SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 15 NO 10 / NOV/DEC 2014

HAPPY & SAFE FESTIVE SEASON

More than $1.5 million of Research Scholarships awarded! p50

SURGEONS: Professionals or Tradesmen?

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

2015

PROFESSIONAL DEVELOPMENT

WORKSHOPS & ACTIVITIES

Royal Australasian College of Surgeons

Professional development supports life-long learning. College activities are tailored to needs of surgeons and enable you to acquire new skills and knowledge while providing an opportunity for reflection about to apply them in today's dynamic world. Additional workshops are available from the 2015 Active Learning booklet, which will shortly be published on the College website and distributed to all Fellows.

Supervisors and Trainers for SET (SAT SET)

10 February - Brisbane, 21 February - Sydney, 21 April – Melbourne

This course assists supervisors and trainers to effectively fulfil the responsibilities of their very important roles. You can learn to use workplace assessment tools such as the Mini Clinical Examination (Mini CEX) and Directly Observed Procedural Skills (DOPS) that have been introduced as part of SET. You can also explore strategies to help you to support trainees at the mid-term meeting. It is an excellent opportunity to gain insight into legal issues. This workshop is also available as an eLearning activity by logging into the RACS website.

Foundation Skills for Surgical Educators

20 February – Sydney

The Foundations Skills for Surgical Educators is a new course directed at facilitating the education and training of surgical trainees and will establish the basic standards expected of our surgical educators within the College. This free one day course will provide an opportunity for participants to identify their own personal strengths and weaknesses as an educator and explore how they are likely to influence their learners and the learning environment. The course will further knowledge and skills in teaching and learning concepts and look at how these principles can be applied into participants own teaching context.

Communication Skills for Cancer Clinicians: Breaking Bad News

28 February – Melbourne

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

International Medical Symposium

13 March – Melbourne

This one day seminar, hosted by the Royal Australasian College of Surgeons in collaboration with the Royal Australasian College of Physicians (RACP) and the Royal College of Physicians and Surgeons of Canada (RCPSC), will explore the subject of "The Future of Medicine". This will include contributions from the specialist medical colleges, a number of key note international speakers, as well as futurists and junior doctors.

Process Communication (PCM) – Part 1

21 to 22 March – Melbourne

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 personality types; each person represents a combination of these types, but usually one is dominant.

Keeping Trainees on Track (KToT)

25 March - Launceston, 21 April – Melbourne

This 3 hour workshop focuses on how to manage trainees by setting clear goals, giving effective feedback and discussing expected levels of performance. You can also find out more about encouraging self-directed learning at the start of term meeting.

Non-Technical Skills for Surgeons (NOTSS)

27 March - Sydney

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

Younger Fellows Forum

1 to 3 May – Margaret River

This annual 2½ day residential workshop draws Younger Fellows together to discuss and debate surgical issues that are on the horizon. The Forum will focus on a range of issues including professionalism in the 21st Century, altruism and leadership as well as how to achieve a public /private balance in surgical practice. The core objective of the Forum is to provide an environment that encourages Younger Fellows to address challenging issues relevant to personal, professional and collegiate life. It is a great opportunity to share ideas and experiences with colleagues, international guests, College leaders and external experts.

workshop

February-April

NSW

20 February, Sydney
Foundation Skills in Surgical Education
21 February, Sydney
Supervisors and Trainers for SET
27 March, Sydney
Non-Technical Skills for Surgeons

QLD

10 February, Brisbane
Supervisors and Trainers for SET

SA

18 February, Adelaide
Clinical Decision Making

VIC

12 February, Melbourne
Process Communication Model Refresher
28 February, Melbourne
Communication Skills for Cancer Clinicians: Breaking Bad News
10 March, Melbourne
Academy Educator Studio Session
13 March, Melbourne
International Medical Symposium
21-22 March, Melbourne
Process Communication Model Seminar 1
24 March, Melbourne
Clinical Decision Making
20 April, Melbourne
Foundation Skills in Surgical Education
21 April, Melbourne
Supervisors and Trainers for SET
21 April, Melbourne
Keeping Trainees on Track

Royal Australasian College of Surgeons

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Correspondence to Surgical News should be sent to: **surgical.news@surgeons.org**
Letters to the Editor should be sent to: **letters.editor@surgeons.org**

T: +61 3 9249 1200 **F:** +61 9249 1219
W: www.surgeons.org

ISSN 1443-9603 (Print) / ISSN 1443-9565 (Online)

Surgical News Editor: David Hillis

Published for the Royal Australasian College of Surgeons by RL Media Pty Ltd. ACN 081 735 891, ABN 44081 735 891of 129 Bouverie St, Carlton. Vic 3053.

ON THE COVER:
Vic Regional Chair Jason Chuen.

SURGEONS OF THE 21ST CENTURY

MICHAEL GRIGG
PRESIDENT

Professionals or Tradesmen?

This is perhaps the most important question facing surgeons at this stage of the 21st century. It is a topic that I have spoken about both in Australia and New Zealand and internationally with resonance from countries as diverse as Poland and India, Japan and Argentina. It is an issue to be confronted proactively and fully.

I declare that my starting premise is that professionals are good for Society. In this I am supported by Professor Lord Ralf Dahrendorf, previously the Director of the London School of Economics who said "the independence of the professions is perhaps the best index of the personal freedoms of individuals within Society". He went on to warn, "but the winds of change are blowing".

So what is the difference between professionals and tradesmen? Both are knowledgeable and highly skilled and focused on doing a great job. Again Dahrendorf assists, "the professions at their best: oriented to expertise rather than commercial interest, bound by self-imposed rules of behavior, they base their status on the unwritten agreement with the public of which the professional organisation is the guardian".

So professionals are deemed to have the motivation and the autonomy to place the interests of their patients above all other considerations. In return they are granted the privilege of autonomy (and monopoly) and the responsibility of self-regulation by Society with subsequent benefits. But is this autonomy still valued by Society? Is the self-regulation and accountability understood by the profession and our professional organisations? The 21st Century question could perhaps be restated – how do we reflect our autonomy in our accountability?

Setting standards

In 1776, Adam Smith, a Scottish moral philosopher, who has also been described as the father of modern economics, published 'The Wealth of Nations'. In this treatise he established both a definition of professionals and the social contract between doctors and Society that continues today. Dr Thomas Percival, an English physician was among the first to invoke Smith's social contract documenting this within one of the modern codes of medical ethics in 1794.

Smith proposed that a hallmark of professionalism was the necessity of being able to act in a patient's best interest, free of both State and Church control. Smith was no fool and he foresaw the risk that independence might degenerate into an exploitive monopoly. He sought to balance the privilege of autonomy with the responsibility of self-regulation. It was not his intention to legitimise idiosyncratic individualistic behavior, but rather to impose this responsibility on professional peer groups i.e., professional organisations.

The Royal Australasian College of Surgeons, formed in 1927, is an organisation of surgical professionals. A catalyst for its formation was a letter signed by three prominent surgeons of the time that expressed concern at the degradation of the high standards of the surgical profession and proposed the formation of a College of Surgeons whose members would conform to certain standards. I believe Adam Smith would have approved. Today, 87 years on, professional standards remains the cornerstone of all College activities.

Practical manifestations include surgical training, certification, Code of Conduct, professional development courses, peer review and even Continuing Professional Development.

Professional standards, determined by the profession, are the manifestation of "self-regulation" allowing us to fulfill our part of the social contract and to continue professional life as we know it. This is one reason that I believe professional organisations are essential in the 21st Century.

Professional standards need to be determined by the profession. This enables the autonomy necessary to be a professional rather than being subject to the different types of accountability confronted by tradesmen. I am often asked, "What is the role of professional organisations?" The answer is easy for the College of Surgeons – it exists to ensure and to protect the professional standing of surgeons for the benefit of Society.

The embodiment of Adam Smith's views of the relationship between Professionals and Society was the 'Doctor – Patient' relationship that has rightly been held in high regard by both the medical profession and Society. It is the value placed on this relationship that has until recent times provided almost complete protection to the profession from the State. The social contract was between Professionals and Society – it never involved the State.

Autonomy under threat

Government, bureaucracy, instrumentalities and even politicians make up the State, an inherent and unifying characteristic of which is a desire for control. The Professions therefore represent an anathema to the State and we should not forget that we are constantly at risk. In the event that Society comes to doubt the value of autonomy of medical professionals, or the ability of the medical profession to self-regulate it is predictable that Society will turn to the State for the remedy. Internationally there is evidence that this is already happening.

In a world where the individual relationship between doctor and patient is often within larger organisational structures such as hospitals, the dilemma that comes to mind is apparent in the question, "Can employed doctors be professional?" The answer of course is "yes", provided the standards of professional behaviour are determined not by the employer or by the State, but by a strong independent professional body. It is also apparent that it is desirable that the body determining professional standards is separate from the body negotiating pay and conditions.

Unlike other professional groups, such as university academics, the medical profession still enjoys relative autonomy. However, this is under threat with increasing intrusions of accountability imposed by the State, occurring because of the perception of failure of self-regulation.

This failure is portrayed in many ways – avoidable medical harm, exploitive fees, suspect relationships with third party providers, "closed shop" turf protection, rogue behaviour to name but a few. Ultimately, however, the challenge for the State is the increasing cost of healthcare and the need for reform. Alas the autonomy of healthcare professionals is perceived to be an impediment, indeed a substantial impediment.

We live in an era of increasing accountability, but we can survive as professionals provided we nurture our professional organisations and they in turn retain the trust and support of Society. As President of this College, I know this is vitally important to each and all of us. It is the differentiator, the key difference between a tradesman and a professional.

THE VALUE IN VALUES

Do you know what your own values are or even those of the hospital you work at? Have you agreed corporate values define and inspire your own private practice?

DAVID WATTERS
VICE PRESIDENT

Why do organisations such as the College need values? Does anyone really pay any attention to them?

I believe we need values, because they define who we are and what we aspire to be. They emanate from our inner beliefs and make a statement about what motivates our actions and underpin the way we behave towards each other.

Most companies have values, even those whose principle motivation might be profit for their shareholders. If you take a few moments to search the web you will likely find many espouse common values. For example, Coca-Cola's seven corporate values include quality, passion, leadership, collaboration and integrity. Medibank Private has four values including customer focus, integrity and respect. BHP has six values which include integrity, respect, sustainability and accountability.

Corporations often go to great lengths to ingrain their values into their corporate culture. They reward exceptional display of values and continuously train staff to encourage behaviour that reflects the desired corporate values.

There has been much research over the last few years about the 'value of values' in organisations and whether values can predict such things as performance, emotional intelligence and compliance with occupational health and safety standards.

The experts in these fields of study say that although personality traits are largely inherited, values can be learned. Values then influence behaviour and are found to be significant predictors of positive and negative work outcomes. Furthermore, in the field of Human Resources, assessments that look at both personality and values have greater accuracy in predicting emotional intelligence, success in customer focused roles and safety compliance.[1]

Shalom H. Schwartz, an academic in Social Sciences, developed a 'Theory of Basic Values' based on studies of over 60,000 people from 82 countries.[2] He identified ten basic personal values that are emotionally distinct, are recognised across cultures, and determined how they are derived. It is interesting to note that whilst the values are structured in similar ways across culturally diverse groups, particularly as to conflict and congruence between values, individuals and groups differ substantially in the relative importance they attribute to the values.

So as individuals and groups in society, we do have different value 'priorities' or 'hierarchies'. Are we able to be collective in our thinking as surgeons, and as a College, about the priority of our values? Do our values drive us to action? Do they define our actions? Schwartz makes the connection that "Values are beliefs linked inextricably to affect. When values are activated, they become infused with feeling." These feelings then lead us to action.

Our College values have been on the minds of Councillors recently, particularly because the development of our communication strategies highlighted the importance of being able to articulate 'what we stand for'.

The current College values, applicable to Fellows, Trainees and staff, were first introduced in 2000 and comprise four pairs and one singleton:

- ✓ **Service and Professionalism**
- ✓ **Integrity**
- ✓ **Respect and Compassion**
- ✓ **Commitment and Diligence**
- ✓ **Collaboration and Teamwork**

In reflecting on these values, the members of the Governance and Advocacy Committee, chaired by the Vice-President, believed it was time to simplify them into five key values to enhance impact. So which values best apply to us as surgeons and Fellows of the College?

The committee and other Councillors favour the following five values:

- ✓ **Service**
- ✓ **Respect**
- ✓ **Integrity**
- ✓ **Compassion**
- ✓ **Collaboration**

As you can imagine, getting consensus on these was a challenge and generated much interesting discussion! Some was about semantics, but we definitely wanted to include values each Fellow would think were important. I am pleased to say that 'service' was high on the list. As one Councillor said, "It is outward looking, patient and society focussed and a prime motivation and reason for our existence as individual professionals and as a representative professional organisation."

I trust that our values will be worthy of what you aspire to be as a surgeon. Our values should inspire behaviour that is worthy of the trust placed in us by the public and describe the motivation behind our actions.

Each of our values are manifest in recent areas of College activity: advocacy on appropriate training hours for Trainees [service, respect and collaboration], safe surgical care and global health [service, collaboration and compassion], the unacceptability of excessive fees [service, compassion and respect]; promoting professionalism [all our values], collaborating with others to mitigate the effects of alcohol, tobacco and obesity on our patients and the community [compassion, service, collaboration].

Integrity should drive us to willingly participate in Continuing Professional Development (CPD), by which I mean lifelong learning related to our scope of practice, reflection on our performance through audit, peer review and other types of feedback [collaboration], participation in clinical governance [service and collaboration], and documentation of our CPD compliance [respect and integrity]. Common values assure us we should work together. As a fellowship that is the unifying voice for surgery we can have much more effect than the sum of our individual efforts.

References

1. Griffin, M. A., Neal, A. (2006) A longitudinal study of the relationships among, safety climate, safety behaviour, and accidents at the individual and group levels. *Journal of Applied Psychology,* 91, 946-953
2. Schwartz, S. H. (2012). An Overview of the Schwartz Theory of Basic Values. *Online Readings in Psychology and Culture,* 2(1).

I would be pleased to hear your thoughts about our College values and their importance. Email me at college.vicepresident@surgeons.org

Anatomy course in demand

A three day anatomy course held at James Cook University and accredited by the College gives aspiring surgeons hand-on experience.
Now in its second year, JCU Associate Professor of Surgery Alan DeCosta has said there is high demand for the course.
"Most of our Trainees are very good at keyhole surgery, but they have very little experience with open surgery," he said.
"Open surgery is still very necessary … especially in emergency situations."

***Cairns Post*, 2 November**

Neighbourly help

The College continues to build its relationship with Pacific communities with assistance in the development of new postgraduate surgical program in Fiji. While the program was suspended in 2013, new facilities and staffing has allowed the program to grow. Fiji National University School of Medicine Dean Professor Ian Rouse has said that all Pacific Islands will benefit from the program.
"The recently opened world-class operating theatres at CWM Hospital mean that we now have quality facilities to ensure the best possible training for regional surgeons," Mr Rouse said.

***The Fiji Times*, 6 November**

Audit participation commended

The Western Australian Audit of Surgical Mortality, coordinated by the College, is ensuring continuing improvement in the treatment of patients.
The latest report shows surgical deaths continue to fall, at a rate of 22 per cent between 2009 and 2013. Encouraging is the level of participation among surgeons, Acting-Director General of the Department of Health Bryant Stokes has said.
"This demonstrates that the surgical community wants to learn from mistakes and improve clinical practice," Professor Stokes said.

***PSNews.com.au*, 21 October**

Revived hearts give hope

Surgeons have opened new possibilities after restarting hearts for transplant surgery in a world first.
The dormant hearts were flushed with saline solution before being removed from bodies, then connected to a machine that supplied new blood and kept them pulsing. Cardiothoracic surgeon Emily Granger hopes the new method will go some way to relieving wait list pressure.
"I carry around a briefcase that seems to be getting heavier by the day and that's just the transplant wait list," Dr Granger said.

***Sydney Morning Herald*, 25 October**

Buttons and gender


SURGICAL SKETCHES AND SILHOUETTES

BUTTONS & SURGICAL BOWS

A protean perspective

In my story about Buttons and Bows ('Surgical News', September 2014), there are a few points I would have liked to add for completeness sake and the first is, why I used that title in that article.

Bob Hope is one of my favourite comedians and this was the song, 'Buttons and Bows', of his Oscar winning film, 'Paleface', with Jane Russell, produced in 1947. One of his famous quotes that stick in my mind relating to the ageing population is embraced by his words, "You know you are old when the cost of the candles costs more than the cake."

The second point of interest relates to the reason why ladies' buttons are on the left hand side of their garments. It harks back to the 18th century when the mistress of the household in the wealthier classes was dressed by her ladies-in-waiting. They would insert the buttons into the buttonholes with a pincer grip using a right hand dominant gesture, as we know 90 per cent of the population is right handed. This meant les boutons were attached to the left hand side of the tunic. And some say the reasons why men's clothing has buttons on the right was the fold of the coats etc. meant easy access to the sword on the left hip in the days of Dick Turpin etc.

It is interesting to note how someone explained, when working in an op shop where bundles of clothing are given en masse that when one has to decide their gender to place them on the appropriate rack, one just looked at the button orientation and stacked them accordingly. I presume the same principle would apply to clothing with zip fasteners.

Statistically female surgeons in the UK amount to 9.7 per cent, whereas entering a medical course in their undergraduate years they comprise 55 per cent. In Australia and New Zealand the figure comes out at just under 11 per cent for female surgeons. Imagine the logistics in having male and female theatre gear governed by button orientation. Thankfully we use slip on theatre garb and pyjama cords.

Finally another pearl about pearls: along the Dampier coast of northern Western Australia near the 80 mile beach, pearl luggers would retrieve from the oyster reefs beyond, enough shells to supply 90 per cent of the world's pearl buttons in the 1890s.

Felix Behan
Victorian Fellow

Airline industry could learn from us

The President, Michael Grigg, mentions in his President's Perspective: "How to be alert like the airline industry" ('Surgical News', October 2014) his interest in DVT (Deep Vein Thrombosis) prophylaxis.

