

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 16 NO 3 / APRIL 2015



ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

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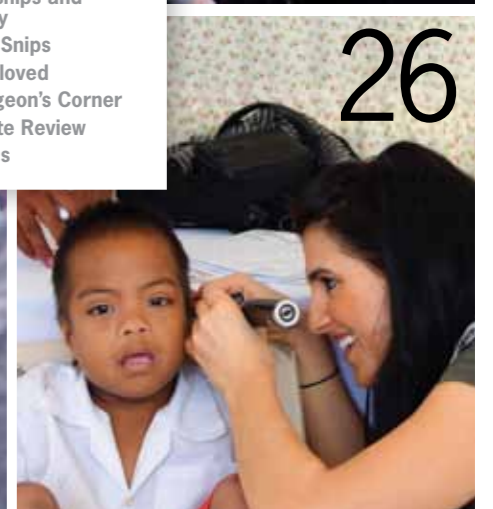
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2015

PROFESSIONAL DEVELOPMENT

WORKSHOPS & ACTIVITIES

ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

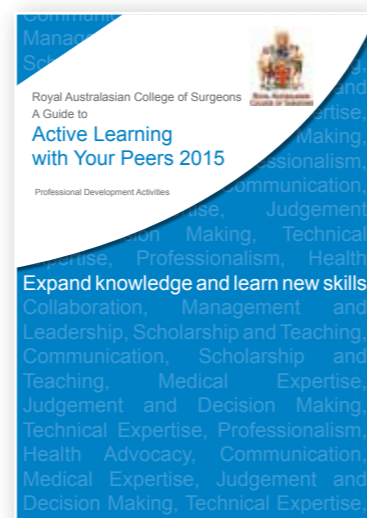
workshop

April-July

Online registration form is available now
(login required).

Inside are professional development activities that enable you to acquire new skills and knowledge and reflect on how you can apply them in today's dynamic world. Don't forget that you can register online at www.surgeons.org

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



Supervisors and Trainers for SET (SAT SET)

21 April – Melbourne; 4 May – Perth
(register via ASC website)

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

Keeping Trainees on Track (KToT)

21 April – Melbourne; 20 May – Brisbane

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

Foundation Skills for Surgical Educators

4 May – Perth (register via ASC website)

The Foundations Skills for Surgical Educators is a new course directed at those undertaking the education and training of surgical trainees and will establish the basic

standards expected of our surgical educators within the College. This free one day course will provide an opportunity for you to identify personal strengths and weaknesses as an educator and explore how you can influence learners and the learning environment. The course aims to improve your knowledge and skills about teaching and learning concepts and looks at how these principles are applied.

Communication Skills for Cancer Clinicians: Transitioning to Palliative Care

13 June – Melbourne

When a patient's cancer cannot be cured, health professionals are often required to deliver difficult news and discuss challenging topics around death and dying. This communications module from Cancer Council Victoria is designed to equip clinicians with the tools to talk about death and dying professionally with empathy to patients and their families. By developing your skills in the area, you can help create a more comfortable environment for your patients, promoting effective communication around the decisions they'll need to make at this time. This educational program is proudly supported by Cancer Council Victoria.

Process Communication Model Seminar 1

26 to 28 June – Brisbane

Patient care is a team effort and a functioning team is based on effective communication. PCM is a tool which can help

you to understand, motivate and communicate more effectively with others. It can help you detect early signs of miscommunication and thus avoid errors. PCM can also help to identify stress in yourself and others, providing you with a means to re-connect with those you may be struggling to understand.

Non-Technical Skills for Surgeons (NOTSS)

24 July - Brisbane

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.



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/professional-development](http://www.surgeons.org/for-health-professionals/register-courses-events/professional-development)

NSW

16 June, Sydney

Keeping Trainees on Track

28 July, Sydney

Clinical Decision Making

QLD

20 May, Brisbane

Keeping Trainees on Track

26-28 June, Brisbane

Process Communication Model Seminar 1

17 July, Magnetic Island

Foundation Skills in Surgical Education

24 July

Non-Technical Skills for Surgeons (NOTSS)

30 July, Gold Coast

Supervisors and Trainers for SET

31 July, Gold Coast Keeping Trainees on Track

VIC

21 April, Melbourne

Supervisors and Trainers for SET

21 April, Melbourne

Keeping Trainees on Track

13 June, Melbourne

Communication Skills for Cancer Clinicians:

Transitioning to Palliative Care

23-25 July, Yarra Glen

Surgical Teachers Course

WA

1-3 May, Margaret River

Younger Fellows Forum

4 May, Perth

Supervisors and Trainers for SET

4 May, Perth

Foundation Skills for Surgical Educators

TAS

17-19 July, Hobart

Process Communication Model Seminar 1



‘IN THE LOOKING GLASS’

Making organisations better and people safer

The time is fast approaching when I will no longer be President of our College – no doubt a relief to many. To be truthful, I have mixed feelings about it, but what I am certain of is that it has been an honour and a privilege to have been the leader of such a great institution. I am proud to be a surgeon and proud to belong to a profession that is basically ‘good’ and does ‘good’. I admire and am inspired by the great majority of my colleagues. We are a profession in every sense of the word – we insist on high standards for the benefit of the communities we serve.

This may make us ‘elitist’, but the high standards and our adherence to them benefits the community. However, being elitist is an anathema for some. We have enemies and a media willing to exploit anything for a sensational story. This negativity reflects on all of us. Being part of a College and an elite group has conferred both privilege and prestige to us as surgeons. It also confers responsibility. This responsibility relates to appropriate professional behaviours and most importantly to self-regulation.

I had intended to reflect on the things I had attempted to achieve over the past 12 months, the focus on professionalism. Indeed I had started to draft it in my mind as I attended the scientific meeting of the Otolaryngology, Head and Neck society just a few days ago.

Instead, I now find that I have to write about a threat to the integrity of the College and the broader medical profession. A similar threat arose when the Australian Competition and Consumer Commission (ACCC) reviewed the College almost 15 years ago. Not everyone is conscious that the College came very close to losing the ability to train future surgeons and to effectively represent the profession on issues of standards. Our authorisation from the ACCC for a number of years allowed us to provide a transparency, a diligence and a rigour of approach that ensured we now match any educational provider. It is these structures that are the foundation to the public benefit of this College and indeed all medical Colleges in providing specialist training.

Both threats question the College’s role, particularly with respect to training. Interestingly, the debates discount the benefits that have flowed to our communities through an emphasis on high standards. The FRACS brand is recognised throughout the world and is synonymous with surgical quality. It represents, if not guarantees, surgical wisdom and expertise. It is not easy to obtain – I make no apology for this. Some Trainees will not achieve the standard. There is increasing scrutiny on all Fellows to ensure the standard is maintained. Reflection and insight into improving

The current threat to our existence relates to the issue of culture, to support of our Trainees and Fellows and protection of them in the workplace and our educational environment. It is well documented that harassment and bullying exists in society, in the health sector and unfortunately in surgical practice and training. We have made substantial strides in addressing these issues, but we can do more despite the fact that these are primarily workplace issues. However, the College does have an important role to play – particularly culturally. During the recent furore the College has been accused of having a vindictive attitude to those who complain. This is an accusation that I have never personally observed and would regard as reprehensible. I accept, however, that there is this perception that it exists. This is a major cultural anomaly that we must work on. The College needs greater insight and understanding around these concerns. In recognition of this, the College has appointed an independent Expert Advisory Group to look closely and uninhibitedly at what we do.

We must have an absolute conviction that bullying and harassment should not be in the workplace and should not affect the educational environment for our Trainees. As I wrote in email correspondence to all Trainees and Fellows, bullying and harassment is a scourge of the modern day workplace. We all need to work to ensure it is a scourge of the past

Sexual harassment is particularly abhorrent. To say that female Trainees and Surgeons need to suffer this in silence is not consistent with any belief system that I understand or respect. It is certainly not consistent with the Code of Conduct that underpins our professional standards and activities.

However, this is without doubt an issue on which the College will be judged. And beyond us, the medical profession in its entirety will also be judged. As stated in the ‘The Age’ Editorial (March 10, 2015), “too often lip service is paid to anti-harassment policies, victims are not believed, their complaints are belittled, and the disciplinary processes that should follow become



MICHAEL GRIGG
PRESIDENT

“It does take leadership and it does take courage.”

unnecessarily difficult or untenable”. The Editorial continued... “It’s (the College’s) task as a professional body to ensure that all its members abide by the highest ethical standards, including those that apply to workplace culture.”

Ken Lay APM (Former Victorian Chief Police Commissioner) wrote in a prominent opinion piece the following day, “for any proud organisation none of this is easy. It can be painful as once hidden issues become public. It does take leadership and it does take courage”. We all have a responsibility to make our communities and our workplaces safer. It goes beyond mere documents; it goes to the leadership in shaping a respectful and safe culture that does not tolerate bullying harassment. This College as a leading professional organisation will be judged on this. All of us as surgeons will be judged in a similar vein. We have another defining moment in the history of this College. For the College to have a future, this issue must be positively and comprehensively addressed.

Yes, my article on ‘in the looking glass’ was going to focus on a small number of issues where positive action had been taken, of changes that we have achieved for the better. But it now has an additional layer of urgency and importance. As Ken Lay in his article states, “looking in the mirror and reflecting on the ugliness that may be present will make organisations better, people safer and build community confidence”.

That is now the challenge for the College. It is a challenge to the very core of our professionalism. We will be judged and judged comprehensively by how we respond both individually and collectively.



WHO ARE WE?

The Workforce Census and Activities Report

The College's Workforce Assessment Department has just completed two key initiatives of the College – the annual Activities Report and the bi-annual Workforce Census. These reports capture not only data on surgical training and workforce environments, but also showcase the vast array of activities, from global health to examinations.

Sixty per cent of Fellows responded to the 2014 workforce survey, which is a great result and likely to be highly representative. The census will enable us to advocate on your behalf in the coming year. The full details will be published soon, but in the meantime I wanted to share some early results.

Fellows were asked a variety of questions in the survey including present employment issues, volunteerism, stress levels and intention to retire. There are around 7000 Fellows, and just over 6000 are active. There are around 1400 Trainees and 100 International Medical Graduates with between 200 and 250 new Fellows gaining a fellowship with the College annually (235 were admitted in 2014). Younger Fellows are defined as being in their first 10 years of Fellowship.

Younger Fellows reported higher levels of stress particularly in regards to maintaining knowledge and skills, along with adapting to new technologies. They also expressed worries about underemployment or lack of employment opportunities after acquiring the Fellowship. The College does provide training in preparing for practice and our Younger Fellows are working on an update to the 2011 edition of the booklet and workshop designed to provide the basic information on this topic.

In the past 12 to 18 months the beyond blue survey has convinced us of the need to recognise the importance of

mental health issues in the workplace. All Fellows need to help provide supportive leadership and mentorship, and to ensure that our workplace style does not inadvertently bully or harass.

Recently in March, the College held its annual tripartite meeting with the RACP and RCPSC (Canadian College). This year we invited the Colleges of Psychiatrists and Anaesthetists to join us. There we discussed transitions of a professional career and the needs of various Fellows during each stage. Essentially there is the 'Getting in and Setting up' phase (Younger Fellows), then the middle years of a career which are often busy, but in which there may be opportunities to take on management and leadership roles, and finally a transition to retirement phase.

Those surgeons who manage the latter phases most successfully are those who develop other options, have interests outside surgery and can maintain a personal and professional identity despite transitioning towards retirement. Regular reflection on one's career and how it is to be managed, with consideration as to what one does well and how one might take new opportunities that present themselves is key to a successful transition through the stages of a professional career. The transition to retirement phase is all the more challenging when other career opportunities and outside interests are not taken or embraced during the mid-career years.

All Fellows are expected to participate in lifelong learning which is stimulated by reflecting on surgical outcomes (surgical audit, peer review and the audit of surgical mortality), performance (practice visits or assessment of surgical performance), participation in clinical governance (reviewing clinical practice and delivery of care) and



DAVID THEILE
CHAIR, WORKFORCE



DAVID WATTERS
VICE PRESIDENT

maintenance of knowledge and skills. For those Fellows required to complete the RACS Continuing Professional Development (CPD) program, all but one finally complied for 2013, a remarkable result for any College Program. Documentation and verification of CPD compliance is essential if we are to continue to self-regulate and maintain professional standards.

During our years of clinical practice it is important that we reflect on how we work and the hours we work. The average surgeon works 53 hours per week, with Cardiothoracic surgeons averaging the most at 58 hours per week, while ENT surgeons work an average of 50 hours per week. Some surgeons, about 10 per cent of those responding and usually those aged under 40, prefer to work part-time. Of those younger who worked less than 40 hours per week, 60 per cent were satisfied with this workload and 40 per cent would have preferred more work.

The census suggests there are still many surgeons at all stages of their career who work more than would be desired, with one in five required to be on call more than 1:4, and double this proportion providing similar on-call coverage in private. Twenty-five per cent work outside cities in rural or regional hospitals. The areas of stress for those in their 40s and 50s were administrative processes, administrative regulation and fear of litigation.

Retirement is a multifaceted stage of life with many variations. Of those over age 65 and still working, 76 per cent indicated they intended to retire in the next two years. The College now defines retirement as no further requirement with AHPRA and the Medical Board to maintain CPD.

On top of paid employment, 40 per cent of respondents volunteer in some capacity. This includes clinical education (not related to SET), non-clinical governance activities, and humanitarian and international development work. For example, there were 66 clinical and 46 educational teams who provided over 11,000 consultations and 2,800 operations overseas in 2014. The most active age group in volunteering are those in their 50s. Of the Fellows who volunteer, 60 per cent provide pro-bono work for the College and proportionately a higher number of these are female. These wide-ranging pro-bono contributions constitute some of the College's most valuable resources.

Recent newspaper headlines have inferred the College is a white male Anglo-Saxon institution. This is certainly no longer the case, though in decades past the RACS demographics reflected this. Although our senior surgeons still tend to represent this group, the composition of the Fellowship is changing with one in three applicants to surgical training now being female; some 25 per cent of Fellows aged under 40 are female. One only has to attend a convocation at the ASC to see that our new and younger Fellows represent all ethnic groups around the globe and no longer predominately Anglo-Saxons. These changes are appropriately reflective of how New Zealand and Australia have become multicultural societies. As surgeons remain Fellows for 40-50 years, it is hardly surprising that in absolute numbers some of these proportions will take time to equilibrate.

The Census results will be published in April. If you are involved in a committee or special interest group and would like specific data on a topic, please let me know at college.vicepresident@surgeons.org

Australian and New Zealand Post Fellowship Training Program in Colon and Rectal Surgery 2016

Applications are invited for the two year Post Fellowship Colorectal Training Program, conducted by the Training Board in Colon and Rectal Surgery (TBCRS). The TBCRS 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 2016. Further information can be obtained from A/Prof Christopher Young via the email below.

**Application Closing Date:
Friday 15 May 2015**

Applications: Please include –

1. Covering letter
(please see the Selection Criteria document for information to be included).
2. Curriculum Vitae
3. Contact details (including email address and contact number) for three referees.
4. Application Payment of \$440.00 inc GST.
(See website link above for details).

Email your application to:
Mr Andrew Hunter
Chair, Training Board in Colon & Rectal Surgery
E: secretariat@cssanz.org
P: +61 3 9853 8013



Specialist Training Funds

The Federal Government has announced that it will provide funding for the Specialist Training Programs for 2016, and will consult on further years funding. The Health Department plans to look at providing for areas of need and determining the distribution of doctors. "This consultation will focus on in-depth work-force planning to better match investments in training identified specialties of potential shortage and areas that may be over-subscribed into the future," Health Minister Susan Ley said.

The Australian, March 19.



NSW children's surgery crisis

Paediatric surgeons have called on NSW politicians to fix a system in crisis. Surgeons say they have reached breaking point and children and families are suffering. In an open letter they have called to stop major children's hospitals from being swamped with cases who are forced to travel too far or face long delays for surgery. The letter, signed by Sydney Children's Hospital network says despite numerous warnings the problem has not been fixed.

Sydney Morning Herald, March 15.



Road trauma black boxes

In a submission to address road trauma, the College has called for black boxes to be installed in all cars and trucks. The submission also included recommendations for fitted alcohol ignition locks and stricter enforcement of speed limits. "The 2020 vision for the UN decade on road safety is zero deaths," Dr John Crozier, Chair of the College Trauma Committee said. "It is not an aspirational goal, it's an achievable goal."

