ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 17 NO 02 MARCH 2016

PAEDIATRIC SURGERY
Mr Sebastian King leading advances
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THE 'EYES' HAVE IT
In Timor-Leste
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OPPORTUNITIES FOR 2017

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The College of Surgeons of Australia and New Zealand

ChloraPrep™ with Tint Surgical Applicators

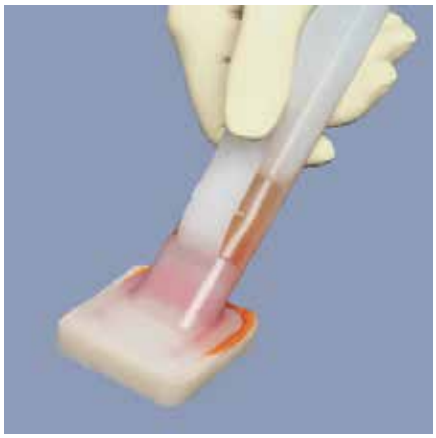
Cutaneous Solution
2% Chlorhexidine Gluconate w/v and 70% Isopropyl Alcohol v/v
Sterile applicator and solution

Squeeze

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

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

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



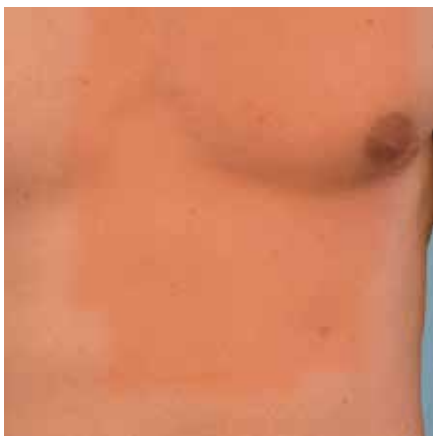
Apply

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

Dry

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

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



Skin Preparation for all Surgical Procedures

3 mL		Coverage Area: 15 cm x 15 cm Product Code: 600415 25/Box 100/Case: UOM Case
10.5 mL		Coverage Area: 25 cm x 30 cm Product Code: 600715 25/Box 100/Case: UOM Case
26 mL		Coverage Area: 50 cm x 50 cm Product Code: 600815 25/Case: UOM Case

Before Using the ChloraPrep™ applicator, read the instructions for use.
Use in accordance with the policies and procedures of your hospital.

ChloraPrep™ with Tint
Cutaneous Solution
2% w/v chlorhexidine gluconate (CHG)
70% v/v isopropyl alcohol (IPA)

CareFusion Australia
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Seven Hills, NSW 2147
Ph: 1800 833 372

CareFusion New Zealand
14B George Bourke Drive
Mt. Wellington, Auckland.
Ph: 0508 422 734

CareFusion has joined BD

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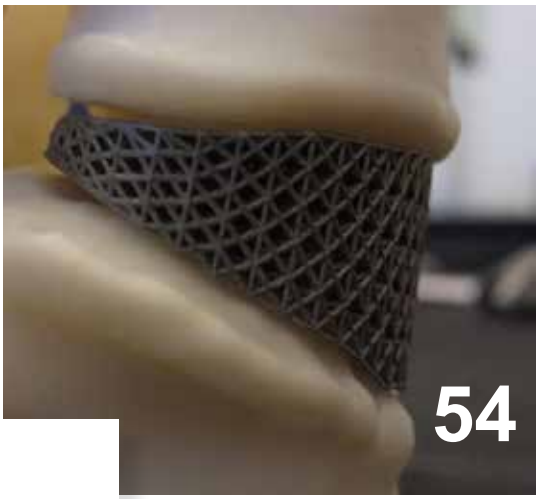

REGULAR PAGES

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ON THE COVER: Opportunities for 2017

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.

Clinical Decision Making

21 March 2016 – Melbourne, VIC

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.

Foundation Skills for Surgical Educators

22 April 2016 – Melbourne, VIC

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.

Process Communication (PCM) – Part 1

22 to 24 April – Sydney, NSW

PCM is one tool that you can use to detect early signs of miscommunication and turn ineffective communication into effective communication. This workshop can also help to detect stress in yourself and others as well as providing you with a means to reconnect with individuals you may be struggling to understand and reach. The PCM theory proposes that each person has motivational needs that must be met if that person is to be successful. These needs are different for each of the 6 different communication types; each person uses a combination of these types but usually one is dominant.

Supervisors and Trainers for SET (SAT SET)

23 April 2016 – Melbourne, VIC

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

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

workshop

assessment tools; the Mini-Clinical Evaluation Exercise (Mini CEX) and Directly Observed Procedural Skills (DOPS).

Keeping Trainees on Track (KToT)

23 April 2016 – Melbourne, VIC

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.

March 2016 - May 2016

NSW

22-24 April 2016
Process Communication Model: Seminar 1, Sydney

QLD

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

VIC

21 March 2016
Clinical Decision Making, Melbourne
22 April 2016
Foundation Skills for Surgical Educators, Melbourne
23 April 2016
Keeping Trainees on Track, Melbourne
23 April 2016
SAT SET Course, Melbourne

WORKING TOGETHER

Collaboration is key to achieveing optimal patient outcomes

DAVID WATTERS
President

Imagine a junior surgical trainee working in the most prestigious hospital of Neverland.

One day Junior makes an allegation of being bullied repeatedly by a particular senior consultant of renown. Working for Great Professor, Junior often feels humiliated, becomes increasingly anxious, and struggles to retain motivation. The matter is reported to Hospital Supervisor (by Registrar) who recognises there may well be a problem after consulting other witnesses. Supervisor holds a confidential discussion with the Great Professor, who denies there has been any wrong doing, but counters that the trainee just needs to become more resilient and "toughen up".

But Supervisor, actually a more junior consultant than Great Professor, has recently done the RACS course to address discrimination, bullying and sexual harassment. Supervisor knows to escalate the issue and consults with the Hospital HR department, the specialty training board, and the RACS complaints resolution manager. The RACS complaints resolution manager and the Hospital discuss the division of responsibilities, what needs to be communicated by whom, and agree that the allegations need to be promptly investigated. The Training Board are kept in the loop though it is recognised that some of the Board members know Great Professor well. They welcome an independent investigation and acknowledge their potential for bias. In the meantime Junior is allocated duties that avoid contact with Great Professor. At the start, the training Board is concerned about Junior's term and whether to post other trainees to the University Hospital in Neverland. However timely and independent investigation, sees Junior's claim substantiated with Great Professor being offered an opportunity to improve workplace behaviours and be subject to subsequent reviews of performance. The whole process of investigation took just three months, Great Professor did not involve lawyers, and learned to do things differently. . In time great Professor was re-allocated trainees.

The aggressive, intimidating behavioural cycle was broken, without destroying a career, but only because there had been ownership of the problem, coupled with recognition of what needed to change. Everyone gained. Junior was protected and continued training, and in time recovered motivation. Registrar and Hospital Supervisor had had the guts to speak up for the trainee. They did not stand by silently and let it all go on. Great Professor took the opportunity to change; the hospital maintained their accreditation, and the training Board did the right thing by Junior and the hospital. It all took collaboration, cooperation and communication. It took courage and determination to address uncomfortable topics, and insight by Great Professor to be aware that behaviours that had previously been tolerated back in 2014, were no longer acceptable in 2016. Indeed Great Professor even acknowledged they probably had never been acceptable, only no one had ever said anything.

Could this happen in your hospital? Or would the outcomes that finally eventuate be far worse at least for some parties? Imagine the scenario where there is little collaboration, cooperation or communication, where lawyers become involved and investigations are stymied by confidentiality and confrontation. The legal bills escalate, it takes many months or years to resolve and no one will be satisfied with the outcome. Quite possibly no one would learn anything that would change things for the future. Everyone suffers and some careers and reputations are ruined.

Collaboration and Teamwork are key to safe high quality patient care. Indeed this is one of the nine RACS competencies against which all of our Trainees are assessed. The RACS competencies are based on CanMEDS which have been under intensive review and were updated for CanMEDS 2015. The emphasis on collaboration and teamwork has been heightened.

To achieve good patient outcomes, and create a healthy working environment, specialist surgeons need to work effectively with other health care professionals in undertaking their daily clinical activities. Inappropriate, unacceptable or illegal behaviours do no one any good; certainly not the junior staff, and certainly not the patient.

The RACS will lead cultural change in the surgical profession and the surgical workplace. This is part of the Action Plan outlined in response to the Expert Advisory Group report on discrimination, bullying and sexual harassment. But it cannot happen without collaborating with the many other stakeholders in the health sector. These include Specialty societies and Associations, other Medical Colleges, Universities, Regulators, Ministries of Health, Departments of Health, Private and Public Hospitals, Private Hospital Insurers, Medical Defence

Organisations and Unions. They are all on the 'must talk to' and 'will work with' list. I am pleased to report that all have offered support for the RACS Action Plan and have stated they are willing to work with us to create a safer and healthier workplace. However, the proof will be in the pudding, and being willing needs to be followed by making it all happen. There will be challenges, there will be some failures and setbacks but I am confident we will succeed but we cannot do it all alone.

RACS has highlighted principles that underpin the action of Vanderbilt University Medical Centre in their comprehensive approach to professional behaviour. These are an absolute commitment by the leadership of the organisation to preventing discrimination, bullying and sexual harassment; the mission, goals and core values of the organisation support respectful clinical and educational activities; surveillance and monitoring tools are in place; processes are in place to review the observations and reports; models for graduated interventions are in place; multi-level professional and leader training is available and is essential as both an employee and educator / trainee; resources are available to address the causes of unnecessary variation in performance and there are also resources available to help those affected.

Core to our collaboration are relationships based in trust, respect and shared decision making between individuals and groups with complementary skills in multiple settings. Sharing knowledge, perspectives and responsibilities with a willingness to learn together is vital. It is obvious but so important to appreciate that there are multiple solutions that will need to be identified as the action plan is implemented in many different work places and training environments.

We must all be involved though our individual role will depend on our position and our responsibility. Everyone should be prepared to show leadership. This includes being bold enough to call out unacceptable and inappropriate behaviours in the workplace and bring an end to being a silent bystander. Allegations need to be investigated according to the principles of natural justice but trainees and others who perceive they have been discriminated against, bullied or sexually harassed deserve to work in a safe environment. Indeed that is optimal for patient safety. All of us can benefit from reviewing our behaviours and performance and be aware of the need to give feedback to junior staff with appropriate language and tone, and strongly motivated towards the individual's development, learning and progress.

As you can imagine, there will also be a complex endeavour that spans all College activities, which will offer all of us opportunities to be individual champions, and role models. That will be the foundation for collaboration – not only with building respect but in so many issues that we must be addressing into the future. We surgeons and the RACS cannot do it alone, because most discrimination, bullying and harassment takes place at work, and so we always need to collaborate with employers – the hospitals, universities and practices – and the responsibility to address these issues lies with all of us, as well as employers, Colleges and the Medical Board/Council.

We need every surgeon, trainee and IMG to become involved and become a champion of respectful behaviours wherever you work – to ensure a safe working environment for us all. Happier, more collaborative and supportive teams will also improve safety for our patients. The story at the start of this article was set in Neverland, but I challenge you to make it happen in Yourplace!

RACS Support Program

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

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

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

How to contact Converge International:

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

Converge international
incorporating resolutionsRTK

BREAKING BARRIERS

The changing shape of New Zealand's Medical Workforce

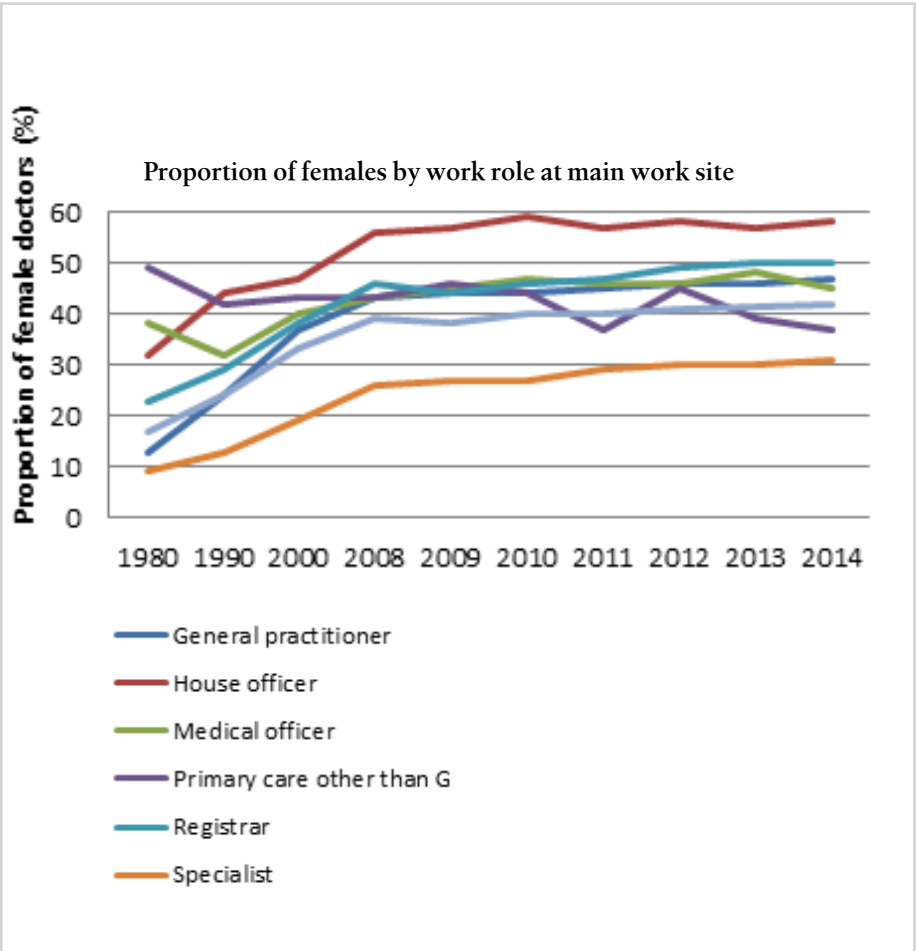
GRAEME CAMPBELL
Vice President

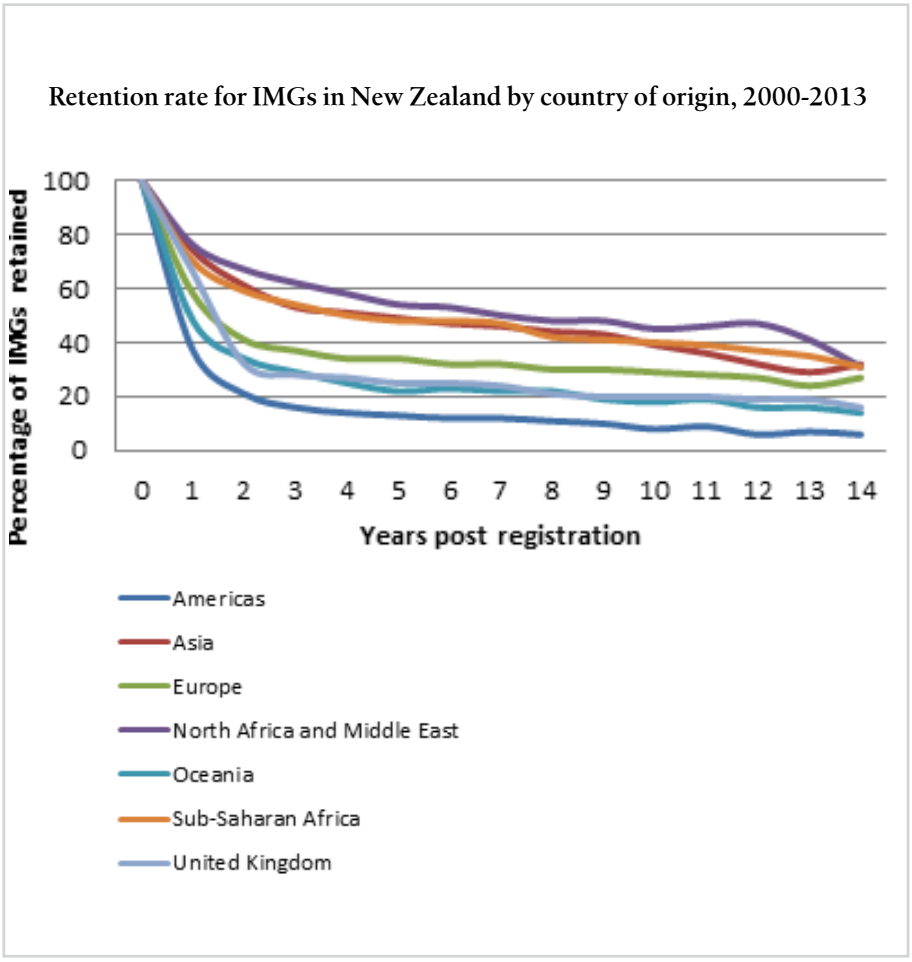
2015 was a breakthrough year for New Zealand. For the first time, the number of Māori students entering the country's medical schools was proportionate to the Māori population. Out of the 474 students that were accepted into the Otago and Auckland medical schools in 2015, 75 identify as Māori. That is 15.8 percent of the class – ever so slightly higher than the most recent population figures where Māori make up 15.5 percent of New Zealand. This fact represents an important milestone for Māori health in New Zealand.

Despite these promising numbers, the Medical Council of New Zealand's (MCNZ) recent survey, *The New Zealand Medical Workforce in 2013 and 2014* indicates that there is still a significant distance to go before Māori are proportionally represented in New Zealand's medical workforce. In 2014, the proportion of doctors who identified as Māori was only 3.2 percent, up from 2.7 percent in 2013. Based on these numbers, it is clear that medical schools will need to sustain their current intake of Māori medical students for quite some time if the medical workforce is to more accurately represent the Māori demographic of New Zealand. By comparison, the Australian Institute of Health and Welfare estimates that the proportion of Australian medical practitioners in 2014 who identified as an Aboriginal or Torres Strait Islander was 0.5 percent. According to the latest Australian census Aborigines make up 2.7% of Australia's population and Torres Strait Islanders 0.018%.

The MCNZ survey shows that Māori doctors are more highly represented among house officers and registrars, at 5.4 percent and 4 percent respectively. Traditionally, the number of Māori entering vocational training for any specialty has been low - in 2014 only 2 percent of specialists were Māori. It is anticipated that, as these house officers and registrars advance in their careers, their numbers will translate into a larger proportion of Māori specialists. This is an area of particular interest to the College - a core element of our *Māori Health Action Plan* is to encourage more Māori to pursue a career in surgery.

Another aspect of New Zealand's medical workforce that has been undergoing change is its increasing proportion of female doctors. For





some time this has been slowly moving towards parity and was estimated to be at 42 percent in 2014, increasing slightly from 41 percent in 2012. A similar trend can be seen in Australia where women now make up more than 39.4 percent of the medical workforce, up from 37.9 percent in 2012. While these numbers are promising, the non-GP Specialists are lagging behind. For the College in particular, the RACS Activities Report for 2014 found that female Fellows comprise just 11.3 percent of the Fellowship in New Zealand and 10.5 percent in Australia.One other aspect of the MCNZ survey that I wish to highlight is the data regarding International Medical Graduates (IMGs). IMGs make up a large portion of both Australia and New Zealand's medical workforce. MCNZ registration data indicates that the proportion of IMGs in the New Zealand medical workforce in 2014 was 43.4 percent. In Australia, this number is closer to 36 percent. Only 55 percent of IMGs will stay in New Zealand for longer than a year. This drops to 36.6 percent in the second year, and slowly decreases from 31.9 percent from the third year onwards. Interestingly, IMGs from within Asia and Africa are much more likely to remain in New Zealand for longer than IMGs from the Americas and Europe.

The College is committed to removing discrimination from the medical workforce and promoting surgery as a career to Māori and Aboriginal and Torres Strait Islanders. The results from the MCNZ's survey show that New Zealand's medical workforce is slowly becoming more diverse – I am hopeful that the College's efforts will help to contribute towards this.

Social Media Surgery

What is #FOAMed?

FOAM stands for Free Open Access Meducation (medical education). The goal of FOAM is to break down barriers in medical education, and enhance the learning experience, taking it outside of the hospital and making it available anytime, anywhere.

According to Dr Chris Nickson, Emergency physician and co-founder of medical blog Life in the Fast Lane:

"FOAM is a collection of resources, a community and an ethos. The FOAM community spontaneously emerged from the collection of constantly evolving, collaborative and interactive open access medical education resources being distributed on the web with one objective — to make the world a better place. FOAM is independent of platform or media — it includes blogs, podcasts, tweets, Google hangouts, online videos, text documents, photographs, Facebook groups, and a whole lot more."

This movement has taken off across social media platforms, and is often tweeted about with the hashtag #FOAMed. Variations on the theme include #FOAMSurg for surgical education. Simply enter #FOAMed into Twitter and you'll be bombarded with resources, freely available to all in the community.

