ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 17 NO 03 APRIL 2016

CLINICAL VARIATION

RACS and Medibank are collaborating to make data more accessible p38

The College of Surgeons of Australia and New Zealand

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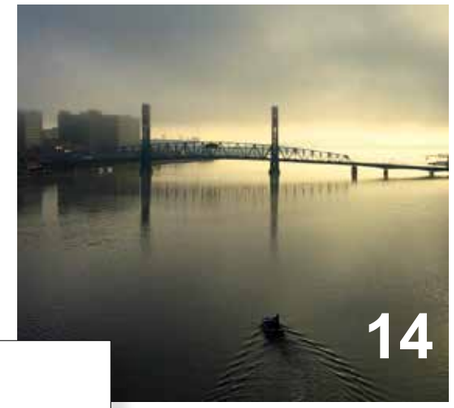

REGULAR PAGES

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

ON THE COVER

PROFESSIONAL DEVELOPMENT

WORKSHOPS & ACTIVITIES

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

Foundation Skills for Surgical Educators Course

23 May 2016 - Lismore, NSW, Australia
2 June 2016 - Auckland, New Zealand
4 June 2016 - Bendigo, VIC, Australia

The new Foundations Skills for Surgical Educators is an introductory course aimed at expanding knowledge and skills in surgical teaching and education. The aim of the course is to establish the basic standards expected of our surgical educators within the College.

This free one day course will provide an opportunity for participants to reflect on their own personal strengths and weaknesses as an educator and explore how they are likely to influence their learners and the learning environment. The course will further knowledge in teaching and learning concepts and look at how these principles can be applied into participants own teaching context.

Keeping Trainees on Track (KToT)

4 June 2016 - Sydney, NSW, Australia

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

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

Non-Technical Skills for Surgeons (NOTSS)

22 July 2016 - Perth, WA, Australia

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

Clinical Decision Making

4 June 2016 - Sydney, NSW, Australia

This three 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.

Supervisors and Trainers for SET (SAT SET)

28 June 2016 - Perth, WA, Australia

The Supervisors and Trainers for Surgical Education and Training (SAT SET) course aims to enable supervisors and trainers to effectively fulfil the responsibilities of their important roles, under the new Surgical Education and Training (SET) program. This free 3 hour workshop assists Supervisors and Trainers to understand their roles and

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

workshop

responsibilities, including legal issues around assessment. It explores strategies which focus on the performance improvement of trainees, introducing the concept of work-based training and two work based assessment tools; the Mini-Clinical Evaluation Exercise (Mini CEX) and Directly Observed Procedural Skills (DOPS).

Process Communication (PCM) Part 2

29 to 31 July 2016 - Melbourne, VIC, Australia

The advanced three day program allows you to build on and deepen your knowledge while practicing the skills you learned during PCM Part I. You will learn more about understanding your own reactions under distress, recognising distress in others, understanding your own behaviour and making communication happen. PCM enables you to listen to what has been said, while at the same time being aware of how it has been said. At times we are preoccupied with concentrating on what is said, formulating our own reply and focussing solely on the contents of the conversation. To communicate effectively, we need to focus on the communication channels others are using and to recognise when they are under distress.

April 2016 - June 2016

NSW

22-24 April 2016
Process Communication Model: Seminar 1, Sydney
23 May 2016
Foundation Skills for Surgical Educators, Lismore
4 June 2016
Clinical Decision Making, Sydney
Keeping Trainees on Track, Sydney

NZ

4 June 2016
Foundation Skills for Surgical Educators, Auckland

QLD

29 April – 1 May 2016
Younger Fellows Forum (YFF), Canungra
2 May 2016
Foundation Skills for Surgical Educators, Brisbane
2 May 2016
Keeping Trainees on Track, Brisbane
2 May 2016
Non-Technical Skills for Surgeons, Brisbane
2 May 2016
SAT SET Course, Brisbane

VIC

22 April 2016
Foundation Skills for Surgical Educators, Melbourne
23 April 2016
Keeping Trainees on Track, Melbourne
SAT SET Course, Melbourne
4 June 2016
Transitioning to Palliative Care, Melbourne
4 June 2016
Foundation Skills for Surgical Educators, Bendigo

WA

28 June 2016
SAT SET Course, Perth

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

INTEGRITY

Integrity means we will take our responsibilities seriously

DAVID WATTERS
President

Integrity is one of our core College values. It means that we do what is right, or at least that what we do is motivated by our intention to do so. It should underpin how we treat our patients, other members of the surgical team, and indeed all those we meet. Integrity requires a strong moral compass and embraces honesty, considering the needs of others, and avoids exploiting others.

Integrity is at the centre and a fulcrum for the other RACS values – service, respect, compassion, collaboration.

As I reflect on my nine years on Council, and in particular during the last year as President, I hope RACS has lived up to its core value of integrity. Let's consider our record. The past year has not been easy - it is one in which the surgical profession in New Zealand and Australia has been examined and found wanting in terms of its previous tolerance of unacceptable behaviours associated with discrimination, bullying and sexual harassment. We were forced to face up to uncomfortable and disturbing facts; we were reluctantly exposed as a profession to the scrutiny of the media, regulators and government. All of a sudden our proud profession, that had deservedly earned a reputation for its skills and service, was caught short, with our right to autonomy and ability for self regulation placed in jeopardy. In the last year it was incumbent on your College to face reality, acknowledge that we collectively were guilty of tolerating what should not have been tolerated, and in so doing had made some of our juniors and colleagues suffer, forcing some out of the profession, and also imperilling patient safety.

Integrity is not about being perfect. It is having the guts to acknowledge imperfections and to address them. The report of the Expert Advisory Group (EAG)* was damning. A College that has a value of integrity must apologise for its failings and last September we did. We did this publicly, and despite the discrimination, bullying and sexual harassment exhibited by the surgical profession in the past, our apology was appreciated by both observers and those who had suffered. We deliberately chose not to deny it was our problem, we did not try to deflect attention towards other parts of the medical profession, nor did we delegate the primary responsibility for amassing the evidence or determining the way forwards to others such as employers or governments.

Integrity requires action to counter the unacceptable and demands more than just an apology. RACS accepted the 42 recommendations of the EAG, and published an Action Plan* designed to Build Respect and Improve Patient Safety, and to create a safer surgical workplace for Surgeons, Trainees and International Medical Graduates. Integrity meant that we put our money where our mouth was, and did not ask others to subsidise us when addressing our own problems. Over the next three or more years we will continue to invest in leadership and cultural change, education of surgeons concerning supervision, training and workplace behaviours, as well as effective complaints management. It will be a journey for us all with our determination to achieve our aims founded on our integrity.

Integrity should also influence how we as surgeons establish our fees. Fees should be fair and truly reflect the cost of providing a service, the skills exhibited, the resources expended and risks of practice that need to absorbed. Fees should be transparently disclosed to patients and to funders. Our government is determined to empower patients to understand the costs of private healthcare, both those to health funders and those out of pocket. We should not be guilty of exploiting the vulnerability and fear of our patients when sick, by charging higher than necessary fees just because we can. We should not use multiple item numbers inappropriately, and indeed RACS and its Specialty Societies are collaborating in the MBS review, in the hope that this will become a practice of the past. We should not charge "booking fees" or send second invoices – these are not transparent and are a way of hiding extra gap fees from the health insurers or Medicare. These practices are not born of integrity.

The College has been very clear in its position in these issues over the past three years and will become progressively more involved. A revised and updated Code of Conduct will be more explicit, and there are now Sanctions that accompany our Breach of the Code of Conduct policy that specifically address fees, fee splitting and behaviours. We have deliberately entered into discussions with funders. RACS must work at understanding variations in clinical practice including those that relate to outcomes and fees. Another article in this edition of Surgical News highlights how we have progressed using data made available through Medibank. Giving information back to surgeons is incredibly useful so we can reflect on our practice.

Integrity means we will take seriously our responsibilities towards the affordability and sustainability of healthcare, and the role of surgery that is so important to any health system. This not only affects our fee structures but also our decision making as to when an operation is indicated and when it is not. The needs of the patient must be paramount.

We pride ourselves on our clinical decision making and our ability to choose or not choose operations that will benefit our patients. We accept that surgeons should not operate when there is little value and indeed only operate in the patient's best interest. As I write this article there is substantial media interest in a book recently published by Professor Ian Harris 'Surgery, The Ultimate Placebo', where he challenges us to take a more evidence-based approach to both the benefits of surgery and the associated risk. We avoid this discussion at our peril. Equally as a profession we must get better at transparent reporting of surgical outcomes. I have spent much time over the past six months in active discussion with the Hon Geoff Davies AO, previous Expert Community Advisor of our Council who continues to be highly concerned about the perception that we protect our own, even when they are incompetent. Unfortunately he is not alone in these views and unless we wish to see individual surgeon league tables and their unintended consequences imposed on us, we must be champions of transparency, ensuring those surgeons not meeting required standards are made of aware of the need to be retrained or alter their scope of practice. Reporting the outcomes of surgical care will require high standards of morbidity audits, similar to what the Vascular Society has already intitiated. We need to encourage all surgeons to audit effectively, so that they can be confident they comprehend their scope of practice, its variations and the outcomes.

Over the past few years I have been privileged to be one of the College advocates for global surgery and in particular for '*Universal access to safe, affordable surgery and anaesthesia care when needed*'. This is a global imperative for all countries' health systems but particularly in low and middle-income countries (LMICs). Five billion of the world's 7 billion population do not have access to safe, affordable or timely surgery. In 2015, the World Health Assembly passed resolution 68/15 addressing this and in the coming years our College will be active in this region supporting the health systems to include surgery, adopt surgical indicators such as Surgical volume and Perioperative Mortality Rates, reporting against them to measure progress.

I return again to the values of the College. Service, integrity, respect, compassion, collaboration. They are all important as they combine and reinforce each other. During my time as a Councillor, and this year as President, I have become aware as to how these values should define our practice as surgeons; in particular, the core value of Integrity. Long may it be so.

I have written in the Annual Report as to the honour, privilege and opportunity of having served this College as President, for which I thank you all."

**Information regarding the Expert Advisory Group, their findings and RACS Action Plan can be found on RACS website at: http://www.surgeons.org/about/building-respect,-improving-patient-safety/expert-advisory-group/*

RACS Support Program

The College recognises that Trainees, Fellows and International Medical Graduates may face stressful situations on a daily basis. Coping with the demands of a busy profession, maintaining skills and knowledge and balancing family and personal commitments can be difficult.

The College has partnered with Converge International to provide confidential support to Surgeons. This can be for any personal or work related matter. Converge counsellors are experienced in working with individuals in the medical profession.

- Support is confidential and private
- Four sessions per calendar year are offered (funded by the College)
- Assistance can be provided face to face, via telephone or online
- Services are available throughout Australia and New Zealand

How to contact Converge International:

- Telephone 1300 687 327 in Australia or 0800 666 367 in New Zealand
- Email eap@convergeintl.com.au
- Identify yourself as a Fellow, Trainee or IMG of RACS
- Appointments are available from 8.30am to 6.00pm Monday to Friday (excluding public holidays)
- 24/7 Emergency telephone counselling is available.

Converge international
incorporating resolutionsRTK

AUSTRALASIAN ADVOCACY

RACS successes are already accumulating for 2016

GRAEME CAMPBELL
Vice President

We may only be in the first quarter of the year, but already RACS has achieved significant advocacy success in 2016.

As many of you will have witnessed first-hand, the number of hospitalisations relating to alcohol misuse continues to represent a substantial and concerning proportion of the surgical workload. RACS has advocated against the harmful effects of alcohol for many years, not only for the increased risk of complication that it poses to surgical patients, but also for the broader ramifications it has on the sustainability of our public health system and society as a whole. Governments and policy makers are increasingly recognising the link between alcohol misuse and health costs, and the need to mitigate these risks by introducing sensible legislation.

RACS has supported the New South Wales Government for its courageous stance, despite ongoing and often alarmist opposition from the alcohol industry. We have publically and privately supported them, and urged other governments to follow suit. In February our efforts were rewarded when the Queensland Parliament passed similar legislation.

In the lead up to this major policy change, RACS-Qld worked with Labor MP and maxillofacial surgeon Dr Anthony Lynham and the Queensland Government to highlight why change was necessary. In 2014/15, there were 11,241 alcohol-related emergency department presentations found not just in major population centres, but across Queensland. They affected individuals, families and communities with 30 per cent of Queenslanders impacted in some way by alcohol related violence.

RACS expertise on this issue was noticed by other jurisdictions. In the weeks following the passing of the Queensland legislation, the College was contacted by ABC Darwin radio. The producers ran a week-long discussion on their morning program about whether similar laws would benefit the Northern Territory. Fellows John Crozier and Mahiban Thomas were invited on to the show along with other medical and police experts. We were also invited by the South Australian Government to meet with the Hon Tim Anderson QC, to inform an independent review of that state's liquor licensing framework.

New measures come into effect in April in the Thames Coromandel district of New Zealand with the introduction of earlier closing times for bars and liquor outlets in an effort to limit the negative impact that alcohol has on their community. The new rules that require off-licences to close at 9pm and on-licences at 1am, and allow for one-way door policies to be imposed at the discretion of the alcohol licensing authority, are part of a two staged introduction that commenced in January. Again this followed strong RACS advocacy on alcohol-related harm and sets a positive example for other district councils across the country to follow.

In addition to our alcohol advocacy success, RACS has made significant progress in securing ongoing funding for the Australian Trauma Registry (ATR). Without the ATR, Australia has no way of measuring the number of serious injuries due to road crashes nationally. This presents a major gap in efforts to improve road safety, and the evidence base available for governments to draw upon when developing targeted policies aimed at reducing road trauma.

Our Fellows and staff have been liaising with the Department of Health and the Bureau of Transport and Regional Economics (BITRE), and the ATR has been added to the April COAG Health Council agenda. RACS has also been contacted by BITRE to discuss possible funding options for the ATR. Furthermore, RACS was invited for a second time to give evidence at the Senate Rural and Regional Affairs and Transport References Committee, and a second supplementary submission is being prepared.

While some may view advocacy as a process of lobbying governments to adopt a position based on the self-interest of an individual or an organisation, it is much more than this. For RACS, advocacy has always been about effecting positive change in our community by adopting informed and principled positions on issues of public health. We will continue to stand behind these principles throughout 2016, and advocate strongly on behalf of our Fellows and the broader community, some of whom are our patients.

RELATIONSHIPS
AND ADVOCACY

JOIN THE CONVERSATION AT #RACS16

Interacting with other conference attendees

With the 2016 RACS ASC fast approaching, it's time to get yourself acquainted with how you can join the conversation at the event.

One of the best ways to interact with other conference attendees is by getting involved on Twitter. Over 400 people used the official conference hashtag over the course of last year's conference, and this year promises to engage an even larger and more active audience.

I've never used Twitter at a conference – in fact, I've never used Twitter at all!

No problem – simply head over to Twitter (www.twitter.com) and sign up. Follow the prompts, and create a profile for yourself to get started.

Some handy hints for creating your profile:

Choose a short username (i.e. @DrJaneSmith, @DrJonesENT, @JohnDoeSurg)

- Use your real name and a clear headshot as your profile picture
- In the Bio section, include a short explanation about your area of surgery and interests
- Start following a few different people and organisations you're interested in
- Play around with tweeting so you get the hang of it by the time the ASC arrives – it's a lot easier to get involved if you've already experimented with the platform before the event

How do I get involved at the ASC?

Simply search for the official event hashtag #RACS16 on Twitter to keep up to date with all of the conversation. Include the hashtag in your tweets so that other people who are at the event, or are interested in it, can speak with you.

For example:

Learnt a lot from the first session – can't wait to see what the rest of the day holds #RACS16

Many of the presenters at the conference will have their own Twitter accounts, so you will be able to tweet your questions and messages directly to them. Also, if you have any questions, you can also tweet RACS at our Twitter account, @RACSurgeons.

But what should I say?

People use Twitter in many different ways – some use it to 'live tweet' during a session, some use it to ask questions of the presenter or the audience, or engage in polls, and others use it to add their own opinions of the subjects being spoken about, creating a conversation that continues even after the event has concluded.

No matter what content you decide to tweet about, it is important to be respectful and courteous. A good rule of thumb is to remember the 'elevator test' – if you wouldn't say it in a crowded elevator full of people, then it's wise not to say it on Twitter.

Make sure that you have permission to post during the session – this will often be made clear at the beginning, and if you're not sure, don't be afraid to ask. Also, keep in mind that your tweets will be public, even when replying to someone, so take anything you want to keep private offline.

I've started using Twitter – and I'm hooked! Where can I find out more?

The event hashtag has been registered with the Symplur Healthcare Hashtag project, which tracks the activity around the hashtag (including the amount of participants and metrics around the volume of conversation). You can see all the data and metrics by heading to Symplur.com and searching for #RACS16.

#RACS16 Livestreaming – Periscope

What is Periscope?

Periscope is an app that allows you to livestream videos from your smartphone and share them over the Internet. The videos can be viewed and shared from the Periscope app itself, and also through additional platforms such as Twitter.

Periscope is owned by Twitter, and allows users to view livestreams up to 24 hours after they have occurred. This is just one of the many benefits of the platform, and it may be worth experimenting with the platform, to realise the full range of functions.

Can I use Periscope at the RACS ASC?

