SurgicalNews

www.surgeons.org | June 2018, Vol 19, No 5

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

ASC 2018

Highlights of this year's Annual Scientific Congress

GLOBAL HEALTH

RACS aid teams return to Indonesia

DR GLEN GUERRA

Colorectal Fellow conducts world-first research into rare cancer

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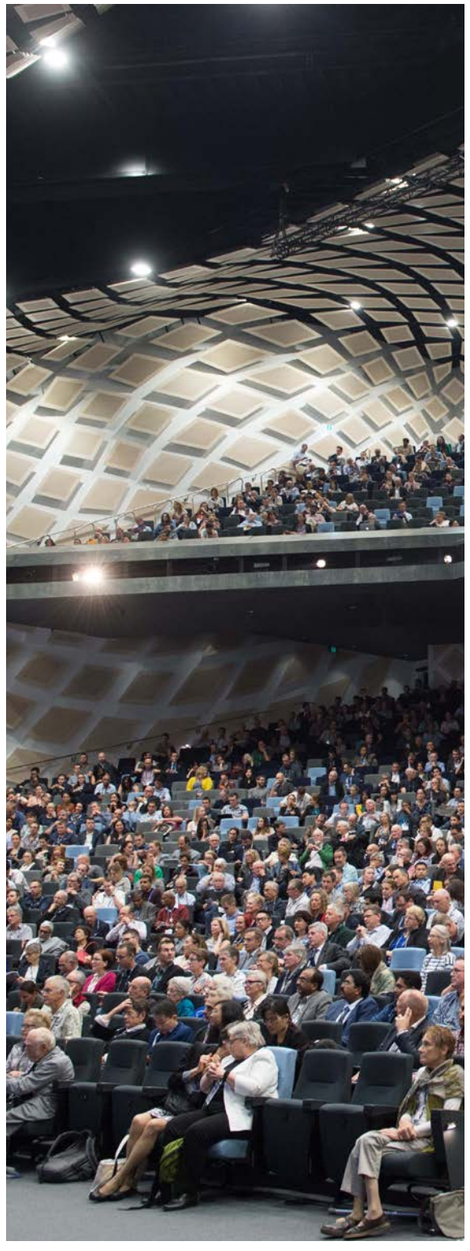


Correspondence and Letters to the Editor to *Surgical News* should be sent to: surgical.news@surgeons.org
Surgical News Editor: Mary Harney, CEO T: +61 3 9249 1200 | F: +61 3 9249 1219 | W: www.surgeons.org
ISSN 1443-9603 (Print)/ISSN 1443-9565 (Online).
 Published for the Royal Australasian College of Surgeons by RL Media Pty Ltd. ACN 081 735 891, ABN 44081 735 891 of 129 Bourverie St, Carlton Vic 3053.

Reflections from the RACS Annual Scientific Congress

We have had yet another successful RACS Annual Scientific Congress (ASC). The event, held in Sydney's scenic Darling Harbour, in the new International Convention Centre (ICC), attracted more than 2,500 delegates from Australia, New Zealand, the USA, the United Kingdom, China, Singapore, Malaysia, Fiji and many other countries.

The theme of the Congress "Reflecting on what really matters" was a particularly relevant one for us as surgeons. We often face many competing demands, and sometimes in our efforts to manage what is facing us, we forget the value of reflection. This year's Congress program was designed to help us focus on the importance of reflection in our practice.

The first day of the Congress culminated in the Convocation Ceremony—a highlight for me. The Convocation is a celebration of the introduction of new Fellows into full fellowship of the Royal Australasian College of Surgeons. It is also an acknowledgement of their hard work and discipline that led to this day. We watched this encouragingly diverse group of graduates mature, some of us were involved in their training, some we mentored, assessed or examined, and some inspired us as they trained. So it was with immense pleasure that I welcomed these new Fellows into the Fellowship of RACS.

Talking of Fellows, I would like to acknowledge the many award nominees that we celebrated during the week of the Congress. Congratulations to Professor Mark Smithers who received the Sir Hugh Devine medal which is the highest honour a Fellow can receive in their lifetime from the College. Congratulations also to Grant Fraser-Kirk and Kimberly Aikin who were awarded the John Corboy Medals. I was also delighted to present the RACS Aboriginal and Torres Strait Islander Health Medal to Council Member, Chris Perry, and to recognise a number of Māori and Aboriginal & Torres Strait Islander Trainees, among others. Well done!

Another highlight for me was the opening plenary session on the second day of the Congress. It was good to hear from our colleague, Australia and New Zealand College of Anaesthetists (ANZCA) President David Scott and listen to the discussion on the weighty topic of decision making around end of life management.

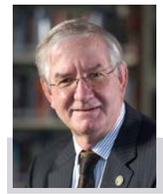
I know from talking with many of the delegates that the program had much to offer. A session that gripped me was one on injury prevention and trauma. Dr John Crozier presented on alcohol related violence followed by a very personal story of domestic violence shared by Dr Angela Jay, an obstetrics and gynaecology Trainee, who was stabbed 11 times by an ex-partner. Dr Jay's story showed that health workers are often ill equipped and not supported enough when they face domestic violence. The health implications of domestic violence when caring for patients as well as issues of education and awareness of domestic violence among health workers is an area that is important for us to focus on. I applaud Associate Professor Payal Mukherjee, Adult and Paediatric ENT Surgeon and deputy chair elect, RACS NSW state committee, who brought this important issue to the Congress.

I was also pleased to see many medical students participating in the Congress. These are the surgeons of the future and we must do everything we can to support and nurture them. One presentation that stood out for me was by Sarah McLain, a final year medical student at the University of Sydney. Sarah's research showed that females make up 50 per cent of all medical graduates in Australia, but only 34 per cent of specialists and 12 per cent of surgeons.

We have much work to do to reduce the gender gap in our profession, but I am heartened that we are making progress. The College's *2017 Progress Report Building Respect, Improving Patient Safety* showed women made up 22 per cent of new Fellows, 29 per cent of surgical Trainees and 25 per cent of major committee members in 2017. RACS has set a target of raising the percentage of female surgical Trainees to 40 per cent by 2021 and increasing representation on boards and committees to 40 per cent by 2020.

I believe many would agree with me when I say that the Congress was a great success. I think this was not only because of the quality of the presentations, the experienced presenters, but also the support of our colleagues from the American College of Surgeons who co-hosted the 87th Annual RACS ASC with us. We were also joined by the ANZCA which held its scientific meeting in parallel with ours.

I could say so much more about the RACS ASC and how it made so many of us reflect on our practice, but let me finish by thanking the many people who contributed to the success of the Congress. Firstly, my thanks to the ASC convenors, Arthur Richardson and Julie Howle, the section convenors, our Fellows and those of the American College of Surgeons, anaesthetist colleagues, and our events team who made this wonderful Congress possible. My gratitude also goes to Dame Clare Marx Immediate Past President RCSEng, my Presidential guest, Vice-Admiral Raquel Bono of the US Defence Health Agency, this year's Syme Orator, and my esteemed colleague Dr Barbara Bass, the President of the American College of Surgeons.



Mr John Batten
President

Get involved in your local Annual Scientific Meeting

The Annual Scientific Congress (ASC) might be over, but there are still a number of interesting local annual scientific meetings (ASMs) that RACS will be hosting this year. From central Australia, to the south of New Zealand – the quality of the programs and the locations are outstanding.

As part of the Vice President's portfolio, I am pleased to promote these events which take place in the second half of the year, that provide a perfect opportunity for Fellows to meet somewhat closer to home than the ASC normally allows.

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

The RACS office in your jurisdiction is where the events will come together. Staff, regional chairs and local conveners put in a lot of work to organise them by accepting and sorting through abstracts, lining up speakers of interest, and sourcing sponsorship. I wish to thank them for their efforts.

The local ASMs and events attract not only Fellows but also a large number of SET Trainees, International Medical Graduates, junior doctors and medical students. These events provide an avenue for the next generation of surgeons to present papers, compete for awards and prizes, and seek mentors.

In chronological order our ASMs for 2018 are:

Queenstown, 9-10 August, 'Planning for Change'

Our New Zealand meeting returns to the stunning surroundings of Queenstown, with the focus being on how to plan for, and tackle challenges associated with change. Sessions will explore subjects such as challenging patients, challenging situations, and how to manage when things change pre-operatively, intra-operatively, and post-operatively.

Speakers this year include orthopaedic and trauma surgeon, Ms Annette Holian, Dr Claudius Conrad, Assistant Professor in the Department of Surgical Oncology at the University of Texas MD Anderson Cancer Centre, and Adelaide based plastic surgeon Dr Rodney Cooter.

Currently the Chair of the RACS Military Surgery section, Ms Holian is a reservist in the Royal Australian Air Force (RAAF), holds the rank of Group Captain, and is the Clinical Director for Surgery and Perioperative Services for the RAAF. She has undertaken five deployments to war zones, including three tours in Afghanistan, and several humanitarian disaster responses both as a civilian and in uniform. Ms Holian will be speaking from her extensive military experience of how the RAAF adapts to change.

Dr Conrad will be providing an insight into the management of theatre teams in the United States - how they plan for change, what they do well and what they can do better.

Dr Cooter will speak on his role coordinating an international study to explore informed consent variations in an effort to get international consensus for aesthetic surgery, and breast implant surgery- in particular, in medical tourism facilities.

Alice Springs, 23-25 August, 'Infections From Head to Toe'

The Tristate (WA, SA and NT) ASM offers an interactive program, which will be combined with the Rural Surgery and Indigenous Health sections. The event will commence with an Australian and New Zealand Audit of Surgical Mortality (ANZASM) Symposium on the 'Changing Face of Infectious Diseases' on Thursday afternoon.

There are a number of other presentations that I am excited about including one from Professor Bart Currie, a well-known infectious diseases physician, and the Henry Windsor Lecture which will be presented by South Australian Fellow Associate Professor Susan Neuhaus.

It is a rare opportunity to attend a meeting in central northern Australia, and it would not be complete without experiencing the area's culture. A welcome event, showcasing local indigenous children playing their music, a Traditional Welcome to Country, and an up close and personal experience with the 'wild life' of the area are just a few of the highlights I am looking forward to. The conference dinner will be held at the Telegraph Station with a star-gazing presentation by local experts, and the opportunity to learn about the history of the station.

Melbourne, 20-21 October, 'Trauma Surgery in 2018'

This year's program will see collaboration between the three major trauma centres in Melbourne and our regional surgical partners across Victoria, and will explore contemporary surgical management of severe trauma. Key presentations will include trauma care in different settings, time critical operative intervention, and trauma reception and resuscitation.

Free paper sessions demonstrating the breadth of surgical research of our Fellows, Trainees, junior doctors and medical students will also be held throughout the day.

The one day scientific program on the Saturday will be combined with two half-day professional development workshops to be held on the Friday. The first of these workshops will be a Surgical Leaders Forum. This will be followed by an interactive workshop hosted by the Victorian Audit of Surgical Mortality (VASM).

Canberra, 27 October, 'The Role of Surgeons in Health Advocacy'

The ACT is undergoing a decade long redesign of its health services which has the potential to significantly improve patient outcomes and better align resources. Clinicians are uniquely placed to provide complex, well-considered, reasonable solutions to challenging issues. However, they will only be successful in doing this if they engage constructively with administrators.

This year's meeting will feature presentations from a range of healthcare experts, with a particular focus on how to develop solutions for service access and delivery problems and public health issues which have a significant impact on surgical workload.

Hobart, 9-10 November, 'Regional Trauma in Australasia: What is possible and how far can we reach?'

Our final ASM program for the year will be held in Hobart, and will be combined with the Trauma Symposium to be held at the Medical Science Precinct, at the University of Tasmania. Planning is well underway for this event; Stay tuned for more program information shortly!

Queensland will reconvene for their next ASM in 2019, but in the meantime the inaugural Charity Ball on 10 November promises to be one of the highlights of the RACS social calendar. All Fellows, Trainees, IMGs and their partners are invited to support this worthy event, with proceeds being directed to the Foundation for Surgery.

New South Wales dedicates the month of November to "Surgeons' Month" with various events targeting a range of stakeholders from medical students to retired surgeons.

I encourage you all to support your local meetings and I look forward to seeing you there.

For more information on the ASMs and all other RACS events, please visit the Regional pages of the RACS website, or get in touch with your local RACS office.

Ms Cathy Ferguson
Vice President

ASC 2018

Kelvin Kong and Maxine Ronald at a visit to the LaPerouse community centre

Annual Scientific Congress wrap-up

The 2018 RACS Annual Scientific Congress took place from 7 to 11 May in Sydney, returning to the Harbour City for the first time in a decade. The event was held at the world-class facilities of the International Convention Centre in Sydney's picturesque Darling Harbour.

The Congress was a joint meeting between the Royal Australasian College of Surgeons (RACS), the American College of Surgeons (ACS) and the Australian and New Zealand College of Anaesthetists (ANZCA).

Day 1

Monday 7 May

Associate Professor Kelvin Kong and Dr Maxine Ronald were part of a group that paid a visit to the LaPerouse Community Centre on the opening day of the 2018 RACS Annual Scientific Congress. Delegates had the opportunity to meet with elders and leaders from the longest functioning Aboriginal community in Sydney. Professor of Epidemology at University College London, and Immediate Past President of the World Medical Association, Professor Sir Michael Marmot, presented on the global health consequences of chronic disease in indigenous communities and the developing world.

The opening day's program included a number of cross-discipline workshops however the main event was the Convocation Ceremony where a number of surgeons took the first step into becoming RACS Fellows. RACS President John Batten, and Syme Orator US Navy Vice Admiral Raquel Bono congratulated convocating Fellows at the ceremony.

Mark Smithers receiving the Sir Hugh Devine medal, the highest honour a Fellow can receive

Children at the LaPerouse Community Centre

Vice Admiral Raquel Bono

"I'm very honoured and privileged to be here to talk with you. I congratulate all of you, family, friends and I look forward to seeing what more you will help provide and how you will help evolve surgery," Vice Admiral Bono said.

“If the amount of dedication and thoughtfulness that I see going into this ceremony is any proof, not only are you highly regarded but you are well schooled, well coached and well prepared to take us to the next level, congratulations," Bono added. ►

Convocating Fellows

Day 2

Tuesday 8 May

The second day of the RACS Annual Scientific Congress featured a brilliant opening session in the plenary of the world-class International Convention Centre. RACS President John Batten gave the opening address and delegates were shown a number of case study vignettes with some challenging scenarios. A panel featuring Dr Linda Sheahan, Dr Andrew Klein, Professor Ken Hillman, Dr Ming Loh and Professor Arden Morris discussed the series of case studies and provided some insights from a variety of professional perspectives.

Delegates then took part in a number of programs in what was a stacked scientific program with plenty on offer for attendees. One of the most important sessions of the day was the injury prevention and trauma session which featured a presentation by Dr John Crozier on alcohol related violence followed by a touching and personal story of domestic violence affecting healthcare workers from Dr Angela Jay. This was then followed by a panel discussion on domestic violence and healthcare from individuals such as Inspector Sean McDermott, Troy Roderick, Barbara Bass, Spencer Beasley, and Secretary of Health Elizabeth Koff.

