ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 17 NO 05 JUNE 2016

MOST OF US HAVE EXPERIENCED BULLYING OR WE'VE SEEN IT HAPPEN.
WE NEED TO OWN THE PROBLEM AND DO SOMETHING ABOUT IT.

Jason Chuen, Vascular and Endovascular Surgeon

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ASC HIGHLIGHTS

This year's Annual Scientific Congress hosted a wealth of quality speakers and research

RACS LET'S OPERATE WITH RESPECT

The College of Surgeons of Australia and New Zealand

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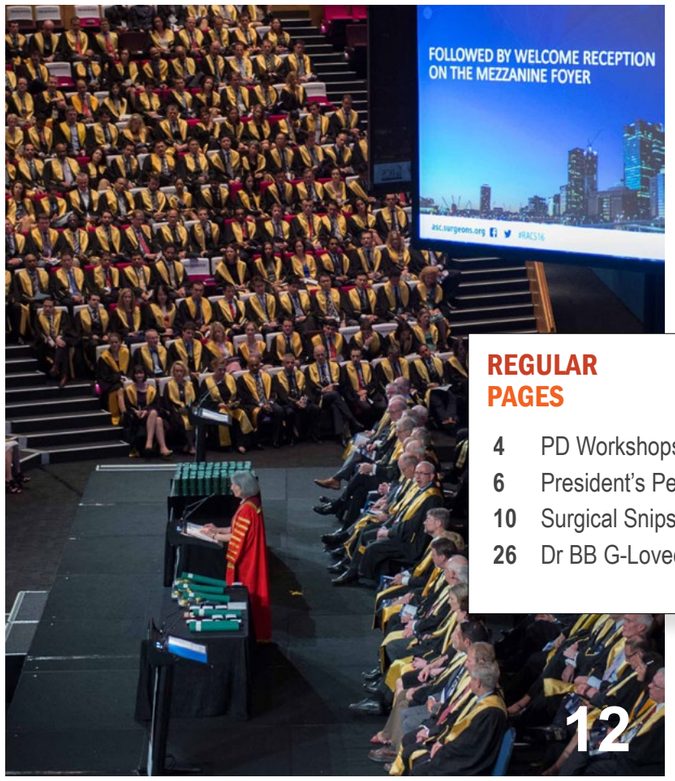

REGULAR PAGES

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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

9 July 2016 - Canberra, ACT, Australia
15 July 2016 - Melbourne, VIC, Australia
16 July 2016 - Gold Coast, QLD, Australia
28 July 2016 - Footscray, VIC, Australia
3 August 2016 - Queenstown, New Zealand
13 August 2016 - Liverpool, NSW, Australia
12 August 2016 - Launceston, TAS, Australia
25 August 2016 - Adelaide, SA, 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.

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 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).

Keeping Trainees on Track (KToT)

20 July 2016 - Adelaide, SA, Australia
6 August 2016 - Melbourne, VIC, 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.

Clinical Decision Making

21 July 2016 - Perth, WA, 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.

Surgical Teachers Course

21 to 23 July 2016 - Adelaide Hills, SA, Australia

The Surgical Teachers course builds upon the concepts and skills developed in the SAT SET and KTOT courses. The most substantial of the RACS' suite of faculty education courses, this new course replaces the previous STC course which was developed and delivered over the period 1999-2011. The course is given over 2+ days and covers adult learning, teaching skills, feedback and assessment as applicable to the clinical surgical workplace.

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Non-Technical Skills for Surgeons (NOTSS)

22 July 2016 - Perth, WA, Australia

This workshop focuses on the non-technical skills that underpin safer operative surgery. It explores a behaviour rating system developed by the Royal College of Surgeons of Edinburgh, 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.

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.

Contact the Professional Development Department

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May 2016 - July 2016

ACT
9 July 2016
Process Communication Model: Seminar 1, Sydney
Foundation Skills for Surgical Educators, Canberra

NSW
31 August 2016
Foundation skills for Surgical Educators, Liverpool
Keeping Trainees on Track, Sydney

NZ
3 August 2016
Foundation Skills for Surgical Educators, Queenstown

SA
12 July 2016
SAT SET Course, Adelaide
20 July 2016
Keeping Trainees on Track, Adelaide
21 – 23 July 2016
Surgical Teachers Course, Adelaide Hills
25 August 2016
Foundation Skills for Surgical Educators, Adelaide

QLD
16 July 2016
Foundation Skills for Surgical Eductors, Gold Coast
19 August 2016
AMA Impairment Guidelines 5th Edition: Difficult Cases, Noosa

VIC
15 July 2016
Foundation Skills for Surgical Educators, Melbourne
28 July 2016
Foundation Skills for Surgical Educators, Footscray
29 -31 July 2016
Process Communication Model: Seminar 2, Melbourne

WA
28 June 2016
SAT SET Course, Perth
21 July 2016
Clinical Decision Making, Perth
22 July 2016
Non-Technical Skills for Surgeons, Perth

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

STANDING OVATION - FOR LEADERSHIP

The 2016 President's Lecture from Australian of the Year Lieutenant General David Morrison was a stand out

PHILIP TRUSKETT
President

The auditorium was very full. Easily a thousand surgeons from Australia, New Zealand and many other countries around the world.

And they were all on their feet, providing a standing ovation to Lieutenant General David Morrison, previous Chief of the Australian Army and 2016 Australian of the Year. A standing ovation is a rare event. We take a lot to be so substantially impressed. It spoke to the moving and passionate address that David Morrison had delivered as the President's Lecture.

He spoke of leaders living in three time zones – permanently. The first time zone speaking to the heritage of their profession, built in the case of the Army on the stories of the Australian nation such as Gallipoli and the Somme, and the names of people who had sacrificed themselves in the service of our country.

The second is the present where one speaks to capability, to competency and the ability to get things done. He had thought as Chief of the Army that this would be the dominant area for his strategy and attention. However as he spoke he clearly outlined that he had been spending substantial effort and time in addressing the third time zone, this one for the future.

As a leader he felt it is critical to always be planning for the future, developing the culture to ensure the success of your organisation and profession and the ability to maximise potential in the decades to come.

Repeatedly he focused on the most important legacy, which was to leave an organisation and a profession that would maximise potential. This meant that although critical issues of standards to be achieved, hard work to be done and individuals to be held account had to be achieved, leadership was also much more.

Leadership demands recognition that we are not perfect, that we all struggle and that at times issues need to be addressed with compassion as well as judgement.

The words of respect, dignity, inclusiveness, ability to achieve individual and organisational potential had been repeatedly highlighted, with the skill of an outstanding orator and an exceptional leader. David Morrison was clear that being a leader also requires a capacity to inspire others to follow. And this required a commitment to cultural change at both an individual and profession level.

He had shared the horror of the stories where individual service women had suffered terribly with their dignity and self-respect having being stripped away. The mother of one of these individuals had confronted him with the statement

David Morrison

'I gave you my daughter and this is what you have done to her'. The requirement for David Morrison to respond both individually and through his role as Chief of Army had since then shaped his ongoing career and his life.

He has been a keen observer of how RACS has responded to its own issues of discrimination, bullying and sexual harassment. He acknowledged our hurt as the statistics of what was found reflect personally on us individually and collectively.

He emphasised that as a leader one of the important things is to acknowledge that the views of our society are always changing. There is a different view of the world and particularly around acceptable culture. As leaders we must see the world in the context of change and when we identify the big challenge we need to stand next to it and commit.

David Morrison had highlighted a vested interest at the start of the address. He is a patient. He wants

"As a leader he felt it is critical to always be planning for the future, developing the culture to ensure the success of our organisation and profession and the ability to maximise potential in the decades to come."

to know he and his family will receive the best of patient care now and into the future. His view of surgeons, the surgical profession and the College is our view of the army. We do not want to see it fail. We want to see it maximise its potential. The legacy, the future of the army is clearly based on respect, development of individuals, recognition, inclusiveness and diversity. When each individual can reach their potential then everybody and the profession are so much better off.

David Morrison left us with no doubt that he has this same view of our profession and of surgery. He does not want to see us fail. The legacy he wishes as a leader of the Army is very much the legacy that he expects us to have as the vision for surgery and as leaders of our profession and the community.

A thousand surgeons and a standing ovation. I believe we share the commitment and vision for leadership of David Morrison. My thanks to him for an outstanding address.

RACS Support Program

RACS 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.

RACS 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

YOUR REGIONAL ASM - A GREAT PLACE TO MEET

Make the most of surgical meetings in your area

Queenstown, New Zealand

SPENCER BEASLEY
Vice President

As part of the Vice President's portfolio, I am pleased to promote the upcoming Annual Scientific Meetings (ASM) for the regions. These take place in the second half of the year and provide a perfect opportunity for Fellows to meet somewhat closer to home than the ASC normally allows.

Typically, they include a variety of high quality presentations relevant to all surgeons, irrespective of specialty. Participants gain CPD points, and have an opportunity to network with colleagues, often in pleasant surroundings.

These meetings do not just happen! The regional convenors, committee chairs and regional staff put in a lot of work to organise them: accepting and sorting through abstracts, lining up speakers of interest, and finding sponsorship, let alone the social program. We can all be grateful to them for their efforts on our behalf.

The most vibrant regional ASMs attract not only Fellows but also a large number of SET trainees, International Medical Graduates, junior doctors and medical students.

Abstracts for these meetings are now open for oral and poster presentations. I would encourage Trainees in particular to submit their abstracts to their local ASM early on.

The season kicks off on 4-5 August in Queenstown, New Zealand with Surgery 2016. The conference will be exploring the theme of "Getting the Measure of Outcomes." Who owns it? How do we best measure it? What can we do with it? What can we learn from other countries? Professor Justin Dimick - Director of the Center for Healthcare Outcomes & Policy at the University of Michigan will be one of the guest speakers.

This theme would no doubt be of interest to many of you and I would encourage those 'across the ditch' to come to this ASM – and perhaps even fit in some snow skiing while you are in Queenstown! There are now many direct flights from Australia to Queenstown.

The Tasmanian ASM on 12-13 August in Launceston has taken inspiration from the geographic dispersion of its speakers with the theme "Poles Apart." Dr Lauren Smithson, General Surgeon from Charles S. Curtis Memorial Hospital, St Anthony, Canada will speak in addition to Dr Roland Watzl, Deputy Chief Medical Officer, Australian Antarctic Division.

Dr Smithson founded the Society for Young Rural Surgeons (SYRUS) to help students and residents interested in rural medicine connect with communities and physicians.

Attendees will certainly be inspired by the experience and knowledge of these speakers.

Our regions often collaborate if there are synergies: an example of that is the upcoming combined WA/SA/NT meeting that will be held in Adelaide on 26-27 August with the theme "New Buildings, New Systems and the New Surgeon – Surviving Change."

"The most vibrant regional ASMs attract not only Fellows but also a large number of SET trainees, International Medical Graduates, junior doctors and medical students."

Program highlights include:

- Presentations from surgeons on latest technologies in surgery including robotics and 3D innovation
- South Australian of the Year Mr John Greenwood presenting on 'What's new in wound healing and burns"
- Dr Gill Hicks, survivor of the 2005 London Terrorist Bombings as the Anstey Giles Speaker

The Victorian ASM will be Melbourne-based this year (21-22 October) with the theme of Evidence Based Surgery. Professor Peter Choong will open the meeting with his presentation on "Modern Medicine – the tension between evidence and practice." The Victorian Audit of Surgical Mortality will host a workshop and the Foundation Skills for Surgical Educators course will also be held during the conference.

This year's Queensland ASM from 4-6 November will link with Trauma Week and the Queensland Health Forum. It promises to be a powerful event with the theme "We collect data – let's put it to work" – A look into the influence of trauma registries, education, research and data.

Professor Michael Schuetz will be the David Theile Lecturer. The Health Forum is held in conjunction with the health department and normally attracts a large number of multi-disciplinary medical professionals.

NSW dedicates the month of November to "Surgeons' Month" with various events targeting a range of stakeholders from medical students to retired surgeons. I would encourage NSW Fellows who are able to attend and support these events to do so.

I look forward to seeing many of you at the meetings I am able to attend. I would encourage you all to support your local ASMs. Even if your regional meeting is 'not so local' this year – many of the states are not so small! – traveling to a different location may still provide just that bit of inspiration you need!

Launceston, Tasmania

New Zealand Surgeons honoured

Two New Zealand surgeons from the Bay of Plenty were honoured with prestigious surgical awards at the recent RACS ASC in Brisbane.

Mr Chris Dawe is the first New Zealander to receive the ESR Hughes Medal for distinguished contributions to surgery.

“I personally see it as a collective honour for all my mentors, team as well as recognition for the support of my family,” Mr Dawes said.

Professor Peter Gilling was awarded the Excellence in Surgical Research award, and acknowledged the support of colleague Mark Fraundorfer.

“Mark’s been a consistent collaborator and supporter of the research and without his support I could not have done a lot of the things which have led to this award,” Professor Gilling said.
New Zealand Herald, 26 May

4D printing for clinical outcomes

Surgeons could soon be using 4D technology to assist with surgical planning. Dr Michael Chae presented an example at the RACS ASC in Brisbane.

Dr Chae and his team developed 4D haptic models to accurately represent the hand movements, enabling important information on the patient’s physiology.

Since experiencing the benefits, Dr Chae believes the process could be widely adapted for the benefit of patients.

“With the increasing availability of 4D CT Scanners, 4D printing has the potential to become widely accessible for surgical planning and improve clinical outcomes,” Dr Chae said.

3ders.org, 25 May

Junior doctor to give back

Young Maori Doctor Kopa Manahi was one of a group of junior doctors to be selected to attend the RACS ASC.

The general surgical registrar is one of the first in his family to go to university and see the path to surgery as a way to improve Maori health and build organ donation.

“My ultimate goal is to return back to Rotorua as a surgeon.

“It’s also about giving back to the community and my iwi who helped me through the challenges and to where I am now, it makes sense to return,” Dr Manahi said.
New Zealand Herald, 17 May

Transforming support

Despite a wide consultation, the new cosmetic guidelines for doctors published by the Medical Board of Australia do not go far enough, Professor of Medical Education Merrilyn Walton has said.

Two important areas have been neglected in the guidelines, that being the use of the title cosmetic surgeon and the facility in which the surgery is performed.

Previous reports have recommended that those performing invasive cosmetic procedures should have equivalent training to that of Fellows of RACS.

Professor Walton says that while the guidelines make clear that ethical decisions considering patients should be paramount, the MBA do not have ju*risdiction over facilities, a job for the states and territories.*
The Conversation, 11 May

HIGHLIGHTS FROM THE ASC

This year's Annual Scientific Congress hosted a wealth of quality speakers and research

Key addresses by the Australian of the Year and former Chief of Army, Lieutenant David Morrison, key US behavioural change expert Professor Gerald Hickson, and the President of the Royal College of Surgeons of England (RCSEng), Miss Clare Marx, were highlights of this year's Annual Scientific Congress (ASC) held in Brisbane in May.

In one of the largest surgical conferences ever held in Australia, this year's ASC with over 2000 surgical minds in attendance, was a combined meeting between RACS and the RCSEng designed around the theme "Surgery, Technology and Communication".

Miss Marx, the first female President of the RCSEng, delivered this year's Syme Oration with an address on Communicating through Attitude, Words and Deeds.

The ASC was also the springboard for the College's campaign to tackle discrimination, bullying and sexual harassment (DBSH) in surgery.

The Let's Operate with Respect campaign supports the roll-out of the RACS Action Plan designed around building respect, improving patient safety and creating safe and supportive surgical workplaces throughout the health system.

Lieutenant Morrison, famed for his anti-misogyny video and commitment to creating an inclusive army, showed his support for the RACS campaign by delivering this year's President's Lecture titled Driving Cultural Change – from the Head to the Heart.

Delegates also heard from US guest speaker Professor Gerald Hickson, an international authority on quality and patient safety and the design of systems to reduce adverse outcomes caused by human factors.

Founder of the Vanderbilt Centre for Patient and Professional Advocacy in Nashville, Tennessee, Professor Hickson has led research into why families choose to file malpractice suits, why certain doctors attract a disproportionate share of claims and how best to identify and intervene with high-risk physicians.

Professor Hickson told the ASC that his research had now demonstrated a concrete link between unprofessional behaviour and adverse outcomes and has designed a model to address such issues.

Widely known as the Vanderbilt Principles, the model has been adopted as a core component of the RACS Action Plan.

"Our research shows that working with a challenging surgeon can impair the situational awareness of other team members and inhibit their ability to respond and adapt quickly to circumstances and most of all speak up about a problem or complication," Professor Hickson said.

"That surgeon might have outstanding surgical skills, but if they are having a negative impact on those around them, they increase the risk of adverse outcomes."

He said supporting key people, introducing robust reporting systems and optimising data capture technology could drive cultural change and decrease adverse outcomes.

Mr James Aitken, a WA general surgeon, told the ASC that mortality audits were also helping to drive a culture of safety in hospitals and reduce mortality rates.

