safety* initiative has been teaching surgeons about ways to build a culture of respect. It is not enough to be a technically competent surgeon. We require our Fellows to be skilled in clinical judgement and decision making, and to be ethical and compassionate, placing their patients' best interests first.

This advice also applies to fees. RACS does not prescribe or mandate any schedule of fees and does not have regulatory powers to control fees, but we believe full disclosure and transparency are essential. Professional fees charged should be justifiable and must not exploit a patient's need or take financial advantage of the patient. This principle is stipulated in the RACS Code of Conduct.

We recently updated our position papers on surgeons' fees, informed financial consent and informed consent. These guidelines were developed collaboratively with the assistance of our Fellows. I encourage all Fellows to familiarise themselves with these guidelines.

In conclusion, I would like to note that the month of October in Australia and New Zealand focuses on creating more awareness of mental health and wellbeing. RACS encourages all surgeons, Trainees and International Medical Graduates to recognise and discuss the challenges facing them and to ensure that self-care is part of managing their professional and personal lives. Like everyone else, surgeons are at risk from stress, burn out and a range of illnesses. It's our responsibility to discuss and recognise any symptoms and to seek appropriate professional care when necessary. Visit the RACS Surgeons' wellbeing webpages to find out more and know that support is available from RACS.

Mr Tony Sparnon
President

RACS

APPLICATIONS OPEN

Court of Examiners for the Fellowship Examination

Applications for appointment to the Court of Examiners are now open for the following specialties.

- **Cardiothoracic Surgery**
- **General Surgery**
- **Neurosurgery**
- **Orthopaedic Surgery**
- **Otolaryngology Head and Neck Surgery**
- **Plastic and Reconstructive Surgery**
- **Urology**

Please email your completed application form and a current curriculum vitae to Court.Examiners@surgeons.org by Friday, 8 November 2019 for appointment in 2020.

Application forms and relevant policies are available on the Court of Examiner webpage or by request from the Examinations Department.

www.surgeons.org/about-racs/about-the-college-of-surgeons/governance-committees/training-education-examinations-boards/court-of-examiners

For further information please contact the Examinations Department.

Email Court.Examiners@surgeons.org

Phone 03 9276 7471

Transforming the College and improving our future

Over the past two decades, RACS has responded and adapted its processes to the increasingly diverse needs of the fellowship. We have now reached a point where there is very limited capacity for our existing systems to adapt further.

The RACS 'One College Transformation' is a comprehensive transformation program, initiated earlier this year, that looks at everything we do in a cohesive and strategic manner. It encompasses our organisational structure and capabilities, governance, communication channels, external relations and member needs to allow us to build technology requirements from the ground-up.

From a governance perspective, the program will focus on improving the governance structure to reduce complexity and duplication, and enable increased agility and more effective strategic oversight. We will do this by designing a more streamlined RACS committee structure and developing a new policy framework that improves member engagement.

The One College Transformation program has a substantial technology component. A transformation team of internal and external resources has been tasked with reviewing, redesigning or reconfiguring all RACS systems, platforms, data and applications. This will ensure that we meet future needs and requirements, in partnership with our Fellows, Trainees and International Medical Graduates (IMGs) and specialty societies.

The transformation team has completed its initial internal discovery and found that the College operates many disparate systems, processes and information that are dated or have reached end of life. The consequence of this has been sub-optimal experiences for our Fellows, Trainees, IMGs, specialty societies and staff in their interactions with RACS and its technology.

These findings were presented to RACS Council in late June 2019, where funding was approved to progress the 'One College Transformation' program.

Improvements and upgrades

The delivery of the technology program will be phased over three to four years, with the first 18 months focusing on:

- establishing a "single view" of our members and their College activities so that everything is linked and interactivity for members is facilitated
- embedding a new, modern customer relationship management platform, available across all channels including mobile and tablet
- a new digital workspace for staff, including new intranet, team collaboration space and video conferencing
- a new education and training platform which will enable us to enhance the learning and examination management experience of our Trainees and Fellows
- a new continuing professional development platform which will provide more flexible tracking of activities and professional development to support learning plans and reflective practice
- a new platform to provide more consistent support scholarships
- a new eHub for our members to engage with RACS and access resources
- a new website platform to deliver a more personalised experience
- a faster and more secure network and operating environment.

Perhaps the best way to describe the future state we are aiming for is to use our vision:

"We will be One College to serve all members (Fellows and their specialty societies, Trainees, IMGs) and staff."

"As a member, RACS will understand my life journey with the College and provide me with timely, accurate and relevant information and experiences throughout all stages to build on my existing knowledge, skills and attitudes."

What's next?

The One College Transformation team is in the detailed planning phase to establish the required program and project governance. It is consulting and engaging with all our stakeholders and especially with Fellows and staff through a number of steering committees and fora.

The team is also in the design phase to deliver a 'target state' technology blueprint. As part of this phase we are keen to understand how our stakeholders such as the specialty societies operate and engage with RACS. It would be invaluable for us to forge a strong, collaborative relationship early on to ensure that the needs of the societies are catered for.

The One College Transformation program is a complex and ambitious program of work. Inevitably, there will be challenges as we move forward, and we ask for your patience, support and feedback. We will continue to keep you informed of progress and to seek your input.

The outcomes of the transformation will enable RACS to meet its strategic intentions by providing excellent service to our internal and external stakeholders as we fulfil our mission of being a leading advocate for surgical standards, education and professionalism in Australia and New Zealand.

Mr Richard Perry
Vice President

In September, Australia held RU OK Day? and in October joined New Zealand in marking World Mental Health Day and Mental Health Awareness Week.

RACS encourages all surgeons to recognise and discuss the challenges facing them and to ensure that self-care is part of managing professional life.
For strategies and resources on practising self-care, looking after your health, coping strategies, maintaining support networks and RACS surgeon support, visit the Surgeons' wellbeing pages at surgeons.org

General Surgeons Australia – The Wellbeing Summit

With repeated news stories around doctors-in-training and the risk a surgical career poses to their mental and emotional health, a few like-minded surgeons decided to come together to propose a new initiative under General Surgeons Australia – The Wellbeing Summit: For You, For Your Patients – a wellbeing program focusing on just that – the wellbeing of our registrars and surgical Trainees.

As we are all aware, from the commencement of their training, doctors are under immense pressure which then continues throughout their career. The emotional and physical impact can be devasting, with burnout often the result. In extreme cases, the impact can lead to a complete mental breakdown, walking away from their chosen career, or worse.

[1]The World Health Organisation defines health as "a state of complete physical, mental and social wellbeing."[1] While doctors strive to achieve this for their patients on a day-to-day basis, it is becoming clear that when it comes to doctors in training, this is not the case. Many factors play into this: time, management, institutions, colleagues, superiors, competitiveness and homelife to name a few. Harnessing insight, awareness and knowledge, summit convenors Dr Sue Velovski, Dr Rebecca Lendzion and Dr Trafford Fehlberg set out to develop a weekend program focusing on the tools and skills required to improve overall wellbeing; and to start an important conversation.

With the assistance of a faculty made up of surgical Trainees, Fellows, senior surgeons and supervisors of training, the weekend program was presented in Brisbane in September to 35 attendees from across Australia. The program shone the spotlight on the importance of non-technical skills including: the role of the surgeon, resilience and work-life balance, burnout, human factors, life hurdles and overall wellbeing.

What came to fruition was an honest weekend of shared knowledge, ideas and experience that we aim to continue, and hopefully breaking down barriers and positively impacting hospital workplace culture.

Sincere thanks to all who were involved, and in particular Dr Sue Velovski, Dr Rebecca Lendzion and Dr Trafford Fehlberg; all of whom are passionate about the wellbeing of their surgical colleagues.

Reference:

1. HealthKnowledge: https://www.healthknowledge.org.uk/public-health-textbook/medical-sociology-policy-economics/4a-concepts-health-illness/section2/activity3

Creating a culture of support

We are rapidly developing a certain knee-jerk reaction to the issues of surgeon wellbeing, burnout and mental health. For some of us, these words evoke a passionate response because we have had a personal experience or know a colleague who has gone through this journey. Still for others, I can almost hear the sound of eyeballs rolling so far to the back of the heads whenever this is mentioned. *"Why is everyone burned out?" "Nobody burned out back in my day!"*

Not everything is burnout. We are confusing burnout with mental health disorders and daily stress. Stress is a normal expected psychological and physiological response to a challenge. The work of a surgeon is stressful. Stress is a normal part of life and growth. A healthy amount of stress is helpful to increase learning and performance, but of course, excessive undue stress is potentially damaging physiologically and psychologically. Much like physical exercise or mental challenge from examinations, these stresses improve our general performance. High intensity stresses interweaved with periods of rest is what the mind and body need to develop resilience over time. Resilience arises from stress and rest. Stress and rest.

Mental health disorders, such as depression and anxiety, are diagnosable medical conditions on the basis of Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and International Classification of Diseases (ICD-11) categories. One needs to meet certain criteria to be diagnosed with a mental illness. It's that black dog that we know has affected our surgical efficiencies but because of stigma we have not been able to reach out for help. For many of us, these are the biggest hurdles to our improved performance. To that end, RACS is supportive of all initiatives to break down stigma of mental disorders and is continually encouraging all Fellows, Trainees and International Medical Graduates to engage with their GPs. Treatment of mental health disorders require the involvement of GPs and mental health professionals (counsellors, psychologists, psychiatrists, etc). Early engagement reduces risk.

Burnout is not a mental disorder. It is not a medical diagnosis. Burnout is a state of chronic occupational stress characterised by the triad of emotional exhaustion, high cynicism and reduced professional efficacy (ICD-11 definition). Modern surgical practice is not like what it used to be. The relentless academic, bureaucratic, administrative and electronic demands are not insignificant and intrude daily on clinical work. It is this chronic relentless occupational stress that up to half of us are experiencing[1]. It affects our work efficiency and safety.

The solutions to burnout require occupational intervention. No amount of antidepressants will fix a toxic workplace environment or poor rostering. Yoga, mindfulness and resilience training will not be sufficient treatment in a major depressive disorder.

We don't beat burnout alone. We do it as a department.

Check in on your colleagues. Ask "R U OK?"

Provide practical support.

Encourage GP reviews.

These measures are inexpensive yet invaluable.

As surgeons, we have a duty of care to attend to our own health and wellbeing in order to deliver care of the highest standards to our patients[2]. This means we need to learn to deal with daily stresses and manage our mental and physical health through engaging with our GPs. As leaders of our immediate spheres of influence we need to create a safe and positive workplace by operating with respect and creating a culture of support for our colleagues. We don't beat burnout alone. We do it as a department. Check in on your colleagues. Ask "R U OK?" Provide practical support. Encourage GP reviews. These measures are inexpensive yet invaluable. What can you do in your department that will increase engagement and reduce burnout? Ultimately, we do this for the benefit of our patients. A healthy, supported and engaged surgeon will provide care of the highest standards to their patients.

References

1. Beyond Blue. National Mental Health Survey of Doctors and Medical Students. October 2013.
2. World Medical Association. Declaration of Geneva. Oct 2017. Cited on 20 Aug 2019. https://www.wma.net/policies-post/wma-declaration-of-geneva/

Dr Eric Levi
FRACS

Reaching out to end burnout

Two years ago, we were talking about how to make people more resilient, Dr Carrie Kollias said, "as if it were an individual person problem". But the discussion has now shifted "to whatever systemic issues are causing this problem".

Dr Kollias (left) is an orthopaedic surgeon who led a national wellness study of Canadian orthopaedic surgeons. The issue she is talking about is doctor burnout, which is affecting a troubling number of surgeons across Australia and New Zealand.

Burnout is defined as occupational stress, and can be characterised by three factors – emotional exhaustion, cynicism and low professional efficacy. It is not a mental illness, but can be considered a mental health issue. The assessment tool most commonly used to measure burnout in doctors is the Maslach Burnout Inventory (MBI).

In February 2019, *Beyond Blue* released its updated National Mental Health Survey of Doctors and Medical Students,[1] which reported measurements in burnout as high as 47.5 per cent and 45.8 per cent for emotional exhaustion and cynicism in Australian doctors aged between 18 and 30 years.

This is not surprising to Dr Kollias. "People are giving up their 20s and 30s, and they've gone into this profession with largely idealistic reasons ... they're met with a stark reality of a mismatch in the culture where they can't provide the care they want to provide because they're handcuffed in many ways."

The result of this is what Dr Kollias refers to as "moral injury", where younger doctors are not able to live up to their own "standards and expectations".

Dr Trafford Fehlberg (right) is a specialist general surgeon in the Northern Rivers of NSW. He was on the organising committee of the General Surgeons Australia Wellbeing Summit, which was held in Brisbane over a weekend in late August this year.

"Part of it is that you have a lot of hoops to jump through in your training years, and don't have much control over your life," Dr Fehlberg said. Trainees can also be "often moving ... which is quite arduous," resulting in moving away from colleagues at work and support networks at home. It can also be difficult to eat well and keep fit. "Some people manage to maintain a healthy lifestyle, but often people who are struggling at work find it hard to get out and enjoy things," Dr Fehlberg said.

While burnout is more common in younger doctors, Dr Fehlberg said that doesn't make it uncommon "in any way for people in their middle or later stages of their careers". In fact, doctors aged between 31 and 40 years reported measurements for emotional exhaustion and cynicism of 34.8 per cent and 36.5 per cent in the *Beyond Blue* study, and doctors between the ages of 40 and 60 years measured between 29.1 per cent and 36.5 per cent for the same domains.

Surgeons often don't recognise they're heading for burnout. They're also disinclined to ask for help. "Surgeons tend to get on with it, keep going, marching on – completely lost and depersonalised", Dr Kollias said, and "the risk is that you go on and then literally just crash and burn, and you have to stop practising abruptly."

When Dr Kollias was on the Medical Regulator Board in Canada, prior to coming to Australia, she'd get phone calls "from people saying 'I have a surgeon in my department who has to stop and I need to redistribute their patients'," she said. "We don't want anybody to get to that point."

Another poignant experience occurred while Dr Kollias was leading a symposium of predominantly orthopaedic surgeons in Canada. She asked them: "How many of you, as a Trainee, ever had a consultant talk to you about what it's like to have a medical regulator complaint?" Out of 250 attendees, "only five put their hand up," she said. This is particularly noteworthy in view of evidence that a medical regulator complaint is a risk factor for burnout and even suicide.

It can be difficult to discuss a real-life problem when there's potential that colleagues may perceive it as a weakness and, unfortunately, this fear is backed up by research. *Beyond Blue* found that 48 per cent of medical professionals believed doctors with a history of mental health disorders were less likely to be appointed than those without such a history. And approximately 59 per cent of doctors believed that being a patient "caused embarrassment for a doctor".

"If you're worried that your career will be affected if you properly identify a mental health disorder then you're going to try and mask it as much as possible," Dr Fehlberg said. "Colleagues should keep an eye out for each other," he added. They should look for early warning signs such as "decreased satisfaction in your work, loss of enthusiasm for the job and expressing negative thoughts about your patients." He also suggested identifying emotional exhaustion. "If this appears to be a frequent or common thing, then you should get help for yourself or support any colleagues who might need help."

A report in the *American Association for Physician Leadership* (AAPL) concluded that "physician-directed interventions were associated with important but small decreases in burnout", while individual-directed approaches supplemented by organisational-directed interventions "had longer lasting positive effects."[2] The report identified four domains that allow doctors "to better cope with the consequences of burnout at the individual level". These are "emotional (calming techniques), mental (mindfulness), spiritual (knowing one's purpose) and physical (including exercise and proper sleep)".

"It's interesting when you're working in a hospital or team with a really good culture then the stress of the long hours is often not as taxing," Dr Fehlberg said. Any individual person can work on their team culture, he added, and what happens with positive people is "they lift the people around them up and that has a good flow-on effect".

Opening up and confiding in somebody is an important thing to do – somebody who's looking out for you as a friend at work, as well as a colleague

Research demonstrates the strength of this observation. Three studies by Shanafelt and Rosengart in AAPL[2] found that surgical leaders "have a profound impact on the job satisfaction rates of the physicians they lead." When their behaviour "models a positive and healthy work environment" it enables other doctors to "be engaged and effectively communicate with peers". Further, leaders who keep an "open-door policy" and who "offer praise and recognition" for achievements, help workers to "bring out their best qualities in the workplace".

Dr Kolias said the literature shows the following factors are protective against burnout:

- Fair and supportive leadership
- Aligning personal and organisational values
- Mentorship
- Active participation in decision-making
- Work group cohesion (and having a best buddy at work)
- Exercise
- Career fit: being able to dedicate 20 per cent of one's professional activities to what you find to be high meaning, for example – research, a specific type of surgery, teaching or administration.

Burnout can be addressed at the individual, team and organisational levels. Whether it's exercising regularly, having a best buddy at work or involving staff in decision-making, the most effective strategies consider the multidimensional workplace demands of Trainees and surgeons.

"Go and see a GP," Dr Fehlberg advised as an essential early step. "It's also really important to maintain a strong network of friends and family. Opening up and confiding in somebody is an important thing to do – somebody who's looking out for you as a friend at work, as well as a colleague."

References

1 Beyond Blue. National Mental Health Survey of Doctors and Medical Students. Feb 2019 (Updated). Retrieved from https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report_web.

2 Klevos GA & Ezuddin NS. In Search of the Most Effective Interventions for Physician Burnout. American Association for Physician Leadership. 15 May 2018. Retrieved from https://www.physicianleaders.org/news/discussion-burning-brightly-burning-out.

More information at surgeons.org

- *Do You Have a GP?*
- Surgeons wellbeing
- RACS support

Engaging in self-care

Get the health and wellbeing support you need

As a community, our understanding of mental health within the context of the workplace has grown significantly over the last few years, thanks to events like R U OK Day? and organisations like Beyond Blue. The facts are, one in five Australians will experience a mental health issue at some point of their lives. This means statistically if not yourself, then one of your friends, family members or colleagues will experience a mental health issue. At present approximately 2 million Australians live with anxiety and 1 million Australians live with depression. Sadly though, according to Sane Australia, only half of these people will access support.

We also live busy and increasingly fragmented lives. The demands of work, family, friends and extra-curricular activities continue to impact us. This is all aided and compounded with the dramatic infusion of modern technology in so much of what we do and how we communicate on a daily basis. This is both a blessing and a curse. It means sometimes we can be flexible with our work, but it can also result in us working outside of hours and not switching off when we are home and not being fully present no matter where we are.

It is extremely important that we can disconnect from the demands and intensity of work and engage in self-care or proper time-out on a regular basis.

Needless to say, it is extremely important that we disconnect from the demands and intensity of work and engage in self-care or proper time-out on a regular basis. Operating at 110 per cent all the time is not feasible in the longer term – intuitively we know this to be true.

Research demonstrates an excessive load and feeling chronically conflicted or exhausted increases the severity and morbidity associated with anxiety, depression and more significant mental illness. Collectively this reduces the capacity to function day-to-day and can lead to professional burnout with all the financial and reputational consequences that may then ensue.

Feeling stressed, overwhelmed or that you're just not coping should not be anyone's new normal. These are signs that you may benefit from some extra support, something beyond your usual coping strategies as they are falling short in some way. Seeking support from a skilled mental health professional is an obvious but frequently resisted option. Why this might be the case is worth exploring.

So where can you get good mental health support? Most medically trained individuals or people who work in the health world have a better grasp of the options available than most. Indeed, some have trusted colleagues and work connections that can help find the highest quality, credentialed and talented mental health professionals available. But having this knowledge so often is as far as most health professionals go. Interestingly though, there are still significant barriers and inherent cautiousness to take up these at-your-fingertips options. This is a deeper and more complex dynamic that shapes the likelihood of whether or not surgeons, or medical staff more broadly, access professional support for mental health conditions when they need it, even when they are at high risk of negative mental health outcomes.

Some time ago, RACS recognised that members were not taking up the option of accessing mental health support for a complex range of reasons. It was also recognised these same surgeons may well qualify to be able to access any number of Employee Assistance Programs (EAPs) through the organisation(s) where they work. For some surgeons, this may represent several choices if they hold a portfolio of roles across several health settings which is common in surgical practice – not to mention those who may be able to access their partner's EAP.

RACS recognised this but notes that the take-up of organisational EAPs was consistently low for surgeons and medical staff generally. Questions around trust, confidentiality, sense of belonging all variously contribute to the reasons driving this dynamic. So RACS worked with Converge International to rethink things and develop an EAP program that was better suited to the preferences of surgeons and surgical Trainees while guaranteeing confidentiality and access to top-tier mental health professionals. This is now available to all RACS members.

Sessions can be offered face to face at multiple locations across Australia and New Zealand or through phone, tablet via Zoom and Live Chat. RACS members can access four sessions per issue on a self-referral basis. Immediate family members are also entitled to four sessions per issue. Appointments can be made through the call centre, 1300 OUR EAP, at convergeinternational.com.au or through the Converge app, which is available to download for free through the iTunes and Google Play store.

