ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 18 NO 2 MARCH 2017

Research under the Microscope

From the lab to the OR

Highlighting #EarHealthforLife

A campaign focused on Closing the Gap

ICOSET 2017

International Education & Training Conference, details inside

2018 Grants & Scholarships

Travel and research opportunities announced

RACS LET'S OPERATE WITH RESPECT

The College of Surgeons of Australia and New Zealand

Developing a Career and Skills in Academic Surgery Course

Adelaide Convention Centre, South Australia, Australia
Monday 8 May 2017, 7:00am - 4:00pm

Keynote Speaker:
Professor Mary Hawn
Chair, Department of Surgery,
Stanford University, Palo Alto, California, USA

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

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

2016 comments:
"Equally as good as previous years. Very well structured"

"Brilliant opportunity to gain insight into academic surgery"

Association for Academic Surgery and international invited speakers:

Karl Bilimoria
Northwestern University, Illinois, USA

Ankush Gosain
Children's Foundation Research Institute, Tennessee, USA

Amir Ghaferi
University of Michigan, Michigan, USA

Eugene Kim
Children's Hospital Los Angeles, California, USA

Rebecca Sippel
University of Wisconsin, Wisconsin, USA

Tracy Wang
Medical College of Wisconsin, Wisconsin, USA

Australasian Faculty:
For the list of Australasian faculty, please visit www.tinyurl.com/DCAS2017

DCAS course participation
Cost: $220.00 per person incl. GST
Register online: www.tinyurl.com/DCAS2017
There are fifteen complimentary spaces available for interested medical students. Medical students should register their interest to attend by emailing dcas@surgeons.org.

Further information:
Conferences and Events Management
Royal Australasian College of Surgeons

T: +61 3 9249 1260
F: +61 3 9276 7431
E: dcas@surgeons.org

NOTE: New RACS Fellows presenting for convocation in 2017 will be required to marshal at 3:45pm for the Convocation Ceremony.

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

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

General Surgery Trainees who attend the RACS Developing a Career and Skills in Academic Surgery course may, upon proof of attendance submitted to: board@generalsurgeons.com.au, count this course towards one of the four compulsory GSA Trainees' Days.

Provisional Program

6:45am	Registration Desk Open	
7:15am	Welcome	
7:20am	Introduction	Marc Gladman / Amir Ghaferi
7:30am - 9:30am	**Session 1: A Career in Academic Surgery**	**Chairs: Richard Hanney / Amir Ghaferi**
7:30am	What is an academic and why every surgeon can and should be one	John Windsor
7:50am	The research cycle	Marc Gladman
8:10am	Clinical research	Guy Maddern
8:30am	Education / simulation research	Rebecca Sippel
8:50am	Translational Research	Klaus-Martin Schulte
9:10am	Discussion	
9:30am	**Morning Tea**	
10:00am - 10:20am	**Hot Topic In Academic Surgery**	
10:00am	Introduction	Marc Gladman
10:02am	Challenges of Optimizing Surgical Training – The FIRST Trial	Karl Bilimoria
10:20am - 11:30am	**Session 2: Ensuring Academic Output**	**Chairs: Marc Gladman / Mary Hawn**
10:20am	Writing an abstract	Amir Ghaferi
10:40am	Writing and submitting a manuscript	Tracy Wang
11:00am	Presenting at a scientific meeting	Eugene Kim
11:20am	Discussion	
11:30am - 12:15pm	**Keynote**	
11:30am	Introduction	Amir Ghaferi
11:35am	The Art of Success: Learning from Failure	Mary Hawn
12:15pm	**Lunch**	
1:10pm - 2:40pm	**Session 3: Concurrent Academic Workshops**	
1:10pm - 2:40pm	**Workshop 1: Early Career Development**	**Chairs: Eugene Kim / Yishay Orr**
	What can I do as a:	
	Medical Student	Andrew MacCormick
	Junior Doctor	Peter Pockney
	SET Trainee	Julie Howle
	Fellow	Jonathan Karpelowsky
	Consultant	Sebastian King
1:10pm - 2:40pm	**Workshop 2: Higher degrees – which one?**	**Chairs: Karl Bilimoria / Christine Lai**
	The doctorate the ultimate higher degree?	Greg O Grady
	Masters by coursework	Cherry Koh
	Masters by research	Ian Bissett
	Overseas experience – when, what and why	Alexander Heriot
1:10pm - 2:40pm	**Workshop 3: Practicalities of Research**	**Chairs: Susan Neuhaus / Tracy Wang**
	Building a career pathway: opportunites, obstacles and getting past them	Ankush Gosain
	Assembling the team and establishing collaborations	Julian Smith
	Randomised clinical trials	Andrew Hill
	Funding opportunities	David Watson
2:40pm	**Afternoon Tea**	
3:00pm - 4:00pm	**Session 4: Sustainability in Academic Surgery**	**Chairs: James Lee / Rebecca Sippel**
3:00pm	Academic surgery in private practice	Henry Woo
3:20pm	Trainee-led multi-centre clinical trials: the benefits for ANZ (TBC)	Dion Morton
3:40pm	Standing on the shoulders of giants	Glyn Jamieson
4:00pm	Discussion and close	Marc Gladman / Amir Ghaferi

Presented by:

AAS Association for Academic Surgery

Royal Australasian College of Surgeons – Section of Academic Surgery

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CONTENTS

FEATURE: Academic Surgery series: From the Lab to the OR.

#EarHealthForLife
Working towards a national approach to Aboriginal and Torres Strait Islander ear health

Tour de Cure
The perfect combination of scenery, comradery, challenge and charity

Battle of Ypres
Frank Hurley - a pictorial history of the Third Battle of Ypres, 1917

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Surgical News Editor: David Hillis

Concerned about Complaining

PHILIP TRUSKETT AM
President

An important part of our B*uilding Respect, Improving Patient Safety* program is our Complaints process. As I travel around, I have been getting a lot of feedback from Fellows and Trainees. Although we have publicised it and talked about it, some are concerned about using the process as they are unclear as to what might happen. Trainees in particular, express concern as they are understandably worried about what might happen to them. Others are uncertain as to how to lodge a complaint and if they do, what will RACS do at the workplace?

This, of course, is a complex issue. I will go through the process.

Firstly, the complaints page is easy to find. It is in the public section of the RACS website so anyone can access it, or simply Google: *RACS Complaints*. Your first hit will be the RACS Complaint Hotline. This landing page contains a number of resources. There are contact details by email complaints@surgeons.org or telephone for Australia (1800892491) and New Zealand (0800787470). These lines are open 24/7. If outside office hours, a message can be left and you will receive a return call by the next working day. The Hotline is not just about registering a complaint; expert advice will also be given.

The resource I would like to focus on is the *Complaints User Guide* that outlines the different pathways. It is understandable that in some cases the complainant does not wish to be identified to the person they are reporting, for fear of potential retribution, particularly if a hierarchy is in place. From the perspective of natural justice it can be hard to proceed if the accuser is not identified. Despite this there is still a process in place.

There are two available options. You can make an *anonymous or a confidential* complaint. In an anonymous complaint you may not wish to give your name but the complaint can be lodged. A *confidential* complaint is where you agree to identify yourself but do not wish your name to be linked to the report. In both of these examples the details will be recorded. The purpose of this is that if multiple complaints are made about the same individual, an inquiry can be triggered due to a *body of knowledge*.

> *When trying to change a culture, we need co-operation, collaboration and a common goal with all concerned, to ensure that our workplace is a safe environment for all.*

The other issue that I am asked about is: How will RACS intervene? This is a complex issue relating to both timing and jurisdictional responsibility. For those who have not yet done so, I would strongly urge you to do the *Operating with Respect* e-module. It is on the RACS home page; just click on the banner option. It is a mandatory requirement to complete this by the end of this year for all Fellows and Trainees. So far 30 per cent of Fellows have done the module. It is an excellent interactive tool that relates directly to the workplace and is highly tuned to surgeons. It graphically outlines how things can go wrong and how this might be addressed.

We are recommending the Vanderbilt approach as outlined in our *Building Respect, Improving Patient Safety* document that is available from the RACS website. This approach describes an early and an appropriate intervention at the workplace within 24-48 hours. It is a non-judgemental intervention by a peer that is designed to encourage reflection. Clearly, RACS cannot provide such a service, however we can advise on various options and we are promoting this approach within hospitals. It is our expectation that this methodology will be propagated by surgical departments with local advocates to promote the process. Some networks such as St Vincent's Hospital Group and Cabrini are rolling out formal programs, which is excellent. This approach is gathering widespread support. The early stages of the Vanderbilt process centre on early intervention that is non-judgemental to encourage reflection. If these processes fail, then the College, at the very least, needs to be made aware of those who require formal remediation. We are looking upon sustained discrimination, bullying and sexual harassment (DBSH) behaviour as a breach of professionalism. We do have processes in place to address this. Remediation is of course the intent and RACS may be able to assist in that regard. We must also be engaged if the safety of Trainees or others in the work environment, is placed in jeopardy by any Fellow or Trainee. Engagement with the jurisdictions is vital and this is the purpose of the growing number of memorandums of understanding (MoUs) and letters of agreement we are signing with hospitals and health authorities.

When trying to change a culture, we need co-operation, collaboration and a common goal with all concerned, to ensure that our workplace is a safe environment for all.

The other issue that concerns me greatly is feedback that some trainers and supervisors are reluctant to give negative feedback to Trainees for fear of being accused of bullying. Our training program is competency-based. As a result it must be rich in feedback if Trainees are to progress. If performance is not up to standard then it is an imperative that the Trainee is made aware of this in a constructive way. Feedback given properly is the key to training. It is what makes practice "purposeful". We cannot *fail to fail* Trainees who are not reaching their learning objectives. All Training Boards have processes in place to remediate these Trainees if possible. We cannot expect the Fellowship exam to sort the matter out. It is not designed to do this.

The RACS Foundation Skills for Surgical Educators course (FSSE) is designed to provide a basis for proper feedback and debriefing. The College has invested heavily in ensuring there is sufficient capacity to train all supervisors and trainers. If vexatious complaints are generated by Trainees who are unhappy with negative feedback, I am confident that our complaints process is strong enough to deal with this.

I am very pleased with the enormous effort that Fellows and College staff have put into our *Building Respect, Improving Patient Safety* program. More needs to be done and I am asking all Fellows, Trainees and IMGs for their ongoing commitment. Now is the period of consolidation and refinement. Think about what you can do in your own workplace; I am counting on all Fellows to lead by example.

Funding for public health – a key NZ election issue

PROFESSOR SPENCER BEASLEY
Vice President

On 23 September this year, New Zealanders will head to the polling booths for the country's 52nd general election. While the lead-up to these elections (hopefully) will be less intense than the more high-profile events we have recently witnessed overseas, the political rhetoric in New Zealand has already begun to ramp up as the numerous parties spawned by the Mixed Member Proportional (MMP) system jockey for position. The parties try to identify those issues they believe will be key to their electoral success, and then push them hard in the media. One area of contention is almost certainly going to be around funding of the public health sector. This is an issue that should be of interest to all New Zealand Fellows who work in the public sector (85%), but it is also one that affects – albeit less directly - those in the private sector.

In theory, patients with exactly the same needs at opposite ends of the country should have equal access to surgery

The presence of inequity and unmet need across the health sector has been a recurring subject of debate in New Zealand. The opposition recently estimated that the total health sector is underfunded by $2.2 billion. The Government, in relation to surgery, has repeatedly drawn attention to figures that show the number of elective operations being performed in the New Zealand public system has never been higher, and is growing at an average rate of 4,000 procedures every year. Moreover, it points out that patients placed on the waiting list, even those with low acuity, have greater certainty about getting their procedures done within a defined timespan (currently 4 months for non-urgent cases).

Without focusing too much on these statements, it is probably fair to say that there are still a large number of New Zealanders who could benefit from an elective procedure, but because of limited resources, inequitable decision-making and variations in access, are unlikely to receive it from the public purse. While increasing funding for elective surgery and greater throughput has helped, it seems unlikely there will ever be sufficient resources to address all elective surgery unmet need in New Zealand. I am not aware that any country has achieved this aspirational goal.

In New Zealand, the idea that there may be insufficient resources to meet all the healthcare needs of the entire population is certainly not a novel one. The New Zealand Ministry of Health itself clearly acknowledges on its elective services website that there are not enough resources to meet everybody's needs right away, so the resources available must be distributed in a way that is fair to all – or as close to that as is reasonably possible

Initially released in 2000 (and then updated in 2012), the Electives Health Strategy has seen New Zealand take a utilitarian approach to allocating elective resources by moving from the use of waiting lists towards a system of prioritisation. Most surgical specialties have helped develop Clinical Priority Access Criteria (CPAC): these are tools that allow patients assessed by a surgeon for elective surgery to be given a priority score according to their level of need and potential to benefit from the treatment. If this score is above a certain threshold set by the District Health Board (DHB), then the Government requires that the patient receives their procedure within four months. Based on this, DHBs set the threshold according to how many procedures they believe they can perform within this timeframe. The system, in part, relies on each surgical specialty correctly prioritising the patients they see. Conditions that are potentially life-threatening or where surgery makes a significant difference tend to be scored more highly, whereas those where surgery is judged to contribute little overall benefit, or the conditions are deemed minor with few longterm consequences, tend to be scored lower.

Two clear benefits to the prioritisation system are that it provides public patients with certainty that they will receive their elective surgery within the specified timeframe, and that those judged to have high clinical need are given priority. On the other hand, if their priority score is not high enough they will not receive the treatment in the public system. The score can change with time. For example, where the severity of symptoms increases, or complications arise, patients can be re-assessed and if their score is now above the threshold, surgery is undertaken. Yet patient expectations are not always aligned with the clinical prioritisation score, and this leads to disappointment and dissatisfaction. Also, the resource constraints that define the threshold mean that some patients who would potentially benefit from surgery are denied it.

There are a number of key principles that underpin the Ministry of Health's prioritisation system (*see the Coloured Box*). These principles aim to provide public patients with equitable access to elective services regardless of where they live. In theory, patients with exactly the same needs at opposite ends of the country should have equal access to surgery, but in practice this has proved difficult to achieve. Variables such as population demographics, configuration of surgical services and inconsistent application of the criteria have led to the thresholds for electives differing according to region. This variance, or "healthcare by postcode", shows why the system must be regularly evaluated and improved.

To help resolve issues around the prioritisation system, the Ministry of Health has recently begun publishing quarterly reports on the percentage of patients accepted for First Specialist Assessment, by region and by specialty. This data provides valuable information on the demand for services, and the capacity of each DHB to meet this demand.

While the CPAC scoring criteria for each specialty has been determined in large part by our Fellows, there remains considerable room for improvement. Their efficacy in maximising quality and timely elective services can be hampered by their design which, is sometimes too complex, and in some specialties there are local variations to the scoring system. This must be viewed in the context of issues around the efficiency of theatre utilisation and limitations in the capacity of hospitals to provide sufficient elective lists. The assessment of priority is far from being a finished product.

In December 2016, the New Zealand National Board agreed that the further development of prioritisation tools and addressing unmet surgical need would be key items of its strategic plan for 2017. While part of this will involve advocating for New Zealand's health system to be better funded and more efficient, it will also include working to ensure that there are transparent and on-going improvements to the prioritisation of services. At least, surgeons are very much involved and influential in this process, perhaps to the envy of their Australian counterparts.

Electives must be provided in a way that:

- Meets the population's health needs to a reasonable level
- Provides the best possible health gain to individuals and to New Zealand as a whole
- Gives priority to patients who need treatment most and who will benefit most
- Respects people's privacy, individuality and dignity and their wishes to be well informed and fairly treated
- Is regularly evaluated and improved
- Is well-integrated with other health services.

New Smart Fabric that Replicates Bone Tissue

A University of New South Wales (UNSW) Professor and her team have created a type of fabric that replicates bone tissue, with potential for wide-ranging medical, commercial and safety applications according to an article in the Saturday Paper. Biomedical engineer Professor Melissa Knothe Tate had her sights set on replicating the natural weave of the tissue around human bones. According to the news article, the quirky world-first technology her team used to develop the smart materials is now at the stage where Australian and international patents are pending. "The potential medical, safety and commercial applications range from more efficient compression sleeves for women suffering lymphoedema after breast cancer surgery, to bullet proof vests. We even have a company interested in our materials for a new range of steel-belt radial tyres," the Professor told the paper.

High-flow oxygen boost for bronchiolitis treatment

A study conducted at the John Hunter Children's Hospital has found that the use of a new oxygen treatment, so-called high-flow oxygen therapy, can support more children with bronchiolitis for longer and rescue most of those children who failed the standard oxygen treatment, preventing a large number of admissions to the paediatric intensive care unit.

As the first completed clinical trial on high-flow oxygen in children, it confirmed its safety and effectiveness. The results have just been published in the international medical journal The Lancet.

The trial, involving 202 babies, found that high-flow oxygen was needed for a similar length of time when first administered, however it supported more infants for longer as compared to the standard low-flow oxygen therapy. Most children who failed standard therapy were rescued with high-flow oxygen preventing intensive care intervention.

Melanoma research breakthrough gives hope for treatment

A Queensland University of Technology (QUT)-driven project has identified the way in which melanoma cells spread, opening up new pathways to treatment via drugs to 'turn off' the invasive gene. Led by Dr Aaron Smith from QUT's School of Biomedical Sciences, the project results have just been published in international journal EBiomedicine and could offer a new avenue for cancer treatment.

"Cancer is characterised by uncontrolled growth of cells but if uncontrolled growth was the only problem then cancer cells would be easily treated with surgery in most cases," said Dr Smith.

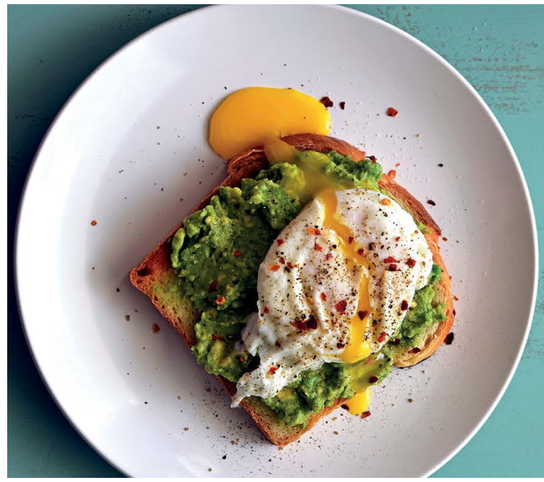
"What makes cancer deadly is its tendency to invade tissue and migrate to other regions of the body, a process we call metastasis.

"By examining melanoma tumour samples we know that some cells are primarily proliferative and some are more invasive and migratory. We also know some cells can switch between those two behaviours; in other words a cell capable of establishing a new tumour at the same site can change to be more invasive and facilitate the spread the cancer to other parts of the body.

"What we did not know though was the reason why this happened. Our research project has discovered the mechanism by which those melanoma cells switch behaviours."

New laser-based camera could provide better view of carotid artery

A camera small enough to enter the blood vessels and allow a specialist to see potentially stroke-causing surface lesions, could identify at-risk patients prior to a cardiac event. The camera, a scanning fibre endoscope, originally developed for the early detection of cancer cells, is powerful enough to produce high-quality images generated from multiple laser beams coupled with digital reconstruction. According to a paper reported in Nature Biomedical Engineering, the imaging platform uses fluorescent indicators that show key biological features associated with those with an increased risk of stroke. "In addition to discovering the cause of the stroke, the endoscope can also assist neurosurgeons with therapeutic interventions by guiding stent placement, and releasing drugs and biomaterials," University of Washington Developer Prof Eric Seibel said.



The Breakfast Fat Burner

DR BB-G-LOVED

Last month we heard how the overweight Tubby and Chewbar made resolutions to lose weight, exercise more, and eat better. When motivating patients, I like to avoid the word 'diet' as diets usually fail in the long-term. They are short-lived, result in temporary weight loss, half of which is fluid, and real improvement only occurs when individuals change how, when and what they eat. One can call it training one's taste buds, though it may be in reality also switching one's microbiota to less obesogenic ones.

Each day we should eat breakfast recognising it is not health-smart to make a habit of skipping this vital meal that should provide protein, healthy fats, limited carbohydrates and minimal sugar. Branded breakfast cereals are generally unhealthy; often containing excessive sugar, as are many mueslis although there are exceptions. Avoid yoghurts that have been sweetened. Read contents carefully for sugar content; their added, free and total sugars.

Saturated fats increase blood cholesterol, whilst mono, poly-unsaturated fats and omega-3 fatty acids reduce it. Yet many of us do not consider what we are eating but breakfast as we always have, perhaps to our peril.

My breakfast advice usually begins: "Go to work on an egg", with a single slice of multi-grain or rye toast (69 cal, 26g carbohydrate) preferably spread with smashed avocado. The egg provides protein to maintain lean body mass (29% protein, 2% carbohydrate, 69% fat – 60% of which is monounsaturated or polyunsaturated), the avocado is high in healthy fat, protein, energy and potassium. Clinical trials confirm avocado is effective in reducing your cholesterol and improving lipid profiles. Potassium is needed to counter balance excess sodium in our diets to the benefit of blood pressure.

An alternative breakfast is a smoothie, perhaps with added protein powder, though be careful that the fruit content is not so high that you consume your entire recommended sugar intake for the day (max 32-40g/day, equiv to 8-10 tsps). Greenies can use Kiwi fruit, baby spinach leaves, coconut juice, and natural yoghurt. Smoothies may be rendered orange with freshly squeezed orange juice and/or carrots; or go yellow with banana. A wide variety of fruit, vegetables, nuts or seeds can be added. Recipes abound.

A red cherry smoothie might benefit those exercising regularly. Cherries, like many berries, are rich in vitamins, minerals, anti-oxidants (anthocyanins), but also have anti-inflammatory properties. Montmorency Tart cherry (*Prunus cerasus L*) extract has anti-inflammatory polyphenols that reduce oxidative stress. Randomised double-blinded clinical trials on cyclists, recreational marathon runners and those engaging in resistance training have shown reduced muscle soreness and lower inflammatory markers following exercise. Last year the American Journal of Clinical Nutrition published a trial in which cherry extract also reduced blood pressure in men with early hypertension. Antioxidant ability is measured in Oxygen Radical Absorbance Capacity (ORAC) units per 100gms. Montmorency tart cherry juice concentrate has a greater ORAC than other worthy alternatives such as prunes, blueberries or blackberries. Cherries also contain melatonin, which can benefit your circadian rhythm and improve your sleep.