He pointed to statistics from the Australian Institute of Health and Welfare which showed that while surgical admissions in Australia had risen by 23 per cent between 2005/6 and 2012/13, the mortality rate had declined by 18 per cent.

Mr Aitken said that although mortality audits delivered only minor improvements upon initial implementation, significant reductions were observed over time.


Clare Marx

Two leading surgeons were recognised at this year's ASC for their contribution to improving Aboriginal and Torres Strait Islander and Maori health outcomes.

ENT surgeon Professor Francis Lannigan received this year's RACS Aboriginal and Torres Strait Islander Health Medal for setting up a pro bono ear clinic for Aboriginal children 20 years ago and for his on-going work with children across the Eastern Goldfields and Gascoyne regions of WA.

A general surgeon and leading NZ academic, Professor Andrew Hill, received the 2016 RACS Maori Health Medal in recognition of his robust support and mentoring of Maori and Pacific Islander trainees and junior surgeons to help them achieve high clinical and academic attainments.

Continuing the College's long tradition in advocating for improvements in public health, a surgeon from St Vincent's Hospital in Sydney presented the findings of a study which showed that serious facial trauma admissions had dropped by around 60 per cent since liquor law reforms were introduced in NSW.

Dr Elias Moisidis from the Department of Plastic, Reconstructive and Maxillofacial Surgery told delegates that there had been 145 facial trauma patients who received surgical care in the two years before the laws were introduced, compared with only 58 patients in the two years following.

Of the single punch attacks that were known to be alcohol-related, there were 26 in the two years prior, compared with four in the two years after the introduction of the new laws.


(L-R) Palayan Kandasami (Malaysia), Peter Wong (Malaysia), David Galloway (UK)

"The most notable reduction regarding the location of injuries was in the Kings Cross and city areas where the liquor law reforms were implemented," Dr Moisidis said.

Plastic surgery registrar Dr Sarah Lonie told the Congress that steam emitted from humidifiers and vaporisers could pose a significant risk of burns to children. This attracted considerable media attention as did research presented by Dr Edwin Gibson.

Dr Gibson, an acute surgery registrar at Adelaide's Lyell McEwin Hospital, talked about injuries caused by mobility scooters being on the rise and that further research could help determine if drivers should wear helmets to reduce the incidence of head injuries.

Delegates at the ASC were also told of the first presentation in Australia of the rare condition Cannabis Arteritis.

The condition, caused by long-term daily cannabis use, results in lesions growing on arteries and while rare, it can culminate in lower limb amputation.

The case was presented by Dr David Soon who explained that the patient had been successfully treated with balloon angioplasty and started on a life-long aspirin regimen.

"Due to the increase in cannabis usage and the legalisation of medicinal cannabis, awareness of this condition is important as it may become a growing problem in the future," Dr Soon said.

Again the media were calling for interviews and the story went out far and wide.

Overall RACS put out 23 media releases at the ASC resulting in 11 feature newspaper articles, 426 other newspaper and online articles including syndications as well as 50 radio interviews across Australia and New Zealand. The College's social media hashtag #RACS16 registered almost 11 million impressions with over 1000 people participating in the conversation.

L-R Daliah Moss receiving the International Medal with David Watters; Htun Oo representing the President of the Myanmar Medical Association and colleague at the welcome reception.

L-R Women in Surgery Breakfast with Susan Morris, Ruth Bollard, Clare Marx, Jennifer Chambers, Annette Holian, Marianne Vonau, Teresa Withers

L-R Palayan Kandasame (Malaysia), Graeme Campbell, De Selan Sayampanathan

L-R John Quinn and wife Deborah Quinn; Marianne Vonau and Clare Marx; David Watters; David Watters and Phil Truskett; ASC dinner; Vicki Andersons with Parinya Thavichaigarn (Thailand).

BUILDING RESPECT,
IMPROVING PATIENT SAFETY

LET'S OPERATE WITH RESPECT

RACS raises stakes in its campaign against discrimination, bullying and sexual harassment in surgery

RACS used the 2016 ASC to launch its campaign to help deal effectively with discrimination, bullying and sexual harassment in surgery.

Let's Operate With Respect is a call to action for our 7,000 surgeons and 1,300 Trainees and International Medical Graduates in Australia and New Zealand.

The campaign is about surgeons, for surgeons and aims to get us all talking about these problems and supporting culture change in the profession.

It marks the start of a new, long-term effort supporting the roll out of the RACS Action Plan, which details the work RACS is doing in education, complaints management and culture and leadership.

What we can do

As a profession, we need to keep up the momentum started at the ASC, by getting involved and showing leadership on this important issue. We can shape our culture and the future of our profession around respect.

There are lots of things RACS Fellows, IMGs and Trainees can do now and we will keep you informed as more options are available:

- Show your support for the campaign, by going to the website at http://www.surgeons.org/about-respect/what-you-can-do/
- Check out the campaign resources on the members only section of the website and put up the posters in your workplace, to trigger conversations about these important issues
- Watch the campaign video
- Use the campaign email signature block (instructions in members only section of the website)
- If you're active on social media, get tweeting and support the campaign
- Watch out for updates on the Action Plan and options for training and education that will be coming soon.

How the campaign started

Surgeons from across the world lent their support to the campaign and endorsed RACS' strong stand. Surgeons from Australia and New Zealand pledged their support, as did the presidents of international surgical colleges and leaders of the profession, RACSTA Chair Ruth Mitchell, the former Chief

"The campaign is about surgeons, for surgeons and aims to get us all talking about these problems and supporting culture change in the profession."

of Army Lt General David Morrison AO and US academic, architect of the Vanderbilt principles and advocate for professionalism in medicine, Professor Gerald Hickson. The collage on these pages shows some of the delegates at the ASC putting their names and faces to the campaign.

Within 24 hours of the launch, hundreds of surgeons were getting behind the campaign and the response – online and off – has been overwhelmingly positive. Many surgeons took to social media to congratulate the College and to share their support.

Hours after launching, the campaign had more than 250 likes and retweets on Twitter, and the video had been viewed almost 500 times on YouTube. Overall, the video received 1,271 post clicks, was shared 42 times and reached 11, 599 people. This is also an amazing achievement given that the post was organic, not paid.

Both outgoing and incoming RACS Presidents, Professor David Watters OBE and Mr Philip Truskett AM, encouraged all surgeons to support Let's Operate With Respect initiatives, including the work outlined in the RACS Action Plan: Building respect, improving patient safety.

Professor Watters told the ASC that while these problems were common throughout the health sector, it's up to us to improve things in surgery.

Current President, Mr Philip Truskett AM, said the focus of the campaign was on advancing professionalism, by promoting respect.

"We will get better outcomes for our patients when we reflect on our practice and consciously focus on showing respect for our peers, our trainees, our theatre colleagues and our patients," Mr Truskett said.

RACS has published a dedicated new section of its website – About respect *(http://www.surgeons.org/news/let's-operate-with-respect/)*. There is also a video with surgeons talking about respect, posters for workplaces, individual stories, and an opportunity for individuals to show their support.

The About Respect section of the website aims to make it easy for surgeons to find out about what we are doing and what they can each do to support the campaign and find out about the RACS Action Plan and promote respect in surgical practice.

Background

It is now more than a year since RACS was in the national spotlight because of discrimination, bullying and sexual harassment in surgery. In March 2015, RACS appointed an Expert Advisory Group to advise it on the extent of these problems and what the College should do about them. The College accepted all the recommendations made in the EAG report and launched its Action Plan: Building Respect, Improving Patient Safety.

Clockwise from top: Clare Marx, Phil Trusket, Jennifer Chambers and Annette Holian, David Galloway, David Watters and David Morrison, Parinya Thavichaigarn, Centre: Peter Wong

CHAMPIONS FOR CHANGE

One of the key speakers at this year's Annual Scientific Congress Professor Gerald Hickson on how to change the path of a profession

Professor Gerald Hickson

Establishing a system that incorporates local 'champions for change', accesses input from patients and staff and that incorporates graduated interventions to address problem behaviours exhibited by surgeons has been shown to improve patient safety and drive cultural change, according to Professor Gerald Hickson.

The keynote speaker at this year's Annual Scientific Congress (ASC), Professor Hickson is an international authority on quality and patient safety and the design of systems proven to reduce adverse outcomes caused by human factors.

He is a Professor of Paediatrics and is Senior Vice President of Quality, Safety and Risk Prevention, Assistant Vice Chancellor for Health Affairs and Joseph C. Ross Chair of Medical Education and Administration at Vanderbilt University School of Medicine in Nashville, Tennessee.

For the past 25 years, Professor Hickson has led research into why families choose to file malpractice suits, why certain physicians attract a disproportionate share of claims and how best to identify and intervene with high-risk physicians.

In recent years he has developed and implemented a number of initiatives to address behaviours that undermine a culture of safety including the Patient Advocacy Reporting System (PARS) and, more recently, the Co-Worker Observation Reporting System (CORS).

Professor Hickson addressed the Congress on his research and its relevance to the work recently undertaken by the College to eradicate discrimination, bullying and sexual harassment (DBSH) from the surgical profession.

He said the research, conducted at Vanderbilt University's Centre for Patient and Professional Advocacy, had now demonstrated a concrete link between unprofessional behaviour and adverse outcomes.

The remedy – now widely known as the 'Vanderbilt Model' – required supporting key people, designing robust reporting systems and making the best use of data capture technology.

All the work has been based on research conducted at Vanderbilt University Medical Center (VUMC), which encompasses three hospitals plus primary care and specialty clinics and employs 1,352 physicians and 674 allied health staff including nurses and physician assistants, all of whom are potential subjects of a CORS report.

"The idea that a person's behaviour can affect patient outcomes is relatively recent yet we found over the years – after we started investigating malpractice suits and conducting human factors research – that there is indeed a correlation," Professor Hickson said.

"Last year we published a paper that linked information collected through PARS with adverse outcomes such as wound infection, metabolic derangement and return to hospital that showed that surgeons who were rude and disrespectful were 15 per cent more likely to have an adverse outcome.

"Our research shows that working with a challenging surgeon can impair the situational awareness of other team members and inhibit their ability to respond and adapt quickly to circumstances and most of all speak up about a problem or complication.

"That surgeon might have outstanding surgical skills, but if they are having a negative impact on those around them, they increase the risk of adverse outcomes."

One way to change that behaviour and decrease medical errors was to establish a system of local champions for change within hospitals or health districts who had the support of the profession and hospital management to address particular surgeons about their behaviour.

Under the 'Vanderbilt Model', this involves graduated interventions from what Professor Hickson calls the "cup of coffee conversation" up to the threat of dismissal for non-compliance.

Under this system, the first intervention should be private, timely (within five day of a complaint being made), respectful, collegial and non-judgemental and is designed to offer the physician the opportunity to reflect and self regulate.

Although informal, this initial approach is highly effective, according to Professor Hickson's research.

"The local champion who has taken on the responsibility of conducting the initial intervention must be senior enough to have no fear of retribution but more importantly, they must have sufficient ego strength to exercise self-restraint to avoid anger or blame and have a sense of humour and good judgement," Professor Hickson said.

"Yet the great news about this system is that it works and we have found that of the five per cent of physicians with a pattern of complaints, four per cent self regulate after this initial peer-to-peer conversation.

"Of the remaining one per cent, half of those physicians will require more formal intervention before they change their behaviour which may involve an intervention by a senior staff member who has the power to dismiss the physician from their post.

"This leaves only 0.5 per cent of physicians who are unable or unwilling to respond and change their behaviour and this can be caused by a range of factors including personality disorders, cognitive impairment or even early on-set dementia."

Professor Hickson said that while building respectful behaviour models into surgical training and Continuing Professional Development requirements was useful, the greatest driver of cultural change was a top-down model.

"That surgeon might have outstanding surgical skills, but if they are having a negative impact on those around them, they increase the risk of adverse outcomes."

"We have conducted studies that show the willingness of trainees to share information or keep silent about medical errors or adverse events is directly related to the behaviour of their mentors and supervisors despite what they may have been taught," he said.

"That is why at VUMC we did not go for a train-the-trainer model but went straight to faculty and institutional leaders because cultural change of this magnitude absolutely starts from the top and by taking on this issue of unprofessional behaviour, the RACS has a great opportunity to lead change across all medical fields.

"I think the public declaration by the College that it will no longer accept disrespectful behaviour is very important and the apology by the President is incredibly powerful and yet while they are exactly the right first steps to take, clear and concomitant action remains vital in creating lasting change."

Professor Hickson said setting up systems to allow patients and co-workers to report their concerns had proven to be of great value at the VUMC but that the systems had to be easily accessed, secure and confidential.

"We have found that the eyes and ears of team members, in particular, are incredibly important and provide a treasure trove of information," he said.

"Yet the systems set up to gather this information must make it easy and safe for staff to report their concerns, they must be regularly monitored so that patterns of problematic behaviour can be picked up quickly and, preferably, the data should be centralised otherwise only a splintered picture will emerge.

"In the first year following the introduction of CORS we received only 35 anonymous complaints about physicians from fellow staff members yet now we receive up to 1000 each year because people began to trust the process."

Professor Hickson stressed, however, that his research showed that 90 per cent of physicians never received a complaint, that complaints were not randomly distributed and that a small group of physicians were the focus of the majority of difficulties and adverse events caused by human factors.

Yet a commitment to change can create benefit to both patients and the profession, he said.

"In modern society, professionals are not just people who have gained a particular set of skills, they are people who have committed to undertake self regulation and group regulation.

"That commitment with society should be honoured but can fail when leaders do not hold all team members – no matter how senior – to the highest professional codes of conduct."

ASC 2016

Aboriginal, Torres Strait Islander and Māori health in the spotlight

DAVID MURRAY
Chair, Indigenous Health

The 2016 ASC Indigenous Health program provided education of Aboriginal, Torres Strait Islander and Māori health as well as the opportunity to acknowledge the contribution of RACS Fellows in improving health outcomes. The program included a site visit to the Inala Indigenous Health Service Centre of Excellence to hear stories about the centre and its success. The Indigenous Doctors' Roundtable Breakfast acknowledged the contribution of RACS Fellows to Aboriginal, Torres Strait Islander and Māori health as well as the announcement of an exciting new partnership between RACS and Johnson and Johnson Medical. Finally, the Indigenous Health Keynote lecture and Head and Neck Cancer session brought a focus on the importance of the social and clinical foundations required to provide high quality surgical care.

Inala Visit

On Monday May the second on Queensland's first newly annointed May Labour Day holiday Associate Professor Noel Hayman and Claudette (Sissy) Tyson warmly welcomed 20 RACS delegates to the Inala Indigenous Health Service Centre of Excellence. Delegates were treated to a personal tour of the facility by Associate Professor Hayman and Ms Tyson who provided insight into the history of the centre, the current service and the future plans. The centre was opened in 1995 as an Indigenous health clinic as part of the Inala Community Health Centre. When it was established only 12 patients identified as being Aboriginal and/or Torres Strait Islander and it involved fewer than 900 general practice consultations. Today the service boasts more than 6000 patients who attend 20,000 consultations each year.

Richard Perry, Noel Heyman and Owen Ung

The visit provided an opportunity for delegates, including recipients of the 2016 Foundation for Surgery Māori and Aboriginal and Torres Strait Islander ASC Awards, to gain a better understanding of how the variety of services were provided. With a strong focus on research, generating essential evidence of health outcomes, the Centre of Excellence has gained bi-partisan political support and expanded well beyond its initial GP Clinic roots. All of the centres activities aim to improve the health and wellbeing of Aboriginal and Torres Strait Islander peoples and are supported by services focused on health promotion and prevention as well as a range of visiting specialists.

Over morning tea discussion turned to the future of the centre. In 2013, the Queensland government committed to funding stage 2. In addition to providing more space for existing services including allied health, research and community engagement, the expansion will incorporate dental care facilities with eight dental chairs to provide improved oral health services to the local community.

"It's fantastic to see such strong support this morning, all of the fantastic work being acknowledged today is a real demonstration of the College's commitment to Aboriginal, Torres Strait Islander and Māori Health"

Indigenous Doctors Roundtable Breakfast

The sold out Indigenous Doctor's Roundtable Breakfast was pushing capacity as last minute delegates were admitted. Mr Chris Perry hushed the vibrant assembly as Turrbul Songwoman Maroochy Barambah welcomed the Australian and New Zealand delegates to her country with a song. Māori surgeon Mr Jonathon Koea led the New Zealand delegates in a Māori mihi (greeting). The formal portion of the breakfast saw the presentation of the RACS Māori Health Medal to Professor Andrew Hill for his ongoing commitment, support and mentoring of Māori medical students and doctors ; and the presentation of RACS Aboriginal and Torres Strait Islander Health Medal to Professor Francis Lannigan. Māori doctors in the audience honoured Professor Hill with a spontaneous haka.

Foundation for Surgery Aboriginal, Torres Strait Islander and Māori award recipients

Four Māori junior doctors Dr Zanazir Alexander, Dr Jaclyn Aramoana-Arlidge, Dr Joshua Knudsen, Dr Kopa Manahi and two final year Aboriginal medical students Ms Claudia Paul and Ms Kersandra Begley were awarded the Foundation for Surgery Aboriginal, Torres Strait Islander and Māori ASC Award certificates by Foundation Chair Professor Kingsley Faulkner. The awards provided the opportunity for recipients to attend the ASC, participate in workshops, meet with RACS Fellows and Trainees and gain insight into options for a career in surgery and the associated training pathways.