As long as the speaker permits it (and if this is not allowed, the speaker will say so or you will be advised at the start of the session), attendees are welcome to use this app.

A few things to remember when livestreaming:

- Confidentiality, privacy and intellectual property rules still apply
- Avoid holding your smartphone up too high, to prevent impeding the view of the people sitting behind you
- Share your livestreams on Twitter with the hashtag #RACS16 and let other attendees and interested Twitter users find them.

Chantel Thornton with a patient

Melissa Bochner and Kate Drummond

Women of Melbourne Medicine

In celebration of International Women's Day, some of our leading female Fellows were featured in the news.

Epworth breast surgeon Chantel Thornton ensures a team effort when working with her patients on their treatment and recovery. She is also on the Alfred's Committee of Women, the board for the Foundation for Surgery and an honorary lecturer at Monash University.

General and trauma surgeon Kate Martin works across a variety of wards, emergency and intensive care but says all treatment comes down to a team effort.

"It's very much a privilege to work with patients and seeing into parts of their lives not seen in any other forum."

Daily Telegraph, 7 March

Leadership within a team

Neurosurgeon Kate Drummond was also featured as part of a series on leadership, interviewed by journalist Alan Kohler.

Kate Drummond discussed how she came to the specialty and about her drive to improve quality of life for her patients.

She also discussed emotional stamina and also the importance of exhibiting leadership by enjoying being part of a team.

"Leading a team is about enjoying people and trying to get the best out of them while understanding that everyone has a different part to play and perhaps a different level of ability. My job is to let them do it to the best of their ability."

See the video at theaustralian.com.au/performance, 5 March

Social Media Surgery

You've probably been told that you should 'be on social media' at least once – but what does that mean, and why should you bother? In part 2 of this feature, Dr Eric Levi and Dr David Grayson explain.

Dr Eric Levi FRACS @DrEricLevi

When did you start using social media for professional purposes?

I've been blogging and tweeting for five years under a pseudonym, inspired by Mr Curmudgeon, Mr BB Gloved and Prof U.R. Kidding. Just last year I decided to tweet and blog under my real name.

What is your favourite social media platform and why?

It's like asking whether I prefer the Metzenbaum scissors or the number 15 blade. There's a proper place for each instrument around the jugular.

Twitter provides quick immediate multiple person discussion on a wide range of topics. It's also great for collaboration and dissemination of information. Blogging provide a more extensive and detailed discussion on certain topics from a single point of view. They both enhance each other. Twitter connects. Blogging dissects. Twitter is like a group problem-based learning. Blogging is like a well prepared lecture. They're both needed.

What have been the biggest benefits of being active on social media?

Three benefits:

1. Education: I get rapid updates on a broad range of topics of personal interest including surgery, emergency, politics, arts, patient advocacy, travel, the list goes on.

2. Engagement: I get to connect with people I don't normally connect with (med student from France, photographer from Canada, medical artist from Brazil, journalist from the UK, etc.)

3. Enjoyment: It's social, after all. I get to share good information and stories with common-minded friends across social media while I wait for the next case to begin. During my registrar training and the demise of my traditional social network, Twitter provided the virtual social support I needed.

Why would you recommend that other surgeons get involved?

For the simple and compelling reason that our patients and future trainees are already there. Social media does not make me a better surgeon. It makes me a more accessible surgeon. In this age of information overload where every person has a megaphone on social media, surgeons need to be present to maintain the necessary standards. Social media provide a platform of collaboration among surgeons and other healthcare workers for the benefit of our patients and trainees.

Dr David Grayson FRACS @sasanof

When did you start using social media for professional purposes?

My exposure to social media began with my work at Ko Awatea, the centre for innovation and improvement at Counties Manukau Health. I was the Clinical lead for a series of improvement collaboratives and our improvement advisor Brandon Bennett (@BrandonB_ISC) began tweeting from our first learning session. I watched, amazed, as responders from around the world contributed to our work with support and advice. All for free and instantaneously. It was a no-brainer to join in.

I wasn't sure how Twitter would relate to clinical work but before long I discovered our clinical nurse manager was a prolific user of social media and he introduced me to the vagaries of Instagram and Facebook. We began sharing ideas and links with each other and a host of others, all aimed at improving our service. It really has helped us open our eyes to new ideas and brought some welcome light relief as well. There is something about the combination of words, pictures, links and hashtags (links ontology) that makes social media an advanced way of communicating and collaborating.

What have been the biggest benefits of being active on social media?

For me, it is the ease with which one can collaborate with so many others that provides the benefit of participation. It has expanded my networks both in breadth and depth. My favoured medium is Twitter for its ease of use and variety of contacts and material. I enjoy the characteristics of the other channels including Instagram, Facebook and YouTube as well as the more recent new kids on the block Periscope and Blab. All have pros and cons depending on your style and preferences but all are worth checking out.

Why would you recommend that other surgeons get involved?

Social media is here to stay and will replace email and other legacy ways of communicating. It has huge potential for surgeons and doctors in general.

The College @RACSurgeons is an active and valued voice across all social media channels and an increasing number of Fellows are leading the way and mapping a social media digital footprint for us to follow. Check out @DrHWoo @KelvinKongENT and @HillNicolaHill for starters.

There is someone and something there for everybody and any taste – enjoy!

Some suggestions:

1. *Ask an active colleague to show you around*
2. *Have a play, follow random links and people*
3. *Attend a course such as #MayoInOz - look out for this in Melbourne in 2016*
4. *Have your say - share pics, links, articles, quotes or anything you find interesting.*

YOUNGER FELLOWS

Each year a Younger Fellow is invited to be involved in the Leadership Exchange Program

Dr Julie R Howle FRACS was selected by the Younger Fellows Committee as part of the Younger Fellows Leadership Exchange to attend the 2016 Academic Surgical Congress in Jacksonville, Florida. These are her reflections on the event.

The Association for Academic Surgery (AAS) is a dynamic organisation of young academic surgeons that was founded in 1966 and now has around 3000 active members. The Younger Fellows of RACS and the AAS have set up the Younger Fellows Leadership Exchange Program, which involves a member of the AAS visiting the RACS Annual Scientific Congress and the Younger Fellows Forum, and a Younger Fellow from Australia visiting the Annual Academic Surgical Congress in the USA. I was fortunate to be selected as the RACS Younger Fellows representative for 2016 and have recently travelled to the congress, which was held in Jacksonville, Florida.

Each year, in conjunction with the Society of University Surgeons (SUS), the AAS holds the Academic Surgical Congress, which provides the opportunity for young academic surgeons to present their work. This year, around 1600 made the journey to Jacksonville, including a who's who of American academic surgery with over 1000 abstracts presented as either oral presentations, "quickshot" presentations, or in plenary sessions. The Congress also featured a number of sessions covering topics such as surgical leadership, surgical research, surgical residency training and burnout. One of the many highlights of the first day of the Congress was to hear the results of the FIRST trial, a randomised controlled trial comparing the effects of standard duty-hour policies with more flexible policies on patient outcomes and residents satisfaction reported by Karl Bilimoria, the first author of the study.

In my role as the Younger Fellows visitor, I had the honour of making an oral presentation and attended the AAS Executive Council and the Global Affairs Committee meetings, which gave me valuable insight into the structure and goals of the AAS. I was also invited to the AAS/SUS executive and the International Visiting Guests dinners which gave me the opportunity to meet members of both associations, and other international visitors who came from countries including Colombia, South Africa and England.

I would like to thank the Younger Fellows Committee for selecting me as the Younger Fellows Exchange program recipient and would recommend other interested Younger Fellows apply in the future. The Academic Surgical Congress provides an excellent opportunity for surgeons, registrars and medical students to present their work at an international meeting and I would also encourage members and Trainees of the RACS to submit abstracts for the next congress, which will be held in Las Vegas on February 7-9, 2017.

Each year a Younger Fellow is invited to be involved in the Leadership Exchange Program between the Royal Australasian College of Surgeons (the College) and the Association for Academic Surgery (AAS). The successful applicant travels to the US and attend the annual AAS Congress and AAS Executive Committee meeting in America.

In 2017, the AAS Academic Surgical Congress is being held in Encore Las Vegas, Las Vegas, Nevada, February 7-9, 2017. The AAS will cover airfares, accommodation, transfers and conference attendance expenses for the College's representative.

Applications for 2017 open May 2016. Application procedures can be found at:

www.surgeons.org/member-services/interest-groups-sections/younger-fellows/younger-fellows-leadership-exchange/

A LACK OF DESIRE?

Diet and lifestyle based approaches can assist

DR BB G-LOVED

Damian and Anna are a middle-aged medical couple who are time-poor, over stressed and have busy practices. I've been worried about them for some time. They've not taken as much care of themselves as they should, both have BMI's approaching 30 kg/m2, hypertension and hyperlipidaemia. Metabolic syndrome is approaching but they didn't come about their blood glucose but rather their love-u-lose. What could I recommend? Did they want a love pill?

2016 is the 20 year anniversary of Pfizer patenting Sildenafil (Viagra) to treat erectile dysfunction. This was not their original intent as the drug first underwent an unimpressive Phase I trial to treat hypertension and angina. But then an unwanted side-effect became it's main game. Up, up and up went sales and profits after FDA approval in 1998, rising to almost US$ 2bn per annum within a decade. Later competitors, Tadalafil (Cialis) and Vardenafil (Levitra), have similar actions.

They enhance the effect of nitrous oxide produced during sexual stimulation, by inhibiting phosphodiesterase 5, thus increasing cGMP within the corpora cavernosum, leading to relaxation of vascular musculature, and penile blood inflow. Headache, heartburn are major side-effects, and if taken with nitrates [for angina] can cause serious hypotension.

Loss of libido is firmly entrenched in our too busy, over-worked, stressed and frenetic societies. Imagine what having time and making space might achieve -slowing down, breathing deeply, and enjoying the birds and the bees!

Too many of my patients eat badly [and too much], drink more than they should, and are so tired by the time their children are in bed they quickly pass out – experiencing limited desire and less satisfaction despite distant memories of better years gone by.

If you or your partner hasn't had a radical prostatectomy, or doesn't have an autonomic nervous system 'down there' impaired by diabetic neuropathy, you may not want to swallow an "afil" pill. It's not likely to address the root cause.

Far better to sleep well. Chill out. Warm up. Be Mindful. Meditate. Light a candle. Soak in a bath. Relax. Breathe fresh air. Take a holiday. Feel the warmth of the sun on your skin.

Eat well. You could even try the list of natural aphrodisiacs in the table opposite. For some you may have to visit Tibet or walk in the Himalayas. Others are almost certainly harmless - with the exception of the Cantharide, [Spanish Fly] that stimulates a rush of blood to the some regions but can poison or burn others, causing damage to the urethra, and occasionally death.

There is evidence in the medical and scientific literature for some of those listed, even in human studies. For example, extracts of the Amazonian plant, MuraPuama (Ptychopetalum olacoides) have shown benefit in cognitive impairment.

There is certainly a thriving industry for others. The past 20 years have seen the Tibetan Plateau region of Yushu, home to some 400,000 people living at 4000m, where villagers prosper from sending their school children during the merry month of May to dig up a Tibetan caterpillar fungus, Yartsa Gunbu [dongchong xiacao]. As the snow recedes, the riches are found in a brown shoot of the fungus, Cordyceps sinensis, which emerges from the caterpillar shell, and sells for more than its weight in gold to wealthy Chinese who perceive the need of an aphrodisiac. In 2013, some 50 tonnes were harvested, worth US$1.2bn. Similar amounts are produced in China, Nepal and Bhutan. Its global market is as big as Viagra's.

Natural Aphrodisiacs

Foods	Herbs
Eggs	Yohimbe (African/ ndian herb)
Caviar	Fenugreek (a vegetable leaf)
Asparagus	Saffron
Dates	Shatavari - Asparagus racemosus (Asparganine, 5 steroidal saponins and isoflavone)
Oysters (high in zinc)	Yartsa Gunbu (Tibetan Caterpillar fungus)
Pumpkin seeds (high in Mg & zinc	Cantharidin (Spanish Fly) – extracted from a green beetle, Lytta vesicatoria
Onions	Tribulus Terrestris
Ginseng (may work in animals only)	Damiana tea (Mexico,)
Okra (vegetable of love - magnesium)	L-Arginine
Cacao (Chocolate)	Lepidium meyenii (Maca)
Warming spices - Cinnamon, Ginger, Nutmeg, and Capsaicin (pepper)	MuraPuama (Amazonian plant)

Although Dr BB G-loved cannot personally vouch for any of the above spicing up your life, but persistence, rest, and a rich and varied diet may assist Damian and Anna more in the long term than any "love pill" could.

Dr Diarmuid McCoy
MB Bch BAO(NUI) FFARCSI FANZCA FFPMCAI
Specialist Pain Medicine Physician

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Suite 8 Level 2 73 Little Ryrie St
Geelong Vic 3220
Provider No: 2316245T

Prof David Watters
President
Royal Australasian of Surgeons
College of Surgeons' Gardens
250 – 290 Spring Street
East Melbourne
VIC 3002 Australia

December 3, 2015

Dear Prof Watters,

I wanted to alert you to some developments that have come to my attention.

In the last couple of weeks one recently graduated Fellow in anaesthesia (FANZCA) and pain medicine (FFPMANZCA) had occasion to contact me on a clinical matter. At the conclusion of the primary reason for this call she asked me my opinion of the following:

She provides anaesthesia for patients in the private sector for general (colorectal) and orthopaedics with two also recently graduated surgical specialists. She was approached by both, on different occasions, offering her guaranteed work on a number of occasions per month in return for 7% of her fee to the patient. She felt very uncomfortable about this and declined the offer. The reasoning given by the surgeons was that they did all the sales and marketing, brought in the patients and that they had overheads such as rooms, websites and business managers to maintain. They also mentioned that there was currently (in Melbourne, and I believe in Sydney) a surplus of anaesthetists, intimating that some were underemployed.

This type of approach could be seen as intimidatory, disrespectful and perhaps bullying.

This development is disturbing on a number of levels. It certainly alters the perception of the professional relationship and respect between these two specialties. If the practice of medicine is solely reduced to a financial arrangement than the quality of care will almost certainly suffer. I read through the code of conduct on the RACS website. This type of behaviour is contrary to the letter of some of the clauses and certainly against the spirit of the document. Should this arrangement be entered into, it would introduce into the equation an opportunity for a surgeon to dictate aspect of practice that may become even more problematic. These might include timetabling of work, the setting, further demands of commission and perhaps clinical practice. I'm not sure of the solution to this problem. I understand that this has occurred in Sydney. This is however as yet hearsay.

At the conferring ceremony every year the graduands take a pledge regarding their behaviour as professional specialist anaesthetists. I imagined that this is similar for the surgeons. This might be an opportunity to remind everyone of the expectations of the College. This might have applications in terms of the disclosures that an anaesthetist might give to the patient in line with the ACCC.

I've reproduced some of the information I have read on the ACCC website.

- Make agreements with associates or partners operating a separate legal entities and patient fees or joint negotiations with suppliers, financial service providers or landlords unless they have gained an authorisation from the ACCC.
- Act unconscionably by using a superior commercial position to subject another party to, or force them to accept, harsh or oppressive behaviour.
- Employee on fair tactics or attempts to unreasonably extract benefits from another business or professional by using their size or bargaining power.

I would be most interested in your thoughts on this one.

Dr Diarmuid McCoy
MB BCh BAO (NUI) FFARCSI FFPMANZCA FFPMCAI
FANZCA
Specialist Pain Medicine Physician

Patron: H.R.H. The Prince of Wales
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OFFICE OF THE PRESIDENT
Professor David Watters

7 January 2016

RACS ID: 120053

Dr Diarmuid McCoy
Pain Matrix
Suite 8, Level 2
73 Little Ryrio Street
GEELONG VIC 3220

Dear Diarmuid

Thank you for your letter dated 3 December 2015, bringing to the College's attention the practice of surgical specialists seeking to take a portion of another practitioner's fees.

I am shocked to hear of this practice as it is clearly unethical and unprofessional, and want to reassure you that now that we are alerted, a strong stand will be taken against it. Unfortunately, our sources suggest this is not an isolated case.

We shall certainly communicate with the Fellowship on this matter through Surgical News (monthly magazine) and Fax Mentis (weekly e-newsletter). We will consider updating our Preparation for Practice booklet (Preparation for Practice) on the website to highlight that taking a cut of another practitioner's fees will not be supported by the College. I shall also raise this issue directly with the ANZCA Council for appropriate action and advice back to their fellowship.

Our Code of Conduct is currently being revised, and we will ensure that this type of behaviour is highlighted on the Code as constituting a breach in the new edition.

Please provide details of the relevant Surgical Specialty and I shall inform the Specialty Society President also.

Yours sincerely

Professor David Watters OBE
President

College of Surgeons of Australia and New Zealand

THROW A SHRIMP ON THE BBQ

Can you trust the trust - Langdale's rule?

THE BARONESS

My first article on the Gillick test has echoed around the BBQs of Australia and New Zealand. That pleases me much. Did you pass?

I would have heightened your awareness of what is in front of you at your next BBQ- a shrimp or a prawn? To all of us they are crustaceans but Paul Hogan did make them famous in both USA and Australia when he decided to throw a few on the barbie..... I prefer them marinaded in coconut, lime and chilli. Delightful. And of course, I do call them prawns but that is the joy in the debate, in the discussion amidst my friends and learned legal colleagues.