At breakfast drink coffee or tea, but not orange juice, which is full of sugar even if labelled "no added sugar"! The caffeine of coffee speeds up metabolism and, improves performance, but avoid adding sugar. Caffeine in combination with hypoglycaemia will increase catecholeamines and blood pressure if you skip breakfast. If you prefer tea, Green Tea might be the best choice. Green tea's Catechin (GTC), is a flavanol with anti-carcinogenic, anti-bacterial, anti-oxidant and cholesterol-lowering properties. GTC's benefits are supported by evidence from *in vitro, in vivo* and clinical trials. China's Yunnan province produces a special Pu-erh tea whose extract in 3 daily doses has been found to reduce weight and lipid profiles.

Winnie the Pooh said "Don't think too much, you'll create a problem that wasn't there in the first place!" That's a philosophy for those of you who are close to your ideal weight. But for Tubby and Chewbar, they've emptied the honey pot rather too often and developed body shapes Pooh would be proud of. Yet now, within a month, with refashioned breakfasts their lipid profiles and blood pressures have improved. So now to work on lunch and dinner!

FEATURE ARTICLE

Research: From the lab to the OR

ADRIAN ANTHONY
Chair, Surgical Audit Committee

ANDREW HILL
Chair, Research and Academic Surgery Committee

As surgeons, we benefit from the labours of research in a number of ways: It advances a range of areas including knowledge of disease processes, surgical techniques, diagnostics, drugs and medical devices. It informs clinical practice guidelines and identifies where new developments are needed. More recently, research has also played an important role in informing public policy around reimbursement, which is often a linchpin for the widespread dissemination and uptake of new procedures and devices. Without good quality research, the high level of care and patient outcomes we enjoy in modern surgical practice, would not be possible.

To ensure that we continue to make advancements in surgery, RACS is committed to research in a number of areas. We have dedicated departments that conduct evidence-based evaluations and perform quality improvement auditing processes. This work can only succeed with the expertise and patient-specific understanding that surgeons possess. RACS also provides funded opportunities for surgical academics.

In this issue, are a series of articles related to the work conducted at RACS, and a brief overview of each of the departments that have contributed to this work.

Research and Evaluation, incorporating ASERNIP-S

As you may know, the Australian Safety and Efficacy Register of New Interventional Procedures - Surgical or ASERNIP-S has been a part of RACS since its inception in 1998 and for many years it has been majority funded by external contract activity. Consequently, although our work has been relevant to surgery most projects have addressed the explicit needs of clients external to RACS. Over the years our experienced staff have completed many hundreds of projects, published 141 peer-reviewed articles, and regularly present at conferences.

Last year RACS approved a Research Strategy that confirmed the critical role of RACS to support and lead research, training and quality improvement in surgery. ASERNIP-S was re-branded as Research and Evaluation, incorporating ASERNIP-S to signify our role in this vision.

Throughout 2016 we undertook many targeted projects for RACS to inform and assist College positions and decision-making, and we will be publishing the results regularly in Surgical News. In 2017, we will continue supporting RACS in a range of activities and look forward to engaging with Fellows along this journey.

The Australian and New Zealand Audit of Surgical Mortality (ANZASM)

The Australian and New Zealand Audit of Surgical Mortality (ANZASM) is an independent, external peer review of surgical mortality in all states and territories of Australia.

The principal aims of the audit are to inform, educate, facilitate change and improve the quality of practice within surgery. The primary mechanism is peer review of all deaths associated with surgical care. The audit process is designed to highlight system and process errors, and to identify trends in surgical mortality. The objective is to facilitate reflective learning and improve surgical care and is intended as an educational rather than punitive process.

At a local level, the Audits of Surgical Mortality (ASM) monitor trends in mortalities and clinical management outcomes. Strategies have been developed to redress these issues. A series of reports and publications are generated by each region. The material includes: Hospital Clinical Governance Reports, Regional and National Case Note Review Booklets, Educational Seminars, Annual reports and 25 Research publications to date.

Morbidity Audits

The Morbidity Audits Department has two main purposes: to support RACS logbook and morbidity audit and logbook system, MALT, and to operate clinical audits on behalf of specialty societies. Currently, the department manages two such audits under contract, where the audits are funded and directed by the Breast Surgeons of Australia and New Zealand (BSANZ), and the Australian and New Zealand Gastric and Oesophageal Surgical Association (ANZGOSA). The BreastSurgANZ Quality Audit has been operating continuously for almost 20 years, while the ANZGOSA Audit is more recent, collecting data since 2010. The BreastSurgANZ Quality Audit has published over 30 research articles directly, and allowed the de-identified data to be used for many external research projects. The MALT system contains 34 different logbooks and over 1.5 million procedures logged by 1400 current users (Fellows, SETs, IMGs, subscribers to MOPS and JDocs, and surgeons from the pacific islands connected with the RACS Global Health program).

Image: John Colvin Storey, operating theatre (Australian War Memorial)

> *Surgery performed by today's surgeons would not have even been dreamt about in the past. Future surgeons will thank the researchers of today for their discoveries of new technologies and treatments.*

Academic Surgery

The mission of the Section of Academic Surgery is to nurture and promote surgical research, support research supervisors and assist all surgeons to remain informed research consumers. Within the Section, there are conferences designed to foster innovation, collaboration and support from like-minded surgeons. Academic Surgery is also establishing initiatives to ensure the next generation of clinical researchers are fully supported through training pathways, achieving sufficient research competencies, and a bi-national network of multi-centred trials. Articles on this clinical trials network and on one of the conferences are included in this edition of *Surgical News*. For further information or to become a member of the Section please contact academic.surgery@surgeons.org or 08 8219 0900.

Scholarship Program

On the first of March the 2018 Scholarship Program opened for applications. Whether you want to travel overseas to learn a new skill, complete your PhD or Masters, or work collaboratively on a research project, you may find a suitable RACS award that will help you along the way. In this edition of *Surgical News* is a four page spread outlining what is on offer for 2018. More information can be found at www.surgeons.org/scholarships including stories and articles about past recipients, many of whom have had significant and successful outcomes from their research.

Perhaps you know someone who could benefit from one of these scholarships or grants? If so then point them to the program. Closing date is 26 April 2017, with all outcomes being known by August.

> *As Fellows of RACS, we should be proud of the knowledge and expertise that we contribute to these advancements.*

Maximising the impact of surgical research

Surgical research should always aim to achieve impact, by informing clinical practice, or supporting policy decisions. Using methods appropriate to the development stage of surgical innovations will maximise impact and reduce waste in surgical research.

PROFESSOR GUY MADDERN
Surgical Director of Research and Evaluation

ASSOCIATE PROFESSOR IAN BENNETT
Chair, Research and Evaluation, Incorporating ASERNIP-S Committee

Research is most useful when it advances our knowledge of surgical practice, or informs public policy. The challenges in achieving these aims are to ensure that quality research is the norm, that it meets an unmet need, and that the results are accessible and used to impact practice and policy. Unfortunately, this is not always the case.

What prevents surgical research from achieving impact?

RACS Research and Evaluation, incorporating ASERNIP-S, has conducted evaluations of new surgical procedures and devices for public funding on the Medicare Benefits Schedule (MBS) since 2001. A recurring theme in the work we conduct is the limited availability of appropriately designed research to inform decision making around reimbursement.

Designing appropriate research is often challenging, due to the fundamental nature of surgical innovations: procedures are complex, they continually evolve, randomisation is often difficult or impractical, masking is often absent, outcomes are often inconsistent or do not reflect clinical practice, and learning curves impact outcomes.

Poor reporting and dissemination are also endemic in biomedical research. Indeed, a Lancet paper from 2009 estimated that these issues contribute greatly to the underutilisation of biomedical research[i]. These issues compound the challenge of conducting surgical research and limit the available evidence that can reliably support decision making.

How can we improve the impact of research?

We support the Lancet REWARD campaign,[ii] which builds on the 2009 publication. This campaign provides a sensible way forward for improving the impact of research across five domains relevant to surgery:

1. **Prioritisation** –research targets need to address relevant, useful questions that are justified by a systematic review of current evidence, and which acknowledge ongoing clinical trials.
2. **Methodology** – case reports and single arm trials provide limited additional evidence for the efficacy of established devices or procedures. Controlled trials, randomised or not, are sorely lacking in many areas of surgery.
3. **Transparency** – prospective clinical trials should be conducted in line with a research protocol that is accessible, e.g. through a registry such as anzctr.org.au or clinialtrials.gov. Results should be published, and ideally the complete data set for the trial should be made public.
4. **Regulation** – regulations should be proportionate to risk, acknowledging that randomised controlled trial evidence is not needed for every healthcare intervention. In this area, Australia's risk-based system of regulation does reasonably well.
5. **Diligence** – all research efforts should result in a useable, published report, even for negative or indeterminate results.

Appropriate methodology is a key factor for ensuring that research achieves impact, particularly for informing reimbursement decisions. Although randomised controlled trials (RCT) are the gold standard of evidence to determine the comparative effectiveness of surgical procedures, they are not appropriate for addressing all research questions.

Rather than thinking about RCTs as a necessary standard for all research, it is more helpful to consider research designs that are appropriate to the stage of development of a new surgical procedure.

What type of evidence is needed to inform decisions?

The type of evidence needed to inform a clinical or policy decision depends on the stage of development of a surgical procedure. Surgical innovation can be characterised into a number of development stages: conception/innovation, development, early exploration, assessment, and long-term use.[iii] Surgical innovations often progress rapidly through these stages, undergoing constant iteration and refinement along the way. As a result, early studies of surgical innovations are often out of date by the time the innovation is ready for widespread uptake into clinical practice.

Developed by surgeons for surgeons, and cited more than 430 times since 2009, the IDEAL recommendations provide guidance on appropriate study design at different stages of surgical innovation:[iv]

1. **Stage 1 – Idea***: structured case reports*
2. **Stage 2a – Development**: *prospective development studies*
3. **Stage 2b – Exploration**: *Research database; explanatory or feasibility RCT (efficacy trial); disease based (diagnostic)*
4. **Stage 3 – Assessment:** *RCT with or without additional/ modifications; alternative designs (e.g. robust non-randomised comparative study)*
5. **Stage 4 – Long-term study:** *Registry; routine database (e.g. SCOAP, STS, NSQIP); rare-case reports.*

For public reimbursement, which typically occurs at Stage 3 in the development cycle, comparative evidence is needed. Without comparative data on the safety and effectiveness of a procedure or device, relative to current practice, decision makers find it challenging to recommend new services be included on the MBS.

Why follow the IDEAL and REWARD recommendations?

Relevant, high quality, transparent and accessible research is needed in order to continually progress surgical practice for the benefit of patients. Taken together, the REWARD and IDEAL recommendations enable surgical research to inform decisions, both in clinical practice and in public policy. They also aim to ensure research is relevant and applicable to the current stage of the innovation, and help increase the dissemination and citation of our work. By following these recommendations, we will maximise the impact of our research, and continually improve our craft.

i Chalmers I and Glasziou P, Avoidable waste in the production and reporting of research evidence, *Lancet* 2009; 374: 86-89.
ii http://www.thelancet.com/campaigns/efficiency
iii Barkun JS, Aronson JK, Feldman LS, Maddern GJ et al, Surgical Innovation and Evaluation 1: Evaluation and stages of surgical innovations, Lancet 2009; 374: 1089-96.
iv McCulloch P, Altman DG, Campbell WB, Flum DR et al, No surgical innovation without evaluation: the IDEAL recommendations, *Lancet* 2009; 374: 1105-12.

When research ends, it's just the beginning

PROFESSOR GUY MADDERN
Surgical Director of Research and Evaluation

ASSOCIATE PROFESSOR IAN BENNETT
Chair, Research and Evaluation, Incorporating ASERNIP-S Committee

As principle investigator on a research program, there are always mixed feelings when a project draws to its conclusion. You are pleased with its implementation and results, saddened by the inevitable departure of fellow researchers, but hopeful that research outcomes will be acknowledged and drive change. On December 31st 2016, the Laparoscopic Simulation Skills Program officially concluded. The project objective was to examine the optimum format (composition and delivery) for the provision of laparoscopic skills training in rural Australia. To achieve this we used existing RACS infrastructure available from previous research work, specifically a Mobile Simulation Unit (MSU – a specially modified van), and a collection of simulation equipment.

This project completed its research objectives by enrolling a total of 207 participants during 17 site visits in hospitals across Victoria and South Australia between June 2015 and November 2016. By visiting the on-site MSU, participants were enrolled and randomised to one of two cohorts: Cohort 1 undertook self-directed learning (SDL) only; Cohort 2 were able to have one weeks' formal supervised training in the MSU, and they also undertook SDL. By collecting and analysing assessments, training logbooks and survey data the project was able to examine factors that can enable the provision of skills training.

Our findings identified that both cohorts achieved improved scores for all tasks, with a number of participants reaching proficiency. There was no statistically significant difference between cohorts at final assessment. Survey results identified that participants prefer training on equipment that is located at their place of employment – this is primarily due to their busy schedules and their inability to find time to travel to a site where they can practice.

Simply completing this research, however, is not enough; the benefit of these results can only be realised through their dissemination to those for whom the research was intended. To this end I am pleased to report that the research team has drafted nine peer reviewed articles: three of which have been accepted for publication, three of which are under review, and three of which are soon to be submitted. Notification of their publication will be provided through RACS general and social media platforms.

Simply completing this research, however, is not enough; the benefit of these results can only be realised through their dissemination to those for whom the research was intended.

With the completion of this project, our focus now shifts to consider other research and training opportunities related to laparoscopic skills training and services that we could offer Fellows and Trainees.

I would like to end by thanking the James and Diana Ramsay Foundation for funding this work through the James Ramsay Project Grant.

10 years of Surgical Mortality Audits – an overview

ANZASM
Australian and New Zealand Audit of Surgical Mortality

PROFESSOR GUY MADDERN
Surgical Director of Research and Evaluation

Throughout the first ten years of Surgical Mortality Audits, the audit process has been continually developed and improved. The type of data collected has been refined in consultation with stakeholders. The audits now have a sophisticated, tailored database that stores all of the data associated with each case, from recording of notifications of death to data analysis, as well as an interface that allows surgeons to enter data electronically.

For both the surgical community and the health administration authorities, peer review of surgical deaths is vitally important to inform, educate and improve the care of patients. Findings have been disseminated through Annual Reports and articles, and the education role has included individual reporting to the treating consultant surgeon, workshops and Case Note Review Booklets.

Clinical Governance Report with de-identified and aggregated data to enable benchmarking and monitoring of clinical management trends within a hospital, and compare it against other participating peer-grouped hospitals, both within the region and nationally.
Regional and National Case Note Review Booklets with selected de-identified cases that feature clinical issues for improvement.
Educational Seminars designed to highlight important quality and safety issues identified through the audit.
Annual Reports published to identify clinical management issues via independent peer review assessments that are designed to actively manage and improve patient safety.
Research publications - the data generated from the audit is analysed and widely distributed. Over the last five years there have been 25 publications that have been published in a range of peer review journals with more projects in the pipeline. This provides not only vital feedback to the performance of the Australian audit but also insights that can be picked up by other countries and surgical groups around the world. One interesting trend observed in a number of regions has been the fall in surgically-related deaths that fit the ANZASM inclusion criteria.

The audits will maintain a continuous improvement approach to maximise efficiency and best meet the needs of surgeons and other stakeholders. At the same time, now that the systems and processes have reached the current level of maturity and high levels of participation and support have been achieved, more attention can be focused on how best to utilise the valuable information gained, in collaboration with stakeholders.

For more information pertaining to the audits of surgical mortality visit: http://www.surgeons.org/for-health-professionals/audits-and-surgical-research/anzasm/

A selection of research publications resulting from the Surgical Mortality Audits include:

1. Wong TH, Guy G, Babidge W and Maddern GJ. (2012). Impact of consultant operative supervision and surgical mortality in Australia. *ANZ J. Surg.*, 82(12), 895-901.

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8. Raju RS, Guy GS, Majid AJ, Babidge W and Maddern GJ. (2015). The Australian and New Zealand Audit of Surgical Mortality-birth, deaths, and carriage. *Ann. Surg.*, 261(2), 304-8.

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Surgical deaths & lessons learned

MR GLENN MCCULLOCH
SAAPM Chair

The South Australian Audit of Perioperative Mortality (SAAPM): Lessons from avoidable clinical management issues.

In 2014-15 (the most recent SAAPM report), 9% of surgical deaths reported to SAAPM had an avoidable clinical management issue (CMI) identified by the assessor. The detailed information collected for each CMI is a valuable quality improvement resource. The SAAPM aims to highlight lessons that can be learnt from these assessments through seminars, articles in peer review journals and other surgical publications, and 'case note review' booklets (and an associated 'App').

Research on potentially avoidable issues in surgical deaths

SAAPM's first journal article was accepted for publication last year and appeared in the ANZ Journal of Surgery earlier in 2017, a thematic analysis of potentially avoidable issues in neurosurgical mortality cases in Australia (excluding New South Wales) from 2009 to 2014.[1]

While limited to neurosurgical deaths, the basic findings apply to other specialties. Work is underway to publish a series of similar papers analysing CMIs in other surgical specialties. The key findings in neurosurgery are listed below:

- Avoidable contributors to mortality occurred most frequently at the preoperative stage, most commonly relating to inadequate assessment and delays.
- Specific issues included delay in diagnosis, misdiagnosis, inappropriate treatment and inappropriate inter-hospital transfers.
- There were 35 cases identified in which assessors raised concerns about delay in diagnosis. The majority of these delays were attributed not to neurosurgeons but to other hospital departments or clinicians, hospital management or general practitioners.
- Most commonly among the cases with delay in diagnosis, emergency departments were identified as having failed to recognise symptoms and undertake appropriate investigations and/or transfer the patient to neurosurgical care.
- Failure of communication was the second most frequently occurring avoidable issue, identified across the spectrum of neurosurgical care, most commonly at the points of documentation, communication between teams and handover.

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Career and Skills in Academic Surgery

MARC GLADMAN, FRACS
RICHARD HANNEY, FRACS

The Developing a Career and Skills in Academic Surgery (DCAS) Course is now in its ninth year. The success of this Course is credited to the highly inspirational and diverse international and Australasian faculty that present each year.

Last year, in 2016, we were very fortunate to welcome Professor Derek Alderson, President-Elect of the Royal College of Surgeons (RCS) of England, as the Keynote speaker. Professor Alderson presented on the Clinical Trials Network (CTN) in the UK which he co-founded. This network consists of Trainee-led, multi-centred trials that are supported by senior clinical academics

This presentation has now inspired the proposal that such a network would also flourish in Australasia. The Section of Academic Surgery has initiated plans to establish a similar network in Australasia with expert advice and support of Professor Dion Morton, who co-founded the CTN UK and is currently Director of Clinical Research at the RCS of England. Excitingly, Professor Dion Morton is a distinguished presenter at this year's DCAS Course where he will discuss approaches in establishing a CTN in Australasia.

We also welcome Professor Mary Hawn, Chair of the Department of Surgery at Stanford University, as a keynote for the 2017 DCAS Course. Professor Hawn is not only presenting on 'The Art of Success: Learning from Failure' but is also a plenary speaker for the Quality and Safety Program at the RACS Annual Scientific Congress 2017.

We warmly invite you to attend the DCAS Course. The Course will be held

DCAS Course speaker (Professor Derek Alderson, RCS of England President-Elect)

at the Adelaide Convention Centre on Monday 8 May, preceding the RACS ASC.

For provisional program details or to register to attend the DCAS course visit www.tinyurl.com/DCAS2017, or contact dcas@surgeons.org

Would a Trainee-led Clinical Trials Network succeed in Australasia?

On behalf of the CTNANZ Establishment Working Group, Section of Academic Surgery, Royal Australasian College of Surgeons

JOHN A WINDSOR FRACS
TARIK SAMMOUR FRACS
RUTH MITCHELL (Neurosurgery Trainee)
ANDREW G HILL FRACS
GUY MADDERN FRACS

The need for surgical Trainees to acquire knowledge, skills and attitudes about research and its importance in the advance of surgical science and care is no longer contentious. It is tremendous that some surgical Trainees will commit to completing significant research and gaining a higher degree, but it is likely that this will be the minority of future surgeons.

The Section of Academic Surgery continues to work on two substantial projects that relate to improving training in surgical research. The first project, headed by Mr Jonathan Karpelowsky, aims to increase the content and quality of research training for all trainees across all surgical specialties to develop research competencies during training[1]. The second project, headed by Professor Julian Smith, seeks to develop a more defined, supported and integrated training pathway for those Trainees who are committed to a clinical academic career with a significant research component, alongside clinical practice, teaching and leadership. The latter 'Clinical Academic Pathways' project involves a broad range of stakeholders, including RACS, Royal Australasian College of Physicians, other specialty colleges, the Australian Academy of Health and Medical Sciences, the Australian Medical Association, the Australian Medical Council, as well as other research institutes, funding bodies and government agencies.

To support these projects and promote greater engagement in clinical research, we are introducing another major initiative modelled on international experience. In the United Kingdom, a need and a willingness arose to involve surgical Trainees in the design, conduct, analysis and publication of clinical trials due to widespread recognition that there was a dearth of quality clinical trials being designed and conducted within the Departments of Surgery. This was also seen as an opportunity to meet many of the objectives of research training. However, one of the impediments to conducting clinical trials as a surgical Trainee is the regular rotation between services and hospitals and so in 2011 a central coordinating Clinical Trials Network was established[2,3]. The hallmark of this network is that surgical trainees are the principal investigators in multi-centre prospective clinical trials that are surgical specialty based. No single centre studies are conducted that address the issue of surgical Trainees rotating between services and hospitals. The Trainees themselves take the lead, but are very well supported. This support involves a Director-based within the Royal College of Surgeons in London, a Surgical Specialty Lead for each specialty group, a designated Surgical Trials Centre with expertise in study design and data analysis, and assistance with targeted fundraising.

The UK initiative has been a great success. Over 60 clinical trials have been registered with active recruitment in over 40. So far, these trials have recruited over 19,000 patients from 338 active surgical units. The reported experience of the Trainees leading these studies has been that, while the conduct of clinical trials is not dependent on the active participation of consultant surgeons, they became increasingly engaged and supportive with time. Surgical companies and funding bodies have welcomed this coordinated national approach with over GBP28 million raised to support the conduct of these clinical trials. The vision of the UK CTN is to internationalise the approach and have they have been actively involved with the authors in developing a similar program in Australia and New Zealand.