The breakfast concluded with the announcement of three annual RACS Aboriginal, Torres Strait Islander and Māori SET Trainee One Year Scholarships by immediate past President Professor David Watters OBE and Johnson and Johnson Medical Managing Director Gavin Fox-Smith. The collaboration between RACS and Johnson and Johnson Medical will provide funding for three $20,000 scholarships annually for the next three years. The scholarships will support Aboriginal, Torres Strait Islander and Māori surgical trainees as part of RACS commitment to increase the number of Aboriginal, Torres Strait Islander and Māori surgeons in an effort to close the gap in health outcomes in Australia and New Zealand.

Indigenous Health Session

The Indigenous Health keynote lecture was delivered by Mr Kiki Maoate on the subject of cultural competence. Mr Maoate spoke about the concept more broadly, about the culture of surgery and how listening to the names being called out during the 2016 convocation gave an example of the diversity of cultures embraced within the RACS Fellowship. Mr Maoate provided insight into how the concept of cultural competence could be applied in different contexts and how cultural competence supports the nine RACS Competencies to provide high quality patient care. The engaging and entertaining session set the stage for the clinical focus of the sessions to come that concentrated on the head and neck cancers in Australian Aboriginal populations.

Kelvin Kong and family

The Audience was reminded that Aboriginal and Torres Strait Islander life expectancy is currently 17 years lower than the rest of the Australian population and the chronic disease burden is 2.5 times greater. Associate Professor Carsten Palme introduced the challenges facing Aboriginal and Torres Strait Islander peoples with head and neck cancers and Mr Hemi Patel provided insights into the management of Aboriginal head and neck cancer patients in the Northern Territory, including a look at how communication, culture and clinicians must come together to provide positive outcomes. Dr Jasmine Micklem presented on quality of life assessment for Aboriginal and Torres Strait Islander patients with head and neck cancers and adapting Quality of Life tools to ensure cultural appropriateness. To close the session Dr Manjuka Raj presented research findings into hepatic abscesses in Alice Springs with insight into the unique challenges of managing rare pathology in a remote setting.

If you weren't able to attend these excellent sessions but would like to learn more, video recordings of the ASC Indigenous health sessions are now available to all Fellows, trainees and IMGs as part of the RACS Virtual Congress **https://asc.surgeons.org/**

SOCIAL MEDIA AT THE ASC

Here, there and everywhere – how people all over the world engaged with our conference

This year at the RACS ASC, the conversations weren't just happening in the conference halls, they were happening online. The official hashtag, #RACS16, was used by over 1000 people during the week of ASC events. Whether you attended in person, or watched the action from afar, Twitter allowed people from all over the world to feel a part of our conference.

Read about the experiences of some of our very engaged Twitter users, and how you can get involved next year.

Dr Ruth Mitchell @drruthmitchell

RACSTA Chair. Used Twitter in person at the ASC.

When I got back from Brisbane, people wanted to know, what did you do at #RACS16? The answer is this: I tweeted. Who would have thought I could condense my thoughts and comments into 140 characters or less?

By tweeting during sessions, and by following the tweets of other surgical 'Twitterati', I felt like an active participant instead of a passive observer. Having interactions with people in other cities or countries who wished they could be in Brisbane meant I was bringing all of the wonderful conference content to them. It was amazing to realise an orthopaedic registrar in London had been following #RACS16 all week while on nights through Twitter.

I heartily recommend Twitter to surgical Trainees. It's not just another opportunity to watch cute videos; it's a platform for interaction with senior surgeons, potential mentors and fellow sojourners. It allows us to step outside of the hierarchy of surgery and share ideas.

I started tweeting in earnest after #RACS15 when I found that data I had presented there was being discussed on Twitter. I realised I wanted to part of that conversation, and that has led to so many other great things – research collaborations, new friendships. Conferences are now a chance to meet my Twitter friends in person!

Dr Pecky De Silva @PeckyDeSilva

Vascular surgeon. Used Twitter in person at the ASC.

I started using Twitter last year at the ANZSVS meeting in Hawaii. I sat next to a committed Twitter user, Jason Chuen and thought he was being rude by playing with his phone. I later found out he had actually been tweeting! I was impressed with the way he had managed to express the major points made by the speaker.

I enjoyed using Twitter during the ASC for the networking with other attendees and speakers. I had a number of people who recognised me from my tweets and it gives you a basis for a chat! A number of the international guests had Twitter accounts and I could follow the ones I found relevant to my speciality and surgical interests.

Another benefit of Twitter was that I could see what was happening in sessions I wasn't attending, and read other Twitter users' highlights. It was nice to be able to tweet the salient points I found worthwhile during the talks. The tweets are forever saved to your account for future reference, and I found myself paying very close attention to speakers when trying to summarise their lecture into 140 characters.

I would recommend all surgeons to give it a go, especially if you do a lot of speaking at conferences – it will certainly increase your profile. However, Twitter is a public forum so as RACS recommends, don't tweet anything your grandmother would be embarrassed to read!

Dr Jason Chuen @ozvascdoc

RACS Victorian Regional Chair. Used Twitter in person at the ASC.

I joined Twitter in May 2014 when Niraj Gusani (@NirajGusani) from the Association of Academic Surgeons couldn't stop talking about social media while visiting from the United States. It took me six months before I was brave enough to tweet anything myself.

Last year Twitter use at the RACS ASC started to take off. The conference hashtag for the 2014 conference, #RACS14, got 131 thousand impressions, #RACS15 got 2.1 million, and #RACS16 is currently over 10 million. It is amazing to have three to four silent conversations at once across multiple topics, but it can also be distracting. But, a large benefit is that I can virtually attend several different talks at the same time and then decide which session to physically go to.

If you are a surgeon who is new to Twitter, don't jump in and start tweeting immediately. Spend some time getting a feel for how it works and what other people do. And remember that everything is public, so on Twitter, everyone can hear you scream.

"I realised I wanted to part of that conversation, and that has led to so many other great things – research collaborations, new friendships."

Participants viewing Twitter screens at the RACS ASC

Dr Eric Levi @DrEricLevi

ENT Surgeon. Tweeted and followed the ASC from Canada.

I was a Fellow from a distance at the time of the 2016 ASC. From Canada, I had the pleasure of listening to and taking part in the discussions around the conference. Thanks to social media, I was 'virtually' there at the ASC.

Here are the three benefits I experienced through following the Congress on Social Media:

1. Hearing: Live distilled summaries of talks.

Congress attendees were tweeting summaries, quotes, essential data, and core topics being discussed. Pictures of slides were tweeted out. I got to see the most important slides and summaries of the important issues live (or delayed by a few hours, at my own convenience). I was learning about Academic Surgery while putting the kids to sleep.

2. Talking: Immediate interactive discussion on matters of interest.

I got to take part in several live discussions over important issues such as professionalism and training. Social media converted the discussion from a one-way presentation into a vibrant conversation. This was way more engaging than watching the talk online alone a few weeks later.

3. Sharing: The topical discussions were elevated to a more global audience.

Tweets from one presentation were retweeted multiple times to a global audience. In effect, patients, surgeons and surgical Colleges in other countries were listening in when we in a meeting room in Brisbane spoke about bullying, harassment and women in surgery.

Ryan Burnett @Triple0Ryan @Triple0_Medical

Digital Marketing Specialist, Triple 0 Medical Recruitment. Tweeted and followed the ASC from New Zealand.

Let's get one thing straight – I'm not a surgeon. In fact, I think you couldn't get further away than a digital marketing specialist. My scalpels, scrubs and sutures are replaced with impressions, reach and click-through rates! I do however have an affiliation to the surgical realm. My wife is a surgical Trainee, and recently attended the RACS ASC.

I decided to conduct my own 'social experiment'. Could I, a digital marketing specialist sitting in an office in Christchurch, attend the conference only armed with the 140 characters that Twitter allows?

Diving into the Twitter pool, I was immediately able to comment and interact with people regarding keynote talks, and areas of interest at the conference. We all found common ground on a number of key topics around harassment and bullying within the workplace. Retweets started to come from surgeons from around the world. By the end of the conference, the total number of impressions (eyes on the conference) was a staggering 10 million!

So does social media for surgeons, and non-surgeons work? The ultimate measure came from my returning wife who said "You are more connected to my colleagues than I am!"

Saying 'I don't understand how Twitter works' is not a viable excuse for the surgeon of 2016. Twitter can only enhance your learning and networking.

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

IN MEMORIAM

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

2016

Gordon Bougher, WA
Ian Lishman, WA
Geoffrey Buckham, Qld
Donald (Scotty) Macleish, Vic

2015

Anwar Girgis, SA
William J Garrett, NSW
Donald Llewelyn, NSW

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.

TIME FOR POLLIES TO SHINE

There is one thing that annoys me and it is politicians

PROFESSOR GRUMPY

Many of the topics that I complain about may not resonate with most readers but this one will. Everyone seems to have a gripe about politicians – even the politicians gripe about other politicians, including ones from their own party.

Their dress is one thing – the men in their suits, almost identical to each other. It is so easy to mistake one polly for another. Why isn't there some individuality? We curmudgeons have long memories and long held biases against certain political parties. Some of us recall Donny Dunstan. As much as we might have hated his policies he at least had the ability to shock and amaze when it came to dress – but pink shorts?

"I am sure that buried in Canberra in a secret basement there is a school that teaches 'polly speak"

The main annoyance that is evident again and again is their press interviews. I am sure that buried in Canberra in a secret basement there is a school that teaches 'polly speak'. The rules of this language are simple:

- Never answer a question in less than five sentences, even if the answer is "No".
- In the case of the answer being "No" say something about the negative impact, best practice, gold standard, community expectation, wide spread consultative process, advice from a world class expert (even if he is your mate from university days who was and still is a thorough rat bag).
- Always start your answer with "Well, Virginia, that is an excellent question".
- If the other side have a good idea never admit it.
- When your proposition is dead in the water complain about the biases of the media and the total lack of any workable solutions from the other side (unfortunately the latter may be true).
- Pollies also have to be schooled in how to extract the most from the public purse. Some suggestions are:
- Now that postage has risen by nearly 50 per cent demand a rise in the postage allowance of 70 per cent (to cover extra costs of handling the more valuable stamps) and then get an amendment to the Postal Act that exempts pollies from postage.
- Alter the Superannuation Benefits that pollies get to include benefits paid out of the public purse on the postage allowance as this is no longer an allowance but a salary.
- Make a personal sacrifice to international relationships by providing a car allowance that enables the purchase of the highest priced imported car on the basis of trade expansion.
- Alter the laws of defamation to exempt from any action all spoken, written and unvoiced thoughts of the pollies.

How would we curmudgeons sort out the pollies? Easy! We would ban all who had law degrees, all former teachers and everyone under 60 from being elected. In fact, the ideal would be a parliament of curmudgeons!

CASE NOTE REVIEW

Delegation of care in a postoperative patient

GUY MADDERN
Chair, ANZASM

Summary:

A patient in their 70s presented with a two week history of abdominal pain and vomiting, consistent with an incomplete small bowel obstruction. Relevant was a history of an abdomino-perineal resection with adjuvant radiotherapy for rectal carcinoma, some 20 years earlier. The patient had subsequently developed a small bowel obstruction due to a fibrotic stricture in the previously irradiated proximal jejunum, which required resection, 14 years later.

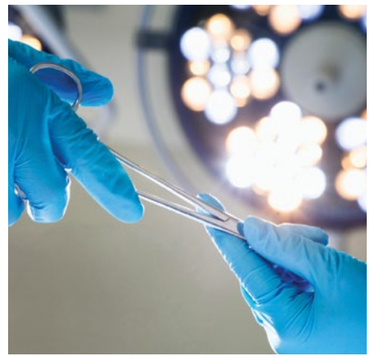
The patient was initially investigated as an outpatient, and by the time a high-grade recurrent jejunal stricture was confirmed with a contrast study, little more than fluids had been tolerated for over four weeks.

Scheduled laparotomy in a tertiary public hospital was deferred at the last minute by another surgical emergency, and the patient accepted a proposition to transfer to a nearby hospital in order to expedite surgery. This transfer was undertaken on the understanding that early postoperative care would be assumed by a surgeon other than the primary surgeon, due to a prior commitment.

The operation was difficult by virtue of extremely dense small bowel adhesions, secondary to radiation fibrosis. A significant length of small bowel was resected, and a single anastomosis constructed. Some serosal tears were oversewn, and saline lavage performed.

The patient was managed in the intensive care unit (ICU) postoperatively, and was in a satisfactory condition when reviewed on the first postoperative day by the operating surgeon. Formal arrangements were made to hand over care to a colleague for the next three days.

On the second postoperative day there were clear indications that all was not well, with increasing abdominal distension, marked positive fluid balance, neutropenia and a rising creatinine level. The covering surgeon was consulted, and agreed to review the patient. In the interim, a computed tomography (CT) scan was arranged.



Over the next two days, the covering surgeon was consulted several times by ICU staff, but the surgeon did not attend the patient. The CT scan report was discussed with the radiologist, but the findings were reported as non-specific, and supportive treatment was continued – without physical examination by the covering surgeon.

Soon after the return of the operating surgeon on the fourth postoperative day, the condition of the patient suddenly deteriorated with a septic collapse. A laparotomy revealed an enteric leak proximal to the anastomosis. The now gravely ill patient struggled on, but required a further laparotomy for another enteric leak five days later, and two further washouts.

Deterioration occurred, and on the twelfth postoperative day the patient required a substantial resection of the minimal remaining bowel, and a de-functioning end ileostomy. Following transfer to a tertiary hospital for further ICU care, and despite full support, the patient's condition steadily declined, and death occurred approximately 5 weeks postoperatively.

Assessor Comments:

This case illustrates that the patient posed a formidable management challenge from the outset the early postoperative management required close supervision. Valuable as radiological imaging may be, the clinical acumen of an attending surgeon was also needed. Having said this however, the likelihood of this patient surviving a significant complication was slim, and the outcome may have been little changed by earlier intervention.

Additional Comment: Case Note Review, Surgical News, March 2016 Edition

"I believe the third laparotomy was probably unnecessary, and had the patient been treated with TPN and an NG tube, the functional obstruction (or even ileus) may have resolved on its own."

TIME FOR TEA?

It could be good for you

DR BB G-LOVED

Some readers regard Dr BB G-loved as promoting alternative medicine. This is not true at all. Dr BB G-loved advocates for health, that good health should be maintained as normally or naturally as possible, and believes that most of her readers would rather stay healthy than suffer, or suffer more than necessary, from medicine's major comorbidities in the future.

Thus we all need to eat well, and not too much, recognising that even surgeons need exercise, antioxidants, sunlight and work-life balance. I admit that exercise and sport might sometimes increase the risk of injury, but even in contact sports there is much that can be done to mitigate risk.

Every article I have written is based on evidence derived from peer-reviewed leading journals. This month's is based on the BMJ, impact factor (IF) of 17.4, American Journal of Clinical Nutrition (IF 6.7), and others with impact factors of greater than two.

In March my column on drinking moderate amounts of one of our favourite stimulants, coffee, stimulated readers to request a similar article on tea. The health benefits of tea, particularly black tea and green teas, arise from its non-caffeine components, the flavonols.

Flavonoids (see below) are bioactive, non-nutrient, three ringed polyphenolic compounds. They are present in a wide variety of foods we ingest and important for health. Cherry tomatoes, red grapes, berries, kale, lettuce and leeks are rich

Flavonols (quercetin, myricetin, kaempferol)
in leafy vegetables, apples, onions, broccoli and berries;

Flavones (apigenin and luteolin) and anthocyanidins
small quantities in grains, leafy vegetables and herbs;

Flavanones (naringenin and hesperetin)
in citrus fruit and their juices;

Isoflavones (daidzein and genistein)
present in soya beans and their products;

Catechins (catechin and epicatechin)
tea, apples, grapes, chocolate and red wine.
[50g dark chocolate is equivalent to 200ml red wine]

sources. Dark, (not milk or white) chocolate has even higher flavonol and anthocyanidin content than tea.

They have anti-inflammatory and antioxidant activity including inhibition of the oxidation of LDL cholesterol. They are associated with a reduction in blood pressure, reduced risk of cardiovascular disease including stoke, less insulin resistance, and possibly a lower incidence of gastric, colorectal, breast and ovarian cancers.

Environmental conditions and seasonal changes influence the amount of flavonoid content in many plants, with both carbon dioxide and ultraviolet light having a positive effect. Flavonoid content goes up in summer in many foods.

Earlier this year the *BMJ* published results from cohort studies of US Nurses and Health Professionals suggesting that a higher intake of food rich in flavonoids 'may contribute to weight maintenance in adulthood.' The potential implications for the prevention of obesity prompted headlines that 'How a morning cup of tea helps you stay trim' and that flavonoids 'can help stall middle-age spread'.