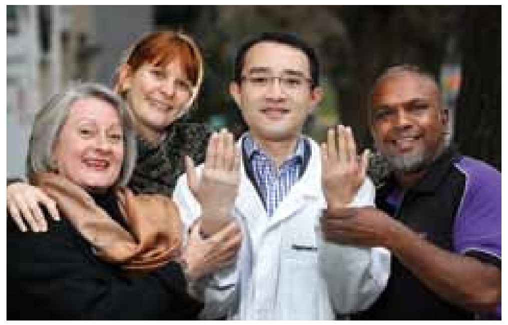
My interesting in DVT stems from the 1960-70's when I began to use subcutaneous heparin pre and post-op in major general surgery to prevent pulmonary embolism (PE). Others followed, but orthopaedic surgeons were particularly wary because of the risks of bleeding. One particularly well-known O & G surgeon had bilateral hip replacements without prophylaxis and died of PE.

Over the years since, I thought DVT prophylaxis had become routine, but apparently not, from the President's article. Then, when laparoscopic cholecystectomy (LC) came in, it was thought by some that the rapid ambulation would negate the need for prophylaxis: forgotten was the abdomen filled with gas slowing flow in the inferior vena cava and predisposing to DVT. The modern trend for early discharge after major surgery was found to necessitate the use of DVT prophylaxis for a period after going home. One of my own patients died of a PE after discharge.

Then in the airline industry itself, the long flights taken commonly today expose passengers to DVT/PE because of the long period of inactivity – have they learnt from us?

President Grigg's idea of an industry-wide alert in matters involving patient safety is emphasised in the history of DVT/PE prophylaxis!

Kevin B. Orr
NSW Fellow



All deserve praise in Wong case

Re. Michael Wong ('Surgical News', October 2014).

He suffered a terrible attack and ghastly injuries in February. He is fortunate to have survived and fortunate to be making a great recovery, thanks to every single person involved in his care. But most of the congratulations go to not only to these wonderful team members, but to Michael himself who tried so hard but then said we must think more of the three-year-old with a brain tumour!

Well done everyone!

Donald Beard
South Australian Fellow

New Councillors to serve you

Results of elections to council

Fellowship Elected Councillors

There were four Fellowship Elected Councillor positions to be filled.

Re-elected to Council are:

Phillip Carson (General, NT)

Lawrence Malisano (Orthopaedic, QLD)

Newly elected to Council are:

Andrew G Hill (General, NZ)

Jonathan Serpell (General, VIC)

Specialty Elected Councillors

Re-elected to Council are:

Cardiothoracic Surgery – Julie Mundy (QLD)

Otolaryngology Head & Neck Surgery – Neil Vallance (VIC)

Paediatric Surgery – Anthony Sparnon (SA)

Plastic & Reconstructive Surgery – David Theile (QLD)

Newly elected to Council are:

General Surgery – David Fletcher (WA)

Vascular Surgery – John Crozier (NSW)

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

The pro bono contribution of Fellows has been, and continues to be, the College's most valuable asset and resource. We are grateful for their commitment. We are also grateful to the voting Fellows (22 per cent) who demonstrated their engagement with the governance of the College.

The poll results are verified by Mr Ralph McKay of BigPulse.

The results will be tabled at the Annual General Meeting in Perth on Thursday, May 7, 2015 when newly elected Councillors take office.

RECOGNITION FOR BRAIN TUMOUR WORK

Fellow Sarah Olson is driving awareness on brain cancer to find a cure, becoming a finalist for a national award in the process

LEFT: Sarah with husband Brad Armstrong, daughters Ingrid and Charlotte and son Sam.

After being shortlisted, Queensland Neurosurgeon Dr Sarah Olson became a finalist to receive a national award for her work to establish a brain tumour bank and her extraordinary fund-raising efforts to support brain tumour research.

In the past two years, Dr Olson has raised more than $300,000 for brain tumour research and has established a Queensland brain tumour bank through the John Trivett Foundation with the support of neurosurgeons across the state.

She is now in the process of extending the tumour bank across the country and raising further funds to support research throughout Australia in a bid to extend survival rates for patients with brain tumours, which currently have some of the lowest survival rates of any cancer.

Dr Olson was announced as a finalist for a Pride of Australia Medal in October, an award offered by News Corp Australia to recognise and reward outstanding Australians.

She was nominated earlier this year in the Care and Compassion category by the Princess Alexandra Hospital in Brisbane that specifically commended her selflessness in offering to pay for the maintenance of the tumour bank if enough funds could not be raised and for choosing to forgo private patient fees in lieu of charitable donations.

Dr Olson has a public appointment at the Princess Alexandra Hospital and private practice through the Mater and Greenslopes Hospitals.

She has particular interests in minimally invasive brain surgery, pituitary disorders, trigeminal neuralgia and in recent years she supervised the introduction of deep brain stimulation into the public sector in Queensland.

She said she became motivated to raise money to boost brain cancer research and establish the tumour bank when she could no longer tolerate going into the brain cancer clinic knowing there had been little advance in treatment options for decades.

"Like most surgeons, I spent all my time working to become better and better at what I did, but then one day I had this horrible moment when it struck me like a sledge-hammer that no matter how good I became at this, I still won't be able to save my patients," she said.

"Glioblastomas have only a 10 per cent five-year survival rate; they are the biggest killer in people under 40 and yet still so little is known about them and I got sick of going into clinic knowing that the treatment I could offer now was no better than it was 10 years ago.

"The treatment of breast, prostate and bowel cancers have been almost revolutionised in that time – from detection, to removal, to remission or cure – yet brain cancers still remain as lethal as they were.

"The difference is, of course, that those diseases have the financial resources available to support and advance the necessary research.

"So I decided to do something about it and while I did everything I could think of to raise money, I also began work on the brain tumour bank to allow scientists to conduct DNA profiles of the pathology."

To do this, Dr Olson first approached brain tumour researchers across Queensland to ask them what they needed; she reached agreement with her neurosurgical colleagues willing to process the tumour samples and found a laboratory equipped to conduct the work at Wesley Hospital.

She then won support and funding from the John Trivett Foundation to pay for the annual running costs of the tumour bank.

Since then, she has also forged links with both the Cure Brain Cancer Foundation and the Brain Foundation.

"When I first started fund raising for this I thought about setting up a stand-alone charity, but it wasn't practical because of the costs involved in meeting legal and administrative requirements, so instead I am working with other brain cancer charities," she said.

"It's important, though, to remain focused and committed toward particular goals that in my case is to support the genetic profiling of as many tumour samples as possible.

"That might sound straightforward, but it isn't. I spent a great deal of time winning ethics approval for the project and working out the logistics of how to store and transport samples so they are of maximum value for the research scientists.

"The good news is, though, that now that all this has been done, there is no reason we cannot standardise the project across Australia and I am now meeting with like-minded people from other states to work on this.

"We are also in discussions about extending the bank to take in tumour samples of all metastatic tumour samples such as those from the pituitary, lung and breast."

Dr Olson's fund-raising campaign now sees her competing marathons, pushing raffle tickets, attending charity balls and dinners and speaking at public functions.

Working as a team

Dr Olson thanked her neurosurgical colleagues for their support of the tumour bank.

"All of us have similar feelings about the poor outcomes our patients face and they are also keen to advocate and get out there to push the case for our patients," she said.

"We all know that the days of throwing tumours in the bin belong to history now that scientific advances mean they can be used as a resource to advance our knowledge.

"It's taken quite a bit of effort getting everyone from the major charities, to the neurosurgeons, to the brain cancer researchers all on the same page and while it's a work in progress we are getting there.

"No glioblastoma is the same, so genetic profiling is crucial if we are ever going to come up with personalised treatment plans."

Dr Olson, a mother of three, has a range of appointments outside her surgical practice including Chair of the multidisciplinary brain tumour clinic at the Princess Alexandra Hospital, surgical advisor to the Australian Pituitary Foundation and Senior Lecturer at the University of Queensland.

Dr Olson said she was taken aback to hear of her nomination and short-listing for the award.

"I'm a little embarrassed about the nomination, but if it raises awareness and therefore funding to boost research to help our patients then I'm happy to go along with it," she said.

"I would dearly love to see better treatment options and better outcomes for our patients during the course of my working life and I believe that is possible if all of us involved in this field work together and find the money to push the research forward."

With Karen Murphy

For more information visit www.curebraincancer.org.au

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COMING TOGETHER

Tripartite meeting signals commitment to issues for Trauma, Indigenous and Rural health

The attendance of Indigenous health leaders at the 2014 Trauma Symposium, 'Indigenous Injury – learning from each other' to discuss injury and trauma in the Indigenous community should be considered a positive step forward, according to the Chair of the College Indigenous Health Committee, Associate Professor Kelvin Kong.

The Symposium, which coincided with the 50th anniversary conference of the PSA, also brought together members of the College Trauma Committee, Indigenous health leaders from Australia and New Zealand, international trauma experts from Canada and India, politicians and local doctors.

Held in Darwin in August, the meeting was designed not only to discuss ways to lower mortality and morbidity rates in the Indigenous community caused by injury and trauma, but to hear first-hand from Indigenous health leaders about the underlying factors behind the statistics.

Speakers at the conference included Ms Donna Ah Chee from the Central Australian Aboriginal Congress, Dr Stephanie Trust from the Australian Indigenous Doctors' Association, Mr John Paterson from the Aboriginal Medical Services Alliances of the Northern Territory and Dr Hinemoa Elder from the Health Research Council of New Zealand.

Associate Professor Kong said the presence and involvement of such health leaders indicated a growing awareness within the Indigenous community that the College was deeply committed to improving outcomes for Indigenous patients.

"The presence of the Indigenous speakers changed the entire tone of the meeting allowing all of us to get a deeper understanding of the issues behind the high rates of injury and trauma that we see in the Indigenous community," he said.

"While the College has recognised for some time that trauma statistics are just one way of understanding Indigenous health issues, this meeting allowed for a wider discussion around trauma such as spiritual and emotional trauma and social dislocation.

"The fact that such respected Indigenous health leaders were keen to participate, I think, indicates that they understand that the College wishes to walk beside them to improve the care and well-being of Aboriginals, Torres Strait Islanders and Māoris whether they live in the city or remote communities.

"The College has a long and proud history in advocating for social change to create safer communities – like the work done to reduce drink-driving and the legislative requirement to wear seat-belts – and this meeting represented an opportunity for us to learn from those leaders about how we can best help their communities.

"Sometimes I think we forget how powerful the College can be, yet I think in the past we haven't really known where our voice as surgeons belongs in the debate about Indigenous health. This meeting represented a change in that."

Associate Professor Kong said the College was now actively lobbying the Northern Territory Government against unlimited speed limits, promoting improved access to telehealth to treat severely injured remote patients while they wait for transport and pushing for limitations on the sale of alcohol to benefit the entire Australian community.

He said the meeting also discussed the need for more liaison officers to work with Indigenous patients and their families as they navigated the health system.

Shared aspirations

The first Aboriginal doctor in Australia to become a surgeon, Associate Professor Kong said the three days of discussions and presentations helped consolidate a growing sense of trust and shared aspirations between Indigenous leaders and the College.

"The presence of the Indigenous health leaders meant a great deal to me because in years past they would not have believed that the College was deeply interested in the issues affecting their communities," Dr Kong said.

"This meeting was very moving to me, then, because it brought together not just Indigenous leaders and surgeons, but three Committees of the College, which indicates great commitment to tackling the issue as well as great collegiality.

"I think sometimes people don't realise how passionate surgeons can be, not only about the welfare of their own patients but also the wider community."

The co-convenor of the Symposium, Mr David Read, said central issues addressed at the meeting included the disproportionately high road death toll in the Northern Territory, injuries caused by alcohol and interpersonal violence and the time taken to transport and transfer severely injured patients.

A general surgeon and the Director of Trauma and Burns at the National Critical Care and Trauma Response Centre at the Royal Darwin Hospital, Mr Read said members of the Indigenous community were over-represented in most indices of trauma and injury.

He said Aboriginal and Torres Strait Islander patients now represented 40 per cent of the Royal Darwin Hospital case load while representing only 29 per cent of the over-all population in the NT.

Latest statistics also show that the Northern Territory now has the highest road toll in Australia at 17.31 deaths per 100,000 people compared with 5.04 for the rest of Australia.

"There are a number of very basic reasons why Indigenous people are over-represented in terms of injury and trauma caused by motor vehicle accidents," Mr Read said.

"There are often vast distances to travel, the variable quality of roads and cars, and the lack of public transport are all factors. The distance from point of injury to definitive care is also often significant.

"The mean time now at the Royal Darwin Hospital for severely injured patients to get into a resuscitation bay is six hours compared to other major trauma units in southern states that can be as low as 30 minutes.

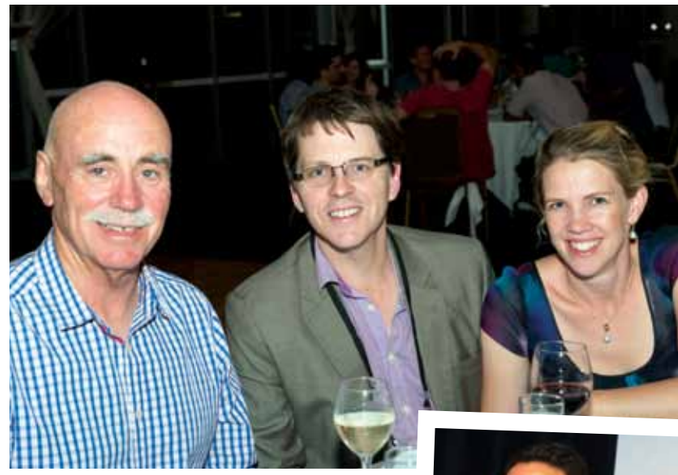
"All of these issues affect Indigenous people disproportionately because they are more likely to live in remote areas and they are more likely to have to drive significant distances for cultural reasons or to access services.

"The Symposium gave us the opportunity to not only look at the epidemiology behind trauma in the Indigenous community, but to discuss ways we could improve outcomes through creating stronger links between trauma units and remote medical centres to provide tele-consultations to help stabilise severely injured patients while they wait for transport."

"We also discussed alcohol-related violence and injury based around the RACS policy called Hours, Outlets and Taxes (HOT), an important advocacy initiative of the College."

Mr Read also described the presence of Indigenous health leaders as a highlight of the meeting and said that their input would be used to further refine the College's Indigenous Health policy.

In particular, he said the call by Indigenous health leaders for an increase in the number of Aboriginal and Torres Strait Islander liaison officers in hospitals across Australia should be promoted so that such assistance becomes a core standard of care. ▶



ABOVE:
From left: Warren Snowden and Co-convenor David Read.
INSET: Kevin Kong

He said many surgeons would find such a cultural and health resource invaluable.

"The Indigenous health leaders were the shining light of the Symposium," Mr Read said.

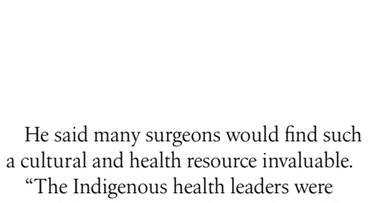
"They were realistic, they were forthright about what works and what doesn't and they were generous with their knowledge.

"I think their presence made the Symposium unique and I think in time their contributions will help Fellows who work within Indigenous communities to discern where gains can be made to improve outcomes for Indigenous patients across the trauma spectrum.

"One of the most profound statements I heard during the conference came from Ms Ah Chee who said that Indigenous people did not want paternalism, but the assistance to bring themselves out of disadvantage.

"To me, that comment emphasised the need for us to keep in mind that any strategy we adopt must be implemented in conjunction with, and with the support of, the Indigenous community if it is to have any meaningful impact."

With Karen Murphy



Convenors Mahiban Thomas and Sarah Weidlich

Carolyn Vasey and Phil Carson.

PSA MEETING REVIEW

Good feeling pervaded at meeting

CAROLYN VASEY

The Provincial Surgeons of Australia (PSA) meeting is one that stands apart from any other; I remember the feeling as an intern at my first meeting of being among friends openly sharing surgical experiences with a sense of honesty and humility, and that feeling has extended to the current day with the 50th anniversary meeting of the PSA in Darwin being my first PSA as a newly graduated Fellow.

Buoyed on by positive training experiences in regional Australia, it is heartening to see such a swell of younger delegates attending the PSA. The Rural Coach program, headed by Sally Butchers and supported by Trish Meldrum, is having a positive effect in supporting these Trainees. Nevertheless, the more mature age groups did not go unrepresented, with a well-attended session on retirement and the Jim Prior Begonia Prize (for the most original surgical innovation) this year going to Peter McNeil from Wagga Wagga who accepted his award in full song!

This year the scientific program focused on managing trauma in regional areas. Guest speakers included Dr Grant Christey who provided insights into trauma systems in regional New Zealand, Professor Ranijinkanth J from Christian Medical College Vellore, India, who spoke about neck trauma and Dr Rajiv Choudhrie from Padhar Hospital in Central and extremely rural India, who spoke on his moving personal experiences with the separation of two conjoined twins in India.

Local Territorian and master surgeon Assoc Professor Phil Carson spoke on a diverse range of topics from the history of surgery in Darwin through to thoracics and hand surgery in regional practice. The free papers section demonstrated the breadth and depth of research being produced from regional units, with the best paper awarded to Dr Tara Luck on her study of neurosurgical management in the Northern Territory (NT).

For the first time the PSA partnered with the RACS Trauma Committee meeting, which culminated in the Saturday symposium on 'Injury in Indigenous Populations', with many experienced practitioners contributing to a discussion platform from which many forward steps will be taken to better tackle longstanding issues facing indigenous populations in rural and regional areas.

Many thanks to the two conveners Mahiban Thomas and Stephanie Weidlich, who complemented each other so well in organising both the scientific program and all of the fabulous dinners, each with a perfect dry-season Darwin sunset as a backdrop to the festivities.

The personalised touches that pervaded the conference (from the hand painted gold crocodiles through to the thoughtful Territory style gifts for the guest speakers) did not go unnoticed. Thank you also for the support provided by the College events team to bring this all together.

We look forward to the 51st PSA meeting from October 28 to 31, 2015 – with a particular invitation extended to any surgeon or Trainee working in provincial Australia and New Zealand, regardless of specialty, to come along to Lismore next year and see what the PSA is all about.

Rural health outcomes will benefit from conference

Medical student Jerry Abraham Alex writes of his experience at the PSA Conference

As a medical student wanting to pursue a career in rural surgery, I was privileged to be sponsored by the College Rural Surgery Section to attend the PSA Conference 2014. With trauma and Indigenous health as the main themes, the list of guest speakers was nothing short of phenomenal. The program covered all aspects of trauma from emergency department to head and neck, upper and lower limbs, thoracic, abdominal and pelvic injuries. It offered multiple sessions of short duration, keeping the audience spell bound as the various specialists discussed some of their harder and obscure clinical vignettes.