Adelaide Advertiser, March 4.



Back on track

New spinal surgery has provided hope for faster recovery for cancer patients. The surgery, developed by Dr Michael Wong, cuts recovery time with a new technique to access sites differently, allowing cancer patients to resume chemotherapy.

"What pleases me most is to give someone a chance and they thrive on it," Dr Wong said.
The Age, March 1.

REGISTRATIONS ARE NOW OPEN

ANZSVS 2015
Foundations for the Guidewire: A Transpacific Collaboration
21 - 24 September 2015
Grand Wailea, Maui, Hawaii

To register, please visit:
www.vascularconference.com/registration

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The Alfred

THE ALFRED GENERAL SURGERY MEETING 2015
Friday 30 - Saturday 31 October 2015
Pullman Melbourne Albert Park, 65 Queens Road, Albert Park, Victoria

KEYNOTE SPEAKERS

- **Professor David Flum** - Professor of Surgery, Gastrointestinal Surgery, University Washington, USA
- **Associate Professor Andrew Spillane** - Surgical Oncologist, Breast Cancer and Melanoma Surgery, Sydney
- **Professor Jonathan Fawcett** - Hepatobiliary and General Surgery, Brisbane

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2015 NSA Annual Scientific Meeting
Wednesday 30 September to Friday 2 October 2015
The Langham Auckland, New Zealand

www.nsa.org.au

NSA ASM 2015

Images courtesy Auckland Tourism, Events and Economic Ltd

THE WAY FORWARD

Among media furore, the College has brought eminent minds together to address concerns

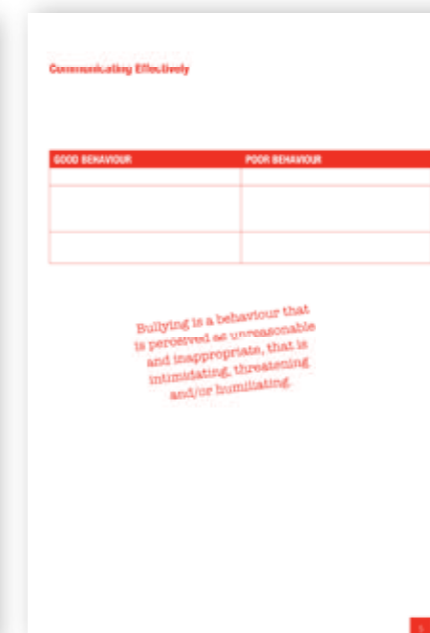
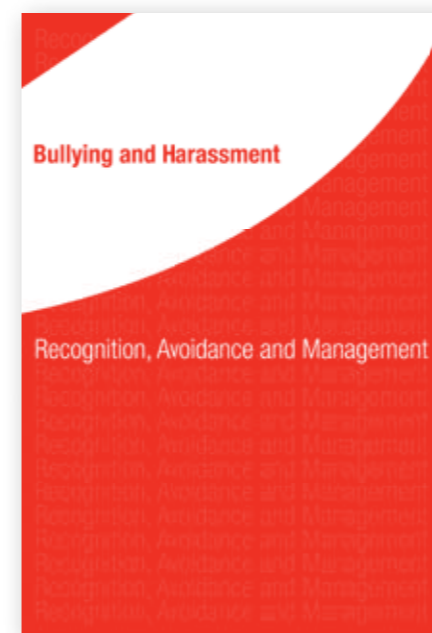


The College last month established an expert advisory group to assist the College in responding to concerns of bullying, harassment and discrimination within surgery and the health sector.

The group is chaired by former Victorian Health Minister and current chair of the Royal Children's Hospital, Mr Rob Knowles AO. Dr Helen Szoke, the current CEO of Oxfam, but previously Australia's Federal Race Discrimination Commissioner and Victorian Equal Opportunity and Human Rights Commissioner, will be Deputy Chair.

Other members include:

- **Dr Joanna Flynn AM**, Chair of the Medical Board of Australia;
- **Mr Ken Lay APM**, the former Chief Commissioner of Victoria Police and an outspoken advocate against discrimination and violence against women;
- **Dame Judith Potter, DNZM, CBE**, Previous High Court Judge
- **Mr Graeme Campbell**, the College's incoming Vice President; and
- **Dr Cathy Ferguson**, the incoming Chair of the College's Professional Standards.



“[Trainees] must be encouraged, they must feel safe, they must be able to speak up and they must be respected.”

Left: The College's Bullying and Harassment Booklet is included with this month's Surgical News.

Below: President Michael Grigg talks to the media.

In announcing the advisory panel, the RACS President Professor Michael Grigg described sexual harassment as “abhorrent” and said it needed to be addressed by professional bodies such as the College, as well as by hospitals and Departments of Health.

He said the expert advisory group's charter will be to review the College's current policies and procedures, establish a reporting framework to measure progress in dealing with bullying and harassment, address the College's gender balance and act as a medium between the College and hospitals/health departments to navigate a path toward eliminating such behaviour.

Professor Grigg said the College had already written to all Ministers of Health across Australia and New Zealand seeking to engage with them to improve the culture of hospitals and the health care sector.

“The increased participation in the surgical workforce by female Trainees is fantastic,” he said.

“They must be encouraged, they must feel safe, they must be able to speak up and they must be respected.

“The College had addressed and continues to address issues of bullying and harassment (but we) must do more



to ensure these changes have impact and endurance in the workplace.”

The Chair of the College Trainee's Association (RACSTA), Dr Grant Fraser-Kirk, also wrote to all Trainees last month encouraging them to report any incidents of bullying and harassment without fear of retribution.

He said that while the feedback he had received indicated that surgery as a profession worked in a respectful and

collegiate manner, there remained the risk that sensitive issues may be under-reported for fear of future reprisal.

He encouraged any Trainee with such concerns to complete the end of term survey sent to Trainees last month or to contact him directly, with such matters addressed as a priority and with the input of Ruth Mitchell, the chair of RACSTA's Support and Advocacy committee.

“The expert advisory group that the RACS has appointed comprises individuals with substantial experience in equal opportunity, racial discrimination and regulatory issues.”



Articles appeared across the media spectrum; Sexism in surgery is unconscious and insidious, by Dr Elizabeth Sigston on the Women's Agenda website, Women in Surgery Deputy Chair Kate Drummond in MJA Insight, The Guardian newspaper and others.

“If this type of behaviour persists in our workplace, we will work our hardest to stamp it out,” Dr Fraser-Kirk said.

“We live in an age of equal rights and entitlement. Included in those rights is the right to thrive in your chosen career without discrimination, harassment or bullying and without fear of retribution should one speak out.”

Under the RACS Discrimination and Harassment Policy, the College states that it is committed to fairness and equity and to ensuring that Fellows, Trainees and International Medical Graduates are not subject to discrimination, bullying or harassment.

It states that Fellows, Trainees and International Medical Graduates are to be treated in a fair and equitable manner regardless of protected attributes including gender, marital status, pregnancy, colour, race, ethnicity, disability, sexual preferences and religious or political beliefs.

Legislation in both Australia and New Zealand place the responsibility on the employer for the provision of a work environment free from unreasonable

behaviours that create a risk to health and safety. The role of the College is to define acceptable behaviour and promote appropriate standards of conduct at all times consistent with the College's Code of Conduct.

The policy highlights the importance of perception. The intention or motive of an alleged harasser is not relevant when determining whether the behaviour was unreasonable. Investigation of a complaint will usually consider how the conduct in question was perceived and experienced by the recipient rather than the intention behind it.

Through its policy, the College also commits to encouraging the reporting of unreasonable behaviour that breaches the policy; an effective complaints process based on the principles of natural justice; treating complaints in a sensitive, fair, timely and confidential manner

and encouraging local resolution or involvement of bodies such as Fairwork, and Equal Opportunity/Human Rights Commissions.

Professor Grigg called on all Fellows and Trainees to work together to ensure discrimination, bullying and harassment were not tolerated anywhere at any time.

“Bullying and harassment must be notified and must be investigated,” he said.

“The expert advisory group that the RACS has appointed comprises individuals with substantial experience in equal opportunity, racial discrimination and regulatory issues.

“I ask all Fellows to work with the College to ensure that we triumph over this scourge of the workplace.”

WHAT IS SEXUAL HARASSMENT?



MICHAEL GORTON
COLLEGE SOLICITOR

Recognise the behaviour

An important issue for workplaces, and the College in particular, in recent times has been the need to address sexual harassment.

This is primarily an issue for the workplace, whether in hospitals or other employing health bodies, and is an occupational health and safety responsibility for every employer.

The College also has an interest in ensuring that its Trainees and Fellows are not subject to sexual harassment, and the College does have its own policies and processes to deal with sexual harassment when it occurs.

The College has a zero tolerance policy. The chief aims of the RACS policy are to ensure:

- that sexual harassment does not occur;
- that there are no reprisals for making a complaint;
- where harassment is identified, that it is addressed; and
- an increased awareness of what sexual harassment is and its consequences.

What is Sexual Harassment?

Sexual harassment is unwelcome conduct of a sexual nature, which offends, humiliates or intimidates the person at which it is directed, regardless of intent. It does not include conduct occurring within a personal relationship of mutual attraction and/or friendship. Sexual harassment may occur in a single incident as well as a series of incidents. The harassment may be subtle and implicit, rather than

explicit. This behaviour frequently involves an abuse of power and/or trust and is often directed at a person who is unable to stop the behaviour easily. The behaviour may occur either at the workplace, or outside the workplace at workplace-related functions. The respective genders of the two parties is not relevant.

Sexual harassment is unacceptable to the College and it is also unlawful.

Sexual harassment may consist of:

- unwelcome physical contact (e.g. touching, patting or brushing against a person);
- leering, patting, touching or unnecessary familiarity;
- demands for sexual favours;
- offensive or demeaning comments, emails, jokes or innuendo;
- unwanted sexual propositions or advances;
- sending emails, text messages or mail that may be sexually explicit and offensive to either gender;
- offensive telephone calls;
- spreading rumours of a sexual nature about a person's private life;
- offensive gestures, staring or displaying offensive material; and
- unwelcome or uncalled for remarks, questions or insinuations about a person's sexual activities or private life.

Sexual harassment has no place in a fair and productive work environment. It may make people feel embarrassed, intimidated, angry, humiliated, anxious and afraid. It can lead to distress, reduced morale and productivity and staff dislocation.

What To Do If You Are Harassed

You have the right not to be sexually harassed in the workplace and the College will support that right. If you are harassed, please take action.

- Tell the other person in a direct and firm manner that their behaviour is unacceptable – tell the person in writing if you are unable to speak to them (telling the person may be enough to stop the person's unwelcome behaviour).
- If you feel you cannot complain directly to the person (or if you have complained and the harassment has not stopped), then speak to your supervisor who will discuss the situation with you in strict confidence.
- The College recognises that in some instances, discussing the matter with your immediate supervisor may not be appropriate. You may therefore discuss your concerns directly with the College.
- You may also make a formal complaint in accordance with the RACS Complaints Policy.
- You can also contact the appropriate government equal opportunity or anti-discrimination body in your state or territory for confidential advice and information.

INTERNSHIP WITH HEART

Cardiothoracic surgeon Dr Victoria Atkinson has developed Australia's first Indigenous Internship

Dr Victoria Atkinson, a Cardiothoracic surgeon and the Director of Medical Governance at the Royal Melbourne Hospital (RMH), has developed Australia's first Indigenous Internship program aimed at attracting and supporting Indigenous medical students.

The full internship, filled by the first candidate earlier this year, is funded, supported and recognised by the Victorian Department of Health and the RMH and has the support of the Post Graduate Medical Council of Victoria, the College and the Australian Indigenous Doctor's Association.

The position is open to Indigenous medical school graduates from Melbourne and Monash universities and is being offered as part of the RMH's Indigenous Employment plan.

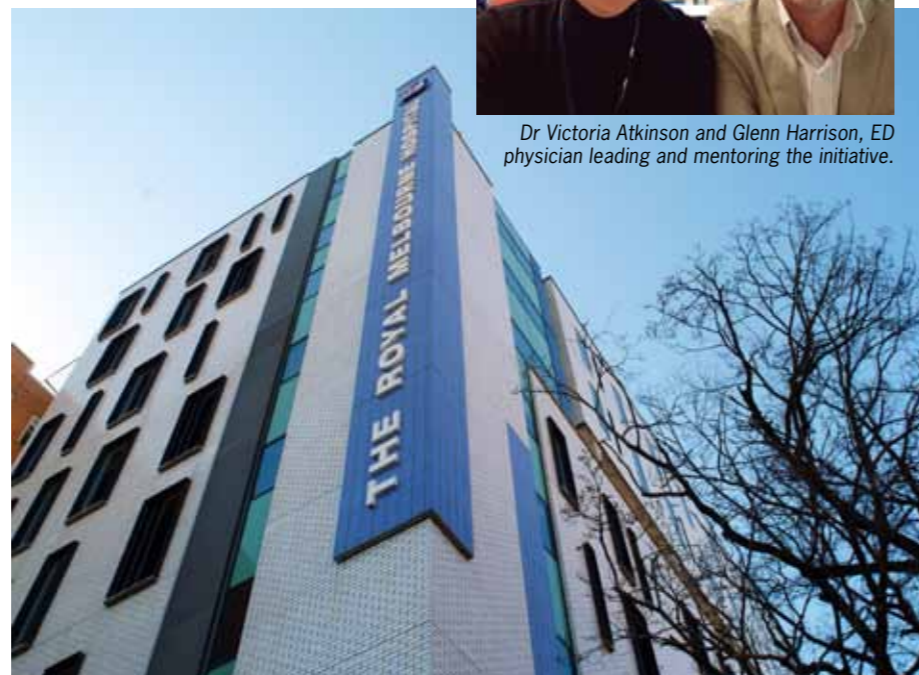
Dr Atkinson has been working to design and launch the program since she took on the role of Director of Medical Governance in 2013 and said she hoped the internship would act as a "germinating centre" to create a strong Indigenous workforce across all medical specialities.

"With the commencement of our first Indigenous intern this year, the RMH doubled its number of Indigenous medical staff, which is an embarrassingly stark illustration of both the problem and the purpose of our Indigenous Internship program," she said.

"While none would dispute the need to commit to excellence in Indigenous health, many institutions and individuals struggle with how best to contribute to this ideal.

"At the RMH we have decided to start with a concrete and practical initiative which we hope will help us create and attract a cohort of Indigenous doctors."

Dr Atkinson, a member of the College's Indigenous Health Committee since November last year, said that as part of



Dr Victoria Atkinson and Glenn Harrison, ED physician leading and mentoring the initiative.

the program, the RMH would support the young doctors through both their internship and their first year as a HMO.

She said that during that time, the Indigenous doctors would be encouraged to access the vast range of medical and research programs both within the hospital and across the Parkville Precinct in Melbourne.

"Being a tertiary and quaternary care hospital, we have a myriad of specialties that these young doctors can access and gain exposure to as they contemplate, and work toward building, their careers in medicine," she said.

"We also have extensive partnerships with other institutions which means we can also offer access to specialties at the Royal Women's and Royal Children's Hospitals, the Peter MacCallum Cancer Centre, which will be moving nearby, and the world class research facilities that are scattered across Parkville.

"We've got almost everything here, but if they're interested in something else, we'll figure out a way to support them in that.

"My hope, of course, is that quite a few will choose to become surgeons and the first candidate to receive this internship has expressed interest in becoming a general surgeon, which is very pleasing."

Dr Atkinson said she had consulted widely with people working within the Indigenous health and education sectors as she designed the internship and particularly thanked Kelvin Kong, the chair of the College's Indigenous Health Committee, and Emergency Medicine Consultant Dr Glenn Harrison, the RMH's only Indigenous consultant, for their help and support.

She said she had been particularly mindful when designing the internship program to ensure that it was not seen – particularly by applicants – as a tokenistic measure designed to address a lack in workforce diversity.

"When talking to medical students when I began working on this initiative, it became very evident, very early that we needed to explicitly say what this program was not," she said.

"We had to ensure that the students understood the position was not bonded to certain expectations that they should be pioneers, or advocates or future leaders within the framework of Indigenous health.

"Instead, the central tenant of this program is that the RMH expects the same of Indigenous and non-Indigenous interns and that is that they become the best doctors they can be and we hope through this program only to nurture that journey."

Dr Atkinson said that since the internship program had been launched, she had already received calls from young Indigenous doctors working at other centres across Australia wishing to further their training at the RMH.

