SurgicalNews

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[To be presented to Parliament at the first Session of 1893.]

To the Honourable the Speaker and Members of the House of Representatives in Parliament assembled.

THE Petition of the undersigned Women, of the age of twenty-one years and upwards, resident in the Colony of New Zealand, humbly sheweth:—

THAT large numbers of Women in the Colony have for several years petitioned Parliament to extend the franchise to them.

THAT the justice of the claim, and the expediency of granting it, was, during the last Session of Parliament, affirmed by both Houses; but, that for reasons not affecting the principle of Women's Franchise, its exercise has not yet been provided for.

THAT if such provision is not made before the next General Election, your petitioners will, for several years, be denied the enjoyment of what has been admitted by Parliament to be a just right, and will suffer a grievous wrong.

THEY therefore earnestly pray your Honourable House to adopt such measures as will enable Women to record their votes for Members of the House of Representatives at the ensuing General Election.

THEY further pray that your Honourable House will pass no Electoral Bill which shall fail to secure to Women this privilege.

And your petitioners, as in duty bound, will ever pray, &c.

NAME. ADDRESS.

Cover: Samantha Khoo, SET3 Vascular Trainee, NSW

Above: Suffrage petition, 1893 Credit: Archives New Zealand, Head Office, Wellington Reference: LE1, 1893/7a

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The year in review

As I write my final President's perspective for *Surgical News* for the year, one of the common themes that stands out for 2018 is engagement. Our CEO Mary Harney has been at RACS for just over twelve months now, and during that time she has demonstrated a keen enthusiasm to build relationships and engage with as many Fellows, Trainees and IMGs as possible. At a Council level, we have embarked on a long term reform agenda aimed at ensuring that our structural processes, and the manner in which we conduct our core business remains relevant to our membership. In order to achieve this we have sought to rejuvenate our most important relationships across our profession, as well as develop new ones.

Central to this has been our determination to forge stronger relationships with the states, territories and New Zealand (STANZ), as well as the specialty societies. An example of this was the Surgical Leaders' Forum which was held on Thursday 25 October, immediately prior to the Council meeting. The topic of 'Ethics' was decided by the Specialty Societies, their Training Board Chairs and CEOs at a successful pre-planning meeting on 13 September. The Forum was led by Dr David Martin, President and Mr Adrian Cosenza, CEO of the Australian Orthopaedic Association (AOA) and Professor Mark Ashton, President and Mr Keith Bryant of the Australian Society of Plastic Surgeons (ASPS). Approximately 70 people attended the Forum, with 23 of those representing the Specialty Societies and Training Boards.

Earlier this year we amalgamated the Board of Regional Chairs and the Governance and Advocacy Committee to form a new Advocacy Board (AB). October Council Week saw the second meeting of our Advocacy Board (AB) which brings together all of the STANZ Chairs, the PDSB Chair, the Censor in Chief, community representatives, as well as other relevant groups. The aim of this is to ensure that our STANZ play a more prominent and visible role during these weeks. Many of these committe Chairs stayed on for the Council meeting to provide us with an update from their jurisdiction.

Another potential change we are looking to make to our governance structure is a merger of the Education Board (EB) and Board of Surgical Education & Training (BSET), to form the Education & Training Committee (ETC). This is currently progressing with societal agreement and a definitive plan is expected to be presented to Council in February 2019. I am pleased to announce that Professor Julian Archer has been appointed as the new ExecutiveGenereal Manager of Education at RACS, and as part of his many responsibilities, Julian will have oversight of this merger.

Strategy development was another a key feature of the meeting, with Council reaffirming RACS' priorities. The major areas of endeavour will focus on the constitutional requirements of Standards and

Professionalism, Enduring Value and Membership. The 2019 Budget has also been approved, with fellowship fees capped at CPI of 2 per cent.

October marked the first meeting of the Council since elections were held. I would like to thank everyone who voted, and also all of those who put themselves forward as candidates. Congratulations to all of the successful candidates, particularly our newly elected Councillors, Dr Sarah Coll, Professor Henry Woo, and Dr Lawrence Malisano. I would also like to extend my congratulations to all of the award recipients and new Fellows that were recognised during Council Week.

For the first time in a number of years we will be heading off-shore for next year's ASC as we convene in Bangkok in May 2019. I am pleased to share that we are also looking to venture off-shore in 2022 and planning is underway for the ASC to be held in China. The Hon. John Brumby AO, National President, Australia China Business Council (ACBC) addressed Council on the opportunities of connecting with China and the potential benefits to RACS.

On a final note, many if you know I am a long-term supporter of the Foundation for Surgery. I am continually inspired by the positive impact achieved in our communities thanks to the support of our Fellows. In particular, I have an enormous sense of pride that surgeons are proving to be great philanthropists in supporting the Foundation. It is through your extraordinary support, as Fellows, Trainees and donors that the Foundation for Surgery has achieved so much in global health, indigenous health and research over the last year. This year as you renew your subscription, I urge you to donate to the Foundation for Surgery to help ensure children, families and communities can access safe and quality surgery when they need it most.

Thank everyone for your support throughout 2018, and I encourage you to continue to engage with the College that supports you in 2019.

Mr John Batten
President

A lasting legacy

"We make a living by what we get, but we make a life by what we give." This quote, often attributed to Winston Churchill is as relevant to us today as surgeons as it was in the 1940s. Being a surgeon is our living, but through our profession and through our support of the Foundation for Surgery, we change lives, we save lives and ensure that those who most need care can access it.

Every two seconds someone dies unnecessarily from conditions and injuries that are treatable by surgery. Globally, this is more than the total deaths from HIV, tuberculosis and malaria combined. Unfortunately, this also disproportionately affects children.

However, there is something that we can do about this. While the lead up to Christmas is traditionally a very busy time for all surgeons, it is also a time when we start to reflect on the year that has passed and remember that many are not as fortunate. At this time of the year, I encourage you to take a moment and consider donating to the Foundation for Surgery, either via your annual subscription fee payment or online on our website. Your donation will help ensure children, families and communities within our region and across Australia and New Zealand have greater access to quality surgical care.

As we reflect on the year that has been, we also remember Professor Richard (Dick) Clayton Bennett AM, FRACS who passed away on 2 October 2018.

Professor Bennett had been a Fellow of our College since 1960 and during his prestigious career had a significant impact on the College. Professor Bennett was personally and professionally committed to philanthropy to forge greater access to quality surgical care. As a RACS Councillor, he established the Foundation for Surgery in 1980 and since that time, continued to serve the Foundation for Surgery as its Patron and advocated for Fellows to leave their surgical legacy through bequests. He made significant contributions to surgical research and surgery in Malaysia, the Pacific and Papua New Guinea and to surgical research. Professor Bennett is remembered as a great leader, surgeon, teacher and researcher. His hard work, determination and compassion to establish not only the Foundation for Surgery but also the Surgeons International Award and the Younger Fellows Forum will ensure his influence will continue for many generations. Surgery as a profession and the Australian and New Zealand communities owe an enormous amount to this forward thinking, generous and courageous man. Professor Bennett was a truly great role model and one who we can learn from as we reflect at this time of the year.

Since 1980, Professor Bennett's vision for the Foundation for Surgery has grown significantly thanks to your support. In the last year alone, over 25,000 patients from developing countries in the Asia-Pacific region have received specialist consultations from our Fellows. More than 2,555 patients have had

life changing surgery and over 509 health workers participated in training. Eight Aboriginal medical students and four Māori doctors were supported to undertake specialised professional development opportunities, and a significant ear nose and throat advocacy campaign commenced to forge better health outcomes for Aboriginal and Torres Strait Islander communities. In addition, more than 39 scholarships were awarded to Fellows and Trainees to support pioneering research resulting in better patient care, as well as research into the early detection and treatment of many cancers, disorders and diseases to assist all people to live their healthiest lives.

It is through your extraordinary support as Fellows, Trainees and donors, that the Foundation for Surgery has achieved so much in global and Indigenous health, and research. We need your help to continue and expand these essential activities.

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

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

Alternatively, if you would like to make a more substantial personal contribution to the Foundation for Surgery's work or start your own scholarship, please contact Jessica Redwood, Manager, Foundation for Surgery, on +61 3 9249 1110 or email foundation@surgeons.org

Ms Cathy Ferguson
Vice President

RACS Council Election results 2018

We are pleased to share the results of the RACS Council elections 2018.

Fellowship Elected Councillors

There were nine Fellowship Elected Councillor positions to be filled. The successful candidates in alpahabetical order are:

Re-elected to RACS Council

Adrian Anthony

Ruth Bollard

Jennifer Chambers

Kerin Fielding

Annette Holian

Christopher Pyke

Newly elected to RACS Council

Sarah Coll

Lawrence Malisano

Henry Woo

Specialty Elected Councillors

There was one vacancy for Orthopaedic Surgery Specialty Elected Councillor. The re-elected candidate was:

Re-elected to Council unopposed

Greg Witherow

The pro bono contribution of Fellows has been, and continues to be the College's most valuable asset and resource. We are grateful for their commitment. We are also grateful to the voting Fellows who demonstrated their engagement with the governance of the College.

Congratulations to the successful candidates and sincere thanks to all candidates who nominated.

Women vote for the first time at a polling station in the tiny South Otago settlement of Tahakopa on 28 November 1893. Credit: McWhannell Collection, PA1-o-550-34-1Librabry, reference: F31495-1/2

Kia kaha, wahine!

How far have we come since the suffrage vote?

125 years ago on 19 September 1893, Royal Assent was given to New Zealand legislation that gave all adult women the right to vote. New Zealand was the first country in the world to achieve this with Australia becoming the second, in 1902, however Aboriginal women were excluded until 1962.

Published lobbying began in New Zealand in 1869 and the first petitions were circulated by both Pākehā and Māori in 1886. Public debate was often acrimonious and parliamentary attempts had failed on two previous occasions. New Zealand had two parliamentary houses at that time and Bills passed by the House of Representatives in 1891 and again in 1892, did not succeed in the upper house, (the Legislative Council).

One of the groups that supported the suffrage movement for many years was the Women's Christian Temperance Union. Liquor interests were concerned female voters would support the prohibitionist and had successfully petitioned previous Councils to reject the Bills; and they sought to do so again in 1893. Presenting a counter argument, women's petitions from around the country were presented to parliament, including one with almost 20,000 signatures. In total over 32,000 women signed a petition, almost one quarter of the adult women in New Zealand at that time.

The 1893 vote for the Suffrage Bill was very close - 20 for and 18 against. At the national elections in November 1893, 90,000 women chose to cast a vote.

So has 'tampering with men's and women's natural gender roles' caused a breakdown of society, as was predicted by the cartoon? Have the women of New Zealand advanced?

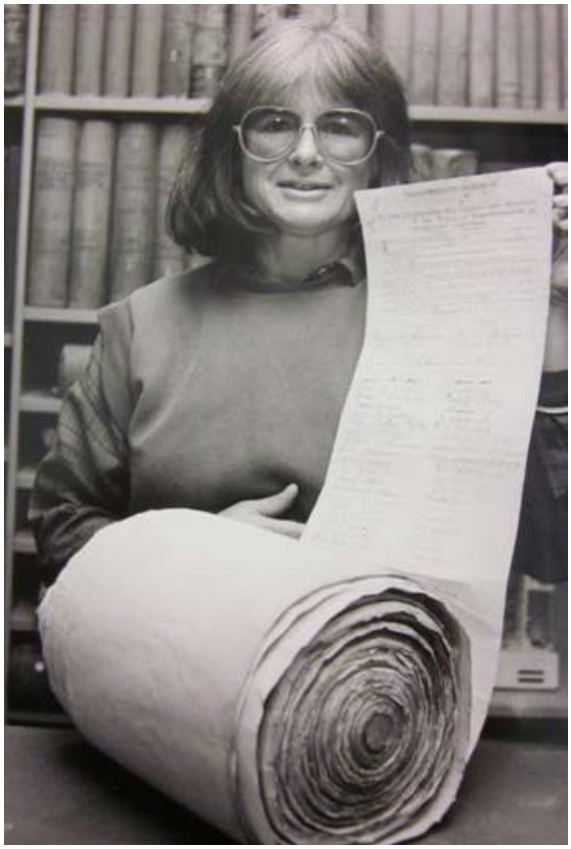
In 1893, 47 per cent of New Zealand's population was female. Statistically their average life expectancy was 57 years; they would have their first of five children at 22.5 years; 26 per cent of working women were in paid employment, mainly in education, domestic work and retail; and 25 per cent of undergraduate students were women. A total of 85 per cent of registered women voted in the first election after the law was passed but there were no female members

of parliament. The infant mortality rate was at least 12 per cent and just doing the week's wash was a day of hard labour!

In 2018, 50 per cent of New Zealand's population is female. Statistically their average life expectancy is 83 years (regrettably for Māori women it is only 77 years and for 79 year for Pacific women), a vast increase of 26 years. They will have their first of two children at 28.8 years (or 2.5 children if Māori); 65.5 per cent of working women are in paid employment, largely in education and retail but also in health care and in science and professional industries; two thirds work in full-time employment and 30 per cent of working women are mothers. About 64 per cent of university degrees are earned by women. Almost 40 per cent of today's members of parliament are now women and women are more likely to vote than men (83 per cent to 76 per cent). Women now hold 45.7 per cent of appointed roles on state sector boards and committees. The infant mortality rate is 0.4 per cent (0.46 per cent for Māori) and most houses, thankfully, have fully automated washing machines.

Progress? Definitely – but women still have a way to go. 70 per cent of the childcare in the home is managed by a woman; the gender pay gap overall is 9.2 per cent, and for Māori women it is much worse at 20 per cent; only 20 per cent of directors of listed New Zealand companies are women: 25 per cent of women experience partner violence, and for Māori and disabled women this is twice as likely as for their Pākehā sisters.

A College of Surgeons would not have been even a thought in the head of Sir Louis Barnett in 1893, but women's suffrage would undoubtedly have been a topic of conversation in his family. His mother-in-law, Catherine Fulton, was very much involved in the suffragist movement. She was Dominion President of the Women's Christian Temperance Union from 1889 to 1982 and was a signatory to one of the 1893 suffrage petitions. The first woman entered medical school in New Zealand in 1891 – the same year that Melbourne had its first two female graduates. New Zealand lagged behind Australia in female medical graduates – and in female RACS Fellows – for some years. The first New Zealand based doctor to be awarded FRACS was Pearl Anna Inglis MacLeod, specialising in orthopaedics in 1954, by which time 10 Australian based doctors had already been awarded the qualification. However, the 2017 RACS Activities Report identifies 12.4 per cent of New Zealand based active Fellows as female, compared to 12.1 per cent in Australia. The percentage of females in the medical workforces are approximately 44 per cent and 41 per cent respectively, so both countries have some way to go before women medical graduates are reasonably represented in our surgical workforces.



The 1893 Women's Suffrage Petition in 1985 just before restoration work was started.

So on 19 September we celebrated 125 years since a great advance in the rights of all women in New Zealand; and today, we recognise the need to focus on the considerable distance yet to travel on the surgical road.

Justine Peterson,
Regional Manager, RACS New Zealand

RACS supports research into Māori paediatric ENT diseases

The recipient of last year's RACS Māori Surgical Education and Training One Year Trainee Scholarship has used the funds to investigate the disparities that exist between Māori and non-Māori children suffering from ear, nose and throat (ENT) diseases.

PhD candidate Dr James Johnston said disparities in ear, nose and throat health between Māori and non-Māori children in New Zealand were some of the greatest in the world but underlying causes were little understood.

He conducted retrospective data analysis of children presenting with adenotonsillar disease and otitis media with effusion (OME) in a bid to better understand the differences in presentation, disease progression and post-treatment outcomes.

He found that Māori children presented later than non-Māori children, had more severe disease and were less likely to have been given antibiotics and pain relief prior to surgery.

He also found that Māori children presenting for surgery to treat adenotonsillar disease tended to be older and more likely to have nasal symptoms and OME, and he said that this may support the theory that larger adenoids may act as a reservoir for bacterial infection.

Dr Johnston also conducted a separate study which aimed to compare the incidence and outcomes of Māori and non-Māori children with OME who underwent myringotomy plus ventilation tube insertion (MVTI).

He examined the outcomes of more than 11,000 children who had at least one MVTI procedure between 1996 and 2016 at the Starship Children's Hospital in Auckland.

He found that 20 per cent of patients were Māori and that there was no difference in gender, age, length of stay, readmission or complication rates between Māori and non-Māori children.

"While there is epidemiological evidence to suggest that Māori have higher rates of middle ear disease, the results of my research indicated there was no difference in the post-operative course between Māori and non-Māori children who had MVTI," Dr Johnston said.

"This is very reassuring because Starship Children's Hospital performs many paediatric Otorhinolaryngology (ORL) procedures across the broader Auckland region, which has a large Māori population.

"Our findings suggest that once Māori children are referred to the hospital and undergo grommet insertion, they do equally as well as non-Māori children."

He said that while his research focussed on ENT conditions, disparities also existed across a range of conditions such as respiratory tract infections, bronchiolitis among infants, pneumonia and OME.

Dr James Johnston

"We know that Māori are disadvantaged from a socio-economic point of view, are less likely to seek medical help and are more likely to live in rural areas which have fewer medical services," he said.

"The stand-out finding from my research was that Māori present to hospital with more severe disease which probably reflects the fact that they see the GP less often or later in the presentation than non-Māori.

"We also found that they are less likely to be readmitted to hospital following a surgical ENT procedure.

"This may indicate that they either have a higher threshold for representing or that because they present with more severe disease, they stay longer in hospital and therefore are less likely to have disease recurrence."

Dr Johnston said greater access to warm, dry housing and healthy food and the creation of stronger links between GPs and Māori communities could all work to lower the disparities in health care.

"Disease of the ear, nose and throat in the Māori population is a very understudied area, yet an incredibly important one," Dr Johnston said.

> "We need to understand what is happening to Māori children if we are to treat them in a timely manner, ensure good post-operative care and prevent disease in the first place.

"I believe there is a need for stronger links to be established between Māori communities and GPs, but for that to happen doctors need to have a desire to learn about the Māori culture and health model.

"As we become increasingly multicultural, all doctors will need to be more culturally aware and spend time learning about other cultures and models of health, education which should be incorporated into the medical school and specialty training curriculums.

"As doctors, we do not just deal with disease but with people, and we need to acknowledge cultural differences.

"Having more Māori GPs may help, but more importantly the GPs who work in areas with a high percentage of Māori patients must develop a good understanding of Māori culture."

Dr Johnston is also conducting PhD research into the nature of microbial involvement in the development of adenotonsillar hyperplasia through the University of Auckland.

He is conducting that research under the supervision of Professor Richard Douglas, a consultant Surgeon at Auckland City Hospital and Professor of Surgery at the University of Auckland, and Associate Professor Murali Mahadevan, an Otolaryngology surgeon with a special interest in Paediatric ENT surgery.

Dr Johnston has received further support from RACS to conduct this research through the Garnett Passe and Rodney Williams Memorial Foundation Surgeon Scientist Scholarship.

He said he hoped to pursue both clinical and academic surgery with a special interest in Paediatric ENT and Māori health throughout his career and thanked Fellows for the support provided to him.

"Many people think that funding for research into Māori health is easy to come by but only RACS offered support for this work which has given us a unique opportunity to research a very important but understudied area.

"The disparities in ear, nose and throat health between Māori and non-Māori children in Aotearoa (NZ) are perhaps some of the greatest seen worldwide and the support from the College is allowing us to identify these disparities and investigate ways that we may be able to reduce or eliminate them," Dr Johnston said.

"Johnson & Johnson is proud to partner with RACS to offer scholarships for Aboriginal and Torres Strait Islander and Māori surgeons to advance our understanding of how we can improve health outcomes for these populations. It is encouraging to see the work of Dr Johnston and the outcomes of his research into health disparities in Māori children. The more we understand about the underlying causes, the more we are able to effect change. I extend my congratulations to Dr Johnston for winning this scholarship and his contribution to this field of research," said Sue Martin, Managing Director, Johnson & Johnson Medical Devices.

RACS Māori SET Trainee One Year Scholarship is one of three scholarships offered annually with generous support from Johnson and Johnson Medical Devices. The scholarships are open to Aboriginal, Torres Strait Islander and Māori surgical trainees and valued up to $20,000 annually.

CAREER HIGHLIGHTS

- 2018: RACS Career Enhancement Scholarship
- 2017: RACS Māori SET One Year Trainee Scholarship
- 2017: Garnett Passe and Rodney Williams Memorial Foundation Surgeon Scientist Scholarship
- 2011: JDK North Prize in Clinical Medicine – Auckland Medical School

Karen Murphy
Surgical News journalist

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12 noon
Friday 14 December

Lecture:
"Sir William Upjohn and his Rolls-Royce". A historical lecture.

This lecture will be delivered by
Cas McInnes and
Mr Ian Upjohn
(Sir William Upjohn's grandson)

RACV City Club,
501 Bourke St,
Melbourne
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The lecture followed by a two-course lunch.

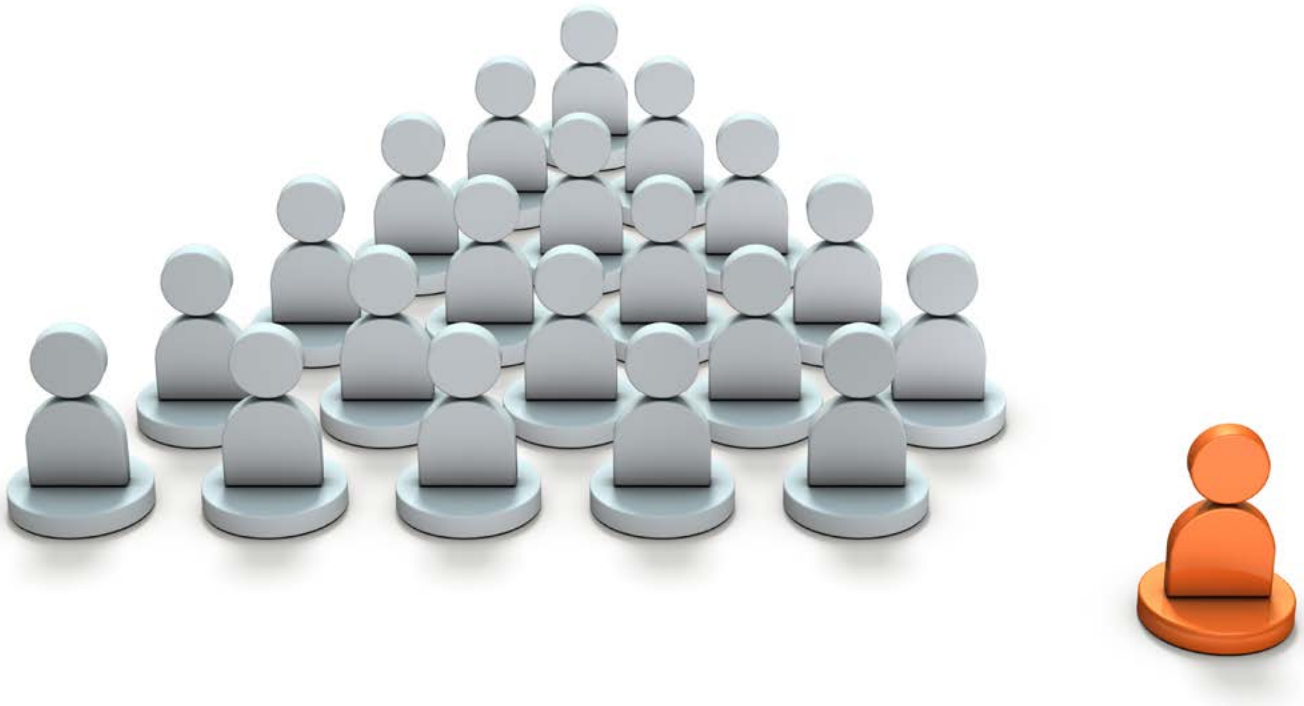
$110 per person.
Guests are encouraged. Please feel free to forward this email to your colleagues, friends and family.

