ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 17 NO 08 SEPTEMBER 2016

SHARING KNOWLEDGE

Why be a surgical educator?

CPD FRAMEWORK

Program review and changes

SURGICAL NEWS September 2016 Vol 17 No 08

RACS LET'S OPERATE WITH RESPECT

The College of Surgeons of Australia and New Zealand

Program highlights 2016

Annual Joint Academic Meetings

Thursday 10 - Friday 11 November 2016
Melbourne College Office, 250-290 Spring Street, VICTORIA

DAY ONE – SECTION OF ACADEMIC SURGERY MEETING

Morning session: Mid-Career Course

Leadership: Identifying leadership opportunity

Balance: Balancing academic and clinical practice

Innovation: Innovation and research in practice.

Impact: Developing a broad academic impact

Legacy: The importance of legacy in surgery.

Afternoon session: Principles of research – planning and funding your research

RACS Scholarships

NHMRC / HRCNZ

Translational Research

Held jointly with the Academy of Surgical Educators Forum Evening of Thursday 10 November 2016

DAY TWO – SURGICAL RESEARCH SOCIETY MEETING

Invited guest speakers

Society of University Surgeons Guest Speaker – Dr David Hackam

Association of Academic Surgeons Guest Speaker – Dr Daniel Abbott

Jepson Lecturer – Professor Andrew Hill

Presentation of original research by surgeons/trainees/students/scientists

Awards for the best presentations;

Young Investigator Award, DCAS Award and Travel Grants

We would like to acknowledge Medtronic as the Foundation Sponsor for the Section of Academic Surgery

Online Registration NOW OPEN

Day one - Complimentary

Day two - Only $100 for SAS members to attend - *no membership joining fee*

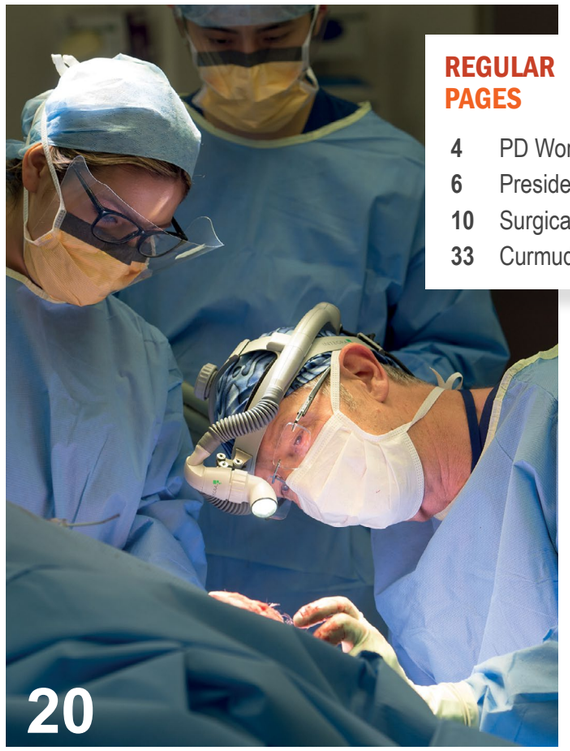
Places will be limited at these meetings

Abstract submission now open. Deadline Friday 30 September

Contact Details

E: academic.surgery@surgeons.org T: +61 8 8219 0900

CONTENTS



REGULAR PAGES

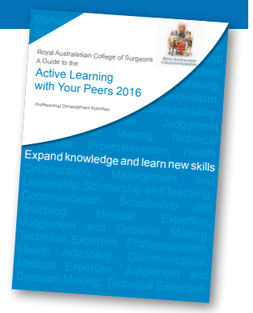
FRONT COVER IMAGE

Dr Kate Gibson is a colorectal surgeon who was mentoring junior doctors at a clinical teaching session at Sydney's Liverpool Hospital when the photo was taken

Correspondence and Letters to the Editor to Surgical News should be sent to:
surgical.news@surgeons.org
T: +61 3 9249 1200 F: +61 3 9249 1219
W: www.surgeons.org
ISSN 1443-9603 (Print) / ISSN 1443-9565 (Online)
Surgical News Editor: David Hillis

PROFESSIONAL DEVELOPMENT

WORKSHOPS & ACTIVITIES



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

Foundation Skills for Surgical Educators Course

7 October 2016 - Logan, QLD, Australia
15 October 2016 - Box Hill, VIC, Australia
16 October 2016 - Christchurch, New Zealand
19 October 2016 - Christchurch, New Zealand
21 October 2016 - Melbourne, VIC, Australia
29 October 2016 - Adelaide, SA, Australia
4 November 2016 – Brisbane, QLD, Australia
6 November 2016 – Cairns, QLD, Australia
11 November 2016 – Perth, WA, Australia
12 November 2016 – Coffs Harbour, NSW, Australia
25 November 2016 – Sydney, NSW, Australia

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

Keeping Trainees on Track (KToT)

15 October 2016, Wellington, New Zealand

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

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

Supervisors and Trainers for SET (SAT SET)

15 October 2016, Wellington, New Zealand

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

Academy Forum
'What It Takes to Take the Lead'

10 November 2016 – Melbourne, VIC, Australia

The Academy Forum will feature preeminent thought leaders discussing progressive topics in medical education. Attendees will enjoy a 3-course meal and drinks whilst workshopping questions at their tables and engaging in a Q&A session with the panel of experts. Confirmation of speakers will be announced ans posted on the website.

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

Finance for Surgeons

21 October, Sydney

This whole day course establishes a basic understanding of how to assess a company's performance using a range of analytical methods and financial and non-financial indicators. It reviews the three key parts of a financial statement; balance sheet, income (profit and loss) and cash flow. Participants learn how these statements are used to monitor financial performance.

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

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Bioethics Forum
'Bioethical Framework Implementation in Clinical Practice'

22 October 2016 - Sydney, NSW, Australia

The Forum will stimulate robust bioethical discussions amongst surgeons.

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

PROFESSIONAL DEVELOPMENT WORKSHOP DATES: September – November 2016

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

NZ
15 October 2016
Keeping Trainees on Track, Wellington
15 October 2016
SAT SET Course, Wellington
16 October 2016
Foundation Skills for Surgical Educators, Christchurch
19 October 2016
Foundation Skills for Surgical Educators, Christchurch
20 October 2016
Surgical Teachers Course, Hanmer Springs

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

QLD
23 September 2016
Foundation Skills for Surgical Educators, Brisbane
30 September 2016
Foundation Skills for Surgical Educators, Townsville
7 October 2016
Foundation Skills for Surgical Educators, Logan
4 November 2016
Foundation Skills for Surgical Educators, Brisbane
6 November 2016
Foundation Skills for Surgical Educators, Cairns

VIC
15 October 2016
Foundation Skills for Surgical Educators, Box Hill
21 October 2016
Foundation Skills for Surgical Educators, Melbourne
10 November 2016
Academy Forum, Melbourne
25 November 2016
Non-Technical Skills for Surgeons, Melbourne

WA
11 November 2016
Foundation Skills for Surgical Educators, Perth

Contact the Professional Development Department

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

TOGETHER WE STAND

Strength in a common voice that reflects and understands our diversity

PHILIP TRUSKETT
President

It is a privilege as President of the College to be able to attend the various specialty society meetings and talk to so many surgeons who are passionate and committed to the many specialties of surgery. They are so committed to education and ongoing standards as well as endlessly providing better clinical solutions and care to their patients. It is always great to listen and observe the conviction and enthusiasm.

Within the nine RACS specialties there are well developed arrangements that support the training programs and CPD requirements. These arrangements vary across the 13 national or bi-national surgical societies and that is highly appropriate given the differing critical mass and internal resources of the individual societies.

These 13 specialty societies are autonomous and this must be respected but we do have structured arrangements reflective of common objectives. Arrangements, although complex in nature, now reliably underpin the Surgical Education and Training program and aspects of lifelong learning for all Fellows. They provide a springboard to the support that RACS provides to professional development opportunities at society meetings but also to the more generic RACS development programs that are accessed by so many Fellows, Trainees and International Medical Graduates.

It is that diversity of clinical activities and surgical environments that underpins the necessity of standards being based in a practical and pragmatic world. That is our common voice.

However, it is important to continue to reflect on our diversity. Diversity exists not only between the nine specialties but also in the areas where we undertake our surgical practice. Full time practice in the private sector places different demands and pressures on people than full time public hospital employment or being employed across three different hospitals or more.

The back-up and resources available to a major teaching hospital are so significantly different to a smaller regional hospital. Yet in all of these, surgeons strive to provide the best possible care to the patients they are treating.

RACS must always be cognisant that the delivery of high quality care reflects not only on the aptitudes of the surgeon but the depth of skills and the breadth of resources of the surgical team involved.

PRESIDENT'S
PERSPECTIVE

It is that diversity of clinical activities and surgical environments that underpins the necessity of standards being based in a practical and pragmatic world. That is our common voice.

Over the past 18 months, RACS has been confronted by issues of diversity. These have been different aspects of diversity and reflect particularly on the gender of surgeons and medical graduates aspiring to be surgeons.

RACS has looked in great detail at the application rate and success rate of female Trainees. Although the results are complex it appears that female Trainees are as successful as their male counterparts but are significantly more likely to leave the training program.

In so many ways this is tragic and a considerable amount of work is being undertaken in our educational committees to understand and counteract the reasons for this. This is one of the reasons that RACS is putting so much effort into the Building Respect program.

Diversity is critical. We need to not only attract but retain the best people into the profession of surgery. We may not be doing this as effectively as we might; yet it needs to be an aspiration for us all.

But again back to the strength of diversity across surgery. We do have it within our various craft groups; we have it in our geography and in the ways we deliver surgical care.

We all embrace this actively and I admire how the specialty societies promote not only their own differences but the adherence to our high standards that can be found across the entire Fellowship.

It is critical that we build on this and understand that diversity requires more support and more active championing, and that needs to be undertaken individually, within our specialty societies, within our hospitals and across the entire RACS Fellowship.

I will look forward to discussing these really important challenges with you further.

BUILDING RESPECT

One building block at a time

PROFESSOR SPENCER BEASLEY
Vice President

In the first four months I have been RACS Vice President, and in that role as the senior office bearer responsible for the implementation of the "*Action Plan: Building Respect, Improving Patient Safety*", I have had the pleasure of progressing this substantial yet important initiative of our College.

Things are moving remarkably quickly and the enormous work and resources put into this by RACS – both staff and Fellows – is beginning to bear fruit. Already we have some evidence that surgical culture is changing, and with it, the effects will be felt more broadly across the entire health system.

As an avid reader of *Surgical News* you would have noticed many updates and features on this topic over the past 12 months. The momentum for change is gathering pace and we are no longer a lone voice wanting to improve behaviours and increase respect across medicine.

It is clear that many health jurisdictions and hospitals now see it as a priority to create a respectful culture in which our Trainees are safe and patient outcomes are not compromised by the behaviour of surgeons.

Right across New Zealand and Australia, health departments and hospitals are at various stages of implementing better processes, education and other initiatives that should help us all deal more effectively with this issue.

They are and will continue to work very closely with RACS. In addition, it is encouraging to learn of initiatives in which many of our colleagues have been involved locally, and to see those Fellows in each hospital who are willing to be leaders and champions of change in their workplaces.

So far, we have signed Memoranda of Understanding with four hospital networks and many others are in discussion with us across the states of Australia and in New Zealand. We have also had fruitful discussions with several other medical colleges and speciality societies to enable the sharing of educational resources around discrimination, bullying and sexual harassment (DBSH) and aligning them with our efforts where this makes sense.

The recently-released e-Learning module 'Operate with Respect' is an excellent resource that enables us to reflect on our own behaviour and raises awareness of what constitutes acceptable and unacceptable behaviour in the workplace. I wish to thank members of the Education Reference Group led by Adrian Anthony who were responsible for the production of this resource.

Completion of the module is required for all Fellows to remain CPD compliant. It is also built into SET training and IMG requirements so that all our Trainees and IMGs will be obliged to complete it too.

Some of you have put your faces to the 'Let's Operate with Respect' campaign. Thank you! The current posters can be viewed, downloaded and printed from our website. We have mailed these to the operating theatre managers and CEOs of the teaching hospitals.

If you do not see them in your hospital please be sure to print some and put them up! Our MoU partner hospitals will have co-branded material to strengthen the message of our mutual commitment to 'operate with respect.'

Development of a Diversity Plan to address some of the recommendations of the Expert Advisory Group is well underway. Already many RACS committees have reviewed and contributed to its content.

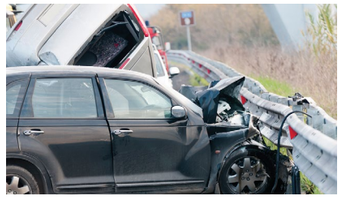
One component of it is RACS' commitment to increasing women's representation in surgery. But first, we need to recognise any hidden biases that might exist in medical schools, why women may not be selecting surgery as a career option, whether our processes of selection are fair, and that our surgical training program has no impediments to women progressing through training.

This is a complex matter, with many aspects and nuances. And a request: if you are aware of any successful models for flexible training programs and less than full-time training, please contact me.

Lastly, I will mention the importance of education and feedback for our Fellows who have regular contact with SET Trainees and IMGs. Make time to attend the 1-day course in Foundation Skills for Surgical Educators.

This course focuses on learning, teaching, feedback, and assessment and is targeted at all Fellows who are involved in surgical training. We are also seeking additional faculty for this course, so if you are interested, please email PDactivities@surgeons.org

Thank you to all the Fellows, Trainees and IMGs who are taking this message back to their workplaces and helping build respect – one building block at a time.



Safe use of mobiles on the road

A policy guide for mobile phone users was launched last month by the National Road Safety Partnership Program, an alliance concerned with road safety and mobile use of which RACS is a member.

The guide includes recommendations on in-car phone systems as well as tips for the safest approach to mobile phone use in.

Victorian Trauma Chair Christian Kenfield also took part in the development of a short video for the campaign.

Manager of the Partnership Jerome Carslake hopes that it will become the best practice for big business when protecting their travelling employees.

"Vehicles represent the greatest risk to workers with two thirds of all work related fatalities involving a vehicle, a third on public and a third on private roads. Clearly we need to do more in the business community," Mr Carslake said.

Motoring.com, 17 August

Push for new Canberra Hospital building

Promises of funding for a new wing at Canberra hospital have been met with support throughout the sector, however the Government will not commit to further spending on a system in need of reorganising.

ACT RACS Chair Sivakumar Ganadha said surgeons welcomed the promised increase in the public operating theatre space.

Health Minister Simon Corbell has rebutted the promise from Labor, saying that advice received says that more efficient use of beds would provide capacity for the next decade.

The ACT Government plan to address 'bed utilisation' is said to deliver more than 50 beds to the system while Labor's promise of a new building would only deliver 30 beds.

Canberra Times, 11 August

SURGICAL
SNIPS

High-Risk Injuries In Low-Contact Sport

An Australian rugby code 'Oztag' branded as a safe alternative to higher-contact sports has been deemed a high-risk for hand injuries by Sydney hospital specialists.

An audit into the prevalence of Oztag-related hand injuries presenting at Concord Repatriation General Hospital (CRGH) found that the 'tag' tackle, which involves players running at speed with outstretched hands meant that the pattern of these injuries was complex and often involved fractures which required operative management.

The study is detailed in the latest issue of the *Australia and New Zealand Journal of Surgery* (ANZJS).

Plastic and Reconstructive Surgeon Mr Steve Merten wants players and organisers to be aware of the potential dangers of the 'low-contact' sport.

"While the overall prevalence of Oztag-related hand injuries is low, the occurrence of these injuries in a young working population raises concern," Mr Merten said.