Epidemiological studies support an inverse association between dietary isoflavones (soy) and breast cancer. Flavonol and flavonone intake are associated with a reduced risk of ovarian cancer. A West Australian study looking at flavonol intake showed a reduced overall mortality in older women, including mortality from cardiovascular disease and cancer.

Of course this reduced mortality may have been the result of life-long dietary and exercise patterns. Although there are a number of in vitro studies to unravel how flavonoids may exert their effects at the hormonal and cellular level, translating these results into positive dietary or supplement intervention studies will be challenging and may in the end be intervention at the wrong phase of life.

For tea, finer particles allow more flavonoid extraction (tea bags rather than coarse leaves), whilst a longer brewing time enables more flavonol to infuse.

Excuse me, I hear the children singing:

"Polly put the kettle on, Polly put the kettle on, Polly put the kettle on, let's all have tea."

I must admit, I think they've got the right idea!

Food or Plant	Flavonol	mg/100g edible portion
Green tea	Myricetin	1.02
	Quercetin	2.49
Black tea	Quercetin	0.45
	Quercetin	2.19
Cocoa	Kaempferol	1.31
	Quercetin	2.03
Red wine	Quercetin	2.11
Onions (red, raw)	Myricetin	2.70
	Quercetin	39.21
	Kaempferol	12.30
Kale (raw)	Myricetin	0.00
	Quercetin	22.58
	Kaempferol	0.65
Apple (skin only)	Quercetin	19.36
	Kaempferol	0.14
Apple (raw with skin)	Quercetin	4.01
Blueberries	Myricetin	2.92
	Quercetin	14.42
	Kaempferol	0.01
Strawberries (raw)	Myricetin	0.04
	Quercetin	1.11
	Kaempferol	34.89

Table footnote: Raw fruit is better than dried fruit which reduces flavonol content

EVIDENCE BASED SURGERY

TRISTAN LEECH
Convenor, Victorian ASM

"By definition", I begin
"Alternative Medicine", I continue
"Has either not been proved to work,
or been proved not to work.
do you know what they call
'Alternative Medicine'
that's been proved to work?
Medicine."- Storm, Tim Minchin

What should we call surgery that has either not been proved to work, or has been proven not to work? Or proven to be unnecessary?

The obstacles to developing high-level evidence to support specific surgical treatments are well-known. Many of the procedures that we have inherited from our forebears were developed well before the widespread acceptance of the randomised controlled trial (RCT) paradigm for medical research.

It takes courage and groundwork to challenge dogma, but success can be the catalyst for change in practice, potentially improving health outcomes for patients. High quality studies challenging orthodoxy gain a rapid sort of notoriety. The results may be accepted or carefully refuted, but cannot be ignored.

Trials randomising patients with appendicitis to surgery or antibiotics only; and randomising breast cancer patients with known axillary metastasis to complete axillary treatment or have systemic therapy only are two recent examples that show that it is not only possible, but also valuable to question what we have always 'known'.

Further studies confirming the finding are generally called for before surgeons slowly begin to question their beliefs and change their behaviour. A healthy amount of scepticism is required – studies may contain serious biases in their design or execution that are not immediately obvious.

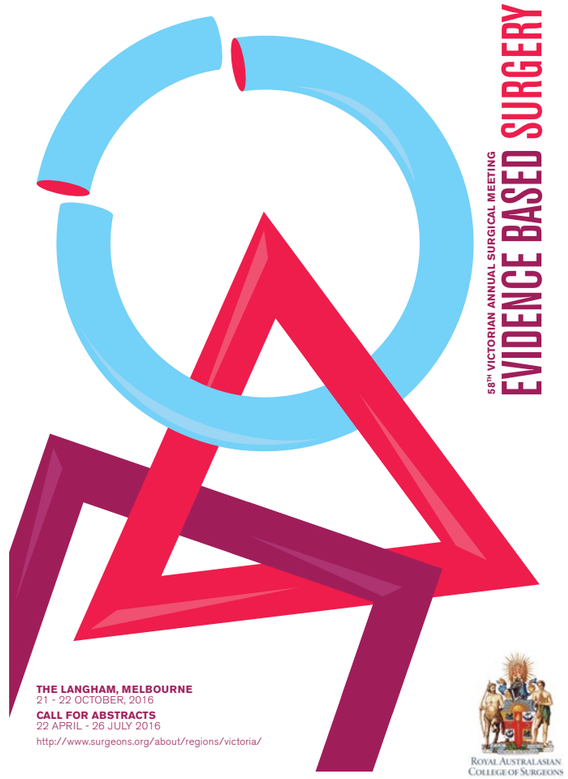
Unfortunately, surgical intervention does not facilitate examination by an RCT in several significant ways; randomising to 'placebo' is fraught if not impossible and quality control and technical variation in performing a procedure make it difficult to interpret or extrapolate findings.

As Peter McCulloch argues in an article for the Canadian Institute of Health Research, we face a choice between "staunch agnosticism" as to the real value of surgery, and taking an approach of making the best possible use of the evidence we do have, while acknowledging the limitations. If clinicians don't take the lead in promoting evidence-based surgery, the alternative may be 'policy-based surgery'. We may need to consider the idea that we should stop something that we have tried and now know does not work.

It is vital for each of us to ensure that we are in fact practising Surgery – and not 'Alternative Surgery'.

The RACS Victorian Regional Committee Annual Surgical Meeting will explore these and other challenges in compiling and utilising evidence in surgical practice.

All surgeons, trainees, IMGs, Junior Doctors and other interested health practitioners are warmly welcomed to come and hear from our panel of expert presenters in what promises to be an excellent scientific program.



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PLEDGING SUSTAINABLE CHANGE IN MYANMAR

Did you know in Myanmar road traffic accidents result in more fatalities of children than malaria, HIV/AIDS, or diarrhoea?

PHILLIP CARSON
Chair, Global Health

The Royal Australasian College of Surgeons (RACS) and the Foundation for Surgery are working hard to address this through strategic partnerships and 'training the trainers'.

The capacity building program in Myanmar was initiated in 2009 following the Cyclone Nargis tragedy that resulted in 138,000 fatalities and another million people homeless. Today, the program is conducted in partnership with the Universities of Medicine with the approval and support of the Ministry of Health of the Union Republic of Myanmar, and funding support from the Kimberley Foundation through the Peter F. Williams AO International Surgery Grant.

In April 2016, the then President Professor David Watters visited Myanmar where he met with specialist leaders including the Rectors of the University of Medicine 1 (UM1) and University of Medicine 2 in Yangon, the Rector of the University of Medicine, Mandalay and senior specialists of the Universities' Teaching Hospitals.

In 2015 RACS signed formal agreements with the UM1 and University of Medicine, Mandalay to cover the training activities including license agreements to adapt RACS-owned Skills Courses for use in the Myanmar environment. In April, Professor Watters signed the agreement with the University of Medicine 2, completing the triad of formal agreements with the major medical training faculties of Myanmar.

The approach to 'training the trainers' in Myanmar had been established initially through the Rowan Nicks Scholarship. However, it was the initiation of the Primary Trauma Care (PTC) program and the sustained effort by the RACS-supported international faculty that led to the invitation by the Minister of Health in 2011 to help develop Emergency Medicine (EM) in Myanmar.

Since 2009 the Program has trained over 1500 national Primary Trauma Care providers to deliver frontline basic trauma care. More than 200 have been trained as instructors to teach the course, and 22 have received higher level,

David Watters visiting an Emergency Department in Myanmar

leadership training to supervise the instructor courses locally with external support.

The establishment of a sustainable local PTC Foundation to provide regular courses for the needs of both the primary care physicians and all the postgraduate trainees in the next two to three years will be the cornerstone in the transition of PTC training in Myanmar to national ownership and independence.

The RACS has completed its initial commitment to help the Myanmar Ministry of Health develop a sustainable emergency medicine training program through the University of Medicine 1. Since 2012, 26 national doctors have graduated with Post Graduate Diplomas in Emergency Medicine.

Today these graduates provide emergency care in Yangon, Mandalay and the new capital Nay Pyi Taw, and are conducting the national emergency medicine training independently, with minimal external support.

During his stay, Professor Watters visited the Emergency Departments at Yangon General, Nay Pyi Taw and Mandalay General Hospitals, addressed the Myanmar senior surgeons and surgical trainees on the issue of "access to safe and affordable surgical and anaesthesia care" and witnessed first-hand the impact of and progress made as a result of the RACS-supported Emergency Medicine Development Program.

Visit www.surgeons.org/foundation/ to donate to Pledge-a-Procedure

Professor Watters commented on the advances of the program: "I am most impressed with all the work going on to support Surgical Training in Myanmar."

I am also impressed with the vision and efforts of the local faculties and their determination to succeed."

Professor Watters highlighted that two scholars from Myanmar, Hepato-biliary surgeon Professor Tin Tin Mar and Orthopaedic surgeon, Dr Myat Lwin, the inaugural recipients of the Myanmar Scholarship were undertaking a program of hospital visits in Australia and New Zealand this year.

The Scholarship Program was established by RACS with funding support by the Foundation for Surgery and the UM1. Professor Watters stressed the need to expand the corpus in order that more recipients may benefit.

As part of the national drive to expedite training of specialist providers, the Myanmar Universities have recently embarked on a number of new initiatives, including sub-specialty as well as diploma training. The previous approach of completing a 'general surgery' masters before embarking on sub-specialty is to be curtailed.

The year 2016 is to be the first of direct subspecialty MMed Sc training in Myanmar, and there is significant interest in receiving support from RACS and relevant specialty societies, specifically in Paediatric, Cardiac and Thoracic Surgery, Neurosurgery and Urology. RACS Global Health is exploring how these areas can be supported to ensure more children, families and communities can have access to safe surgery when they need it.

Background

Following the military coup d'etat in 1962, a succession of military dictatorships has kept Myanmar's development struggling significantly behind its neighbours. The election of 2010 led to the government of President U Thein Sein, which brought major changes.

For instance, the cost of a SIM card reduced from US $3000 to $1.50 and the house arrest of Daw Aung San Suu Kyi was rescinded. She, together with several members of her party, the National League of Democracy was elected to the National Parliament soon after and in November 2015 won the election.

The party is taking office after a landslide election victory, transitioning the country into a (mainly) civilian democratic government, the first in a long time.

Pledge-a-Procedure

Foundation for Surgery
Passion. Skill. Legacy.

Road traffic accidents are increasing dramatically in Myanmar and these accidents disproportionately affect children and result in more fatalities than malaria, HIV/AIDS, or diarrhoea. This end of financial year please Pledge-a-Procedure and give a one-off donation to ensure children, families and communities in Myanmar can access the vital assistance they need, when they need it most.

100 per cent of all donations assist in addressing critical surgical needs in Myanmar. All costs for administering the Foundation for Surgery are provided for with thanks to the Royal Australasian College of Surgeons so that every dollar of your donation can go where it is needed most.

So much has already been done with your generous support but this May and June we need your help to continue and expand the delivery of these essential activities in Myanmar. Without adequate funding, the Myanmar program will not be able to continue providing a full range of essential services to meet the urgent needs of families and children as well as the longer term needs of communities.

Donating is very simple: please go to https://www.surgeons.org/foundation/ to donate and gain an immediate tax receipt.

This simple act will have an enormous impact on our work, the Myanmar program and our ability to have a positive impact.

When we deny our stories, they define us.
When we own our stories, we get to write a brave new ending.

Brené Brown

RACS CODE OF CONDUCT: DEFINING OUR STANDARD

In updating the RACS Code of Conduct we have reaffirmed our commitment to ensuring an inclusive surgical culture

CATHERINE FERGUSON
Chair, Code of Conduct Working Party

Our RACS *Code of Conduct* is a powerful reflection of our Fellows and our profession. The Code expresses the values by which we operate and is indicative of the highest surgical and ethical standards. The Code expresses the importance of surgeons being holistic practitioners in their specialty, skilled in both the technical aspects of surgery and the collaborative principles of teamwork and patient care.

Revising our Code regularly is important to ensure that it remains relevant to the contemporary practice of surgery across Australia and New Zealand. The Code has been revised in consultation with specialty societies, regulatory and statutory authorities and industry groups to ensure that it remains relevant to practicing surgeons and reflects the expectations of the communities we serve.

The 2016 Code has been updated to reflect emerging challenges and issues in our practice, such as excessive fees, informed consent and responses to new technology. The structure of the Code has been simplified to ensure that all Fellows are aware that failure to adhere to any provision of the Code is a breach. Fellows who are found to be in breach of the Code are subject to sanctions which may include loss of Fellowship.

Over the past 18 months the College has come under intense scrutiny in regards to bullying, discrimination and sexual harassment and the ways in which we have responded to these poor behaviours in the past.

As a profession we have been challenged to reflect on our behaviour towards each other and our colleagues, giving consideration to the disruptive influence these behaviours have had on developing an environment that is respectful and centred upon patient safety.

The Code responds to the above challenges by clearly articulating that bullying, discrimination and sexual harassment are unacceptable and a breach of the Code. In this revision we have reaffirmed our commitment to ensuring an inclusive surgical culture in Australia and New Zealand.

The Code promotes the College's position as a leader in setting standards for surgery across Australia and New Zealand and recognises that our Fellows are active leaders and role models in their places of work, promoting positive and supportive environments that are focused on excellence in patient care.

You will receive a hard copy of the *Code of Conduct* shortly and an e-copy is available at http://www.surgeons.org/policies-publications/publications/

I would encourage you to review the Code and reflect on its provisions at your earliest convenience.

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

OPEN HOUSE

Melbourne

30 July 2016

The College is again opening its doors to the general public as a part of the Open House Melbourne weekend.

If you would like to be involved and volunteer as a room presenter we would like to hear from you.

For more information and to register as a volunteer please contact Megan Sproule:

+61 3 9249 1220
megan.sproule@surgeons.org

RACS VISITING SPEAKER GRANT

Guest Speaker Simon Talbot to attend Queenstown meeting

SALLY LANGLEY
President, NZAPS

The New Zealand Association of Plastic Surgeons (NZAPS) and New Zealand Society of Hand Surgeons are pleased to announce that the RACS Visiting Speaker for their 2016 Queenstown meeting is Mr Simon Talbot, MD, of Boston USA.

Mr Talbot will speak across both meetings which are held consecutively across the dates of 13 to 17 July, and which are cooperative both in their arrangement and educational program. Mr Talbot is the current Director of Hand Transplantation at Brigham and Women's Hospital in Boston, where he holds academic posts at Harvard.

He will be speaking on aspects of the successes and future challenges for hand and other allogenic transplantation that currently face the surgical community. His talks will be relevant and informative.

Mr Talbot will be addressing member surgeons as the RACS Visiting Speaker and will be available for interactive discussions and questions from those in attendance. This event is an opportunity not to be missed and you are invited to attend.

Simon Talbot

NZAPS thanks RACS for its generous support of Mr Talbot through the RACS Visitor Program.

MENTORING: A PRACTICAL GUIDE

A new resource for Mentors and Mentees is now available through the RACS website

BARRY O'LOUGHLIN
Chair, Mentoring Working Party

New Mentoring resources are now available on the RACS website. They include a new booklet Mentoring: A Practical Guide, which aims to guide Trainees, International Medical Graduates and Fellows through the four phases of a Mentoring Relationship.

Mentoring has been identified as an important learning and development strategy for surgeons. The College advocates for mentoring at all stages of a surgeon's education and throughout their career. Research has shown that having a mentor supports the achievement of personal and professional goals and improves motivation, engagement and work performance.

RACS has developed and run several of its own facilitated mentoring programs over a number of years with mixed results. In developing this resource, RACS has consulted with Mentoring experts and reviewed the mentoring programmes offered by other medical Colleges in order to provide a practical toolkit for surgery. This resource is aimed for use by Trainees, International Medical Graduates and Fellows for any stage that may be appropriate for them.

The foundation of this resource is based on adapted components from the Australasian College for Emergency Medicine Mentoring Framework. The Mentoring Framework follows the four distinct phases of an effective mentoring partnership:

1. Preparing for Mentoring,
2. Building the Relationship,
3. Developing the Mentee, and
4. Transitioning the Relationship

"Research has shown that having a mentor supports the achievement of personal and professional goals and improves motivation, engagement and work performance."

This guide will assist mentors and mentees towards a positive and effective mentoring experience. It provides a summary of the concepts in each phase, as well as suggesting tasks to undertake and tools to use as you move through your mentoring journey. All of the templates from the guide are also included below so that you have easy access to print copies as required.

As RACS currently does not offer formal training on mentoring, it is hoped this guide will provide support to both a mentor and mentee. The website also provides other tools, templates and articles that will assist the mentor or mentee to understand their roles and responsibilities, helping to frame any mentoring relationship.

Mentoring is a great way to support the learning and career development that occurs within surgery and is complementary to the supervision of developing surgical specialists within the surgical unit. The mentor may be a surgeon whom the mentee has met within the workplace, but is usually not the supervisor, even if this is how the career relationship may have originated.