Dr Jay's story was picked up by Fairfax media and the important issue of domestic violence was shared across the country. There were a large number of posters and presentations from this year's ASC that garnered media coverage in Australia and New Zealand. Stories on 3D printing to colorectal cancer were broadcast on Seven's nightly news and Professor Jeffrey Rosenfeld was interviewed on national radio about the importance of the HEMCON course for first respondents.

Dr Christine Lai presented the facts and findings from the latest Younger Fellows Survey during a session on workforce issues facing the College's younger Fellows and Associate Professor Cliff Pollard delivered the Sir Edward 'Weary' Dunlop Memorial Lecture in the afternoon of Day Two. Pollard examined the roles of the three Australian Casualty Clearing Stations on the Western Front in 1918; identified key personnel and spoke on their post-war careers during the lecture.

The Younger Fellows/Trainees & Senior Surgeons Dinner took place in the evening at Taronga Zoo and during the event, Grant Fraser-Kirk and Kimberly Aikin were awarded the 2017 and 2018 John Corboy Medals (respectively) by RACS President John Batten.

Day 3

Wednesday 9 May

Day three of the Congress kicked off with an Indigenous Health Breakfast held at the ICC Sydney. Associate Professor Kelvin Kong chaired the event and there was a video address to attendees from Federal Minister for Health Greg Hunt. RACS President John Batten spoke about championing indigenous health and advocating for quality health outcomes for all people during this session.

The President also presented the RACS Aboriginal and Torres Strait Islander Health Medal to Christopher Perry and a number of Māori and Aboriginal & Torres Strait Islander doctors and medical students were recognised and celebrated during the event.

Dr Lisa Waia, Pirpantji Rive-Nelson, Yaraji Green and Dr Claudia Paul each received the Foundation for Surgery Aboriginal & Torres Strait Islander ASC Award. Jamie-Lee Rahiri and Dr Hinewaiora McCleery each received the Foundation for Surgery Māori ASC Award, and Dr James Johnston received the RACS Māori Career Enhancement Scholarship.

The plenary session on day three focused on the topic of "Leadership Matters" and featured presentations from Professor Rachel Kelz from the University of Pennsylvania, Professor Melina Kibbe, Chair of the Department of Surgery, University of North Carolina, Dr Meron Pitcher and Professor Taylor Riall from the University of Arizona's College of Medicine.

(Left to right) Kimberly Aikin, RACS President John Batten and Grant Fraser-Kirk

(Left to right) Jamie-Lee Rahiri, James Johnston and Hinewaiora McCleery

Professor Riall spoke about communication and leadership saying "every interaction we have provides us an opportunity to lead" and said that we are all role models in the surgical workforce regardless of being surgeons, trainees or students.

Philip Truskett, Martin Nakata, Christopher Perry, David Murray, Maxine Ronald, Artiene Tatian, Natasha Martin, Kelvin Kong and Gregory Philips contributed to a panel discussion on cultural competency during the morning's Indigenous Health session and internationally-recognised scholar Professor Martin Nakata presented the Indigenous Health keynote lecture on the topic of equality vs equity in the Indigenous medical workforce.

In the afternoon's Trauma Surgery session, Chief Superintendent John Stapleton APM (who has served with NSW Police for 32 years) spoke about the threat of terrorist attacks to the public and responding to mass casualty incidents.

The third day of the Congress also featured a Women in Surgery networking function, which was attended by leaders such as RACS Vice President Cathy Ferguson, Dr Christine Lai, Dr Ruth Mitchell and Professor Kerin Fielding.

A number of these trailblazing female surgeons were also profiled in the media during the ASC and featured in a story about increasing the number of females in the profession which was run in Fairfax media and syndicated across Australia.

Day 4

Thursday 10 May

The Women in Surgery Section Breakfast and Annual Business Meeting took place on Day Four and was followed by the Women and Leadership session. Medical student Sarah McLain presented her talk on barriers to women's participation in surgery which raised awareness of female students' perceptions of surgery. Sarah's presentation was well-received by many delegates and the issue gained strong media coverage.

Professor Anne Kolbe, the first female President of RACS also presented in the Women and Leadership session, giving an inspiring talk on the topic of leadership and governance. Other presentations ►

(Left to right) Melina Kibbe, Meron Pitcher, Rachel Kelz, Taylor Riall and Julie Howle

Women in surgery

included a talk on leadership in the military by Tracy Smart and leadership in academia by Melina Kibbe.

Dr Barbara Bass, President of the American College of Surgeons presented in the cross-discipline ACS Plenary Session speaking about the topic of skill validation, credentialing and privileging.

Former President of the Royal College of Surgeons of England and the first woman to hold the position, Dame Clare Marx also presented the President's Lecture on the topic of clinical leadership on Day Four. Dame Marx touched upon issues of leadership, support and training, telling the audience that "leadership is the most important influence on culture - every interaction by every leader in healthcare shapes the culture of their organisations."

In the afternoon, a number of attendees sat in on insightful and inspiring talks from Dr Henry Marsh, Associate Professor Andrew Davidson and Professor Jeffrey Rosenfeld during the Neurosurgery Scientific Session.

To round out day four, the RACS ASC and ANZCA ASM Gala Dinner took place in the Grand Ballroom and provided an opportunity for delegates to have some fun with colleagues after a day of lectures, presentations and workshops.

Day 5

Friday 11 May

The important topic of practitioner wellbeing took centre stage during the final day's plenary session on Keeping

Lisa Waia, Pirpantji Rive-Nelson, Yaritji Green and Claudia Paul receiving the RACS Aboriginal & Torres Strait Islander ASC Award

the Passion Alive: Surviving 21st Century Practice in the Darling Harbour Theatre. Professor Simon Willcock from Macquarie University Hospital opened the session and provided background on the issue of burnout and an overview of the extent of the problem.

Dr Taylor Riall (United States) spoke about maintaining work-life balance and about the need to cultivate our own wellbeing but also the responsibility to cultivate the wellbeing of those around us. Dr Riall's presentation was followed by a brilliant address by Dr Eric Levi who spoke

Aboriginaland, Torres Strait and Māori banners

about the importance of self-care and discussed the issue of doctors' mental health, often viewed as the "elephant in the room".

The Challenges in Leadership session took place in the afternoon of the last day. RACS President John Batten opened the session, speaking about leading cultural change and addressing discrimination, bullying and harassment in the medical profession. Past RACS Presidents Philip Truskett and Spencer Beasley, and Oscar Guillamondegui also presented during the session.

We had great media coverage at the RACS ASC with more than 120 media clips across broadcast, print and online in Australia and New Zealand.

Our social media presence continued to grow with the RACS ASC providing lots of content and engagement. Total impressions for Facebook grew by 183.2 per cent and total engagements increased by an impressive 341 per cent since the last month. Twitter engagements also went up by 224.5 per cent and LinkedIn engagements were up by 94.4 per cent.

Agron Dauti
Digital Media & Internal Communications Coordinator, RACS

(Left to right) Kerin Fielding, Christine Lai, Pecky De Silva, Michelle Locke, and Sarah McLain

A demonstration at one of the stands at this year's ASC

Dr Eric Levi

RACS President John Batten with Dame Clare Marx

The border from Timor-Leste to West Timor, Indonesia

RACS aid teams return to Indonesia

Volunteer surgeons with the non-profit Overseas Specialist Surgical Association of Australia (OSSAA) have again begun to provide support to improve surgical care in eastern Indonesia following the lifting of a moratorium on visiting medical teams.

Plastic and Reconstructive Surgeon and Vice President of OSSAA, Dr Mark Moore AM, visited Papua and West Timor with colleagues last year for the first time since the Indonesian Government placed restrictions on visiting medical teams in 2014.

He described both visits as successful and praised the work of RACS' Global Health department for negotiating the new agreement that allows RACS-affiliated surgical teams to provide specialist medical education including hands-on skills training, in Indonesia.

Dr Moore, from South Australia, led a team visit to Papua last year and West Timor earlier this year to work with Indonesian surgeons and medical staff to provide cleft lip and palate repair and maxillofacial reconstructive surgery to communities who would otherwise not have access to these treatments.

In April, he continued his long involvement in the development of plastic surgery in East Timor by working with the RACS-supported local surgeon, Dr Joao Ximenes, to conduct a range of cleft lip and palate surgeries.

He is now collaborating with a group of orthodontists in Adelaide and Darwin who wish to assist the work of OSSAA by volunteering their expertise to train local counterparts to help those who require specialist dental intervention.

Speaking to *Surgical News*, Dr Moore said that by the time the team returned from the April visit, the program would have conducted 1,000 cleft repairs since the organisation began in 2002.

"This is a great milestone and we continue to build networks and relationships so that we can go on helping our neighbours provide the best care possible for the people of East Timor and eastern Indonesia," he said.

"There is a speech pathologist in Dili right now with links to a speech pathologist in Darwin and Celina Lai from the Royal Darwin Hospital, who is of East Timorese descent, will be part of the team visiting East Timor in April.

"This year, we will have an orthodontist travelling with us after a small group of specialists, led by Professor Craig Dreyer, head of the Orthodontics Unit at the University of Adelaide, offered us their support.

"Their skills represent a wonderful addition to the development work we do, because cleft patients often require dental intervention as they age, something the program has not been able to offer until now."

OSSAA was originally established by Mr John Hargrave to provide major surgery for people in East Timor and eastern Indonesia who suffered from burns, cleft palates, congenital defects, leprosy, disease and trauma.

Specialist services provided include reconstructive surgery, ENT, orthopaedic surgery and general surgery, and voluntary surgical teams typically consist of a surgeon, anaesthetist and specialist nursing and allied health staff working alongside the local team to transfer skills and knowledge.

Dr Mark Moore AM with a patient

From 2002 to 2016, RACS-affiliated teams conducted 100 surgical team visits, which resulted in 11,000 consultations and 5,000 free operations to improve the lives of the poorest people in the region.

The teams work out of the Dili and Baucau hospitals in East Timor and have now returned to work at the Hospital of St Damian and St Raphael in Flores and the Marianum Hospital at Halilulik in West Timor. They travel only at the invitation of the local authorities who appreciate the support provided to their medical staff and their communities.

Dr Moore, who received the RACS International Medal in 2014 for his international development work, said that while the visiting teams had now addressed most of the backlog of cleft cases in East Timor, older patients were still waiting for treatment in the other regions visited.

He said that while surgical services had expanded dramatically in Indonesia in recent years, there was still no plastic surgeon based east of Bali and the country had only 180 plastic surgeons to treat a population of over 300 million people.

He said that while there was some initial concern about the systems that would be in place in West Timor and Flores to support the team visits following the three-year hiatus, the trips were a success.

"For more than 20 years, we have been building robust systems and relationships which stood us in good stead when we returned to eastern Indonesia," Dr Moore said.

"One of the great strengths of OSSAA is the commitment of our volunteers who return again and again to these hospitals.

"There is a strong system of church groups and government agencies in eastern Indonesia that is keen for us to come back and push forward with our work because we are remembered not just as an organisation but as people."

"This allows us to build relationships and trust with local health care providers, develop pathways to treatment so that patients are ready when we arrive and to spread the word of our visits to isolated areas. ►

Surgeons and theatre staff

"There is a strong system of church groups and government agencies in eastern Indonesia that is keen for us to come back and push forward with our work because we are remembered not just as an organisation but as people. This continuity also allows us to identify and support local colleagues who are the future of the region."

Dr Moore said that although he has been travelling to the region for more than two decades he still sometimes found the suffering of some patients confronting.

"These are some of the poorest people in the world who have little to no access to specialist surgical care," he said.

"On our visit to West Timor we met a mother with a three-week-old baby who had been born with terrible cranial deformities and I had to tell her that her baby would die and that nothing could be done.

"Then, at the end of the week we met a woman in her 60s who came into the clinic with her face covered by a mask.

"She had chewed betel nut for most of her life which had caused part of her mouth to be eaten away from oral cancer and we couldn't do much for her either.

"These cases book-ended our visit and in both cases all you can do is hope the patients are shown compassion and love by the people around them."

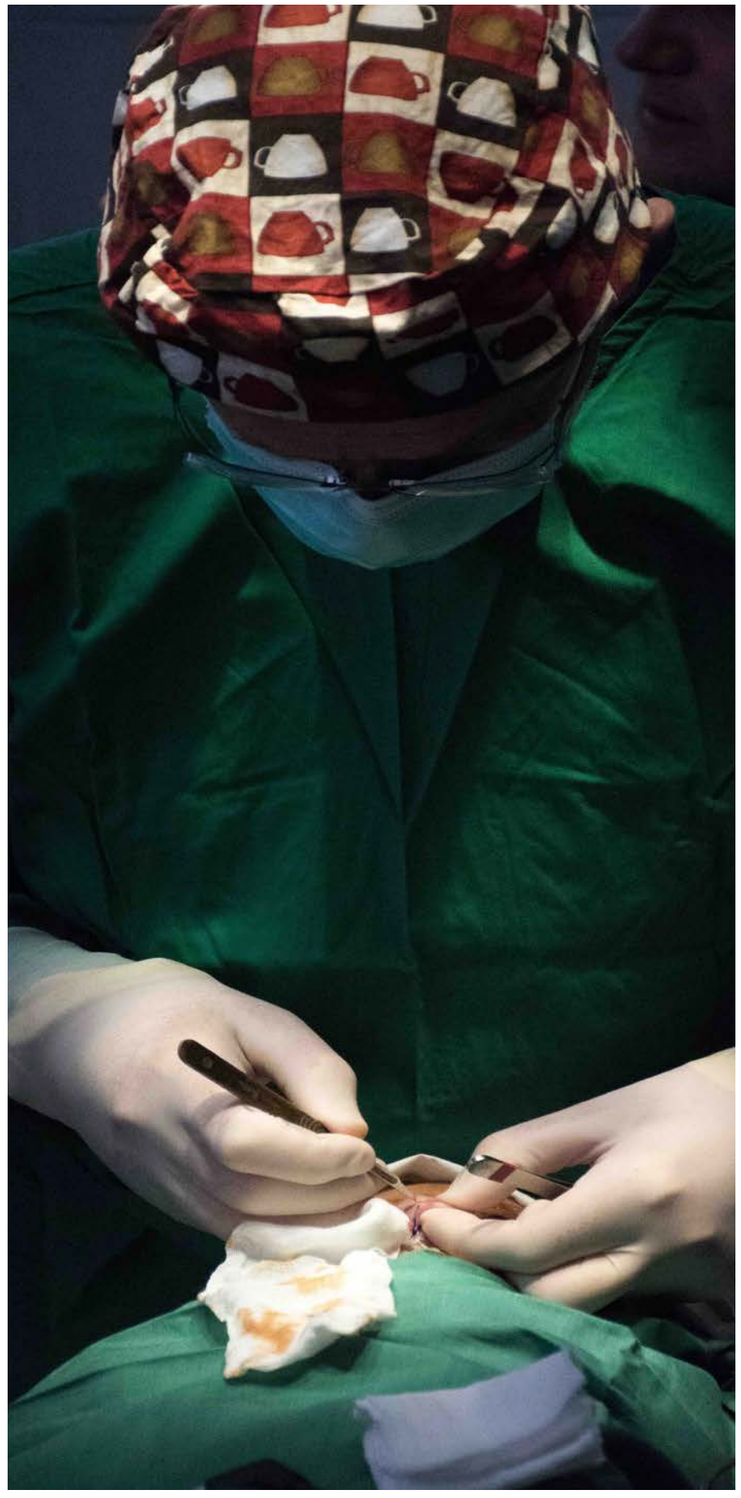
Now in his 60s, Dr Moore said he planned to continue his international work for another decade and even downsize his Australian practice to give him more time to spend in East Timor and eastern Indonesia.