She said that while there were not the funded intern positions at present to enable such transfers, she was happy to develop resident positions beyond internship to allow Indigenous doctors to transfer once their internships were completed.

"It is our intention that over the next five to 10 years this internship will signal to all that the RMH is committed to growing both the number of Indigenous doctors and to allowing them to create their own voice within our organisation," she said.

"It would be wonderful if, in the future, we began receiving applications from Indigenous doctors at various levels of training or expertise because that would allow us to build a cohort of Indigenous doctors which would be an asset to the hospital and great for our Indigenous patients.

"The RMH prides itself on the diversity of our medical workforce and yet we lack a strong Indigenous voice to guide us in the care of our Indigenous patients.

"As a surgeon I know that I haven't always provided the best possible care to my Indigenous patients simply because I don't know what that looks like so to have the input of a range of voices would be of immense value."

As part of the Indigenous Internship program, an annual oration has also been established by the RMH in honour of Professor Ian Anderson.

The first Indigenous medical graduate from Melbourne University, Professor Anderson is now the Assistant Vice Chancellor (Indigenous Higher Education Policy) at the university and has chaired the National Aboriginal and Torres Strait Islander Health Equality Council since 2008.

The inaugural oration was delivered late last year by Mr Kelvin Kong.

Dr Atkinson is now in the process of meeting with university officials and medical students to seek applications for the second internship to be offered later this year.

With Karen Murphy

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Dr. Craig Bond, ENT surgeon, Visiting Medical Specialist, on (07) 3202 4636; or
Ms Chris Went, Chief Executive Officer on (07) 3816 9901; m: 0417 998 322 or email: wentc@ramsayhealth.com.au

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TOGETHER WE CARE

AWARDING PROGRAM

The program will include the presentation of the inaugural Indigenous Health medals

KELVIN KONG, CHAIR INDIGENOUS HEALTH COMMITTEE
MAXINE RONALD, IHC AND CO-CONVENOR ASC 2015

The Annual Scientific Congress (ASC) is the key event on the Fellowship calendar. For the Indigenous Health Committee it presents an exciting opportunity to raise the profile and our collective understanding of Indigenous health issues, as well as promote the work we are doing in Australia and New Zealand.

The Committee's annual face to meeting will be hosted by the Derbarl Yerrigan Health Service in Perth. Derbarl Yerrigan is an Aboriginal community controlled organisation that delivers a range of health services across multiple sites in Perth. The service is staffed by a range of health professionals, including Aboriginal Health Workers and provides a spectrum of clinical and health promotion services.

Since 2009 the Committee has held its annual meetings in Indigenous centres providing either health care or engaged in medical education. This has enabled committee members and other College officials and Fellows to engage with the community controlled sector and be better informed about the important work they do and how we can improve surgical care and services to Indigenous communities.

This year's Indigenous Health scientific program focuses on breast cancer in Indigenous populations – a morbidity quite often forgotten in public discussion about poor health outcomes experienced by Indigenous people. Presenters will explore the clinical and cultural aspects of breast cancer in Australia and New Zealand.

Of great anticipation is the inaugural presentation of College medals for excellence in Aboriginal and Torres Strait

Islander Health and Māori Health. These new awards recognise the excellent work in Indigenous health already being done by Fellows in both Australia and New Zealand, many of whom have been engaged with Aboriginal, Torres Strait Island and Māori communities well before the establishment of the College's Indigenous Health Committee.

Importantly, we will be joined at the ASC by six Aboriginal and Māori junior doctors and final year medical students interested in surgical training. Their participation has been made possible by travel bursaries sponsored by the Foundation for Surgery.

The adoption by Council of the College Aboriginal and Torres Strait Islander Health Plan 2014-2016 was a major first step towards progression of our ambitions in Indigenous Health. The New Zealand members of our committee, with support from the NZ Board and staff, are developing a Māori health Action Plan to complement the work being done in Australia.

On behalf of the Committee, we extend a warm invitation to all members of the College to come and join us at the Indigenous Health session to acknowledge the work of our peers and to welcome our Indigenous doctors.

Further information on the Indigenous Health Committee and College activities in Aboriginal, Torres Strait Islander and Māori Health is available at Indigenous Health <http://www.surgeons.org/member-services/interest-groups-sections/indigenous-health/>

Indigenous Health at the ASC Perth 2015

Monday 4 May – Indigenous Health Committee Annual Face to Face Meeting, Derbarl Yerrigan Health Service, East Perth, 10am-2pm

Wednesday 7 May – Indigenous Doctors' Breakfast, Perth Convention Centre 7am-8.15am

Thursday 8 May – Indigenous Health Session Breast Cancer in Indigenous Populations, 8.30 am – 12.30 pm

Presentation of the inaugural RACS Aboriginal and Torres Strait Islander Health Medal
RACS Māori Health Medal



HOT NIGHTS



Are you Under-Testosterous or is that Preposterous?

DR BB G-LOVED

Last month I introduced you to Andre and Genevieve (Gen) who were disturbed by night sweats. Later they also suggested their libido had been waning and wanted to know if this was to be blamed on normal ageing or were they (I) missing some treatable condition.

Whenever I discuss a couple's coupling I always run through the big five potential problem areas. These are energy, relationship, lubrication, erectile function and hormones. Stage of life considerations also dictate that at times of pregnancy, parenting babies and toddlers, menopause, or ill health it is natural for one or other of the couple to experience reduced libido, less interest and affected performance.

However, Andre has in recent years gained weight, suffered from reduced libido, often feeling tired or depressed. He had no thyroid dysfunction (TSH in low normal range), but had noticed shaving less frequently and experiencing less spontaneous erections. Examination revealed thinning body hair, gynaecomastia and just possibly some testicular atrophy, though we had no baseline measurements.

Androgen deficiency is becoming increasingly recognised particularly, but not exclusively, in men and was featured as an issue topic in 'Medicine Today' last year. It may be due to underlying disease or lifestyle factors and is associated with an increased risk of cerebro and cardiovascular diseases and loss of bone mineral density. There are European and Massachusetts Male Ageing Studies that suggest the prevalence of symptomatic hypogonadism is 2-9 per cent. A study from Western Australia reported 5.2 per cent of 3638 community dwelling men aged 70-89 were androgen deficient.

The diagnosis of androgen deficiency is confirmed by a serum testosterone level less than 8nmol/L on at least two mornings after an overnight fast, or 8-15nmol/L when luteinizing hormone (LH) is greater than 1.5 times the upper limit of the eugonadal reference range for young men. When there is testosterone deficiency, measuring LH and follicle-stimulating hormone (FSH) levels helps to determine whether the problem lies at the testicular or hypothalamic/pituitary level.

Total testosterone levels reflect albumin and sex-hormone-binding-globulin (SHBG) bound testosterone, which is produced in the liver. Increased SBGH levels are associated with hyperthyroidism, cirrhosis, oestrogens, aging, poor nutrition and use of anticonvulsants. Decreased SBGH levels are associated with obesity, insulin resistance, impaired glucose tolerance, glucocorticoid use, androgens and hypothyroidism.

Men with an increased BMI have increased testicular temperature, but the adipose tissue also causes more aromatisation of androgens leading to hypogonadism and abnormal spermatogenesis. The gain in BMI may also result in obstructive sleep apnoea, mood disorders, lack of physical activity as well as increased cardiovascular risk and diabetic risk, themselves inhibitors of energy, libido, erectile function and fertility.

A meta-analysis of trials of testosterone therapy that included 1089 men with a mean age of just under 65 years and baseline testosterone levels of 10.9nmol/L showed benefit in terms of reduced total body fat and increased bone mineral density.

Testosterone therapy may be administered by intramuscular injection

(250mg), or by topical application (5g sachets of gel or patches applied daily). Oral therapy is not advised for adults as its absorption is variable and clinical response suboptimal. Though generally safe, injections may be associated with surge and wane effects which can be unpleasant, whereas topical applications may cause skin reactions. Testosterone therapy is contraindicated for heart disease, urinary tract obstruction, known prostate cancer, breast cancer and untreated sleep apnoea. There is no evidence that testosterone therapy causes prostate cancer in those who do not have it. It should not be prescribed for men who still aspire to fertility.

There are bio-identical creams or gels that use testosterone in its natural form in distinction to pharmaceutically adjusted products that fit the receptor site to evoke similar actions and justify expensive patents.

Bio-identical testosterone cream can assist women like Gen who ask for extra help with loss of libido post menopause. I warn them about side effects of facial hair, acne or feeling aggressive, and these imply the dose is too strong for them! I start by prescribing such a small dose that this is very unlikely, but, be warned, patients do vary with their hormone level requirements. Best to check serum levels post testosterone replacement and then once or twice a year.

Those with normal testosterone levels should be discouraged from seeking hormonal therapy. When appropriately prescribed for libido, and if successful, a partner's demands can become overwhelming. Best always to start with low doses and work up. The revived desire of one partner needs to match the ability to deliver in the other!

IN MEMORIAM

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

Peter Britton Milsom,
NZ Fellow

Peter Thomas Bruce,
NSW Fellow

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

Informing the College

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

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

CURMUDGEON'S CORNER



BY PROFESSOR GRUMPY

KNOW YOUR SPORT

Standards in media are plummeting

There is one thing that really annoys me and that is TV reporters. We curmudgeons would once have been charmed by a pretty girl even if she could not speak the Queen's English and make sensible comments. Not any more – we see through that superficiality and look for quality and depth. How can you take seriously a reporter who is reporting on something as serious as a comment from our beloved politicians who starts the report with, "Yeah, well, see the PM has ..."

That sounds like the start of a school yard conversation, not a serious evaluation of a matter of national importance.

When they do manage to ask a sensible question such as, "What are you going to do about the budget deficit?" they are so easily put into a state of confusion by the usual political hogwash such as, "The fiscal restraints obviated by the previous government have resulted in a state of negativity in the economic outlook."

Surely there should be a further question by the reporter along the lines of, "With respect, Minister, what are YOU going to do about the budget deficit?"

What about the clothes? If you are reading the news or running a current affairs program, surely a suit (AND TIE) for blokes is a minimum requirement. Collared shirts are meant to have ties, not sit partly open at the neck. The shape of the collar demands a tie – not wearing one implies a certain degree of sloppiness and as we all know well (at least we curmudgeons know well), where there is sloppiness of clothing there is sloppiness of thought. If you want to not have a tie, wear a proper casual shirt (and don't read the news on my TV station).

As for sports reporters, well the mind boggles. Not only do they not have ties (most sports jocks probably don't have one), but they can't pronounce words properly. The delightful cricket ground in the State of South Australia (now ruined by a modern development - but that is another story) is easy to pronounce. It is the Ad-el-aide O-val in South Aus-tra-li-a. It most definitely is not the Al-ai Ov-ul in Sou Os-tra-ya. TV presenters – listen and learn!

Also what about knowing your subject? Some years ago a well-known female actor was given the task of an honorary cricket commentator at the revered SCG. Equality of gender is fine, but if you are to be a cricket commentator the primary object is that you should know your cricket. She spoke elegantly about the old members' stand being like a well-dressed dame, but she did not know the difference between a leg-break and a googly. We curmudgeons were not impressed.

And as for inane comments – the presenters who approach a sportsman or woman after some extreme performance when they are a mild shade of blue and ask, "How are you feeling?" should get the answer that the sports-person really wants to say, but can't because of the oxygen deficit. Unfortunately the reply would not be publishable here, nor could it be broadcast on national TV.

New ways to access the library

Keep up-to-date with the Read by QxMD app

The Library is always looking for new and improved ways to make its extensive collection of information resources more accessible. This now includes mobile apps for smartphones or tablet computers. We have recently identified a useful and simple app called 'Read by QxMD'. 'Read by QxMD' is described as "a personalised medical journal" which "drives discovery and seamless access to the medical literature by reformatting it..." The majority of the College's e-journals have been included within the app. A personalised profile is created by selecting from these to receive new journal article content alerts. Abstracts are shown and full text can then be accessed. New articles can be viewed on a phone, a tablet or on the desktop computer – notification by email is another option. There are many other features and customisations available and it's free.

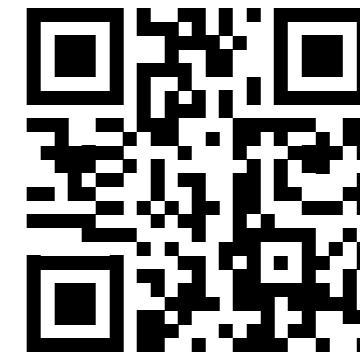
Apple iPads or iPhones

it is available at:
<http://qx.md/read-ios>

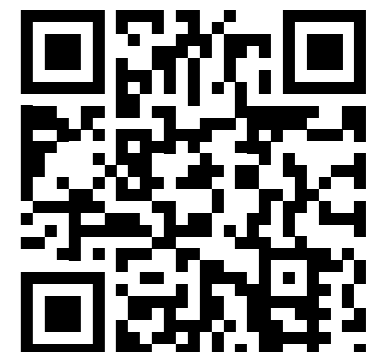


Android tablets or smartphones

it is available at:
<http://qx.md/read-android>



There is also an option to set up Read on a computer and then get the information pushed out to your device. See: <http://www.qxmd.com/apps/read-by-qxmd-app>



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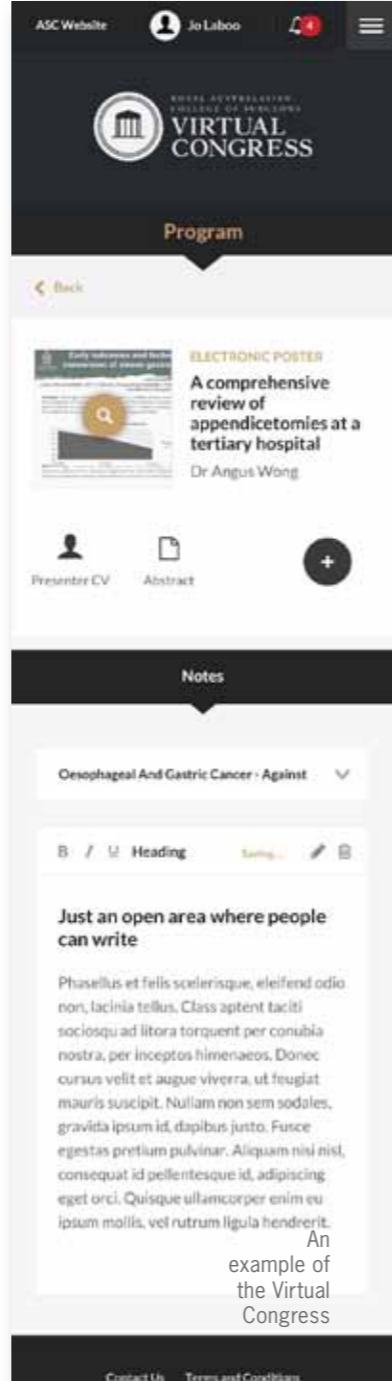
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An example of the Virtual Congress for smartphones



Connecting at the ASC

Go to asc.surgeons.org for further details on how to obtain the 2015 ASC App

What type of information will I have access to from the app?

The RACS 2015 eProgram will allow you to access various forms of congress information. Users will be provided with event specific information, exhibition hall maps, handy tips, news/updates and a full event and program guide.

Will the app let me plan my days while I am attending the congress?

The tablet app will allow users to explore the Annual Scientific Congress (ASC) program guide and manage your schedule. Users can plan their day by adding the sessions and presentations of their choosing to their schedule. Within the app there will be full visibility of session and presentation times and locations. For each presentation Abstracts, Presenter CVs and related media will be available on demand.

Through the app, an 'On Now' feature will allow users to quickly see what sessions and presentations are currently running or are about to start. Delegates can quickly change sessions and presentations as required or attend unplanned events. Ultimately, these features ensure seamless integration with member accounts for easy event schedule management.

What additional benefits will the app have compared to the printed guide?

While the printed program is a great resource, the tablet app provides users with ability to 'Ask a Question' within a session or presentation without interrupting the presenter. Similarly, it allows delegates to participate in polls run within a session. Delegates can also take notes via their tablet app whilst attending a session or presentation.

As an attendee are there any other features I should be made aware of?

The eProgram will also allow you to browse and view all available ePosters submitted for the event. There is the ability to 'favourite' posters for easier reference, as well as access to their associated Abstracts and Author CVs. Delegates can also highlight/add presentations to their schedules to view at a later date (dependant on the presentation being given permission to be viewed). Presentations will be available shortly after they've been presented and delegates will have continued access to these presentations long after the ASC is over.