We were at it again, almost autumn, the prawns consumed, the BBQ now just a red glow and the evening closing in. The slow progression through a South Australian red – deep, rich and gutsy. The conversation was around Lord Langdale who first conceptualised those three certainties in Knight v Knight (1840) 49 ER 58.

Did he have it right? His three certainties refer to a rule within English trusts law on the creation and validity of express trusts in that they must show certainty of intention, subject matter and object. The certainties ensure that assets can be validly distributed. In the example of a will, issues might arise where the wording of the will is too vague to allow the beneficiaries to collect what may appear to be theirs on the face of the will.

It has always sounded a bit esoteric to me and I was the lawyer in the group but the intentions relate to the testator wishing to create a trust (not always certain), ensuring that the subject matter which is usually property is very clearly within the discussion (and it is amazing where you can hide or confuse things) and ensuring that the objects of the trust are clearly identified (there are so many beneficiaries at times you almost need an additional court room). And of course lawyers being lawyers, the three "certainties" involve a number of uncertainties of which detailed legal opinion can be obtained and then obtained again. Wait until you actually ask a judge!!

My university friend who now has a flourishing surgical practice continued on and said that he was becoming an expert in discretionary trusts. In Australia and New Zealand these are often referred to as family trusts. He even started quoting Lord Wilberforce to me. I was stunned. Lord Wilberforce is sometimes thought to be the benefactor of most tax planners. He restated the test for certainty of object in the context of discretionary trusts outlined in McPhail v Doulton [1971] AC 424. Effectively, you must be able to say with certainty that any given individual is or is not a member of the class of beneficiaries. No one beneficiary could be said to have title to any trust assets prior to a distribution. You could understand how most tax departments around the world have worked reasonably hard at closing any 'loop holes' related to this one!

I listened with interest to my friend as he refilled his glass and gave me benefit of his newly acquired knowledge. Surgeons are after all knowledgeable people. He had a close colleague who had a discretionary family trust which was structured to make distributions to his adult children. One of his children had separated from her defacto partner and amazingly (to him) the trust had then been subject to divorce proceedings. Indeed the trust had been vested (that is 'wound up for the non-lawyers) by the court. The money in the trust had been divided between all the 'objects' with only a small amount being allocated by the court to his colleague. Obviously his daughter's share had been included in the matrimonial assets which were then divided as part of the divorce proceedings. Oh, the displeasure of my friend's colleague at passing on his family wealth to an ex-son in law, and learning of the complex interaction between family law and corporate law.

There was a pause. People were reflecting a bit on generational planning. It was if a winter chill had come to the evening. People quietly contemplated the glass of red in front of them. My eclectic group of university friends pondered the whims of fate. I raised my glass. My words were spoken to the autumn night sky. This is why you need lawyers – you need to be able to trust your trust.

Legal material contributed by Daniel Kaufman, Senior Associate in Family and Relationship Law. Lander and Rogers

MENTORING IN SURGERY

A Trainee's perspective

FIONA HILL
OHNS Australian Trainee Representative

Surgery provides us with the opportunity to improve the lives of patients every day. This is often the legacy that the community sees when looking at a surgeon's life. However the surgeon as a mentor, role model and teacher is perhaps their greatest legacy of all.

Often a consultant role in a public hospital is a very desired position. This can seem contradictory as public work often takes away from time that could be spent in the private; it normally requires extra time to be spent oncall and extra politics. However many consultants describe it as a great honour, with one of the most consistent explanations being the joy of working with trainees.

As a trainee I have been lucky enough that each new hospital has provided a team of motivated consultants to learn from. I fondly remember the first surgeon to watch me put in a grommet, and their good humour as I dropped it three times before getting it right. The patience of the first surgeon to take me through FESS, and putting up with my nauseating camera skills. And the first surgeon to supervise me do a mastoidectomy on a living temporal bone, reminding me to keep breathing throughout the operation. Each surgeon could have done the operation in a fraction of the time it took me, and yet not only did they have patience, they also did it with a smile on their face.

Increasingly I realize that mentoring in surgery is not only about operations but also about teaching a way of thinking. Some of the most important lessons are those of values, to meet high standards not just when somebody is watching, but in everything I do. Learning how to be an advocate for your patients, your team and your hospital can sometimes be more difficult than surgery itself!

As a registrar I am also blessed to also be in a mentor position. During internship it was the registrars that inspired and encouraged me to be a surgeon. Perhaps my greatest joy to date is supporting exceptional residents through the process of getting onto the program, knowing that surely one day they will be a leader in the field.

So to all the mentors I have had so far I would like to say thank you. To all my future mentors: I hope you can have patience with me. And to all my juniors: I really look forward to helping you reach your full potential.

Consultant Sheryl Wagstaff, Registrar Fiona Hill and Consultant and current president of ASOHNS Neil Vallance

Interested In Global Surgery and International Medical Development?

RACS International Forum at the ASC

The 2016 International Forum, convened by Dr Neil Wetzig FRACS, will be held on Monday 2nd and Tuesday 3rd May 2016 at the ASC in Brisbane. The program includes sessions on:

- Regional approaches to global surgery: case studies and perspectives from Timor Leste, Pacific Islands, China, Myanmar and Africa
- An international approach to global surgery: the Lancet Commission on Global Surgery and the WHO - are these real opportunities for change?
- The role of surgery in national health plans in low and middle income countries
- Presentations by Asia-Pacific representatives on their progress in collecting country data on the four identified global surgery metrics to contribute to a global dataset to measure population access to safe surgery and anaesthesia
- Rowan Nicks Scholars' presentations and research papers
- A Master Class on Tuesday 3rd May: Working as a surgeon in the global environment: Why? Who? When? and Where?

The provisional program is available at : http://www.surgeons.org/for-the-public/racs-global-health/symposium-international-forums/

Enquiries may be directed to: stephanie.korin@surgeons.org

INTERNATIONAL FORUM AT THE ASC 2016

Monday 02- Tuesday 03 May

NEIL WETZIG
Convenor, International Forum

The 2016 International Forum to be held at the RACS Annual Scientific Congress in Brisbane and which is combined with the Royal College of Surgeons of England (RCS) will bring together surgeons from across the globe who are leaders in the initiative to make safe, affordable surgical and anaesthesia care available to all when needed.

The Forum will highlight the impetus gained by significant Global Surgery events that occurred during 2015. These include a focus on the release of the report by the Lancet Commission on Global Surgery in April 2015, the passing of the World Health Assembly Resolution 68/15 to strengthen universal surgical care in May 2015 and the RACS Global Health Symposium held at the RACS headquarters in Melbourne in October 2015. This latter meeting brought together surgical influencers from the Asia-Pacific Region.

The Forum will commence on Monday 2 May with a session that will highlight global surgery projects conducted by the RCS, the College of Surgeons of East, Central and Southern Africa (COSECSA) and RACS Global Health projects in the Asia-Pacific region. This will be followed by a specific session dedicated to the Lancet Commission on Global Surgery where 3 Australian Commissioners including the RACS President Prof David Watters, and Keynote Speaker Prof Chris Lavy (UK), will present details of the recent report by the Commission including evidence of the need to scale up surgical and anaesthesia care in low and middle income countries, and the cost-effectiveness of doing so.

In the afternoon representatives from various Asia-Pacific countries will outline their countries' measurements of surgical care currently being provided. The afternoon will conclude with the presentation of the Rowan Nicks Lecture. This celebrates 25 years of the Rowan Nicks Scholarship which has brought young surgeons from developing countries to Australia, New Zealand and appropriate centres in Southeast Asia to further their surgical training and increase capacity in their home country. This anniversary lecture will be presented by Professor Godfrey Muguti, Professor of Surgery from Harare, Zimbabwe, who was the first Rowan Nicks Scholar.

On Tuesday 3 May a breakfast session will focus on 'Working as a Surgeon in the Global Environment: Why? Who? When? and Where?' Speakers will include Prof Chris Lavy who has worked in Malawi and has been the Medical Director of the CURE Clubfoot Program in Africa. Prof Lavy will speak on what it is like to work in resource-poor areas of the world. Other speakers are Dr Neil Wetzig who currently works in the Democratic Republic of Congo and Prof Declan Magee, President of the Royal College of Surgeons in Ireland who will discuss 'Ethics of Surgical Engagement in Low and Middle Income Countries'. This session will be particularly suited to any Fellow who may, at some stage in the future be interested in working in surgery in the developing world.

On Tuesday morning, a session will address the Practicalities of Global Surgery with an array of speakers including Prof Chris Lavy, Prof Pankaj Jani, Vice President of COSECSA and the G4 Alliance, and Prof Declan Magee, bringing a truly international flavour to the meeting. A particular topic of interest will be 'The Use of New Technologies to Improve Surgery in Low and Middle Income Countries'.

In the final International Forum session, research papers on Global Surgery will be presented. These range from unusual surgical conditions, to assessment of the effectiveness of cleft palate repair in Timor Leste, to researching surgical care in the Pacific.

The full program and biographies of keynotes speakers are available on the International Forum page of the RACS website.

Enquiries may be directed to RACS Global Health on phone: +61 3 9249 1211 or email: stephanie.korin@surgeons.org

I look forward to welcoming you to the International Forum.

2015 FELLOWSHIP SURVEY

Summarising the results of the 2015 survey

RICHARD PERRY
Chair, Fellowship Services

Fellows have provided valuable feedback on the services and activities offered by the College as part of the 2015 Fellowship Survey. The survey results have identified areas of strength, improvements and challenges that Fellows see the College facing over the next five years.

The 2015 Fellowship Survey Report was approved by RACS Council in February 2016 and a range of recommendations are being implemented in response to the feedback received. In addition, the survey results have contributed to the recently published RACS Strategic Plan Strategic Plan 2014-2018 and Business Plan 2016-2017. Your voice has had a direct impact on the College's future priorities.

The Fellowship Survey was conducted August - September 2015 as an online survey open to all active and retired Fellows in Australia and New Zealand. A participation rate of 31.1% was achieved (n=6595 Fellows) following email and telephone follow up. Importantly, Fellows who participated were a representative sample of the broader Fellowship in terms of country, specialty, gender. The only exception to representativeness was that less retired surgeons participated in the survey compared to retired surgeons in the wider Fellowship. The results build on feedback received from the 2006 and 2010 Fellowship Surveys and where possible comparisons have been made to previous results.

How satisfied are members?

It is pleasing to report that the majority of active Fellows indicated that they were 'satisfied' or 'very satisfied' with the College overall (76%), an increase from 2010 results (68%). About 15% of Fellows were 'somewhat satisfied', and just over 5% reported dissatisfaction with RACS. Almost 80% of Fellows considered RACS to be of real benefit to them as a Fellow, a statistically significant increase from 76% in 2010.

A new question was added in the 2015 survey, which asked Fellows to provide an overall satisfaction level for the main Fellowship services provided. Publications and communications received the largest percentage of satisfaction levels (92%), and the Member Benefits Program received the lowest satisfaction levels (45%). The Find a Surgeon and Practice Card was the lowest profile service and will require additional focus in 2016.

Core Activities

Surgical Standards Policies and Guidelines

Fellows were asked about satisfaction with professional standards guidelines and policies to support surgeons in everyday practice. Just over 90% of Fellows gave a 'somewhat satisfied' rating. When asked how RACS can improve the professional standards guidelines and policies, over 250 comments were made. The most commonly received responses were to ensure RACS guidelines and policies are enforced and to improve streamlining and access to standards documentation.

Delivery of Surgical Education and Training

Fellows were asked for the first time to evaluate RACS' delivery of surgical education and training. Approximately 84% of Fellows gave a 'somewhat satisfied' rating or higher and almost 12% of Fellows gave a 'somewhat dissatisfied' rating or lower. There were 270 comments from satisfied Fellows and 150 from dissatisfied Fellows raising issues such as selection process, managing trainee underperformance and recognition of supervisors and skills course educators as areas that require review.

Advocacy

When evaluating how well RACS has been advocating on key health issues, trauma had the highest satisfaction level (89% satisfaction), and excessive fees had the lowest satisfaction level (68% satisfaction). Government election issues had the lowest advocacy profile, with one in five respondents unable to provide a prompted response (21%). Results indicate that the College is focused on the issues that Fellows wish to see highlighted and that advocacy is viewed by members as a necessary function to better support the patients we serve.

Communication and Publications

Fellows were largely satisfied with RACS' publications and e-newsletters. Results indicated that Fax Mentis (weekly email) and Surgical News were the mode of communication Fellows prefer. Social media feeds were the least preferred means of receiving communications.

Fellows were asked to indicate interest in a range of topics for Surgical News. Professional standards issues, research and new technology were ranked by the most number of Fellows as topics of interest to them. When asked to provide other topics, the most frequently reported topics were

Workforce (both current status and future planning), monitoring of the action plan to address bullying, harassment and sexual harassment and more on professional development opportunities.

Interestingly, almost two-thirds of Fellows reported that they did not engage in any social media platforms for professional purposes and many Fellows reported reservations using this communication mode. The College is increasing its social media presence and we anticipate that Fellow participation will grow in the coming years.

Only 27% of Fellows reported that they used the RACS Pocket Diary provided to them each year. A review of the product will take place, given the low usage reported in both 2010 and 2015.

Customer Service

Almost 85% of respondents reported that they were 'always' or 'very often' able to easily make contact with the appropriate RACS staff member to assist them. Fellows who contacted RACS mostly reported satisfaction with their interactions with staff members, with 85% of respondents reported being either 'satisfied' or 'very satisfied'. This feedback is a positive increase when compared to results from the 2010 Fellowship Survey, with 65% of participating Fellows reporting 'always' or 'very often' for ease of contact at that time. During 2013–14 all College staff undertook customer service training with an emphasis on telephone protocols. Ensuring Fellows are able to reach the appropriate person to assist with their enquiries in an efficient manner is a high priority and it is pleasing to see that the increase focus on customer service is reflected in the latest survey results.

CPD Program

Of those Fellows who participate in the RACS CPD Program, most reported that they have now transitioned to the CPD Online Diary. The survey has collected important data on reasons why Fellows do not participate online, barriers that prevent Fellows from doing using the online system along with how it can be improved.

Professional Development Opportunities

RACS continues to offer a range of educational activities to encourage development of knowledge, skills and attitudes as part of life-long learning. The professional development topics of most interest to Fellows are surgical education, managing adverse outcomes, clinical governance, business/practice management, leadership, mentoring and work/life balance. Workshops continue to be the most preferred delivery method however results indicate an increasing interest in online learning when comparing results to the 2010 Fellowship Survey.

Survey participants were also invited to reflect on their Annual Scientific Congress attendance. Most respondents reported that they did not attend the 2015 ASC (83%, n=1485). The most common reason for not attending was a preference to specialty specific meetings (42%). This reinforces Conference and Events Strategic Plan Key Result Area aim to 'include more sub-specialties in programs that are educationally innovative and of high quality'. Although use of the Virtual Congress was low with just under a quarter of participants reporting access, there was a high satisfaction level of satisfaction from those who used the resource.

Strengths, Improvements and Ongoing Challenges

The final questions of the survey were an opportunity for qualitative comments by Fellows on the strengths, improvements and challenges facing RACS over the next five years. I will be reporting on these results in a future edition of Surgical News and how this feedback has been incorporated in the 2014 – 2018 RACS Strategic Plan.

I would like to take this opportunity to thank the Fellows who took the time to participate in the survey. The survey has provided valuable feedback and gives Council confidence that decisions and plans for the future reflect the views of Fellows.

The 2015 Fellowship Survey Report is available via the RACS Portfolio (https://portfolio.surgeons.org).

BRISBANE ASC

Aboriginal, Torres Strait Islander and Māori health to feature at Brisbane ASC 2016

CHRIS PERRY
Indigenous Health Committee and Convenor, ASC 2016

The Annual Scientific Congress in Brisbane is the key event on the RACS calendar. For the Indigenous Health Committee it is an exciting opportunity to raise the profile of Aboriginal, Torres Strait Islander and Māori health issues, as well as promote the work RACS are doing in Australia and New Zealand. The endorsement of the Aboriginal and Torres Strait Islander Health Plan 2014-2016 and the Maori Health Action Plan 2016-2018 by Council are landmark steps which enable RACS to advance Indigenous Health.

This year the Indigenous Health Committee will be visiting the Inala Indigenous Health Service as part of their regular community visits at each ASC. Inala provides health services to Aboriginal and Torres Strait Islander people living in and around Brisbane, and also monthly fly-in medical service to Cunnamulla, 750 km west of Brisbane. The service has won numerous awards and its Clinical Director Dr Noel Hayman was Queensland's nominee for Australian of the Year in 2011.

The Indigenous Health scientific program at the ASC focuses on head and neck pathology in Indigenous populations in Australia and New Zealand. Presentations will highlight the high incidence of head and neck cancer and provide insights from South Australia, the Northern Territory and Queensland on how improvements can be made.

The scientific session will be preceded by two important events. The Committee will host an Indigenous Doctors' Roundtable Breakfast to welcome this year's recipients of the Foundation for Surgery Aboriginal and Torres Strait Islander and Māori ASC Awards. Six Aboriginal and Māori, junior doctors aspiring to surgical training will be attending the ASC to network with Fellows and College leadership and discuss career path options and issues facing Aboriginal, Torres Strait Islander and Māori medical professionals.