Professor Derek Alderson, recent Editor in Chief of the British Journal of Surgery, President-Elect of the Royal College of Surgeons of England and co-founder of the UK CTN spoke at the 2016 DCAS course last year about the UK experience and sparked considerable interest. The Section of Academic Surgery has since endorsed the plan to establish the CTANZ – the Clinical Trials Network of Australia and New Zealand. An Establishment Working Group has been appointed. Professor Dion Morton, one of the founders and now Director of the UK CTN, will be speaking at the DCAS course in May 2017 in Adelaide. It has been agreed that we should confine the pilot phase to three surgical specialties: Colorectal, Cardiothoracic and Paediatric Surgery, with the expectation that this will encompass all surgical specialties. The establishment working group is beginning to work with RACSTA, and will be working with the surgical specialties to advertise and appoint Surgical Specialty Leads, set-up an independent Advisory Board for CTANZ and invite expressions of interest from potential Surgical Trials Centres. CTANZ is an exciting opportunity which, in the fullness of time, will give an opportunity for all surgical Trainees and training centres to participate in clinical trials. In the meantime we will be working hard to commence the pilot phase in the three specialties this year. The Establishment Working Group would value any feedback (Tamsin.Garrod@surgeons.org).

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The value of audit data

JOHN TREACY
Chair, Morbidity Audits Committee

DAVID WALTERS
Chair, BreastSurgANZ Quality Audit Steering Committee

ANDREW MACCORMICK
Chair, ANZGOSA Scientific Research and Audit Committee

The primary purpose of collecting audit data is to support the peer-review process. However, audits will in many cases collect large and representative amounts of data (especially those that operate perpetually). This makes the data valuable for research. RACS has a 20 year history of supporting research using audit data, through the work of its Morbidity Audits Department.

In the late 1990's the Breast Section of the College set up the National Breast Cancer Audit. Now directed by Breast Surgeons of Australia and New Zealand and renamed the BreastSurgANZ Quality Audit. They contract and fund RACS to operate the audit day to day. Comprising over 180,000 cases of early and locally advanced breast cancer from Australia and New Zealand collected since 1998, the audit has published over 30 peer-reviewed papers. Many of these provide valuable insights into the standard and availability of care. A notable piece of recent research is the 2016 article in The Breast, which shows patterns of breast reconstruction in Australia and highlights significant disparities in uptake and access[1].

In 2009 the Australian and New Zealand Gastric and Oesophageal Surgical Association (ANZGOSA) established the ANZGOSA Audit. It funds RACS to operate the audit day to day. The dataset comprises 2,500 cases of upper gastrointestinal cancer and gastrointestinal stromal tumour (GIST), collected since 2010. The first research article is currently being prepared on the incidence and management of GISTs. This will provide the first bi-national picture of the disease burden and treatment patterns for this relatively rare cancer.

Interested in accessing audit data?

Both audits are happy to receive requests for their data to be used for research. Applications are considered on their merits. In some instances, a fee may apply. Both audits have information available on their webpage explaining how to apply, and details on how to contact audit help desk staff for more information. See www.surgeons.org/bqa and www.surgeons.org/anzgosa

1 Flitcroft K, Brennan ME, Costa D, Spillane AJ. "Documenting patterns of breast reconstruction in Australia: The national picture" THE BREAST, 2016-12-01, Volume 30, Pages 47-53

Going Live?

Live streaming is the latest weapon in Social Media's arsenal of ongoing domination of the way we consume information as well as the way we spend our time

Livestreaming app Periscope, in its yearly review, announced social media users watch over 110 years' worth of live video daily on the platform.

At the beginning of 2016, Mark Zuckerberg announced that Facebook users watched over 100 million hours of video on the platform every day. And the network is investing heavily in live streaming technology as a significant area of growth in the future. Most recently offering a 360 degree live option perfect for capturing crowds, events and panoramic locations.

Instagram and Twitter released their own versions of live video streaming in late 2016. YouTube also offers the option.

The sheer volume of it all is immense. But so are opportunities.

Universities around the globe are exploring the cost-effective benefits of offering education en-mass.

Surgeons have been making headlines with an increasing trend of broadcasting live operations. This doubles down as a means of enhancing public literacy around operating-room procedures - as well as allowing a new level of educational immersion for medical students and surgical Trainees.

Politicians are promulgating their messages with immediacy and are able to, in some cases, bypass the traditional media circuit.

But for all of the opportunities there are also some dangers. Crimes have been live streamed as well as acts that violate community broadcast standards. The huge swathes of content being uploaded in real-time, present a unique challenge for legislators and their host platforms. How can this be policed – and how do we ensure people aren't exposed to harmful or triggering material? The jury is still out.

There has always been a semblance of media, corporate or government ownership of the broadcast waves. But this now being placed back in the hands of the people. Pirate Radio style. What we do with it, remains to be seen.

Access All Areas – RACS Digital

The Digital College Program has been a multi-year initiative that has resulted in new and improved online services to Fellows, Trainees, IMGs and JDocs.

RICHARD PERRY
Chair, Fellowship Services

The RACS Digital College Program was a three-year initiative, kicking off in 2014, to produce new and improved online services for Fellows, Trainees, IMGs and JDocs.

The initial plan was to:

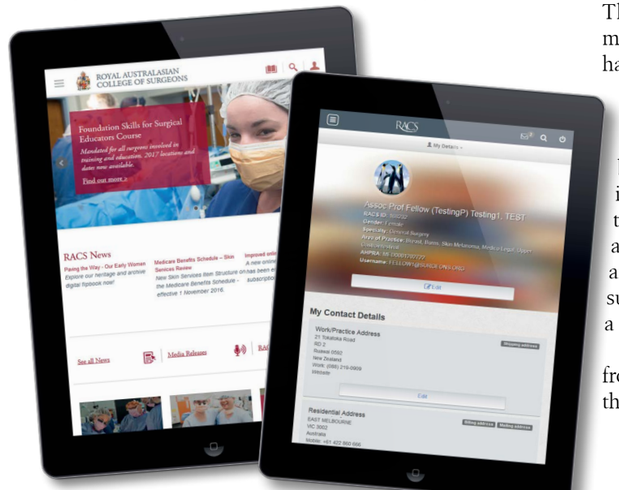
1. Enable online registrations, enrolments, and payments
2. Create a portfolio that would make it easier for you to manage your educational journey with RACS
3. Make these services easily accessible from a computer, tablet or smartphone.

The Program is now complete, but that doesn't mean that online services will not continue to evolve and improve. A major upgrade of the website is underway, with a launch anticipated later in the year.

The Digital College Program has produced a quantum leap forward for RACS IT and online presence. Amongst other things, the website has become more personalised and user-friendly, particularly with the introduction of the Portfolio. Some of the key improvements include:

Greater control of your own details with RACS

Managing changes to your contact details is now easier with the RACS Portfolio. The experience has been simplified and integrated with address lookup functionality. We've also centralised the opt-in to *Find a Surgeon* and management of your Practice Card in this same area.



Improved access to RACS resources

The Portfolio centralises all the resources you need to help you manage your educational journey with RACS. The CPD experience was redesigned to make it easier and more intuitive to enter CPD activities and see your progress, with further enhancements introduced at the beginning of this year. CPD points are now added for you automatically when you attend a RACS organised educational event. Handy notifications are provided so you know when those points have been allocated.

Online learning

There has been extensive development of new learning material, and the majority of courses and workshops are now available online including resources for participants and faculty.

Online assessment

MiniCEX and DOPS assessments can be done online via the Portfolio, and IMGs or Supervisors have the option to download an iPhone app.

eCommerce facilities for self-service payments

Subscriptions can now be paid online, and there are plans to integrate this further with the Portfolio. RACS merchandise can be purchased and donations made online.

Online applications for SET have been modernised and the process for IMG application has also been made available online. There is no need to fill in paper forms and send them to RACS. The whole process is streamlined meaning that RACS staff are more available to help. The online payment options are secure and provide for both credit card as well as PayPal.

Increased access to mobile-friendly functionality

The RACS Website, RACS Portfolio and online forms are all mobile and tablet-friendly and are available wherever you have Internet connectivity.

A recent survey with our users asked for feedback on the benefits of the Digital College Program. The results of the survey confirm that these improvements have been successful and well received. However, the feedback indicates, a desire for more. The plan for 2017 is to build on this success and continue to add value to further improve and enhance what has already been delivered. Plans are already underway to improve the online payment of subscriptions and instalments as well as the development of a new website.

We welcome your comments and look forward to hearing from you via one of the feedback forms on the website or in the RACS Portfolio.

Surgery, missionary work & fly fishing have one thing in common

Elected to the RACS Council in 2015, Professor Andrew Hill is currently the Chair of Research and Academic Surgery at the College. Surgical News caught up with the Auckland based surgeon to talk about his experience on Council, missionary work in Kenya, and trout fishing.

Professor Andrew Hill

Professor Andrew Hill is a General Surgeon with an interest in colorectal surgery and perioperative care. Passionate about surgical education, he is internationally renowned for his surgical research and supervision of post-graduate students - recently recognised with the prestigious Gluckman Medal from the University of Auckland in 2016. However, despite a clear passion for fostering and developing the future of surgery, Professor Hill did not always plan to become a surgeon.

"My father was a successful surgeon, but my initial intention was not to follow a career in surgery - I actually wanted to become a GP."

"I didn't change my mind until the late 1980's when I was on my medical elective in Kenya; up until that point I had always wanted to be a missionary in Africa, but when I got there I realised that being a GP meant that there would be a lot of things that I couldn't do. We didn't have a surgeon with us at the time, so we were performing a lot of procedures ourselves, straight out of a book. It was fairly stressful stuff, so I decided there that I would be more useful in those circumstances if I trained as a surgeon."

> *When we stand together as a profession we can achieve great things for the people of our two countries.*

Professor Hill was awarded his RACS Fellowship in 1997, having completed a Doctorate in Medicine at Harvard the year before. He has a clear passion for education, receiving a Doctorate in Education from the University of Auckland in 2011, as well as a Graduate Diploma in Theology from Laidlaw College in 2017 – the latter a committed undertaking by correspondence over the course of 15 years.

Now the Head of the University of Auckland's South Auckland Clinical Campus, Professor Hill is credited with establishing the internationally recognised research group in perioperative care at Counties Manukau Health, as well as supervising numerous post-graduate students, many of whom have gone on to win prizes or scholarships for their research regionally and internationally.

"I think the one thing I am most proud of is the young men and women who have succeeded, individuals that I have had the privilege of working alongside. Especially the Māori and Pacific students - they have made me very proud with their hard work, just showing what they are made of and their potential."

"A lot of Kiwis don't get to see that very often in their lives. I am very fortunate."

In 2016, Professor Hill was awarded the RACS Māori Health medal in recognition for his years of work mentoring Māori and Pacific Islander students.

"It was not actually something that I chose to do on purpose. I run a research programme and every year I take two students into my research group – it just so happened that over the last few years a good number of these students have been Māori and Pacific Islanders."

"It has been a really good experience – they trust me, and I respect them. We have had a lot of success with these students obtaining their PhDs, giving presentations on their research, and getting onto training programmes. It has been a real joy to experience this part of their lives and be involved where they wanted me to be."

In 2015, Professor Hill was elected to the RACS Council and is the current Chair of the RACS Research and Academic Surgery Committee having previously chaired the RACS Board of Surgical Research.

Professor Andrew Hill receiving the Auckland University Gluckman Medal from Professor John Fraser (Dean, Faculty of Medical and Health Sciences)

"I've believed for a long time that surgeons in Australasia should have a role in the College in some way – whether it is being part of a committee or running something, I think involvement is important. Given the things that I have done, Council seemed like a natural place for me to contribute and give a New Zealand perspective on things.

"I am also a great believer in general surgery and I want to make sure that that voice is represented on Council. Obviously we act for the good of the entire College and not just for individual specialties, but it is important that individual views are heard."

"I believe that one of the major challenges facing the profession is holding surgery together. We used to be just general surgeons, but over time we have continued to split into sub specialties. While this has brought obvious benefits, if we fracture too much then we will be limited as a profession in what we can achieve. We have more similarities than differences - when we stand together as a profession we can achieve great things for the people of our two countries."

Outside of surgery, Andrew is keen fisherman, although he admits that his technique could do with some work.

"I like gardening, and trout fishing, and getting out in the New Zealand bush. I am not a particularly active tramper though, so I am much more inclined to use a 4x4 vehicle where I can and only then walk the rest - usually to get somewhere for fly fishing."

"In terms of what I consider to be my perfect day, I would probably spend the morning doing research type things, going over papers, etc. In the afternoon I would have a decent steak sandwich for lunch and go trout fishing. In the evening I'd have a BBQ and lie on the couch and read a book. That is pretty close to my idea of perfect."

And if he wasn't a surgeon?

"If I was still in the medical profession, I'd be a GP in Turangi in the morning and go fishing in the afternoon."

"If I wasn't in the medical profession I'd be a trout fishing guide, albeit a very bad one."

Case Note Review

Fatal absence of DVT prophylaxis following knee replacement

PROFESSOR GUY MADDERN
Surgical Director of Research and Evaluation incorporating ASERNIP-S

Clinical details

An eighty year old patient had an elective total knee replacement (TKR) complicated by a significant pulmonary embolus (PE) day three postoperatively. This resulted in a transfer to the intensive care unit (ICU) in a state of cardiogenic shock that did not respond to active treatment and the patient died day four postoperatively. The major concern in this case was the lack of thromboprophylaxis prior to the PE.

The documents provided were adequate to identify the issues involved in the case. A cemented TKR was performed with no intraoperative issues noted. A combination of local anaesthetic infiltration and a femoral nerve catheter were used for analgesia. The postoperative orders noted standard deep vein thrombosis (DVT) prophylaxis and an order for enoxaparin 40 mg was written up but not given for the first two postoperative days. The reason given was that there was increased "wound ooze" in recovery requiring reinforcement of the dressings.

The patient had normal postoperative course until day two when it was noted the patient was febrile and had slightly lower oxygen saturation (88%) on room air. A medical emergency team call was made on day three when the patient became hypoxic and hypotensive. The patient was transferred to ICU where inotropes and vasopressors were given. A computed tomography pulmonary angiogram showed bilateral segmental PE with occlusion of the right upper lobe, middle lobe and lingula. Enoxaparin was only given after the PE was diagnosed. Thrombolysis was also performed but the patient failed to improve significantly and continued in a state of cardiogenic shock as well as anuric renal failure. After discussion with the family, a decision was made to withdraw treatment.

While chemical thromboprophylaxis was still somewhat of a controversial topic in Orthopaedic literature, the current National Health and Medical Research Centre guidelines for TKR is to recommend thromboprophylaxis for all patients undergoing total knee arthroplasty and this was clearly the protocol at this hospital. Enoxaparin was charted but not given on the basis that there was excessive "wound ooze" in recovery. This was only documented in the nursing notes and no mention was made in the medical notes, nor was there an identifier regarding who made the decision to withhold the enoxaparin.

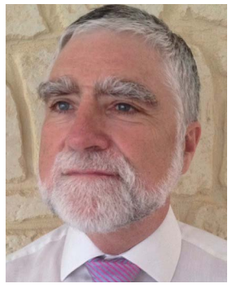
The cause of the bleeding was operative and not related to enoxaparin (which had not been given at this point). It is debatable whether withholding this would have made much difference in reducing the bleeding from the wound. In any event, once the decision had been made, an alternative method for thromboprophylaxis such as a foot pump or intermittent pneumatic calf compression should have been started. Enoxaparin should then have been restarted at the first opportunity.

Comments:

While it has yet to be proven that chemical thromboprophylaxis can eliminate the risk of PE, the current standard of care is to use chemical or mechanical (or a combination of) thromboprophylaxis in joint replacements. Cessation of thromboprophylaxis is a decision that should be discussed at a consultant level. The hospital clearly had a protocol where a daily checklist regarding the use of chemical thromboprophylaxis was part of the nursing plan. The recommendation would be to include mechanical prophylaxis as an option to be activated in the event of cessation of chemical thromboprophylaxis.

The End of Life conversation

Surgeons can do more to avoid Futile Care and advise on End of Life Matters



MR JAMES AITKEN
Chair, WAASM

Almost 250 people attended a sold out symposium on *Futile Care and End of Life Matters* hosted by the Western Australian Audit of Surgical Mortality (WAASM). The speakers included Jim McGinty, the former West Australian (WA) Minister of Health and Attorney General who was responsible for the creation of the WA statutory Advanced Health Directive and Enduring Power of Guardianship, Penny Flett, former CEO of the Brightwater Care Group and Matt Anstey a medical advisor to the Australian Commission on Safety and Quality in Health Care.

During the first half, speakers considered the legal framework. In the second half, Intensivist Tim Patterson explained how patients were 'eternal optimists' and both over estimated their chances of survival whilst underestimating their risks. Neurosurgeon Stephen Honeybul then considered some of the ethical issues around uncertainty and in particular the risk of long term disability and how survivors managed that.

The penultimate speaker was Zaza Lyons, a medical lecturer, but who on this occasion spoke as a mother, as she reflected on her experiences when her son Albie sustained a severe head injury and spent a prolong period in the intensive care and rehabilitation unit. The final speaker was Albie himself! Now a teacher and motivation speaker, he introduced himself as the 1 in 1000 chance - a truly sobering balance on which to end a symposium on futile care.

Despite a largely medical audience, and presumably one with an interest in the subject, an interactive quiz with the audience using an App on their smart phone, revealed that only 18 per cent had an Advanced Health Directive. This supported Jim McGinity's earlier comments that Advanced Health Directives were not widely or well used and that in some circumstance they should be mandatory, such as on admission to nursing homes.

Penny Flett argued that in many cases this already occurred and that many newly admitted residents had an overwhelming sense of relief when the subject was raised. She felt that carers generally are very well placed to discuss their wishes as they often have the most frequent contact with the elderly. She, like Jim McGinity, raised the issue of cost in a rapidly ageing demographic.

Among the many speakers from the floor, there were two interesting suggestions. In many New Zealand hospitals, completion of an Advanced Health Directive, or at least documentation of care goals, is a routine and mandatory part of all emergency admissions. Patients cannot leave the Emergency Department until one is completed. While this might adversely impact on the four hour rule, it would likely free up beds as prolongation of often unwanted care is avoided. Another suggested that the out-patient clinic following a 'near miss' admission was a useful place to discuss, and document, the patient's preferred management in the likely event that they have another admission for a similar reason.

There were two clear messages from the symposium. The first was that most patients, whilst often reluctant to initiate an End of Life conversation, welcome and embrace the opportunity to discuss their wishes once raised. The second was that medical staff miss many appropriate opportunities to initiate End of Life discussion and this should be considered an essential and routine part of good care. In particular, any such discussion must be properly documented to avoid often futile, unnecessary and frequently unwanted care.

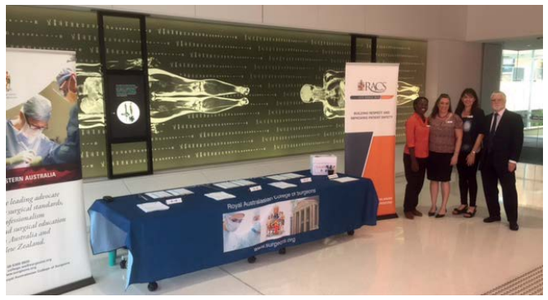


Image (from left): Dr Franca Itotoh (WAASM Project Manager), Ms Sonya Furneyvall (WAASM Project Officer), Ms Natalie Zorbas-Connell (WAASM Senior Project Officer) and Mr James Aitken (WAASM Clinical Director)

Travel and research scholarship & grant opportunities for 2018

ANDREW HILL
Chair, Research and
Academic Surgery Committee

KERIN FIELDING
Chair, Australia & New Zealand
Scholarship and Grant Committee

The Foundation for Surgery Scholarship Programme is now open for funding to be distributed to assist Fellows, Trainees, and International Medical Graduates (IMGs) in their research, education and other learning aspirations in 2018. This year we have three new opportunities:

The Anwar and Myrtha Girgis IMG Scholarship has been established due to a generous donation from the estate of Dr Anwar Girgis, an Orthopaedic surgeon. Research related to vascular surgical disease could be supported by the new **Foundation for Surgery Professor Philip Walker RACS Vascular Surgery Research Scholarship,** which was made possible by a donation from the late Professor Walker. Another new opportunity has been established by the Academy of Surgical Educators; the **ASE Surgical Education Research Scholarship**. More details below.

The ANZ Scholarship and Grant Committee invites Fellows, Trainees and other eligible applicants to apply for the following Scholarships, Fellowships and Grants for 2018.

Please note:

- These advertised opportunities are to be used as an initial guide only. Please consult the RACS scholarship website (www.surgeons.org/scholarships) from 1 March 2017 for detailed information, including application forms and award Policies. Ensure that you read the Important General Information Conditions document before applying to confirm eligibility.
- Applications for scholarships and fellowships below must be received by midnight ACST 26 April 2017.
- The values of these awards are in Australian dollars unless otherwise stated.

Research Scholarships, Fellowships and Grants

John Mitchell Crouch Fellowship

The John Mitchell Crouch Fellowship valued at **$150,000** is awarded to an individual who is making an outstanding contribution to the advancement of surgery, or to fundamental scientific research in this area. The Fellowship commemorates the memory of John Mitchell Crouch, a RACS Fellow who died in 1977 at the age of 36. Tenure is for one year.

The Council of the Royal Australasian College of Surgeons invites applications for the Fellowship. Applicants must meet the following criteria:

- Working actively in his/her field.
- The award must be used to assist continuation of this work.
- The applicant must be a Fellow of the Royal Australasian College of Surgeons who is a resident of Australia or New Zealand.
- RACS Fellowship or comparable overseas qualification obtained within the past 15 years (2002 or later).

The successful applicant is expected to attend the convocation ceremony at the RACS 2018 Annual Scientific Congress (ASC) in May for a formal presentation and be prepared to make a 20-25 minute oral presentation at the ASC on their research work including the contribution arising from the award.

Foundation for Surgery Senior Lecturer Fellowship

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

Foundation for Surgery
Passion. Skill. Legacy.

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

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

Foundation for Surgery Tour de Cure Cancer Research Scholarship

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

Applications are open to Fellows, SET Trainees and IMGs on a pathway to Fellowship who are proposing to undertake an important cancer research project. Gross value of this Scholarship is **$125,000** comprising $112,500 stipend plus $12,500 departmental maintenance. Recipients are expected to procure $25,000 of this amount from his/her research department, with the Tour de Cure corpus supplying the remaining $100,000. Tenure is for one scholarship year.

For information on Tour de Cure, please go to www.tourdecure.com.au

Foundation for Surgery John Loewenthal Project Grant

The Foundation for Surgery John Loewenthal Research Scholarship was established in honour of Sir John Loewenthal who served as President of RACS from 1971-1974. The scholarship was intended to promote surgical research. In 2015 it was decided to change the conditions of the scholarship to broaden its appeal, raise its profile and increase applications. As a result, it has been re-scoped and relaunched as the Foundation for Surgery John Loewenthal Project Grant. This Grant offers funding for surgical initiatives.

Applications are welcome from individuals or groups wishing to undertake clinical or research projects. Value of Grant in 2017/18 is **$100,000** per annum. Tenure is for up to two scholarship years.