The guide is designed to support mentors and mentees who may be taking part in formal mentoring scenarios, as well as those in quite informal mentoring relationships. It is recommended that this guide be used as a toolkit for the various stages of the 'cycle' that mentoring can involve, as the mentee may have several mentors within their career.

Please visit the Mentoring section on the RACS website for further information
http://www.surgeons.org/education-training/mentoring/

LAUNCH OF SURGICAL CAREER TRANSITIONS

A guide to opportunities and challenges

MARIANNE VONAU
Immediate Past Tresurer

JULIAN SMITH
Immediate Past Chair,
Professional Development
and Standards Board

A surgeon may experience several phases of transition throughout their careers, each representing a significant period of change and stress. The College recognises the importance of providing support in this area and has launched the Surgical Career Transitions Guide that is progressively staged across a surgical career.

The guide starts from when a surgeon enters practice as a Younger Fellow, defined as the first 10 years of practice through to the Mid-Career stage and then into the Senior Surgeon or final 10 years of practice.

For surgeons practising in their home country, transitional periods may result from a new role, new team, geographic move, changing scope of practice, response to technical and scientific discoveries, family needs, community needs, adverse health issues, business opportunities or re-entry after a period of leave.

For those who have moved to a foreign country to practise, there may be additional complexities including language and cultural barriers, differing disease management, varied patient expectations and working within a completely different health care system. While these changes often represent an exciting new phase in their career, they may be associated with increased stress, anxiety and vulnerability which can affect the mental health, competence and performance of the surgeon.

Awareness of the challenges surgeons face during transitional periods is important to ensure appropriate support mechanisms are in place. This benefits their own health and wellbeing and also the care they provide to their patients and community that they serve.

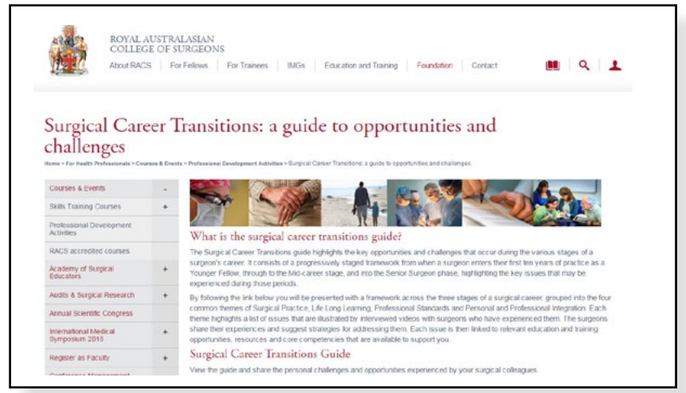
Four common themes occur across the three stages of the career and they include Surgical Practice; Life Long Learning; Professional Standards and Personal and Professional Integration. Each theme is broken down into a number of opportunities and challenges that occur at each stage (Figure 1).

These are illustrated by more than 200 interviews with surgeons. Each video elaborates on the surgeon's experience of that issue and their suggested strategy to overcome it. These are then linked to the RACS core competencies, relevant education and training opportunities, surgical roles that could be adopted and resources that are available to support surgeons experiencing similar issues.

In addressing each unique phase of a surgeon's career, the Surgical Career Transitions Guide will:

- act to mark career progression;
- encourage dialogue around these stages;
- engage and identify with the narratives of surgeons who have successfully navigated challenging stages;
- provide targets to guide professional development;
- enable surgeons to focus their learning activities more effectively; and
- suggest learning activities that they can access.

The guide gives voice to the personal stories of surgeons who have successfully chartered a course through the different career stages.



These narratives provide a valuable resource for learning about the lived experience of Fellows, and in doing so, others will have a better appreciation of the challenges they may encounter as they transition throughout their career and how their interests, inclinations, skills and life choices can steer them.

Perhaps most importantly, this guide will provide surgeons with a greater awareness of the programs and resources available to support them through these career phases.

The *Surgical Career Transitions Guide* can be publicly accessed on the RACS website landing pages for Fellows, Trainees and IMGs under courses and workshops or the Professional Development activities page.

If you would like to contribute your surgical career journey to the resource please contact us at *career.story@surgeons.org*

Theme: Career of the practising surgeon		
Younger Fellows	**Mid-Career Surgeons**	**Senior Surgeons**
Intrinsically motivated career choices Externally influenced career choices Dealing with uncertainty Transitioning to independence Joining or establishing a practice Managing workload Returning to clinical work Changing scope of practice	Intrinsically motivated career choices Externally influenced career choices Joining or establishing a practice Managing workload Managing the practice Returning to work Changing scope of practice	Intrinsically motivated career choices Externally influenced career choices Winding down the practice Managing workload Returning to work Changing scope of practice Mentoring others in career planning
Theme: Life Long Learning		
Younger Fellows	**Mid-Career Surgeons**	**Senior Surgeons**
Developing clinical and operative competencies Response to adverse events Seeking support Monitoring performance Professional development Developing management and leadership competencies Learning from experience Share understanding	Developing, maintaining and improving clinical and operative competencies Professional development Being a mentor Monitoring performance Alignment of learning to scope of practice Refining management and leadership competencies Learning from experience Share understanding	Maintaining and improving clinical and operative competencies Professional development Monitoring and recognising cognitive decline Being a mentor Planning for retirement Passing on management and leadership competencies Learning from experience Share understanding
Theme: Professional standards		
Younger Fellows	**Mid-Career Surgeons**	**Senior Surgeons**
Developing resilience Role modelling Ethical practice Setting the right price Managing extrinsic influences Recognising personal strengths and limits Recognition, response, remediation and regulation of professional behaviours in yourself and others	Demonstrating resilience Role modelling Ethical practice Setting the right price Managing extrinsic influences Recognising personal strengths and limits Managing higher clinical responsibility Recognition, response, remediation and regulation of professional behaviours in yourself and others	Being the experienced expert Demonstrating resilience Role modelling Ethical Practice Setting the right price Managing extrinsic influences Recognising personal strengths and limits Recognition, response, remediation and regulation of professional behaviours in yourself and others
Theme: Personal and professional integration		
Younger Fellows	**Mid-Career Surgeons**	**Senior Surgeons**
Balancing financial commitments Relationships with family, friends, peers and partners Dealing with family crisis and change Burnout and stress Mental and physical health of self and others Hobbies and interests Career satisfaction Personal and professional identity Managing stressors	Balancing financial commitments Relationships with family, friends, peers and partners Dealing with family crisis and change Burnout and stress Mental and physical health of self and others Hobbies and interests Career satisfaction Personal and professional identity Managing stressors	Balancing financial commitments Relationships with family, friends, peers and partners Dealing with family crisis and change Burnout and stress Mental and physical health of self and others Hobbies and interests Career satisfaction Personal and professional identity Managing stressors

Figure 1. Opportunities and Challenges at each stage of a surgical career

Bioethical Framework Implementation in Clinical Practice

Saturday 22 October 2016

Royal Australasian College of Surgeons, NSW Regional Office

RACS Medico Legal Section proudly presents the Bioethical Framework Implementation in Clinical Practice forum at RACS Sydney, New South Wales Regional Office.

The forum will stimulate robust bioethical discussions among surgeons.

The 2016 Forum has a broad clinical emphasis to reveal current medical, surgical and hospital practice and to bring into focus innovations in medicine, nursing, pain relief and surgery that continue to evolve.

Target groups - Fellows, International Medical Graduates, Trainees and other interested participants

Presenters: RACS Fellows and industry experts

Date and time: 8.30am to 5.00pm on Saturday 22 October 2016

Fee: (all values include GST):

A$200 incl. GST for Trainees or International Medical Graduates within the College

A$350 incl. GST for Fellows

A$440 incl. GST for non-members of the College

Registrations: Participants can register via the online enrolment form (log in required) on the Professional Development page or email pdactivities@surgeons.org to secure your place.

More information:

Telephone: +61 3 9249 1106 Fax: +61 3 9276 7412 Email: PDactivities@surgeons.org

Book now to avoid disappointment!

THE PURSUIT OF ACADEMIC SURGERY

Learning the art of balancing clinical and research work

BY YI CHEN
Surgical Research Society Award Recipient

Growing up in a family of academics, I witnessed first-hand the pressures academics are under to attract substantial grants, to consistently produce high quality data, to publish and present their results in respected journals and at renowned conferences, and perhaps most importantly, to generate novel ideas for their research. Luckily, my parents are not surgeons.

I could not imagine how academic surgeons have the time to partake in both academia and clinical work, and succeed in both. In November 2015. I decided to attend the 52nd Annual Meeting of the Surgical Research Society (SRS) of Australasia to present some of my research, and to gain an insight into an academic surgeon's world.

The SRS meeting was an eye opener. Never before had I been in the presence of so many academic surgeons and surgical aspirants. I was pleasantly surprised to see the balance of clinical and basic sciences research undertaken by surgeons, junior doctors, and medical students, as well as the significant time and effort these surgeons have invested into their academic careers. I was humbled to receive the Developing a Career in Academic Surgery (DCAS) Award, which gave me the opportunity to attend the DCAS course in Brisbane in 2016.

The Developing a Career in Academic Surgery Course was intellectually dense, packed tightly into the space of one day. The course commenced and ended with a line-up of successful academic surgeons from around the world. Academic surgeons from places including the US and UK discussed how their hard working attitude and eagerness to improve patient outcomes led to their fulfilling career.

One of my favourite presenters was Dr Adil Haider, the Kessler Director of the Center for Surgery and Public Health for Brigham and Women's Hospital and Harvard Medical School. I felt that his message of "work harder, and work smarter" instead of "don't work harder, work smarter" resonated with me and allowed me to gain an insight into the world of an academic surgery.

To sum up my experiences at the two meetings in one word, I choose 'inspirational'. Reflecting upon the two fantastic opportunities that I have been presented with, not only do I feel motivated to study, become a competent clinician, and to keep up to date with the advanced in the literature, but to also work towards one day playing a key role in improving patient outcomes through a career in academic surgery.

RESEARCH PRIZE WINNER ANNOUNCED

The competition was fierce for the Surgical Education Research Prize

STEPHEN TOBIN
Dean of Education

The Academy of Surgical Educators would like to congratulate Dr John Farey and Dr David Bui for taking out this year's Surgical Education Research Prize at the RACS Annual Scientific Congress (ASC). The Surgical Education Research Prize is awarded for the best research paper presented during the Surgical Education program at the ASC. Dr Farey and Dr Bui presented the findings of their educational research entitled "Experiences and Perceptions of Anatomy Education in Australian Medical Schools: Results of a Cross-Sectional National Survey Of 1100 Medical Students".

Presentations are scored using the following criteria: abstract quality (20 per cent), scientific merit (40 per cent) and quality of presentation (40 per cent). The Surgical Education Research Prize was this year judged by Professor Jonathan Beard, Professor Caprice Greenberg and Professor Peter Anderson.

An article on Dr John Farey and Dr David Bui's work will be published in the next edition of Surgical News.

The prize is open to all RACS Fellows, Trainees, International Medical Graduates, researchers, junior doctors and medical students who present research papers in the surgical educational program at the ASC. The prize is a certificate and cheque for $1000.

A note on May's edition of Surgical News

Stephen Tobin wishes to reassure the College community that he is well and is not outgoing as Dean of Education nor as a surgeon.
As Mark Twain wrote in May 1897 "...the report of my death was an exaggeration..."
In the same year. Twain also said "Humor is the great thing, the saving thing. The minute it crops up, our hardnesses yield, all our irritations and resentments flit away and a sunny spirit takes their place"

Let's operate with respect: do something about improving one's role as a surgeon/trainee/IMG-on-pathway in 2016

Provisional Program 2016

Annual Joint Academic Meetings

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

Day one Section of Academic Surgery Meeting

SESSION 1 : Mid-Career Course **Leadership, Innovation and Academic Advancement**	**CHAIR: Sarah Aitken**
Introduction	Sarah Aitken
Identifying leadership opportunity	Andrew Hill
Growing academic units	Paul Bannon
Balancing academic and clinical practice	Wendy Brown
The future of the Section of Academic Surgery	Guy Maddern
SESSION 2	
Innovation and research in practice	Munjed Al Muderis
Developing a broad academic impact	Christobel Saunders
The importance of legacy in surgery	David Hackam
SESSION 3 : Principles of Research – Planning and Funding your Research	**CHAIR: Sarah Aitken/James Lee**
Introduction	James Lee
Building a research team	Christobel Saunders
Developing hypothesis and aims	Wendy Brown
Research methods and budget	Greg O'Grady
Innovation vs significance	David Hackam

SESSION 4

Concurrent workshops		
1. RACS Scholarships Chair: Sebastian King Presenter: Andrew Hill	2. NHMRC/HRCNZ pearls & wisdoms Chair: Greg O'Grady Presenter: Reg Lord	3.Translational research is not just for laboratory researchers Chair: Julie Howle Presenter: Paul Bannon

AAS/SUS international guests experience (main meeting room)
Chair: Richard Hanney
Presenters: Andrew Hill
Julie Howle

Day two Surgical Research Society Meeting

Invited guest speakers
Society of University Surgeons Guest Speaker – Dr David Hackam
Association of Academic Surgeons Guest Speaker – Dr Daniel Abbott
Jepson Lecturer – Professor Andrew Hill
Presentation of original research by surgeons/trainees/students/scientists
Awards for the best oral presentations;
Young Investigator Award, DCAS Award and Travel Grants

REGISTRATION NOW OPEN

For more information contact
academic.surgery@surgeons.org

Royal Australasian College of Surgeons | Section of Academic Surgery | Surgical Research Society

GOOD FOUNDATIONS

Associate Professor Eric Chung is laying the groundwork for a trauma protocol that will improve outcomes for urological patients

Queensland Urological Surgeon Associate Professor Eric Chung is conducting research that could lay the foundations for the development of a comprehensive trauma protocol in Australia designed to manage patients with pelvic injuries at risk of genitourinary complications.

A/Prof Chung has used the findings of a retrospective 10-year review of the urological outcomes for pelvic injury patients to design a comprehensive trauma treatment protocol aimed at reducing complications such as urinary incontinence, urethral stricture, recurrent infection and sexual dysfunction.

This Australian-first protocol, which is in the process of being trialled at Princess Alexandra Hospital's trauma department, will streamline diagnostic imaging. It involves the input of general and trauma surgeons and emergency physicians to mandate expedient and appropriate urological referral for patients at risk of genitourinary injury and complications.

Conducting his research through the University of Queensland and the Princess Alexandra Hospital, A/Prof Chung said the six-month trial had proven feasible and successful, with pelvic trauma patients now receiving coordinated care including fast and accurate diagnostic imaging test and prompt urological service.

The Chair of the Andrology Special Advisory Group for the Urological Society of Australia and New Zealand, A/P Chung is the first urologist in Australia to complete a formal Andrology Fellowship accredited by the Sexual Medicine Society of North America (SMSNA).

He is conducting his research with funding support provided by the MAIC-RACS Trauma Scholarship established from a grant from the Queensland Motor Accident Insurance Commission (MAIC) and matched by the Foundation for Surgery to provide annual funding for research into trauma.

A/P Chung said that until now, the treatment of genitourinary injuries in the trauma setting – most commonly caused by car or motorbike accidents – had been ad hoc and never been adequately managed on a standardised basis, mainly because of a lack of research and data analysis.

"This aspect of trauma care has been overlooked because the data is missing, not just in Australia but in most parts of the world," he said.

"This, in turn has led to a lack of widely adopted guidelines and treatment protocols and also to a lack of co-ordination between the various trauma unit specialists.

"We wanted to get this project going as soon as possible to evaluate trauma functional outcomes and hopefully prevent future pelvic trauma patients from suffering unnecessarily."

"While a rapid trauma CT scan provides high-resolution studies of the head, cervical spine, chest, abdomen and the pelvis, lower urinary tract injury is often missed.

"Research has shown that pelvic fracture pattern alone does not always predict the presence of lower urinary tract injury and its diagnosis is often difficult when the patient is clinically unstable and/or has sustained multi-organ trauma."

A/Prof Chung said the retrospective study analysing the management and clinical outcomes of pelvic trauma patients admitted to Princess Alexandra Hospital indicated only half of those patients received urology input during their hospitalisation.

Of those who did not receive urological input, six per cent then required subsequent and delayed urological intervention which resulted in prolonged hospitalisation and on-going urinary and sexual dysfunction.

However, A/Prof Chung said the statistics compiled in the pilot study were likely to be the "tip of the iceberg" given that the long-term urinary and sexual complications following pelvic injury remained largely unknown.

"Our research shows that we can now say that between five and ten per cent of pelvic injury trauma patients are not being adequately managed in hospital and although many urological surgeons are aware of this, until now there has never been a standardised protocol to manage them, particularly within the first 24 to 48 hours," A/Prof Chung said.

"Our pilot study has shown that the current clinical care provided to patients with pelvic trauma has been mostly reactive rather than proactive and that there is an urgent need for a multi-disciplinary approach.

Eric Chung

"Many medical staff are ignorant of the importance of early diagnosis and appropriate care and many patients are poorly counselled about the long-term impact of pelvic trauma on genitourinary function or, more importantly, that proper and prompt treatment may minimise and/or prevent subsequent complications."