The second event is the presentation of RACS medals for excellence in Aboriginal and Torres Strait Islander Health and Māori, Health. These awards recognise excellence in Indigenous health being done by Fellows in both Australia and New Zealand; many of whom have been engaged with Aboriginal, Torres Strait Island and Māori, communities for a considerable time.

The Indigenous Health Committee extends a warm invitation to delegates to participate in any or all of these significant events.

Further information on the Indigenous Health Committee and RACS activities in Aboriginal, Torres Strait Islander and Māori Health is available at Indigenous Health on the RACS website.

Indigenous Health at the ASC Brisbane 2016 - A snapshot

Monday 2nd May

Visit to the Inala Indigenous Health Service (morning)

Wednesday 4th May, 7:00am -8:20am

RACS Indigenous Doctors' Roundtable Breakfast

Wednesday 4th May, 1:30pm – 3:30pm

Indigenous Health Scientific Session

Developing a Career and Skills in Academic Surgery Course

Monday 2 May 2016
7:00am - 4:00pm
Brisbane Convention & Exhibition Centre
Queensland, Australia

For Faculty updates visit
tinyurl.com/DCAS2016

Cost
$250.00 per person incl. GST

Register online at
tinyurl.com/DCAS2016

Contact
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AAS Association for Academic Surgery

Royal Australasian College of Surgeons
Section of Academic Surgery

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Provisional Program

Information correct at time of printing

6:45am - 7:15am	Registration Desk Opens	
7:15am	Welcome	*David Watters*
7:20am	Introduction	*Marc Gladman / Julie Ann Sosa*
7:30am - 9:30am	**Session 1: A Career In Academic Surgery**	*Henry Pleass / Caprice Greenberg*
7:30am	Why every surgeon can and should be an academic surgeon	*Tom Hugh*
7:50am	Training to become an academic surgeon: pathways and goals	*Julian Smith*
8:10am	Securing an appointment as an academic surgeon: options, contracts and responsibilities	*John Windsor*
8:30am	Getting started: research - ideas, process and outcomes	*Christobel Saunders*
8:50am	Getting started: teaching, leadership and administration	*Adil Haider*
9:10am	Discussion	
9:30am	**Morning Tea**	
10:00am - 10:20am	**Hot Topic in Academic Surgery**	
10:00am	Introduction	*Michael Grigg*
10:02am	Professionalism in Academic Surgery	*Cathy Ferguson*
10:20am - 11:30am	**Session 2: Ensuring Academic Output**	*James Lee / Rachel Kelz*
10:20am	Writing an abstract	*Julie Ann Sosa*
10:40am	Writing and submitting a manuscript	*Rebekah White*
11:00am	Presenting at a scientific meeting	*Jacob Greenberg*
11:20am	Discussion	
11:30am - 12:05pm	**Keynote**	
11:30am	Introduction	*Mark Smithers*
11:35am	Keynote: The UK clinical trials network	*Derek Alderson*
12 noon	Discussion	
12:05pm	**Lunch**	
1:00pm - 2:40pm	**Session 3: Concurrent Academic Workshops**	

Workshop 1: Career Development — *Adil Haider / Kelvin Kong*

Introduction

What can I do as a:

- Medical Student — *Jonty Karpelowsky*
- Junior Doctor — *Greg O'Grady*
- SET Trainee — *Sarah Aitken*
- Fellow — *Michelle Locke*
- Consultant — *Jonathan Golledge*

Discussion

Workshop 2: Research Opportunities — *Alan Guo / Richard Hanney*

Introduction

Clinical research — *Fiona Wood*

Lab-based / animal model research — *Alexander Heriot*

Education / simulation research — *Rachel Kelz*

Health services research — *Caprice Greenberg*

Discussion

Workshop 3: Practicalities of Research — *Christine Lai / Jacob Greenberg*

Indroduction

Critical ethical issues in medical and surgical research — *Amir Ghaferi*

Assembling the team and establishing collaborations — *Ian Bissett*

Funding opportunities — *Paul Bannon*

Grant writing — *David Watson*

Discussion

2:40pm	**Afternoon Tea**	
3:00pm - 4:00pm	**Session 4: Sustainability in Academic Surgery**	*Julie Howle / Julie Ann Sosa*
3:00pm	Finding and being a mentor	*Mark Smithers*
3:15pm	Work-life balance	*Andrew Hill*
3:30pm	The future of academic surgery	*Guy Maddern*
3:45pm	Discussion and close	*Marc Gladman / Julie Ann Sosa*

CPD UPDATE

Recent news in CPD

CATHY FERGUSON
Chair, Professional Standards

I would like to extend my thanks to the 75% of Fellows participating in the RACS program who finalised their CPD ahead of the 28 February deadline. I would strongly urge those Fellows who have not yet completed their CPD to do so at the earliest opportunity to avoid further ramifications under the College's Code of Conduct.

False CPD Declarations

A recent finding by the New Zealand Health Practitioners Disciplinary Tribunal has provided a timely reminder of the importance of complying with CPD requirements and ensuring that participation is accurately reported to medical regulatory authorities.

The matter before the Tribunal involved a now retired medical practitioner who held general and vocational registration in New Zealand. The practitioner was randomly selected for audit by the Medical Council of New Zealand (MCNZ) where it was discovered that they had made five false declarations to the MCNZ about compliance with their CPD requirements.

The tribunal heard that the practitioner had not participated in an appropriate CPD program, had failed to maintain CPD in both scopes of practice and raised potential concerns of public safety. The charge was the practitioner was likely to bring discredit to the medical profession and that these acts warrant disciplinary sanction. A fine of $9000 (NZD) was imposed on the practitioner - no other sanctions were applied.

http://hpdt.org.nz/portals/0/med14298pdecisionweb.pdf

Revised CPD Framework

The College is in the process of revising the CPD framework with a focus on strengthening surgical audit and peer review, incorporating and incentivising activities arising from the Building Respect and Improving Patient Safety Action Plan to counter discrimination, bullying and sexual harassment. It also includes a reflective practice component as is now mandated by regulatory authorities in Australia and New Zealand. We would appreciate any feedback you have on the current CPD program and what you would like to see in 2017. Please send your feedback to professional.standards@surgeons.org or you can speak to staff at the upcoming Brisbane Annual Scientific Congress.

IS PEER REVIEW EFFECTIVE?

Peer review and the Surgical Arena

JOHN NORTH
QASM/NTASM Clinical Director

Australia is a leader in the field of surgical mortality peer review (1). Most surgical deaths in Australia are reviewed via the Australian and New Zealand Audits of Surgical Mortality (ANZASM). This extensive peer review is not the case in other countries (2).

Is peer review effective? Does it help surgeons? Does it reduce morbidity and mortality in patients? It may be too early to note reductions in morbidity and mortality in most Australian States and Territories. However, in the Western Australian Audit of Surgical Mortality (WAASM), early positive trends are apparent (3).

While each case is unique, the audits do highlight collective issues. They are least often in theatre.

The Queensland Audit of Surgical Mortality (QASM) data highlights that the most common issues relate to the patient assessment or the situation assessment.

To evaluate these issues, the QASM counted how surgeon peer assessors determined how often a clinical management event occurred in surgical deaths in Queensland between 2007 and 2013.

"Peer review assessment and feedback can change surgical practice for the better"

The QASM then looked at all the cases which fulfilled the inclusion criteria of the audit, of which there were 4,816. The cases were then counted and classified by the most serious clinical event, if there was one, for each patient.

Encouragingly, 70.7% (3,406/4,816) of patients who died had no clinical management events. When patients did have an 'event' (1,410), 58% (688/1,186) of those events were assessed as being preventable.

The three most frequent groups of 'serious clinical events' were:

- problems in patient assessment (34.5%; 487/1,410) of events
- problems in suboptimal therapy (15.3%; 215/1,410) of events and
- delays in various stages of the patient care pathway (15.1%; 213/1,410) of events.

The specific preventable issues most commonly noted were:

- the decision to operate
- should have performed different operation
- delay in diagnosis

Peer review, as seen in this audit, significantly contributes to the recognition of management 'clinical events'. It also allows comment on the 'preventability' of these events.

The feedback from the peer reviewer to their colleague surgeon then closes the loop of the quality assurance process.

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THE COWLISHAW SYMPOSIUM 2016

Cowlishaw's influence and rich heritage continue at the College

MR PETER F BURKE
Specialty Editor - Surgical History: ANZJSurg

Sir George Adlington Syme, the first President of the Australasian College of Surgeons died on April 19, 1929. A great man and eminent surgeon, his memory is perpetuated with the Syme oration delivered at each annual meeting of the College: Lady Syme and her family presented the College with a sum of money to enable this and the precedent was established in 1932.

At the Convocation ceremony of the Annual Scientific Congress in Brisbane, in May this year, the Syme Oration, will be delivered by Miss Clare Marx FRCS, President Royal College of Surgeons of England on the topic of, "Communicating through attitude, words and deeds".

The fourth Syme oration was read at the annual meeting of the RACS in March 1936, by Dr Leslie Cowlishaw of Sydney: his oration was entitled 'The First Fifty Years of Medicine in Australia'.

COWLISHAW RETURNS!

The Cowlishaw Symposium returns to Melbourne this year.

Saturday 15th October

Hughes Room

Further details as they come to hand.

Cowlishaw had commenced general practice in Cooma, NSW, in 1908, and at the outset of the First World War enlisted in the Australian Imperial Force as a medical officer serving in Egypt and Gallipoli. Subsequently invalided to England he held an administrative post which provided him with valuable opportunities for making contacts with the leaders in the medical history field: one such contact was Sir William Osler and the two quickly became firm friends, Osler presenting Cowlishaw with a number of books and labelling him "the bibliophile from the bush".

Through the 1920s Cowlishaw was recognised as a medical historian but this early interest was not encouraged by his seniors; Cowlishaw recalled that one of his senior colleagues had advised that his interest in medical history was "an amiable and harmless form of eccentricity, but inadvisable in one of my tender age; there would be enough time to take it when I had reached that state of senility in which new ideas were difficult to assimilate and apt to shake cherished beliefs".

In 1931 the University of Sydney established a lectureship in the history of medicine, which was filled by Cowlishaw in an honorary capacity. He gave a course of 12 lectures, illustrated by lantern slides and displays of books from his library. Attendances were voluntary and averaged about 70% of students.

For his Syme oration of 1936, College Council suggested that Cowlishaw choose as his subject some portion of the history of the medical profession in Australia: his address included the following extract:

"The story of the next hundred years has yet to be written, for the medical profession in Australia has yet to produce its historian. The opportunity is there for the man with sufficient leisure and the necessary historical enthusiasm. I am sure it would be a tale well worth the telling.

The medical profession has made great progress during its lifetime of 150 years in Australia, but I venture to say that of one aspect of our medical life we have no reason to be proud. I am thinking of our medical libraries. Australia lags far behind other countries in this respect, and many small towns in Canada and the United States would look with pitying eyes at our collection of medical books. We have yet to find a Mitchell or a Dixson to endow our medical libraries. Might I suggest to our wealthy fellow citizens, both lay and medical, that a good way to lessen the amount to be paid in probate and other taxes is to endow a medical library. Incidentally, immortality may thus be attained. In the words of that great physician, Sir William Osler",

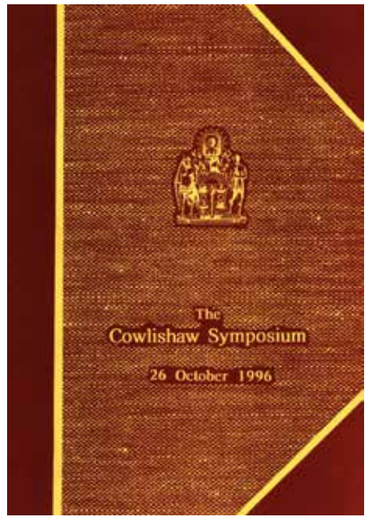
"The organisation of a library means effort, it means union, it means progress. It does good to men who start it, who help with money, with time, and with the gift of books. It does good to the young men with whom our hopes rest, and a library gradually and insensibly moulds the profession of a town to a better and higher status".

Throughout his life Cowlishaw remained a student of medicine, as well as of its history, and in 1939 gained by examination, membership of the Royal Australasian College of Physicians.

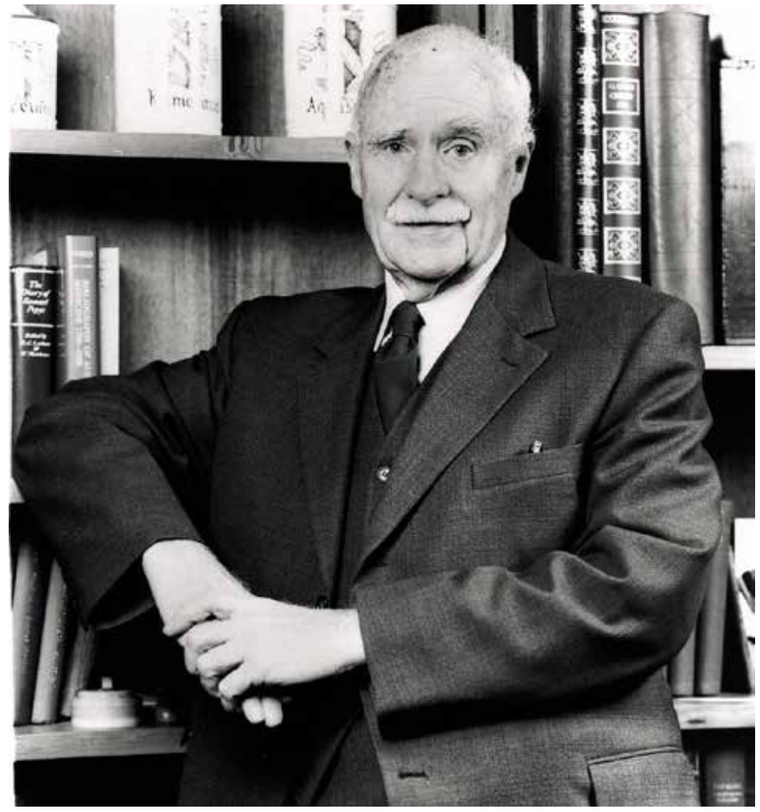
When Cowlishaw died on December 11, 1943 his library was offered for sale by his trustees; by his will the Royal Australasian College of Physicians had the first refusal but decided not to buy it, although he had been their honorary librarian and had designed the College library to house his collection!

Accordingly, the trustees were then prepared to hold the collection for any other institution and it was then that fate decreed that Kenneth Russell was in Sydney, on leave from the Army, when he learned of this opportunity.

Russell immediately contacted the College Secretary, Gordon Wheeler,



Program cover for the first Cowlishaw symposium



Kenneth Fitzpatrick Russell

and via him, made contact with Sir Alan Newton, PRACS 1943-1945, and succeeded in convincing him to make arrangements for the immediate purchase of the library.

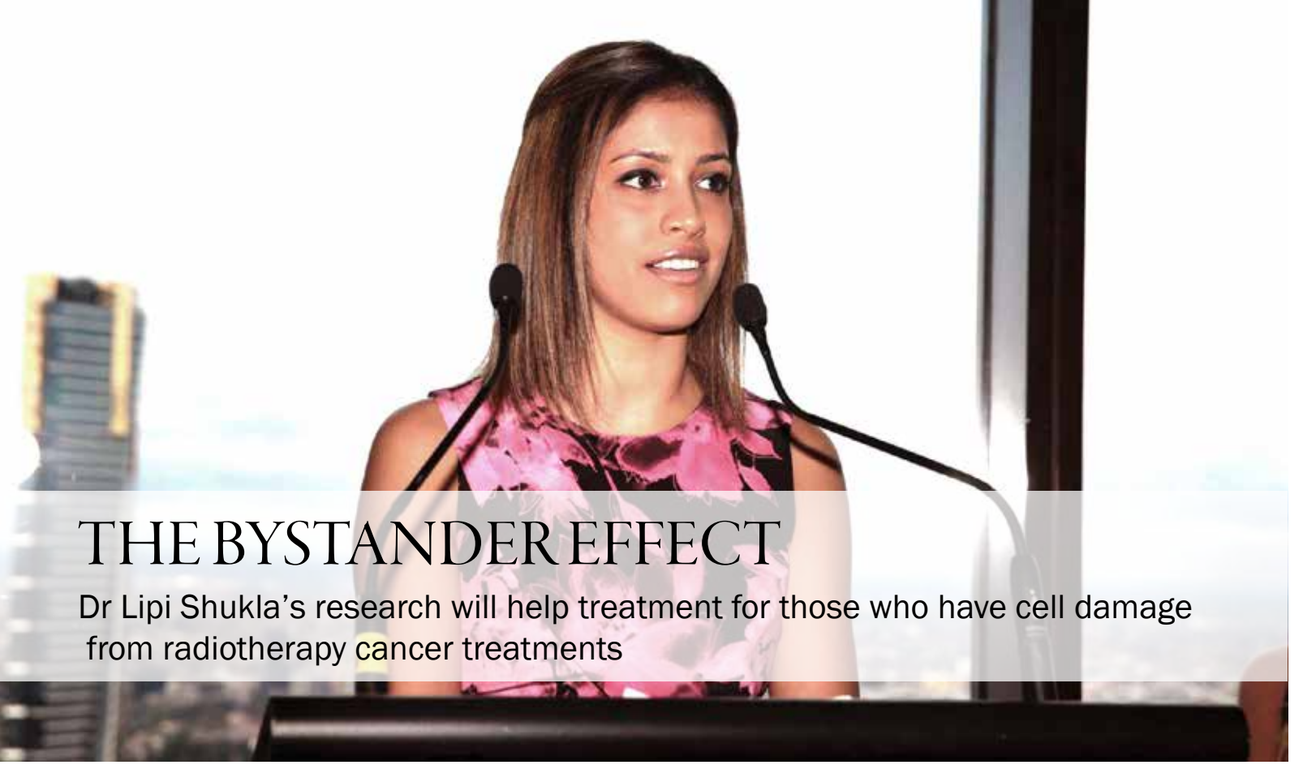
Apart from his writings and his persisting influence, Cowlishaw also left us a rich heritage, the library of his lifelong collecting, which was almost part of himself. The Cowlishaw Collection at the RACS is the main centre for the study of the history of medicine in Australia.