Foundation for Surgery Herbert and Gloria Kees Scholarship

The Foundation for Surgery Herbert and Gloria Kees Scholarship, first offered for 2017, was established from a generous donation from the estate of the late Gloria Joyce Kees. The purpose of the scholarship is to support medical research and/or the advancement of surgical technologies, techniques and treatments. Applications are open to SET Trainees, IMGs on a pathway to Fellowship and Fellows who have had their Fellowship for five years or less (since 2012). The value of Scholarship is **$66,000**. Tenure is for one scholarship year.

Anwar and Myrtha Girgis IMG Scholarship – NEW

Dr Anwar Riad Girgis was an Orthopaedic surgeon in Whyalla and Adelaide after migrating to Australia in 1969. He initially trained in medicine in Egypt, and then undertook postgraduate training in the UK. Dr Girgis appreciated the assistance given to him by generous colleagues in the UK and Australia, and he and his wife, Myrtha Girgis, later gave the same support to Trainees and IMGs who wished to settle in Australia. Upon his death, his children Mona and Peter Girgis pioneered the establishment of this Scholarship with the Foundation for Surgery.

This scholarship is open to doctors who are of refugee or asylum seeker background or who are recent migrants, who are experiencing financial hardship to gain the professional development required to be able to practice surgery in Australia or New Zealand. The value of the scholarship is **$10,000** and is for one year's tenure.

Further information on the life of Dr Anwar Riad Girgis can be found on the RACS Scholarship website.

Foundation for Surgery Professor Philip Walker RACS Vascular Surgery Research Scholarship - NEW

Professor Philip Walker was a Vascular Surgeon, educated in Sydney (Royal Prince Alfred Hospital), Capetown (Groote Schurr) and USA (Stanford University). He moved to Brisbane in 1992 and having held various academic positions from that time was appointed Professor of Clinical Surgery & Head, Academic Discipline of Surgery at the University of Queensland School Of Medicine in 2011. He was a pre-eminent teacher, researcher and clinically active hands-on-surgeon who served as an examiner in Vascular Surgery for RACS. He died as a result of illness whilst still very active in all of his areas of interest. ▶

This scholarship is funded by a generous donation from the late Professor Walker himself. Applications for the scholarship are open to RACS Surgical Trainees who are undertaking a postgraduate higher degree with research that is in an area related to vascular surgical disease. The value of the scholarship is **$10,000** and it is for a term of one year.

Academy of Surgical Educators Surgical Education Research Scholarship

The Academy of Surgical Educators Surgical Education Research Scholarship has been established to encourage surgeons to conduct research into the efficacy of existing surgical education or innovation of new surgical education practices. It is governed under the auspices of the RACS Professional Development and Standards Board (PDSB) through the Academy of Surgical Educators (ASE).

Applications for the Scholarship are open to Fellows, Surgical Trainees and IMGs. The value of this Scholarship is **$10,000** and is for a term of one year.

> *Excellence is not a destination. It is a continuous journey that never ends.*
>
> *Brian Tracy*

Foundation for Surgery Small Project Grant

This Grant is intended to support Trainees and Fellows who are undertaking or wish to undertake a small clinical or research project or who require limited funding to purchase equipment to carry out a research project. RACS Fellows, Surgical Trainees and IMGs on a pathway to Fellowship can apply.

The Grant is valued at **$10,000**. Tenure is for one scholarship year.

MAIC-RACS Trauma Scholarship

This Scholarship was established from a grant from the MAIC (Queensland Motor Accident Insurance Commission) being matched by the Foundation for Surgery to enable RACS to offer annual research funding for research into trauma. RACS Fellows and SET Trainees are invited to apply. The proposed research may be in any of the following areas: Epidemiology, prevention, protection, rehabilitation or immediate or definitive management in trauma. Whilst it is not a requirement of this scholarship that the research be conducted in Queensland it must be shown that the potential benefits flowing from the research will assist the people of Queensland. The value of this scholarship is **$66,000**. Tenure is for one scholarship year.

Travel and Education Scholarships, Fellowships and Grants

Margorie Hooper Travel Scholarship

The Margorie Hooper Travel Scholarship has been made possible through a bequest from the late Margorie Hooper of South Australia. The Scholarship is open to RACS SET Trainees and Fellows who reside permanently in South Australia. It is designed to enable the recipient to reside temporarily outside the State of SA, either elsewhere in Australia or overseas, in order to undertake postgraduate studies and is also available for surgeons to travel overseas to learn a new surgical skill for the benefit of the SA surgical community. Preference will be given to the latter.

It is mandatory for the scholarship holder to make a presentation at the SA, NT & WA Annual Scientific Meeting in the year following the conclusion of the scholarship year.

This scholarship is for 12 months. The stipend is **$65,000** and there is provision for accommodation and travel expenses upon application.

RACS Aboriginal and Torres Strait Islander SET Trainee One Year Scholarship

RACS Māori SET Trainee One Year Scholarship

These Scholarships which were first offered for 2017 were established by the Indigenous Health Committee in partnership with Johnson & Johnson Medical Devices to support Trainees who identify either as Aboriginal and/or Torres Strait Islander or Māori. It could be used to cover one or more of the following:

- SET registration fees
- SET course fees
- SET examination fees
- Research projects
- Mentoring Programs
- Travel, accommodation and registration fees to attend conferences
- Relevant professional development activities.

The value of each scholarship is **$20,000** and the tenure is for one scholarship year commencing in January 2018.

Applications for the RACS Aboriginal and Torres Strait Islander SET Trainee One Year Scholarship are open to SET Trainees who identify as being Aboriginal or Torres Strait Islander. To be eligible for the Scholarship an applicant needs to fulfil the eligibility requirements for membership of the Australian Indigenous Doctors' Association (AIDA). Details can be found on www.aida.org.com.au/membership/eligibility/.

To be eligible for the RACS Māori SET Trainee One Year Scholarship an applicant needs to fulfil the eligibility requirements for membership of Te Ohu Rata o Aotearoa (Te ORA). Details can be found on http://www.teora.maori.nz/membership.

Hugh Johnston Travel Grant

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

Foundation for Surgery Ian and Ruth Gough Surgical Education Scholarship

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

Morgan Travelling Fellowship

The Morgan Travelling Fellowship was formed following a series of donations made by Mr Brian Morgan. The purpose of the Fellowship is to fund a RACS Fellow to travel overseas to gain clinical experience or to conduct research for a period of approximately one year. To be eligible, the surgeon must have gained their Fellowship in the past five years (2012 or later). The scholarship is open to a Fellow from any specialty. The scholarship must be the only RACS funding secured by the Fellow but the candidate is permitted to obtain alternative external funding concurrent with the Morgan Travelling Scholarship. The value of the scholarship is **$10,000** and the duration is for up to 12 months. Applicants must not have commenced their travels prior to closing date for applications.

Murray and Unity Pheils Travel Scholarship

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

Hugh Johnston ANZ ACS Travelling Fellowship

The Hugh Johnston ANZ Chapter American College of Surgeons Travelling Fellowship is intended to support an Australian or New Zealand RACS Fellow to attend the annual American College of Surgeons (ACS) Clinical Congress in October 2018. It forms part of a bi-lateral exchange with the ACS and is open those who have gained their RACS Fellowship in the past 10 years (2007 or later). Applicants are expected to have a major interest and accomplishment in basic or clinical sciences related to surgery and would preferably hold an academic appointment in Australia or New Zealand. The applicant must spend a minimum of three weeks in the United States of America in the year of their fellowship. While there, they must:

- Attend and participate in the American College of Surgeons Annual Clinical Congress in 2018.
- Participate in the formal convocation ceremony of that congress.
- Visit at least two medical centres in North America before or after the Annual Clinical Congress to lecture and to share clinical and scientific expertise with the local surgeons.

Applicants must not have commenced their travels prior to the closing date for applications. This Fellowship is valued at $8,000.

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

John Buckingham Travelling Scholarship

This scholarship was established to encourage international exchange of information concerning surgical science, practice and education, as well as to establish professional and academic collaborations and friendships amongst Trainees. It is open to current SET Trainees to enable them to attend the annual American College of Surgeons (ACS) Clinical Congress in 2018. This scholarship is valued at **$4,000**.

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

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

Applications close midnight ACST 26 April 2017

Melbourne surgeon to conduct world leading immunotherapy trials

Victorian Colorectal Surgical Trainee and PhD candidate Dr Joseph Kong has received industry funding to conduct one of the first trials in the world of an immunotherapy agent - currently being tested in advanced lung and pancreatic cancer - to treat patients with locally advanced rectal cancer (LARC).

The recipient of a number of RACS scholarships, Dr Kong has spent the past three years conducting PhD research aimed at finding immune markers to predict response in patients with LARC to neoadjuvant therapy and the use of immunotherapy in treating the disease.

His work has proven promising and in the last few months Dr Kong, with collaborators including medical oncologists, radiation oncologists and surgeons, has successfully submitted and obtained a grant to conduct Phase 1/2 clinical trials on PD-L1 blockade in combination with chemoradiotherapy at the Peter MacCallum Cancer Centre (PMCC) in Melbourne.

Dr Kong said he was delighted with the news of the grant but that much work was still needed to set up the clinical trial, which would require months of preliminary ethics and design work before commencement. He said the first trial would likely include ten patients while the Phase 2 study would incorporate more patients and other cancer centres around Australia.

"This will be one of the first trials in Australia where an immunotherapy agent is tested in patients with LARC which is very exciting," he said.

"Patients who will gain the most benefit will be those who did not respond to neoadjuvant chemoradiotherapy which represents around 20-30 per cent of all LARC patients. We hope this work will improve their overall and disease-free survival as these patients have exhausted all conventional clinical treatments with no other alternatives available to improve tumour response rates.

"We are now in the process of designing the trial to determine the best way of incorporating immunotherapy in the neoadjuvant setting in terms of timing, frequency of delivery and dosage."

Dr Kong said he had undertaken his PhD research because while Australia has the highest rates of bowel cancer in the world with the disease being the second most common cause of cancer death, there were few methods to determine which patients would get the most benefit from neoadjuvant therapy.

He said that while up to 30 per cent of patients with LARC showed a complete response to current clinical treatments – including resection and chemoradiotherapy – a significant number of patients showed poor to little response with correspondingly poor overall survival.

As such he set out to:

- Validate known methods in quantifying immune cells in LARC and to correlate that with response to neoadjuvant chemoradiotherapy;
- Develop a novel functional immune assay using rectal cancer organoids and matched tumour-derived tumour infiltrating lymphocytes to predict response to treatment; and
- Develop methods to incorporate immunotherapy in the neoadjuvant setting for LARC as an alternative method to increase the tumour response rate.

As clinicians, we strive to improve patient outcomes and minimise harm from therapies that have significant side effects. Being able to stratify patients into specific treatment pathways is at the forefront of medical care.

Now in the process of writing up his thesis, Dr Kong said that while some cancer centres around the world were offering patients with LARC neoadjuvant treatment only without surgery, up to ten per cent of the patients who were deemed in complete remission have tumour regrowth.

He said current diagnostic modalities to confirm complete tumour regression relied on conventional tests – such as colonoscopy, biopsy and/or imaging – which were limited in their ability to predict response accurately.

Woking at the Division of Cancer Research at the PMCC and the University of Melbourne, Dr Kong uses fresh tissue samples obtained by biopsy to grow tumours in the laboratory which he then tests with a range of molecular compounds including immunotherapy to see which had the greatest impact on tumour cells.

"This is personalised medicine, which is designed to provide patients with the best possible treatment regime," Dr Kong said.

"As clinicians, we strive to improve patient outcomes and minimise harm from therapies that have significant side effects. Being able to stratify patients into specific treatment pathways is the forefront of medical care.

"As an example, patients with complete response to neoadjuvant therapy may avoid surgery completely, eliminating the risk associated with surgery.

"However, this 'watch and wait' approach is not routine clinical practice and there is still a pressing need to identify an accurate predictive tool."

Dr Kong received his FRACS in 2014 and is now in the Colorectal Surgical Society of Australia and New Zealand (CSSANZ) training stream.

He has conducted his research under the supervision of Professor Alexander Heriot, Director of Cancer Surgery at the PMCC, Professor Robert Ramsey, Head of the Differentiation and Transcription Laboratory at PMCC, and Professor Wayne Phillips, Head of PMCC's Cancer Biology and Surgical Oncology Research Laboratory.

Dr Kong completed his medical training in New Zealand and his surgical training in Australia. He has a Master of Surgery Degree and has received a number of awards, scholarships and grants in recent years.

Last year he was awarded the RACS Foundation for Surgery John Loewenthal Research Scholarship, which is awarded to Fellows undertaking research in any cancer-related field and won the prestigious Young Investigator Award at the Surgical Research Society held in Melbourne. The award provides Dr Kong with the funds to attend the Association for Academic Surgery/Society of University Surgeons Congress and to present his work in the United States in 2018. Dr Kong thanked the College and Fellows for their support.

"While I have missed surgery, I believe that this research has the potential to help patients by refining diagnostic tools and developing novel therapies, which can hopefully improve patient outcomes," he said.

"It's extremely stimulating to confront complex problems and answer clinical research questions through translational research, which plays a small part in a global effort to advance our understanding of, and treatments for, cancer.

"The support I have received from the RACS has been invaluable and greatly appreciated because it allowed me to fully concentrate on my research which has, in turn, led to the clinical trials that we expect to run next year."

- With Karen Murphy

CAREER HIGHLIGHTS: GRANTS, AWARDS & SCHOLARSHIPS

2017:
Clinical Trials Phase I/II of PD-L1 blockade 2017: RACS Paul MacKay Bolton Scholarship for Cancer Research

2016:
- **RACS Foundation for Surgery John Leowenthal Research Scholarship**
- **Young Investigators Award – Surgical Research Society for best research paper**

2016:
CSSANZ Foundation Grant to investigate methods or predict response in LARC

2016 – 2018:
NHMRC Post Graduate Scholarship

2015:
RACS Raelene Boyle Research Scholarship

Workshops 2017

Online registration form is available now (login required)

Inside 'Active Learning with Your Peers 2017' booklet are professional development activities enabling you to acquire new skills and knowledge and reflect on how to apply them in today's dynamic world.

Foundation Skills for Surgical Educators Course

Tuesday, 21 March 2017	Adelaide	SA
Friday, 24 March 2017	Palmerston North	NZ
Saturday, 1 April 2017	Hobart	TAS
Saturday, 1 April 2017	Port Macquarie	NSW
Monday, 3 April 2017	Clayton	VIC
Monday, 3 April 2017	Perth	WA
Friday, 7 April 2017	Sydney	NSW
Friday, 21 April 2017	Melbourne	VIC
Saturday, 29 April 2017	Geelong	VIC

The Foundation Skills for Surgical Educators 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. With the release of the RACS Action Plan: Building Respect and Improving Patient Safety, the Foundation Skills for Surgical Educators course is now **mandatory** for Surgeons who are involved in the training and assessment of RACS SET Trainees.

Comcare: Difficult Cases

Tuesday, 21 March 2017	Sydney	NSW

The Comcare Guide to the Assessment of the Degree of Impairment informs medico legal practitioners as to the level of impairment suffered by patients. This assists with determining their patients' suitability to return to work. While the guidelines are extensive, they sometimes do not account for unusual or difficult cases. This evening workshop provides surgeons involved in the management of medico legal cases with a forum to discuss their difficult cases, the problems they encountered and the strategies employed to solve them. Cases will be circulated beforehand. This workshop complements the accredited Comcare Guideline Training Courses. Please note: Each attendee needs to bring with them a copy of the Comcare Guide 2nd Edition. This educational program is proudly supported by eReports.

Non-Technical Skills for Surgeons (NOTSS)

Friday, 24 March 2017	Melbourne	VIC

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

National Health Education and Training in Simulation (NHET-Sim)

Friday, 31 March 2017	Melbourne	VIC

The NHET-Sim Program is a nationwide training program for healthcare professionals aimed at improving clinical training capacity. NHET-Sim offers a training program for healthcare educators and clinicians from all health professions. The curriculum has been developed and reviewed by leaders in the simulation field across Australia and internationally.

Clinical Decision Making

Saturday, 8 April 2017	Sydney	NSW

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.

PROFESSIONAL DEVELOPMENT WORKSHOP DATES

March – April 2017

NSW		
Comcare: Difficult Cases	Tuesday, 21 March 2017	Sydney
Foundation Skills for Surgical Educators	Saturday, 1 April 2017	Port Macquarie
Foundation Skills for Surgical Educators	Friday, 7 April 2017	Sydney
Clinical Decision Making	Saturday, 8 April 2017	Sydney
NZ		
Foundation Skills for Surgical Educators	Friday, 24 March 2017	Palmerston North
QLD		
Foundation Skills for Surgical Educators	Saturday, 18 March 2017	Brisbane
SA		
Foundation Skills for Surgical Educators	Tuesday, 21 March 2017	Adelaide
TAS		
Foundation Skills for Surgical Educators	Saturday, 1 April 2017	Hobart
VIC		
NHET-Sim	Friday, 31 March 2017	Melbourne
Non-Technical Skills for Surgeons	Friday, 24 March 2017	Melbourne
Foundation Skills for Surgical Educators	Monday, 3 April 2017	Clayton
Foundation Skills for Surgical Educators	Friday, 21 April 2017	Melbourne
Foundation Skills for Surgical Educators	Saturday, 29 April 2017	Geelong
WA		
Foundation Skills for Surgical Educators	Monday, 3 April 2017	Perth

Contact the Professional Development Department

Phone on +61 3 9249 1106 | email **PDactivities@surgeons.org** | visit **www.surgeons.org**

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 from the Homepage to Activities.

WORKSHOPS • ACTIVITIES • EVENTS

#RACS17

Revalidation

A hot topic for 2017 Surgeon's Congress in Adelaide

PETER SUBRAMANIAM
ASC 2017 Convener

DAVID WALSH
ASC 2017 Scientific Convener

There is little disagreement that revalidation of surgeons to ensure currency of competency has definite benefits. Whilst the process of revalidation is an emerging concept in the Australasian surgical environment; for the surgeon and the patient, the aim is simple – to ensure that an up-to-date, competent surgeon is in place to provide the best surgical care and outcome to the patient.

At the upcoming Annual Scientific Congress (ASC) in Adelaide, Council has selected as its Plenary focus the timely and challenging issue of *Revalidation*. The challenges of developing (and maintaining) a process of revalidation of surgeons from varying specialty areas will be critically and forensically examined by knowledgeable international speakers. Revalidation completes the suite of plenary topics focussed on the Congress theme of *Safe and Sustainable – The Future of Surgery?* – A question we all hope will be answered in the affirmative. This will also be challenged by the President's Lecture to follow, where Professor Ian Harris will contest the notion of *Surgery as a value proposition.*

The ASC 2017 convening committee continues to excitedly finalise preparations for the 86th RACS Congress at the Adelaide Convention Centre.

The Provisional Program outlines the Plenary and Scientific program, now nearing completion. We remind you that accommodation in Adelaide will be in demand at this time of year. We encourage you to visit the Congress website http://asc.surgeons.org early to register and reserve your room.

The Convocation and Welcome Reception on Monday 8th May 2017 at 5.00pm will feature the Syme Oration will hopefully be delivered by His Excellency the Hon. Hieu Van Le AC, the first Vietnamese-born Vice-Regal representative in the Commonwealth.

As we have been doing periodically in Surgical News, we highlight a number of aspects of the scientific program for ASC 2017. The Provisional Program is also available online at http://asc.surgeons.org

Orthopaedic Surgery

Mark Rickman has developed an integrated program in Orthopaedic Surgery for the ASC 2017 Adelaide. Section Visitor, Professor Justin Cobb, from Imperial College, London, will cover the latest information on surgical innovation in 3D planning and 3D printing in orthopaedics and explore the outcomes of these in modern orthopaedic surgery.

Mark also has a *Hot Topics in Orthopaedic Surgery* session with Miss Clare Marx, President of the Royal College of Surgeons England, Mr David Campbell, President of the Arthroplasty Society and Mr Richard Lander RACS EDSANZ. The session covers quality control, financial restraints and surgeon level outcome data - a relevant session for all surgeons.

Craniomaxillofacial Surgery

Walter Flapper has constructed sessions to cover craniosynostosis, secondary craniofacial surgery and in conjunction with the Pain Medicine program, craniofacial pain. Section Visitor, Professor Anil Madaree from South Africa will deliver a number of keynote lectures covering developmental abnormalities – Facial Clefts, Correction of scaphocephaly and Encephalocoeles.

Acknowledging the important role of the past from which the future of craniofacial surgery is emerging, Professor David David will deliver a keynote lecture on the history of Craniomaxillofacial surgery.

Endocrine Surgery

Christine Lai's program combines interesting aspects of thyroid cancer, parathyroid and adrenal disease along with a masterclass *Tips and techniques on ultrasound guided biopsy of breast and thyroid masses - a hands-on workshop*.

Michael Yeh from the USA and local visitors Robert Parkyn and Rory Clifton-Bligh add an international and medical perspective to the program.

The debate that *Thyroid surgery should only be performed by high volume surgeons* is certain to attract a lot of attention with a clear segue to the issues of revalidation and currency of surgical competency.

Head and Neck Surgery

Along a similar theme, John-Charles Hodge has selected as keynote, a lecture by David Goldstein (Toronto) focussing on surgical volume and outcomes in H&N cancer and the impact of regionalisation of surgical oncology in a universal healthcare system. He will address the concept of high volume surgeons in high volume centres and their outcomes, compared to low volume surgeons in low volume units and, interestingly, what happens when a high volume surgeon in a high volume unit moves to a low volume unit and any impact on outcome. Mark Shrime from Harvard will also explore clinical data derived from limited trials in ICU.

General Surgery

Adrian Anthony has brought together two eminent speakers - Jacques Belghiti from France and Meron Pitcher from Melbourne.

Both visitors have extensive experience in general surgery and will present up to date coverage on topics of interest to all those in these fields.

Sessions will cover the difficult topics of palliative surgery and dealing with bariatric complications along with current practice issues such as *Robotics in general surgery* and *On call upper GI emergencies*.

We trust you will join us in Adelaide for what we know will be a memorable ASC.

Remember to register early and book your place at ASC 2017 as accommodation is already heavily booked.

Register now through the Congress website asc.surgeons.org

2016 Neurosurgical Society of Australasia ASM

RICHARD PERRY
Chair, Fellowship Services

With support from the RACS' Visitors Program Professor Peter Hutchinson participated in the well attended 2016 Neurosurgical Society of Australasia Annual Scientific Meeting held in Sydney from 31 August to 2 September.

Peter Hutchinson BSc (Hons), MBBS, PhD (Cantab), FRCS (Surg Neurol) is Professor of Neurosurgery, NIHR Research Professor and Head of the Division of Academic Neurosurgery within the Department of Clinical Neurosciences, University of Cambridge. He holds an Honorary Consultant Neurosurgeon post at Addenbrooke's Hospital. He is also Director of Clinical Studies at Robinson College, Cambridge.