Community-based support is also available. Referrals can be made to community-based psychologists through your GP. You can locate a psychologist to suit your needs through the 'Find a Psychologist' services with the Australian Psychological Society at psychology.org.au. RACS lists a variety of support options on the surgeons' wellbeing web pages at surgeons.org.

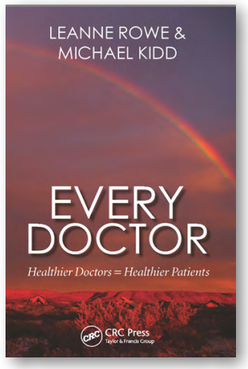
Most importantly, if you are struggling or someone you care about is, take action, as long-term passivity is usually part of the problem.

Article provided by Converge International.

Build better relationships at work

Speak in total confidence to a Converge International consultant.
Australia 1300 our eap (1300 687 327) **New Zealand** 0800 666 367
International +613 8620 5300 or **visit** convergeinternational.com.au

RACS library book recommendation



Every Doctor

Healthier Doctors = Healthier Patients

Leanne Rowe and Michael Kidd

Leanne Rowe is a family doctor and clinical professor at Monash University, Australia, who has cared for other doctors as patients for many years. Michael Kidd is a family doctor, current Professor and Chair of the Department of Family and Community Medicine at the University of Toronto in Canada, Professorial Fellow with the Murdoch Children's Research Institute in Melbourne and Honorary Professor of Global Primary Care with the Southgate Institute for Health, Equity and Society at Flinders University in Adelaide.

Every Doctor follows several themes, including: "be kind to yourself and enjoy your work", "develop a workplace culture of positivity, happiness, caring and love", "promote optimal standards of patient care" and "cultivate positive change in your workplace".

From the authors

Who is this book for?
As audacious as it sounds, this book is for every doctor – doctors of all specialties at all career stages, including medical students, recent graduates, doctors in training, experienced doctors and those approaching or beyond retirement; because exemplary care of our patients, our peers, our profession, our community and ourselves is a life journey.

Why this book?
Our starting point is excellence in patient care. Clearly, to provide consistent high-quality patient care, we must care for our own health and for the health of our colleagues.

What is this book about?
This book is different from generic self-help and mental health books in that it discusses practical strategies that work in medicine, based both on the medical literature and the wisdom of experienced doctors.

Key themes:
- Every doctor, mentally and physically healthier
- Every doctor working together to create a healthier medical culture
- Every doctor leading and influencing positive changes in their workplaces

E-Book version available via RACS Library at: https://bit.ly/2AtoI5w

Good listening and reading

Good listening

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Strategies to build resilience, reduce stress and maintain standards of performance

Professor Richard Turner – 4 September 2019

Stress can sneak up on anyone over time, and if left unchecked can affect the quality of behaviour and performance. But there are strategies to help build resilience – not only at the individual level but for teams and organisations as well. General surgeon Professor Richard Turner explains the steps you can take to build resilience.

Combating the rise of mental illness

Dr Geoffrey Toogood – 2 October 2019

After facing his own battle with mental illness, cardiologist Dr Geoffrey Toogood champions mental health support for fellow medical professionals and the general public.

Grappling with burnout, mental health and 'institutional health'

Dr Eric Levi – 21 August 2018

In this 2018 episode of the #PostOp podcast, Dr Levi discusses the widespread incidence of depression in the medical profession and some ways to address the issues of mental health.

Good reading

Contact the RACS library for any of these recommended good reads.

E-book chapters

Gee D.W., Zak Y. (2017) **Strategies to Help Establish Your Practice While Simultaneously Achieving Work Life Balance.** In: Renton D., Nau P., Gee D. (eds) The SAGES Manual Transitioning to Practice. Springer, Cham

Balch C.M., Shanafelt T.D. (2018) **The Role of Leaders, Supervisors, and Individual Surgeons in Reducing Burnout and Promoting Physician Wellness.** In: Scoggins C., Pollock R., Pawlik T. (eds) Surgical Mentorship and Leadership. Success in Academic Surgery. Springer, Cham

Latifi R. (2019) **The Human Cost of Modern Hospital and Healthcare.** In: Latifi R. (eds) The Modern Hospital. Springer, Cham

Panayiotou Charalambous C. (2017) **Emotions in Surgery.** In: Career Skills for Surgeons. Springer, Cham.

E-journal articles

Surgeon Wellness Results from Efficiency, Culture, Resiliency. Same - Day Surgery 2017 02/;41(2).

Squiers JJ, Lobdell KW, Fann JI, DiMaio JM. Physician **Burnout: Are We Treating the Symptoms Instead of the Disease?** The Annals of Thoracic Surgery 2017 10/;104(4):1117-1122.

Walker R, Pine H. **Physician Wellness Is an Ethical and Public Health Issue.** Otolaryngology–Head and Neck Surgery 2018 06/;158(6):970-971.

Nguyen CT. **Integrative Medicine as a Bridge to Physician Wellness.** Otolaryngology–Head and Neck Surgery 2018 06/;158(6):987-988.

Braun L, Stanguts C, Spitzer O, Hose L, Gunawan M, Kure CE, et al. **A wellness program for cardiac surgery improves clinical outcomes.** Advances in Integrative Medicine 2014 01/;1(1):32-37.

Theresa Jackson, Jake Morgan, Diane Jackson, Taylor Cook, Kevin McLean, Vaidehi Agrawal, et al. **Trends in Surgeon Wellness (Take a Sad Song and Make It Better): A Comparison of Surgical Residents, Fellows, and Attendings.** The American Surgeon 2019 06/;85(6):579-586.

Marmon, Louis M., MD, PhD, Heiss K, MD. **Improving surgeon wellness: The second victim syndrome and quality of care.** Seminars in Pediatric Surgery 2015;24(6):315-318.

Greenbaum A, Lawrence E, Auyang ED, Russell JC, Paul JS. **Mandatory Participation in a Wellness Program: The General Surgery Resident's Perspective.** Journal of the American College of Surgeons 2017 10/;225(4):S178-S179.

Lee EW, Hasty BN, Lau JN, Merrell SB, Hawn MT, Shanafelt T, et al. **Emotional Intelligence as a Possible Safeguard to Surgeon Wellness.** Journal of the American College of Surgeons 2018 10/;227(4):S145.

Spiotta AM. **Pursuing Wellness in Neurosurgery: Resiliency.** Neurosurgery 2019 02/;84(2):339-340.

Shanafelt TD, Oreskovich MR, Dyrbye LN, Satele DV, Hanks JB, Sloan JA, et al. **Avoiding burnout: the personal health habits and wellness practices of US surgeons.** Annals of surgery 2012 04/;255(4):625-633.

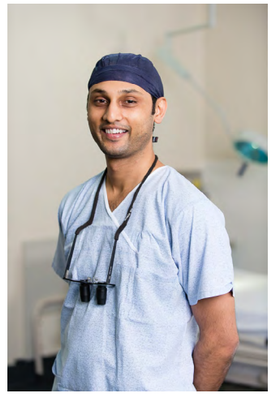
Chandrasekhar SS. **Equality Promotes Wellness.** Otolaryngology–Head and Neck Surgery 2018 06/;158(6):981-982.

Gold, Katherine J., MD MSW MS, Andrew, Louise B., MD JD, Goldman EB, JD, Schwenk TL, MD. **"I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting.** General Hospital Psychiatry 2016;43:51-57.

Spiotta AM, Fargen KM, Patel S, Larrew T, Turner RD. **Impact of a Residency-Integrated Wellness Program on Resident Mental Health, Sleepiness, and Quality of Life.** Neurosurgery 2019 02/;84(2):341-346.

Salles, Arghavan, MD, PhD, Lin, Dana T., MD, FACS, Liebert CA, MD, Esquivel M, MD, Mueller, Claudia, PhD, MD. **Belonging, Well-being, and Attrition in General Surgery.** Journal of the American College of Surgeons 2016;223(4):e40-e41.

Deutsch ES. **Staying Well in a Sea of Harm.** Otolaryngology–Head and Neck Surgery 2018 06/;158(6):983-984.



International experience pays off for Dr Iyer

Cardiothoracic surgeon Dr Arjun Iyer has been back in Australia for just a few months, but the surgical skills and expertise he acquired working with leading surgeons at St Paul's Hospital in Vancouver are still fresh.

Dr Iyer was awarded the prestigious RACS Margorie Hooper Travel Scholarship while he was a cardiothoracic Fellow at St Vincent's Hospital in Sydney. He had travelled extensively for training in his specialty within Australia, but until his journey to the northern hemisphere in 2018, he had not had international exposure to different approaches and techniques. The scholarship enabled him to experience new programs in a diverse surgical field, as well as further fine-tuning his skills in an internationally recognised institution.

"The scholarship was very much about further developing my established skillset, both technically and in decision-making", he said. This led to an amalgamation of techniques from the various institutions Dr Iyer had worked in, both nationally – including St Vincent's Hospital Sydney and Princess Alexandra Hospital in Brisbane – and internationally at St Paul's Hospital in Vancouver.

Focusing on cardiac surgery for a year and, in particular, the areas of cardiac transplantation and mechanical support, Dr Iyer gained invaluable experience at St Paul's Hospital under the tutelage of Dr Anson Cheung and Dr Jamil Bashir. In addition, he acquired new skills in off pump coronary surgery and in lead extraction treatments.

Dr Iyer not only flourished in the operating theatre, but he wholeheartedly embraced the vibrant city of Vancouver. Finding himself a place harbourside, he thoroughly enjoyed the time and opportunity to run and ride on most days.

The Canadians' zest for the outdoors is something that resonated with Dr Iyer. "It's very much about providing world-class care for your patients and then clocking off and running up Grouse Mountain, or smashing some runs at Whistler on the weekend and I loved it," he said.

Dr Iyer was encouraged by his mentors to seek a work-life balance, and it was ideal that the ski resort of Whistler was less than two hours away. "You could head to the ski slopes and, with adequate notice, still get back for any transplants," he remembered fondly.

These snatches of the wild outdoors were vitally important to him because it was the first time in Dr Iyer's career as a surgeon that he had "stepped back and actively sought the balance he hadn't necessarily made time for before". The benefits are obvious, he said. "Your productivity is better, your efficiency is improved, how you operate, and how you interact with the people around you."

Dr Iyer is currently a consultant surgeon at both Flinders Hospital in Adelaide and The Alfred in Melbourne. His roots very much lie in South Australia where his family live, and his formative years in medicine were spread between Adelaide University and the Royal Adelaide Hospital.

In the near future Dr Iyer hopes to see a heart failure service established in South Australia, as the current setup requires patients to travel to the eastern states for surgical therapy. "While we may not have the population for a cardiac transplant service, the rise of mechanical assist devices may yet prove to be a therapy we can offer here one day soon," he said. Having further nurtured these skills overseas, Dr Iyer is eager to contribute to the establishment of a service in South Australia.

> It provided me with the opportunity to learn from master surgeons while enjoying the people and the landscape of a beautiful country

The RACS scholarship has provided immensely meaningful experiences to Dr Iyer, and he is extremely grateful for them. "It provided me with the opportunity to learn from master surgeons while enjoying the people and the landscape of a beautiful country," he said.

The Margorie Hooper Travel Scholarship was established by bequest from the late Margorie Hooper to enable the recipient to travel or temporarily reside overseas or interstate to learn a new surgical skill for the benefit of the surgical community of South Australia.

Vascular Surgery: tradition and technology

It's been a busy couple of years for Mr Andrew Hill (pictured), a consultant vascular surgeon in Auckland since 1997 and Clinical Director of Vascular Services at the Auckland District Health Board.

In 2018, Mr Hill was the first New Zealand surgeon to be appointed President of the Australian and New Zealand Vascular Society (ANZSVS). That year he was also appointed an Officer of the New Zealand Order of Merit for his “meritorious service to the Crown and nation” as well as being appointed President of the World Federation of Vascular Societies.

Mr Hill's remarkable contributions to medicine are reminiscent of his predecessors – those determined and innovative young surgeons of the 1950s and '60s who led the way in vascular surgery, and whose clinical work and advocacy have left a rich legacy for Australians and New Zealanders.

It's no surprise that Mr Hill is showing no signs of slowing down. The World Federation of Vascular Societies is holding its conference in Australia next year and is expecting 400 attendees. As president, he will play an important role in that event.

His vision for ANZSVS is comprehensive – to provide “holistic and complete services for all vascular conditions including surgical treatment, endovascular treatment, post-operative follow-up and surveillance, as well as rigorous quality control”. On a more personal note, Mr Hill said he would strive to “keep the Australian and New Zealand collaboration strong”.

RACS collaborates with the ANZSVS to administer the Surgical Education and Training (SET) program, Mr Hill said, and “there's strong collaboration between the countries with a rotation of Trainees between Australia and New Zealand.”

Places in the SET program are highly sought after. In 2019, more than 30 applicants applied for the program and only 10 were accepted. The current SET Trainee cohort consists of 28 males and 14 females, and the Society is aiming to achieve a 50 per cent quota of females in the program. Dr Lupe Taumoepeau, who completed her vascular training in 2013, is a fine example. She is New Zealand's first locally trained female vascular surgeon and the only Pacific Island female vascular surgeon in Australasia.

Another strength of the collaboration is the annual ANZSVS Conference, which provides significant opportunities for medical students, Trainees and surgeons to present at the meeting. As a quality assurance measure, ANZSVS also conducts a web-based audit of all vascular surgery performed in public and private practice. The 2018 audit recorded 46,723 vascular operations across the two countries.

Over the last 10 to 15 years, there has been an evolution in vascular surgery, Mr Hill said, and “a significant move to endovascular intervention in the form of minimally invasive catheter-based technologies done by surgeons”. It's been “particularly driven by the Australian group,” he added.

Vascular surgery does have its challenges and near the top is its reliance on technology that is constantly updating and even revolutionising. The cost is substantial and ongoing, and the “reimbursement mechanisms do lag behind some of the technologies,” Mr Hill said.

A study[1] published by the National Center for Biotechnology Information (NCBI) in 2015 signalled the exponentially increasing number of endovascular interventions, but it also warned about the reduction of time spent learning open surgery techniques. That Trainees need to master both tradition and technology is not news to Mr Hill, who skilfully provides ongoing oversight to this expanding area of surgery.

1 Aziz F (2015). Vascular surgery trainees still need to learn how to sew: Importance of learning surgical techniques in the era of endovascular surgery. NCBI: Pub Med. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/26029698

Interesting facts

1. Dr Lupe Taumoepeau is New Zealand's first locally trained female vascular surgeon and the only Pacific Island female vascular surgeon in Australasia.
2. The first carotid artery surgery was performed in Australia by Dr Sam Mellick in 1959.
3. The first arterial grafts stitched into vascular patients were cut and sewn from synthetic shirts on a Singer sewing machine in Queensland.
4. Studies of Egyptian mummies have shown that atherosclerosis and arterial calcification were common 3500 years ago.
5. Albert Einstein died in 1955 from an abdominal aortic aneurysm.
6. French artist Henri Matisse was a patient of vascular surgery pioneer René Leriche (1879–1955). Matisse sketched the portrait of Leriche for his book *Surgery, Discipline of Knowledge.*
7. One of the earliest medical writings (Ebers Papyrus, 2000 BC) recommended the following treatment for arterial aneurysms: “treat it with a knife and burn it with a fire so that it bleeds not too much”.

A short history of Vascular Surgery

In the 1930s the treatment of vascular disease in Australia and New Zealand was very limited. By 1950, a small group of surgeons was performing vascular surgery and, according to the late Emeritus Professor Doug Tracy, Dr Sam Mellick FRACS[1] was “doing more arterial operations than anybody in the country”. Dr Mellick went on to become a renowned vascular surgeon, affectionately referred to as the 'Father of Australian vascular surgery'. He died in July 2019 at the age of 93.

As there was no vascular training available in Australia or New Zealand during the 1950s, surgeons needed to travel to the United States or England to specialise. This resulted in a generation of post-war surgeons who were comprehensively trained overseas.

However, the post-war authorities in Australia would not supply the grafts needed for vascular surgeries, and for more than two-and-a-half years two of the surgeons' wives made arterial grafts from Teflon on their Singer sewing machines. Dr Mellick used to “measure the arteries of cadavers to find the size” in the autopsy room, and he would then translate those measurements “into diagrams on pieces of brown paper”[2] for his wife to cut and sew the grafts.

It became clear that surgeons who performed vascular surgery repetitively and frequently got much better results. Dr Andrew Roberts,[3] a Melbourne vascular surgeon said, of the time, “It was an emerging specialty with a rapidly increasing workload.” So, at the end of the Scientific Meeting in Hobart in 1972, the subject was discussed and it was then moved that RACS form a section of vascular surgery.

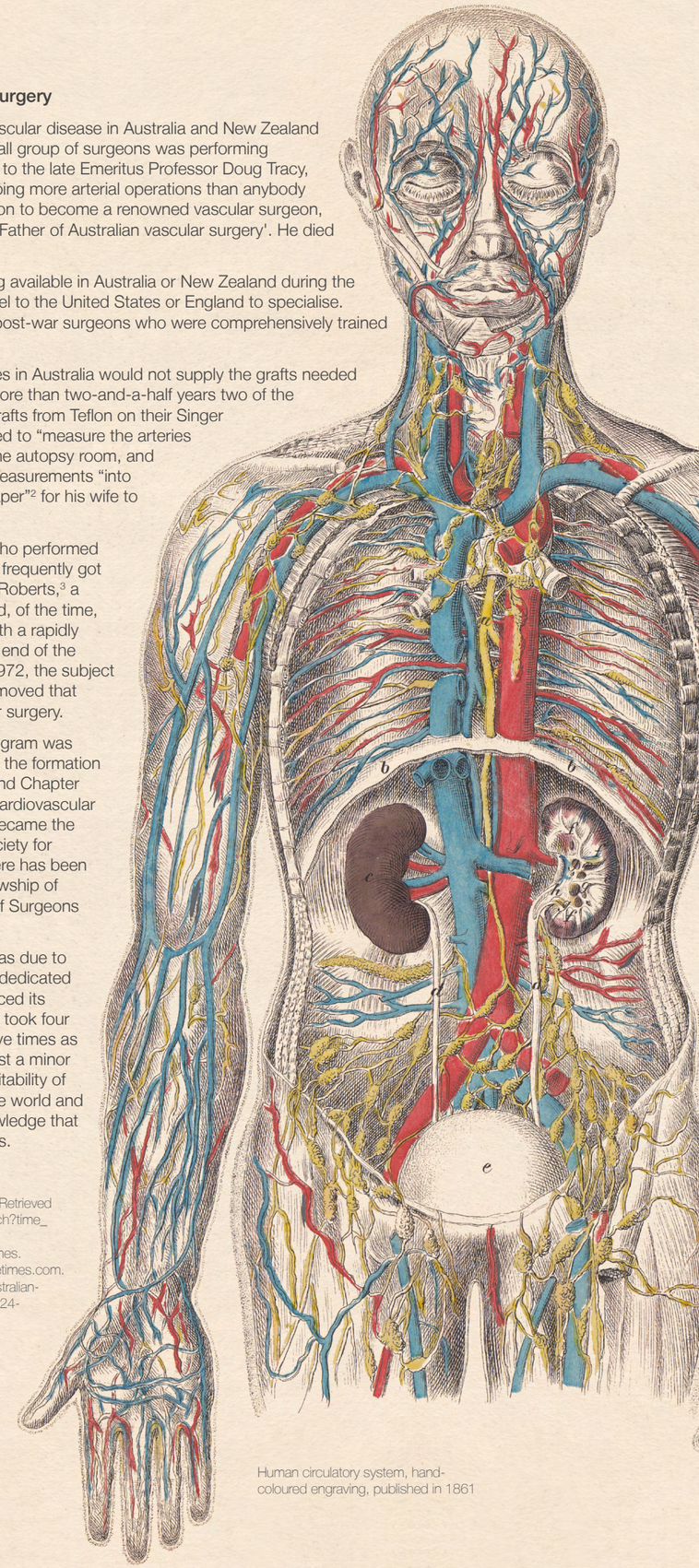
By 1981, a two-year training program was established, followed in 1983 by the formation of the Australian and New Zealand Chapter of the International Society for Cardiovascular Surgery. In 2001, this Chapter became the Australian and New Zealand Society for Vascular Surgery (ANZSVS). There has been a separate examination for Fellowship of the Royal Australasian College of Surgeons (Vascular) since 1997.

The formation of the ANZSVS was due to a generation of determined and dedicated surgeons. When Qantas introduced its Sydney–London flight in 1947, it took four days and six stops – and cost five times as much as it does today. This is just a minor point, but it illustrates the indomitability of these surgeons who travelled the world and brought back the skills and knowledge that have benefitted so many patients.