Will the eProgram work on my device?

The eProgram app has been developed to work across iPad and Android Tablet devices and will be made available via the Apple App and Google Play stores. The links to download the eProgram app will be provided closer to the date of the Congress.

The Virtual Congress web app will also allow delegates without a tablet device to access online features via their mobile phones and/or laptops. The tablet apps will be linked to the Virtual Congress website, allowing participants to manage their schedules and take notes across their various devices.

What is the Virtual Congress?

The Virtual Congress is a responsive website designed to extend and assist your ASC experience. Registered members can view program information, take notes, manage their schedules, ask questions to the session Chair and participate in polls. Primarily used on a desktop the Virtual Congress is also accessible from mobile devices.

Both the Virtual Congress and the app are secure with new password protection and allow delegates access to data even if they have missed an event. A rich media experience is provided to users in which multimedia features are made available as the event progresses. This includes audio, video and ePosters with playback functionality (when online) and gateways to further information. These features ensure the ASC is a global reaching event and caters for those delegates who are unable to attend.

Can you use the app without being connected to the internet/offline?

Once the app is installed and initial content is downloaded, you can view the program offline and add sessions to your schedule. General event information will also be available to delegates without being connected to the Internet.

Will the App keep me informed throughout the Congress?

Yes, the app will keep delegates informed of important announcements that will be made throughout the congress. Delegates will be kept informed via in app notifications and general information updates.

Do I need to register/login to use the app?

Registration is not necessary to view the program or general information. However, to fully utilise all functionality within the app, i.e. create a custom schedule, take notes on specific sessions, ask questions of a presenter or participate in a poll, you must establish an account. This account can be used across both apps as well as the virtual congress web app.

Delegates need to know that while being registered to attend the ASC, this does not mean you have registered for the App. The registration process can take place on either the app or Virtual Congress web app and only requires general user profile requirements; there is no additional fee to gain access to these applications. Please see the Mobile App help desk next to the registration desk if you need help during the ASC.

How else can I stay informed and participate?

The biggest opportunity is to participate in the conversation on Twitter. Anyone can join in by using #RACS15 to discuss sessions they've enjoyed, people they've met, interesting knowledge shared and more. You can also follow the College using @RACSurgeons or mention the College in relevant posts.

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Dr John Corboy (1969-2007) was elected chair of the Royal Australasian College of Surgeons Trainees' Association (RACSTA) in 2007.



He was a great leader and a selfless representative of Trainees of the Royal Australasian College of Surgeons. He gave generously to his peers his time and wisdom. His energetic service to the profession and his tenacious passion for surgery despite personal adversity was remarkable. This distinguished award for surgical Trainees commemorates Dr John Corboy's achievements and recognises exceptional service by other Trainees.

The John Corboy Medal may be awarded annually to a Trainee who demonstrates the characteristics for which John was admired. As this is a unique award that recognises Trainees of the College the presentation is made at the Annual Scientific Congress (ASC).

The award is made to a candidate who shows some or all of the following qualities in the performance of his/her duties, in service to the surgical community, in the manner and approach to the fulfilment of their surgical training or by their commitment to and involvement with the community of surgical Trainees:

- Outstanding leadership
- Selfless service
- Tenacity
- Service to Trainees of the College

NOMINATIONS FOR 2015 are now open. To obtain a nomination form, or for any queries, please contact Ms. Fiona Bull, Manager, Surgical Training, at fiona.bull@surgeons.org.

Nominations will close 5 p.m. on Friday 25 September 2015.

RACSTA

A PROGRAM FOR TRAINEES TOO

Come to the 2015 ASC



GENEVIEVE GIBBONS
RACSTA WA REPRESENTATIVE, CONVENOR TRAINEE SECTION ASC

Preparations for the 2015 Royal Australasian College of Surgeons Annual Scientific Conference (ASC) are well underway. The ASC will be held in May in Perth this year with a military and ethics theme.

The ASC provides several excellent opportunities for Trainees including the opportunity to present research, attend educational courses, network with other Trainees and Fellows including senior members of the college as well as participation in the extensive social program. Exposure to these events is important for Trainees as it helps to foster a sense of belonging to the surgical community as well as highlighting several of the functions of the College itself.

The Trainees Association (RACSTA) will present a session on the Tuesday morning targeted at Trainees from all surgical disciplines. This will include both local and international speakers

discussing a wide range of issues relevant to Trainees. All Trainees attending the ASC are strongly encouraged to come and support their colleagues.

RACSTA warmly welcomes as a guest Dr Ammara Abbasi Watkins from Boston, a Trainee of the American College of Surgeons (ACS), who will attend the ASC as a part of an International Exchange program between the two colleges. Dr Watkins will be presenting to Trainees on the Tuesday morning about her experiences and challenges as a surgical Trainee in the US.

The session will be followed by a combined Trainees and younger Fellows dinner at the Perth Zoo on the Tuesday evening. This is always an unforgettable evening and the highlight of the ASC social calendar!

I strongly encourage all Trainees to consider registering for the ASC.

YOUNGER FELLOWS



RICHARD MARTIN
CHAIR OF THE YOUNGER FELLOWS COMMITTEE AND YF PROGRAM CONVENOR ASC

Success of mentoring session

Take up your opportunity through the link

The Younger Fellows Mentoring Session was a success at the Singapore ASC last year. Admission was self-nomination via filling in an online demographic survey link through Fax Mentis. Mentees were matched with Mentors according to needs and the match was made on the Tuesday at 5pm immediately following the Younger Fellows Session.

Cook kindly sponsored food and drinks. We were delighted that Censor in Chief Simon Williams was present among a number of other Councillors, senior surgeons, younger Fellows, IMGs and Trainees.

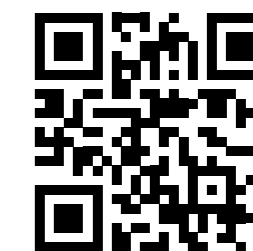
The session aims to connect those who need guidance as to future career paths, advice for mixing family with work, work life balance, starting private practice, developing an academic surgical career, etc with those who have already walked the path and have a deeper understanding of errors and mistakes that can potentially be avoided.

While there is no formal contract to continue the relationship past the mentoring session, certainly those who wish to continue are free to do so.

This session represents the first step in building a comprehensive mentoring network within the College

to help all those along their surgical career path.

I strongly encourage all those with an interest in either mentoring or being mentored, or both, to register online via the Fax Mentis link for what should be an excellent and enlightening session.



To register for the Mentoring Matching session, access the Survey Monkey link in the QR code here by COB Friday, 10 April 2015 or access the link <https://www.surveymonkey.com/s/3LKVJX6>



COMPLEX GENERAL SURGERY CAIRNS, QLD 25-27 SEPT
MORE INFO - ASM.GENERALSURGEONS.COM.AU



SURGICAL FELLOW IN TRAUMA AND RURAL SURGERY (CLINICAL)

A position exists for a suitably qualified candidate for 12 months commencing late January/early February 2016.

The position is funded by the National Critical Care & Disaster Response Centre (NCCTRC) and there is opportunity for planning and participating in disaster response, and opportunities for trauma research.

The position is based at Royal Darwin Hospital but involves outreach work to regional hospitals in Katherine and Gove, as well as visits to isolated Indigenous communities.

As a 'General Surgeon' you will have the opportunity to definitively manage subspecialty areas such as neurotrauma, burns, vascular, paediatrics, urology and thoracic surgery, both electively and in acute care/trauma.

This position would be of interest to those interested in rural surgery, or working as a surgeon in remote environments such as humanitarian or military situations. There is extensive exposure to indigenous health issues.

Enquiries and further information can be obtained from DavidJ.Read@nt.gov.au



This year marks the 20th anniversary of the College's highly regarded Pacific Islands Program

COMING OF AGE

Launched in 1995, the Pacific Islands Program (PIP) has allowed Fellows to help train and mentor a new generation of surgeons across the region and conduct thousands of life-saving operations in host countries while developing the ability of the College to deliver world-class international medical assistance through its Global Health department.

Since the College commenced management of the Australian Government-funded program, Fellows and other medical professionals working through the PIP have:

- Conducted more than 680 service-delivery visits to Pacific Island nations delivered by more than 2,700 volunteer contributions across a range of specialties;
- Provided more than 83,000 patients with specialist consultations and medical assistance;
- Given 22,200 people potentially lifesaving surgical treatment otherwise unavailable in-country; and
- Delivered more than 200 training activities with recorded attendances by more than 2,700 Pacific medical personnel.

In the 20 years of its operations, the PIP has progressed through three defining stages from a focus on the delivery of surgery by specialist teams, to education and capacity building across the region to the modern era in which PIP activities are increasingly determined by surgeons and medical leaders from the Pacific Islands.

In the process of that progression, the College has developed expertise unmatched by any other Australasian medical college in the delivery of international medical aid and training and now acts as a conduit for engaging other specialist medical skills by working with other colleges and societies.

In the beginning the PIP had no money allocated for training, yet now almost every PIP team visit is designed around education, training and capacity building.

With a focus on helping Pacific Island nations become as self-sufficient as possible in their provision of surgery and specialist services, PIP teams have provided train-the-trainer courses such as the Primary Trauma Care workshop, the Essential Pain Management workshop, the Emergency Management of Severe Burns course and the Emergency Management of Severe Trauma course.

The PIP also works in close alignment with regional training



Lisa Rosenfeld conducts audiology consultation in Kiribati. Photo courtesy Lisa Rosenfeld.



Mr John Batten teaching Ponseti treatment techniques in Vanuatu. Photo courtesy John Batten.



Mr Phil McCahy in theatre with Tonga surgeon, Dr Kolini Vaea. Photo courtesy of Phil McCahy.

institutes such as the Fiji National University, the Pacific Eye Institute and the Papua New Guinea School of Health and Medical Sciences.

The relationships developed through this long-standing collaboration have also enabled graduates from a number of Pacific Island nations to access College scholarships to help them further their training in New Zealand or Australia or to attend international medical conferences.

And while the Australian Government has contributed an estimated \$30 million over the life of the project, the value added from pro bono contributions by specialist teams, project coordinators and directors has now been estimated to be worth an equivalent amount.

The former PIP Project Director and current Vice-President and soon to be President of the College, Professor David Watters, described the PIP as “the most successful health project ever delivered through foreign aid in Australia”.

He said there was now a highly trained and competent specialist medical workforce spread across the Pacific Island

region, which had been developed, in part, through the College's involvement in the Fiji School of Medicine Project (FSMP) coupled with the on-going professional support provided through PIP visiting teams.

The FSMP, which ran from 1997 to 2002, was designed to assist medical leaders in Fiji to develop a postgraduate training program under the leadership of the esteemed orthopaedic surgeon, Professor Eddie McCaig.

Although managed by the RACS, the FSMP also included input by the Royal Australasian College of Physicians, the Australian and New Zealand College of Anaesthetists, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the Universities of Otago and Melbourne.

Professor Watters said the combination of local support and international assistance for specialist medical education meant that there were 30 Masters of Medicine (Surgery) graduates now working in Fiji, Kiribati the Solomon Islands, Vanuatu, Samoa and Tonga.

“It is wonderful to see these surgeons now working to such a high level, helping their colleagues in smaller countries that cannot sustain a specialist medical workforce and becoming health leaders in their home nations,” Professor Watters said.

“Yet all that has been achieved is a credit to so many people, not least Professor McCaig who was last year chosen to receive the ESR Hughes Medal in recognition of his outstanding contribution to surgery.”

“The contribution of Gordon Clunie was also instrumental in the development of surgery in the Pacific region. He was Dean of Medicine at Melbourne University who chose, upon his retirement, to work at the Fiji National University to assist in the FSMP project.”

“The success of the PIP is due in large part to those two Fellows along with Dick Bennett who wrote the winning project tender and former President David Theile who had the foresight to promote the project as a way for the

“In the beginning the PIP had no money allocated for training, yet now almost every PIP team visit is designed around education, training and capacity building.”



RACS/PIP Management (L-R) Dr L McLeod, Ms D Moss, Ms H Postma, Ms J Cossar, Prof. D Watters, (back row) Mr J Batten, A/Prof. H Ewing, Dr K Alexander, Prof. P Carson, Dr K Maoate,



Mr Phil McCahy with Tongan surgeon, Dr Kolini Vaea, with a cystoscope Mr McCahy personally donated to Tonga. Photo courtesy of Phil McCahy.



Brett Chapman conducts audiology consultation in Nauru. Photo courtesy Brett Chapman.



Ponseti workshop in Vanuatu. Photo courtesy PIP

College to support our colleagues in the region and help improve the lives of patients in poorer countries.”

Professor Watters said it was a testament to the commitment of FRACS volunteers and the skills of College support staff that the PIP had never again been put out to tender since the RACS took on the project, despite changes in government and shifts in spending priorities.

He also said one of the keys to the success of the program was its longevity which had enabled deep professional relationships to be formed between Pacific Island medical leaders and surgeons and Fellows of the College which allowed for frank discussions and practical assistance.

“For a relatively small investment the PIP has delivered huge returns,” he said.

“It takes more than 10 years to train a surgeon so now we are in a position to support our regional colleagues as they do wonderful work.

“Yet while more and more Pacific Island surgeons are completing their training in Fiji or doing post-graduate placements elsewhere, the medical workforce in the region still has gaps such as in anaesthesia while some of the smaller nations will always need specialist team visits because of small populations or their remoteness.

“The RACS has always been very proud to offer this assistance and support to our regional neighbours.”

Professor McCaig said the support of Australian and New Zealand Fellows through PIP had been instrumental in training the new generation of surgical leaders through the Fiji National University

He said that local graduates had now taken leadership roles in Fiji, the Cook Islands, Tonga, Samoa, American Samoa, Tuvalu, Kiribati, Pohnpei, the Solomon Islands and Nauru.

“I think that the first time surgeon to the Pacific is often surprised with the standard of the work done by our people,” Professor McCaig said.

“However, this level and quality of training would not have achieved its present standing without the networking, support and mentoring provided through the PIP.”

Associate Professor Hamish Ewing, the Chair of the PIP Evaluation and Monitoring Committee, said the PIP was also successful because open communication channels allowed for a clear understanding of the skills that medical personnel in Pacific Island nations wished to learn.

He said that while the majority of Pacific Island surgeons were general surgeons, visiting Fellows helped

younger surgeons begin subspecialist training in such fields as urology and paediatrics while anaesthetists also delivered specialist training packages.

Some PIP team visits also include radiologists, physiotherapists, optometrists, audiologists and specialist nurses – all of whom conduct training while there.

“Fiji now has a paediatric surgeon and a neurosurgeon, both of whom are now teaching a new generation of specialist surgeons,” Associate Professor Ewing said.

“Now, it is the local Pacific Island surgeons and trainees who tell us what they want to learn and on many team visits, it is the local surgeons who take the lead in theatre, which is a way to ensure that capacity building continues.”

Associate Professor Ewing said that such a successful collaboration was only possible through time, commitment and the development of relationships.

“Many of the PIP projects and visits are now being driven through the Pacific Island Surgical Association,” he said.

“I have been attending these meetings for a number of years but last year it was spectacular because the young surgical registrars of yesterday have become today’s health leaders in their countries and it is wonderful to witness.

“I believe that with projects such as the PIP, as long as you have the right guiding philosophy, the right teams and honest relationships with host nations, a very great deal can be achieved.”

The current Director of the PIP, Mr Kiki Maoate, works out of the Christchurch Hospital, was born in the Cook Islands and returns there frequently.

In the role since 2011, Mr Maoate said he believed the PIP in future could expand beyond service delivery, training and skills development, to providing assistance and advice to help Pacific Island nations to develop complete health systems.

“I think the most important priority for the PIP in coming years will be to provide support for the new post-graduate surgeons returning home from their training,” Mr Maoate said.

“Then, I think we need to become more intimately involved with the Ministries of Health in the various countries so that they feel a greater sense of ownership over their health systems and they decide the priorities and strategies to achieve the outcomes they seek to achieve.

“The expectation of the College through the PIP is to ensure that the people of Pacific Island countries get the best possible outcome from the program.”

HOSPITAL SHIPS IN THE GALLIPOLI CAMPAIGN

An excerpt from the 'Surgeons of Gallipoli' book



DAVID WATTERS
VICE PRESIDENT



There was no historical precedent as never before had an amphibious landing of this magnitude been attempted. The initial estimate of casualties was 3000, but instead close to this number were killed or injured on the first day. On April 25 the limited medical facilities on Lemnos were already congested with the sick so that evacuations from the Dardanelles had to be shipped to Alexandria, a journey of two to three days and over 1000km. This presented enormous logistic challenges particularly when there was insufficient capacity on the ships assigned to evacuate casualties. It had been hoped that hospitals could be landed within a few days of the landing. This never eventuated.