What's New in Fitness, 18 August

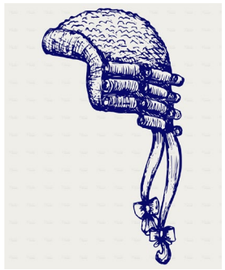
ASC evaluation prize winner

Congratulations to Dr Sawjin Tew, Plastic & Reconstructive surgeon in NSW, who has won a $500 JB Hi Fi voucher for completing the 2016 Annual Scientific Congress (ASC) evaluation.

Thank you to everyone who participated in the evaluation for the quality and improvement of the ASC into the future.

SHRIMP ON THE BBQ

So it was a loan?



THE BARONESS

I stared at the wok. Shrimps, or prawns (my preferred name) have always been done on a BBQ. Romanticised by Paul Hogan, that phrase had always been one of my favourites. "Throw a shrimp on the barbie" had encapsulated all that was carefree, summery and bountiful in Australia.

Even my pet niggle about shrimp versus prawn did not prove too much of a hindrance to pleasure. But the biggest BBQ disaster of all had struck – no gas.

I stared at the wok. It may be a popular niche cookware across the world but I had never felt comfortable with this versatile Chinese cooking vessel. Sure, it does a stir fry or pan fry or deep fry and even when pushed it can poach, boil, braise or stew. But there is something special about the BBQ sizzle - so very special. But with no gas, the heat needed to be different.

My Uni colleagues had gathered again. They had been stunned by the lack of a BBQ and somewhat overwhelmed by the appearance of the kitchen based wok. Fortunately, one of my colleagues had come accompanied by an outstanding Rose.

The Charles Melton Rose of Virginia 2010 had been awarded a medal in some international competition. Although it sounds American, it is actually one of my favourites from the Barossa Valley. It quenches the fires that were created by the peppers and chilli. A blend of Grenache, Cabernet Sauvignon, Shiraz and Pinot Meunier. An outstanding wine to accompany a hot-wok-creation. I liked that.

A second serving of the prawns had been demanded and the wine was flowing well. We continued a discussion that had already galvanised us at our recent gatherings. An eclectic group, we had all gone our separate ways. Lawyers, surgeons, theologians, as well as entrepreneurial businessmen. Some perpetually poor, others incredibly successful in many ways.

We were all drawn together by the ritual of "the shrimp". My jaw had dropped when it was explained that one of the offspring of my entrepreneurial friend had received assistance in buying their first house. Personally I do not have a spare million dollars. Not a fraction of that. However, the amazing generosity had been well utilised and happiness had spread - at least for a while, until the ground shaking reality of divorce had snuck up on them.

And so the associated difficulties became the centre of our discussions following the shrimp. The money had been extended to the happy family group with the most glorious of smiles and embrace.

However, with almost no supporting documentation, the expectation of repayment was vague and certainly none had been made. The words formed in my mind. Was it a loan? Was it a gift? A bit like is it a shrimp or is it a prawn? Are they the same? Are they different?

It may seem self-evident to my pedantic and legally trained mind that documentation (preferably legally drafted) is critical to clearly differentiating whether the transfer of money could be classified as a gift or a loan.

Even my surgically trained friend had got this point – maybe surgeons do know a bit about money after all. Put somewhat harshly, a gift is a sum of money that parents should have no expectation about being repaid or having any equitable right in assets purchased or secured. Not a cent of it. Not only that, but in Family Law, gifts are certainly included in the matrimonial pool of assets that the Court will divide as it sees fit.

Loans however, with clear evidence of the expectation of regular repayments, will be repaid before distribution by the Court. However even in this, the Court goes an extra mile and as highlighted by Justice Watts in *Sulo & Colpetti* [2010] FamCA 493 there needs to be evidence of the lender's intention *"to actively pursue a claim against the (lendee) for the monies"*.

My friend had learnt this the hard way, to his absolute chagrin. On recounting the issue again, he almost choked on a prawn. He pushed away the Rose and just poured a straight vodka. He who was so careful in so many things and had significant success had suffered from the "this will be alright" approach. The feeling of family warmth had been so strong. Ah, children, the most wonderful of gifts. And that is what the Family court had decided. The money was a gift. Divided it became.

A loan is not a loan if there are no regular repayments, the interest on the principal is 0 per cent, it is uncommercial or there is limited evidence of the lender's intention to "actively pursue a claim". It is a gift.

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

THE PUBLIC HEALTH SURGEON

We have responsibility to play a holistic role

DR SU MEI HOH
RACSTA Executive Committee

Slightly over a year ago, *Surgical News* published an article by former RACS president Prof Kingsley Faulkner who wrote: "Surgeons have had a leadership role in times of conflict, but are not usually the vanguard of public health leadership".

The article went on to discuss the global health issues of climate change, and urged all in the surgical community to engage in what the Lancet Commission identified as the 'greatest global health opportunity in the twenty-first century'.

Since then we have had further editorials from our immediate past president Prof David Watters (*Surgical News* Nov-Dec 15) and the RACS NZ National board chair Prof Randall Morton (*Cutting Edge* – Dec 15) urging the same message of a planet in peril with the health of all its nine billion strong community at stake.

So what role does a surgeon have in public health? Is it not a facet of health care that is separate from our core business? After all, as clinicians we are at the opposite end of the spectrum from public health, dealing with individual-based specific treatment as opposed to population-based general preventative interventions.

Sitting in our sub-specialised niches, are we really the best qualified people to be influencing this discourse? Also is now really the right time to be focusing our energies on public health debates when there is already so much on our plates?

I would argue that the answer to both those questions is a resounding yes or in the words of Emma Watson, UN Women Goodwill Ambassador: "If not me who? If not now when?"

Public health, global concerns

The earliest public health systems were set up in response to the epidemic and subsequent pandemic of The Black Death. Fourteenth century Venetian ports introduced the practices of quarantine and by the sixteenth century, three of the largest Italian cities had standing health commissions whose chief task was to eliminate sources of 'bad air', which medieval thinkers believed was the cause of disease and pestilence.

From these beginnings, public health has mainly concerned itself with the management and eradication of communicable diseases and this has been the driving paradigm behind global and development health agendas.

However, the end of the twentieth century has seen a shift in the discourse with increasing recognition of the burden of non-communicable diseases. With this has come an increasing appreciation of the burden of surgical disease.

The Global Burden of Disease survey estimates about 11 per cent of the global disease can be treated surgically. In some settings, surveys have also found surgical conditions among the top 15 causes of disability, which account for up to 15 per cent of DALYs (disability adjusted life years) lost globally. Surgically treatable conditions include traumatic injuries, malignancies, congenital abnormalities, obstetric complications and cataracts.

These numbers compel against the traditional notion that surgery treats only a limited part of the global burden of disease and does not warrant prioritisation. As our global health metrics and evaluation efforts become more sophisticated, we can no longer afford to ignore surgery as a necessary component of global public health.

Public health a surgical concern

The need to build more robust health systems that include surgery will not be an effort without its challenges. Surgery is a resource intensive activity requiring: large capital, a steady supply of consumable materials and also expert human skill.

There is still need for much research into the best forms of surgical care provision that is not only effective and delivers quality interventions, but also a system that champions equity, equality and sustainability. In the coming decades where our public health resources become more scarce and our nine billion strong global community continues to grow, there will be much soul searching in ethical and economic debates of how the global surgical dollar is to be spent as we seek to define what is necessary from what is a luxury.

So back to our questions of the role surgeons' play in public health efforts? Well I would say, given the challenges and storms to come, who better to contribute to the debate than the men and women in medicine who are most familiar with the pointy end of things.

Royal Australasian College of Surgeons | RACSTA Your Trainees' Association

RACS AND ITS MORTALITY AUDIT

There is more to be done

MR JAMES AITKEN
Clinical Director WAASM

James Aitken is Chairman of the Western Australian Audit of Surgical Mortality. This article is intended to stimulate debate around the role and responsibilities of the Royal Australasian College of Surgeons in the practice of audit. The views expressed are those of the author.

The Royal Australasian College of Surgeons (RACS) has every reason to promote the success of the Australian and New Zealand Audit of Surgical Mortality (ANZASM). Australia is the only country that independently and externally peer reviews every death under a surgeon. The ANZASM is now the RACS flagship safety and quality programme.

The Australian quality and safety agenda has changed since ANZASM commenced. What was acceptable 15 years ago no longer meets the standards required. Almost uniquely for a safety critical industry, medicine has been given the privilege of professional self-regulation. Governments and the public expect the profession to manage this responsibility competently and completely. Death after surgery, although relatively rare, is a high profile, easily understood and simply counted outcome. ANZASM is an important way for RACS to demonstrate its understanding of this responsibility.

ANZASM needs to evolve so it can meet current and future expectations. At the heart of ANZASM lies Qualified Privilege (QP). The state and territory health departments believe that even within the context of QP certain information can be shared and so support joint care. They understandably seek confirmation that ANZASM has discharged its responsibilities and want direct confirmation that (i) all surgeons participate; (ii) all deaths are reviewed in a timely manner; and (iii) they are advised of any unexpected death (Health Round Table 4 and 5) so they can ensure hospitals undertake their own review.

It is also their view that RACS has a professional responsibility to support and encourage high quality care. If RACS does not do so there is a real risk of its authority and independence in this area being removed.

ANZASM sees its prime aim and role as education. ANZASM's external, independent peer review is its unique hallmark that not only separates it from all other audits, but is also key to its success.

ANZASM sees its prime aim and role as education. ANZASM's external, independent peer review is its unique hallmark that not only separates it from all other audits, but is also key to its success. ANZASM believes QP is essential to protect surgeons and assessors so their reports can be written without fear that their genuine attempt to better understand and learn from a death will later be used against them. Without QP protection surgeons will not take part in ANZASM.

So the current debate is how to balance these conflicting demands. ANZASM Clinical Directors and others have robustly, intensively and extensively debated all aspects of these perceived conflicts.

I do not believe there is any reason for surgeons to object to ANZASM notifying a health department of their participation or the deaths reviewed. Advising health departments of unexpected deaths may be seen as more contentious, but it is merely ANZASM, through health departments, imposing on hospitals, its own standards of external review.

I have compared many hospital reviews against second line assessments and it is concerning when hospitals have not perceived a problem when the second line assessor has documented unsatisfactory care.

I believe unexpected deaths should be reviewed by the hospital and with an external surgeon included in the review team. External review is the standard that RACS has set for itself and is the legislated standard for other safety critical industries. Hospitals should be no different. So I believe ANZASM should provide health departments with the information they seek.

What would be unacceptable is for health departments to seek access to the surgeons or assessors reports. These are and must remain protected by QP. There has been no suggestion that health departments wish to access these reports. They recognise QP is the essence of their value. Health departments can always seek their own reviews.

To meet these standards RACS has to ensure its compliance is robust. If the primary aim of ANZASM is education, it has to meet three requirements. The first is that all surgeons complete all forms (turn up to school). When ANZASM was voluntary some 20 per cent of surgeons did not take part and others did not fully participate. Since ANZASM became a mandatory part of CPD participation this has been complete.

The second requirement is that surgeons complete their forms diligently (do their homework). Many are returned with incomplete sections. Sometimes the surgeon does not appear to have checked the data accuracy.

For example, WAASM reviews every patient who dies from a pulmonary embolus and has very frequently found that despite what was entered into the form, prophylaxis did not meet current guidelines. Such care would be indefensible if subject to medico-legal scrutiny so it is disappointing that even after a patient died from a pulmonary embolus, some surgeons do not critically check what had, or more frequently what had not, actually been delivered

With electronic submission it would be simple for ANZASM not to accept any form that has not been completed in full. The surgeon would then not have fully participated and so would not be CPD compliant.

The third requirement is that all forms are returned punctually (assignments submitted on time). If SET do not return their assessments on time they risk RACS not accrediting the term. NHMRC grant applications are returned electronically and not accepted even if one second late.

Yet some surgeons delay return of forms until the CPD deadline. Until the first line assessment has been completed the death has not undergone any scrutiny and so it is a key step. At this point almost 90 per cent of cases can be closed.

It would seem reasonable that the surgeon return the form within six weeks and the first line assessment is completed within six weeks. This will not happen unless there is a consequence, and RACS should consider strengthening this. It is in nobody's interest that potential poor care remains undetected.

The unsung heroes of ANZASM are its assessors, and especially the second line assessors. These assessments are almost without exception undertaken in a detailed and professional manner, and consistent feedback confirms their value to surgeons. Their quality is such that only a handful of surgeons have appealed a second line review.

It should be a matter of personal and professional courtesy that surgeons assist assessors by completing their forms completely and in detail. Without a detailed report it is often difficult to determine why an event happened. Better (and complete) data will greatly strengthen the quality of the audit. This is becoming of greater importance as statistical analyses are applied to ANZASM's data.

Other 'meditech' advances such as machine reading and key word extraction will also permit greater analysis. Surgeons who provide incomplete data do themselves, their colleagues and RACS a disservice.

It is now timely for RACS to build on its mortality audit. Many audits led by surgeons have demonstrated improved care. The United Kingdom cardiac and cancer surgery audits have demonstrated reducing mortality and more recently its National Emergency Laparotomy Audit (NELA) has demonstrated improved care for these high-risk patients. Hospitals participating in the American College of Surgeons National Surgical Quality Improvement Program have demonstrated reduced mortality and morbidity.

In Australia there are national programs of excellence, such as the Australian Orthopaedic Association National Joint Replacement Registry, but others either do not openly publish their data (cardiac surgery audit) or only capture partial data (Bi-national Colorectal Cancer Audit, Australian Vascular Audit). Australian surgeons have shown that given appropriate support they can undertake audits that will improve patient care. RACS must build on this.

However, RACS cannot do this alone and Australian governments need to demonstrate their clear commitment and leadership. Although the cost of audit is often cited as a barrier, these are small when compared to the long-term potential gains. For example, in only two years NELA has demonstrated a two day reduction in average length of stay, that if translated pro rata to Australia, would equate to savings of over $15 million per year.

ANZASM UPDATE 2016

The Australia and New Zealand Audits of Surgical Mortality continues to grow in resources and research

PROFESSOR GUY MADDERN
Surgical Director of Research and Evaluation

The Australian and New Zealand Audits of Surgical Mortality (ANZASM) program has been operational for over 10 years, beginning in Western Australia. It has been operating in Australia, with all states and territories contributing since 2010.

The principal aims of the audit are to inform, educate, facilitate change and improve quality of practice within surgery. The primary mechanism is peer review of all deaths associated with surgical care. The audit process is designed to highlight system and process errors and to identify trends in surgical mortality. It is intended as an educational rather than a punitive process.

The ANZASM is managed through the Research, Audit and Academic Surgery Division of the RACS. The ANZASM oversees the implementation and standardisation of each regional audit to ensure consistency in audit process and governance structure. The individual regional audits are funded by their Departments of Health.
The RACS provides infrastructure support and oversight to the project. The ANZASM receives protection under the Commonwealth Qualified Privilege Scheme; part VC of the Health Insurance Act 1973 (gazetted 10 July 2016).

There have been a number of encouraging developments during the course of 2016 which are worth highlighting:

1. Information Technology

Fellows Interface enhancements

Third party delegation of cases - The Fellows Interface has been enhanced to enable users to delegate the completion of their surgical case forms (SCFs) to a third party (e.g. trainee, registrar). Once the delegate has completed the SCF, the form is returned to the original case owner for review and approval before submission.

Self-notifying a notification of death (NoD) - Users are now able to generate their own notifications of death (NoD), rather than waiting for notification through the hospital and the audit office processes. From this NoD, the Fellows Interface will create a new case with a unique study ID and enable the user to immediately complete and submit the SCF online to their audit office.

Individual Surgeons Report – This downloadable report is now available online, once a date range is selected via a link at the bottom of the summary page of the Fellows Interface, at login. The report contains a summary of the cases reported to the audit office, under the surgeon's name. The data is compared with that of peers, within the same specialty in the same region and also nationally, in a deidentified format.