References

1,3 ANZSVS (2018). Origins [Video file]. Retrieved from https://www.youtube.com/watch?time_continue=60&v=41vmRlYtwRo

2 Lynch, L. (2 July 2019). Brisbane Times. Retrieved from https://www.brisbanetimes.com.au/national/queensland/father-of-australian-vascular-surgery-dies-at-93-20190624-p520t7.html



Human circulatory system, hand-coloured engraving, published in 1861

Theodor Billroth

Theodor Billroth, surgeon-polymath

Christian Theodor Albert Billroth died of heart disease on 5 February 1894, aged 65 years, after a life rich in work, rich in results, and rich in honours.

The son of a Lutheran pastor, he was born on 26 April 1829 in Bergen, Norway. In 1848 he began the study of medicine, finally graduating in Berlin in 1852 prior to the customary scientific *Wanderjahr*, visiting Paris and Vienna before returning to Berlin.

He attempted to set up in private practice but after not receiving a single patient in two months, took up a vacancy on Bernhard von Langenbeck's surgical service as his first assistant. He held the position for four years while also operating independently – during this time that relationship became strained.

In 1860 he was appointed to the Chair of Clinical Surgery at Zürich: in supporting Billroth's appointment Langenbeck wrote, *"his unusual diagnostic thoroughness, resulting from his independent pathological anatomical studies, as well as his surgical skill must also be highly praised"*.

The *Kantonspital* in Zürich in 1860 had continued the mediaeval tradition of domiciling patients with chronic diseases and uncomplicated senility. Billroth's concept of the hospital was that it be used for active treatment of patients and for teaching, incorporating the right to refuse admission to those who did not require active treatment and were not suitable for student teaching.

On his arrival he found that all surgical instruments had been the personal property of his predecessor and were kept under lock and key; an inventory revealed no instruments for intestinal or upper abdominal surgery – the only abdominal instruments were for procedures on the urinary bladder and for the management of hernias.

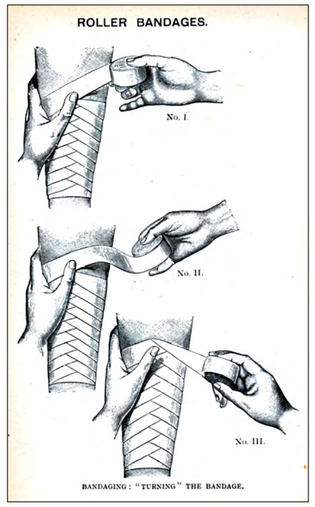
His Zürich routine began in the morning with cadaver demonstrations, clinics and lectures. Operations were scheduled for the early afternoon and he operated with three assistants: the most experienced stood opposite him at the operating table, the second passed the instruments, and the third administered the chloroform anaesthesia. Billroth limited his operating to difficult, unusual or private cases, allowing his assistants to perform most of the other surgery. He was one of the first to introduce antisepsis into the Continental operating-room.

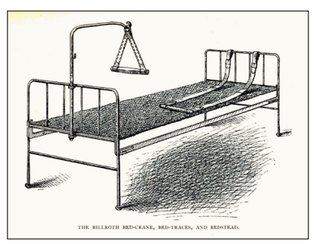
He worked late into the night at his desk – his capacity for writing through the early morning hours was to remain a lifelong pattern. During his time in Zürich from 1860 to 1867, Billroth wrote almost one quarter of his stated 160 publications: writing widely on surgical pathology, general/special and military surgery, diseases of the breast, historical studies of gunshot wounds and infection, *inter alia*.

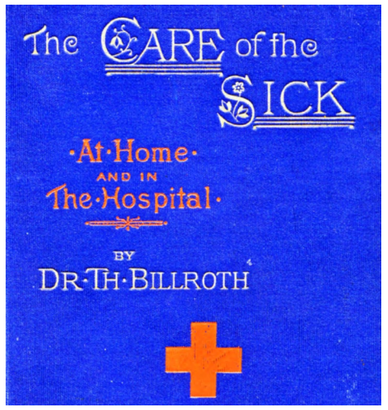
A lifelong friendship developed over this time with Wilhelm His Sr. (1831-1904) who was Professor of Anatomy at Basel: His Sr. undertook the best contemporary work on the origin of tissues, histogenesis, hence, embryology.

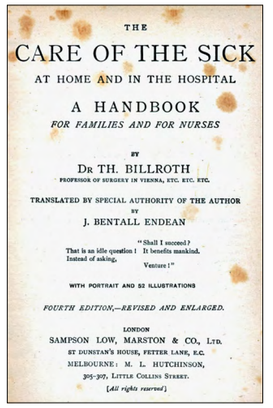
In 1866 he instituted follow-up for patients by contacting their local pastors for information regarding their wellbeing, writing to Esmarch in 1867,

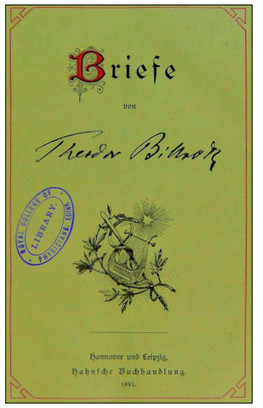
IMAGES (clockwise from left): Theodor Billroth; Illustrations: The Care of the Sick: Bandaging technique, The Billroth Bed.











"I now know exactly how many people I have cured and how many I have not".

His most important diversion in Zürich was playing chamber music and piano duets, also learning to play the viola in order to participate in Haydn and Mozart quartets, practising early in the morning before his 7am lecture. He composed three trios, a piano quartet and a string quartet; later burning them, noting, *"awful stuff that stank terribly during the burning"*.

Billroth was popular with the students and keenly interested in teaching: his lectures were diligently prepared, well organised and copiously illustrated, later being published in many editions and languages.

He was actively concerned with the physical features of the hospital and its architectural and administrative problems: *"all my life I have never been happy with just practical surgery, that is, with just operating"*.

When in 1867 he was offered the Chair of Surgery at the University of Vienna, Billroth had transformed Zurich into an active teaching centre with full-time personnel, a residency system, and its own equipment.

He worked the rest of his life in Vienna, in 1872 performing the first resection of the oesophagus; in 1873 first excising the larynx for cancer; and in 1881 first successfully resecting the pylorus for cancer: he took a special interest in surgical procedures of the stomach and intestines and could be called the founder of modern abdominal surgery: a contemporary described Billroth's operations as, *"autopsies in vivo"*.

Billroth was also greatly interested in nursing – he founded a training school for nurses in Vienna and wrote a book, *The Care of the Sick, At Home and in The Hospital*, which was considered a model of what such a book should be, and successfully published in multiple editions.

In his preface he noted that although many similar books had been published, *"These books and others like them, although ably written, contain in my opinion, either too little or too much"*.

His introductory chapter commenced with these words:

> *Practice surpasses study;*
>
> *But, if thou hast not learnt the way,*
>
> *Then wilt thou oft be led astray.*

Some excerpts:

> *"In the German method of treatment of the sick, particularly in hospitals, one great advantage is, that the head doctor and his assistants themselves do as much as possible in wound dressing (bandaging) and this is of material consequence. In England, France, Italy, Russia the doctors leave wound-dressing almost exclusively to the nurses."*
>
> *"The shape of the sick room must be considered and still more the provision for adequate ventilation. Formerly, churches were preferred for military hospitals, yet these churches were always offensive, there were no possible means of ventilation, for air-motion in the highest part there was none, or it was so insignificant that the exhalations from the wounded and their uniforms could not be overcome".*
>
> *"The sickbed, the iron bedstead has this great advantage, it is most easy to keep clean and easy to move. A hospital iron bedstead is not beautiful; for whom should the bed look beautiful? It can only be for those around; the invalid in the bed sees nothing of it, and yet it is he for whom care must be taken".*
>
> *"A non-striking clock of good size should be in every sick room, as many patients desire to be able always to see it; it is much more simple and easy for the nurse punctually to carry out her orders with the clock before her, than if obliged constantly to look at her watch".*

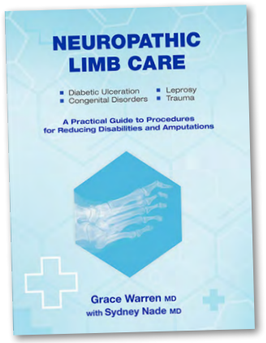
Billroth exhibited a concern with nursing problems, wanting one nurse for every 12 beds, and delegated male attendants for certain specific heavy-duty tasks.

His obituary in the *British Medical Journal* of 10 February 1894 noted that Billroth had been *"in broken health for some years"*: in his prime he had demonstrated at the operative amphitheatre clinic in Vienna, talking constantly while he operated, tall, impressively bearded, blue-eyed, confident and apparently all-knowing, at once the anatomist, the pathologist and performing surgeon, as well as the striking articulate personality.

A man of charming, genial personality with a strong artistic bent, as revealed in the few specimens of verse and music which he left, and in his delightful *Briefe* or "Letters", which Fielding Garrison noted in his *History of Medicine*, were, *"in some sort, a memorial of his lifelong friendship with the great North German composer, Johannes Brahms"*.

His obituary recorded, *"as an artist with the scalpel he was second to none of his contemporaries, but he was also a thoroughly scientific surgeon"*, the latter comment highlighted, in a letter Billroth wrote to His Sr. in 1893, *"even the most successful operation never gave me the absolute joy and contentment that I felt in working with a microscope"*.

Mr Peter F. Burke
FRACS



RACS library book recommendation

Neuropathic Limb Care: A Practical Guide to Procedures for Reducing Disabilities and Amputations

Grace Warren with Sydney Nade

Dr Grace Warren was an advisor in Leprosy and Reconstructive Surgery for The Leprosy Mission International and a Consultant Surgeon in major hospitals in Australia up until 2017. She has brought hope and healing to thousands worldwide, saving feet and transforming the lives of those with diabetes and leprosy with her inventive surgical skills, as well as her tireless willingness to travel and teach.

Dr Sydney Nade was the Former Clinical Professor of Orthopaedics at the Western Clinical School of the University of Sydney.

This second edition of Grace Warren's book includes all the practical advice from the first edition, updated and amended as needed with some additional contributions.

The object of the book is to assist medical carers to:

- Know that it is possible to prevent some problems and to actively treat other problems that have previously been considered untreatable
- Detect nerve problems early
- Take the necessary steps to prevent the development of irreversible damage and disability
- Instruct affected persons in the art of effective self-care.

Neuropathic Limb Care is the distillation of the author's expertise gathered over more than 60 years while treating patients with neuropathic limbs as a result of diabetic ulceration, leprosy, congenital disorders and trauma.

The book shows that the principles do produce excellent results when applied to any patient with neuropathy problems, if the patient is prepared to do their part. Warren's experience has confirmed that the application of practical but simple techniques, which are inexpensive in developing countries, afford improved outcomes for patients.

Available as both a paperback and e-book. Two print copies have been donated to the RACS Library by Warren Wickman at Honeysett Press.

RACS Trauma Symposium 2019

Pedestrians – Staying Safe

Each year in November the RACS Trauma Committee runs a symposium or workshop on different aspects of trauma management and prevention. Unique to these symposiums is the multidisciplinary, multi-industry nature of the program. We usually bring together experts from various groups representing medical, industry, government and community interests.

This year's Trauma Symposium will focus exclusively on the issue of pedestrian safety. Pedestrian injuries and deaths should never be accepted as inevitable – this thinking often leads to complacency in addressing the problem. Just as we see in other road traffic related trauma, they are both predictable and very much preventable. Globally, pedestrians comprise over 20 per cent of road traffic fatalities. In Australia, our rate of serious injury and deaths is increasing and now makes up more than 15 per cent of our road toll. Pedestrian deaths on our roads have increased by 9.3 per cent year-on-year despite road safety campaigns.

The key risks to pedestrians are well known and include issues related to drivers, road and community design, vehicle design and pedestrians themselves. Driver issues include problematic attitudes to road "ownership" as well as behaviour, particularly in terms of speeding, drinking and taking drugs. Road and community design issues include lack of infrastructure to enable safe walking or crossings, safe lighting and sidewalks. Vehicle design issues include a lack of safety features such as brake assists or vehicle elements reducing collision impact and severity. Finally, pedestrians are at risk from their own behaviour, particularly as it relates to distracted walking with mobiles and the influence of alcohol and drugs on pedestrian cognition and decision making. Vulnerable road users such as children, the elderly or disabled are also at risk.

Given the complexity of the issue, it is clear the only way forward is to involve all agencies in the discussions and the solutions. A multi-disciplinary approach is critical to addressing this, including road and vehicle engineers, educators, community planners and government, police and public health professionals. This symposium will bring together a number of experts in their field to explore the scope of the problem, look at the risk factors and discuss prevention strategies and a way forward. The program includes the impact of alcohol and distraction, the scooter epidemic, speed, hospital trauma care, tips to stay safe, public health, education, law enforcement, vehicle, road and future city design.

Our expected audience includes surgeons, emergency department doctors, intensivists, paramedics, nurses, ambulance officers, police, road safety professionals, engineers, insurance representatives, and local, state and federal government representation.

It is imperative that RACS is seen to lead such initiatives and lend its voice and credibility to reducing pedestrian deaths and serious injury. The College has long recognised that road trauma is a serious public health issue and has a longstanding well-known, well-respected reputation in the area of road safety advocacy.

"Walking is the first thing an infant wants to do and the last thing an old person wants to give up. Walking is the exercise that does not need a gym. It is the prescription without medicine, the weight control without diet, and the cosmetic that can't be found in a chemist. It is the tranquilliser without a pill, the therapy without a psychoanalyst, and the holiday that does not cost a penny. What's more, it does not pollute, consumes few natural resources and is highly efficient. Walking is convenient, it needs no special equipment, is self-regulating and inherently safe. Walking is as natural as breathing."

John Butcher - Founder Walk21

In 2005 **Prince Charles** said on 60 Minutes: "The whole of the 20th century has always put the car at the centre. So by putting the pedestrian first, you create these liveable places I think, with more attraction and interest and character ... liveability."

Dr Valerie Malka
FRACS

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Advocating for positive change

RACS has advocated against the harmful effects of alcohol and illicit drugs over a number of years, not only due to the increased risk of complication they pose to surgical patients, but also because of the broader ramifications they have on the sustainability of our public health system and society as a whole.

In the past couple of months, we have seen mixed results from across Australia in relation to alcohol related harm minimisation policies.

Northern Territory

In 2017 The Riley Review, which was commissioned by the Northern Territory (NT) Government last year, highlighted just how unhealthy the drinking culture in the NT has become. It highlighted a long list of unenviable records held by the Territory, including the highest levels of both alcohol related hospitalisations and deaths in Australia.

The recommendations put forward in the Review were widely applauded by public health bodies, including the Foundation for Alcohol Research and Education (FARE), for their comprehensive nature. FARE described the review as setting the benchmark for effective alcohol harm reductions measures, and one that would transform the NT from lagging behind the rest of the country to become a national leader.

Despite vocal and alarmist opposition from the alcohol industry and many within the media, the Liquor Bill 2019 was recently passed in the Northern Territory. RACS congratulates the NT parliament for passing this legislation, and in particular commends NT Health minister, the Hon. Natasha Fyles, for her tireless efforts.

Congratulations also to our RACS representatives, Mr Mahiban Thomas, Chair of the NT Committee, Associate Professor Phillip Carson, RACS Councillor, and the rest of the NT Regional Committee for all their hard work over a number of years. Although few in number, our NT surgeons have a proud tradition of effective advocacy to implement positive change. This has previously been publicly recognised by the NT Health Minister who has personally thanked surgeons for their efforts and acknowledged that the continued public support offered by RACS had been a crucial element in allowing the government to implement its reform agenda.

A recent example of the effectiveness of the reforms was a decision by the newly formed NT Liquor Commission to reject an application for a new alcohol 'superstore' outlet. The store was far in excess of the allowable floor size permitted under NT regulations and in a location with one of Darwin's highest rates of reported alcohol related violence. Our NT Committee has previously voiced its concern about this application, and we once again congratulate them on this success and their effort to promote a safer drinking culture within the Northern Territory.

New South Wales

In 2014 the New South Wales Government introduced laws that prevented operators admitting patrons to licensed premises after 1:30 am or serving alcohol after 3:00 am. The introduction of the laws was in responses to a marked increase in alcohol-fuelled violence, particularly in the Kings Cross area of Sydney, which culminated in the tragic deaths of two teenagers in separate assaults committed by violently drunk individuals within the space of twelve months.

Since that time data from St Vincent's Hospital and anecdotal reports highlighted a noticeable decrease in the rate of alcohol fuelled assaults and serious facial injuries requiring surgery. Unfortunately, the introduction of the laws was also met with many vocal opponents, including those with vested interests within the alcohol industry.

Earlier this year the government established a Joint Select Committee on Sydney's Night Time Economy. The terms of reference for the committee included a review of whether Sydney's lockout laws were 'appropriately balanced.' At the time of writing the committee had yet to release its final report, however, the Premier has flagged that it is likely that lockouts will be lifted in the CBD entertainment district but will remain in place for Kings Cross.

Regardless of which way the decision goes, there are many representatives in the College who have greatly assisted in our efforts to improve community safety in NSW. Thanks in particular to the NSW State Committee, with special mention to Dr Ken Loi, RACS NSW Committee Chair; Dr SVS Soundappan, Trauma and Paediatric Representative; Mr Anthony Grabs, Dr Elias Mosidis and the surgical team at St Vincent's; Dr John Crozier, National Trauma Committee Chair; and the entire RACS Trauma Committee. The College will continue to advocate for sensible harm minimisation policies in NSW and we will keep you updated on our progress.

Recognition of paid parental leave entitlements in New South Wales

In other recent advocacy news, RACS congratulates the NSW Government for its recent decision to formally recognise the parental leave entitlements for surgical Trainees returning to NSW, after completing a rotation of their training elsewhere in Australia or New Zealand.

RACS has been a long-term advocate on this issue. Many of the smaller surgical specialties require interstate and even trans-Tasman moves for broad exposure during surgical training. At present, New Zealand and each state and territory have separate policies determining eligibility for paid parental leave, mostly requiring 12 months' continuous service in that jurisdiction. This means that if these Trainees have to move interstate while they or their partner is pregnant, the Trainee is no longer eligible for paid parental leave. This issue is one of many factors identified about surgical training that discourages women choosing surgery as a career.

The NSW decision is a good sign of progress being made on this issue, and RACS will continue to advocate for formal leave recognition arrangements across Australia and New Zealand.

Victoria road safety strategy to be released in 2020

Following extensive community consultation, the Victorian Government will release its road safety strategy in 2020. Towards Zero 2016-2020, the government's plan to lower the number of lives lost on Victoria's roads, identified four factors to keep people safer on the roads – safer roads, safer speeds, safer vehicles and safer people. The WHO Global Plan for Road Safety identified a fifth pillar post-crash care; an area of great interest and concern to RACS.

RACS made the following recommendations:

- Appropriate speed limits should be adopted having regard to the environment and traffic density.
- Speed limits should be reduced on both urban non-arterial roads and regional and small towns.
- Vehicle safety features should be installed in all new cars.
- ANCAP car safety ratings should be at point of sale.
- Mandatory wearing of approved child restraints.
- Graduated licensing systems.
- Prohibition of use of mobiles within motor vehicles by learner or probationary drivers.
- Mandatory basic first aid training as part of the driver licensing system.

The state government recently restructured its functions to create a dedicated new road safety office, Road Safety Victoria, with a focus on tackling the state's high road toll.

Mandatory rollover protection for quad bikes

In September, ABC News reported that the Federal Government, after pressure from farming and medical groups, looks set to introduce laws requiring new quad bikes to be fitted with mandatory rollover protection within two years.

RACS, led by National Trauma Committee Chair John Crozier, has lobbied for mandatory rollover protection, along with rural doctors, the National Farmers' Federation and union groups.

The ABC reports that the New South Wales, Victorian and Tasmanian governments already offer rebates to retrofit operator or crush protection bars devices which sit upright on the back of a quad bike and are designed to reduce the risk of the driver being caught between the ground and the vehicle.

The Australian Competition and Consumer Commission (ACCC) recommended the changes earlier this year in response to fatalities involving rollovers, with 136 people having died in quad bike accidents over the past eight years, 60 per cent of which the ACCC attributes to rollovers.

Nationals MP Mark Coulton is reported to have said he assumed quad bike manufacturers were more concerned about the litigation risk overseas.

"My understanding is that there have been about 15,000 deaths in the United States involving quad bikes. I think there might be some concerns around litigation that might come from an admission that there is an issue in design... It's not a huge added cost to the machine so I think there's deeper concerns as to why the manufacturers are behaving the way they are."

Dr John Crozier, in response to the ABC report said "More deaths and horrific injuries will happen on Australian farms unless roll bars on quad bikes are made mandatory. We are very hopeful that the government will implement this, and I would like to thank Warwick Teague, Soundapan Soundapan, Michael Ee and Susan Adams for their high quality quad bike advocacy work."