RSVP
foundation@surgeons.org
by Friday 30 November.

PLEASE NOTE
places are limited and we regularly have a full-house, so please RSVP as soon as possible to avoid disappointment.

Donations in memory of Professor Dick Bennett will also be collected on the day

Racial discrimination …. perspectives



The United Nations was established after the Second World War in 1945 to prevent another such conflict and pursue the realisation of human rights. Australia and New Zealand were among the 51 founding member states. There are now 193.

The Convention on the Elimination of All Forms of Racial Discrimination 1966 was adopted and opened for signature by the United Nations General Assembly in 1965 and entered into force in 1969. Australia and New Zealand were signatories; Australia signed on 13 October 1966 and New Zealand on 25 October 1966. As of 2018 there were 88 signatories and 179 member states that had ratified the Convention. New Zealand ratified the Convention on 22 November 1972 and Australia on 30 September 1975. Our nations took a leading role bedding down independent domestic legislation to protect people from racial hatred and unfair treatment on the basis of race, colour, descent, national origin and ethnicity in different areas of public life.

The foundations laid by our parliaments so that workplaces, education and service provision could be free of race related discrimination, harassment and vilification, have a 50 year anniversary looming. Race discrimination and measures to educate, combat, and seek redress are not new to our countries, and the pages of our rule books in Australia and New Zealand are indeed well worn.

We have a Māori footprint of a thousand years on Aotearoa – Land of the Long White Cloud. Australia is home to the world's oldest continuous cultures and people identifying with over 270 ancestries having arrived tens of thousands of years prior to the hypothesising of Terra Australis in antiquity, and the ventures of a range of intrepid European sailors over more recent centuries. It is of significant concern that despite the ancient history, and our modern 20th century history, that our legislative frameworks are indispensable. They are requented repeatedly due to

race discrimination in the 21st century and serve their purpose well.

Less favourable treatment can be covert, subtle or blatant. It can manifest in the simplest of stereotypes. Nourished by inherent bias, it will often lay dormant until triggered. The outcome can be specific for an individual or reflected in systemic barriers that limit options and opportunities. Either way, discrimination, harassment and vilification on the basis of race continues to minimise the prospects of people to achieve their potential and participate in a manner that ensures an equivalency of training, employment and quality of life.

Be it demeaning, debilitating, inciting harm or inequitable treatment, the intent or motive of the perpetrator of racial discrimination is irrelevant. It is the impact and the nature of the behaviour, and the disadvantage amassed that will be assessed. There are no excuses given our modern history. However, much effort is needed to fight the good fight as direct, and increasingly indirect discrimination on the basis of race, gnaws away at the genuine efforts to realise the objectives of the Convention.

The efforts of our nations to enact laws to realise our international human rights commitment to promote equality between people of different backgrounds, continue to be binding. While some have tried with gusto to dismantle the relevant statutes, they have failed. The 50th anniversaries will be marked in the not too distant future; 2021 and 2025. While none of us will be any the wiser of the ultimate outcome, we all have an opportunity to make our societies fairer and in turn help determine whether there is a need for the 100th anniversary – the centenary of the original *Race Relations Act 1971* in New Zealand and the current *Racial Discrimination Act 1975* in Australia.

NOTE

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

Susan Halliday
Australian Government Defence Abuse Response Taskforce (DART) 2012-2016 and former Commissioner with the Australian Human Rights Commission

Preparations for ASC Bangkok underway

There are only six months to go until the 2019 Annual Scientific Congress in Bangkok and preparations continue apace!

The individual sections have been busy arranging and confirming their invited speakers and working on their programs. Collaboration between the sections is proceeding smoothly, and combined sessions utilising the various invited speakers will provide something for all.

The Wellington based RACS Executive, along with section conveners across New Zealand, along with the Wellington and Melbourne RACS staff, have managed to secure some exciting and thought provoking speakers for plenary, named lectures and scientific sessions from widely varied (and not always surgical) backgrounds.

Professor Sir Malcolm Grant, current Chair of the National Health Service (NHS), has accepted the invitation to deliver the Syme oration titled, "*Doctoring in an age of data - the future for medical practice*". As an academic lawyer, he specialised in planning, property and environmental law. Professor Grant is also the ASC Visitor for the Medico-Legal section and will deliver the James Pryor Memorial Lecture scheduled for Thursday 9 May.

In keeping with the theme of *The Complete Surgeon*, the ASC will be opened with a 'generalism' plenary session on Tuesday 7 May. Professor Richard Murray from Townsville, with a national and international profile in rural medicine education, will speak on training and educating generalists while Mr Andrew Connolly, current Chair of the Medical Council New Zealand (MCNZ) will speak from a regulator's perspective.

The scope will be broadened, examining essential emergency surgical care initiatives on a global stage with a Global Health plenary on Wednesday morning. Dr Mark Jacobs, the Director for Communicable Diseases and current Acting Director for Programme Management at World Health Organisation (WHO) for Western Pacific region, will provide the WHO standpoint. Mr Mark Moore, well-known and respected by his patients and peers alike will share his experience on global outreach, and Dr Lay Hooi Lim from Penang will speak on securing global assistance to build a surgical service.

Four esteemed speakers will present on diversity in the Thursday plenary session. Professor Papaarangi Reid will utilise her research interest on analysing disparities between indigenous and non-indigenous citizens to provide a viewpoint on ethnicity. Air Vice-Marshal Tracy Smart from the Royal Australian Air Force (RAAF) will discuss LGBT in the defence force and Dr Nicola Dean will provide insight on why diversity is important.

Professor Paul Bo-San Lai, President of the College of Surgeons of Hong Kong will deliver the 2019 President's Lecture titled, "*Beyond core competencies of surgical training – the STEPWISE approach*".

On Friday 10 May, the 'Future Horizon' plenary session presents cutting edge research and innovation that could change the course of surgery and medicine. Dr James Kirkland, from Mayo Clinic, who has focused his research on the impact of cellular aging, will deliver the British Journal of Surgery (BJS) Lecture. Dr Swee Tan, the Founder and Executive Director of Gillies McIndoe Research Institute, will speak on the progress of cancer research.

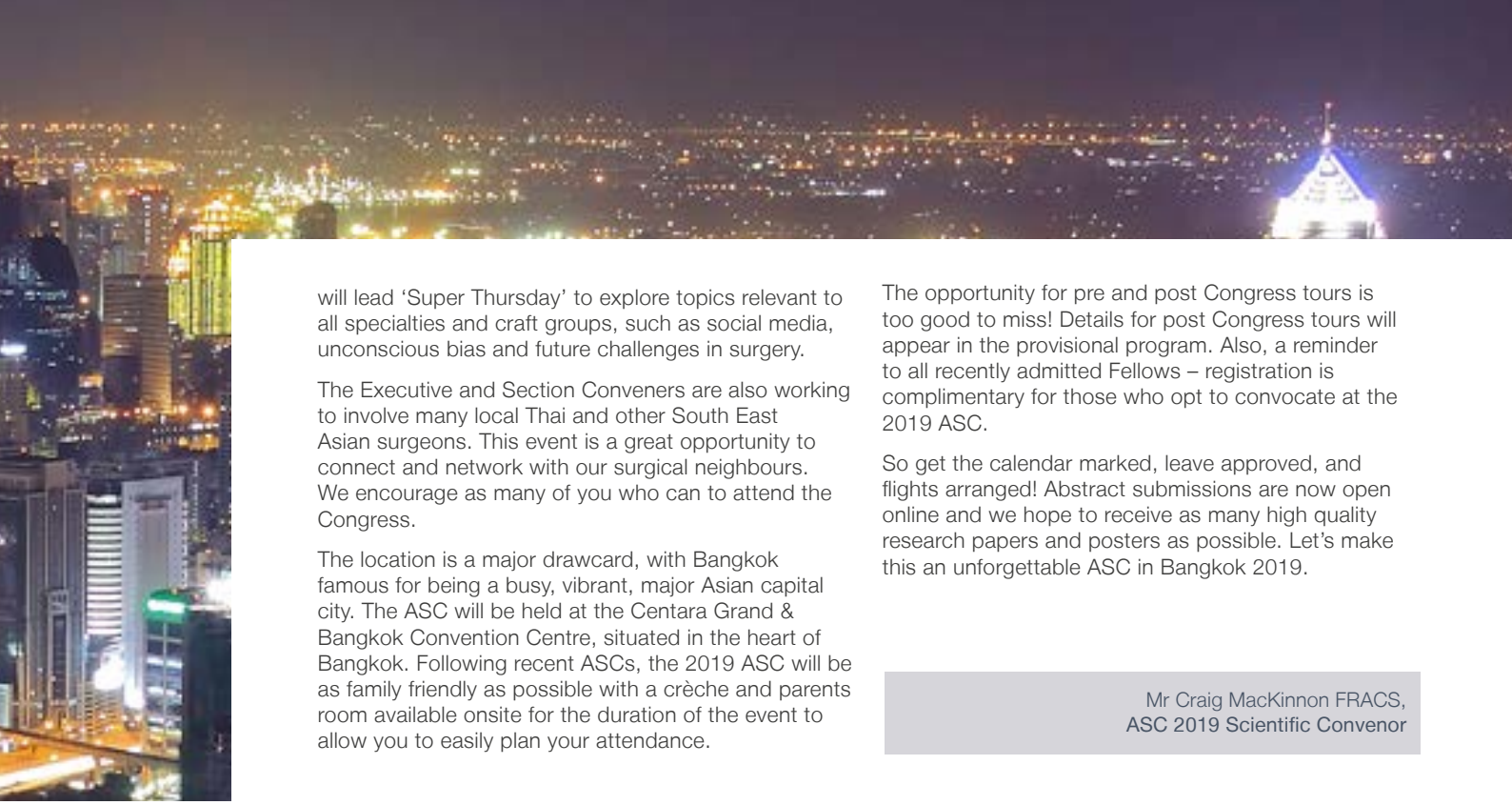
These invited speakers are renowned leaders in their fields and will contribute to various sessions throughout the week.

A new feature, '*The President's Town Hall*', a concept which was explored in 2018 is now included in the 2019 program, and scheduled for Friday 10 May from 12 noon to 12:30pm. The session is intended for delegates to voice opinions and pose questions to the RACS President.

A wide range of scientific topics will also be covered at this ASC with combined sessions on amputation, benign thyroid disease and biliary challenges, just to name a few.

For 2019, the Otolaryngology Head & Neck group (which replaced the original Head & Neck section) will participate in the ASC. Speciality subjects including otology, rhinology, paediatric otolaryngology and head and neck surgery will feature in the section program.

The Pain Medicine section has organised combined sessions with orthopaedic surgery to investigate acute and chronic back pain. The Women in Surgery section



will lead ‘Super Thursday’ to explore topics relevant to all specialties and craft groups, such as social media, unconscious bias and future challenges in surgery.

The Executive and Section Conveners are also working to involve many local Thai and other South East Asian surgeons. This event is a great opportunity to connect and network with our surgical neighbours. We encourage as many of you who can to attend the Congress.

The location is a major drawcard, with Bangkok famous for being a busy, vibrant, major Asian capital city. The ASC will be held at the Centara Grand & Bangkok Convention Centre, situated in the heart of Bangkok. Following recent ASCs, the 2019 ASC will be as family friendly as possible with a crèche and parents room available onsite for the duration of the event to allow you to easily plan your attendance.

The opportunity for pre and post Congress tours is too good to miss! Details for post Congress tours will appear in the provisional program. Also, a reminder to all recently admitted Fellows – registration is complimentary for those who opt to convocate at the 2019 ASC.

So get the calendar marked, leave approved, and flights arranged! Abstract submissions are now open online and we hope to receive as many high quality research papers and posters as possible. Let’s make this an unforgettable ASC in Bangkok 2019.

Mr Craig MacKinnon FRACS,
ASC 2019 Scientific Convenor

Audit functionality... MALT has it covered

Did you know you that RACS can facilitate and support your audit needs?

The College is a leading advocate for surgical audit. It is a key part of the annual Continuing Professional Development cycle.

MALT, the College’s online logbook tool offers a peer-review feature to help make conducting an audit easier. MALT also offers self-audit functionality, providing data collection, exporting and reporting features.

Why use MALT for peer-review audit?

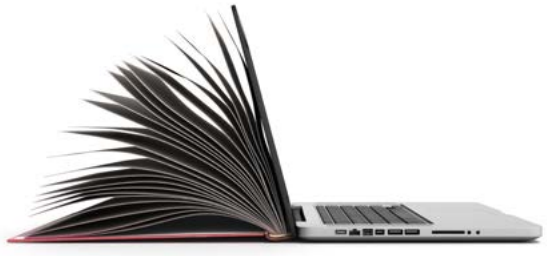
- Surgeons without access to local audit activities can use MALT as a peer review tool
- Audit groups can be set up to include anyone with a MALT account, regardless of specialty, member type (Fellow, Trainee, IMG, JDoc) or location
- MALT provides the data points recommended in the College's Surgical Audit and Peer Review Guide (PDF)
- Procedures are coded using SNOMED CT-AU terminology, meaning data is comparable internationally.

MALT audit reporting

A suite of reports allow easy comparison of outcomes whether you use MALT in a peer review audit group or for self-reflection with the self-audit reports.

Surgical outcome reports are available for:

- complications
- mortality



- return to theatre
- unplanned ICU admissions
- unplanned readmissions.

The reporting suite can assist in facilitating your Mortality and Morbidity meetings by allowing you to:

- share de-identified, tabulated information
- undertake basic risk adjustment
- compare your surgical results with the aggregate
- compare performance and identify outliers with funnel plot reports.

Want to know more?

If you would like to find out if MALT audit functionality can assist you, please contact the MALT Helpdesk on +61 8 8219 0939 or submit an Expression of Interest form.

Respectful and effective communication with patients key to positive outcomes

Professor Gerald Hickson

Surgeons who are frequently reported for being rude or disrespectful have higher rates of surgical site infections and other avoidable complications, a study of more than 800 surgeons has found.

The research conducted by the Center for Patient and Professional Advocacy at Vanderbilt University Medical Center, USA is the most comprehensive to date on the connection between a surgeon's behaviour towards their patients and colleagues, and their patients' outcomes.

One of the authors, Professor Gerald Hickson, said the findings showed that having excellent technical skills alone is not enough to be a good surgeon and that unprofessional behaviour, including bullying and harassment, undermines a team's performance.

The world leading expert on clinician behaviour and patient safety outlined the findings to RACS Fellows during a visit to Australia in October.

The study, published in *JAMA Surgery*, examined de-identified data from the National Surgical Quality Improvement Program for 32,125 patients having surgery at one of seven hospitals. The outcome data was then correlated with patient and family complaints of unprofessional behaviour by surgeons reported to patient relations officers during the two years prior to the studied surgical procedures.

Unprofessional behaviour included anything that might intimidate or deter communication such as surgeons rudely shutting down questions from family members or humiliating another staff member in front of others.

Complications included surgical site infections, pneumonia, renal conditions, stroke, cardiovascular conditions, thromboembolic conditions, sepsis and urinary tract infections.

The study adjusted for several patient, surgeon and operative factors known to increase the risk of adverse

events, such as case urgency and whether patients already had contaminated wounds.

It found that patients receiving care from surgeons who had the highest number of patient complaints (14-60 in the previous two years) experienced nearly 14 per cent more surgical and medical complications in the 30 days following procedures than patients treated by surgeons with lower numbers of complaints or none at all. For all surgeons included in the study, the average number of complaints over two years was 10.

Professor Hickson said while a 14 per cent difference between patients cared for by the most respectful and least respectful surgeons might seem small, if you model those numbers across the US, it could account for more than 350,000 preventable complications.

"This goes to the issue of team work," he said.

"At the end of the day, you have to question if other members of the surgical team are paying attention to their job or living in fear of the surgeon being disrespectful to them."

The research builds on other studies that have shown rude and intimidating behaviour in medical teams is associated with less communication and lower performance. An Israeli study published in 2015 reported that when intensive care unit teams were exposed to mildly rude comments during training simulations, their diagnostic and procedural performance deteriorated.

Professor Hickson said research demonstrating the connection between unprofessional conduct and adverse events for patients was mounting, with another large study from his team soon to be published on staff complaints about clinicians and patient safety. He said unprofessional conduct included discrimination, bullying and harassment, but also low value care such as performing operations unlikely to benefit a patient. He said surgeons in the top two per cent for productivity were also more likely to have higher complication rates and attract more law suits.

While the "*Me Too*" movement has led to scores of powerful people being publicly punished for misconduct in recent years, Professor Hickson said empowering people to speak up is not enough to bring about meaningful culture change in medicine. If surgeons want to be on the right side of history, he said they need to model the right behaviour themselves, understand the research on this topic, and advocate for effective systems to address poor behaviour swiftly. Otherwise, he said, you create moral distress for those raising concerns because they don't see anything happening.

The Vanderbilt model, which is now used by more than 140 hospitals in the US, has demonstrated that if an organisation listens to and documents patient and staff concerns about clinicians in real-time, they can identify at-risk physicians and intervene within 48 hours to discuss it with that physician.

Professor Gerald Hickson at RACS, Melbourne

Professor Hickson said the system highlighted that the vast majority of physicians behave professionally because it produced patterns of reports for only two to four per cent of physicians. Eighty per cent change their behaviour when alerted to the problem, leaving about one per cent who don't respond.

"If they're directed by authority to change, that goes down to 0.4 per cent who are unwilling or unable to change. Included in this group are people who may have illnesses affecting their performance," he said.

"The vast majority of our team members do good work and most are professional… but the behaviour of a few needs to be appropriately addressed."

Professor Hickson is the International Visitor for the 2019 ASC Surgical Directors Program in Bangkok.

Julia Medew
Surgical News journalist

The benefits of intermittent fasting

Two years ago I came across a former colleague, Dr X Pande who had grown from being a fit, athletic, rugby player into an obese late-middle aged, glucose intolerant, insulin resistant, 'big man' over a period of 25 years. Recently, I met Dr X Pande again and I was surprised to find a distinct resemblance to the physique of his former years. He saw my surprise at his size, so explained how he had restored his shape through regular, 16-hour daily fasting. He was in no way starving, he was rejuvenated! His reformed eating patterns were promoting autophagy.

Autophagy is not a mentally deranged, self-mutilating blood sport but a normal homeostatic process, designed to benefit the autophagist. The term, autophagy, was first coined in 1963 by Christian de Duve, a Belgian, but really hit the medical headlines in 2016, when the Nobel Prize in physiology or medicine, was awarded to Japanese researcher, Yoshinori Ohsumi, for his work on the topic. It describes a process whereby cells in response to temporary starvation autolyse damaged organelles and recycle their components to revitalise or rejuvenate. The damaged parts and unwanted proteins are shipped through the cytoplasm to lysosomes for dismantling and recycling.

Autophagy is currently being investigated for its many potential benefits in weight loss, rejuvenation, diabetes, chronic renal insufficiency, cancer therapy, Alzheimer's and Parkinson's disease.

For example, intermittent fasting reduces oxidative stress, is anti-inflammatory, and benefits the microbiome (at least in animal studies). Intermittent fasting regimens such as the 5:2 diet, 16-hour fasting and alternate day fasting, improve blood lipid profiles, insulin sensitivity, and blood glucose metabolism. For adherents the results are actually quite rapid, but further randomised clinical trials in humans are awaited.

Intermittent fasting, or energy restriction certainly addresses overweight. This will benefit all of you who were once slim, but are now overweight and worried about your body mass index (BMI) trajectory to obesity. Given the evidence of metabolic improvements from autophagy, one expects a similar benefit in humans. Polyphenol rich diets also enhance autophagy as well as benefit the gut microbiome.

Alzheimer's disease is a proteinopathy in which hyperphosphorylated Tau and amyloid accumulate in the brain. Elimination of these nasties through lysosomal digestion is to be encouraged. One possible mechanism that the Mediterranean Diet and polyphenols, such as oleuropein aglycone (OLE) in extra virgin olive oil, manages to decrease aggregations and improves cognition is through activation of autophagy gene expression.

Chronic renal disease and renal injury mechanisms are enhanced by inhibiting autophagy but for those whose kidneys are damaged or ageing, promoting autophagy through intermittent fasting is likely only to be beneficial. Similarly, with your hepatocytes. In the skin, autophagy has been described as a 'homeostatic rheostat, that works tirelessly to uphold the delicate balance in immunoregulation and tolerance'. Healthier skin would undoubtedly be attractive to many of us, myself included.

Autophagy failure is one of the main reasons aged, decrepit cells accumulate, rather than being replaced. When this happens we age. We need, at the subcellular level, to clear out our junky proteins, and discard malfunctioning organelles. Hormonally, fasting results in glucagon levels rising while insulin levels fall. Hyperinsulaemia promotes obesity as well as inflammation. Glucagon does the reverse. At a tissue or organ level autophagy generates healthier skin, better cognitive function, maintains kidney function, glucose homeostasis, and even undoes or at least halts life-threatening atherosclerosis.

So as you ponder your health at the end of the year, consider the potential benefits of intermittent fasting. One option is to eat for eight hours a day with a 16-hour fast. This promotes autophagy without too much pain, just the rearrangement of when you eat. Or adopt the 5:2 diet that has you eat what you like for five days then restricts your to two days with only 600 kcals. I'm not suggesting you take the option of spending a week fasting in a monastery, but going without, at least for a short while, will help you, like Dr X Pande, 'go' longer. Christmas feasting is on the horizon so, in preparation, some fasting would not go amiss.

DR BB-G-LOVED

Operating with Respect

RACS was thrown into the limelight in 2015 with widespread media stories about a culture of bullying and sexual harrassment. For many Trainees this was not breaking news but a basic, unspoken truth. RACS responded, establishing an Expert Advisory Group that investigated the extent of the problem and produced a detailed report. The findings were published in the *ANZ Journal of Surgery*, concluding "Discrimination, bullying and sexual harassment are common in surgical practice and training in Australia and New Zealand. RACS needs to urgently address these behaviours in surgery."