Single sign-on - Fellows can now login to Fellows Interface using their existing RACS login details. This means that the use of a separate account is no longer needed for participating FRACS to access the Fellows Interface. Fellows who have not accessed ANZASM case data online before can now do so using their RACS login, and Fellows who require access to ANZASM cases from multiple regions can access all of their data using a single account.

The Fellows Interface system has been in use for five years now and the feedback received during this time has been encouraging. This initiative provides users with a dynamic, user-friendly tool to enter SCFs and complete first-line assessments online. Completing audit forms has been made more convenient and faster. The process is more streamlined with less paperwork.

2. Radiologists engagement

The ANZASM has been in discussions with the Royal Australian and New Zealand College of Radiologists (RANZCR) regarding a collaboration to review surgical mortality deaths associated with radiological intervention within the ANZASM audit process.

This venture would be modelled on existing successful collaborations between the ANZASM and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), and the Australian and New Zealand College of Anaesthetists (ANZCA); with whom we currently collaborate in Tasmania, the Australian Capital Territory, South Australia and the Northern Territory. Two other regions are expected to follow shortly.

3. ANZASM App

Due to the substantial information now available, a selection of second-line case note reviews have been incorporated into an App format, which are displayed in a de-identified manner. This free App is compatible for both Android and iPhone tablets and phones. Search for "RACS National Case Note Reviews" on the Apple App store and on Google Play. We have had almost a thousand downloads of this informative and educative App.

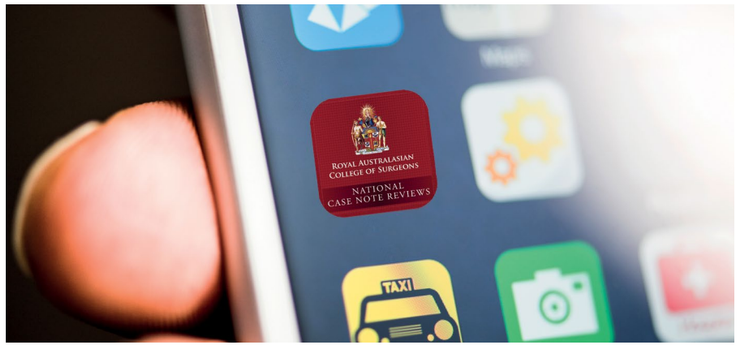


Image: ANZASM app button

4. Research articles

With the wealth of data now available, the ANZASM has started to publish articles in peer review journals such as the *World Journal of Surgery*, *Annals of Surgery*, *American and British Journals of Surgery*, *Medical Journal of Australia* and *ANZ Journal of Surgery*. Topics have included consultant supervision in the operating theatre and postoperative complications in surgical death cases, causes and effects of delay in surgical diagnosis in Queensland and the Western Australian Audit of Surgical Mortality – a 30 per cent reduction in observed deaths over 10 years.

The deidentified data is available for research purposes and anyone with an interest in writing an article should contact their local audit office for further information.

5. National Case Note Review Booklets

These booklets, produced twice yearly, include cases from all states and territories, and form part of the feedback process that is well received and deemed useful for practice improvement.

A national booklet is produced for a wider readership using cases across all states and territories. It also serves to assist smaller states who do not have enough cases to produce their own booklet due to difficulty in adequately de-identifying cases.

These national booklets are themed; with recent examples including issues around communication, obesity in surgery and clinical leadership.

The ANZASM is in a good position to utilise the extensive information as learnings to promote safer health care practices. The reports and publications from ANZASM contain in-depth investigations and summaries of key surgical issues and lessons learnt.

Thank you for your ongoing support of this important RACS initiative.

2017 CPD FRAMEWORK CHANGES

This year RACS has undertaken an in depth review of the Continuing Professional Development (CPD) program framework, in consultation with the specialty societies, regions, sections and with consideration to the standards of the regulatory authorities in both Australia and New Zealand. Changes to the program will be implemented on 1 January for the 2017 CPD year.

Type of Practice	Annual Requirement
Type 1: Operative Practice in hospitals or day surgery units	Category 1: Surgical Audit and Peer Review • Peer reviewed surgical audit • Audit of surgical mortality Category 2: Clinical Governance & Quality Improvement • Accrue a minimum 10 points Category 3: Maintenance of Knowledge and Skills • Accrue a minimum 50 points Category 4: Reflective Practice • 2017 RACS bullying eLearning module • 2018 Onwards – one activity from this category
Type 2: Operative procedures in rooms only	Category 1: Surgical Audit and Peer Review • Peer reviewed surgical audit • Audit of surgical mortality Category 3: Maintenance of Knowledge and Skills • Accrue a minimum 50 points Category 4: Reflective Practice • 2017 RACS bullying eLearning module • 2018 Onwards – one activity from this category
Type 3: Operative practice as a locum only	Category 1: Surgical Audit and Peer Review • Peer reviewed surgical audit • Audit of surgical mortality Category 3: Maintenance of Knowledge and Skills • Accrue a minimum 50 points Category 4: Reflective Practice • 2017 RACS bullying eLearning module • 2018 Onwards – one activity from this category
Type 4: Clinical consulting practice only	Category 1: Surgical Audit and Peer Review • Peer reviewed surgical audit Category 3: Maintenance of Knowledge and Skills • Accrue a minimum 50 points Category 4: Reflective Practice • 2017 RACS bullying eLearning module • 2018 Onwards – one activity from this category
Type 5: Surgical Assisting or other Non-Consulting Practice	Category 3: Maintenance of Knowledge and Skills • Accrue a minimum 30 points Category 4: Reflective Practice • 2017 RACS bullying eLearning module • 2018 Onwards – one activity from this category

PROFESSIONAL
STANDARDS

DR LAWRIE MALISANO
Chair, Professional Standards

Changes to the CPD Program:

- Practice Types 1, 2, 3 and 4 are required to accrue a minimum of 50 points under the Category 3: Maintenance of Knowledge and Skills (previously Category 4) on a yearly basis, Practice Type 5 remains unchanged at 30 points
- Category 4: Reflective Practice is new to the framework and will be mandated across all practice types with the completion of one activity from this category annually
- Fellows in Clinical Consulting Practice will be required to complete a yearly peer reviewed surgical audit
- Practice Type 5 has been renamed to 'Surgical Assisting or other Non-Consulting Practice'
- The requirements for Category 1: Surgical Audit and Peer Review and Category 2: Clinical Governance remain unchanged
- Automatic population and points allocation for completion of Surgical Case Forms, First and Second Line assessments

NEW! Category 4: Reflective Practice

Reflective practice is incorporated in the CPD framework as its own category to promote a culture of learner driven education. While many activities within the CPD program remain the same, a number of activities have been regrouped. The program will provide more tools and resources in order to facilitate completing activities in this category. The completion of one activity within Category 4: Reflective Practice is required each year.

All Fellows, International Medical Graduates and Trainees are required to complete the 'Operating with Respect' eLearning module. This module is available now and completion will meet the Category 4 annual requirement for 2017.

'Operating with Respect' eLearning module – All Fellows will be required to complete this training by the end of 2017. This module is designed to help surgeons identify discrimination, bullying and sexual harassment and give them the knowledge and skills to deal with it effectively.

From 2018, Fellows will have a range of options in this category to satisfy their reflective practice requirements.

A few examples are; completing a learning plan; participate in a practice visit as a visitor; multisource feedback; participate in a structured mentoring program; complete a patient feedback survey with action plan or attending a clinical attachment to a peer. At least one activity per year must be completed in this category.

NEW! Addition to activity types

Participation in annual individual and/or department performance review is a new activity added to Category 2: Clinical Governance and will accrue a maximum of 2 points per annum. Further adjustments have been made to Category 3: Maintenance of Knowledge and Skills.

Courses that focus on technical competencies (e.g. hands-on skills workshops, masterclasses) will accrue 1 point per hour and Peer Review of three reports (e.g. medico-legal, clinical etc.) will accrue a maximum of 15 points per annum. These additional activities were added to the revised CPD Program to enable Fellows to have further options under those categories when claiming CPD points.

NEW! Greater Integration

RACS continues to streamline reporting of CPD participation and to facilitate this process, all providers of 'RACS approved' CME events are required to report attendance directly to the College. In 2016, RACS has approved over 150 CME activities relevant to the field of surgery.

To assist Fellows, the College is in the process of integrating all RACS Examiners and Supervisors participation into CPD Online. Fellows selected to verify are not required to provide any supporting documentation for these auto-populated activities.

RACS Competencies – From 2017, Fellows' CPD will show activities reflected against the surgical competencies as a core feature of lifelong learning and self-reflection. This process occurs automatically as activities are populated into CPD online, via both self-reporting and CME approved activities. For personal Fellow reference, the RACS Portfolio will provide an overview on how CPD activities incorporate the competencies annually and over a period of 3 years.

We are here for you!

Further communication including the new program guide will be sent directly to all Fellows over the coming months. The most important message is that the changes will come into effect on 1 January 2017 and the RACS Professional Standards Department is available to assist and support you at any time.

WHY BE A SURGICAL EDUCATOR?

As members of the surgical community, we all have a responsibility to teach, supervise, mentor and coach the next generation. This was a privilege that was afforded to us during our training and is one that we should provide for the next generation

ASSOC PROFESSOR STEPHEN TOBIN
Dean of Education

We all have an inherent responsibility to conduct that training respectfully and competently. Surgical 'educators' are surgeons who teach, who supervise and those who may have specific roles e.g. the designated hospital specialty supervisor.

The medical profession's obligation to teach is embedded in its Latin derivate docēre meaning 'to teach'. It is reiterated in the Hippocratic Oath and the RACS Pledge upon acceptance to Fellowship. It is also embedded throughout the *JDOCs Framework*, *Becoming a Competent and Proficient Surgeon: Training Standards for the Nine RACS Competencies* and the *Surgical Competence and Performance Guide*.

With the publication of the *Building Respect*, *Improving Patient Safety Action Plan* in 2015 the professional role of the surgical educator was noted and many actions to support and improve surgical educator skills have commenced. Amongst these, the new one-day Foundation Skills for Surgical Educators course is prominent.

There are many constraints on a busy clinician's time. The competing priorities of clinical service delivery and surgical education remain and must be allowed for by the surgeon and the hospital environment.

Feedback and assessment may require some dedicated time after observation of clinical service tasks performed by Trainees or junior doctors. It may be possible to discuss as you go, but it often needs appropriate timing after the task, in the right place, when the milieu is right.

As surgeons, we have tended to focus on the technical aspects of care, using our medical knowledge and making well-judged clinical decisions. However the non-technical aspects of surgical care, particularly around scholarship and teaching, are equally as important. These are described in the Surgical Competence and Performance Guide as follows: 'As scholars and teachers, surgeons demonstrate a lifelong commitment to reflective learning and the creation, dissemination, application and translation of medical knowledge.' As surgeons, we can do this.

Surgeons take great pride in their clinical work. We all ensure we are up-to-date, professional and competent. Just as we lead and collaborate well in teams, we can all teach, supervise and facilitate well. Let's take pride in doing this well too.

Observing those Trainees that you have supervised in SET training do well as surgeons is a profoundly rewarding experience. Assessing their general progression, reflecting and adapting your own teaching style, benefits the surgical educator as well.

About three-quarters of the Fellowship have regular involvement with SET Trainees as part of their clinical practice, mostly in public hospitals but also in private settings. This is a major commitment to the hospital in which they work and the profession as a whole. There are many ways to get involved as a surgical educator. Some may have designated roles within surgical education and training, as a supervisor for the surgical unit, hospital or network. Others may become part of their specialty board and contribute to their specialty's training program governance. Some adopt a faculty role as an instructor on the skills courses, facilitate professional development courses or contribute to educational development projects. Whatever way you get involved will benefit yourself, the broader surgical community and ultimately our patients.

RACS delivers one of the most comprehensive and diverse faculty development programs of all the specialist medical colleges in Australasia.

Every year, RACS delivers about 60 educational courses and resources specifically tailored to support the competency of Scholarship and Teaching: all of these support surgical educators. Most are delivered free of charge or for a nominal registration fee across Australia and New Zealand.

These educational opportunities cover a wide range of subjects including:

- Understanding workplace-based assessment
- Appreciating and utilising good feedback technique
- Managing underperformance in trainees
- Developing good teaching skills
- Conducting difficult conversations, or
- Hot topics in medical education.

Surgical educators also have an opportunity to contribute to the community of practice that is the Academy of Surgical Educators. This is a group of surgical educators that comes together to discuss and explore issues in surgical education and provides a resource for those involved in surgical teaching.

Professional development programming is delivered in a range of modalities including webinars, podcasts, blogs, workshops, residential workshops, online learning programs, blended learning, seminars and the Surgical Education stream at the Annual Scientific Congress.

The Foundation Skills for Surgical Educators (FSSE) course was mandated for all those involved with surgical training and teaching by the actions associated with upskilling our surgical educators in the *RACS Building Respect, Improving Patient Safety Action Plan*:

'Using the RACS Foundation Skills for Surgical Educators course as the basis – renew, identify and accredit training for all surgeons involved in education in the areas of adult education principles, effective assessment and constructive feedback.'

Many surgeons have previously completed faculty training for surgical education and skills courses, higher learning in medical education or the Surgical Teachers' Course, and as a result have satisfied this requirement. An approach to recognise comparable programs to the FSSE has been developed.

Consider taking the initiative to be an active surgical educator within your hospital or practice. There is always something that you can do. There are always ways that we can do things better. Don't wait for someone else to do it. Be a surgical educator who demonstrates the way for others in your workplace – and don't hesitate to have a conversation with RACS staff.

Useful contacts include:

Academy of Surgical Educators: ase@surgeons.org
Professional Development: pdactivities@surgeons.org
Foundation Skills for Surgical Educators (FSSE): chris.gillies@surgeons.org
Dean of Education: stephen.tobin@surgeons.org or grace.chan@surgeons.org

ASERNIP-S: ENHANCING THE PROFILE OF RACS THROUGH INFORMED HEALTHCARE PUBLICATIONS

A synopsis of recent reviews

PROFESSOR GUY MADDERN
Surgical Director of Research and Evaluation

ASSOC. PROFESSOR IAN BENNETT
Chair of ASERNIP-S Advisory Committee

So far in 2016, ASERNIP-S has been involved in a number of projects for a range of stakeholders. This has included three projects for RACS (with others ongoing), four projects for the Medical Services Advisory Committee (MSAC), 16 horizon scanning reports for the HealthPACT and five projects for others including Health Quality and Safety Commission New Zealand, American College of Surgeons and VicHealth. Throughout, our focus remains on the synthesis of evidence relevant to surgery.

To ensure this project work is communicated effectively and to maintain and enhance a positive influence in the advancement of surgical care, ASERNIP-S staff are actively translating research outcomes into peer-reviewed publications. Recent examples are two systematic reviews based on Department of Health (MSAC) commissioned work and a commentary describing a review method to deliver appropriate and timely evidence for health policy review. These articles covered topics of post- cardiothoracic surgery analgesia, [1] imaging to detect early stage liver cancer [2] and the development of a rapid review method [3] that ASERNIP-S applied to the review of six surgical services for VicHealth in 2014-15.[4] The following is a synopsis of these recent publications.

Continuous paravertebral block for post-cardiothoracic surgery analgesia: a systematic review and meta-analysis[1]

The current gold standard for post-cardiothoracic surgery pain management is epidural analgesia. However, there are associated contraindications, including; a failure rate of up to 12% and risk of complications such as epidural abscess and spinal haematoma.

This systematic review and meta-analysis aimed to investigate the use of a continuous paravertebral block as an alternative analgesia for post-cardiothoracic surgery pain management.

The review identified 23 randomised controlled trials that included 1120 participants in total. Based on these trials, continuous paravertebral block provided equivalent pain relief compared with epidural analgesia.

The benefit of continuous paravertebral block was associated with a significant reduction in incidence of nausea and vomiting, hypotension, urinary retention and the avoidance of epidural specific complications.