The first Cowlishaw Symposium was held at the College on 26 October 1996 and the Introduction noted: 'The Cowlishaw Symposium is designed to make the College's collection of historical volumes better known, both to Fellows of the College and to the wider bibliophile community'.

October 15 2016 marks the staging of the eleventh biennial Cowlishaw Symposium: just one day in duration, invited speakers are chosen to present papers based on volumes contained within the collection.

Fellows are strongly urged to consider attending; one day that could change your life and make for true 'fellowship'.

Your College has both a Curator and Archivist who are there to assist you with any research or gift enquiry: why not avail yourself of their expertise and arrange your own visit to this, **our** national treasure!



THE BYSTANDER EFFECT

Dr Lipi Shukla's research will help treatment for those who have cell damage from radiotherapy cancer treatments

Plastic and Reconstructive Surgery Trainee Dr Lipi Shukla has spent the past three years investigating the cellular and molecular causes, and progression of, the damage done to healthy nearby tissue by radiotherapy cancer treatments, a condition known as Radiation Induced Bystander Effect (RIBE).

Considered an inevitable side-effect of radiotherapy, RIBE is a progressive, late-onset soft-tissue injury that can expose vital underlying structures and is characterised by symptoms including pain, contracture, tissue breakdown, recurrent infection and lymphoedema.

With improvements in cancer treatments and the consequent cohort of cancer survivors growing year by year, RIBE is now presenting as both a significant quality of life issue for such patients and an increasing challenge to surgeons across all specialties.

It is now part of a growing list of ailments called "diseases of survivorship".

Dr Shukla said that RIBE-affected tissue had a restricted ability to redevelop a new blood supply and recover from injury, which restricts surgical treatments particularly in such specialties as Plastic and Reconstructive Surgery, ENT, General Surgery and Colon Surgery.

"Important implications of RIBE for surgeons are that surgical procedures – whether for functional restoration or cancer recurrence – in irradiated tissues are made more difficult," Dr Shukla said.

"Direct wound closure or local flaps are restricted by stiff, non-compliant tissue and even if wound edges are opposable, they are frequently subject to poor wound healing or breakdown.

"The ability of an irradiated wound bed to accept a skin graft is also diminished, which often necessitates more complex, potentially hazardous reconstructive procedures such as free microvascular tissue transfer from distant sites, in which radiation is a chief contributing factor to poor patient outcomes.

"Methods to salvage irradiated tissues to a point at which soft-tissue quality permits simple wound or tissue repair is desperately needed by clinicians."

Dr Shukla undertook the research into RIBE as part of a PhD through the Australian Catholic University, St Vincent's Hospital in Melbourne and the O'Brien Institute of Tissue Engineering with financial support from the College as the first recipient of the Foundation for Surgery Tour de Cure Cancer Research Scholarship.

Not only did she set out to understand the effects of radiotherapy injury on cell function in-vitro and the role such alterations played in the development of lymphoedema and fibrosis but also to find out if there was scientific evidence to support anecdotal reports that fat grafts could ameliorate the effects of RIBE.

"For some time, Plastic and Reconstructive Surgeons, particularly those conducting breast reconstruction surgeries following mastectomy, were anecdotally reporting that irradiated tissue overlying the fat graft became more complaint and less lymphoedematous," Dr Shukla said.

"While these effects had been clinically validated in murine models, the scientific mechanisms behind the phenomenon remained poorly understood so I wanted to find out why this was happening.

"As part of this research, we broke down RIBE effected tissue to the cellular level to understand the molecular signalling changes that were taking place in damaged cells, while also trying to identify growth factors that may reverse the effects."

Dr Shukla said she investigated adipose derived stem cells, extracted from samples of excess fat and found that these cells secreted specific growth factors that were able to reverse the effects of radiotherapy injury on cells such as fibroblasts and lymphatic endothelial cells.

"Important implications of RIBE for surgeons are that surgical procedures – whether for functional restoration or cancer recurrence – in irradiated tissues are made more difficult."

Another series of laboratory experiments investigating the effects of irradiation on normal human dermal fibroblasts, indicated that it resulted in a hyperactivity, rather than suppression of certain physiological functions

"This was a significant finding because it suggests that this hyper-active state represents cellular dysfunction resulting from sub-lethal radiotherapy injury and that it could be a contributing factor to the formation of fibrosis and the spread of RIBE rather than the more traditional hypotheses of large scale cell death," Dr Shukla said.

"We also found in our model of fat grafting that hyperactivity of irradiated normal human dermal fibroblasts was reduced and reversed in the presence of growth factors secreted by adipose derived stem cells.

"We now believe that these stem cells have great regenerative potential and aim to identify specific growth factors that can reduce the effects of radiotherapy injury in a cell-specific manner.

"It was very exciting to build up a scientific base which supports the anecdotal evidence that has been the subject of increasing interest in Plastic and Reconstructive Surgery literature for the last decade."

Dr Shukla conducted her research under the supervision of Professor Wayne Morrison, the former Director of the O'Brien Institute, and Mr Ramin Shayan, the current Director of the Institute.

She is now back at work as a SET1 Plastic and Reconstruction Registrar at the Maroondah and Box Hill Hospitals in Melbourne.

Now in the process of writing up her thesis, Dr Shukla thanked the College and Tour de Cure Foundation for the generous support given to her to complete her research.

"It is always a difficult decision to take time away from training to dedicate to research, but this area of medicine is of great intellectual and clinical interest to me. It has given me the opportunity to develop a set of skills facilitating bedside to lab bench research, seeing the problems in clinic and trying to find a scientific solution to the problems faced by our patients," she said.

"This PhD has allowed me to acquire expertise in the rapidly evolving area of fat grafting and radiotherapy injury, with the hopes to discover novel and targeted ways to restore normality to the lives of patients who have already been through the pain and discomfort of cancer treatments.

"It was also rewarding to be able to contribute to a surgical specialty that I will be working in for the rest of my life and I hope to incorporate ongoing contributions to translational research, tissue engineering and regenerative surgery throughout my surgical career."

The Foundation for Surgery Tour de Cure Cancer Research Scholarship was established in 2014 and provides a stipend and departmental maintenance for Fellows, Trainees and International Medical Graduates wishing to undertake a cancer research project.

With Karen Murphy

UPCOMING COURSE

Developing a career and skills in academic surgery

LAURA WANG
Trainee Representative,
RACS section of Academic Surgeons

- Are you interested in participating in research during or after training?
- Do you want to apply the published literature to your clinical practice with greater understanding and confidence?
- Do you want to deliver more engaging presentations and publish in high-impact journals?

If you answered yes to any to these questions, then this is for you.

Developing a Career and Skills in Academic Surgery (DCAS) Course is a day-long course that conveniently leads into the Annual Scientific Congress at the Brisbane Convention and Exhibition Centre on Monday 2nd May 2016 (7am-4pm).

This year, the 8th annual DCAS course aims to equip attendees with the ability to read publications with deeper understanding and the skills to perform research. The faculty includes members of all RACS subspecialties, reflecting the relevance of the meeting to all branches of surgery. The course is thus aimed at all Trainees and Surgeons who read journal articles or participate in research, across all subspecialties.

As in previous years, a diverse panel of outstanding national and international faculty will share their personal career experiences through a series of informative, interactive and inspiring sessions. Key advice will be given about how to: write a paper, present your work, get started in an academic career, and secure academic appointments. Concurrent workshops will be held on career development, research opportunities and practicalities of research. Perhaps of even greater value is the friendly and collegiate nature of the day. The many scheduled intervals between sessions allow delegates ample time to interact with faculty members.

The highlight of last year's very successful course was the keynote address by Nobel Laureate Prof. Barry Marshall, who shared the path to his success as a researcher. This year, the Keynote Speaker is the outstanding Professor Derek Alderson, Vice President of the Royal College of Surgeons, England and Editor-in-Chief of the prestigious British Journal of Surgery. Other members of the international faculty include Professor Julie Ann Sosa and husband/wife duo Drs Caprice and Jake Greenberg.

Professor Sosa is the Head of Endocrine Surgery Department at Duke University. She is an international leader in the field of endocrine surgery and currently serves as the Deputy Editor of JAMA-Surgery. Among her many achievements, she was on the committee for the recently published and highly anticipated 2015 American Thyroid Association management guidelines. In the past, Prof. Sosa has arranged several elective visits for interested students and trainees.

Drs Caprice and Jake Greenberg are accomplished academics and surgeons each in their own right. Dr. Caprice Greenberg is the President-Elect of the Association for Academic Surgery and a breast surgeon at University of Wisconsin. Dr. Jake Greenberg is a minimally invasive and bariatric surgeon, whose research interests also includes simulation of surgical education and training. The Greenbergs will have 2 of their three daughters with them on their visit. No doubt, they will have sage suggestions on balancing the demands of an academic career, clinical practice and family life.

The DCAS course is dedicated to expose trainees and younger surgeons to the opportunities in surgical research. The national and international faculty of surgeon researchers exposure delegates to a broad range of career opportunities and the professional networks to facilitate it. Furthermore, general surgical trainees can record DCAS course attendance as a requirement for one compulsory training day.

Finally, this course is a reflection of the Section of Academic Surgeons, cross-specialty commitment to the future of Australian and New Zealand academic surgical departments. We hope to see you in Brisbane in May!

DCAS course Co- Conveners

- Prof. Marc Gladman
- Prof. Julie Ann Sosa
- Dr. Richard Hanney

DCAS 2016 Provisional Program and registration form can be found on the section of Academic Surgery webpage: *tinyurl.com/DCAS2016*

For further information please email dcas@surgeons.org

THE SWEET SOUND OF RETIREMENT

Victorian Vascular Surgeon Mr Barry Beiles made a painless transition into retirement earlier this year through a combination of his love of music and an ongoing part-time professional engagement

Mr Beiles plays the guitar and has been the Clinical Director of the Victorian Audit of Surgical Mortality (VASM) since 2012.

Originally from South Africa, Mr Beiles left in the chaotic final era of the apartheid regime when the country was riven by civil revolt.

With students rioting, people being burnt in the streets and children virtually imprisoned in schools for their own safety, Mr Beiles and his wife Deirdre immigrated to Australia in search of a safe haven to raise their two children and arrived here in 1988. Yet it was not an easy decision.

Although a qualified surgeon, Mr Beiles was required to sit the medical degree exam (AMC), work for three years as an unaccredited registrar, two years as an accredited registrar and sit the Part Two General Surgery Exam before completing a year as a vascular surgical Fellow.

He completed that training at the Austin Hospital in Melbourne and spent the majority of his career in Australia in public and private practice working out of the Western and Box Hill Hospitals.

Throughout his working life and through the upheaval of moving to a new country and establishing himself professionally in a new system, he has found delight, personal challenge and relaxation in playing the acoustic guitar.

Mr Beiles took up the instrument as a teenager and describes his musical interest as acoustic finger-style guitar that takes in ragtime, blues and modern American finger-style guitar as pioneered by Chet Atkins.

His guitar heroes include Tommy Emmanuel and Michael Fix from Australia and Jerry Reed, Buster B Jones and Leo Kottke from the US.

Mr Beiles does not read musical notation but has learnt the instrument through the painstaking process of repeatedly listening to the guitar greats on disc and audiotape in the early days and watching them on-line more recently.

He now has more than 60 songs in his repertoire.

"I try and play every day because if you don't use it you lose it and if I don't play a song for three weeks or more I forget it because it's all about muscle memory," he said.

"Like most surgeons know, when you do something all the time, no matter how challenging, it becomes instinctive."

"Yet like most surgeons know, when you do something all the time, no matter how challenging, it becomes instinctive.

"Playing this style of guitar has helped keep my hands deft and flexible but even more, it inspires great wonder about the workings of the human brain.

"Each time I play a complex piece of music, I am amazed at the differences in how each note is played and how you incorporate memory, emotion, improvisation, rhythm and tempo so that each time you play a song it can be subtly different from the time before.

"Music also gave me a reason and opportunity to stop thinking about work throughout my career.

"I don't think you need a psychiatrist in your life if you play a musical instrument because it can elevate a low mood and soothe stress and pressure.

"This interest has greatly enriched my life and is probably one reason why I haven't gone crazy in retirement."

Mr Beiles said he also found the transition into retirement smoothed through his ongoing role at the VASM and said he took up the position of the Clinical Director as a way to give back to the Australian surgical profession.

A collaborative program between the Victorian Government's Department of Health, the Victorian Surgical Consultative Council and the RACS, the VASM exams the deaths of all patients who have died in a Victorian hospital while under the care of a surgeon.

Under the Victorian system, each such death is notified to the VASM by the hospital involved. The circumstances are then reflected upon by the treating surgeon and peer reviewed by at least one surgeon practicing in the same specialty but from a different hospital who is unaware of the identity of the treating surgeon.

The findings are then considered by, and reported on, by the VASM in regular reports, booklets and seminars.

Mr Beiles said the VASM was not a punitive program, but an educational tool which provides data and case studies through its Annual Report, Seminars and Casebook publications.

"The data in Victoria shows that there has been a steady, year by year decrease in surgical mortality, a result that is not necessarily replicated across Australia," he said.

"This reduction is particularly pleasing given that the patients who make up the majority of cases referred to us are elderly patients with co-morbidities who are admitted into hospital as emergency cases.

"We know that the standard of surgical care in Victoria is very high, that audits act to support that standard and we now have years of data to prove it.

"We now also know that the top three aspects of surgical care that can reduce surgical mortality are preventing delay in diagnosis or transfer, the management of the deteriorating patient and surgical emergencies, and shared care."

Mr Beiles and his wife Deidre have returned to South Africa every two years since their arrival in Australia to visit family.

He has watched the transformation of his homeland with hope and optimism from the calm of Australia and said he was there when Nelson Mandela was commemorated.

He has also visited Robben Island where the South African leader was incarcerated for 16 years.

Mr Beiles described both experiences as greatly moving.

Now a grandfather of four children, he said he was keen to pass on the joy and stimulation of music to the youngest members of the Beiles family.

"I made a resolution a while ago that I would encourage my grandchildren to learn to play a musical instrument so I plan to give each grandchild a guitar when they turn eight years old," he said.

With Karen Murphy

SNAPPING HISTORY

Fellow John Henderson has had a long enthusiasm for the photographic medium

Victorian General Surgeon John Henderson developed his interest in photography as a schoolboy and has given his photographic skills and services to the College throughout his surgical career. As a young surgeon, he began taking his camera to Provincial Surgeons of Australia (PSA) meetings and as word of his skills spread through the profession he was later asked to photograph College meetings, orations and award ceremonies. These requests have since resulted in an archival treasure trove of thousands of images of Fellows from every major College meeting held in the past two decades. Now retired, Mr Henderson talks to Surgical News about the pleasure he has taken in creating a rich visual history for the benefit of current and future Fellows.

What inspired you to take up photography?

My interest in photography was originally fostered by my mother Mrs Mary Henderson who, for as long as I can remember, used to take 3.5 x 2.5 inch black and white photos of family events, from time to time, with her Kodak (620 film) Box Brownie camera. In 1947, my parents came back to Victoria to live in Geelong and in August 1948 I was presented with a Box Brownie camera for my 16th birthday, just before my last term of school at St Ignatius College, Riverview, in Sydney. I was still taking black and white photographs with that camera during my six years in Newman College, Melbourne University, up until the time of my graduation at the end of 1955.

What cameras did you use as a budding photographer?

After I graduated, I started taking Kodachrome colour slides (reversal film) with a Zeiss Ikon Contaflex camera at St Vincent's Hospital in Melbourne in 1956, the Geelong hospital in 1957, the Royal Women's Hospital in 1958 and the Royal Children's Hospital in 1959. I was still taking Kodachrome colour slides as a surgical registrar at the Alfred Hospital in 1966 and back again at St Vincent's Hospital in 1967. After Pam and I were married in January 1970, we went to London where I stated using Kodachrome colour negative film for colour prints. It was during those three years living in London that I obtained my English and Australasian Fellowships in 1972 and my Edinburgh Fellowship in 1973.

When did you first combine this artistic interest with your life as a surgeon?