As the Co-Chair of the National Rural Health Students' Network, I was able to represent the NRHSN, which acts as a national voice for all rural health students to help address the disparity in health outcomes among Indigenous and non-Indigenous populations and between rural and metropolitan Australia. The NRHSN supports students in rural schools considering health careers and encourages them to return to rural areas. The meeting with the PSA is a significant milestone, as RACS is the first specialist college within the discipline of medicine to express its support in partnering with the NRHSN to help address the dearth of medical specialists in rural and remote Australia. It provides networking opportunities for students to engage with potential mentors as they navigate their way to specialty training.

Managing a trauma scene competently requires knowledge, experience, great teamwork and nerves of steel. Listening to the management of rural trauma in Australia, Canada, New Zealand and India has helped me understand how rural surgeons often utilise limited resources to save lives. Innovation lies within the heart of rural Australia, as the economy of this nation was once dependent on this sector. Although we do not observe much of that today, one thing is certain – the brain power I witnessed at the PSA conference among these rural surgeons is a force, I believe, able to set in motion ground-breaking work to dramatically improve health outcomes of rural and remote Australians in years to come.

With thanks also to Stephanie Weidlich and Mahiban Thomas for their kind invitation to attend.

MOTIVATED
by the PSA Conference

Four Trainees tell of their PSA 2014 experiences

Findings presented

I was fortunate the abstract deadline for PSA 2014 coincided with me completing a small review project regarding the introduction of acute general surgery unit in Bendigo Hospital, Victoria. I was overjoyed when I was given the opportunity to present my findings to an audience whom the results are relevant to.

The sight of surgeon mentors and the kind introduction afforded by Brian Kirkby, who I have worked with, eased me into my oral presentation, which I am glad was well received. I would like to thank the GSA for the grant which supported my attendance at the PSA.

Wei Ming Ooi,
Rural Trainee

Inspirational

The academic and social programs of the PSA ran like clockwork thanks to the hard work and planning of the organisers who even managed to arrange balmy 25 degree days and pleasantly cool nights. Inspirational presentations were given by surgeons undertaking humanitarian work, and I don't think I was alone as I surreptitiously wiped away tears when Rajiv Choudhrie described the lives and separation surgery of conjoined twins at his rural hospital in Vellore, India.

The rural coach project Trainees were encouraged to use the conference to establish relationships and make our interest clear at an early stage. The camaraderie between the older PSA members was evident, but younger members were seamlessly included. I was welcomed in true country hospitality and would like to thank the College, Rural Coach Project and the GSA for funding my attendance.

Julie Flynn,
Rural Trainee

High quality care

Local Darwin surgeons presented at the PSA on their extensive experience in the surgical management of mandible fractures, neck and chest trauma. Of particular interest was the session from the National Critical Care and Trauma Response Centre outlining its support for victims of Typhoon Haiyan. Another highlight was the Jim Pryor Begonia prize for 'surgical innovation', which was hotly contested. Entries included a heated poncho styled to fit under a surgical gown, innumerable methods of gaining pneumoperitoneum, but the prize was eventually awarded for a modified wooden spoon designed for thoracic aortic compression.

As my first visit to a PSA conference, I developed a better appreciation of the broad, high quality surgical care being delivered in the provincial setting across Australia and New Zealand and also the significant role rural and regional surgeons play in surgical training. I would like to acknowledge the support of GSA and encourage any Trainee looking to enrich their rural surgery training experience or considering any future role as a regional surgeon to get involved in the rural coach project, apply for the GSA grant and attend the PSA conference in Lismore 2015.

Jesse Beumer,
Rural Trainee

A bright future

The first two days at the PSA were filled with engaging talks related to rural trauma – from the approach to prevention of a frozen 'open' abdomen from Ollapallil Jacob to large mammal-related trauma in the Yukon, Canada by Alex Poole. My interest in surgical history was piqued with a thorough and insightful narrative of the history of rural surgery in Darwin by Phillip Carson.

The strong attendance and multiple papers suggest a bright future for Rural and Trauma Surgery. The evenings comprised of fantastic activities and venues such as the Mindil Beach Markets, Parliament House and even encounters with crocodiles and lions at Crocodylus Park. I would like to thank the GSA for the grant which supported my attendance at the PSA.

Gausihi Sivarajah,
Rural Trainee

GUY MADDERN
CHAIR, ANZASM

Case Note Review

A simple fall is not so simple

An elderly patient fell, resulting in a fracture of the left proximal humerus and a sub-capital fracture of the left femur. When retrieved by the ambulance, the patient was fully conscious and there was no evidence of a head injury (or other injuries).

The patient was admitted to hospital and operated on (under the same anaesthetic) for both fractures (stabilisation of a two-part proximal humerus fracture with a locked fixation device and a hemiarthroplasty of the intra-capsular fracture of the left hip). The operation report suggests minimal blood loss and surgery time was not excessive.

The patient had significant medical comorbidities including chronic renal failure, mild chronic obstructive airways disease (COAD), and previous gastrectomy with associated anaemia, gastritis and congestive cardiac failure. These comorbidities do not contra-indicate the appropriate surgical stabilisation of these fractures. Indeed, in a patient of this nature it would have been extremely difficult, if not impossible, to manage them without fracture fixation.

The patient had a cardiac arrest on day three post-operation and died. The patient was 'not for resuscitation' as per an advanced health directive.

Comment

The treating surgeons had little choice, but to perform the surgery that was undertaken. Early internal fixation of multiple fractures is indicated even when multiple comorbidities are present. This may very well allow for best nursing care and reduced pain, even though a frail patient does not have a long life expectancy.

Although the patient had a difficult postoperative course as a consequence of the comorbidities, the assessor could not see anything in the medical record to suggest that the postoperative course was compromised by any area of management. There was nothing to indicate excessive intraoperative or postoperative blood loss or other complications of surgery which may have worsened the situation.

The assessor could see nothing in either the decision to undertake such surgery or subsequent treatment that was undertaken that would have prejudiced this patient's outcome in any way.

ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

Court of Examiners for the Fellowship Examination

Applications from eligible Fellows willing to serve on the Court should be forwarded to the Department of Examinations of the College no later than Friday, 30th January 2015 for appointment in 2015.

Fellows are asked to note the following vacancies on the Court, in the specialties of:

- General Surgery
- Neurosurgery
- Orthopaedic Surgery
- Paediatric Surgery
- Urology
- Vascular Surgery

Should you wish to apply to be an Examiner/member of the Court of Examiners, please forward your application form with your curriculum vitae to:
examinations@surgeons.org
or post to:
Department of Examinations
Royal Australasian College
of Surgeons
250 - 290 Spring Street,
EAST MELBOURNE VIC 3002

> Application forms are available for downloading via the College website **www.surgeons.org**

> The policy in respect to Appointments to the Court of Examiners and Conduct of the Fellowship Examination can be found on the College website.

For inquiries, please email examinations@surgeons.org

EXAMS NOW ONLINE

The first ever computer based RACS Generic Surgical Science Examination is a major milestone

RICHARD WONG SHE
CHAIR, SSE&CE COMMITTEE

On October 9 and 10 this year the Generic Surgical Science Examination (GSSE) was delivered to more than 100 candidates distributed across seven locations in Australia and New Zealand via computers based in a number of examination centres.

Until now, all College examinations have been paper based; the move to an electronic format via the web for the GSSE heralds the first time a major College examination has been delivered in this way.

The examination, which is a requirement for all SET Trainees, is run over two days and tests basic knowledge of surgical Anatomy, Physiology and Pathology. In addition to MCQ type questions, the GSSE also includes short answer questions (Spot Test Questions). These questions have required manual marking of each paper. This is labour-intensive and time consuming for the Anatomy Committee members, and a major barrier to offering the GSSE beyond current capacity. This technology will support the delivery of the examination to many more candidates, allowing access for non-Trainees. The opportunity to sit the examination prior to entry into SET will enable the GSSE to become part of pre-vocational training and in time, a pre-requisite for application and entry into SET.

Work to establish a secure platform by which to deliver the exam and a process for collating and marking answers was developed in-house by the IT staff with the support of the College Examinations Department.

This is a major milestone, not just in the way the examination is delivered, but in building our capacity to offer the GSSE to a wider audience. Importantly, many improvements planned for the near future will be supported through this initiative.

Benefits associated with this development include:

- An improved exam experience for candidates; feedback from the candidates was very positive.
- More efficient marking that will support a faster turnaround of results.
- Integration of examination delivery with College plans for improved digital interaction with Fellows and Trainees.
- Paves the way for the GSSE to become widely available prior to entry to SET and ultimately to become a prerequisite for SET selection.

The College is now looking forward to expanding computer delivery to other examinations starting with Specialty Specific Surgical Science exams in 2015. The written components of the Fellowship Examination are also being considered for computer delivery in the future.

I would like to thank the College Examinations and IT Departments for their assistance in developing and delivering the examination system. Thank you also to College Regional office staff for their assistance onsite at the examination venues across Australia and New Zealand.

CATHY FERGUSON
CHAIR, FELLOWSHIP
SERVICES

Your College service

Find a Surgeon and Practice Card services updated

Find a Surgeon is a free to use directory listing service for all Fellows of the College who are CPD compliant.

It is the most visited area of the website (after the College library), so it presents a great opportunity to help your patients and referring GPs to find you.

The service has recently been given a refresh to make records more visually appealing and easier to understand, and those Fellows who have a Practice Card will also now have their image shown in their listing.

To opt in to be displayed on Find a Surgeon, or to update your details, visit the My Account section of My Page.

Practice card

Practice Card is an extension of the Find a Surgeon facility that creates a page all about you on the College website. It's essentially a professional online business brochure that encourages both GP referrals and, if you choose, increased engagement with prospective patients.

Following feedback from our Fellows, the College has recently made improvements to the Practice Card service to make it easier setup and use.

Firstly, your Practice Card can now be found via a more user friendly web address with your name or other text inserted e.g. http://www.surgeons.org/profile/dr-generic-surgeon This is a big improvement over the numeric URL used before; you can certainly select your own words, but it will be subject to approval before going live.

Also, it's now also easier to setup your Practice Card. Your profile's image can be resized and cropped online to save you time, or if preferred, you can import your headshot from LinkedIn. Additionally, you can now list up to three separate practices. Your Practice Card will now print neatly when required, so it's useful for creating patient handouts.

Why not check out the new and improved Find a Surgeon and Practice Card areas next time you visit the College website.

IN MEMORIAM

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

Richard Wingate,
NSW Fellow

Claude Mann,
Qld Fellow

Kenneth James Brown,
Qld Fellow

Garth Powell,
New Zealand Fellow

Alan Poole,
NSW Fellow

Earl Owen,
NSW Fellow

Mark, McGree,
Qld Fellow

Donald Golinger,
WA Fellow

Iain Macfarlane,
New Zealand Fellow

Malcolm Stening,
NSW Fellow

We would like to notify readers that it is not the practice of *Surgical News* to publish obituaries. When provided they are published along with the names of deceased Fellows under In Memoriam on the College website **www.surgeons.org**

Informing the College

If you wish to notify the College of the death of a Fellow, please contact the Manager in your Regional Office. They are

ACT: Eve.edwards@surgeons.org
NSW: Allan.Chapman@surgeons.org
NZ: Justine.peterson@surgeons.org
QLD: David.watson@surgeons.org
SA: Meryl.Altree@surgeons.org
TAS: Dianne.cornish@surgeons.org
VIC: Denice.spence@surgeons.org
WA: Angela.D'Castro@surgeons.org
NT: college.nt@surgeons.org

THE PROBLEM WITH LYCRA

Why are they in such a rush?

BY **PROFESSOR GRUMPY**

There is one thing that really annoys me and that is bicycles. It is not so much the machine but the users and their attitude. We curmudgeons like to walk sometimes and some of the nice paths along the river or beach are described as 'shared paths'. The attitude of the cyclists is, "Yes, we will share our path with you as long as you get out of our way." The 'Slow' sign is interpreted as 1-2 kms per hour less than maximum speed. A cyclist passing within 2cms at 60 kms per hour is rather startling. If I was quick enough my walking stick might get stuck in their spokes.

In my city we had a very good road that enabled a driver to get away from the CBD quite quickly – two lanes in each direction and a clearway. So what have the nincompoops at the city council done? They have amputated a lane in each direction for a few parking spaces interspersed with garden and a bike lane on the inner most portion of the road. An excellent CBD escape turned into a parking lot! In the many minutes that I have been stuck there, how many bikes have I seen? Not one!

Why is it that some cyclists are always in lycra and some look so, so – well, slim and gorgeous? (Some, however, reveal way too much information that would be better covered). How come they don't have sore backs that prevent them from leaning over the handle bars? Just because they are slim and gorgeous or think that they are slim and gorgeous does not mean they can cut in front of cars or make rude gestures when we quite legitimately nick into the bike lane for a few seconds to get past that slow car ahead. We curmudgeons pay the transport taxes of various sorts and the cyclists pay nothing – not a brass razoo! We pay for the bike lanes so on the principle of equity they are ours to do as we wish. I would turn them all back into car lanes.

The latest concession to these cycling commandos is special traffic lights for them. At some intersections the busses have a special green light, then the pedestrians and then the cyclists and at last a few seconds for the motorists. That way they can get in front again and congest the next set of lights with their metal monsters.

The only cyclist that I would allow is my three year-old granddaughter and she would only be allowed on the back patio. As for the rest of the lycra set I would say to them, "On your bike!"

Have a Healthy & Merry Christmas

Don't become a pudding

BY **DR BB G-LOVED**

The festive season heralds joy and gaiety, but is laced with toxicity. Christmas parties and family gatherings, sparkled by the excitement of children and grandchildren, belie the risk of ulcerating atheromatous plaques, increased platelet adhesiveness and inflammation across the foregut.

The Yuletide can be lethal. In the Northern Hemisphere mortality rates are highest in December and January. Downunder and in the Antipodes, where Christmas may be spent lazing about on the river, the beach or cowering from the heat in wafting vents of an airconditioner, mortality rates rise with the temperature, as do road fatalities with the festive season.

Dr Chris Toomas has struggled with the usual features of impending metabolic syndrome – hypertension (BP 160/105), hyperlipidaemia (Cholesterol 7.6mmol/l) and increasing adipositiy (BMI 28). Chris is not currently diabetic, but could well develop it over the next decade or so. So what cheer (advice) could I offer this busy and stressed surgeon for the on-rushing Christmas?

Minimise stress that increases inflammatory markers. Free radicals should not be allowed to play havoc with your neuroendocrine system. Relax, take a break, avoid last minute shopping and do not enter a shopping mall. Providing you are exercising, shop online; in time for your presents to be gift wrapped at source and delivered without scuffing your shoes.

Though it might be tempting to shop till you drop, the malls are crowded with desperados and the prices are high. Last minute buys are usually poorly matched even when for a newborn. 'Bearing gifts we trespass too far'.

In Oceania's Orient we may not be Kings; wisdom forsakes us when out of our comfort zone Christmas shopping. Witness the case series of useless, readily discarded gifts from our family members over the years – driven by guilt, obligation and advertising-induced commercial pressure. Tom Lehrer aptly sang: 'Angels from the realms on high, tell us to go out and buy'!

Eat well. Turkey is a lean meat so tradition is a healthy option. Cranberries are rich in antioxidants, so a tick for the sauce. Christmas pudding is, like Christmas, a mix of the good, the bad and the ugly. The pudding is high in fibre, B vitamins, potassium, calcium and rich in antioxidants that emerge from the raisins and sultanas, but also potentially glycaemic due to its sugar and carbohydrate load. The traditionalist who smears or dowses it in brandy butter (1 tablespoon 15g = 81kcal, 5.8g fat, 3.9g saturated) and/or cream (2tbsp or 30g of double cream has 133kcal, 14.2g fat, 8.9g saturated) should rather consider vanilla custard or Greek Yoghurt instead. And for those of you who like brandy butter or cream, since when have you limited it to one or two tablespoons?

The traditional stocking wants as requested by AA Milne's King John:

I want some crackers,
And I want some candy,
I think a box of chocolates would come in handy;
I don't mind oranges,
I do like nuts
I haven't got a pocket knife, not one that cuts,
And Oh if Father Christmas had loved me at all,
He would have brought a big, red india-rubber ball.

So what of King John's list? Crackers – maybe, if not too salty. Candy – bad, definitely a sugar fix. Chocolates – dark chocolate has antioxidants and flavanols which improve cognition and cerebral perfusion, promote vasodilation, reduces blood pressure, inhibits platelet activity and decreases inflammation. Wow! Enjoy in moderation. Avoid milk and white chocolate.

Oranges are rich in flavanols as well as Vitamin C, an antioxidant that reduces plasma lipid peroxidation – so ideal for stockings, even for grandparents whose memories and mood will only benefit. Nuts are rich in magnesium, which reduces risk of hypertension, hyperlipidaemia, metabolic syndrome and obesity. The traditional Brazil nuts (410mg/100g) almonds (260mg/100g) and walnuts (130mg/100g) are all good sources of magnesium and also provide zinc, for those of you who think zinc after last month's column.

I must admit I cannot recommend 'a pocket knife that cuts', not even for King John to commemorate the 800th anniversary of the signing of the Magna Carta next year. That pocket knife portends alcohol fuelled violence between relatives who'd rather not congregate, but pretend they must; or children playing with sharp knives (or adults with chain saws) suffering finger lacerations requiring surgeons to spend Christmas managing wounds.

And what of that red india-rubber ball? Whatever shape you like your balls, playing with them is good for you. You and the kids can be out in the park, or playing on the beach, avoiding obesity. Chris Toomas can be stretching and strengthening back, buttock and abdominal muscles across one of those big gym balls which, providing there is sobriety, won't normally cause an injury. And on that note of sobriety – drink alcohol in moderation, don't drink and drive, and enjoy a healthy and merry Christmas.

PACIFIC ISLANDS SURGEONS CONFERENCE

A gathering of Pacific communities was the biggest yet

NIGEL WILLIS
CHAIR, NEW ZEALAND NATIONAL BOARD

The Pacific Islands Surgeons Conference was held recently in Suva, Fiji, under the banner of the Pacific Islands Surgeons Association (PISA). With more than 70 attendees this was the largest of these biennial Pacific meetings to date. Indigenous surgeons and surgical Trainees from 10 Pacific Island nations were present – from the Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu. The College Vice President David Watters, and, as Chair of the New Zealand National Board, I attended, along with several other surgeons and one surgical Trainee from New Zealand, Australia and Hong Kong.