This evidence synthesis supports the use of continuous paravertebral block to manage effectively a patient's pain following cardiothoracic surgery.

Gadoxetic acid-enhanced MRI for the characterization of hepatocellular carcinoma: A systematic review and meta-analysis[2]

Hepatocellular carcinoma (HCC) is the third most common cause of cancer-related death. Very early stage (single tumor <2 cm) and early stage (3 or less nodules, smaller than 3 cm each) liver cancer can be treated with curative intent, with a 5-year survival between 70 to 80 per cent.

In contrast, later stage disease is treated with palliative intent and survival is markedly lower. With less than 30 per cent of HCC patients eligible for curative treatment at diagnosis there is a significant research focus to improve the diagnosis of early stage HCC.

This aim of this systematic review and meta-analysis was to establish the relative diagnostic accuracy of gadoxetic acid-enhanced magnetic resonance imaging (GA-MRI) compared with other imaging methods including contrast-enhanced computed tomography (CE-CT) in patients with known or suspected HCC.

Based on 35 included studies, GA-MRI when compared with CE-CT had an improved sensitivity (0.92 vs 0.64) and comparable specificity (0.94 vs 0.97) in patients with small lesions. However, in patients with any size lesions GA-MRI and CE-CT were equivalent.

This evidence base demonstrates GA- MRI superiority over contrast-enhanced CT for the detection of small liver lesions and may improve the diagnosis of early stage HCC.

Practical applications of rapid review methods in the development of Australian health policy[3]

Policy makers are increasingly faced with complex issues in healthcare that require decisions to be made quickly. Policy questions may focus on issues of efficacy, service delivery and service organisation.

Rapid reviews (RRs) are a pragmatic adaption of systematic evidence synthesis methods and are designed to provide robust evidence to support policy decision making in a timely manner.

ASERNIP-S adaption of RR methodology allows eight weeks from commission of the review to completion and delivery of the final report. The proposed methodology includes stakeholder engagement to contextualise the best available evidence synthesised by the review team. This combination is essential for policy recommendations based on the RR reports to be realistic and implementable.

ASERNIP-S successfully applied this RR method to six reviews of surgical services for VicHealth. These reports are now publically available from the VicHealth surgical services research webpage and have been influential in the decision making process regarding the provision of service in Victoria.[4]

Summary

These recent publications are a snapshot of the work that ASERNIP-S staff undertake to communicate research to the surgical community. Indeed, the diversity of the above research topics reflects the breadth of the staff's skills, their ability to apply skills to novel and challenging projects in short timeframes and passion to communicate research outcomes, a rare and indispensable combination.

1. Scarfe AJ, Schuhmann-Hingel S, Duncan JK, Ma N, Atukorale YN and Cameron AL. (2016). Continuous paravertebral block for post-cardiothoracic surgery analgesia: a systematic review and meta-analysis. *Eur. J. Cardiothorac. Surg*., 10.1093/ejcts/ezw168.
2. Duncan JK, Ma N, Vreugdenburg TD, Cameron AL and Maddern G. (2016). Gadoxetic acid-enhanced MRI for the characterization of hepatocellular carcinoma: A systematic review and meta-analysis. J. *Magn. Reson. Imaging*, 10.1002/jmri.25345.
3. Lambert R, Vreugdenburg TD, Marlow N, Scott NA, McGahan L and Tivey D. (2016). Practical applications of rapid review methods in the development of Australian health policy. *Aust. Health Rev.*, 10.1071/ah16041.
4. State Government of Victoria DoHHS. (2016). Surgical services research and reviews. https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/acute-care/surgical-services/surgical-services-research

For further information please contact David Tivey
David.Tivey@surgeons.org

A TRIP ABROAD

Developing skills in prognostic research at Utrecht University in the Netherlands

DR SARAH AITKEN
FRACS

In November 2015, I was honoured to receive the Surgical Research Society Travel Grant Award for my presentation on 'Systematic review of frailty models in Vascular and General Surgery'. With this award, I sought to increase my skills in prognostic research and attended a conference at the University of Utrecht in the Netherlands on 'Systematic Reviews of Prognostic Studies'. This conference was hosted by Utrecht University Masters of Epidemiology Program and affiliated with the Cochrane Collaboration and the Progress Prognostic UK Research Group.

Prognostic research is an emerging field in epidemiology with a significant relevance to surgeons. Prognostic research refers to the ability to quantifiably predict a future outcome in a patient and includes both prognostic factor research (such as predictive biomarkers) and prognostic model research (like the Glasgow Aneurysm Score to predict mortality after ruptured aneurysm repair).

Until this time, it has not been possible to combine prognostic studies with reliability due to significant study variation and lack of bias assessment. This course taught me newly validated methods of multivariate meta-analysis and risk of bias assessment to allow meta-analysis of prognostic factor studies and prognostic model studies. I hope to employ these methods in my own research into the outcomes of vascular surgery in older patients.

Utrecht was a richly rewarding city to visit. Travel to the university each morning was very Dutch – on a bicycle through flat country lanes! The city is an old cathedral town, based around canals and with a rich history and culture to explore.

Utrecht University is currently celebrating its 380th Anniversary and has a very well recognised medical program. I had the opportunity to tour the medical school facilities and building, to hear about their medical curriculum, 'team-based' learning environment and application of entrustable professional activities (EPAs) into the curriculum.

Professor Olle Ten Cate from Utrecht has recently been in Australia and spoke to the NSW RACS on EPAs and it was fantastic to see application of his presentation.

I wish to thank the Surgical Research Society for this fantastic opportunity to expand my academic surgical skills. I would encourage all aspiring academic surgeons to present at the SRS meeting this coming November.

Image: Dutch Transport

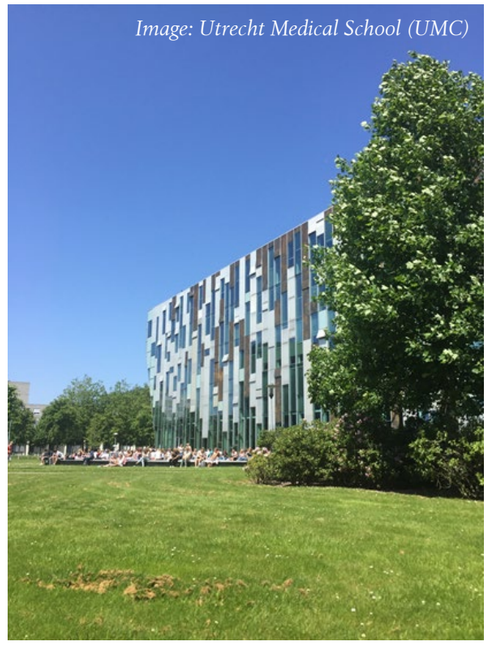


Image: Utrecht Medical School (UMC)

CONGRATULATIONS AND THANK YOU

SA Surgeon receives surprise RACS community award

DR SONJA LATZEL
Immediate past Chair
SA, Regional Committee

On 17 June Mr Samsher (Sam) Ali, was presented with an Outstanding Service to the Community Award in a surprise ceremony by RACS, in recognition of his long and distinguished career.

Mr Ali was lured to the clubrooms of the Port Pirie Returned Services League by his wife Debbie, on the pretext that he was to hear a speech by colleague and former military doctor in Vietnam, Peter Byrne.

Instead Mr Ali was stunned to find family, friends, patients and colleagues past and present, all gathered to celebrate his career and to see him presented with the award.

"I had absolutely no idea. It is an honour. At the end of the day, it is the patients we are here for and as long as you make them the focus of your work and your life, it usually works out well," Mr Ali said.

The award was presented to Mr Ali by Dr Sonja Latzel, in one of her last official duties as SA Regional Chair.

"The Award recognises surgeons with a dedicated history of service to their local community – more often than not unheralded – but without which the standard of surgical care in that community would have been less than society expects," Dr Latzel said.

"Sam certainly embeds all of these qualities, and it is my great pleasure to have been able to present him with this award."

Originally from Fiji, Mr Ali has called Port Pirie home for more than two decades, after completing surgical training in Australia and New Zealand.

Since that time Mr Ali has tirelessly dedicated himself to the region, providing an exceptional level of care where services would otherwise have been unavailable, and in many cases patients would have had to travel hundreds of kilometres to receive similar treatment.

Recognising the emerging need in the community, he was one of the earliest surgeons in Australia to undertake training in laparoscopic cholecystectomy and hernia repairs – becoming exceptionally skilled in these.

He also undertook additional training in hand surgery and plastic surgery to enhance the service he could provide to the community, and even obtained a pilot's licence so that he could provide services to some of the more remote areas of the region.

Friend and colleague, Dr Allan Golding, described Sam Ali as an extremely humble and honourable man who had dedicated so much of his life to serving the community and bettering the lives of others.

"Our city and region has been very lucky indeed to retain the services of such a highly skilled and ethical surgeon," Dr Golding said.

"Beyond that is his personal relationship with many he has touched. He will go out of his way to assist when no one else seems to care. He shows respect for the innate dignity of life, and has often put himself out to assist with no prospect of any reward."

Dr Golding paid tribute to Mr Ali's strong sense of community service, particularly for his commitment to foreign aid.

"Sam has always felt strongly that he should repay the country that has given him so much, and he became an Australian citizen many years ago – then joined the army reserve so he could assist with overseas aid."

"He has been posted to many overseas theatres within the military, and had also made himself available for charitable service as a civilian volunteer before this."

QUEENSLAND REGIONAL COMMITTEE CHAIR'S REPORT

PROFESSOR OWEN UNG
QLD Regional Committee Chair

The *Lets Operate with Respect* campaign has had significant traction in Queensland and it has been great to have our Vice Presidents, Graham Campbell and now Spencer Beasley, leading discussions with the Queensland Health Department to find areas of commonality.

The initiatives have been welcomed and already Brisbane's Metro South has signed an MOU with RACS and we look forward to further progress with other Queensland hospital and health services.

The QLD committee hopes to visit most regional areas on a regular basis to discuss issues of importance and receive feedback from local Trainees, IMGs and Fellows. Like all the states of Australia, our populations are largely metropolitan and while Brisbane is only the third largest city, Queensland has seven of the top 20 largest population centres.

Workforce is a significant issue and we have been heavily involved with 'Developing a health workforce strategy for Queensland' initiative of the government. To their credit, the state government is doing its best to quantify our existing resources and plan for the future.

The biggest challenge for surgery is the provision of services, particularly subspecialties, in our regional areas and access to necessary surgery for populations in remote locations. In our visits to regional centres significant time is taken to talk with local health service administrators about what strategies are being implemented to attract surgeons.

Surgeons in remote locations, such as Mt Isa, not only have to struggle with long distances and isolation, but scant relief and difficulty in getting time away from their practice. In larger regional centres that can accommodate a few general and orthopaedic surgeons, collegiate support is available, but there are still difficulties for subspecialties like plastics and urology.

We need to keep working towards solutions and make regional careers more attractive for our young locally trained surgeons. The workforce plan is trying to address these problems. It is recognised that better working conditions, support and a family friendly environment are essential to make these locations attractive.

RACS has been very active in supporting medical student surgical interest groups at our four universities that have medical schools – University of Queensland, Griffith University, James Cook University and Bond University.

Surgical interest groups organise career information events and surgical workshops and students have introduced inter-university competition and RACS in turn supports these activities. Many Fellows offer supervision and instruction, but we always need more and I encourage all the local surgeons to continue to support these endeavours.

When surveying our domestic medical graduates, surgery and medicine remain the most popular intended future specialist training programs. There are four times as many specialist training posts for physicians for similar numbers of aspiring Trainees so competition for surgical training posts remains strong.

It is hoped that by encouraging Trainees to spend time in rural locations, more might see a long-term future in these regions. The northern rotation remains popular and if we can get more surgeons into those regions we may be able to create more advanced surgical training posts outside of our large Brisbane teaching hospitals. To that end, we have proposed a rural/regional fellowship for surgeons who have recently obtained their FRACS and we hope that by offering further training at this level in regional Queensland more surgeons will see the benefits of a rural lifestyle.

The scheme proposed, a two year rural surgical fellowship that involves time in metropolitan teaching hospitals, large regional hospitals and remote locations has the strong support of the rural section of RACS and the Qld chief medical officer as one initiative of the workforce plan. Following intensive lobbying and very positive discussions, we hope to see this position implemented and funded.

Our Queensland Annual Scientific Meeting will be held in Brisbane in our newly refurbished Brisbane City Hall on the 4 to 6 November 2016. For the first time we will be combining with the RACS trauma section to deliver a three day program looking at trauma systems, data collection and information, but also some very practical aspects of trauma management.

Traditionally we also run in conjunction with the Queensland Health Surgical Forum on the first day of our program. At the forum we will look at public policy issues around surgery such as waiting times both for surgery and for outpatient appointments.

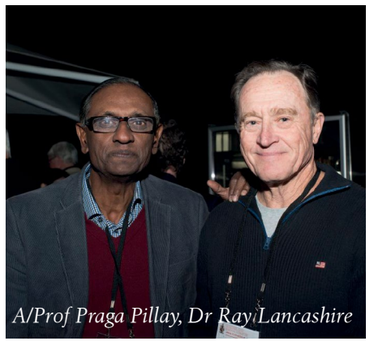
There is a current drive to abolish or at least reduce outpatient waiting times. Of course, a direct result of seeing more outpatients will be the creation of more surgical workload and potentially adding further to surgical wait times. A balance is required, but ultimately with a finite resource our public hospitals, I feel, will have no choice but to decide how they wish to "ration" services.

There is potential for greater pressure on our public surgical departments if more people opt out of private health insurance. Less than half of Australians have hospital health cover and the annual growth rate is slowing and quite likely to go into decline with the rising cost of premiums, the proliferation of restrictive policies and the concerns over out-of-pocket expenses.

The 'Medicare freeze' is obviously poor public health policy that aggravates an unsatisfactory situation. There is growing dissatisfaction with the system as it exists, and it is not only the AMA and RACGP, but also the Private Hospital Association that are calling for a major overhaul of private health insurance and better government policy around Medicare.

WHAT GOES ON IN YOUR REGION?

Regional committees are critical to the success of our College


A/Prof Praga Pillay, Dr Ray Lancashire


A/Prof Praga Pillay, Dr Bernard Whitfield, Dr Maurice Stevens, Prof Owen Ung


Prof Marianne Vonau, Dr Christina Steffen

SPENCER BEASLEY
Vice President

As I settle into the role of Vice President of our College, I have come to reflect on – and more fully appreciate – the critical importance of our regional committees.

Even as a membership organisation, our College would struggle to maintain relevance at a local or regional level without the enormous amount of work put in on our behalf by our regional Fellows. The regional committees date back to our earliest days.

The Australian regional committees and the New Zealand National Board were appointed by Council in 1927. Their duties were to arrange regionally-based scientific meetings, and advise Council on regional matters and breaches of the rules. Their importance in providing advice to Council was recognised from the outset.

Their role as a conduit to and from 'RACS Central' on regional matters remains undiminished. Along with the regional offices, these committees provide the main interface between RACS and the thousands of Fellows, Trainees and IMGs that it represents.

The other way that RACS connects with the broader Fellowship is through the specialty societies and the specialty representatives on our committees. The advice and guidance the specialty representatives give to RACS also contributes to the effectiveness and influence that our College has in both countries.

As in any membership-based organisation, it is important that all Fellows feel they are adequately represented, regardless of where and how they practice. We are all aware of the challenges of geography and distance, but on top of that, there is marked regional variation in the configuration and range of services provided, the types of hospitals, and the way they are managed.

While many issues are common to us all, specific challenges and opportunities emerge that may be unique to certain regions, or craft groups. Often the locally appointed representatives, with the advantage of their local knowledge and networks, are in the best position to take leadership within their own jurisdiction – and it is for the benefit of us all that they do.