He said younger surgeons like Dr Yugesh Caplash, the Director of the Department of Plastic and Reconstructive Surgery at the Royal Adelaide Hospital, were dedicated OSSAA volunteers and well placed to take the lead some day in the future.

"As with all global health activities, we work to make ourselves redundant in the future as local capacity improves."

Dr Moore particularly thanked Daliah Moss, RACS' Director of External Affairs, for her tireless efforts in negotiating the new contract with Indonesian health authorities.

Karen Murphy
Surgical News journalist



Are you a leader or a follower?

Surgeons as Leaders in Everyday Practice

The RACS Surgeons as Leaders in Everyday Practice course takes place on the Gold Coast, Queensland. With this and our upcoming Sydney event fully booked, we are excited to provide Australian and New Zealand surgeons with a chance to develop their leadership capabilities in their everyday practice.

Upcoming courses:

- Gold Coast 8 – 9 June 2018 (fully booked)
- Sydney 3 – 4 August 2018 (fully booked)
- Canberra 10 – 11 August 2018
- Melbourne 23 – 24 August 2018

Many topics relevant to all surgeons are covered within the one and a half-day course. One of these is 'followership', perhaps a concept not widely understood by surgeons. The reality is that without followers, a leader isn't actually a leader at all, yet the style of leadership influences the style of followership (and vice versa) and how well the surgical team works. When should the surgeon become a follower?

Participants in the Surgeons as Leaders in Everyday Practice course undertake pre-course reading that includes an article from the American Journal of Surgery ('), which suggests that a surgical leader is still following somebody, whether they're a director, a chair of a board, or even a mentor. It also describes five different styles of followership and how they relate to leadership, teams and outcomes.

Being interactive, the course encourages its participants to discuss different viewpoints and perspectives around various aspects of leadership in the surgical context. Participants will thrive on the discussions they have in a supportive but intellectually critical faculty and if the course is successful, with their views reinforced, challenged and extended.

The course starts on a Friday evening and is followed by a full day of training. It includes four sessions that cover understanding leadership, self-awareness, communication and leading teams, along with some more contemporary themes such as human factors. Accommodation for the Friday night and all meals are included within the registration fee.

Surgeons as Leaders in Everyday Practice is relevant to all surgeons, but particularly those in the first years of their consultant practice who have no formal leadership role. It is also relevant to surgical Trainees.

Register for upcoming courses at
https://www.surgeons.org/for-health-professionals/register-courses-events/professional-development/

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Professor Spencer Beasley
Former Vice-President

Call for clamp down on smoking on hospital property

A Townsville Orthopaedic Surgeon, Dr Kaushik Hazratwala has called for public health administrators to lead a national campaign to clamp down on patients and visitors smoking on hospital property and insist that fines mandated in state jurisdictions are enforced.

Dr Kaushik (Kosh) Hazratwala (pictured above) is a Specialist Lower Limb Orthopaedic Surgeon, the former Director of the Department of Orthopaedics at The Townsville Hospital, Queensland and the founder of the Townsville Lower Limb Clinic.

He said that senior hospital administrators had a duty of care to all patients, staff and visitors at their institutions and need to push Government officials to enforce smoking bans on hospital property.

He said that although there was strong public support for the bans on smoking in areas surrounding public buildings, a lack of enforcement meant that such laws were routinely ignored.

“We know that tobacco smoking is one of the leading preventable causes of premature disease and death and that smokers have a higher risk of experiencing adverse perioperative events, yet we look the other way when it comes to people smoking outside hospitals – the very place where bans should be enforced,” Dr Hazratwala said.

“Smoking, along with alcohol and sugar, is a significant contributor to the ill-health of a high percentage of Australians.

“Our public health system is struggling to provide the level of care that the public insist upon receiving, yet there is no accountability from public patients themselves to maintain their own health.

“I despair sometimes when I see patients attached to IV tubes sitting outside the hospital doors smoking and forcing others to risk the harm of passive smoking.

“I believe that both patients and visitors would stop smoking outside health facilities if penalties were enforced.”

Dr Hazratwala said that smoking was prohibited within five metres of all public and private health facilities in Queensland, with fines of $252.30 applicable to those breaching the laws.

He first went public with his call for action in early March through a story in the Townsville Bulletin and found strong support for his stance from colleagues at the Townsville Hospital.

However, in the same article a senior hospital representative said the hospital employed security officers to conduct foot patrols of the campus and educate the public about the smoking bans but that some patients can find hospital care stressful and smoking can often be a coping mechanism.

Dr Hazratwala said such sensitivity was misplaced.

“The blatant disregard shown by some patients and visitors to the smoking bans should not be condoned for any reason,” he said.

“The public health sector needs to be more vigilant about smoking bans, particularly given that everyone working in the health system knows the damage it does.

“We need to clearly mark the five-metre limit around facilities, we need to enforce penalties, and we need to make it clear to patients and visitors that if they are attending a health facility anywhere in the country, they need to abide by the rules.”

RACS has worked for many years to reduce the harm done by smoking. In the most recent position paper, RACS supported the New Zealand Government’s efforts to reduce smoking rates to five per cent by 2025 and the Australian Government’s plan to reduce smoking to 10 per cent by 2018.

To achieve these targets, RACS recommends and supports:

- Nationally consistent legislation across Australia;
- City Council advocacy to support those councils who have been vigilant in reducing exposure to cigarette smoking and who encourage other city councils with more relaxed policies to adopt stronger measures;
- Cessation advice provided by Fellows to patients outlining the risk of complications during and after surgery and the benefits of quitting prior to surgery.

Dr Hazratwala’s call for action comes in the wake of the tragic death of Melbourne surgeon Patrick Pritzwald-Stegmann who died after an altercation over smoking outside the doors of the Box Hill Hospital in 2017.

Dr Hazratwala is not only concerned about the health and wellbeing of Australian patients, but also the healthcare professionals that provide care to the patients.

Interview by Gabrielle Forman, Communications and Policy Officer, RACS.

If you’re so amazing why are you unhappy?

S P Eshal attended an annual health check recently. S P Eshal was generally healthy from the perspective of blood pressure, BMI, haemoglobin, folate/ B12, lipids etc., but also working flat-out, getting too little exercise and was rarely out of doors during daylight hours. Knowing that there is still much toxicity in the medical work place, after sharing the good physical report I asked, “so how are you feeling?”

S P Eshal paused for a moment and then replied, “I am unhappy, I have a sense of not meeting my own expectations.” I waited and allowed a pause in conversation, so S P Eshal continued, “I was brought up to think I am special, I’ve been told ever since I was a child, how clever I am, how I can achieve anything I want to. I was led to believe I could be prime minister, attorney general or a professor. Now that I’m a surgeon, working with other surgeons, I find compared with my colleagues I am, quite frankly, not special. My bosses treat me well but they don’t make me think I am special.”

I’ve heard this from many of S P Eshal’s generation, and those in the medical or surgical profession are not special cases. It is a common finding that when you consider the equation, Happiness = Reality minus Expectation, many perceive that their reality is less than their expectations and so feel unhappy. It evokes a sense of dissatisfaction and frustration deep inside, unnerving the soul. Sociologists describe the plight of many Gen Y’s, raised by their baby boomer parents to have great expectations of themselves, to become the leading actors of life’s play and prone to deflect negative feedback. Constantly chasing perfection, like mice in a rotating treadwheel, some are driven by ambitions that won’t match reality. This makes them unhappy.

I asked S P Eshal, “does this affect how you treat other people?” “Sometimes unfairly, short temperedly, and badly” was the response. In the workplace, the shortfall between reality and expectations may make you not only dissatisfied, but also irritable and sometimes angry. This can provoke taking out that irritation on others, because deep inside you feel your life is not delivering what has been promised, or rather what you’ve allowed yourself to be led to expect.

And yet, where is the deep sense of gratitude for life thus far? S P Eshal has good health, has had a good education, has become a competent doctor and surgeon. These opportunities have already offered great reward. Doctors are financially secure and are not usually required to take out mortgage insurance – a banking predictor of an enduring, well-remunerated and secure career! Where is the pride, as opposed to self-inflated ego, the genuine pride at what has already been achieved? Such pride should be matched by reflecting with humility that there is still a long way to go, and that the final destination will require a long journey with sustained input of service, diligence, professionalism, integrity and patience.

“You’re doing fine, S P, you are just not amazing. Being ambitious for a fulfilling career is a worthy aim and likely outcome. However, feeling ‘over-entitled’ with an inflated view of yourself will doom you to disappointment and depression. You’ve been brought up to think you are special but so have many others in your generation and quite frankly you’re no more special than most other human beings with whom you are sharing life’s journey. That’s what reality is teaching you. Even those who you most admire, you probably admire them because they don’t give you the impression that they think of themselves as special.

“Take the opportunity to learn from these emotions, and instead, be grateful for all that you are and all that you have. In the mean-time practice mindfulness to reflect on the above and recalibrate your reactions and how they influence your behaviours. Also, don’t underestimate the value of fresh air, daylight, and exercise to help you find balance and further improve your mood and self-confidence. Just don’t expect to reach perfection. It is elusive. You really are doing OK.”

DR BB-G-LOVED

A bit of give and take

Dr Bridget Clancy, FRACS
Rural Surgeons Series

Dr Bridget Clancy

You do not need to spend very long chatting with Dr Bridget Clancy to observe that two things in particular have remained from her childhood. One is a deep sense of social justice that was instilled in her by her parents, and the second is her love of the country lifestyle.

Despite being born in Melbourne, Bridget and her six siblings spent many years living in rural areas as her father, a state school principal, was rotated through various country towns. This upbringing left her knowing that she would always like to give back to rural and remote areas.

As a medical student, she initially aspired to be a rural and remote 'jack of all trades,' but after a series of encounters with inspiring mentors, as well as her interest in the 'complexities and the beauty of the head and neck,' she instead concentrated on becoming an ENT surgeon.

Although most of her training was 'city-centric' due to the need to train with city-based specialists, Bridget took every opportunity she could to work in country areas. Following her training, Bridget settled in to the Cobden area, and has commuted to the town of Warrnambool, seventy kilometres away, where she has provided both public and private services to the town and its surrounding region.

"The reason I selected Warrnambool was that my husband (whom I met while he was an accountant), and I decided to go back to dairy farming. We are in a region that is one of the best places in Australia to do that sort of work," Dr Clancy said.

"I am an outdoor person, I have two acres of garden, and I just need and love trees. The physical beauty of where we live, including the Otways and Great Ocean Road, is something I will never tire of.

"We love to travel, so we feel like we have the best of both worlds for our children, who are able to enjoy an ideal lifestyle in our beautiful natural surrounds. They also learn so much through working on a farm and through our business ownership.

"From a surgical perspective, I love the diverse patient mix and the ability to provide care for patients of all ages. I feel I am able to maintain and use a breadth of skills developed during my training, which I might not have if I lived in the city and sub-specialised.

"We have three areas of traditional ownership in our region. I work in partnership with Aboriginal and Torres Strait Islander cooperatives to provide care to these communities," she said.

While she is passionate about rural health and ensuring all Australians are able to access high quality care and services, she is also realistic about why it is often difficult to attract specialists to regional areas, and she does not sugar-coat some of the harsh realities.

"My feedback from registrars and others looking to come to the country, is that the added expectation of on-call work and overtime are a strong disincentive. When you consider what people have to give up to meet these expectations, such as family time, then you can't really blame them."

Rather than be deterred by these difficulties however, Bridget has instead embraced the opportunity to become a passionate advocate for rural health. She describes herself as someone who enjoys change and innovation, and thrives on a challenge.

As well as being an active member of many surgical organisations and advisory committees; she also utilises her qualifications with the Australian Institute of Company Directors to Chair and serve on the boards of profit and not-for-profit organisations.

She has many ideas as to how health services to rural communities can be restructured to provide optimal care. In particular, she has a long term vision to establish a program whereby metro-based specialists spend two to four weeks every year working in a regional area, while also experiencing many of the unique local attractions that regional areas have to offer.

Bridget's Cobden home is located close to the picturesque Great Ocean Road

"If this sort of program could be set up and marketed properly then I think it could be enormously beneficial, not to mention the great experiences that surgeons will then be able to take with them back to the cities.

"We don't necessarily need an ENT surgeon to be here 365 days of the year, but if they were to be involved for a short period of time this would allow for skills to be acquired and transferred, and could be very exciting and rewarding for both the surgeon, regional generalists and the community.

"It would allow elective surgery to be provided close to home for patients with post-operative care provided by local generalists," she said.

In addition to this, Bridget believes there are several enhancements to policies and processes, which could greatly benefit rural health. These include, providing publically funded outpatient clinics (which do not exist in most regional settings), and introducing a dual funding system for Medicare rebates which would provide greater funding for remote and rural patients.

Bridget's dairy farm in Cobden

She also supports movements towards safe working hours, as well as initiatives to increase the profile of regional and remote general surgery.

"Medicine is behind government and the corporate world in terms of processes and I think we need to learn more from other sectors and adapt them in a way that can work in our profession.

"I know that there are concerns that moving towards safe working hours for Trainees may result in reduced exposure and time to acquire skills. However, when you have done a 72-hour shift without sleep then you are not learning anyway. But at the same time, if you were to make a mistake then that is something you will live with forever, regardless of how tired you are.

"We have lots of people who are highly-skilled and capable of doing the things they need to do, but in my case because it will always be an ENT problem then the logic is that it always needs to be done by the ENT surgeon. When you are the only ENT surgeon in the region this is unsustainable.

Ultimately, Bridget said that her vision is to see the provision of elective surgical services in remote and regional settings, without burning out the existing surgeons.

"This would be a team based approach involving specialist surgeons partnering with generalist colleagues, including general surgeons and rural health practitioners, to enable patients to get the care they need close to home, without the specialist surgeon needing to be on call 24/7. This would involve transfer of skills from the specialist to the generalists, which will benefit their patients in other settings."

Interview by Mark Morgan, Communications and Policy Officer, RACS

Renovations improve outpatient facility in Timor-Leste

With the support of the Australian Government, RACS has renovated and refurbished the Outpatients Department at Vera Cruz Community Health Centre into a comfortable service facility for patients and a more conducive learning environment for doctors and Trainees. Partitions were erected to create private patient examination rooms and new examination beds and desks were installed.

Discussions with the Ministry of Health's Dili Municipality to improve the clinic as a patient care and teaching facility began in September 2017, with renovations beginning in February, then completed in March 2018. On 15 March, the refurbished building was presented to the municipality.

Dr Odete Anita da Costa and Dr Piter Brando Li (Post Graduate Diploma student and graduate respectively), reported that the new equipment and the privacy offered in the refurbished clinic allows staff to conduct more thorough examinations and make more accurate diagnoses. They were very pleased to have a space for the students and doctors to share information, discuss cases and conduct education sessions.