And so, Operating with Respect (OWR) was born.

RACSTA has been a keen supporter of OWR from its inception. The 2016/17 RACSTA Support and Advocacy member, Dr Stewart Morrison, took on the role of RACSTA representative on the OWR education committee. Dr Morrison played an integral part in the development of both the online module and the face-to-face course for surgical supervisors. OWR Chair Dr Adrian Anthony has maintained regular communication with RACSTA and sought feedback throughout the development of the course.

In early 2017 the first OWR face-to-face pilot courses were undertaken. Members of the RACSTA committee were invited to observe the course and provide feedback on content, delivery and relevance to surgical training. Since then the course has been rolled out across Australia and New Zealand.

At the start of 2018 I took over the role of RACSTA representative on the OWR committee. I have been genuinely in awe of this group of surgeons who dedicate so much of their own time, not only to running and facilitating these courses, but also to reviewing feedback and continually working to improve the course. They are passionate about achieving culture change in our profession. They are realistic; this course is not the whole answer. OWR encourages reflection on how words or actions may be perceived by others. It provides surgeons with strategies for recognising and changing their own negative behaviours, and those of their colleagues.

Participants are asked to provide feedback at the end of the course. For the most part, this is extremely positive. Many participants make comment as to how valuable they have found the course, in particular sessions around 'speaking up'. Some make suggestions as to areas they think could be improved. This is evidence to the fact that surgeons are taking OWR seriously and demonstrates support of culture change. I have attended the course as an observer and found it encouraging that participants were so engaged in the discussions. The faculty was enthusiastic and insightful, qualities that are often acknowledged in the feedback.

Going forward, it will be important for RACS to gauge the impact that OWR is having on bullying, harassment and discrimination in surgery. RACS is preparing a framework to assess this in the medium and long-term. 'Bullying, harassment and discrimination' is one of the domains in the RACSTA end-of-term survey, which all Trainees are asked to complete at the end of each six month rotation. This will be a useful measure for RACSTA to assess the impact that OWR is having on Trainees.

It is important that supervisors do not become scared to provide feedback to Trainees for fear it may be perceived as bullying. As a Trainee, receiving feedback is essential for development into a competent surgeon thus having implications for patient safety. While praise is pleasing to receive, constructive criticism is invaluable. Providing this 'negative' feedback is far more challenging and, therefore, some shy away from giving it. This can have a detrimental effect on a Trainee's progress, and to the safety of patients. The Foundation Skills for Surgical Educators (FSSE) course is part of the RACS OWR initiative and addresses these issues. The responsibility also lies with the Trainee, and feedback should be actively sought.

Eradicating bullying and harassment is much like weight loss. It doesn't happen overnight. To achieve success there's no point fad dieting. It's about a lifestyle change, acknowledging that we're going to make a few mistakes along the way. Not everyone is starting from the same baseline. But if we work together we can get there in the end. The problem is not confined to surgery, it permeates healthcare. RACS has pioneered a plan for change and hopefully our colleagues will follow suit. We should all be proud to be part of the revolution.

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Dr Imogen Ibbett
RACSTA Representative,
Operating with Respect Committee

International expertise to inspire and impress at 2019 ASOHNS ASM

Dr Karen Zur

Dr Carole Fakhry

Two high profile female surgeons from the US will be presenting at the Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) Annual Scientific Meeting in Brisbane in March 2019.

Associate Professor Carole Fakhry, Head and Neck Surgeon and Dr Karen Zur, paediatric ENT surgeon are sponsored by the RACS Visitor Grant Program. They will present on many aspects of the OHN surgical specialty, and will join Dr Nikki Stamp at the Women in Otolaryngology breakfast on Saturday 23 March 2019.

During the ASM, Dr Fakhry will present session topics including 'HPV – Role and prevention in SCC' and Prognostic groups in 'HPV-positive oropharynx cancers'.

Dr Zur will participate in the pre-meeting Paediatric ENT Airway workshop as well as present 'Recurrent laryngeal nerve reinnervation: a new approach for managing dysphonia and aspiration, Laryngeal Papillomatosis and Management of bilateral vocal cord palsy'.

Dr Fakhry serves as Associate Professor in the Department of Otolaryngology Head and Neck Surgery at Johns Hopkins University. She also has appointments in the Johns Hopkins Sidney Kimmel Cancer Center Department of Oncology and the Johns Hopkins Bloomberg School of Public Health Department of Epidemiology. She serves as Director of the Fellowship in Head and Neck Surgical Oncology and Co-director of the Head and Neck program in Bloomberg-Kimmel Immunotherapy.

Her clinical and research interests include determining the prognostic significance of human papillomavirus in head and neck cancers, understanding the changing landscape of head and neck cancer, oral HPV natural history, and innovative mechanisms for the screening and early discovery of oropharyngeal cancers. She also serves as Associate Editor for Oral Oncology, Science Advisory Board Member for the Oral Cancer Foundation, and participates in various peer review activities.

Dr Karen Zur is the Director of the Voice Program and Associate Director of the Center for Peadiatric Airway Disorders at the Children's Hospital of Philadelphia. She is Associate Professor of Otolaryngology: Head and Neck Surgery at Perelman School of Medicine at the University of Pennsylvania. She completed her undergraduate studies at Yale University and obtained a medical degree at Albert Einstein College of Medicine. Her residency in Otolaryngology: Head and Neck Surgery took place at Mt Sinai Hospital in New York City, and she pursued a subspecialty in paediatric otolaryngology at Cincinnati Children's Hospital. Dr Zur's research interests include paediatric voice, airway and swallowing dysfunction.

For further information and to register, please visit: http://asm.asohns.org.au

Lorna Watson,
CEO, ASOHNS

Surgery Volumes and Outcomes in Pancreaticoduodenectomy

Over the past two years, the Royal Australasian College of Surgeons (RACS) has collaborated with Medibank on a series of reports on surgical variation in Australian clinical practice. Inspired by these reports, RACS and Medibank undertook reviews into the evidence supporting hernia repair and rehabilitation after hip and knee arthroplasty. The reports have been disseminated across the surgical community, and the research findings were also published in *Surgical News*, with positive feedback received.

As a part of the ongoing collaboration between RACS and Medibank on surgical variation, the next topic selected for review is the impact of surgical volume on the clinical outcomes of pancreaticoduodenectomy (PD), also known as the Whipple procedure.

The Whipple procedure is a challenging and complex surgical operation, primarily undertaken with curative intent for peripapillary pancreatic tumours. In addition to the relatively poor prognosis of pancreatic cancer, the Whipple procedure has traditionally been associated with high operative morbidity and mortality.

Significant variation in clinical outcomes has been observed when the Whipple procedure is performed in low volume centres. Queensland Health investigated the impact of hospital volume on outcomes, with those centres performing less than three procedures per year having significantly greater variation in clinical outcomes.[1] In Western Australia, the Health Department mandated that all pancreatic surgeries be performed at one of two metropolitan cancer centres to optimise surgical volume for both the surgical team and the centre.[2, 3]

The association between surgical volume and clinical outcomes has been a trending topic for the past two decades. Debate exists around whether there should be an absolute volume threshold to qualify hospitals to perform complex operations like the Whipple procedure. This has led to discussion around surgical service regionalisation and centralisation.

Procedural volume is influenced by numerous factors, as are clinical outcomes following Whipple procedures. The research questions of our review will focus on the effect of surgical volume as an independent factor towards clinical outcomes of the Whipple procedure, under different clinical settings. We will also identify initiatives for improving surgical outcomes under low and high volume settings, as well as levers and barriers to mitigate variations in Whipple surgery to promote current best practice.

To ensure that our results are contextually relevant, the review will be informed by a working group of representatives made up of RACS Fellows and Medibank. The results and recommendations will be published on the RACS website and disseminated through *Surgical News* and other platforms.

The review will be completed in December 2018, so stay tuned for the results in the January-February edition of *Surgical News*.

For further information please visit:

http://www.surgeons.org/policies-publications/publications/surgical-variance-reports/, www.surgeons.org/HTA

Or contact college.asernip@surgeons.org

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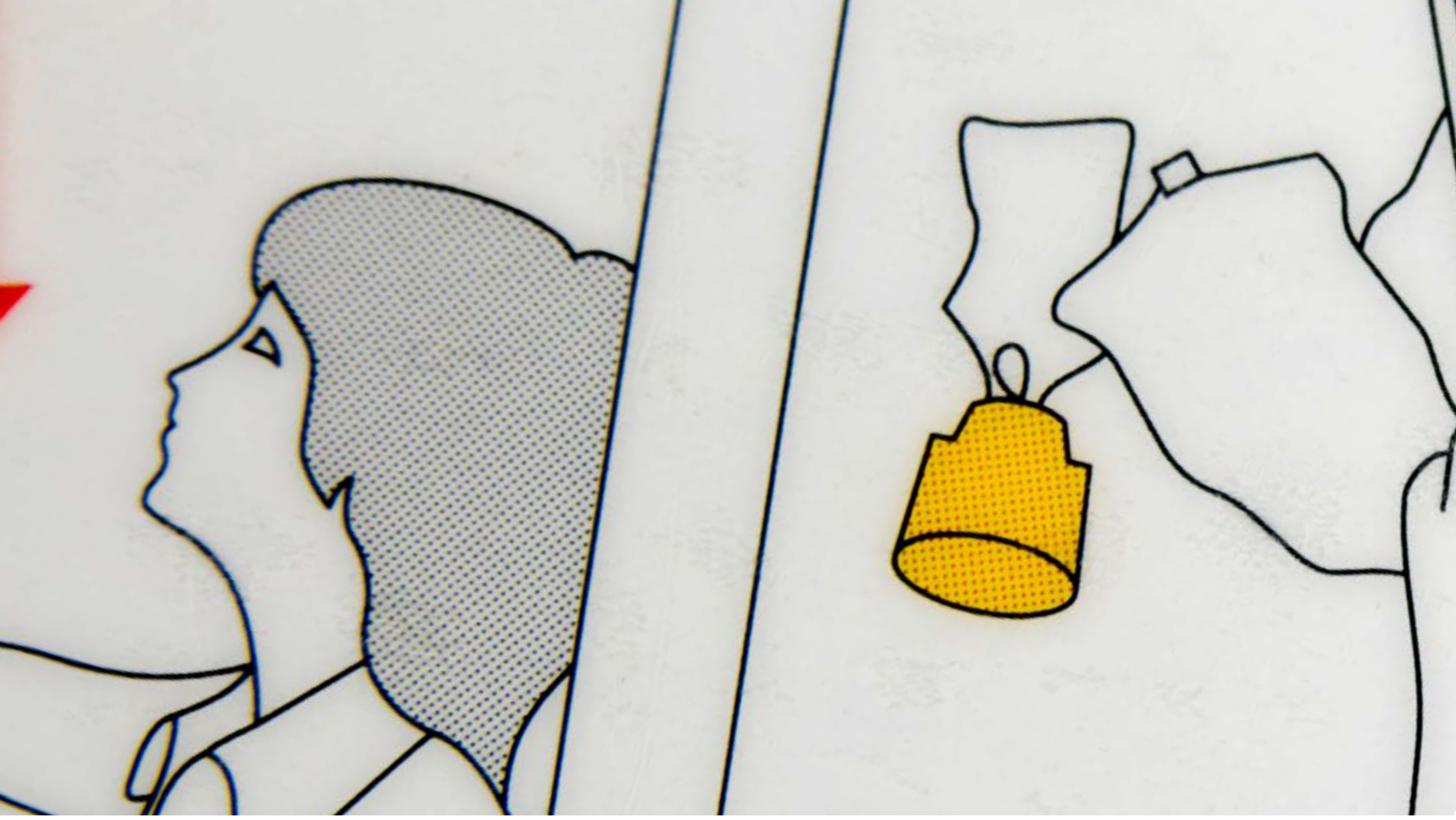
Professor Guy Maddern
Surgical Director of Research and Evaluation incorporating ASERNIP-s



Put on your mask first

As frequent flyers, many of us will be able to recite the safety briefing routinely broadcast at the start of every flight. Part of that briefing goes: “In the unlikely event of an emergency, oxygen masks will drop from the panel above you. Put on your oxygen mask first before assisting others.” The practical and critical reason is that if you don’t get your own oxygen first, you will not be able to help others. In the unlikely event of an in-flight emergency, you need to help yourself before helping others. Similarly, in the likely event of routine regular excessive surgical demands, we too need to put on our own oxygen masks first before helping others.

As surgeons, we took the oath to place our patients' needs as priority. This is often done at the expense of our own health. The RACS Fellowship pledge begins with “I pledge to always act in the best interests of my patients”. This is certainly a noble pledge that underpins all of our motives, but it can also be detrimental to our own health when we repeatedly pursue excellence and perfection for our patients at the expense of family and our own physical and mental health. In our pursuit of the best interests of our patients sometimes unwisely we neglect our own. As a byproduct of our training we put on the oxygen masks for others first. Could this be one of the reasons many of us are struggling to give our best to our patients? Could it be that many of us are struggling with emotional exhaustion, inefficiency, cynicism, and burnout because we have forgotten to put on our oxygen mask first?

The World Medical Association Declaration of Geneva for the first time in 2017 included self-care as a critical part of being a doctor. The Physician’s Pledge begins with the same noble standards: “As a member of the Medical Profession, I solemnly pledge to dedicate my life to the service of humanity.” But further down it adds: “I will attend to my own health, wellbeing, and abilities in order to provide care of the highest standard.” This is a small step but a big leap in terms of thinking about how we care for ourselves and each other. Put on your mask first.

What’s your oxygen mask? Many surgeons are already doing this well: painting, sculpting, wine-making, travelling, bike-riding, running, triathlon, music, writing, etc. Many surgeons are well and truly gifted and accomplished in non-surgical arenas. What is done as a rejuvenating hobby outside of the operating theatre and the wards fuel the passion and excitement for the work done within them. Various techniques of self-care have been shown to be beneficial in improving doctors' well-being so that we can provide care for our patients[1]. Doctors who find value in what they do are less likely to have symptoms of burnout. Physicians who spend 20 per cent of their time on the aspect of their job that they find most meaningful have a significantly higher job satisfaction rate. Intrinsic motivators (meaning, personal philosophy of practice, commitment to medicine) were found to play a large role in career and life satisfaction compared with external motivators (e.g income and work hours). Self-reflection with journaling or small groups that discuss difficult and traumatic situations without judgment are beneficial. Physical exercise, emotional and cognitive resilience training, mindfulness meditation and Cognitive Behavioural Therapy have all been shown to improve doctor’s wellbeing1. In addition to finding institutional solutions to institutional problems[2], the evidence is clear that various self-care techniques are beneficial in reducing burnout, improving our mood, job satisfaction and engagement with work[1]. For many of us, having a GP, mental health professional, coach or mentor

is a necessary, if not a critical lifeline. RACS strongly encourages all Fellows to regularly engage with a GP. We know that those self-care methods work. We just need to do it.

Now that we have put on our own masks first, how do we assist others with their masks? It's enshrined in our Fellowship Pledge: "I will be respectful of my colleagues, and readily offer them my assistance and support." How do we practically do that? In the elective routine day-to-day activities, we need to continue to provide safe spaces for social engagement. As modern surgery demands longer and flexible hours, less time is available to us to connect with our colleagues. The busier we are the further we are travelling from each other. The loss of doctors' lounges and departmental offices have also meant that traditional safe spaces for social connections have disappeared. Carving out a safe space or time to recreate social connections would be beneficial. A Post-MDT Meeting coffee, a cake break during clinic, fortnightly departmental drinks, an early birds breakfast before grand rounds, and reclaiming a social space for chats are all possible interventions that any surgical department can introduce. Studies have shown doctors who set aside time to cultivate meaningful relationships are more fulfilled and engaged[3]. Building a regular departmental social support in the elective will prepare you for the emergency.

How do you render emergency assistance to a colleague who is struggling? The R U OK website[4] has good simple advice on how to start a conversation. It is highly recommended. They suggest four simple steps: Ask, Listen, Encourage Action and Check in. Before asking, think about your own headspace and readiness. You may not be the right person at the right time to do it. If you feel ready, know that you should not intend on 'fixing' someone else's problems. Choose a safe time and space for that question, then listen without judgement. Thirdly, encourage action by providing options for connecting with professional support or assisting the colleague to find their own practical solutions. Finally, check in after a few days to ensure that your colleague is safe and well. Being aware of these simple steps is in effect helping your colleague with their oxygen mask. Each time a colleague helps me with my mask, I become more engaged as a surgeon and my patients benefit. Ultimately, we are not mental health professionals. Your colleague may need a formal therapeutic relationship with a professional. Our role as colleagues is to render assistance and to be a bridge to that formal support.

Just as first aid proficiency is part of medical competence, there are formal skills on providing Mental Health First Aid in emergencies. Mental Health First Aid Australia[5] is an organization that provides courses readily available in every state in Australia on developing these skills. They're evidence based courses developed by the University of Melbourne's Population Mental Health Group. One in five of us suffer from a mental health condition. Therefore it is proper that we upskill ourselves in the area of providing first aid in mental health emergencies.

In the likely event of excessive surgical demand, we need to remember to put on our own oxygen masks first before assisting others. Once we have put on our masks, we are then better able to offer assistance to our colleagues through elective social support or urgent compassionate assistance if so required. It's part of being a Fellowship.

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Dr Eric Levi
FRACS

Broadening services to support diversity

Dr Rachel Care

An update of policies and procedures surrounding disability services including assessment and examinations is important if we are to truly embrace diversity, according to the Chair of the RACS Trainees' Association (RACSTA).

Dr Rachel Care became a Fellow of the College in September and currently works as an ENT surgeon at Christchurch Hospital, New Zealand.

She is a co-opted Councilor of the College, the RACSTA Representative on the Women in Surgery Committee and is currently completing a master's degree in Surgical education.

She also suffers from dyslexia, a neurobiological disorder that makes it difficult to recognise letters and word patterns which in turn creates challenges in reading and other language-based tasks such as writing and spelling.

Believed to be an hereditary condition, dyslexia affects over 10 per cent of the Australasian population.

Dr Care said that while many people with the condition were highly intelligent with an increased capacity for lateral thinking, many had struggled academically, particularly in the decades before dyslexia was fully understood.

She said that while there was now a much greater understanding of the disorder - with support offered in schools and universities to help people with dyslexia to flourish alongside their peers - some educational institutions had not kept pace with the research.

Dr Care said it was time for RACS to undertake a review of its disability services based on the procedures introduced by tertiary institutions to accommodate the specific educational needs of those with a learning disability.

"Dyslexia is a neurobiological disability that occurs along a spectrum from mild to severe," she said.

"People with the disorder find fluent word recognition and decoding more difficult and often have an inability to break down multi-syllable words into their component parts.

"Once we have a diagnosis, however, we often work with educational psychologists and educational support workers to develop strategies to overcome the difficulties we face particularly in reading and writing."

Dr Care said such strategies included:

- Receiving oral instruction and teaching rather than written texts;
- Having the assistance of educational support workers to help translate and decode complex text and implement novel learning strategies;

- Working on computers rather than with pen and paper to help with writing and spelling;
- Using coloured paper or coloured glasses for those who have difficulty reading black words on a white background.
- Being given extra time during exams to accommodate the need to read a text several times to fully comprehend its meaning; and
- Sitting examinations alone to limit distractions;

Dr Care said that while dyslexia had not affected her practical surgical training, given the verbal communication and manual aspects of training, it had made the written components of exams challenging.

Having sat her final Fellowship exam three times before her success this year, she said she applied for assistance from the College to accommodate her learning disability during the examination but that current policies and procedures made that difficult.

She said the time had come for RACS to update those policies and services it provides if it was to fully embrace diversity within the profession.

"People with dyslexia can be very intelligent, very creative and are particularly good in areas including science, maths and engineering," she said.

"Throughout my training I had no difficulty in the manual tasks required in theatre, communication with patients or with diagnosis and pattern recognition, but major obstacles I faced were the written components of the basic exams and the Fellowship exam.

"It was very daunting to keep pursuing my aim of becoming a Fellow of the College because there is very little understanding of dyslexia within RACS and there were times when I felt like I wasn't going to make it, which was very demoralising after so many years of training.

"Finally, however, I received assistance from a former Examiner who helped me understand how to decode the questions and structure my answers to include everything required.

"It is sometimes difficult for people to understand that while I have the skills and knowledge required to be an Otolaryngologist, I simply have difficulty reading, writing and decoding questions to provide fluent answers under exam pressure."

Dr Care said the difficulties she had faced in finding support to pass her exams had made her determined to lead change so that others with learning disabilities did not face the same barriers.

She said she believed more people with learning disabilities would be pursuing a career in surgery given that they could now access the support needed at school and university to pass their Bachelor of Medicine degree.

It was vital for the College to review and update its policies and procedures surrounding disabilities to accommodate their needs, she said.

"We have prioritised diversity as a core ambition of modern surgery and we have made great strides in encouraging and supporting women and Indigenous people to enter the profession," Dr Care said.

"Developing support and special circumstances provisions for those with a diagnosis of dyslexia or other learning disorders will further allow us to truly reflect the broader community.

"This will not require the College to re-invent the wheel because a great deal of work and research has already been done in the tertiary sector to accommodate the needs of people with learning disabilities.

"If the College can start with disabilities like mine, we could then go on to work out how to accommodate those with other disabilities and then we will truly reflect the community we serve."

Dr Care said that there remained a stigma attached to dyslexia caused by a lack of understanding.

"People with dyslexia are not stupid or lazy and are not asking for special consideration to make up for a lack of intelligence," she said.

"It is well understood in research literature that people with dyslexia have brains that work differently, and I think this should be embraced by our profession.

"Some of the greatest minds in history had dyslexia and that ability to think outside the box, to innovate and offer unique insights through the working of different neurobiology should be celebrated."

Karen Murphy
Surgical News journalist

Managing infections no longer as simple as selecting another antibiotic

Surgical site infection is a potential risk of surgery that needs to be managed effectively as part of good patient care. The advent of antibiotics in the 20th century and their associated use as surgical antibiotic prophylaxis, often along with other interventions such as oxygenation, glycaemic control and surgical anti-sepsis and advances in practice, has enabled us to minimise this procedural burden. However, the march of antimicrobial resistance across the globe is limiting the ability of the antibiotics we have at our disposal to provide safe and effective care for our patients.

Many current infections are no longer responsive to first line antibiotic choices. The overuse and misuse of antibiotics, wherever this occurs, impacts the efficacy of surgical antibiotic prophylaxis. This, compounded by the decreased antibiotic development pipeline, means managing infections is no longer as simple as just selecting another antibiotic.

Complex infections are now being treated with more toxic, costly and complicated regimens than in the past, due to the reality of antimicrobial resistance. This creates additional risks for our patients, including adverse outcomes from the antibiotic choices and increased length of stay due to a paucity of oral therapeutic choices. Patients with unnecessary exposure to long courses of antibiotic prophylaxis are also at higher risk of morbidity and mortality if they develop an infection, as it is more likely the organism will be resistant.