For such a large and complex organisation, operating across two countries and many states can be a challenge. It is almost impossible to reach total agreement on every issue all the time. But we are in a rapidly changing environment where our College does need to adapt quickly to political events and social agendas.

To best serve our membership, we must anticipate change and threats, and be sensitive to the aspirations of our Fellows. This means that good lines of communication in both directions is critical. It is the regional committees, together with the specialty societies, who will often be the first to identify a problem, or to see where we can take advantage of an opportunity. It is through their efforts that we can nurture productive relationships with the jurisdictions and other stakeholders with whom we work.

But the role of regional committees extends far beyond ensuring Council is aware of regional surgical concerns. They attend a wide range of forums, organise educational activities, act as advocates for surgery and engage their state governments on matters relevant to surgical practice.

They protect the reputation and integrity of our craft in their region and influence policies that might affect patient outcomes and the surgical workforce. It is through their hard work on our behalf that the rest of us can practise in relative peace! I extend my sincere thanks to the regional committees.

ADVOCACY IN THE TOP END

Putting the Brakes on the Northern Territory Open Speed Zone

For several years surgeons in the Northern Territory have been lobbying with their medical colleagues in other colleges to put an end to unrestricted speeds on a 336 kilometre stretch of highway between Alice Springs and Ali Curung.

The Royal Australasian College of Surgeons (RACS) communications and advocacy team got together with the Royal Australasian College of Physicians (RACP) and the Australasian College of Emergency Medicine (ACEM) to develop a video on a shoestring budget to highlight the dangers of the NT Open Speed trial.

RACS surgeon, Dr Phil Carson, said that since the reintroduction of unrestricted speeds on sections of the highway in 2014, the three Colleges have repeatedly warned of the risks involved.

"So far our calls to end the open speeds have fallen on deaf ears, but I am really hopeful that by bringing the issue to the forefront during an election campaign we can generate a much more mature discussion focussed on the evidence," Dr Carson said.

ACEM's Dr James Fordyce also highlighted that the NT was the only jurisdiction taking the regressive step of bringing back roads without speed limits, despite having a road toll three times higher than the rest of the nation.

"The Northern Territory rate of deaths in motor vehicle accidents is 15 deaths per 100,000 people per year, which is comparable to Indonesia, Pakistan or Bhutan," Dr Fordyce stated.

'The difference between driving at 130 km/h versus 160 km/h versus 190 km/h, is that your physical ability to react in an accident just isn't there'

"Whether it is your fault or not, things go wrong on the road. Regardless of the initial cause of an accident, the reality is that the faster you are travelling, the greater your risk of death or serious injury."

The RACP's Dr Christine Connors, said that drivers were increasingly vulnerable for every additional kilometre they travelled over 130km/h (the standard speed limit on most rural roads in the NT).

"The difference between driving at 130 km/h versus 160 km/h versus 190 km/h, is that your physical ability to react in an accident just isn't there. Open speeds place us all at significantly greater risk."

"We are hopeful that by relaying our direct experiences with road trauma victims in this manner, the community will get a better understanding of what we see on a daily basis, and why we are so convinced of the need to end open speed limits." Dr Carson said.

The video was released on Friday 12 August to widespread media attention in the Northern Territory and across the country, even ending up in *Wheels Magazine*, prompting the NT opposition to reportedly commit to reversing the policy if elected.

The strength of a simple video, coupled with a strong social media campaign, cannot be underestimated and goes to show how effective RACS can be in influencing government policy when advocating on behalf of its Fellowship.

The video can be viewed on the RACS website *http://www.surgeons.org/news/put-the-brakes-on-open-speeds-in-the-northern-territory/*

SEEING EYE TO PROSTHETIC EYE IN TIMOR-LESTE

With the support of the East Timor Eye Program, the country's eye health system continues to expand and develop and now includes the delivery of this unique service which is giving individuals new found confidence and opportunities

DR NITIN VERMA
Founder and Director of the East Timor Eye Program

A Prosthetic Eye Lab has been established at the Hospital Nacional Guido Valadares Hospital (HNGV) in Dili with the country's first Ocularist, Mr Filipe Soares completing his training in 2015. Mr Soares undertook an intensive training program in Perth, Bali and Dili in 2014 and 2015, which provided him with the skills and confidence to deliver this important service to allow people who have had to have their eye(s) removed, to be fitted with a prosthetic eye.

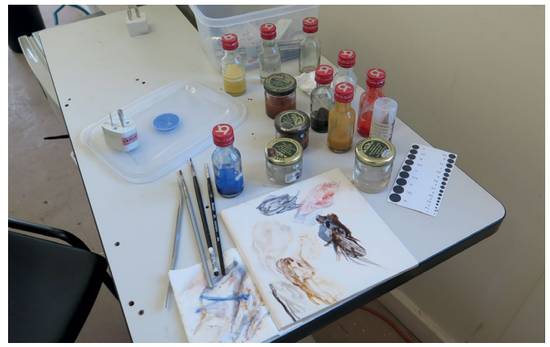
Mr Soares is now creating prosthetic eyes and providing the first ever prosthetic eye services in Timor-Leste. Mr Soares is the only person in Dili with these skills and is proud to help Timorese people in need of prosthetic eyes. "I am really enjoying learning a new skill. No one else in Timor can do this, it's only me," Mr Soares said.

It can take up to 10 years to become fully proficient as an Ocularist, so Mr Soares will continue to be mentored by Australian Ocularist, Ms Jenny Geelen over the coming years to further develop his skills. Ms Geelen has been instrumental in Mr Soares' development, providing training in Australia, Dili and from afar.

More and more people are becoming aware of this service and Mr Soares' clients are increasing on a monthly basis. In January 2016 Mr Soares was creating and fitting an average of two to three prostheses per month, which has steadily increased to an average of six to eight per month by July 2016.

The HNGV Department of Ophthalmology delivers essential ophthalmic services to rural and remote districts each month and plays a key role in promoting the prosthetic eye service to the Timorese community.

Mr Filipe Soares, Timor-Leste's sole Ocularist at the Prosthetic Eye Lab



Clockwise from top left: Eye moulds, painting station at the lab, Patient Mr Andre de Ataide, before and after having a prosthetic eye fitted

One of Mr Soares' patients, Mr Andre de Ataide, a 30 year old East Timorese, relates the impact his new prosthetic eye is having on his life. When Mr Ataide was seven years old he was playing outside with a friend who accidently poked him in the eye with a sharp stick, which eventually resulted in Mr Ataide losing his right eye.

After the accident he continued life as normal into early adulthood though started to feel self-conscious and depressed about his appearance. Nevertheless, he completed a Bachelor of Economics degree at Universidade Nacional Timor Lorosa'e (UNTL) in 2013, but was unable to secure a job.

"I was too frightened and embarrassed to find jobs and to do other activities. Mostly I failed on the interview, sometimes I was disqualified because of my appearance or sometimes I was discouraged to go to interviews and I just let the opportunity pass," he said.

Mr Ataide was referred to the Prosthetic Eye Lab by the Comoro Community Health Clinic just outside Dili, where by chance he was taking his son to the doctor for an unrelated issue. He feels very lucky to have been referred to Mr Soares to be fitted with a prosthetic eye.

"For me, that day was a fortunate day for me meeting the doctor."

Since being fitted with a prosthetic eye, Mr Ataide's attitude has changed and he now feels confident enough to face society.

"Since the time I put in this prosthetic eye, I feel strong enough to face other people. Now I am not afraid anymore".

Mr Ataide now has a job and can support his children to go to school.

The reaction from his family, friends and community has also been positive. Mr Ataide said that Mr Soares did a fantastic job and that no one has realised that his right eye was a prosthesis.

"Family and friends think that I undertook surgery to replace my eye, but in fact it's not, it's a prosthetic.

I feel like I found a way now to live my life as other people normally do."

The Prosthetic Eye Lab will continue to provide this valuable service to the Timorese community. It is hoped that the service will expand through health promotion initiatives to the regional districts of Timor-Leste.

In association with HNGV Department of Opthalmology (formerly National Eye Centre), the set-up of the Prosthetic Eye Lab and training of Mr Soares was supported with grant funding from the Lions Club International Foundation (LCIF) SightFirst program and coursed through the RACS East Timor Eye Program (ETEP).

The ETEP would also like to acknowledge Former Australian Ambassador Mr Miles Armitage and RMS Engineering and Construction for the donation of the structure of the prosthetic eye lab (formerly a shipping container).

If you would like to support the work of the East Timor Eye Program, please make a donation through the Foundation for Surgery via the RACS website or by contacting the Foundation directly on: jessica.redwood@surgeons.org | Phone: +61 3 9249 1110 www.surgeons.org/foundation

Asia-Pacific surgeons seek your help with essential CME

Help support continuing medical education for Asia-Pacific surgeons by donating your used copies of the ANZ Journal of Surgery, World Journal of Surgery or other appropriate journals and making an annual donation of AU $200 to cover the international postage

Our surgical colleagues in Papua New Guinea, the Pacific Islands and Myanmar are hungry for access to the ANZ Journal of Surgery, but for many people in these low and middle income countries, the subscription fees are unaffordable.

What do you do with your copies of the medical journals once you've finished reading them? Why not donate them to the Vaiola Hospital library in Tonga, or the Journal Club at Port Moresby General Hospital? You will be helping your fellow surgeons in a neighbouring country continue their medical education, while helping the environment and giving your office that much needed clean out!

We are seeking 11 more sponsors to commit to donating their used copies of the ANZ Journal of Surgery and other appropriate medical journals to the overseas institutions listed below, for a minimum of one year.

At over AUD 2,500 per year for a print subscription for an institution in the Asia-Pacific region (more than double the subscription fee for Australian and New Zealand Institutions) the ANZ Journal of Surgery is unaffordable for many hospitals and medical universities in Asia-Pacific countries.

Medical journals, particularly the ANZ Journal of Surgery are highly sought after in these countries and will be read by many. Your donation will have a significant multiplying effect as the journals will be consigned to the hospital libraries, ensuring that all staff and trainees can access these valuable educational resources.

Donating your journals is easy. Select which institution you would like to support and make a donation of AU $200 to cover the international postage from Australia to the recipient country for the year ahead. RACS Global Health will send you a prepaid satchel each quarter (at our expense) to send your journals to the College for distribution, once you've finished reading them. You'll receive a photograph of the institution and the surgical team that you are supporting, and an annual update on the benefits of your generous support.

The ANZ Journal of Surgery online has been made available either free of charge or at a very low cost to institutions in developing countries through the World Health Organization's Hinari program. Donating your hard copy journals to these institutions' library collections will significantly augment the local surgeons' access to essential CME.

Please contact RACS Global Health on +61 3 9249 1211 or global.health@surgeons.org to participate. We look forward to hearing from you!

The surgical team at Labasa Hospital, Fiji

Institutions in need of your support:

Myanmar
University of Medicine 2, Yangon

Papua New Guinea
Port Moresby General Hospital

Kiribati
Tungaru Central Hospital

Tonga
Vaiola Hospital

Vanuatu
Vila Central Hospital

Samoa
Tupua Tamasese Memorial Hospital

Solomon Islands
National Referral Hospital

Fiji
Colonial War Memorial Hospital
Lautoka Hospital
Labasa Hospital
Fiji National University - College of Medicine, Nursing and Health Sciences

HI TECH OR NO TECH?

Things used to be so much quieter

PROFESSOR GRUMPY

There is one thing that really annoys me and it is electronics. I realise that I have complained about some aspects of this before. Passwords have been a previous diatribe – particularly passwords used in internet activities.

They seem to be deemed by the grand password poohbah as being either too long, too short, not enough non-numeric characters, used before, a string of three repeated symbols or characters or simply not to his (or her) liking.

I had grown used to Windows 7 and lived with its oddities. But then there were the unexpected and unasked-for changes to an operating system on my computer. Suddenly icons are different or don't work as they used to. The whole appearance of the screen has changed and I am lost.

That was when Windows 10 came along. I must ask what happened to Windows 9? There is Windows 8 but no 9. The only conclusion that I can reach is that Windows 9 was so dreadful that it was scrapped before it was released.

Another theory is that it all worked seamlessly and never crashed or froze. There was no need for upgrades or patches and no further potential sales. That developer is now scrambling around Silicone Valley looking for another job and seen as a pariah.

It is however the humbler electronic items that invoke my ire this month – fridges, microwaves, irons etc. Why do they all have to beep to indicate some event – turning on or off, changing a setting, finishing part one of the cycle, changing the volume etc.

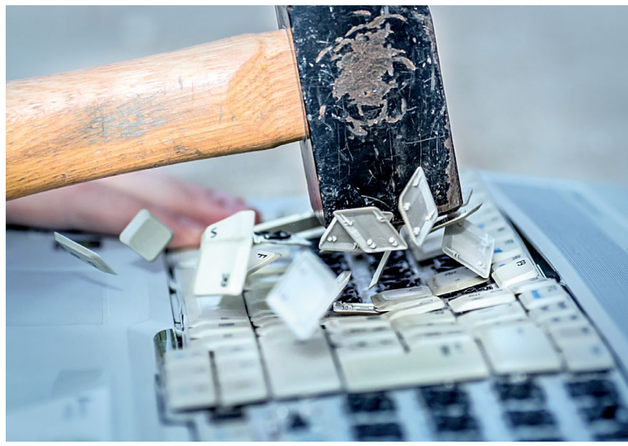
Is that the fridge door still open or is it the kettle boiling? Is the dishwasher finished or was it the washing machine? Was that the door bell (a misnomer as there are virtually no bells on doors) or was that my phone?

I recently bought a new iron – yes, this curmudgeon can iron a shirt! It may have something to do with Mrs. Curmudgeon taking umbrage at well intended advice on how to iron shirts. Now knowing if the iron is on is easy as a red light shows up but which way on the dial for hotter or more steam?

There are some symbols but too small to read and in universal sign language. I am not sure which universe these signs come from but certainly not from mine. Eventually a magnifying glass shows the symbols to be little clouds that gradually get bigger around the dial. After much experimentation (and a few slightly damaged shirts) I found the best settings.

Cars were once outside the realm of electronics, but not any longer. Now there are on screen warnings about seatbelts not on (you can't place a package on the passenger seat without a symbol asking for a seatbelt for it). Lights that indicated check your engine, tyres need attention, service due or "unexpected event". Various bleeps and noises that mean something (I assume) often accompanied by a visual message that disappears by the time you find your reading glasses.

There is one advantage for ageing curmudgeons to avoid all this turmoil, namely age-related deafness. Eventually one cannot hear this cacophony of unwanted beeps and whistles, which prompts the question "Do all these warning noises really matter?" A resounding "No" from this curmudgeon!



SAM MELLICK TRAVELING FELLOWSHIP

Final year SET receives contributions to skill development

The Australian and New Zealand Society for Vascular Surgery awards the *Sam Mellick Travelling Fellowship* each year at its annual scientific conference.

The Sam Mellick Travelling Fellowship is awarded to a vascular surgeon who has recently obtained their Vascular Fellowship to provide support to undertake overseas travel to an international meeting.

The Fellowship has once again been awarded at this year's Australia and New Zealand Society for Vascular Surgery (ANZSVS) Annual Scientific Conference in Sydney in August to Dr Andrew Bullen who is currently in his final year of SET program. He plans to attend the Leipzig interventional course (LINK) from 24 to 27 January 2017 as well as undertake an observership at the Department of Cardiology-Angiology at the University of Leipzig, Germany.

Professor Mellick, who recently celebrated his 91st birthday in August, is the most senior member of the ANZSVS and he received a CBE in 1987. Professor Mellick was the first Australian to be President of the International Society of Cardiovascular Surgery in 1991. He is also an active participant in the annual scientific conference of the ANZSVS.