Vera Cruz Community Health Centre is the primary teaching site for the community-based Postgraduate Diploma (PGD) in Family Medicine. This Program is funded by the Australian Government Aid Program and implemented by RACS in partnership with Hospital Nacional Guido Valadares (HNGV), Maluk Timor and Marie Stopes International. It is accredited through the Universidade Nacional Timor Lorosae and supported by the Ministry of Health.

The PGD is an initiative of the Ministry of Health to address the critical medical workforce shortage outside of the national hospital. Approximately 70 per cent of Timor-Leste's 1.2 million people live in rural and remote areas, with limited access to health services.

The Program addresses a major health service delivery issue by strengthening the capacity of the medical workforce at the district level. It aims to equip graduates with essential knowledge, skills, behaviours and competencies in key clinical areas to deliver essential health services in community health centres, across Timor-Leste.

The workplace based curriculum is designed specifically for the Timorese context and includes clinical rotations in core areas of Emergency Medicine and Anaesthesia, Internal Medicine, Obstetrics, Paediatrics and Surgery. Trainees who complete the Foundation Year then choose

Dr Odete Anita da Costa, PGD Family Medicine Trainee

from a suite of post graduate diploma courses, including Family Medicine. Graduates are equipped to provide broad quality health care to the community in general, maternity and paediatric consultations, immunisations, eye care, health promotion, mental health and family planning advice.

3D floor plan

Refurbished outpatients clinic

Other post graduate programs coordinated by RACS are in areas of Surgery, Obstetrics and Gynaecology, Paediatrics, Anaesthesia and Internal Medicine. Graduates of the Post Graduate Diploma in Paediatrics can enrol in a Masters of Paediatrics delivered at HNGV. RACS also delivers a Post Graduate Diploma in Ophthalmology, as part of the East Timor Eye Program.

Annette Holian
Chair, External Affairs

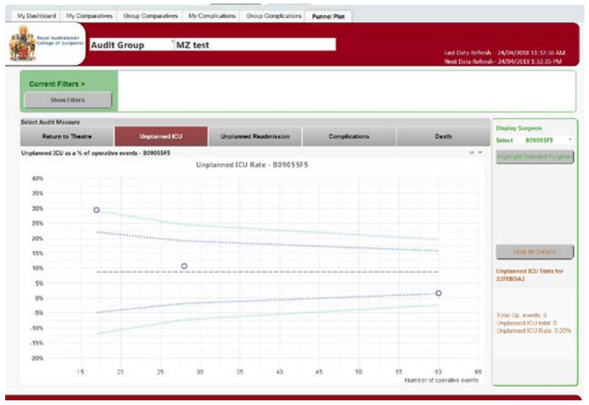
with Stephanie Korin, Monitoring & Evaluation Officer, RACS

Australian Aid

Australian Government
Department of Foreign Affairs and Trade

Piloting MALT for peer review audit

Royal Darwin Hospital has been used as a pilot site to field test the new peer review features of the Morbidity Audit and Logbook Tool (MALT), which commenced in May 2017. Our experience and learnings from the pilot may prove useful to anyone wanting to use MALT for their own peer review process.



Example of peer review audit report available in MALT

Issues encountered

Our original intention was to undertake a total practice audit of all procedures performed by all Surgeons (Fellows and Registrars) on our Unit. MALT can accommodate use by any Fellow, Trainee (in an accredited SET program), Junior Doctor (registered with RACS's JDocs program) and International Medical Graduate, as well as surgeons enrolled in the Maintenance of Professional Standards (MOPS) Program, and surgeons associated with the Pacific Islands Program (PIP). If not part of these groups, the surgeon will not have access to MALT.

Data entry was intended to occur at the completion of surgery, or as soon as a complication was identified on a ward round. Difficulties in gaining internet access to log into MALT and the demands of data entry itself for every single procedure has meant a drop-off in enthusiasm as the pilot has progressed.

Duplicated effort was also noted, with cases entered by Fellows where the Registrar had already entered data into their own MALT Logbook.

Solutions and results

In order to streamline the demands of data entry for Fellows, we are now concentrating on a selected audit, where Fellows only enter data on major cases and cases where an event has occurred.

We access the MALT Peer Review reports at the end of our Unit's weekly main ward round. Two main areas of interest have been counts of procedures performed by each Registrar and morbidity/mortality events.

The supervised procedure counts are displayed within My Dashboard of the Peer Review Audit section of MALT reports. Through this, we can now more closely ensure that each Registrar will gain exposure to enough major procedures within their six-month attachment on our Unit.

We review the morbidity and mortality events within the Group Comparatives (for deaths, unplanned returns to theatre, unplanned admissions to ICU and unplanned readmissions within 30 days) and the Group Complications of the MALT Peer Review audit reports. We aim to discuss the previous week's significant events while the information is fresh in our minds and prepare case presentations for the upcoming main departmental Morbidity and Mortality meetings.

Finally, each surgeon in the Audit Group is now able to generate their own MALT reports that fulfil the requirements of our hospital's Credentialing Committee. These reports display each surgeon's activities and rates of significant events, compared to the other surgeons in the Audit Group, corrected for basic risk factors such as ASA grade.

Future of MALT

MALT is a continually evolving system, providing enhancements based on user feedback and requirements. Items currently being considered to further improve the peer review audit experience include:

- Offline app for data entry – this will allow users to enter data on their mobile device, without internet access;
- Fee-for-service access to MALT for those who do not currently have access through RACS affiliation;
- Data entry by proxy to allow a Registrar to enter a case into their own MALT Logbook and also populate the Logbook of the Fellow in theatre with them.

More information on the peer review functionality of MALT is available from the RACS website, or by contacting the MALT Helpdesk on **+61 8 8219 0939** or **malt@surgeons.org.**

John Treacy, FRACS
Morbidity Audit Committee

VASM audit outcomes and audit impact

The current report of the Victorian Audit of Surgical Mortality (VASM), a quality assurance programme aimed at the ongoing improvement of surgical care, was released this month. The VASM is part of the Australia New Zealand audit of Surgical Mortality (ANZASM), a national network of regionally-based audits of surgical mortality that aim to ensure the highest standard of safe and comprehensive surgical care. The VASM is a collaboration between RACS and the Victorian Government's Safer Care branch, Victorian Consultative Council on Anaesthetic Mortality and Morbidity, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Australian Orthopaedic Association and the Victorian Surgical Consultative Council. Safer Care Victoria replaced the Office for Safety and Quality Improvement and is Victoria's leading agency for healthcare safety, quality and innovation. Safer Care Victoria works with patients and health services to take a patient-centred approach to quality and safety improvement.

VASM involves the clinical review of all cases where patients have died while under the care of a surgeon. Cases notified to VASM are reviewed by at least one surgeon, practicing in the same specialty. These 'first line assessors' are unaware of the identity of the treating surgeon, the hospital in which the death occurred or the name of the patient. Where there is insufficient information for the assessor to reach a conclusion or if a more thorough review of the case is felt to be necessary, a detailed case note review by another independent surgeon is undertaken.

All Victorian hospitals providing surgical services have been recruited into the audit process. In 2010, RACS determined that participation in audits of surgical mortality should be a required component of recertification in its Continuing Professional Development Program (CPD).

In the 2016-2017 financial year, 632,000 surgical procedures were performed in Victoria. The number of deaths reported to VASM over the same period was 1,945. There has been a decrease in surgical mortality over the last ten years, from 0.4 per cent to 0.3 per cent. This indicates that surgery overall is safe with the majority of these deaths being elderly patients undergoing emergency surgery, with a real chance that they may have died without the attempt at saving them.

The 2018 annual report contains clinical information on 8,375 deaths reported over the last five years.

Of these deaths, 5,348 have completed the audit process. The remaining cases are still under review and will be included in next year's Annual Report. The Annual Report is sent to all surgeons and hospitals and is available to the community on the RACS website.

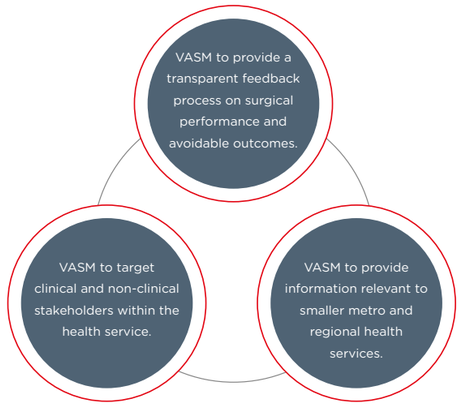


Fig 1: Recommendations for improvement

Among the findings in the 2018 Annual Report:

- The actual cause of death was often linked to the patient's pre-existing health status in that the cause of death frequently mirrored the pre-existing illness;
- Death was most often adjudged to be not preventable and to be a direct result of the disease processes involved and not the treatment provided;
- Unplanned return to the operating theatre, often necessitated by a complication of the initial procedure, is associated with increased risk of death. Consultant involvement in such complex cases is important and has increased significantly with time;
- A detailed case note review, or second-line assessment, indicated that in 70 per cent of the cases no clinical management issues were identified;
- Assessors perceived that clinical management issues occurred in 29 per cent (1,554/5,348) of cases;
- Minor issues of patient management (areas of consideration) were perceived to have occurred in 17 per cent (907/5,289) of cases while areas of concern were identified in 8.0 per cent (425/5,289) of cases. In 4.2 per cent (222/5,289) of cases assessors identified a clinical management issue serious enough to be categorised as an adverse event;
- The hospital performance results prepared on clinical management issues and relevant findings have been forwarded to Safer Care Victoria and all collaborating hospitals for a comprehensive clinical performance review. Hospitals that have been identified as requiring improvement have been notified and are expected to perform further internal investigations;
- Assessors identified more clinical management issues than the treating surgeons. This is not unexpected and underlines the value of independent peer review.

VASM was externally audited in 2015 by Aspex Consulting. It was suggested that an assessment relating to: "The perceived value of information provided by VASM in order to promote ongoing improvements to surgical safety, quality and confidence across the Victorian health system" be undertaken.

Communication with stakeholders was considered effective and efficient.

This project was delivered as a mixed methods project with the aim of seeking and examining the feedback from VASM's health service stakeholders by conducting 82 interviews.

Three major themes emerged from the interviews conducted (see Figures 1 and 2) that showed the audit is viewed as a valuable educational tool.

Communication with stakeholders was considered effective and efficient.

Some respondents highlighted that the VASM recommendations, and the subsequent implementation of those recommendations, are useful for improving surgical care.

A few recommendations for improvement have been highlighted. The current emphasis was on the VASM's role in providing transparent feedback on avoidable outcomes.

The results from this sample cannot be generalised to represent those of a broader population. While the data reached saturation, with such a diverse pool of

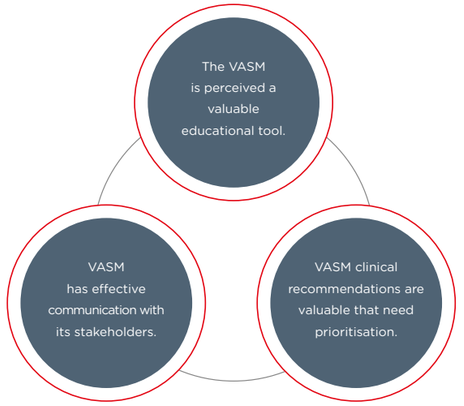


Fig 2: Major themes regarding the perceived usefulness of the VASM

participants, it is possible that intricate nuances between different stakeholder types might not have emerged.

The main recommendations came from stakeholders emphasising the importance of a transparent, identifiable feedback process on measurable outcomes, beneficial to all health services to improve surgical care. In general, the VASM will continue to identify, assess and review factors associated with surgical mortality as well as develop action plans, educational programs and recommendations for further patient care improvements in Victoria. From this year, the VASM aims to disseminate lessons learned from the audit through annual regional seminars starting with Latrobe Regional Hospital in Traralgon on 5 September.

Philip McCahy, VASM Clinical Director

Claudia Retegan, VASM Project Manager

Update from Queensland State Committee

The State Committee feels, like Council, it should also reassess its role and relationship with Queensland Fellows. In the second half of 2018, the Committee will seek the views of the Queensland Fellowship, including IMGs and Trainees, on what RACS should be focussing on locally in terms of advocacy and engagement activities.

Dr Brian McGowan
Chair, Queensland State Committee

Earlier this year Queensland State Committee Chair Dr Brian McGowan attended the RACS Council meeting and presented an overview of recent State RACS activities and a synopsis of feedback of the perceptions of the relationship between the State Committee and the Melbourne office, which the Committee had agreed upon prior to the meeting. This included a desire for greater autonomy and a more mature relationship between central office and the regions.

This feedback was well received, generating good discussion and mirrored the outcomes of a recent review of the whole College and a planned organisational restructure. Dr McGowan emphasised the State Committee's support for the Building Respect Improving Patient Safety initiative and stressed that an agenda of civility, respect and professional accountability is a crucial matter in the delivery of safe surgical services.

Chairs from Western Australia and Northern Territory also presented at the RACS Council meeting and there was significant coherence of views expressed.

The Queensland State Committee is grateful for the improved interactions with Council over the past few months and, in particular, for Council's commitment to 'get out and about' visiting the regions.

This was visibly manifested by the Council Executive attending the State Committee meeting on the evening of 26 April. There were two guests from Queensland Health, Dr John Wakefield, Deputy DG and Dr Jeannette Young, Chief Health Officer who presented a discussion on workforce matters as well as culture and professional accountability.

The Council Executive held its normal meeting in the Brisbane office on Friday 27 April 2018.

Interested in joining the Academy of Surgical Educators?

The Academy of Surgical Educators was developed by RACS to foster and promote the pursuit of excellence in surgical education. The Academy helps to support and develop all who are interested in surgical education whether they are surgeons, trainees, International Medical Graduates or non-surgeons.

The Academy is open to anyone who has an active interest or involvement in surgical education or training in Australasia as well as internationally. We encourage you join to benefit from the broad range of activities and resources available to members.

To apply for membership to the Academy, please provide the following to the Academy secretariat via email to **ase@surgeons.org** :

- A covering letter explaining your reasons for applying for membership
- Your curriculum vitae (no longer than 2 pages)
- Two referees
- Your RACS ID number

ACADEMY OF SURGICAL EDUCATORS
Royal Australasian College of Surgeons

Colorectal Fellow conducts world-first research into rare cancer

Dr Glen Guerra

Colorectal Fellow Glen Guerra has developed the world's first panel of human anal cancer cell lines and a unique murine model of the disease as part of his PhD research aimed at improving survival rates for patients suffering this rare cancer.

With financial support provided by RACS, Dr Guerra has spent the past three years investigating the immune landscape of anal squamous cell carcinoma (SCC) and developing preclinical models of the disease to assess the impact of novel treatments including immunotherapy.

Anal SCC currently has a five year survival rate of 65 per cent, with patients who fail to respond to primary treatment, having limited treatment options apart from surgery. For those with unresectable or metastatic disease, no effective treatment options currently exist.

Dr Guerra said that while there had been intense interest and research in the development of immunotherapies for a range of cancers, limited work had been undertaken on the effect of such therapy in anal cancer.