He has a general neurosurgical practice with a sub-specialist interest in the management of neurotrauma, specifically head and traumatic brain injury. He has a research interest in acute brain injury, utilising multimodality monitoring technology (measurement of pressure, oxygenation and chemistry) to increase the understanding of the pathophysiology of brain injury. He also leads the international RESCUE studies evaluating the role of decompressive craniectomy in traumatic brain injury. He has co-authored over 200 publications (including Lancet and Brain) and been lead applicant in over £6m of grants (including MRC and NIHR). He is joint editor of the book *Head Injury – A Multidisciplinary Approach*.

He has a track record in leadership including his current role as Royal College of Surgeons Neurosurgical Specialty lead for clinical trials and member of the Research board of the College, and Chair of the Academic Committee of the Society of British Neurological Surgeons. He is also a Vice-President of the European Association of Neurosurgical Societies, Neurosurgical Representative on the NICE head guidelines development group and Chief Medical Officer for the Formula One British Grand Prix.

Professor Hutchinson presented in highly attended sessions including:

a) Session 1 (New Horizons in Neurotrauma) – New horizons in brain trauma management
b) Session 12 (Invited Lecture) - The role of microdialysis in increasing our understanding of the pathophysiology of traumatic brain injury
c) Session 13 (Education and Standards) – Academic neurosurgical training in the United Kingdom

The NSA is grateful to the RACS Visitors Program for supporting Professor Hutchinson's attendance.

2018 RACS Visitor Grant Program
(For Non-RACS Meetings)

Applications are now open for the 2018 round of the RACS Visitor Grant Program (For Non-RACS meetings). The RACS Visitor Grant Program provides grants of up to $15,000 to support the attendance of eminent speakers at eligible surgical society and association meetings in Australia and New Zealand.

Eligible groups are encouraged to apply now for funding in support of travel, accommodation and registration for visiting speakers to 2018 scientific meetings. Supported speakers and meetings will be promoted through Surgical News, fax mentis and online.

RACS is committed to excellence in surgical education and practice and is proud to support Fellows within sub-specialties and other groups who wish to enhance their scientific meetings by inviting visitors of note from Australia, New Zealand and overseas.

Applications for meetings in 2018 are now open and closing on 20 March 2017.

Further information and application forms are available from the RACS website at http://www.surgeons.org/member-services/racs-visitor-grant-program/

Any queries can be directed to Paul Cargill, Manager, Fellowship Services +61 3 9276 7415 or fsc@surgeons.org

Australian and New Zealand Post Fellowship Training Program in Colon and Rectal Surgery 2018

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

For details about the Training Program and applications, please see https://cssanz.org/index.php/training/about

A Notaras Scholarship will be awarded in 2018. Further information can be obtained from A/Prof Christopher Young via the email below.

Application Closing Date:
Friday 5 May 2017

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

Please email your application to:

A/Prof Andrew Stevenson
Chair, Australia and New Zealand Training Board in Colon & Rectal Surgery

Email: secretariat@cssanz.org
Enquiries: +61 3 9853 8013

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

REGIONAL MEETINGS UPDATE

Surgery 2017: Future Proofing Surgical Practice

Date: 17 –18 August 2017
Venue: TE PAPA, Wellington, New Zealand
In addition, the NZ Surgical Pioneers session will be held the day before on Wednesday 16 August from 1pm-6.30pm.

Find out more:
T: +64 4 385 8247 • E: college.nz@surgeons.org
www.surgeons.org/about/regions/new-zealand

2017 RACS Queensland Annual State Meeting combined with the Surgical Directors Section Leadership Forum

Date: 18 – 20 August 2017
Venue: Pullman Palm Cove Sea Temple Resort & Spa, Palm Cove

'Will surgeons be redundant? Artificial intelligence, robotics, advances in medical care and molecular genetics'

For additional information regarding the ASM:
David Watson
T: +61 7 3249 2900 • E: college.qld@surgeons.org
W: surgeons.org/about/regions/queensland/
For enquiries regarding the Surgical Directors Section:
Kylie Mahoney
T: +61 3 9276 7494 • E: surgical.directors@surgeons.org
W: surgeons.org/member-services/interest-groups-sections/surgical-directors/

WA, NT & SA Annual Scientific Meeting

Dates: 25 – 26 August 2017
Venue: Pan Pacific Hotel, Perth

'Trauma: When Disaster Strikes'

A foundation course will be offered on the 24 August.

Find out more:
RACS WA Regional Office
T: +61 8 6389 8600 • E: college.wa@surgeons.org
www.surgeons.org/about/regions/western-australia

RACS SA Regional Office
T: +61 8 8239 1000 • E: college.sa@surgeons.org
www.surgeons.org/about/regions/south-australia

83rd TAS Annual Scientific Meeting

Date: 22 - 23 September 2017
Venue: The Old Woolstore Apartment Hotel, Hobart

"Surgery in One State, One Health System, Better Outcomes"

Find out more:
E: college.tas@surgeons.org
www.surgeons.org/about/regions/tasmania

59th Victorian Annual Surgical Meeting

Dates: 20 - 21 October 2017
Venue: Novotel, Geelong

'Safety in Surgery'

Find out more:
T: +61 3 9249 1188 • E: college.vic@surgeons.org
www.surgeons.org/about/regions/victoria

ACT Annual Scientific Meeting

Date: 4 November 2017
Venue: Australian National University, Medical School, Canberra

Systems of care: collaboration and innovation

Find out more:
T: +61 2 6285 4023 • E: college.act@surgeons.org
www.surgeons.org/about/regions/australian-capital-territory

International Conference on Surgical Education & Training (ICOSET)

Adelaide 7 – 8 May 2017

ASSOC. PROF. STEPHEN TOBIN
ICOSET Convener

PROF. PETER ANDERSON
ICOSET Convener

Dear Fellows and Colleagues,

The International Conference on Surgical Education & Training (ICOSET), to be held in Adelaide is a global gathering of surgeons, Trainees, educators, researchers and healthcare professionals.

This year's theme is *Rethinking Surgical Training* will provide a platform to explore the latest standards and innovations in surgical training worldwide.

Program Review

The extensive scientific program for the ICOSET can be viewed online at www.tinyurl.com/icoset17.

Surgical Training

Surgical Training is a multi-faceted area with its own complexities in subjects such as outcomes, selection and preparation. Day One explores the complex nature of Surgical Training with Assoc Prof Stephen Tobin focussing on 'Outcomes of Surgical Training'. Prof Oscar Traynor (Ireland), Mr Craig Mcillhenny (Scotland) and Prof Torben Schroeder (Denmark). Dr Ken Harris (Canada) and Dr Ajit Sachdeva (USA) will present the nuances between Generalisation and Specialisation.

The keynote speaker, Dr Brian Dunkin (USA) continues to blaze the path with his presentation *Is There an Evidence-Base for Selection Approaches Utilised by Surgical Colleges?* Later part of the day, Dr Richard Reznick (Canada) and Mr Humphrey Scott (England) will be debating on *Pre-Surgical Training Resident Years are Necessary before Entering Surgical Training Programs*. Prof Peter Anderson continues on with the emphasis on Preparation for Surgical Training.

In-Training Assessments

Prof Oscar Traynor and Prof Debra Nestel (Australia) will explore how technology and simulation can enhance assessment. Assessments are not complete without feedback and Dr Teodor Grantcharov (Canada), Prof Elizabeth Molloy (Australia) and Mr Craig Mcilhenny will delve into this topic further on Day Two. *Nationwide Project around Technical Training for Operations*, a topical subject in Europe, will be presented by Prof Lars Konge (Denmark). Dr Richard Reznick will close Day Two morning by presenting the topic *CBME, CanMeds15 and the New Queens System*.

Good Professional Behaviours

More than anything, cultural change relies on leadership from surgeons who are personally committed to building respect and improving patient safety in surgery. Surgical education is also critical and RACS is committed to building good professional behaviours amongst our surgeons. Assoc Prof Stephen Tobin and Prof Oscar Traynor will address the RACS Action Plan and Online Professionalism Module respectively in the afternoon of Day Two. Mr Simon Fleming (England) will be a major contributor on the day with his views on the professionalism topic as a UK Trainee as well as his surgical education research towards PhD.

Networking Dinner

There will be a networking dinner event on 7 May at the National Wine Centre, so come and mingle with the other conference participants and faculty.

Go online to www.tinyurl.com/icoset17 to register your participation and to reserve your accommodation before it gets booked out.

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

In association with RCSEng, RCSEd, RCSI, UEMS, RCPSC and the ACS present:

INTERNATIONAL CONFERENCE ON SURGICAL EDUCATION & TRAINING

ICOSET 2017

7 – 8 May 2017

Adelaide Convention Centre, Adelaide, Australia

PROVISIONAL PROGRAM

SCIENTIFIC PROGRAM – Sunday 7 May 2017

9:00am - 9:15am	Introduction
9:15am - 11:05am	Outcomes of Surgical Training **Chair: Stephen Tobin (Australia)**
9:15am	The Community Need and the College Views **Stephen Tobin (Australia)**
9:25am	Overspecialising vs Needs of Health Service Greenway Report **Oscar Traynor (Ireland)**
9:35am	Improving Surgical Training and Response to Greenway **Craig Mcillhenny (Scotland)**
9:45am	Certification is the Norm **Torben Schroeder (Denmark)**
9:55am	Generalism can't be Forgotten: Generalism vs Specialisation **Ken Harris (Canada)**
10:05am	The Transition to Being an In(ter)dependent Surgeon: How Surgeons Start on their Careers (Pre-Recorded Presentation) **Ajit Sachdeva (USA)**
10:15am	I Have My FRACS – Now What? **TBC**
10:35am	Questions and Discussion
11:05am - 11:35am	MORNING TEA
11:35am - 1:15pm	Preparation for Surgical Training (Residency) **Chair: Peter Anderson (Australia)**
11:35am	College Update: RACS, RCPSC, RCSEng, RCSEd, RCSI and UEMS
12:05pm	Update: Preparation for Surgical Training in USA (Pre-Recorded Presentation) **Ajit Sachdeva (USA)**
12:15pm	Debate: That Post-Medical School /Pre Surgical Training Resident Years are Necessary Before Entering Surgical Training Programs **For: Humphrey Scott (England)** **Against: Richard Reznick (Canada)**
1:15pm - 2:15pm	LUNCH
2:15pm - 2:45pm	Selection for Surgical Training **Chair: Ken Harris (Canada)**
2:15pm	Is There an Evidence-Base for Selection Approaches Utilized by Surgical Colleges? **Brian Dunkin (USA)**
2:45pm - 4:15pm	Breakout Sessions: The Best Approach to Selection *(Afternoon Tea will be available during the session)*
4:15pm - 5:15pm	Report Back on the Way Forward
7:00pm	Conference Dinner National Wine Centre

Royal Australasian College of Surgeons
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INTERNATIONAL CONFERENCE ON SURGICAL EDUCATION & TRAINING
ICOSET 2017
7 – 8 May 2017
Adelaide Convention Centre, Adelaide, Australia

SCIENTIFIC PROGRAM – Monday 8 May 2017

8:15am - 8:30am	Recap of Day One (Summary of Selection for Surgical Training) **Stephen Tobin & Peter Anderson (Australia)**
8:30am - 10:00am	What's New About In-Training Assessments? **Chair: Stephen Tobin & Peter Anderson (Australia)**
	GROUP 1
8:30am	Nationwide Project Around Technical Training for Operations **Lars Konge (Denmark)**
8:40am	Technology to Enhance Surgical Training **Oscar Traynor (Ireland)**
8:50am	Can Simulation Help with Training – Assessments? **Debra Nestel (Australia)**
9:00am	Q&A Session **Group 1 Panel Discussion**
	GROUP 2
9:10am	Feedback Approaches **Liz Molloy (Australia)**
9:20am	Assessment Needs Judgement – More than Standard Tools and EPAs **Craig Mcilhenny (Scotland)**
9:30am	Update on Research Work About In-Training-Assessments and Certification **Teodor Grantcharov (Canada)**
9:40am	CBME, CanMeds15 and the New Queens System **Richard Reznick (Canada)**
9:50am	Q&A Session **Group 2 Panel Discussion**
10:00am - 10:30am	MORNING TEA
10:30am - 12:30pm	Free Papers and Poster Presentations
12:30pm - 1:30pm	LUNCH
1:30pm - 3:00pm	Issues Going Forward **Chair: Peter Anderson (Australia)**
1:30pm	RACS and Media 2015 – Action Plan and Progress 2016-2017 **Stephen Tobin (Australia)**
1:45pm	Online Professionalism Module **Oscar Traynor (Ireland)**
2:00pm	How I See SET in 5 and 10 Years **TBC**
2:15pm	Presentation by Overseas Trainee **Simon Fleming (England)**
2:30pm	Medical School Approach **TBC**
2:45pm	Discussion
3:00pm - 3:30pm	Next Steps and Thanks **Chair: Stephen Tobin & Peter Anderson (Australia)**
3:30pm - 4:00pm	AFTERNOON TEA
4:00pm	Meeting Concludes

EarHealthForLife

A key to Closing the Gap

DAVID MURRAY
Chair, Indigenous Health Committee

RACS ENT Fellows have been active in treating ear disease in Aboriginal and Torres Strait Islander communities for many years, regularly committing to outreach work in remote Australia.

In both remote and metropolitan areas Aboriginal and Torres Strait Islander Australians suffer higher rates of early onset ear infection and subsequent chronic suppurative otitis media and permanent hearing impairment. The lack of progress and the absence of nationally agreed benchmarks around best practice and service delivery have been frustrating for health workers involved in this life changing work.

As a result, RACS and ASOHNS, together with key medical, research and Aboriginal and Torres Strait Islander peak bodies, have joined together to advocate for a national approach and to show how hearing impairment is a key barrier and risk to Closing the Gap priorities. The Ear Health for Life campaign has helped shed light on the preventable pandemic of ear disease.

Hearing health is now clearly recognised as a key factor in early childhood development, educational attainment and employment prospects. Hearing problems are a key risk factor in negative social behaviours, including school absenteeism and involvement in the justice system.

> *...Chronic otitis media, or middle ear infections, should not be a normal part of childhood...*
>
> *A/Prof Kelvin Kong*

On 24 November 2016 ear disease experts from around the country gathered to discuss the problem and solutions. The group acknowledged the tremendous work that health workers, researchers, and specialists have done in investigating and treating chronic ear disease in Australia over many years, in particular through the biennial Australian Otitis Media Conference (OMOZ).

The roundtable group discussed the critical importance of developing a national framework that will guide and support governments, Primary Health Networks, Aboriginal Community-Controlled Health Organisations and health practitioners in the provision of ear healthcare services across states and territories, ensuring that pathways and access to primary healthcare and specialist services are clear.

The group later met with key parliamentarians Hon Ken Wyatt, Hon Warren Snowdon, Hon Mike Freelander and Hon Sharon Claydon to highlight that in Australia's Aboriginal community, up to 91 per cent of Aboriginal children have deafness for up to three months a year, and 100 per cent have an ear infection under the age of three months. One quarter of Northern Territory Aboriginal children have eardrum perforations and in the APY lands of South Australia the rate is 35 per cent.

These statistics are an indictment on a country with one of the best health systems in the world.

According to A/Prof Chris Perry, 'We should be embarrassed that Aboriginal Australians have the world's worst incidence of middle ear infection and the worst deafness rates because of those infections. The situation is a disgrace."

The World Health Organization has classified prevalence rates of otitis media at above 4 per cent as a 'massive public health problem'. A/Prof Kelvin Kong notes that, 'Chronic otitis media, or middle ear infections, should not be a normal part of childhood - yet we are seeing extraordinarily high rates of hearing loss from this condition.'

A National Aboriginal and Torres Strait Islander Hearing Health Taskforce would help evaluate the existing efficacy of health services addressing Aboriginal and Torres Strait Islander ear disease and ensure that Indigenous people are involved in determining how to address hearing health in their communities.

As part of its Reconciliation Action Plan RACS is committed to promoting measures aimed at Closing the Gap in Aboriginal and Torres Strait Islander health outcomes. Throughout this campaign the leadership of ENT surgeons across Australia has been critical in getting this issue onto the national agenda.

RACS Fellows have a long history of working collaboratively with Aboriginal and Torres Strait Islander communities and as we welcome more Indigenous Fellows as surgeons we can have an even greater impact on better health outcomes for first Australians.

Join in the twitter conversation **#EarHealthForLife** to show our support for a national approach to Aboriginal and Torres Strait Islander ear health and for associated initiatives and programs.

Images (left): ENT Surgeons - Hemi Patel (NT), Stephen O'Leary (Vic), Trish Macfarlane (SA); (above) The Roundtable group - Meeting a Parliament House (Canberra).

CampaignTimeline

2016

- August – A/Prof Kelvin Kong and A/Prof Chris Perry publish articles in major national newspapers drawing attention to the issue.
- September – OMOZ4 passes a motion supporting the concept of a National Aboriginal Ear Disease program.
- September – RACS President Phil Truskett meets with Federal Health Minister Hon. Sussan Ley.
- October – A/Prof Kelvin Kong and A/Prof Chris Perry meet with assistant Health Minister Hon. Ken Wyatt and other key MPs.
- November – RACS contributes a submission to the Royal Commission into the protection and detention of children in the NT.
- November – Ear disease experts including surgeons, audiologists, paediatricians, researchers and peak Aboriginal organisations gather in Canberra to discuss a national solution to the ear health crisis.
- Roundtable representatives meet with key parliamentarians to propose the formation of a national taskforce to develop a best practice national approach to ear health.
- December – RACS writes to Hon Ken Wyatt, Australia's Chief Scientist and the Department of Prime Minister and Cabinet to outline recommendations.
- December – RACS meets with Hon Warren Snowdon in Melbourne to discuss our bi-partisan advocacy on this issue.
- December – RACS contributes a submission to the Senate Inquiry into hearing health

2017

- January – Chris Perry, President ASOHNS is successful in highlighting these issues in an article in The Australian.
- January – A national approach to ear health and the formation of a taskforce is recognised as a priority area in the AMA's Pre-budget submission 2017-18.
- February – Advocacy continues aimed at placing proposal on the COAG Agenda.

Looking back and looking forward to build momentum

Writing as the Chair of the NSW State Committee of RACS I particularly want to share the direction that the NSW Committee is moving in for the coming year.

RAFFI QASABIAN
Chair, NSW Regional Committee

Reflecting on the previous year, one of the most visible areas that we have been working on has been our role within *Building Respect, Improving Patient Safety* or BRIPS. RACS has acknowledged that bullying and harassment are issues for us, and have initiated plans to affect cultural change, not just within, but also externally, in the operating theatres and greater hospitals.. Initially many surgeons felt that it did not affect them, but have come to the realisation that this is an important area that not only affects our College, but our work spaces and the overarching healthcare profession.

Looking forward RACS is mandating that all Fellows, Trainees and IMGs undertake the online course that can be found by logging onto the RACS website. This course is an essential part of CPD. As well as the online course RACS is rolling out the FSSE, or Foundation course, that all Fellows who interact with Trainees are expected to undertake, especially Supervisors. RACS and the Fellows are being recognised as leaders in this field, which is a remarkable turnaround.

A second area that we have worked hard to maintain and develop is our relationship with the Ministry of Health in NSW. Since my last message, there has been a change in leadership in the NSW government and a reshuffle of Cabinet means that we now have a new Minister of Health and Medical Research, Mr Brad Hazzard, and a new Minister of Mental Health, Women and Ageing, Ms Tanya Davies. We have also asked to meet with them in the coming weeks to maintain the NSW State Committee's strong relationships with our government. These ongoing relationships, developed through regular meetings, give us the opportunity to voice comments to key groups. We have been fortunate to have the ear of key decision makers in the State and it is even more important that we maintain this momentum so that we can represent the Fellows, Trainees and IMGs of NSW.

The relationships that have been developed with the Department of Health through regular meetings with the NSW Agency for Clinical Innovation, the Health Education and Training Institute and the Clinical Excellence Commission have given us the opportunity to voice our comments to key groups within NSW Health and I would like to thank these organisations for the support and encouragement that they have provided.

One thing that we have come to realise is that although we are all FRACS, there are skills and experiences that we don't necessarily gain outside of surgery, which would be useful given the opportunities that develop from being FRACS. This is why the banner for my time as Chair is *Enhancing the surgeon*. We intend to create opportunities for our NSW stakeholders to develop the skills that we haven't needed as surgeons such as how exactly do you run a meeting and how do I network to improve my business? These are questions that pop up surprisingly often.

As the Chair of the NSW Committee I feel that it is important that the Committee truly represents the Fellows, Trainees and IMGs in NSW. We want to hear from our membership on issues, with comments, and through voting for committee members or for awards nominations as well as turning up at events. As you can see there is a lot that you can be involved with in NSW along with your state committee and I would encourage you to get involved.

Medical Prostheses – costing an arm and a leg

Why do we pay so much more than almost anywhere for medical prostheses?

DESMOND SOARES
FRACS

Health care costs in Australia now make up 10 per cent of gross domestic product (GDP). They have been increasing at a rate of three per year. Of total healthcare costs 20 per cent are hospital costs

Prostheses make up a significant portion of these costs. In the private hospital system – in 2014 private insurance raised about $14 billion plus $4 billion in federal rebates. 10 per cent of this is spent on prosthesis costs - $1.7 billion in 2014.

The prices paid by insurance funds are regulated by the Federal government. All prostheses are first listed with the Therapeutic Goods Association (TGA) - this is a paper based audit. The TGA lacks any detailed clinical expertise and lists all new prostheses with an ARTG number. The manufacturer or agent then sponsors the prosthesis for listing on the prosthesis list (PL). A new prosthesis is sponsored by the manufacturer or their agent and offered for listing - it is assessed by the Prostheses List Advisory Committee (PLAC).

The PLAC refers the prosthesis to one of its subcommittees a Clinical Advisory Group (CAG). These groups are made up of expert clinicians in their field who specifically assess the prosthesis for suitability and efficacy. Does it do what it says? Is it a novel prosthesis or are there other equivalents on the list? Is it safe? The prosthesis is categorised according to group, subgroup and suffix. Once the CAG approves a prosthesis then the Department of Health agrees on the price. This is set by a band for prostheses that are similar – a novel prosthesis may get its own band.

The prices for each subgroup band are set under an archaic mechanism. All prices at 2005 when the PLAC was introduced were maintained. The industry that was represented on the PLAC advisory panel was able to insert a clause into the pricing, which stated that prices for the band could not be changed until and a prosthesis with a different price achieved at least 25 per cent market share. This has meant that substantially cheaper prostheses are still paid at the higher rate. By way of example one particular brand ofsurgical stapler used for gallbladder surgery is listed at $99. The list price for the two equivalent prostheses) is $412.