Academic gown donation

RACS would like to thank Ms Alice Coates and Ms Sally Culter for the generous donation of **Professor Sam Mellick's** academic gown to the College.

RACS preserves academic gowns for use by Convocating Fellows and at graduation ceremonies at the College. If you no longer have use for your gown, RACS would be grateful to add to our reserve. We can acknowledge your donation and place your name on the gown if you approve.

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

New Zealand Annual Scientific Meeting sparks lively discussion

Wellington behaved perfectly, turning on brilliant blue skies and hardly a breath of its notorious wind, when it hosted New Zealand's annual scientific meeting, *Surgery 2019: Back to the Suture!* at Te Papa on Wellington's glistening waterfront on 15-16 August.

Ballarat Plastic Surgeon Rob Sheen provoked a lively discussion during the first morning of the meeting as he made the case for protection of specialist titles – "Patients need clearer labelling of the title of their provider or practitioner; this can lead to better choices." Dr Sheen said he and his colleagues constantly encountered problems with 'cosmetic surgeons' performing botched procedures on patients who were not aware that their chosen practitioners lacked specialist registration. "Deceptive use of titles can lead to poor patient choices and compromise patient safety. The problem needs to be solved. Our patients deserve nothing less."

Delegates particularly enjoyed a range of insightful and challenging presentations in a session on diversity and how it enhances surgical practice. "Diversity is like getting invited to the ball. Inclusion is like being asked to dance," said Rita Yang, a plastic and reconstructive surgeon who practises in Auckland. She encouraged all health professionals to provide gender sensitive care. Little things mattered, such as asking patients about their preferred pronoun, and using affirmative language. It was important to create a clinical environment that reflected gender diversity, where, for example, registration forms included non binary gender identity options and gender-neutral bathrooms were provided.

P J Faumuina, an otolaryngology head and neck surgeon, who practises in Whanganui, said he came to New Zealand from Samoa 30 years ago and health issues for Māori and Pacific Island people had changed very little. "We're over represented in all the bad health statistics such as diabetes, obesity, and cancer, and we're very under represented in those tasked with treating and looking after them, including surgery. Only 1-2 per cent of Fellows are Pacific Island and 2-3 per cent are Māori. The health sector has the biggest potential for the worst ramifications if we don't get diversity right."

IMAGES (l-r): Chelsea Jacobs-Prescott, Dr Maxine Ronald, Mr PJ Faumuina; Louis Barnett Prize - winner.

During the meeting, RACS President Tony Sparnon presented Christchurch general surgeon, Professor Frank Frizelle, with the Colin McRae medal. The medal commemorates the life and work of Colin Ulric McRae, an outstanding New Zealand surgeon and former president of RACS. The award recognises and promotes the art and science of surgery and honours outstanding contributions to surgery in New Zealand through clinical excellence, surgical leadership, research and/or surgical education.

Professor Frizelle was instrumental in setting up the colorectal service in Christchurch as a specific sub-specialty. His sound clinical judgement and technical expertise have been recognised through roles on various national committees. He has more than 400 publications in peer reviewed journals and has written more than 30 book chapters. As Editor in Chief of the *New Zealand Medical Journal* since 2002, Professor Frizelle has promoted the publication of quality research. His research contributions are acknowledged internationally and he has been invited speaker at international conferences and visiting professor to units in many countries. He has trained many of New Zealand's general surgeons and is a recipient of the Sumner Award which is determined by the general surgery Trainees in recognition of excellence in clinical teaching.

IMAGES (from top): Mr Russell Blakelock, Professor Ian Civil, RACS President Mr Tony Sparnon; Winner of the Colin McRea Medal, Professor Frank Frizelle, with RACS President Mr Tony Sparnon.

Celebrating the art of surgery

Annual Scientific Congress, Melbourne, 2020

On behalf of the Organising Committee we invite you to the 89th Annual Scientific Congress (ASC) to be held at the Melbourne Convention and Exhibition Centre in Melbourne from 11 – 15 May 2020. It's been 15 years since the ASC has been held in Melbourne and we are very excited to assemble the program.

The theme of the 2020 ASC is **"Celebrating the Art of Surgery"**. The plenary and scientific sessions have been designed to explore this theme from different angles, hoping to consider not only how we can learn from artistic practice, but how art can be incorporated in to our own practices.

Opening Plenary Session: The Art of Being a Creative Surgeon

The opening plenary session, scheduled for 8:30am on Tuesday 12 May, will celebrate the achievements of surgeons who are also artists. Professor Mohamad Kahdra AO is a urologist from Sydney and a celebrated playwright. Professor Averil Mansfield CBE is a retired vascular surgeon from London and a fine musician. Mr Christopher Edwards is a plastic surgeon from Hobart and an acclaimed sculptor. Dr Katherine Gale is a breast surgeon from Auckland and a successful fashion designer. These speakers will reflect on their artistic practice, discuss the natural synergies between a surgical and artistic practice and consider how this translates to them being better surgeons.

Global Health

The Global Health section is co-convened by Liz McLeod and Ram Nataraja. Following the success from 2019, the Global Health Section will again allow more combined sessions with other surgical sections and with invited speakers from around the world throughout the week, providing a vibrant experience for the participants.

The program will run from 11 to 14 May. This year, we are excited to offer a pre-congress workshop on the Monday morning for Fellows and Trainees interested, in or currently volunteering in, development and humanitarian assistance programs; covering topics such as cultural complexity, risk and security, and managing team expectations.

There will be the opportunity to meet a large number of regional partners from the Pacific and Asia, at informal functions such as our Pacific Breakfast and section dinner and of course, at scientific sessions which will cover research by regional Trainees as well as progress we have made towards our goal of surgery as an indispensable component of universal health care in the last few years.

We are looking forward to presentations by our international invited speaker, Professor Diana Farmer from the UC Davis Department of Surgery in Sacramento. Professor Farmer is a paediatric surgeon with a research interest in pre-natal treatment of spina bifida. She is also a founding leader of the Global Initiative for Children's Surgery whose goal is to unite leaders from throughout the world of surgery to improve access to quality surgical services for children in low and/or middle-income countries (LMICs).

We are planning a combined session covering issues of regional health security on the Tuesday afternoon, with a panel of local and Pacific experts from health, military and legal backgrounds. We will discuss emerging threats such as climate change in the context of health, disaster preparedness, displacement of people and changing patterns of disease. This promises to be a dynamic discussion of issues which are of relevance to all surgeons.

Other invited speakers include Professor John Meara, a Professor of Global Health and Social Medicine in the field of Global Surgery, Professor Zaw Wai Soe, the Director of the University of Medicine 1 in Yangon, Myanmar and Professor Paul McMenamin, the previous Director of the Centre for Human Anatomy Education who is an expert in anatomical 3D printing. There will also be a masterclass in research methodology, and a session on simulation education in LMICs.

Paediatric Surgery

The Paediatric Surgery section at the RACS ASC 2020 is co-convened by Ram Nataraja and Tom Clarnette. Combined sessions for paediatric surgery will include collaborations with the Global Health program, Burns Surgery, Developing a Career and Skills in Academic Surgery (DCAS) and the Senior Surgeons sections. It will include discussions of controversial current topics such as bullying, harassment and underperformance, in addition to techniques to deliver feedback in an efficient way. The program runs from the Tuesday to Thursday.

Some of these will take place in the form of interactive simulation-based educational sessions in collaboration with world-class leading medical educational experts.

There will also be a strong oncology focus with invited speakers Professor Sabine Sarnacki and Professor Diana Farmer who are world-leading paediatric oncology surgeons from France and the USA. They will be conducting a masterclass on oncology surgery in paediatric patients, as well as sharing their vast surgical clinical experience. Professor Farmer is also a leader in the development of paediatric surgical services worldwide, especially in LMICs, and the program will explore these complex topical issues as highlighted by the recent *Lancet* report. We will also have paediatric surgical colleagues from the Pacific and Myanmar at the ASC and it will no doubt be the beginning of interesting collaborations. A masterclass dedicated for Trainees with an interest in contributing to global paediatric surgery is also scheduled for the Tuesday.

A paediatric urology session to cover controversial and topical challenges is another focus of the program this year. A busy social calendar with a section dinner and other events throughout the program will certainly be a highlight.

Surgical Directors

Subsequent to the success of Super Thursday at 2019 ASC in Bangkok, we invite you to join us for Super Tuesday at 2020 ASC in Melbourne. Surgical Education, Surgical Directors and Quality and Safety in Surgical Practice combined forces and produced a leadership program that will appeal to all Surgeons and Trainees. Super Tuesday, as conceived, involves domains that cut across all disciplines that our College espouses, including leadership, safety, cultural competence and diversity. Our sessions reflect on engaging for sustainability in leadership, engaging for safety, and engaging for diversity. The invited international, interstate and local speakers will tease out the issues and discuss possible solutions.

Our keynote lectures will consider the eternal question of what it takes to change a system. Professor David Pencheon from Exeter, UK, will address how individual and organisational actions can promote change and how one can't work without the other. Professor Jason Leitch from Edinburgh, UK will discuss how to encourage cultural change around safety that is tangible and makes a difference.

Before you immerse yourself in Super Tuesday, we are offering you our masterclass – *Wellbeing: The New Frontier in Surgery!* Wellbeing is a science and not a myth; the science of wellbeing explains doctor burnout, resilience and your wellbeing. Find out how the way you practise impacts on you and what you can do to improve your work and your life balance. The masterclass will set you up for the rest of Super Tuesday armed with a mindset that allows you to actively engage in the discussions around the micro/macro elements needed to achieve sustainable leadership, a safe culture and diversity in surgery. Finish Super Tuesday the same way as you started by joining your colleagues at the bucolic culinary oasis of fusion cuisine that is Jardin Tan at the Royal Botanical Gardens for the section dinner.

We will continue to highlight programs from various sections over the next few months and look forward to welcoming our Fellowship, in addition to our international faculties, to this exciting event.

Article provided by:

Professor Wendy Brown FRACS
Dr Elizabeth McLeod FRACS
Dr Ramesh Nataraja FRACS
MS Wanda Stelmach FRACS

Celebrating the art of surgery

To celebrate the 'Art of Surgery', the Annual Scientific Congress is partnering with Monash University's Museum of Art (MUMA) to produce an innovative and engaging program of arts at the Congress.

Professor Wendy Brown, Head of Monash University's Department of Surgery, is the Congress Convener and Charlotte Day, Director of MUMA, has joined her as adviser. Together they're planning a compelling and intriguing program that explores the relationship between the arts and surgery.

"There will be a whole suite of sessions that look at the art of being a creative surgeon," Ms Day said, adding that many surgeons are involved in the arts as writers, musicians and painters, or employ other forms of art that inform their surgical work, and that there may be opportunity to showcase some of this work in the program.

The scope of art activities and experiences will be broad and Ms Day is looking at bringing one or two exhibitions together onsite, plus breakout sessions and perhaps drawing classes too. The focus will be on topics such as design, architecture, developing innovative and observational thinking, and bringing the two disciplines of art and medicine together. The aim is to "make it less generic", Ms Day said, and to show that "art is always the point of reflection or intersection for something else that's going on".

There is also an exciting social program being developed that includes options to visit different museums and galleries in and outside Melbourne. These will be ideal for partners who come along. Some of the museum and gallery visits will extend to behind-the-scenes chats with staff who work in these spaces and also opportunities to speak directly with artists.

IMAGES (above): Shapes of Knowledge, Monash University Museum of Art, Melbourne 2019.

PREDICT: A Training Fellow Based International Collaborative Network

CTANZ (Clinical Trials Australia and New Zealand) is the umbrella organisation endorsed by RACS that is fostering the development of collaborative networks in surgery in Australia and New Zealand across all specialties and sub-specialties. Based on the UK model where Trainee research has been successfully integrated into surgical training in the UK and Europe, interest in Trainee-led research collaboratives across Australia and New Zealand is certainly growing. CTANZ actively encourages participation from all levels of surgical training and welcomes medical students, pre-vocational Trainees and JDOCs, SET Trainees and Specialty Fellows.

The fundamental goal of these research collaboratives is to produce high-quality, fast-accruing studies that answer clinical questions of interest to Trainees and of relevance to their discipline. This multi-specialty and multi-level group is supported by its current Clinical Director, Professor David Watson, and invites any interested Fellow or Trainee to take part in what is sure to be a successful and familiar surgical research pathway in the future.

Colorectal Surgery Society (CSSANZ) Fellows have seized this opportunity to take the lead with the first ANZ-instigated, subspecialty fellow-based collaborative research project. This study was coordinated by Dr Bree Stephensen, the-then Colorectal Fellow at John Hunter Hospital, Newcastle with support from Associate Professor Stephen Smith and Dr Peter Pockney.

The *PREDICT Study* assessed the feasibility of CRP trajectory modelling for prediction of anastomotic leak after elective colorectal anastomosis. In less than 18 months, 933 patients were recruited from 20 centres across Australia, New Zealand, England and Scotland. Each site was led and coordinated by a Trainee, and recruitment was completed ahead of schedule. Results of the investigation were presented at the 2019 RACS Annual Scientific Congress in Bangkok and the Association of Coloproctology of Great Britain and Ireland (ACPGBI) Annual Meeting in Dublin, Ireland. This study demonstrates the power of the Trainee led collaborative model in delivering rapid accrual of a large patient cohort in the Australia and New Zealand setting, allowing meaningful and timely analysis, within the confines of a two-year training program.

In general surgery, the two-year post-fellowship training programs in disciplines such as colorectal surgery lend themselves particularly well to the collaborative model. These programs involve groups of highly-motivated individuals facing the limitations of fixed training terms at different centres, often widely separated geographically. It is challenging for an individual Trainee to deliver a meaningful research project within one of their training placements. With collaborative research, a Fellow can commence a study at their first hospital, and take it to their next, and incoming Fellows can take up the responsibility as they come into a new position, while their own project at their first hospital is continued by their successor.

Other local research networks of general surgery Trainees in Australia and New Zealand include the QUEST collaborative in Queensland and the VERITAS network in Victoria. These groups have led studies into, for example, the treatment of Right Iliac Fossa pain, which have led to publications and further projects. Student-based projects, under the banner of the 'TASMAN' alliance, have delivered successful projects across Australia and New Zealand, in cooperation with colleagues in the UK and Europe.

For more information about how to be part of a network in your specialty contact CTANZ@surgeons.org.

Dr Bree Stephensen
FRACS

STRIVE-ing for success

CTANZ is committed to supporting Trainees, JDocs and medical students passionate about being involved in surgical research, in particular multi-centred clinical trials and collaborative studies.

Congratulations to STRIVE, a collaboration of medical students from Western Australia's three medical schools (University of Western Australia, Curtin University and Notre Dame University) for winning the Best Poster Presentation at the recent International Surgical Students Conference 2019.

The team worked together to audit 120 patients for the multi centred REspiratory COmplications after abdomiNal Surgery (RECON) study.

STRIVE is the largest student network in Australia supervised by Prof Toby Richards, Dr Ed O'Loughlin and nine junior doctors from the South Metropolitan Health Service in Perth.

IMAGE: Team representing STRIVE WA from left to right; Marcel Nejatian, Salar Sobhi and Blake Sanchez.

Addressing health inequities in our system

"Māori and Indigenous motifs mean nothing unless we are prepared to make real change."

This was one of several powerful messages that RACS Councillor and Chair of the Indigenous Health Committee, Dr Maxine Ronald, delivered to Surgery 2019, New Zealand's Annual Scientific Meeting, held in Wellington in mid-August.

Dr Ronald presented a range of evidence illustrating the significant gaps in health outcomes between Māori and non-Māori cancer patients in New Zealand. Māori have longer waiting times from diagnosis to treatment even after adjusting for disease, patient characteristics and patients declining treatment. For example, a recent study of colorectal cancer patients found 52 per cent of Māori patients waited longer than eight weeks to start chemotherapy, compared to 28 per cent of non-Māori patients. Similar patterns are seen in many other cancer pathways.

The systems in which healthcare is delivered have significant impact on perpetuating inequity and creating even greater health disparities. Māori women with screening-detected breast cancer have similar chances of survival as non-Māori women. But Māori women who are diagnosed with breast cancer outside of screening have a 30 per cent lower chance of survival compared to non-Maori.

"We need to be honest with ourselves and look at the impact of systems on healthcare. This can be emotionally confronting. None of us would deliberately develop a system that delivers poor outcomes for one group of people."

Examination of the health system shows that "health inequity is fundamentally driven by the legacy and continued impacts of colonisation and resultant racism and privilege".

"Often racism is invisible and passive, or unconscious, and people who have privilege often aren't as aware of it as those who don't have it."

"If we really want to address health inequities in our system we need to think about cultural safety," Dr Ronald said. "We have to push back against these systemic effects and look for real change. We need to name racism, ask ourselves how is racism operating here, understand that we have the power to share our power, decolonise and recognise privilege. Often racism is invisible and passive, or unconscious, and people who have privilege often aren't as aware of it as those who don't have it."

Cultural safety requires health professionals and their associated healthcare organisations to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery. This involves acknowledging and addressing their own biases, attitudes, assumptions, stereotypes and prejudices that may be contributing to a lower quality of healthcare for some patients.

Asked by a member of the audience which practical steps surgeons could take to address the unequal health outcomes between Māori and non-Māori, Dr Ronald encouraged people to check that all departments in their hospitals were auditing their outcomes in terms of inequity, and to consider the terms by which Māori stakeholders are engaged in their own healthcare development.

Surgical safety remains a priority in Victoria

Victoria remains one of the safest places in Australia to have surgery with continuing low death rates, according to the latest Victorian Audit of Surgical Mortality (VASM) report.

In the past financial year, 891 clinical reviews were conducted for cases where patients died while under the care of a surgeon.

The audit findings are similar to the national figures:

- The majority of surgical deaths in this audited series occurred in elderly patients with underlying health problems, admitted as an emergency with an acute life-threatening condition often requiring surgery
- The actual cause of death was often non-preventable and linked to their pre-existing health status in that the cause of death frequently mirrored the pre-existing illness
- From more than 703,530 surgical procedures there were 1,777 deaths reported to VASM, representing 0.25 per cent
- Elective surgeries were performed as planned and 82.4 per cent of deaths were emergency surgeries
- Unplanned return to the operating theatre increased. This was associated with an increased risk of death and was often due to a complication of the initial procedure
- There was a reduction in transfer delays to and between hospitals
- There was a reduction in clinically significant surgical infections
- There was a reduction in adverse events and areas of concern that were preventable.

Clinical Director of VASM Associate Professor Philip McCahy said "The audit monitors surgical safety, addresses process errors and identifies any significant trends in surgical care. VASM aims to focus on its educational role in disseminating 'lessons learned' to clinical teams and using the hospital governance reports to develop further improvements".

"Feedback on patient management is formally directed to the treating surgeons and is also disseminated for their ongoing education through workshops, seminars and scientific publications."

In the VASM 2018-19 report nine key recommendations had been made that reflect the National Safety and Quality Health Service Standards to improve the quality and safety of surgical care in Victoria. Hospital performance results have been prepared for the state's lead agency on quality and safety, Safer Care Victoria.

The report also contains clinical information on 10,132 deaths over the past six years. Of these deaths, 8,582 have gone through the full audit process. The remaining cases are still under review and will be included in next year's annual report.

All Victorian public and private hospitals providing surgical services are part of the audit process. VASM is managed by RACS and supported by Safer Care Victoria, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the Australian Orthopaedic Association.

The report is available at surgeons.org/VASM

Climate change:

Red alert

I have enjoyed my practice of medicine but I am contemplating retirement. I don't expect to witness the second half of the century but do hope to watch the millennials take on running the world. The recent school strikes give me hope for the world my children's children will inherit, sadly one less hospitable and habitable than I have enjoyed. It is one that is on track to be 2.9-3.4°C warmer at the end of the century, despite the 2015 Paris agreement that aimed to restrict temperature rises to less than 2°C above 1850-1900 levels.

On 22 September the UN released the latest report on climate change ahead of a UN summit. The last five years are on track to be the warmest five-year period ever on record, it reports a two per cent annual rise in greenhouse gas (GHG) emissions, with 37 billion tons of CO2 emitted in 2018. Emissions won't peak in 2030, they will keep rising and although we need to triple emission cuts by 2030, any action will still take 30 years to have any effect on global temperatures. The glaciers will continue to melt, the Arctic and Antarctic ice will shrink. Sea levels already rise at rates of 5mm per year.