> "I set out to understand the immune system's role in the disease in the hope of identifying how we can best use immunotherapy to upregulate the patient's own defence system against cancer."

He said that anal SCC particularly affected people with a compromised immune system and that nine out of ten cases were driven by the Human Papillomavirus (HPV) in a similar fashion to cervical and other perineal cancers.

He said that the most treatment-resistant forms of the disease were viral negative and that this would be the predominant cohort of patients in three to four decades once the Gardasil vaccine has taken effect.

Conducting his research through the Department of Surgical Oncology at the Peter MacCallum Cancer Centre (PMCC), Dr Guerra has:

- identified the immune landscape as a predictive and prognostic biomarker in anal SCC;
- developed a panel of anal SCC cell lines to assess the efficacy of various novel therapeutics; and
- established a syngeneic murine model of anal SCC, based upon the two most common genetic mutations present in anal cancer.

As part of this work, Dr Guerra processed primary pre-treatment patient samples by immunohistochemistry to examine the density of immune cells and to correlate the findings with both treatment response and outcome.

"While virally driven anal cancer is more common and responds best to current treatment, the non-viral form of this cancer will remain once Gardasil has taken effect, leaving us with a problem in the next few decades," he said.

"I set out to understand the immune system's role in the disease in the hope of identifying how we can best use immunotherapy to upregulate the patient's own defence system against cancer.

"I found that 85 per cent of patients with high rates of immune cells in the pre-treatment tumour, called tumour-infiltrating lymphocytes (TILs), achieve a complete response to treatment.

"For relapsed patients, however, 83 per cent of those with a low rate of TILs will succumb to the disease despite surgery.

"This means that by measuring the presence of TILs via a pre-treatment biopsy, we can identify which patients are less likely to respond to current treatments and require further therapy.

"Immunotherapy has been established as the fourth pillar of cancer treatment and, in a similar manner to melanoma and lung cancer, it may have utility in anal SCC alongside chemotherapy, radiotherapy and surgery.

"This research paves the way for the use of immunotherapy to fight the more aggressive forms of this disease."

Dr Guerra is working under the supervision of Professor Alexander Heriot, the Director of Cancer Surgery at the PMCC and Professor Wayne Phillips and Professor Robert Ramsay, both Laboratory Heads within the Gastrointestinal Cancer Research Program at the PMCC.

Throughout his research, Dr Guerra has received support from RACS through a Foundation for Surgery Research Scholarship (2015), the ANZ Journal of Surgery Research Scholarship (2016) and the Foundation for Surgery Tour de Cure Cancer Research Scholarship (2017).

Dr Guerra thanked RACS for its support, which he said was invaluable to the success of his project in allowing him to focus on achieving his aims.

He said his murine model was the first relevant anal cancer mouse model to represent both viral positive and, most importantly, non-virally driven disease and he is in the process finalising papers on the cell line and mouse models.

"Both the mouse model and the cell lines open the door to rapid testing of novel therapies and allow us to better understand the underlying biology and development of anal cancer", he said.

Dr Guerra has presented his research findings at national and international surgical meetings and has established collaborations with leading researchers at major international institutions.

Last year he was awarded the Association of Coloproctology of Great Britain and Ireland (ACPGBI) Travelling Fellowship to visit Colorectal Units across both countries and present his work at the ACPGBI annual meeting.

Through a collaboration he established while overseas, Dr Guerra is now transferring the panel of world-first cell lines he developed to the Christie Cancer Centre and Manchester University, one of the leading cancer hospitals in Europe and the UK.

He said with the accruing preclinical data, it would be ideal to utilise an established sister collaboration with The MD Anderson Cancer Centre in Houston, Texas, to look towards human trials, to confirm the effectiveness of immunotherapy.

Dr Guerra obtained his FRACS in 2015 and chose to incorporate cancer research as part of his career after suffering from acute myeloid leukemia (AML) during his general surgery training.

"I was drawn to the treatment of patients with cancer after I was diagnosed with AML in 2009 and suffered multi-organ failure due to sepsis following chemotherapy," he said.

"I only received one of a planned four cycles of chemotherapy, but have been in remission ever since. While only anecdotal, the possibility that the sepsis upregulated my immune response and played a role in eradicating the tumour has been the impetus behind me undertaking research in this area."

ACADEMIC HIGHLIGHTS

- 2017 – Association of Coloproctology of Great Britain and Ireland Travelling Fellowship
- 2017 – RACS Foundation for Surgery Tour de Cure Cancer Research Scholarship
- 2016 - 2018 – NHMRC Postgraduate Research Scholarship
- 2016 – RACS ANZ Journal of Surgery Research Scholarship
- 2016 – Colorectal Surgical Society of Australia and New Zealand Foundation (CSSANZ) Research Grant
- 2015 – RACS Foundation for Surgery Research Scholarship

Karen Murphy
Surgical News journalist

Building a course for change

Operating with Respect

Since its launch in April 2017, 446 senior surgeons have completed the Operating with Respect (OWR) one day course. The OWR course was developed in the preceding 12 months by the RACS Education Reference Group (ERG) represented by a dedicated group of clinicians and RACS education staff.

The course builds on the principles of the OWR e-Learning Module, with an emphasis on equipping surgeons with behavioural skills to enhance self-regulation and to effectively moderate the behaviour of colleagues. The course covers three key themes on building respect, building resilience and speaking up to address unacceptable behaviour.

The make-up of the ERG was carefully formed to ensure a diverse range of skills and experience. Meeting once a month, the group worked collaboratively to progress the curriculum development, piloting and implementation of OWR. The ERG felt a significant responsibility to create a learning package that would resonate with surgeons. The ERG reflected on this principle throughout development, to ensure that the course 'hit the mark' and didn't disenfranchise surgeons required to complete the course. The curriculum, which stems from the Building Respect, Improving Patient Safety action plan, had input from a variety of experts from legal, human rights and psychosocial backgrounds.

OWR was piloted three times before being launched. With each pilot, the ERG examined the extensive feedback provided by course participants and invited experts and reworked the curriculum, reducing the theory and increasing interactive elements and opportunities for practice in behavioural skills.

The resulting course provides a safe and confidential setting for learning and includes blended learning activities and frequent guided reflection on past and present behaviours. The program is evidence-based and designed to challenge common biases and assumptions.

The session on 'Speaking Up' aligns closely to the Vanderbilt model, which is the framework many hospitals in Australia and New Zealand are adopting to directly and systematically address instances of unacceptable behaviour.

Concurrent to refining the curriculum, other aspects of the course required rapid development: targeted recruitment of surgical faculty; creating a tailored instructor course; and setting up the infrastructure for course delivery across Australia and New Zealand. Governing all aspects of program delivery, the Operating with Respect Education Committee (OWREC) was formed in April 2017.

The course is currently being offered to surgeons in leadership positions including supervisors. In 2017, RACS delivered 14 courses to 256 surgeons – with only 17 faculty. Steadily building faculty capacity, the OWR program is now supported by 31 dedicated pro-bono instructors and directors.

We are indebted to this core group of faculty for their tireless efforts, who have given their time, energy and expertise to contribute to shaping a changing culture within surgery.

Thank you to those 446 surgeons who have completed the OWR course, your feedback and insights have contributed significantly to the ongoing refinement of the course. Feedback, including where the course is not rated particularly useful, continues to be carefully considered. The vast majority of feedback however, has endorsed the utility of the course.

To help promote a positive work and training environment, all SET Supervisors, IMG Supervisors and Senior Board Members are required to participate in an OWR Course by the end of 2018.

Enrol: Visit www.surgeons.org/owr

Inquiries: owr@surgeons.org

Please note that 2018 course places are prioritised for those surgeons required to complete OWR.

Turn to page 36 to review list of courses.

Education Reference Group
(Dec 2015 - Apr 2017)

Adrian Anthony FRACS (Chair)
Garry Dyke FRACS (IMG representative)
Anne Leditschke FCICM
Rhea Liang FRACS
Philip Morreau FRACS
Stewart Morrison (RACSTA representative)
William Perry (RACSTA representative)
Rosalynd Pochin FRACS
Stephen Tobin, FRACS, Dean of Education
Ellen Webber, Manager Skills Training Department
Sally Drummond, Learning and Development Officer
Jacky Heath, Manager Prevocational and Online Education Department
Kathleen Hickey, General Manager, Education Development and Assesment
Zaita Oldfield, Manager, Education Development and Research Department
Kim Tauroa, Operating with Respect Program Administrator

Adrian Anthony
Chair, Operating with Respect Education Committee and Chair, Board of Surgical Education and Training

Ellen Webber, Manager, Skills Training Department, RACS

Open House Melbourne

Sunday 29th July 2018

A major public event in the calendar of Melbourne

RACS is again opening its doors to the general public as part of the Open House Melbourne weekend
A number of buildings not normally open to the public will be participating

If you would like to be involved in Open House and volunteer as a tour guide we would like to hear from you

For more information and to register as a volunteer please contact **Megan Sproule**
+61 3 9249 1220
megan.sproule@surgeons.org

OPEN HOUSE MELBOURNE

American Society of Colon and Rectal Surgeons Tripartite Meeting (2017)

As the recipient of the 2016 Mark Killingback Prize, I was fortunate to attend the American Society of Colon and Rectal Surgeons (ASCRS) Tripartite Meeting held in Seattle in June 2017.

2017 ASCRS Tripartite Meeting in Seattle

Being a tripartite meeting, this was the combined meeting of the ASCRS in collaboration with the Association of Coloproctology of Great Britain and Ireland, the Royal Society of Medicine, Colon and Rectal Surgery of the RACS and the Colorectal Surgical Society of Australia and New Zealand, as well as the European Society of Coloproctology. As part of this prize, it was a great privilege to present my research paper, 'Microsatellite instability testing by high resolution capillary electrophoresis analysis'. This was well received and it was a great opportunity for me to meet with and discuss research with surgeons from around the world.

I also presented 'Major abdominal and perianal surgery in Crohn's Disease: long-term follow-up of Australian patients with Crohn's Disease', 'Peristomal pyoderma gangrenosum: 12-year experience in a single tertiary referral centre' and 'Histopathological characteristics of colorectal cancer in Crohn's Disease and Ulcerative Colitis: 25-year experience in a single tertiary referral centre'.

I enjoyed the sessions 'Magnum Opus: Surgical Techniques from Around the World' and 'ERAS: Taking Your Enhanced Recovery Program (ERP) to the next level'. The videos of surgical techniques were outstanding and it was also great to see trends in open, laparoscopic and robotic colorectal surgery in America as well as internationally. I also attended several research scientific sessions. Of note, the work by Sun et al from Cleveland on regenerating smooth and skeletal muscle after anal sphincter injury from plasmid, was outstanding.

It was an incredible experience to attend the Alumni of Minnesota dinner and to meet with Stanley Goldberg, a very dear friend of Mark Killingback, his wife Luella Goldberg, as well as with Neil Mortensen, Emmanuel Tiret and Justin Maykel. I enjoyed learning of their life experiences and amazing careers and it was great to see the collegiality within this Alumni.

(Left to right): Alumni of Minnesota Dinner – with Stanley Goldberg & Daisy Guo

(Left to right): Alumni of Minnesota Dinner – with Neil Mortensen & Emmanuel Tiret

When I returned from Seattle, it was a real privilege to meet with Mark and Bobbie Killingback at their home. I learnt a lot from Mark and Bobbie and we enjoyed an afternoon by the seaside talking about the history of colorectal surgery in Australia - Mark had some truly amazing stories. At my request, Mark showed me the original manuscript for the diverticulitis Killingback classification and "Scribe with a Scalpel: From Merrylands to Macquarie St."

Winning the Mark Killingback prize was a rewarding experience. The Seattle Tripartite meeting was a thoroughly enjoyable conference and I would like to thank RACS and the Colon and Rectal Surgery section for this incredible opportunity. It is definitely one of the highlights of my career thus far. Thank you!

The Crab Pot in Seattle - CSSANZ Fellows attending the Tripartite Meeting

Dr James Toh
FRACS

Nobody told me

Almost one hundred participants from across the health sector gathered at the Education Development Centre in Adelaide, to attend the thought provoking seminar 'Nobody Told Me: Poor Communication Kills' hosted by the South Australian Audit of Surgical Mortality (SAASM).

Communication is a core competency of RACS and our ability to do so effectively impacts on almost every facet of our lives. In the health care context, communication failures can directly contribute to morbidity and mortality.

Among cases audited by SAASM, recommendations for improved communication are reported across the entire spectrum of care by all specialties and are attributed to both surgeons and non-surgeons.

The seminar, hosted on 12 April this year, presented audience members with a series of case studies and panel discussions from a diverse range of speakers. Each speaker discussed examples of communication challenges and strategies for improvement.

Feedback from the event was overwhelmingly positive, with many attendees reporting an increased awareness of the impacts of poor communication and that they will share their learnings within their hospital teams.

This is the fourth seminar that has been held by SAASM since 2012. Each seminar has been designed to deliver upon SAASM's principle aim of improving the quality of health care through feedback and education.

Seminar themes are guided by evidence from local audit data and feedback from the surgical community. If you would like to see a particular topic discussed at a future seminar, please email the team at saasm@surgeons.org with your suggestions.

For those who were unable to attend the seminar, a video link is available on the SAASM page on the RACS website as well as PowerPoint presentations for each of the speakers.

Mr Glenn McCulloch
(retiring) SAASM Clinical Director

Photographing RACS

The early years

A New Zealander by birth Balcombe Quick (1883-1969) moved to Australia when he was very young and studied medicine at the University of Melbourne. Deciding on a career in surgery,

AGM participants, in front of Sydney Hospital, 1931

he completed postgraduate studies in London and in 1912, was appointed as a consultant surgeon at the Alfred Hospital. At the start of World War 1 he enlisted and served at Gallipoli, Egypt and on the Western Front.

Group including RACS Secretary Gordon Wheeler (far right), Sydney 1931

From 1919 until his retirement in 1945, he worked as a consultant surgeon at the Alfred Hospital. A Foundation Fellow of RACS, he was a Councillor from 1933-1949 and was also the College's unofficial photographer.

Unidentified man with wombat and heron, Sydney 1931.

In March 1931, the College's Annual General Meeting was held in Sydney and it was followed by a Council meeting on 2 April, held in Macquarie Street at the New South Wales branch of the British Medical Association.

There were social events associated with the meeting and Quick appears to have enjoyed the harbour, taking several photographs of the ferries and tugs.

Tug, Circular Quay, Sydney, 1931

In February 1932, C. H. Fagge, the Vice President of the Royal College of Surgeons of England, brought the College mace to Australia. This was formally handed over to RACS President, Sir Henry Newland in a ceremony at the University of Melbourne's Wilson Hall.

Mace ceremony, RACS President Sir Henry Newland (third from right) is seated beside RACS Secretary, (Sir) Alan Newton (fourth from right). E. D. Ahern is closest to the camera

Council meeting in the (Hailes) room, c1946 – President, (Sir)Hugh Poate, W. H. Hailes (far right), (Sir) Victor Hurley (far left) and Sir Alan Newton (on left, closest to camera)

Socialising at the Melbourne Club, c1947 – Victor Hurley (left), Sir Gordon Gordon -Taylor (right) and Sir Alan Newton (centre)

In the 1940s, the Council often met in the RACS Library but they also used what was to become the Hailes Room (named after W. H. Hailes in the 1950s). Presidents during the war years included Sir Hugh Devine (1939-1941), E. D. Ahern (1941-1943), Sir Alan Newton (1943-1945) and (Sir) Hugh Poate (1945-1947)

Surgeons operating, 1940s

Mentor and friend to Australian surgeons, Sir Gordon Gordon-Taylor, a Surgeon Rear Admiral in the Royal Navy travelled extensively during the war and assessed the medical services of Commonwealth countries like Australia. He also visited Australia after the war.