The Australian Commission on Safety and Quality in Health Care coordinates the Antimicrobial Use and Resistance in Australia (AURA) program which provides a platform for voluntary standardised audits of surgical prophylaxis within the Hospital National Antimicrobial Prescribing Survey (NAPS) framework. Data from participating hospitals in 2017 demonstrates that 30.5 per cent of surgical prophylaxis prescriptions for inpatients extended 24 hours beyond the time of surgery. This is despite guidelines generally recommending surgical prophylaxis durations of less than 24 hours. Commonly, surgical antibiotic prophylaxis was found to be too broad or too narrow for the likely organisms; were inconsistent with guidelines (with no indication of patient characteristics that would require variation), or the wrong dose was prescribed.

In reality, variation in surgical antibiotic prophylaxis prescription is often because of our own individual prophylaxis preferences. There may be the perception of reduced adverse outcome with longer and broader spectrum intravenous courses, and topical or deep surgical site administration has been reported. Despite evidence to the contrary, some of these perceptions remain.[1,2] The documented increased healthcare-associated complications of prolonged or novel intra-operative antibiotic use, also need to be considered, particularly where the evidence base for alternative practices is poor. As antibiotic prophylaxis is important in reducing complications for our patients, attention should be paid to relative benefits of these considerations.

Process issues still account for many variations from guidelines-based practice. Improved standardisation could harmonise our practice towards more consistent and reliable delivery of antibiotic prophylaxis. There are many opportunities for improvement including:

- Consistency in documentation of fixed antibiotic duration
- Development and adherence to evidence or consensus-based guidelines
- Optimising administration timing for optimal concentration during the procedure.

Simple changes such as elevating the importance of correct surgical antimicrobial prophylaxis for every procedure, rather than as a peripheral consideration to the surgery at hand, could also increase consistent administration and improve choice practices. Clarity in the ownership of the choice of antibiotic between the anaesthetic and surgical specialties may aid in more consistent administration practices within organisations.[3]

Under the National Safety and Quality Health Service (NSQHS) Standards, every hospital is required to have a local antimicrobial stewardship program to optimise use of antimicrobials and improve the use of surgical antimicrobial prophylaxis within hospitals. They may also be able to facilitate peer group or individual audit and feedback procedures or dedicated quality improvement projects. We all want the same outcome - the provision of safe and effective care to our patients. To achieve this, we need to understand how to balance the risks and benefits of antimicrobial use by utilising specialty knowledge.

The Commission is working with RACS to provide you with resources to assist in this.

Visit the Commission web page and download a useful presentation and other resources to help you improve surgical antibiotic prophylaxis in your organisation.

1.Harbarth S, Samore MH, Lichtenberg D, Carmeli Y. Prolonged antibiotic prophylaxis after cardiovascular surgery and its effect on surgical site infections and antimicrobial resistance. Circulation. 2000 Jun 27;101(25):2916-21

2.Improvisation versus guideline concordance in surgical antibiotic prophylaxis: a qualitative study, Broom, J., Broom, A., Kirby, E. et al. Infection (2018) 46: 541).

3.Understanding antibiotic decision making in surgery-a qualitative analysis, Clinical Microbiology and Infection , Volume 23 , Issue 10 , 752 - 760, Charani, E. et al.

Dr Robert Herkes FRACS
Dr Bruce Hall FRACS
and Dr Jenny Chambers FRACS

Funding support for rural specialists

Now is the time for rural specialists to start thinking about future continuing professional development (CPD) activities that they may like to register for. The Support for Rural Specialists in Australia (SRSA) program Governing Committee have approved the key dates for Funding Round 4. They are as follows:

Application window	1 December 2018 to 31 March 2019
Assessment panel review	April 2019
Outcome letters distributed via email	May 2019
CPD activity completion window	1 June 2019 to 30 June 2020

Rural specialists who live and work in areas determined using the Modified Monash Model (MMM) system categories MM2 to MM7 are eligible to apply for grants of up to $10,000 (up to $2,000 per training day, up to five days) to support participation in CPD activities. Information on the remoteness classification of any town or community in Australia are provided through the Department of Health “Map Locator” via: http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator

CPD activities must be completed between 1 June 2019 and 30 June 2020.
The SRSA website for more information on how to apply, including the online application form and guidelines. Email contact: admin@ruralspecialist.org.au.

Rural surgery

Desire, confidence and generalism

(Left to right) David Fletcher, Councillor; Sally Butchers, Chair Rural Surgery Section; Richard Murray, President, Medical Deans Australia and New Zealand; Mary Harney, RACS CEO; John Batten, RACS President; Brian Kirkby, Rural Surgery Section; Paul Worley, National Rural Health Commissioner; Cathy Ferguson, RACS Vice President.

When Sally Butchers hears about traffic jams in major cities, she can't help feeling very happy about her decision to become a rural surgeon.

For the past decade, Dr Butchers has lived on 46 acres in Lismore near Byron Bay in northern New South Wales. From home, she can see a stretch of the Pacific Ocean, visited by whales from June to October every year. It takes her 15 minutes to drive to work at Lismore Base Hospital every day, and when she gets there, there's usually a list of diverse cases waiting to keep her on her toes.

The town is just the right size for Dr Butchers who says she started to love the lifestyle when she did some of her surgical training there before a two year stint in the UK. With a population of 27,000, she says Lismore has a good pool of doctors to support the community and if she needs advice from specialists who are not there, she can always call on colleagues in other cities.

"If I have an issue that I'm not capable of dealing with, I have a referral pattern of people I can use," she says.

But Dr Butchers, Chair of the RACS Rural Surgery Section, says there are not enough rural surgeons like her in Australia.

At the moment, about 30 per cent of Australians live in rural and remote locations and 14 per cent of RACS Fellows live and work in rural and remote locations. Another 34 per cent of Fellows who live in metropolitan cities spend some time visiting rural locations for work.

Last year, the shortage contributed to the Commonwealth Government asking Australia's first National Rural Health Commissioner Paul Worley to develop a rural generalist pathway so that GPs could learn more emergency medicine, anaesthesia, obstetrics and surgical skills.

While RACS can see value in this and is working with the Australian College of Rural and Remote Medicine on its curriculum review, it is also committed to supporting regional surgical generalism to ensure specialist surgeons provide more services where they are needed.

(Left to right) Damian Fry, RACSTA/Rural Surgery Section; Frank Piscioneri, ACT State Committee; Ken Loi, Chair, NSW State Committee; Sally Butchers, Chair, Rural Surgery Section; Brendan Murphy, Chief Medical Officer, Commonwealth ;Tom Bowles, WA State Committee; Bridget Clancy, Rural Surgery Section; Mahiban Thomas, Rural Surgery Section; Claire Langdon, Assistant Director, Workforce Planning and Capability, Victorian Department of Health and Human Services.

Following a summit on the topic in September, which was attended by Chief Medical Officer Brendan Murphy, Dr Butchers says RACS is looking at various ways to attract and retain rural surgeons. One way is to ensure that RACS is training surgeons who have a desire and confidence to work in rural and regional areas.

With the bulk of surgical training currently occurring in metropolitan centres, Dr Butchers says developing rural training centres or hubs would help. Given many Trainees are at a stage of life where they are settling down and sometimes having children, she says providing training in rural centres would allow rural Trainees to stay in familiar territory while they set up their life.

These Trainees can rotate through metropolitan centres for particular training, exposing them to all of the skills they need to learn, and if they choose to stay in that area after Fellowship, they can look at rotations in metropolitan centres. There they would develop professional and referral networks, and continue their professional development. Dr Butchers said the South West Victorian Regional Surgical Training Hub, which covers Geelong, Ballarat, Warrnambool and Hamilton, was a successful example of how this works.

Another focus is making sure surgeons in rural and regional areas have good working conditions and have the skills to provide an extended scope of practice beyond their own discipline. Professor David Fletcher, chair of the rural working group and RACS Councillor, said although it was important to attract Trainees to rural areas in the first place, there was also a need to provide more skills for Fellows already working rurally, as well as Fellows in metropolitan areas who want to go bush.

He said that in March this year, the Board of Surgical Education and Training agreed to provide such training so that a general surgeon could, for example, learn how to manage straight forward fractures and do some basic urology and plastic surgery.

“We need to provide that additional skill set so that surgeons feel comfortable,” he said, adding that safe hours and support for rural surgeons to take breaks from their towns is crucial.

Longer term, Dr Butchers says RACS wants to expose more medical students to the attractions of rural surgery and may focus on selecting Trainees with a desire to work in rural and regional areas. She does not think it will be hard to find junior doctors keen to train in rural hubs.

“Some of the people asking ‘when will rural surgical training happen?’ are medical students who have been to medical school in rural centres and have been rural preferential Junior Medical Officers. So they’ve already elected to do all of their placements in rural settings and they want to keep going,” she said. “There is definitely interest out there.”

Julia Medew
Surgical News journalist

Trainees enthusiastic about the future of surgery

As surgery enters a new era of rapid scientific advances, super-specialisation and professionalism, *Surgical News* talks to three Trainees who represent the future of surgery.

Samantha Khoo, SET3 Vascular Trainee, NSW

Why did you choose surgery and vascular surgery in particular?

Feeling disenchanted with studying for a Bachelor of Laws/Bachelor of Medical Science, I took on a work experience practical and found myself watching a coronary bypass. The minute they cracked open the chest I was hooked. I knew that surgery was for me. It was not until my internship that I found Vascular surgery. It seemed a fantastic mix of complex patients with difficult surgical problems and a specialty that rewarded lateral thinking, problem solving and a little bit of imagination.

What do you most enjoy about life as a Trainee surgeon?

I love the tempo and anticipation the job brings. No two days are ever the same and every day brings a new learning opportunity. You never know how the day will end, a life-changing event for a patient could be the next phone call you receive.

What are the greatest challenges?

Being beaten by the pathology. Since I've started surgical training, I've become acutely aware that primary care has so much to offer in disease prevention. Too often the patient is too far down the disease process for us to be able to offer any hopeful option.

As a mother of three, how do you balance training and family life?

My family are my greatest asset. They keep me grounded. My husband, an airline pilot, is a source of great support and stability in our family and has taken time off from his employment to help. It is difficult having to move to a new city or state every year and finding schools and child-care but I have been lucky that he has been able to take away from his career to support our growing family.

Has the RACS Operating with Respect initiative and introduction of procedures designed to tackle bullying and discrimination improved the training experience?

Vast improvements have been made and I have been proud of my colleagues who have spoken up against unprofessional behaviour. Unfortunately, there are still too many instances of begrudging acceptance of bullying and intimidating behaviour. We all know departments who protect the perpetrators because of their seniority or skills. The response to any kind of bullying, discrimination and harassment should be a firm zero tolerance.

Samantha Khoo

What would you say to medical students or junior doctors considering a career in surgery who may be hesitant because of the years of training required or the culture of the profession in the past?

It is time to move on from the culture of the past. You will be the surgeons of the future so start creating the environment you want to be working in. Although we need the years of dedicated training to be the best surgeons we can be, I appreciate that it can seem a long period of time to have instability and lack of autonomy in many aspects of your life. If you desire to be a surgeon, find a way to make it work for you and embark on your decision with passion and optimism.

Benjamin Chan, SET4 ENT Trainee, New Zealand

Why did you choose surgery and ENT surgery in particular?

I was drawn to surgery because I like working with my hands and being able to directly solve a medical problem. After doing an ENT rotation in Christchurch I knew that was the specialty for me. Not only did I find head and neck anatomy fascinating, the people I worked with were passionate about their job and it was contagious.

What do you most enjoy about life as a Trainee surgeon?

Seeing the great outcomes we can achieve and the effect we can have on the lives of our patients. We can be working with some head and neck patients for weeks as they learn to talk or swallow again and to see them achieve milestones is very rewarding. I also like the team environment we have in ENT. As medicine has evolved, team work has become more crucial and this is especially evident in ENT where we must work closely with our anaesthetist colleagues and other theatre staff.

What are the greatest challenges?

Dealing with complications and bad outcomes. We all have cases where we know that the cancer will win but it can still be difficult to accept. It is sometimes challenging to step back and think about the quality of a patient's life rather than the quantity. It's about knowing the limits of what you should do not just what you can do.

Having recently become a first-time father, how do you balance training and family life?

I took a few weeks off when Lachlan was born nine months ago and work was very supportive. I often work long hours during the week and can go for days without seeing him. I still find this difficult but with the hours that babies sleep this situation is not exclusive to me, or to surgery. Most working parents would like to spend more time with their families.

Has the RACS Operating with Respect initiative and introduction of procedures designed to tackle bullying and discrimination improved the training experience?

There has been a tangible shift in the training environment even before the College started this campaign. But the initiative has definitely given greater awareness to the issues. There are still some dinosaurs left in the profession but as a group, we are becoming more comfortable sticking up for ourselves and our colleagues. There is still a way to go to change the culture completely, but progress has been made which should be celebrated.

What would you say to medical students or junior doctors considering a career in surgery who may be hesitant because of the years of training required or the culture of the profession in the past?

It may seem like it takes a long time to become a surgeon but in simple terms we cause harm to patients in the hope that we will make them better for it. We need to be confident in our skills and knowledge to ensure that whatever we do will have the greatest chance of providing a benefit to the patient. Surgical training is an apprenticeship, it takes time, and there can be some long days but I love my job and I'm happy to tell junior doctors that.

Imogen Ibbett, SET5 Neurosurgery Trainee, QLD

Why did you choose surgery and Neurosurgery in particular?

I wanted to be a surgeon from my teenage years because I was drawn to the pathology and treatment

Benjamin Chan

strategies involved in surgery more than those of other medical specialties. I completed a degree in neurophysiology in the UK and found the anatomy of the brain utterly fascinating. When I came to Australia, I did two neurosurgery resident rotations at Monash Medical Centre and the senior staff there were extremely supportive and encouraged me to enter the training program in Australia.

What do you most enjoy about life as a Trainee surgeon?

I most enjoy the teamwork involved in neurosurgery, not just with other surgeons and theatre staff, but also the collaboration and collegiality that exists between neurosurgery Trainees around the country. Because we are a small surgical specialty, we form close bonds and when we meet at conferences it is a bit like a family reunion. There are 11 of us who will be sitting final exams next year and we study together. I find that support extremely valuable. Also, of course, I really enjoy operating and working with senior surgeons to learn different tricks and techniques.

What are the greatest challenges?

One challenge faced by Trainees who move interstate for rotations is that we cannot rollover sick leave, maternity leave or long service leave when we move to a different state. This is caused by State Government workplace laws and we continue to fight for change on this through the RACS Trainees' Association. I also find dealing with complications very difficult. Adverse outcomes are extremely rare but they can happen and it can be hard to bounce back and not become too cautious in theatre.

Having recently married, how do you balance training and family life?

My husband Rob also works in health care and we met when I was on rotation in Tasmania. He understands the long hours and the time I must spend studying and offers great support.

Imogen Ibbett

Has the RACS Operating with Respect initiative and introduction of procedures designed to tackle bullying and discrimination improved the training experience?

I was one of the surgeons who spoke about this on Four Corners some years ago and after it went to air I was overwhelmed with the support I received. Many Trainees and surgeons thanked me for starting the conversation. The work done by the College since then has made a difference by making it possible for people to speak openly about how they are being treated. I think it has empowered junior doctors and surgeons to stand up against bullying as a matter of our core professional values and behaviour.

What would you say to medical students or junior doctors considering a career in surgery who may be hesitant because of the years of training required or the culture of the profession in the past?

Training to become a surgeon may be longer than other specialties but there are great upsides to life as a Trainee surgeon. We have a full-time job, for one thing, whereas once we become consultants we will be self-employed which comes with its own challenges. We also get to work with, and learn from, senior surgeons which represents an awesome opportunity to work with world class surgeons and leaders in their field. Bullying is widespread in medicine and I think RACS has dealt with it very well whereas come colleges refuse to recognise they even have a problem.

RACSTA
Your Trainees' Association

Samantha Khoo, Benjamin Chan and Imogen Ibbett are members of the Royal Australasian College of Surgeons Trainees' Association (RACSTA).

Karen Murphy
Surgical News journalist

South Australian surgeon honoured with Community Award

On Wednesday 29 August 2018, Mr Matthias Wichmann, was presented with an Outstanding Service to the Community Award by RACS in a surprise ceremony at the Mount Gambier Hospital.

A clearly surprised Mr Wichmann was lured to the event on the premise that he would be attending a community forum, but was instead stunned to find family, friends, and colleagues both past and present, celebrating his distinguished career.

"I had absolutely no idea what was happening. I actually met a couple of friends walking in to the hospital and they told me they were there to visit another friend, so I walked in there thinking I was about to give an interview to the local newspaper.

"It was amazing, most of the time you get grateful patients, but to be recognised in this way by the College was incredibly humbling. It was a very proud and happy moment for me."

The award was established to recognise surgeons with a dedicated history of service to their local community.

SA State Committee Chair, Mr Phil Worley, who presented the award, said that Mr Wichmann had embodied all of these values, and was held in high regard across the surgical profession.

"Matthias works hard, often as the public face of the hospital in matters beyond just surgical, to raise support for the health service, be it for political, public awareness, service provision or fundraising purposes. His contribution is diverse, and far beyond the expected." Mr Worley said.

"The residents of Mount Gambier are increasingly appreciative and thankful to have Matthias as a member of their community. Many are benefiting from his skills as a surgeon, and also the fruits of his time given to improve health outcomes now and in to the future."

Originally hailing from Germany, Mr Wichmann migrated to Mount Gambier thirteen years ago. It did not take long for him to develop a reputation in the community as an empathetic and highly gifted surgeon, and for his work at the forefront of medical research and education.

Mr Worley particularly paid tribute to Mr Wichmann's passionate health advocacy and ability to campaign for improved health outcomes. As an example, he highlighted the instrumental role Mr Wichmann played in the establishment of a state-of-the-art colorectal practice in Mount Gambier.

Echoing these sentiments was Mount Gambier Hospital Health Advisory Council presiding member, Ms Maureen Klintberg, who also spoke at the ceremony.

"Last year Matthias sought ways to increase community awareness of health service needs and was instrumental in securing a donation of $10,000 from a local Rotary club to purchase a portable ECG machine for the renal dialysis unit.

Matthias Wichmann receiving the Outstanding Service to the Community Award from SA State Committe Chair, Phil Worley.

"Many of us are benefiting from not only his skills as a surgeon, but also the outcomes of his time given to improve health outcomes now and into the future," Ms Klintberg said.

While Mount Gambier is half a world away from Mr Wichmann's native Germany, he said the transition had been a relatively easy one, and he had not regretted his decision.

"When we moved from Germany we had to come to an area of need, so we ended up in Mount Gambier almost by accident.

"We were struck by the similarities in the climate and the people, particularly their sense of humour. I also come from a farming background in Germany, so for me the move to a rural area wasn't difficult.

"It was absolutely the right decision. It has been a great place to live and to raise our children. This is my home now, and I love being involved in and working for this community."

Mark Morgan,
Communications and Policy Officer, RACS

Scholarship and grant recipients for 2019

Outgoing Chair ANZSGC, Associate Professor Kerin Fielding

Incoming Chair ANZSGC, Mr Christopher Perry

The ANZ Scholarship and Grant Committee (ANZSGC) thanks the many applicants and congratulates the following successful 2019 RACS Scholarship, Fellowship and Grant recipients.

Thank you to all donors and sponsors for your generosity in funding the following scholarships, Fellowships and grants. Without your support the following critical life-changing research and education would not be possible. Most of these awards are for the duration of one year, with some exceptions, as noted.

A considerable amount of time and energy has been spent on properly evaluating the extensive number of high quality applications that were received. The Chair would like to thank all those involved in the assessment process, in particular Associate Professor Christopher Young, Mr Michael Barnes, Professor Wendy Brown, Mr Niall Corcoran, Professor Robert Fitridge, Miss Sarah Hulme, Professor Andrew Hill and Associate Professor Siven Seevanayagam who all put in extra work towards this result.

Research scholarship, fellowship and grant recipients

John Mitchell Crouch Fellowship

Value: $150,000

Professor Antonio Di Ieva (NSW)

Specialty: Neurosurgery

Professor Antonio Di Ieva is an academic neurosurgeon, Professor of Neuroanatomy and Neurosurgery and a clinical and computational neuroscientist at Macquarie University (Sydney). He has been a staff consultant and/or a clinical/research Fellow in Italy, Austria, Canada and Australia and will use this Fellowship to establish the first "Computational Neurosurgery Lab", aimed to use Artificial Intelligence and fractal-based computational modelling to characterise "fingerprints" of brain tumours and other diseases of neurosurgical interest. He aims to use artificial intelligence to help clinicians and surgeons with differential diagnosis and decision-making, reducing errors in judgement, with the final goal of improving patients' treatment and outcome.

Foundation for Surgery Tour de Cure Cancer Research Scholarship

Value: $125,000 including $25,000 procured externally

Dr Vignesh Narasimhan (Vic)

Speciality: General

Topic: Exploring the immune landscape and developing a novel platform for personalised therapy in colorectal peritoneal metastase

Academy of Surgical Educators Surgical Education Research Scholarship

Value: $10,000

Dr Kathryn McLeod (Vic)

Specialty: Urology

Topic: What are the reasons for underperformance in Urology Trainees?