The evacuation of casualties by sea involved three types of transports: hospital ships, transport or black ships

and, later in the campaign, hospital carriers.

1 Hospital ships were fully equipped. The *Sicilia* was assigned to the British 29th Division at Cape Helles and the *Gascon* for Anzac. 1 Australian Fd Amb, including George Adlington Syme, was aboard the *Gascon*, under the command of Lt Col Professor Huy of Lahore and the Indian Medical Service. The *Gascon* had a good operating theatre and an X-ray plant and the IMS provided three majors and one captain, as well as two Hindus of the subordinate Indian Medical Service, one of whom gave anaesthetics, and had charge of the X-ray department. Another hospital ship, the *Guildford Castle*, had been wired for and sailed on April 21 with the intent of evacuating the congested, overflowing 1 ASH at Mudros

on Lemnos. It was delayed and so failed to create hospital accommodation before the landing.

2 Transport (Black) ships which were used first to transport troops, animals and equipment but which could be converted to carry the wounded for the return journey.

Four were assigned for the Australia and New Zealand Corps, *Lutzow*, *Ionian*, *Clan McGillivray*, *Seang-Chang*. They were to be staffed by 2 ASH which sailed from Alexandria aboard the *Hindu* on April 20. It was intended that these black ships would only carry the lightly wounded as they weren't equipped with operating theatres and the like. On some of them the animals weren't able to be disembarked. To carry horses and wounded on one ship must occasion suffering to the latter. Lt Col Ryan told the Dardanelles Commission that on least half of these ships there were insufficient medical officers and limited equipment, including bedpans, dressing and clothing.

3 Hospital Carriers – these were converted cruise and other ships, hastily improvised and only used in this sphere of operations late in the Campaign.

By May 11, 11,000 men had been evacuated from the Dardanelles, with about 2000 being transported to Malta. Many waited up to 80 hours to be evacuated.

Later in the campaign other hospital ships were brought in, including NZHS Maheno, which operated in the Mediterranean, and the *Marama*, which was used to transport repatriated troops to NZ, bringing reinforcements on the return journey.



The College's first President and surgeon on the *Gascon* at Gallipoli

(Sir) George Adlington Syme, H/Col, KBE (1859-1929), MB ChB Melbourne 1881-2, MS 1888, FRCS 1885, MCRS England, 1885, LSA 1885, FRACS (f), FACS

EARLY LIFE

The son of a Baptist minister, George Syme was born at Sherwood, Nottinghamshire, England. His uncles, David and Ebenezer founded the Age, which resulted in his father taking the family to Melbourne in 1863. Educated at Wesley College and the University of Melbourne, he was a resident at the Melbourne Hospital before further surgical study at Kings College, London and the FRCS in 1885.

He returned to Melbourne in 1887, where his general surgical interests included ophthalmology, otolaryngology, orthopaedics and neurosurgery. In 1893, at St Vincent's Hospital, he performed the first successful removal of an intra-cranial meningioma in Australia. He was to work at St Vincents until 1903 when he was appointed in-patient surgeon to the Melbourne Hospital. He married Mabel Berry in 1899 and they had one son and three daughters.

GALLIPOLI

In October 1914 he enlisted with the rank of Lt Col and embarked on the *Kyarra*. He served first the 1 AGH in Egypt as Chief of Surgical Staff and then was assigned to the hospital ship *Gascon* for the landing. Syme wrote that: "The *Gascon* was fitted for 350 patients... We arranged to accommodate 150 more and actually took on 540. We were anchored about half a mile from the shore. The landing took place at 2am and we began to receive the wounded about 9am.¹"

Once full, the *Gascon* sailed to Egypt and returned for a second trip to collect men who had been left on the peninsula for a week. At that time Syme noted the cases had been wounded a longer time before being sent on board and were much more infected.²

WW1 AFTER GALLIPOLI

During September, October and November 1915 Syme was attached to 3 LGH at Wandsworth and the Australian Hospital at Harefield. He was at that time interested in the management of residual injuries, rehabilitation of amputees and localisation of retained bullets by X-ray. He was always impressed by the extraordinary cheerfulness, patience, courage and unselfishness displayed by wounded soldiers, whether Australian or British.

PROFESSIONAL LIFE AFTER WW1

Syme was a leader of the Medical Profession in Australia including being twice President of the Victorian Branch of the BMA. Retiring from practice in 1924, George Syme was instrumental in the formation of the RACS and was elected the first President (1927-9). He was a man of few words, speaking slowly and deliberately, and sometimes known as Silent Syme but with a reputation for honesty, integrity and ethics.³ In 1928, he was awarded an honorary LLD by the University of Wales and an honorary fellowship by the American College of Surgeons.

The Syme Oration is given in his honour at each Annual Scientific Congress of the RACS.



ANZAC SURGEONS OF GALLIPOLI

Exhibition in the
College Museum,
250-290 Spring St,
East Melbourne,
from 24th April,
open 9-5
Monday-Thursday

The exhibition includes surgical instruments and equipment used by surgeons in the Dardanelles campaign, maps and memorabilia. Starting with a mock-up of a Casualty Clearing Station in the foyer area, the exhibition continues in the museum. An accompanying book of the same name can be purchased at the exhibition or by request. It contains the biographies of over 130 surgeons and medical students who later became surgeons and chapters including the management of wounds and the Turkish medical arrangements at Gallipoli.



EIGHTY YEARS AT SPRING STREET

The award winning building has seen changing times

Sir Holbert Waring, President of the Royal College of Surgeons, unlocked the front door of the present College building, College of Surgeons' Gardens, Spring Street, East Melbourne, accompanied by RACS President, Sir Henry Newland, on March 4, 1935, 80 years ago last month. To commemorate the occasion, the current president Professor Michael Grigg, re-enacted that moment entering the front door of the College, on March 4, 2015.

The journey that ended with the construction of College headquarters, on a quadrilateral-shaped piece of land, bordered by Spring, Victoria, Nicholson and Lonsdale streets, in East Melbourne was not straightforward and was the consequence of: vice-regal foresight, a paradox of interstate support, philanthropy from unexpected sources and persuasive negotiations with successive Victorian Premiers with a degree of 'Devine Providence'.



BRUCE P WAXMAN
CLINICAL DIRECTOR,
VICTORIAN SKILLS AND EDUCATION CENTRE

Choosing a site for the College started with the annual meeting in Canberra in 1928, with the plan to commission a site on the federal capital territory in Canberra. Indeed a site visit of councillors took place with a fair degree of enthusiasm. Eventually, however, this idea lost favour and paradoxically, at the 1931 annual meeting in Sydney, two Sydney fellows, HRG Poate and AJ Aspinall, proposed that Melbourne should be the site of the colleague headquarters.

Initially, the Royal Society of Victoria, which occupied a triangular site bounded by Latrobe, Exhibition and Victoria streets was considered, but the Society demanded the College erect a lecture hall, which would be used as well for its own meetings, an arrangement that was totally unsatisfactory and the site being too small for any expansion, attention was turned to the current site.

The foresight of Victoria's first Lieutenant Governor Charles Latrobe, whose legacy not only includes the many parks and gardens that adorn Melbourne, but the promise to the Education Department that the future site of the College should be set aside for education and learning, was realised and is currently perpetuated by the College's values of education and training. The Melbourne Model high school, the first government-funded "public" school in Melbourne, was built on the site in 1852 and survived for 80 years before being condemned.

In 1932 negotiations between the College and the Victorian state government commenced. Enter, Sir Hugh Devine.

Devine's contributions to the College are legendary and diverse, but he was able to convince the Premier at the time, Edmond Hogan, to set aside the southern part of the sites occupied for the high school, for a 50-year peppercorn rental, with the right of renewal in 50 years. The College was to take over the northern part of the site for 10 years, attending to tidying, fencing and landscaping and it was required within these 10 years to spend £15,000 on



FAR LEFT: Opening of the College 1935. **BELOW LEFT:** President Michael Grigg replicating historic actions. **RIGHT:** Sir Holbert Waring and Sir Henry Newland open the College doors, 1935.

a building project. Thus, the contract was signed on April 14, 1932, which coincided with a change in government. The new Premier, Stanley Argyle, a very close friend of Devine, modified the terms so the College gained its 50-year renewable lease over the whole area, while the government offered to construct the necessary gardens, at no cost to the college, hence the ultimate name for the site being the College of Surgeons Gardens, officially named in 1965.

That the address would be Spring Street, on its west side, despite the College facade facing south, is likely because the road on the south side was neither Lonsdale nor Albert, but a lane successively called Evelyn and Flint streets.

Construction of the building commenced in 1933 and was completed ahead of schedule towards the end of 1934, but without the portico, such a major feature of Leighton Irwin's, later award winning design. It was the philanthropic generosity of Dr AE (later Sir) Rowden White, a prominent physician, and FJ Cato, father of ET Cato, a Fellow of the College, who provided the necessary funds for the portico, to create the façade that would forever characterise our College.

The year 1935 was a big one for Melbourne, not only celebrating its centenary, but the British Medical Association decided to have a rare off-shore annual meeting in Melbourne, in September.

Rather than the opening of the building being a side show of both the celebrations and the BMA meeting, and serendipitously the unavailability of Sir Holbert Waring in September, the opening ceremony occurred earlier in the year, on the afternoon of March 4, 1935, in the company of eminent overseas surgeons including Sir D'Arcy Power, John Fraser, Henry Wade, EW Archibald, Donald C. Balfour, Dean Lewis and CFM Saint, all of whom were conferred with Honorary Fellowships at the evening annual College meeting with the fourth Syme Oration, delivered by Prof Frederick Wood-Jones.

The past 80 years have seen significant building developments on the site with the west wing and the great hall in the east wing in 1965, and the later destruction of the great hall, the archeological exploration of the foundations of the Model School with the construction of the east wing Skills and Education Centre, opened in 2002.

The dream of Latrobe has been realised within the walls of the building that has now occupied the College of Surgeons Gardens, for 80 years, but our journey to maintain high standards of education and the practice of surgery in Australia and New Zealand continues.

I acknowledge the permission from AW Beasley, to use information from his book 'The Mantle of Surgery' published by RACS in 2002.

OPEN HOUSE MELBOURNE

SATURDAY & SUNDAY 25-26TH JULY



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

A number of buildings not normally open to the public will be participating

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

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

RECORDS ARE YOUR BEST DEFENCE

Don't rely on just your memory to relay events



MICHAEL GORTON
COLLEGE SOLICITOR

Most doctors are likely to receive one complaint or claim during their professional life. It is a 'life event', likely to be stressful and filled with uncertainty. None of us like our professionalism questioned or suggestions that we may have done wrong.

Upon receipt of a complaint or a claim, you will of course immediately notify your medical indemnity insurer.

Your insurer is unlikely to say: "That's terrible doctor. Please come round and have a cup of tea and a biscuit so that we can discuss the matter with you."

Your insurer is more likely to say: "That's terrible doctor. Can you please send us a copy of your medical records and file in relation to this claim, and then we will have you around for a cup of tea and a biscuit to discuss the matter with you."

Your insurer will want to know what documentary evidence exists in relation to the claim. In many cases, your medical and other records will be your best defence.

For a patient, an adverse outcome following medical treatment or a procedure will be a 'life event' for them. They will apparently remember everything about their treatment, conversations and even what they had for breakfast! The doctor, on the other hand, will have seen many patients that day and that week, and direct recollection of all of the events, all of the circumstances, and all of the details may be difficult. That is why professionals need to keep detailed records.

Doctors and hospitals are very good at keeping records on observations, medications, the course of treatment and clinical observations. Doctors and nurses will have contributed to the medical records. However, it is just as important to be fulsome in describing details of observations, details of the precise procedure undertaken, and any unusual



features that appeared on presentation. It is also important to record any significant conversations, particularly warnings to the patient of the risks of the procedure in advance of the procedure ("informed consent"). Also, following an adverse event or outcome, record details of the conversation with the patient to ensure that no admission of liability was made, although you may, of course, extend as a matter of courtesy, an apology to the patient that they have suffered an adverse outcome. Conversations with a patient after an adverse event should of course be done carefully, and potentially with the assistance of hospital management if necessary.

Depending on the nature of the allegation by a patient, simply relying on your memory may not be adequate. The fact that you had detailed contemporaneous notes of what actually occurred, will be a godsend.

In the unlikely event that a matter proceeds to a trial in court, the patient is likely to be a credible witness. The doctor, in the witness box, will be attempting to

recollect all of the events from memory – unless there are detailed records also available.

Judges are aware that, no matter how credible a witness a patient appears to be, their memory is also likely to be variable. They cannot possibly remember everything. So, in the event of competing versions of the events – yours and the patient's – yours will be preferred if there is also written evidence and documentation of the details.

Maintaining detailed notes is not just for your medico-legal defence. It is also a professional obligation, reinforced by the Medical Board of Australia, as part of expected good practice. The MBA Guideline 'Good Medical Practice – A Code of Conduct for Doctors in Australia' outlines professional obligations in relation to record keeping.

Good medical records are also essential from the point of view of patient safety and accordingly is also "just good practice".

Just remember: "Good records = defence".

What is the h-index and is it important?

ASERNIP-S scores 30 with outstanding performance



GUY MADDERN
CHAIR ASERNIP-S

Publish or perish is the modern researchers mantra and drives the need to be published. Once publication has been achieved the next step is to communicate research productivity to justify professional existence. In the past it has been problematic thus a simple metric that communicates productivity to a wide audience would be useful. In 2005 Professor Hirsch (University of California) addressed this issue by proposing the h-index which is a single number that describes both research output and impact.¹ Since its introduction the h-index has gained traction and been adopted by bibliometric databases, for example Scopus (www.scopus.com).

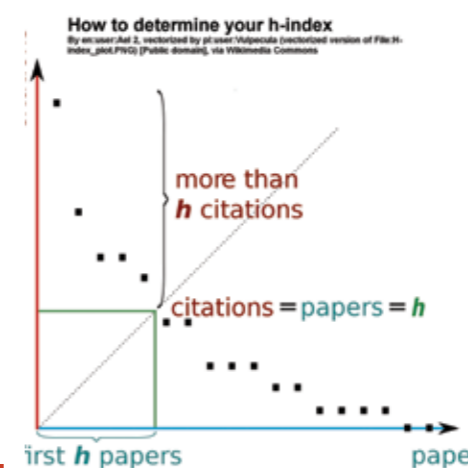
How is the h-index calculated? The figure shows the graphical method used to determine the h-index. All articles are numbered in decreasing order based on the number of citations. The intersect between the curve and the 45 degree parity line is the h-index. Yes – it is that simple and databases such as Scopus perform such analyses and report the h-index.

Surgery, 2004; 135(3):326-51
Cited 366 times (at march 2015)

Clinical review

Laparoscopic adjustable gastric banding in the treatment of obesity: A systematic literature review

Andrew E. Chapman, BA (Hons.), George Kiroff, FRACS, Philip Game, FRACS, Bruce Foster, FRACS, Paul O'Brien, FRACS, John Ham, FRACS, and Guy J. Maddern, FRACS, PhD, Adelaide, Victoria, New South Wales, and Woodville, Australia



score of 6 (range 0 to 81) and a cut-off score of 26 to be in the 95th percentile for productivity.³ Against these benchmarks, the ASERNIP-S team is in the top five per cent of surgical research output, again an outstanding achievement and one to be celebrated.

Determining an h-index is easy and when presented with the m-parameter it is an effective and important way to communicate past research performance and the potential for future performance.

More information on the work conducted by ASERNIP-S can be found at: www.surgeons.org/asernip-s and through the College's Twitter feed (@RACSurgeons) and Facebook account. For additional information regarding h-index contact Dr David Tivey (david.tivey@surgeons.org).

To account for years in research, Hirsch established the m-parameter which is the h-index by dividing by the years of scientific activity. Hirsch benchmarked the m-parameter scores such:

- [1]** indicates a successful scientist
- [2]** represents outstanding achievement
- [3]** characterises unique individuals.

How is ASERNIP-S performing?

ASERNIP-S has produced 113 peer reviewed publications in 17 years with a total of 3715 citations with our top article receiving more 350.² This translates to:

- an h-index score of 30 and an m-parameter of 1.76
- an outstanding performance of ASERNIP-S researchers.