These meetings provide one of the very few opportunities for continuing medical education focused on surgery in the Pacific Islands. The program is organised and delivered predominantly by Pacific Islands' surgeons, with assistance when requested from New Zealand and Australian colleagues.

The 2014 meeting focused primarily on disaster response, non-communicable diseases (NCDs) and surgical training. However, there were also opportunities to discuss the treatment of burns and limb trauma, for Pacific registrars to present their research papers and for participants to be informed about activities of Interplast and the TRIPP team.

Pacific Island countries are particularly prone to earthquakes, tsunamis and extreme weather events. The health consequences of these are a major concern for the countries themselves and for many international aid agencies. While the events cannot be controlled, pre-disaster planning and skilled local staff are key to organising and managing the immediate health services response and thus mitigating and reducing the associated mortality and morbidity. Dr Douglas Pikacha from the Solomon Islands and Dr Petueli Emose from Samoa discussed the impact of recent disasters on their health services and the improvements that had been made or were to be made in their disaster plans. James Kong had travelled to Myanmar to assist after a cyclone and spoke on issues that had arisen several days after the disaster event.

Cancers are one of the major NCDs affecting Pacific Island countries and oncology was a major focus for this meeting. Oncology outcome data from Tonga, PNG, Samoa, Kiribati and Fiji was presented and discussed. A lack of the resources, taken for granted in New Zealand and Australia, combines with late presentations to result in high mortality rates. Surgeons in several of the Pacific Island nations are recording and reviewing their hospital's perioperative mortality, and data from Tonga, Tuvalu and Fiji were presented for discussion. It was concerning to learn that, in some countries, they are not able to include in their data the work of visiting specialist teams.

The number of surgeons in Pacific Island countries is still very low by New Zealand and Australian standards. However, there has been a considerable increase in the past 15 years with graduates from the Fiji School of Medicine (now Fiji National University (FNU)) program joining those from the PNG programs. The majority of surgical services in Pacific Island countries are now provided by surgeons who have received most of their training through these programs. Continued growth of the workforce is important for the further development of surgical services in the Pacific Islands. Consequently FNU's 'postponement' of its post graduate surgical training programs is of considerable concern to Pacific Islands' surgeons, the Trainees who are part way through one of those programs, the young doctors who had hoped to join a program and to the countries who have lost access to this training option. That and other training and workforce matters generated considerable discussion. FNU has asked the College for assistance and the PISA supported the College acting on that FNU request and, in liaison with PISA members, seeking ways in which the surgical training programs could be re-instated as soon as possible.

The networks that develop from these meetings have led to new graduates of the Fiji program gaining placements in New Zealand or Australian hospitals to extend their experience before taking up consultant posts in the Pacific. Since this 2014 meeting a new placement opportunity has been identified in orthopaedics in Wellington and an existing orthopaedic placement in Christchurch may extend to provide some plastic surgery experience also.

These meetings are also an opportunity for PISA to hold its General Meeting and to elect its Executive. The new Executive is:-

President: Lord Viliami Tangi FRACS, Tonga
Vice President: Ifereimi Waqainabete, Fiji
Secretary / Treasurer: Richard Leona, Vanuatu
Immediate Past President: Eddie McCaig FRACS. Fiji
Other Executive members: Sireli Kaloucava, Fiji; Ikau Kevau, PNG; Saia Piukala, Tonga; Ponifasio Ponifasio, Samoa; and Deacon Teapa, Cook Islands
Trainee representatives: Micky Siota (PNG programme) and Ronal Kumar (Fiji program)

Eddie McCaig FRACS and Alex Auldist FRACS have been made life members of PISA. Eddie trained in medicine and orthopaedic surgery in New Zealand and then returned to Fiji where he has worked for many years. In addition to his skill as a clinician, Dr McCaig has been an acknowledged leader within the surgical services in Fiji and has been Professor of Surgery and Head of Department for the Fiji School of Medicine / FNU postgraduate surgery training programs. He has been a forceful proponent for surgical training that produced graduates suited for practice in PICs, and was the inaugural President of the Pacific Islands Surgeons Association. Alex is an Australian paediatric surgeon who, over many years, has provided direct service in many Pacific Islands countries and has assisted with the training of many Pacific Islands surgeons.

The biennial Pacific meetings would not be possible without considerable financial and administrative support. NZAID has assisted since 1996 and funded the attendance of surgeons from eight Pacific countries to the 2014 meeting. Assistance also came from the PIP programme for two surgeons and from Strengthening Specialised Clinical Services in the Pacific (SSCSiP), which is funded by AusAid. College staff in the New Zealand Office and SSCSiP staff in Fiji provided the administrative support.

For any Fellows or Trainees interested in supporting this initiative, the next Pacific Islands Surgeons Conference will be in Samoa in 2016.

SURGICAL MORTALITY

An international perspective

JOHN NORTH
CLINICAL DIRECTOR,
QASM AND NTASM

In September 2014, I visited the Royal College of Surgeons (Edinburgh) at the invitation of Mr Ian Ritchie (College President).

During my visit, the College Vice-President and Director of the Scottish Audit of Surgical Mortality (SASM), Professor James Hutchison, organised a group of interested parties to meet. This group discussed why the Queensland Audit of Surgical Mortality (QASM) and why the Australian and New Zealand Audits of Surgical Mortality (ANZASM) successfully continue, whereas the SASM ceased to audit in May 2014.

Professor Hutchison described the slow and progressive reduction of surgeons' participation in SASM. This lack of surgeon support was the final blow to what was initially seen as a golden age of surgical mortality audits in Scotland.

Prior to May 2014, health bureaucrats in the United Kingdom's National Health Service (NHS) viewed the audit as a worthwhile activity. Unfortunately, the protection afforded surgeons in Australia (that is, qualified privilege: the Commonwealth legislation that protects release of any information in any form) did not exist in Scotland. For many reasons, over time, the surgeons in Scotland lost enthusiasm about responding to and being participants in their surgical mortality audit.

When Dr James Aitken moved from Scotland to Australia and established the audit process in Western Australia in 2001, the Scottish audit was functioning well. Sadly, SASM no longer exists.

Senior health administration in Scotland and the Executive Clinical Director of Health Improvement Scotland (HIS), Dr Brian Robson, joined our Edinburgh-based meeting and expressed his regret that the SASM had failed. He suggested that a morbidity and mortality audit for Scotland was his vision. He sought advice on how to emulate the surgeon participation/volunteerism that we know in Australia (and especially in Queensland with 100 per cent participation of public and private hospitals, and 100 per cent surgeon participation).

There is no doubt that Australian surgeons have been incredibly positive about and supportive of their surgical mortality audits. They continue to be diligent in their returning of surgical case forms, first-line assessments and second-line assessments.

This kind of surgeon involvement has created an extremely useful and robust database. From this database, aggregated de-identified data can be extracted by surgeons and health care providers. Many lessons can be learned from this data at all levels of surgical care.

Australian surgeons who are participating in their state-based surgical mortality audits need to be congratulated on their enthusiastic volunteerism.

To Australian surgeons, I would say that this is your audit. This data is your data. You can learn from this data and you can use this data to present, to publish and to change practice that will improve surgical healthcare delivery across our nation.

To know that the SASM has ceased is disappointing, but we hope that out of the ruins of that establishment might rise a 'phoenix' that will improve both the morbidity and mortality audit process in Scotland. And thereby create a learning arena as strong as ours.

My thanks to the Vice-President of the Royal College of Surgeons, Edinburgh and to the Executive Clinical Director of Health Improvements Scotland as well as other participants; Dr Frank Dunn, President RCPSG, Dr Derek Bell, President RCPEd and Surgical Vice-Presidents Ian Colquhoun and Mike McKirdy for their enthusiastic participation when I joined them at Surgeons' Hall in Edinburgh, Scotland.

I would like to thank Professor Guy Maddern, Mr Gordon Guy and Ms Therese Rey-Conde for their assistance at this meeting by teleconference.

JULIE MUNDY
CHAIR, PROFESSIONAL
STANDARDS

CPD VERIFICATION

It's not as hard as you think!

If you are one of the seven per cent of Fellows who are asked to verify their Continuing Professional Development (CPD) participation – don't panic! It's not as hard as you think!

In November each year, notification is sent to Fellows who have been randomly selected to provide evidence of their CPD participation for that year.

If you have been selected to verify your activities in 2014, it is mandatory for you to complete your CPD online diary and provide your verification evidence online.

How do I use the Online Diary?

In four easy steps you can finalise your CPD participation and upload evidence of attendance:

STEP 1 CPD Diary

Logon to your Online Diary to check your outstanding requirements

STEP 2 Add Activity

Enter any remaining activities relevant for your practice type

STEP 3 + Add files...

Add supporting documents to any activities that are not College-run

STEP 4 Finalise my 2014 CPD

When you have entered your activities and attached evidence of participation, submit your diary by clicking the 'Finalise my 2014 CPD'.

The College continues to refine the CPD program to improve usability for Fellows. This includes a recurring events tool for activities you regularly attend and the ability to upload, store and retrieve documents throughout the year as you go. The more information you provide for activities you attend throughout the year, the easier it is to verify your participation if you are randomly selected.

What evidence can I use to support my CPD?

The College accepts a wide range of evidence to support your participation including:

Surgical Audit and ANZASM (mortality audit)

- A letter from your head of department confirming your participation
- A copy of the audit presentation
- Certificate of participation for CHASM*

*The mortality audit is automatically verified for all states other than NSW. This is not a requirement in NZ

Clinical Governance

- A letter from the Chair or Head of Unit confirming your attendance
- The first page of meeting minutes with your name on the attendees list

Performance Review

- Letters from head of unit/director confirming multisource feedback
- Copy of learning plan
- Letter from peer confirming practice visit with details of the evaluation and action plan
- Summary and action plan of patient feedback report
- Letter from peer confirming they peer reviewed three of your medico-legal reports

Maintenance of Knowledge and Skills

- Certificate of attendance for workshops and scientific meetings
- List of journals/articles read, copy of receipt for journal subscription
- Letters to confirm teaching and supervision
- Copy or links to publications
- Letters to confirm volunteer position

For information on what documents are acceptable, please see the CPD Guide which can be found on the College website: http://www.surgeons.org/policies-publications/publications/

HELPFUL HINTS

Check your practice type to make sure it still best reflects your current situation and review any activities that are already in your CPD Online Diary, including those populated by RACS.

Activities that have been automatically populated through your attendance at College-run events do not need to be verified.

For Fellows in operative practice, you need to provide evidence to verify:

✓**Surgical Audit and Peer Review**
– If participating in a specialty group audit, ask the administrators to provide you with a certificate of participation

✓**ANZASM**
– Only Fellows in NSW need to provide evidence of participation in CHASM. All other Fellows (including NZ) do not need to enter an activity or provide evidence of participation

✓**Clinical Governance Meetings**
– Set regular meetings (i.e. M&M) up as a recurring event in your diary

✓**Activities that are not College run**
– The Head of Unit, Chair or Director can provide you with a letter confirming your participation in a range of activities including Surgical Audit and Peer Review, attendance at Clinical Governance meetings and Teaching/Supervision duties

The CPD Team is available to support you in completing your CPD and verification requirements. Please don't hesitate to contact the Fellowship and Verification Officer on +61 3 9276 7474 or cpd.verification@surgeons.org.

2015 ANNUAL SCIENTIFIC CONGRESS

Perth welcomes the ASC 2015; register at asc.surgeons.org

STEPHEN HONEYBUL
CONGRESS CONVENER
CHRISTOBEL SAUNDERS
SCIENTIFIC CONVENER

The next Annual Scientific Congress (ASC) is being held in Perth in 2015 from May 5 to May 8 and the Scientific and Social programs are now finalised. This event will provide delegates with the opportunity to participate in both an exciting scientific program exploring the theme of 'Ethical challenges faced by surgeons both in peacetime and in times of military conflict' and to network with colleagues. As this is the 100th Anniversary of the campaign in Gallipoli (and the fleet left from Albany in WA) we are using this as an opportunity to highlight military surgery, including the fascinating subject of the ethics involved in this.

The meeting will also feature the involvement of the Royal College of Surgeons of Edinburgh and we look forward to their participation in both the Scientific and the Social programs. Those who can remember the RCSEd involvement in an earlier Adelaide meeting will attest to the value of the input of the Edinburgh College Fellows in both areas of the Congress.

By now all Fellows and Trainees should have received the provisional program for the 84th Annual Scientific Congress in Perth. If you have not received a program it can be accessed via the Congress website asc.surgeons.org

It is not too soon to register for the congress. Go online to the website asc.surgeons.org click the link and follow the instructions.

The congress officially starts with the Convocation and Syme oration at 5pm on Monday, May 4, with the President's Welcome Reception at 7pm. The Syme oration will be delivered by Major General the Honourable Michael Jeffery AC, AO (Mil), CVO, MC (Ret'd).

Fellows who have received their Fellowship in the past five years and have not previously convocated may apply to convocate. They will receive complimentary registration for the meeting. All eligible fellows will be contacted by e-mail.

On Monday, May 4, before the Convocation Ceremony there are a number of important activities. The 'GSA Trainees' Day' and the 'Developing a Career in Academic Surgery' course are high profile events that attract big attendances. In addition to these programs there will be a number of other workshop sessions including an oncoplastic course for the breast surgeons.

The scientific program will run over four days from Tuesday, May 5, to Friday, May 8. In all, 26 section programs are being convened so there is sure to be one that relates to your area of practice. A new feature being trialled this year is a "ring-fenced" Thursday morning in which most of the cross-discipline sections are putting on their main programs, with the craft related sections excluded that morning. This gives delegates the chance to attend what looks like a real treat of sessions without having the "pull" of their main discipline to distract them – these will include for example Surgical Oncology, Women in Surgery, Rural Surgery and Quality Assurance and Audit.

Some of the highlights of the congress will be;

Plenary program

The overall theme of the congress is ethics. The ethical challenges and dilemmas faced by surgeons will be explored from a number of differing viewpoints and the services of a number of prominent medical ethicists have been secured. There has been an enthusiastic response from the surgical specialties and there will be a number of ethical presentations throughout the specialty program. The four plenary sessions will highlight:

'Contemporary ethical challenges in Surgical Practice'

'Surgery and the ethics of military conflict'

'Royal College of Surgeons Edinburgh – 'Ethics and Surgical Practice in Edinburgh'

'Ethical dilemmas and challenges facing surgical practice in the Future'

Named Lectures

This year the speakers who will deliver the Named Lectures will generate great interest.

President's Lecture
Professor Rowan Parks

John Mitchell Crouch Lecture
Professor Zsolt Balogh

BJS Lecture
Professor Richard Satava

ANZJS Lecture
A/Professor Ian Kerridge

Herbert Moran Lecture
Professor Stephen Hopper

James Pryor Memorial Lecture
Mr George Sikorski

Tom Reeve Lecture
Professor the Lord Ajay Kakkar

Mike Wertheimer Lecture
Mr John Crozier

American College of Surgeons
A/Professor Clifford Cho

Colorectal Surgery

The three-day colorectal surgery program is highlighted by the visiting speakers from Australia and overseas. Professor Robin McLeod from the Toronto, Dr Tsuyoshi Konishi from Tokyo and Professor Norman Williams from London will lead discussions on a wide range of colorectal topics from rectal cancer treatment to enhanced recovery programs in colorectal surgery. The Mark Killingback prize for the best research paper by a Trainee or recent Fellow is always fiercely contested and the program will be enhanced by the colorectal Masterclass program. The section dinner will be held at Frasers on Wednesday, May 6.

Head and Neck Surgery

This program has been convened by Des Wee. Des has arranged an extensive program on head and neck malignancy. The international visitor is Professor Chris Holsinger from the Stanford University. In addition to discussing current issues in head and neck malignancy the use of robots in head and neck surgery will be covered.

Surgical History

The surgical history program, convened by Kingsley Faulkner, this year will have a focus on the history of the First World War with the visiting speaker Mr Thomas Scotland from Scotland providing a number of presentations relating to the war in France as well as Gallipoli.

The Executive and Scientific Convener look forward to welcoming you to Perth for an outstanding Congress. For further information on the 2015 Annual Scientific Congress in Perth, go to http://asc.surgeons.org

BINATIONAL COLORECTAL CANCER AUDIT

Changes to make contributing to the audit easier

ALEXANDER HERIOT
CHAIR, COLORECTAL CANCER AUDIT COMMITTEE
MATT RICKARD
CHAIR, COLON AND RECTAL SURGERY SECTION, RACS

There are around 18,000 new cases of colorectal cancer diagnosed in Australia and New Zealand each year and it remains the second most common cause of cancer death. There have been many advances in the management of colorectal cancer over the past decade including chemotherapy and screening, but the primary treatment for bowel cancer remains surgery.

The RACS Annual Scientific Congress (ASC) in Singapore highlighted the importance of quality in surgery and the integral role of audit in undertaking a continual evaluation of the work that individual surgeons undertake. It provides the ability to both assess how we are performing as surgeons and also the opportunity to identify areas where we can improve our individual and hospital practice. A comprehensive binational audit provides the ability to benchmark an individual's personal results against an appropriate comparative group. Collecting data in an efficient manner has always been a challenge for surgeons with increasing demands on their time.

The Binational Colorectal Cancer Audit (BCCA) was set up in 2006 under the auspices of the Colorectal Surgical Society (CSSANZ) and the Research, Audit, and Academic Surgical Division of the College to facilitate surgeons undertaking surgery for colorectal cancer to record and audit their patients and benchmark their results against a large number of colorectal cancer cases across Australia and New Zealand. The audit was initially run through both the College and through BioGrid Australia, with data being able to be submitted on both paper forms and electronically, uploading from hospital based servers. The BCCA database has recently been upgraded to allow online submission of data through a secure web portal, hence facilitating data input from anywhere with Internet access.

What does this mean for me?

The new database provides a number of advantages to surgeons submitting patients to the BCCA. Data can be submitted from any computer with Internet access at any time. Any patient data submitted by a surgeon remains under the ownership of the surgeon, or their supporting hospital if a public patient. A summary of all the data submitted by an individual surgeon, or by a hospital with appropriate approval, can be obtained at any time through the BCCA portal on the web. As well as an easy way to collect data on all the colorectal cancer cases operated on by the surgeon, the audit will also allow real time benchmarking of the surgeon's practice to the rest of the patients on the database to be obtained at the same time.