Prevention success in Queensland

RACS received praise from the Queensland Attorney General as part of group of organisations who supported the Tackling Alcohol-Fuelled Violence Legislation Amendment Bill, which was passed through Parliament recently.

Dr John Crozier, Chair of the RACS Trauma Committee, praised the spirit of collaboration that culminated in passage of the legislation.

"It is a powerful demonstration of effective advocacy on behalf of the overwhelming majority of Queenslanders who are committed to reducing alcohol-related harm.

"Queensland is now the first state in Australia to enact these evidence-based alcohol related harm reduction measures and 2am last drink sales, at a whole of state level," Dr Crozier said.

www.surgeons.org, 18 February

Hep B awareness push in NZ

A gap in vaccinations in the 1980s has meant that thousands of Māori, Pasifika and Asian New Zealanders may be infected with the liver disease Hepatitis B without knowing it.

Dr Jonathan Koea, who specialises in cancer and liver disease surgery, is leading the charge in improving health outcomes by advocating for a Hepatitis B screening program.

"There doesn't seem to be any concerted effort to go out into the community and actually find those people," Dr Koea said.

"That's where, I think, primary health care providers go through the patients on their books, particularly the at-risk populations: check their Hepatitis status, [it is a] simple blood test, check their liver function tests, and if they do have evidence of an active infection then refer them to specialist assessment at their hospital."

Radio New Zealand, 3 February

Vic outdoor smoking laws

Health groups are pressuring the Victorian Government to follow Queensland's model for laws on smoke-free outdoor dining.

The Victorian Government plans to introduce the laws by August next year however they will be restricted to areas that serve food, rather than a blanket ban outdoor areas of cafes, bars and clubs as seen in Queensland for more than a decade.

Fears that the laws will be difficult to enforce, confusing and only encouraging alcohol consumption without the pairing with food have been heard from Cancer Council Victoria and many other health organisations.

Herald-Sun, 12 February

Australia Day binge

Australia Day 2016 saw a big increase in the number of emergency department patients admitted because of alcohol-related harm.

A snapshot survey from the Australasian College of Emergency Medicine (ACEM) found that the rate of admissions for alcohol-related harm almost doubled on Australia Day to 15 per cent.

Chair of the ACEM Public Health Committee Assoc Professor Diane Warburton revealed the level reached almost 30 per cent in certain parts of Queensland and Western Australia.

"That is a huge and entirely unnecessary burden placed on our already overstretched emergency departments." Assoc Professor Egerton-Warburton said.

msn.com, 2 February

Australian and New Zealand
Head & Neck Cancer Society
Annual Scientific Meeting

and the

International Federation of
Head and Neck Oncologic Societies
2016 World Tour

25 – 27 October 2016

The Langham Auckland, Auckland, New Zealand

For further information:
T: +61 3 9249 1260
F: +61 3 9276 7431
E: anzhncs.asm@surgeons.org
W: www.ifhnosauckland2016.org

AUSTRALIAN AND NEW ZEALAND HEAD & NECK CANCER SOCIETY

Why do old dogs learn new tricks?

Are you an experienced spine surgeon who has adopted a new surgical technique in the last five years? Would you be prepared to participate in a research project which is the basis of my minor thesis for a Master of Surgical Education?

If so, please read the information document at: *https://dl.dropboxusercontent.com/u/28106368/Information%20sheet%20-%20old%20dogs%20new%20tricks.docx*

If you would like to participate please contact me at **bryan.ashman@act.gov.au**

Leasing opportunities

Eastlink Surgical Centre is a modern fully accredited Day Surgery Centre in Wantirna, Victoria opposite Knox Private Hospital and next to the Eastlink freeway exit.

Permanent or sessional surgical and consulting leasing opportunities exist in this growth corridor of eastern Melbourne.

Contact

- info@eastlinksc.com.au
- 03 9887 0000
- www.eastlinksc.com.au

BRISBANE 2016

Preparations continue for the 85th Annual Scientific Congress

RICHARD LEWANDOWSKI
ASC 2016 Convenor
OWEN UNG
ASC 2016 Convenor

Dear Fellows and Colleagues,

It is not long to go now and all is ready for the 85th Annual Scientific Congress to be held at the Brisbane Convention and Exhibition Centre at Southbank in Brisbane.

After a successful program last year in Perth with the Royal College of Surgeons of Edinburgh, we are continuing the theme of inviting our sister Royal Colleges and the Royal College of Surgeons of England will join us in 2016.

You will have received your Provisional Program booklet outlining the excellent program arranged by your hardworking Scientific Committee.

Accommodation in Brisbane will be in demand at this time of year, so visit the Congress website http://asc.surgeons.org early to register and reserve your room.

The Convocation and Welcome Reception is on Monday 2 May 2016 at 5.00pm at the Brisbane Convention and Exhibition Centre.

The theme of the Congress is "Surgery, Technology and Communication". The Syme oration and plenary sessions carry the theme and you will see this throughout the program. Our RCS England colleagues will present one of the plenaries.

The four plenary sessions will highlight the themes:-

New Technology- Where Are We And How Far Can We Go

Data Management – How Does It Affect Patient Care

Innovation – Learning From The Next Generation

Technology And The Trainee

An additional feature this year is the President's Plenary that will address current topics affecting all surgeons. This will be followed by the President's Lecture to be delivered by Lt. General David Morrison, recently retired Chief Of Staff, Australian Defence Force. The title of his lecture will be "Driving cultural change - from the head and the heart".

There is an extensive scientific program arranged for the ASC in Brisbane that you can read in the Provisional Program or online http://asc.surgeons.org and a few are highlighted below.

Craniomaxillofacial Surgery

Susan O'Mahony and Raymond Goh have arranged an excellent program covering issues that should be of interest to surgeons who work on overseas aid programs..

They are running a workshop on Cleft Lip and Palate for overseas missions on the Monday and running a specialty specific program on Tuesday on the outcomes of overseas mission surgery in conjunction with the Plastic Surgery Program.

The lecture "Eustachian tube function following cleft Palate Repair" by Dr Sharma from India and 'Dynamic Pre-Surgical Nasal Moulding Of Unilateral Clefts Using A Spring Activated Device – Comparison With Naso-alveolar Moulding' by Dr Richard Hopper will be of interest to all involved in this area of surgery.

Endocrine Surgery

Jenny Gough has been instrumental in arranging a comprehensive program covering interesting aspects of thyroid cancer and parathyroid disease.

Dr Michael Tuttle from the USA and Professor Peter Goretzki from Germany will add an international perspective to the program from the vast international experience. The keynote lecture by Professor Stan Sidhu 'Thyroid Cancer Surgery In Australia – Where Are We Now?' will present the local experience

The American College of Surgeons Lecture 'Vocal Cord Ultrasonography - Is It Ready For Prime Time?' by Dr. Sareh Paragni will be of interest to all in the area of head and neck surgery.

General Surgery

Andrew Hughes has put together a comprehensive program that with two eminent overseas speakers Dr Todd Heniford from USA and Professor John MacFie from Scarborough in the UK.

Both visitors have an extensive experience in gastrointestinal surgery and hernia repair and will present up to date coverage on topics of interest to all those involved in these fields.

Todd Heniford will present a timely keynote lecture on "Early assessment of Robotics in a major US hospital system and John MacFie a keynote lecture on "The Importance of Gut Function"

Hand Surgery

Steven Frederiksen has arranged a comprehensive program with two distinguished visitors, Dr Donald LaLonde from Canada and Mr Mark Ross from Brisbane. The program will focus on aspects of hand surgery including a small bone fixation masterclass on the Wednesday. The issue of performing hand surgery under local anaesthesia with adrenalin will be addressed by Donald LaLonde.

We sincerely trust you will join us in Brisbane for what is shaping up to be our most memorable ASC.

It is not long now until the Congress so register now and book your place at the ASC and accommodation which is already heavily booked.

Register now through the Congress website asc.surgeons.org

Younger Fellows

Presenting at the 2016 Annual Scientific Congress

CHRISTINE LAI
Chair, Younger Fellows Committee

The Younger Fellows have traditionally held the Younger Fellows Forum a few days prior to the ASC, which will be held at O'Reilly's in Lamington National Park, Qld. This year marks the third year of the Younger Fellows having an individual presence at the ASC. Professor Julie Ann Sosa, Duke University, has accepted to be our Section Visitor, sponsored by the South Australian Regional Committee. The format of the annual Mentor-Matching will be different this year and held on Tuesday morning as a breakfast session, sponsored by Cook Medical.

We have collaborated with the Surgical Education group, RACSTA and Senior Surgeons and have included the sessions on "Managing Professionalism, Ethics and Honesty" and "When is it Performance Management and When is it Bullying?" included in our programme.

Many high profile speakers have generously accepted invitations to speak at our sessions on Tuesday afternoon, including current and past RACS Councillors Professors Julian Smith, Guy Maddern, Philip Carson and Marianne Vonau, the RCS Dean of Surgical Education, Professor Jonathan Beard and Mr Mark Moore AM.

The first session focuses on early to mid career transitions - "Out of the Starting Blocks - Achieving Your Best for You and Your Practice". The RACS Navigating the Stages of a Surgeon's Career programme will be launched by Prof Vonau during that session.

"What Younger Fellows can do to contribute on the Global Stage" focuses on how and why Younger Fellow should consider becoming involved with surgical societies beyond the borders of Australia and New Zealand and Global Health Programmes.

The annual dinner will be held after the academic programme finishes at Customs House, in The Longroom Tuesday night. It will be, once again, held with the RACS Trainees Association and looks to be a great night!

I would like to take the opportunity to invite not only Younger Fellows but anyone with an interest in the sessions to attend, and also to thank our other sponsors, Online aMedical and MDA National.

National Close the Gap Day

17th March, 2016

DAVID MURRAY
Chair, Indigenous Health Committee

Equal access to healthcare is a basic human right, and in Australia, we expect it. So what if we told you that you can expect to live almost 20 years less than your next-door neighbour? You wouldn't accept it. No-one should. Unfortunately, Aboriginal and Torres Strait Islander peoples can expect to live up to 10–17 years less than non-Indigenous Australians.

In 2008, the Council of Australian Governments (COAG) agreed to six ambitious targets to address the disadvantage faced by Indigenous Australians in life expectancy, child mortality, education and employment.

They were to:

- close the gap in life expectancy within a generation (by 2031);
- halve the gap in mortality rates for Indigenous children under five by 2018;
- ensure access to early childhood education for all Indigenous four year olds in remote communities by 2013;
- halve the gap in reading, writing and numeracy achievements for children by 2018;
- halve the gap for Indigenous students in Year 12 (or equivalent) attainment rates by 2020; and
- halve the gap in employment outcomes between Indigenous and other Australians by 2018.

Closing the Gap is a long-term, ambitious framework that builds on the foundation of respect and unity provided by the 2008 National Apology to Aboriginal and Torres Strait Islander Peoples. It acknowledges that improving opportunities for Indigenous Australians requires intensive and sustained effort from all levels of government, as well as the private and not-for-profit sectors, communities and individuals.

Working in partnership with Aboriginal and Torres Strait Islander people is one of the critical success factors. RACS Aboriginal and Torres Strait Islander Health Action Plan 2014-6 is committed to closing the gap by increasing the cultural competency of the surgical workforce and increasing the number of Aboriginal and Torres Strait Islander Fellows http://www.surgeons.org/media/21763722/ATSI-Health-Action-Plan.pdf

You can sign the Close the Gap pledge and help to show your commitment at:

https://www.oxfam.org.au/what-we-do/indigenous-australia/close-the-gap/

RACS website and RACS Portfolio

Both mobile and tablet friendly

RICHARD PERRY
Chair, Fellowship Services

This March the RACS website gets a face-lift. The new look, with its adaptive screens, makes it easier to use on smart phones and tablets. The content of the website has not changed and pages have not moved - it just looks a little different.

The main difference will be evident when you log in. Instead of 'My Page', you will go directly to your RACS Portfolio.

All the commonly used areas you previously accessed from 'My Page' are easily accessible from your Portfolio Dashboard including eCommittees, Library, CPD and MALT. If you choose to go back to the RACS website while logged in, you will have access to the same commonly used areas from the 'My Menu' in the top right corner of the page.

The RACS Portfolio was launched in June 2015 as part of a comprehensive digital strategy to deliver better access to:

- lifelong learning,
- professional development, and
- assessment and examination systems.

For those who have used the Portfolio before, you will notice two new features; News and Notifications.

RACS News is now a feature of the Portfolio Dashboard. Read the headlines and full stories without leaving your Portfolio.

Notifications are initially intended to be useful for Fellows in their management of CPD. Reminders will be sent to update and finalise CPD and alerts will be sent to those under verification. Over time, notifications will expand to include reminders about subscription and instalment payments as well as reminders about upcoming events you have registered for.

The updated RACS website with the RACS Portfolio is another significant step for RACS in providing you with a modern and easily accessible online experience across desktop, tablet and smart phone.

Visit: http://www.surgeons.org/ and

https://portfolio.surgeons.org/

SURVEY SUSPICION

So many pointless questions, so little time

BY PROFESSOR GRUMPY

There is one thing that really annoys me and it is surveys. It seems that in the last three years they have reproduced like rabbits. Car service depots, on-line banking, government offices, telephone companies – they all have them. One thing stands out to the average curmudgeon and, I hope, to the average person – how useless they are.

Firstly they are voluntary and so only the obsessional, nit-picking, opinionated persons are going to respond. In short only curmudgeons will respond. Not a wide sample !

Secondly often there is no suitable response in the offered answers. "Why have you used our services?

a) referred by a friend

b) used our services previously

c) saw the services on the internet

d) other. "Other" may seem to cover all bases but what about the response "I had no option as you have a monopoly".

Thirdly, after you have spoken to a nice young man or woman about a service and they (very politely and with good inter-personal skills) have provided no real information of use as their company cannot answer your needs it seems to be rather harsh to respond to the post service survey with "Useless". That seems to be critical of the person rather than the product.

Recently on a Saturday morning when I was in a hurry to get out a man from a very well-known opinion pollster called in to see me. I had seen him in the street in his car and he seemed uncertain as he stopped in front of our place then a neighbour's and then back to us. Were we really chosen at random – I think not as it was obvious our neighbour was out and equally as obvious that we were not. Were we a random sample?

He wanted "a few minutes" to do a survey. Would I help? OK but what was there in it for me? Surely a weekend in the Hilton or bottle of wine or at least a beer. No – nothing, only the satisfaction that I would "influence marketing intentions". Now that was the wrong word to use with a curmudgeon as we hate marketers. My second question was how long will this take. About an hour and a half!!

So when you see an advertisement that 95 per cent of people prefer XYZ do not be deceived as it is not true, as one very annoyed curmudgeon showed him the door and produced a skewed sample.

RACS VISITOR PROGRAM

Supporting Specialty Societies Annual Scientific Meetings

RICHARD PERRY
Chair, Fellowship Services

The RACS Visitor Program was established by Council in 2014 to enable Specialty Societies to fund travel and accommodation for renowned international or interstate speakers to enable them to present at their own Annual Scientific Meetings (ASM). Having keynote speakers of international standing is a feature drawcard of any ASM. Funds of up to $15,000 per international visitor are available through the Visitor Program.

In 2016 there will be 22 speakers in Australia and New Zealand funded by the RACS Visitor Program.

Conference	Speaker(s)	Area of Expertise
Australian Hand Surgery Society (AHSS) ASM Sydney 30 March – 2 April	Professor Moroe Beppu MD, Chairman & Professor Department of Orthopaedic Surgery St.Marianna University, School of Medicine	Gene expression in chondrocytes and muscle pathologies, hand & wrist trauma.
	Dr William H Seitz. Current President of the American Society of Surgery of the Hand.	Gene expression in chondrocytes and muscle pathologies, hand & wrist trauma.
Post-RACS ASC speaking tour	Professor Donald Lalonde, Chief of Plastic and Reconstructive Surgery, Dalhousie University	Wide awake reconstructive surgery, minimal pain injection of local anaesthesia to avoid the need for operative sedation, pain guided hand therapy, evidence based operative sterility
Australian & New Zealand Society of Cardiac & Thoracic Surgeons (ANZSCTS) ASM Cairns, 6-9 November	Professor David Paul Taggart. University of Oxford, Department of Cardiovascular Surgery, Department Cardiac Surgery, John Radcliffe Hospital	All aspects of cardiovascular surgery, coronary artery bypass grafting (CABG), off-pump CABG and arterial revascularisation.
Australian Orthopaedic Association (AOA) ASM Cairns, 9-13 October	Prof Jan Verhaar, Professor of Orthopaedic Surgery. Incoming President, The European Federation of Orthopaedic Trauma (EFORT). Chair Department of Orthopaedics Erasmus MC. Erasmus University Medical Center.	Complex knee replacement and revision surgery of total knee including infections.
	Dr Kevin Black, Immediate Past President, American Orthopaedic Association, and Professor at Penn State in Hershey, USA.	Knee ligament and patellofemoral instability
Australian Society of Otolaryngology Head & Neck Surgery (ASOHNS) ASM Melbourne, 6-8 March	Professor Ian Witterick MD, MSc, FRCSC Professor and Chair of the Department of Otolaryngology, University of Toronto, and works at Mt Sinai Hospital.	Rhinology, Advanced Sinus and Skull Base Surgery; Head and Neck Cancer Surgery
	Mr Haytham Kubba MBBS, FRCSEd, FRCS. Consultant ENT surgeon, Royal Hospital for Sick Children, Yorkhill, Glasgow.	Quality of life outcomes in ENT surgery in children, airway reconstruction surgery, ENT problems in Down syndrome, management of drooling, tonsils and adenoids and cosmetic pinnaplasty

Conference	Speaker(s)	Area of Expertise
Australian Society of Plastic Surgeons (ASPS) 17th International Course on Perforator Flaps Sydney, 10-13 November	Dr Philip Blondeel, Head-Physician of the Plastic and Reconstructive Surgery Unit at Ghent University Hospital in Belgium	Cosmetic and reconstructive breast surgery
General Surgeons Australia GSA ASM - Tales of the Unexpected – Dealing with Unexpected Surgical Findings Melbourne, 29 September – 1 October	Dr Brendon Moran, MCh, FRCS, FRCSI Consultant General and Colorectal Surgeon, North Hampshire Hospital, Basingstoke	Colorectal surgery, colorectal cancer, appendiceal tumours, Pseudomyxoma Peritonei
	Mr Nick Maynard, BA (Hons) Oxon, MBBS, MS, FRCS Consultant Upper Gastrointestinal Surgeon - John Radcliffe Hospital, Oxford, UK	Colorectal surgery. hernia, pilonidal disease, piles, colonoscopy, colon cancer, ulcerative colitis and Crohn's
Neurosurgical Society of Australasia (NSA) ASM Sydney, 21 August – 2 September	Dr William E. Bingaman, MD, Vice-Chairman of the Neurological Institute and Head of the Section of Epilepsy Surgery at Cleveland Clinic in Cleveland	Complex spinal disorders, epilepsy surgery, general neurosurgery, paediatric epilepsy and epilepsy surgery, spine surgery, vagus nerve stimulation
	Dr Nicholas Theodore, MD Director of the NYU Hospital for Joint Diseases Spine Service and Director of the NYU Hospital for Joint Diseases Spine Fellowship	Brain and spinal cord injury, minimally invasive surgery, and robotics
	Dr Jeffrey A. Goldstein Director of the NYU Hospital for Joint Diseases Spine Service and Director of the NYU Hospital for Joint Diseases Spine Fellowship	Spine surgical treatment including degenerative diseases, deformity, trauma, tumours, and infections, disc replacement
New Zealand Association of General Surgeons (NZAGS) ASM Auckland, 12-13 March	Professor Sue Clark MA MB BChir MD FRCS(Gen Surg) Consultant Colorectal Surgeon, Adjunct Professor, Department of Surgery and Cancer, Imperial College, London Department: Department of Surgery	Inherited colorectal cancer syndromes, chronic anastomotic leak, rare colorectal tumours
	Professor Richard Schulick, Upper GI Surgical Oncologist, Professor of Surgery at the University of Colorado.	Clinical Pharmacology, Advanced GI Surgery, Surgical Oncology
New Zealand Association of Plastic Surgeons (NZAPS) ASM Queenstown, 13-17 July	Mr Simon Talbot, MD, Consultant Plastic Surgeon and Director of Upper Extremity Transplantation at Brigham and Women's Hospital, in Boston, USA.	Upper extremity transplantation
New Zealand Orthopaedic Association (NZOA) ASM Cairns, 9-13 October	Dr Dror Paley, M.D., FRCSC, Director of the Paley Advanced Limb Lengthening Institute at St. Mary's Hospital in West Palm Beach, Florida	Paediatric & adult limb reconstruction, limb-length discrepancy, limb deformity, skeletal dysplasia's and dwarfism's, non-unions, joint preservation
New Zealand Society of Otolaryngology, Head & Neck Surgery (NZSOHNS) ASM Christchurch, 16-20 October	Professor Janet Ann Wilson, Professor of Otolaryngology Head & Neck Surgery, Newcastle University and Honorary Consultant at Newcastle Upon Tyne Hospitals, UK	Tumour suppression genes in head and neck cancer, evidence based otolarynological surgery, swallowing and speech disorders
Paediatric Surgery -Paediatric Colorectal Surgery Symposium Melbourne, 17-21 October	Professor Marc Levitt, MD Director, Center for Colorectal and Pelvic Reconstruction, Columbus, OH.	Management of complex congenital anorectal anomalies.
Provincial Surgeons of Australia (PSA) ASC Albany, 27-30 July	Dr Lauren Smithson, MD, MPhil General Surgeon, Charles S. Curtis Memorial Hospital, St Anthony, Canada Founder and Co-President of the Society for Young Rural Surgeons	General surgery with emphasis on endocrine, advanced laparoscopic colorectal surgery and endoscopy
Urological Society of Australia & New Zealand (USANZ) ASM Gold Coast, 16-19 April	Prof Margit Fisch Director & Chair, Dept of Urology & Paediatric Urology, University Medical Centre Hamburg-Eppendorf, Germany	Reconstructive and Paediatric Urology

ADVANCES IN PAEDIATRIC COLORECTAL SURGERY

Mr Sebastian King

This year's recipient of the College's Foundation for Surgery Senior Lecturer Fellowship, Mr Sebastian King, plans to use the attached funds to extend his research interests in Paediatric Colorectal Surgery, develop international research partnerships and perform research using new technologies in Australia.