Catherine Marie Enright Kelly Memorial Research Scholarship

Value: $66,000

Dr Kheng-Seong Ng (NSW)

Speciality: General

Topic: Outcomes following colorectal surgery: A population based health record-linkage study

Eric Bishop Research Scholarship

Value: $66,000 including 25 per cent procured externally

Dr Brendan Jones (Qld)

Speciality: Paediatric

Topic: Development of functional bowel reconstruction for patients with short bowel syndrome using an autologous tissue engineering strategy

F & P Thornell-Shore Memorial Trust for Medical Research Scholarship

Value: $66,000 including 25 per cent procured externally

Dr Eunice Lee (Vic)

Speciality: General

Topic: Assessing and optimising donation after cardiac death liver grafts for transplantation

Foundation for Surgery Research Scholarship

Value: $66,000 including 25 per cent procured externally

Dr Ran Li (Vic)

Speciality: General

Topic: Investigating the immune microenvironment of HER-2 positive breast cancer

Mr Joseph Dawson (SA)

Specialty: Vascular

Topic: Use of a biodegradable polyurethane matrix in the reconstruction of diabetic foot wounds

Herbert and Gloria Kees Research Scholarship

Value: $66,000

Dr Joseph Dusseldorp (NSW)

Speciality: Plastic and Reconstructive

Topic: Utilising biotechnology advances to obtain superior outcomes in reconstructive surgery

Dr Alice Krige (SA)

Speciality: General

Topic: Normothermic extra-corporeal perfusion in an ovine model of kidney transplantation as a means of organ preservation

Health Technology Assessment Scholarship

Value: $66,000

Dr Dilshan Udayasiri (Vic)

Speciality: General

Topic: A study exploring the use of administrative data as a surrogate for clinical data in outcomes research for colorectal cancer resection

James Ramsay Project Grant

Value: $78,000 per annum

Duration: Two years

Professor Jonathan Golledge (Qld)

Speciality: Vascular

Topic: Metformin in the mAnaGement of abdominal aortic aneurysm (MAGIC)

MAIC-RACS Trauma Scholarship

Value: $66,000

Dr Bhavik Patel (Qld)

Speciality: General

Topic: Management of splenic injuries in Queensland: Retrospective trend analysis over five years and one year prospective evaluation of clinical practice guideline implementation

Paul Mackay Bolton Scholarship for Cancer Research

Value: $66,000 per annum each including 25 per cent procured externally

Duration: Two years

Dr Toan Pham (Vic)

Speciality: General

Topic: Novel immunotherapy targeting MYB-expressing colorectal cancer

Dr Akbar Ashrafi (Qld)

Speciality: Urology

Topic: Evaluating the role of bone marrow disseminated tumour cells in prostrate cancer progression

Reg Worcester Research Scholarship

Value: $66,000

Dr Georgina Riddiough (Vic)

Speciality: General

Topic: Searching for the link: The role of liver progenitor cells in liver regeneration and tumour biology

Richard Jepson Research Scholarship

Value: $66,000, including 25 per cent procured externally

Dr Thomas Eldredge (SA)

Speciality: General

Topic: Bile reflux post-bariatric surgery – A cohort study

W G Norman Research Scholarship

Value: $66,000, including 25 per cent procured externally

Dr Nagendra Dudi-Venkata (SA)

Specialty: General

Topic: STIMULAX Study: Open label randomized controlled trial of combination of simple STIMUlants and LAXatives to prevent post-operative ileus in patients undergoing colorectal surgery

Professor Philip Walker RACS Vascular Surgery Research Scholarship

Value: $20,000

Dr Guilherme Pena (SA)

Specialty: Vascular

Topic: The use of Siemens Syngo Parenchymal Blood Volume during revascularisation of diabetic patients with foot tissue loss to predict likelihood of wound healing

Brendan Dooley/Gordon Trinca Trauma Research Scholarship

Value: $10,000

Dr Michael Bullen (Vic)

Specialty: Orthopaedic

Topic: Evaluation of vitamin D supplementation on fracture healing in a vitamin D deficient paediatric population using pQCT – A randomised trial

Small Project Grant

Value: $10,000

Chief Investigator: Dr Anthony Glover (NSW)

Specialty: General

Project: Single cell transcriptomics of primary and metastatic papillary thyroid cancer

Chief Investigator: Dr Alex Karatassas (SA)

Specialty: General

Project: Developing a hernia mesh tissue integration index

Travel and education scholarship, fellowship and grant recipients

Margorie Hooper Travel Scholarship

Value: $75,000

Dr Yu Chao Lee (SA)

Specialty: Orthopaedic

Travelling to the UK to undertake a spinal clinical Fellowship at the Royal National Orthopaedic Hospital in Stanmore to learn advanced techniques in spinal surgery

Stuart Morson Scholarship in Neurosurgery

Value: $30,000

Dr Andrew Gogos (Vic)

Speciality: Neurosurgery

Undertaking a Neuro-oncology Fellowship at the Western General Hospital in Toronto and UCSF in San Francisco

Pickard Robotic Training Scholarship

Value: $30,000

Mr Rick Catterwell (SA)

Specialty: Urology

Funding towards a structured training program for robotic bedside assistants

Value: $20,000

Dr Thomas Cundy and Dr Sanjeev Khurana (joint award) (SA)

Specialty: Paediatric

Funding to introduce Paediatric robotic surgery in South Australia and establish the Australian Paediatric Robotic Surgery Collaborative

Value: $20,000

Dr Alex Karatassas (SA)

Specialty: General

Funding to assist in the development of ideas and techniques in robotic colorectal and hernia surgery

Value: $20,000

Dr Andrew Kurmis (SA)

Specialty: Orthopaedic

Completing stage 2 of the Mako Advanced Robotics in Arthroplasty international clinical training program

Value: $15,000

Dr Andrew Fuller (SA)

Specialty: Urology

Undertaking an observership at Karolinska Institute in Sweden to develop skills in performing robotic cystectomy and intracorporeal urinary diversion

Ian and Ruth Gough Surgical Education Scholarship

Value: $10,000

Dr Steven Craig (NSW)

Specialty: General

Funding to attend the International Conference on Residency Education in Canada, complete the 'Surgical education: Principles and Practice' course in conjunction with the American College of Surgeons Clinical Congress and the 'Endocrine University' course in Los Angeles, California

Hugh Johnston ANZ Chapter of the American College of Surgeons Travelling Fellowship

Value: $8,000

Dr Jeremy Hsu (NSW)

Specialty: General

Visiting the Rocky Mountain Trauma Centre in Denver Colorado USA to collaborate with surgeons regarding operative chest wall injury fixation techniques and management of pelvic fractures and the LA County Medical Centre, California USA, to collaborate in the use of REBOA

Hugh Johnston Travel Grant

Value: $10,000 each

Mr William Perry (NZ)

Specialty: General

Attending Oxford University to undertake Fellowship Training and travelling to Aarhus University Hospital in Denmark to get greater exposure to robotic colorectal surgery

Dr Saissan Rajendran (NSW)

Specialty: Vascular

Funding to undertake Fellowships in St George's Hospital, London UK, and at the Foot and Ankle Clinic, Policlinico Abano Terme, Italy

Mr Raymond Yap (Vic)

Specialty: General

Undertaking a colorectal Fellowship in Florida Hospital, Orlando USA, to learn new techniques.

John Buckingham Travelling Scholarship

Value: $4,000

Dr Matthew Roberts (Qld)

Specialty: Urology

Attending the 2018 American College of Surgeons Clinical Congress in Boston, USA

Morgan Travelling Fellowship

Value: $10,000 each

Dr Joshua Jervis-Bardy (SA)

Specialty: Otolaryngology

Undertaking an Otology Fellowship at the University of Arkansas Medical Sciences, Little Rock USA, with a focus on gaining ear surgery skills to improve the management of chronic suppuratives otitis media (CSOM) in indigenous people

Dr Ramez Ailabouni (NZ)

Specialty: Orthopaedic

Undertaking a clinical Fellowship at Inselspital Bern, Switzerland to expand surgical abilities and perform complex procedures on the hip

RACS ATSI SET Trainee One Year Scholarship

Value: $20,000

Dr Robert Grant (NSW)

Specialty: Cardiothoracic

To assist with the funding of textbooks, college and examination fees as well as research, conferences and courses costs.

RACS Māori SET Trainee One Year Scholarship

Value: $20,000 each

Dr Lance Buckthought (NZ)

Specialty: Otolaryngology

Research: Indigenous Middle Ear Disease and treatment and quality of life outcomes in vestibula schwannoma

Dr James Johnston (NZ)

Specialty: Otolaryngology

Research: Disparities of Māori with regards to diseases of the ear, nose and throat

Preliminary Notice: Applications for 2020 scholarships will open in March 2019.

Please see RACS Website for more information on opportunities in your area.

Surgeon presented with prestigious Sir Henry Newland Award

Mr Glenn McCulloch is presented with the Sir Henry Newland Award by SA Chair Phil Worley

On 12 October 2018, Mr Glenn McCulloch was presented with the Sir Henry Newland Award, in front of family and friends at the South Australian Annual Dinner, in recognition of his extraordinary contribution to the surgical community in South Australia over a number of years.

Mr McCulloch proved to be a popular choice for the award, as evidenced by the large contingent of the state's neurosurgical community (many of whom were trained in part by Glenn) who all attended the dinner specifically to see him presented.

The award is named after Sir Henry Newland, who is remembered for the extensive and honorary service he provided to the South Australian, Australian and international surgical communities throughout his lifetime. His accolades include being recognised for his services during World War One with the Distinguished Service Order in 1917, and then later being appointed CBE in 1919.

Following the war, he was one of the original founders of RACS, where he served as President from 1929 to 1934, and Chairman of the RACS State Committee in SA from 1939 to 1942. In Sir Henry's honour the award recognises a surgeon who has provided distinguished service to surgery in the state.

Friend and former colleague, Professor Peter Reilly AO, who provided a citation at the event, described Mr McCulloch as a thoroughly deserving recipient, who had embodied all the values for which the award seeks to recognise.

"I have known Glenn all his professional life and found him, whenever we worked together, to be a man of integrity, good sense and with the ability to thoroughly engage in whatever activity he was involved."

"I know from the witness of others that he has applied the same thoughtfulness, commitment and expertise to each the many roles in which he has served surgery nationally and in this state. I commend Glenn as a most worthy recipient of the Sir Henry Newland Award."

Mr Glenn McCulloch (centre) with former neurosurgical colleagues

Mr McCulloch retired from surgical practice in 2005 after a career spanning 31 years. The majority of his career was spent working at the Queen Elizabeth Hospital, as well as providing emergency neurosurgical services at the Women's and Children's Hospital and the Royal Adelaide Hospital.

After his retirement he remained active as a College Councillor until 2011 (a role he had held since 2002), and he worked as the Clinical Director of the South Australian Audit of Surgical Mortality (SAASM) from 2011 until earlier this year. He remains the neurosurgical member of the Surgical Science Examination Committee, as well as Deputy Chair of the RACS Anatomy sub-committee, and Vice President of the Neurosurgical Research Foundation. In addition to this, he was recently appointed as a Visiting Research Fellow of the University of Adelaide, testament to his ability to engage and inspire young students and Trainees.

The September edition of *Surgical News* also featured a story on Mr McCulloch, detailing how he recently became one of the first donors to RACS' Foundation for Surgery to arrange a bequest in his will that specifically supports global health initiatives.

Speaking after the ceremony, Mr McCulloch said that he was grateful and humbled to have received the award.

> "It means a lot to me to know that my colleagues appreciate the work that I, and many others who have supported me, have done over the years for the benefit of the College and of surgery in South Australia."

"It was very touching that so many of my neurosurgical colleagues who might not otherwise have attended were able to make it, and it was also nice to be able to share the moment with staff and surgeons that have been involved in the development of SAASM."

"While there have been many highlights and great moments throughout my career, probably the thing that I am most proud of is the establishment and evolution of the surgical mortality audit process."

The presentation of the Sir Henry Newland Award was the final part of a highly successful evening. The dinner was held at the Sanctuary Restaurant at the Adelaide Zoo, and earlier in the night guests were given the opportunity to get up close and personal with some of the zoo's inhabitants.

Another highlight from the dinner was the annual Anstey Giles Lecture, which was delivered by Adelaide University Vice Chancellor, Professor Peter Rathjen. In his speech Professor Rathjen paid tribute to the man, for whom the lecture is named after, particularly for the continual pursuit of excellence and ongoing learning that he displayed throughout his life. Professor Rathjen highlighted that although the education and employment landscape has changed significantly since Anstey Giles' time, there were still many lessons that can we can learn from his example.

Work is already underway for next year's annual diner, which will also be the conference dinner for the SA/WA/NT Annual Scientific Meeting. The event will be held in the beautiful seaside setting of Port Lincoln, with one of the highlights being the delivery of the next instalment of the Anstey Giles Lecture by Dr Richard (Harry) Harris OAM, SC. Dr Harris is a South Australian anaesthetist and cave diver, who was instrumental in the recent rescue of the Thai Wild Boar soccer team. Stay tuned for more information about the ASM, including how to register, in future editions of *Surgical News.*

Mark Morgan,
Communications and Policy Officer, RACS

Pacific Islands Surgeons Association Meeting 2018

The biennial Pacific Islands Surgeons Association Meeting was held in Fiji in October 2018. These meetings began in 1994 with a small gathering in the Cook Islands with local surgeons and a surgeon from Samoa, plus members of what was then the New Zealand Committee of RACS. From 1996 onwards there have been between eight and thirteen Pacific Island countries represented at each meeting, plus a number of New Zealand and Australian surgeons from various specialties. The cross-country networking during the meetings gave rise to the Pacific Islands Surgeons Association (PISA), formed in 2003.

For the first time, the meeting was run in conjunction with General Surgery Australia (GSA), and PISA representatives. Financial assistance to allow attendance of surgeons from thirteen Pacific Island countries came from New Zealand's Ministry of Foreign Affairs and Trade and through GSA Travel Grants. Additional funding was sourced from the Strengthening Specialist Clinical Services in the Pacific arm of the South Pacific Commission, the East Timor Aid Program and the RACS Global Health Committee. Around 60 Pacific Island surgeons and Trainees from the Cook Islands, East Timor, Federated States of Micronesia, Fiji, Kiribati, Marshall Islands, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu attended the meeting. GSA was also extremely generous in funding attendance and 17 members provided locum cover in various areas of the Pacific so that Pacific Island surgeons could attend.

The main conference was preceded by a Trainee's Day, with presentations to and by Pacific Islands' surgical Trainees and general surgery Trainees from Australia. Trainee presentations on this day and throughout the meeting were judged. Awards made included PISA's Best Trainee's Paper Prize, awarded to Dr Esala Vakamacawai for his paper on '*A six year review on liver abscess aspiration versus tube drainage*'.

The meeting was opened with a formal Fijian ceremony performed by Fijian surgeons that included the presentation of gifts and kava to the Fijian Minister of Health, the Honourable Rosy Akbar, and other dignitaries including Mr Matthew Lapworth, representing the Australian High Commissioner to Fiji, the President of PISA, Lord Viliami Tangi, the President of GSA, Mr Trevor Collinson, and the President of RACS, Mr John Batten.

A major theme was global surgery and there were outstanding international speakers including RACS funded Dr Walter Johnson, a neurosurgeon who leads the Emergency & Essential Surgical Care Programme for the World Health Organisation (WHO), and Dr Stephen

Traditional Fijian kava ceremony during the opening.

Group of Pacific Islands attendees with RACS representitives.

Bickler, a paediatric surgeon who has been a consultant for WHO on surgery in low income countries; and also Dr Kelly McQueen, an anaesthetist and Director of the Vanderbilt Institute for Global Health. The invited speakers brought an international perspective on global health metrics, while presentations by Pacific Islands' surgeons such as Lord Viliami Tangi, Head of Surgery for Tonga, brought the focus to Pacific Island countries and the work surgeons in this region are undertaking to record and review their own surgical metrics.

Due to the combined nature of the conference, there were fewer presentations from Pacific Island surgeons than usual, but the organisers took the opportunity to bring global surgery issues and strategy to the attention of GSA delegates. There were presentations on Pacific Islands' perspectives and research on surgical care associated with diabetes, which continues to place an enormous burden on all health services in the Pacific Islands. Diabetic foot sepsis forms a large part of surgical practice in the Pacific Islands. Other topics included liver abscesses, complex abdominal conditions, acute appendicitis, breast and other cancers, emergency surgery, mortality following neck of femur fractures, surgical management of spinal tuberculous and the importance of multi-disciplinary meetings for safer patient care.

PISA recognised Dr Johnny Hedson from Pohnpei in the Federated States of Micronesia for his long commitment to surgery in the Pacific Islands and for his service to PISA. Johnny first attended the Pacific Islands Surgeons Meeting in 1996, at Sinalei in Samoa. He attended regularly until the 2010 Meeting in Port Vila, Vanuatu. Johnny was an inaugural member of PISA when it was formalised in Rarotonga in 2003 and was a member of the first PISA Executive Committee. He served as the Association's Vice-President for several years. The Pacific Island countries are spread over an enormous area and Johnny has had to travel the furthest of anyone to attend these meetings, going west from his home to Guam, then north east to Japan or Honolulu before dropping southwards to the meeting venues in the South Pacific. Johnny retired from surgery a few years ago to spend his time on his other passion, fishing; but has more recently been called back to head the Department of Surgery in Pohnpei.

Group of 'officials' after opening : Glenn Guest (Co-Convener (GSA)), Viliami Tangi (President, PISA), Walter Johnston (Invited Speaker, WHO), John Batten (President, RACS),Nicola Hill (Chair, NZ National Board); Trevor Collinson (President, GSA), Matthew Lapworth (Representative of Australian High Commission).

Trevor Collinson (President GSA) receiving a gift to GSA from Dr Alamea Fulivai (surgical Trainee, Tonga) watched by PISA President Viliami Tangi.

The biennial PISA conferences provide the opportunity for the Association to elect its Executive Committee and its Office Bearers. Lord Viliami Tangi has now completed his term as President and has been succeeded by Associate Professor Ifereimi Waqainabete, Head of the Department of Surgery, Anaesthesia & Women's Health at Fiji National University and a general surgeon at Colonial War Memorial Hospital in Suva.

Nicola Hill, FRACS,
Chair, New Zealand National Board

Academy of Surgical Educators

2018: Year in Review

The yeat 2018 has been a wonderful year for the Academy of Surgical Educators (ASE) with the membership base growing to 820. Around 2,000 attendees participated in our surgical educator activities and courses.

With the RACS Building Respect, Improving Patient Safety Action Plan in full swing, the Academy has been involved in the development of several new surgical education courses. The Advanced Feedback in Surgical Education course was formed in response to survey data collected from FSSE attendees who indicated they would like to learn more about providing feedback using alternative methods. This course is now being piloted with plans to be implemented in 2019. There is also another new course in the pipeline, tentatively named the Advanced Surgical Educators Course. This course is based on a flexible model as participants can opt between a full two day course of four modules or take one module as a short course.

2018 Educational events:

Educator Studio Sessions and eebinars

Since the inception of the Academy, it has grown into an active community of practice. This year, the Academy ramped up the number of Educator Studio Sessions due to the demand for them. The Educator Studio Sessions showcase presentations from medical educators and thought leaders on topics of interest to members. In total, there were 11 planned Studio Sessions with eight delivered (three cancellations due to presenter illness and unforeseen circumstances), all held at the various regions in Australia and New Zealand. The Educator Studio Sessions are free with options of face-to-face or online webinar attendance.

Annual Scientific Congress Surgical Education stream

In May, the Annual Scientific Congress (ASC) Surgical Education stream was convened by Associate Professor Andrew Davidson FRACS, (neurosurgeon). In keeping with the Congress theme of 'Reflecting on what really matters', the Surgical Education programme aimed to bring together the broadest possible range of participants. Dr Jason Frank, Royal College of Physicians and Surgeons of Canada presented the Hamilton Russell Memorial Lecture on 'Medical education: what really matters?'. The stream was generally well-attended, with a high participation rate from medical students.

Academy Forum

The annual Academy Forum was held in Sydney in November. The Forum saw presentations from Professor Renae Ryan from the University of Sydney on 'Diversity and Inclusion: An Essential Mix for Excellence in Science and Medicine' and Dr Anthony Llewellyn, from the University of Newcastle on 'Personalised Learning and Work Readiness'. This year's Forum was held in conjunction with RACS NSW Surgeons Month and the Annual Joint Academic Meetings Section of Academic Surgery (SAS) and the Surgical Research Society (SRS).

Graduate Programs in Surgical Education

The Graduate Programs in Surgical Education offered jointly by the University of Melbourne and RACS offer a suite of programs that address the specialised needs of teaching and learning in the modern surgical environment. There were two main weeks of workshops in February and August led by Professor Debra Nestel, supported by Associate Professor Stephen Tobin. The Graduate Programs have produced 22 Masters of Surgical Education graduates since its inception.

Professor Mark Smithers at the July Educator Studio Session in Brisbane

Rewards and Recognition: Educators of Merit

The Academy recognises the contribution of surgical educators via the ASE Recognition Awards. The recipients of the Educators of Merit for 2018 are:

SET Supervisor/IMG Supervisor of the Year Awards:

VIC: Professor Igor Konstantinov FRACS

NSW: Dr Amanda Dawson FRACS

QLD: Dr John Preston FRACS

SA: Professor Peter Anderson FRACS

WA: Professor Peter Friedland FRACS

TAS: Mr Hung Nguyen FRACS

NT: Mr Michael Wilson FRACS

NZ: Mr Richard Wong She FRACS

NZ: Mr Simon McMahon FRACS

Facilitator/ Instructor of the Year Award:

Dr Wendy Crebbin

Many of the Educator of Merit winners were presented with their awards at the Academy Forum on 8 November in Sydney. The Academy also recognises the length of service of SET Supervisors, IMG Supervisors and Professional Development Facilitators through the Educator of Commitment Award. The list of these awardees can be seen in the 'Appreciating Our Educators' article in this month's Surgical News.

Scholarships and Prizes

ASE Surgical Education Research Scholarship

The ASE Surgical Education Research Scholarship has been established to encourage surgeons to conduct research into the efficacy of existing surgical education or innovation of new surgical education practices. This year's scholarship recipient is Dr Kathryn McLeod.

ASC Surgical Education Research Prize

Mr Dennis King won the Surgical Education Research prize with his paper entitled 'Nobody is going to be there

The pilot for Advanced Feedback in Surgical Education course in session

to tell them: Development of a framework of factors and behaviours which influence assessment of competence of urology Trainees.' An article on Mr King's research was published in the October 2018 issue of Surgical News.

Resources and membership

The Academy is supported by an interactive online learning community where members can gather ideas, share interests and research, find resources and keep abreast of upcoming events. The environment is supportive, collaborative and fosters enthusiasm in surgical education. It includes a database resource which contains searchable items such as articles, e-newsletters and recordings* of webinars together with listings of workshops and courses, pathways to become Trainers and Supervisors and award information.

Membership of the Academy is open to all Fellows, Trainees, IMGs and external medical educators who have strong educational interests and expertise. For more information on getting involved in Academy activities or how to become a member, please contact Grace Chan on +61 3 9249 1111 or email ase@surgeons.org

**To access the vodcasts for the above presentations, login to the RACS website, go to My Page, eLearning, Academy of Surgical Educators, Database Resources.*

Dr Sally Langley FRACS
and Assoicate Professor Stephen Tobin FRACS

On behalf of RACSTA and Morbidity Audits Committee with Grace Chan, Academy Program Coordinator, RACS

The College finances and budget 2019

A report from the Treasurer

The 2019 budget will place a clear emphasis on targeted investment on strategic imperatives while still providing sustainable and appropriate levels of funding for the effective delivery of core education and training services to our Fellows, Trainees and IMGs.

Looking at how RACS can better add value to our members was the central theme of the budget program with Council and the management team prioritising expenditures on where we can best provide opportunities for our members' professional growth. This has resulted in new project funding earmarked for continuing professional development (CPD), implementation of a concierge customer service model and developing a multi-year Education Program of Works related to our Australian Medical Association accreditation.

The budget also has provision for increased funding to underpin our strong commitment to ensuring RACS maintains its reputation as the major provider of surgical grants, research, scholarships and philanthropic causes in our region.

We know that our library resources and services are a key area of engagement with our members with the budget reflecting continual significant investment in a wealth of content and search tools. We also more broadly continue to enhance the Trainees' program and advance surgical advocacy positions to improve services to the Fellowship. This should be considered a balanced yet forward looking budget for 2019.