The Travelling Fellowship has been awarded on four occasions to date and the past recipients included:

- **2012** - Dr Simon Quinn who travelled to the 2013 ESVS meeting in Budapest
- **2013** - Dr Domenic Robinson who travelled to the 2014 Charing Cross International Symposium in London
- **2014** - Mr Charles Milne who utilised the fund for a six month Fellowship in France
- **2015** - Dr Nguyen who intends to use the fund for working with Dr Marco Manzi at Abano Terme in Italy in 2016

Image: Dr Douglas Cavaye (left), immediate past president of the ANZSVS, received the certificate from Professor Sam Mellick CBE, on behalf of the recipient, Dr Andrew Bullen.

SKILLING UP

RACS Travelling Scholars join RCH Department of Paediatric Surgery

Welcome to Dr Tranvir Chowdhury and Dr Putharee Taisab who join the Royal Children's Hospital (RCH) Department of Paediatric Surgery on prestigious scholarships from the Royal Australasian College of Surgeons.

Dr Tranvir Chowdhury, from Bangladesh, has been awarded the Rowan Nicks International Scholarship which aims to enhance the recipients skills and expertise so they can train their colleagues upon return to their home country.

Dr Chowdhury, who arrived last year and will be with the RCH until October 2016, said the program is a great opportunity to gain exposure to a broad range of paediatric cases.

"The facility and resources at the RCH are really wonderful and I am gaining a lot by working alongside the RCH surgical and theatre staff," he said.

Dr Putharee Taisab, from Thailand, was awarded the Weary Dunlop Boonpong Fellowship which, since its inception in 1988, has supported more than ninety Thai Fellows to undertake clinical placements in Australian hospitals.

Dr Taisab said the Fellowship is a wonderful opportunity to expand her clinical practice which in turn will help build the capacity of colleagues when she returns to Thailand.

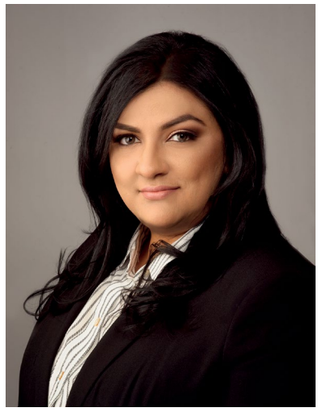
"Here, there are many different and improved techniques that I am excited to be learning. Because of this

Fellowship I will be able to share the knowledge I gain at the RCH with my colleagues back home to improve care," she said.

The Rowan Nicks International Scholarship and Weary Dunlop Boonpong Fellowship are supported by the Royal Australasian College of Surgeons (RACS).

LATEST RESEARCH COULD CHANGE BREAST CANCER TREATMENT

General Surgery Trainee Dr Anannya Chakrabarti is finalising PhD research which could change the way metastatic breast cancer is treated through a paradigm shift away from treatments that aim to kill migrating cancer cells toward targeted genetic therapy designed to keep such cells dormant and negate malignant transformation



Dr Chakrabarti has spent the past four years investigating both the genetic pathways involved in the spread of metastatic breast cancer and the use of the MEK inhibitor Selumetinib, a drug to inhibit cellular proliferation, that has shown early promise in lung cancer trials.

She has also discovered a gene that is under-expressed in breast cancer, which could be used as a biomarker and tested through biopsy to allow clinicians to assess malignant potential.

She has conducted her research at the Metastasis Laboratory at the Peter MacCallum Cancer Centre in collaboration with scientists at the Walter and Eliza Hall Institute of Medical Research and the University of Melbourne.

Dr Chakrabarti said that while metastatic breast cancer accounts for 90 per cent of breast cancer-related deaths, there was no method currently available to pick up early disease spread or a targeted therapy available to suppress the progression of advanced disease.

Working under a broader project called "Dormancy in Breast Cancer" and with financial support from RACS, she used in vitro and in vivo preclinical models to assess the impact of Selumetinib on breast cancer cell growth.

"This work was very exciting because we found that the drug was significantly effective in both suppressing breast cancer cell growth of the primary tumour as well as decreasing metastatic progression," she said.

"We now believe that it could be used to treat all breast cancers to inhibit metastasis which would be a great advance because we cannot yet detect early metastatic disease.

"This means that we can begin to consider treating breast cancer like we treat a range of chronic conditions such as hypertension because we are not aiming to cure or kill cancer but to control it.

"Selumetinib is already being used in trials for advanced lung cancer disease so once we have finalised all the work required to provide proof of concept we would then progress forward to clinical trials for breast cancer patients.

"So far there is no known severe toxicity caused by the drug, which would make it much easier on the patient than chemotherapy, while animal models suggest a great benefit from removing the metastatic load."

Dr Chakrabarti also spent considerable time investigating the role played by the tumour suppressor gene ARHI in the development and recurrence of breast cancer and found that the loss of the gene was shown to be involved with the development of up to 80 per cent of breast cancer patients.

She said she analysed fixed formalin paraffin embedded human tissue to test the validity of ARHI as a predictor of disease free and overall survival and found that it was down regulated in the majority of breast cancers.

"We know that ARHI is involved in autophagy so we decided to look at it more broadly in relation to breast cancer both in terms of using it as a diagnostic tool as well as its potential role in reducing the metastatic load through up-regulation," she said.

"We now believe that we could use this gene to determine malignant potential in pre-cancerous tumours, which means that we could avoid unnecessary surgery or stratify which invasive tumours would benefit from the use of adjuvant therapies.

"We have conducted this work on a small number of breast tissue samples and the research group is now waiting to conduct similar experiments on a larger group of samples to provide definitive correlation.

"We hope to soon be in a position where was could measure ARHI levels to determine prognosis and potentially utilise drug therapy to up-regulate ARHI, to prevent progression of disease.

"All of this represents a fundamental shift in our approach to breast cancer because we believe AHRI alone can be used as a prognostic marker, a stratification tool and a drug target.

"We can approach problems from our different perspectives and, in collaboration, produce novel solutions.

"We also believe that once we have refined this work there is no reason why it could not be used to treat a range of cancers."

Dr Chakrabarti has completed her research work under the supervision of Professor Robin Anderson, the current Head of the Translational Breast Cancer Programme and Head of the Metastasis Research Laboratory at the Olivia Newton-John Cancer Research Institute, and Dr Ian Street, the Head of the Biology and Personalised Medicine Laboratory at the Walter and Eliza Hall Institute of Medical Research.

Throughout her PhD research she has received financial support from RACS through two Foundation for Surgery Catherine Marie Enright Research Scholarships (2013 and 2014) and a Foundation for Surgery Scholarship (2012).

Now working at St Vincent's Hospital in Melbourne in her final year of training, Dr Chakrabarti hopes to finalise her PhD and receive her Fellowship next year and plans to continue her career as a General Surgeon with an interest in Surgical Oncology and as an academic surgeon.

She thanked RACS for the support given to her and said there were great advantages in having surgeons and scientists combining their knowledge and skills to the benefit of all patients.

"It is widely known that it takes on average 17 years for scientific discoveries to reach the bedside but I believe that with stronger collaboration between clinicians and scientists we will dramatically reduce this time lag," Dr Chakrabarti said.

"We can approach problems from our different perspectives and, in collaboration, produce novel solutions.

"It was wonderful to have the opportunity to see how pure science works and the RACS support was crucial in allowing me to undertake this work. It is also important for Trainees to know that the College supports us taking time out to conduct research while the interest shown by the College in our work acts as a strong motivation."

With Karen Murphy

CAREER HIGHLIGHTS

2015: RACS Breast Section Research Prize
2015: Peter Ryan Prize for Surgical Research
2014: RACS Surgical Research Society Poster Prize
2014: RACS Foundation for Surgery Catherine Marie Enright Research Scholarship
2014: VRC Developing a Career in Academic Surgery Scholarship
2013: RACS Foundation for Surgery Catherine Marie Enright Research Scholarship
2012: RACS Foundation for Surgery Scholarship
2012: Lorne Cancer Conference Research Prize

THE MANY HATS OF A MODERN SURGEON

PETER SHIN
Co-Convenor, Younger Fellows Forum, 2017

The bus continued its winding ascent, teasing us with brief glimpses of breathtaking panoramas of Queensland rainforest. One of the international delegates, Alan Guo from Buffalo, New York, flanked by the future convenor and co-convenor of Younger Fellows Forum 2017, casually revealed that he had recently attended a Donald Trump rally as an educational exercise for his son.

For the remainder of the bus trip he was peppered with questions about the forthcoming election, his opinions and his personal role in influencing the outcome. Comparisons and contrasts were made with our own forthcoming antipodean election season. Thus in this highly charged domestic and international political milieu, the genesis of next year's YFF theme – "Leading Surgeons" – emerged.

The 2016 Younger Fellow Forum theme was "The Many Hats of a Modern Surgeon", held at the O'Reily's Rainforest Retreat. Joanne Dale and her co-conspirator Tim McMeniman arranged a fantastic program, bringing together delegates from Australia and New Zealand, representatives from our 'sister' College organisations in the UK, US, Thailand and Hong Kong, as well as two RACS councillors and College President David Watters. Of course, the ubiquitous Christine Lai was also in attendance as the Chair of the Younger Fellows Committee.

Day one included the traditional YFF team building exercise, in this incarnation an 'Amazing Race' style activity in the rainforest. It seems that briskly walking 12,000 steps or so while carrying out tasks and solving puzzles (no mobile reception for those inclined to cheat) is actually an excellent ice-breaker for participants.

Surgeons are naturally selected to be competitive; the prospect of winning a small souvenir coffee cup was efficacious at bringing out each delegate's inner Michael Phelps, aptly demonstrated by the fact that most of us chose to leap, in various states of undress, into the resort's infinity pool at the finish line to get those final few points!

Fittingly, the best looking and most intelligent team ultimately came out on top, with our victory eventually being begrudgingly acknowledged by the others.

A hearty meal provided further opportunity for everyone to get to know each other, and set the scene for an industrious day two. We spent the day brainstorming in small groups, discussing ideas and hot topics, and working out strategies and possible solutions to the problems raised.

Among other things we discussed what it means to be a head of unit, governance issues and managing a business, complaints management, teaching and performance management. The RACS President's address from David Watters was challenging and thought-provoking, and was a germane segue into some of the challenging themes to be discussed at the upcoming Annual Scientific Congress.

The forum encouraged intense discussion of ideas pertinent to Younger Fellows in a non-threatening and open environment. We were aided by the presence and wisdom of the invited Councillors, who helped to guide us and channel our ideas and enthusiasm into practical suggestions.

By the close of day two, our brains were full and ready to relax with a barn themed dinner with farm house style cooking. I was surprised and somewhat disappointed that we didn't end up line dancing – perhaps something to rectify for next year's Forum?

On day three we spent the morning summarising our ideas into succinct recommendations before making our way back to Brisbane. Some delegates stayed on for the ASC while others chose to leave the sunshine state to head back home to family and friends. Although it might seem trite, we all left the rainforest with new friends, too.

The Younger Fellow Forum 2017 will be held in Mt Lofty House in the Adelaide Hills. This will be an idyllic location to escape from the usual stresses of surgical life. Come and spend quality time with like-minded fellows and enjoy the unusual balance of fun, relaxation and intellectual stimulation as we try to formulate new ideas that can bring about positive change within the College. Anyone within 10 years of their FRACS qualification is eligible to apply. Get nominating!

PAEDIATRIC COLORECTAL SURGERY SYMPOSIUM

Paediatric Colorectal Surgery Course, 18-20 October 2016, Royal Children's Hospital, Melbourne

RICHARD PERRY
Chair, Fellowship Services Committee

The Royal Children's Hospital, Melbourne is delighted to welcome Professor Marc Levitt to its Paediatric Colorectal Course.

There are many world-famous surgeons who have become renowned by publishing widely and operating upon patients in their own institutions. However, far fewer of these surgeons have spent extensive time away from their home countries dedicating themselves to educating surgeons operatively around the world. Professor Marc Levitt, of Nationwide Children's Hospital, Ohio is one of those special surgeons.

Professor Marc Levitt

Professor Levitt is the world's pre-eminent paediatric colorectal surgeon. He has spent the past 15 years educating surgeons around the world in the management of complex congenital anorectal anomalies. He is energised by the opportunity to teach fellow surgeons, whilst working to improve the functional outcomes for children born with complex congenital anomalies.

By operating upon children on almost every continent (Australia next, Antarctica unlikely!) and coordinating paediatric colorectal symposia he has educated hundreds of surgeons in the under-appreciated art of correcting anorectal malformations.

His Colorectal Courses at the Cincinnati Children's Hospital and Nationwide Children's Hospital, Ohio have brought together experts from across the globe to discuss the best management strategies for these patients.

It is a great honour that Professor Levitt has agreed to visit Australia to not only teach the surgeons of Australasia, but also to dedicate a full day to teaching the current paediatric Surgical Trainees. We are privileged to host Professor Levitt's first visit to Melbourne and expect that our symposium will be attended by surgeons from across Australasia and the Pacific.

The Royal Children's Hospital thanks RACS for its generous support of Professor Levitt through the RACS Visitor Program.

ATTENTION SENIOR SURGEONS!

Be a representative for your College

RICHARD PERRY
Chair, Fellowship Services

In October this year the RACS Senior Surgeons Section will be inviting nominations from members interested in serving on the Section Committee (seven positions).

Senior Surgeons is a large Section – over 1700 members – and represents a wealth of knowledge and experience with the potential to enrich both RACS as a whole, and its individual Fellows, Trainees and IMGs.

The aims of the Section are to:

- Advise the College on senior surgeons issues, through the Fellowship Services Committee.
- Facilitate support for senior surgeons, including those who are retired, semi-retired or contemplating retirement.
- Promote the planning of all aspects of retirement well in advance, addressing the physical, financial and psychological implications.
- Promote and facilitate the ongoing involvement of senior surgeons.in College activities such as training, mentoring and credentialing.
- Provide oversight for the Building Towards Retirement workshops.

The Committee meets three times per year by teleconference, and membership is not onerous. It is an effective way for older surgeons to stay involved with their College and share their knowledge. Fresh faces and new ideas are welcome.

Further information about the Call for Nominations will be circulated in September, however please contact the Secretariat (snr.surgeons@surgeons.org) if you have any queries in the meantime.

RACS VISITOR PROGRAM

Urological Society of Australia and New Zealand (USANZ) Annual Scientific Meeting 16-19 April 2016

RICHARD PERRY
Chair, Fellowship Services

USANZ was pleased to welcome Professor Margit Fisch to its 2016 ASM.

Professor Margit Fisch

Margit Fisch trained in Mainz, Germany. In 2002 she became Director of the Department of Urology at the AK Harburg in Hamburg. Since 2008 she has been Chair of the Department of Urology at the University Medical Center Hamburg-Eppendorf. Her major interests are Reconstructive and Paediatric Urology. Professor Fisch has been President of the Society of Genito-Urinary Surgeons and the European Society of Genito-Urinary Surgeons. She is an inter alia member of the American Academy of Genito-Urinary Surgeons, the Society of Pelvic Surgeons and the Society of Pediatric Urologic Surgeons. She has published more than 300 papers and organises the International Meeting on Reconstructive Urology (IMORU).

Professor Fisch was scheduled to present at the USANZ ASM held in New Zealand in 2011. Unfortunately, on the second day of that ASM, Christchurch was rocked by an earthquake and the meeting could not proceed. USANZ was grateful that Professor Fisch was able to attend the ASM again and to present in 2016.

Professor Fisch presented the following talks to USANZ delegates:

- A major diversion – which one and in whom? Update on the PROMETRICS study
- State of the Art: Urethral Reconstruction – Which technique for which stricture and when…(this talk was also presented separately to the Australia and New Zealand Urological Nurses Society (ANZUNS) session of the ASM)
- Chronic Pelvic Pain Syndrome and Chronic Prostatitis – Inflammatory or a state of mind?
- Recurrent Bladder neck stenosis after Radical Prostatectomy and BPH treatment - Perineal Re-anastomosis and VY-Plasty
- Prospective outcome analysis of the Artificial Urinary Sphincter.