Mr King, who has a PhD in Paediatric Colorectal Surgery, is a Paediatric Surgeon at The Royal Children's Hospital (RCH) in Melbourne, a Senior Clinical Lecturer at the University of Melbourne and conducts Paediatric Colorectal Research through the RCH and the Murdoch Childrens Research Institute.

The Senior Lecturer Fellowship was designed by the Section of Academic Surgery to provide salary support for a senior lecturer and surgeon early in their career to help them establish a pathway in academic surgery.

Mr King has particular research interests in colorectal anatomy, pathology and motility, as well as the use of high resolution Manometry in the assessment and management of children with previously repaired Oesophageal Atresia (OA).

In 2014, Mr King used the funds attached to the Hugh Johnston Travel Fellowship to take up a Fellowship at the Hospital for Sick Children (SickKids) in Toronto, Canada.

One of the largest paediatric hospitals in North America, SickKids is also one of the few hospitals in the world to have a Surgical Fellow dedicated to the Neonatal Intensive Care Unit, a position Mr King filled from July to December.

He also spent time as a Visiting Fellow at the Nationwide Children's Hospital in Columbus, Ohio, where he worked under the supervision of Professor Marc Levitt, a world leader in anorectal malformations and Hirschsprung disease.

This year, Professor Levitt will visit Melbourne at Mr King's invitation to conduct paediatric colorectal courses at the RCH for trainees and surgeons from across Australasia.

Currently, Mr King is concentrating on two major research projects: the investigation and management of colonic dysmotility in children with chronic constipation, and the investigation and management of oesophageal dysmotility in patients with previously repaired OA.

Working in collaboration with Associate Professor Phil Dinning from Flinders University, Adelaide, Mr King will use colonic Manometry to understand the pathology of slow transit constipation (STC).

"Chronic constipation may be a lifelong problem, and it currently affects three per cent of children and accounts for up to five per cent of visits to paediatricians and 25 per cent of referrals to paediatric gastroenterologists," Mr King said.

"As a Paediatric Surgeon, a large portion of my clinical time is dedicated to children affected by STC and OA patients and every week I see around five new children suffering from chronic constipation who have gone through all other avenues of treatment before they ended up in hospital.

"Yet, STC is a relatively recent discovery in the paediatric population and we are now trying to understand the pathology behind the condition.

"We know that STC develops after birth and we know there are abnormalities in the nerve cells and neurotransmitters in kids with STC but we are now trying to understand why they occur and how they may be treated."

Mr King said that his research team, which currently comprises five students from the University of Melbourne, had recently received seed funding through the RACS Brian

Smith Memorial Colorectal Award to pay for high-resolution Manometry equipment and fibre-optic catheters.

Mr King said the equipment would be used to investigate the pathology and mechanics driving STC by comparing the colonic function of STC patients with that of children born with birth defects such as Hirschsprung Disease and anorectal malformations.

"This research will help us understand the physiology behind the abnormalities that drive STC, which in turn could help us develop new treatments and interventions," Mr King said.

"I am also in the process of introducing new technology and advanced automated quantative analysis software, which allows us to focus on more accurately identifying segmental colonic dysmotility.

"This may lead to more focused surgical resections rather than the practice of colectomy, which is sometimes required in children with refractory disease.

"Approximately 30 per cent of children with chronic constipation are affected by the condition throughout their lives, which imposes a massive financial burden upon health care systems. We believe this work, therefore, has the potential to greatly benefit affected children and the health budget. "

Mr King is also leading a research project investigating oesophageal dysmotility in children with OA in collaboration with world leaders in the field, including Associate Professor Taher Omari from Flinders University, Adelaide.

He said the RCH was a world leader in the assessment and management of OA with the Oesophageal Atresia Database, established by Mr Nate Myers in 1955, the most comprehensive of its type in the world.

He said the research group would use the data to investigate oesophageal dysmotility characteristics of children born with OA.

"The majority of these children are affected by oesophageal dysmotility, which may present with swallowing difficulties, dysphagia and/or gastro-oesophageal reflux," Mr King said.

"Until now it has been assumed that the dysmotility is largely a congenital phenomenon yet we believe it may be that the operative ligation of the tracheo-oesophageal fistula and the subsequent oesophageal anastomosis damages the vagal innervations.

"By using oesophageal Manometry and fibre-optic catheters we believe we will be able to obtain evidence of segmental or global dysmotility, which could lead to more appropriate post-operative management of the complications of OA repair."

Mr King's research group has already conducted motility studies in 20 OA children aged less than three years, an investigation that will be expanded this year.

He is also conducting other clinical trials at the RCH, including investigating the long-term outcomes for children with Hirschsprung disease, the role for transcutaneous electrical therapy in children with spina bifida and the non-operative management of post-splenic trauma.

He said that during 2016 he hoped to attract surgeons and trainees wishing to complete a higher degree into his research team.

"I feel extremely fortunate to have been selected for this prestigious Fellowship, particularly given that it represents a belief by senior Fellows that my work is of sufficient quality and importance"

Mr King thanked the College for the support provided through the Foundation for Surgery Senior Lecturer Fellowship.

"I feel extremely fortunate to have been selected for this prestigious Fellowship, particularly given that it represents a belief by senior Fellows that my work is of sufficient quality and importance," he said.

"I have been very lucky to have Professor John Hutson as a mentor. He encouraged me to become an academic surgeon and I am glad I took his advice.

"Academic surgery creates a wonderful professional balance because you are able to treat and heal patients through clinical practice while leading change and making discoveries and introducing advances through scientific research."

JDOCS LAUNCH

Relevant and practical support for junior doctors aspiring to a career in Surgery

STEPHEN TOBIN
Dean of Education

The College is pleased to announce the launch of JDocs, relevant and practical support for junior doctors aspiring to a career in surgery. Registered doctors in their prevocational career phase can now subscribe to an ePortfolio and educational resources that have been designed to support the JDocs Framework and promote flexible and self-directed learning. The ePortfolio also provides opportunities for junior doctors to record and log their surgical experiences and capture evidence of personal achievements and work-based assessment.

The JDocs Framework is based on the College's nine core competencies, with each competency considered to be of equal importance, and described in stages appropriate for each of the first three postgraduate clinical years, as well as those beyond. In order to link the many tasks, skills and behaviours of the Framework to everyday work, key clinical tasks have been developed that are meaningful for the junior doctor. These tasks can be used to demonstrate achievement of the competencies and standards outlined in the Framework. The key clinical tasks thus map the JDocs Framework to the clinical workplace. They also make it possible for the junior doctor to show they are competent at the tasks required for commencing specialty training.

The College sees this as an important initiative which should improve work-based assessment for the junior doctors. Some of these junior doctors will become the applicants for Surgical Education and Training (SET).

Subscribing to JDocs

Doctors subscribe to JDocs via the JDocs website http://jdocs.surgeons.org, also accessible from the RACS homepage under Surgery as a Career/JDocs.

The website provides information and guidance about how the JDocs Framework can support:

- a prevocational doctor;
- a director of clinical training, supervisor and/or a medical education officer;
- an education provider.

Provides open access to:

- online and downloadable versions of the JDocs Framework and key clinical tasks;
- information and guidance for the GSSE;
- courses and events accredited by the College for junior doctors;
- links to College surgical skills videos produced by the ASSET committee* and practise tasks;
- links to other useful external resources;
- JDocs subscription form.

The JDocs ePortfolio

While much of the website is open access, subscription to JDocs provides increased resources especially the ePortfolio, which will enable doctors to:

- manage and update their personal profile;
- self-assess current skills and knowledge against the Framework and check progress against each of the surgical nine core competencies;
- access JDocs eLearning and the Generic Surgical Science Examination resources;
- access online library resources;
- access the MALT online surgical skills logbook tool;
- upload evidence of clinical experience, achievements and assessments (e.g. certificates, end-of-term report, Mini-CEX, DOPS, key clinical tasks);
- upload any additional documentation;
- extract a report of work-based assessment, experiences and achievements that can support application to advanced specialty training.

New Zealand Interns

In New Zealand all interns are mandated to to participate in the New Zealand ePortfolio (ePort) during PGY 1–2. Those interested in a surgical career can access the JDocs ePortfolio as an additional resource to support their personal and professional development. Discussions have been held with MCNZ about importation of information between the ePortfolios, if desired.

How can Fellows support JDocs?

This is a significant development for College, one which we hope you will both support and foster. JDocs provides junior doctors with a better understanding of suitable development needed before applying to a specialty training program; JDocs provides guidance for the self-directed, motivated junior doctor. As consultant surgeons in your work environment, and in your roles as clinical teachers, you are encouraged to visit the website so that you understand the direction your College is taking to support junior doctors as they plan and work towards a career in surgery.

Although JDocs does not guarantee selection into any procedural specialty training programs, engagement with the Framework and its supporting resources will describe the skills and performance standards expected prior to applying to a specialty training program.

Please contact Stephen Tobin, Dean of Education:

stephen.tobin@surgeons.org

or Kathleen Hickey, Director of Education Development & Assessment:

kathleen.hickey@surgeons.org or 03 92491291

with any comments or questions.

**A surgical skills kit will shortly be available for purchase from the JDocs website for doctors to practice those skills demonstrated in the surgical skills videos*

ON THE SOMME

Successful theatres of the First World War

GEOFF DOWN
Curator, College Collection

The Somme proved to be one of the bloodiest and most costly, but also the most successful, theatres of the War for ANZAC troops. In the many battles which comprised the Somme campaigns of 1916 and 1918, failure and success ranged from Fromelles, in which Australian forces suffered their most disastrous casualties, to Villers-Bretonneux, where the Australians finally brought the German army to a halt. Australian and New Zealand troops took part in the battles of Pozières, Mouquet Farm, Fromelles, Flers/Courcelette, Amiens/Villers-Bretonneux and Mont St.-Quentin.

The Somme was the first great battle of mass-industrial warfare, and the number of casualties was unlike anything seen before. On the first day of the offensive, 1 July 1916, British forces suffered 57,470 casualties, 19,240 of which were fatalities. At the battle of Fromelles, 19-20 July 1916, the Australian 5th Division suffered 5,533 killed and wounded. Charles Bean estimated that at the battle of Pozières, 23 July to 3 September 1916, the Australian 1st Division suffered 7,700 casualties, the 2nd Division 8,100, and the 4th Division 7,100 men. Three Australians won the Victoria Cross in this action. By the time the campaign ended on 18 November 1916, some 1.5 million men on all sides were dead. The Australians had suffered over 23,000, the New Zealanders about 7,400, casualties.

To deal with the enormous number of wounded, casualty clearing stations were set up along the length of the battlefield. These were mobile and were sent to wherever there was need, at Villers-Bretonneux, Amiens, Albert and Doingt near Péronne. At Namps near Amiens there were no fewer than seven stations. Some were set up in the middle of nowhere, in which case they were given appropriate names such as Mendinghem and Bandagehem. 3 ACCS was set up at Gézaincourt near Doullens. From the CCS patients were evacuated to base hospitals, 1 AGH at Rouen, 2 AGH at Wimereux and 3 AGH at Abbeville. Among the many ANZAC surgeons serving in this region were Jack Beard, John Corbin and Ernest Culpin.

John CORBIN

Lt-Col. (1878 - 1930)
LRCP MRCS England (1902), FRACS 1927

EARLY LIFE

John Corbin was born in Adelaide and educated at St Peter's College. He studied medicine at St Bartholomew's Hospital London but returned to medical practice in Adelaide after graduation. He enlisted in the AAMC in 1905 as a Captain, being posted RMO 10 Bn until 1908.

GALLIPOLI

In 1914 he was initially posted 1 ASH but transferred to 1 ACCS in March 1915 and landed at ANZAC on 25th April. His unit was on the beach at the southern end.

It was not disorder really; everyone was doing his job. But it was so cramped… During the first four days, 3,300 wounded passed through our hands. We gave up recording them, as our only book was filled up on the first day and simply counted them… During this time all urgent operations were done including necessary amputations, tying of arteries, several belly cases, depressed compound fractures of the skull, bladder cases and big, compound fractures of the thigh[1].

He was mentioned in despatches for his work with casualties,

[1] AWM PR00176 Diary of Lt-Colonel John Corbin

including some who had been wounded for a second time while lying on the beach. He was strong-willed and when later transferred to the Ionian, a transport that was in a filthy condition, his strength of character ensured these defects were corrected in a very short time. Corbin returned to ANZAC in May 1915 and was promoted Major. In August he was appointed medical embarkation officer at ANZAC in anticipation of the casualties to be suffered during the August offensive. However, he was evacuated with dysentery to Lemnos, then to Egypt and ultimately, to Australia.

AFTER GALLIPOLI

In February 1916, he was promoted Lt-Col. commanding 3 ACCS. The unit was sent to France in September, to Gézaincourt receiving casualties from the Somme battlefields. In 1917, it moved to Edgehill and then to Grévillers-Bapaume and Poperinge, in preparation for the Ypres offensive. Corbin received his second MID here.

John Corbin

In 1917, he returned to Australia and from October, was visiting surgeon to 15 AGH and then 7 AGH.

PROFESSIONAL LIFE AFTER WW1

He was appointed Honorary Assistant Surgeon, then Honorary Surgeon (1935) at the Adelaide Hospital, and surgeon to RGH Daw Park. He was President of the SA Branch of the BMA in 1928. A man of fine physique and handsome bearing, he had great personal charm but also had an impulsive and explosive temper, though he never bore a grudge.

Ernest CULPIN

Colonel (1881-1963)

MB Sydney 1905, MCh 1909, FRACS 1932

EARLY LIFE

Ernest Culpin was born in London, the son of Dr Millice Culpin. The family immigrated to Melbourne in 1891 and then to the suburb of Taringa in Brisbane. Educated at the Brisbane Grammar School and the University of Sydney, he obtained posts at Goulburn, Gunnedah and Burketown, before joining the staff of the Lady Bowen Hospital in Brisbane.

GALLIPOLI

Culpin enlisted in May 1915 and went to Gallipoli with 7 Fd Amb on the 15th September when the Dardanelles campaign had stagnated, and disease and the increasingly inclement weather were beginning to take their toll on the troops.

AFTER GALLIPOLI

Culpin's unit moved to France in March 1916, acting as a Corps Rest Station at Château Vadencourt, during the battles of Pozières and Mouquet Farm. In one month the unit treated over 7000 casualties, many with 'shell shock'. Later in the year, he went to 28 Bn as RMO and shortly after was promoted to Major. He distinguished himself during the advance to the Hindenburg Line in May 1917 and was recommended for the Belgian Order of Leopold, but was not awarded. The next appointment was to 2 AGH as a surgeon. After the Armistice, Culpin was posted to 5 Fd Amb as CO and promoted to Lt-Col.

PROFESSIONAL LIFE AFTER WW1

He was given leave in 1919 to study at the London Ear Nose and Throat Hospital, returning to Australia at the end of the year. He became an ENT surgeon at the Mater Misericordiæ Hospital in Brisbane. Culpin held several AMF command positions between the wars. During WW2 he served briefly as CO of 119 AGH, before being medically discharged in May 1942.

Jack Roland Stanley Grose BEARD

Major, MC (1890–1980)

MBBS Adelaide 1914, FRACS 1931, FRCSEd 1932, FRCOG 1934

EARLY LIFE

Always known as Jack, Beard was born in Norwood SA. He was educated privately and then at the University of Adelaide, graduating MBBS in 1914.

GALLIPOLI

On completing his residency at the Adelaide Hospital, he enlisted in the

Jack Beard

AAMC and was commissioned in July 1915. He sailed for the Middle East and on arrival was posted as RMO of the Otago Battalion, New Zealand Army at Gallipoli. In September 1915 he contracted acute cholecystitis and was evacuated to Lemnos and then to 3 LGH where he underwent cholecystectomy.

AFTER GALLIPOLI

He was attached to 1 AAH, Harefield until March 1916 when he was posted to the 15 Fd Amb in France. During the Somme battles of 1916 he was detached as MO 25th Howitzer Brigade and to the 50 Bn. In January 1917 he was transferred to 14 Fd Amb with short detachments to Infantry Battalions. In May 1917 as RMO 53 Bn at Bullecourt, he was awarded the Military Cross for heroism in rescuing wounded stretcher bearers in the middle of an artillery barrage after his RAP had been destroyed. He was promoted to Major in August 1917 and in March 1918, was posted O/C 5 Sanitary Section and then as DADMS 5 Div. He returned to Australia in November 1919 but after discharge returned to study in the UK for five years. He also married his French sweetheart who had helped him with wound dressings in an underground dressing station in near Villers-Bretonneux.

PROFESSIONAL LIFE AFTER WW1

He was appointed Honorary Gynæcologist at the Royal Adelaide Hospital in 1948, and Honorary Obstetrician at the Queen Victoria Hospital.

UPCOMING COURSE

Developing a career and skills in academic surgery

LAURA WANG
Trainee Representative,
RACS section of Academic Surgeons

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

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

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

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

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

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

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

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

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

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

DCAS course Co- Conveners

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

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

For further information please email dcas@surgeons.org

Nobel Laureate Prof. Barry Marshall with Co-convener Dr. Richard Hanney at the Perth 2015 DCAS course

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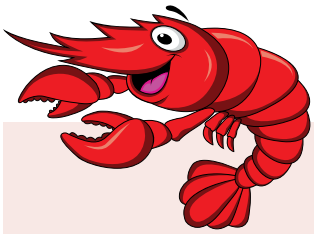
THROW A SHRIMP ON THE BBQ

Passing the Gillick Test

BY **THE BARONESS**

Little did Paul Hogan know that he was creating a controversy back in 1984 with that Australian Tourism Commission advertisement. That wasn't a shrimp – it was a prawn! And then the controversy grew. Arguments about crustaceans and their body shape are something that make my Summer BBQs a really enjoyable pastime. My long term university friends from a variety of backgrounds gather, we open the appropriate beverage and argue the time away. I embraced lots of friends at Uni so it is an eclectic group – engineers, IT developers, medicos and some who are now surgeons and even someone who drifted through a number of courses and is now a minister of religion. So 'time for a BBQ' is always interesting.



But what of this definitional quandary?

But what of this definitional quandary? It focuses on the age of consent. When is a minor, truly a minor? As most medical practitioners are aware, a person who is under the age of 18 is considered a minor. Patients over the age of 18 can make their own decisions about treatment and decide that it is confidential to them. However, we also have the category of the 'mature minor'. In a clinical setting, where a child is under 18 and where the decision can be made that the child has the capacity to understand fully what is going on, then they can also consent to treatment and are able to access independent and confidential medical care.

This very issue was considered in the case of Gillick v West Norfolk and Wisbech Area Health Service (1985), where Lord Scarman defined the test of 'Gillick competency'. He specifically stated that 'As a matter of Law the parental right to determine whether or not their minor child below the age of sixteen will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to understand fully what is proposed'.

So there you have it – passing the Gillick competency test – is something that has occupied many a barbecue afternoon. Strange group we are. What does the word 'terminate' really mean? How do you judge it? The Medical Practitioner's Board provides useful detail in their approach to Consent for Treatment. In considering the issue of a mature minor, they highlight factors of age, general maturity of speech and hearing, level of independence from parental care, level of schooling, the doctor's knowledge of the patient, reason for seeing the doctor, ability to explain the clinical problem and the ability to understand the gravity and complexity proposed.