People everywhere need to breathe clean air. Today, over seven million deaths occur annually because of air pollution. The poor and those living in low and middle-income countries are the most disadvantaged. In 2016 alone, the World Health Organisation (WHO) reported ambient and household air pollution caused over half a million deaths in children under five. Some of the most exposed survivors will grow up with stunted lungs, impaired mental and motor development, be prone to cancers and have a higher rate of heart disease, diabetes and stroke through adult life. Climate change is UN sustainable development goal (SDG) no.13. Dr Tedros, WHO Director General, has also called the climate crisis a health crisis. Health and wellbeing for all is SDG no.3. They are interlinked. Pollution and GHGs are a by-product of burning fossil fuels for energy. It's not just air pollution, but rising temperatures increase the risk of natural disasters, such as drought, fires and cyclones. Climate change will not only increase the incidence of vector-borne diseases but also non-communicable diseases and victims of disasters.

The next generation get it. Greta Thunberg, the Swedish grade nine student, was alone last year in staging a strike in front of her school. But her courageous stance then led to waves of strikes on behalf of action on climate change, made by school students in many countries. On 20 September 2019, millions of students across 140 countries of the world held strikes, in advance of the UN summit. In the major cities of New Zealand and Australia there were tens of thousands in each location with 100,000 in Melbourne. Although some of Australia's leading politicians advised the students to attend school, they didn't appear to appreciate that the momentum has shifted. Jacqueline Maley (*Herald Sun*) headlined, "The kids didn't stay in school, the politicians lost their cool". Those politicians would have been wiser to say nothing. Those 'kids' will be voting in the next and all subsequent elections. They will create a great political disruption for those politicians and parties who don't take climate action seriously. Yet this should not be a political issue. It is a global one about well-being and our future. It embraces health, the economy, food supply, clean water and waste management.

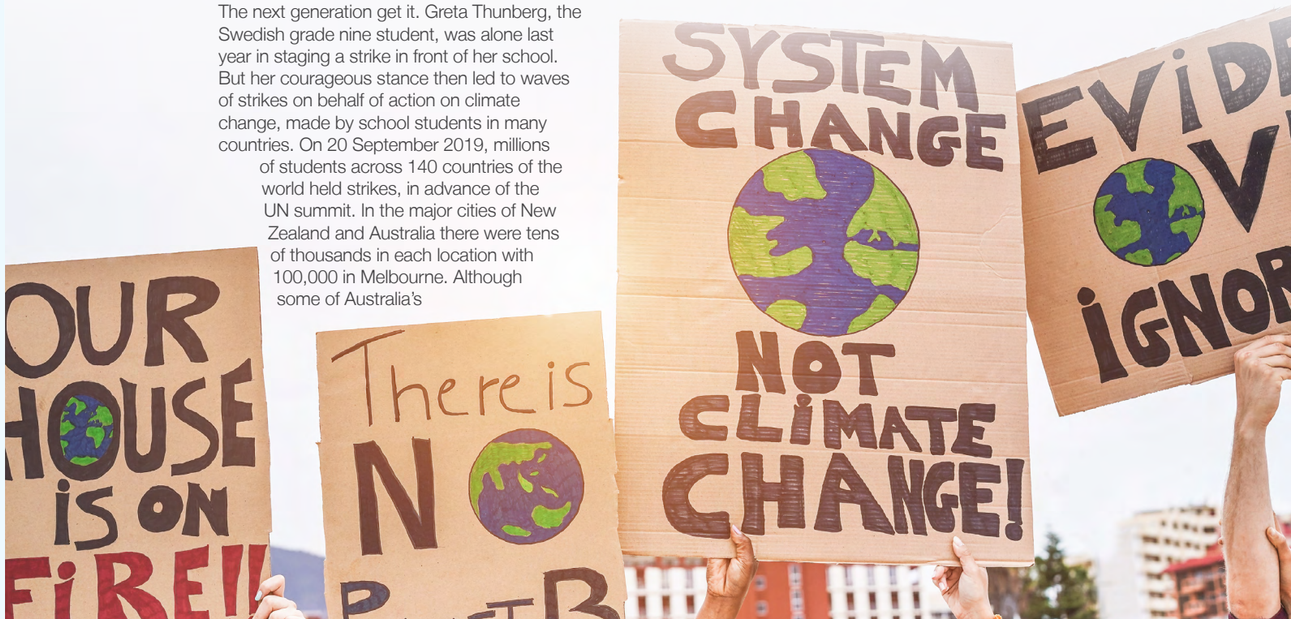
What's the message? That climate change is real. That action is needed. Those savvy students have learned to weigh the evidence through their science education. They have enough gumption and courage to stand up to the passivity of their parents generation, the greed of financial institutions and global corporations, and lack of courage in their politicians.

Given the evidence, it's no surprise that medical associations all around the world have declared climate change a topic for which urgent action is required. The Committee of Professional Medical Colleges (CPMC) issued a consensus statement signed by at least a dozen colleges. The AMA and its news magazine *Australian Medicine* have called climate change 'a health emergency'. Royal Australasian College of Physicians (RACP) has published in their *Internal Medicine Journal* what doctors can do (IJM2019;49:1044-8).

RACS has a surgery and environmental impact statement (Reduce, Re-use, Recycle, Rethink, Research), and the *ANZ Journal of Surgery* lecture at your Annual Scientific Congress was given by Alistair Woodward on "Climate change and the surgeon…what can be done?" The health sector is responsible for seven per cent of national carbon emissions as well as considerable waste. There is much that can be done in individual health care organisations to provide leadership, set strategy and become more sustainable. Some health services are already reducing their carbon emissions and increasing recycling. This is something each practice and each hospital campus can engage in. It is how a difference will be made.

Congratulations to the high school students and those who supported them. We should all be inspired to play our part #actonclimatechange.

DR BB-G-LOVED



Improving informed consent

Most patients believe it's important to know the level of training of the doctor performing their surgery but less than a third could identify the level correctly, a survey of Christchurch hospital patients has found.

Dr Heath Lash, former representative of the New Zealand RACS Trainees' Association, presented the results of two survey findings and a review of current consent forms in New Zealand to Surgery 2019, New Zealand's Annual Scientific Meeting, held in Wellington in August.

The surveys were part of several initiatives sparked by a complaint, upheld by New Zealand's Health and Disability Commissioner (HDC), involving a patient who was operated on by a Trainee, with a consultant assisting. The patient suffered a complication as a result of the surgery. The HDC determined that the Trainee had not sufficiently explained before the surgery that they were a Trainee and did not inform the patient of the risk associated with having a Trainee performing the operation.

"This led us to ask: Do patients know who is treating them and who do they expect to be operating on them?"

"This led us to ask: Do patients know who is treating them and who do they expect to be operating on them?"

Previously, 140 surgical patients were surveyed at Christchurch Hospital. A third of respondents thought they knew who operated on them but were wrong; 22 per cent thought a doctor in training did the surgery whereas in fact 59 per cent of respondents had been operated on by a Trainee; 32 per cent thought a surgical Trainee was a new graduate or university student. Only 38 per cent of respondents ranked house surgeon, registrar and consultant surgeon in the correct order of seniority.

Seventy-five per cent of respondents expected their surgery to be performed by a consultant; in fact consultants performed only 28 per cent of respondents' operations.

"While 61 per cent of respondents believed it was important to know the level of training and experience of the doctor doing their surgery only 27 per cent could correctly identify them."

Along with the survey, Dr Lash and his colleagues reviewed 17 out of 20 consent forms used by District Health Boards. "Only two of these forms contained statements that adequately covered Trainees. These forms included an acknowledgement that there were no guarantees a particular person would perform the surgery but the person who did the procedure would have appropriate training and experience."

Only one District Health Board had a pamphlet regarding surgical team makeup that could be given to patients before surgery.

Dr Lash and his colleagues designed a pamphlet and gave it to 100 surgical patients at Christchurch Hospital. They then surveyed two groups of 100 surgical patients: one group had received the pamphlet while the other group hadn't.

"Significantly, more patients who received the pamphlet could rank doctors from least to most experienced, knew that a registrar was more experienced than a house surgeon, defined the terms senior registrar and identified the term used for a fully qualified surgeon correctly.

"A pamphlet like this could enhance the informed consent process and help us better meet the requirement, for example, for any reasonable patient to know who will be performing their procedure," Dr Lash added.

Case note review correspondence

In a letter to RACS, the Neurosurgical Society of Australasia responds to the case note review – "No consideration for a decompressive trauma craniectomy" – published earlier this year in *Surgical News*.

Decompressive craniectomy – an alternative interpretation

We read with interest the article *A case note review: No consideration for a decompressive trauma craniectomy,* published in a recent edition of *Surgical news*.[1] Concerns were raised regarding the means and timing of intracranial pressure control and the use of decompressive craniectomy in the context of severe traumatic brain injury. We would like the opportunity to present an alternative interpretation of the management strategy.

For many years the management of severe traumatic brain injury (TBI) has been based on information gained from intracranial pressure (ICP) monitoring and patients were routinely hyperventilated, frequently placed in a barbiturate coma, or more recently rendered hypothermic or surgically decompressed because these measures consistently reduce intracranial pressure. However, clinical studies have failed to show that lowering intracranial pressure by these techniques provides clinical benefit, and in some instances, they may have caused harm.

The recent Randomised Evaluation of Surgery with Elevation of Intracranial Pressure (RESCUEicp) trial demonstrated a clear survival benefit in those patients randomised to surgical decompression; however, the reduction in mortality resulted in an increase in the number of survivors with severe disability or in a vegetative state.[2] In addition, amongst the 196 patients randomised to receive medical therapy seventy-three crossed over to have a decompressive procedure. The outcome of this group is not reported however, if many of these patients went on to make a good long-term recovery there would be grounds to argue in favour of the ongoing use of decompressive craniectomy. Conversely, if a significant number of survivors in this group had either severe disability or were in a vegetative state (and who were analysed in the medical arm of the trial), support for ongoing use of the procedure would be seriously called into question.

Overall, there is now good evidence that decompressive craniectomy will not reverse the effects of the pathology that precipitated the neurological deterioration and it represents an aggressive intervention with significant morbidity.[3]

In the article, concerns were raised that there was no discussion of the procedure in the patient's notes. We would contend that in the light of current evidence there would be far greater concern if the procedure had been performed and there had not been clear documentation that survival with severe disability would be acceptable to the person on whom the procedure was being performed.

On behalf of the Neurosurgical Society of Australasia

Professor Stephen Honeybul, Statewide Director of Neurosurgery Western Australia

References

1. A case note review: No consideration for a decompressive trauma craniotomy. *Surgical news* 2019;20(1):49.
2. Hutchinson PJ, Kolias AG, Timofeev IS, et al. RESCUEicp Trial Collaborators. Trial of Decompressive Craniectomy for Traumatic Intracranial Hypertension. *N Engl J Med* 2016;**375**:1119-30.
3. Honeybul S, Ho KM, Gillett GR. Long-term outcome following decompressive craniectomy: an inconvenient truth? *Curr Opin Crit Care* 2018;**24**:97-104.

Lifelong learning

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Mandatory courses

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

- Foundation Skills for Surgical Educators Course: mandatory for SET surgical supervisors, surgeons in the clinical environment who teach or train SET Trainees, IMG supervisors, research supervisors, Education board members, Board of Surgical Education and Training and Specialty Training boards members.
- Operating with Respect one-day course: Mandatory for SET supervisors, IMG supervisors and major RACS committees.

Foundation Skills for Surgical Educators course (FSSE)

25 October	Adelaide	SA
22 November	Brisbane	QLD

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

Operating with Respect course (OWR)

8 November	Sydney	NSW

The OWR course provides advanced training in recognising, managing and preventing discrimination, bullying and sexual harassment.
The aim of this course is to equip surgeons with the ability to self-regulate behaviour in the workplace and to moderate the behaviour of colleagues, in order to build respect and strengthen patient safety.

Academy Forum 2019

7 November 2019	Melbourne	VIC

The Academy Forum is held in conjunction with the Annual Joint Academic Meetings.

A special evening to acknowledge surgical educators and the leaders among us.

Theme: Changing Landscapes in Surgical Education

Speakers: Professor Margaret Hay and Dr Claudia Di Bella

Surgeons as Leaders in Everyday Practice

Friday 25 to Saturday 26 October	Melbourne	VIC
Sunday 27 to Monday 28 October	Launceston	TAS
Friday 1 to Saturday 2 November	Sydney	NSW

Surgeons as leaders in everyday practice is a one and a half day program that looks at the development of both the individual and clinical teams leadership capabilities. It concentrates on leadership styles, emotional intelligence, values and communication and how they all influence their capacity to lead others to enhance patient outcomes. The program forms part of a leadership journey sharing and gaining valuable experiences and tools to implement in the workplace.

Safer Surgical Teamwork (SST)

Saturday 16 November	Sydney	NSW

Safer Surgical Teamwork (previously known as Safer Australian Surgical Teamwork – SAST) is a combined workshop for surgeons, anaesthetists and scrub practitioners. The workshop focuses on non-technical skills that can enhance performance and teamwork in the operating theatre thus improving patient safety. These skills are explored using three frameworks developed by The University of Aberdeen, Royal College of Surgeons of Edinburgh and the National Health Service – Non-Technical Skills for Surgeons (NOTSS), Anaesthetists Non-Technical Skills (ANTS) and Scrub Practitioners' List of Intra-operative Non-Technical Skills (SPLINTS). These frameworks can help participants develop the knowledge and skills to improve their performance in the operating theatre in relation to communication/teamwork, decision making, task management/ leadership and situational awareness. The program looks at the relationship between human factors and safer surgical practice and explores team dynamics.

Process Communication Model Seminar 1

Friday 18 to Sunday 20 October	Adelaide	SA
Friday 15 to Sunday 17 November	Brisbane	QLD

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

Partners are encouraged to register.

Before the introductory PCM course each participant is required to complete a diagnostic questionnaire which forms the basis of an individualised report about their preferred communication style.

Clinical Decision Making

Friday 29 November	Adelaide	SA

This four hour workshop is designed to enhance a participant's understanding of their decision making process and that of their Trainees and colleagues. The workshop provides a roadmap (or algorithm) of how the surgeon forms a decision. This algorithm illustrates the attributes of expert clinical decision making and was developed as a means to address poor clinical decision making processes, particularly as a guide for the supervisor dealing with a struggling Trainee or as a self improvement exercise.

SAT SET Course

Friday 8 November	Launceston	TAS

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).

Keeping Trainees on Track

Friday 8 November	Launceston	TAS

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

This free three hour course is aimed at College Fellows who provide supervision and training to 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.

Non-Technical Skills for Surgeons (NOTSS)

Saturday 26 October	Sydney	NSW

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

Please contact the Professional Development Department on: +61 3 9276 7440, PDactivities@surgeons.org or visit the website at surgeons.org and follow the links from the homepage to activities.

PROFESSIONAL DEVELOPMENT WORKSHOP
DATES: October– November

NSW		
Non-Technical Skills for Surgeons	26 October	Sydney
Surgeons as Leaders in Everyday Practice	1 to 2 November	Sydney
Operating with Respect	8 November	Sydney
Safer Surgical Teamwork	16 November	Sydney
VIC		
Surgeons as Leaders in Everyday Practice	25 to 26 October	Melbourne
Academy of Surgical Educators Forum	7 November	Melbourne
SA		
Process Communication Model Seminar 1	18 to 20 October	Adelaide
Foundation Skills for Surgical Educators	25 October	Adelaide
Clinical Decision Making	29 November	Adelaide
QLD		
Process Communication Model Seminar 1	15 to 17 November	Brisbane
Foundation Skills for Surgical Educators	22 November	Brisbane
TAS		
Surgeons as Leaders in Everyday Practice	27 to 28 October	Launceston
Keeping Trainees on Track	8 November	Launceston
Supervisors and Trainers for Surgical Education and Training (SAT SET)	8 November	Launceston

Register online

For more information phone **+61 3 9276 7440**, email **PDactivities@surgeons.org**
or visit our website **surgeons.org** and search Professional Development

Skills Training courses

RACS offers a range of skills training courses to eligible medical graduates that are supported by volunteer faculty across a range of medical disciplines. Eligible candidates are able to enrol online for RACS skills courses.

ASSET: Australian and New Zealand Surgical Skills Education and Training

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

EMST: Early Management of Severe Trauma

RACS has officially launched the 10th Edition of Emergency Management of Severe Trauma across Australia and New Zealand. EMST teaches the management of injury victims in the first hour or two following injury, emphasising a systematic clinical approach. It has been tailored from the Advanced Trauma Life Support (ATLS®) course of the American College of Surgeons. The course is designed for all doctors who are involved in the early treatment of serious injuries in urban or rural areas, whether or not sophisticated emergency facilities are available.

CCrISP®: Care of the Critically Ill Surgical Patient

RACS has officially launched Edition 4 of the Care of the Critically Ill Surgical Patient (CCrISP®) course across Australia and New Zealand. The CCrISP® Committee has extensively reviewed materials provided by the Royal College of Surgeons of England (RCS), resulting in an engaging new program which is highly reflective of current Australian and New Zealand clinical practice and standards in management of critically ill patients.

CLEAR: Critical Literature Evaluation and Research

CLEAR is designed to provide surgeons with the tools to undertake critical appraisal of surgical literature and to assist surgeons in the conduct of clinical trials. Topics covered include: Guide to clinical epidemiology, Framing clinical questions, Randomised controlled trial, non-randomised and uncontrolled studies, Evidence based surgery, Diagnostic and screening tests, Statistical significance, Searching medical literature and decision analysis and Cost effectiveness studies.

TIPS: Training in Professional Skills

TIPS is a unique course designed to teach surgeons-in-training core skills in patient-centred communication and teamwork, with the aim to improve patient care. Through simulation participants address issues and events that occur in the clinical and operating theatre environment that require skills in communication, teamwork, crisis resource management and leadership.

SKILLS TRAINING COURSE DATES
SEPTEMBER - DECEMBER 2019 | *Available courses

ASSET	www.surgeons.org/asset
All remaining 2019 ASSET courses are fully subscribed. You can elect to register for a course waiting list via the ASSET webpage. Invites are sent to those on a course waiting list, based on date of registration.	
Registration for 2020 courses will open early October 2019	
CCrISP	**www.surgeons.org/ccrisp**
All remaining 2019 CCrISP courses are fully subscribed. You can elect to register for a course waiting list via the CCrISP webpage. Invites are sent to those on a course waiting list, based on date of registration.	
Registration for 2020 courses will open early October 2019	
CLEAR	**www.surgeons.org/clear**
Friday, 20 September – Saturday, 21September	Sydney
Friday, 8 November – Saturday, 9 November	Wellington
EMST	**www.surgeons.org/emst**
Friday, 25 October – Sunday, 27 October	Canberra
Friday, 22 November – Sunday, 24 November	Brisbane
Friday, 22 November – Sunday, 24 November	Adelaide
TIPS	**www.surgeons.org/tips**
Friday, 15 November – Saturday, 16 November	Melbourne
Friday, 22 November – Saturday, 23 November	Auckland

**Courses available at the time of publishing*

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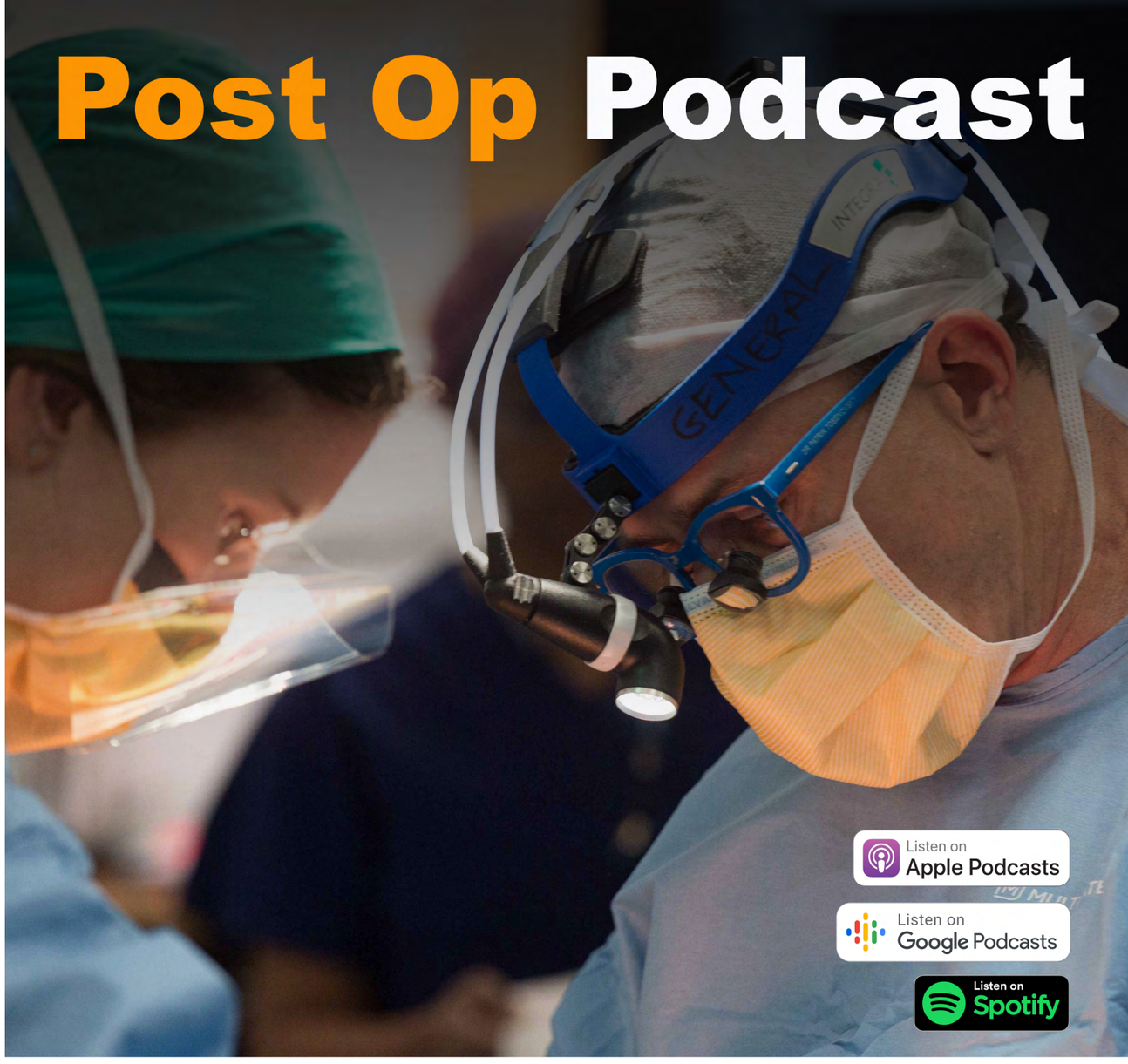

- Check out the interviews with some of the most inspiring and forward-thinking industry professionals.
- Developed by RACS, and sponsored by the Bongiorno Group, the Post Op Podcast features interviews on the latest research across the medical industry as well as practical advice that surgeons can implement in their practices, such as insights on financial management, wealth creation, legal and tax advice and economic forecasts.
- A new podcast is available each fortnight and you can listen on Apple Podcasts, Google Podcasts, Spotify or wherever you find your podcasts. Simply search 'RACS Post Op'.
- If you have a story or topic you'd like to see covered on the Post Op Podcast please email RACS. Communications@surgeons.org – we'd love to hear from you.