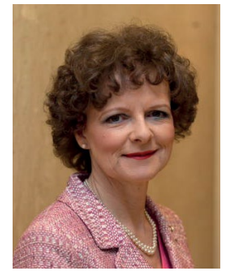
Professor Fisch was extremely generous with her time at the ASM, also participating in a networking session with trainees in the SET program in Urology where she imparted her wisdom on international fellowships and her specialty, and other matters of interest to Trainees.

NZSOHNS ANNUAL GENERAL AND SCIENTIFIC MEETING

16-19 October 2016

RICHARD PERRY
Chair, Fellowship Services

NZSOHNS is delighted to welcome Professor Janet Wilson to its Annual General and Scientific Meeting.



Professor Janet Wilson

Professor Janet Wilson is an internationally highly regarded otolaryngologist/head/neck surgeon who has energetically involved herself in clinic work and teaching. She trained in Edinburgh and is currently Professor of Otolaryngology Head/Neck Surgery in Newcastle, U.K. She is a past Council member of the Royal College of Surgeons (Edinburgh), the Royal Society of Medicine, past President of the North of England Surgical Society, the Otolaryngology Research Society, as well as holding numerous other official posts.

She established the National Otolaryngology Trials Office in 1997. Currently her research centres on the extra oesophageal manifestations of gastro-oesophagus reflux (she is a world authority in this area). She is also carrying out original research in the role of cognitive behaviour therapy in medically unexplained symptoms such as globus and dysphonia.

She has given over 400 international and eponymous lectures, written over 160 papers, 33 review articles, 18 book chapters, and co-authored two books on head and neck surgery.

As a keynote speaker at the New Zealand Society of Otolaryngology Head/Neck Surgery Annual Conference (October 16-20 2016) she will give one, or possibly two plenary addresses as well as a number of other presentations and workshops. Immediately following the conference she will be invited to talk at Christchurch Hospital, Christchurch, to both the surgical staff and general medical staff weekly meetings.

The NZSOHNS thanks RACS for its generous support of Prof Wilson through the RACS Visitor Program.

RACS VISITOR PROGRAM

AOA/NZOA Combined Scientific Meeting 9-13 October 2016

RICHARD PERRY
Chair, Fellowship Services

Dr Dror Paley

The NZOA is pleased to welcome Dr Dror Paley as its Keynote Speaker to the NZOA/AOA Combined Scientific Meeting, 2016.

Dror Paley is a Canadian orthopaedic surgeon well recognised as an international expert in limb lengthening and deformity correction procedures. He graduated from the University of Toronto Medical School and worked at the University of Maryland as an Orthopaedic Professor (1987 – 2001).

In 1991 he co-founded the Maryland Centre for Limb Lengthening and Reconstruction at James Lawrence Kernan Hospital with Dr John Herzenberg. Over the last 24 years Dr Paley has been widely published including a text book Principles of Deformity Corrections published in 2002. He was the first North American orthopaedic surgeon to study under Gavril Ilizarov and in 1986 introduced the Ilizarov apparatus to the US.

Dr Paley is currently based at his Institute in Florida – the Paley Advanced Limb Reconstruction Institute. He has had remarkable success in reconstruction and preservation of upper and lower limbs in children and adults, and has drawn patients from fifty states and more than thirty countries. His pioneering work covers treatment for:

- limb-length discrepancy
- limb deformity
- skeletal dysplasia's and dwarfisms
- non-unions
- joint preservation

Dror Paley has travelled widely and given his assistance to many orthopaedic surgeons around the world. In New Zealand he has worked with Mr John McKie in Christchurch.

The NZOA thanks RACS for its generous support of Dr Paley through the RACS Visitor Program.

CONGRATULATIONS

Professor David Brewster awarded the RACP International Medal

Professor Brewster is the Long Term Advisor – Paediatrician for the *Australia Timor-Leste Program of Assistance for Secondary Services – Phase II* (ATLASS II). This health workforce program is funded by the Australian Government and is managed by RACS. It was the first time that the RACP had awarded this International Medal.

Professor Brewster did his paediatric training in Wellington NZ and Sydney (Camperdown), completing his FRACP in 1983. His MPH in tropical child health was through the University of Sydney and his PhD was at the University of Newcastle, with the research carried out in Malawi on enteropathy in kwashiorkor.

In addition to academic positions in Darwin, Cairns and Canberra, he has spent the last three years in East Timor training Paediatricians. There are now 15 doctors in paediatric training, with the first five doctors completing their specialist training this year.

It is generally acknowledged that clinical practice at the National Hospital in Dili has been transformed and that the competence of paediatric trainees has improved greatly over this time.

The major challenge to improving clinical practice in developing countries is good clinical skills, using the full range of available investigations, making as accurate clinical diagnoses as possible and avoiding polypharmacy by practising Evidence-Based Medicine (EBM) as much as possible, although evidence is often lacking in the context of poor countries.

This has been Professor Brewster's mission in improving the quality of clinical paediatric practice in poor countries, which is a major challenge in East Timor where most of the doctors have been trained in Cuba. He has extensive international experience, having worked as a paediatrician in Botswana (2 yrs), Vanuatu (1 yr), Malawi (2 yrs), Solomon Islands (2 yrs), The Gambia (4 yrs) and Samoa (2 yrs).

Professor Brewster's research has improved our understanding of environmental enteropathy and contributed to improvements in dietary management of severe malnutrition.

This was acknowledged by his invitation to the Gates Foundation in Seattle in 2010 and to chair a WHO Nutrition Committee in 2012. He applied this research to Aboriginal child health during his nine years in Darwin as Clinical Dean of the NT Clinical School and Head of Paediatrics.

Citation provided by Royal Australasian College of Physicians

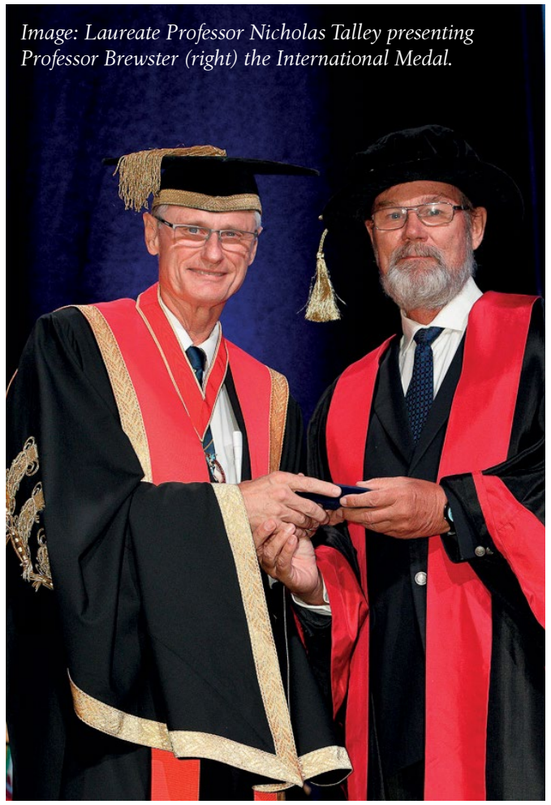


Image: Laureate Professor Nicholas Talley presenting Professor Brewster (right) the International Medal.

CANCER – MAN VERSUS WOMAN

The issue of sex differences in medical research

Men with a variety of cancers could benefit from a greater focus being placed on female physiology in scientific and medical research, according to PhD candidate Dr Zoe Wainer.

A former Cardiothoracic Surgical Trainee and RACS scholarship recipient, Dr Wainer has spent many years researching survival differences between men and women with non-small cell lung cancer.

She has found that despite new drug therapies, men were still dying in greater numbers than women, and not just in lung cancer.

She said that while researchers continued to predominantly use male animal models or male or undifferentiated or sex-undeclared cells lines, it was impossible to determine if men were being under-treated or women over-treated or to find out what biological mechanisms might lie behind the variation in mortality rates.

Dr Wainer said that mortality rates are different in men and women suffering from colorectal cancer and melanoma but that no-one yet fully understood the causes behind the rate differences.

Now she is working with Professor of Gynaecology and Obstetrics Martha Hickey from the University of Melbourne and the Royal Women's Hospital to gain support to help drive research in the field.

She has also become a leading Australian voice in the international movement to incorporate sex differences into all aspects of medical research, from molecular science to human trials to publicly recommended pharmaceutical guidelines.

"My research found that men with Stage 1A lung cancer have worse survival outcomes than women with Stage 2A lung cancer but we don't know why," Dr Wainer said.

"Epidemiological differences in survival in lung cancer and cancer more broadly have been reported around the world repeatedly for years yet while we keep describing the pattern that men are doing worse no research institution has taken up the challenge to understand the underlying causes.

"We now understand that physiological differences between the sexes can be quite profound such as those found in pain receptors, liver enzymes, immunological profiles, the differences in the symptoms and response to treatment in cardiovascular disease and even in diabetes.

"We now believe that in this era of personalised medicine, the time has come for medical research to ensure that sex is not just considered a variable to include in a multivariate analysis but that it should examine men and women as separate populations with comparisons between them included in all research conducted.

"Until we fully understand the pathological and physiological differences between the sexes we risk not giving the right care to the right person at the right time at the right place because we don't know what we need to know."

Dr Wainer is the Chair of Dental Health Services Victoria, the Head of Public Health BUPA Australia and New Zealand, the health advisor to the Bracks Timor-Leste Governance Project and an Honorary Research Fellow at the Peter MacCallum Cancer Centre.

In July, Dr Wainer and Professor Hickey co-convened a conference on sex differences in cancer at the Royal Women's Hospital which was attended by the CEO of Cancer Australia, representatives from the NHMRC, Cancer Australia, both the Federal and State Governments and medical staff.

Recommendations made following the conference include:

- Gathering information from multiple data sets to allow for a deeper understanding of the difference in mortality rates between men and women across the full spectrum of cancer- related diseases
- Lobbying for changes to be made to Australian research funding guidelines to require the inclusion of equal numbers of both sexes in research projects in line with many international organisations
- A cost analysis to be undertaken to determine if gender-focused programs to reduce the national cancer burden are more effective than non-gendered programs;
- Developing international collaborations, particularly for less common tumour streams, to allow for the generation of greater numbers and statistical power
- Creating a Foundation as a funding model to attract support from benefactors and government to help establish a National Research Centre for Sex Differences in Cancer to act as a research hub and driver of change within cancer research.

"The time has come for medical research to ensure that sex is not just considered a variable to include in a multivariate analysis but that it should examine men and women as separate populations with comparisons between them included in all research conducted."

Professor Hickey, the Director of the Gynaecology Research Centre at the Royal Women's Hospital in Melbourne, gave a presentation at the Conference in which she pointed out that Australia was almost 20 years behind other western countries in understanding sex differences in health outcomes.

She said that while her particular focus related to differences in cancer, there were marked variations in the rates of diseases affecting men and women including ischaemic heart disease, dementia, cerebrovascular diseases and chronic lower respiratory diseases.

She said that the study of sex difference was now evolving into a mature science and that barriers to the advancement of knowledge about sex differences in health needed to be eliminated.

Professor Hickey said that many countries – including the US, Canada, Ireland, France and Sweden, in particular – now required grant applicants to respond to mandatory questions about whether their research design included a focus on sex and gender before funding support was provided.

She also said that many international funding organisations were now refusing to support research that did not have an equal weighting of both sexes while an increasing number of international medical journals were now refusing to publish research which did not factor in sex differences.

"The National Institutes of Health in America required all funded research to include equal numbers of males and females 20 years ago and we haven't done that yet which is a powerful indicator of how far behind we are," Professor Hickey said.

"Yet the risks of doing nothing are substantial in that our research will become less and less relevant and Australian researchers and scientists may be unable to publish in major international journals.

"We have talked to the Government and representatives from the NHMRC and they do recognise that we have a problem in that there are so many questions and so few answers in terms of sex differences in health outcomes and we hope for leadership from them on this.

"This is both an equity issue and a scientific issue in that men are dying from cancer in greater numbers than women and maybe there are important things we can learn by studying women that could ultimately be of great benefit to men."

Dr Wainer received a RACS Research Foundation Scholarship in 2009 and the Raelene Boyle Scholarship for 2010 as well as the University of Melbourne's Melville Hughes Scholarship in 2014.

She thanked RACS for its support and said that she was now discussing the issue of sex differences in medical research with funding bodies and Government organisations.

"A highly respected institution like the RACS could also take a lead in this field by developing a policy that says it won't fund research or give scholarships unless applications address sex differences," Dr Wainer said.

"This issue also has relevance to surgeons because men and women metabolise medications differently, their tissue can be different, they recover differently, there is a difference in immunology and variations in the perception and experience of pain.

"We can truly say that we don't really know if we are giving men and women the correct dose across a range of drugs or offering them the right surgical options at the right time and it is fascinating that we don't know the answers to such basic questions in 2016."

With Karen Murphy

CASE NOTE REVIEW

Pulmonary embolic death following trauma

PROFESSOR GUY MADDERN
Surgical Director of Research and Evaluation

Case summary:

A middle-aged patient with no known significant comorbidities was admitted after a motorcycle accident which resulted in fractured left ribs 4–9 and a fractured left scapula. A computed tomography of the head, neck, chest and abdomen was performed.

There was timely treatment in the Emergency Department and the high dependency unit. No form of thromboembolic prophylaxis was given, and the patient's course was uncomplicated until the second post-admission day.

Following physiotherapy, the patient suffered a cardiac arrest and underwent successful cardiopulmonary resuscitation (CPR) and was then transferred to the intensive care unit with subsequent support with adrenaline and noradrenaline.

A transthoracic echocardiogram demonstrated thrombus in the inferior vena cava and right atrium. Tenecteplase was administered and further CPR was required. After a second dose of tenecteplase a haemothorax was diagnosed by chest x-ray. There was a three minute period of asystole.

The patient was reviewed by a cardiothoracic Consultant; a pigtail catheter was inserted and approximately two litres of "bloody fluid" were drained. A total of four units of blood were administered. Further asystole culminated in death.

Assessor's comments:

Thromboembolic prophylaxis was not used, probably due to concern relating to bleeding from fractures. However, such patients are vulnerable to deep vein thrombosis (DVT), although it is most unusual to have this occur so soon after the injury. Therefore, some form of prophylaxis is advisable.

The risk-benefit of prophylactic doses of clexane would be positive. It is unlikely that prophylactic doses would precipitate significant haemorrhage and if so, the haemothorax can be drained. Pneumatic compression stockings are an alternative, but do not affect the pelvic veins.

If the hospital had a cardiothoracic service, pulmonary embolectomy could have been considered on the basis that:

a. the original pulmonary embolus (PE) caused cardiac arrest
b. the patient demonstrated persisting hypoxia
c. the patient demonstrated thrombus in the right atrium and inferior vena cava.

Admittedly, such surgery has a very high risk in this setting. However, thrombolysis is even more unlikely to be successful in this situation. Regardless, such a course of action required a call to the cardiothoracic team at the time of diagnosis, rather than three hours later.

Essentially, this patient was unfortunate to have had such an early DVT and PE. The likelihood of survival after a PE massive enough to cause arrest and persisting hypoxia is low, because of associated acute right ventricular failure. The situation was desperate.

In hindsight, surgery may have been successful. Thrombolytics are unlikely to resolve this clinical situation. Within those parameters, management of the patient was acceptable.

In Memoriam

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

Vivian Francis Sorrell
General & Vascular Surgeon

31 October 1934 - 3 November 2015

Vivian Francis Sorrell died in Auckland aged 81, after a brief illness. He was a pioneer New Zealand liver and bariatric surgeon.

Viv (as he was commonly known) was born in Hobsonville, Auckland to Frederick Sorrell, an aeronautical engineer, and Doris Hopkins, an artist and seamstress. He had an older brother, Len, and a younger sister, Irene. The family moved to Wellington when Viv was an infant, returning to Auckland when he was nine years old. Following primary education at Epsom Normal School, Viv attended Auckland Grammar School where he excelled academically and on the sports field. In his final year he captained the First XI football team and he was also a very good cross country runner finishing first or second in the school "steeplechase" four years in succession.