Hospitals purchase the devices for $412 and receive a full reimbursement from the health fund for $142. Hospitals then get a rebate for the difference between the list price and their negotiated price and use that to purchase other products from the company. For example two large prosthesis companies offer their own 'shop currencies' as rebates for discounts on hip and knee prostheses. These rebates are then used to purchase power tools - surgical drills and saws as well as disposables (sawblades, shields, lavage guns etc.). The winners in this are the device companies and the private hospital operators. The device companies get top dollar for their product and offer a small rebate. The private hospitals get rebates to purchase equipment and this goes straight to their profit margin. The losers are the heath funds and the Australian public who pay among the highest prices in the world.

Public hospitals used to function in the same way. About 10 years ago, state governments began implementing volume base purchasing deals.

From publicly available documents the difference between average prosthesis costs for private hospitals versus public hospitals was $650 million in 2014.

The Senate is holding an inquiry into "Price regulation associated with the Prosthesis List framework" and prosthesis costs in Australia. Submissions closed on 30 January 2017. Surgeons should take a keen interest and make their voice heard.

http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ProsthesesListFramework

12 October 2016
Dear Editor,

Thank you for your letter of 6 December 2016.

In the Snippets and Silhouettes section of the Surgical News there has been another most enlightening article by Mr. Felix Behan.

The article in the September 2016 edition titled "Winnie the Pooh and her links to the Somme" was again most interesting and excelled Mr. Behan's usually high standard of writing. The link to the battlefied of the Somme was most poignant.

Yours sincerely,
Philip Slattery FRACS *[Brief extract]*

The article Mr Slattery refers to can be found online on page 48: http://www.surgeons.org/flipbook3d/Digital/SNSeptember2016/index.html

Bullying...should we speak up?

SUSAN HALLIDAY

Twenty first century workplaces are awash with different experiences, diverse personalities, and alternative beliefs when it comes to *how* things should be managed. Add assorted views about what workplace participants are accountable for and divergent positions on the meaning of professionalism in relation to legally regulated practitioners and it is obvious why it is essential that standards of behaviour and organisational requirements are articulated.

On the ground individuals react to untoward, negative and awkward workplace interactions differently. While the reasons for this may form the basis of an interesting conversation, some of the reasons people share are clearly passé given workplace policies and the legislative obligations of employees, consultants, contractors and those who train others.

Having agreed to be a workplace participant, consultant or trainer comes with the responsibility to view all interactions through a professional lens, ever mindful of the individual obligation to act when there is a risk or potential risk to the physical or mental health and safety of others.

Most do not encourage, reward, incite or instruct bullying behaviour. But some people aid and foster it, albeit unwittingly. More regularly however people allow and permit bullying behaviour through their lack of action. To do nothing when you have experienced or witnessed conduct of concern presents as a level of acceptance. To fail to speak up or to intervene, be it directly or indirectly, can be viewed as condoning the poor standard of behaviour.

Professionally we all have a responsibility to be astute and proactive about workplace conduct. It is incumbent upon us to contemplate and make a personal assessment about how our behaviour and decisions can impact others, before we interact or act. Further failing to act when someone else resorts to bullying is a decision that we are accountable for. We have an obligation to adopt a pre-emptive approach to 'how' and 'why' we engage with others. Continuous assessment of the 'how' and 'why' forms part of the relationship we have with an employer and who we represent when training.

Yet many in a workplace don't speak up about bullying. While some present the related complexities, vulnerabilities and careers risks as viable excuses, the question remains given the negative impact and potential for harm - why do adults not call out behaviour of concern? Let's answer the question this way – *for the same reasons that children don't!* which is an alarming fact.

Children and adults can over estimate how comfortable people are and misread the cues the humiliated person adopts to lessen their embarrassment. "…. *and when it happened it looked like everyone was okay with what was said to him and how it was said, including the Trainee.*"

Children and adults alike tend to lean towards it not being their responsibility to intervene; there is someone closer or more senior or less vulnerable to do so, hence abdicating personal responsibility. "…. *an HR officer was within hearing distance on each time the supervisor yelled at him that morning.*"

People of all ages fail to recognise and categorise conduct in an informed way, either missing that what they are witnessing is bullying, or rationalising or excusing the poor behaviour. "…. *in reality we all experienced it in the past and survived; add to that, that she didn't do exactly what she was told to do.*"

Denial or feeling like it's not possible to speak up can silence children and adults. The inability to face the fact that someone we like and respect professionally could behave poorly places people in an uncomfortable position. Many rely on the hope that it won't happen again. "… *and when I made the decision to say nothing I took into account that she is well respected in the community and highly valued as a surgeon.*"

It can take courage to speak up. It involves a conscious decision to do the right thing, as opposed to deciding not to speak up. A decision to do nothing will always be the wrong decision. That said there are different ways to call out poor behaviour, be it as a recipient, a witness or bystander, or someone with knowledge of a systematic pattern of bullying behaviour.

A powerful tool we have to call out poor behaviour is our body language. Often taken for granted our visual messaging when utilsed in a deliberate and conscious way can speak volumes. It can result in immediate reflection and an apology from an offender. Yet unfortunately when a person is bullied people will freeze, look down or away and even step away. This must stop.

The way we react with our posture, gestures, facial expressions, direct and purposeful eye contact and head movements can put an offending party on notice or pull the power rug out from under them. A public put-down can be challenged by an observer's questioning glance and facial expression accompanied by an open hand gesture, palm facing up, with the elbow tucked in at the waist; it adds up and begs the non-verbal question … '*was that really called for?*' followed by the assessment that what happened was not okay.

A fearless shake of the head and a look indicating disappointment puts the ball back into the offending party's court removing attention from the negatively impacted person. A confident visual retort where eye contact is maintained and facial expressions that show disbelief and opposition should never be underestimated. Offending parties spontaneously absorb the non-verbal cues and will often act to remedy the discomfort and disdain in the room they have created. That said the non-verbal approach doesn't always work and it's not the answer to systemic bullying. But if there is no visual information the offending party has nothing to answer to, and those present have evidenced an acceptance of the poor conduct.

Body language that is passive and avoidance laden does nothing to call out poor behaviour; rather it *allows* and *permits* it. Aggressive body language on the other hand can escalate a tense and intimidating situation with the offending party reading the non-verbal intervention as posturing, a threat to their power base, criticism and a challenge to a confrontation if not a duel.

Body language that is assertive sends messages that prompt a sense of reasonableness while demonstrating self control and a willingness to stand up for what is fair and respectful. It extends an opportunity for people to reflect, and address conduct that crossed the line in a timely way.

Verbally there are many responses that can be utilised to call out poor behaviour. Timing can be important and privacy may be an advantage or a disadvantage – the circumstances need to be considered.

In a bullying situation a bystander witnesses or knows what's going on. Bystanders can be part of the problem or part of the solution depending on their reactions and comments. Some due to poor judgement, vulnerability or self-protection, appear to take the side of the offending party by laughing, offering visual or verbal encouragement or silent approval by doing nothing.

A bystander can call out poor behaviour by suggesting that the offending party revisit an encounter from the shoes of the person on the receiving end. A bystander can use a personal hook and suggest that the offending party replay the incident placing their son, daughter or partner in the firing line and ask what advice the offending party would provide their loved one for their written complaint. Or a simple honest comment that notes 'you're better than that' followed by 'deal with the issue, but step back from the personal attack.'

A supportive bystander acts to respect and protect the rights of others, using language that's supportive of the affected person. People respect those who stand up for others. By making it clear that you won't be involved, that you empathise with the victim and are obliged and willing to speak up about the poor behaviour, you are taking proactive steps that leave lasting messages.

Those who experience bullying often struggle with challenging the conduct and raising complaints. It can be a hard thing to do for those with limited power who fear reprisal or future detriment that may lurk in the shadows for many years until it is payback time. But if you are impacted it's important to seek help and to understand how your rights are denied or compromised.

You have the right to be free from mental, emotional and physical harm and the right to work and train in a fair safe environment. You have the right to relaxation and not to be impacted by cyber-bullying. You have the right to training that is professional where criticism is constructive and specific. You have the right to a voice, the right to express your views and to have any issues taken seriously, and the right to privacy.

With that knowledge in tow there are ways to deliver your messages if bullied. Be they delivered in person or writing always opt for carefully chosen professional language that doesn't lower you to the level of the offending party. Be clam, evenly paced, courteous and deliberate in your delivery.

Speak to the professional respect you have for the offending party and note your disappointment/humiliation/disbelief/embarrassment given the behaviour. Describe the psychological impact and how it left you feeling, for example worthless, stupid, devalued, unnerved or intimidated. State that you would prefer constructive criticism without the personal attack.

Talk to your understanding of workplace respect and dignity. Ask if the transfer of information could be encouraging rather than position you as the brunt of the jokes. Be honest, succinct, measured and genuine in your messaging about the conduct that causes you concern – do not make it personal. There is no place for return insults, bad language or sarcasm.

"I want to explain what it is like to experience some of the things you say to me, from my shoes."

"I'm aware I wasn't doing exactly what you wanted but your comments left me feeling dejected and embarrassed at the same time."

"When we need to have a difficult conversation like that would it be possible to do it without an audience? People felt uncomfortable and raised it with me."

There are times when facing a bully will not be possible or professionally viable. Seek help – to do nothing falls short of your own obligations to ensure that you care for your physical and mental health. Document what you are experiencing. Speak to people you trust, to Human Resources, the EAP provider, your GP, the College, or to inquiries officers in external agencies who are tasked with the provision of workplace bullying information.

NOTE

This article is not legal advice. If legal advice concerning workplace bullying is required, an employment law specialist should be consulted with reference to the specific circumstances.

SUSAN HALLIDAY
Australian Government's Defence Abuse Response Taskforce (DART) 2012-2016 and former Commissioner with the Australian Human Rights Commission.

ARTICLE OF INTEREST

Challenges in surgical training - past, present and future

Lessons from the urology program

ASSOC. PROFESSOR PREM RASHID
FRACS

In trying to improve a surgical training program, it sometimes requires those who could advise to stop and evaluate what they know and what they don't know. College Fellow A/Professor Prem Rashid had been on the New South Wales (Urology) Training, Accreditation & Education (TAE) sub-committee for many years, culminating his time as the Board of Urology Chair (2012-14). After completing that phase, he chose to review the program chronicling how the program had developed over the years, but more importantly, how current opinion leaders see the issues and solutions to challenges. This was evaluated in an ethics-approved qualitative interview-based study and documented in a Doctorate thesis. The summary findings are being published. In the text that follows, direct quotes appear in *italics*.

In earlier times, as was common in all branches of surgery, potential applicants for training became aware of the process by *word of mouth*. Formal training was relatively *unstructured* and *self-driven*. Assessments were often informal chats. Today, the program follows a *very structured and formalised process*. There is concern that the *pendulum has swung too far*. Trainees are commonly 'directed at each stage'. Some of that relates to how *green* junior Trainees are upon selection, having spent much less time in surgical jobs. The College JDocs framework is anticipated to offer an *adjunctive structure* for junior procedural doctors to help identify *readiness for the commencement* of training.

National selection has also resulted in *less certainty* and loss of '*connectedness*' with local applicants. Additionally, while the current selection processes are *fair and objective*, they have become *too bland* and a *true feel* of future workplace performance can be challenging for both junior Trainees and those supervising them. The clear majority of applicants were felt to be of *high calibre* but the main issue was their *lack surgical experience* and exposure to the *diversity of urology* before they started.

The increasing numbers of women coming into the program was universally seen as a positive bringing in a *different style of practice*. They have *enriched the profession* and brought about *better work/life balance*. Sadly, while flexible training was 'universally endorsed', the program is still 'poorly resourced' and this relates more to *workplace logistics* than a desire to offer it to Trainees.

Principles of *natural justice* were important but it had *made the process very complex*. It is not to say that procedural fairness is negotiable, that is not in question, but how surgical supervisors manage trainees has revealed a lack of skill. Surgeons are not skilled in human resource management protocols and in that regard, are an *amateur workforce trying to run a professional program*. There are *complex legal frameworks* that are *poorly understood* by some supervisors and in fairness, many have not been trained to deal with *difficult or under-performance issues*. This is a key area where *global improvement* is required. RACS has been at the forefront in trying to ensure that all supervising surgeons undertake upskilling courses but there remain practical *difficulty in ensuring that all supervisors have attended all courses*.

Teaching is important but the *lack of enthusiasm* and *apathy* seems to be multi-factorial. It *remains an unpaid extra duty* for many. The pro-bono model so important in surgical training, has become *less of a priority* for many surgeons. Cultivating good surgical teaching requires *training*, *support* and *recognition*. Some units manage this well by apportioning clinical, administrative and teaching duties.

Surgical supervision roles are commonly handed over to the most junior member of the unit. The *combination of an inexperienced, under-resourced supervisor and an underperforming Trainee, can have serious consequences*. Ultimately, supervisors can be inadvertently *failing in their duty* to manage training processes.

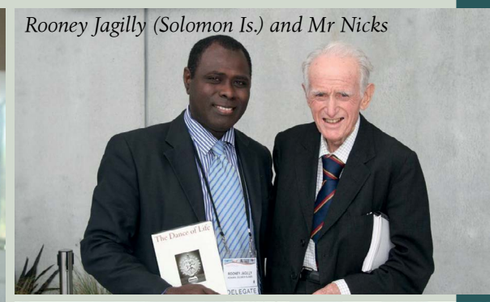
Finally, support for all office bearers needs focus. Surgical supervisors are the backbone of the program. They need recognition, support and skill development to ensure they can do what they need to do. Some roles are perceived as *not attractive* and *difficult to appoint*. This is a critical issue as there are real *financial and non-financial costs* when taking up leadership roles.

A process of *strategic change* and *structural reform* to help *separate (the Board) from day to day management* has already begun. Some of this will allow for the development of educational reform and *long term constructive strategies*. Much of this needs to focus on supervisor upskilling which needs to be relevant, progressive and helpful in the day to day management of Trainees. We have been through a critical *how things were* stage and now need to focus on how practical innovative measures can address the challenges ahead.

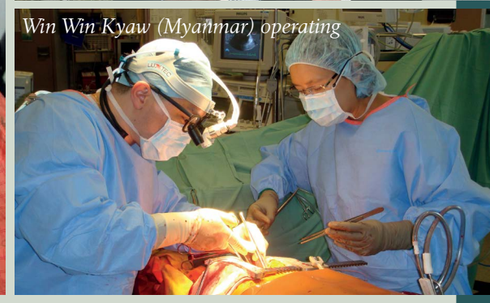
GLOBAL HEALTH

2018 Rowan Nicks **AWARDS**

Dr Vuthy Chhoeurn (Cambodia) with patient



Rooney Jagilly (Solomon Is.) and Mr Nicks



Win Win Kyaw (Myanmar) operating

- **2018 Rowan Nicks Pacific Islands Scholarship**
- **2018 Rowan Nicks International Scholarship**
- **2018 Rowan Nicks Australia and New Zealand Exchange Fellowship**

The Royal Australasian College of Surgeons invites suitable applicants for the 2018 Rowan Nicks Scholarships and Fellowships. These are the most prestigious of the College's International Awards and are directed at qualified surgeons who are destined to become leaders in their home countries.

Rowan Nicks International and Pacific Islands Scholarships
The Rowan Nicks International and Pacific Islands Scholarships provide opportunities for surgeons to develop their management, leadership, teaching, research and clinical skills through clinical attachments in selected hospitals in Australia, New Zealand and South-East Asia.
The goal of these Scholarships is to improve the health outcomes for disadvantaged communities in the region, by providing training opportunities to promising individuals who will contribute to the development of the long-term surgical capacity in their country.
Applications for the International Scholarship are open to citizens of Bangladesh, Bhutan, Cambodia, Indonesia, Laos, Mongolia, Myanmar, Nepal and Vietnam.

Applications for the Pacific Islands Scholarship are open to citizens of the Cook Islands, Fiji, Kiribati, Federated States of Micronesia, Marshall Islands, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu or Vanuatu.

Selection will primarily be based on merit, with applicants providing an essential service in remote areas, without opportunities for institutional support or educational facilities, being given earnest consideration.

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

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

Value

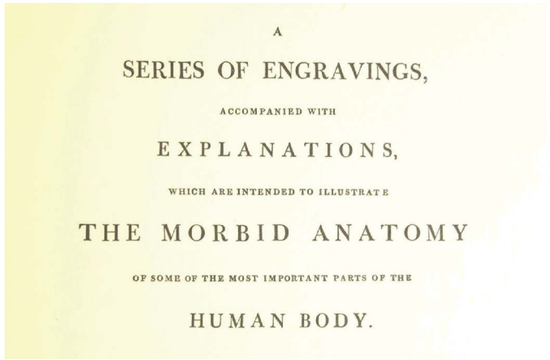
The value of the Scholarships and Fellowships is up to AU$50,000 for a 12 month attachment, depending on the funding situation of the candidate and provided sufficient funds are available, including support to attend the Annual Scientific Congress of the College, if the Scholar is in country at the time of the Congress.

Further Information

Application forms with the full criteria and submission instructions will be available from the RACS website from December 2016: www.surgeons.org
Closing date: Monday 5 June, 2017. Applicants will be notified of the outcome of their application by 31 October 2017.
Please contact:
Secretariat, International Scholarships Committee
Royal Australasian College of Surgeons
250 - 290 Spring Street, East Melbourne VIC 3002
Email: international.scholarships@surgeons.org
Phone: +61 3 9249 1211 Fax: +61 3 9276 7431

The Cowlishaw Symposium 2016

RICHARD LANDER
FRACS, Convenor Cowlishaw Symposium


A
SERIES OF ENGRAVINGS,
ACCOMPANIED WITH
EXPLANATIONS,
WHICH ARE INTENDED TO ILLUSTRATE
THE MORBID ANATOMY
OF SOME OF THE MOST IMPORTANT PARTS OF THE
HUMAN BODY.

The 11th biennial Cowlishaw Symposium was held at the RACS Melbourne Office in October 2016, a meeting that has become one of the principal events on the history of medicine calendar. RACS is fortunate to own the impressive collection of historical medical texts that was amassed by Leslie Cowlishaw from the early 20th Century until his death in 1943.

The Collection includes a number of volumes published in the 15th Century including an Avicenna *Canon* of 1497 from Padua and the 1483 Nuremberg *De proprietatibus rerum* of Bartholomæus Anglicus. In 1996, Wyn Beasley initiated the Symposium in order to promote the Cowlishaw Collection, both to Fellows of the College and to the wider community of medical professionals and bibliophiles.

Embedded in this Symposium is the eponymous lecture named in the memory of Kenneth Fitzpatrick Russell, who helped secure the collection for RACS and then set about cataloguing it. The 2016 Kenneth Fitzpatrick Russell Memorial Lecturer was given by **Mr Peter Burke**, on "Matthew Baillie's *Morbid Anatomy*, its sequel and the Melbourne 'Connexion'" (pictured above).

Matthew Baillie's *Morbid Anatomy*, published in 1793 when he was 32, offered a new approach to the understanding of disease by systematically describing the morbid appearance of each organ at autopsy and correlating these findings with a case history. It was perhaps the first example of the modern concept of pathology.

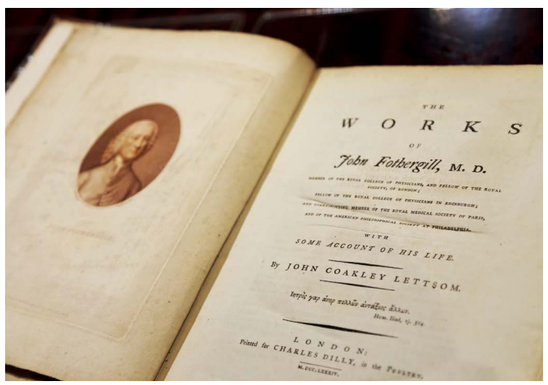
The 1793 book contained no illustrations; between 1799 and 1802, Baillie issued in ten fascicules, *A Series of Engravings accompanied with Explanations that are intended to illustrate the Morbid Anatomy of some of the most important Parts of the human Body.* Baillie wrote: "The order of the engravings will correspond very much with that of the description of diseased changes of structure in my book upon Morbid Anatomy; but the two works will be independent of each other....so that a person may possess the one work, without being obliged to purchase the other".

William Clift, then in his early twenties, provided the drawings from which the engravings were made. In 1953, William Clift's very own copy of *Morbid Anatomy* was discovered by Professor Ken Russell when he rescued it from the flooded basement of the old Medical Library at the University of Melbourne!

As in years gone past, the 2016 Cowlishaw Symposium featured many other interesting talks on a variety of subjects:

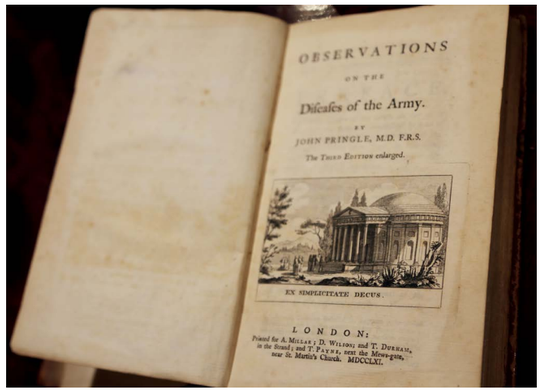
Mr Brian Brophy - 'FOTHERGILL'S DISEASE'

Fothergill (pictured, below) was a highly regarded physician in mid-18th Century London. In a paper presented to the Medical Society in London (1773) entitled *Of a Painful Affection of the Face*, he gave a clear description of what we now recognise as trigeminal neuralgia and the condition became known as Fothergill's Disease. He was impressed with the facial contortions that accompany an attack and gave us the term *tic douloureux*. He saw and treated it successfully in 1732. He was assisted by Georges Marechal, *premier chirurgien* to Louis XIV and Louis XV. This was at a time when the precise functions of the nerves ramifying through the face were unknown.


THE
WORKS
OF
John Fothergill, M. D.
WITH
SOME ACCOUNT OF HIS LIFE.
By JOHN COAKLEY LETTSOM.
LONDON:
Printed for CHARLES DILLY, in the Poultry.

Mr Campbell Miles - 'JOHN PRINGLE and THE FOUNDATION OF MODERN MILITARY MEDICINE'

John Pringle's monograph (Pictured below)extends to over 400 pages and is concerned with the diagnosis, management and, most importantly, the prevention of the diseases that afflict soldiers during encampment, and the proper management of military hospitals. While the management of war wounds and retrieval of the injured were important in their own right, the greatest loss of life was before and after battle due to diseases such as dysentery, hospital or jail fever and pneumonic infections.