Overall financial position

The financial position of RACS is sound and our operations continue to perform prudently to budget. The net worth has steadily grown over time mostly from appreciation through careful management of the investment portfolio, generosity from our Fellows and others donating to the Foundation for Surgery and achieving modest annual operational surpluses. Income generated from the investment portfolio is primarily committed to funding research scholarships and grants programs.

Financial categories

Figure 2 shows the three categories of activities that make up the RACS business. Council has long held a principle that Category 1, our core business, with the aim to achieve longer term financial sustainability. Category 2 is for projects delivered under various funding agreements from third parties, including significant government funded initiatives such as the multi-year Specialist Training Program (STP) that aims to improve the quality of the future specialist workforce. Category 3 is the Foundation,

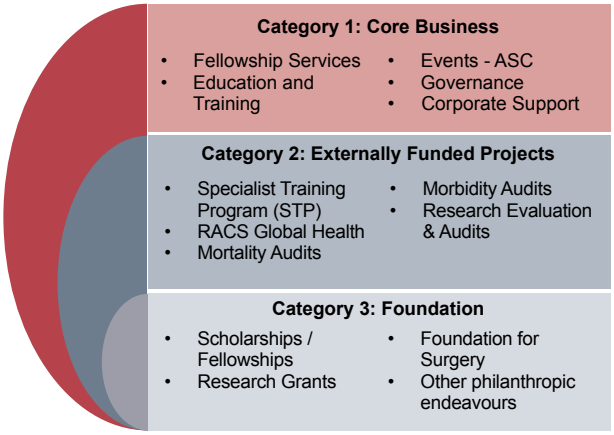


Figure 2: RACS categories

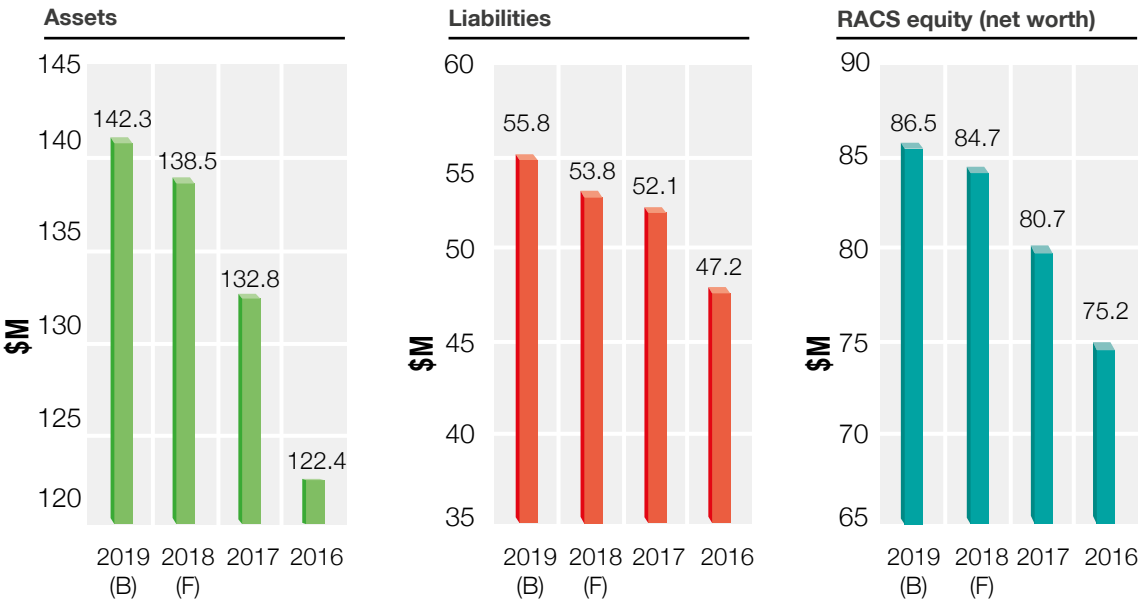


Figure 1: RACS Assets, Liabilities and Equity (Net Worth)

where monies generated are committed to fund our grants, scholarships and philanthropic causes.

Budget 2019 major items

There have been six key frequently profiled items for Budget 2019:

- Building Respect, Improving Patient Safety (BRIPS)
- Annual Scientific Congress
- Travel and Accommodation
- Staffing
- Core Revenues
- Investments and Funding Scholarships.

Building Respect, Improving Patient Safety

Budget 2019 has sufficient funding to continue the multi-year implementation of the recommendations from the Expert Advisory Group, which is work that continues to position surgeons as leaders in championing a respectful and inclusive culture in the workforce. The total funding for 2019 inclusive of the Foundation Skills for Surgical Educators courses and other related initiatives has been set at $1.1million. Other planned areas of action include continuing engagement with partner hospitals and adoption of an Evaluation Framework to objectively analyse how effectively the Action Plan has been implemented over the longer term.

Annual Scientific Congress (ASC)

The ASC 2019 will be held in Bangkok, Thailand being our major educational annual activity and offers our Fellows and others the opportunity to experience this premier surgical education event. The budgeted revenues of $2.5M have been more conservatively set, compared to the Sydney held event this year, but equally the staging costs are anticipated to be lower thus ensuring the event is financially sound. The budget also provides funding allowance for the various travel arrangements of the invited distinguished speakers, both locally and abroad. The ASC continues to attract strong industry support, having now developed a truly international forum for the various scientific programs on offer.

Travel and accommodation

This aspect of Budget 2019 is important to supporting our services such as course delivery, examinations, governance, advocacy and other educational work. As 10 per cent of the expenditure budget ($7.3M), it must be adequately funded to respect the pro-bono work that our Fellows deliver across all portfolios including the significant work of our volunteer specialists under various government funded programs throughout the Asia-Pacific region. For core operational service activities management has focussed its efforts on cost efficiency measures and has achieved a 10 per cent reduction in the budget for next year.

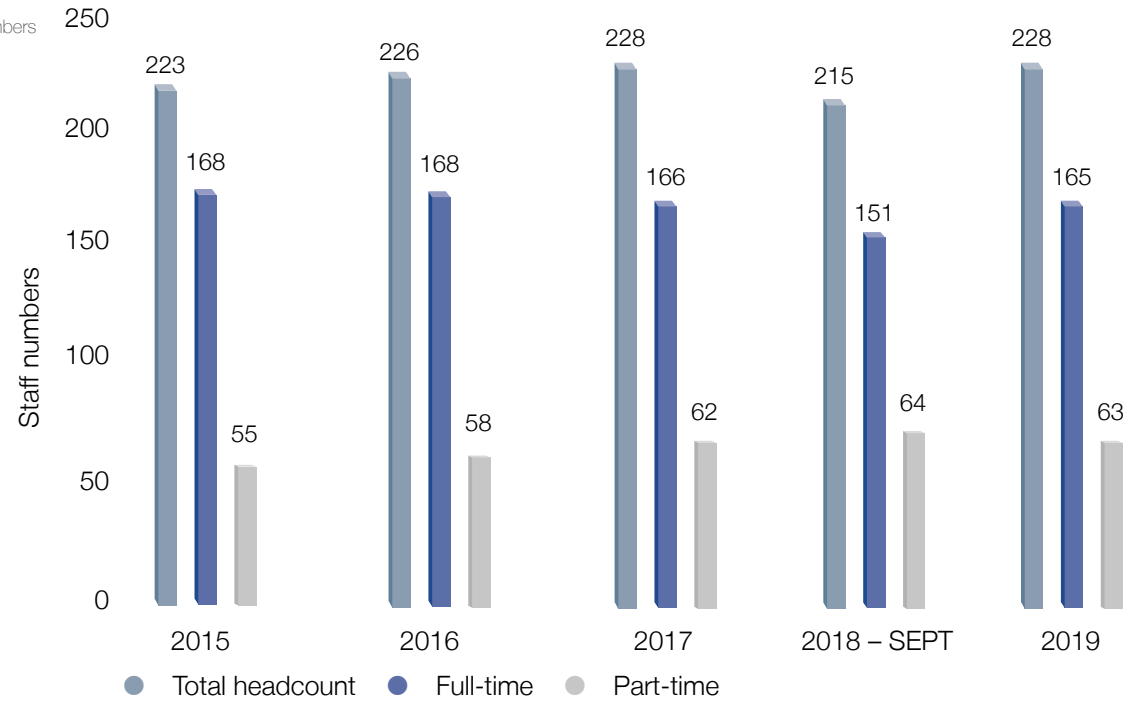
Staffing

It is not surprising that staffing is the single biggest service delivery cost at $25.5 million or 35 per cent of the total cost base. This includes $4.3M for those staff employed under external funding agreements or category 2 such as STP, who have set employment terms in line with the agreed funding. Staffing for core operations or category 1, accounts for $21.2 million of the above total and due to a number of organisational restructure measures throughout 2018 represents an annual increase of less than 1 per cent. There are no staffing costs for the work of the Foundation or category 3 in keeping with the long standing principle that 100 per cent of all donations received go where they are needed most.

Core revenues

About 95 per cent of total operational revenues of $49.4M come from three activities. Training, examination and assessment fees make up 50 per cent; Fellows annual subscriptions 37 per cent; and conference registrations and sponsorship across various events is 8%. Repositioning our skills training courses has been important in response to increased market competition with fee increases contained and a strategic focus on the mix and volume of courses offered. The budget ▶

Figure 3: Staffing Numbers



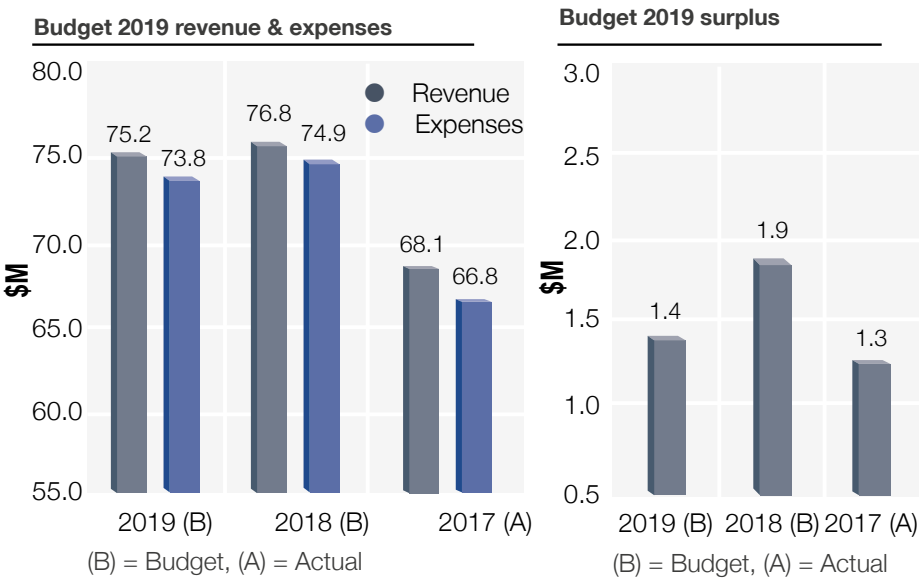


Figure 4: Budget 2019 – All Categories - Financial Performance

also factors in lower exam candidate numbers from the prevocational sector which have normalised from the peaks of 2016. Fellow's annual subscription fees have been capped to CPI of 2 per cent.

Investments and funding scholarships

RACS is very proud of its long-standing commitment to offer a large number of scholarships, awards, lectures and prizes under the umbrella of the Foundation for Surgery. As we have carefully managed the investment funds and thus over time the capability to expand the annual scholarship program has seen the minimum commitment grow to $1.7 million in 2019. Council for future budget years has approved a strategic funding aim to commit to funding of up to $2.5 million annually.

Surplus

Council supports that each budget should aim for a modest surplus. Across all categories the goal is to achieve a surplus of $1.4 million representing a 1.8 per cent surplus return on overall revenues of $75.2 million. At the end of each year, this surplus can then be allocated to fund future new key initiatives (NKIs) or added to the Corpora.

New key initiatives

In selecting new initiatives, the focus has been very much on prioritisation of strategic investments, improving service, supporting our Fellows, Trainees and IMGs and quality improvements. Some of the key investments include:

- Initiating the Continuing Professional Development (CPD) project as part of strategy of investment in improving the opportunities for Fellows professional growth.
- Developing a more streamlined customer service support for our Fellows, Trainees and IMGs via the concept of a concierge service model.
- Developing a peer support program as part of the BRIPS complaints framework.
- Ongoing enhancement of educational activities with multi-year roll out of Education Program of Works related to our AMC accreditation.

Selection of key 2019 RACS fees

Fee description all GST inclusive (unless otherwise indicated*)	AUD$ 2019	NZD$ 2019
Annual subscription	3,195	3,565
Fellowship entrance fee	6,105	6,830
SET annual training fee - RACS	3,545*	4,405
Fellowship examination fee	8,495*	10,555
Pre Vocational – Generic Surgical Science examination fee	4,495	5.080
IMG Specialist assessment fee	10,175	N/A

For summary listing of key 2019 fees refer to RACS website www.surgeons.org *GST Exempt

- Further technology enhancements to support the Digital College including new investment in online registration and enrolment systems and improved
- eCommerce capabilities.
- Closing out final examination delivery improvements related to question management systems and tablet marking.

All up the continuing work and NKI's for 2019 have a total funding allocation of $1 million.

Budget 2019 in summary

Council supports this prudent budget that takes into account many internal and external impacting factors. Budget 2019 ensures the core operations of Fellowship services and education and training are appropriately resourced, and that our strategic imperatives will be achieved. We also remain committed to funding surgical research initiatives and charitable endeavours now and into the future. Budget 2019 achieves what the Fellowship should see as a sound budget setting enabling a modest surplus result that is sufficient to build future capacity for any unexpected challenges while also maintaining good fiscal stewardship for RACS.

Associate Professor Julie Mundy
College Treasurer

Developing a Career and skills in Academic Surgery (DCAS) course

Monday 6 May 2019, 7:15am - 4:00pm

Centara Grand & Bangkok Convention Centre, Bangkok

Provisional Program

6:15am	Registrations open
7:15am - 7:30am	Welcome and introduction
7:30am - 9:30am	**Session 1: A Career in Academic Surgery**
7:30am - 7:50am	What is an academic surgeon
7:50am - 8:10am	How to get research started
8:10am - 8:30am	Research pathways: Outcomes, translational, educational, basic science – which one is right for you?
8:30am - 8:50am	Tech options for data collection
8:50am - 9:10am	How to keep academic balance - clinical work, research, teaching and leadership
9:10am - 9:30am	Discussion
9:30am - 10:00am	Morning tea
10:00am - 10:30am	**Hot topic in Academic Surgery: Big Data**
10:30am - 12:30pm	**Session 2: Ensuring Academic Output**
10:30am - 10:50am	Writing an abstract
10:50am - 11:10am	Writing and submitting a manuscript
11:10am - 11:30am	Presenting at a scientific meeting
11:30am - 11:40am	Discussion
11:40am - 11:45am	**Keynote Presentation: Transforming health outcomes – how a surgeon can do it**
12:30pm - 1:30pm	Lunch
1:30pm - 2:40pm	**Session 3: Concurrent Academic Workshops**

Concurrent workshop 1:
Early career development "What can I do to enhance my academic career?"

- Student
- Junior doctor
- Registrar
- Finding a mentor and being a mentee
- Supporting yourself through fulltime research

Concurrent workshop 2:
Tools to help with research

- Data storage
- Understanding statistics for clinical research and trials
- Navigating the ethics framework – human, ethics, animal and tissue banks
- Building teams and collaborations

Concurrent workshop 3:
Getting funded

- Tips for successful grants
- Beyond NHMRC - seeking support from non-Government sources
- NHMRC and MRFF – impact of a rapidly changing funding landscape
- Industry funding / partnerships benefits and pitfalls

2:40pm - 3:00pm	Afternoon tea
3:00pm - 4:00pm	**Session 4: Thriving in Academic Surgery** Leadership, mentorship and sponsorship Work life balance Where are the gaps - future trends in research Closing remarks

DCAS course participation

Cost: $220.00 per person GST not applicable

Register online: www.tinyurl.com/DCAS2019

There are fifteen complimentary spaces available for interested medical students. Medical students should register their interest to attend by emailing dcas@surgeons.org

Further information:

Conferences and Events Management
Royal Australasian College of Surgeons
T: +61 3 9249 1260
F: +61 3 9276 7431
E: dcas@surgeons.org

Presented by:
Association for Academic Surgery in partnership with the RACS Section of Academic Surgery.

AAS Association for Academic Surgery

Royal Australasian College of Surgeons
Section of Academic Surgery

Proudly sponsored by: Johnson & Johnson MEDICAL DEVICES COMPANIES

Hot topic speaker:

Amir Ghaferi

Keynote speaker:

Christobel Saunders

Who should attend?

Surgical Trainees, research Fellows, early career academics and any surgeon who has ever considered involvement with publication or presentation of any academic work.

If you have been to a DCAS course before, the program is designed to provide previous attendees with something new and of interest each year.

2018 comments:

"Fantastic event that has reaffirmed my passion for academia in surgery. I can't wait to be back next year"

"Outstanding course in every regard"

"Usual high standard maintained. Excellent faculty"

"This is a life changing course. It gives me new tools and goals as a medical student and for my future career"

Association for Academic Surgery invited speakers:

Karl Bilimoria - Illinois, USA
Amir Ghaferi - Michigan, USA
Fabian Johnston - Maryland, USA
Colin Martin - Alabama, USA
Caroline Reinke - North Carolina, USA
Drew Shirley - Ohio, USA

Australasian Faculty:

Sarah Aitken - New South Wales
John Batten - Tasmania
Jane Cross - New South Wales
Marc Gladman - South Australia
Andrew Hill - Auckland
Julie Howle - New South Wales
Jonathan Karpelowsky - New South Wales
Christine Lai - South Australia
James Lee - Victoria
Michelle Locke - Auckland
Guy Maddern - South Australia
Greg O'Grady - Auckland
Tarik Sammour - South Australia
Julian Smith - Victoria
Mark Smithers - Queensland
James Toh - New South Wales
David Watson - South Australia
John Windsor - Auckland
Deborah Wright - Birmingham, England

NOTE: New RACS Fellows presenting for convocation in 2019 will be required to marshal at 4:15pm for the Convocation Ceremony.

CPD points will be awarded for attendance at the course with point allocation to be advised at a later date.

Information correct at time of printing, subject to change without notice.

General Surgery Trainees who attend the RACS Developing a Career and skills in Academic Surgery course during their SET Training may, upon proof of attendance submitted to board@generalsurgeons.com.au, count this course towards one of the four compulsory GSA Trainees' Days.

RACS Visitor Grant Program 2018

Fellowship Services Department

As a Fellowship based organisation, RACS is committed to excellence in surgical education and practice. RACS provides funding for scientific visitors of note from Australia, New Zealand and internationally to attend Specialty Society, Association and Sub-Specialty conferences.

RACS is pleased to profile the scientific visitors it has supported in 2018 through the RACS Visitor Grant Program, and would like to thank all applicants and congratulate the successful grant recipients.

Australasian Hand Surgery Society (AHSS)

AHSS Annual Scientific Meeting

28 February – 3 March 2018, Perth

Visitor: Dr Daniel Herren, Chief of Hand Surgery and Chief Medical Officer, Schulthess Klinic, Zurich, Switzerland

Presentations:

- Update on Surgery of the Rheumatoid Hand
- Small Joint Arthroplasty
- Basal Thumb Arthritis
- To Fuse or Not to Fuse? That is the Question
- Outcome Measurement in Hand Surgery
- Patient Specific Implants for Correction of Radius Malunion: Is it Needed?
- Treatment of Dupuytren's Disease: The Swiss Perspective

Australia and New Zealand Gastric and Oesophageal Surgery Association (ANZGOSA)

ANZHPBA/ANZGOSA 2018 Meeting 'Risk: measurement and management'

8 – 9 October 2018, Wellington

Visitor: Dr David Flum, Director of Surgical Outcomes Research Center, Medical Director of the Surgical Care and Outcomes Assessment Program Comparative Effectiveness Research Translation Network, UW Professor of Surgery and adjunct Professor of Health Services and Pharmacy, University of Washington USA.

Presentations:

- Tools for predicting risk
- Patient centred outcomes
- Practice bench marking and risk adjustment

Australia and New Zealand Hepatic, Pancreatic and Biliary Association (ANZHPBA)

ANZHPBA/ANZGOSA 2018 Meeting 'Risk: measurement and management'

8-9 October 2018, Wellington

Visitor: Associate Professor Thomas Aloia, Hepatobiliary Surgical Oncologist in the Gastrointestinal Center at the University of Texas MD Anderson Cancer Center.

Presentations:

- Preoperative psychological testing?
- Small remnant syndrome and ALPPS
- Laparoscopic approach (discussion)
- Spontaneous hepatic haemorrhage

Australian & New Zealand Society of Cardiac and Thoracic Surgeons (ANZSCTS)

ANZSCTS 27th Annual Scientific Meeting 2018

7 – 11 November 2018, Noosa

Visitor: Professor Dr. Volkmar Falk MD, Medical Director and Director of the DHZB Department of Cardiothoracic and Vascular Surgery of the German Heart Center Berlin and Chair of the Division of Cardiovascular Surgery at the Charité Berlin.

Presentations:

- Heart failure strategies and new artificial heart systems
- Minimally invasive valve surgery
- Minimally invasive mitral valve repair - Volume outcome relation and implications for training
- 2018 ESC/EACTS guidelines on myocardial revascularization
- Mechanical circ support - new momentum?
- TAVI - a surgical procedure?

Australian and New Zealand Society for Vascular Surgery (ANZSVS)

ANZSVS 2017 Annual Scientific Conference

29 September – 1 October 2018, Auckland

Visitor: Dr Dainis Krievins, Director of Institute of Research and Chief of Endovascular Program at Pauls Stradins Clinical university Hospital.

Presentations:

- Pre-operative coronary CT-Fractional Flow Reserve (FFR-CT) evaluation may reduce risk of post-op MI/ death
- Thinking outside the circle: Kissing endografts for AAA
- The Percutaneous bypass: How it is done
- Healthcare delivery in Eastern Europe - How is it done?

Australian Orthopaedic Association (AOA)

AOA 2018 Annual Scientific Meeting

7 – 11 October 2018, Perth

Visitor: Professor Keith Willett, Medical Director for Acute Care and Emergency Preparedness to NHS England and Professor of Orthopaedic Trauma Surgery at the University of Oxford.

Presentations:

- Platelet Rich Plasma for acute Achilles tendon rupture: results of the PATH-2 study, a double-blind multicentre randomised placebo-controlled trial.
- Trauma registry insights to improve patient care
- Lessons from NOF fracture management programs in the UK.
- Address to AORA - Australian Orthopaedic Registrars Association at their dedicated meeting on Sunday 7 October.
- Formal address at the AOA opening ceremony – 'Better Patient Outcomes'
- Motivational address to new Fellows at the Formal Fellowship Ceremony.