Furthermore, the Scopus h-index for surgical research has been benchmarked. Analysis of performance of more than 3000 authors returned a median h-index

1. Hirsch JE. An index to quantify an individual's scientific research output. Proc Natl Acad Sci U S A. 2005;102 (46):16569-72.
2. Chapman AE, Kiroff G, Game P et al. Laparoscopic adjustable gastric banding in the treatment of obesity: A systematic literature review. Surgery. 2004;135 (3):326-51.
3. Cucchetti A, Mazzotti F, Pellegrini S et al. The use of the Hirsch index in benchmarking hepatic surgery research. Am J Surg. 2013;206 (4):560-6.

SITUATIONAL AWARENESS AND THE SURGEON

Challenges include the many interruptions in theatre



JOHN NORTH
QASM CLINICAL DIRECTOR

In November 2014, the Queensland Audit of Surgical Mortality (QASM) held its annual one-day seminar. This seminar, Situational Awareness and the Surgeon, took place in Brisbane and attracted 42 Queensland surgeons – a smaller than usual seminar, but with stronger-than-usual participant involvement

Guest speakers included: Royal Australasian College of Surgeons President, Professor Michael Grigg presenting on 'Situational Awareness in Surgery' and Medical Education consultant, Debbie Paltridge, presenting on 'Recognising Loss of Situational Awareness'.

These two presentations were enhanced by the viewing of 'Just a Routine Operation' (available on YouTube, <http://youtu.be/JzlvgtPl0f4>). This video sparked much constructive debate and supported small-group discussions throughout the day. Feedback from one surgeon noted that, "This video, seen with appropriate supervision and discussion should be mandatory for all members of RACS for Continuing Professional Development completion." This could

be difficult, but I found the surgeon's comment interesting.

The debate's discussions centred around the question: 'Should there be mandatory assessment of non-technical competencies for surgical revalidation?' Entertaining and challenging opinions were offered by both the proponents (Professor Michael Grigg and Dr Lindy Jeffree) and the opponents (Professor David Watters and Dr Leigh Rutherford). Audience participation was enthusiastic.

Overall, from the evaluation forms, surgeons considered that the seminar was a success. Evaluation forms were completed by 50 per cent of attendees and of these, 95 per cent said that they could now better understand how to evaluate the signs of loss of situational awareness in the surgical environment. Eighty-eight per cent said they would devise a personal plan for analysing situational awareness in their practice.

One surgeon, when asked about making a personal plan for analysing situational awareness, noted that they would move "toward pre-planning difficult cases by having discussions across disciplines/other sub-specialists and in other cities – by utilising video conferencing etc."

QASM also asked attendees the following two questions (some of their responses are included right):

I would like to give special thanks to all presenters for contributing to the success of QASM's annual educational seminar, 'Situational Awareness and the Surgeon' in Brisbane (November 2014).



What are the challenges you face with situational awareness?

- So many interruptions in theatre – tea break, bed block, registrar/consultant on-call interruptions, 'switch' putting patients through etc.
- Assuming my opinion is the correct one.
- Knowing what to do once I get lost.
- Problematic colleagues.
- Achieving awareness of "situational awareness" for all members of the team.
- Effective communication.

Which aspects of the seminar did you find most useful?

- Theory of situational awareness and indicators of loss of it.
- Need to access our individual awareness.
- Educational talks led well into the debate.
- Good large group discussions. Useful cases scenarios.
- Case scenario discussion.

Case Note Review

A cardiac and vascular spiral



GUY MADDERN
CHAIR ASERNIP-S

Case summary:

A patient in their seventies with a history of hypertension and type 2 diabetes with previous coronary artery stents, presented with a six-month history of exertional angina and developed a non ST-elevation myocardial infarction (NSTEMI) for which they were admitted to hospital.

Clinical examination indicated that peripheral pulses were present, but that 'there was decreased circulation in both feet due to diabetes'. Coronary angiography was performed two days after admission and revealed a left main stenosis 70 per cent, left anterior descending (LAD), occlusion, 90 per cent circumflex stenosis and 90 per cent right circumflex artery (RCA) stenosis with an ejection fraction of 0.25–0.3.

Surgery was performed several days later and consisted of a left internal mammary artery (LIMA) to LAD, saphenous vein graft to the intermediate and to the posterolateral branch of the circumflex. An intra-aortic balloon (IAB) was inserted preoperatively – the exact reasons for this were not apparent from the case notes. There also appears to have been no anticoagulation measures while the IAB was in place. It is acknowledged that anti-coagulation is not always used with an IAB. Initially the haemodynamic

status was stable and therefore the pulmonary artery catheter and the IAB were removed within 24 hours of operation. However, 48 hours after operation there was deterioration in the haemodynamic situation, requiring reintubation and further cardiac support.

One of the complicating features was that the patient developed a new problem, namely peripheral vascular ischaemia. The pulse chart suggested that the right pedal pulses were not palpable; the distal right leg became cool, the patient complained of being unable to feel the leg and subsequently complained of pain in the leg. Within a few hours the leg was pulseless and Doppler confirmed no distal flow. More than 24 hours after the deterioration in vascular function of the leg an embolectomy and thrombolysis on the right leg was performed, combined with dilatation of the superficial femoral popliteal and posterior tibial arteries. More than 24 hours later it was suspected that a compartment syndrome had developed, but no fasciotomy was performed for a further 12 hours as a vascular Registrar was not available.

At the same time that the peripheral circulation was deteriorating there was also evidence of an acute abdomen with abdominal distension and x-ray evidence of dilated proximal small bowel loops and large volumes of faeculent losses via the NG tube. By this stage it was decided that exploration of the abdomen was not indicated.

The combination of these three factors (haemodynamic deterioration, leg ischaemia and the evolving acute abdomen) resulted in a downward spiral of sepsis, cardiogenic shock and acidosis which resulted in a decision to withdraw therapy. The patient died shortly after.

Clinical lessons:

1. The patient appeared to have a routine early postoperative course in ICU until the removal of the IAB when distal ischaemia was demonstrated. There is no evidence of the nature, if any, of the type of anticoagulant therapy employed during the first postoperative day, that is, whilst the IAB was in situ. There was also nothing in the notes to indicate whether IAB was placed on the same side as the leg ischaemia. The question must be raised whether these factors contributed to the lower limb ischaemia.
2. Vascular consultation was not obtained until approximately 24 hours after the development of lower limb ischaemia, and embolectomy and thrombolysis was not performed until a further four hours later. This is a significant delay.
3. Subsequently, the patient developed a distended abdomen which may well have been due to ischaemic bowel (post-mortem showed a 70 per cent stenosis to the superior mesentery artery). In view of the two areas of peripheral ischaemia (gut and leg) one must wonder if atrial fibrillation with distal emboli was a factor, but the case report is silent on this issue.
4. A late fasciotomy did nothing to lessen increasing acidosis and haemodynamic deterioration.
5. The final area of concern is why the right coronary artery or its branches were not grafted. The angiogram describes a 90 per cent stenosis of the RCA (at post-mortem a 70 per cent stenosis was noted), but no branch of right coronary artery appears to have been grafted. If this is the case, then this may have contributed to the patient's haemodynamic deterioration.



Wendy Yu, Daniel Lemanu, Andrew MacCormick, Rob Shao, Andrew Hill, Parry Singh. At the RACS ASC in Malaysia

IMPROVING PATIENT OUTCOMES

Research aims to speed up recovery times following abdominal surgery

The 2014 recipient of the College's prestigious John Mitchell Crouch (JMC) Research Fellowship, Professor Andrew Hill, has used the attached funds to conduct experiments aimed at finding ways to improve patient outcomes following abdominal surgery.

Professor Hill is a Colorectal Surgeon, a Professor of Surgery and Assistant Dean and Head of the South Auckland Clinical Campus of the University of Auckland at Middlemore Hospital.

In a rare occurrence for the RACS, his father, the late Professor Graham Hill, also received the JMC Fellowship in 1984.

Professor Hill said that after years of surgeons conducting minimally-invasive abdominal surgery, it was clear that patients still took months to recover and that recovery rates remained similar for patients undergoing open surgery.

He said this was due to the insult to the peritoneum, a highly metabolically active sheet of tissue that envelops the majority of the abdominal viscera.

He is now researching methods to minimise that insult, work which could change clinical practice for all surgical specialties working in the abdominal cavity.

"The experience of major abdominal surgery for the patient is dominated by pain, fatigue, loss of control,

inability to eat, disturbance of circadian rhythms, lack of sleep and mixed emotions including anxiety and fear," Professor Hill said.

"Even following successful discharge from hospital and successful healing of all external wounds, the patient continues to feel tired, despondent and lacking energy to carry out usual daily tasks for up to three months.

"This is because there are two wounds caused in abdominal surgery; the somatic or skin wound and the autonomic wound which I believe to be of greater importance.

"I think in recent decades that we surgeons have become overly focused on the skin wound – because technology has enabled us to make smaller incisions, because we think a small wound is a good wound and because patients do appear to do better in the first few days following surgery.

"But I believe that it is the peritoneal and visceral wounds, that collectively make up the autonomic wound, that are of greater importance and there have been a number of studies now that indicate in my field, that laparoscopic colonic surgery has only marginal clinical benefits over open colonic surgery.

"This is almost heretical to say these days, but still it is true.

"It is like we are taking all the care in the world to make a tiny external wound and then going in and setting off a nuclear bomb anyway."

As the head of the Auckland Enhanced Recovery after Surgery (AERAS) research group, Professor Hill has conducted a number of experiments aimed at reducing the effects of the autonomic wound.

These include pre and intra-operative interventions aimed at limiting peritoneal inflammation and using anaesthetics to block signals carried by the vagus to the brain.

Professor Hill said that because surgery, anaesthesia and antibiotics had improved so greatly, such a massive reaction by the body to the surgery no longer served any purpose.

"The vagus nerve is the largest visceral sensory nerve in the body with approximately 50,000 afferent fibres, most of which innervate the peritoneum," he said.

"Thus vagal inputs originating from the peritoneum have great potential to modulate and regulate behaviour in humans.

"As such, studies now seem to be telling us that what appears to be most important in abdominal surgery is not the skin wound, but the extent to which the peritoneum is itself entered, dissected and manipulated.

"Yet until now, the surgical insult to the peritoneal cavity and viscera has not been emphasised as an important entity and a target for interventions.

"However, while the somatic wound might almost be dispensed with in the foreseeable future, the autonomic wound created by the surgeon and its downstream effects will require much more attention."

Over the past few years, Professor Hill and his team of researchers have studied:

- the effects of using pre-operative steroids to control the inflammation response;
- the benefits or otherwise of using humidified gas in laparoscopic surgery;
- the use of optimising fluid administration during surgery; and
- the impact of local anaesthetics blocking the vagus during and after surgery.

"We found from these studies that the humidified gas and the optimising fluid made no discernible difference, even though both are highly thought of in some centres around the world," Professor Hill said.

"Yet we also found that patients did recover more quickly if they were given the local anaesthetic to block the vagus and later this year we will begin a clinical trial at the Middlemore Hospital of 100 patients given long-acting pre and post operative therapy.

Professor Hill's interest in research and academic surgery extends further than his clinical work for he also has a particular interest in medical education.

He completed a Doctorate in Surgery from the University of Auckland in 1996 and a Doctorate in



LEFT: Professor Andrew Hill awarded the John Mitchell Crouch Research Fellowship, his father (inset) Professor Graham Hill received it 30 years previous.

Education in 2011 and completed a research Fellowship at Harvard University in 1993-1994.

He became a Fellow of the College in 1997 and worked in Kenya as a medical missionary before returning to New Zealand in 2002.

He has received extensive research funding from the University of Auckland and other sources and has published over 170 peer-reviewed papers in the areas of recovery following abdominal surgery and medical education.

Professor Hill will be taking up a position on the College Council in May this year.

He said he had become fascinated in post-operative recovery as a Trainee and also because his father, Professor Graham Hill, had spent years researching why patients lost muscle mass following surgery and the causes behind post-operative fatigue.

He thanked the College for its support in awarding him the JMC Fellowship and said it was particularly valuable in New Zealand.

"It was huge not just for me, but for the research group as a whole to receive the Fellowship and that untied pot of money," he said.

"In New Zealand, research grants are hard to get and highly constrained so the JMC funds allowed me to employ some PhD students, buy some kit and attend a conference, all of which moved our work forward considerably.

"It is an extremely prestigious Fellowship to receive and it is certainly one of the highlights of my research career."

The John Mitchell Crouch Fellowship is awarded to Fellows who are making an outstanding contribution to the advancement of surgery or to fundamental scientific research in the field and was established in 1978 by Mrs Elizabeth Unsworth in honour of her son.

Professor Hill was formally presented the JMC Fellowship at the College's ASC last year in Singapore.

With Karen Murphy

LEASING OPPORTUNITIES

Castle Hill Day Surgery Building

THREE SUITES ARE BECOMING AVAILABLE WITH IN NEXT MONTH



SUITE 4

86.2 Sq Metres

- Reception area and waiting room
- Large open area suitable for conversion in to 2 offices or therapy/ treatment area, plans available
- Onsite parking

SUITE 5

127.8 Sq Metres

- Three Consulting Rooms
- Large Reception area and waiting room
- Storage area
- Kitchenette and bathroom
- On Site Parking

SUITE 8

54.2 Sq Metres

- Two consulting rooms
- Reception area and waiting room
- Storage area
- Onsite parking
- Available for lease or as sessional room

With the opening of the new rail line, bus interchange and the proposed building of multi-story residential and shopping facility adjacent to the station, this is a excellent site for the accessibility to and for patients and staff.

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Email: mbirchall@chds.com.au

autumn *lifestyle* post op



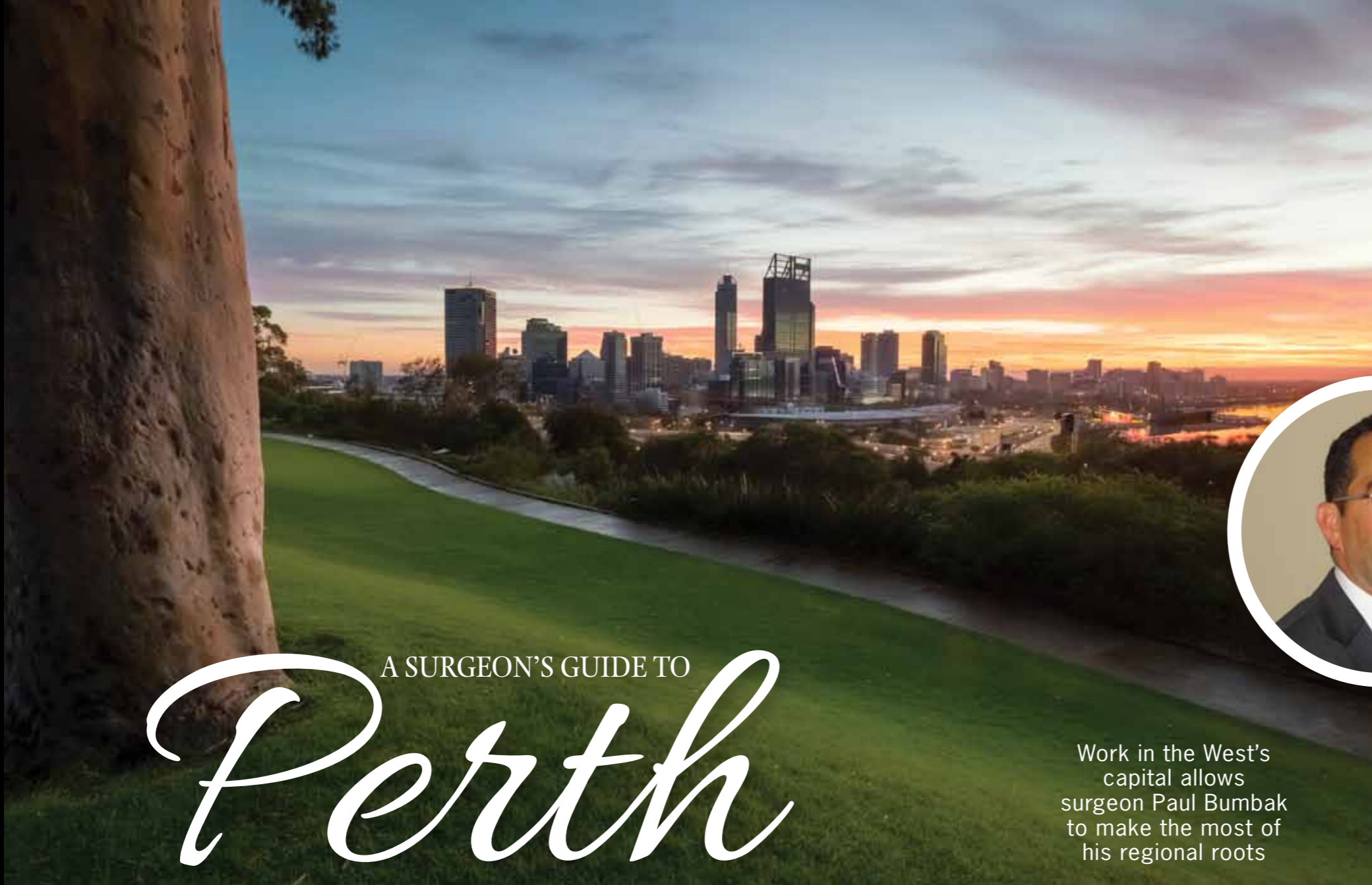
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A SURGEON'S GUIDE TO Perth

Work in the West's capital allows surgeon Paul Bumbak to make the most of his regional roots

ENT surgeon Mr Paul Bumbak has an affinity with the wide open spaces, the red soil and the people of regional Western Australia forged from a childhood spent on the family banana, mango and sweet-corn plantation in Carnarvon and a secondary boarding-school boyhood in Geraldton.