This may not only be particularly relevant for general practitioners when seeing teenagers for contraceptive advice, but it also concerns surgeons who are operating on teenagers. In emergency and life-threatening situations, treatments can generally proceed without specific consent. However, it becomes complicated in more elective situations. Is the person of the age of consent? Are they a minor or a 'mature minor'? Then you can throw in the added complexity of considering if the accompanying adult is able to give consent. When contemplating the Family Law Act 1975 (Cth), in the absence of a Court order to the contrary, each parent of a child under the age of 18 has parental responsibility for the child whether or not the parents are married, separated or divorced. So if a child is in the care of one parent, the views of the other parent may still need to be considered unless a 'sole parental responsibility' has been obtained by court order.

So as a treating surgeon, although you could assume that the parent bringing the child in for medical treatment has the authority, in the case of parents being separated it is always wise to ask about that authority. Particularly for non-emergency or life-preserving procedures, or if there is any risk and that is implicit in surgical procedures. In the case of any controversy between parents, a court order or parenting order may be required before the surgery can be performed.

So you can see what will be considered again as the prawn goes on at the next BBQ.... Who would pass the Gillick test? Who would not? Telling the difference.....

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

YET ANOTHER CUP OF COFFEE

BY **DR BB G-LOVED**

Another slow and sluggish start to what might prove a wretched day. I had to drag myself out of deep slumber, resist my propensity to sloth, stagger downstairs and jump start my reluctant organism into daily action. And how did I do it? I charged myself with a strong long black, plus an extra shot, and re-hydrated with a glass of cool water. Having savoured the smell and the taste of that coffee, with its 150 mg of caffeine, my pulse is racing, I am almost trembling, but I am now ready for action.

Caffeine, the active ingredient of coffee, is a purine, a methyl-xanthine alkaloid closely related to the adenine and guanine in our DNA. Most adults enjoy or need at least a daily fix to rouse them from drowsiness and encourage their alert performance. Withdrawal symptoms of irritability, headache, slowness and sleepiness are common in those of us that develop dependence. A willingness to queue patiently for the attentions of the Barista in the hospital 'caf', bears evidence to our widespread craving for this legal, unregulated, active substance that is available without prescription.

A cup of coffee contains generally 80-175mg of caffeine, with 50-75mg for one shot of espresso. Caffenism [overdose] requires 1-1.5g per day, with clinical features of nervousness, irritability, restlessness, mood swings, insomnia, headaches and palpitations. Actual toxicity is exhibited in psychomotor agitation, tachycardia, arrhythmias, muscle twitching. A lethal dose requires some 10g or more than 50 cups of coffee.

Caffeine, first identified in the early 1800's, is both water and lipid soluble so readily crosses the blood brain barrier. It blocks the action of the inhibitory neurotransmitter adenosine on all its receptors [A1,A2A&B,A3]. Neurotransmitters [dopamines and acetylcholine] are released. It increases the heart rate, basal metabolic rate, respiratory rate and acts as a diuretic by blocking adenosine in the proximal tubule. It has weak bronchodilator effects lasting up to four hours in asthmatics. Xanthines inhibit phosphodiesterase, raise intracellular cAMP, reduce cytokines, and inflammation.

Tea is an ancient drink with many thousands of years of history, first chronicled in China. [Black tea 75mg, Green tea 30mg per cup]. Cocoa has a small amount of caffeine (10mg) and was used by the Maya in the 7th century BC. Coffee is a relative newcomer as a stimulant with the first documented evidence from the Arabian Peninsula in the 15th Century. Several unsuccessful attempts were made to regulate it by the Ottoman Empire, by Charles II in Britain [1676] and by Frederick II of Prussia [1777]. Today Seventh Day Adventists and Christian Scientists are not supposed to consume caffeine as it is addictive.

Indeed it is its addictive properties that alarms society about its inclusion in soft drinks consumed by children and adolescents[Coca Cola 34mg per 355mL; Pepsi Max 69mg per 355mL; Red Bull 80mg per 250mL].

So is a life of coffee drinking good for my patients? The short answer is yes and throughout life.

Caffeine is widely used in neonatal intensive care units as it reduces the frequency of apnea, intermittent hypoxaemia, and reduces the incidence of pulmonary dysplasia in pre-term low birthweight neonates.

Coffee and caffeine are associated with less risk of cognitive decline, stroke, and Alzheimer's. It may be used to treating Parkinson's Disease as adenosine A2A receptor antagonists potentiate dopamine-mediated neurotransmission.

A large cohort study of post-menopausal women involving over 100,000 years of follow up shows coffee consumption, whether decaffeinated or not, is not associated with hypertension. Another meta-analysis has found no association with atrial fibrillation, indeed, almost the reverse in that moderate coffee drinking may protect.

For those concerned about their liver, coffee consumption is associated with lower GGT and ALT levels. In those with liver disease caffeine slows the progression of fibrosis.

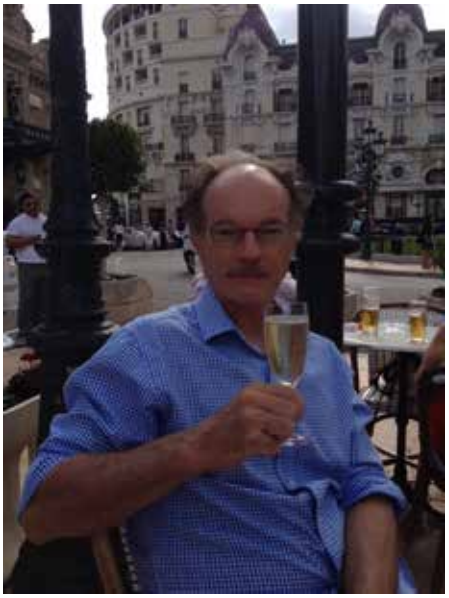
A Cochrane review found 100mg caffeine allows lower doses of ibuprofen to be used for postoperative analgesia.

If you are pregnant or planning to become pregnant perhaps you should minimise consumption of coffee during pregnancy as it is associated with increased fetal loss - at a dose response relationship of 19% per 150mg caffeine or 8% for each increase in two cups per day.

There's a time and a place for everything under the sun. For coffee that's the morning to early afternoon. Thereafter, please value the quality of your sleep and shun till the morrow. Don't drink coffee in the evening. It doesn't give you more energy over time, just more energy and alertness during the hours it exerts its effects. Right now I need those effects. My consultation list is fully booked for the day. If athletes can really jump higher with caffeine maybe I can bounce through my clinic.

Changing lives and surgical culture

The Process Communication Model



STEPHEN WILKINSON
Tasmanian Fellow

The first time I came across the Process Communication Model (PCM) was at an Annual Scientific Meeting in Tasmania. I established that PCM was a model of how our personalities are structured, and this structure leads to how we perceive the world and communicate with others. It made a lot of sense so my wife and I registered for the upcoming three day PCM Seminar 1 at RACS. I figured that if there was anything in it, we both should understand it.

About an hour into the course I was stunned. The model accurately predicted my personality traits, my behaviour, my communication problems, how I came across to others, how I was rubbing people up the wrong way, why I found certain people irritating, and much more. At the end of the course I was given my Personal Personality Inventory, which included strategies for self-management. I now had a set of skills that could dramatically improve my self-management, help me communicate effectively and help others out of distress. I had never heard or read anything like this before.

To learn more about distress patterns we both immediately booked into the PCM Seminar 2. At the end of the course I could clearly see that this was a powerful model. It provided practical tools that were helping me in both my personal and professional life. The effectiveness of the model spurred me to make PCM available to others and I enrolled to become a PCM instructor – a fairly arduous process under strict quality control. Since then I have been teaching PCM for RACS. I personally see this as the best professional (and personal) development I have ever done.

What is PCM?

PCM is a research-based model of personality structure and communication dynamics. It is almost unique in communications courses, because people come out of it with a set of useful, workable and universal tools to better manage themselves and others. It becomes a new 'language'.

PCM came out of research by psychologist Taibi Kahler in the 1970's. A large block of observational data showed that there were six typical distress patterns. In a type of psychological reverse engineering, Kahler discovered that these patterns were linked to six personality types. Further observation and statistical analysis showed that each person had elements of all six personality types, but that one was dominant. This dominant personality type was called the base personality type and was visualised as the ground floor in a building of six floors. The other five personality types were arranged on the five floors above, with the least accessible personality type on the sixth floor.

We spend most time on the ground floor, and communicate in the typical pattern of that type, but we can move up to the other floors at times to communicate with different personality types. Some people are better at this than others, but it can be learned.

Further, each personality type has a specific way to show distress. The triggers and the subsequent distress behaviours are very predictable. By learning to see these triggers and behaviours we can use PCM to enable ourselves and others out of distress and back to effective communication and collaboration.

Apart from trying to get PCM knowledge out to as many surgeons as possible, I also have an interest in showing how PCM can effect cultural change in medicine – a hot topic in RACS at present. When people are trained in and practice PCM, communication dramatically improves, distress in the workplace is significantly reduced, and people start to understand themselves and others better. This obviously in turn leads to institutional cultural change. This is much more effective than simply firing apparently dysfunctional individuals while the underlying culture remains unchanged, awaiting a recurrence of the same disasters.

My whole family has now attended PCM seminars and we utilise the framework to communicate and support each other more effectively. It has had a profound effect on the functionality of both my personal and professional life and I would highly recommend it to others.

Would you like to learn more? There are a few places available on PCM Seminar 1, Fri 22 – Sun 24 April in Sydney or Fri 11 – Sun 13 November in Adelaide. PCM Seminar 2 is scheduled for Fri 29 – Sun 31 July in Melbourne. Places are strictly limited to 16 per course and registration is open online through the RACS website.

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THE FIRST GENERATION

Training Opthalmologists in Timor-Leste

The Post Graduate Diploma of Ophthalmology (PGDO), delivered at the National Eye Centre (NEC) on the grounds of the national hospital in Dili, Timor-Leste, has been training the next generation of Timorese ophthalmologists since 2014.

The PGDO is a primary focus of the East Timor Eye Program (ETEP), which is managed by the Royal Australasian College of Surgeons (RACS). The PGDO is led by expatriate ophthalmologist Dr Manoj Sharma and Timor-Leste's only national ophthalmologist Dr Marcelino Correia, with a visiting teaching faculty of experienced international ophthalmologists. The PGDO has been approved as an official training program at the Universidade Nacional Timor Lorosa'e (UNTL) and is currently awaiting final endorsement from the Vice Chancellor.

It is expected that seven Timorese doctors will complete the PGDO and graduate as medical ophthalmologists by 2018, contributing to the Ministry of Health's (MoH) plan for an increased number of doctors with ophthalmology skills to deliver essential eye health services in the country. In December 2015, the MoH, through the national hospital, took over the management of the NEC, which further demonstrates the importance of training national eye care workers to effectively diagnose, treat and manage eye health conditions.

The PGDO is delivered as an 18 month training program. The PGDO trainees undertake pre-training in English language and basic medicine prior to the formal commencement of the PGDO training. The training program is made up of weekly theoretical lectures as well practical work and problem based learning in the clinic alongside the national and expatriate ophthalmologists, including assisting in surgery. Another requirement for all PGDO trainees is participation in weekly general Grand Rounds at the national hospital, with participation in presentation of topics in eye health according to the schedule.

As part of the PGDO training program, trainees also undertake a two to three month intensive training attachment in Nepal, where they are taught Small Incision Cataract Surgery (SICS) in addition to other ocular surface surgeries and oculoplastic surgeries. SICS is a crucial skill to learn in the PGDO trainees' development, especially in a context such as Timor-Leste where there is still a backlog of cataract cases to be treated.

In a significant milestone for the program, PGDO trainees Dr Bernadete Pereira, Dr Julia Magno and Dr Valerio Andrade sat and passed their final exams in November 2015 and will graduate in 2016. They are now working as senior registrars at the NEC.

Dr Bernadete, Dr Julia and Dr Valerio were the first PGDO trainees

"Dr Valerio Andrade has good surgical skill, clinical ability and OPD management. His behaviour with the patient is polite and friendly. He is very sincere, hardworking and dedicated to his profession.."

to undertake the SICS training attachment at the Mechi Eye Hospital (MEH) in Nepal in 2015. They all felt that the training attachment was a valuable learning experience as part of their ongoing training, where they were able to perform SICS and other minor surgeries as well as observe

operations and techniques that are not performed in Timor-Leste such as retinal detachment surgery, intravitreal avastin injection, intrastomal voriconazole injection for fungal ulcer and penetrating keratoplasty.

MEH was selected for the training attachment as it is renowned for its high volume of cataract cases and calibre of teaching staff and facilities. All three doctors spoke very highly of MEH, explaining that it was inspiring to see a well-functioning, well equipped, high volume hospital. Dr Bernadete said "Nepal is also a developing country, but they have a very good hospital, and system, and everyone enjoys working there. Timor is a developing country also; maybe we can use some of their systems here." Similarly, Dr Valerio explained that he "...learnt how efficiently they work in OT and how the system is working very well. The training attachment was not only a great opportunity for the trainees to enhance their SICS skills, but also to gain a greater understanding of how other hospitals are run and managed.

Typically, the trainees saw post-op patients and observed clinic in the mornings, and operated in the afternoons. Over the course of the training attachment, the trainees' confidence in their SICS skills increased and by the end of the attachment they were able to undertake surgery independently. Dr Bernadete said "Before we left for Nepal I could do some steps in the surgery, but after Nepal I can do it independently, and with more confidence."

Feedback from senior ophthalmologists at MEH also demonstrates the increase in the trainees' skills and confidence as a result of the attachment. The Medical Director of the MEH, Dr Prabha Subedi, commented on Dr Valerio's performance following his attachment;

"Dr Valerio Andrade do Esperito Santo has good surgical skill, clinical ability and OPD management. His behaviour with the patient is polite and friendly. He is very sincere, hardworking and dedicated to his profession. Dr Valerio can now independently perform Manual Small Incision cataract surgery."

Dr Valerio felt that the training attachment was very valuable, stating "The visit was very valuable and useful, because now I can do SICS and other surgeries independently. I am confident that I can handle SICS and other eye injury cases better than before."

Associate Professor Nitin Verma, founder and Project Director of the ETEP in Timor-Leste has seen the eye health system develop over the last 14 years and was instrumental in establishing the PGDO. He says "Timor-Leste has had a long and hard road to independence. The graduation of these young ophthalmologists will take Timor-Leste one step closer to being self-sufficient in providing eye care to their people."

The PGDO has been funded through the Australian Government through the Vision 2020 East Asia Vision Program, Lions SightFirst Timor-Leste Eye Care Project, the Eye Surgery Foundation Western Australia, St John Ambulance Western Australia and the many generous individuals and businesses who have supported the ETEP.

With Karen Murphy

Dr Bernadete and Dr Julia outside the National Eye Centre, Dili

VASM INFORMATION

The perceived quality of the Victorian Audit of Surgical Mortality

BARRY BEILES
Clinical Director, VASM

The VASM program in its ninth year since inception in 2007, and has implemented a number of activities and improvements to meet its contractual deliverables. The primary aim of the audit is to educate, inform, facilitate change and assist in improving the quality of surgical care through ongoing investigation and analysis into the surgical deaths of patients in Victoria.

The VASM is funded by the Victorian Department of Health and Human Services, and managed by the Royal Australasian College of Surgeons (RACS) to undertake a quality assurance program in both public and private Victorian hospitals that provide surgical services.

To ensure its contract deliverables are being met, the VASM was externally audited in 2015 by Aspex Consulting. This was a follow-up evaluation from the 2011 external audit review conducted by the same company.(1) A number of key recommendations were made to the VASM from the 2015 audit, which included five annual key performance indicators (KPIs). One of these KPIs related to "the perceived value of information provided by the VASM in order to promote ongoing improvements to surgical safety, quality and confidence across the Victorian health system."(2)

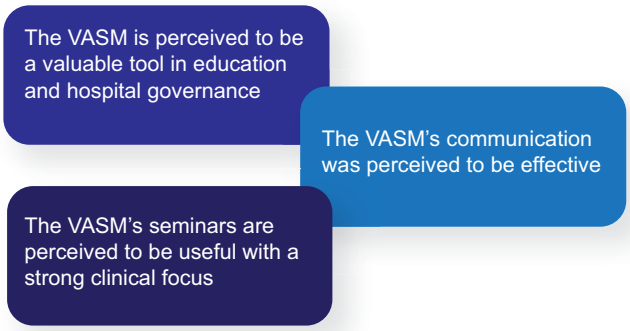
In response to these new recommendations made by Aspex Consulting, the VASM commenced a three year qualitative project. The aim of this project was to seek feedback from its primary stakeholders on the 'perceived quality of VASM information'.

The interviews involved telephonic data collection between November and December 2015 from staff of the Victorian health services. The cohort was then randomised to ensure the pool of participants represented different levels of management and administration staff. These included chief executive officers, surgical directors, quality assurance managers, health information managers, and medical records and administration staff. Participation was voluntary with informed consent. Approximately 5% (26/ 578) of VASM health service stakeholders were recruited.

The interview process utilised a specifically designed, semi-structured questionnaire. The questionnaire consisted of seven open- and closed-ended questions about the quality of information reported by the VASM. The interviewer asked the participant's perception of the value of the audit process, the quality and usefulness of the audit information, and their awareness and attendance of the educational workshops and seminars. The data collection was audio-recorded, transcribed and analysed using a qualitative methodology of content analysis(3, 4) and Microsoft Excel (2010).

The results from the interviews indicated that the VASM information is considered of high quality, concise and perceived as a benchmarking and validation tool, that highlights deficiencies and recommendations to improve surgical care.

Figure 1: Major categories regarding the perceived use of the VASM



The results also outlined the need for the VASM to: improve its method of disseminating information; target specific readership within the health service; and provide a more interactive approach to the VASM seminars and workshops.

Figure 2: Recommendations for VASM's improvement

Conclusion

The objective of this activity is to improve the VASM's engagement with its health service stakeholders. It is anticipated that the VASM will continue this method of engagement with its stakeholders over the next three years. Results from the current data analysed will be presented in the 2015 VASM Report, which will be available on www.surgeons.org/vasm.

Reference

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CASE NOTE REVIEW

Timing of second-look laparotomies is important

GUY MADDERN
Chair, ANZASM

An elderly patient was admitted to hospital with recurrent small bowel obstruction. The general surgical registrar diagnosed and appropriately managed the patient with intravenous fluids and nasogastric (NG) tube aspiration. The following day the patient had a computed tomography (CT) scan of the abdomen. The assessor's analysis of the images suggested the patient had small bowel obstruction consistent with an adhesion.

The patient failed to settle with conservative management within a 48-hour period and underwent a laparotomy and adhesiolysis by a consultant surgeon. The operation report noted dense adhesions, and two or three bands were divided, which were thought to be causing the small bowel dilatation. Complete adhesiolysis was not performed.

The patient failed to settle postoperatively and had a series of repeat CT scans and gastrografin follow throughs. A second-look laparotomy and complete adhesiolysis was performed six days later. Total parenteral nutrition (TPN) was commenced and an NG tube left in situ. The patient did not experience any abdominal pain. The high NG aspirates persisted and a gastroscopy was performed two weeks after the second laparotomy. The iSOFT report stated there were large amounts of fluid in D1, which was grossly dilated with the suggestion of luminal narrowing, possibly extrinsic. On the basis of this investigation the patient underwent a laparotomy and a Roux-en-Y gastrojejunostomy three weeks following the second-look laparotomy.

There were dense adhesions throughout the abdomen and multiple serosal tears. A gastrojejunostomy was performed with a feeding nasojejunal tube. The patient leaked from several of the enterotomies and underwent several laparotomies throughout the next few days. Each time attempts were made to suture close the enterotomies and the abdominal wall was closed until the fourth or fifth laparotomy, when the abdomen was left open. There are no further operation notes available to me, but according to the intensive care unit comments, the patient did undergo further surgery in the abdominal wall. The patient eventually died.

Comment:

Division of adhesions can be a difficult and complex procedure. It could be argued that a complete adhesiolysis should have been performed at the first operation. The second-look laparotomy was performed within a week of the first laparotomy and complete adhesiolysis was performed at this time and was probably appropriate.

Following adhesiolysis, some patients develop a prolonged ileus. At no time between the second and third laparotomy was there abdominal pain. This is consistent with an ileus rather than a true obstruction.

It appears that the decision to perform a Roux-en-Y gastrojejunostomy was based on the endoscopy of a dilated D1. It was brave to undertake this radical operation in such a patient. This was three weeks following the second-look laparotomy, where adhesions were known to be very unfavourable and the timing questionable. A more appropriate course may have been to maintain the patient with an NG tube and TPN given that the patient had no abdominal pain and to wait at least six to eight weeks.

Once the patient was on the pathway of laparotomies and inadvertent enterotomies, the inevitable happened. Attempting to close the abdomen each time probably increased the chances that

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:

Edgeworth McIntyre	**Tasmania**
John McLeish	Victoria
Ram Gupta (2014)	India

RACS is currently trialling the publication of 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

RACS ABROAD

The College on the International medical education scene

SPENCER BEASLEY
Chair, Professional Development
CATHY FERGUSON
Chair, Professional Standards

Last October, Prof Spencer Beasley and Dr Cathy Ferguson attended the International Medical Education Leaders Forum (IMELF) and the Tri-Partite Alliance (TPA) Executive meeting in Vancouver. Here they present some of the main issues that were debated at these meetings.