For the full version see the webpage:
http://www.surgeons.org/member-services/in-memoriam/vivian-francis-sorrell/

Antonio (Tony) C Oposa

1 April 1924 - 26 December 2015

Antonio (Tony) C Oposa was an Honorary Fellow of our College from The Republic of the Philippines. He was born on 1 April 1924 and died 26 December 2015. He graduated from The University of the Philippines in 1951 and received further training with Dr Benson Roe at UCSF where he encountered early heart transplantation. Despite an invitation to remain in USA, he found that the pull of his country to be very strong and ensured his return home, where his mark was clearly made.

For the full version see the webpage:
http://www.surgeons.org/member-services/in-memoriam/antonio-(tony)-c-oposa/

Thomas William Milliken
Plastic & Reconstructive Surgeon

23 January 1925 - 18 November 2015

Tom Milliken was born in Christchurch in 1925 to Thomas, a solicitor, and Winifred Kate. He had two younger sisters, Dawn and Betty. Tom commenced school at Fendalton Open Air School in 1930 and moved to Julius House at Christ's College in 1938. At the age of 16, and as a result of the death of his father, killed at Sid Rezegh in North Africa in 1941, Tom largely assumed the responsibility of looking out for his sisters. At Christ's Tom represented the College at athletics and rugby and was both a house and school prefect. Rugby was his passion and he was destined to take this to a national level.

For the full version see the webpage:
http://www.surgeons.org/member-services/in-memoriam/thomas-william-milliken/

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

IN MEMORIAM

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

2016

Terence Morgan, TAS

Thomas Stevenson, SA

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

Informing the College

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

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

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

OPUS XLIII

WINNIE THE POOH AND HER LINKS TO THE SOMME

FELIX BEHAN
Victorian Fellow

The word SOMBRE comes from the French word for sad, gloomy and desolate. When articulated the enunciation is not dissimilar to the word SOMME and is almost onomatopoeic. It realistically depicts in words the devastation experienced by our war dead and later acknowledgment by their descendents as we saw portrayed on that July 16th anniversary of the events 100 years ago from the Western Front.

Representatives from Australian and French forces recently participated in commemorations of that sad, gloomy and desolate period remembering the thousands who gave their lives for King and Country.

The lyric poet Horace in 50 BC wrote of *Disjecta Membra*, which means scattered misplaced parts or disjointed ideas (in the literary sense). I could not help thinking this description could be applied metaphorically to the graphic images we see of the Somme – the mutilation and devastation.

At Fromelles over 1,917 troops walked to their deaths under a hail of machine gun bullets, mutilating another 5,500. Pozieres was even worse with over 6,731 dead and 25,139 casualties far outstripping the Gallipoli numbers, which to date has always been the focus of our ANZAC memorials.

The ANZACS – Antipodeans – are all islanders reflecting intuitive characteristics and innate quality of survival no matter what the odds. And to think the English commanders wanted to continue the Gallipoli campaign after that initial eight months despite such devastating losses. Fortunately General Hamilton's


Image: British Mark I tank


Image: Winnie with her mate in a park in Winnipeg.

authority was revoked by the British War Cabinet. Subsequently it was the likes of General Monash with his engineering skills using field tanks that ultimately turned the tide of war 'leading to victory' in 1918 following the earlier devastating losses on the Somme.

The *Antiques Roadshow* (ARS) recently recounted the William Foster story and his experiences in constructing agricultural machinery. This was to be the prototype of the tank which was, in effect, an agricultural tractor with an armoured body fortified with guns.

Napoleon coined the phrase that every setback should be the introduction to another victory and I have used this philosophical concept to offer some humane contrast to temper the devastations of war so often represented and remembered simply by cold granite headstones. The milk of human kindness is mirrored in the following stories one from the German side - the 'Red Baron' one from the Canadian allied forces somewhat surprisingly about Winnie the Pooh and her Winnipeg links and a musical vignette from the French.

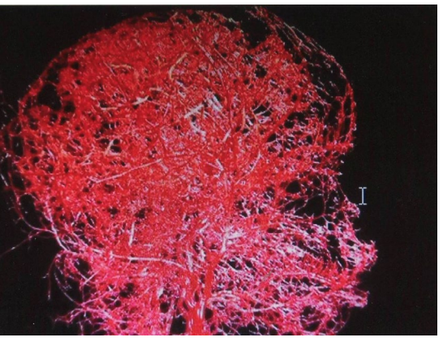
The story of the Red Baron, though interesting, may not meet with total acceptance but it is entrenched in history. I recently saw on the ARS a black and white image of Australian forces saluting the Red Baron at his funeral service in April 1918 after he was mortally injured. He died when an Australian soldier (reportedly) using a Vicker's machinegun fired that deadly shot up through the Baron's armpit and out through his neck. Despite his injuries he landed his Fokker Dr.1 triplane behind allied lines and his dying words were quoted *Kaput* – 'twas the end of the flying ace.

This 1918 image (above) depicts the Australian 'slouch hats' giving the Red Baron a 21 gun salute. Some may say fancy saluting the enemy – I say what a marvellous humane gesture. It is not dissimilar to the Australian carrying a red cross on a white sheet to rescue his comrades with the approval of German command but was nonetheless charged ignominiously with treason for consorting with the enemy.

My second story relates to the Canadian forces also part of the British Empire's contribution "where", Kipling once remarked, "the sun never sets". The tale of Winnie the Pooh – the black bear whose story takes us from Winnipeg, to London, to the Somme then finally to London Zoo is worth recalling.

My awareness of this came from an SBS TV programme some time ago. A young vet in Winnipeg called Colbourne was in charge of the horses for the future expeditionary ventures into the Somme when he bought a bear from a trapper at a railway station for $20 - a huge sum in those days (Reference: Lindsay Mattick children's book "Finding Winnie"). He took the bear back to army quarters and housed it overnight. The following morning the Company Sergeant Major found the bear and, in typical military style with a stentorian blast, tore shreds off the vet for daring to bring the animal into the army precinct. The situation was saved by the Company Colonel who just happened to pass by the army quarters when he heard this savage commotion. The Colonel saw the bear and observed "what a marvellous company mascot". He asked the vet the animal's name. Colbourne was still recovering from the verbal tirade and said stutteringly W-I-N---- W-I-N--- in an awkward manner finally bursting out with "Winnie" – indicating the bear's hometown origin. So Winnie was now part of the military establishment growing bigger every day on a diet of fruit and sweets from the Army Mess. Honey may been part of her dietary regime (bears love sweets) and being a laxative perhaps this is the origin of the eventual title of the books "WINNIE THE POOH"!

So Winnie was now the mascot for the Second Canadian Infantry Brigade and went to London. Needless to say when the orders were given to the Canadian contingent to depart to the Somme it was decided that Winnie could not be part of their war effort of the 25,000 Canadians and the London Zoo became her new home.



In 1972 I also ended up at London Zoo (but not on display as some might say)! Let me explain. I was a Bernard Sunley Research Fellow at the Royal College of Surgeons England into flap vascularity under David Tompsett my supervisor. These investigations were carried out at the Nuffield Institute of Comparative Medicine based at the London Zoo where I did my radiographic investigations with human tissue. Incidentally Tompsett was the first to do methacrylate injection studies (see illustration above) to create the first 3-D network pattern of vascular perfusion in a stillborn.

This research led me to the Angiotome concept of island flap vascularity based on embryological patterns, employing dermatomes with their neurovascular connections. After a 40 year career applying such principles, this resulted in my textbook on Keystone Concepts of Reconstruction - the *Arc of the Smart* some have observed.

The tragedies of the Somme affected many people. Colbourne survived the war but returned to Canada a broken man becoming mute and irreconcilable and was institutionalised. Eventually his friends decided to take him back to London to see his old charge Winnie. When they arrived at the zoo the bear was sitting there munching on a honey roll no doubt. When Colbourne saw Winnie he grasped the metal bars of the cage, crumbled emotionally and in ecstasy melted into tears streaming down his face. But something radically changed - he began to speak for the first time since he left the Somme. *This sure beats ECT!*

A.A. Milne and his grandson Christopher Robin met Winnie at the zoo in 1925. She captured their hearts and became immortalised in the Winnie the Pooh stories that have delighted generations of children. I was given a copy of Winnie the Pooh by my Godfather, Eric Shaw, whose family emigrated from Russia to Queensland at the time of the Bolshevik Revolution in 1917. He graduated in medicine in 1942 with my Father and served with the Australian forces in Borneo. After the war he became Director of the Blood Bank in Queensland but his important medical contribution was an *MJA* article in 1942 about intravenous resuscitation and the maintenance of the intravascular milieu in any hypovolemic emergency. No doubt he applied these techniques to the war injured in Borneo.

The French connection focuses on Ravel's Le tombeau de Couperin. Prior to WW1 he was planning to write a "French Suite" for piano but it became the 1917 homage to friends who died in the war. One movement is dedicated to each friend. Incidentally two brothers who were died were killed by the one shell. Every time I hear this piece what a memory it evokes – more information from ABC FM.

Coincidentally Miki Pohl an accomplished plastic surgeon and also accomplished concert violinist trained in Winnipeg under Mirek Stranc in 1981/82. This reminds me of the story of Rodney Smith – President of the RCS in London and also an accomplished musician was asked why he also did not become a concert violinist replied "Felix, being a surgeon I can do both".

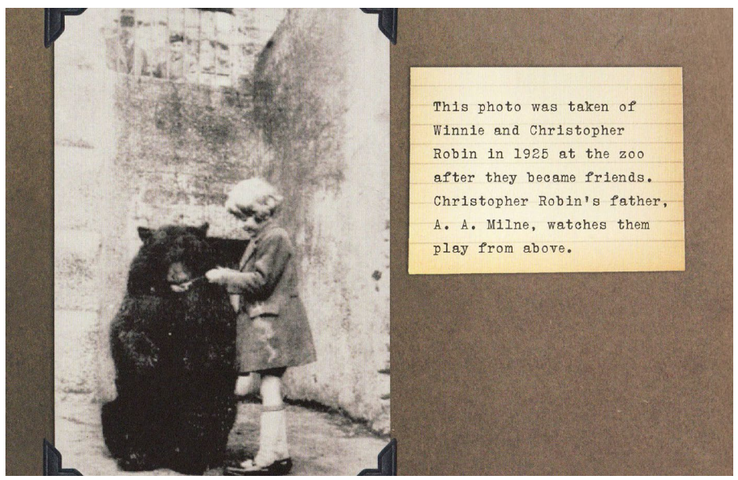
Don Marshall when vetting these writings mentioned that he met Stranc at Mount Vernon in his early career remarking on his likeable personality.

I finish with some winning (Winnie) quotes from the philosophical thinking of Milne relevant in this war setting:

About mateship –
"You are braver than you believe, you are stronger than you seem, you are smarter than you think".

About the joy of friendship:
"A day without a friend is like a honey pot without a drop inside".

And to conclude with a quote about love Piglet asks Winnie:
"How do you spell love" – Winnie replies "you don't spell it, you feel it".



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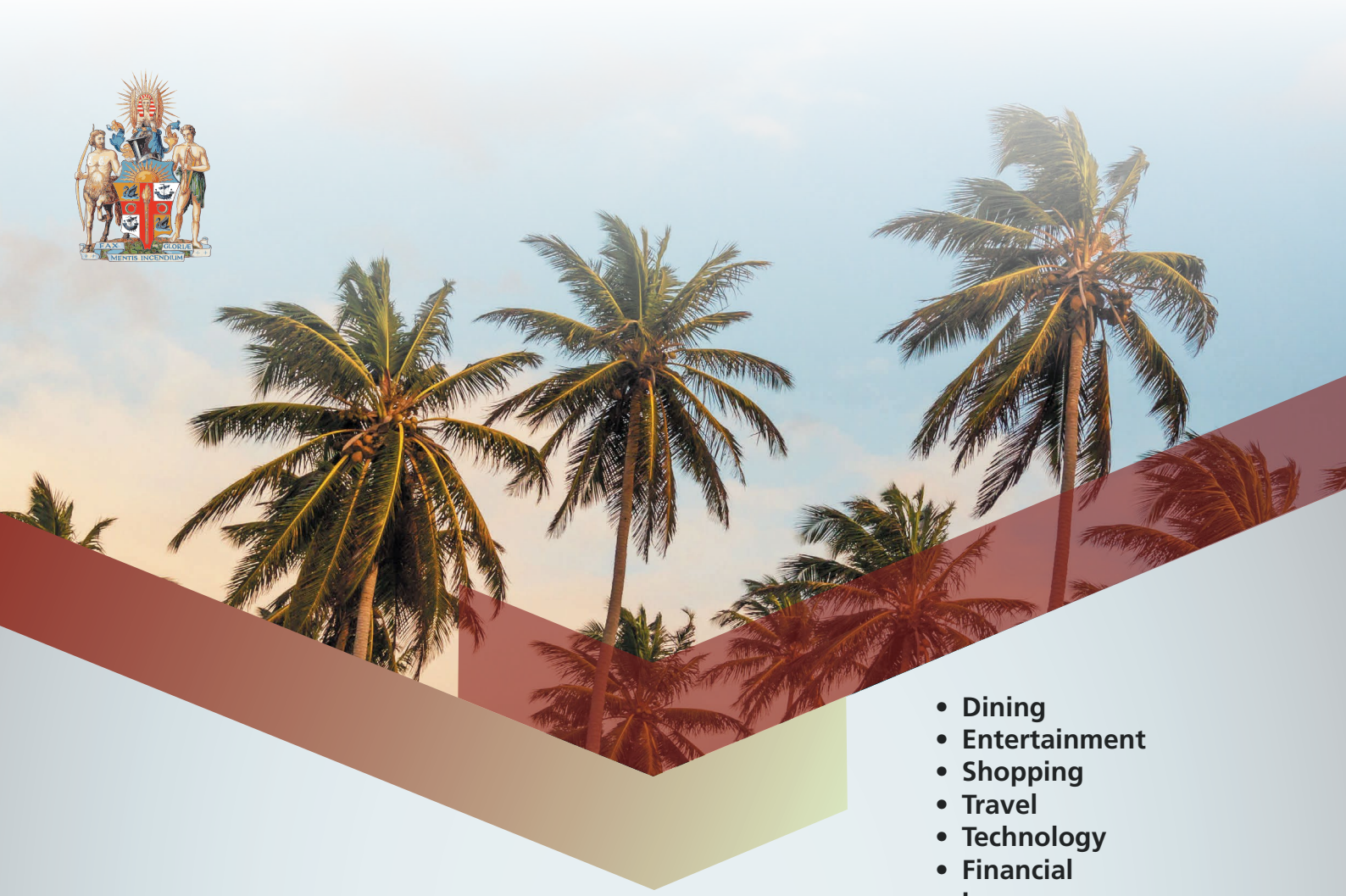

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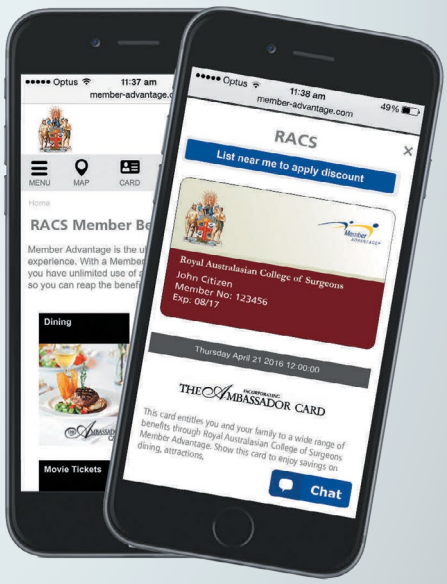

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