Visitor: Gerald B. Hickson, Senior Vice President of Quality, Safety and Risk Prevention and Joseph C. Ross Chair of Medical Education and Administration at Vanderbilt University Medical Center.

Presentations:

- We can identify high risk professionals, but do they know they are at risk? And can we do anything to help?
- Patient stories identify surgeons with evidence of neurocognitive disorders, 'He has his good days and his bad days'.
- Address to Australian Orthopaedic Registrars Association (AORA) at their dedicated meeting on Sunday 7 October.
- Formal address at the AOA opening ceremony – 'Better Patient Outcomes'.

Australasian Orthopaedic Trauma Society (AOTS)

2018 AOTS Annual Scientific Meeting

22 – 24 June 2018, Noosa

Visitor: Professor Endre Varga, Head of Trauma Department and Head of Central Operations Rooms and Sterilization Unit at the Department of Trauma Surgery, University of Szeged, Hungary

Presentations:

- Case Discussion on Pelvic Fractures
- The Failed Neck of Femur Fracture – my experience in salvage
- The Future of Trauma Surgery – Planning, Navigation and 3D Printing
- Chest Wall Stabilisation

Australasian Society of Aesthetic Plastic Surgeons (ASAPS)

41st Annual ASAPS Conference

2 – 5 August 2018, Auckland

Visitor: Dr Jay Calvert - Board Certified Plastic Surgeon who graduated from Cornell University Medical College. He has practices in Beverly Hills and Newport Beach with 23 years of experience. He has a special focus on rhinoplasty, secondary rhinoplasty, and nasal reconstruction.

Presentations:

- Primary Rhinoplasty: Analysis and Planning
- Asian Rhinoplasty
- Nasal Tip Support Revisited
- Dorsal Grafting with Diced Cartilage and Fascia Grafts
- Secondary Rhinoplasty: Strategies for Success
- Rib Grafts in Secondary Rhinoplasty
- Building a Rhinoplasty Practice
- My approach to nasal reconstruction

Dr Calvert's talk was attended by specialist plastic surgeons from Australia and New Zealand including SET Trainees in plastic surgery.

Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS)

ASOHNS Annual Scientific Meeting 2018

9-11 March 2018, Perth

Visitor: Dr David Eisele, Andelot Professor and Director of the Department of Otolaryngology, Head and Neck Surgery, Johns Hopkins University School of Medicine, Baltimore, USA.

Presentations:

- Surgical Management of Parotid Malignancy
- Facial Nerve Monitoring In Parotid Surgery

- Management of Salivary Stones
- Management of Metastatic SCC With Unknown Primary
- Parapharyngeal Space Tumours- New Perspectives

Visitor: Professor Rhona Flin, Emeritus Professor, Industrial Psychology Research Centre, William Guild Building, Kings College, University of Aberdeen, United Kingdom

Presentations:

- Non-Technical Skills – Why They Should Matter to You
- Dissecting Surgeons' Intra-Operative Decision Making

General Surgeons Australia (GSA)

GSA & PISA 2018 Combined ASM – Emergency Responses & Humanitarian Aid

1 – 4 October, 2018, Fiji

Visitor: Dr Walter Johnson MD MPH MBA, Lead, Emergency & Essential Surgical Care Programme, World Health Organization, Geneva, Switzerland.

Presentations:

- Keynote Address: Emergency and Essential Surgical Care Programme
- Keynote Address: WHO Collaborating Centres and Partnerships
- Non-communicable diseases: Where does WHO see surgery's role?

Visitor: Dr Stephen Bickler MD FACS - Professor of Surgery & Pediatrics - University of California San Diego; Attending Pediatric Surgeon - Rady Children's Hospital, San Diego.

Presentations:

- Keynote Address: Economic case for surgical care in low resource setting
- Keynote Address: Optimal resources for children's surgical care in low-and middle-income countries"

Provincial Surgeons of Australia (PSA)

PSA 2018 Annual Scientific Congress

25 – 27 October 2018, Bundaberg

Visitor: Dr Lauren Smithson, General Surgeon - Charles S. Curtis Memorial Hospital, St Anthony, Canada; founder and co-President of SYRUS - Society for Young Rural Surgeons.

Presentations:

- Society for Young Rural Surgeons
- Trainees Session with Lauren Smithson
- Keynote Address: The challenges in my practice

New Zealand Association of Plastic Surgeons (NZAPS)

NZAPS Annual Scientific Meeting

3 – 5 August 2018, Auckland

Visitor: Dr Foad Nahai, Editor in Chief of Aesthetic Surgery Journal, Maurice J Jurkiewicz chair in Plastic Surgery and Professor of Surgery at Emory University. He practices at the Emory Aesthetic Center in Atlanta Georgia USA.

Presentations:

- Four Critical Concepts to consider in any Facelift Technique: Incision, Flap Elevation and Fixation, Volume Management and Ancillary Procedures
- Facial Rejuvenation Injectables vs Surgery
- Blepharoplasty in 2018: 40 years of breast reductions: What have we learned?
- Insights from the Editor of ASJ
- Invited oration: 'Real Leadership in a World of Fakes'

New Zealand Orthopaedic Association (NZOA)

NZOA Annual Scientific Meeting

14 – 17 October 2018, Rotorua, New Zealand

Visitor: Professor Colin R Howie MB., Ch.B., FRCS (Ed Glas) OrthCons Orth Surgeon and Hon Professor Edinburgh University.

Presentations:

- Removing well fixed implants in revision hip replacement
- RACS Guest Lecture: Outcomes, Registers and Evidence of Orthopaedic Success
- Solutions – Multi-centre RCT in Scotland

Urological Society of Australia and New Zealand (USANZ)

USANZ 71st Annual Scientific Meeting

24 – 27 February 2018, Melbourne

Visitor: Dr Michael Lipkin, Associate Professor of Urologic Surgery at Duke University, USA.

Presentations:

- Medical management of stone disease – guideline consensus on stone prevention
- Treating and surveying the upper tract
- Prone PCNL – technique and indication
- Technological innovations in stone management

Ruth Bollard
Chair,
Fellowship Services Committee

Please visit https://www.surgeons.org/member-services/racs-visitor-grant-program/ for more information about the Program.

Travelling for RACS business

RACS has engaged Corporate Traveller as the preferred travel supplier to manage domestic and international travel services for RACS related business.

RACS has implemented an online booking tool through Corporate Traveller called Serko which will manage all your travel needs including flights, hotels and car hire online.

Log on to the RACS website http://portfolio.surgeons.org and under useful links select Book Travel

Royal Australasian College of Surgeons

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Website: www.surgeons.org

Fellowship Survey 2017 – action on your feedback

Twelve months have now passed since the 2017 RACS Fellowship Survey was conducted. The survey gauged the views of Fellows to ensure that RACS services and activities were meeting the needs of the Fellowship. The results are an important source of information for strategic planning, to identify areas for improvement, and the strengths and challenges for surgery in the coming years.

Open to all active and retired Fellows, the online survey had a response rate of 20.4 per cent (n=1403). A summary of the results were published earlier in the year. I would like to take this opportunity to look at some of the qualitative results based on your comments and reflect on progress in response to feedback.

Fellows were asked to identify areas for improvement and how these can be achieved. Nearly 600 Fellows provided comment on improvements, and many of the themes raised as areas for improvement were also recorded as perceived strengths and/or identified as ongoing challenges for RACS.

Organisational improvements

The most frequently suggested improvement was to reduce fees. Fellows questioned the cost of Surgical Education and Training (SET) Program fees, raising this as a pressure point for Trainees and called for greater transparency around fees in general.

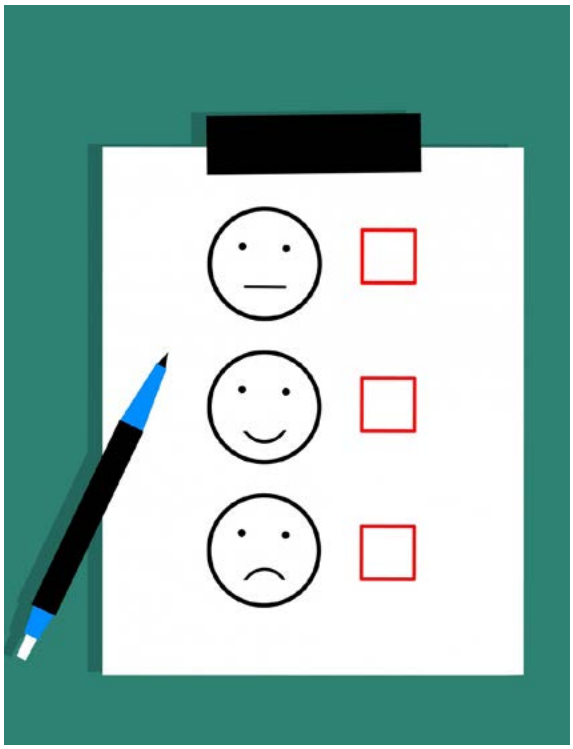
A commitment has been made to cap RACS fees to CPI for 2019. There are a number of subscription concessional fee categories available that better reflect the changing work circumstance of our Fellows. More information is available from https://www.surgeons.org/about/college-fees/

Fellows wish to see a more streamlined governance structure, improvements to the website as well as reduced bureaucracy.

RACS is continuing a period of renewal with the appointment of CEO Mary Harney and an organisational and engagement review. A number of boards and committees are being amalgamated (e.g. Board of Surgical Education Training and Education Board) or disbanded. Changes are also being considered to the size and role of Council. Policies are being rationalised and streamlined. RACS is preparing to launch a new website, based on consultation with Fellows, updating content and providing a more intuitive user experience.

Relationships with Specialty Societies and Associations

The second most frequently identified improvement was to strengthen relationships with Specialty Societies and Associations.



Collaboration with our surgical partners will be a major focus for the 2019 – 2021 RACS Strategic Plan. Relationships are improving. The complementary roles of Specialty Societies and RACS offer the opportunity to extend the influence and reach of the surgical profession, not only for quality surgical education and training but for patient safety and advocacy.

Surgical Education and Training (SET) Program

Fellows wish to see improvements made to the SET Program including the candidate selection process, managing underperformance and better support for Trainees and newly admitted Fellows the most frequently identified issues.

A workshop was held in April this year to consider the findings of studies into SET outcomes and review selection processes. Professor Julian Archer has been appointed to the position of Executive General Manager, Education at RACS to oversee education and training, commencing in January 2019. Julian is a leading expert on medical education design and workplace based assessment, establishing the Collaboration of the Advancement of Medical Education Research & Assessment (CAMERA) at Plymouth University Peninsula Schools of Medicine and Dentistry, United Kingdom. The Fellowship Services portfolio is also reviewing

communication and support for newly admitted Fellows transitioning to consultant practice.

Workforce issues

Fellows identified the need for better regional representation and a greater focus on workforce planning, including succession planning. The issue of sub-specialisation and the effect it has on the surgical workforce was also raised in the survey.

RACS hosted two Australian rural and regional surgical workforce summits in March and September, with the first focused on training, discussing issues across specialties with training board representatives. The second expanded that discussion to include state workforce representatives, State Chairs, the Chair of the Medical Deans of Australia and New Zealand and the National Rural Health Commissioner to progress a coordinated approach to improving surgical training and workforce growth in rural and regional areas. RACS continues to collect important data via the RACS Census for workforce planning.

The Board of Council has commenced regular meetings in the states, territories and New Zealand to increase engagement on local workforce and quality improvement issues. Board of Council meetings have been held in New Zealand, Queensland and Western Australia in 2018, allowing RACS Councillors to attend State and National committee meetings.

Feedback from the 2017 Fellowship Survey has informed the 2019 – 2021 RACS Strategic Plan and we look forward to sharing this with you shortly. Thank you again to the Fellows who provided valuable feedback. We will continue to make improvements to RACS services and programs to ensure we meet the needs of all RACS Members. We are listening!

The 2017 Fellowship Survey Report is available at www.surgeons.org

Ms Ruth Bollard
Chair,
Fellowship Services Committee

A case note review

Major complication being sepsis and subsequent death following an elective surgical intervention

Case summary:

A 72 year old patient with multiple co-morbidities underwent an elective procedure at a metropolitan pubic hospital and was subsequently transferred to a rural hospital. A general practitioner at the rural hospital noted ischemia or gangrene and immediately arranged transfer back to the metropolitan hospital. The assessor in this case expressed concern that, despite the 'serious clinical circumstance portrayed in the medical record', the treating team persisted with conservative management for a further nine days before surgical debridement. The assessor commented:

Clinical lessons:

With an individual suffering from major medical co-morbidities and who was initially well stabilised in the early period post-transfer to this major metropolitan hospital, one would normally consider prompt debridement of ischemic/gangrenous tissue. The patient was recorded repeatedly as having episodes of confusion and agitation, clinically consistent with a degree of uncontrolled sepsis or infection. Despite repeated assessments from medical officers trained to provide more specialised intensive care medicine, at no time was there a recommendation to transfer the patient to a higher care unit in the hospital.

Professor Guy Maddern
Surgical Director of Research and Evaluation incorporating ASERNIP-s

Courses for every stage of your career

Online registration form *is now available (login required).*

The 'Active Learning with Your Peers 2018' booklet contains professional development activities enabling you to acquire new skills and knowledge and reflect on how to apply them in today's dynamic world.

Mandatory courses

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

- Foundation Skills for Surgical Educators course: Mandatory for SET Surgical Supervisors, Surgeons in the clinical environment who teach or train SET Trainees, IMG Clinical Assessors, Research supervisors, Education Board members, Board of Surgical Education and Training and Specialty Training Boards members.
- Operating with Respect one-day course: Mandatory for SET Supervisors, IMG Clinical Assessors and major RACS Committees.

Foundation Skills for Surgical Educators course (FSSE)

19 November 2018	Sydney	NSW
23 November 2018	Perth	WA
1 December 2018	Melbourne	VIC
2 December 2018	Canberra	ACT
8 December 2018	Auckland	NZ
10 December 2018	Melbourne	VIC

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

Operating with Respect course (OWR)

11 November 2018	Hobart	AU
22 November 2018	Melbourne	AU

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

Academy of Surgical Educators Studio Sessions

Each month, the Academy of Surgical Educators presents a comprehensive schedule of education events curated to support surgical educators.

The Educator Studio Sessions are presented around Australia and New Zealand and deliver topics relevant to the importance of surgical education and help to raise the profile of educators. They provide insight, a platform for discussions and an opportunity to learn from experts.

All sessions are also simulcast via webinar. Register here: www.surgeons.org/studiosessions

Safer Australian Surgical Teamwork (SAST)

24 November 2018	Perth	WA

SAST is a combined workshop for surgeons, anaesthetists and scrub practitioners. The workshop focuses on non-technical skills which can enhance performance and teamwork in the operating theatre thus improving patient safety.

It explores these skills using three frameworks developed by The University of Aberdeen, Royal College of Surgeons of Edinburgh and the National Health Service - Non-Technical Skills for Surgeons (NOTSS), Anaesthetists Non-Technical Skills (ANTS) and Scrub Practitioners' List of Intra-operative Non-Technical Skills (SPLINTS). These frameworks can help participants develop the knowledge and skills to improve their performance in the operating theatre in relation to communication/teamwork, decision making, task management/leadership and situational awareness. The program looks at the relationship between human factors and safer surgical practice and explores team dynamics. Facilitators will lead participants through a series of interactive exercises to help reflect on performance and that of the operative team.

Surgeons as Leaders in Everyday Practice

23-24 November 2018	Melbourne	VIC

Surgeons as Leaders in Everyday Practice is a one and a half day program which looks at the development of both the individual and clinical teams' leadership capabilities. It will concentrate on leadership styles, emotional intelligence, values and communication and how they all influence their capacity to lead others to enhance patient outcomes. It will form part of a leadership journey sharing and gaining valuable experiences and tools to implement in the own workplace. All meals, accommodation and educational expenses are included in the registration fee. The evening session will involve an inspirational leadership speaker.

Process Communication Model Seminar 1

16 -18 November 2018	Adelaide	SA

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

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

Partners are encouraged to register.

Clinical Decision Making

30 November 2018	Adelaide	SA

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

Non-Technical Skills for Surgeons (NOTSS)

23 November 2018	Sydney	NSW

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

Younger Fellows Forum

2019 Younger Fellows Forum, Bangkok, Thailand

Friday 3 May - Sunday 5 May 2019

The Younger Fellows Forum will once again precede the 2019 ASC in Bangkok. The forum provides a unique opportunity for a diverse group of younger fellows (those gaining fellowship within the last 10 years) to meet and discuss issues that are of importance to the college now and going into the future. Delegates will gain a greater understanding of the workings of the college, meet new friends in a relaxed environment and have the opportunity debate important issues facing surgeons in 2019 and beyond.

Applications for 2019 YFF are now open via an online nomination form https://www.surgeons.org/181074.aspx.

Nominations will close second week of December 2018. Please note the forum is limited to 20 places.

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

PROFESSIONAL DEVELOPMENT WORKSHOP DATES: October - December 2018

ACT		
Foundation Skills for Surgical Educators	2 Dec	Canberra
NSW		
Foundation Skills for Surgical Educators	19 Nov	Sydney
Non-Technical Skills for Surgeons	23 Nov	Sydney
NZ		
Foundation Skills for Surgical Educators	8 Dec	Auckland
VIC		
Surgeons as Leaders in Everyday Practice	23-24 Nov	Melbourne
Foundation Skills for Surgical Educators	1 Dec	Melbourne
Foundation Skills for Surgical Educators	10 Dec	Melbourne
WA		
Foundation Skills for Surgical Educators	23 Nov	Perth
Safer Australian Surgical Teamwork	24 Nov	Perth
SA		
Process Communication Model Seminar 1	16-18 Nov	Adelaide
Clinical Decision Making	30 Nov	Adelaide

Register online

For future course dates or to register for any of the courses detailed above, please visit https://www.surgeons.org/for-health-professionals/register-courses-events/
Contact the Professional Development Department on +61 3 9249 1106 or email **PDactivities@surgeons.org**

Appreciating our educators

Thank You to all of our SET Supervisors, PD Facilitators, IMG Clinical Assessors who have contributed to surgical education and training in the RACS community. We wish to acknowledge the following educators in achieving these service milestones (as of 31 December 2018*):

Those who have served for 9 years or more

SET Supervisors
Dr Sumit Yadav
Mr Robert Stuklis
Dr Yves D'Udekem
Mr Moheb Ghaly
Mr Stephen Allison
Mr Midhat Ghali
Mr Stephen Clifforth
Assoc Prof Vijayaragavan Muralidharan
Mr Allan Smith
Mr Stephen Fulham
Mr Ralph Gourlay
Dr Linda Fenton
Mr Thomas Bowles
Mr Gerard Coren
Mr Stephen Jancewicz
Dr Katherine Martin
Mr Andrew Parasyn
Prof Glenn Guest
Mr Pravin Kumar
Mr Atul Dhabuwala
Dr Arvind Dubey
Mr Nikitas Vrodos
Mr Michael Edger
Mr James Baker
Mr David Pohl
Mr Martin Forer
Dr William Johnston
Mr Ian Jacobson
Assoc Prof Nigel Biggs
Mr Thomas Kertesz
Dr Roger Grigg
Mr Michel Neeff
Mr Dilhan Cabraal
Mr David Vokes
Dr Margaret Pohl
Dr Elizabeth Whan
Dr Roland Jiang
Mr Terry Wu
Dr Elias Moisidis
Assoc Prof John Vandervord
Dr Richard Rahdon
Mr Graham Sellars
Mr Richard Wong She
Dr Raymond Ko
Mr Gordon O'Neill
Mr Brendan Stanley
Dr Wendell Neilson
Mr Mark Lovelock
Dr Lubomyr Lemech
Dr Ravi Huilgol
Assoc Prof David McClure
Prof Justin Roake
Dr Mark Jackson
Mr Laurence Ferguson
Dr Bernard Bourke
Dr Jennifer Chambers
Mr Alan Saunder
Mr Vikram Puttaswamy
Dr Phillip Puckridge
Dr Mathew Sebastian
Mr Kevin Varty
Mr Francis Kimble
PD Facilitator
Dr John North
IMG Supervisor
Mr Donald Pitchford
Mr Scott Fletcher

Those who have served for 6 years

SET Supervisors
Dr Cheng-Hon Yap
Mr Peter Skillington
Dr Ashutosh Hardikar
Mr David Bird
Dr David Taylor
Mr Dean Fisher
Mr David Koong
Mr Robert Tasevski
Mr Ken Davey
Mr Hugh Lukins
Mr Quentin Ralph
Assoc Prof Robert Spychal
Dr Ollapallil Jacob
Dr Sarah Martin
Mr Steven Kelly
Dr Simon Bann
Dr Andrew Kam
Mr David McDowell
Dr John-Charles Hodge
Mr Simon Ellul
Dr Michael Chin
Mr Brent Uren
Dr Adnan Safdar
Mr Christopher Que Hee
Dr Benjamin Wallwork
Mr Simon Hadlow
Mr Dawson Muir
Mr Teariki Maoate
Dr Catherine Boorer
Mr Derek Neoh
Mr David McCombe
Mr Steve Merten
Dr David Stewart
Mr Shiby Ninan
Mr Kenneth Lee
Dr James Southwell-Keely
Mr Peter Randle
Dr Agneta Fullarton
Mr Roger Hinsch
Dr Garrath Evans
Dr Nader Awad
Mr Rupert Ouyang
Mr Niall Corcoran
Dr Jon Paul Meyer
Dr Chi Huynh
Dr Peter Vanniasingham
Mr Mark Westcott
Mr David Ferrar
Mr Jason Chuen
PD Facilitator
Dr Jai Bagia
Mr Ian Gilfillan
Dr Sylvia Provenzano
IMG Supervisor
Prof Glyn Jamieson
Dr John North
Mr Robert Stunden
Prof Neil Merrett
Mr Dugal James
Mr Rami Sorial
Mr Nikitas Vrodos
Mr David Mitchell