The IMELF meeting involved medical educator representatives from over 23 countries across Europe, Asia, the Americas and Australasia. Surgery in Australia was represented by us as well as Ian Incoll and Adrian Cosenza (CEO, AOA).

The various organizations outlined what they perceived to be their main challenges for the next five years. Common themes related to introducing competency based education, processes around revalidation, selection issues, provision of high quality training, credentialing, the tension between generalism and specialism, the role of community based training, and ensuring training is socially and culturally valid. We highlighted two of our challenges: (1) how to make the training environment safe and supportive by eliminating Discrimination, Bullying and Sexual Harassment (DBSH); and (2) how to better measure and assess trainee progression as we move to a more competency-based (rather than purely time-based) training program.

The plenary speaker was impressive. Dr Lincoln Chen, President of the China Medical Board and co-author of the 2010 Lancet Commission Report – 'Health Professionals for a New Century: Transforming Education to Strengthen Health Systems in an Independent World', summarised the key themes of the Lancet report. He described how we have moved from science-based university-led training, through problem-based academic centre-led training, to systems-based academic health-education led training – the terms themselves sound complex but the concepts behind them were well explained. The implications and consequences of each were outlined. The underlying drivers for change clarified why the shifts were occurring. He used specific examples from the Canadian and Chinese health systems to show why problems in medical education exist and how systems theory can be used to address them. The rest of the meeting involved workshops and discussion around:

1. Mobilizing leadership in medical education

There was discussion about how to harness the energy created by the meeting, and the benefits of having a link with other groups such as Toronto International Summit on Leadership Education for Physicians (TISLEP). There was also agreement that leadership has to be valued, including for those who move into management leadership.

2. Specialization vs Generalism

The critical consideration was about putting the patient's needs first, and designing training programs to help health systems meet these needs. There was discussion about the relationship between the length of time it takes to train and the quality of the trainee it produces, and the paucity of evidence around this. It was suggested that specialists know more about less than generalists – which validated the importance of having generalists with their broader perspective. This might equally apply within surgery.

3. Competency Based Medical Education (CBME)

The need for inclusion of cultural competence was emphasized, and this certainly applies to both New Zealand and Australia. Changes to the configuration of service provision and the recognition that institutional reform is needed to implement CBME; was highlighted. We need to start talking about this with our jurisdictions, being cognisant of the potential implications for service delivery. Perhaps surprisingly at this type of forum the question was raised whether CBME really was the holy grail of teaching?

4. Shaping health education to fit global health issues

This topic raised many questions. One related to the difficulties around movement of medical practitioners between countries, and the acceptance and recognition of foreign graduates. Clearly there is conflict between the aspirations of regulators and educators. Again, the regional variation in what was accepted as cultural competence and its effect on patient care was raised. The importance of international assistance not undermining existing services, and how best to build up local resources and increase local capacity and capability was stressed. Educational resources could be better shared between training programs. Finally, the consequences of migration of doctors away from emerging countries was acknowledged.

There is considerable alignment between many of our College's initiatives and the aims of the IMELF, such that ongoing involvement by RACS in IMELF would seem to be advantageous.

The Tri-Partite Alliance Meeting (TpA)

The Tri-Partite Alliance Meeting was attended by its member Colleges: RCPSC, RACS and RACP. Representatives from ANZCA and RANZCP were also welcomed, and it was agreed that membership of the TpA would be extended to include ANZCA and RANZCP – now to be called the Tri-Nations Alliance (TNA). RCPSC is developing a new web-based collaborative site to ensure all documents and activities are more accessible.

Finally, there was considerable dialogue about the International Medical Symposium (IMS) to be held in Sydney in March 2016, http://www.internationalmedicalsymposium.com.au/ particularly with reference to the 'diversity in medical practice' session. The emphasis was about the need to accommodate diversity in patient needs rather than diversity in the medical profession.

International Conference on Residency Education (ICRE)

The International Conference on Residency Education (ICRE) was held in conjunction with the IMELF meeting and the Executive Committee of the Tri-Nations Alliance (TNA). ICRE is regarded as one of the key events on Medical, Health, Health Care, Residency and Residency Education aspects. ICRE 2015 featured five plenaries, 15 learning tracks, more than 50 workshops and approximately 200 poster and paper presentations. The theme was 'Residency Rediscovered: Transforming Training for Modern Care' and we found the following events particularly worthwhile.

Toronto International Summit on Leadership Education for Physicians

- Transforming the Health Care System through Physician Leadership

This was the second TISLEP meeting and was held as a separate summit before the IMELF meeting. The initial discussion focussed on three themes; the importance of physician leadership, physician leadership in the political sense and its contribution to healthcare transformation as well as the concept of distinguishing between essential and extended competencies of physician leadership.

ICRE - Plenary Panel – Residency rediscovered:

There were presentations from experts from Toronto, Cincinatti, Alberta and Saudi Arabia. The overriding message was that while there are significant challenges in establishing these competency-based education programs, particularly in regards to physician co-operation; the programs all generate a significantly larger body of narrative data, which vastly improves the quality of assessment. It also shortens the training time in some cases. The importance of trainee driven assessment and 'guided self-reflection' were also emphasised by all speakers.

Some of the other workshops looked at the effect of workplace culture on learning, the role of narrative based workplace assessment as a tool to improve trainee performance, and the role of social media platforms in modern learning.

Overall, this was a highly educational week - stimulating, thought provoking and a great way to demonstrate RACS' commitment to medical education on an international level.

The 2015 ICRE Plenary Podcasts may be downloaded from the following link: http://www.royalcollege.ca/portal/page/portal/rc/events/icre/past_conferences#health

STREAMLINING PRACTICES

Automation in the Specialist's Office

ANDREW RENAUT
Queensland Fellow

There is currently a huge push by software developers to produce systems that automate processes that hitherto have been performed by humans. Hence the enormous interest and investment in projects such as the driverless car. The simple fact is that humans are fallible, whilst computers are considerably less so. The other significant driving factor of course is cost. The biggest financial burden for any business (a specialist's practice included) is the personnel that it employs. Whilst there are some initial costs in developing a system that employees would otherwise do, once that system is in place the employees are redundant and the ongoing cost is maintenance only. Many automatic processes have been in place for decades, for example the instrument landing system for aircrafts. Within the same industry, airlines have now made it so difficult for passengers to book a seat by telephone, that online booking is now the standard.

There are many processes within a specialist's office that can be similarly automated:

Appointment booking

The more popular practice management software systems now allow the booking of appointments online. This is done through the practice website using an application programming interface (API). The integration is relatively easy and the costs are minimal. This is clearly an advantage within a multi-specialist practice where numerous staff are employed just to make appointments.

Patient registration

All new patients are required to fill out a registration form. This can now be done using an online form, once again via the practice website. The patient can complete the form at their leisure prior to their appointment or when they attend on the day using a tablet supplied by the office or their own smartphone. With regard to the latter it is obviously essential that the website is mobile responsive to facilitate this. The data entered can be automatically imported via an API into the practice management software, saving the office staff the task of having to input this manually.

Secure patient portal

Using the same data a login facility on the website for individual patients permits access of essential information. A simple patient profile is created automatically and patients are sent a verification email together with username and password details. Information regarding their condition and procedure can be posted within the portal by the practice staff, with automatic email notification to the patient. The other things that can be potentially posted within the portal include information about billing processes as well as invoices and upcoming appointments. Security of patient data is an obvious concern and significant effort would be expended to make the digital storage and access of this data as secure as possible.

Risk management

Placing information about the patient's condition and procedure with important links through to the relevant section of the practice website has important implications with regards to risk management. This process rightly places considerably more responsibility on the patient as far as understanding their procedure and in particular the risks involved. Pairing an online booking process with a very simple tick-box form facility ensures that they have fully understood the benefits, risks and complications of their procedure. This essential step is completed before their procedure and there is an electronic record in the form of an email verifying the process.

GP information

With the ever-increasing sub-specialisation within our profession it is an enormous expectation that GPs understand the latest technology and procedures that are currently available to patients and how this impacts upon their own responsibility in general practice. GPs are as hungry as patients for this information. Clearly the information they need is somewhat more technical than that required by the patient. But why make them look beyond the practice for that information?

The solution is to provide a dedicated, secure part of the practice website, explicitly for medical professionals. A simple registration process especially for GPs allows them to access material in the form of videos and PowerPoint presentations, or other content that can placed within this section. If these presentations are amenable to gaining CPD points then so much the better. This will also double up as an excellent marketing tool for the practice as it demonstrates to the GP that the specialist is an expert in that field and is contemporary.

All of these processes can be facilitated through the practice website. The latter is no longer just an online brochure – it is now a tool that can potentially make life in the office a whole lot easier.

SURGICAL RESEARCH SOCIETY MEETING

Friday 13th November, 2015

ANDREW HILL
Chair, Surgical Research Society

The Surgical Research Society (SRS) meeting, held in Sydney on Friday 13 November 2015, was another huge success. This was the first year it had been held outside of Adelaide since 2007.

The key objective of this meeting is to provide a platform for Medical Students, JDocs, SET Trainees and Junior Fellows to present their novel surgery-related research. The meeting facilitates insightful feedback from senior Fellows and international guests from the United States (US).

The SRS meeting offers awards for the best oral and poster presentations. The Young Investigator Award funds the recipient to attend the prestigious Academic Surgical Congress held in the US. This is co-convened by the Association of Academic Surgeons and the Society of University Surgeons and will be held in Las Vegas February 2017. This award was presented to Dr Mohammad Amer from Dunedin who presented "Preoperative carbohydrates for enhancing recovery after elective surgery: A multiple-treatment meta-analysis".

The Developing a Career and Skills in Academic Surgery (DCAS) Award funds travel, accommodation and registration to the DCAS Course held in May prior to the RACS Annual Scientific Congress (ASC). The DCAS course aims to nurture and promote academic skills to Medical students, JDocs, SET Trainees and Fellows. Ms Bi Yi Chen was the recipient of this award for presenting "Radiation induced gene expression of tissue factor, thrombomodulin, cadherin 5 and cadherin 13 in cerebral mouse endothelial cells".

The Travel Grants, funding surgical research-related travel, were awarded to; Dr Joseph Dusseldorp who presented "Vascular anatomy of the medial sural artery perforator flap: A new classification system of intramuscular branching patterns"; Dr Sarah Aitken presented "Frailty models predict morbidity and mortality after major general and vascular surgery"; Dr Omar Bangash presented "Deep brain stimulation targeting the zona incerta modulates eye movements in humans"; and Dr Kiryu Yap presented "Tissue engineering vascularised human liver". Finally, Dr Derek Liang received the award for the best poster presentation for "Running barbed suture quilting reduces abdominal drainage in perforator-based breast reconstruction".

We were also very fortunate to have three outstanding presentations from senior Australian and American guest speakers. An inspirational Jepson Lecture was provided by Professor Peter Choong, Sir Hugh Devine Professor of Surgery and Head of the Department of Surgery University of Melbourne, presenting "Advanced limb reconstruction – piecing it together", as well as two exceptional US guest lectures provided by Dr O. Joe Hines, Professor and Chief of the Division of General Surgery and the Robert and Kelly Day Chair in General Surgery and representing the Society of University Surgeons, presenting "The academic surgeons – the cycle of innovation" and Dr Ankit Bharat, Assistant Professor of Surgery, Division of Thoracic Surgery and Surgical Director of Lung Transplantation at Northwestern University and representing the Association of Academic Surgeons, presenting "CXCL12 Reverse hypercapnia-induced suppression of epithelial cell migration and lung healing".

This year's SRS meeting will be held in Melbourne on Friday 11 November 2016. We look forward to another successful and inspiring meeting. If you would like any information on this meeting please contact *academic.surgery@surgeons.org*.

Developing a Career and Skills in Academic Surgery Course

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

Provisional Program

Information correct at time of printing

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

Workshop 1: Career Development
Adil Haider / Kelvin Kong

Introduction

What can I do as a:

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

Discussion

Workshop 2: Research Opportunities
Alan Guo / Richard Hanney

Introduction

Clinical research
Fiona Wood

Lab-based / animal model research
Alexander Heriot

Education / simulation research
Rachel Kelz

Health services research
Caprice Greenberg

Discussion

Workshop 3: Practicalities of Research
Christine Lai / Jacob Greenberg

Indroduction

Critical ethical issues in medical and surgical research
Amir Ghaferi

Assembling the team and establishing collaborations
Ian Bissett

Funding opportunities
Paul Bannon

Grant writing
David Watson

Discussion

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

For Faculty updates visit
tinyurl.com/DCAS2016

Cost
$250.00 per person incl. GST

Register online at
tinyurl.com/DCAS2016

Contact

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AAS Association for Academic Surgery

Royal Australasian College of Surgeons
Section of Academic Surgery

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FROM THE LIBRARY

New texts available

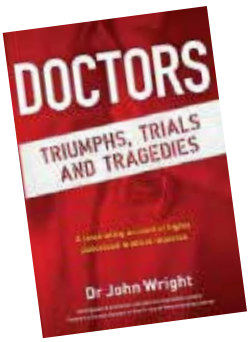
The Whispering Surgeon 2013 by John Wright

John Wright calls on his great experience as a cardiothoracic surgeon, his medical friends and pas patients to tell the story of McKenzie, the enduring "surgical whisperer".

John Wright's moving novel is based entirely on real events and people, countless experiences, reliable testimony and recorded history. The Whispering Surgeon explores the surgical life of Paddy McKenzie and his freakish skills, tireless dedication, courage, wisdom and innovation. It is a very human love story of Paddy McKenzie's own battles and the depth and selflessness of his involvement in devastated lives and flagging hopes of the damaged and disillusioned. It seems that it was inevitable that his surgical life would be directed towards the most devastated victims of war. He accompanies them on journeys that had never expected to make, though mindlessness, disorientation, fear and confusion, never letting them go it alone.

John Wright calls on his great experience as a cardiothoracic surgeon to tell the wonderful, endearing story of McKenzie, the enduring "surgical whisperer".

Kindly donated by the author



Doctors triumphs, trails and tragedies: a fascinating account of highly publicised medical inquiries 2012 by John Wright

Covers some of the most publicized and notorious cases of medical malpractice reported in Australia and elsewhere. The revealed diversity of medical misconduct is staggering. Cases such as Dr William McBride, Jayant Patel (Dr Death), Winifred Childs and Clarence Gluskie, both senior psychiatrists. Well known entrepreneur and socialite, Geoffrey Edelsten, cases in America and Britain such as Dr Jack Kevorkian, the world famous advocate of euthanasia.

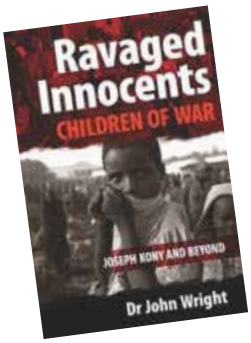
THIS BOOK ALSO COVERS:

- The damaging influence of pharmaceutical companies on doctors
- The debate between abortion and the right to life
- Cloning and medical experiments, including those conducted
- under the Nazi regime
- Dr Christian Barnard and heart transplant donors
- Legal lawsuits
- The violation of medical ethics in Abu Ghraib prison in Iraq, in Afghanistan and in Guantanamo Bay, Cuba

The great majority of doctors are honourable, generous, reliable and effective. Many of them work in sheltered environments such as laboratories where they are never likely to encounter temptations to misbehave professionally and scarcely understand how others might feel and act differently. All of them have been high achievers, prepared to wait 10 or 20 years after secondary schooling before being able to command a reasonable income. Regardless of the media's and lawyers' preoccupation with doctors' negligence and other sins, they are still trusted and respected much more widely than any other professional group.

Why do some doctors put at risk the whole of their medical life and prospects of doing good when they have strived for years to achieve those goals? Almost all of them began their medical studies with an ambition and expectation to make the world somehow a better place. Are the risk-takers any different from those in other jobs who cross a boundary into the dangerous territory of being investigated, penalised and, perhaps, sent into professional oblivion? Of course, their possible foibles are not generically different from any other human's weaknesses. Greed, dishonesty, lust and lack of scruple in doctors are no different from others but their flaws are probably more at odds with their original incentives, aspirations and belief systems.

Kindly donated by the author



Ravaged innocents: children of war 2012 by John Wright

There are millions of innocent children who observe wars as nonparticipating civilians—simple, inoffensive bystanders who lose their families, friends, and lives just by being in a war zone. They endure starvation, disease, dehydration, exposure, and the blinding depression of nothinghood. Many are in lonely, exposed, desolate, denied places from where they wander through dangerous worlds seeking their old homes and families. But the most spectacular victims are the child soldiers who fight and die in violent combat. They do so just like adults do, but more quickly because they are amateurs. They are most prolific in the third world, but they can also be found in central Europe, Great Britain, the United States, and even Ireland.

An estimated 300,000 child soldiers have been involved in conflict in over 30 countries worldwide within the last decade. There is an appalling record in Northern Uganda where a boy of eleven reported on Joseph Kony's "Lord's Resistance Army". There is nothing really new in the young boy's chilling words but they describe the typical conduct of programmed brigands and killers.

One victim said: "The soldiers took me from school. They had guns and the teachers couldn't stop them. They took me to the bush and made me carry rifles and other things - really heavy loads. Many boys died of hunger and thirst. Then they taught me how to shoot.

One day, a boy tried to escape but they caught him. They ordered us to stand around him in a circle and beat him. If we did not beat him, they would beat us. They would kill us. So we beat him ... again and again until he died. The next time a boy escaped; each of us had to run him through with a bayonet. I still see his face. Then they made us fight in battles – to shoot guns at soldiers. Life was hard and many children died."

During 20 years of war in Uganda more than 45,000 children were taken from their homes, schools and villages to rebel hideouts where they were initiated into an army culture. They were taught to kill non-compliant, abducted children, burn and loot villages and maim civilians - even their own families. Their dependency on their captors induced most children to cooperate, at least to begin. Many girls were taken as wives and bore children to Kony's brutal, irresponsible commanders.

Kindly donated by the author

Henry Gray, surgeon of the Great War: saving lives in a theatre of destruction, Tom Scotland and Ann Boyer

Henry Gray (1870 - 1938), qualified as a surgeon at the University of Aberdeen, and revolutionised the treatment of gunshot wounds during WWI saving many lives.

He also successfully tackled one of the greatest killers of the war - compound fractures of the thighbone. In WW1, thigh-bones smashed by shell fragments were a major killer. His discoveries allowed many young soldiers a chance to survive and return home for further treatment.

The broken bones weren't just serious in themselves; the wound lay open to filth and disease. It was one of the most common injuries on the western front - and in 1914-15 it was 80 per cent fatal. Young lives were being needlessly lost all the time to it. The biggest problem was antiquated rifle-splints used on the legs - which meant that the bone ends weren't immobilised - they moved in the wound causing agony, blood loss and further damage as the casualty was taken down the line. Soldiers arrived at casualty clearing stations in shock, bleeding to death, and in no fit state for surgery.

Sir Henry saw that there were two key ways to stop this killer: firstly he introduced the new Thomas splint - which successfully held the bones in place, giving casualties a fighting chance of making it to surgery. The second was wound excision - radical surgery early on to clear out all the dead flesh and filth from the wound to stop infection. This was absolutely vital because the well-manured fields of Flanders harboured the deadly organism that caused gas gangrene - and it easily made its way into these big open wounds in the thigh. Through these two innovations, Sir Henry not only cut the fatality rate to only 15%, but also greatly dropped the number of amputations. When you think that he saw 1009 of these wounds in the battle of Arras alone, you start to realise how many lives he saved.

Retired surgeon Thomas Scotland's book describes Sir Henry's remarkable contribution. His work was internationally recognised and after the war he was invited to take up a post as Surgeon-in-Chief at the Royal Victoria Hospital in Montreal, which usually carried high academic status. However, when the President of the RVH tried to browbeat the Principal of McGill into offering Gray the Professorship of Surgery, he became embroiled in local political infighting, through no fault of his own, which tarnished his reputation, forced his resignation and ended a professional life, which had started with such promise, in disgrace. This biography restores the reputation of a brilliant surgeon and objectively assesses his contribution to medicine.

Kindly donated by the author

Extractions to reconstruction: the development of Oral and Maxillofacial Surgery in Australia and New Zealand 2015 by Alastair Goss and Rob Linn

The full history of the development of Oral & Maxillofacial Surgery in Australia and New Zealand is told in this book.

In the 20th century, war was the major stimulus to developments in health and science and Oral & Maxillofacial Surgery was no different. In the First World War, Professor Percy Pickerill, the inaugural Dean of Dentistry at the University of Otago, New Zealand, headed the New Zealand Maxillofacial Surgery Unit based in Siddcup in the United Kingdom. This was under the broad leadership of Harold Gillies, who was also from Otago, who headed the British Maxillofacial Surgery Services. This set the pattern for further development in the Second World War, with Gilbert Henderson and AJ Arnott, amongst others, serving in Maxillofacial Units in Australia. Arthur Amies went to the Middle East with the army as a Maxillofacial Surgeon and indeed was a Rat of Tobruk.