OBSERVATIONS
ON THE
Diseases of the Army.
BY
JOHN PRINGLE, M.D. F.R.S.
The THIRD EDITION enlarged.
EX SIMPLICITATE DECUS.
LONDON:
Printed for A. MILLAR, J. D. WILSON and T. DURHAM, in the Strand; and T. PAYNE, near the Mews-gate, near St. Martin's Church. MDCCLXI.

Professor John Royle - 'MEDICAL ETHICS: CHANGES OVER 200 YEARS'

In 1792 Thomas Percival produced a code of medical ethics for doctors attending patients at the Manchester Infirmary. Over the next few years he added to this work and in 1803 published it as *Medical Ethics*. To the code of ethics for hospital patients he added a code for private and general practice, a code for collaboration with apothecaries and a section devoted to requirements of the law in specific circumstances.

This code became the underlying directive for hospitals in the United Kingdom and the United States of America. In the early 19th Century the American Medical Association produced a code of ethics, which it acknowledged was based on Dr Percival's book.

Mr Philip Sharp - 'A GLORIOUS REVOLUTION: DID BRITISH NAVAL MEDICINE INFLUENCE 'MODERN' MEDICINE?'

How did a small island, of no great population, and which had, for the most part, played an insignificant role in 17th Century Europe, transform itself, in the space of sixty years, into a great naval power with an immense empire? Following the Glorious Revolution in 1688, where William of Orange seized the crown from James II, the ideology of liberty was founded on a highly organised bureaucracy. Warfare and taxes reshaped the English economy.

For the civilian population the restructuring of the naval medical establishment and the scientific revolution meant: a new career structure for doctors, a framework for investigations into public hygiene and clinical problems, the changing role of the hospital, the movement of medicine in a "clinical" direction and the 'rise of the surgeons'.

Associate Professor Graham Stewart - 'SIR THOMAS BROWNE and THE HYDRIOTAPHIA URNE-BURIALL: OSLER, RELICS and BIBLIOGRAPHY'

The most famous literary work of the Norfolk physician Sir Thomas Browne is undoubtedly *Religio Medici* (1643). It can be argued that much of the enthusiasm for Browne's works, especially in the early 20th Century, most particularly amongst the medical profession stems from the expressed adulation of Sir William Osler (1849-1919) about this author. Osler was accepted as the North American "Father of Modern Medicine" and later became Regius Professor of Medicine at Oxford.

The volume *Hydriotaphia: Urne-buriall*, although less famous than *Religio*, in this context, is of great interest. This philosophical discussion on ancient funeral remains presaged an extraordinary series of events surrounding Thomas Browne's own skeletal remains, in the late 19th and early 20th Centuries. The Thomas Browne publications were used and noted by K.F. Russell in his creation of the Cowlishaw collection catalogue.

Professor Alan Thurston - 'THE ART OF THE ITINERANT BONE-SETTER'

Among the itinerant practitioners in 15th Century France, Joseph-François Malgaigne lists incisors for stone, herniotomists, couchers for cataracts, tooth pullers, drug vendors, dosers and bone setters. A bone-setter was an empirical practitioner who claimed the power of diagnosing and setting fractures, reducing dislocations and relieving painful and stiff joints. Bone-setters considered their craft to be a natural gift and both men and women could possess this gift. As a consequence, most had no education beyond an apprenticeship, as noted by Percival Pott in his book on the treatment of fractures. It was believed to be inherited so that whole families became known as bone-setters. One famous family was descended from the Welshman Evan Thomas, whose son, Hugh Owen Thomas, is well known to modern day orthopædic surgeons for Thomas's test for fixed flexion deformity of the hip and the Thomas splint.

Mr Richard Lander - 'THE QUEST FOR THE SOURCE AND TERMINATION OF THE NIGER'

Stephen Gwynn's book in the Cowlishaw Collection states that Scottish surgeon Mungo Park's instructions were very plain and concise. He was directed by The Association for Promoting Discoveries in the Interior of Africa, on his arrival in Africa, "to pass on to the river Niger, either by the way of Bambouk, or by such other route as should be found most convenient: That he should ascertain the course, and, if possible, the rise and termination of that river. That he should use his utmost exertions to visit the principal towns, or cities in its neighbourhood, particularly Tombuctoo and Houssa; and that he should be afterwards at liberty to return to Europe, either by way of the Gambia, or by such other route as, under all the then existing circumstances of his situation and prospects, should appear to him to be most advisable." Leaving a medical career behind him Mungo Park sailed from Portsmouth in May 1795 in pursuit of the quest to find the source and termination of the Niger River and solve the greatest mystery of the time.

Meet the Awardees

ASSOC. PROF. STEPHEN TOBIN Dean of Education
DR SALLY LANGLEY Chair, Professional Development

In November 2016, the Academy of Surgical Educators (ASE) presented the Educator of Merit and Educator of Commitment awards to our surgical educators. These awards acknowledge and recognise the dedication and excellence of our surgical educators. Some of the awardees will be featured over the next few editions of Surgical News. Here's the Part 2 snapshot.

Bruce Waxman
Educator of Commitment

Bruce has been a RACS Fellow since 1982, in the General Surgery specialty practicing in Melbourne, Australia.

What is your proudest moment as a surgical educator?
Having my Trainees obtain fellowship and share their joy at the Annual Scientific Congress (ASC) Convocation ceremony and cocktails following the ceremony. The objective of a surgical educator is to impart the skills, knowledge and experience that you have gained, onto the next generation of surgeons focusing on the nine core competences of RACS, enabling the Trainees to obtain the FRACS. Nurturing them through that process is fulfilling and the culmination is the convocation ceremony when all their hard work is recognised and to share that moment with them is indeed a proud occasion. Many years later they may come to you, often at an ASC or other conferences and reinforce their appreciation for what you may have taught them and how those principles may have helped them deal with a difficult case. Needless to say that positive feedback adds to the pride of what you felt on the day of their convocation.

Any advice for new surgical educators (facilitators/ instructors)?
Being a facilitator/instructor on an RACS course is stimulating and enjoyable as the candidates on the course are motivated to achieve. Your job is to convey to them your passion for the course curriculum and deliver it in a style that is both educative, in changing their behaviour but also with some degree of entertainment, to make the material more appetising. This will require a great deal of preparation and planning. So spend some time going through the course material beforehand and even add some extra slides or videos to add to the experience. Plan some of the questions you will be asking in such a way that will *involve* all the candidates. Make your presentation as interactive as possible and draw on their experiences and those of your faculty s to add a surgical context to the course material. Participate in and possibly even initiate courses in your own hospital for SET Trainees including a curriculum-based tutorial program and exam preparation courses with an emphasis on the clinical component of the examination. Encourage your Trainees to form study groups to feed off each other, again with the experiential theme. You will surprised how much you learn from your Trainees and from the preparation for the courses, but also how much they appreciate your efforts.

How has the Academy of Surgical Educators impacted you as a surgical educator?
As I had established my credentials as an educator before the Academy was formed, the Academy may not have had a huge impact on me in my development as an educator. However I do believe it is has an important influence for the new surgical educators who benefit from the governance the Academy provides in channelling their passion for education; particularly in offering graduate programs, at the certificate, diploma and masters levels. I have benefitted from the Academy's programs when I undertook research in simulation through the National Health Education Training in Simulation (NHET-Sim) courses and was able to present my research in progress and final results and conclusions at consecutive Victorian Showcases in Education Research into Health Professionals facilitated by the Academy. I have also been impressed with the quality of the annual Academy Forums and the Academy's Educator Studio sessions and webinars and indeed was a moderator for two sessions.

How do you feel receiving the ASE Educator of Commitment award?
It is an honour to receive an such award from the Academy, in recognition of my contributions to surgical education. It is important that recognition in some form or other is given to surgeons who make a significant pro-bono contribution to the education of Trainees and fellow surgeons.

Many surgeons appreciate being rewarded for their efforts and are proud to display their framed certificates often in their consulting rooms, so their patients can appreciate the extra work they do over and above their clinical work, to educate the next generation of surgeons. Many patients are not aware of the role their surgeons take in this process, or even the role that RACS plays in this process.

Tushar Halder
Educator of Commitment

Tushar has been a RACS Fellow since 2005, in the General Surgery specialty practicing in Sydney, New South Wales.

What inspired you to pursue surgical education?
My inspiration to pursue surgical education came from my experience of my surgical training as surgical registrar. I spend most of my surgical training in peripheral smaller hospitals. I did only two terms in a tertiary hospital with a formal teaching arrangement. Allocation in a smaller hospital felt like I was doing a service job. Most of the hospitals didn't have any dedicated surgical teaching or tutorials.

I did introduce a weekly surgical tutorial for surgical registrars and interns at Canterbury hospital in 2006 soon after my appointment as VMO. This tutorial has been running regularly for the past 10 years. I made a list of topics covering Surgical Anatomy including Radio Anatomy, Surgical Pathology, Clinical Short case, Operative method. Close to the end of term, I ran a short spot diagnosis question session on the basis of my surgical photograph. Seeing my interest in teaching, the Head of the Department of Surgery offered me the role of Surgical Supervisor of Canterbury hospital.

In your opinion, what does the future of RACS Surgical Education look like?
The future of Surgical Training under RACS is bright as long as all the surgeons get involved with some teaching activities. The College may come under challenges from Universities if we don't get this right.

What advice do you have for health professionals who are passionate about surgical education?
I think everyone should get involved with teaching if they can spare some time from their busy schedule. The educators should be trained to do this well.

How do you feel receiving the ASE Educator of Commitment award?
The ASE Educator of Commitment award was a very satisfying experience for me. I did my commitment for teaching activities at Canterbury hospital during my job interview for a VMO position. I started the Wednesday Surgical Tutorials in 2005 and became Supervisor of Surgical training in 2006. I did these teaching activities without any expectation of reward. By receiving this award I feel that I have been honoured and that my small contribution in teaching has been well recognised by ASE.

Images (From far-left): Bruce Waxman receiving the Educator of Merit award from Dr Sally Langley, Chair ASE; The Surgical tutorial room of Canterbury Hospital: (From left to right) Dr Tushar Halder, Dr Apresh Singla and Dr Faisal Farooque.

On the surgical approaches to bad behaviour

DR RUTH MITCHELL
(Chair) RACSTA

What does it mean to change culture? What does it mean to improve training for medical students and doctors in training? The medical profession has been going through an earnest time in the past two years. In March 2015, Dr Gabrielle McMullin made comments that brought to light the spectre of sexual harassment in the surgical workforce. This broadened a conversation about the wellbeing of doctors in training and medical students, which had begun with the release of a world-first report on the mental health of doctors and medical students by *beyondblue*. And it profoundly changed the way in which surgeons managed bad behaviour. The Royal Australasian College of Surgeons (RACS) established an Expert Advisory Group which led to a detailed report on the problem, and finally, an action plan.

Change requires commitment at personal and system-wide levels. In a culture of mutual respect, everyone has responsibilities. This doesn't minimise the importance of dismantling oppressive systems, but it is a prerequisite for participation in a workforce with high stress, high stakes, and with the lives of patients and the wellbeing of our colleagues on the line.

Every day, when I walk into a room, I must ask myself: does it become safer? This is relevant for the operating theatre, the resuscitation room, the clinic waiting room and the residents' quarters. In every encounter, do I bring peace?

If we want to make a change that is lasting and robust, we have to make sure everyone knows the rules. I frequently hear from Trainees about the bad behaviour of their seniors, and in their voices, a certain incredulity – "I can't believe he doesn't know this isn't okay".

How do we ensure that everyone knows what professional behaviour looks like? It isn't obvious, or we wouldn't have such dramatic rates of bullying, discrimination and sexual harassment. Unprofessional and illegal behaviour are far too common.

It is my privilege to represent the Trainees of the RACS, and I recently completed the new RACS eLearning module developed as part of the *Building Respect, Improving Patient Safety* action plan. Crucially, this module will be a CPD requirement for all surgeons. It will also be a requirement for current Trainees, and those applying to surgical training in 2017 will have to complete it before applying.

For Trainees, this is a major breakthrough, as mandatory training on bullying, discrimination and sexual harassment is something we have called for. Trainees were involved in developing the module, and in doing so strengthened its content and approach. Online learning has limitations and in response to this, a more comprehensive face-to-face course is in the pipeline.

One of the challenges that arises when we mandate training for established clinicians is resistance. It's common that someone who has been in practice for 20 or 30 years doesn't really see what the problem is, and doesn't want to modify their own approaches to their colleagues.

This is why the ongoing advocacy role of RACSTA (the Trainees' Association of RACS) is so important. RACSTA surveys members every six months, and will soon be able to share a five-year analysis of trends in the surgical training experience. The advocacy roles of both the Australian Medical Students' Association and the Australian Medical Association's Council of Doctors in Training have been of paramount importance in changing perceptions and driving change.

One of the emerging challenges in surgical training is that, as consultants are told they must not engage in belittling or discriminatory behaviour, they lose confidence as educators. How does one give feedback when one is frightened of being accused of bullying? Trainees are reporting a concern that the antibullying messages are eclipsing feedback.

Here, too, formal training is required. How to give and receive feedback is a competency that is learned, and it needs to be taught.

Ideally, feedback should be given frequently, not only when a Trainee is underperforming or when their career is circling the drain. Feedback needs to be timely and engage the learner. While a growing number of surgeons are undertaking higher degrees in surgical education, most surgical supervisors have no formal teacher-training.

And this is why the Foundation Course for Surgical Educators is so important. It has been developed by the RACS, and is mandatory for anyone training a surgeon.

As a Trainee, I feel it's important to actively seek out and receive feedback in good faith. It's part of being a professional. As a registrar, I'm responsible for the teaching and training of medical students and residents on my team. Giving them structured regular feedback in a respectful manner is also my professional responsibility. The good news is that like operating, it gets easier and better with practice, and like operating, it's a genuine privilege.

My hope for my profession is that one day it will be as diverse as the community we serve. But we won't get there unless we commit to a rigorous self-assessment of our own professionalism.

It starts with the words that come out of our mouths. If anyone in the room could be offended by something, don't say it. But it goes further than that: if anyone who could be in the room, but isn't yet, could be offended, don't say it.

That way, when you have a Trainee who is a Muslim woman who wears a hijab, or a medical student who is transgender, they will not meet this wall of awkwardness on their way into the operating theatre, because, all of a sudden, somebody realises they have to change their behaviour. Our conduct should be good enough for the whole community already, so that the medical students and junior doctors entrusted to our care will feel our welcome, and our patients will benefit from the richness that they bring.

This article was originally published in MJA InSight on the 30th of January 2017.

The Power of Mass Collaboration

DR TOM ARTHUR
Founding member of the Queensland Surgical Trainee (QUEST) Collaboration

The disruptive power of mass collaboration has become increasingly apparent over the last two decades.

The encyclopaedic website Wikipedia is a clear example of this. Beginning as a small project by two internet developers in 2001, Wikipedia was initially designed as an adjunct to a different online encyclopaedia, Nupedia, which featured content that was written by experts and underwent a peer reviewed process. The issue with Nupedia was that the processes behind the website were excessively slow at creating content, leading to the production of only two articles in six months. Wikipedia was created to speed up this process, allowing content to be written and edited by the general community.

The website exceeded expectations - after only one year online, Wikipedia contained 18,000 articles in eighteen languages. Wikipedia now has over forty-three million articles written in 250 languages, with thirty million registered contributors. It is the sixth most visited site on the internet with a monthly readership of 495 million people, tallying an overwhelming eighteen billion page views a month. Mass collaboration transformed the Encyclopaedia Britannica into the twenty-first century.

Mass collaboration has already made a significant impact in medicine, notably with the Human Genome Project, which successfully sequenced the human genome in 2003 . Foldit, an online game created by researchers at the University of Washington, is an innovative example of the power of mass collaboration. Thousands of players from around the world use Foldit to compete to predict the structure of proteins. The program gained notoriety in 2011 when players solved the structure of the Simian retrovirus in ten days, a feat which had eluded scientists for 15 years.

Mass collaboration has the potential to transform surgical research. Trainee-led research collaboratives (TRCs) consist of a network of Trainees working together on a single project across multiple centres. These groups were started by a team of registrars in the West Midland area of the United Kingdom in 2007. The impetus for their formation was stimulated by a discussion between the registrars about the issues they were having with getting involved in research, as well as the quality of the research in which they were involved.

Two of the key problems that they identified, and they're problems that permeate throughout the profession when it comes to Trainees performing research, is that it's hard to find research opportunities, and when research opportunities do come about they're often dealing with small numbers of patients. This results in research that's of limited benefit to their patients, themselves, or their discipline. The solution that the registrars identified was simple, and that was to pool their resources and work together on the same project across multiple sites. In effect, the solution was to crowdsource the human capital required to produce clinically relevant research with translatable findings.

Several TRCs have made significant contributions to the scientific literature. Large-scale multicentre audits of appendicectomy and cholecystectomy outcomes across the United Kingdom have yielded publications in high profile journals, including the British Journal of Surgery and the Annals of Surgery. TRCs have been (and continue to be) involved in running a number of randomised controlled trials, with hundreds of thousands of pounds in funding grants from government and non-governmental organisations, including private industry. The collaborative effort of hundreds of doctors-in-training working in concert is producing higher powered research than could be achieved by acting alone.

Quality in research is predicated on the incentives that drive individuals to pursue research in the first place. Mandatory research requirements (including emphasis on research as a discriminatory factor for application to surgical training programmes) could be seen as a disincentive to the production of quality research by Trainees. Recognition of a research project usually requires a trainee to be one of the primary authors. A significant amount of time and effort is expended by Trainees in the production of publications and presentations with the primary purpose of getting onto a training program, or satisfying training program requirements. Mandatory participation in research has a number of positives for Trainees, including improving their own skills in critical appraisal and knowledge of the scientific method. However, the pressure to publish or present is undoubtedly leading some to produce research that does little to advance the practice of medicine.

TRCs provide a valuable alternative opportunity for Trainees to be involved in research and make a significant contribution to the scientific literature. Involvement in large scale, multi-centre projects should be recognised as a positive contribution by Trainees in the selection policies and training regulations of surgical programs. The Board in General Surgery is considering such a change and hopefully more training boards will follow their lead.

Medical College Trainee death investigated by NSW Coroner – the findings

MICHAEL GORTON AM
Principal, Russell Kennedy Lawyers

An issue in a recent New South Wales coronial investigation was whether the stresses and pressures of a College training program contributed to the death of a Trainee. The Coroner concluded that other factors were responsible for the death. The Coroner concluded there was no evidence to suggest that participation in the College training program, or any aspect of it, directly contributed to the death.

Summary

In findings published 24 November 2016, the New South Wales Coroners Court investigated the circumstances of the 2013 death of Royal Australian and New Zealand College of Obstetricians and Gynaecologists Trainee Dr Beata Vandeville. The report concluded that Dr Vandeville's death was the result of an accidental overdose.

Deputy State Coroner Derek Lee also made some comments regarding the regulation of access to restricted drugs in hospitals, particularly access to the anaesthetic drug propofol.

Introduction

When a person's death is reported to a coroner, the coroner has an obligation to make findings in order to answer questions about the identity of the person, the location and time of death, and the cause and circumstances of the death.[1]

The Coroner noted that the main issues at hand in the investigation were the cause of death, how restricted substances came to be found in Dr Vandeville's home, how said substances were found in her system post-mortem, the events surrounding the discovery of her death on 18 January 2013 and the nature and circumstances of her enrolment at the Royal Australian and New Zealand College of Obstetricians and Gynaecologists ("the College") Training Program (and whether it in any way contributed to her death).[2]

The Coroner remarked that Dr Vandeville had been described as a "gifted and skilled" surgeon, a "dream" of hers which she would sadly never realise.[3]

Cause and circumstances of the death of Dr Vandeville

In the days preceding her death, evidence showed that Dr Vandeville was bedridden with a temperature and low blood pressure. Dr Kapir had suggested that she go to hospital but she refused.[4] Subsequently, she was "home hospitalised" by Dr Kapir using antibiotics and pain relief medication.[5] Dr Kapir found Dr Vandeville unresponsive on 18 January 2013 in her Sydney home.[6] He performed CPR on Dr Vandeville, calling emergency services some two hours later.[7]

The Coroner concluded that: Dr Vandeville self-administered substances which led to an accidental overdose and her subsequent death.[8] Among others, the drugs found in her system post-mortem included propofol, midazolam, fentanyl and alfentanil (all of which are used in anaesthetic procedures).[9] However, there was insufficient evidence to demonstrate that she had intended to end her life, despite some threats of self-harm and suicide in the past and ongoing troubles with her mental well-being at the time.[10]

Additionally, the Coroner found that whilst Dr Vandeville had made attempts to obtain restricted substances during various hospital-based training placements, the drugs involved in her death were supplied by her fiancé, despite his denying that this was the case.[11] The Coroner concluded that Dr Kapir, as an anaesthetist, would have had been able to access the drugs, albeit with some difficulty[12]. It would have been highly unlikely for Dr Vandeville to have done so.[13]

Dr Vandeville's medical training

Dr Vandeville was in the process of undergoing specialty training at the College at the time of her death.[14] After four years in the program, Dr Vandeville failed multiple attempts at an exam over the 2010 to 2012 period.[15] Evidence demonstrated that she was often unwell and stressed during this period, and had been critical of how her assessments had been conducted.[16]

Dr Vandeville had expressed several concerns and dissatisfaction with aspects of the training program, and with the overall examination process. The College granted several requests for extension of time and gave additional feedback sessions to address her concerns. She was allowed five attempts to sit the oral examinations, where the College would typically only allow four attempts.

The Coroner also considered Dr Vanderville's practical training in the work place and rejected suggestions that this had contributed to her death.

However, the Coroner found that no aspect of Dr Vandeville's participation in the training program of the College directly contributed to her death.[17] He concluded that the College exceeded the obligations it owed to Dr Vandeville following her failed assessments (such as granting more feedback sessions and more opportunities to sit the examination than were provided for by RACS policy).[18]

Recommendations regarding access to restricted drugs in hospitals

Mr Lee made some remarks regarding the unauthorised diversion of drugs and restricted substances from hospitals.[19] Coroners may make recommendations in relation to any matter regarding the person's death, and issues of public health and safety often form the subject of these recommendations.