In surgical practice as an Assistant General Surgeon at the Geelong Hospital since July 1973, I attended several RACS General Scientific Meetings (GSMs) and by that time I was using a Nikon film camera, F-801s. When I first came back to the Geelong Hospital my very first mentor, Geoff Royal insisted that I attend PSA meetings. The first PSA meeting I attended was at Traralgon in 1981 where I took photos of family and friends and the venue. The most enigmatic photograph that I took at that meeting, however, was of a bird's nest in the engine compartment of our PA32 Piper Lance aeroplane, out at the Latrobe Valley Airport. Fortunately, someone at the airport had attached a big A4 note warning us about the nest inside the engine! My departure back to Geelong with Pam and our four children had to be delayed for an hour or two while we cleaned all of the straw and grass of the nest out of the engine!

How did your role as informal RACS photographer develop?

During the 1980s, Pam and I took more and more photographs at the PSA meetings each year which were included in the PSA "Proceedings Book" which mainly comprised summaries of all the papers presented at the meeting held the previous year. Consequently, when people arrived for the PSA each year, these Proceedings Books would be eagerly scrutinised to see the colour photos of the meeting from the previous year. The annual scientific meeting of the College, in Canberra, in 1992 was the last time this meeting was called the GSM. The College meeting in Adelaide in 1993 was the first Annual Scientific Congress (ASC). In 1996, the ASC was in Melbourne and the convenor for that meeting was Mr Peter King, a long-time dedicated PSA aficionado as well as an experienced provincial surgeon, a College Councillor, an aviator (like at least a dozen other PSA regulars), a scholar and a gentleman. Peter King rang me and said: "You have to do the photos for the ASC just like you do them for the PSA!" Initially I protested believing that it would just not be possible to cover such a big meeting, the way we did every year for the PSA, but he insisted that I absolutely had to do it, so I did! The photos for the 1996 ASC were done, as requested by him, and I have been doing them for the College every year since.

Were you solely responsible for all the images captured at these meetings?

The College has always had professional photographers to photograph the official proceedings of the Convocation itself, the Syme Orator, the recipients of Medals and Awards and Honorary Fellowships and all the new Fellows getting their Diplomas. In later years, a number of very capable people became available to take more and more of the iconic photographs during the rest of each meeting while Pam and I continue to take more informal images.

Can you list a highlight of your time as a photographer for the RACS?

The year 2000 was the 75th anniversary year for the College and the ASC was held again in Melbourne. There, with the very considerable support of the College, we were able to set up an exhibition of colour prints mounted on large black card boards of previous GSMs and ASCs dating back several years which was greatly rewarding.

How has photography changed since you first began providing your skills to the College?

Back in the days of analogue photography, we would take our reels of Kodak Ektachrome, colour negative Kodachrome or Fujifilm along to the camera shops and they would produce sets of 10 x 15cm colour prints, as well as the cut-up strips of the colour negative film. Now, however, much of the photographic content of the ASC has been available as digital files to everybody with access to the Virtual Congress website. This facility makes it very easy for people to download and print their own copies of these photographs.

Where are the photographs now stored and how can Fellows access them?

Large format photographic albums of photos taken at the ASCs from Melbourne 1996 to Adelaide 2002 are now in the College Archives and since Brisbane 2003, appropriately labelled DVDs of all the ASCs and PSAs, as well as the Saturday Cowlishaw Symposium meetings are now in the College archives. I have also endeavoured to put together a video-photographic record of surgical conferences and events as well. These events include the "Begonia Prize" session at nearly every annual PSA meeting since 1981; some of the proceedings at SGMS and ASCs over the years including Surgical History papers; and, more recently, papers presented at the biennial Cowlishaw Symposiums.

Some of these video-photographic records are in the form of fully edited (Avid Media Composer) DVDs and even Blu-ray discs but much of this video-photographic record still exists, currently, as unedited high definition BPAV and, more recently, AVCHD computer files on (in triplicate) external hard drives.

What have you most enjoyed about taking on this role for the College throughout your surgical career?

Pam and I feel very fortunate to have had the opportunity to take photographs at so many surgical conferences and events. But more importantly, this video-photographic documentation is not so much about the papers presented but rather the people who presented them! I believe that future generations of surgeons will want to be able to see both the photographic and the video-photographic record of our generation.

With Karen Murphy

CLINICAL VARIATION

Procedure in profile: Laparoscopic Cholecystectomy

DAVID WATTERS
Chair,
Clinical Variation Working Party

Understanding clinical variation is becoming increasingly important both locally and internationally. Fifty years ago medical interventions were limited, more straight forward and carried a much lower cost impact on the community. Today people live longer, generally their health is better, and there is more demand for surgery even in the elderly. Medical and surgical interventions have become incredibly complex, involving multidisciplinary decision making by sophisticated teams, and chronic disease must be managed for decades at substantial expense both to the individual patient, private health insurance and government funders. Everyone feels they have a legitimate perspective on the potential role of surgery. Within the context of these ongoing changes and the sustainability challenges faced by the health sector, it is vital that the College is able to advocate for safe, affordable and high quality health care that represents best practice.

Consequently it is a strategic priority for RACS to work with health funders and other groups that 'own' big data sets, so we can understand the approach they use in interpreting them, and ensure that relevant and meaningful information is made available to all surgeons. These data sets were not originally established to determine the quality and outcome of care and therefore suffer some limitations. However, we still need to be informed as to what variation there is within surgical practice, particularly given the attention that has arisen from the publication last November of an Atlas of Healthcare Variation including a section on surgery. RACS needs to be actively involved in the discussions about how health care can be affordable whilst ensuring good surgical practice. An outcome that will certainly benefit our patients, as well as the profession.

The College and Medibank have established a collaboration to progress the analysis of the administrative data sets that Medibank has available from over one million surgical interventions per year. By focusing on high volume procedures, we are developing an approach in reporting that can be applied across most areas of surgical practice and enable a careful review of clinical practice. As expected our analysis is generating a substantial number of questions about the data and individual variation. Many of the answers are not determined by the reports themselves but arise from the reflection, review or discussions that surgeons will now be able to undertake. The data is published in the report on a global basis as well as a regional basis, where appropriate. We are looking into making the data available at a hospital level without identifying any individual surgeon.

RACS and Medibank are currently exploring a way to provide information to individual surgeons as to where they are within the global data-set. This process will take several months to develop and will be via a direct enquiry between the surgeon and Medibank with consent being given for the data to be extracted.

The College will never have individual surgeon performance data made available to it.

The role of the College is to ensure a meaningful approach is established and that education can be provided across the entire Fellowship as to what variation exists. We are very fortunate that Medibank has engaged so productively with the College in this endeavour. We are hopeful of progressively replicating this process with other funders and their data sets.

We are presenting these initial reports through Surgical News as the first part of a broader communication strategy. The procedure within this report is **Laparoscopic cholecystectomy.** In 2014 Medibank funded 4675 procedures where it was recorded as the principal procedure (highest value MBS fee in the medical claim). The most significant number was Laparoscopic Cholecystectomy with MBS code 30445 (97%) with laparoscopic exploration of the common bile duct,30448 (3%). During the one year time period 682 surgeons billed Medibank with 330 (48%) of these surgeons

Figure 1: The Median age of the patients was 54 years

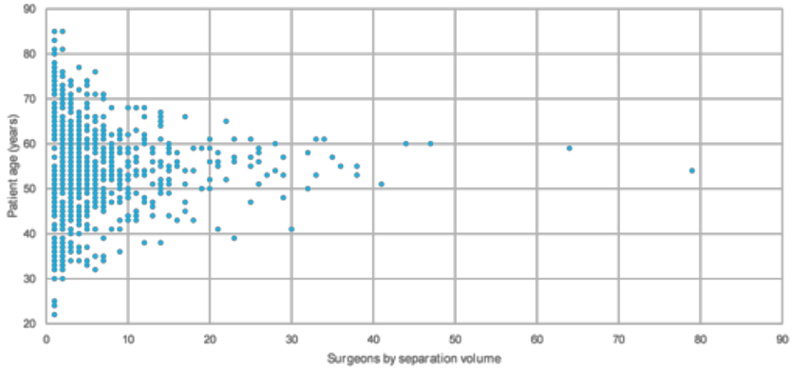


Figure 2: The Median patient length of stay in hospital

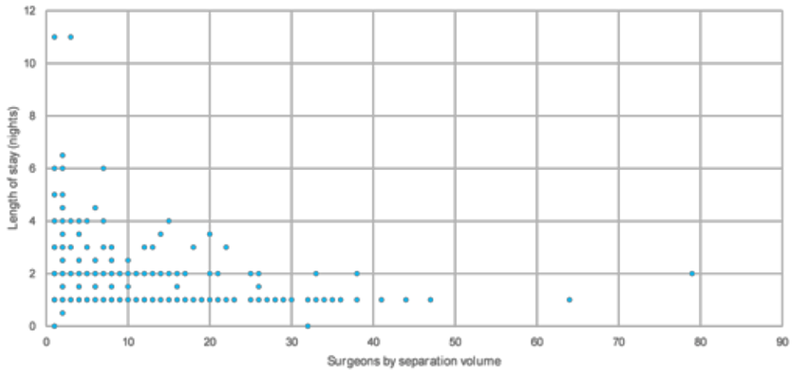


Figure 3: Percentage of separations where patient was transferred to ICU or another hospital

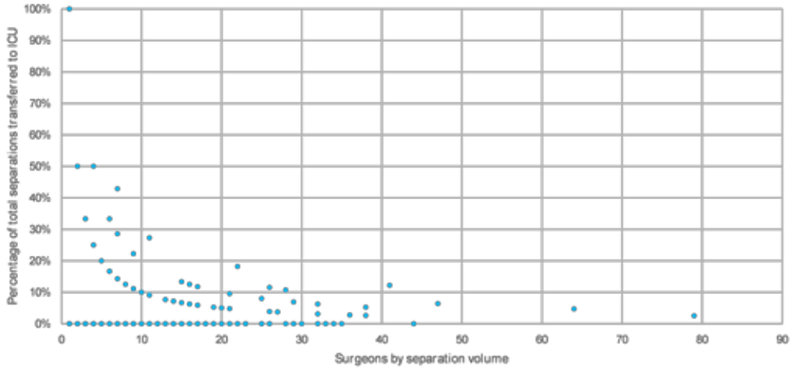


Figure 4: Percentage of separations where patient was readmitted (all causes) within 30 days

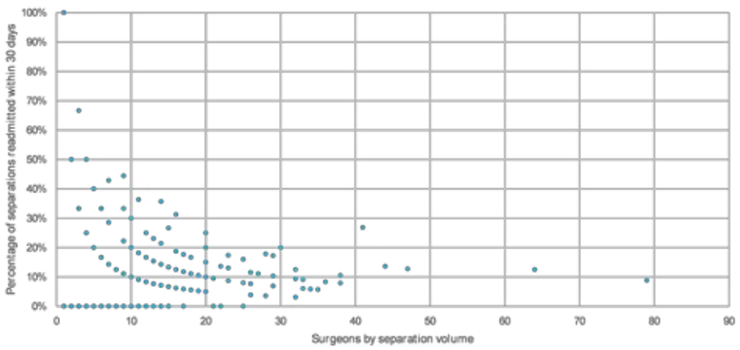


Figure 5: Average separation cost includes hospital chargers, Surgeon(s), anaesthetists and diagnostic services

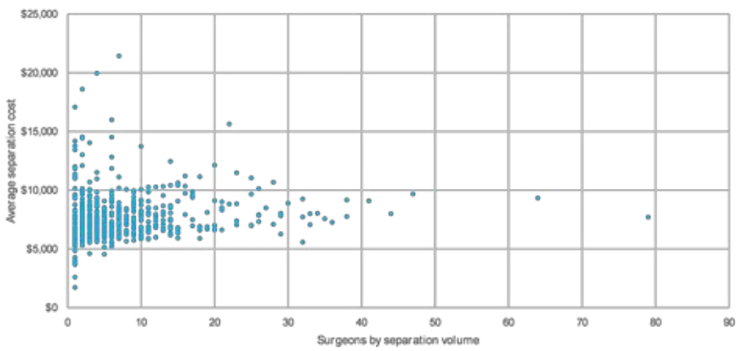
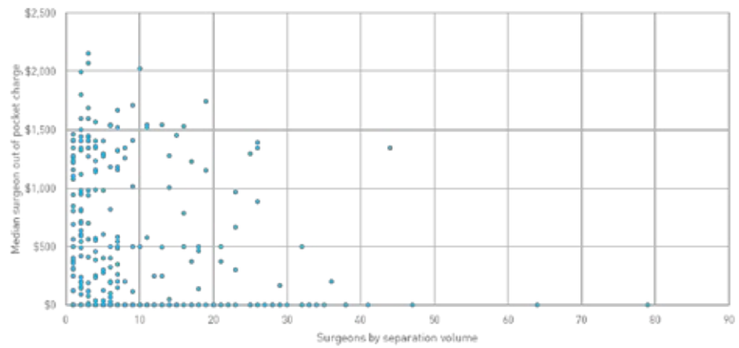


Figure 6: Average Surgeon out of pocket charge from the principal Surgeon



performing at least 5 procedures that were billed to Medibank. The calculations in the charts relate only to the 330 surgeons and their patients.

Of course the surgeons could also be doing many more of these procedures in the public sector or on patients with other private health insurers. The Medibank dataset does not have this information.

The median length of patient stay for the 330 surgeons who performed at least 5 procedures ranged from 0 nights (same day discharge) to 6 nights with a median of 1 night (**Figure 2**). There was a regional difference with ACT having a median length of stay of 2 nights with all other regions being 1 night.

Of the 330 surgeons who performed more than five procedures, 75 surgeons (23%) performed at least one procedure where the patient was transferred to ICU or another hospital during the hospital separation (**Figure 3**).

There were 456 patients (10%) who were readmitted within 30 days following a laparoscopic procedure (**Figure 4**).

The separation cost is the total charge that Medibank processes including payments made by Medibank, Medicare and the patient. Of the 330 surgeons who performed at least 5 procedures that average total separation charge ranged from $4,542 to $21,419 with a median of $7,266. There are substantial regional differences with the average separation cost in NSW being $6,370 and WA being $8,139 (**Figure 5**).

For the 330 surgeons who performed more than 5 procedures, the average out of pocket cost ranged from $0 to $2,067. The average patient out of pocket for all medical services (including the surgeon, assistant surgeon, anaesthetist and diagnostics) was between $0 and $3,436 for each surgeon.

Like all reports of administrative data sets there is substantial work in ensuring the data is represented in a meaningful and relevant style. I would like to acknowledge the substantial commitment of Medibank in accessing and representing this data in a way that can be usefully interpreted. I would also like to acknowledge the Clinical Variation Working Party including general surgeons, cardiothoracic surgeons, orthopaedic surgeons, otolaryngologists, urologists and vascular surgeons who are now reviewing the data and its presentation. They are trying to ensure that these reports can be sent to surgeons and that they will be seen as valuable despite their limitations. The reports will become progressively available over the coming months.

And that is when both the interesting and challenging part starts. As Fellows of RACS we need to have an understanding of what drives variation in health care. We are all responsible for the quality of care that our patients receive and the resources that are utilised in providing that care.

I would be delighted in receiving feedback about this process. Also, if you wish to pursue this data further with specific questions to Medibank, our key clinical contact is Dr Linda Swan, Chief Medical Officer, Provider Networks and Integrated Care at:

Linda.Swan@medibank.com.au

OPHTHALMOLOGY IN MICRONESIA

Dr John Kearney OAM, FRACS & a RACS volunteer team have helped do themselves out of a job, and they couldn't be happier.

Most surgeons who undertake volunteer global health work aim to build up local capacity and capability so that they are no longer needed, yet reality often falls short of the dream.

Yet three Queenslanders have done just that.

Dr John Kearney OAM, an Ophthalmologist, Optometrist Michael Hare and theatre Nurse Pavla Jones set out to help establish a national ophthalmic service to the people of the Federated States of Micronesia (FSM). Today, the country's first ophthalmologist is performing world class surgery in a new National Eye Clinic.

Over numerous team visits and with considerable personal financial support from Dr Kearney and his family, Dr Kearney selected, mentored and funded local surgeon Dr Padwick Gallen to undertake specialist ophthalmic training.

Now all that effort and commitment has paid off.

In late 2015, Dr Gallen graduated from the Pacific Eye Institute in Fiji to become the national Ophthalmologist in FSM while the country's dedicated National Eye Clinic was unofficially opened in January.

The Clinic, located in the Pohnpei State Hospital, will allow Dr Gallen to conduct procedures such as cataract and intraocular lens surgery, a surgical service that until now has only been available through international team visits or through off-island referral. The Philippines Lions Club's was one of a number of donors contributing to the Clinic's establishment, donating an estimated US $100,000 worth of equipment.

Dr Kearney and Mr Hare, members of a team of four dedicated volunteers which also includes clinic assistant Ms Elena Plotnitskaya, have been visiting FSM to provide eye care services since 2010. The regular one to two week trips were funded through the Australian Government supported Pacific Islands Program (PIP), managed by the RACS. During this time, the team has provided more than 1000 consultations and 150 operations for Micronesians with eye conditions.

In January, Dr Kearney visited Pohnpei to attend the unofficial opening of the National Eye Clinic and assist Dr Gallen in a number of surgeries, a moment he described as a highlight of his career.

"This was a great trip and somewhat different to others in that Dr Gallen did most of the work," Dr Kearney said.

"He does beautiful surgery and his patients were ecstatic with the results and the looks on their faces when they regained their eyesight was a joy to behold.