Organisation into a specialist Oral Surgery Society was talked about in the fifties but only came to fruition following the leadership of Everitt Magnus and Frank Helmore, which lead to the formative meeting of the Australian Society of Oral Surgeons in 1959 in Adelaide. Before the official meeting was held in Perth in 1961, the New Zealanders had joined. The first President was Gilbert Henderson and the ground work was laid by the first Honorary Secretary, Ted Adler.

Since that time the Society has evolved into the Australian and New Zealand Association of Oral & Maxillofacial Surgeons. Over the years considerable work was done to evolve a binational curricula and an efficient examination process so that high standards have been achieved. The Association holds annual conferences and multiple continuing professional development courses for its membership.

The Australian and New Zealand Association of Oral & Maxillofacial Surgeons was a foundation member organisation of the International Association of Oral & Maxillofacial Surgeons. It has contributed two International Presidents, Sandy McAllister from New Zealand, and Bob Cook from Australia, with many other members taking active executive roles.

Kindly donated by Associate Professor Andrew Heggie, President ANZOAMS

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Interested In Global Surgery and International Medical Development?

RACS International Forum at the ASC

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

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

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

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

Post Fellowship Training in HPB Surgery

Applications are invited from eligible Post Fellowship Trainees for training in HPB Surgery.

The ANZHPBA's Post Fellowship Training Program is for Hepatic-Pancreatic and Biliary surgeons. The program consists of two years education and training following completion of a general surgery fellowship. A compulsory portion of the program will include clinical research. A successful Fellowship in HPB surgery will involve satisfactory completion of the curriculum requirements, completion of research requirements, minimum of twenty four months clinical training, successful case load achievement, assessment, and final exam. Successful applicants will be assigned to an accredited hospital unit.

To be eligible to apply, applicants should have FRACS or sitting FRACS exam in May 2016. Any exam fails will not be offered an interview.

For further information please contact the Executive Officer at anzhpba@gmail.com or the website http://www.anzhpba.com/fellowship-training.html

Applicants should submit a CV, an outline of career plans and nominate four references, one must be Head of Unit, (with email addresses and mobile phone numbers), to Leanne Rogers, Executive Officer ANZHPBA, P.O. Box 374, Belair S.A. 5052, or email anzhpba@gmail.com.

Successful applicants will need to be able to attend interviews on Saturday May 28th in Melbourne.

Applications close 5pm, Thursday March 31st 2016

anz HPBA
Australia New Zealand Hepatic, Pancreatic & Biliary Association

Post Fellowship Training in Upper GI Surgery

Applications are invited from eligible Post Fellowship Trainees for training in Upper GI Surgery.

ANZGOSA's Post Fellowship Training Program is for Upper GI surgeons. The program consists of two years education and training following completion of a general surgery fellowship. A compulsory portion of the program will include clinical research. A successful Fellowship in Upper GI surgery will involve satisfactory completion of the curriculum requirements, completion of research requirements, minimum of twenty four months clinical training, successful case load achievement, and assessment. Successful applicants will be assigned to an accredited hospital unit. Year one fellows are given the option to preference a state but not a hospital unit.

For further information please contact the Executive Officer at anzgosa@gmail.com or the website http://www.anzgosa.org/advertise_info.html

To be eligible to apply, applicants should have FRACS or sitting FRACS exam in May 2016. Any exam fails will not be offered an interview.

Applicants should submit a CV, an outline of career plans and nominate four references, one must be Head of Unit, (with email addresses and mobile phone numbers), to Leanne Rogers, Executive Officer ANZGOSA, P.O. Box 374, Belair S.A. 5052, or email anzgosa@gmail.com.

Successful applicants will need to be able to attend interviews on Saturday May 28th in Melbourne.

Applications close 5pm, Thursday March 31st 2016.

ANZGOSA
Australia & New Zealand Gastric & Oesophageal Surgery Association

TRAVEL AND RESEARCH SCHOLARSHIP OPPORTUNITIES FOR 2017

Excellence comes from hard work and dedication

IAN BENNETT
Chair, Research Audit & Academic Surgery

ANDREW HILL
Chair, Board of Surgical Research

The Foundation for Surgery Scholarship programme continues to expand each year and for 2017 a record more than $1.7 million in research and grant monies will be distributed to assist Fellows and Trainees in their research aspirations.

While there are numerous types of scholarships and fellowships available to fund individuals in research posts, there is an increasing recognition of the need for monetary grants per se to fund research activities. For this reason, two research grants are being offered in this format in 2017; the John Loewenthal Project grant and the James Ramsay Project grant. Additionally four Small Project grants will be offered in this latest round each worth $10,000.

The Foundation for Surgery Research Scholarship in Surgical Ethics will give a priority to research into the impact of climate change on surgical practice.

All Fellows and Trainees are invited to apply and to take advantage of these varied and significant opportunities for research funding.

The Board of Surgical Research invites Fellows, Trainees and other eligible applicants to apply for the following Scholarships, Fellowships and Grants for 2017.

Please note:

- These advertised opportunities are to be used as an initial guide only. Please consult the RACS website (www.surgeons.org/scholarships) from 1 March 2016 for detailed information, including application forms and award Policies. Ensure that you read the Important General Conditions before applying to confirm eligibility.
- Applications for scholarships and fellowships below must be received by midnight ACST 26 April 2016.
- Where applications are open to all SET Trainees, applicants to surgical training are also eligible to apply in anticipation of their acceptance into the SET Program. They must be accepted into the SET Program by 1 August 2016 in order to take up the award.
- The values of these awards are in $AUD unless otherwise stated.

John Mitchell Crouch Fellowship

This Fellowship of $150,000 is awarded to an individual who is making an outstanding contribution to the advancement of surgery, or to fundamental scientific research in this area.

It commemorates the memory of John Mitchell Crouch, a RACS Fellow who died in 1977 at the age of 36. The Council of the Royal Australasian College of Surgeons invites applications or nominations for the above Fellowship. Applicants must meet the following criteria:

- Working actively in his/her field.
- The award must be used to assist continuation of this work.
- The applicant must be a Fellow of the Royal Australasian College of Surgeons who is a resident of Australia or New Zealand.
- RACS Fellowship or comparable overseas qualification obtained within the past 15 years (2001 or later)
- The successful applicant is expected to attend the convocation ceremony at the RACS 2017 Annual Scientific Congress (ASC) for a formal presentation and be prepared to make a 20-25 minute oral presentation at the ASC on their research work including the contribution arising from the award.

Foundation for Surgery Herbert and Gloria Kees Scholarship - NEW

The Foundation for Surgery Herbert and Gloria Kees Scholarship was established from a generous donation from the estate of the late Gloria Joyce Kees. Gloria's nephew, Mr Franklin Yee, is a General Surgeon Fellow from Sydney. The purpose of the scholarship is to support medical research and/or the advancement of surgical technologies, techniques and treatments. Applications are open to SET Trainees, IMGs accepted into RACS as a Trainee and Fellows who have had their Fellowship for five years or less (since 2011). Value of Scholarship is $66,000. Tenure is for one scholarship year.

Foundation for Surgery Senior Lecturer Fellowship

The Foundation for Surgery Senior Lecturer Fellowship is intended to provide salary support for a surgeon, early in their career, to assist them to establish themselves on an academic surgery pathway.

Applications are open to RACS Fellows who are permanent residents or citizens of Australia or New Zealand. The emphasis of the Fellowship is to be clearly focused on research and/or educational activities. Funding will be provided to individual applicants who will be employed by an academic department which has agreed to match the funding provided by RACS.

Gross value of this Fellowship is $132,000 per annum, comprising $120,000 stipend plus $12,000 departmental maintenance. RACS will fund $66,000 and the applicant's institution will be expected to co-fund to the same amount ($66,000). Tenure is for up to two years.

Previous recipient

You are encouraged to read the inspiring letter from Dr Sarah Aitken, 2015/16 Foundation for Surgery Senior Lecturer Fellowship recipient, in which she encourages all aspiring clinical academics to consider applying for this Fellowship. This can be found on the RACS Research and Scholarships web page.

Foundation for Surgery
Passion. Skill. Legacy.

TOUR de Cure
RIDING TO CURE CANCER

Foundation for Surgery Tour de Cure Cancer Research Scholarship

Tour de Cure is a pre-eminent health promotion charity that raises funds for cancer research through cycling and other events. Together with the Foundation for Surgery, Tour de Cure has generously offered to fund the prestigious Foundation for Surgery Tour de Cure Cancer Research Scholarship.

Applications are open to Fellows and SET Trainees and International Medical Graduates on a pathway to Fellowship who are proposing to undertake an important cancer research project.

Gross value of this Scholarship is $125,000 comprising $112,500 stipend plus $12,500 departmental maintenance. Tenure is for one scholarship year.

Foundation for Surgery John Loewenthal Project Grant - NEW

The Foundation for Surgery John Loewenthal Research Scholarship was established in honour of Sir John Loewenthal who served as President of RACS from 1971-1974. The scholarship was intended to promote surgical research. In 2015 it was decided to change the conditions of the scholarship to broaden its appeal, raise its profile and increase applications. As a result, it has been re-scoped and relaunched as the Foundation for Surgery John Loewenthal Project Grant. This Grant offers funding for surgical initiatives. Applications are welcome from individuals or groups wishing to undertake clinical or research projects. Value of Grant in 2017/18 is $100,000. Tenure for 2017 is for one scholarship year.

Foundation for Surgery Health Technology Assessment Scholarship - NEW

The Foundation for Surgery Health Technology Assessment (HTA) Scholarship is intended to support Trainees, Fellows and junior doctors who wish to take time away from clinical positions to undertake a systematic review (as part of an HTA) under the supervision of a clinical supervisor and a HTA expert. Potential applicants are asked to contact the Scholarship Program Coordinator to assist them in nominating supervisors. Applications are open to Fellows, SET Trainees or junior doctors who may be enrolled in a Master's program. It is not a requirement to be enrolled in a higher degree; but production of a systematic review and production of a peer-reviewed publication would be a minimum requirement on completion of the scholarship. Junior doctors would need to conduct this work in conjunction with the ASERNIP-S program of RACS in Adelaide. This would be conducted as a collaborative research project on a mutually agreed topic. Value of Scholarship is $66,000. Tenure is for 12 months duration full-time or 2 years part-time.

Surgeon Scientist Scholarship

The Surgeon Scientist Scholarship was instituted by RACS to make a combined PhD/FRACS program an attractive option for SET Trainees. Open to Fellows and SET Trainees enrolled in or intending to enrol in a PhD. Gross value $77,000 per annum, comprising $70,000 stipend plus $7,000 departmental maintenance. Tenure is for up to three years.

Eric Bishop Research Scholarship

The establishment of the Eric Bishop Research Scholarship was made possible due to a donation from the late Eric Bishop, who was a Queensland pastoralist, and is open to Fellows and SET Trainees enrolled in or intending to enrol in a higher degree. Gross value $66,000, comprising $60,000 stipend plus $6,000 departmental maintenance. Tenure is for one scholarship year.

Foundation for Surgery Brendan Dooley and Gordon Trinca Trauma Research Scholarship

This scholarship was established to honour the late Mr Gordon Trinca, a trauma surgeon who was instrumental in the introduction of the Early Management of Severe Trauma Program, and to retired orthopaedic surgeon Mr Brendan Dooley who contributed greatly to the work of the RACS Road Trauma Committee. It is open to RACS Fellows, SET Trainees and Medical Scientists who are conducting a research topic relating to the prevention and treatment of trauma injuries in Australia and New Zealand, this scholarship offers a stipend of $10,000. Tenure is for one scholarship year.

Foundation for Surgery Catherine Marie Enright Kelly Scholarship

Foundation for Surgery Reg Worcester Research Scholarship

The Catherine Marie Enright Kelly Memorial Research Scholarship arose from a bequest of the late T D Kelly, FRACS, of South Australia, and was first awarded in about 1987. The Reg Worcester Research Fellowship arose from a gift by the late Alan Worcester, FRACS, to memorialise his brother, Reg, a great educator, doctor and humanitarian. These scholarships are open to Fellows and SET Trainees enrolled in or intending to enrol in a higher degree. Gross value $66,000, comprising $60,000 stipend plus $6,000 departmental maintenance. Tenure is for one scholarship year.

Foundation for Surgery New Zealand Research Scholarship

Open to Fellows and SET Trainees enrolled in or intending to enrol in a higher degree. Applicants must be a New Zealand citizen currently residing in New Zealand. Gross value $66,000, comprising $60,000 stipend plus $6,000 departmental maintenance. Tenure is for one scholarship year.

Foundation for Surgery Research Scholarship in Surgical Ethics

Open to Fellows, SET Trainees and members of the public with a special interest in ethical issues of modern surgery. Lay applicants must be sponsored by a RACS Fellow.

Climate Change

In support of the United Nations Climate Change Conference that was held in Paris in 2015, with the objective of achieving a legally binding and universal agreement from all nations of the world to reduce carbon emissions, preference will be given to applicants for this scholarship who are undertaking a research project with a focus on Climate Change.

Applicants must be enrolled in or intending to enrol in a higher degree with a topic relevant to ethical problems confronting surgery. Gross value $66,000, comprising $60,000 stipend plus $6,000 departmental maintenance. Tenure is for one scholarship year.

Foundation for Surgery Small Project Grant

This Grant is intended to support Trainees and Fellows who are undertaking or wish to undertake a small clinical or research project or who require limited funding to purchase equipment to carry out a research project.

RACS Fellows, Surgical Trainees and International Medical Graduates on a pathway to Fellowship can apply.

Each Grant is valued at $10,000. Up to four grants offered for 2017. Tenure is for one scholarship year.

Francis & Phyllis Mary Thornell-Shore Memorial Trust for Medical Research Scholarship

Open to Fellows and SET Trainees enrolled in or intending to enrol in a higher degree. Gross value $66,000, comprising $60,000 stipend plus $6,000 departmental maintenance. Tenure is for one scholarship year.

James Ramsay Project Grant

The James Ramsay Project Grant has been developed from donations made by Mr James Ramsay and subsequently the generosity of Mrs Diana Ramsay. It recognises James Ramsay's father, Sir John Ramsay, as a co-founder of RACS. Open to individuals or groups wishing to undertake clinical or research projects. Applicants who are either from South Australia or who are able to demonstrate a clear benefit to the people of South Australia will be given preference. Value of Grant in 2017/18 is $95,000 per annum. Tenure is for up to two scholarship years.

MAIC
MOTOR ACCIDENT INSURANCE COMMISSION

MAIC-RACS Trauma Scholarship

Open to RACS Fellows and SET Trainees. Proposed research may be in any of the following areas: Epidemiology, prevention, protection, rehabilitation or immediate or definitive management in trauma. Whilst it is not a requirement of this scholarship that the research be conducted in Queensland it must be shown that the potential benefits flowing from the research will assist the people of Queensland. Gross value $66,000. Tenure is for one scholarship year.

Paul Mackay Bolton Scholarship for Cancer Research

This scholarship was established by Harry Bolton in memory of his late son, Paul. Professor Paul Bolton was a distinguished surgeon, teacher and researcher who died from colorectal cancer in 1978, aged 39. The applicant's research topic must focus on the prevention, causes, effects treatment and/or care of cancer. Preference may be given to those currently working in Queensland or Tasmania. Young researchers, who are relatively early in their careers and show promise, may be given first choice over more senior established researchers. Projects which are likely to have clinical relevance within a relatively short period of time, as well as to applicants who are enrolled in or intend to enrol in a higher degree will be looked upon favourably. Gross value $66,000, comprising $60,000 stipend plus $6,000 departmental maintenance. Tenure is for one scholarship year.

Roy and Marjory Edwards Research Scholarship

Roy and Marjory Edwards owned a large pastoral company in South Australia. When the property was sold and Mr Edwards passed away, the late Mrs Edwards donated income from her investments to RACS. This scholarship is open to Fellows and SET Trainees enrolled in or intending to enrol in a post-graduate at a South Australian university. Gross value $66,000 per annum, comprising $60,000 stipend plus $6,000 departmental maintenance. Tenure is for up to three years. Continuation each year is dependent upon satisfactory progress.

Sir Roy McCaughey Surgical Research Scholarship

This scholarship was established as a result of a bequest to RACS from the late Sir Roy McCaughey. Open to Fellows and SET Trainees enrolled in or intending to enrol in a PhD. The research must be conducted in NSW. Gross value $66,000 per annum comprising $60,000 stipend plus $6,000 departmental maintenance. Tenure is for up to three years.

WG Norman Research Fellowship

Open to Fellows and SET Trainees enrolled in or intending to enrol in a higher degree. Applicants must be resident in South Australia, with their research being conducted in South Australia and topics which have a trauma focus will be given preference. Gross value $66,000, comprising $60,000 stipend plus $6,000 departmental maintenance. Tenure is for one scholarship year.

Travel Scholarships, Fellowships and Grants

Margorie Hooper Travel Scholarship

The Margorie Hooper Travel Scholarship has been made possible through a bequest from the late Margorie Hooper of South Australia. The Scholarship is open to RACS SET Trainees and Fellows who reside in South Australia. The Scholarship is designed to enable the recipient to undertake postgraduate studies outside the State of South Australia, either elsewhere in Australia or overseas. It is also available for surgeons to travel overseas to learn a new surgical skill for the benefit of the surgical community of South Australia. Preference will be given to the latter. This scholarship is for 12 months. The stipend is $65,000 and there is provision for accommodation and travel expenses upon application.

Stuart Morson Scholarship in Neurosurgery

The Stuart Morson Scholarship in Neurosurgery has been established following a generous donation by Mrs Elisabeth Morson in memory of her late husband. The Scholarship is designed to assist Neurosurgical Trainees or young Neurosurgeons within five years of obtaining their RACS Fellowship (2011 or later) to spend time overseas furthering their neurosurgical skills by undertaking research or further training. The Scholarship is also open to exceptional young surgeons who are registered to practice neurosurgery in Australia or New Zealand but are not RACS Fellows. Overseas surgeons who wish to spend time in Australia or New Zealand to further their training and/or research in neurosurgery may apply. Overseas applicants cannot have commenced travel prior to applying for the scholarship. The value of the Scholarship is $30,000 and is intended to contribute to the costs of undertaking further training and/or research work in neurosurgery.

Hugh Johnston Travel Grant

The Hugh Johnston Travel Grant arose from a bequest of the late Eugenie Johnston in memory of her late husband, Hugh Johnston. This $10,000 Grant is designed to assist needy and deserving RACS Fellows and SET Trainees to gain specialist training overseas. Applicants must not have commenced their travels prior to the closing date for applications.

Foundation for Surgery Ian and Ruth Gough Surgical Education Scholarship

This scholarship, valued at $10,000, was established by Ian and Ruth Gough to encourage surgeons to become expert surgical educators. Applicants must be RACS Fellows or SET Trainees, with permanent residency of Australia or New Zealand. Tenure is for one scholarship year.

Morgan Travelling Fellowship

The Morgan Travelling Fellowship was formed following a series of donations made by Mr Brian Morgan. The purpose of the Fellowship is to fund a RACS Fellow to travel overseas to gain clinical experience or to conduct research for a period of approximately one year. To be eligible, the surgeon must have gained their Fellowship in the past five years (2011 or later). The Fellowship is open to a Fellow from any specialty. The Fellowship must be the only RACS funding secured by the Fellow but the candidate is permitted to obtain alternative external funding concurrent with the Morgan Travelling Fellowship. The value of the Fellowship is $10,000 and the duration is for up to 12 months. Applicants must not have commenced travels prior to closing date for applications.

Morgan-Opie Travelling Fellowship

The Morgan-Opie Travelling Fellowship was started following a bequest from the estate of the late Dr Richard Opie, a General Surgeon. To be eligible, the surgeon must have gained their Fellowship in the past five years (2011 or later). The Fellowship is open to a Fellow from any specialty. The Fellowship must be the only RACS funding secured by the Fellow but the candidate is permitted to obtain alternative external funding concurrent with the Morgan-Opie Travelling Fellowship. The value of the Fellowship is $10,000 and the duration is for up to 12 months. Applicants must not have commenced travels prior to closing date for applications

Murray and Unity Pheils Travel Scholarship

The Murray and Unity Pheils Travel Scholarship was established following a generous donation made by the late Professor Murray Pheils. It has a value of $10,000 and is awarded to a RACS SET Trainee or recent Fellow to assist them to travel overseas to obtain further training and experience in the field of colorectal surgery. Similarly, overseas graduates wishing to obtain further training and experience in a specialist colorectal unit in Australia or New Zealand are also eligible to apply. Applicants must not have commenced their travels prior to the closing date for applications. The Scholarship is for up to 12 months.