Now a Paediatric ENT specialist working out of the Princess Margaret Hospital for Children and with a private practice sharing rooms with the renowned Professor Harvey Coates, Mr Bumbak has retained his attachment to the people and places of his past.

Every three months, he swaps his suit for shorts and t-shirts and heads north with ENT teams to treat Indigenous children and their families in the ongoing campaign to help reduce the impact of chronic ear infections and disease.

He does this work through the WA Country Health Service including the Mid West and Gascoyne Health Service (which covers

Carnarvon, Exmouth, Burringurrah), the West Kimberley Health Service (Broome, Derby, Fitzroy Crossing) and the East Kimberley Health Service (Kununurra, Wyndham, Halls Creek).

He described the trips as a highlight of his working life.

"Growing up in Carnarvon meant I had considerable exposure to Indigenous culture from an early age and when I was going through my medical training I thought long and hard about which specialty I could do that would allow me to offer real, practical assistance," he said.

"Instead of just sitting in the city waiting for patients to be referred to me, I wanted work that would allow me to go to them so they didn't have to deal with the associated costs and upheaval of travel.

"Working with Professor Coates has been a great privilege and I absolutely love my trips up North.

"I get to dress down so I am not an intimidating figure and have the opportunity not just to

treat kids and their families, but also to educate them as well as train local nurses and GPs in the screening for, and treatment of, ear disease and the complications of infection."

When up in the air and out on the road, Mr Bumbak travels with audiologists, specialist nurses and anaesthetists and treats the children, following screening at various clinics, at the Carnarvon, Broome, Derby and Kununurra hospitals.

He said that although he had lived in Perth for many years, having done his undergraduate degree through the UWA Faculty of Medicine and Dentistry then surgical training with the RACS and a post-Fellowship year at the Starship Children's Hospital in Auckland, he retained a strong connection to the people of the more remote regions of Western Australia.

"I think you have to really care about these kids and their families to have any kind of impact," he said.

"The more often the Indigenous people in these communities see you, the more they feel they can

trust you and the more you can get across in terms of education.

"It means that we are not seen as judgemental intruders, but as partners so we can have conversations about the kids and their ear infections from a holistic perspective including issues around housing, nutrition and hygiene.

"All of us who are passionate about this work just keep trying to empower local communities so they can achieve the best possible outcome for the kids."

Next month, the College's Annual Scientific Congress will be held at the Perth Convention and Exhibition Centre. As well as the busy scientific program, a number of activities and tours have been organised to regions such as the Kimberley, the renowned Margaret River with its wineries and surf breaks and to Albany for those with an interest in military history.

However, if you're more inclined to potter and poke around Perth, here are some suggestions from Mr Bumbak. ▶

PARK FIT FOR A KING

Straddling the hills that look down on the Perth CBD, Kings Park is one of the world's largest inner city parks. Rich in Aboriginal and European history, the park is home to the Western Australian Botanic Gardens, which displays over 3,000 species of the state's unique flora. From high on the hills, visitors can enjoy sweeping views of the Swan and Canning rivers, the city skyline and the Darling Ranges to the east. Two thirds of the 400 hectare park is protected as bushland and provides a haven for native wildlife, while the rest comprises walking trails and manicured gardens. First named the Perth Park in 1895, the inner city oasis was renamed the Kings Park to mark the rise to the British throne of King Edward VII. "I love spending time in King's Park and go up there quite often because I work nearby," Mr Bumbak said. "It's great for us locals, but it's also a good way for visitors to get a sense of the layout of the city."



WESTERN TREATS

With a boom-bust economy as bouncy as the WACA wicket, Perth has a range of shopping options to suit all purses from the city's upmarket West End, where international fashion houses have made their home, to the bargain hunters' delights found in Harbour Town, located just out of the city centre on Wellington Street. To get a taste for local life, culture and music visit the Fremantle Market. Known for its wide range of food and goods, the Fremantle Market has also been a launching pad for successful musicians who once were buskers. The market is also dedicated to promoting Indigenous and independent producers of art and crafts. Mr Bumbak also recommended visits to the Swan Bell Tower, the Perth Zoo and the Perth Mint.



WINING AND DINING WA STYLE

Mr Bumbak said that one of the things he most loved about Perth was its vibrancy and multicultural flavour, both of which underpin the food and wine scene. He said visitors could easily find wonderful dining options via a stroll through the CBD and Northbridge, but said his current favourites were the Print Hall Bar and Dining Room (Brookfield Place, 125 Georges Terrace) and Pleased to Meet You (38 Roe Street, Northbridge). The Print Hall, as the name suggests, was once the home of the West Australian printing presses and is now a luxurious space hosting a number of venues. Pleased to Meet You serves Central and South American food on plates designed to share. For a touch of glamour, Mr Bumbak said visitors should check out C Restaurant, a revolving restaurant offering stunning views located on the 33rd floor of St Martin's Tower, St Georges Terrace.

FUNKY FREO

The meeting place and settlement area of the Whadjuk Nyoongar Aboriginal people, Fremantle has always been culturally and economically important to the people of the West. Once a boom town on the back of the gold rush and agriculture, Fremantle still retains an impressive suite of late Victorian and early Edwardian buildings funded by that wealth as well as some more Gothic constructions, such as the Fremantle Prison and Fremantle Arts Centre, built by the sweat of convict labour. The Western Australian Museum – Shipwreck Galleries is also found in Fremantle and is recognised as the foremost maritime archaeology museum in the Southern Hemisphere. The galleries house hundreds of relics from the ships wrecked along WA's treacherous coastline including the original timbers from the Batavia which met her doom in 1629.



WILDLIFE ON ROTTNEST

Located 18km off the coast west of Fremantle, Rottnest Island is a Class A Nature Reserve covering just 19 square kilometres of land. Served by a regular ferry service, the island is home to spectacular flora, marine life and wildlife, many species of which are unique to the island. Standing just 30 centimetres high, the quokka is Rottnest's most famous inhabitant, but not the only star of the show. Wild birds to watch out for include Banded Stilts, Crested Terns and Red-capped Plovers while Osprey nests believed to be over 70-years-old can be found at Fish Hook Bay. For an evening acoustic treat, listen out for the wonderfully named moaning frog (Burrowing Frog), motorbike frog (Western Green Tree Frog) and squelching frog (Sandplain Froglet). Rottnest is also home to 135 species of tropical fish, has spectacular walking trails and scenic looks outs for whale watching.

With Karen Murphy



WALKING AWAY THE WORRIES

IMG surgeon Matthew Hadfield uses hiking to achieve his work-life balance

Vascular surgeon Mr Matthew Hadfield resolved with his wife Lynn a few years ago that if they moved to Australia from their home in England they would re-establish a better work-life balance.

That discussion took place in 2011 when Mr Hadfield was working more than 80 hours a week as the Director of Surgery at the Pennine Acute Hospital Trust, an NHS facility with sites spread across the North East of Greater Manchester.

Head-hunted by the Ballarat Base Hospital to take up the position of Director of Surgery, he moved to Victoria in 2012 and has been true to his word.

A keen hiker and mountain climber during his youth in Scotland, Mr Hadfield has made the most of his

continental shift by taking time away from work to spend with Lynn and friends on adventures in remote and rugged country.

In 2013, they spent three weeks trekking through the jungles and mountains of East Timor then last year went further afield to trek through remote passes of the Himalayan Mountains in the dizzying region where India, Pakistan and China all begin to merge.

“We decided to go to East Timor for two reasons,” Mr Hadfield said.

“First we wanted to go trekking in remote, but beautiful country before it became a tourist destination which East Timor will become, in time, because it’s so lovely.”



Shingo-la crossing the great Himalaya range

“We also went because Ballarat is twinned with a town there called Ainaro and Lynn and I had participated in fundraising activities to get some sports equipment for schools there, so we combined the two.

“The mountain country in East Timor is fantastic and we trekked up Mount Ramelau, East Timor’s highest mountain, so we were at the top in time for sunrise.

“Then we hiked through jungle to get to Ainaro, staying in the villages, so we could deliver soccer balls, netballs and sports kit that we could carry to the kids of the towns and villages.

“The combination of doing hard physical trekking in beautiful country as well as having the chance to meet local people made for a wonderful holiday.

“There is no other way to reach some of the villages other than walking, so the schools were delighted with our deliveries while the kids were just fantastic, swarming us and fizzing with joy.

“East Timor is a wonderful country and the people are so friendly that it makes their poverty even more

heart-breaking. However, they are starting to develop the seeds of a tourism industry, with pockets of home stay and guest house accommodation now available; so in the years to come these more isolated places might develop a more secure income stream.”

Last year Mr Hadfield, Lynn and a small group of hardy trekkers set out to explore the Himalayas of North West India in the region of Ladakh, which means ‘land of high passes’.

The group spent three weeks trekking at altitudes of 5,500 metres with horses to carry equipment and guides to lead the way.

It was, Mr Hadfield said, a world away from picture post card images of the snow capped Himalayas.

“This is extraordinarily remote country where you may be the only people to go over a pass for a whole year as we were in 2014,” he said.

“Unlike how most of us imagine the Himalayas, the region that we travelled is not snow capped mountain country, but brown, rocky desert with huge rocky mountains towering above and it’s completely barren.

“There is nothing there to see apart from the mountains, little wildlife or flora and no other human beings, which made for an incredible experience.

“It was unlike anywhere I had ever been before and opened up to us a completely different aspect to the Himalayas.

“While we trekked across, walking about 25km per day, we went for days without seeing any sign of life except for ancient Tibetan monasteries carved high up into the rock face.

“Then we took in a bit of civilisation by visiting Agra and the Taj Mahal before we came home.”

Mr Hadfield said that he was greatly enjoying his new life in Australia, not least because it had given him the chance to hit the ‘reset’ button on how he creates an optimal balance between work and the rest of his life.

He said that a life in surgery can easily push out other interests without a conscious decision to set and maintain work limitations.

“As a student in Scotland I often trekked around the highlands on weekends, but then when you begin your career, work takes up more and more time and before you know it you have stopped doing things that you really like to do,” he said.

“That’s just how our profession works, but it doesn’t necessarily make for the best surgeons or the most contented human beings.

“To me, one of the best things about leaving the UK to come to Australia was having the chance to get my working life back in balance.

“I now get to really enjoy my life as a surgeon while having adventures with my wife and friends.

“My time here has taught me that all aspects of your life benefit if you can just get out from under the work load and prioritise time away.”

With Karen Murphy



NO CHALLENGE TOO BIG

Victorian Paediatric Surgeon Robert Stunden does not seem inclined to shy away from a challenge

As a young man Robert Stunden had to learn to walk again after a motorcycle accident left him with multiple limb injuries. He began his working life in Scotland as a GP anaesthetist before becoming a surgeon and he has worked or volunteered on almost every continent.

Now head of Paediatric Surgery at the Casey and Frankston Hospitals in Victoria, he has a lectureship appointment at Monash University, a busy private practice and is one of the few outside surgical specialists invited to participate in overseas Interplast team visits. He also lectures and examines at the combined RACS / Melbourne University postgraduate surgical anatomy course.

He has mixed it with witchdoctors and herbalists in East Africa, and while working for the Red Cross Children’s Hospital in Cape Town, became the warden of South Africa’s first mixed-race university residence even before the collapse of the brutal Apartheid regime.

There, with rioting and mass showdowns

between students and authorities and with laws in place that allowed for the arrest of injured protestors presenting to hospital, Mr Stunden set up a clandestine first-aid station within the university grounds to treat the wounded.

In more recent and more sedate times, Mr Stunden has worked in Nauru and Kiribas treating children who would otherwise never be able to access or afford surgical care.

But his desire to make his time count does not just extend to his professional life for Mr Stunden and his wife Carol also own and run two environmentally pioneering commercial farms.

The first, near the coastal village of Tooradin, has transformed the ecosystem of the land while the second, a commercial chicken farm, has pioneered the use of sustainable solar energy.

Mr Stunden said the Tooradin farm comprised 50 acres and was the idyllic home of goats, sheep, horses, alpacas, chooks, geese, ducks, guinea fowl, peacocks and bees, as well as the usual farm dogs and cats.

The chicken farm, near the Gippsland town of Bunyip, provides 2.4 million kilograms of chicken meat per year and is made up of enormous air-conditioned hangars spread across 25 acres.

It was upon that massive roof space that Mr Stunden first envisioned placing solar panels to create the power to cool the buildings with any surplus fed back into the electricity grid.

"We have acres of roof space and high energy demands with electric motors, sensors and air conditioning, so it made sense to me to cover that space with solar panels because our power demands are greatest when the sun is at its hottest," he said.

"But it wasn't quite as simple as just deciding to do it.

"We were the first farm in Victoria – if not Australia – to produce a commercial quantity of energy, which by necessity meant that we had to pioneer the way.

"That meant we had to work out very detailed contracts with the power company setting out rights, responsibilities and returns all of which took over two years because such agreements hadn't been negotiated before.

"It was exciting to be part of a first, but it was gruelling too.

"But now it is clear, in both the money saved on energy costs and the commercial returns, that it was absolutely worth it in terms of time and the initial outlay.

"The farm has even been used in advertisements for commercial electricity production from agriculture."

The Stundens have also been busy working on the homestead property in Tooradin since they moved in 26 years ago, the two creating a harmonious relationship between agricultural and environmental interests.

With time at a premium, the couple is in the process of moving away from breeding award-winning goats and are now flirting with the idea of replacing them with shaggy highland cattle, perhaps as a nostalgic nod to Mr Stunden's medical training in Edinburgh or his wife's Scottish ancestry.

"For many years we used to breed goats for their genetics and to show them in competition," he said.

"We won quite a few medals for them, which meant that they were in high demand by larger breeders for their blood lines – given that they can double a goat farmer's annual income – but it is a very time-consuming business. Our goats were also used to start breeding studs in Malaysia and the Philippines, a means of helping them foster their own breeding industries.

"Now I'm thinking that I'd just like to look out of the window and see those lovely highland cattle grazing instead."

Over the years, the Stundens have also planted 14,000 trees while building dams and undertaking soil improvement.



The chicken farm

"When we first started replanting the land, I was somewhat disparagingly known in the district as the farmer who grows trees," Mr Stunden said.

"But that effort has utterly changed the bird life and the ecosystems on the land to a degree that is almost a miracle. The paddocks remain greener for much longer than before, and the best compliment our neighbours bestow on us is that they have begun to copy our methods.

"Now we get ducks, geese, and a huge variety of native birds either visiting us or moving in to live here permanently where they were never seen before.

"But Carol and I would not call ourselves greenies. We are actively interested in the environment and conservation without feeling the need to be political about it."

Mr Stunden said he loved spending time at his farm and while he had an employee supervising the chicken farm, visited regularly.

He said that although it might sound like a rather unusual investment, it had been carefully considered.

"Because I had done so much volunteer work through my career, I had little superannuation so at 50, Carol and I felt we had to make a decision about how best to finance our future," he said.

"We wanted a commercial proposition that would also give us a personal interest and involvement to take forward into retirement.