"Dr Gallen's graduation as the national Ophthalmologist in FSM signifies a great step forward in health care for the local people and is a reflection of his skills, hard work and commitment.

"The support of the RACS and the FSM Government and the enthusiastic support of Dr Johnny Hedson, the Director of the Pohnpei Hospital, have also been pivotal."

Dr Kearney described his financial support of Dr Gallen's specialist training as "worth every cent" and said he expected him to make a dramatic difference to eye care and the cost of eye care in FSM, including for those from outlying islands who have previously had little access to such care.

He said Dr Gallen had garnered such broad local support through his commitment to his training, that he hoped that he would be given on-going support to establish outreach services to remote populations and to promote eye care education across all the islands of FSM.

"Sadly, almost 50 per cent of adults in FSM have diabetes Type 2, mainly caused by a western diet, and Dr Gallen is now in a position to spread the message of the dangers of the disease as well as promoting the use of sunglasses to avoid cataracts," Dr Kearney said.

"It sounds like Dr Gallen has a mountain to climb going forward but he is a wonderful surgeon although challenges remain because not only is he the new kid on the block, he's on a whole new block.

"I have been working across the Pacific region for many years now and sometimes it is difficult to create lasting change but I am very confident that this new Ophthalmic service will thrive in FSM not only because of Dr Gallen's skills but also because he has the political support which is often vital."

"There is a great need for such eye care in the Pacific region where severe vision loss is widely caused by cataracts caused by exposure to UV light and glare from the ocean waters."

Dr Kearney said that while the National Eye Clinic was reasonably well-equipped, Dr Gallen still needed cataract packs, a Vitrectomy machine, a computerized Visual Field machine and retinal imaging equipment and that he was in the process of seeking funds in Australia and the US to help pay for the equipment.

He also said he would continue to assist Dr Gallen's continuing professional development by organising and funding visits by specialists in ocular plastic, anterior segment, retinal and paediatric eye surgery.

Optometrist Michael Hare said it had been a hugely satisfying experience to help establish sustainable eye care services in FSM with a skilled local surgeon now in place to deliver the service for decades to come.

He said there was a great need for such eye care in the Pacific region where severe vision loss was widely caused by cataracts and pterygiums caused by exposure to UV light and glare from the ocean waters.

"Both of these are preventable conditions but there is a need for an education campaign about both the need of protection against the glare and about early detection so that patients do not present when it is too late to reverse the effects of pterygiums," Mr Hare said.

"In the past, the people from the outer islands have often suffered from severe visual loss because they have no access to eye care and they often travel vast distances when they hear of an international team visit.

"We would expect this situation to improve greatly now that FSM has its own ophthalmologist and a dedicated national eye care service.

"Dr Gallen is very highly regarded and liked within his community and is in a position, I believe, to change the entire population's approach to eye care, particularly in relation to the need for eye protection and the dangers of diabetic retinopathy.

"I feel very proud to be associated with this team of volunteers who have worked so hard for the past few years to support Dr Gallen and improve the health care provided to the people of FSM, particularly John Kearney whose generosity has been significant.

"We have worked our way out of a job over six years or more which is very satisfying and it is wonderful to be able to say mission accomplished!"

With Karen Murphy

THE TWO MR SMITHS

Charles and William Smith were both impressive in the medical field

ELIZABETH MILFORD
College Archivist

In the late nineteenth century, two highly qualified doctors, brothers, William John (1840-1929) and Charles (1843-1921) Smith made their way to Australia. Charles, a ship's surgeon on the Yalata arrived first, landing in Adelaide in October 1869, then travelling to Melbourne. William took passage in the Orient to Adelaide, then in the Aldinga, arriving in Melbourne in December 1869.

As copies of testimonials and letters in the College Archive indicate, the brothers were highly regarded in the medical circles of their time. William had an impressive record from the University of London and University College Hospital, winning eleven gold and two silver medals. He obtained membership of the Royal College (MRCS) in 1861 and an MB in 1863. His testimonials include one from the physician William Jenner who discovered the difference between typhus and typhoid. Another testimonial is from John Gay, surgeon to the Great Northern Hospital and known for his operations on femoral hernias.

William's younger brother Charles was similarly gifted. Obtaining his MB in 1861, he completed his MD in London netting a gold medal in the process; and became a Fellow of the Royal College in 1866. Charles's testimonials include one from 'Anatomical John', the anatomist John Hilton appointed Surgeon Extraordinary to Queen Victoria in 1871 and renowned for his tract: 'On the influence of Mechanical and Physiological Rest in the Treatment of Accidents and Surgical Disease and the Diagnostic Value of Pain'. Another testimonial is from Obstetric Physician, John Braxton Hicks, who was the first to first to describe bipolar and other versions of the foetus and Braxton Hicks contractions – 'false' uterine contractions not resulting in childbirth.

Why did the Smith brothers come to Australia?

In William's case, the decision was clear - having been told by his prospective father-in-law that he could not marry until he had done something useful, he went to the colonies. When he arrived in Melbourne, he worked as an Anatomy Demonstrator at the University of Melbourne (1870-1871) and as a Curator of the Pathology Museum at the Melbourne Hospital. But his crowning achievement was the founding (with John Singleton) of the Melbourne Free Hospital for Sick Children in June 1870. Renamed the Children's Hospital in 1903, the hospital was first established at the corner of Romeo Lane (now Crossley St), Melbourne, with six inpatient beds and a large number of outpatients. Elected Honorary Surgeon at the hospital, William was also Secretary of the Management Committee and Life Governor. However for some reason, he resigned in 1871 and travelled to Casterton in the Western Districts to work as a General Practitioner.

William Smith sold his Casterton practice to his brother Charles in 1875, returned to England and married his sweetheart, Louise Crampton. Research in Germany followed then a Lectureship at the Oxford University. He died in York in 1929.

Ostensibly Charles Smith came to Australia for his heath but his relationship with Lady Emily Shaftesbury may also have created difficulties for him. Explaining his decision to emigrate in a letter to her he says: 'I am going to write to you what is a most painful disappointment to you... [ie parting company]'. Charles went to Melbourne with recommendations from WD Wilmot who had resided in the colony fourteen years earlier. Wilmot wrote:

I trust the medical friends to whom I have written are still amongst the living and most flourishing of their Brethren in the Colony.

Charles did flourish in the Colony, working as a resident physician at the Melbourne Hospital (1870) and physician at the newly completed hospital at Clunes (1875). He also married Marry Helen Brown, the granddaughter of 'Como' Brown. Charles seemed to enjoy country life and after taking over his brother's practice in Casterton, remained in the Western Districts until he retired to Melbourne. Charles lived at a time when country doctors worked both as surgeons and physicians and primarily regarded himself as a surgeon. His operations included an emergency tracheotomy in a train, using only a penknife, arthrodesis of the knee and removal of hydatid cysts in the liver and brain. A clever and meticulous man, he also developed an antiserum for diphtheria but was unsuccessful in convincing worthies like Lord Lister of its efficacy.

Copies of the 'Smith' papers were given to the Archive by Charles Smith's great grandson, Professor Ken Hardy. The papers give interesting insights into the medical personalities in 1860s Britain and also act as catalyst for investigating the lives of these two significant 'colonial' doctors.

NEW SURGICAL DIRECTORS PROGRAM

2016 Annual Scientific Congress

DAVID FLETCHER
Chair, Surgical Directors Section
Convenor, ASC Surgical Directors Program

The College has recently established a Surgical Directors Section. The Section aims to support surgeons in leadership positions by providing a network of peers, professional development opportunities and a forum for discussion on leadership in healthcare settings.

The Section will offer a Surgical Directors Program at the 2016 Annual Scientific Congress for the first time with the theme 'Leadership for Cultural Change and Improving Surgical Outcomes'.

We are pleased to announce that Professor Gerald Hickson MD, Senior Vice President for Quality, Safety and Risk Prevention at Vanderbilt University, USA will be the inaugural Surgical Directors Program International Visitor. Professor Hickson is world-renowned expert on medical professional accountability.

Professor Hickson is a faculty member of the Vanderbilt Centre for Patient and Professional Advocacy which supports professionalism as the foundation of safe, quality healthcare. He has presented extensively on addressing behaviours that undermine a culture of safety and offers a range of research, tools and strategies that have a direct impact on improving patient safety.

Professor Hickson's research has focused on why families choose to file law suits, and why certain medical specialists attract a disproportionate share of claims, and how to identify and intervene with high-risk medical specialists. His work has resulted in over 150 peer reviewed articles and chapters; the development of PARS (Patient Advocacy Reporting System) and several educational initiatives to promote disclosure of medical errors and address behaviours that undermine a culture of safety. This work has application to the RACS Building Respect and Improving Patient Safety Action Plan and Professor Hickson's presentations at the 2016 ASC are expected to create considerable interest.

The Surgical Directors Section's 2016 ASC activities include:

Pre Annual Scientific Congress Workshop

Monday 2 May 2016

Surgical Leaders Workshop – The Power of the Role Model

A limited place pre-ASC workshop is being offered, $50 per person including afternoon tea. The workshop will be held 1.00pm - 4.00pm at the Brisbane Convention and Exhibition Centre.

Professor Gerald Hickson will facilitate the workshops and present on roles models and surgical outcomes. Other contributions will be made by local Directors of Surgery. Registrations are required via ASC Online Registration at www.asc.surgeons.org/registration.

Annual Scientific Congress 3 – 6 May 2016

Brisbane Convention and Exhibition Centre

Wednesday 4 May 2016

Surgical Directors Section Annual Business Meeting

5.30pm – 6.30pm

We encourage you to join us at the inaugural Annual Business Meeting and tell us how the Surgical Directors Section can support you in your position of leadership. Feedback at this meeting will help shape the priorities for the section's future activities.

Friday 6 May 2016

Surgical Directors Program: Leadership for Cultural Change and Improving Surgical Outcomes

8.00am – 10.00am

Professor Gerald Hickson will present on 'The Vanderbilt Model – Cultural Change and How to Achieve Better Outcomes'. This will be followed by a panel discussion on disruptive behaviour case studies by local Directors of Surgery and teaching faculty from RACS professional development courses.

In addition, Professor Hickson will speak at the Quality and Safety Program session on 'Making Change' (1.30pm – 3.30pm) and Surgical Education Program session on When is it Performance Management and When it is Bullying? (4.00pm – 5.00pm) on Friday 6 May 2016.

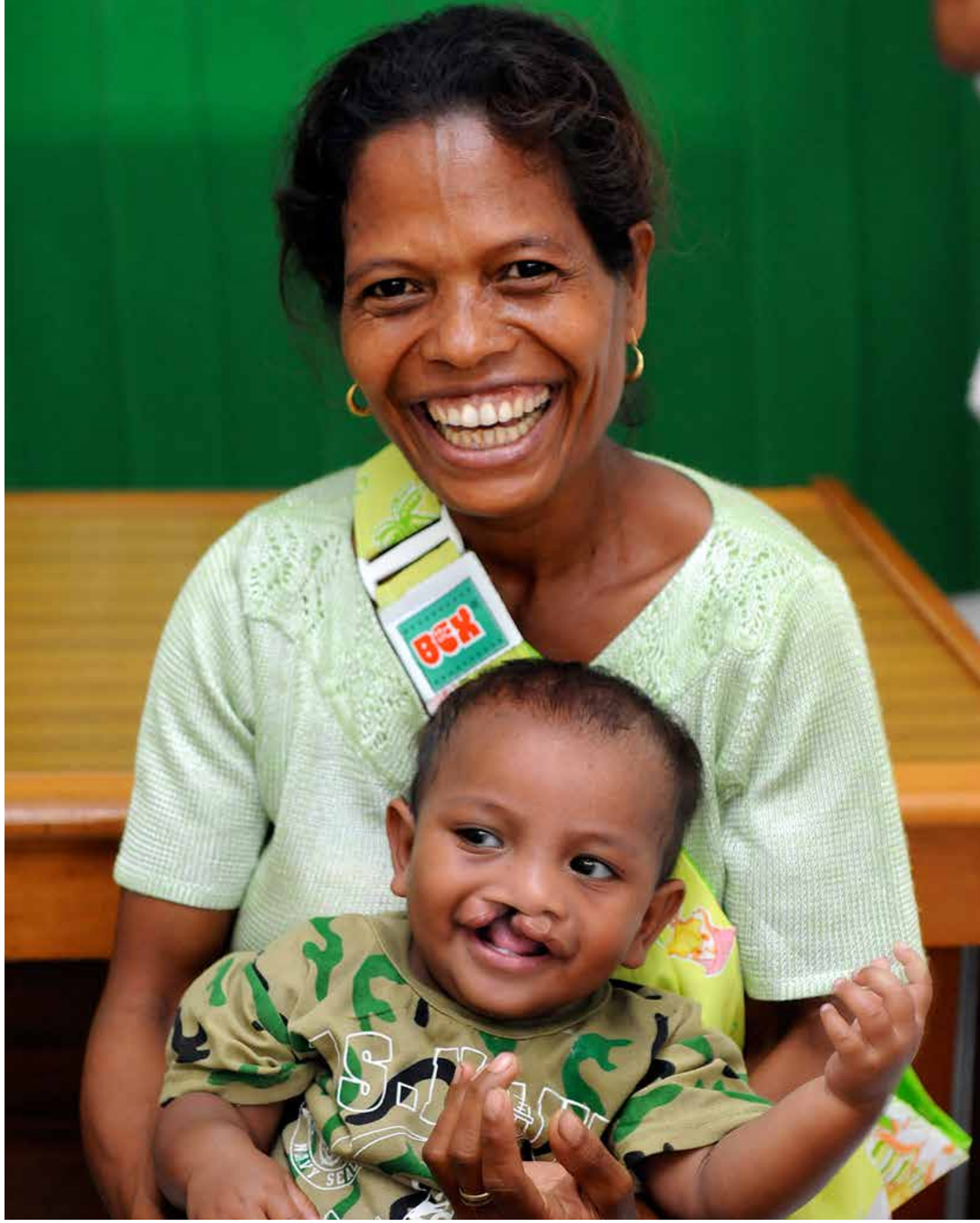
Planning is also underway for a Surgical Directors Program at the 2017 ASC in Adelaide, convened by Professor Rob Padbury.

Section Membership

Membership to the Surgical Directors Section is open to all Fellows and International Medical Graduates who aspire to or hold a surgical leadership position. To become a member of the Surgical Directors Section please contact Kylie Mahoney on telephone +61 3 9276 7494 or email at *SurgDirectors@surgeons.org.*

Further information on the section's executive committee, structure and terms of reference is available on the College website www.surgeons.org under Interest Groups and Sections.

We look forward to a successful Surgical Directors Program at the 2016 ASC.



COMING SOON - *Pledge A Procedure*
May/June 2016

Foundation for Surgery
Passion. Skill. Legacy.

MAKING AUDITS EASIER

MALT now provides a peer-review audit tool

The main purpose of audit is to examine whether what you think is happening really is, and whether current performance meets existing standards.

The College strongly supports the practice of audit. As part of the Continuing Professional Development program (CPD), all surgeons who perform procedures in hospitals, day surgery units or private rooms are required to participate in a peer-reviewed surgical audit annually. The College's Surgical Audit and Peer Review Guide provides further guidance and information.

There can be hurdles to establishing an audit and the process may be time-consuming and costly. For those in rural areas, locums, solo private practitioners and those in smaller specialties, forming a peer-review group provides extra challenges due the nature of their practice.

Acknowledging these challenges, the College saw the need to make audit easier and more accessible. The Morbidity Audit and Logbook Tool (MALT) has been enhanced to include peer-review audit functionality utilising SNOMED clinical terminology.

The MALT team can set up 'Audit Groups' which can include Fellows, IMGs, SETs and JDocs to accommodate various types of audits:

- Total practice audit: entire workload
- Selected audit: specific procedure(s) and/or timeframe
- Unit/team audit: entire unit or team
- Specialty or group audit: single specialty or group
- Focused audit: specific indicator(s) and/or process

Enhancement	Description
Audit groups	Allows MALT to 'group' together units, specialties and geographically dispersed peer-groups of any size. These groups share their data in the audit reports.
Ability to opt-in	All members of an audit group must confirm they wish to participate and acknowledge that their data will be contributed to the comparative audit report. Users can opt out at any time.
Audit Champion/s	User/s can be identified as the audit facilitator. These user/s can also see additional information on the audit reports that allow them to monitor audit participation.
Comparative audit reports	Comparative reports updated in real-time
Procedure lists use SNOMED CT	14,000+ terms available covering all specialties
Increased reporting power	Utilising the hierarchical nature of SNOMED allows for smarter reports
International data comparability	As SNOMED CT has been implemented in over 50 countries, standardised terminology allows for descriptions of terms to mean the same around the world and in different languages
Enhanced user interface	Improved keyword search of procedures and synonyms, most recently used and most commonly used procedures with the ability to flag procedures as favourites

PROFESSIONAL
STANDARDS

MALT now offers a suite of comparative audit reports. These reports compare individuals to the aggregate of the audit group. These reports can then be discussed as a peer-group.