Mr Lee noted that the unauthorised diversion of drugs and restricted substances from hospitals was not a novel issue, and that the diversion of propofol and its misuse has become a general problem in recent years, particularly in the medical community.[20]

Mr Lee referred to the current recommendations set in place by the Department of Health ("the Department") and the Australian and New Zealand College of Anaesthetists ("ANZCA") as adequately balancing patient safety with the need for safe and secure storage of drugs of anaesthesia.[21] He referred to submissions that the drugs had to be readily accessible in order to prevent delay in administration to patients under anaesthesia in order to avoid potentially catastrophic implications, as well as the need for drugs to be stored securely so as to prevent unauthorised procurement.[22] The coroner did not however make formal recommendations regarding this.[23]

Implications for Medical Colleges

This case raises a number of issues for consideration by Colleges:

- Monitoring the stress and pressures for trainees in being part of the training program and facing significant examination pressures. Most Colleges will have a health and wellbeing policy with appropriate clinical support where trainees are in need of assistance.
- Access to drugs, particularly drugs of dependence, is a critical issue for some medical Colleges. Special policies and monitoring approaches should form part of these policies. Reference to the policies of the Medical Board of Australia and MCNZ may assist.
- Warning signs of poor wellbeing for trainees should include multiple failed attempts at examinations, consistent poor performance in training, multiple complaints or expressions of concern which may hide undue stress, irrational behaviour or responses.
- This is not first time where the death of or injury to a trainee has been raised in the context of overwork and unsafe work hours. The "safe work hours" campaign has addressed some of these issues, although it is not always confirmed in practice in all hospitals. It is a wellbeing issue for Colleges to ensure that the safe hours program is in place for its Trainees.

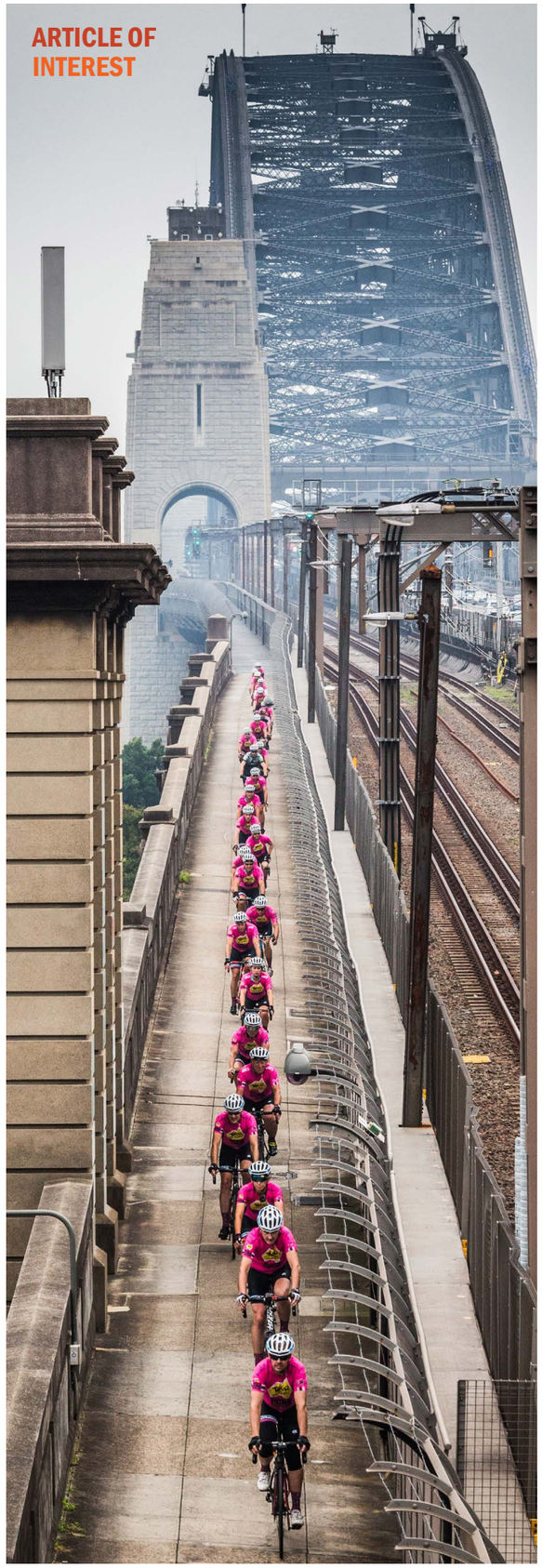
For more information regarding the report, a copy is available here:
http://www.coroners.justice.nsw.gov.au/Documents/VANDEVILLE%20Beata%20-%20Findings.pdf

A copy of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists media statement is available here:
https://www.ranzcog.edu.au/news/Coronial-findings-of-trainee-point-to-accidental-d

- with Isla Tobin, Law Clerk

1 Coroner's Court (NSW) Inquest into the death of Dr Beata Vandeville (24 November 2013).
2 Above n 1, at para 4.
3 Above n 1, at para 1.
4 Above n 1, at para 15.
5 Above n 1, at paras 15, 85.
6 Above n 1, at para 27.
7 Above n 1, at para 83.
8 Above n 1, at para 56.
9 Above n 1, at paras 34 – 43.
10 Above n 1, at paras 123 – 142.
11 Above n 1, at paras 71 – 80, 83.
12 Above n 1, at paras 67 – 70, 88.
13 Above n 1, at paras 66, 80.
14 Above n 1, at paras 89 – 131.
15 Above n 1, at paras 98 – 118.
16 Ibid.
17 Above n 1, at para 131.
18 Above n 1, at paras 89 – 131.
19 Above n 1, at paras 143 – 149.
20 Above n 1, at paras 144 and 145.
21 Above n 1, at para 147.
22 Above n 1, at para 146.
23 Above n 1, at paras 147 and 148.

ARTICLE OF INTEREST



The Research Cycle

Riding a bicycle for up to 230km a day for ten consecutive days may not appeal to everyone, but for a select few, it provides the perfect combination of scenery, comradery, challenge and charity

ANDREW GOGOS
RACS Trainee

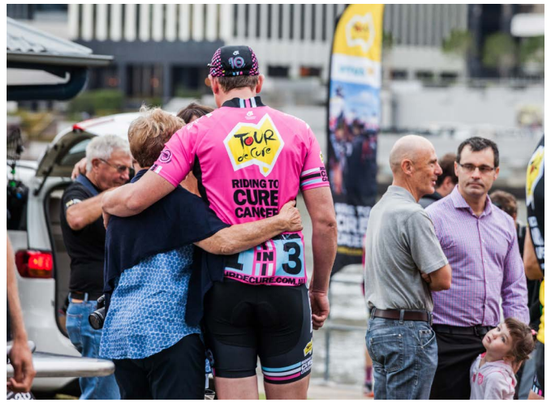
Tour de Cure was founded in 2007 by three friends who wanted to leverage their passion and enthusiasm for cycling to raise money for cancer research. In the charity's first year, they assembled a group of 29 cyclists and rode 1,175km along the coast from Brisbane to Sydney. Collectively, they raised $308,677 and provided a solid foundation for the charity's future.

Subsequently, Tour de Cures breadth and scope has grown dramatically. They now run multiple events around Australia, have raised over $25 million and funded more than 250 cancer research, support and prevention projects. Their funding has contributed to over 18 high impact publications.

2016 marked the 10th anniversary of Tour de Cure's Signature Tour. To celebrate, the team rode from Brisbane to Sydney, taking in the spectacular coast and hinterland. I was fortunate enough to take part. The route was less direct than in 2007, heading inland from Grafton to climb the Gibraltar Range. In 10 days, we rode over 1500km with 16,000m of climbing before arriving at Darling Harbour.

The riders were as varied as the scenery. The peloton of 150 cyclists included a veteran Tour de France competitor (Jens Voight), an Olympic rower and member of the "Oarsome Foursome" (Drew Ginn), the CEO of one of Australia's largest companies, television personalities, bankers, lawyers, business owners, army officers, tradies, retail workers and a raft of others. Each had raised at least $12,000 or had otherwise justified their inclusion. Riders were assisted by a dedicated support crew of 50, who worked at least as hard as the riders, but on a lot less sleep.

Each participant had a personal or family cancer story of suffering, courage and resilience. The ride was incredibly difficult, and (at least for me) would not have been possible without the camaraderie and shared passion of the riders and support crew. In 10 days, we raised $2.8 million, an incredible result for an organisation with such humble beginnings.



Images (Clockwise from far left): Riding over the Sydney Harbour Bridge; Greeting the riders; Dr Gogos suffering halfway up the 16km, 1,059m Gibraltar Range climb.

Quality research costs money. In 2015, success rates for National Health and Medical Research Council funding fell to a record low of 13.7 per cent. Philanthropic organisations such like Tour de Cure and our own Foundation for Surgery are increasingly carrying the deficit in research funding.

To responsibly disperse funds to projects and individuals of the highest merit, Tour de Cure has partnered with other key cancer and research organisations. One such partnership with RACS resulted in the *Foundation for Surgery Tour de Cure Cancer Research Scholarship*. Now in its fourth year, this award has allowed Surgical Trainees, Fellows and International Medical Graduates to commit the time necessary to contribute substantively to cancer research.

In 2014, I was awarded the *Foundation for Surgery Tour de Cure Cancer Research Scholarship* towards my PhD research. We completed a basic science project demonstrating that YAP, a stem-cell factor and putative oncogene, is integral to glioma migration and proliferation and is a viable therapeutic target. The award afforded me the financial freedom, performing full-time cancer research, and confirmed trajectory towards becoming a surgeon-scientist.

On March 24 the 11th Annual Signature Tour will depart from Mt Hotham. Riders will take in the Victoria high country, South Gippsland and Mornington Peninsula before crossing the Tasman and riding to Hobart via the rugged east coast. I wish I was one of them.

For more information about research scholarships and the Foundation for Surgery see www.surgeons.org. For more information about Tour de Cure see www.tourdecure.com.au.

Foundation for Surgery
Passion. Skill. Legacy.

Tour de Cure
RIDING TO CURE CANCER

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

New Zealand New Year & Australia Day Honours 2017

New Zealand New Year Honours

Member of the New Zealand Order of Merit (MNZM)

Mr Stuart Whitaker Brown MNZM

Australia Day Honours

Officer (AO) in the General Division of the Order of Australia

Prof William Peter Gibson AO
Mr William David Proudman AO

Member (AM) in the General Division

Mr Noel Alpins AM
A/Prof Stephen Robert Bradshaw AM
A/Prof Patrick Charles Cregan AM
Dr Iain Stirling Dunlop AM
Dr John Michael Quinn AM

Medal (OAM) of the Order of Australia in the General Division

Mr Leslie Clifton Thompson OAM

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:

Patrick Cregan AM (NSW)
James Downie (VIC)
Graeme Griffith (VIC)

2016

Robert Leggatt (VIC)
Frank Sullivan OAM (QLD)
John Bruce Wells (NZ/VIC)

2015

Sarah Kruger (NZ)

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

Informing the College

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

ACT: college.act@surgeons.org
NSW: college.nsw@surgeons.org
NZ: college.nz@surgeons.org
QLD: college.qld@surgeons.org
SA: college.sa@surgeons.org
TAS: college.tas@surgeons.org
VIC: college.vic@surgeons.org
WA: college.wa@surgeons.org
NT: college.nt@surgeons.org

In Memoriam

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

Patrick Charles Cregan AM
FRACS
General Surgeon and Surgical Leader

19 November 1951 – 23 January 2017

Patrick Charles Cregan was born in Sydney on 19 November 1951. He had three younger sisters; Catherine, Jennifer and Anne. After completing his secondary education at St Ignatius' College Riverview in 1969, he entered Medical School at The University of Sydney. He did his clinical years at the Royal North Shore Hospital graduating in 1975. He completed his residency training at Royal North Shore Hospital and moved to Concord Hospital in 1978 for his surgical training. He completed his training and was awarded his FRACS in General Surgery in 1982.

In 1983 he moved to what was then known as Nepean District Hospital as a Visiting Consultant General Surgeon. He continued his busy clinical practice at Nepean Hospital until his premature retirement from clinical practice in late 2014. He was an outstanding clinician with excellent clinical judgement and was an exceptionally good technical surgeon. Initially, he performed a broad range of general surgical procedures. Pat was a pioneer and pursued all new techniques with great enthusiasm and skill. On October 20, 1990 he performed the first laparoscopic cholecystectomy in the Nepean region. Following this there were many other new innovations pioneered by him.

Sarah Jane Kruger,
FRACS
General Surgeon

15 June 1972 - 1 May 2015

Fittingly, it was under the canopy of the huge pohutukawa trees in the Parnell Rose Gardens overlooking the Waitemata Harbour in Auckland that Sarah Kruger's family, friends and colleagues gathered for her memorial service in April 2016. Sarah's funeral was in England in 2015 and the memorial took place when Sarah's husband, Simon, and son, Charlie, were in New Zealand. Sarah had loved taking Charlie to climb on the undulating branches of the pohutukawa trees. This iconic New Zealand tree symbolises Sarah's life. Pohutukawa trees typically grow on the sea shore (Sarah loved the coast), and, defying the odds, hang stubbornly to life on rugged cliffs. They do so with grace and still manage to flower in brilliant red exuberance, while providing shelter.

Sarah, the second child of Linda Roberts and Paul White (Radiologist), was born in Auckland. She had an older sister Tracey and younger brother Christopher. Sarah attended Epsom Normal Primary School and Epsom Girls Grammar School in Auckland, where she was an enthusiastic hockey player and loved amateur dramatics. She then moved to Dunedin and attending the Otago University to complete a BHB. Sarah gained entry to the Auckland Medical School where she graduated MB ChB in 1997. She spent three years as a house-surgeon at Tauranga Hospital where her interest in surgery was first kindled. After passing the Part 1 examination in 2001, Sarah spent a year working in London as a general surgery registrar before returning to New Zealand to begin advanced training in general surgery.

Frank Sullivan OAM
FRACS FRANZCO
Ophthalmologist

14 February 1931 - 20 March 2016

Francis Patrick Sullivan was endowed with more than his fair share of natural abilities. He was educated at St Joseph's College, Gregory Terrace, where in his senior year, he was School Captain, Swimming Captain, First XI captain, First XV 15 captain, a feat not repeated since.

He graduated from the University of Queensland Medical School in 1954. He undertook his residency at the Royal Brisbane Hospital and was an eye registrar at both the Royal Brisbane and Princess Alexandra hospitals, in Brisbane. It was about the time that he met and married his wife, Colleen. As was common at the time, he undertook postgraduate ophthalmology training at Moorfields Eye Hospital, London, working his way in both directions as a ship's surgeon.

John Raeburn Talbot
FRCS FRACS
Orthopaedic Surgeon

28 July 1940 - 25 October 2015

John Talbot was born to Graeme Talbot, a New Zealander who following postgraduate training had secured a consultant position as an Ophthalmic Surgeon in London, and Joan Betts, the daughter of a London journalist and newspaper editor. John had an identical twin brother, Richard, and a younger sister, Elizabeth. At the end of the War, and following his de-mobilisation from the RAMC, Graeme decided to return to New Zealand with the family, settling in Auckland. There John attended King's Preparatory School and King's College where he was a very capable student. With a fine treble voice, he shared a Choral Scholarship to Kings College with Richard. He was a soloist in the chapel choir and took principal parts in the annual operas.

Following two years at Auckland University John gained entry to the Otago Medical School in 1960, residing at Selwyn College. On completion of his MB ChB he returned to Auckland as a house surgeon. In 1968 John moved back to Dunedin for a year as a physiology demonstrator, preparing for the surgery Primary examination. Returning to Auckland in 1969 as a surgical registrar, John had several unsuccessful attempts at the RACS Primary examination. Seriously considering general practice as an alternative, John moved to London where he quickly completed the Primary FRCS examination and secured a position as a surgical registrar in the London Hospital. From there he obtained a post in the Barts rotation, working there 1971-77 initially as registrar and subsequently Senior Registrar, and obtaining his FRCS (Eng) in 1972. While working at the London Hospital John met Georgina Creffield, a physiotherapist and they married. They had two children, Matthew (1974) and Rachel (1976), and separated in 1982.

John Bruce Russell Wells,
FRCS FRCS(Ed) FRACS
General Surgeon

28 April 1922 - 21 August 2016

John Bruce Russell Wells (known as Bruce, throughout his life) was born in Ashburton to John Russell Wells, a doctor, and Phoebe Maslin. He had a younger sister, Jeanette, and brother, Guyon. Commencing at Ashburton Borough School in 1927, he subsequently boarded at Waihi School in Winchester 1933-35. Secondary schooling was at Christ College 1936 - 1940, where he was a boarder in Jacob's House. Bruce was a capable scholar receiving a science academic prize and being made a prefect in his final year. He excelled in music, especially as a pianist. (He once played with Maurice Till!) While a career in music or farming appealed he eventually chose medicine - feeling just a little coerced by his father and several uncles in medical practice.

Bruce commenced at the University of Otago in 1941, residing at Selwyn College. He gained entry to the Otago Medical School in 1942 completing his final year at Christchurch Hospital in 1947. Bruce remained in Christchurch as a house surgeon and there he met his future wife, Katherine Wickham (known as Kath), a nurse at Christchurch Hospital. On gaining his MB ChB registration he had a three-month stint as Medical Officer on the Chatham Islands with his dear friend Lindo Ferguson. He next secured a position as Clinical Assistant at the Royal Melbourne Hospital 1949-50, working also as private assistant to Sir Hugh Devine. Moving to the UK in 1951, Bruce worked as a surgical registrar at Borough General Hospital, Ipswich 1951 - 1952, and at Stourbridge, Birmingham and the Canadian Red Cross Hospital, Taplow, Windsor in 1953. In 1953 he obtained his FRCS - Edinburgh and England.

RACS ARCHIVES

RACS Archive: Frank Hurley – Wounded on Menin Rd, 1917

Frank Hurley
- a pictorial history of the Third Battle of Ypres, 1917

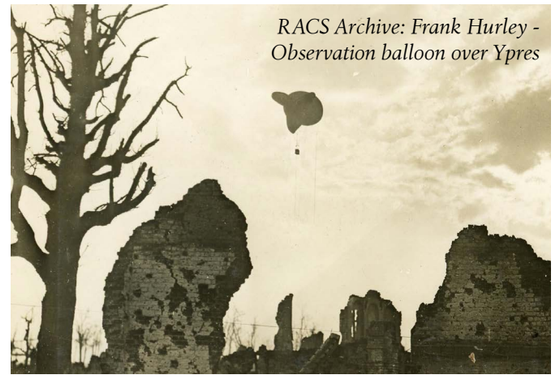
Frank Hurley: Ruined Cloth Hall at Ypres

RACS Archive: Frank Hurley - Australian 4th Division pass through Chateau Wood near Hooge

ELIZABETH MILFORD
RACS Archivist

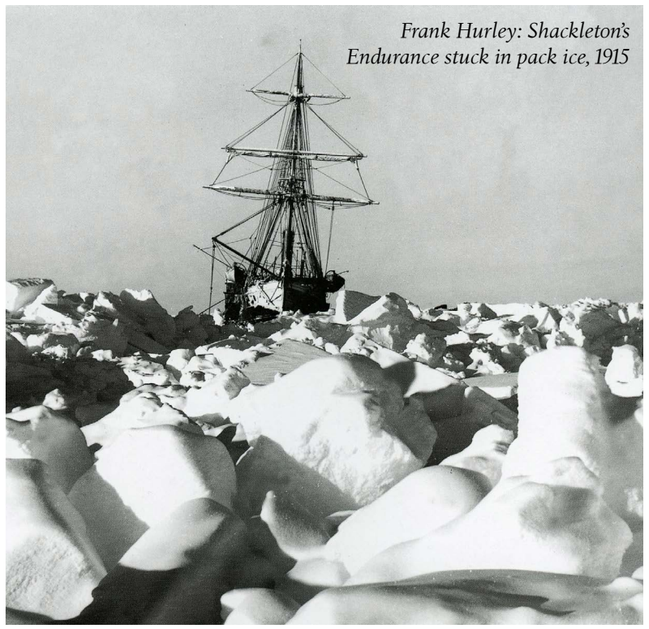
The Third Battle of Ypres consisted of a series of major offensives designed to obliterate the entrenched German positions in the Ypres Salient, Flanders.

One of the better known offensives was Passchendaele (July- November 1917). The campaign was arduous and as it dragged into winter, conditions worsened and the devastated battlefield became waterlogged and impassable. The two battles of Passchendaele resulted in horrendous casualties with an estimated 275,000 Allied and 200,000 German troops, either killed, wounded or missing.



RACS Archive: Frank Hurley - Observation balloon over Ypres

RACS Archive: Frank Hurley – Guns on the battlefield



Frank Hurley: Shackleton's Endurance stuck in pack ice, 1915

Many surgeons including future Presidents, Ivan Jose, in charge of the forward bearers at Broodseinde, and Henry Newland, specialist surgeon with the 3 ACCS at Brandhoek Siding, were at Passchendaele. Jose was mentioned in Despatches for his work at the front and in 1918, won the Military Cross. Newland specialised in abdominal cases but the slaughter during the Ypres campaign meant that this 'first class surgeon who was as strong as a horse' gained experience in all kinds of military surgery.

Located in the RACS Archive, one of Henry Newland's most important legacies is his World War 1 photograph album. Together with images of the Queen's Hospital, Sidcup, it contains photographs (often commonly available) of the Western Front. Although some of these images are unidentified, several are taken in the Ypres area and significantly, many are by the Australian war photographer, Frank Hurley.

Born in Sydney, Hurley is best known for his photographs of Ernest Shackleton's *Imperial Trans-Antarctic Expedition* (1914-1916). He joined the AIF in 1917 as an Honorary Captain and was present at Ypres. Photography for Hurley was not just a static recording of events. His composite photographs capture the stark and desolate battlefield and reflect the drama of the moment. ▶

RACS Archive: Frank Hurley – Will Dyson sketching

Observation balloons were a common sight during the Ypres' battles. Nurse Mary Tilton described them as:

Suspended in the air, like immense sausages, eighteen observation balloons hung over both lines as far as we could see. These observers would telephone to the men below where the Germans were massing their troops. It was interesting to watch the efforts of the airmen to bring them down.

Another of the offensives was the Battle of Menin Rd (September 1917) which aimed to capture the ridges east of Ypres. The battle was largely successful and for the first time in the third Ypres campaign, Australian units were involved, suffering 5,013 casualties.

Journalist, Charles Bean was appointed as a war correspondent in 1914 – he served at Gallipoli and the Western Front. From 1919 he edited and partially wrote the *Official History of Australia in the War of 1914-1918*.

RACS Archive: Frank Hurley - Captain Charles Bean on battlefield

RACS Archive: Frank Hurley – Camouflage, Menin Rd

Bean also contributed to the establishment of the Australian War Memorial.

Satirist, artist and friend of Norman Lindsay, Will Dyson was commissioned in 1916 as Australia's first war artist. He often worked under fire and his work was published in *Australia at War* (1917).

Frank Hurley's pictorial response to World War 1 is unique and innovative and successfully augments the written record. However, his vision was not always appreciated. At the 1918 London Exhibition of War Pictures and Photographs, Hurley's large composite photomurals were labelled by Charles Bean as 'fakes'.

But, Hurley's technical acumen and creativity have now been acknowledged and place him firmly as a forerunner of early twentieth century photography.

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