Balcombe Quick's informal photography provides interesting insights into the activities of the 1930s and 40s and reveals the personalities who feature in the early years of the College.

Elizabeth Milford
Archivist, RACS

Courses for every stage of your career

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

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

Mandatory courses

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

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

Foundation Skills for Surgical Educators course (FSSE)

25 June 2018	Sydney	NSW
25 June 2018	Auckland	NZ
30 June 2018	Brisbane	QLD
30 June 2018	Melbourne	VIC
8 July 2018	Sydney	NSW
20 July 2018	Brisbane	QLD
20 July 2018	Hobart	TAS
17 August 2018	Christchurch	NZ
17 August 2018	Melbourne	VIC
25 August 2018	Brisbane	QLD
20 September 2018	Orange	NSW
16 October 2018	Queenstown	NZ

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

Operating with Respect course (OWR)

7 July 2018	Sydney	NSW
20 July 2018	Gold Coast	Qld
27 July 2018	Sydney	NSW
30 August 2018	Melbourne	VIC
1 September 2018	Wellington	NZ
5 September 2018	Brisbane	Qld
14 September 2018	Adelaide	SA
29 September 2018	Canberra	ACT

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

Clinical Decision Making

22 June 2018	Auckland	NZ

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

Academy of Surgical Educators Studio Sessions

26 June 2018	Melbourne	VIC
25 July 2018	Brisbane	QLD
10 August 2018	Hobart	TAS

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

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

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

Leading the way in Surgical Education.

Non-Technical Skills for Surgeons (NOTSS)

6 July 2018	Adelaide	SA

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 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 the participants' own performance as well as their colleagues.

Safer Australian Surgical Teamwork (SAST)

21 July 2018	Sydney	NSW
11 August 2018	Brisbane	QLD

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

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

Surgeons as Leaders in Everyday Practice

10-11 August 2018	Canberra	ACT
23-24 November 2018	Melbourne	VIC

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

Combined Meeting of AOA/RACS/AMLC includes AMA Guidelines: Difficult Cases

7-8 September 2018	Melbourne	VIC

This meeting includes:

- Clinical updates on micro-invasive surgery, on elbows, particularly the stiff
- Elbow, on surgery for arthritis of the ankle, foot surgery, and on degenerative and post traumatic conditions
- Risk management in bariatric surgery
- Robotic surgery
- Medico-legal matters such as "operating on the futile case"
- Current litigation presentations by indemnity providers
- Expert Evidence
- Pain Management including opiate overload and complex regional pain syndrome
- Difficult cases assessed under AMA 4th, 5th and 6th Editions

External registration through AOA.

SAT SET course

8 September 2018	Brisbane	QLD

The Supervisors and Trainers for Surgical Education and Training (SAT SET) course aims to enable supervisors and trainers to effectively fulfil the responsibilities of their important roles under the new Surgical Education and Training (SET) program. This free three hour workshop assists Supervisors and Trainers to understand their roles and responsibilities, including legal issues around assessment. It explores strategies which focus on the performance improvement of Trainees, introducing the concept of work-based training and two work-based assessment tools; the Mini-Clinical Evaluation Exercise (Mini CEX) and Directly Observed Procedural Skills (DOPS). ►

Keeping Trainees on Track

8 September 2018	Brisbane	QLD

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

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

Process Communication Model Seminar 2

14 -16 September 2018	Sydney	NSW

The advanced three day program allows participants to build on and deepen their knowledge while practicing the skills learned during PCM Seminar 1. Participants will learn more about understanding their own reactions under distress, recognising distress in others, understanding their own behaviour and making communication happen. PCM enables them to listen to what has been said, while at the same time being aware of how it has been said. At times we are preoccupied with concentrating on what is said, formulating our own reply and focussing solely on the contents of the conversation. To communicate effectively, we need to focus on the communication channels others are using and to recognise when they are in distress.

Note: In order to participate in PCM Seminar 2, registrants must have attended and be familiar with the content of PCM Seminar 1.

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

PROFESSIONAL DEVELOPMENT WORKSHOP
DATES: June - September 2018

ACT		
Surgeons as Leaders in Everyday Practice	10-11Aug	Canberra
NSW		
Foundation Skills for Surgical Educators	25 June	Sydney
Foundation Skills for Surgical Educators	8 July	Sydney
Safer Australian Surgical Teamwork	21 July	Sydney
Process Communication Model Seminar 2	14 -16 Sep	Sydney
Foundation Skills for Surgical Educators	20 Sep	Orange
NZ		
Clinical Decision Making	22 June	Auckland
Foundation Skills for Surgical Educators	25 June	Auckland
Foundation Skills for Surgical Educators	17 Aug	Christchurch
Foundation Skills for Surgical Educators	16 Oct	Queenstown
QLD		
Foundation Skills for Surgical Educators	30 June	Brisbane
Foundation Skills for Surgical Educators	20 July	Brisbane
Foundation Skills for Surgical Educators	20 July	Brisbane
Academy of Surgical Educators – Studio Sessions	25 July	Brisbane
Safer Australian Surgical Teamwork	11 Aug	Brisbane
Foundation Skills for Surgical Educators	25 Aug	Brisbane
SAT SET Course	8 Sep	Brisbane
Keeping Trainees on Track	8 Sep	Brisbane
SA		
Non-Technical Skills for Surgeons	6 July	Adelaide
VIC		
Process Communication Model Seminar 1	22-24 June	Melbourne
Academy of Surgical Educators – Studio Sessions	26 June	Melbourne
Foundation Skills for Surgical Educators	30 June	Melbourne
Foundation Skills for Surgical Educators	17 Aug	Melbourne
Combined Meeting of AOA/RACS/AMLC includes AMA Guidelines: Difficult Cases	7-8 Sep	Melbourne
Surgeons as Leaders in Everyday Practice	23-24 Nov	Melbourne
TAS		
Foundation Skills for Surgical Educators	20 July	Hobart
Academy of Surgical Educators – Studio Sessions	10 Aug	Hobart

Register online
For future course dates or to register for any of the courses detailed above, please visit
https://www.surgeons.org/for-health-professionals/register-courses-events/
Contact the Professional Development Department on +61 3 9249 1122 or email **PDactivities@surgeons.org**

Skills training courses 2018

RACS offers a range of skills training courses to eligible medical graduates that are supported by volunteer faculty across a range of medical disciplines. Eligible candidates are able to enrol online for RACS Skills courses.

ASSET: Australian and New Zealand Surgical Skills Education and Training

ASSET teaches an educational package of generic surgical skills with an emphasis on small group teaching, intensive hands-on practice of basic skills, individual tuition, personal feedback to participants and the performance of practical procedures.

EMST: Early Management of Severe Trauma

EMST Edition 10 has launched! EMST teaches the management of injury victims in the first hour or two following injury, emphasising a systematic clinical approach. It has been tailored from the Advanced Trauma Life Support (ATLS®) course of the American College of Surgeons. The course is designed for all doctors who are involved in the early treatment of serious injuries in urban or rural areas, whether or not sophisticated emergency facilities are available.

CCrISP®: Care of the Critically Ill Surgical Patient

CCrISP Edition 4 has launched! RACS has officially launched Edition 4 of the Care of the Critically Ill Surgical Patient (CCrISP®) course across Australia and New Zealand. The CCrISP® Committee has extensively reviewed materials provided by the Royal College of Surgeons of England (RCS) - resulting in an engaging new program which is highly reflective of current Australian and New Zealand clinical practice and standards in management of critically ill patients.

CLEAR: Critical Literature Evaluation and Research

CLEAR is designed to provide surgeons with the tools to undertake critical appraisal of surgical literature and to assist surgeons in the conduct of clinical trials. Topics covered include: guide to clinical epidemiology, framing clinical questions, randomised controlled trial, non-randomised and uncontrolled studies, evidence based surgery, diagnostic and screening tests, statistical significance, searching medical literature and decision analysis and cost effectiveness studies.

TIPS: Training in Professional Skills

TIPS is a unique course designed to teach surgeons-in-training core skills in patient-centred communication and teamwork, with the aim to improve patient care. Through simulation participants address issues and events that occur in the clinical and operating theatre environment that require skills in communication, teamwork, crisis resource management and leadership.

SKILLS TRAINING COURSE DATES:
JULY - SEPTEMBER 2018 | *Available Courses

ASSET	
Thursday, 5 July – Friday, 6 July	Adelaide
Thursday, 9 August – Friday, 10 August	Perth
Friday, 10 August – Saturday, 11 August	Wellington
Friday, 17 August – Saturday, 18 August	Melbourne
Friday, 24 August – Saturday, 25 August	Brisbane
Friday, 7 September – Saturday, 8 September	Sydney
CCrISP	
Friday, 20 July – Sunday, 22 July	Melbourne
Friday, 27 July – Sunday, 29 July	Brisbane
Friday, 27 July – Sunday, 29 July	Melbourne
Friday, 10 August – Sunday, 12 August	Perth
Thursday, 16 August – Saturday, 18 August	Wellington
Friday, 24 August – Sunday, 26 August	Brisbane
Thursday, 6 September – Saturday, 8 September	Auckland
Friday, 7 September– Sunday, 8 September	Melbourne
CLEAR	
Friday, 20 July – Saturday, 21 July	Brisbane
Friday, 24 August – Saturday, 25 August	Sydney
Friday, 14 September – Saturday, 15 September	Melbourne
EMST	
Friday, 29 June – Sunday, 1 July	Auckland
Friday, 29 June – Sunday, 1 July	Adelaide
Thursday, 19 July – Sunday, 21 July	Perth
Friday, 20 July – Sunday, 22 July	Brisbane
Friday, 27 July – Sunday, 29 July	Christchurch
Friday, 27 July – Sunday, 29 July	Adelaide
Saturday, 4 August – Sunday, 5 August	Brisbane
Friday, 10 August – Sunday, 12 August	Sydney
Friday, 24 August – Sunday, 26 August	Dunedin
Friday, 31 August – Sunday, 2 September	Melbourne
Friday, 31 August – Sunday, 2 September	Brisbane
Friday, 14 September – Sunday, 16 September	Sydney
Friday, 14 September – Sunday, 16 September	Auckland
Saturday, 29 September – Sunday, 30 September	Auckland
TIPS	
Friday, 27 July – Saturday, 28 July	Adelaide
Friday, 24 August – Sunday, 26 August	Perth
Friday, 14 September – Sunday, 16 September	Melbourne

**Courses available at the time of publishing*

Contact the Skills Training Department
Email: skills.courses@surgeons.org • Visit: www.surgeons.org click on Education and Training then select Skills Training courses.
ASSET: +61 3 9249 1227 asset@surgeons.org • **CCrISP:** +61 3 9276 7421 ccrisp@surgeons.org • **CLEAR:** +61 3 9276 7450 clear@surgeons.org **EMST:** +61 3 9249 1145 emst@surgeons.org • **TIPS:** +61 3 9276 7419 tips@surgeons.org • **OWR:** +61 3 9276 7486 owr@surgeons.org

OPUS LI (51)

How the Fellowship influenced my career

The influence of the Fellowship on my career and its significance can obviously be viewed from a personal perspective, but has more relevance when it is embraced universally. As da Vinci said years ago “the greatest deception that men are guilty of is of their own self opinion”, so with editorial privilege I thought I would ask some of the senior men randomly selected from the D’Extinguished Surgical Group. Here historical lectures are presented which reflect their late interests but with surgical overtones. This has created a series of redacted pen pictures of Senior Surgeons.

When I addressed them with the question of the meaning of the Fellowship, I qualified it by asking them for a synoptic response hoping to initiate some spontaneity. Such responses without premeditation produced a variety of facets that mirrored their surgical careers. Picking the personalities at random I now list their responses, *un reflect de la vie.*

Royal Australasian College of Surgeons Melbourne

Professor Dick Bennett (Retired)

Professor of Surgery at St Vincent’s Hospital in Victoria and South Australia

I met Professor Bennett recently in his aged care facility at Kew and confronted him with my question.

In a simple response in an almost disparaging way his opinion was that he wanted to be recognised as a contributor to the College’s success, its welfare and scientific development where we all can benefit from its munificence in a figurative way.

Professor Bennett was Foundation Hugh Devine Chair of Surgery at St. Vincent’s Hospital, he participated in College affairs and on the Court of Examiners for five years from 1982 - 1986, was a member of RACS Council until 1987, Honorary Treasurer and then Vice President.

His role as Chairman of the Editorial Board of the Australian & New Zealand Journal of Surgery (ANZJS), then to the establishment of the RACS Foundation for Surgery, reflect this contribution even extending to College activities in South East Asia.

Professor Bennett said to me that the Fellowship had given him eminence if not pre-eminence including prestige and prominence in the field of surgical development. He still stands reflected in this glory.

Emeritus Professor Vernon Marshall - A Fulbright Scholar

Head of Surgery, Monash Medical Centre, formerly Prince Henry’s Hospital

Vernon’s response to my question was quite revealing. “Felix,” he said simply, “it has given me a licence to operate.” Then he went on, “The sequence of academic development with local and international exposure is a most rewarding development. One meets many personalities — model types of one's own surgical career producing mentors cultivating surgical prestige”. He continued to elaborate that working with an International Head of Department engenders the same attitude in the emerging personality and academic contributions cultivated research and international journal publications – thus leading to text book chapters. "Finally, this Fellowship, that teaches others the standards of surgical excellence," he said "is best contained in an institution." Such a foundation of a College Fellowship with its political allegiances becomes the basis of ongoing surgical development.

Royal College of Surgeons London

The new generations of surgeons are thus adopted into the fold where they learn under College regulations and exams, the value of surgical craftsmanship. This creates a heritage which becomes the tradition for future generations of surgeons.

Associate Professor Joe Epstein (Retired)

Director of Emergency Medicine, Western Health

Another one of my colleagues from the Western Hospital where I worked for almost 40 years, Joe and I shared clinics when he was the Director of Emergency Medicine. Many emergency cases that needed plastic surgical refinement, Joe would invite my opinion and techniques that I had established in Hand Surgery, most of which were engendered by our combined consultations. Joe was the prime instigator in establishing the College of Emergency Medicine in Australia.

When I addressed my question to Joe regarding the importance of his FRACS, his direct response was “it gave me respectability from the presidents of other associated Medical Colleges, locally and internationally. Their acceptance was critical in the eventual establishment of the Royal Australasian College of Emergency Medicine, one of the first in the world to be established.”