What do I need to do to get involved?

All surgeons treating patients with colorectal cancer are encouraged to contribute patients' data to the BCCA. This includes both general surgeons and colorectal surgeons. It is necessary to obtain registration and ethical approval at each centre and this will be facilitated by the BCCA if it has not already been undertaken. In order to maintain the running of the audit, there is an annual fee of $100 for each surgeon submitting data to the database.

Continuing Professional Development (CPD) program

Participation in approved audits contributes CPD points used in issuing of College CPD Certificate. Fellows will be aware that in their annual AHPRA registration they must state that they are compliant with the CPD program. James Aitken recently outlined in the article 'Value your Audit' ('Surgical News', July 2014) that AHPRA itself will now be auditing 15 per cent of registrations. BCCA is an approved audit for CPD purposes and participation assists compliance with the College CPD program.

The Binational Colorectal Cancer Audit is an easy and convenient way to audit and benchmark the workload of surgeons treating colorectal cancer across Australia and New Zealand. Participation is voluntary, but surgeons and hospitals are encouraged to get involved. For enquiries, contact Michaela O'Regan, BCCA project manager; telephone +61 3 9853 8013 or email at bcca@cssanz.org https://bcca.registry.org.au

Automatic ANZASM entry into CPD Online

The College is committed to strengthening and streamlining the CPD Program.

IAN BENNETT
CHAIR, RESEARCH,
AUDIT AND ACADEMIC SURGERY

It is important that Fellows can demonstrate they meet the RACS standards without the need for onerous record keeping. Participation in the Australian and New Zealand Audit of Surgical Mortality (ANZASM) is a Continuing Professional Development (CPD) Program requirement that is now automated to save you time and effort. This improvement also increases the rigour of the CPD Program.

ANZASM is an independent peer-review audit of patient deaths that currently takes place in all Australian states and territories. Fellows in operative practice must participate in the audit annually, irrespective of whether they have a patient death or not. Participation relates only to those in hospitals where the audit is available to them. Fellows residing in New Zealand do not currently participate in ANZASM, but are expected to participate in other mortality reviews such as those run by their employing District Health Board.

Each audit of surgical mortality (ASM) is managed by a local office. In New South Wales (NSW), however, the Collaborative Hospitals Audit of Surgical Mortality (CHASM) is managed separately by the Clinical Excellence Commission and provides de-identified data to ANZASM annually for national reporting.

ANZASM aims to improve quality of practice, highlight system errors and identify trends in surgical mortality. Independent peer review takes place in the form of first line and (if required) second line assessments. The audit is intended to be an educational rather than a punitive process and individual feedback on clinical management from a peer promotes reflective learning.

Case forms

To meet the CPD Program requirements, Australian Fellows who experience a patient death and receive a surgical case form (SCF) must complete and return the form to their local ANZASM office within three months of receiving the SCF. As of 2014, Fellows who have met this requirement will have their ANZASM participation automatically populated in their personalised CPD Online Diary. The diary will display the number of outstanding SCFs (for the period October 1, 2013 - September 30, 2014) that need to be completed and returned to ANZASM. Fellows selected to verify their CPD activities are no longer required to provide supporting evidence for this activity. This improvement will ensure that only Fellows who have met the ANZASM requirement are eligible to receive the CPD Program Statement of Participation, which is required for ongoing medical registration. An ANZASM electronic interface is available to assist Fellows to capture audit information directly into a surgical case form template.

Fellows who reside in NSW will continue to self-report their ASM participation through the CPD Program. NSW Fellows will receive a letter from CHASM in January 2015 providing information regarding their participation for the period October 1, 2013, to September 30, 2014.

If you have any questions about your ANZASM participation or require assistance completing a surgical case form, please contact your local ASM Office. Further information about ANZASM is available at www.surgeons.org/anzasm

All Souls College, Oxford, England

SMART TRAVEL

A College scholarship has helped Kristian Bulluss expand his skills

The 2013 recipient of the Stuart Morson Scholarship in Neurosurgery, Mr Kristian Bulluss, used the stipend provided to undertake a 10-month Fellowship in Functional Neurosurgery at the Radcliffe Hospital in Oxford, UK, one of the largest specialist neurosurgical units in the United Kingdom.

Functional Neurosurgery is a growing subspecialty that seeks to modulate brain function either through the use of electrical stimulation or by destroying those parts of the brain that are misfiring or over-stimulated.

In Australia, Functional Neurosurgery is used to treat movement disorders such as Parkinson's disease, essential tremor, dystonia and the movement disorders associated with multiple sclerosis.

However, an increasing number of neurosurgeons are now expanding their use of Deep Brain Stimulation (DBS) to treat such disorders through the use of implanted electrodes designed to alter brain activity.

Mr Bulluss said DBS was also useful in the treatment of some forms of epilepsy and was being used by British surgeons to treat particular forms of chronic pain.

He said that the Fellowship in Oxford had allowed him to work alongside experts such as Professor Tipu Aziz, Mr Alex Green and Mr James Fitzgerald at one of Europe's pre-eminent DBS units.

"As this subspecialty has grown, many small functional neurosurgical units have started around the UK that in turn has resulted in the Oxford unit being referred the more complex and complicated cases," he said.

"This added to the value of my Fellowship because it allowed me not only to learn the techniques of functional neurosurgery and DBS, but to apply them across a range of complex cases, disorders and for a variety of therapeutic uses.

"I gained an insight into rare movement disorders that we would be unlikely to see in Australia as well as the ability to manage complex complications that can only be seen in a unit with a large caseload such as the one at the Radcliffe Hospital.

"I now have the skill set to supplement an existing DBS program as well as the ability to start a unit within a hospital that has not previously offered this type of surgical therapy."

"This added to the value of my Fellowship because it allowed me not only to learn the techniques of functional neurosurgery and DBS, but to apply them across a range of complex cases"

Mr Bulluss said the use of DBS had grown rapidly following the publication of a major trial in the US six years ago, which won the procedure FDA approval for the use in medical refractory focal epilepsy. Europe embraced the therapy the following year while Australia was now rapidly catching up.

"This surgical therapy can be extremely effective for a range of disorders including for those patients with epilepsy that cannot be treated surgically and those people with Parkinson's disease that are suffering from the side-effects of their medication," he said.

"The management of pain is the other big area of utility and in the Oxford unit about 40 per cent of the caseload was using DBS for the management of chronic pain, particularly for returning soldiers with wounds involving severe nerve damage.

"However, given that is an expensive procedure, it is not approved for pain management in Australia."

Now back home in Melbourne, Mr Bulluss is now providing DBS surgery at St Vincent's, the Austin and Cabrini Hospitals.

He said that each surgery took about three hours and involved the placement of electrical wires into the brain that are attached to an implanted device known as a brain pacemaker.

He said he conducted such surgery a few times each month, working closely with Neurologist Dr Wesley Thevathasan who completed a PhD at Oxford.

Mr Bulluss said that one of the great benefits of the Fellowship in Oxford was gaining the knowledge to assess which patients would have the most to gain by DBS as well as spinal cord stimulation.

"Working closely with Dr Thevathasan, we assess the patient and take very detailed scans so we can see exactly which parts of the brain are misfiring or overstimulated," he said.

"In theatre, the patients are awake for about 60 per cent of the procedure while we place the wires, conduct tests and ask questions to ensure the wires are positioned correctly.

"The DBS therapy does not cure movement disorders, but it can dramatically reduce tremors and the side effects caused by medication because the patient requires less to manage their condition.

"In Australia, over 95 per cent of patients having this treatment suffer from movement disorders while we are planning to implant patients with medical refractory focal epilepsy.

"DBS can make a great difference to the quality of life for the majority of these patients, which makes it an extremely rewarding surgical service to offer."

International links

Mr Bulluss said that one of the major benefits of his Fellowship in Oxford was the chance to develop strong links between UK and Australian Neurosurgeons and Neurosurgical Trainees keen to undertake reciprocal Fellowships in Melbourne.

"I have retained those links with my colleagues in the UK and Dr Thevathasan and I are also closely connected to our local colleagues so we can extend this subspecialty, refine the technology and surgical placement and targeting of the electrodes and also to promote and conduct research," Mr Bulluss said.

"In Australia we are now doing world class DBS surgery and research is now being conducted at the Bionic Institute in Melbourne into neuro modulation.

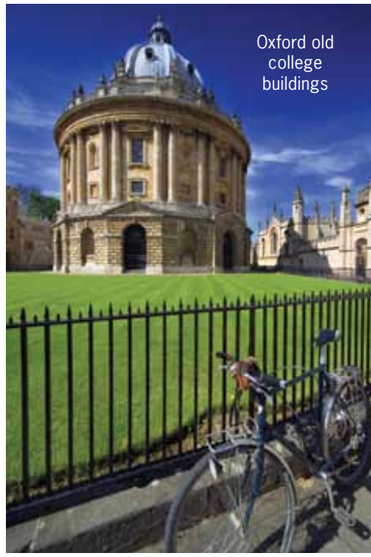
"Professor Mark Cook is also conducting research in the use of DBS for the treatment of epilepsy by using DBS to remove seizures in animal models at the Royal Melbourne and Austin hospitals."

Mr Bulluss thanked the College for its support in awarding him the travel scholarship.

"I took my wife and children with me and the funds provided through the Scholarship were greatly appreciated because Fellowships such as the one in Oxford aren't greatly remunerated," he said.

"However, most of all I appreciated the opportunity to expand my skills and knowledge and develop links with such a renowned international institution."

The Stuart Morson Scholarship in Neurosurgery was established following a donation by Mrs Elisabeth Morson in memory of her husband. It is designed to assist young Neurosurgeons to travel overseas to further their training or research.



Oxford old college buildings

KRISTIAN BULLUSS: Career highlights

2012 – 2013
Neurosurgical Functional Fellow, West Wing, John Radcliffe Hospital, Oxford, UK

2012
RACS Fellowship, Royal Australasian College of Surgeons

2012
Doctor of Philosophy: "Early gene expression following peripheral nerve injury," The University of Melbourne

2012
Royal Australasian College of Surgeons Stuart Morson Scholarship in Neurosurgery

2008
Royal Australasian College of Surgeons Foundation for Surgery Scholarship ($40,000AUD)

THE HIGHEST STANDARDS IN SURGICAL PRACTICE

A busy and productive year in Professional Standards

JULIE MUNDY
CHAIR, PROFESSIONAL STANDARDS

In 2014 the Professional Standards portfolio has been actively involved in a diverse range of consultations and policy initiatives aimed at promoting the highest standards in surgical practice. We have keenly promoted and represented the views and opinions of Fellows, ensuring that the voice of surgeons is heard on matters ranging from engagement with regulatory authorities to improving patient outcomes.

Responding to Key Consultations

The College has participated in a number of government and regulatory consultations and policy reviews over the past 12 months. Responding to the Medical Board of Australia (MBA) consultation on standards regarding Continuing Professional Development (CPD), Recency of Practice and Personal Indemnity Insurance, the College emphasised the importance of close consultation with Colleges and Speciality societies in proposals around CPD and revalidation. The College, recognising that CPD is a rapidly evolving area, also recommended that standards be reviewed every three years rather than the proposed five years.

The Prevention of Healthcare Associated Infection (PHAIC) Committee reviewed and endorsed the 'Therapeutic Guidelines: Antibiotic Version 15' as a source of comprehensive information and a framework for medical practitioners to utilise in their management of antibiotic prophylaxis and post-operative care. The guidelines highlight the continuing evolution of antimicrobial disease management that necessitates a proactive and consistent approach from all stakeholders. The College recognises the importance of these developments and the PHAIC committee will be considering further how it can actively promote the principles of antimicrobial stewardship in the near future.

The College has given its endorsement to 'The Australian and New Zealand Guideline for Hip Fracture Care', being represented on the review committee by Professor Ian Harris. The guide is designed to assist professionals providing care for people with a hip fracture to deliver consistent, effective and efficient care. Every person with a hip fracture should be given the best possible chance of making a meaningful recovery from a significant injury and strategies should be put in place to reduce the occurrence of future falls and fractures.

The College responded to the 'Review of the National Registration and Accreditation Scheme (NRAS)' for health professions. While recognising the significant achievements of AHPRA and the national scheme since its inception in 2010, there was some disappointment regarding the scope and content of the review. The College suggested that a key focus for the review should be an evaluation of notifications and complaints processes and strengthening the uniform standards and processes that were established in the national scheme. Concern was also expressed at a proposal to introduce additional layers of bureaucracy to address scope of practice determinations. The College believes that the key issues of transparency, natural justice, timeliness and better communication and support to all parties are the core issues that AHPRA should work towards improving.

> *"The College will continue to review and enhance the services that it offers to Fellows and advocate on issues that matter to the Fellowship"*

Policies and Position Papers

Long Elective Surgery Lists

The College responded to concerns over the length of some elective operating lists, developing a position paper that highlights the inherent dangers associated with operating lists that exceed 12 hours. Issues discussed include the effect of fatigue on psychomotor performance and cognitive awareness, strains placed upon staff when operations conclude late at night and the diversion of resources and capacity away from emergency surgery. The College recommends that elective operating lists should be performed during routine hours with appropriate fatigue management employed when a single elective case is expected to last more than 12 hours.

Informed Consent & Informed Financial Consent

The College has been engaged in on-going consultations in reviewing its position on informed consent and informed financial consent. The College recognises the autonomy of patients to make their own decisions about treatment pathways and the importance of appropriate and readily understandable information about treatment options, associated risk, costs and expected outcomes. The paper also acknowledges that it is not always possible to provide complete information or predict outcomes with absolute certainty, highlighting the importance of communicating to patients any uncertainty where possible. The position papers should provide both clinicians and the public with a clear understanding of the responsibilities of all parties and the elements that an informed consent process should involve.

Elective Surgery

Following partnership with the Australian Institute of Health and Welfare (AIHW) in 2013 on elective surgery categorisation, the College has revised its position paper on Elective Surgery and incorporated a number of the accepted principles suggested in the consultation. The work undertaken by College Fellows in this area has provided a solid foundation for renewed advocacy that encourages governments to further invest in elective surgery and for the continued development of sustainable and effective elective surgical waiting list schemes throughout Australia and New Zealand.

Excessive Fees

The College continues to engage in on-going discussions on excessive fees with the President recently presenting at an Australian Medical Association (AMA) forum to convey the College's position. The College acknowledges that the majority of its Fellows charge appropriate fees, but is also cognisant of its obligations to champion standards in relation to those surgeons who charge excessive and/or extortionate fees and the risk this poses to the good standing of the profession. In 2015 the College will continue to explore and respond to this issue and we welcome the input of Fellows in shaping our ongoing response.

Compliance in the CPD Program

Compliance with the 2013 CPD Program currently stands at 99.4 per cent, the highest level of compliance with the program since the College started reporting CPD in the annual workforce data reports. With Council support, non-compliance is now managed as a breach of the Code of Conduct. A small number of Fellows remained non-compliant and in September were requested to complete a statutory declaration reaffirming their commitment to CPD and the College's Code of Conduct. As has been stated in previous communications, failure to comply with CPD is considered a breach of the Code of Conduct with the ultimate sanction being loss of Fellowship.

Continuing Medical Education (CME) – Making CPD Participation Easy

The College approved over 250 CME activities in 2014, providing an exceptionally diverse range of opportunities for Fellows to complete their CPD requirements across the RACS competencies. The Professional Standards Committee have overseen the endorsement of a number of new CME activities, evaluating proposals against robust criteria that ensures the content and educational value of the activities is relevant, up-to-date and in line with industry best practice. From 2015 College sponsored CME activities will also be auto-populated into your CPD Online Diary.

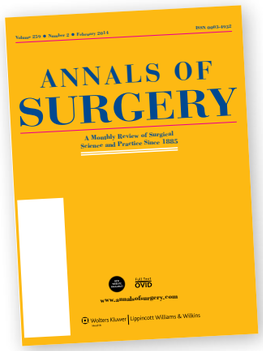
Moving Forward

The College will continue to review and enhance the services that it offers to Fellows and advocate on issues that matter to the Fellowship. As a member driven organisation, we invite you to contact us on any matters you feel we should address as your representatives. On behalf of the Professional Standards Committee, I wish you all the best for the coming year and look forward to working together with you on promoting the highest standards in our profession.

RESEARCH FROM THE COLLEGE

"Surgical simulation: Efficient, safe and available."

Dawe, S. R., et al. (2014).
"Systematic review of skills transfer after surgical simulation-based training."
British Journal of Surgery 101(9): 1063-1076.



Simulation of cholecystectomy and endoscopy works!

Dawe, S. R., et al. (2014).
"A systematic review of surgical skills transfer after simulation-based training: Laparoscopic cholecystectomy and endoscopy."
Annals of Surgery 259(2): 236-248.

Systematic review

Systematic review of skills transfer after surgical simulation-based training

S. R. Dawe[1], G. N. Pena[1,2], J. A. Windsor[4], J. A. J. L. Broeders[2], P. C. Cregan[3], P. J. Hewett[2] and G. J. Maddern[1,2]

[1]Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S), Royal Australasian College of Surgeons, and [2]Discipline of Surgery, University of Adelaide, Queen Elizabeth Hospital, Adelaide, South Australia, and [3]Department of Surgery, University of Sydney, Nepean Clinical School, Penrith, New South Wales, Australia, and [4]Department of Surgery, University of Auckland, Auckland City Hospital, Auckland, New Zealand

Correspondence to: Professor G. J. Maddern, Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S), Royal Australasian College of Surgeons, 199 Ward Street, North Adelaide, South Australia 5006, Australia (e-mail: asernips@surgeons.org)

Background: **Simulation-based training assumes that skills are directly transferable to the patient-based setting, but few studies have correlated simulated performance with surgical performance.**

Methods: **A systematic search strategy was undertaken to find studies published since the last systematic review, published in 2007. Inclusion of articles was determined using a predetermined protocol, independent assessment by two reviewers and a final consensus decision. Studies that reported on the use of surgical simulation-based training and assessed the transferability of the acquired skills to a patient-based setting were included.**

Results: **Twenty-seven randomized clinical trials and seven non-randomized comparative studies were included. Fourteen studies investigated laparoscopic procedures, 13 endoscopic procedures and seven other procedures. These studies provided strong evidence that participants who reached proficiency in simulation-based training performed better in the patient-based setting than their counterparts who did not have simulation-based training. Simulation-based training was equally as effective as patient-based training for colonoscopy, laparoscopic camera navigation and endoscopic sinus surgery in the patient-based setting.**

Conclusion: **These studies strengthen the evidence that simulation-based training, as part of a structured programme and incorporating predetermined proficiency levels, results in skills transfer to the operative setting.**

Paper accepted 30 January 2014
Published online 15 May 2014 in Wiley Online Library (www.bjs.co.uk). **DOI:** 10.1002/bjs.9482

Introduction

Simulation-based training allows trainees to learn technical and non-technical skills without risking patient safety[1,2]. It is increasingly being incorporated into surgical training or mandated by registration bodies[3]. Before simulation is incorporated into training curricula, important questions must be answered: does it work (train the appropriate skills) and how well does it work (does it improve skills performance in the patient-based setting and how strong is the evidence[4,5])?