A/Prof Chung said a comprehensive protocol to manage such patients could not only have positive economic impacts – by saving health dollars through speedier hospital discharge and the patient's ability to return to work – but also vastly improve the quality of life of those affected.

"This is not just an anatomical issue because genitourinary health directly impacts on various functional outcomes such as psychosexual and mental health, and pelvic trauma patients who do not receive timely urological intervention can suffer urinary incontinence and sexual dysfunction, which can lead to depression and emotional distress," he said.

A/Prof Chung used part of the funds provided by the MAIC-RACS Trauma Fellowship to support registrars and residents to gather data (for the initial part of the study) and patient input (for the clinical database) and to pay for a computer software specialist to establish the genitourinary and pelvic trauma registry.

Now in the process of drafting a best healthcare trauma practice treatment plan for such patients, A/Prof Chung also has several research papers in various stages of submission and publication and has presented his findings at several national and international scientific meetings in the past two years.

"We initially presented our study outcome at the Trauma Grand Rounds at the Princess Alexandra Hospital and the idea of a standardised pelvic trauma protocol to streamline urological care was very well received by all attending radiologists, surgeons and emergency physicians" he said.

"Once we have refined and embedded a treatment protocol and policy here in Queensland, we will establish an audit to determine if it can improve the delivery of care for these patients and their long-term outcomes in the coming months.

"If the audit shows significant improvements – including reducing the time spent in hospital, complication rates and long-term genitourinary damage – we hope to present our findings to various stakeholders, including the RACS, in the hope that our protocol might be adopted across the country."

A/Prof Chung thanked Professor Daryl Wall for his enthusiastic encouragement and the College for the financial support provided to advance his research.

"This funding has been very helpful and was really important due to the global decrease in research funding and increase in grant competitiveness, and also because we wanted to get this project going as soon as possible to evaluate trauma functional outcomes and hopefully prevent future pelvic trauma patients from suffering unnecessarily."

With Karen Murphy

Career and Scholarship Highlights

- Chair of Andrology for the Andrology Special Advisory Group for the Urological Society of Australia and New Zealand
- Australia representative on the executive board of the Asia Pacific Society of Sexual Medicine
- 2015: MAIC-RACS Trauma Fellowship
- 2013: American Medical Systems Investigator Sponsored Research Grant
- 2011: Best Scientific Research Prize at the annual meeting of the Asia Pacific Society for Sexual Medicine
- 2011: Best Clinical Paper Award at the American Urological Association North-Eastern section meeting
- 2010: American Medical System Andrology/Prosthesis Fellowship Grant
- 2010: Canadian Male Sexual Health Council/Pfizer Grant
- 2009: Australian Urological Foundation/Astra Zeneca Grant

Dinesh Ratnapala outside the Trauma department at Maxeke Academic Hospital

OPPORTUNITY OF A LIFETIME

Three months of civilian trauma surgery in Johannesburg

DINESH RATNAPALA
FRACS

I had the immense privilege and life and career consolidating experience of spending three months from December 2014 to March 2015 at the 1200 bed Charlotte Maxeke Academic Hospital in Johannesburg (formerly known as Johannesburg General Hospital) made possible thanks to a grant from Covidien Younger Fellows Travelling Fellowship 2014.

This experience has given me a once-in-a-lifetime experience of managing both some of the most complex penetrating and blunt trauma, with injuries often rarely seen in peacetime, in the civilian world.

This hospital received between 250 and 300 trauma presentations per week with a peak of 70 trauma resuscitations per week – 25 resuscitations in one day was not unusual. Between five and 10 gunshot wounds a day were fairly standard as were 10 to 20 torso and neck stab wounds.

My vast operative experience extended to controlling subclavian vessels, axillary vessels, common carotid at root of neck, oesophagus, trachea in the neck and chest, Inferior Vena Cava in the chest, six stabbed hearts, three Emergency Room thoracotomies, countless theatre thoracotomies, lung injuries, sternotomies, vascular injuries above knee and above elbow, all manner of penetrating and blunt, hollow and solid organ injuries to abdomen, pelvis and complications of thoracic trauma.

All with being involved in the management of a dedicated trauma ICU and trauma emergency department – the famed 163 (run solely by trauma surgeons – with opportunity to intubate, resuscitate, place central access lines and countless chest drains (often delegated to trained medical students the world over).

Trauma outpatients on a Friday morning showed us the amazing outcomes of some of the most complex injuries, as did weekly elective lists, in reconstructing some of the most complex sequelae of open abdomens.

Hand sewn hollow viscus anastomoses were the norm and gave me a great experience under the direction of my consultants and extremely capable and versatile senior registrars with whom I was paired.

Despite intermittent resource constraints, I firmly believe the quality of surgical work done by the trauma unit was second to none.

It was evident to me that our own countries truly could not ever cope with the complexity and frequency and sheer volume in our own resource rich environments. This experience taught me important lifelong lessons of how simultaneously blessed and spoilt we are.

The lifelong friendships I have made in this country were profoundly enriching both personally and professionally, as was the opportunity to attend the Definitive Surgical Trauma Care course run by Ken Boffard and Steve Moeng.

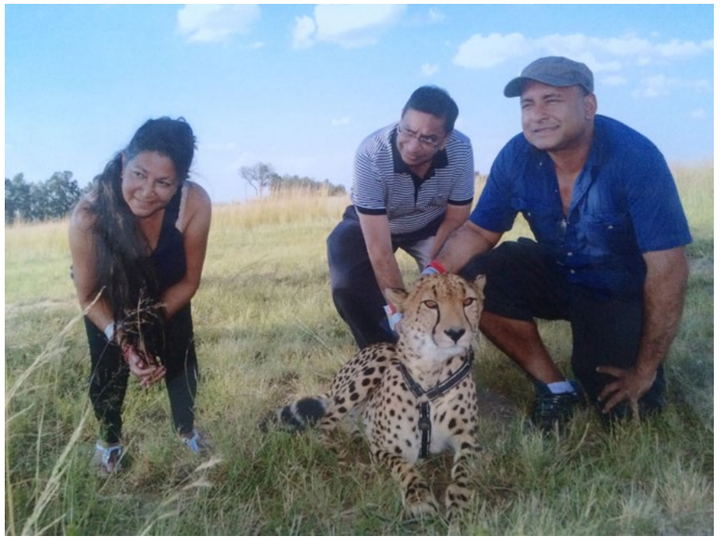
This was complemented by a unique experience to enjoy this uniquely beautiful country and its people adding a beautiful balance to the devastating human cost often seen in the working day.

I am truly indebted to Alison McLean and Shabina Reddy for making this placement possible by doing most of the logistical work and enabling the lengthy medical registration process to occur in a timely manner and looking after me throughout my stint.

"I am all the richer for this [experience] and carry with immense gratitude the memories of our interactions and friendship and comradery for the rest of my life."

To my consultants Steve Moeng, Reuvan Jacks, Denzel Mugabe, Liezel Taylor, Vicky Jennings, Eloise Miller, Helena Alves, the opportunities you gave me to be involved in the clinical and operative management of these patients was second to none. Your lasting friendships and support I could never have dreamt of.

To all the local registrars and medical officers and students, registrars, fellows from the world over I worked with and socialised with – the lessons every single one of you taught me and the opportunities you gave me to operate and be actively involved in patient care was truly unsurpassable. I am all the richer for this and carry with immense gratitude the memories of our interactions and friendship and comradery for the rest of my life.



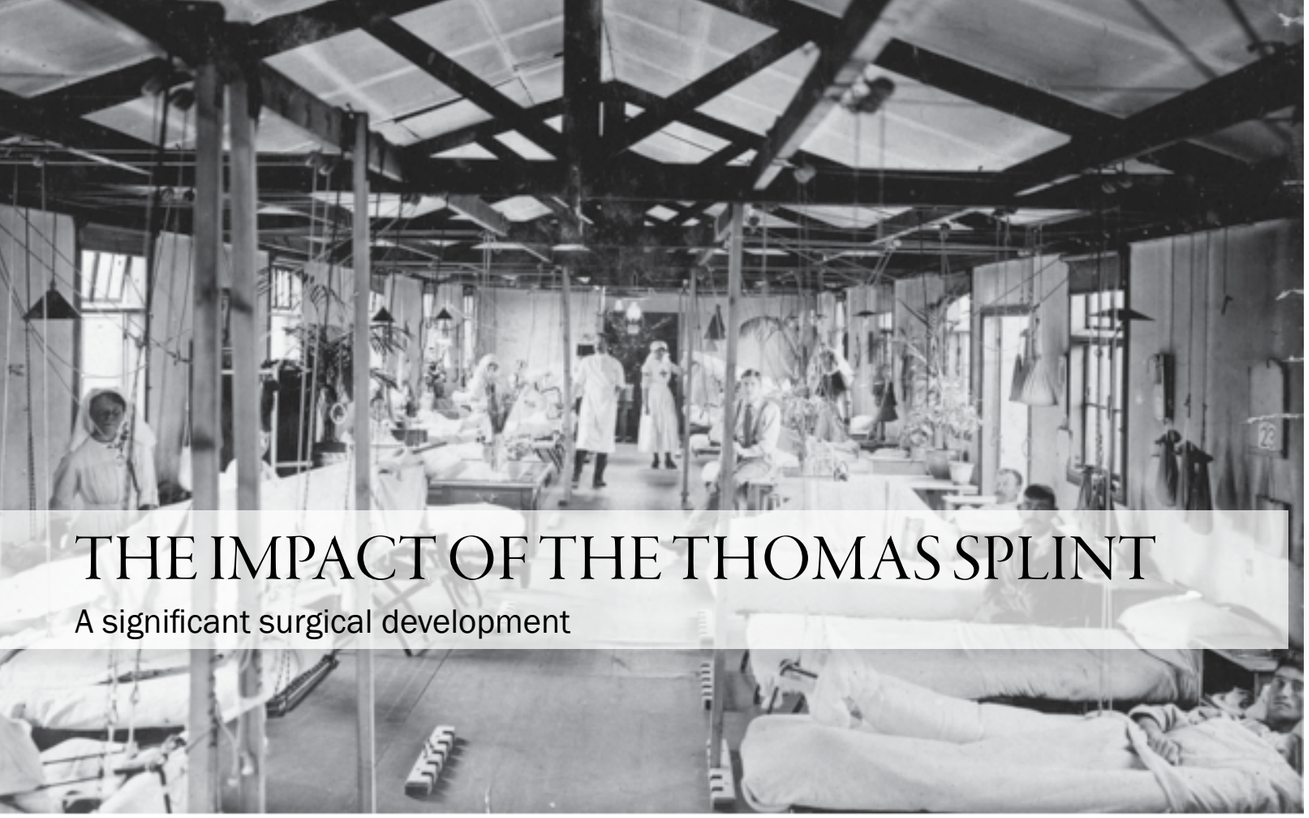
Working in Johannesburg offered unique opportunities

Maxeke Academic Hospital in Johannesburg

This truly was a career-long dream come true, complementing a prior year as trauma/rural general surgical fellow in Darwin, a general surgical and breast/oncoplastics year at Robina, Gold Coast, a current year in colorectal surgery in the UK and training years spent mostly at Robina and Gold Coast, Ipswich and Brisbane City hospitals. This experience will allow me to function as a true rural general surgeon in Australia in the future, with a breadth of emergency capability that I have been blessed to experience first-hand.

I also pray this will lend to future possibilities of being able to work with organisations such as the International Committee of the Red Cross (ICRC) or Médecins Sans Frontières (MSF), be part of an Australian Medical Assistance Team (AUSMAT) and work with the Indigenous populations of the Territory for which I have immense passion for, as part a fulfilling career of what I can give back to humanity in honour of all my teachers and colleagues that have made me who I am.

The Younger Fellows Travelling Fellowship Grants may be available for travel in 2017 with applications generally opening in September. Further information about availability of funding, including how to apply can be found on the RACS website:
http://www.surgeons.org/member-services/scholarships-awards-lectures-prizes/research-and-travel-scholarships/covidien/



THE IMPACT OF THE THOMAS SPLINT

A significant surgical development

PETER SHARWOOD
Queensland Surgeon

The most authoritative account of the medical problems Australian forces encountered during the Great War of 1914-1918 is contained in the three volumes published in 1943 of Official History of the Australian Army Medical Services written by Brisbane Surgeon, Colonel Arthur Graham Butler, DSO, VD.

In his history Butler states: t*he Australian medical units were to serve the purpose of evacuation, not treatment, thus there just does not exist sufficient documentation about what treatment methods were used.*

Descriptions of wound and casualty management recorded in the histories, speak mainly of splinting and dressing. The huge numbers of casualties treated by a small number of surgeons confirms that little else could be done. Butler acknowledges that to a large extent, serious Australian casualties were treated in British hospitals especially after evacuation from France. Major cases evacuated from Gallipoli as well were retained in the British Hospital in Alexandria.

At Gallipoli, with respect to musculo-skeletal injuries there is a paucity of information. The rule at the time was to immobilise fractures. Plaster and splints were usually available in the Casualty Clearing Stations or Stationary Hospitals,

Femoral fractures were a specific problem. The standard method of immobilisation was the Liston splint, a long single board, (for which a rifle was commonly substituted), that

"In his history Butler states: "the Australian medical units were to serve the purpose of evacuation, not treatment, thus there just does not exist sufficient documentation about what treatment methods were used."

extended from the axilla to the ankle to which the damaged limb was bandaged.

It was well recognised that with the Liston splint no traction could be applied, thus there was no tamponade of bleeding which inevitably occurred. When soldiers had to be carried long distances or had to wait for dark to be moved, without traction, near fatal exsanguinations occurred. If the injury was open, contamination was severe and infection, especially from clostridrial organisms occurred with ensuing gas gangrene, making amputation the only hope of relief or survival. Operation though on these debilitated patients was almost universally fatal. If the rifle was used as the splint, there was the added danger of the weapon that had not been unloaded!

Robert Jones, nephew of Hugh Owen Thomas, considered the 'Father of British Orthopaedics' worked with his uncle with whom he had lived since in his teens. Jones published a small book on *The Present Position in the Treatment of Fractures* in 1912 where he strongly supported the use of 'The bed splint' described by his uncle many years earlier for femoral and lower limb disorders. Jones said of the splint, *I have often [used it to] put up a fractured femur and have sent the patient home in a cab*[1] The splint became known as the Thomas Splint.

The work of Robert Jones prior to World War 1 had made Liverpool a centre of learning for trauma and Orthopaedic Surgery which in those times was performed by general surgeons. Despite being away from London and Edinburgh, Robert Jones' clinic became a Mecca for many who were interested in his techniques and procedures, though was held *almost wholly without honour among British surgeons, in particular those of the London schools*.[2] Many foreign surgeons visited Liverpool to observe Jones' work including the Mayo brothers from the USA in 1911.[3] Later, at a time when America entered the war, H Winnett Orr, and other American Orthopaedic surgeons, travelled in England in May 1917 in a group led by Colonel Joel Goldthwaite. They worked with Robert Jones, and used his advice when arranging transport of casualties back to the USA later in the war.

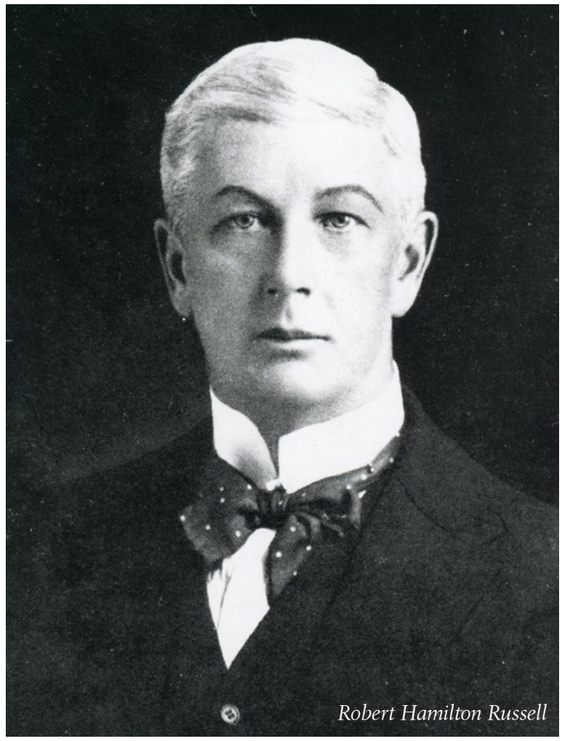
In a report in 1914, Jones had advocated to the British War Office that a Thomas splint would make femoral fracture management a simple matter.