The surgical outcome reports provide comparison of results against the aggregate for:

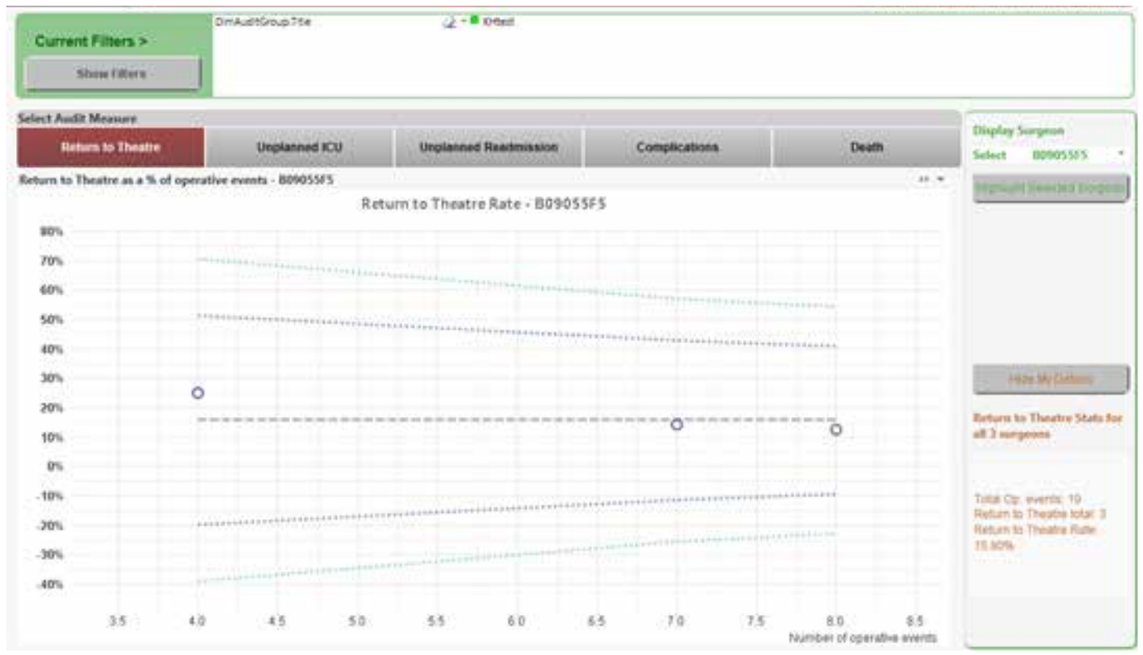
- Complications
- Death
- Return to theatre
- Unplanned Readmission
- Unplanned ICU admission

The data in the reports can be filtered based on various risk factors.

The new functionality was successfully piloted during 2015 at the Royal Darwin and Mount Gambier Hospitals. Dr John Treacy, FRACS, Supervisor and Audit Coordinator for the Department of Surgery at the Royal Darwin Hospital has been an active supporter of MALT and took on the role of audit champion for the duration of the pilot.

All pilot participants were given the opportunity to provide feedback with the majority being positive. Some specific comments included: "It is straightforward to enter data", "The reports are great – very easy to achieve what I set out to do" and "The actual data is great, what we have wanted to see for a long time".

Supported and maintained by the College, the MALT system can now make the audit process easier. If you are interested in using MALT as a peer review tool for an audit, please complete the MALT Peer Review Audit Expression of Interest Form. This form and additional MALT related audit information is available from the MALT peer-review webpage at *www.surgeons.org/maltpeerreview*



Sample of Funnel Plot Report - Return to theatre rate

More information:

Karen Walton, Senior Project Officer *Email: karen.walton@surgeons.org Phone: +61 8 8219 0915*
Kylie Harper, Project Officer *kylie.harper@surgeons.org Phone: +61 8 8219 0970*

ROCK AND/OR ROLL

Why are rock concerts so loud?

BY PROFESSOR GRUMPY

There is one thing that really annoys me and it is rock concerts. This may surprise some readers – not that curmudgeons don't like rock concerts but that we know enough to express a view. As I am sure is obvious from my writings not knowing anything about a subject does not stop a good curmudgeon from expressing a strongly held view. Such matters as being wrong, biased, ignorant of the matter at hand or being of a generation out of step with the issues are quite irrelevant.

Now rock concerts are something that I do know something about as Mrs. Curmudgeon comes from, shall I say, a different background. She has introduced me to all sorts of performers KD Lang, Eric Bogle, Bruce Springsteen, Eric Clapton, Bob Dylan, Leonard Cohen, Robbie Williams and even Doc Neeson. I have been (somewhat unwillingly) to concerts of most of these artists so I can speak with authority.

The first question that must be asked is why are the concerts so loud? I could happily sit 3 blocks away and still hear the concert properly. Even the venues offer free ear plugs. The only problem here is that you have to ask where to get them and the pre-concert music is so loud that you can't hear what the attendant's reply is. I am not good at lip-reading. One concert was so loud that the seats vibrated – at least it eased my aching back from standing in the long line to enter.

The second question is why must the performer wander out onto a boardwalk type of thing and do the rounds? I believe the open area where the fans mingle and try to touch their idol is called the mosh pit. Curmudgeons have a natural curiosity and this caused me to look up the origin of the word. It developed in the early 1980's and was originally spelt "mash" as people mashed together (I suppose as one mashes potatoes). According to curmudgeon's favourite source, Prof Wikipedia, H.R. of the band, Bad Brains, first used the term and because of the Jamaican accent of H.R. the fans took it as "Mosh". I can understand why some of the music may drive you into a frenzy but surely it would be a frenzy to get out and away from the moshing.

The third question that has come to me often is why do the performers crowd surf? Is it to demonstrate their faith in their followers? Is it to save walking back to the stage? Is it a form of fainting or a trance? I hope that the true fans of these groups will forgive me for the wish that I have so often thought but never stated - "Please drop him and then this noise will stop!"

CASE NOTE REVIEW

Allow time for preoperative assessment

GUY MADDERN
Chair, ANZASM

Clinical details

This is the case of a patient in their late-80s who underwent an elective total hip joint replacement (THJR). The patient was assessed preoperatively by the hospital pre-admission clinic (PAC) and then admitted the day before surgery for an anaesthetic review prior to surgery. The patient was graded with an American Society of Anesthesiologists (ASA) score of 2 and judged appropriate for surgery, although the exact level of risk according to the anaesthetist was not recorded. The patient underwent an uneventful and routine THJR the next day. The surgery took approximately 80 minutes and, other than some transient episodes of hypotension during the procedure, the patient had no obvious anaesthetic issues during the case.

During the first 48 hours after the surgery, the patient displayed several episodes of mild hypotension, treated with intravenous fluids, and some confusion, particularly overnight. The patient also showed gradual deterioration in their oxygen saturation and was treated with nasal oxygen. Postoperative haemoglobin was 93 g/L and the patient was subsequently treated with two units of packed cells. The patient had some renal impairment during this time, with a marginal urine output and a creatinine of 153 µmol/L.

Approximately 54 hours after the surgery, the patient had a sudden onset of throat tightness, wheezes and decreased oxygen saturation which led to a transfer to the critical care unit for further treatment and monitoring. The patient was subsequently diagnosed as having had an acute myocardial infarction (AMI) and was worked up by the cardiology unit. The patient developed gradually worsening atrial fibrillation, hypotension and cardiac failure and then also developed possible pneumonia and sepsis. Renal function also gradually deteriorated and a family meeting was held to discuss the patient's prognosis. After this meeting, a decision was made to provide palliative treatment only and the patient passed away 12 days after surgery.

Comments

There are two possible areas for consideration in this case, both of which relate to the preoperative assessment of this patient. The management of this patient over the time of surgery and in the postoperative period was difficult due to age and medical comorbidities but, overall, was adequate and appropriate. Firstly, it is not clear if the patient was medically assessed at the PAC. If the patient had been, a referral to a cardiologist for assessment probably would have been appropriate and may have reduced the risk of this outcome. Secondly, the preoperative anaesthetic assessment occurred the day before surgery and after the patient had been admitted for surgery. This assessment may have been more appropriately carried out as part of the PAC to enable the opportunity for the anaesthetist to arrange further preoperative investigations and opinions, such as a cardiology review. The anaesthetist may feel pressured not to do this if the assessment occurs the day before surgery when the surgical team and, more importantly, the patient are otherwise fully prepared to proceed.

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:

Robert Peter Silverton	**NSW**
Peter Court Grayson	**NZ**
Victor Hadlow	**NZ**
Lindsay Castles	**Victoria**

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

Informing the College

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

ACT: Eve.Edwards@surgeons.org
NSW: Allan.Chapman@surgeons.org
NZ: Justine.Peterson@surgeons.org
QLD: David.Watson@surgeons.org
SA: Daniela.Ciccarello@surgeons.org
TAS: Dianne.Cornish@surgeons.org
VIC: Denice.Spence@surgeons.org
WA: Angela.D'Castro@surgeons.org
NT: college.nt@surgeons.org

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

Royal Australasian College of Surgeons

In Memoriam

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

Ian Philip Torode
Orthopaedic Surgeon
31 October 1949- 9 August 2015

It is a pleasure to provide a tribute to Mr Ian Torode who died at the comparatively early age of 65 on the 9 August 2015. Torode, the son of a general practitioner in Colac was an outstanding student at the Geelong College culminating, as captain of the school, as well as a number of sports teams. He proceeded to read medicine at Melbourne University (Ormond College). He was then a resident medical officer at the Geelong Hospital finding his niche on the orthopaedic unit where he impressed us with his enthusiasm and ability.

For the full version see webpage: http://www.surgeons.org/member-services/in-memoriam/ian-philip-torode/

Geoffrey James Coldham
24 December 1964 - 21 July 2015
Orthopaedic Surgeon

Geoff Coldham achieved much in a life too short, yet in that time accomplished so much more than most. He will be remembered for his practical, enthusiastic, empathetic and committed approach on so many fronts. Geoff is survived by his beloved wife and children, Di, Hunter and Madison and his brother, David, and sisters, Denise and Marianne. Di always called Geoff her 'Gentle Giant'. He touched the lives of so many and he will be fondly remembered by all.

For the full version see webpage: http://www.surgeons.org/member-services/in-memoriam/geoffrey-j-coldham/

Elizabeth Laurence McKinnon Cant
General Surgeon
31 July 1938 - 30 April 2015

Liz Cant was born in Adelaide, educated at Walford Anglican School, graduated from the University of Adelaide (1962) and underwent surgical training at the Royal Adelaide Hospital, obtaining FRACS in 1968. Liz was one of the first female surgeons to be trained in South Australia.

Liz went on to be a research fellow with the renowned surgeon Sir Patrick Forrest at the Royal Infirmary Edinburgh (1973-75) undertaking a MD that involved ground-breaking research into steroid hormone receptors in breast cancer. Liz put this research into practical use when she came back to Australia to take up a position as a senior consultant surgeon at the newly opened Flinders Medical Centre; setting up one of the first steroid hormone receptor laboratories in Australia. This remained the reference centre for SA until the early 1990s when immunocytochemistry for receptors was introduced.

For the full version see webpage: http://www.surgeons.org/member-services/in-memoriam/elizabeth-laurence-mckinnon-cant/

Victor Warren Fazio AO
General Surgeon
2 February 1940 - 7 July 2015

Victor Warren Fazio was born in 1940 to Victor, a fisherman, and Kathleen Fazio and grew up in Tuncurry in the Central Coast of New South Wales. His secondary school education was at St Joseph's College, Hunter's Hill, in Sydney. He won a NSW Railways Scholarship in 1954 and attended Sydney University on a Commonwealth Scholarship. Coming from the country he was supported by Legacy and during term resided in the Glen Mervyn Legacy Hostel in Randwick. He graduated MB BS in 1965 and did his residency at St Vincent's Hospital in Darlinghurst. He did his surgical training at St Vincent's Hospital and obtained the Fellowship of the Royal Australasian College of Surgeons in 1971. He served with the Australian Surgical Team in Vietnam in 1971. He played junior rugby league in the Eastern Suburbs competition and rugby for Sydney University.

For the full version see webpage: http://www.surgeons.org/member-services/in-memoriam/ victor-warren-fazio/

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ChloraPrep™ with Tint Surgical Applicators

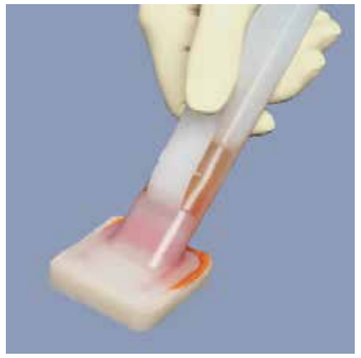
Cutaneous Solution
2% Chlorhexidine Gluconate w/v and 70% Isopropyl Alcohol v/v
Sterile applicator and solution

Squeeze

Hold the applicator as shown, with the sponge facing downward. Squeeze the applicator once gently:

- 26 mL squeeze the lever on handle
- other products, squeeze the wings.

Saturate the sponge by repeatedly pressing gently against the treatment area.



Skin Preparation for all Surgical Procedures

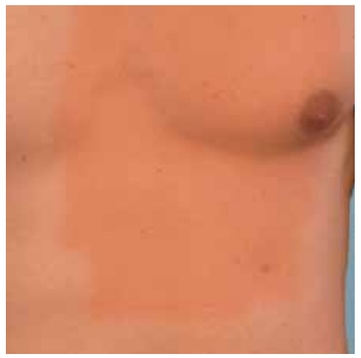
Apply

Starting at the incision site, gently press the applicator against the skin using a gentle back and forth motion for at least 30 seconds, before working outwards to the periphery.

Dry

Leave the area to air dry completely before applying sterile drapes. Do not blot or wipe away. Discard the applicator after a single use.

Important safety point:
Do not drape or use ignition source until the solution has completely dried.



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Use in accordance with the policies and procedures of your hospital.

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70% v/v isopropyl alcohol (IPA)

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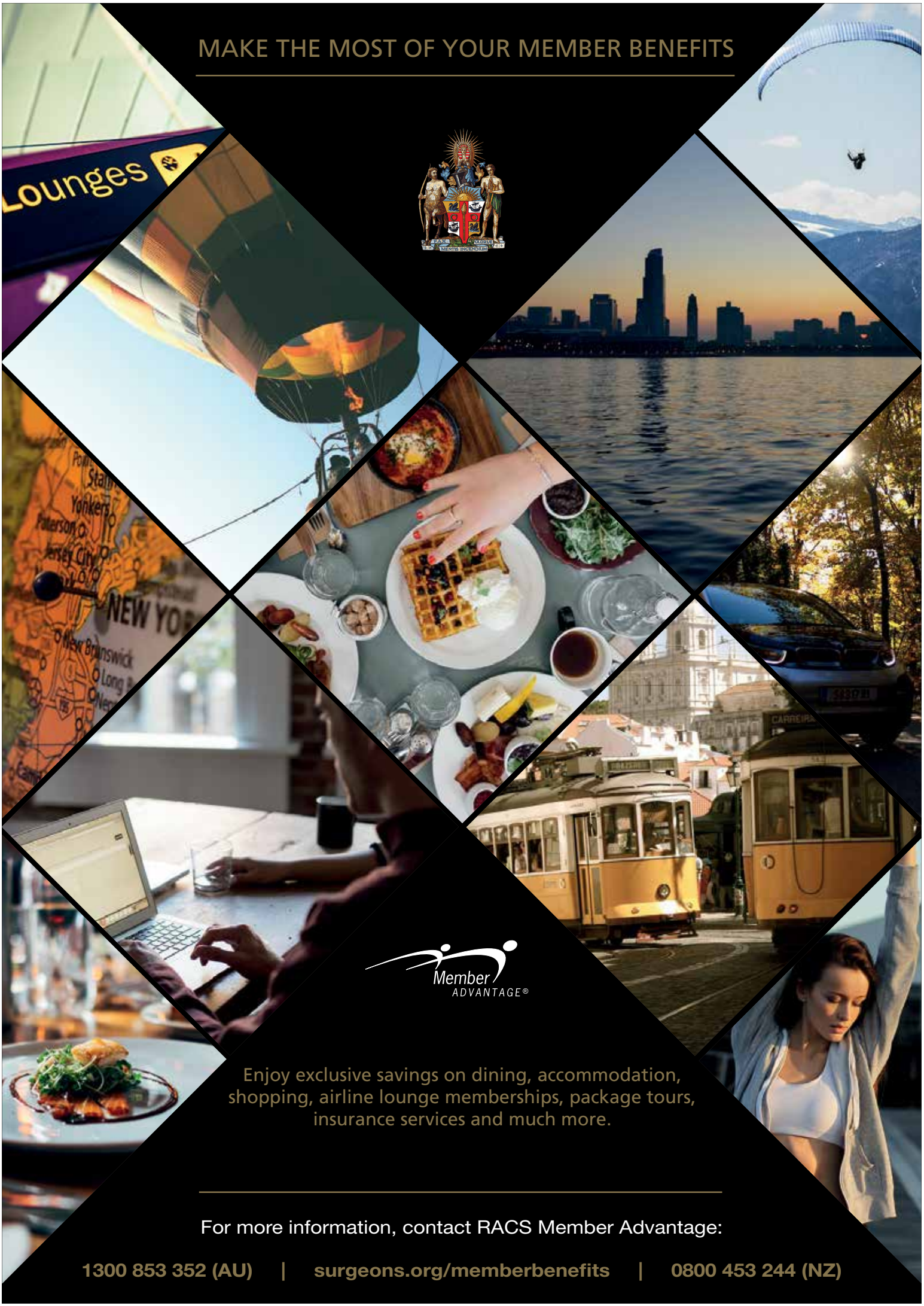
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