Those who have served for 3 years

SET Supervisors
Dr Yishay Orr
Mr Sean Galvin
Dr Sheen Peeceeyen
Dr Michael Byrom
Mr Phillip Harris
Prof RichardTurner
Mr Julian Choi
Assoc Prof Anil Keshava
Dr Corinne Ooi
Dr Susan Taylor
Mr Brendan Mooney
Mr Michael Law
Mr Christian Sutherland
Mr Sanjeeva Kariyawasam
Assoc Prof Navin Niles
Dr Tony Palasovski
Dr Grace Lim
Dr Christos Apostolou
Dr Priscilla Martin
Dr Craig McBride
Assoc Prof Mark Sywak
Mr Peter Stiven
Dr Mark Dexter
Dr Jacob Fairhall
Mr Simon John
Dr Ananthababu Sadasivan
Dr Patrick Schweder
Mr Christopher Thien
Prof Christopher Lind
Mr Matthew Taylor
Mr Halil Ozdemir
Mr Brent McMonagle
Mr Michael Switajewski
Assoc Prof Shyan Vijayasekaran
Dr Piera Taylor
Dr David Hall
Dr Theodore Athanasiadis
Dr Timothy Makeham
Dr Damien Phillips
Dr Faruque Riffat
Assoc Prof Larry Kalish
Dr Andrew Wood
Mr Bruce Currie
Dr Angus Alexander
Dr Japinder Khosa
Mr Sanjeev Khurana
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Mr Rohan Hall
Dr Kathryn McLeod
Dr Marc Heinau
Mr Paul Sved
Mr Andrew Malcolm
Mr Stephen Brough
Dr Andrew Lienert
Dr Ewan Macaulay
Miss Sarah Hulme
PD Facilitator
Dr Marion Andrew
Ms Debbie Paltridge
Assoc Prof Shane Brun
IMG Supervisor
Mr Gerard Powell
Mr Allen-John Collins
Mr Adrian Trivett
Prof David Wood
Dr Robert French
Mr Hugh Martin
Mr Gordon Arthur
Mr Peter Pohlner
Mr Garrett Hunter
Mr Robert Boyle
Mr Donald Laing
Mr Robert Ventura
Dr Stephen Clarke
Assoc Prof Phillip Spratt
Mr Peter Tamblyn
Mr Neil Scholes
Mr Alexander Grant
Prof Noel Tait
Mr Ian Campbell
Assoc Prof Elton Edwards
Mr Chandrashekar Patel
Mr Francis Quigley
Mr David Chan
Dr Hilary Boucaut
Mr Jeffrey Myers
Prof Robert Berkowitz
Assoc Prof Peter Devitt
Mr David Hall
Mr Ian Davis
Mr Peter Bryan
Assoc Prof Julie Mundy
Mr Ngalu Havea
Prof Fiona Wood
Mr Stanley Chen
Mr William Lynch
Dr Elizabeth Rose
Prof Peter Choong
Assoc Prof Michael Murphy
Mr Andrew Graham
Assoc Prof Surendranath Krishnan
Assoc Prof Gary Morgan
Mr Gerard Hardisty
Prof David Little
Dr Scott Campbell
Mr Colin Reid
Dr Andrew Ellis
Mr Russell Bourne
Assoc Prof Christopher Young
Mr Niall McConchie
Assoc Prof Thomas Hughes
Dr Robert Davies
Mr Mark Duncan-Smith
Mr Andrew Mitchell
Prof Stephen O'Leary
Mr Simon Ellul
Dr Ralph Stanford
Mr Stephen Megson
Mr Christopher Kirby
Dr Michael Delaney
Mr Mark Hurworth
Assoc Prof Anil Keshava
Mr Albert Erasmus
Mr Mark Guirguis
Mr Arvind Deshpande
Dr Emma Corrigan
Prof Peter Cosman
Mr James French
Mr Anuradha Jayathillake
Mr Philip Jumeau
Mr David Scott
Mr Dennis King
Mr Melvyn Kuan
Prof Christopher Lind
Prof Richard Naunton Morgan
Mr Ulrich Dorgeloh
Dr Jamie Reynolds
Mr Matthew Ryan
Dr Kevin Seex
Mr Andrew Thompson
Dr Pauline Waites
Dr Adrian Westcott
Mr Benjamin Witte
Prof Andrew Carney
Mr Kevin Tetsworth
Prof Lucian Solomon
Dr Matthew Wilkinson
Mr Christian Sutherland
Mr Christopher O'Brien
Mr Raad Almehdi
Mr Andrew Swanston
Mr Matthew Oliver
Prof Zsolt Balogh
Dr Simon Journeaux
Mr Narayanan Jayachandran
Dr Yves D'Udekem
Dr Rebecca Magee
Dr Fraser Taylor
Dr Amanda Foster
Assoc Prof Bibombe Mwipatayi
Mr Idris Arogundade
Mr Asar Alsaffar
Assoc Prof Bernard Whitfield
Dr Irene Kaiboni
Prof Alasdair Sutherland
Mr Allen Yeo
Dr Swapnil Pandit
Prof James Spark
Dr Abdul Kadhim
Dr Uvarasen Naidoo
Dr Grace Lim
Dr Robert Schreiber

***The Academy of Surgical Educators and the affiliated RACS departments endeavour to publish these lists as accurately as possible. If you know someone whose name is missing from the list, please contact ase@surgeons.org.**

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OPUS LV (55)

Double Helix Wine Corkscrew

This is an unusual title for a surgical story but soon all will be revealed... just wait. The double helix, a pair of parallel helices intertwined around a common axis like a twisted ladder, was conceived by Watson, Crick and Wilkins in 1953, during their studies of the structure of DNA (deoxyribonucleic acid), winning them the Nobel Prize for Medicine in 1962.

However, the story began earlier when scientist, chemist and X-ray crystallographer Rosalind Franklin, a forgotten name in this Nobel Prize story, was working at Kings College, London using X-Ray diffraction techniques on DNA crystals which created cross shaped images. This became the basis of the spiral helix concept, the mechanism for the replication of modules and how hereditary information is coded. Incidentally, it was Watson gazing on the model spiral staircase they say on his desk which possibly may have sparked the concept.

Sadly, Franklin died in 1958 at age 37 of ovarian cancer, never to see the fruits of her labour realised. Watson, Crick and Wilkins shared the Nobel Prize but the prize could not be awarded posthumously.

The Grange story and the Double Helix Concept

My Grange story begins when I made a booking at the Penfold's Wine Clinic to have my 1959 Vintage assessed because of the 2cm gap in the neck height. There I met the Chief Clinician, the Clinic's Wine Ambassador. As most of us know, old corks fragment and when this person inserted double corkscrews at the 6 o'clock and 12 o'clock positions, the cork emerged effortlessly and intact. (See illustration of double helix corkscrew technique). I was allowed to taste a soupçon. The wine which was quite potable, was replenished with a current Shiraz, then recapped, re-corked and redated.

Full of admiration at this technical manoeuvre I asked the Wine Ambassador his name.
"Jamie Sachs," he said, which I thought was rather coincidental. I said "I know a Randall Sachs in Adelaide, a pre-eminent international hand surgeon".
"Interesting…" he said, "He's my father".

While we are on the subject of corkscrews let me add two more interesting facts. Back in the 17th century a technique to remove blocked lead from the barrel of a rifle was devised involving a steel worm, carefully spiralled down the barrel beyond the blockage to displace the fragments backwards. This idea no doubt led to the invention of the first corkscrew by a person named Henshall in England, who in 1795 took out the patent. However, wine in wine bottles has another interesting historical fact.

The double insert sites (left) and an original 1959 cork with two Butler type corkscrews (right)

I mentioned this story to my Senior Colleague Professor Sam Mellick of Brisbane in his 93rd year who continues to impress me with his knowledge. When I told Sam the story of the corkscrew he said, "I gave a Cowlishaw presentation years ago on Sir Kenelm Digby 1603-1665 who was the direct offspring of Guy Fawkes (no wonder he had a name change). He became a scientist, philosopher and surgeon, with commercial cork activity near Madrid. He was also a Naval Administrator and was knighted by James I. He was the one who designed wine bottles with tapered necks and square sides for storage. He also co-produced a book called '*Religio Medici*', a copy of which in its '5th edition' in the Cowlishaw library". Sam's historical review, the words of a real polymath, is published in ANZ Journal of Surgery, 2011.

Another wine vignette – The Hamilton Winery of 1837

Now that we have passed on from corkscrews, let me reveal a few surgical stories about wine, and my recent experience with a bottle of 2000 Richard Hamilton Merlot.

Richard Hamilton's family wine history dates back to 1837. The current vintage Richard Hamilton, the fifth generation, is an eminent plastic surgeon in Adelaide specialising in the full gamut of plastic surgical procedures from head and neck to hand and aesthetics. While attending the RACS Annual Scientific Congress in Adelaide in the 1990s I thought I would use some of my spare time wisely and visit some of the city's world renowned wineries. Richard invited us to his vineyard in McLaren Vale that year where I bought some 2000 McLaren Vale Merlot Lot 148. This has been lost in my cellar from time immemorial.

I really enjoyed my re-acquaintance with this drop recently, enough to photograph the bottle and send it to Richard describing my experience - the aroma was appealing, the

2000 Vintage Merlot

taste delightful, the finish excellent, without using those oenological descriptors; mocha, chocolate, spice etc.

Needless to say I called him about buying some more and he offered to check his cellar storage of its availability. One dozen Merlot Lot 140 arrived safely soon after and I called him again to thank him. On this second occasion, where was he? He was at the Cannes Film Festival about to receive an award for the documentary WineLine 2 Odyssey – a reflection of the Hamilton family wine experience, and not an insignificant achievement at that.

This story has an interesting postscript which harks back to unrecognised talent, similar to the Franklin experience. When Richard was working at the Bernard O'Brian Institute in Melbourne in the mid-70s on abdominal wall vasculature, he took his experience to Gothenburg. In association with another Plastic Surgical colleague, Ingemar Fordestam they were instrumental in establishing scientifically the vascularity of lipectomy tissue of the abdominal wall. This became the basis of the DIEP Flap for breast reconstruction. It was published in the Scandinavian Journal by the single author Hans Holmstrom. No reference was ever made however, to the scientific/anatomical basis nor their micro-surgical contributions to this excellent technique. This is now used worldwide, how galling and even some say sour grapes.

More wine folly

I was recently pleasantly surprised when one of my general surgical colleagues, Associate Professor Val Usatoff, a wine connoisseur with his own cellar, gave me a bottle of Lake's Folly wine from the Hunter Valley. Its Founder Max Lake established the first boutique vineyard in Australia in 1963. My late friend John Hueston, another pre-eminent international hand surgeon (whom I keep quoting as our consulting rooms were adjacent to each other), first acquainted me with this label in 1974 as he once had a bottle on his desk, (a gift from a patient).

Max Lake and John had met through their mutual interest in hand surgery and eventually with the establishment of the Australian Hand Surgical Society. It prompted me to explore the history of this prestigious boutique vineyard and it's Founder, who passed away in early 2009.

But there is another correlation with the surgical fraternity, Max's business partner was Leonard Atkins. My former registrar, Ramin Shayan, now Head of the Bernard O'Brien Microsurgical Unit is the grandson of the late Leonard Atkins. Both Max and Leonard were on the staff at the Bankstown Hospital in the 1960s. Leonard would do the majority of the on-call work while Max was busy doing the "on call" at the vineyard. The name "Lake's Folly" was apparently suggested by Leonard when referring to all of these extenuating surgical circumstances.

Later, when their winery was well established, they entertained Dobell, another Hunter Valley resident and Australia's leading portrait painter with a studio at Wangi (who I also visited with my father in the early 60s). Dobell really enjoyed the wine on a number of occasions prompting Atkins to whisper in Max's ear - sotto vocé - "…looks like Lake's Folly was a success". The vineyard epitomises the ingredients for success, embracing the grape varieties chosen, vine location, pruning for low production with high quality and trellising for flavour concentration reflecting sound surgical techniques. Their production style of hand-picked grapes, gentle crushing, open fermentation and extended yeast lees reflects the Margaux tradition.

Lake's Folly 1994 Cabarnets

In a recent publication of *Surgical Life* I came upon some more historical wine snippets with a medical flavour. The first Australian wine doctor was Dr Penfold – a Bart's man, and as we know you can always tell a Bart's man, but you can't tell them anything. He trained at St Bartholomew's Hospital Medical College in London then settled outside Adelaide in a suburb called Magill (like the Penfold's label). His medical practice was conducted from his cottage which he called The Grange. His wife used French cuttings to produce the Mary Penfold wine – an standard treatment for anaemia at the time.

At Margaret River in Western Australia, Dr Kevin Cullen, a paediatrician, planted his vineyards in 1966. At Vasse Felix the initial plantings by Cullen were followed by the establishment of a vineyard by Tom Cullity, a cardiologist. Another hand surgeon, Michael Tonkin has also been another exponent of this art.

Thus one can appreciate a long standing connection exists between the medical profession and the product of the vine. Is it the reversion to an open air environment with ones hands in the soil and the avoidance of political and surgical intrigue which seems to emanate from hospital establishments? As Phil Slattery quoted years ago at a hand surgeon's meeting, 80 per cent of candidates had a wine growing association on a show of hands.

In synopsis, as Robert Louis Stephenson said, "Wine is poetry in a bottle" but the stories of wine contain exhaustive information, almost encyclopaedic like the fake wine story below.

The *New York Times* bestseller *The Billionaire's Vinegar* by Benjamin Wallace reads like a Sherlock Holmes' detective story and is full of intrigue, where some Chateau Lafite wine of 1789 cellared since the time of the Revolution was placed in auction at Christie's in London. Its estimate in value by their expert was simply 'inestimable' achieving a price of £75,000 on the hammer.

How was the deceit discovered? The legal beavers were called to evaluate and it transpired that the authentic old label attached to an authentic old bottle was stuck with modern glue – be warned, 'Grange' is now being produced in China.

Associate Professor Felix Behan
Victorian Fellow

The demise of surgery for chronic peptic ulcer

Surgery once held a paramount place in the treatment of chronic peptic ulcers, but the development in the 1970s of highly effective antacid drugs, the discovery soon after of the role of Helicobacter pylori and the development of therapeutic endoscopy techniques have relegated surgery to a minor role dealing with complications.

No acid, no ulcer

Gastric ulcers were known by the mid-nineteenth century. In the twentieth century, duodenal ulcers were more commonly diagnosed probably reflecting changes in diet and living standards.

It had long been known that alkaline medicines relieved indigestion, then in 1911 James Adams of Belfast demonstrated the link between duodenal ulceration and hyperacidity – 'no acid, no ulcer.' This fundamental discovery led to more scientific approaches to treatment.

Medical treatments

When a medical student in the 1960s, I was taught that the only proven treatments were bed rest and smoking cessation. Antacids and bland diets were prescribed for symptomatic relief and I recall many inpatients treated with bed rest along with the Sippy Ulcer diet. Alkalinised milk drips administered via a nasogastric tube were often used for bleeding ulcers. Medical treatments often were successful in the short term but ulcer recurrence was common.

Surgery for peptic ulcers

Surgery initially was reserved mainly for pyloric stenosis, using the techniques gastro-jejunostomy or pyloroplasty to relieve obstruction. Gastro-jejunostomy was technically easy with low mortality but complicated by anastomotic ulceration in around 30 per cent of cases.

Austrian surgeon Theodor Billroth, pioneer of gastric surgery

Billroth had performed the first successful gastrectomy in 1881 for malignant gastric outlet obstruction but it was considered too risky for benign diseases. As the safety of surgery increased, partial gastrectomy, which removed the ulcer and reduced acid secretion with only around 5 per cent ulcer recurrence, gained acceptance.

An alternative to gastrectomy was vagotomy. Early in twentieth century vagotomy had been shown to reduce gastric acid secretion by Russian physiologist Ivan Pavlov and French anatomist Andre Latarjet. Latarjet also described in detail the anatomy of the vagus nerves of the stomach (much later, surgeons performing highly selective vagotomies became very familiar with the nerves of Latarjet.)

Lester Dragstedt, pioneer of vagotomy

In 1945 Lester Dragstedt of Chicago reported successful truncal vagotomy for duodenal ulceration, initially performing this transthoracically. A 'drainage' procedure - pyloroplasty or gastro-jejunostomy - was necessary because vagotomy greatly reduced antral motility and hence the ability of the stomach to empty. Truncal vagotomy and pyloroplasty became accepted treatment for chronic duodenal ulceration.

Recurrent ulcer rates of around 10 per cent were reported, but some were believed to be due to technically incomplete vagotomy.

Earning the operation

By the mid-twentieth century elective surgery for peptic ulceration was well established and generally reserved for failures of medical treatment—the patient had to 'earn the operation.' Surgeons such as Norman Tanner at Charing Cross Hospital, London developed enormous experience in gastrectomy for peptic ulcer. In Australia, truncal vagotomy and pyloroplasty was the most frequently performed procedure for chronic duodenal ulcer during this period. Polya-gastrectomy (which isolates the duodenum from the acid stream) had a lower recurrence rate but more side effects; however it was the preferred procedure for many surgeons.

Gastric cripple

The bete noire of surgeons was post-gastrectomy 'dumping', caused by delivery of hyperosmolar loads into the jejunum, and bilious vomiting. Weight loss and late nutritional deficiencies were also common.

Following vagotomy and drainage, chronic diarrhoea could be disabling.

These complications were considered unfortunate but inevitable in a minority. Every surgeon had one or two 'gastric cripples' in their practice.

Comparing operations

The Visick grading scale was devised to assess symptoms and quality of life after surgery and to compare operations.


John Goligher

In 1968 UK surgeon John Goligher published the famous five-year Leeds/York trial comparing three different operations for duodenal ulcers.

Goligher and his team showed that truncal vagotomy combined with antrectomy (which removed the source of gastrin) was superior to both vagotomy/ gastrojejunostomy and Polya-gastrectomy in terms of both post-operative quality of life and ulcer recurrence rates.

The Leeds/York trial was widely quoted and FRACS candidates in the 1970's had to know all about it.

Improvements in vagotomy

Selective vagotomy preserved innervation of the biliary tract and small intestine, but still a total gastric vagotomy required a drainage procedure and in practice did not consistently reduce the incidence of chronic diarrhoea.

Highly selective vagotomy (HSV) was described independently by Johnston in the UK and Amdrup in Denmark in 1969. Known also as proximal gastric and parietal cell vagotomy, HSV preserved vagal supply to the gastric antrum, eliminating the need for a drainage procedure and thus avoiding many of the unpleasant side effects of surgery, with no major increase in ulcer recurrence rates. Ulcers that did reoccur were controllable with medication.

HSV rapidly gained popularity, but required a time consuming dissection on the lesser curve of the proximal stomach, quickly acquiring the sobriquet 'highly monotonous vagotomy'.

Intra-operative tests to avoid incomplete vagotomies, such as those of Burge and Grassi, were described but were not widely used outside of academic departments.

But all of this was about to be swept aside by revolutionary medical discoveries.

A medical revolution and the demise of surgery

The 'game-changers' were the development of potent acid suppressor drugs, identification of the role of Helicobacter pylori, and endoscopic techniques to control ulcer bleeding.

In 1979 the histamine-2 receptor antagonist (H2RA) drugs were released and proton pump inhibitors (PPI) shortly after. These potent antacid drugs enabled virtually complete symptom control in ambulant patients and resulted in ulcer healing in the vast majority of cases.

Then, in 1982 Australian researchers Marshall and Warren identified infection of the stomach with the gram-negative bacterium Helicobacter pylori as the major cause of chronic gastritis and peptic ulceration.

Acceptance by the medical community came slowly. The idea that peptic ulcers could be cured with antibiotics was radical, and it was not until 1996 that triple therapy (two antibiotics + PPI) became accepted as first line treatment for H.pylori-associated gastritis and peptic ulceration.

Endoscopic advances

The advent of flexible fibreoptic endoscopy in the 1970's had allowed precise diagnosis and monitoring of peptic ulcers.

Endoscopic control of bleeding peptic ulcers (often related to NSAID therapy) via injection, thermal or mechanical means combined with high dose intravenous PPI therapy dramatically reduced the need for surgical intervention. Additionally PPI drugs and triple therapy have allowed perforated ulcers to be treated by simple surgical closure often with minimally invasive surgery.

Overview

The advent of PPI drugs and triple therapy wrote the obituary of surgery for elective peptic ulcer treatment, as well as reducing the incidence of ulcer-related complications requiring surgery.

It is ironic that effective medical therapies developed around the same time as the operation of HSV, which was effective, had minimal adverse effects, and soon could be performed with minimally invasive techniques.

I performed many elective operations for chronic peptic ulceration - my logbook shows that I did the last of these in 1994 - but I did not lament the demise of surgery. I had seen disabling side effects and serious complications, and it became known that permanent hypochlorhydria after surgery significantly increases the long-term risk of gastric cancer.

However, those practising in the heyday of peptic ulcer surgery gained tremendous experience with upper gastrointestinal surgery, difficult to replicate now that vagotomy is obsolete and gastrectomy is mostly reserved for malignant disease.

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Mr Randal Williams
FRACS, FRCS (Eng)

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:

Kenneth Carroll (QLD)
William Heape (VIC)
William Phillipps (NZ)
Richard (Dick) Clayton Bennett (VIC)
Brendan Dooley (VIC)
Michael Polke (VIC)
Neil Turner (WA)
John Lee (QLD)
Gavin Cottrell (VIC

Informing RACS

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

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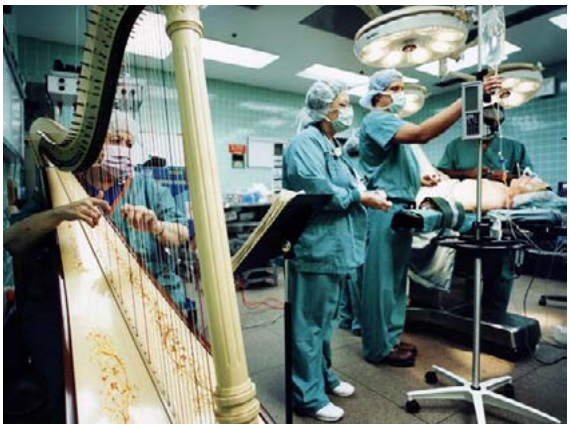
Surgical snips



Influence of music on operation theatre staff

A study conducted at the University of Texas has shown that when plastic surgeons listen to music they prefer, whether it be classical or rock, their surgical technique and efficiency when closing incisions is improved. Playing their preferred music led to a 10 per cent reduction of repair time for senior residents and eight per cent reduction in repair time for junior residents. Researchers say that spending less time in the operating room translates into significant cost reductions, particularly when incision closure is a large portion of the procedure. Longer duration under general anesthesia is also linked with increased risk of adverse events for the patient. Quality of repair was not compromised either, with researchers confirming an overall improvement in repair quality while music was played.

https://www.sciencedaily.com/releases/2015/07/150730162840.html

Acknowledgement

Dr Sally Langley FRACS, Chair and Associate Professor Stephen Tobin FRACS, Dean of Education wish to thank Professor Ian Gough FRACS for his correspondence about the Academy of Surgical Educators article published in *Surgical News* (September 2018).

We wish to clarify that the Academy of Surgical Educators had its origin in 2009-2010, heralded by an article in the *ANZ Journal of Surgery*. The Academy progressed with the support of Professor Gough, Professor John Collins and Professor Bruce Barraclough. It was further developed with the leadership and support of Professor Julian Smith FRACS and Professor Spencer Beasley FRACS as Chairs.

No disrespect was intended. On behalf of the Academy staff as well, we thank Professor Gough for bringing to our attention.

Collins, J & Gough, I : An Academy of Surgical Educators – Sustaining Education, Advancing innovation and Scholarship ANZ J Surgery 80: 13-17, 2010.

Dr Sally Langley FRACS
and Assoicate Professor Stephen Tobin FRACS

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