Associate Professor Ian Edgeworth (Cas) McInnes OAM (Retired)

Research Fellow, Monash University and Senior Surgeon, Alfred Hospital

Another mature mind from the Roman Forum and another one of our associates from the D’Extinguished Group, Cas responded to my question about the importance of the FRACS with “the Fellowship has given me recognition of the standard needed to continue in surgical practice. It was also a stepping stone to the ultimate attainment of important surgical techniques to treat patients, looking always for the best outcome”. Cas, who recently retired after sixteen years as Chair of RACS' Heritage & Archives Commitee, revealed that College association with political appointments go hand-in-hand with these attainments.

Professor Don Marshall OAM (Retired)

Head of Plastic Surgery, Monash Medical Centre, formerly Prince Henry’s Hospital

The youngest of the Marshall trio ensconced in surgery and the protégé of his late brother Bob, whose book on Anatomy '*Living Anatomy: Structure as the Mirror of Function*' has universal academic applications in Surgery. Don followed his lead and was academically pre-eminent, surgically refined and picked by Benny Rank in the 60s to be his partner in fame in Plastic Surgery. As I have quoted before, Benny said to me, “son, the only place to train in Plastic Surgery in Australia is with me.” Don became part of that team, was surgically astute and his subsequent career could have led him to many avenues of political prominence in the College as well. Yet his most rewarding development in these latter stages of his career was his continuing involvement with the work of Interplast Australia, organising altruistically the Pacific and sub-continent teams of surgical talent. His response to my question, the basis of this article, was quite succinct when he said having just passed the exam, “the Fellowship has just been a walk in the park.” This phraseology not only summarises the style of the man, but his confidence in development, all which is paraphrased in his forthcoming book titled *“Footprints in the Sand of Time”*. He subsequently said about the Fellowship that it gave him the privilege of “walking with nobility” going on to elaborate “life offers many opportunities in selecting the prize with fortune favouring the brave.” I have been fortunate in having Don as my mentor and even becoming his amanuensis.

Professor Sam Mellick CBE (Retired)

Vascular Surgeon, University of Queensland

Sam, now in his 90’s with a mind as sharp as ever, is frustrated that his windscreen wipers are not working well. In his response to the value of the Fellowship he said “the College is the basis for maintaining the quality of surgical practice and intrinsically establishes principles for ongoing surgical development. The Australasian Fellowship goes hand-in-hand on the International scene with the Colleges of England, Ireland and Scotland, even venturing across the Atlantic.” These principles are inculcated in collegiate gatherings and the one impedance in this late stage of his career is Sam’s inability to attend the RACS Annual Scientific Congress.

Thus these reflections emanating only from six personalities have given me an idea. Could one compile a comprehensive list of the many and varied Fellowship personalities (more work for me) that the FRACS gemstone reflects?

Associate Professor Felix Behan
Victorian Fellow

RACSTA
Your Trainees' Association

Official app for MALT coming soon

The Morbidity and Audit Logbook Tool (MALT) will be familiar to most of us as a secure web-based logbook system for RACS Fellows, International Medical Graduates (IMGs), Surgical Trainees and subscribed junior doctors. MALT was released in September 2012 and initially was predominantly used by Surgical Trainees to record surgical cases performed during their training programme. The initial uptake by Fellows was low, but has steadily increased over the years.

Mark Stringer

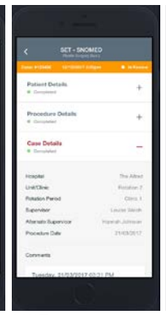
Since its inception, there has been a dedicated MALT team working hard to ensure that MALT meets the requirements of its users, as well as keeping the data recorded on MALT secure. The initial MALT logbook terms were all updated to align with the international Systematized Nomenclature of Medicine (SNOMED) terms and all procedures registered on the initial MALT logbook were migrated to the new SNOMED logbook we currently use. The SNOMED terms are constantly being reviewed, updated and added to from user feedback, and the MALT team encourage users to submit 'missing procedures' to be added.

In February 2016, the JDocs programme was launched to support junior doctors interested in a career in surgery. These junior doctors could subscribe and gain access to MALT to record surgical procedures to reflect their pre-SET experience. This is becoming more popular amongst this group of doctors and uptake amongst interested junior doctors should be encouraged.

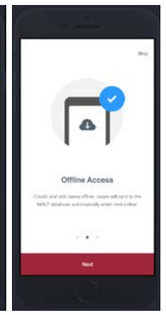
All of the RACS Specialty SET Trainees can use the MALT SNOMED logbook, but not all of the RACS Specialty Boards mandate its use as part of their training programme due to their use of other logbook systems. The logbook summary, often completed at the end of a surgical rotation, highlights those procedures in bold that are 'Board Approved' and reported to the Specialty Board as part of auditing of the Trainee. As a result of the increasing uptake of MALT amongst RACS Trainees and Fellows, the number of procedures recorded has exponentially increased and in August 2017 MALT reached the milestone of 2 million procedures recorded.

Last year the MALT team were keen to explore the possibility of developing an offline app and liaised with the Royal Australasian College of Surgeons Trainees Association (RACSTA) to establish a focus group to determine whether the current surgical Trainees believed an app would be worthwhile building. All Trainees responded that if an app was available, they would use it to enter all data instead of the MALT desktop version, or using it to supplement the desktop version. The majority of Trainees used iPhones, and almost half wanted to use touch ID to login if possible.

MALT app showing touch login



MALT app case entry with dummy data



MALT app offline access

The MALT team has been developing and testing this app and is excited about its upcoming release, which will be compatible with both iPhone and smart phones. This will enable users quick and easy access through a functional platform to record operative cases and complications efficiently. The data would be uploaded to the main MALT platform when the user was connected to the internet. The focus group has been testing the offline app prototype and giving feedback to help ensure when it is released it meets your requirements.

If you would like to be involved in the offline app user testing group, or if you have any feedback or comments, please contact the MALT team on malt@surgeons.org

Dr. Mark Stringer
On behalf of RACSTA and Morbidity Audits Committee

Program highlights 2018

Annual Joint Academic Meetings

Thursday 8 - Friday 9 November 2018
University of Technology Sydney, Aerial UTS Function Centre, Sydney NSW

DAY ONE – SECTION OF ACADEMIC SURGERY MEETING

Morning session: Mid-Career Course - Professional Development

The Ikigai of Academic Surgery
Don't go it alone
Managing up, down and across
Diversity in academia - beyond gender race

Afternoon session: Concurrent work shops

1. Clinical innovation with or without new technology
2. Creating an institutional vision that incorporates academic excellence.

The day will conclude with Working Party updates and debate: *Are private patients an untapped resource for academic surgery?*

Held jointly with the Academy of Surgical Educators Forum Evening of Thursday 8 November 2018

DAY TWO – SURGICAL RESEARCH SOCIETY MEETING

Invited guest speakers

Society of University Surgeons Guest Speaker – Dr Rebecca Minter
Association of Academic Surgeons Guest Speaker – Dr Heather Yeo
Jepson Speaker – Professor David McGiffin, Head of Cardiothoracic Surgery

Presentation of original research by surgeons/trainees/students/scientists

Awards for the best presentations;
Young Investigator Award, DCAS Award and Travel Grants

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Day two - Only $100 for SAS members to attend - *no membership joining fee*
Places will be limited at these meetings

Contact Details

E: academic.surgery@surgeons.org T: +61 8 8219 0900

A climate for change

Members of the Counties Manukau DHB Sustainability Committee with New Zealand Associate Minister of Health Julie Anne Genter (4th from right)

In 2009, the first Lancet Climate Change Commission warned that "Climate change is the biggest global health threat of the 21st Century". Without immediate action, it was predicted that by the end of the 21st Century the average global temperature will have risen by between 2–4°C.

While the health of developing countries and small island nations are likely to suffer the worst effects of climate change, Australia and New Zealand will not be insulated from its impact. Changes to the climate will result in a greater proliferation of vector-borne diseases, an increase in the number of severe weather events such as droughts, floods, heat waves and bushfires, and greater instances of food- and water-borne disease. Higher temperatures will also exacerbate air pollution, leading to an increase in respiratory illness.

It may seem counter-intuitive, but the delivery of healthcare is itself a considerable contributor to climate change - and by association a contributor to the aforementioned threats to health. A study conducted in 2018 estimated that health care in Australia was responsible for about seven per cent of the entire country's CO_2e (carbon dioxide equivalent), with hospitals creating around half of this. No equivalent study has been conducted in New Zealand yet, however it is likely that the figure is similar.

Operating theatres are estimated to produce around 20-30 per cent of an institution's waste. As this waste often needs to also undergo high-energy processing before it is safe for disposal, operating theatres, along with their heating, ventilation and air conditioning requirements, are estimated to be between three to six times more energy intensive than the rest of the hospital.

Given the impact that surgical practice has on the environment, small changes can have a big effect with surgeons well placed to drive initiatives. Many Fellows across Australia and New Zealand have already taken action and are involved in efforts to reduce the carbon footprint of their institutions.

One such individual is Associate Professor Andrew MacCormick, Chair of RACS' Younger Fellows Committee and a General Surgeon at Counties Manukau DHB. For the past six years, Andrew has been involved in his hospital's environmental initiatives and is a staunch advocate for reducing health care's carbon footprint.

"In 2012, a number of us at Counties Manukau began talking about how inefficient we were being with our limited resources - lights were always left on, computers weren't shut down overnight and large amounts of expensive single-use materials were needlessly being sent to the landfill", he said.

"Our group came up with a proposal for the CEO which argued that we needed to be much more mindful of the environment. The CEO put the proposal to the entire Counties Manukau – it was overwhelmingly popular."

Associate Professor MacCormick said that the first step was to understand where improvements could be made. The DHB commissioned CEMARS (Certified Emissions Measurement and Reduction Scheme) as an independent auditor to assess the organisation's environmental impact.

"By looking at our carbon footprint we could begin to identify areas where the biggest gains could be made – energy use, waste and travel immediately stood out."

Based on the footprint data at the start of 2013, Counties Manukau DHB set a target of reducing its emissions by 20 per cent by the end of 2017.

Not only did the hospital meet this goal, but it exceeded it with emissions being 21 per cent lower than five years earlier. The increase in efficiency also saved more than half a million dollars.

"Reducing our environmental impact was the main motivator - however when you reduce your carbon footprint and improve efficiency, the savings naturally follow.

"Top down support, as well as a strong drive and belief from the grass-roots level has been really important. Having a full-time sustainability officer to continuously drive initiatives is also a big reason we have been so successful." ►

Initially, the plan was to appoint a sustainability officer to oversee the project for one year. However, as the project's success continued to grow, the sustainability officer evolved into an on-going role.

Debbie Wilson, previously a senior nurse in critical care, was part of the initial group that proposed a more environmentally conscious approach. With a keen interest in sustainability, Debbie was quick to put her hand up for the new role.

"The key was to get some quick runs on the board to demonstrate to staff that their involvement would make a difference. For example, we measured the amount of yellow bags we were generating both before and after we began our theatre recycling initiative. This provided really meaningful data and showed individuals just how much of an impact their seemingly small change of behaviour was having."

Other initiatives included switching to anaesthetic gases with less impact on the environment, having computers enter sleep mode when not in use and re-assessing supply chain and procurement activities, the latter of which can account for a huge proportion of an institution's emissions.

"My advice for clinicians wishing to get involved with their own departments is that there is no need to re-invent the wheel – there are a lot of resources already out there. In New Zealand for example, Ora Taiao (the New Zealand Climate & Health Council) have a national hospital network which is a great collection of experience and knowledge," Associate Professor MacCormick said.

In recognition of the threat that climate change poses to health worldwide, RACS has developed its own position on the issue, advocating for action to reduce the impact that surgical care has on the environment. The principles behind this are summarised by the five Rs: Reduce, Reuse, Recycle, Rethink, and Research.

RACS has also signed up to support Ora Taiao's Call to Action which seeks to limit the greenhouse gas emissions caused by New Zealand's health sector.

So now that they have reached their 20 per cent target, what is next for Counties Manukau DHB?

"Our Board has just approved our plan to become carbon neutral by 2050", Associate Professor MacCormick said, "…we still have a long way to go to get to that point, but I am confident we can achieve it!"

Are you involved in your hospital's effort to reduce its carbon footprint?

Let us know at Surgical.News@surgeons.org

Calum Barrett
Communications and Policy Officer, RACS

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Friday 15 June

Lecture:
"The Road to Endor – Malingering in Peace & War"

This lecture will be delivered by
Professor Vernon Marshall

RACV City Club,
501 Bourke St,
Melbourne
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Light refreshments will be served after the lecture.

Guests welcome.
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Admission by donation to the Foundation for Surgery.

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by Thursday 14 June.

A case note review

Situational awareness…..LOST

This 72-year-old woman was admitted to a large regional hospital for investigation of painful tongue ulceration accompanied by significant weight loss. Biopsies confirmed the diagnosis of squamous cell carcinoma (SCC) of the tongue. A percutaneous endoscopic gastrostomy (PEG) was inserted and the patient was referred to a tertiary hospital for further assessment and treatment. The patient had been living independently at home, had a supportive family and had minimal medical comorbidities.

Computed tomography (CT) and magnetic resonance imaging (MRI) scans showed an extensive malignancy of the tongue that extended into and beyond the muscles of the floor of the mouth. Bilateral cervical lymph node metastases were confirmed, staging the lesion as a T4N2c oral cavity with no evidence of distant metastases.

The patient underwent a total glossectomy. Bilateral neck dissections were performed with reconstruction of the tongue deficit by a free flap. One internal jugular vein was deliberately sacrificed during the surgery.

Pathological examination of a specimen of resected tissue labelled “carotid tissue” showed extensive perineural and extranodal spread. The carotid artery was not resected. The preoperative positron emission tomography (PET) scan had shown extension of the carcinoma into the carotid space. Examination of the surgical margins showed 1mm of clearance on three margins.

The patient continued with nil-by-mouth with PEG feeds. An endoscopic evaluation of swallowing performed three weeks after surgery showed no movement of the oral flap and enough pharyngeal secretions to warrant the presence of the tracheostomy.

The plan was for the patient to be transferred back to the referring regional hospital. From there she would be discharged into the community with the tracheostomy in place, with follow-up planned at the tertiary hospital for potential chemoradiotherapy.

Discharge from the tertiary hospital occurred a little over three weeks after surgery and the patient remained in the regional hospital for a further week before being discharged home.

The patient was readmitted to the regional hospital five weeks later, having been transferred from a country

hospital to which she had presented with a short history of increasing shortness of breath and the production of increasing amounts of blood-stained sputum. Admission at the regional hospital was to the intensive care unit for treatment of pneumonia. Adenovirus and the influenza virus were both isolated in the sputum, with subsequent isolation of Pseudomonas. Increasing facial oedema was observed and angiography showed occlusion of the remaining internal jugular vein by clot. The patient was not tolerating inflation of the tracheostomy cuff and the clinical notes state that the cuff had not been inflated since well before discharge from the tertiary hospital.

The tracheostomy tube, which had not been changed since insertion, was changed to a larger size three days after admission. The procedure was performed in an operating theatre without incident and the cuff was subsequently kept inflated. Despite this, her pulmonary function continued to worsen and she required ventilation in the intensive care unit. The patient developed acute respiratory distress syndrome and septic shock, and this led to her death 10 days after readmission. Discussions with the family had led to the withdrawal of all active treatment shortly before death occurred.