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RACS Australian policy updates

In any given month, numerous matters and policy issues cross the desk of the Policy and Standards team at RACS. They could relate to workforce issues, surgical variance reports and legislation that affect our Fellows. The following provides some insight into the diverse range of policies our staff here at RACS, with the advice from our Fellows, seek to answer in service of our College and profession.

National Medical Workforce Strategy

The Council of Australian Governments (COAG) Health Council is developing a National Medical Workforce Strategy (NMWS) that commenced in 2019 post-election and will run into 2020. COAG hired business management consultancy McKinsey to help with the administration and organisation of their initial consultation forums in New South Wales, Western Australia and South Australia. RACS representatives attended these forums during May 2019 and encouraged NMWS to be inclusive of Victoria, Queensland, Tasmania and the territories.

The areas of interests were rural, remote and regional, growing the Aboriginal and Torres Strait Islander medical workforce, specialist training positions to meet community needs and workplace culture, doctor health and wellbeing. RACS representatives informed the process along with each state in accordance to their needs. Some common factors did arise as symptomatic of workforce issues in Australia, including:

- geographical maldistribution
- increasing subspecialisation over generalist leading to fragmented care
- over and undersupply of certain specialities.

The development of NMWS has been undertaken by the Medical Workforce Reform Advisory Committee (MWRAC) resulting in a scoping framework report now available on their website. By comparison it is interesting to examine this process with that of the August 2014 Health Workforce Australia (HWA) report, *Australia's Future Health Workforce – Doctors,* which presented long-term, national workforce projections for doctors in 2030. The three key factors highlighted in the HWA report were as follows:

- significant increase in domestic medical students over the last ten years
- age demographic of the medical workforce
- lack of coordination across the medical training pipeline.

When asked if the current NMWS would take into consideration past efforts such as the previously government funded HWA report that engaged with the same stakeholders as the current process, we were met with the position that the Commonwealth Government was building upon previous studies to establish a national coordinating approach. In essence it would appear that NMWS is about developing a supply and demand model. RACS was informed that individual jurisdictions and the Commonwealth had the tendency to clash due to their deferring models. The process continues.

Medibank Hernia Surgical Variance Report – CPD

RACS collaboration with Medibank on the Surgical Variance Reports has evolved over the years. It was designed as a mechanism to provide Fellows on request to anonymously examine where they lie compared to their surgical peers in relation to specific procedures conducted on Medibank patients.

Categories include costs, duration of services, length of hospital stay etc. Some of the final composite reports released are now available in the surgical variance reports section of the RACS website. The incentive being that in Australia, data concerning private hospital outcomes are not centralised due to the blended public and private system. Accessing data from one of Australia biggest private health insurers was thought to be an asset when helping to examine surgical variances while providing a unique insight. These reports are not designed to judge or assess the performance of a Fellow. The most recent report relates to hernia procedures and close to 300 Fellows have been contacted via RACS with a response rate nearing 25 per cent. Participating Fellows have also been granted the opportunity to claim 1 CPD point for completion of this activity under *Category 2 – Clinical Governance and Quality Improvement – Activities related to organisation or review of surgical services.*

Addressing challenges to increase the rural surgery workforce

The RACS Rural Surgery Section is working to improve health outcomes for the 7.5 million people living in rural and remote areas. Our focus is on collaboration with other colleges and organisations with shared goals and increasing the rural surgical workforce. There are three pillars to increasing rural workforce – select for rural, train for rural and retrain for rural.

The Surgery Section has been working with the Specialty Training Boards to identify opportunities to increase exposure of Trainees to positive rural work experience, including leveraging the existing federal government funded rural training hubs.

Earlier this month, the Rural Surgery Section was invited to comment on the Australian Federal Government's program to increase the rural surgery workforce, the Rural Health Multidisciplinary Training Program (RHMT) Program[1]. In this article, we outline the committee's response.

Established in 2016, the RHMT Program aims to improve the recruitment and retention of medical, dental, nursing and allied health professionals in rural and remote Australia. At present it funds a national network of 26 regional training hubs, 19 Rural Clinical Schools, 16 University Departments of Rural Health and six dental schools that support rural placements for students across various health disciplines. The objectives of the program are to:

- provide rural training experiences for health students
- develop an evidence base for the efficacy of rural training strategies in delivering rural health workforce outcomes
- provide support to rural health professionals to improve Aboriginal and Torres Strait Islander health
- increase the number of rural origin medical, nursing, allied health and dental students
- maintain well-supported academic networks to enhance the delivery of training to students, junior doctors and specialist Trainees.

As part of the RHMT Program, the Integrated Rural Training Pipeline (IRTP) was developed to support the regional training hubs with funding of approximately $93.8 million over four years supported by the Department of Health until 31 December 2020.

Our submission focussed primarily on the IRTP and Specialist Training Program (STP) pathway.

Under the auspices of the RHMT program, there is great potential to develop a strong network between RACS, regional training hubs and rural university medical clinical schools. The establishment of the STP and IRTP training posts has been a positive initiative to expand surgical specialist training posts.

However, fulfilling all available STP and IRTP training posts has been challenging for RACS to achieve. RACS unfortunately withdrew from the IRTP activity for the 2019-20 period. This was due to the difficulty in identifying a suitable Trainee and integrating the training post into a rotational surgical training hub that would satisfy the government's requirement to spend 66 per cent of their training in a rural location. The availability of funding and the process of accrediting training posts within the specified timeframe has been problematic.

RACS recommends that the timing of STP and IRTP funding be aligned with the timelines required to accredit hospital training posts, especially those in the rural and regional areas. Ongoing funding certainty is encouraged to ensure new and established training posts can continue to be viable. The STP and IRTP programs need to be structured in a way that fits within RACS processes or provide increased flexibility and support to enable use of available funding.

To assist our Trainees, the IRTP and STP funding should follow the Trainee as they rotate through the settings and not be tied to a particular post location. Trainees will benefit from exposure to different procedures and facilitate cross-specialty training. Portability of entitlements across state and territory boundaries is important.

RACS encourages the Australian Commonwealth Government to consider ways to ensure that state and territory jurisdictions cooperate to deliver health services for patients, especially those in border towns. Appropriate geographic hubs would allow clinicians to seek advice and share skills with colleagues in the same region.

1 https://www1.health.gov.au/internet/main/publishing.nsf/content/rural-health-multidisciplinary-training-program-framework

Dr Bridget Clancy
Chair, Rural Surgery Section

Social media is increasingly becoming an integral part of surgeons' professional lives and brands.

"Social media is instrumental in building your brand – how patients and colleagues perceive you. And it's an increasingly popular way for patients to get a lot of information about health and medical matters. An *Australian Family Physician* survey found that out of almost 3000 patients, 63 per cent had accessed the internet in the last month, 28 per cent of respondents had sought health information online and 17 per cent had obtained information related to problems managed by the GP at their last visit. That was five years ago so I expect those statistics would be much higher now," said RACS Councillor, Dr Christine Lai.

In fact it could be argued that we have an obligation to take part in the debates on social media, particularly for example, around vaccines. It's really important for voices of reason to be heard.

Dr Lai, speaking to participants at New Zealand's Surgery 2019 Annual Scientific Meeting, said social media enables surgeons to give patients valuable information or direct them to reputable sources. "In fact it could be argued that we have an obligation to take part in the debates on social media, particularly for example, around vaccines. It's really important for voices of reason to be heard."

"Social media provides excellent opportunities to connect and engage with colleagues, whether they're in the same workplace or on the other side of the world. I've gained some huge insights and some fantastic professional development from blogs, journal articles, discussions, podcasts and videos that have been recommended to me by people I'm following or who are following me online."

Dr Lai explained there are also a range of very effective channels on social media for raising awareness of, and organising positive action around, issues that affect medical professionals wherever they live and work. "The 'Crazy Socks 4 Docs' day, for example, which started with a simple web page by a Melbourne cardiologist two years ago to normalise the discussion on doctors' mental wellbeing, is now a national and international phenomenon."

"Influencing policy making has become so quick and easy, thanks to social media. Instead of having to write a letter or submission, we can now add our names to electronic petitions to have our say on laws, policies and initiatives that we care about," Dr Lai added.

"If you are going to get more involved in social media and build your image, here are a few tips: as well as creating your own quality content, try to regularly share content created by reputable sources in the surgical and medical profession; keep your profile information up to date; and be active and reponsive on all your social media channels. Enjoy!"

Surgical Workforce Census: Key insights

The RACS Surgical Workforce Census is conducted every two years to guide workforce planning and advocacy. The census collects valuable data on work patterns, wellbeing and future work intentions for Fellows and is an essential activity to inform our policy.

The most recent census was conducted during December 2018. All active and retired Fellows residing in Australia and New Zealand were invited to participate in the online survey via email.

A response rate of 28.8 per cent was achieved, down from 39.5 per cent recorded for the 2016 Surgical Workforce Census. The respondents were overall representative of the wider Fellowship when considering specialty, age ranges, sex and location. Key insights from the 2018 Surgical Workforce Census include:

Work hours and patterns

The reported hours worked by Fellows continues to remain stable. In 2018 full time Fellows worked on average 50 hours per week (compared to 51 in 2016 and 53 in 2014) and preferred to work on average four hours less per week. Part-time Fellows worked on average 19.6 hours per week compared to 21.5 in 2016.

Public and private employment

Sixty per cent of respondents reported working in both public and private practice. During 2018 Fellows in private practice reported working longer hours in consulting work than their public counterparts. Time spent on procedural work and administration was similar for private and public sectors. In the public sector, one in six Fellows worked more than the recommended emergency on-call period of 1:4. These results are consistent with previous census results.

Private Billing

Private billing was a new theme for the 2018 census. Australian Fellows in private practice were asked what they consider to be a fair professional fee. Almost 40 per cent reported that the AMA fee is about right, with a further 18 per cent reporting that higher than the private health insurance amount but less that the AMA was fair.

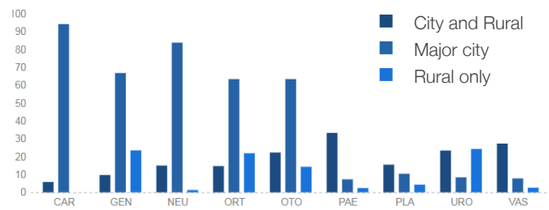
Rural and regional practice

Thirty per cent of respondents worked in a rural or regional location in 2018, including those practising in both metropolitan and rural or regional locations (figure 1). As RACS continues to address challenges in rural workforce retention, it's worthwhile to note that one in five Fellows plan to decrease their hours in regional settings over the next five years.

Wellbeing

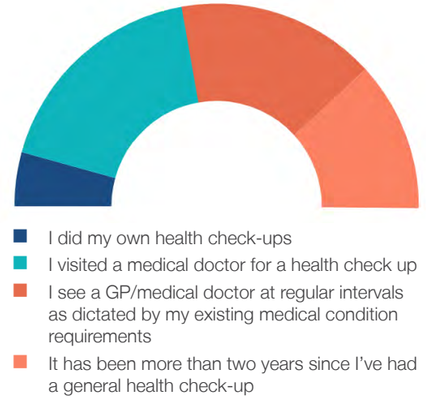
Administrative regulation and processes remain a source of high stress. Surgeon wellbeing is a RACS priority and it's pleasing to see that most participants (68 per cent) reported having a health check-up in the last two years (figure 2). RACS *Do you have a GP?* campaign promotes regular check-ups, however there's still more to do. Almost 25 per cent of Fellows reported that it's been more than two years since their last check-up, only a slight improvement from 29 per cent reported in 2016. There was considerable interest from members in forming a wellbeing working group which will soon commence to review and prioritise wellbeing initiatives for 2020.

Figure 1: Percentage of Fellows practising in a rural or regional area by surgical specialty



Note: data excludes Fellows not currently living in Australia or New Zealand; retired Fellows; missing work location responses.

Figure 2: How Fellows monitored their general health in the last two years



Note: excludes Fellows not currently living in Australia or New Zealand; retired Fellows; missing responses to general health monitoring question.

Thank you to all Fellows who gave their time to participate in the census. To view the report, search 'workforce reports' at surgeons.org or request the report by emailing workforce@surgeons.org

Ruth Bollard
Chair,
Fellowship Services Committee

Australian Capital Territory update

Canberra is often referred to as the Bush Capital of Australia. This title has been at the forefront recently with forums being held on how to reduce wildlife crashes with vehicles on ACT and surrounding regions' roads. This is of concern to surgeons in the ACT due to the high number of patients presenting to the ACT Trauma Unit, requiring varying surgical procedures.

A range of stakeholders have come together to collate data that has previously not been shared with each other to gain a greater understanding of the impact that wildlife crashes have and what actions can be taken to reduce the number of incidents.

The ACT Government is building a centre at the Canberra Hospital campus. The building – the SPIRE (Surgical Procedures, Interventional Radiology and Emergency) – will include a new emergency department, intensive care unit and operating theatres. This expansion of the Canberra Hospital will increase the capacity for patients that is required to support Canberra's growing population.

The ACT has also been growing as a surgical training post over the past few years with a high calibre of Trainees undertaking their surgical training in Canberra hospitals. However, there remains a few areas of concern that need to be improved to ensure that the ACT is providing the best support for our Trainees and training and education in general for all surgeons throughout their career. High on the RACS ACT Committee agenda is ensuring that an appropriate education and training facility be built that would not only include all essential training requirements but also state-of-the-art facilities that would cater for cadaver training, simulation and virtual reality training, and training with robots. Originally, this facility was intended to be incorporated into the SPIRE building however, bigger locations on the Canberra Hospital campus are now being considered.

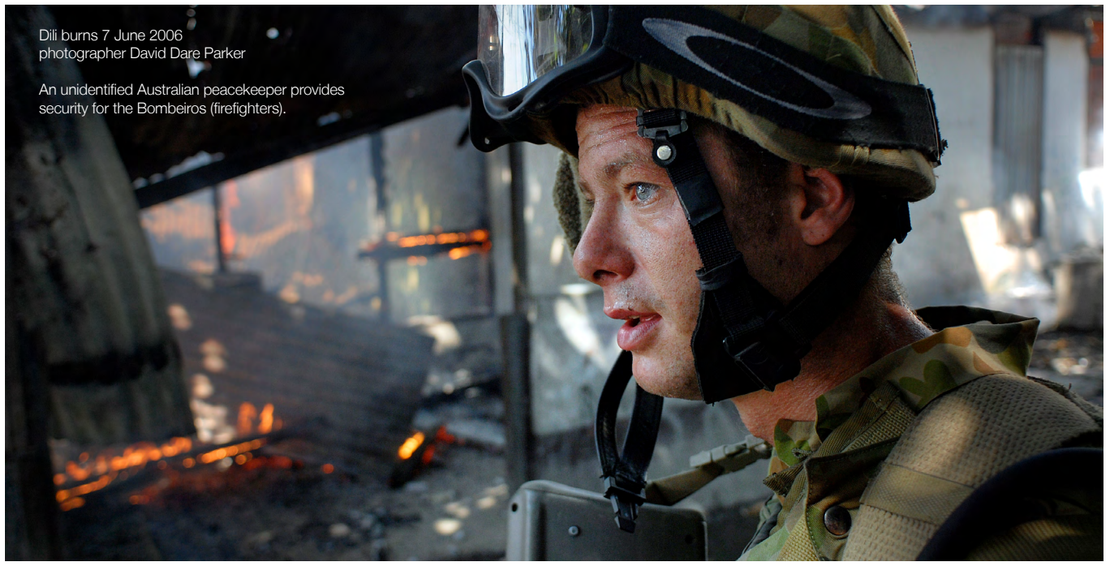
The ACT health system recently underwent a review of its culture which indicated that there were many issues including disengagement with clinicians. Actions are currently being considered and the RACS ACT Committee is ensuring that surgeons and on-the-ground clinicians are at the forefront of the decision making and involved in any implementation.

On 1 November, the ACT will host its Annual Scientific Meeting (ASM) at the stunning National Museum of Australia overlooking the picturesque Lake Burley Griffin in the heart of the city. The ASM centres on the theme "The Cost of Excellence" which will explore the dedication, investment, and commitments of surgeons through three sub-themes – the academic, financial and health economic, and personal costs of excellence in surgery. An outstanding line-up of guest speakers will present throughout the day including Professor Klaus-Martin Shulte, Professor Russell Gruen, Dr Cherry KoH, Professor Michael Talbot, Mr James Downie and Professor Stephen Robson. Delegates will also hear from the Treasurer of the RACS Council, Associate Professor Julie Mundy, and the ACT Health Minister, Rachel Stephen-Smith.

Please join us in our spectacular capital for what will be an extremely interesting and topical discussion.

For more information on the ACT ASM and registration details, please visit the ACT page on the RACS website.

Professor Paul Smith
Chair, ACT Committee



Dili burns 7 June 2006
photographer David Dare Parker

An unidentified Australian peacekeeper provides security for the Bombeiros (firefighters).

Changed Forever: Living with the enduring legacies of conflict

Orthopaedic surgeon Annette Holian (pictured below) has had her military efforts honoured in a touring Victorian exhibition which commemorates the service and sacrifice of Australians through individual accounts of conflict, dislocation and resettlement.

Reflecting the characteristic diversity of Australian society, the exhibition – *Changed Forever: Living with the enduring legacies of conflict* – is based on a collection of oral histories undertaken by Melbourne's Shrine of Remembrance with Australian Defence Force (ADF) veterans of recent conflicts and peacekeeping, and migrants who have come to Australia because of conflict.

Dr Holian joined the Royal Australian Air Force a year after observing the highly professional logistical support of the Defence Forces in Papua New Guinea where she led a medical team to provide tsunami relief in 1998. During the next four years she served in both East Timor and the Solomon Islands and later Afghanistan, as told in an excerpt from the exhibition:

> Three deployments to Afghanistan followed; in Tarin Kowt in 2008, the medical team comprised a general surgeon, an orthopaedic surgeon (Annette), an anaesthetist and two Dutch junior doctors. They treated terrible lower body injuries resulting from the impact of improvised explosive devices. Patients were often awake and could talk and receive oxygen and blood, before being anaesthetised.
>
> *… we were just on the edge of it... in a forward operating base, if you couldn't keep them alive and get them off the table and on to appropriate transport, they were going to die.*
>
> Annette observes that returning service people can judge themselves harshly, as can others. She believes commemoration is vital – to maintain networks, for the unspoken acceptance of those who have shared your experience – and education matters, because people can't commemorate what they don't know about.
>
> *It was an incredibly rewarding experience… it was fulfilling, doing what we were trained to do, working hard every day to make a difference. It is a combination of disaster, medical and military training.*

Stories in the exhibition are told using paintings, sculpture, music, multimedia and images, all showing the extent of the influence of global and civil conflict on our society today.