A systematic review[6] published in 2007, which included 12 randomized clinical trials (RCTs) and two non-randomized comparative studies, found that surgical simulation-based training appeared to result in skills transfer to the patient-based setting. However, the included studies were limited by design and variable quality which reduced the strength of the conclusions. The emergence of new information is important[7] and the publication of studies in the past 6 years, during which there have been improvements in simulation-based training programmes, may have modified this conclusion. An important aspect has been the requirement to reach a predetermined level of proficiency in simulation-based training (often related to the 'expert' surgeon's level)[8–11] before the trainee proceeds to the patient-based setting.

Whether the skills learnt by a trainee in surgical simulation-based training transfer to performance in the patient-based setting must be tested for compliance with standards to meet patient need. Recent studies acknowledge the importance of objective assessment for

REVIEW

A Systematic Review of Surgical Skills Transfer After Simulation-Based Training

Laparoscopic Cholecystectomy and Endoscopy

Susan R. Dawe, MSc, John A. Windsor, MBChB, MD, FRACS, FACS,† Joris A.J.L. Broeders, MD, PhD,‡ Patrick C. Cregan, MBBS, FRACS,§ Peter J. Hewett, MBBS, FRACS,‖ and Guy J. Maddern, MBBS, PhD, FRACS*‡*

Objective: A systematic review to determine whether skills acquired through simulation-based training transfer to the operating room for the procedures of laparoscopic cholecystectomy and endoscopy.

Background: Simulation-based training assumes that skills are directly transferable to the operation room, but only a few studies have investigated the effect of simulation-based training on surgical performance.

Methods: A systematic search strategy that was used in 2006 was updated to retrieve relevant studies. Inclusion of articles was determined using a predetermined protocol, independent assessment by 2 reviewers, and a final consensus decision.

Results: Seventeen randomized controlled trials and 3 nonrandomized comparative studies were included in this review. In most cases, simulation-based training was in addition to patient-based training programs. Only 2 studies directly compared simulation-based training in isolation with patient-based training. For laparoscopic cholecystectomy (n = 10 studies) and endoscopy (n = 10 studies), participants who reached simulation-based skills proficiency before undergoing patient-based assessment performed with higher global assessment scores and fewer errors in the operating room than their counterparts who did not receive simulation training. Not all parameters measured were improved. Two of the endoscopic studies compared simulation-based training in isolation with patient-based training with different results: for sigmoidoscopy, patient-based training was more effective, whereas for colonoscopy, simulation-based training was equally effective.

Conclusions: Skills acquired by simulation-based training seem to be transferable to the operative setting for laparoscopic cholecystectomy and endoscopy. Future research will strengthen these conclusions by evaluating predetermined competency levels on the same simulators and using objective validated global rating scales to measure operative performance.

Keywords: endoscopy, laparoscopy, simulation, surgery, systematic review, training

(*Ann Surg* 2014;259:236–248)

Surgical simulators have an increasing role in the instruction and training in surgical skills, and simulation-based training with life-like experiences has the potential to make a significant contribution to evolution of the surgical curriculum.[1] A surgical training program should combine training for technical and nontechnical skills, and for working as part of a team in the operating room, to make the most effective use of available resources and to maximize patient safety. Although simulation-based training programs were initially "add-ons" to traditional surgical training, simulation-based training is increasingly being incorporated into curricula or even mandated by registration bodies, such as the American Board of Surgery that has required Fundamentals of Laparoscopic Surgery (FLS) certification since 2009.[2]

In 2007, our group published a systematic review which concluded that simulation-based training seemed to result in skills transfer to the operative setting.[3] However, it was noted that the included studies were of variable quality and design that limited the strength of this conclusion. Since then, the number of studies addressing transferability of simulation-based skills to the operative setting has increased.[4] There have been improvements in simulation-based training programs.

The methodology of recent studies has improved by acknowledging the importance of objective assessment when measuring competence in the operative setting to make valid comparisons between simulator-based and/or patient-based training. A number of procedure-specific objective global assessment scales that can be used in operative settings have been developed and validated. These include the Anaesthetist' Nontechnical Skills global rating scale,[5] Global Objective Assessment of Laparoscopic Skills (GOALS),[6] Objective Structured Assessment of Technical Skills,[7] Orthopaedic Competence Assessment Project,[8] and United Kingdom (UK) Joint Advisory Group on Gastrointestinal Endoscopy Direct Observation of Procedural Skills assessment form.[9] Other studies modify global rating scales developed by others[10] or developed their own.[11,12]

The aim of this systematic review was to determine whether skills acquired through simulation-based training are transferable to the operating room for the procedures of laparoscopic cholecystectomy and endoscopy.

METHODS

This systematic review was limited to the literature relating to laparoscopic cholecystectomy and endoscopy (colonoscopy, sigmoidoscopy, or esophagogastroduodenoscopy). The comprehensive Australian Safety and Efficacy Register of New Interventional Procedures—Surgical reports 61[3] and 80,[4] which include additional procedures investigated, and can be found online at http://www.surgeons.org/asernip-s/.

Literature Search Strategy

All randomized controlled trials (RCTs) and nonrandomized comparative studies (non-RCTs) reporting on the use of

From the *ASERNIP-S, Royal Australasian College of Surgeons, Adelaide, South Australia, Australia; †Department of Surgery, Middlemore Hospital, Auckland, New Zealand; ‡Discipline of Surgery, University of Adelaide, The Queen Elizabeth Hospital, Adelaide, South Australia, Australia; and §The University of Sydney, Nepean Hospital, Penrith, New South Wales, Australia.

The ASERNIP-S project is funded by the Australian Commonwealth Department of Health and Ageing and the South Australian Department of Health. The ASERNIP-S project receives no support by commercial sponsorship.
Disclosure: Professor John Windsor is director and educational advisor, Simtics Ltd. No authors declared any relevant financial interests. Other authors have no conflicts of interest.
Reprints: Guy J. Maddern, MBBS, PhD, FRACS, Australian Safety and Efficacy Register of New Interventional Procedures—Surgical (ASERNIP-S), Royal Australasian College of Surgeons, 199 Ward St, North Adelaide SA 5006, Australia. E-mail: asernips@surgeons.org.

ISSN: 0003-4932/13/25902-0236
DOI: 10.1097/SLA.0000000000000245

Developing a Career in Academic Surgery

With special guest speaker
Nobel Laureate Professor Barry Marshall

Monday 4 May 2015, 7:00am - 4:00pm
Perth Convention and Exhibition Centre
Perth, Australia

Provisional Program

Session 1	**A Career In Academic Surgery**
	Why every surgeon can and should be an academic surgeon Where do good research questions come from? Clinical effectiveness research Technology enhanced learning in surgery Educational research
Hot Topic in Academic Surgery: Nanotechnology	
Session 2	**Presenting Your Work**
	Writing an abstract, choosing your journal Submitting and revising your manuscript Presenting your work Panel discussion
Keynote Presentation: *How to be awarded a Nobel Prize in Medical Research* ***Professor Barry Marshall, Nobel Laureate***	
Session 3	**Concurrent Academic Workshops**

Workshop 1: Tools of the Trade	**Workshop 2: Residents / Registrars**	**Workshop 3: Career Academics**
Building a career pathway: opportunities, obstacles and getting past them Getting started as an academic surgeon Why a Trainee should consider fulltime research	Is a higher degree worth pursuing? Which one? When? Overseas experience – clinical or research and when?	Building a career pathway: opportunities, obstacles and getting past them Grants/funding/writing session Academic surgery in private practice

Session 4	**A Career In Academic Surgery**
	Finding and being a mentor Local research changing local practice The future of academic surgery

Who should attend?

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

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

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

2014 comments

"Incredibly thorough and worthwhile day. Inspirational as a young Trainee on an academic path, it was good to be reinvigorated."

"Thank you for organising this. It was very smoothly run and a valuable and very useful overview of how surgical practice and research interact."

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Anthony Gallagher, University College, Cork, Ireland

Association for Academic Surgery invited speakers:

Justin Dimick, University of Michigan, Ann Arbor, Michigan, USA

Amir Ghaferi, University of Michigan, Ann Arbor, Michigan, USA

Caprice Greenberg, University of Wisconsin, Madison, Wisconsin, USA

Muneera Kapadia, University of Iowa, Iowa City, Iowa, USA

John Mansour, University of Texas Southwestern Medical Center, Dallas, Texas, USA

Carla Pugh, University of Wisconsin-Madison, Wisconsin, USA

Julie Ann Sosa, Duke University Medical Center, Durham, North Carolina, USA

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Further information

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NOTE: New RACS Fellows presenting for convocation in 2015 will be required to marshal at 3:45pm for the Convocation Ceremony.

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

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

As per Regulation 4.9.1a for the SET Program in General Surgery, Trainees who attend the RACS Developing a Career in Academic Surgery course may, upon proof of attendance, count this course towards one of the four compulsory GSA Trainees' Days.

A PRODUCTIVE YEAR

Academy of Surgical Educators reflect on 2014

JULIAN SMITH
CHAIR, PROFESSIONAL DEVELOPMENT
CHAIR, ACADEMY OF SURGICAL EDUCATORS
STEPHEN TOBIN
DEAN OF EDUCATION

Dean of Education Stephen Tobin with RACP President Les Bolitho at the 2014 Conjoint Medical Education Seminar on 'Revalidation'.

The Academy of Surgical Educators (ASE) has enjoyed another productive year in 2014 with the establishment of a membership base of over 550 and around 1100 attendees participating in our surgical educator related activities and courses.

The Academy was established to support, enhance and recognise surgical educators within the College. Since its inception, it has evolved into an active community of practice and this year has started to reward and recognise the contributions of its surgical educators. The inaugural winners of the Educator of Merit – Supervisor / International Medical Graduate Clinical Assessor of the Year Award recipients are Prof Phillip Walker for QLD and Prof David Hardman for the ACT. The Educator of Merit Award – Professional Development Facilitator of the Year award has been won by Mr David Birks of Victoria. The Academy Award winners were presented with their awards at the Academy Forum on November 13, 2014.

The Academy also recognises all serving Supervisors and Professional Development facilitators with the Educator of Commitment Awards. Upon acceptance as a supervisor or facilitator for professional development courses a certificate is issued. Then a bronze lapel pin and certificate will be awarded at three years, a silver lapel pin and certificate at six years and gold lapel pin and certificate after nine years. This recognition of service will commence in early 2015.

As part of the Academy's public awareness campaign, the Dean of Education has been presenting about the Academy of Surgical Educators and its educational products such as the Foundation Skills for Surgical Educators course. Presentations have been delivered at the RACS Annual Scientific Congress, International Conference on Surgical Education and Training (ICOSET), Australian and New Zealand Association for Health Professional Educators (ANZAHPE), International Conference on Residency Education (ICRE) and the Australian and New Zealand Medical Education Training Forum (ANZMET) incorporating the National Prevocational Medical Education Forum.

The Academy offers a range of educational activities, resources and recognition to its members in order to support them in their role as a surgical educator. Educational activities delivered this year have included the Conjoint Medical Education Seminar, Academy Forum, National Simulation Health Educator Training program (NHET Sim), Foundation Skills for Surgical Educators, Supervisors and Trainers for Surgical Education and Training (SAT SET), Keeping Trainees on Track (KTOT), Surgical Education and Training Selection Interviewer Training (SET SIT), Non-Technical Skills for Surgeons (NOTSS), Surgical Teachers Course, Graduate Programs in Surgical Education and the Educator Studio Sessions.

The 4th International Medical Symposium on 'Revalidation' was held on Friday, March 14, at Hilton on the Park, Melbourne. It was hosted by the Royal Australasian College of Surgeons, the Royal Australasian College of Physicians and Royal College of Physicians and the Surgeons of Canada and involved international and domestic presenters including Sir Peter Rubin, Dr John Adams, Mr Barry Beiles, Dr Craig Campbell, Dr Linda Snell, Dr Joanna Flynn, Prof Liz Farmer, Dr Jocelyn Lockyer and Dr William Pope. Next year the topic is the 'The Future of the Medical Profession' and will again involve the three colleges, as well as the Australian and New Zealand College of Anaesthetists and the Royal Australian and New Zealand College of Psychiatrists.

The Academy hosted its second Forum in Adelaide with presentations from Assoc Prof Alison Jones on 'Developing Professionalism in Trainees' and Assoc Prof David Hillis on 'Surgeons are role models for professionalism'. This was delivered in association with the Surgical Research Society and Section of Academic Surgeons.

The National Health Education and Training in Simulation is a program for surgical educators who use or intend to use simulation as an educational method to support the education and training of surgeons. Unfortunately the funding has ceased for this program so it will not be offered in 2015; however, this year we were able to offer five courses – four in basic training and one advanced, qualifying 82 surgeons over the course of the program as accredited NHET Sim graduates.

The Foundation Skills for Surgical Educators has been successfully piloted in Noosa – prior to the Queensland ASM, Queenstown – prior to the NZ ASM, Ballarat and in Perth – prior to the GSA ASM and eight to ten courses are scheduled for delivery around Australia and New Zealand in 2014.

The SAT SET and KTOT educational programs have been in circulation for a number of years now and are in need of review. This work is currently underway and the new programs and corresponding online programs will be rolled out in 2015.

The Educator Studio Sessions showcase presentations from renowned medical educators on topics of interest to members. Six sessions* were delivered in the 2014 period including: A/Prof Victoria Brazil in Melbourne; Dr Sarah Yardley in Gold Coast; Dr Gabrielle Reddy in Melbourne; Dr Nick Sevdalis in Adelaide; Dr Simon Patterson Brown in Melbourne and Prof Brian Jolly in Melbourne. 243 members have participated in the sessions this year.

The Graduate Programs in Surgical Education offered jointly by the University of Melbourne and the College offer a suite of programs that address the specialised needs of teaching and learning in a modern surgical environment. Congratulations must be extended to our first cohort of five Masters graduates who complete their studies at the end of this year.

The Academy is supported by an interactive online learning community where members can gather ideas, share interests and research, find resources and keep abreast of upcoming events. The environment is supportive, collaborative and fosters enthusiasm in surgical education. It includes: a discussion forum, resources, links to articles, e-newsletters, grant information and research opportunities, listings of workshops and courses, pathways to become trainers and supervisors and award information. Please let us know your thoughts about the style and content of the online approach.

Membership of the Academy is open to all Fellows and Trainees and external medical educators who have strong educational interests and expertise. For more information on getting involved in Academy activities or how to become a member please contact Kyleigh Smith on +61 3 9249 1212 or ase@surgeons.org

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

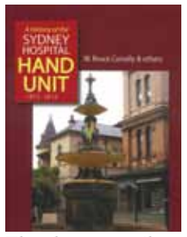
DONATIONS AND NEW ITEMS

MARIANNE VONAU
TREASURER

Some excellent additions to the library collection

The library is extremely grateful for donations from the authors of the following new books, which are now included in the collection.

W. Bruce Conolly and others. A History of the Sydney Hospital Hand Unit 1972-2012



Sydney Hospital is Australia's first hospital and members of the hand unit participated in the world's first hand transplant in France in 1988. They have contributed extensively to research on surgery and rehabilitation of the hand and have provided support to many developing countries. Their teaching model has been internationally recognized and emulated in other countries.

The book includes a brief history of the hospital itself along with chapters on the history of hand surgery and hand therapy in the unit as well as nursing and social work. Brief patient testimonies accompany these chapters and give insight into the benefits that have accrued to a range of patients (including a former Australian rugby captain).

Chapters on research, publications and achievements as well as projects in developing countries are included.

Overall, the book gives testament to the author's words that "In my worldwide travels I had never seen a hand unit like the one at Sydney Hospital".

Prof. Conolly AM has been a Fellow of RACS since 1965. His awards include Excellence in Surgery (RACS) Paul Harris International Rotarian Fellowship, Pioneer in Hand Surgery (IFSSH). He holds academic positions at the University of NSW, University of Sydney and University of Notre Dame. He has authored or co-authored seven books and 70 other publications on Hand Surgery and Rehabilitation.

John C Hall. From Colonial Surgeons to Royal Fellows: the context and social history of surgery in Western Australia 1829-1958.

The author emphasises that the book "is not a 'scholarly' work" and has been "written for people who are interested in surgery".

Before moving onto surgery the book devotes a chapter on the Swan River Colony which sets the context for the chapters to follow.

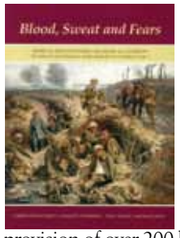
The next chapters then provide a narrative of the path of surgery and surgeons in the west up until 1958. Details of the careers of a number of early surgeons are provided in the chapter on colonial surgery. Subsequent chapters move through the landmarks of Australian history; settlement, federation, the world wars and post-war recovery. Along the way, we are reminded that Simpson (i.e. John Kirkpatrick, famous for his and his donkey's efforts at Gallipoli) was in Perth at the outbreak of war and embarked from Fremantle. Also of interest is the development of the Royal Flying Doctor Service and its importance in a state which encompasses vast distances and some of the most remote places in the world.

Less well known individuals and their lives and times are also found in the pages of this book which should appeal more widely than just those with an interest in the west of the continent.

Prof. Hall has been a Fellow of RACS since 1976 and has received awards (John Mitchell Crouch Fellow) and medals (Sir Louis Barnett Medal) for his research and contributions to surgery. He was also Interim Dean of Education for RACS.

The following new book was purchased for the collection and is also available for loan:

Christopher Verco, Annette Summers, Tony Swain & Michael Jelly. Blood, Sweat and Tears: Medical Practitioners and Medical Students of South Australia Who Served in World War 1.