Hugh Johnston ANZ ACS Travelling Fellowship

The Hugh Johnston ANZ Chapter American College of Surgeons Travelling Fellowship is intended to support an Australian or New Zealand RACS Fellow to attend the annual American College of Surgeons (ACS) Clinical Congress in October 2017. It forms part of a bi-lateral exchange with the ACS and is open those who have gained their RACS Fellowship in the past 10 years (2006 or later). Applicants are expected to have a major interest and accomplishment in basic or clinical sciences related to surgery and would preferably hold an academic appointment in Australia or New Zealand. The applicant must spend a minimum of three weeks in the United States of America in the year of their fellowship. While there, they must:

- Attend and participate in the American College of Surgeons Annual Clinical Congress in 2017
- Participate in the formal convocation ceremony of that congress
- Visit at least two medical centres in North America before or after the Annual Clinical Congress to lecture and to share clinical and scientific expertise with the local surgeons.

Applicants must not have commenced their travels prior to the closing date for applications. This Fellowship is valued at $8,000. More information about the ACS can be found at www.facs.org

John Buckingham Travelling Scholarship

This scholarship was established to encourage international exchange of information concerning surgical science, practice and education, as well as to establish professional and academic collaborations and friendships amongst Trainees. It is open to current SET Trainees to enable them to attend the annual American College of Surgeons (ACS) Clinical Congress in 2017. This scholarship is valued at $4,000.

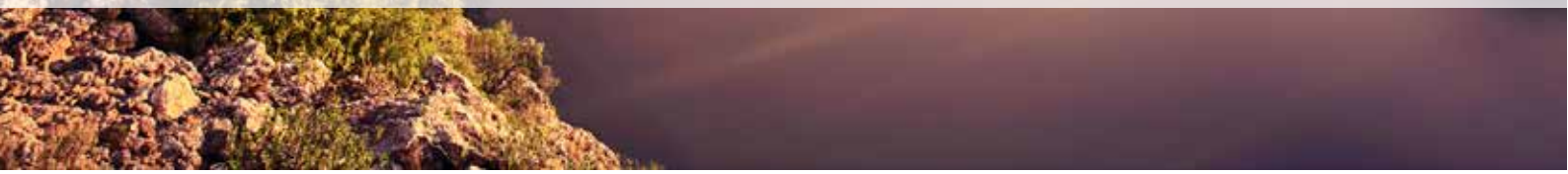
More information about the ACS can be found at www.facs.org

Additional information and links can be found on the RACS website at www.surgeons.org/scholarships.
For any other queries, please contact the Scholarship Program Coordinator,
Mrs Sue Pleass, Royal Australasian College of Surgeons, 199 Ward Street, North Adelaide SA 5006.
Tel: +61 8 8219 0900; Fax: +61 8 8219 0999; Email: scholarships@surgeons.org .

Applications close midnight ACST Tuesday 26 April 2016

ADVOCACY IN THE SOUTH

The South Australian health sector is undergoing significant changes



SONJA LATZEL
Chair, SA Regional Committee

The South Australian health sector is continuing to experience a period of significant change. Advocacy for patients and the community, as well as the support of quality surgical care and training is the core business of the South Australian Regional Committee.

We have been heavily engaged in health advocacy in our region over the past 12 months and will continue to be so in 2016.

Quality Surgical Care, Patient Safety and Transforming Health

SA Health's "Transforming Health" agenda is now in full swing, and aspects of this have already started to affect surgical care. It is an ambitious plan, to streamline medical and surgical services in the metropolitan area of Adelaide, in order try to make the system more cost-effective with the intention, at least, to make it safer and more efficient.

It is planned that multi-day stay surgery at Modbury Hospital will cease very soon, with only 23 hour stays being allowed. Emergency surgical patients are no longer being cared for in this hospital. The South Australian Regional Committee have supported local surgeons who have successfully lobbied the Northern Area Local Health Network, to allow surgeons access to afterhours theatre for emergency care of surgical inpatients, but at present only as a six-month trial.

We remain concerned about the ongoing presence of an Emergency Department, apparently to be fully staffed at current levels, but without the ability to treat surgical emergencies within the hospital. Modbury Hospital has for many years provided a full level of service to emergency patients, including access to intensive care. The intensive care services were downgraded some years ago but most surgical services continued to be offered with HDU back up. Serious surgical emergencies such as ectopic pregnancies and appendicitis could easily be dealt with in a timely fashion. The community has understood this well and have had no hesitation in presenting to the emergency department with most conditions.

We are currently in the process of lobbying the Government to ensure that if they proceed with these plans, the community needs to be educated about the changes. We hope that well informed patients would then attend an appropriately supported emergency department if it is likely that they will require emergency surgery, noting that a large proportion of surgical emergencies arrive by private transport rather than via ambulance. Otherwise the significant delays inherent in transfer of surgical patients may put some at risk of harm. We have also explained that transferring seriously ill patients carries risks independent of delays.

The implications for surgical registrar training are also

significant. The lack of access to a full range of surgical case work including emergency work may mean that some rotations are not accredited. It remains unclear as to who will be expected to take responsibility for patients deemed to have surgical problems in the ED, prior to transfer. There seems to be an expectation from the architects of this plan that surgical registrars and consultants will see these patients, support them until transfer, and that this will keep them safe.

With the restructure of the hospital services, surgeons across several surgical departments faced the New Year with contract negotiations still incomplete. VMO surgeons, some of whom have provided service to the public in South Australia for nearly 30 years, were left in the extraordinary position of having no contract offered with only a few days left prior to expiry of their locum contracts (approaching the downtime of the Christmas/ New Year break). They had been offered 6 month locum contracts in June 2015 in lieu of a new 3 year contract, in order for the health department to negotiate the contract terms over that 6 months but no negotiations occurred until the last minute, when eventually they were offered another 2.5 years. A similar situation was faced by Orthopaedic surgeons midyear in Mount Gambier (rural South Australia) with contracts signed with only hours left on the previous ones. We have advocated strongly for clear and transparent processes in order to avoid this occurring again.

Quality Surgical Care and Equity of Access to cutting edge technologies

The New Royal Adelaide Hospital is due to be delivered at the end of this year. It is shaping up to be a beautiful, state of the art hospital but unfortunately will be delivered without a hybrid surgical suite or a surgical robot. We continue to lobby the Department of Health in the hope that these cutting edge technologies will be retrofitted as soon as possible following completion and handover of the hospital. As private patients have ready access to robotic surgery, it is critical that public patients also have access. This is currently provided through limited lists in private hospitals.

Alcohol Advocacy

We have had several reviews of alcohol licensing, after hours trading and regulation around licensing of venues. We have advocated strongly in favour of continuing strong levels of control over density of outlets and availability in order to minimise alcohol related harm. Mark Morgan, our Policy and Communications officer, has been of enormous value in keeping abreast of these issues.

We will be partnering with the SA Government and Local Health Area Networks in confronting and managing bullying, sexual harassment and discrimination, to improve the culture within our hospitals and build respect and improve patient safety.

We look forward to the coming twelve months, during which we will host the SA/WA/NT tripartite ASM on 26 – 27 August at the Crowne Plaza Adelaide. On Friday 26 August, members will have the opportunity to participate in Professional Development whereby the Academy of Surgical Educators Forum and the Foundation Skills for Surgical Educators sessions will be held. Our Scientific Meeting will then take place on the Saturday and Sunday.

We continue to plan actively for the 86th RACS Annual Scientific Congress due to be held in Adelaide on 8 – 12 May 2017.

Opus XL

LESE MAJESTE

Milking the system

FELIX BEHAN
Victorian Fellow

The story of this French expression meaning "extortion of monies from the State" relates to Nicolas Fouquet, the Minister of Finance at the time of Louis XIV who lived in a lavish residence, the *Vaux-le-Vicomte*. He was guilty of milking the system and was eventually ensconced at his Majesty's pleasure. The genesis of my tale has a more recent perspective. Thanks to Marianne Griffin I read the *Australian Financial Review* (AFR) in December 2015. In it was an article about exorbitant surgical fees – a re-exposure to the concept of greed – human nature being what it is.

We have an established principle in our health care system for Private Practice and the Public Health Service. Costs must be contained for both systems and these are currently under the spotlight.

The AFR article *BUPA goes after high charging surgeons* quotes some specific cases of surgeons and cardiologists earning 7-figure sums - "*some out of pocket expenses may be as high as $10,000 for hip surgery, $8000 for knee joint replacements and $2000 for coronary angiography*".

Private and Public surgical practice is part of our health system to improve our talents and techniques while receiving a rewarding income. Our training system has been acknowledged as one of the best in the world and the graduates should respect their training origins by working in both systems including country surgical practice (only 15% of surgeons operate in the country at this time). If I was in a position of authority to ordain it I would suggest the College possibly make this one of the regulations of a training program to satisfy all surgical needs.

Commercially BUPA is the second largest private health insurer in Australia controlling a little under 30% of the market and as a consequence will be publishing in the near future a list of those high charging surgeons – "*to put pressure on fee-gouging surgeons and reduce customer anger in relation to shock out of pocket expenses*".

Vaux-le-Vicomte

Again The Age quoted recently the NIB experience (just under 10% of the private funds). They have a policy of no gap cover. But if this fee is excessive (eg, $10K for a prostatectomy) the poor patient gets only the MBS refund, possibly for a treatment of malignancy. What is a possible if not probable outcome: people will leave the Private funds in droves. Details of patient (dis)satisfaction will be aired on NIB's website soon. And the Public health sector is broke! And most have read my quote about Aesop's Golden Egg!

In this BUPA article, Dr John Quinn, Executive Director of Surgical Services of RACS confirms that there are a small number of surgeons charging such exorbitant fees. He recognises the additional problem of the referring GP who could be unaware of the out of pocket fees from such cases. He notes that charging high fees does not always reflect the best quality. As Don Marshall observed to me those surgeons with the most experience operate for surgical rewards. Unconscionable fees usually go against the dictates of a surgical conscience. We must maintain our high surgical excellence fearing the pursuit of commercial gain erodes this philosophical ideal.

This group of surgeons numbering between 5% to 10% is the focus of the article and a justified criticism. However, history repeats itself and in the 1900s the story a surgeon displayed in the window of his Collins Street consulting rooms a bladder stone the size of a pigeon egg retrieved via the perineum using lithotomy exposure with a price tag of £1000. This says it all – human nature has not changed.

Health funds are now starting to look at such financial breakdowns of fees, including complications. When a 5-figure sum is charged for procedures the financial managers of these public

corporations ask why such additional costs should not be carried by the operating team and hospital. This is quite controversial but complications can occur in any surgical procedure depending on the circumstances and complexity. However one can see how such ideas evolve. NIB and Medibank Private are public corporations, listed on the stock market, answerable to shareholders and wanting maximum return on equity; and the CFOs want to control costs.

In 2014 The ABC program Four Corners program discussed the complications that arose from use of the DePuy Hip Prostheses (The Walking Wounded, May 2014) showing contamination of tissues caused by titanium and cobalt disintegration. The destruction of the femoral shaft bilaterally precluded the use of further surgery and the patient was obliged to use crutches for the rest of his life like a paraplegic. DePuy has since withdrawn the prosthesis and is now the subject of a class action.

Again Professor Bruce Robinson stated in the Fairfax Press recently that an estimated 30% of Medicare spending could be a waste and goes on to discuss the efficacy of knee arthroscopies being a source of public ridicule, repeating what had already been stated in Four Corners last year that only 5% were necessary. I must have been one of the lucky 5% - I (k)needed an arthroscopic correction of my menisci and freshening of the tibial plateaus (a touch of OA!). I have been grateful ever since.

Accountancy firms play an important role in our financial affairs. We all know Kerry Packer's famous quote about our entitlement to reduce tax liability. Deductible schemes are legion however - from leasing cars to negatively gearing property, to vineyard and primary beef production, let alone reforestation projects etc. The other extreme of multi-million dollar leasing ventures (from corporate buildings to Lear jets) becomes a massive financial burden. Does the stress of this affect clinical decisions and therefore patient outcomes?

One of the more fanciful financial manoeuvres of the 80s was the "*Bottom of the Harbour*" scheme, another accountancy firm orchestration. In this game a skeleton company is stripped, the assets bought, the profit purloined and the tax commitment diluted resulting in bankruptcy. The surgical client walks away with a handsome deduction. However the ATO ruled differently. This scheme floundered, however quite relevant to my recollections (without the experience) whenever I pass that fish and chip shop in Carlton called *Bottom of the Harbour* I have a wry smile. My other rye smile comes from a bottle of the nectar from the Scottish Highlands!

Julian Smith, Chairman of Professional Standards at the RACS, states in the December 2015 *Surgical News* that Fellows who charge excessive fees or engage in deceptive practice using creative accounting with double invoices could be sanctioned under the RACS Code of Conduct.

Don Marshall was given the job by Benny Rank of reviewing the MBS fee schedule for Plastic and Reconstructive Surgery in the 60s. Hence he is fully aware and can make apposite comments on any MBS fee structure. He is of the opinion that all procedures should be based on a single item number and not individualised per stage.

Now returning to *Lese Majeste* - an offence against the Crown or the Establishment of matters financial. It dates back to the time of the French Court and Louis XIV.

When objet d'art was needed to grace the surroundings the orders were carried out through his Financial Minister, Nicolas Fouquet, employing the best artisans (eg silversmiths, stonemasons, furniture makers etc) - all contracts done under imprest – with payment guaranteed by the Crown.

One day Fouquet invited the King to visit his own august surroundings – Vaux-le-Vicomte – which was ostensibly superior to what the King enjoyed.

Sacre Bleu! C'est incroyable !!!

A soto voce King's retort.

Human nature being what it is these artisans may have created additional little objet d'art for Fouquet's pleasure. Over the years this is possibly how he amassed his fortune. The story of one such artisan springs to mind about Paul de Lamerie who had been banished by the King to London because of his religious beliefs (he was a Hugenot – a Calvinistic Protestant). In London he re-established his reputation of being the finest silversmith in 18th century Europe. An example of his work featured recently in the Antiques Roadshow was valued at €23,000 (see illustration below). Similar pieces would have been in the Royal households before the Revolution which resulted in the gratuitous destruction of many fine objet d'art. Thank God he moved across the Channel whereas Fouquet was moved into prison at the Fortress Pignerol.

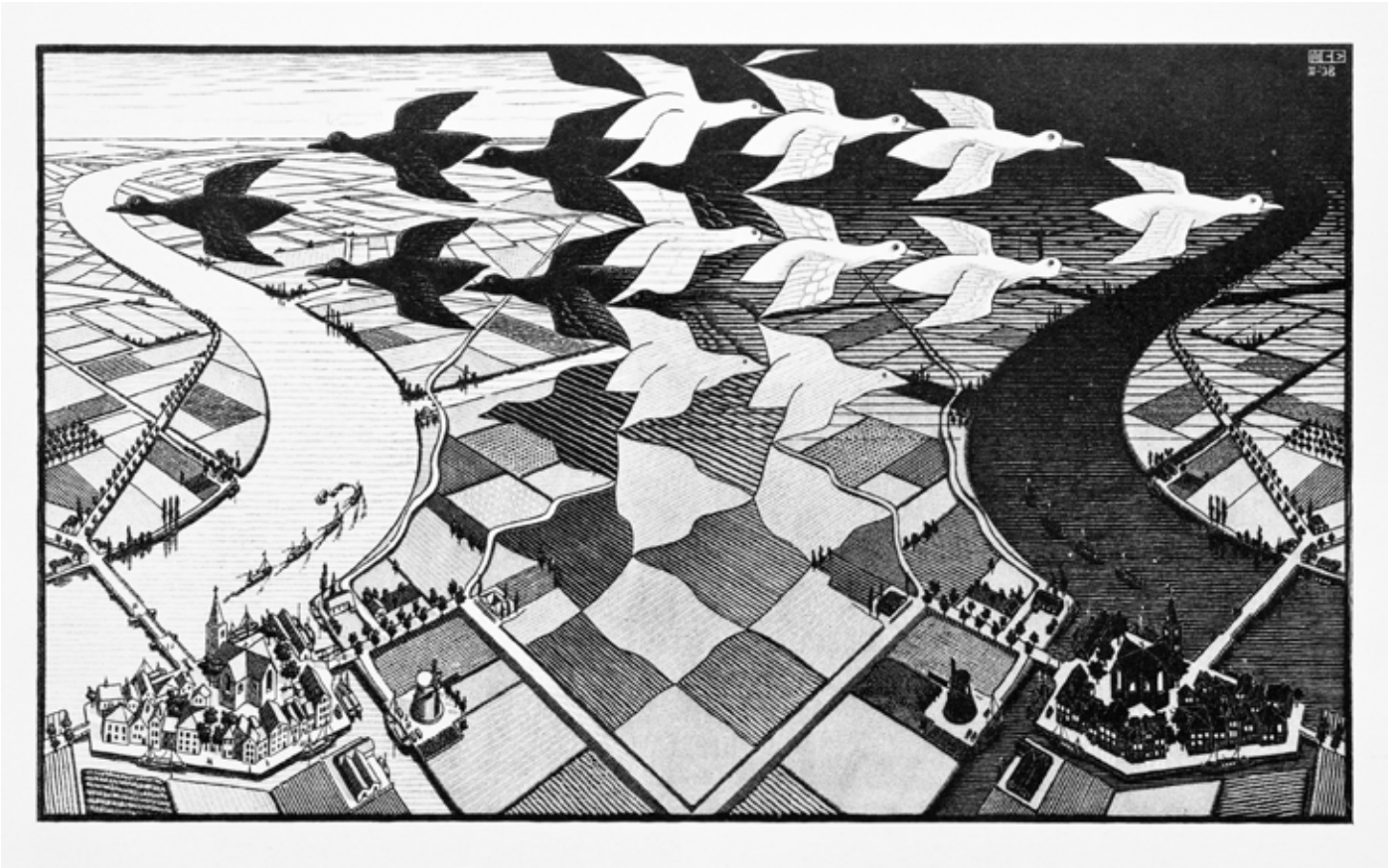
coffee pot

Never forget greed becomes its own decimator, altruism is its own reward.

Finally to massage the message I include a comment from the President, David Watters, following his review of this article.

"*Healthcare needs to be affordable and sustainable. No one should have to access their mortgage or their superannuation to pay for the costs of surgery. Surgeons should not exploit their patients with their fees, nor take advantage of their vulnerability when they are in need of surgery. Patients do receive excellent care in the public system for urgent and life threatening conditions. Those with private health insurance should not be charged large gaps and every surgeon needs to reflect on these matters and the fees they charge.*"

Imprimatur: externally reviewed by Professor David Watters (President RACS) and Professor Donald Marshall



THE ILLUSION OF ADVERSARIAL CONFLICT

Perspective, Empathy and Objectivity

JASON CHUEN
Victorian Fellow

Last week I took my children to see a magic show. This was a new experience for them, seeing the spectacle of illusion played out on a large stage, but whilst we adults were content to suspend our disbelief and enjoy the spectacle, my kids were analysing and dissecting every aspect of the performance. Thankfully they have not been quite as critical of the concept of Santa Claus.

It did surprise me, however, that from sitting in the one spot they were able to observe, infer, postulate and explore numerous theories as to how the illusion was executed - which is quite amazing because clearly magic is a mystical force that cannot be explained like in Star Wars.

As doctors we are taught to recognise disease patterns or "illness scripts". If it looks like a duck, quacks like a duck, and walks like a duck it is probably a duck. Except of course when it is a swan. Furthermore, once we have recognised a familiar pattern we seek out information to reinforce that conclusion but may unconsciously overlook information which raises doubt. This is called confirmation bias and is often imperceptible.

Illusions manipulate cognitive biases, as well as innate visual and auditory processing pathways, to create a belief and then to reinforce it. Once that belief is developed it draws us together with peers who share that belief (herding), and can bring us into direct conflict with those who do not. Thus the level of anguish, debate and controversy over whether "the dress" was blue-and-black or white-and-gold, , or the need to classify people as 'left-brained' or 'right-brained' depending on which way the dancer spins.

Unfortunately the creation and fostering of two directly opposing points of view can be highly counterproductive. When there is no 'right answer' or the solution must be mediated rather than accepting dominance of one view and submission of the other, adversarial debate can descend into an unbreakable stalemate or eternal conflict.

In our current debate over professional behaviour, bullying and discrimination I suggest that our College and our colleagues must consider the perspectives of all the players in these debates. Some of the incidents reported by the RACS

[1] Dual processing and diagnostic errors. 2009 Sep;14 Suppl 1:37–49.
[2] Custers EJFM. Thirty years of illness scripts: Theoretical origins and practical applications. Med Teach. 2015 May;37(5):457–62.
[3] Profiles in patient safety: confirmation bias in emergency medicine. 2006 Jan;13(1):90–4.
[4] Lafer-Sousa R, Hermann KL, Conway BR. Striking individual differences in color perception uncovered by "the dress" photograph. Curr Biol. 2015 Jun 29;25(13):R545–6.
[5] Kruszelnicki KS. Six ways the blue and black dress scrambles your brain [Internet]. 2015 Marc 17. Available from: http://www.abc.net.au/science/articles/2015/03/17/4197384.htm
[6] Troje NF, McAdam M. The viewing-from-above bias and the silhouette illusion. Iperception. SAGE Publications; 2010;1(3):143–8.