The exhibition is now touring in Victoria through to April 2021. For locations and dates please visit shrine.org.au

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS RACS

2019 **Surgeons' NSW Month**

Australian Defence Force in medicine
Victoria Barracks
8 November

Prep for SET
RACS NSW Office
9 November

Equality in Medicine
Art Gallery of New South Wales
13 November

Younger Fellows Preparation for practice
RACS NSW Office
23 & 24 November

NSW Surgeons' Evening
NSW Parliament House
Graham Coupland Lecture:
A/Prof Kelvin Kong
'Good Vibrations'
29 November

New South Wales State Committee
Register now: www.tinyurl.com/SMNSW2019
www.surgeons.org/NSW

Join us at Tasmania's upcoming ASM

Obesity – surgery and surgeons

As always, the second half of the RACS calendar is filled with interesting local annual scientific meetings, and this year's Tasmanian instalment is no exception.

This year's Annual Scientific Meeting (ASM) will be held in Launceston on Saturday 9 November, with a focus on "Obesity – surgery and surgeons." This issue is becoming increasingly important to surgeons of all specialties from across Australia and New Zealand as obesity rates continue to grow.

The ASM provides an important forum for surgeons, IMGs, Trainees, registrars and medical students alike to showcase their research, academic activity and to discuss wider issues relevant to surgery. Among the speakers at this year's event will be Dr Tony Sparnon, RACS President; Mr Gary Fettke who will discuss 'the role of sugar' and Mr Garth Poole who will deliver the Henry Windsor Lecture.

For those considering travelling to Tasmania, Launceston is a vibrant hub for food, culture and nature. Our conference dinner will take advantage of all these aspects and be held in the idyllic setting of Peppers Silo Resort, famous for some of Tasmania's best and freshest seafood and also for its 'paddock to plate' promise.

Two pre-conference workshops will also be held at Peppers Silo Resort on Friday 8 November with a SAT SET course in the morning and a Keeping Trainees on Track course in the afternoon. These courses, as well as the ASM, will attract CPD points.

We encourage all of our Tasmanian Fellows, Trainees and IMGs to support their local meeting, as it is an excellent networking opportunity to meet with old friends, as well as make new ones. For more information on the ASM please visit the Tasmanian page of the RACS website, or contact the local office. We hope to see you there!

Young Investigator Award

November Annual Academic Surgery Conference – incorporating the Surgical Research Society of Australasia

The Young Investigator Award is one of several prizes awarded at the Annual Surgical Research Society of Australasia conference each November. The award contributes to the cost of attending the Academic Surgical Congress (ASC) in the USA, representing the Section of Academic Surgery.

Dr Suh Kah Goh, who was awarded the prize for his presentation entitled "Non-invasive surveillance of organ health after liver transplantation using donor-specific cell-free DNA", recently attended the 2019 Academic Surgical Congress (ASC) in Houston, USA and wrote of his experience:

> I am very grateful to RACS Surgical Research Society (SRS) and Association of Academic Surgery (AAS) for supporting my attendance at the ASC.
>
> On the first day of the congress, I was given the opportunity to participate at the AAS Executive Council Meeting. I observed the focussed role of each key committee member in delivering the AAS vision of promoting academic surgery. Over the next few days, along with over 1800 other attendees, I attended many of the plenary and scientific sessions… I was also fascinated by the phenomenal quality and the scope of scientific papers that were presented across various specialties.

The congress was, overall, an eye-opener. Being able to interact with such a diverse yet dedicated group of academic surgeons has taught me the importance of academia in surgery, the importance of equality, and also the need to build and maintain international relationships. I trust that my 'ASC experience' will continue to reinforce and inspire my career goals to be an academic surgeon.

The next November Annual Academic Surgery Conference – incorporating the Surgical Research Society of Australasia – will be held on 7 and 8 November.

To find out more please visit the Academic Surgery events page at surgeons.org

Tristate ASM wrap

This year's Tristate Annual Scientific Meeting – 'Robots in Surgery – Tsunami or just the next wave?' – saw more than 130 Fellows, Trainees, IMGs and associates from across Australia and New Zealand gather in Port Lincoln to participate in the three day conference.

The program kicked off with an enlightening look at the 'anatomy of a tsunami,' presented by 2018 South Australian Scientist of the Year, Professor Richard Hillis. He explained there are five stages of a tsunami; the initiation, the split, the amplification, the draw down and the run-up. These stages (plus the additional 'wash up'), formed the basis of the scientific program, as delegates explored whether computer-aided technologies are likely to rapidly replace traditional 'manual' surgeons, or whether they are just the next phase in the ongoing cycle of technological development.

Scientific program

The program featured a range of perspectives from across surgical specialties and healthcare, as well as the views of experts in business, science and law.

Highlights included:

- Dr Johan Verjans, an expert in the field of artificial intelligence (AI) and Deputy Director of Medical Machine Learning at the newly established Australian Institute of Machine Learning. Dr Verjans discussed some of the game changing developments that we can expect from AI and also some of the red herrings.
- Dr Tom Cundy, paediatric SET Trainee, who has a PhD in surgical robotics and has been involved in the development of several master-slave robots including the Cyclops and Welcome Trust funded i-Snake platforms. Dr Cundy provided a preview of some of the newest technological innovations that may soon find themselves in our operating theatres.
- The National Rural Health Commissioner, Emeritus Professor Paul Worley, discussed securing a technologically advanced surgical workforce for rural and regional Australia and the possibility that increasing training in the rural environment could increase retention of surgeons pratising in rural locations.
- A quality field of registrants for the paper competitions. Congratulations to the prize winners; Dr Nagendra Dudi-Venkata who won the SA Justin Miller Prize for best clinical paper presentation, and to Dr Sathish Paramasivan who won the 2019 RP Jepson Medal for best research paper.

While the conference took a serious look at the role of robotics in surgery, there were also many light-hearted and humorous moments over the three days. This was particularly evident in the 'Sharks' Tank' where four speakers pitched their ideas for new technologies to a panel of discerning judges, with audience members also voting for their favourite pitch. This was followed by the highly entertaining event finale, where three teams debated whether the best surgical outcomes for patients are best achieved using technologies from the past, the present or the future.

Conference Dinner and Anstey Giles Lecture delivered by Australian of the Year, Richard Harris

The conference dinner was held in the idyllic setting of one of the region's renowned restaurants, the Line and Label. Tickets for the dinner were sold out well in advance, and guests were not left disappointed by the evening's star attraction. Dr Harris is a well-known South Australian anaesthetist, but it was his cave-diving heroics leading to the rescue of 12 young Thai soccer players and their coach that propelled him to international fame.

While most of us are familiar with the story of the rescue as told through the media, hearing the story retold from Dr Harris' point of view provided a unique and very different perspective. His inspirational account of survival, bravery and resilience captivated audience members and made for a truly memorable evening. He received a standing ovation from the entire audience.

Port Lincoln

The excitement the conference generated within Port Lincoln, demonstrated the importance of such events to regional areas.

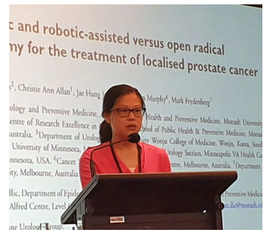
An opening night symposium focusing on 'Navigating safe patient transfers: What can go wrong?' hosted by the South Australian Audit of Surgical Mortality, was attended by many clinicians from Port Lincoln and across the Eyre Peninsula. This was followed by a 'Tasting Port Lincoln' welcome event, showcasing local food and wine for which the region is famous.

Presenting at both the opening night symposium and during the conference was resident Port Lincoln surgeon, Mr Quentin Ralph. Mr Ralph played a key role in attracting delegates to Port Lincoln for the conference and his presentation demonstrated some of the rewards and challenges that come with operating in a regional setting.

From a media perspective, the conference generated more exposure and interest than any previous Annual Scientific Meeting, with ABC journalists attending several of the sessions. This excitement was matched by the interest generated in the local community, largely thanks to the efforts of South Australian Urologist, Mr Rick Catterwell. Mr Catterwell delivered a fascinating presentation to local high school students the day before the conference, which he followed up that evening with an equally popular presentation to community members at one of the local hotels.

The theme for the conference was engaging and very well received, and attendances were high across each of the three days. There are many exciting technologies heading our way. A consistent theme throughout the conference was that our approach should be one of caution and guided by clinical evidence, informed patient consent and accountability, rather than dictated by vested financial interests and potentially dubious marketing.

Congratulations to everyone who was involved in making this event such a huge success. Preparation is already underway for the 2020 Tristate ASM which will be held in Broome. We hope to see you there!



IMAGES (l-r): A/Prof Susan Neuhaus presenting to a discerning panel of judges during the final debate; Dr Christine Lai; Dr Tom Cundy.



IMAGES (l-r): Dr Phil Worley presenting the 2019 RP Jepson Medal for best research paper to Dr Sathish Paramasivan; Dr Richard 'Harry' Harris being recognised by Dr Phil Worley after Dr Harris delivered the Anstey Giles Lecture; Dr Phil Worley presenting the Justin Miller Prize to Dr Nagendra Dudi-Venkata for best clinical paper presentation.

Buckingham Palace: A regal infirmary

OP – LX (60)

I could not help recalling when putting these lines together, the famous words of Samuel Johnson (yes, I had to look it up) of 20 September 1777, "You find no man, even an intellectual who is willing to leave London, so when a man is tired of London he is tired of life". Johnson, as we know, wrote the first English Dictionary 150 years before the Oxford Lexicographic publication.

I never cease to recall the rewards of my time on the London scene, expanding both my worldly experiences and my reconstructive surgical talents. But London was for me a world of many changing vistas and it was here I learnt the advantages of world travel enlightening the mind, as succinctly described by Mark Twain in *The Innocents Abroad:*

"Travel is fatal to prejudice, bigotry and narrow-mindedness, and many of our people need it sorely on these accounts. Broad, wholesome, charitable views of men and things cannot be acquired by vegetating in one little corner of the earth all one's lifetime."

I often recall snippets from those London days, particularly recently when an incident occured on the Antique Road Show. This story was about the Westminster Hospital where I was, incidentally, in training doing Head and Neck surgery with Charlie Westbury, a protégé of Sir Stanford Cade, and where I spent three years.

As we experience registrars in training knew their place in the surgical hierarchy. Every chance someone in authority could denigrate them, that opportunity was never lost. Of course, let's not forget we are Colonials. But I cannot help recalling those Colonial minds that pre-eminently established themselves at Oxford and Cambridge – Florey with penicillin and Rutherford and Oliphant in the atomic nuclear sphere and the prejudice of the establishment still prevails.

One nursing sister in charge of the theatres at the Westminster during my training always adopted one such superior tone, but with good reason – she was the theatre sister in charge of the case when Sir Clement Price Thomas from the Westminster Thoracic Unit did the pneumonectomy on King George VI on 23 September 1951 at Buckingham Palace.

A minor event on a hot summer afternoon is something else I recall. The weather was stiflingly oppressive and our air conditioning 'unit' was an open window on the third floor. With the theatre window slightly ajar, thanks to the orderly, one can guess what arrived unannounced – a blowfly! We know such insects may be the focus of bacterial infection but they may have their use. Let's not forget the experience of the Catalonian surgeon, Trueta in the Spanish Civil War. He immobilised compound tibial fractures in a plaster cask with a hole over the wound for dressing. Thankfully, the maggot infestation came from nowhere but this contamination controlled the staphylococcal and streptococcal super infections and the putrefying open wounds resolved into a clean wound, healing by granulation. Yes, laudable pus is part of surgical history.

Another interesting development on yet another occasion, the sister in charge revealed, and I remember her words in a somewhat belittling way "Do you know Sir, you are actually operating on the very table used at Buckingham Palace for the King's pneumectomy", as though she enjoyed still holding court. A memorial plaque, attached to the theatre table base, commemorated this regal event of the King's surgery with date and location. Let's hope it is now in an archival museum and not in a recycled junk yard where important surgical equipment often find their denouement.

What precipitated this story? It was an episode of the Antique Roadshow. On this occasion the granddaughter of Sir Clement Price Thomas brought along his medals of knighthood – KCVO (below) including the letter of acknowledgement addressed personally to him and signed by the King. The King's letter was thanking him for making him feel the best he has felt for months. The presenter of the program, Fiona Bruce, remarked about its significance and the rarity of the King's signature and put the insurance value at upwards of £5,000.

The granddaughter retold the story that Price Thomas, on a post-operative visit, was awarded his Knighthood by the King who was dressed in pyjamas and dressing gown. The King was so grateful the operation went without mishap that he asked Price Thomas to kneel on a cushion in the bedroom and, obtaining a sword from a nearby sheath, touched the man on the right shoulder and bestowed his Knighthood.

At the *9th International Symposium of the History of Anaesthesia* (2017), the history of the King's diagnosis and the operation that followed it was summarised. Details are listed of the anaesthetic arrangements and equipment, and Price Thomas is quoted as stipulating

H.M. King George VI

that the arrangements should be as normal as possible to create a normal ambiance, and so the surgeon's usual operating table and equipment from the Westminster were brought to Buckingham Palace. His regular anaesthetist, Cyril Scurr, whom I knew personally – the epitome of a gentleman – was in attendance along with his full anaesthetic support team.

According to the granddaughter, Price Thomas insisted that duplicate theatre equipment was available at the Palace – including gas lines and resuscitation needs – should something untoward develop. The operation was delayed until the Sunday morning about 10am, as the King requested there be as little disruption as possible to the regal conventions, including the changing of the guard.

Incidentally the junior assistant, the late Mr Charles Drew, was invited to close the wound. He subsequently became a cardio-thoracic surgeon who popularised the "Drew manoeuvre" of cardiac cooling to reduce metabolic need in open heart surgery in the 1970s. As the granddaughter stated, Price Thomas whimsically remarked that as he had never closed a surgical wound in his consultant years, he wasn't about to start practising on the King's chest wound.

Price Thomas and Sir Stanford Cade were close friends. When I was training with Charlie Westbury the story about Sir Stanford Cade surfaced. Cade escaped from the Russian Revolution in 1917 and landed in the east end docks of London in a cargo vessel without a word of English. The Cockney location and early schooling suited his intrusive personality and eventual acceptance came his way. He subsequently began to top every exam in his schooling, as he did during his Westminster university years along with the English Fellowship, eventually becoming Vice President of the College of Surgeons.

How serendipitous it has been unifying these ideas which have a common link to the Septmeber season from Johnson's utterances of 1770s and the King's pneumonectomy of 1950s are like a thread in a woven surgical tapestry.

Assoc. Professor Felix Behan
FRACS

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13 December

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Professor Vernon Marshall

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VIC 3000

After the presentation, lunch will be follow.

Thanks to the D'Extinguished Surgeons for their ongoing fundraising efforts in support for **Foundation for Surgery**.

RSVP
Please RSVP to
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by 22 November 2019

2020 Younger Fellows Forum, Melbourne

Friday 8 May - Sunday 10 May 2020

The Younger Fellows Forum (YFF) will once again precede the 2020 ASC in Melbourne. The forum provides a unique opportunity for a diverse group of Younger Fellows (those who have gained fellowship within the last ten years) to meet and discuss issues that are of importance to the College now and going into the future.

Delegates will gain a greater understanding of the workings of the College, meet new friends in a relaxed environment and have the opportunity debate important issues facing surgeons in 2020 and beyond. Most importantly the forum offers a unique opportunity for younger members of the College to collectively have a voice on important issues and present a number of collaborative recommendations to College Council.

Participants come from diverse backgrounds, in addition to meeting fellow delegates from Australia and New Zealand, there are opportunities to meet with international younger fellows from the College of Surgeons of Hong Kong and Thailand, as well as a representative from the US Association of Academic Surgery.

The 2019 forum, held at the Courtyard by Marriott Bangkok, Thailand, was a raging success, bringing together a wide range of surgical specialties. The 2020 forum is planned to be held at the CountryPlace, a picturesque award winning conference centre in the Dandenong ranges just under an hour east of Melbourne (visit countryplace.com.au for details).

If you are a younger fellow who wants to be more involved in your College and help shape its future we urge you to consider attending and pencil the forum dates in your calendar. All Younger Fellows who have not previously been to a YFF are invited to nominate for the 2020 YFF. Formal invitations were circulated in September with nominations closing in December 2019. Airport transfers in Melbourne, accommodation, meals and all activities at the forum are covered by the College. Participants must finance their own flights to meet the transfers.

Please keep your eyes open for future correspondence and if you have any questions, please don't hesitate to contact us.

Contact:

Mary Ann Johnson and Vinna An
2020 YFF Conveners
majjam888@gmail.com
vinna_an@yahoo.com.au

Reflecting on the birth of a nation

On 30 August 2019, Timor-Leste commemorated 20 years since its popular consultation. The Timorese people exercised their right to self-determination and voted overwhelmingly for independence.

The anniversary of the deployment of the peacemaking taskforce – International Force East Timor (INTERFET) – was marked on 20 September. The taskforce had arrived in Timor-Leste to address the humanitarian and security crisis from 1999-2000. INTERFET, which was led by Australia, involved 21 countries who made an important contribution at a critical time in the history of Timor-Leste.

Professor Glenn Guest FRACS, RACS Timor Leste Program Director, reflects on his time in Timor-Leste at the beginnings of the new nation.

The Indonesian occupation of East Timor was characterised by a highly violent, decades-long conflict between separatist groups and the military.

In 1999, following the United Nations-sponsored act of self-determination, Indonesia relinquished control of the territory.

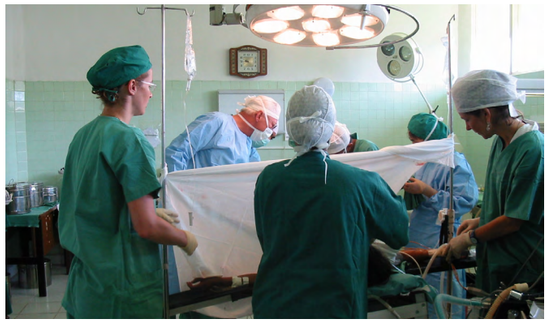
While RACS wasn't there in the immediate aftermath of the vote for independence in 1999, we arrived soon after. We worked with Australia's own military force, with the World Health Organisation (WHO), with the international committee of the Red Cross, and with many Timorese and other international NGOs. It was an amazing period of collaboration with everyone working towards the one goal of trying to get Timor-Leste back on its feet.

The early days after the vote for independence was a very challenging time for health in East Timor with few doctors and no specialists. Many Australian surgeons and anaesthetists went up to contribute during this time and I was one of those. I went as a newly qualified surgeon and found it incredibly challenging as only one of two surgeons in the whole country.

I felt it was a real privilege to be involved with this team effort of trying to get Timor-Leste back on its feet and when I look back now on what was achieved in those early days by the Timorese and their many partners I have a great sense of pride to be involved with that.

I had the opportunity to work side by side with the Timorese doctors and nurses at Dili national hospital. It was really inspirational to see people who had been through such turbulent times themselves, still come to the hospital to work and be involved in others people's care and rebuilding their country's health system.

I've worked as a surgeon in many humanitarian aid programs but the period of time after the independence in Timor-Leste was one of the most rewarding. The size of the problem was very much daunting – building a health system from scratch – but working together with so many dedicated individuals and amazing institutions all working towards the same goal was a really inspirational time.



IMAGES (from top): Prof Guest and East Timor Surgical Trainees; Surgery in East Timor; Dili hospital front.

I often reflect that Timor-Leste was born as a country in very turbulent times but I've seen the passion of the people and the enormous support of its partners give Timor a great head-start as a young nation on a pathway to success.

Professor Glenn Guest
General and Colorectal Surgeon
Professor Deakin University Epworth Geelong

Supporting a new nation

Since 2001, when Timor-Leste gained independence, RACS has managed an Australian Government-funded program that has supported service delivery and capacity building through postgraduate medical training in Timor-Leste.

When Timor-Leste gained independence, there were no nationally qualified surgeons and few health workers had the skills needed to provide essential and emergency medical care to the Timorese community. Since then, RACS has provided extensive clinical teaching, mentoring and training for Timorese doctors, nurses and allied health workers.

The RACS Timor-Leste Program works with the Ministry of Health, the National University of Timor-Leste and other key partners to deliver post graduate medical education and training programs, assisting in the development of the required skills to work in community health centres throughout Timor-Leste.

Professionalism in surgery and perils of social media

Social media (SoMe) is described as online activity that is used to share opinion, information, images and applications.[1] In all its forms it has become pervasive, affecting every aspect of personal and professional activity. Trying to separate the two has become increasingly difficult as surgeons, including Trainees, try to reconcile where the line is drawn.

Some platforms, for example LinkedIn™, can be isolated to professional activity. Others, like Facebook™, may be more conducive to personal activity. Twitter™ can be a bridge between the two. Despite identifying views expressed as 'own', it can be difficult for individuals to separate their 'personal' views, from associated organisations whom they may appear to represent by affiliation, especially when such views become considered inflammatory or divisive. The issue of comments that may be perceived as damaging to another individual's reputation, can be especially problematic. Anything posted is discoverable and lives forever online.