A hundred years after the commencement of 'The Great War', this title about the contribution of South Australia has recently been published. The main focus is the provision of over 200 biographies of one page in length. The biographies are often accompanied by excerpts from primary sources such as contemporary letters or speeches. Each entry also contains a list of sources, often with URL hyperlinks included for further information available in archives or libraries.

Flicking through the work, one finds many individuals who were Fellows of this College. Each had their own experience of the war with some contributing in large measure and others to a lesser degree. Some never returned to family and friends in South Australia while others survived into the latter decades of last century. Among these, some achieved considerable professional success or became leaders in their fields.

Apart from the biographies, the book contains chapters on military and naval defence preparedness, the University of Adelaide and Hospital Ships. A colour list of photos of medals issued to Australians in World War I is also included.

Please contact library staff to arrange for a loan of any of the above titles.

On leave in Egypt - surgeons, William Kay (second from left) and Hugh Poate (at right). Credit: AWM C02157

SURGEONS OF GALLIPOLI

To commemorate the ANZAC centenary, the College will be holding a special exhibition in its Museum in April 2015

ELIZABETH MILFORD,
COLLEGE ARCHIVIST

When the College was formed in 1927, some of its Founders and many of its early Fellows shared a common bond. As medical students, junior doctors or senior surgeons, they had all served in World War 1. And around 120 of them were involved in the Gallipoli campaign, serving in the field or on hospital ships. Some were also sent to hospitals at Lemnos and others worked at base hospitals in Egypt, which had been set up to deal with the seriously wounded.

Captain Hugh Poate, who was later a President of the College, volunteered in August 1914 and was posted to the 1st Field Ambulance. He landed at Gallipoli with his unit on April 25, but the extraordinary number of wounded meant that he was soon posted to the hastily converted transport ship *Itonus*, ferrying the wounded to hospitals in Egypt. The *Itonus* was one of the Black Ships, so called because they were not protected under the Geneva Convention and could be subject to enemy fire. On April 27 he wrote:

The wounded on the Itonus were scattered about all over the ship being packed in and huddled together wherever they could put them, irrespective of the character of their wounds… By the time we took over the ship it was in an awful state – decks filthy, patients in dirty blankets, food debris, bits of dressings, cigarette ends… Altogether we had seven deaths on board before reaching Alexandria.

The rugged terrain and issues with communication meant that those who landed on the Peninsula had a dangerous and difficult job. Alexander Marks was Regimental Medical Officer for the 3rd Field Artillery Brigade. Landing at Anzac on April 25, Marks moved up from the beach to Gaba Tepe and was constantly exposed to shellfire. His brigade was deployed in ten camps and he had to try and visit these each day:
Sometime in June the hot weather started, Diarrhoea and Dysentery set in and I found it impossible with such scattered units to do much in regard to special feeding of the men. The best I could do was issue the men small quantities of oatmeal, milk, eggs or arrowroot…

At the outbreak of war, medical students fuelled by 'patriotism and a sense of adventure' rushed to join up. In August 1914, 21 final year students from Otago University volunteered as medical officers. Second year student Montie Spencer also volunteered and was posted to the New Zealand Field Ambulance at Gallipoli:
On Monday night [June 13] the Turks got the first of our medical students – young Paterson of Gore. He was shot by a stray bullet (or a sniper) right through the heart and only lasted a few seconds. He was standing not five yards from the door of our advanced dressing station up near the firing line, talking over news just received from home that afternoon; he'd been down to the beach with me that afternoon for a swim and to get mail.

In July 1915 all the students including Spencer were ordered back to New Zealand to complete their medical courses.

These excerpts from nearly 100 years ago touch on the experiences of the ' ANZAC Surgeons of Gallipoli'. On April 23, 2015, the College celebrates the centenary of Gallipoli with an exhibition in the College Museum and the launch of an accompanying book. There will also be commemorative activities in New Zealand.

BUILDING INTERNATIONAL SKILLS

A College award has allowed an Indonesian doctor develop her skills with Australian peers

The College recently part-funded a visit to Australia by a senior Indonesian ophthalmologist through the Surgeons International Award to help broaden her skills in the complex surgical treatment of glaucoma, now the second most common cause of blindness in Indonesia. Dr Nikompyang Rahayu arrived in Perth in August this year and spent four weeks undertaking a short Fellowship in glaucoma management and surgery under the supervision of Professor Bill Morgan, Consultant Ophthalmologist at the Royal Perth Hospital and Professor of Ophthalmology and Visual Science at the University of WA.

While in Australia, Dr Rahayu spent the bulk of her time working alongside Professor Morgan at the Lions Eye Institute, St John of God Hospital and Royal Perth Hospital to expand her skills in trabeculectomy and glaucoma drainage device surgery, used to relieve pressure in the eye, as well as refining her gonioscopic skills.

She also spent time working with Dr Philip House at his private rooms and at the Perth Eye Centre, Dr Steve Colley at the Perth Eye Centre, Dr Joshua Yuen at Fremantle Hospital and assisted Dr Anthony Giubilato in theatre at the Royal Perth.

During the trip, Dr Rahayu also attended the annual WA meeting of the Royal Australasian and New Zealand College of Ophthalmology (RANZCO) in Kalgoorlie where she gave a presentation on eye health delivery in Bali.

Upon her return home, Professor Morgan then took one of his regular teaching trips to Bali in October to work with Dr Rahayu to conduct tube implant and drainage surgery and to consult with her on complex patients.

A fully qualified ophthalmologist and experienced teacher at the Australian Bali Memorial Eye Centre (also known as the Indera Hospital), Dr Rahayu described the experience she gained in Perth and the support of Australian colleagues as "amazing".

"I came to Perth to learn more about glaucoma implant surgery and finally I did," she said.

"I learned how to implant drainage tubes, the indications and complications involved and how to manage those complications.

"Basically, I learned how to manage glaucoma patients properly which means a great deal to me because I teach and train medical students and registrars for glaucoma and manual small-incision cataract surgery so now I am in a position to pass on the skills I have learned.

"In Indonesia, many patients come to the hospital in blind or severe stage probably because of a lack of education about glaucoma.

"These patients often need more complex care and sometimes have more complications so the skills I learned in Australia will help me a great deal.

"I am particularly grateful for the support of Professor Morgan who allowed me to work with him in the eye clinic and operating theatre in Perth.

"He taught me how to diagnose early to advanced glaucoma, how to detect the progression and how to treat complications.

"I also observed him doing some filtering and implant surgery and when he visited me in Bali, we worked in the eye clinic and theatre and he supervised me while I did implant surgery.

"It was the best thing in my practice."

Improved eye care

Professor Morgan has been visiting Indonesia for the past 15 years, teaching ophthalmologists and registrars in Jakarta and Bali during twice-yearly trips.

His work there is self-funded and coordinated through the John Fawcett Foundation, a humanitarian organisation which grew out of a number of Rotary projects best known for its Sight Restoration and Blindness Prevention Project.

The Fawcett Foundation supported Dr Rahayu's visit to Australia through the provision of accommodation during her stay.

Professor Morgan said that while he began taking the trips to teach cataract surgery, Indonesian surgeons now had the skills and resources to undertake the required cataract work.

He said glaucoma had now become the more pressing issue.

"The standard of eye health care delivery has improved dramatically in the past 15 years, particularly in Jakarta and Bali," Professor Morgan said.

"In Jakarta there are around 70 ophthalmology registrars in training at the very well-equipped six-storey stand-alone eye hospital there, while in Bali there are 35 registrars training at the Bali Memorial Eye Centre.

"This shows the great efforts they have made to prioritise this aspect of health care.

"Then, however, the urgency was based around cataract blindness whereas now the issue is glaucoma.

"This is because there are two broad categories of glaucoma – open angled and closed angled glaucoma.

"In South East Asia we tend to see more closed angle glaucoma, which is the more aggressive condition. With the increasing uptake of more Western diets, Indonesia is now also seeing an increase in the rate of diabetes which can also lead to very aggressive forms of glaucoma."

Professor Morgan said it was these drivers that made the core team of Perth ophthalmologists so keen to assist Dr Rahayu during her visit.

"Dr Rahayu's main aims during the visit here were to learn glaucoma draining device surgery and to refine her gonioscopic skills," he said.

"The art of gonioscopy revolves mainly around the technique, but also the interpretation of the findings and she was able to distinguish between the key sub-types of angle closure glaucoma including pupil block, ciliary block, plateau iris and the rarer causes with ease at the end of her Fellowship.

"Many of the patients she saw in the Lions Institute clinic were being followed post-surgery and so that exposure, as well as the discussions she had with myself, Dr House and Dr Giubilato added to her skills in relation to post-operative management and the pre-operative assessment of patients requiring glaucoma surgery. ▶

Left: Dr Rahayu operating; Dr Rahayu with team.

2016 Rowan Nicks Pacific Islands Scholarship & 2016 Rowan Nicks International Scholarship
2015 Rowan Nicks Australia & New Zealand Exchange Fellowship

The Royal Australasian College of Surgeons invites suitable applicants for the 2016 Rowan Nicks International Scholarship and the 2016 Rowan Nicks Pacific Islands Scholarship.

The Royal Australasian College of Surgeons invites suitable applicants who are citizens of Australia and New Zealand to apply for the 2016 Rowan Nicks Australia and New Zealand Fellowship.

Royal Australasian College of Surgeons

These are the most prestigious of the College's International Awards and are directed at qualified surgeons who are destined to become leaders in their home countries.

The Rowan Nicks Scholarships provide opportunities for surgeons to develop their management, leadership, teaching and clinical skills through clinical attachments in selected hospitals in Australia, New Zealand and South-East Asia.

Application Criteria:
Applicants for the Rowan Nicks International and Pacific Islands Scholarships must:
- commit to return to their home country on completion of their Scholarship;
- meet the English Language Requirement for medical registration in Australia or New Zealand (equivalent to an IELTS score of 7.0 in every category for Australia, and 7.5 for New Zealand);
- be under 45 years of age at the closing date for applications.

In addition, applicants for the International Scholarship must:
- hold a relevant post-graduate qualification in Surgery;
- be a citizen of one of the nominated countries to be listed on the College website from December 2014.

Applicants for the Pacific Islands Scholarship must:
- be a citizen of the Cook Islands, Fiji, Kiribati, Federated States of Micronesia, Marshall Islands, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu or Vanuatu;
- hold a Masters of Medicine in Surgery (or equivalent). However, consideration will be given to applicants who have completed local general post-graduate surgical training, where appropriate to the needs of their home country.

Selection Criteria
The Committee will
- consider the potential of the applicant to become a surgical leader in the country of origin, and/or to supply a much-needed service in a particular surgical discipline.
- The Committee must be convinced that the applicant is of high calibre in surgical ability, ethical integrity and qualities of leadership.
- Selection will primarily be based on merit, with applicants providing an essential service in remote areas, without opportunities for institutional support or educational facilities, being given earnest consideration.

Value: Up to $50,000 pro-rata, plus one return economy airfare from home country

Tenure: 3 - 12 months

The Rowan Nicks Australia and New Zealand Fellowship **is intended to promote** international surgical interchange at the levels of practice and research, raise and maintain the profile of surgery in Australia and New Zealand and increase interaction between Australian and New Zealand surgical communities.

The Fellowship provides funding to assist a New Zealander to work in an Australian unit judged by the College to be of national excellence for a period of up to one year and an Australian to work in a New Zealand unit using the same criteria.

Application Criteria:
Applicants must
- have gained Fellowship of the RACS within the previous ten years on the closing date for applications.
- provide evidence that they have passed the final exit exam to allow them to obtain a Fellowship of the Royal Australasian College of Surgeons by the time selection takes place.

Selection criteria:
The Committee will
- consider the potential of the applicant to become a surgical leader and ability to provide a particular service that may be deficient in their chosen surgical discipline.
- assess the applicants in the areas of surgical ability, ethical integrity, scholarship and leadership.

The Fellowship is not available for the purpose of extending a candidate's position in Australia or New Zealand, either in their existing position or in another position.

Value: Up to $50,000 pro-rata, depending on the funding situation of the candidate and provided sufficient funds are available, plus one return economy airfare between Australia and New Zealand.

Tenure: 3 - 12 months

Application forms and instructions will be available from the College website from December 2014:
www.surgeons.org

Closing date: **5pm Monday 4 May, 2015.**
Applicants will be notified of the outcome of their application by **30 October 2015.**

Please contact: Secretariat, Rowan Nicks Committee,
Royal Australasian College of Surgeons
250 - 290 Spring Street, East Melbourne VIC 3002
Email: international.scholarships@surgeons.org
Phone: + 61 3 9249 1211 Fax: + 61 3 9276 7431

2016 Rowan Nicks United Kingdom and Republic of Ireland Fellowship

The Royal Australasian College of Surgeons invites suitable applicants who are citizens of the United Kingdom or the Republic of Ireland to apply for the 2016 Rowan Nicks United Kingdom and Republic of Ireland Fellowship.

The Rowan Nicks United Kingdom and Republic of Ireland Fellowship is intended to promote international surgical interchange at the levels of practice and research, and increase interaction between the surgical communities of Australia, New Zealand, the United Kingdom and the Republic of Ireland.

Application Criteria:
Applicants must
- hold his/her country's post-graduate qualification in surgery or its equivalent and must have completed his/her specialist surgical training program within ten years of the closing date for applications.
- provide evidence that he/she has passed the final exit exam which allows him/her to obtain a Fellowship of one of the United Kingdom or Republic of Ireland Colleges by the time selection takes place.

Selection criteria:
The Committee will
- consider the potential of the applicant to become a surgical leader and ability to provide a particular service that may be deficient in their chosen surgical discipline.
- assess the applicants in the areas of surgical ability, ethical integrity, scholarship and leadership.

The Fellowship is not available for the purpose of extending a candidate's position in Australia or New Zealand, either in their existing position or in another position.

Value: Up to $50,000 pro-rata, depending on the funding situation of the candidate and provided sufficient funds are available.

Tenure: 3 - 12 months

"During one weekend in September she also attended the annual WA branch meeting of the RANZCO during which she developed contacts with other ophthalmologists while one of the key-note speakers gave a presentation on gonioscopy which also added to her education.

"It was clear this Fellowship would provide great value not just for Dr Rahayu, but for the people of Indonesia given her excellent surgical skills, intelligence and teaching responsibilities back in Bali."

Professor Morgan said that while great strides had been made in providing complex eye care to glaucoma patients in Indonesia in recent years, the health care system and continuing poverty seen in some communities limited what could be surgically achieved.

He said he was now working with international partners to overcome one such problem.

"The tubes we use in implant surgery cost around $700 each, which is very expensive within the Indonesian context so we now have a project underway in Jakarta working with a Japanese company that makes lenses to try and create the tubes at a much lower cost," he said.

"We now have a prototype, but we are still some time away from conducting human trials.

"Quite a few of us are very enthusiastic about this and hope that it works given the current and future needs of glaucoma patients in Indonesia."

Professor Morgan said he also hoped to find the funding to conduct a survey to measure blindness rates over recent years, both to assess the success of Indonesian ophthalmologists in treating cataracts and to measure the disease burden caused by glaucoma.

"Through the development of complex glaucoma care and surgery, we have halved the rate of glaucoma-related blindness in WA over the past 25 years and we hope that passing on these skills to Indonesian ophthalmologists such as Dr Rahayu will have a similar effect. We are fortunate to have a very cohesive group of Glaucoma surgeons in Perth, who are keen to teach overseas colleagues," he said.

"I thank the RACS for their generosity in donating funds to support her Fellowship."

The Surgeons International Award was established by Professor Richard Bennett and his wife Enid in 1989 to fund short-term visits to Australia by surgeons, doctors, nurses or other health professionals from developing countries.

Aimed at helping to improve the standard and delivery of health care in their home countries, the Surgeons International Award has enabled more than 45 health professionals from 14 countries access further training opportunities in Australia.

With Karen Murphy

More than $1.5 million awarded!

2015 Scholarship and Grant Recipients

The Board of Surgical Research thanks all applicants and congratulates the following successful recipients

The College wishes to acknowledge and thank our benefactors and sponsors for their generosity in funding many of the following scholarships and grants.

There is a considerable amount of time and energy spent to properly evaluate the extensive number of applications that we receive. The Chair would like to thank all those involved, and in particular, Professor Julian Smith, Dr Romi das Gupta, Professor Paul Norman, Associate Professor Christopher Young and Professor Robert Fitridge, who all put in extra work towards this result.

Research SCHOLARSHIP and Fellowship recipients

John Mitchell Crouch Fellowship

Professor Zsolt Balogh – NSW
Specialty: Orthopaedic
Fellowship Value: $150,000
Professor Balogh is a clinically and academically active trauma surgeon. The John Mitchell Crouch Fellowship funding will enable him to continue his work on the characterisation and early recognition of second hits in major trauma patients to prevent multiple organ failure and mortality.