Considerations

The patient was admitted to a large regional hospital on three occasions. The first was prior to referral to the tertiary hospital, the second was as an interhospital transfer following surgery and the third was for treatment of the pneumonia that caused her death. The clinical notes relating to the second admission were not included in the material provided for the audit assessment. On request, only a discharge summary was provided and this described the patient as "struggling to clear her secretions" and requiring frequent tracheostomy suction by nursing staff, including during the night. The discharge summary indicated that a respiratory consult had been requested but had not yet occurred and it is impossible to know whether it did occur.

The social worker’s notes from the last admission documented the anger and frustration expressed by the patient's daughter, the primary carer, about the lack of discharge planning and the fact that the small amount of community care received by the patient was ineffectual. The daughter seems to have invoked Ryan's Rule* when chemotherapy was being planned, as it was her understanding that such treatment was not appropriate due to her mother's ‘frail state’.

It is very concerning that the tracheostomy, left in place to protect the patient’s lungs after she was shown to be aspirating following surgery, was not being used properly. It is likely that the improper use of the tracheostomy worsened her condition. The fact that the cuff seems not to have been inflated for weeks was corrected during the last admission, but by then it was too late. It would be helpful to know what speech pathology assessment was made prior to the patient being discharged into the community, with a tracheostomy that required frequent attention.

The patient was unable to tolerate post-operative radiotherapy (as she was unable to lie flat due to her chest condition), yet this would have been necessary for any chance of survival given the very poor prognostic features of the pathology. Salvage total laryngectomy, as is sometimes necessary after total glossectomy, was discussed during the last admission but by then the patient was too ill and unfit.

Comments

1. There were concerns regarding the decision to transfer the patient from the tertiary hospital to the regional hospital. Due to the advanced malignancy and the surgery the patient did not have a protected airway. While the expertise of staff in the regional speech pathology department is unknown, it is more likely that the patient would have received the necessary training in tracheostomy care, including being able to tolerate cuff inflation, in a large hospital with staff experienced in dealing with such problems.
2. Surgical follow-up does not seem to have occurred, although the relevant notes were not available. At least one oncology appointment was missed at the tertiary hospital, possibly because the patient was too unwell. If follow-up had occurred, the continuing aspiration may have been diagnosed and dealt with before the inevitable pneumonia ensued.
3. The care during the terminal admission, which was the subject of the assessment, appears to have been entirely appropriate.

NOTE: *Ryan’s Rule* is a 3-step process used in Queensland hospitals to enable patients and families to raise and escalate their concerns should a patient not be progressing as well as expected.

https://clinicalexcellence.qld.gov.au/priority-areas/safety-and-quality/ryans-rule

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

The art of itinerant bone-setters

The first known, quoted event of medicinal manipulation occurred in Greece in 400 BC, when Hippocrates wrote about how one can alter the spine through gravity to help alleviate scoliosis. The candidate for treatment was tied onto a ladder, dangled upside down and shaken. In Rome, Claudius Galen wrote in 200 AD that spinal manipulation can be effected by standing or walking along a patient's back.

A bone-setter was an empirical practitioner who claimed the power of diagnosing and setting fractures, reducing dislocations and relieving painful and stiff joints. In medieval times, bone-setters did more than set broken bones. The first recorded written reference to them at that time was by Robert Turner, a Cambridge educated astrologer, occultist and botanist. In his book (1656) *"The compleat bone-setter: wherein the method of curing broken bones, and strains, and dislocated joynts, together with ruptures, vulgarly called broken bellyes, is fully demonstrated. Whereunto is added The perfect oculist, and The mirrour of health, treating of the pestilence, and all other diseases incident to men, women and children. Also, the acute judgement of urines."*, originally written by Friar Moulton of the Order of St Augustine, Turner covers not only the setting of bones but also reducing dislocations and restoring mobility to an injured or diseased joint.

Bone-setters considered their craft to be a natural gift which both men and women could possess. As a consequence, most had no education beyond an apprenticeship as noted in his book on the treatment of fractures by Percival Pott. Individuals born breach or who had been struck by lightning were believed to have such a gift. For the most part, bone-setters were illiterate or at best badly educated and lived in poor rural districts. As a consequence, they have left few accounts of their methods. What descriptions that exist are almost entirely anecdotal.

In the 18th Century, Mrs Sarah Mapp (Figure 1) who was the daughter of an English bone-setter, used a technique of practice that had been handed down through the centuries almost exclusively through family contacts. She was reported to be very strong, cross-eyed, very fat and hideously ugly. She capitalised on her appearance by calling herself Crazy Sally Mapp. By 1735 she was established in Epsom where she was paid to reside and from where she toured London, "setting bones and curing disease." Percival Pott was a contemporary and he regarded her claims "…the most extravagant assertions of an ignorant, illiberal, drunken female savage".

Although quackery ran rampant in the 18th Century, in bone-setting and in every other conceivable approach

Figure 1: Crazy Sal Mapp

appealing to human credulity, qualified practitioners were busy making contributions in the treatment of bones and joints through the field of orthopaedics. Dr John Hunter, for example, was another qualified medical contemporary of "Crazy Sal", who was busy teaching the value of movement of joints after injury in order to prevent stiffness and adhesions. There is no doubt that many bone-setters, such as Sally Mapp, actually did accomplish some good by breaking down adhesions in some of the joints they manipulated.

As the medical profession evolved, barber-surgeons, midwives and bone-setters began to be replaced by trained male physicians and surgeons. During the 19th Century, colourful characters like Mrs Mapp who had widely practiced across all classes, laboured primarily for the poor and could barely scrape a decent living. In his book *"On Bone-Setting so called"* (1871) author Wharton Hood described the practice of one Mr Richard Hutton, a bone-setter resident in London: "He had but a plain education and was entirely destitute of anatomical knowledge, and firmly believed the truth of his ordinary statement that 'the joint was out'… A joint previously stiff, painful, and helpless, was almost instantly restored to freedom of action by his handling (Figure 2), and the change was often attended by an audible sound, which he regarded as an evidence of the return of a bone to its place.

Until Wilhelm Conrad Roentgen's discovery of the X-ray, bone-setters and surgeons alike had to rely on the same methods for diagnosing fractures and dislocations. These involved the patient's history of injury, pain and loss of function, physical findings of deformity, loss of normal motion etc. Thus, the success of the bone-setter depended on his powers of observation and experience.

Diaphyseal fractures were reduced by manual traction by the bone-setter. Dislocations and metaphyseal fractures were reduced by manipulation. This was carried out suddenly and unexpectedly after the patient's attention had been distracted. After the manipulation the bone-setter would apply a dressing and a bandage might be applied that had been treated with wax, bitumen, egg white, flour or even mud to promote cohesion and rigidity.

However, bone-setters didn't restrict their practices to fractures and dislocations – extending their repertoire to other injuries and diseases of joints. William Cheselden in 1784 described the treatment of club-feet by a bone-setter, Mr Presgrove, by holding the foot as near the natural posture as he could and then rolling up with strips of sticking plaster, which he repeated from time to time until the limb was restored to a natural position.

One famous family of bone-setters was descended from the Welshman, Evan Thomas. As a boy, Evan was adopted by Anglesey general practitioner, Dr Lloyd and as the boy grew he took an interest in the doctor's work and soon began to demonstrate an extraordinary skill. Evan Thomas used touch alone to determine where bones were broken and would deftly manipulate them to ensure better alignment when the fracture healed.

Hugh Owen Thomas (Figure 3), the great-grandson of Evan Thomas who would find world-wide acclaim as sowing the seeds of modern orthopaedics. Hugh Owen was the first of the dynasty to be medically trained and qualified, however his marriage to Elizabeth Jones of Rhyl was childless. He offered a home to his wife's nephew, Robert Jones who had moved to Liverpool to study medicine. In this way Robert Jones came under the influence of Hugh Owen Thomas's ideas from an early age. After qualifying in medicine in 1878 he became professional assistant to his uncle before advancing his medical career.

On 7 February 1896, radiology began in England when X-rays were first used to discover the location of a bullet in a 12 year old boy's wrist who shot himself the previous month. When the pellet could not be found on probing, the surgeon, Sir Robert Jones, asked Oliver Lodge, head of the physics department at Liverpool University, if he

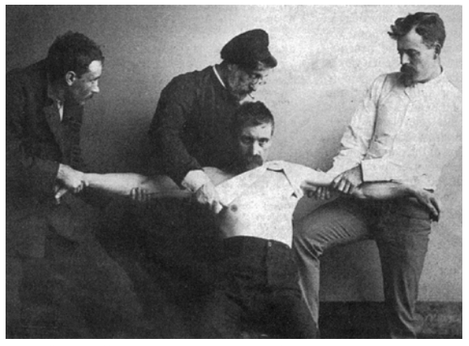


Figure 3: Hugh Owen Thomas (centre) and Robert Jones (right) manipulating a shoulder

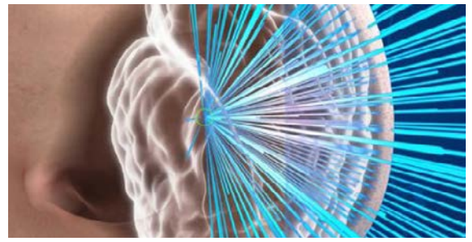
Figure 2: Spinal manipulation by a bone-setter

could help with the new X-rays. The pellet was identified embedded in the third carpo-metacarpal joint. Jones and Lodge reported the case in The Lancet on 22 February 1896, the first published clinical radiograph.

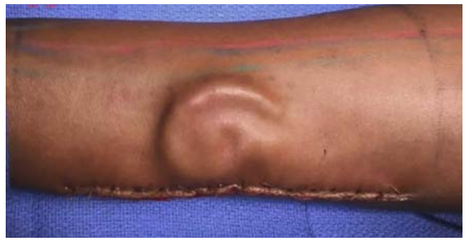
In most countries things have moved on. The management of fractures and dislocations is left largely to qualified orthopaedic surgeons whereas the therapeutic manipulation of the spine and other stiff and painful joints is the domain of chiropractors and osteopaths. However, bone-setting is still practiced in a number of countries around the world.

Professor Alan Thurston
FRACS

Surgical Snips



1,024 ultrasound waves safely passing through the skull



https://cdn3.img.sputniknews.com/images/106436/32/1064363299.png

Incisionless brain surgery the way of the future

A non-invasive focused ultrasound device that neurosurgeons can use to treat essential tremor patients who do not respond to medication has just been recognised with a Gold Edison Award. The Exablate Neuro is the first focused ultrasound device approved by the FDA to treat essential tremor. Essential tremor is the most common movement disorder, affecting millions of people around the world. Exablate Neuro features an innovative helmet that focuses 1,024 ultrasound waves that safely pass through the skull, on to the small spot in the brain responsible for the tremor. A small ablation or burn is made, which results in reducing the tremor. With minimal side effects, performing everyday tasks becomes possible for those having suffered from uncontrollable shaking of their hands.

https://www.mddionline.com/fda-approves-focused-ultrasound-brain-device

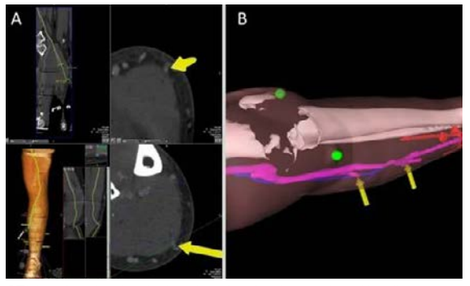
Doctors are growing a new ear for a woman inside her arm

Plastic surgeons in the US are growing a new ear in a patient's forearm using an innovative reconstructive surgery technique where the new ear was carved out of cartilage taken from the patient's ribs.

The carving was placed under the skin to allow the ear to grow, which when reattached, will allow the patient to hear again.

https://www.onenewspage.com.au/video/20180511/10060643/Doctors-Are-Growing-New-Ear-For.htm

HoloLens 3D hologram



CTA imaging showing the location of perforating arteries with yellow arrows. Credit: Imperial College

How Microsoft is getting under the skin of surgery with the HoloLens

'Mixed reality' technology is being trialled in the UK, allowing surgeons to reconstruct damaged tissue, effectively 'seeing through the patient's skin' to locate blood vessels for the transfer of tissue.

The HoloLens, a collaboration between Microsoft and the UK's Imperial College, overlays a virtual 3D hologram version of the patient's anatomy onto real bodies before they start the procedure, potentially revolutionising the operating theatre. Dr Philip Pratt, research fellow at Imperial College's department of surgery and cancer said that, "mixed reality has a crucial role to play in the future of surgery."

The floating virtual limb needs to be manually controlled by the surgeon, moved around and rotated using hand gestures. Future iterations will automatically snap the 3D model to its real-world counterpart, allowing the surgeon to focus on where they need to cut instead of working to a 3D model in the air.

There is even scope for future models to be more reactive to changes in position, shifting tissue and blood vessels depending on whether the body part is being held up or pressed against the operating table.

Simulating the effect of gravity, you can turn the [virtual] leg upside down and the simulation will change the position of the tissue.

https://www.pcauthority.com.au/news/how-microsoft-is-getting-under-the-skin-of-surgery-with-hololens-491350

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In memoriam

RACS publishes abridged Obituaries in *Surgical News*. We reproduce the first two paragraphs of the obituary. The full versions can be found on the RACS website at: www.surgeons.org/member-services/in-memoriam/

Bernard Catchpole

General Surgeon

1923 - 2018

Perth's medical services include one of the world's most respected centres for ophthalmology, the treatment of the eye, and one of its mentors was Bernard Catchpole.

Included in his skills was a gift for persuasion. He played a key role in the recruitment of Ian Constable, a world authority in his field, and the launching of the Lions Eye Institute.

Professor Constable, who still operates at the Institute, describes it as one of the leading centres of research in the world (it now has 200 professional staff). He describes Bernard Catchpole as "having a wonderful set of values" which were apparent in both his professional and his family life.

Medicine was a late starter in Perth's academic sphere. The first medical school was not opened until 1956 and before then, one had to go to another State to study medicine. There was no chair in ophthalmology in the new medical school, but the profession quickly established itself academically and Professor Catchpole played a leading role in this.

John O'Brien

General Surgeon

17 June 1925 - 18 November 2017

Mr O'Brien has been described as many things but, as a young medical student I found him simply "scary". When I was a surgical registrar at The Queen Elizabeth Hospital, Adelaide he was still "scary" and as I took on the role of Director of Surgery at TQEH in 1993 and he retired, nothing had changed. It was not that he behaved in an inappropriate or intimidating fashion, it was his obvious command of the surgical specialty, his enormous expertise clinically, his extraordinary intellect, but mostly his mastery of the empire "TQEH Surgery" which he controlled. I guess many viewed him a bit like a four-year-old views Father Christmas - large, impressive, wise and overwhelming.

There can be no doubting his surgical skill or judgement. But many great surgeons have these talents. It was perhaps more his enthusiasm for teaching, training and guiding medical students, surgical trainees, junior consultants and even peers. Mr O'Brien's opinions and observations were not to be taken lightly and never, in my experience, were.

Royal Australasian College of Surgeons

IN MEMORIAM

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

Bernard Catchpole (WA)
Michael Quinn (NSW)
Keith Jobbins (QLD)
Henry Crock (VIC)

Informing RACS

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

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