Butler states that : *Three Australian medical practitioners drawn from civil life into the war under widely different circumstances observed the article in 1914. The reaction in each case was the same. Each set out to purchase the splints at their own expense.*

The British did not heed Jones' advice to use the Thomas Splint for nearly three years and then, only units at the rear were issued. This splint, it was said reduced the death rate from open fracture of the femur from 80 per cent to 20 per cent[4] though this statistic became a subject for debate as records were incomplete. One anecdote recorded by Butler, is from Palestine from the surgeon from Desert Mounted Corps Operating Unit. *A combat officer was treated for a gunshot wound to his thigh by the application of a Thomas splint. He was then transported from Amman to Jerusalem, some of the journey in a camel cacolet, the roughest ride imaginable, yet he had an excellent result. At the same time a New Zealand officer died about two minutes after arriving at the Desert Operating Unit having travelled from Jericho, simply because he had traveled with his thigh unfixed.*[5]

It was not until later in the campaign that the Thomas splint became more universally used. A variety of ways of application arose, but in October 1918, a directive was issued at 2ACCS on the instructions as to how the splint was to be applied by two or three stretcher bearers. They were practiced in the technique in the dark, and while wearing gas masks.

Application of the splint was a twelve stage operation involving lying the patient upon a stretcher covered in a specific way with folded warmed blankets, then applying traction by holding the limb by the foot and leaning back with the arms extended. A second assistant if present supports



Robert Hamilton Russell

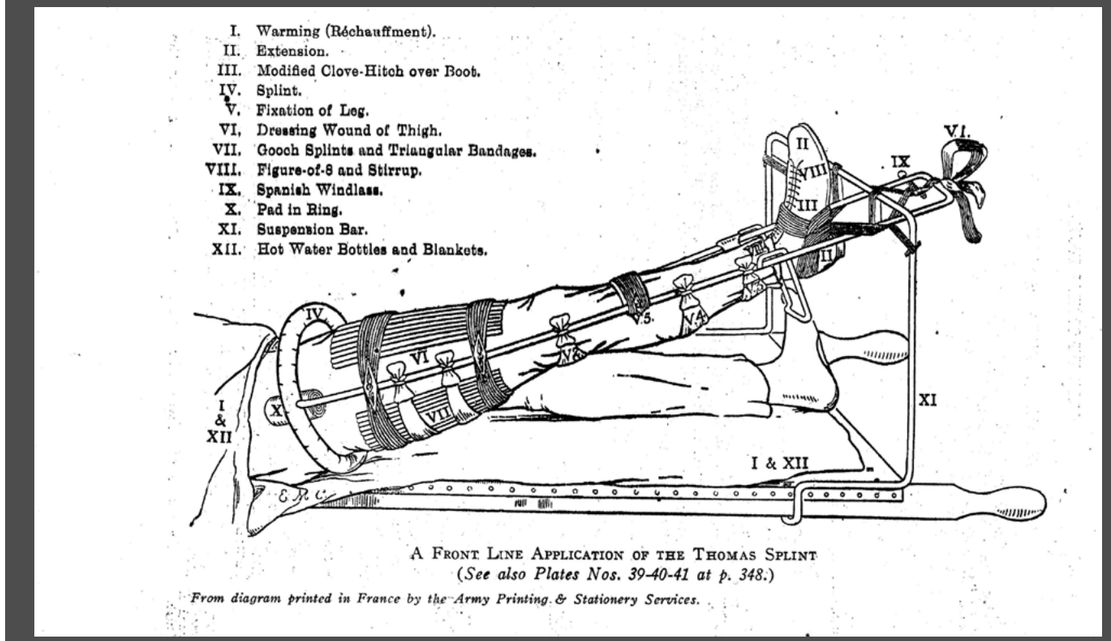
the proximal thigh. The splint is threaded over the limb until the ring lies against the ischial tuberosity. Five slings support the limb which is serially bandaged after dressing wounds. Traction is maintained by bandages around the lower limb being tied to the end of the splint and tightened if necessary with a Spanish windlass, a stick, passed between the crossing bandages. This is turned to twist the bandages thus increasing the tension.

Open fractures, especially of the femur, had an exceptionally high mortality rate, though there much debate as to what the actual mortality figures were.[6,7] Wounds of major joints, considered the 'bete noir of surgeons', had to be addressed. Jones published a monologue on this in 1915 and an Australian surgeon, Balcombe Quick, published, in 1918 a definitive article in The Australian Medical Journal, described by Butler as 'one of the best of this advance'.

The official history also records that Charles Shaw's work on fracture management. His work was acknowledged and commended by Sir Arthur Bowlby.[10] The published illustration from 1917 shows the use of the Thomas splint but not balanced traction.11 Shaw was a pupil of Robert Hamilton Russell from Melbourne.

In 1915, Hamilton Russell, Australian by adoption, was in England and enlisted in the British Army. He served in France and England before returning to Melbourne where he went

Diagram from Butler's history



on to assist in the founding of the RACS.[12] Hamilton Russell was described as a "genius in the treatment of fractures"[13] but did not publish his work on balanced traction which employed for its basis the Thomas Splint, until 1924.[14]

John Kirkup in his RACS Foundation Lecture in 2002[15] discusses the problem of the femoral fracture. He quotes an incidence of thigh wounds at 5.1 per cent of 48,000 documented cases. He refers its high mortality and the use of Hamilton Russell Traction as a definitive therapy, but this treatment required a hospital bed, something the wounded from Gallipoli did not see until they were in Egypt or Malta, and even then there was a shortage. There appears no illustration of balanced traction in the Official History of Butler.

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RACS supporting Surgical Teachers

ACADEMY OF SURGICAL EDUCATORS
Royal Australasian College of Surgeons

The Academy of Surgical Educators is an active community of practice to support, enhance and recognise surgical educators within the College. Since its inception, it has evolved to include over 650 members from Australia, New Zealand and internationally.

The Academy also recognises all serving Supervisors and Professional Development facilitators, with the annual Academy Recognition and Reward program. It offers a range of educational activities, resources and recognition to its members in order to support them in their role as a surgical educator.

The Academy is supported by an interactive online learning community where members can gather ideas, share interests and research, find resources and keep abreast of upcoming events. The environment is supportive, collaborative and fosters enthusiasm in surgical education.

UPCOMING ACADEMY EVENTS NOT TO BE MISSED!

Educator Studio session - Monday, 27 June – RACS Melbourne & live webinar 6.00pm (AEST)

"How Entrustable Professional Activities could assist Surgical Residency Programs in ANZ" - Associate Professor Stephen Tobin

"Surgical Education and Training: A prevocational perspective" - Dr Kirstie MacGill

Foundation Skills for Surgical Educators - Thursday 25 August 2016 - Crowne Plaza, Adelaide 9.00am – 4.00pm

A course directed at facilitating the education and training of Surgical trainees and will establish the basic standards expected of our surgical educators within the College. This free one day course will provide an opportunity for participants to identify 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 and skills in teaching and learning concepts and look at how these principles can be applied into the participant's own teaching context.

Academy Forum – Thursday 25 August 2016 - Crowne Plaza, Adelaide 6.00pm – 9.30pm

"Changes in Health Education 2016 and Beyond "

For further details and registration on any ASE event please contact ase@surgeons.org

MEMBERSHIP

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


ASE Event

DISRESPECT AND BULLYING

A model for understanding the relationship between disrespectful behaviour and perceived bullying

PAUL GRETTON-WATSON
Director, Professional Services, Converge International

Today, many of us have a better understanding about what we know and believe constitutes respectful or disrespectful behaviours in the workplace. We have a solid internal radar that tells us when communication or behaviour might have crossed the line to such an extent that we experience it as harassment or bullying.

This is a function of many factors including our own values, beliefs and norms that enable us to clearly and quickly determine where on that continuum we would label the behaviour as respectful, disrespectful, or worse...bullying.

Needless to say, we were to ask a group of individuals what did or did not constitute respectful or disrespectful behaviour, we'd get a variety of answers that reinforces the subjective nature of this determination.

In recent years, Converge International undertook research into people risk conundrum. We carried out the research in two large professional services organisations in the public sector. Among many things, we explored what employees believed constituted respectful and disrespectful behaviour or communication.

As might be predicted, much of what was deemed either extreme on the behavioural continuum was rarely in dispute. Again, and perhaps not so surprisingly, some behaviour and communication were less clearly agreed upon.

More interestingly, was the challenge of determining when disrespectful behaviour might trip a higher threshold and be deemed bullying behaviour. Again, there was a degree of subjectivity to this but there are some key factors we found that tend to be far more predictive of whether the disrespectful behaviour is deemed bullying or not than necessarily the behaviour itself.

What we established was that a sense of psychological safety and trust were far more powerful predictors of whether behaviour was deemed to be labelled as disrespectful or bullying than the actual behaviour itself. The model below demonstrates this distinction.

In a context where there is high psychological safety and trust, disrespectful behaviour (by most people's measure) may not be considered offensive or unwelcome. We can all relate to the situation where someone we know, trust and like can tell us an off-colour joke or use vulgar language and we are less likely to take offence or label it as anything – least of all – bullying.

In this context we have high trust with that individual and are likely to 'know their form' and therefore know that no harm is intended by the comment or joke and, as a corollary, no offence is taken. In a sense, a greater level of

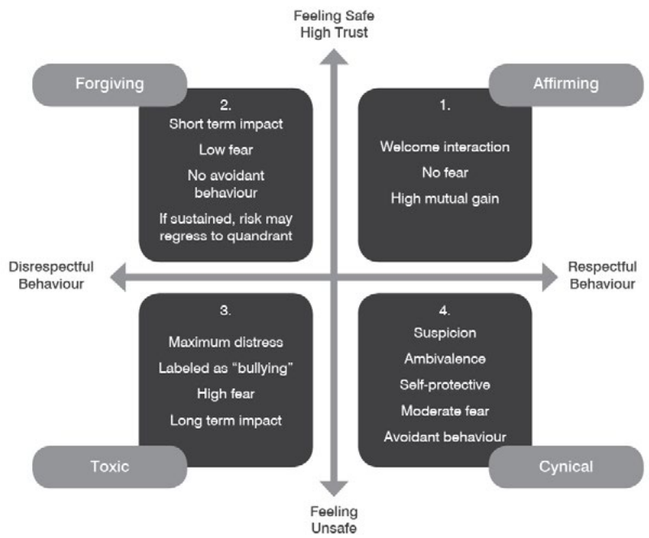

Figure 1

BUILDING RESPECT,
IMPROVING PATIENT SAFETY

latitude is extended to them because of the trusting relationship that is earned over time.

Conversely, where psychological safety is low and we might feel distrustful toward someone or a group of individuals, when the exact same off-colour joke or extreme swearing is made, it is more likely to be experienced as unwelcome or to have 'crossed the line'.

Indeed, it is in this low trust context that we may label such behaviour as distressing or even bullying, irrespective of the intent of the person. Therefore, the dynamic of low trust or psychological safety is a far more powerful predictor of whether behaviour is experienced as bullying or not.

Looking further at this model, it becomes clear that even respectful behaviour such as giving praise or recognising good work are not necessarily experienced by the person as respectful if there is low trust and they continue to feel psychologically unsafe.

As the model demonstrates, the bottom right hand quadrant would suggest that respectful behaviour may be viewed with suspicion or ambivalence while the receiver of that behaviour is questioning the authenticity and trustfulness of these overtures.

When workplace behaviour is poor, there tends to be a flow from quadrant 1 through to 4, and, if things turn around, eventually back to 1. Unquestionably quadrant 1, in the top right of the model, is the ideal and preferred quadrant for any individual or team to operate within.

If however, disrespectful communication or behaviour starts to occur, within the context of high psychological safety (quadrant 2), it is less likely to have an impact on the person or group experiencing it . Should this dynamic be sustained, it is more likely the person experiencing it will have growing cognitive dissonance as they try to reconcile what is going on.

Disrespectful Behaviours	% Often observed in managers	% Often observed in peers	% Perceived as very disrespectful
Basing decisions on relationships not merit.	29.3	22	67.5
Failing to deal with people who display disrespectful behaviours.	25	23	82.5
Lying to/hiding truth from people.	20.5	17.9	84.6
Criticising someone's work in public.	9.8	27.5	72.5
Making jokes/innuendos at someone's expenses.	9.8	24.4	75.6
Spreading gossip and rumours about people.	7.3	26.8	80.5
Making personal derogatory comments about someone.	9.8	22	94.7
Talking about others negatively in public/in front of others.	2.6	27	86.8

Figure 2

If this dynamic persists, erosion of trust and psychological safety typically occurs and a transition to quadrant 3 is more likely. It is when teams or individuals find themselves entrenched in a toxic quadrant 3 that formal complaints or bullying allegations typically occur and psychological injury may eventuate. At this point, aspects of culture are deemed certainly sub-optimal or considered "toxic" and performance is invariably compromised.

The other key distinction about this model is that even if the perpetrator(s) of the adverse behaviour change their approach to respectful and positive, the person(s) who have been impacted are unlikely to snap back to immediately respond positively to quadrant 1. Rather, it can take a long time to rebuild trust and a sense of psychological safety. There tends to be pathway from quadrant 3 to quadrant 4, before returning to 1.

This is often misunderstood by organisations when they address the bullying behaviour or remove the perpetrator of the behaviour and expecting the problem to be immediately solved. Impacted individuals sometimes remain stuck in quadrant 3 or 4 regardless as their trust and sense of safety remain low.

In summary, we all experience respectful and disrespectful behaviours in our lives both at work and outside work. Whether we are negatively impacted or not tends to be much more a function of how psychologically safe we feel in relation to these dynamics over time. Also, once an individual or group are significantly negatively impacted, it may be long road back to rebuilding trust, psychological safety and ultimately high performance.

BUILDING REGIONAL SKILLS

Profile – Dr Alito Soares – Timorese General Surgeon

At the end of a busy day as the Head of the Emergency Department at the Hospital Nacional Guido Valadares (HNGV) in Dili, Timor-Leste, Dr Alito Soares pauses to reflect on the past few years. It has been a busy time for the young Timorese consultant General Surgeon.

After graduating with a Bachelor of Medicine from the University of Andalas in Padang, Indonesia, Dr Soares commenced his Master of Medicine in Surgery at the Fiji National University (FNU) in 2011. Dr Soares received a scholarship and support for living expenses from the Australian Government through the Australia Timor Leste Program of Assistance for Specialist Services (ATLASS), delivered by RACS in Timor-Leste.

Despite living away from his home country and young family, Dr Soares achieved excellent results in his studies. After graduating in 2015, Dr Soares returned to Timor-Leste, where he has demonstrated significant leadership at the HNGV.

Dr Soares is passionate about passing on his skills and expertise to the next generation of Timorese doctors and he continues to work closely with the RACS team based in Timor Leste, including General Surgeon Dr Raj Singh, to deliver training to junior doctors.[1]

Dr Soares sat down with the RACS Program Team to talk about his experiences:

What made you want to specialise in surgery? What are your surgical interests/passions?

"In the beginning I just enjoyed medical school as I went through it. I did my internship in all departments at HNGV and I found that I enjoyed working at the surgical department the most. When I started working in this hospital around early 2006, I personally requested to work in the surgical department. It was hard as I started from limited knowledge but I learnt and enjoyed it.

My first surgical case was a long bone fracture. We had many complicated cases at that time, especially in 2006 when there were many trauma cases due to the civil conflict in Timor-Leste. It was so difficult to work within that situation with less experience. At that time I promised myself to study hard and become a surgeon one day in the future.

In the end, my dream came to reality; in 2011 I got a chance to do surgical training in Fiji (FNU). People like Dr Emma Lang, the late Dr Katherine Edyvane and Dr Xhu Hong were my best teachers and friends who supported me to take that opportunity.

I knew it would not be easy to deal with the English language and the new environment; however I knew I was not alone; I was deeply inspired by my family's dedication in supporting me to continue my study, as well as support from friends and supervisors from both Timor-Leste and Fiji. They were my strength to finish my study.

Apart from general surgery, I am very keen on breast surgery and breast reconstruction; honestly, this branch of surgery is one of my passions. For me the most interesting part of surgery is when we get a good result. You are likely to make people gain their life again or help them get well and live their lives normally as other people".

You finished your Masters of Medicine in Fiji over a year ago and have been back working at HNGV in Timor-Leste since then. What has changed for you now that you are a qualified surgeon?

"I knew it would not be easy to deal with the English language and the new environment; however I knew I was not alone; I was deeply inspired by my family's dedication in supporting me"

"It is a huge change for me since I joined the surgical training in Fiji. There are many things I learnt during the program, i.e. how to manage simple case and very complicated surgical cases.

In fact, now that I am back and working as a surgeon in this country with all my experience from the surgical training, I feel confident to do any surgical cases independently, i.e. bore hole in EDH, exploratory laparotomy, bowel surgery, anastomosis, acute abdomen, chest trauma mx, tracheostomy, open chole, breast surgery, thyroid surgery, surgery for life saving and limb salvation and others".

What do you see as the most important contribution you can make as a recently qualified Timorese surgeon?

"Being involved in clinical teaching to young Timorese doctors in the surgical department and coordinating the weekly surgical audit; we just started it and we have already done two audit activities. Soon we will start pathology sessions, which combine the surgery team, radiology team and histopathology team. This is a very important part of the surgical activities that I am currently responsible for.

Besides that, in a short time we will also open a new breast clinic which I will run. The proposal is already approved by the Head of the Surgery Department and the HNGV's Clinical Director. We are now in the process of finding a location within the hospital.