Foundation for Surgery Senior Lecturer Fellowship

Dr Sarah Aitken – NSW
Specialty: Vascular
Fellowship Value: $132,000
Topic: Epidemiology and outcomes of vascular surgery in elderly patients of NSW.
Supervisor: Associate Professor Vasikaran Naganathan

Surgeon Scientist Scholarship

Dr Ryan Gao – New Zealand
Speciality: Orthopaedic
Scholarship Value: $77,000
Topic: In vitro and in vivo evaluation of novel scaffolds to improve bone healing.
Supervisor: Professor Jillian Cornish

Foundation for Surgery Tour de Cure Cancer Research Scholarship – 2014

Dr Lipi Shukla – Vic
Specialty: General
Fellowship Value: $125,000
Topic: Understanding the role of fat grafting in radiotherapy induced soft tissue injury, lymphedema and fibrosis.
Supervisor: Mr Ramin Shayan

Foundation for Surgery Tour de Cure Cancer Research Scholarship - 2015

Dr Andrew Gogos – Vic
Specialty: Neurosurgery
Fellowship Value: $125,000
Topic: The role of the Hippo-YAP pathway in glioma stem cells.
Supervisor: Mr Andrew Morokoff

Raelene Boyle Scholarship – Sponsored by Sporting Chance Cancer Foundation

Dr Joseph Kong – Vic
Specialty: General
Scholarship Value: $66,000
Topic: Exploiting genetic analysis to predict response and develop novel molecular targeted therapies for rectal cancer.
Supervisor: Professor Alexander Heriot

Eric Bishop Research Scholarship

Dr David Liu – Vic
Specialty: General
Scholarship Value: $66,000
Topic: Investigating targeted molecular therapies in oesophageal cancer.
Supervisor: Associate Professor Wayne Phillips

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

Dr Andrew Cheng – Vic
Specialty: Cardiology
Scholarship Value: $66,000
Topic: Colchicine for the primary prevention of atrial fibrillation after cardiac surgery (Prevent AF).
Supervisor: Associate Professor Bo Zhang

MAIC-RACS Trauma Scholarship

Associate Professor Eric Chung – Qld
Specialty: Urology
Scholarship Value: $66,000
Topic: Genitourinary injury, urinary and sexual dysfunctions following adult pelvic trauma: Clinical outcomes, healthcare advocacy and guideline implementation.
Supervisor: Dr Ross Cartmill

Paul Mackay Bolton Scholarship for Cancer Research

Dr Heidi Cameron – Qld
Specialty: General
Scholarship Value: $66,000
Topic: Towards the personalised management of metastatic melanoma.
Supervisor: Professor Nick Hayward

Sir Roy McCaughey Surgical Research Fellowships

Dr Naseem Mirbagheri – NSW
Specialty: General
Fellowship Value: $66,000
Topic: Phenotypic variations in the centre and peripheral mechanisms of sacral neuromodulation in faecal incontinence.
Supervisor: Professor Marc Gladman

Dr Carlo Pulitano – NSW
Specialty: General
Fellowship Value: $66,000
Topic: Regulation of hepatic microcirculation and patho-physiological role of Endothelin-1 and stress-inducible vasoactive mediators in liver surgery.
Supervisor: Dr Nicholas Shackel

Foundation for Surgery ANZ Journal of Surgery Scholarship

Dr Simon Tsao – Vic
Specialty: General
Scholarship Value: $66,000
Topic: Functional and phenotypic characterisation of melanoma circulating tumour markers.
Supervisor: Professor Christopher Christophi

Foundation for Surgery Catherine Marie Enright Kelly Scholarship

Dr Joshua Petterwood – Vic
Specialty: Orthopaedic
Scholarship Value: $66,000
Topic: A randomised controlled trial measuring three dimensional knee joint kinematics following total knee replacement surgery.
Supervisor: Professor Peter Choong

Foundation for Surgery John Loewenthal Research Scholarship

Dr Rajat Mittal – NSW
Specialty: Orthopaedic
Scholarship Value: $66,000
Topic: Combined randomised and observation study of Type B ankle fracture treatment (CROSSBAT).
Supervisor: Professor Ian Harris

Foundation for Surgery New Zealand Research Scholarship

Dr Melanie Lauti – New Zealand
Specialty: General
Scholarship Value: $66,000
Topic: Better outcomes after bariatric surgery (BOBS)
Supervisor: Professor Andrew Hill

Foundation for Surgery Peter King Research Scholarship

Dr William Shi – Vic
Specialty: Cardiothoracic
Scholarship Value: $66,000
Topic: Clinical and molecular insights into a personalised approach to heart transplantation: From rejection to protection.
Supervisor: Professor Igor Konstantinov

Foundation for Surgery Reg Worcester Research Fellowship

Dr Diana Kirke – SA (TBC)
Specialty: Otolaryngology
Fellowship Value: $66,000
Topic: Differences in brain activation via the utilisation of functional magnetic resonance imaging in patients with spasmodic dysphonia and voice tremor.
Supervisor: Associate Professor Kristina Simonyan

Foundation for Surgery Richard Jepson Research Scholarship

Dr Christopher Daly – NSW
Specialty: Neurosurgery
Scholarship Value: $66,000
Topic: Mesenchymal precursor cells, pentosan polysulphate and lumbar disc regeneration.
Supervisor: Professor Graeme Jenkin

Foundation for Surgery Research Scholarships

Dr Anthony Glover – NSW
Specialty: General
Scholarship Value: $66,000
Topic: Adrenal cortical carcinoma and non-coding RNAs: Unlocking the mechanisms.
Supervisor: Dr Patsy Soon

Dr Ruth Mitchell – NSW
Specialty: Neurosurgery
Scholarship Value: $66,000
Topic: The molecular biology of epilepsy in low grade brain lesions
Supervisor: Dr Andrew Morokoff

Travel Scholarship, Fellowship and Grant Recipients

Hugh Johnston Travel Grants

Dr James McKay – New Zealand|
Specialty: General
Value: $10,000

Dr Charlies Milne – Vic
Specialty: Vascular
Value: $10,000

Hugh Johnston ANZ Chapter American College of Surgeons Travelling Fellowship

Dr Anita Skandarajah – Vic
Specialty: General
Value: $8,000

Ian and Ruth Gough Surgical Education Scholarship

Dr Rhea Liang – Qld
Specialty: General
Value: $10,000

John Buckingham Travelling Scholarship – 2014

Dr Justin Chan – SA
Specialty: Cardiothoracic
Value: $4,000

John Buckingham Travelling Scholarship – 2015

Dr Tarik Sammour – Vic
Specialty: General
Value: $4,000

Margorie Hooper Travel Scholarship

Dr Andrew Foreman – SA
Specialty: Otolaryngology
Value: $75,000

Morgan Travelling Scholarships

Dr Elizabeth Hodge – Qld
Specialty: Otolaryngology
Value: $10,000

Mr Timothy Lording – Vic
Specialty: Orthopaedic
Value: $10,000

Murray and Unity Pheils Travel Fellowship

Dr Sameer Memon – New Zealand
Specialty: General
Value: $10,000

Stuart Morson Scholarship in Neurosurgery

Dr Johnny Wong
Specialty: Neurosurgery
Value: $30,000

Other Scholarships

The following lists external awards that Fellows and Trainees of the College have been successful in attracting from other organisations.

Sam Mellick Travel Fellowship

Dr Charles Milne – Vic
Specialty: Vascular
Award Value: $5,000

Mr Alan Saunder
Chair, Board of Surgical Research

Preliminary Notice: Applications for 2016 scholarships will open in March 2015

2015 College Finances and Budget

A report from the Treasurer, Marianne Vonau

The College Budget for 2015 and the Scholarship Program 2016 Budget were approved at the October meeting of Council. The inclusion of the Scholarship Program 2016 Budget ensures appropriate funding is made available for the ongoing commitment to the College's significant research scholarships and grants program. Prior to approval, the budget progressed through an extensive review by the governing committees and boards of the College.

Fellows' subscriptions and Trainees' fees fund the delivery of a broad range of educational and member related activities which I will outline further in this report.

The College activities are divided into three separate "categories".

1. Activities related to your College's core purpose, namely education and training, professional development and standards, as well as regional and national advocacy. These resources are funded from your subscription and training fees.
2. A growing program of research, aid and audit projects, externally funded predominantly by government agencies. These projects provide multiple health programs from specialist training, indigenous health, audit and international humanitarian assistance.
3. Activities from our philanthropic endeavours. The College has received substantial generosity from benefactors over many years including annual donations from Fellows to fund research activities and international aid. In recent years the College has continued to develop a number of key corpuses from any surpluses for designated activities and the current focus of these funds are related to research scholarships, international development, ASC visitors program, educational innovation and Indigenous health.

The College continues to maintain a strong financial position while still ensuring ongoing investment in initiatives that deliver real value to our Fellows, and Trainees' services are appropriately funded. The Budget is set to achieve a modest surplus of $645k or 1.5 per cent surplus return on projected revenue from its core business activities and demonstrates that the business plans continue to be financially sustainable.

Key attributes incorporated in the budget strategy review and the budget processes were to:

- achieve a modest surplus return from core operations
- set fees from Trainees, International Medical Graduates and Fellows to support the costs of the infrastructure and governance of the College
- increase subscription fees by CPI to ensure all Fellow related activities are fully funded from fees charged
- training, education and international medical graduate fees to be increased by the Education Price Index to ensure all related expenditure is fully funded
- review of all NZD denominated fees to be charged at AUD equivalent to maintain equity in fee structure between the jurisdictions
- project related activity should be fully funded
- new key initiatives proposed will be assessed on the basis of adding value to Fellows and Trainees.

Category 1

In 2015 revenue from operational activities is budgeted to increase by 3 per cent to $40,798k (2014 – $39,521k) while expenditure is budgeted to increase by 4 per cent to $40,154k (2013 - $38,721k).

Specific items of expenditure in category 1 activities include:

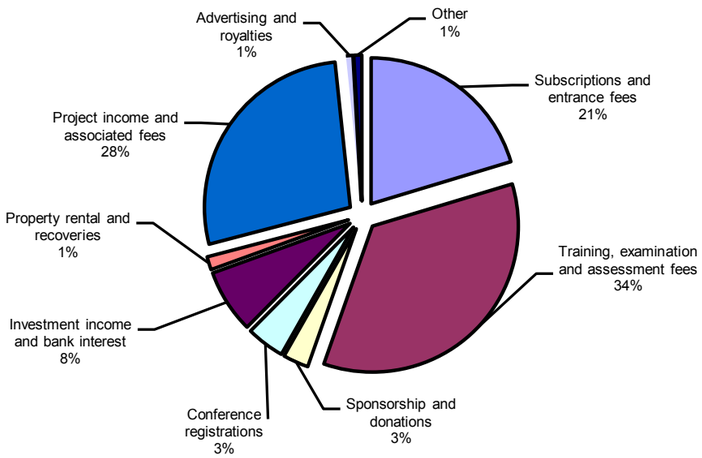
- Personnel costs – increased to support the roll out of the Digital College and our increased advocacy role in Australia and New Zealand jurisdictions.
- Consultants' fees – clinical – $220k (2014 - $197k) – for clinical/medical support and assessments, usually provided by Fellows of the College.
- Printing and general office supplies - $1,457k (2014 - $1,408k) including the very successful 'Surgical News', production of the 'ANZ Journal of Surgery', and the Annual Scientific Congress.
- Travel and accommodation – $4,220k (2014 - $4,046k) – associated with our committee, examination and skills courses activities.
- Property costs – $1,823k (2014 - $1,844k) – leasing of office premises in Sydney, Brisbane, Perth and Wellington – New Zealand and scheduled maintenance and service programs.
- Specialty society funding – fees paid to specialty societies in accordance with training partnership agreements estimated at $3,851k.

In addition to the delivery of core Fellowship services, training and education programs, the Budget also provides significant funding of $965k to further invest in strategically important activities including:

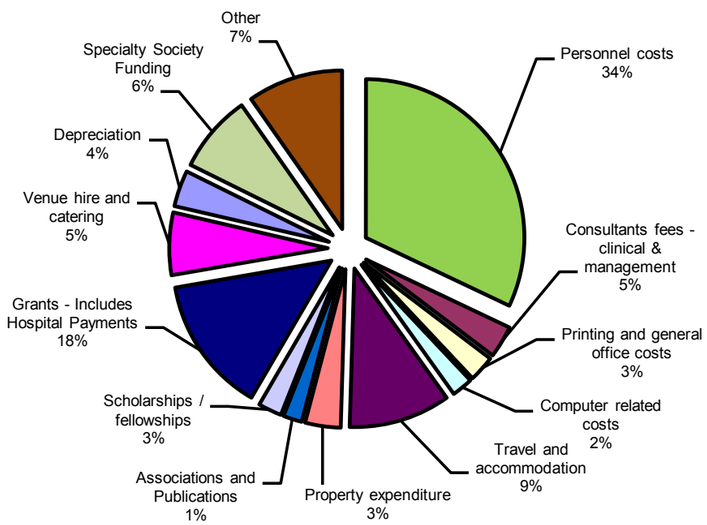
- continuing to promote the FRACS brand as a quality mark standing for excellence in surgical care
- ongoing development of online and Information Technology based resources to support Fellows and Trainees in education and College related activities
- further expansion of library resources for the eLibrary for Fellows and Trainees
- continued investment to improve IT platforms for the development and delivery of the Fellowship and other examinations
- active communication and advocacy initiatives including broader engagement into social media communication channels
- greater advocacy resourcing with funding to appoint a policy and communications staff member for ongoing initiation and co-ordination of advocacy issues ▶

Main sources of revenue and expenditure are represented in the chart display below:

Budget 2015:
Sources of Revenue



Budget 2015:
Sources of Expenditure



Total College Budget 2015 - All Business Activities (2014 Budget Comparison)

	Budget 2015 $000s	Budget 2014 $000s	Increase / (Decrease) %
Revenue	65,389	61,276	7% ↑
Expenditure	62,602	57,750	8% ↑
Total Surplus	2,787	3,526	21% ↓

Category 2

In 2015 revenue for College project activities has increased by 13 per cent to $19,099k (2014 - $16,897k) while expenditure is forecasted to be $19,418k (2014 - $16,852k). The overall result is a projected deficit of ($319k) which is primarily due to investment in further in-house IT resources to support the continual uptake and accessibility to the Fellows interface with IT Systems..

The total contract value of currently operating projects is approximately $81 million and demonstrates continuing significant Commonwealth investment in specialist training programs, research, international aid and surgical audit.

Specific items of expenditure in category 2 activities include:

- Personnel costs – $4,240k (2014 - $4,292k) represents ongoing level of staffing need
- Consultants' fees – $1,517k (2014 - $1,102k) – relates to professional services from external consultants for clinical / medical support and assessments provided to the College projects with increased activity under the funding contract for the Timor Leste Program II
- Grants – $10,549k (2014 - $7,160k) predominantly related to increased specialist training posts and rural loading hospital payments under the Specialist Training Program contract.

Category 3

Revenue for all activities relating to the Foundation and Investments is budgeted to increase 13 per cent to $5,493k (2014 - $4,858k) and mainly relates to the increased pool of fund holdings associated with strong investment returns achieved in the 2012 and 2013 years and build-up of College corpora funds newly established since 2013. Expenditure is budgeted to be $3,030k (2014 – $2,176k) providing increased funding for scholarships, fellowships and research grants and other philanthropic endeavours, resulting in a forecasted surplus of $2,463k (2014 – $2,682k).

Balance Sheet

As at 31 December 2015, it is estimated that the College net assets will be $70,693k (2014 forecast - $67,906k).

College Properties

The College owns properties in Adelaide and Melbourne in Australia. Accommodation is currently leased for College offices in Adelaide, Sydney, Brisbane, Canberra, Hobart, Perth and Wellington.

The College recently sold the Wellington property in New Zealand having already relocated staff to new leased premises last year due to OH&S concerns.

In Closing

As the year draws to a close the College continues to make significant progress regarding the key activities outlined in the Strategic Plan. The proposed initiatives, and challenges, for 2015, which I have outlined in my report, will ensure that the College continues to meet these challenges and progress in 2015.

I would like to thank my Deputy Treasurer, Mr Andrew Brooks, for his continued support during 2014 and his oversight of property related matters.

I would also like to extend my warm thanks to the Honorary Advisers of the College, Mr Brian Randall OAM, Mr Michael Randall OAM, Mr Anthony Lewis, Mr Stuart Gooley, Mr Reg Hobbs, Mr John Craven, Mr Chesley Taylor, Mr Peter Wetherall and Mr Graeme Hope, Investment Adviser of JBWere for their ongoing support and excellent advice, which over many years has been invaluable to the College and its Fellows.

I would also like to thank the Resources staff and the Director, Mr Ian T Burke, for their commitment, support and hard work in assisting me in my role as Treasurer.

The budget has been set to continue to invest in core areas of service to our Fellows and Trainees with an ongoing commitment to focus on matters of strategic priority. The financial position of the College continues on a solid base and is in sound shape for the year ahead.

Marianne Vonau
Treasurer
November 2014

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

FEES FOR 2015

	2015 AUST Fees AUD (Inc. GST)	2015 NZ Fees NZD (Inc. GST)
SUBSCRIPTIONS & ENTRANCE FEES		
Annual Subscription - 2015 payable on 1 January 2015	# $2,645	$3,180
Fellowship Entrance Fee payable in full (10% discount applies) or over 5 years	$6,105	$7,340
EDUCATION & TRAINING		
Surgical Training		
Administration Fee - exam pending, interruption and deferral (SET)	$345	$415
Selection Processing Fee - (Note 6)	$785	$945
Selection Registration Fee	$510	$610
SET Training Fee - College Component - 2015	#* $3,150	$4,165
International Medical Graduates		
Specialist Assessment Fee	$9,045	N/A
Supervision / Oversight Fee- onsite	$7,325	N/A
Supervision / Oversight Fee - remote	$20,915	N/A
Document Assessment Fee - AoN subsequent to specialist assessment	$1,370	N/A
Document Assessment Fee - College endorsement for AoN (Area of Need)	$1,370	N/A
IMG Administration Fee	$905	N/A
Short Term Specified Training Position Application Fee	$1,095	N/A
Examinations		
Clinical Examination Fee *	* $2,085	$2,755
Fellowship Examination Fee *	* $7,550	$9,985
Generic Surgical Science Examination Fee *	* $3,635	$4,805
Orthopaedic Principles & Basic Science Examination Fee *	* $2,730	$3,610
Paediatric Anatomy and Embryology Examination Fee	* $3,445	N/A
Paediatric Pathophysiology Examination Fee	* $1,365	$1,805
Plastic and Reconstructive Surgical Science & Principles Examination Fee	* $2,730	$3,610
Cardiothoracic Surgical Sciences and Principles Examination Fee	* $3,445	N/A
Speciality Surgical Science Examination Fee	* $1,815	$2,400
Pre Vocational Education and Training		
Generic Surgical Science Examination Fee	$3,995	$4,805
OTHER FEES		
Appeals Lodgement Fee	$8250	N/A
MOPS - Maintenance of Professional Standards		
Australia & New Zealand	$2,990	$3,600

1. All fees are payable in either Australian or New Zealand Dollars as invoiced.
2. All New Zealand fees will be subject to GST of 15% unless marked with (**) which are not subject to New Zealand GST.
3. All Australian Fees will be subject to GST of 10% except those approved Education courses marked with an asterisk (*) which are not subject to Australian GST.
4. Examination & training fees for Australian based activities have been approved by the Australian Taxation Office as GST free for all courses relating to the awarding of the RACS Fellowship.
5. Subscriptions and Fees marked (#) may be paid to the College by four equal instalments during the year by AMEX, Visa or MasterCard credit cards only. Further details will be made available when fees are raised.
6. Specialty programs may charge their own selection processing fees, these fees will be published by the respective Specialty Society.
7. N/C relates to College services provided at no charge, N/A relates to College services not charged in stated currency.

A full list of fees can be found on the College website.

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