Expert Advisory Group are frankly shocking, and in dealing with the recommendations and implementing the Action Plan we must empathise with the experiences of those who have been harmed. Whilst it is appalling to realize these incidents have been experienced by our colleagues, it can be more disconcerting to realise that they have also been perpetrated by our colleagues. Thus, we must also consider the perspectives of those who have contributed to these events, and also the systems, cultures and assumptions that are involved.

Only by all stakeholders appreciating the perspectives of others can we hope to come to a resolution that strengthens our College and our profession. It is an easy illusion to believe that there are two opposing sides - good or evil, progressive or conservative, male or female - when in reality we are all on the side of a fairer, better system that benefits and respects patients, our colleagues and trainees, and our society.

Stepping outside the box, so to speak, unprofessional behaviours and events can be seen as analogous to clinical safety events. Bringing an effective safety culture into our working environment has many parallels with building a modern culture of professional behaviour.

In the sphere of health safety and risk management, just as in the management of aviation risk, we view sentinel and critical adverse events as an indicator of an underlying problem. Rather than villainising individuals, we seek to amend systems, culture and behaviour so that those events do not recur.

To engage in a purely punitive system of dealing with bullying, discrimination and harassment may perpetuate the problem of under-reporting. It has long been recognised that shame is a major inhibitor amongst those who err to publicly recognising their problem and seeking assistance. This is why aviation and hospital risk management systems have moved towards no-fault reporting and investigation, and systems of performance improvement, which place outcome and safety first whilst trying to eliminate the blame culture. Lowering barriers to reporting by all participants, including self-recognition, is critical but so is removing the shame, criticism and blame associated with this process.

It is an illusion that these problems exist purely in surgery, medicine, academia, or any single profession. It is an illusion that this issue is related purely to Trainees, to women in surgery, or overseas trained doctors. It is an illusion that bullying is only ever instigated by irredeemable perpetrators, facilitated by innocent bystanders, against powerless victims. Without points of external reference the only indications of an illusion or misperception may be the existence of differing interpretations, or inherent incongruence in the scenario illustrating its absurdity, a key feature of the classical impossible illusory objects of MC Escher.

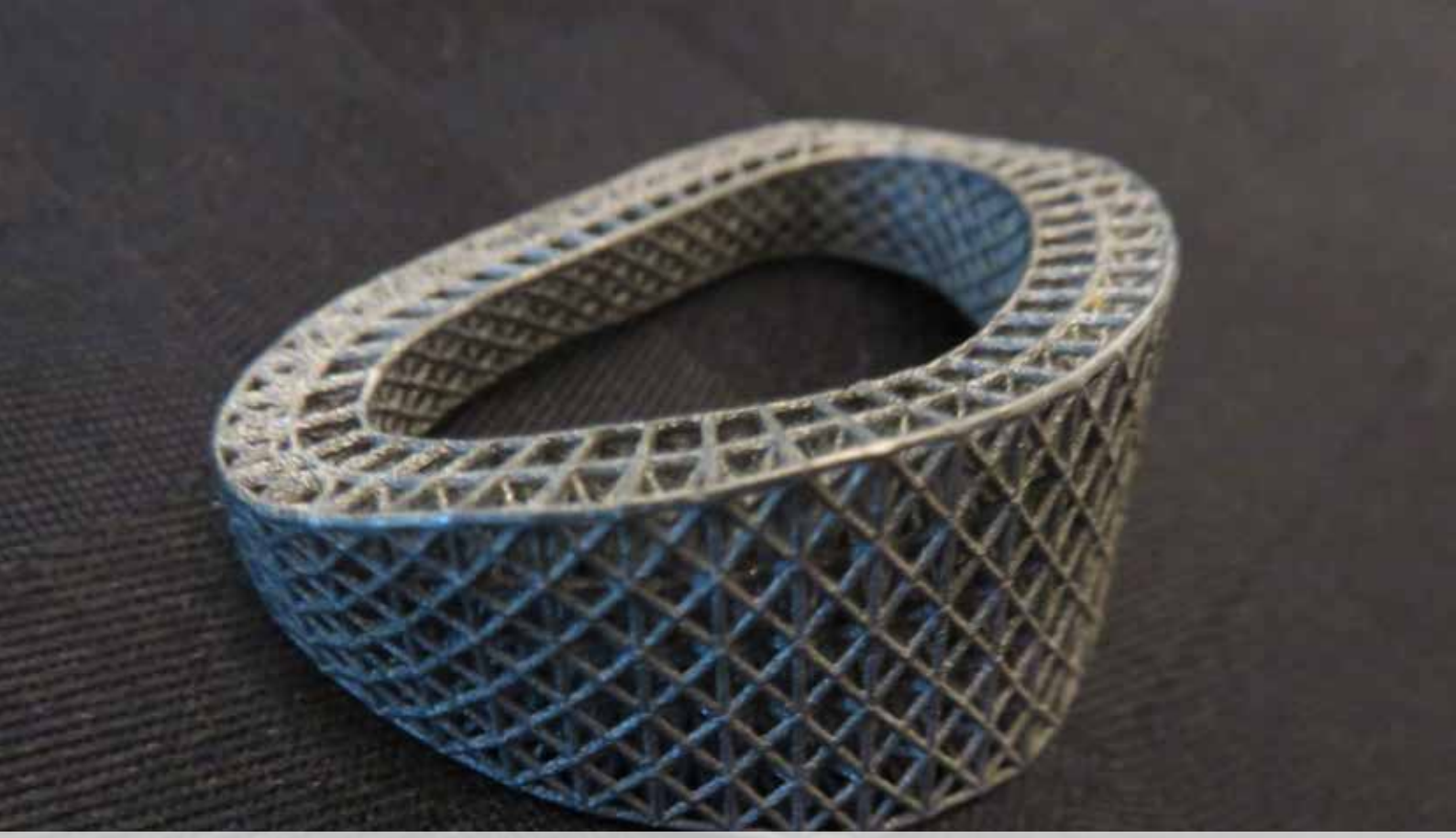
Elevating oneself from an illusion requires an appreciation of its existence, that there may be other perspectives to a larger scenario. That can be a challenging and disorienting exercise, but in the same way that treating our patients requires us to empathise with them whilst also making objective decisions, it is a key step towards effective and constructive change.

[7]RACS Expert Advisory Group on discrimination, bullying and sexual harassment [Internet]. Melbourne: Royal Australasian College of Surgeons; 2015 Jun. Available from: http://www.surgeons.org/media/21827232/background-briefing-16-june-15-final.pdf

[8] Kohn CT, Corrigan JM, Donaldson MS. Creating safety systems in health care organizations. In: To Err is Human Building a Safer Health System. Washington; 1999. pp. 134–74.

[9] Ofri D. Ashamed to admit it: owning up to medical error. Health Aff. 2010 Aug;29(8):1549–51.

[10] Penrose LS, Penrose R. Impossible objects: a special type of visual illusion. Br J Psychol. 1958 Feb;49(1):31–3.



THE PRINTED PART

New 3D printing technology is making waves in surgery

The development of 3D printing technology has the potential to revolutionise a range of surgical specialties, according to Sydney Neurosurgeon Mr Marc Coughlan.

While many surgeons are waiting and watching to see how the technology develops, Mr Coughlan has already conducted four procedures using 3D printed titanium implants.

He said that while the technology was particularly useful in the treatment of degenerative scoliosis, he could also see it utterly changing the treatment options available to Orthopaedic, Maxillofacial and Reconstructive and Plastic surgeons.

"The new buzz word in spinal surgery is sagittal balance whereby patients can maintain a normal weight bearing line between their head and their pelvis which, for patients with spinal deformities, requires a re-alignment of the spine," Mr Coughlan said.

"This can be extremely complex in terms of replacing vertebral bodies but customised 3D printed implants offer a wonderful opportunity to design a unique implant to fit a unique space.

"In the very near future, while the patient is anaesthetised, we will obtain Body Tomography intraoperative CT data, we will design the patient-specific custom spinal implant by computer-programmed criteria, we will manufacture the 3D printed implant in the hospital, the implant will be sterilised and we will then complete the surgery by implanting the device which is a unique solution to the patient's disease or condition.

"We expect this process to occur with no additional surgical time, with superior outcomes and with less cost.

"This 3D printing technology allows us to customise implants so that we can reduce or eliminate pressure points and provide perfect spinal alignment and it has extremely exciting potential in my field, particularly in relation to spinal and bony tumours that affect body morphology."

Mr Coughlan is not alone in embracing the new technology.

"Customised 3D printed implants offer a wonderful opportunity to design a unique implant to fit a unique space."

In September, a Spanish cancer patient became the first person in the world to receive a titanium 3D printed sternum and rib cage while earlier this year a Melbourne man received a titanium 3D printed prosthetic jaw.

Mr Coughlan said he first became interested in the potential of the new technology after using plastic implants to repair skull fracture injuries.

Earlier this year, he used the 3D printing technology to treat a patient suffering severe pain caused by a malformed lumbar vertebra, which had caused the disc to slip and the facet joints to strain under the extra load.

In collaboration with American Spine Surgeon Mr Chet Sutterlin MD of ProCRO, Pty Ltd, Mr Coughlan needed only two weeks to design and manufacture the first Australian-made, patient-specific 3D printed spinal implant.

Mr Coughlan, Mr Sutterlin and ProCRO worked in conjunction with Australian-owned medical device company Anatomics and the Royal Melbourne Institute of Technology (RMIT) to accomplish the task.

In April the surgery was successfully completed and within weeks Mr Coughlan's patient could walk without pain for the first time in years.

He described placing the implant as "fitting a key into a lock".

He is now in the process of describing the procedure for peer-reviewed journals.

"This technology gives us an amazing ability to design implants to fit bony defects and fit into different joint spaces, which will broaden our treatment options for a range of conditions such as wedge compression fractures in the elderly," he said.

"Most 3D printed implants are being made from titanium because it is very inert, the body doesn't react to it, it has similar elasticity to bone and it fuses well.

"There is no increased risk of infection because the implant goes through the same sterilisation process as all other implants so it's just the process of manufacture which is different.

"I think 3D printing technology has, without doubt, the potential to revolutionise a range of surgical specialties."

Mr Coughlan obtained his Neurosurgical Fellowship in South Africa in 2003 before moving to Australia where he spent a year working with Dr Charles Teo to expand his skills in minimally-invasive Neurosurgical techniques and Neuro-oncology.

He received his FRACS in 2005 and now works out of the Prince of Wales and North Gosford Private Hospital and has special interests in minimally-invasive neuro and cranial surgery, Neuro-endoscopy and Paediatric Neurosurgery.

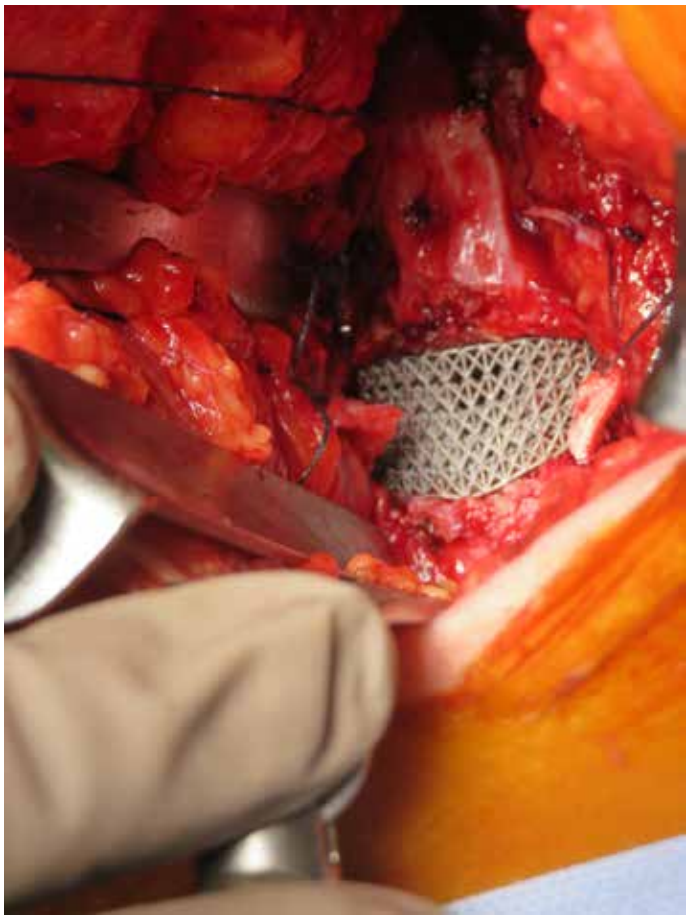
He said he was now leading a multi-centre trial at the Prince of Wales and North Gosford hospitals to analyse the outcomes of anterior spinal surgery using 3D printed implants.

"This will be only a small trial because these implants are only suitable for candidates who have anatomical abnormalities or unusual pathologies caused by disease," Mr Coughlan said.

"It is very exciting technology but we want to introduce it responsibly by doing the procedures, analysing the outcomes and getting the literature out there.

"However, it has been a great success so far. The 39-year-old mother and wife that I treated in March was pain-free within a few weeks after surgery. She is now standing straight for the first time in decades and really seems to be enjoying her life again with family and friends.

With Karen Murphy



Urological Society of Australia and New Zealand Annual Scientific Meeting

Gold Coast 16-19 April 2016

USANZ is pleased to welcome Professor Margit Fisch, Director and Chair of the Department of Urology and Paediatric Urology at the University Medical Centre Hamburg-Eppendorf, in Germany. Professor Fisch's major interests are Reconstructive and Pediatric Urology. She has been president of both the Society of Genito-Urinary Surgeons and the European Society of Genito-Urinary Surgeons and is an inter alia member of the American Academy of Genito-Urinary Surgeons, the Society of Pelvic Surgeons and the Society of Pediatric Urologic Surgeons. She has published more than 300 papers and organises the International Meeting on Reconstructive Urology (IMORU).

At the USANZ 2016 ASM Professor Fisch will present the following papers:

Plenary Sessions:

A major diversion – which one and in whom? Update on the PROMETRICS study

- State of the Art: Urethral Reconstruction – Which technique for which stricture and when....
- Breakout sessions:
- Chronic Pelvic Pain Syndrome and Chronic Prostatitis – inflammatory or a state of mind?
- Recurrent Bladder neck stenosis after Radical Prostatectomy and BPH treatment - Perineal Re-anastomosis and VY-Plasty
- Prospective outcome analysis of the Artificial Urinary Sphincter

Professor Fisch will also present on Chronic Pelvic Pain Syndrome and Chronic Prostatitis to the Urological Nurses Society attendees.

Professor Fisch's attendance at the USANZ ASM has been made possible due to the generous funding made available by the RACS Visitors Program. The USANZ is grateful to RACS for providing funding to enable this world renowned speaker to enhance its ASM.

Australian and New Zealand Post Fellowship Training Program in Colon and Rectal Surgery 2017

Applications are invited for the two year Post Fellowship Colorectal Training Program, conducted by the Australia and New Zealand Training Board in Colon and Rectal Surgery (ANZTBCRS). The ANZTBCRS is a Conjoint Committee representing the Colon and Rectal Surgery Section, RACS, and the Colorectal Surgical Society of Australia and New Zealand (CSSANZ). The program is administered through the CSSANZ office.

For details about the Training Program and applications, please see :

https://cssanz.org/index.php/training/application-for-training-program

Application Closing Date:

Friday 6 May 2016

Applications: All applicants must use the ANZTBCRS Application Template (see website link above).

Please email your application to:

A/Prof Andrew Stevenson

Chair, Australia and New Zealand Training Board in Colon & Rectal Surgery

Email secretariat@cssanz.org

Phone +61 3 9853 8013

ANZTBCRS
Australia and New Zealand Training Board in Colon and Rectal Surgery

In Memoriam

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

Robert (Bob) John Kyd
Orthopaedic Surgeon
8 November 1941 - 17 April 2015

Bob Kyd was born in Auckland to James Kyd (a company accountant) and Alice (nee Willetts). He had a brother, Warren. Bob commenced school at Owairaka Primary School where he was noted to be witty and popular with his classmates. He had a lifelong interest in aircraft and as a boy spent all his money at model shops on balsa wood, glues and paint for his model aircraft. Secondary schooling was at Mt Albert Grammar. He participated as an Air Force cadet becoming a dead shot with a rifle and winning the top marksman award.

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

Professor Ronald Lawrie Huckstep, CMG, FTSE

Orthopaedic Surgeon

1926-2015

1926-Born in China, to missionary parents. At age 15, his family was arrested by the Japanese and placed in a Concentration Camp outside Shanghai, where he received his early medical education there. He presented his CV and was accepted into Cambridge Medical School.

For the full version see webpage: http://www.surgeons.org/member-services/in-memoriam/ronald-lawrie-huckstep/

Peter Thomas Bruce
Urologist
26 February 1931 - 2015

Peter Bruce was born Vienna 26 February 1931. He arrived in Australia in 1939 with his parents Paul and Mizzi Bruce. Peter's grandfather, Richard Bruchsteiner, was born in Hungary but moved to Vienna where he established a specialist printing works. Paul became manager of the business. In the aftermath of the Anschluss, Paul realised that with Jewish ancestry he could not remain in Vienna, and arranged for his family to emigrate to Australia. They left Austria in 1939, and arrived in Melbourne when Peter was 7 years old. They were unable to take money with them, but were able to send a container of some of their possessions to Australia.

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

Major-General William Brian 'Digger' James AC AO(MIL) MBE MC
General Surgeon
14 May 1930 - 16 October 2015

Digger James entered the Royal Military College at Duntroon in 1948 graduating 1951. Having undergone his training as an Infantry Officer he was shortly after sent as an infantry reinforcement Platoon Commander to Korea in late 1952.

For the full version see webpage: http://www.surgeons.org/member-services/in-memoriam/william-brian-digger-james/

Peter Britton Milsom
General Surgeon
27 June 1944 - 25 February 2015

27 June 1944 - 25 February 2015

Peter Milsom, Surgeon, General Practitioner, Obstetrician, Gardener, Polymath, passed away at his home in Pakaraka on 25 February 2015 surrounded by family and friends.

Peter was born in Auckland in 1944, the son of Coates Milsom, an orthopaedic surgeon, and Patricia, an author. His grandfather, Britton, was also a surgeon and his great, great grandfather, John Coates, was secretary to Captain Hobson, a signatory to the Treaty of Waitangi. Peter had three siblings - Mary, Eleanor and Britton. His early childhood was spent in the United Kingdom where his father trained in orthopaedic surgery. The family returned to New Zealand in 1953 to live in Tauranga, where he attended Tauranga Primary School and Tauranga Boys High School. Study and swimming came with ease and he was also a competent athlete. In Tauranga Peter was exposed to a large rural community, especially Māori with whom he developed a lifelong rapport.

http://www.surgeons.org/member-services/in-memoriam/thomas-p-nash/

New Zealand New Year and Australia Day Honours

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

New Zealand New Year Honours

Companion of the New Zealand Order of Merit (CNZM)
Professor Ian Donald Shepherd Civil CNZM MBE KStJ

Officer of the New Zealand Order of Merit (ONZM)
Professor Kevin Craig Pringle ONZM

Australia Day Honours

Member (AM) in the General Division
Mr Ian Carlisle AM
Dr Jay Chandra AM
Dr Timothy Michael Cooper AM
Professor Mark Frydenberg AM
Dr Michael Anthony Gardner AM
Dr Brian Thomas Spain AM

Medal (OAM) in the General Division
Mr John Edward Cunningham OAM

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www.surgeons.org/foundation

ANZMTG 01.09 RTN2 TRIAL

An international randomised trial

Do you have any patients who have recently been diagnosed with neurotropic melanoma?

The Australian and New Zealand Melanoma Trials Group (ANZMTG) in conjunction with the Trans-Tasman Radiation Oncology Group (TROG), is conducting an exciting clinical trial for patients diagnosed with primary neurotropic melanoma.

ANZMTG seeks your support in referring patients to participate in the RTN2 Trial who have recently undergone primary excision surgery for their melanoma lesion (head or neck primaries only). Clinical care varies around the world. This clinical trial is a unique Australian-led initiative, which will generate evidence to determine the efficacy of post-operative radiation therapy. The results of this trial will aim to make improvements in treatment and management of patients with this diagnosis.

Radiation is often given to treat these patients but there is a lack of evidence in this scenario.

More information can found in the following sources:

ANZMTG website: anzmtg.org – *current trials*
ANZ Clinical Trials Registry: anzctr.org.au (ACTRN12610000478011 / NCT00975520)
Contact: anzmtg0109@melanoma.org.au / +61 2 9911 7352

ANZMTG Australia and New Zealand Melanoma Trials Group

Australian Government Cancer Australia

TROG CANCER RESEARCH