The other activity that I am involved in is the Surgical Outreach. This activity is coordinated by Dr Mendes [Timorese surgeon] and me and we have done three visits. The last one was in Ermera [a district to the west of Dili] early this month".

How has RACS helped you over the course of your study and now that you have finished you Masters?

"It is a long story about how RACS has helped me in surgical training; I want to be able to describe it all here. I started working here [at HNGV] in 2006 and was registered as an orthopaedic registrar after a couple of months in Internal Medicine. I waited for a scholarship from the Government [of Timor-Leste] at that time but nothing was happening, and in 2011 my dream came true and I got a chance to go to Fiji for a surgical training [funded by the Australian Government through the ATLASS program].

Seeing now that I am capable of doing surgical cases confidently and I am confident to be the one who is responsible for other important clinical and surgical activities in this hospital, it is all because of the support from RACS. Therefore, on this occasion I would like to thank RACS, the Australian Government and all people in it who supported me a lot to gain all that I have now".

You have been involved in training the next generation of young Timorese doctors who are doing post graduate training at HNGV. What is your vision for these young doctors going through their study? What can you pass on to them from your experiences?

"My vision/ dream as a surgical trainer in this hospital is that with all the basic surgical care that we have provided, we can improve the skills and knowledge of these young doctors to make decisions and implement emergency surgery that can avoid unnecessary disabilities or loss of life.

As a teacher for these junior doctors, I have been involved in lectures and audits in the surgical department along with Dr Raj and I hope that I have passed onto them most of the lessons that I got from my surgical training".

Reference

1. RACS is currently delivering the Australia Timor-Leste Program of Assistance in Secondary Services – Phase II (ATLASS II), which is focused on delivering post graduate training in surgery, anaesthesia, family and community medicine, paediatrics and obstetrics & gynaecology as well as system strengthening activities. ATLASS II is funded by the Australian Government.

SHRIMP ON THE BBQ? ARE THEY REALLY PRAWNS?

Binding...really ?

THE BARONESS

You may recall from an earlier BBQ, the sorry tale of a learned commercial law colleague who was asked that very open question of RU or RU not in a relationship. She had just returned from many years being highly successful in both New York and in Paris. Really tricky law and obviously totally consuming. She had forgotten her family law.

There had been much discussion around how do you really judge a relationship and how many can you be in ... at the one time. Much to reflect on and as I said you can only be limited by your imagination.

I had often reflected on that evening, the preparation of the prawns had been superb and the Riesling outstanding. But today, at our 'open the snow season' event, we were into heat. How long do you marinate your chilli prawns? I have this glorious recipe for Hot (read very) Chilli Prawns.

"High quality and bought by my guests, my old friends from University days. Eclectic, if not unusual. That describes the wine and sometimes my friends"

Prawns (properly prepared), limes (squeezed) and garlic (pressed) is the starting point. You then make your marinade of honey, soy sauce, chilli sauce and olive oil. Not into secrets, but you do need the right chilli sauce.

And I have the best provider at the local market. The conventional may just coat the prawns with the marinade. Not me. I prefer to let them stand for some time. Then onto the skewers just before the hot BBQ grill.

Hot. That is what I like. Great for the 'open the snow season' events. That, combined with the outdoor heaters does make one sit down so you can enjoy the warmth. And I forgot, the wine of choice had to be in the chardonnay class. High quality and bought by my guests, my old friends from University days. Eclectic, if not unusual. That describes the wine and sometimes my friends.

My learned colleague of French-American experience triumphed again. A fantastic Chardonnay-Viogner. It had been described as a 'weighty wine that showed accents of lavender and apricot'. She had sourced it from the Rhone Valley in France. One of the great advantages in spending most of her career between New York and Paris. She just knew the places to go.

So we were sitting back and just enjoying the warmth of great food, wine, radiant heaters thinking about the impending adventures on the skiing slopes. Queenstown, here we come! Of course, New Zealand snow is always better!

I had tried to 'gag' my theological friend from asking any follow up questions on the issue of relationships. I was feeling somewhat pleased that such an outstanding commercial lawyer had attended our little gathering for a second time and was prepared to share such outstanding European wines!

However, he could not resist and made a not so subtle comment about her legally-complex life. Judges of the High Court would find it difficult to match the stare – death-ray like.

However, after topping up her wine glass, she stated 'Fine, I have a fantastic iron-clad binding pre-nup agreement.' I spluttered. The group stared at me. I had just finished representing my third elite sports couple who had discovered the hard way that their iron-clad agreement was not so binding after all. But it could have been.

Ah, the lawyers could not resist. So when is binding, really binding? There was an immediate cry of have you heard of Black and Black (2008) where the Full Court made it clear that only a Court could determine whether a financial agreement was indeed 'binding'?' True, I said, but if it is done correctly, it will be binding.

A detailed understanding of the correct type of financial agreement is needed. Each party must have been independently advised, received this advice before signing and the legal practitioner must sign a certificate. Full disclosure of assets and financial resources must also be provided.

Contract law pitfalls abound – valid offer and acceptance, duress, and a palpable risk that a badly drafted agreement will be 'frustrated' by subsequent marital events. The list goes on. Cutting corners can result in the legal equivalent of an auto-wreck. Perhaps unsurprisingly, proper care must be taken.

And to my friend who specialised in commercial legal undertakings between France and the US, the advice needed to be provided by an Australian legal practitioner. Do you really have an agreement? Will it be binding?

I had spoken too much. Indeed the evening felt too warm. Recollections of pre-nuptials, dashed expectations, the warmth of the chilli and perhaps too much of the grapes of the Rhone Valley.

We turned to our plans for the snowfields of Queenstown.

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

In Memoriam

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

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

Michael Elliott Shackleton OBE
31 March 1927 – 20 September 2015
General and Paediatric Surgeon

Michael was born in Waimate, to Ronald, surgeon, general practitioner and Superintendent of the Waimate Hospital, and Mary Armstrong, a talented amateur artist. Both parents played the violin and from an early age Michael learned the piano and singing. He had a younger sister, Janet who would go on to win a Commonwealth Games medal as a hurdler. Michael attended primary school in Waimate and at an early age demonstrated a sense of adventure. He attended Christ's College where he became a prefect and Deputy Head of School. He enjoyed sport representing Christ's in athletics, swimming, rugby and shooting.

For the full version see the webpage: http://www.surgeons.org/member-services/in-memoriam/michael-elliott-shackleton/

Michael Armstrong
21 November 1961 - 28 April 2015
Orthopaedic Surgeon

It caused great sadness to hear of the unexpected death of Michael Armstrong at the age of 53. Michael was a wonderful friend, father, husband and surgeon. He is survived by his wife Adele and two daughters Bridgette and Olivia, as well as his brother John. Michael cared for and helped those around him immensely – not only his family and patients but also his colleges and staff.
I first met Michael in primary school at Grimwade House (Melbourne Grammar junior school). At school he was routinely called "Rouge" for his full head of curly red hair. He was in the year ahead of me and captain of Austin House; we viewed him with awe. He was both smart and excelled at sport, particularly football but also athletics. At senior school the story repeated itself: Rouge went on to Captain Miller House and played in the first eighteen. He was a keen student and was thoroughly immersed in school. He took part in the Quad Play, the chapel choir and received a number of prizes including one for music.

For the full version see the webpage: http://www.surgeons.org/member-services/in-memoriam/michael-armstrong/

John Ichsan Tan
Cardiothoracic Surgeon
28 December 1956 – 9 December 2015

It is with great sadness that The Australian and New Zealand Society of Cardiac and Thoracic Surgeons reports the passing of John Ichsan Tan, friend and colleague.

John was an enigma. He had so much talent in such a wide variety of activities, even close friends never ceased to be surprised. Of all his activities, cardiac surgery was his greatest love. Like most cardiac surgeons, he felt privileged to do the work and embraced the commitment required.

There is no category for John Ichsan Tan. John was never in a box and indeed, always thought outside the box. He challenged our strongly held beliefs and in that regard, he could be called a heretic. If a heretic successfully puts his ideas into practice, he is called an eccentric. Many people described John as eccentric. If the ideas of the heretic or the practices of the eccentric are embraced by the majority, that person is then called a leader. It is rarely possible to become an innovator or leader without first being a heretic.

For the full version see the webpage: http://www.surgeons.org/member-services/in-memoriam/john-ichsan-tan/

Salil Roy Chowdhury
15 March 1928 – 9 September 2015
General Surgeon

As a surgeon - from his birth in New Delhi, India, his training in England to a career in New Zealand - Roy Chowdhury occupied the world of medicine more than most.
Salil Roy Chowdhury (widely known as Roy) was born in 1928, the sixth child of Abala Bondhu Roy Chowdhury, a manager of a colliery in Dhanbad, and Chapala Sundari Sarkar. With the death of his father prior to his birth, Roy and the family moved to the ancestra l family home in Ulpur, in East Bengal, (now Bangladesh) on the banks of the Padma River, a Ganges tributary, where the family owned large areas of land and buildings. In 1936 the family returned to New Delhi where Roy excelled at school.

For the full version see the webpage: http://www.surgeons.org/member-services/in-memoriam/salil-roy-chowdhury/

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.

PROCEDURES IN PROFILE: VARICOSE VEINS

As highlighted recently in *Surgical News* understanding clinical variation is becoming increasingly important both locally and internationally

DAVID WATTERS
Chair, Clinical Variation Working Party

Fifty years ago medical interventions were limited, more straight forward and carried a much lower cost impact on the community. Today 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.

"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.

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.

RACS needs to be actively involved in the discussions about how health care can be affordable while ensuring good surgical practice. An outcome that will certainly benefit our patients, as well as the profession.

RACS 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.

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 who wish to know 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.

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

The role of RACS 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 RACS in this endeavour. We are hopeful of progressively replicating this process with other funders and their data sets.

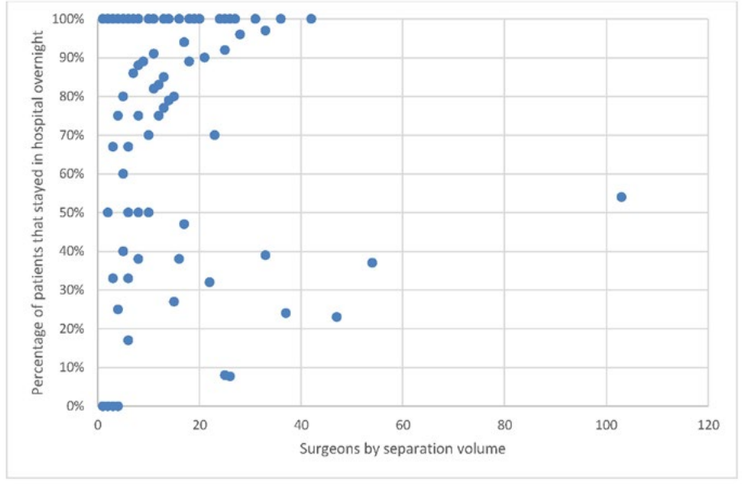

Figure 1. The percentage of patients who stayed in hospital overnight for Varicose Veins

We are presenting these initial reports through Surgical News as the first part of a broader communication strategy. The procedure within this report is varicose veins.

Varicose Veins

In 2014 Medibank funded a total of 1602 operations in private hospitals for which varicose veins surgery was recorded as the principal procedure (highest value MBS fee from the medical claim) for the hospital admission.

The analysis is limited to those 1602 procedures. Identified through the stem of their Medicare provider number, 204 surgeons billed Medibank for those procedures. Of these surgeons, 90 (44 per cent) undertook five or more procedures.

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.

Seventy six per cent of patients stayed in hospital for at least one night following their procedure. The median age of patients that stayed in hospital overnight was 58 years, compared with a median age of 55 years for those discharged on the same day of admission.

For the 90 surgeons who performed at least five procedures:

- 41 (46 per cent) of surgeons had all of their patients stay in hospital for at least one night
- 49 (54 per cent) surgeons had a mix of patients that stayed in hospital overnight or were discharged on the same day as admission.

Fifty-five (5 per cent) of the hospital separations patients were readmitted (for all causes*) to a hospital within 30 days. (*Readmissions for rehabilitation, psychiatric treatment, dialysis and chemotherapy were excluded where identified as well as separations involving a patient aged 80 years or more).

Administrative claims data does not indicate whether the readmissions were planned or unplanned. The median age of patients readmitted was 62 years, compared with a median age of 56 years for those patients not readmitted.

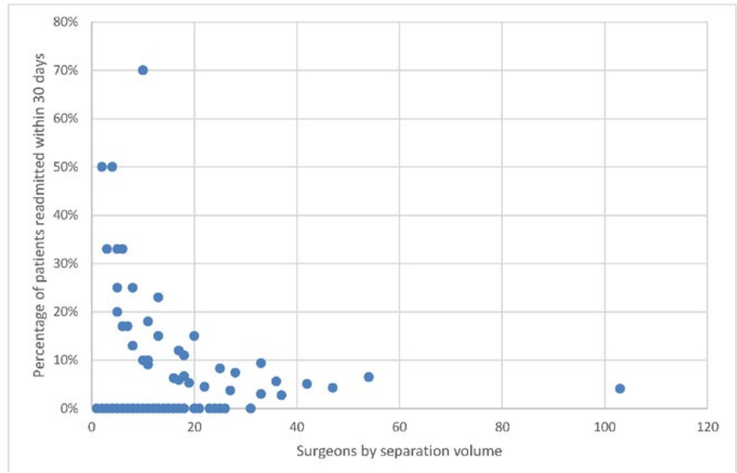

Figure 2. Percentage of patients readmitted within 30 days (all causes)

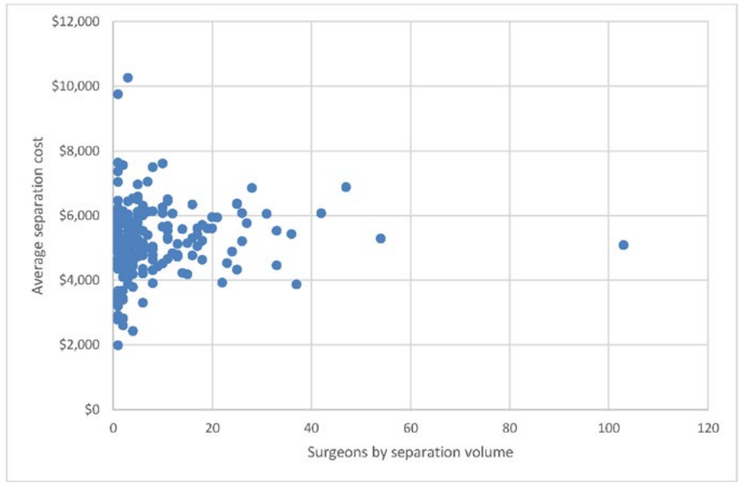

Figure 3. The Average Separation Cost for Varicose Veins

Readmissions to public hospitals, where patients were treated as public patients, are not captured in these datasets.

For the 90 surgeons who performed at least five procedures, the percentage of a surgeon's patients readmitted within 30 days ranged between 0 per cent and 70 per cent with a median of 0 per cent.

The separation cost includes the total charges that Medibank sees including payments made by Medibank, Medicare and the patient. Costs include hospital, prosthesis, surgeon(s) and diagnostic services. For the 1,602 separations, the average separation cost was $5,343.

For the 90 surgeons who performed at least five procedures, the average cost of prostheses used by each surgeon was between $3304 and $7616 with a median of $5298

The patient was charged an out of pocket fee by the principal surgeon in 37 per cent of admissions.

For the 90 surgeons who performed at least five procedures, 36 (40 per cent) did not charge any of their patients an out of pocket for the hospital admission. The average out of pocket charged was between $0 and $1,787 with a median of $20.

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 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.

In this report about Varicose Veins the contribution of Professor Michael Grigg and Dr John Quinn has been particularly instructive. The Working Party 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.

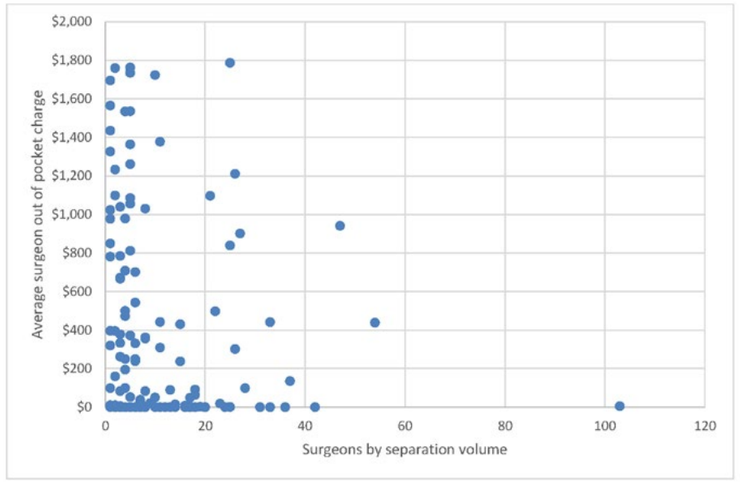

Figure 4. Average out of pocket charge from principal surgeon for varicose veins

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 with 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*

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