Recently, two Tweets from one surgeon highlighted a complex issue, relating to crowdsourced funding and the ethics of understanding what constitutes 'best care.'[2] RACS and other professional bodies have a position on, and are opposed to, excessive fees for services.[3] In addition, there are guidelines including a patient information sheet that recommends full disclosure with transparency of fees, clear discussion of available treatment options, and second opinions to allay any concerns patients may have.[4]

Despite their right to do so, the central issue questions why patients feel the need to access expensive private only services, when excellent public healthcare exists for such treatment. In this case, such care was confirmed by a professional body to be available in the public healthcare sector.[5]

Crowdsourced funding is seen as potentially problematic, as it is unregulated. Monies collected are not audited, and therefore, it will not be known if they were used for the stated purposes. It also remains unclear what happens to excess funds.

The fallout from the two Tweets resulted in a SoMe-storm, with multiple informed and uninformed opinions as well as extensive media coverage. It caused hurt and abuse, and made it difficult to be clear on what the core issue was i.e., care available in the public healthcare system and beyond that, excessive fees.

Surgeons as a professional group need to be mindful of comments made on SoMe platforms, as a *thought* had in a *moment* can last forever and cause unintended consequences. Comment threads can also stray from the core issue by those who choose to divert attention away from the problem.

Being a good and better surgeon is where most surgeons aspire to be professionally. Portraying oneself as 'the best' risks complacency, suggests a lack of insight and at the extreme, demonstrates arrogance.[6]

Professionalism in surgery extends beyond day to day clinical practice. It also encompasses multiple non-technical skills and, in this context, how each surgeon extends their reach using SoMe. The Australian Health Practitioner Regulation Agency (AHPRA) has a clearly stated SoMe policy. There are national laws that need to be abided and with that come professional obligations that include not discussing patients (including posting of pictures), obtaining appropriate and specific consent, presenting unbiased evidence based context, and not making unsubstantiated claims.[1] Claiming to be better than another colleague or being 'the best' may be seen as making unsubstantiated claims. Irrespective of a surgeon's personal opinion about their prowess, there

remain legal, ethical and professional obligations that cannot be ignored in making such claims. Furthermore, the general public expects maintenance of standards by peer review and audit, but don't fully appreciate the detail of how that takes place in practice.

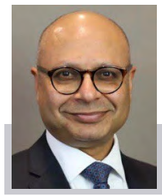
Surgeons cannot ignore the guidelines offered by the various affiliated organisations they belong to and must have a working knowledge of what they are reasonably expected to know. Failing to know could result in serious consequences, and at worst, litigation by an aggrieved party. Finally, codes of conduct are also in existence and must not be breached, as that too carries significant consequences.[7]

SoMe is arguably an extension of some key RACS competencies, including communication and collaboration. It is unquestionably of great value, but all surgeons need to be reminded of why considered thought needs to be exercised, before 'posting' potentially controversial comments or material that may breach guidelines and codes of conduct.

Finally, surgeons who promote themselves as 'the best' must understand that they are failing to appreciate what the term really means, and the possible fallout if proof is eventually required by governing bodies.

References:

1. Social Media policy. Australian Health Practitioner Regulation Agency, 2014. (Accessed 04 June 2019, at https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Social-media-policy.aspx.)
2. Acclaimed brain surgeon Professor Charlie Teo defends prices for his life saving-expertise. Australian Broadcasting Corporation, 2019. (Accessed 04 June 2019, at https://www.abc.net.au/news/2019-05-28/charlie-teo-defends-prices-after-criticism-from-colleague/11155648.)
3. Position paper on excessive fees. Royal Australasian College of Surgeons, 2019. (Accessed 04 June 2019, at https://www.surgeons.org/media/20023066/2014-10-30_pos_fes-pst-036_excessive_fees.pdf.)
4. Information for patients on surgeon fees. Royal Australasian College of Surgeons, 2015. (Accessed 05 June 2019, at https://www.surgeons.org/media/21660272/2015-04-29_surgeons_fees.pdf.)
5. Charlie Teo brain surgery controversy: Society gives assurances. News Corp Australia. (Accessed 04 June 2019, at https://www.theaustralian.com.au/nation/charlie-teo-brain-surgery-controversy-society-gives-assurances/news-story/228ccba27f56a651b23beb134e1ad6d8.)
6. Watters DA, Smith JA. Being a better surgeon: a multi-competency challenge. ANZ journal of surgery 2019;89:461-3.
7. Code of Conduct. Royal Australasian College of Surgeons, 2016. (Accessed 04 June 2019, at https://www.surgeons.org/media/24335322/2016-04-29_mnl_racs_code_of_conduct.pdf.)



Assoc. Prof. Prem Rashid
PhD DClinSurg FRACS

Spotlight on Papua New Guinea

Medical Society of Papua New Guinea Medical Symposium

Our Global Health team attended the Medical Society of Papua New Guinea's 55th Medical Symposium in Port Moresby in September, opened by the Papua New Guinea Prime Minister James Marape and hosted by the University of Papua New Guinea (PNG). The theme of the meeting was Health Education.

Gwyn Low, RACS Global Health senior program officer, said the meeting was an excellent showcase of the clinical leadership which already exists and is flourishing in PNG.

“The future is bright with the next generation of specialists coming through, with many Fellows and RACS Global Health volunteers alike supporting continuing professional development in the country as part of RACS commitment to global health.”

The Australian and New Zealand College of Anaesthetists (ANZCA) and RACS held a joint booth which created an area for Papua New Guinean doctors and nurses to come together. The booth was a major success and visits such as these promote the work of RACS, ANZCA and other specialist colleges including the Australasian College for Emergency Medicine and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) supporting PNG and the Pacific region.

The surgical community in PNG has held a long-standing relationship with RACS. Our Global Health team manage the Australian Government funded PNG Clinical Support Program, which sits under the #PNGAusPartnership investment in health.

IMAGE (l-r): Kate Davis, Policy Officer ANZCA with Gwyn Low RACS Global Health senior program officer.

Port Moresby neurosurgeons visit RACS

The RACS Global Health team recently welcomed Port Moresby General Hospital neurosurgery Trainees, Dr Esther Apuahe, Honorary Fellow in neurosurgery and Dr Benjamin Thomas, who were both attending the Neurosurgical Society of Australasia (NSA) Annual Conference in Melbourne.

After a quick visit to RACS, Dr Thomas and Dr Apuahe spent the day at The Alfred Hospital undertaking a medical observership with Professor Jeffrey Rosenfeld AC OBE FRACS, who was honoured at the NSA conference for his contribution to Papua New Guinea.

Dr Thomas' trip is supported by the #PNGAusPartnership and Dr Apuahe's trip is part of her Rowan Nicks Scholarship. Dr Esther Apuahe is currently completing a 12-month scholarship attachment at Townsville Hospital with Dr Eric Guazzo FRACS.

IMAGE (l-r): Dr Benjamin Thomas and Dr Esther Apuahe.

In the media

September 2019 – ABC Radio Melbourne

Dr Thomas and Professor Rosenfeld were interviewed on ABC Melbourne's Drive program speaking about training and mentoring neurosurgeons in Papua New Guinea.

Professor Rosenfeld, who has authored a book on performing neurosurgery in resource-poor countries, *Neurosurgery in the Tropics*, explained during the interview that he “fell in love with the country… fell in love with the people” when he first went to PNG as a surgical Trainee in the early 1980s. He cited common health issues in PNG as including: infection, tuberculosis, trauma from road accidents and sporting “as you’d see here but exaggerated”; spinal, congenital and hydrocephalus; along with a rise in heart disease and hypertension attributed to a Western diet and lifestyle associated with an improved standard of living.

IMAGE (l-r): Professor Jeffrey Rosenfeld and Dr Benjamin Thomas

Dr Thomas explained the difficulties in addressing these health challenges, “We don’t have sophisticated resources… we have basic resources to deal with medical and surgical problems”. He also spoke of the need for developing neurosurgery, crediting Professor Rosenfeld as “…the main neurosurgical mentor in PNG – the pillar upon which neurosurgery is built there. He’s thought of a lot in PNG.”

Professor Rosenfeld concluded the interview: “Your listeners will be very pleased to know the College of Surgeons here in Australia, through the funding from DFAT (Department of Foreign Affairs and Trade) – the Australian Government, supports the global health program in our region, particularly PNG but also East Timor, the Solomon Islands and Fiji, and they send teams of doctors and nurses into these countries with that funding to provide the specialist health services that those countries don’t have in large supply, but also to mentor the local doctors and nurses to help them build their own service and expertise. So, it’s a wonderful program – I think it’s the best use of foreign aid that Australia has”.

Professor Rosenfeld cited the following facts during the interview:

- Australia has a ratio of one neurosurgeon for every 100,000 people.
- Papua New Guinea has two neurosurgeons in training to meet the neurological needs of 8 million people. General surgeons do neurosurgery in the periphery, without which people would die.
- Globally, it is estimated there are 22.6 million patients every year who suffer from neurological disorders or injuries and 13.8 million who require surgery.
- 23,300 additional neurosurgeons are needed in the world to address the more than 5 million essential neurological cases in low- and middle-income countries. The gross disparity in the allocation of the surgical workforce leaves a large geographic area of the world, particularly in Africa and Sout East Asia, without neurological services.

September 2019 – *The National*, PNG

Commending Australian doctors

The National ran a story on regular PNG visitors – paediatric liver transplant surgeon Mr Albert Shun AM FRACS and anaesthetist Dr Michael Cooper AM FANZCA – who were recently recognised for their efforts in contributing to the development and establishment of paediatric surgical and anaesthetic services in the country.

Paediatric surgeon Prof Albert Shun, who specialises in liver transplants, and anaesthetist Dr Michael Cooper, both based in Sydney, have trained and mentored paediatric surgeons and Trainees in PNG.

Southern region deputy chief surgeon Dr Hoxson Poki is reported as saying “Professors Shun and Cooper have mentored, trained and taught and have been an inspiration in the training of paediatric surgeons in PNG over the last 20 years. Four paediatric surgeons have been trained and are working with this program and three more surgeons are undergoing training.”

September 2019 – *The Post Courier*, PNG

The Post Courier reported on Mr Albert Shun and Dr Michael Cooper teaching and upskilling while working with a team of local surgeons to operate on eleven children during their recent visit to Port Moresby General Hospital.

Dr Cooper is quoted as saying in paediatrics, trauma and injuries were common in children who fell out of trees and it was an equally important part of their surgical care. “This is where a lot of these operations need to be staged as there are surgical and anaesthetic risks and the child has to be in good physical condition to undergo the surgery. In the past 20 years, the visiting team has assessed thousands of children for minor and major surgery because a lot of these surgeries have become more complex. We have done well over 600 – 700 major operations in the last 20 years”.

Rowan Nicks Scholarship

Since 1991, more than 80 international scholars from over 30 countries have been awarded a Rowan Nicks Scholarship or Fellowship to undertake training attachments in hospitals in Australia, New Zealand, Singapore or India.

The Rowan Nicks scholarships are not just personal awards; the orientation is to 'teach the teacher to teach others' and all scholars must come with a sense of responsibility to the needs of their home base. The intention is that the scholar will share the skills and expertise with their colleagues upon return to their home country, thereby increasing capacity to deliver improved surgical care to the local community.

Using virtual reality simulators for surgical research

For Dr David Lam, being awarded the 2018 RACS Academy of Surgical Educators (ASE) Surgical Education Scholarship was an opportunity to pursue his interest in teaching and learning. The scholarship assisted Dr Lam in completing the thesis for his Masters of Surgical Education at The University of Melbourne under the auspices of Professor Debra Nestel.

The thesis was based on a simulation study about ambidexterity in laparoscopic surgery. Dr Lam, a general surgeon with a colorectal sub-specialty interest, said while laparoscopic surgery was becoming the norm, especially in his area of expertise, the use of the non-dominant hand in these surgeries currently wasn't a focus of teaching.

"What happens is that as you progress through training, you naturally develop the use of your non-dominant hand, especially in laparoscopic surgery, to proficiency – but no-one talks about it; no-one teaches it," he said.

So, for Dr Lam, this meant finding a way to measure the proficiency in using the non-dominant hand to achieve laparoscopic surgical tasks. Over the last five to 10 years, he explained, there have been a couple of virtual reality medical simulators into which a large amount of technology has been incorporated to objectively measure performance with laparoscopic tasks.

The cost of purchasing a virtual reality simulator was out of the question, so Dr Lam used the funds from his ASE scholarship to rent a LapMentor medical simulator to conduct his research. The simulator can be used to simulate many laparoscopic tasks, and entire procedures. From those simulated tasks, Dr Lam said, you can "develop metrics to assess basic things such as time and the number of errors, and also at how far you've travelled and other complex metrics to assess performance". It was in the latter setting that Dr Lam looked at non-dominant hand use.

As well as measuring ambidexterity, the objective of the study was to examine whether ambidexterity improved or increased in participants with different levels of expertise – from novices to intermediates to experts, and also whether there is any difference in the ambidextrous levels of left-handed surgeons and right-handed surgeons.

> "We found, fortunately, that whether you're left-handed or right-handed it makes no difference in terms of your ambidexterity levels"

"We found, fortunately, that whether you're left-handed or right-handed it makes no difference in terms of your ambidexterity levels – and for some of the metrics, ambidexterity does improve with increasing surgical experience," Dr Lam said.

An interesting result of Dr Lam's study was that ambidexterity levels didn't increase with experience in every task that was measured. This paves the way for further study, he said.

"It may be better to assess ambidexterity more globally – through a whole procedure perhaps, rather than for basic tasks... making a validated scoring system to look specifically for ambidexterity."

With a completed Masters in Surgical Education, Dr Lam is passionate about the role of simulators and their potential to make surgery safer for patients and more proficient for Trainees. But it's his other passion – colorectal surgery – particularly prolapse, incontinence and other obstetric injuries that will be the focus of his surgical practice over the coming 12 months.

"A very high proportion of patients with incontinence are too scared to talk about it," he said. "It's something that's a real passion of mine, to be able to see them have a better quality of life."

After three years of colorectal Fellowship in Australia, Dr Lam recently left to work for 12 months at the Oxford Colorectal Unit in the UK. "When I come back, hopefully I can help set up a pelvic floor unit and, having a multidisciplinary approach, be able to help a lot of people," he said.

The ASE Surgical Education Scholarship was established to encourage surgeons to conduct research into the efficacy of existing surgical education or innovation of new surgical education practices.

Australian joint replacement registry reports on improved outcomes

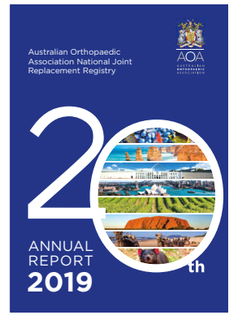
The Australian Orthopaedic Association has released its National Joint Replacement Registry 2019 Annual Report containing information on:

- why joint replacements performed after 2013 have been more successful than in previous years
- outcomes on the 1.5 million joint replacements performed in Australia since records began
- identification of poorly performing prosthesis
- a new initiative being rolled out across 45 hospitals in Australia that will examine specific patient outcomes pre and post joint replacement surgery.

World-class surgeon performance and advancements in surgical techniques has meant Australians who undergo joint replacement surgery have increasingly better outcomes now compared to when the registry records began twenty years ago.

The biggest factors impacting the results for hip surgery are the disuse of metal on metal prosthesis, total hip resurfacing and exchangeable neck prosthesis. All of which are no longer used in Australia. A large proportion of improvements in knee replacement surgery over the same timeframe can be attributed to reduction in the use of unicompartmental knee replacement and reduced revision for loosening and pain when total knee replacement is used.

To view the annual report, visit aoanjrr.sahmri.com



Academic gown and hat donation

RACS would like to acknowledge **Mr Leon Pitchon,** for generously donating his academic gown and hat to the College.

RACS preserves of academic gowns for use by Convocating Fellows and at graduation ceremonies at the College. If you no longer have use for your gown, RACS would be grateful to add to our reserve. We can acknowledge your donation and place your name on the gown if you approve.

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

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Wednesday 13 November 2019 - 9:00am – 4:00pm
Cost: $165 (inc GST) Includes lunch, morning and afternoon tea.

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IN MEMORIAM

Our condolences to the family, friends and colleagues of the following Fellows whose deaths have been recently notified.

2019

Arthur Wynyard Beasley (NZ)
Julie Lawrence (SA)
Donald Leaming (QLD)
Samuel Sakker (NSW)

Informing RACS

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

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

RACS publishes abridged obituaries in *Surgical News*. We reproduce the opening paragraphs of the obituary. Full versions can be found on the RACS website.

Arthur Wynyard Beasley
CNZM OBE FRCS(ED) FRACS
Orthopaedic Surgeon
25 January 1926 - 23 July 2019

Wyn Beasley, with incredible power of observation and memory, and placing great value on intellectual curiosity, acquired an encyclopaedic knowledge of a broad range of subjects. Traversing both arts and sciences he could readily be described as a polymath. Even though he was a very capable musician and artist, he chose to follow a career in orthopaedic surgery, committing strongly to College activities resulting in his election to Vice-President and the Court of Honour. Once he retired from surgery, he devoted the remainder of his life to researching, describing and writing widely acclaimed articles and a series of scholarly historical books.

Arthur Wynyard Beasley (known as Wyn throughout his life) was born in Auckland, the only child of Arthur Beasley, a school headmaster, and Gladys Hannken. Arthur was a calm, kind, patient and generous man while Gladys, of Teutonic descent, was strict and protective to the extent young Wyn had to come home from school for lunch with her each day, rather than play with his friends. Wyn was brought up in a family with a strong musical background. He attended Mt Albert secondary school, where despite taking Greek and Latin among his subjects, he gained the second highest mark in the national University Scholarship examinations.

www.surgeons.org/about-racs/about-the-college-of-surgeons/in-memoriam/obituaries/wyn-beasley

Julie Lawrence
FRACS
Plastic and reconstructive surgeon
18 August 1957 - 26 May 2019

Julie Lawrence became the first female plastic surgeon in South Australia and she supported and mentored young women doctors seeking a career in the specialised field.

She was born to a country policeman in the Mallee town of Lameroo, the only daughter of Win and Kelvin Ragless, with two older brothers.

They came up to Adelaide in 1961 when Kelvin joined a two-man police station on Goodwood Rd and Julie went to Colonel Light Gardens Primary School. His next posting was to Barmera, where Julie went to Glossop High School, and kept busy with sport and Girl Guides.

Naracoorte followed, and Julie was dux of her senior year at the local high school. She set out to be a teacher but at University of Adelaide went from studying organic chemistry to being accepted into medicine.

www.surgeons.org/about-racs/about-the-college-of-surgeons/in-memoriam/obituaries/julie-lawrence

Donald Leaming
FRACS
General Surgeon
1925 - 2019

At 2.00am on 25 May 2019, Don died at the age of 94 after more than seven years of invalidism from a series of strokes. At first Don's walking was affected and he fought back to walking with support. However further lesser strokes occurred until he became bed-bound and his surgical hands 'lost their cunning'. He faced these troubles with dignity and fortitude, uncomplaining. Only once during all that time did he register a comment when he said to me "If you are going to have a stroke, have a big one".

Don, always known to his friends as Spike, was born in Nottingham 6 February1925, the fourth and youngest child of a non-medical family. He had completed his secondary education at the Henry Mellish school and when the family moved to Newcastle-on-Tyne, he commenced his studies at the Medical School, part of the University of Durham, graduating in 1947. Training in Surgery followed and Don earned his English Fellowship in 1953. That year also saw Don's marriage to Margaret (Meg) Smith. Harry, the eldest of his siblings had already graduated in Medicine and subsequently became an anaesthetist.

www.surgeons.org/about-racs/about-the-college-of-surgeons/in-memoriam/obituaries/donald-leaming

Professor Donald Trunkey
MD FACS FRACS(Hon)
Trauma Surgeon
1937-2019

Donald D Trunkey would be regarded by many as the founder of modern trauma care. His "Two Counties" paper published in 1979 convincingly showed that where a trauma system existed the mortality was substantially lower than where it did not. It was this paper, more than any other in the contemporary literature, which led to the drive to systematised trauma care everywhere around the world.

Professor Trunkey was born in Eastern Washington and went to medical school at the University of Washington. He served in the US Army in the mid 60s in Germany and completed his surgical training in San Francisco. In 1986, he was recruited back to Oregon Health Science University where he served as the Mackenzie Professor and Chair of the Department of Surgery from 1986 – 2001.

www.surgeons.org/about-racs/about-the-college-of-surgeons/in-memoriam/obituaries/donald-trunkey

Thank you for your extraordinary compassion and generous support to the Foundation for Surgery in July and August.

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