"We looked at buying a pub at one stage, but because I was raised in the country, on Bodmin Moor in Cornwall, I was very comfortable with primary production so we investigated meat consumption across Australia and decided to go with chickens.

"Keeping all our animals happy and contented takes quite a lot of time after surgery is finished, but I enjoy it along with my other hobbies including travelling and my vintage car collection."

With Karen Murphy



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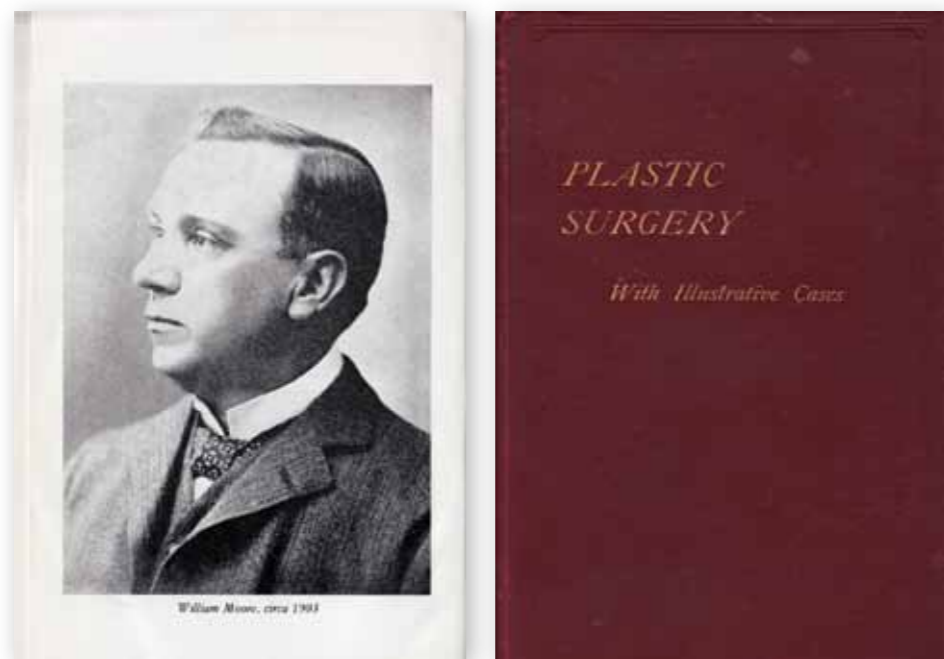
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Left: Front cover the textbook – Plastic Surgery by Jerry Moore 1899

THE FIRST PLASTIC SURGEON IN AUSTRALIA

Jerry Moore is one of the earliest in his field



OPUS
XXXVII

FELIX BEHAN
VICTORIAN FELLOW

Jerry Moore was the first Plastic Surgeon in Australia. He was possibly the first to use the words Plastic Surgery in medical literature. This was the title of his textbook 'Plastic Surgery' published in 1899. It illustrated his wide variety of plastic surgical techniques. He was born in the Brisbane suburb of Milton – famous for its tennis courts and grand slam champions from Queensland – Anderson, Emerson and Laver and of course near the Castlemaine Perkins brewery, maker of the renowned XXXX beer.

Jerry Moore was educated at Brisbane Grammar School gaining entry into Melbourne University where the Medical course was regarded more prestigious. He graduated in Medicine in 1883, topping the year with 1st class honours and exhibitions and appointed to the Melbourne Hospital staff in 1885, only two years after graduation, as Surgeon for Skin Diseases. He held a contemporaneous appointment at St. V's.

In his own textbook, he even referenced and illustrated surgical techniques from Europe, including the Tagliacozzian procedure of 1599 – not bad for a budding surgeon in the Antipodes or, as

Peter Sculthorpe called it, the 5th continent. He did no post graduate training overseas; eventually he visited various clinics in Europe and then across to the Mayo Clinic, possibly discussing surgery with Charlie Mayo and the establishment of the RACS.

It speaks volumes of his initiative and intuitive personality and he was widely read, quoting European publications (in German, Italian, French and Spanish) – arriving three to four months late via mail. Benny Rank's compendium about the man, titled 'Jerry Moore and Some of His Contemporaries' is full of pearls of wisdom.

Jerry Moore built his own hospital calling it Milton House (I wonder why?), in Flinders Lane. This 1901 art deco establishment is now a corporate headquarters. Sharing rooms with Wolfe of Wolfe Graft fame at the Alcaston House (see illustration). One can see how Collins Street became the focus of surgical excellence for Victoria, even Australia wide. With Benny Rank (at the RMH) pre-eminent in the war years and beyond, Melbourne continued this centre of surgical excellence continuing into the microsurgical phase of the 1970s and beyond.

I found my Tagliacozzian textbook – in the backstreets of Carlton in a second-hand bookstore. It is not an original, which would have been worth €15,000 - €20,000, but a facsimile translated by Joan Thomas for the Classics of Medicine Library in 1996 and accompanied with appropriate illustrations. The original 16th century textbook recounts the story of the eminent early Italian surgeon. The translation of his text from the Italian is fully explained and the surgical reconstructions illustrated. It is interesting that every textbook on Plastic Surgery, be it on history or technique, quotes this source. This text has an introduction by the late Bob Goldwyn of PRS fame and the king of medical aphorisms.

Thanks to Ken Myers and a tipoff from Don Marshall, I had access to the Jerry Moore textbook on Plastic Surgery that also surfaced in a second hand bookstore. One wonders if a copy of the Moore textbook had found its way across the Tasman. And could this have influenced the Gillies development of Plastic Surgery in NZ? However, he is reputed to have stated he had never heard of this plastic surgical textbook.

However, there is another story about Gillies and his time at Sidcup and the cross leg flap. This was supposed to be his signature operation. Recently I came upon the textbook I bought in Paris from Alain Brioux (Antiquarian book sellers on the Left Bank) titled 'Les Autoplasties' by the French Plastic Surgeons, Nelaton and Ombredanne of 1907. It illustrated multiple cross leg flap procedures. Yes! The English Channel was a surgical barrier to open communication. I can quote the late Plastic Surgeon, Jack Mustarde, who told me Gilles had a copy of this in East Grinstead (for all and sundry not to see on top of the wardrobe).

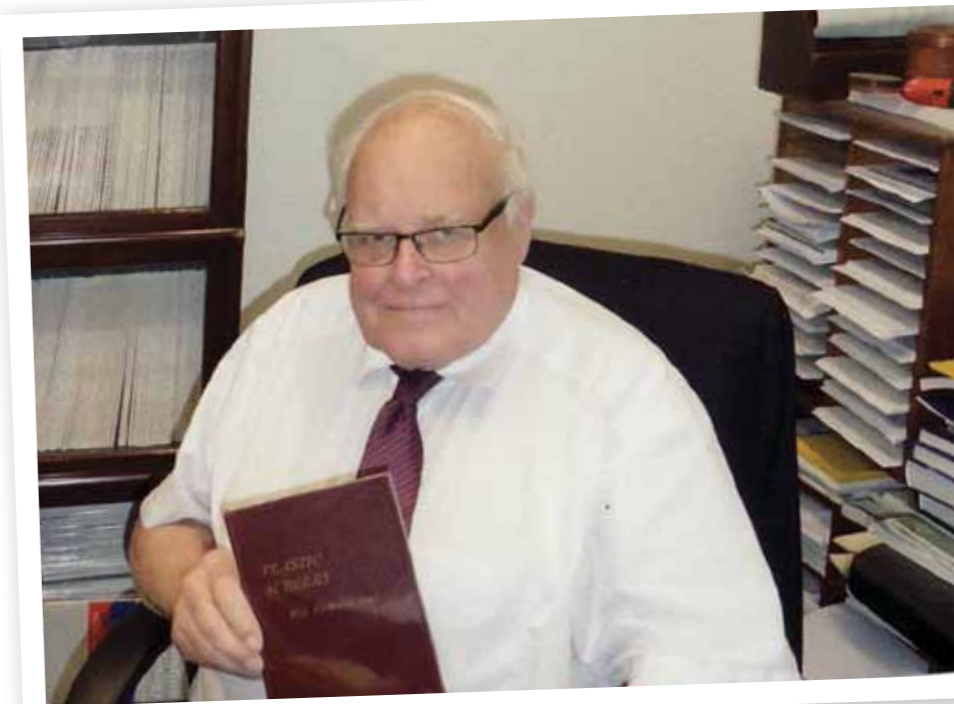
More pearls from Benny's textbook.

Jerry Moore was appointed to the RMH in 1885 as a surgeon for skin diseases and his appointment was on the same day as George Syme.

He caught the eye of a Doctor E.M. James, a Bart's man and proud of it – and we all know the quote about that hospital precinct: 'You can always tell a Bart's man – but not very much'. He offered him professional quarters at Number 2 Collins Street – Alcaston House, where it is still presently located, but refurbished.

Moore's career focused on the transition in surgery from the septic to the antiseptic era, following Listerian principles. Yet scorn and derision was heaped on him. He was even pilloried for those new-fangled ideas by the last of the 'frockcoat' surgeons Sir Thomas Fitzgerald who loved to see pus which, he remarked, "made firmer scars".

“Moore's career focused on the transition in surgery from the septic to the antiseptic era, following Listerian principles.”



Above: Professor Ken Myers, Vascular Surgeon, with his original Jerry Moore textbook, found in a second hand book store by chance.



Left: The frockcoats and the surgical theatre 1891 and 1903 – thanks to Jerry Moore (the beginning of post-Listerian "clean" surgery).



“He was outspoken – sharp in mind, sharp in tongue – and (like his surgery) incisively witty.”

Moore led the field in the introduction of the principles of sterility. In pre-Listerian days, abdominal laparotomies had a mortality rate of over 40 per cent, which was dramatically reduced to 8 per cent with his introduction of these Listerian principles.

He was the first person to acquire the new degree of Master of Surgery and his surgical successes spread far and wide and others began to follow his techniques with improved survival rates. He was noteworthy in doing 7am ward rounds and was quite punctilious, even when cycling up from Mornington. His surgical range covered everything from hydatid disease, gastric surgery, popliteal aneurysm and one of the first exponents of gallbladder surgery.

As Benny said, he was ‘a surgeon 50 years ahead of his time’ particularly in the reconstructive aspects of surgery. Moore wrote many papers and a collection of these became the basis of that textbook of 1899. Various chapters in his textbook covered everything from suturing to grafting to reconstructive flaps. He knew all about the ‘delaying’ of flaps to increase blood supply achieving remarkable results.

Syme described Moore as a remarkably skilful and precise operator with exceptional powers of observation. As Benny said, “insight and truth with technical skills and fearlessness make a rare combination in the art and science of his accomplishments”.

He was outspoken – sharp in mind, sharp in tongue – and (like his surgery) incisively witty. This frankness on matters of principle led sometimes to strained personal relationships.

He was of the view “do it yourself if you want it done properly” – a quote first revealed to me by Bill Hughes in my general Fellowship days and his other adage was “if you want something done, give it to a busy man”. This high degree of self-reliance certainly engendered envy amongst his contemporaries and to build his own hospital, Milton House, would not have won him any friends. However in a nutshell, Moore’s reputation was held in the highest regard. Consequently his clinical opinions and management were sought Australia wide.

However, an unfortunate ethical complaint in 1906 had a regrettable effect on his later career. Help was sought by an international business man, a Mr Palmer, introduced by a friend. He was formerly under the care of Dr William Fox, a general practitioner in Collins Street. He had been treating Mr Palmer for a “syphilitic gumma” of the oral cavity with condiments and lotions from the apothecary’s cabinet. Moore saw the patient at the request of the friend and immediately organised him to have a biopsy of this provisionally diagnosed Ca of the mouth.

In dire straits, the patient promptly decided to return to England. He died on the high seas and his body was committed to the ocean depths. The implacable Dr Fox, learning that Moore visited his patient on a personal and



Jerry Moore's hospital, an art deco establishment of the 1900s, still present in Flinders Lane, now a corporate headquarters.

humanitarian basis without a medical referral, began a vindictive tirade all focused on this ethical principle of referral. The conflict ascended through all echelons of the Local Intercolonial Medical Associations, even reaching the British Medical Council. Finally it was resolved in 1911.

This period had a devastating effect on his personality and work. But local envy and jealousies smouldered, and some say Syme could have nipped this in the bud, but this was not to be. Politically, however, he still managed to establish the principle of honorary hospital appointments by election only and not by financial inducements and donations.

Benny concludes by saying, “Why do we have this enigma?” We have nothing of this reconstructive surgical technique developed between the wars from such a tremendous origin. With radical surgery for malignant disease not as common over the war years, reconstructive techniques went into abeyance.

Above all, Jerry Moore was a surgeon far ahead of his time, reflecting his talent; being the first Master of Surgery at the University of Melbourne.

He was one of the foundation stones of the new era of surgery in Australia with the proposed establishment in 1927 of the Royal Australasian College of Surgeons. With George Syme and Hamilton Russell, he became one of three Victorians on the Credentials Committee. Being the obvious choice to become the first President, he died in 1926 at the age of 66 a hostage to matters medical, and the honour went to George Syme.

Developing a Career in Academic Surgery

with special guest speaker

Nobel Laureate Professor Barry Marshall

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

PROVISIONAL PROGRAM

06:45am	Registration and Breakfast	
07:15am	Welcome	Michael Grigg, RACS PRESIDENT
07:20am	Introduction	Julie Ann Sosa (Durham, USA) and Marc Gladman (Sydney)
07:30am	SESSION 1: A CAREER IN ACADEMIC SURGERY Chairs: John Mansour (Dallas, USA) and Debra Nestel (Melbourne)	
	Why every surgeon can and should be an academic surgeon	Mark Smithers (Brisbane)
	Where do good research questions come from?	Michael Solomon (Sydney)
	Comparative effectiveness research	Caprice Greenberg (Madison, USA)
	Technology enhanced learning in surgery	Anthony Gallagher (Cork, Ireland)
	Educational research	Carla Pugh (Madison, USA)
	Panel discussion	
09:30am	MORNING TEA	
10:00am	HOT TOPIC IN ACADEMIC SURGERY - PATIENT SAFETY	Justin Dimick (Ann Arbor, USA)
	Chair: Marc Gladman (Sydney)	
10:20am	SESSION 2: PRESENTING YOUR WORK Chairs: Caprice Greenberg (Madison, USA) and James Lee (Melbourne)	
	Writing an abstract, choosing the right meeting	Julie Ann Sosa (Durham, USA)
	Submitting and revising your manuscript	John Mansour (Dallas, USA)
	Presenting your work	Muneera Kapadia (Iowa City, USA)
	Panel discussion	
11:50am	LUNCH	
12:50pm	Introduction	Jeffrey Hamdorf (Perth)
12:55pm	KEYNOTE PRESENTATION: How to be awarded a Nobel Prize in medical research	Barry Marshall (Perth)
1:30pm	SESSION 3: CONCURRENT ACADEMIC WORKSHOPS	
	WORKSHOP 1: TOOLS OF THE TRADE Chairs: Caprice Greenberg (Madison, USA) and Richard Hanney (Sydney)	WORKSHOP 2: RESIDENTS / REGISTRARS Chairs: Carla Pugh (Madison, USA) and John Windsor (Auckland)
	Building a career pathway: opportunities, obstacles and getting past them Amir Ghaferi (Ann Arbor, USA) Deborah Amott (Melbourne)	Is a higher degree worth pursuing? Which one? When? Doctorate - Sarah Aitken (Sydney) Masters by coursework - Julian Smith (Melbourne) Masters by research - Guy Maddern (Adelaide)
	Getting started as an academic surgeon Ian Bissett (Auckland)	Overseas experience - clinical or research and when? Warren Hargreaves (Sydney)
	Why a trainee should consider full-time research Deborah Wright (Dunedin)	
	WORKSHOP 3: CAREER ACADEMICS Chairs: Julie Ann Sosa (Durham, USA) and Ian Bennett (Brisbane)	
	Building a career pathway: opportunities, obstacles and getting past them Timothy Pawlik (Baltimore, USA) Clifford Cho (Madison, USA)	Grant writing David Watson (Adelaide)
		Academic surgery in private practice Owen Ung (Brisbane)
2:40pm	AFTERNOON TEA	
3:00pm	SESSION 4: A CAREER IN ACADEMIC SURGERY Chairs: Muneera Kapadia (Iowa City, USA) and Andrew Hill (Auckland)	
	Finding and being a mentor	Michael Wagels (Brisbane)
	Coalface research changing local policy and practice	Didier Palmer (Darwin)
	The future of academic surgery	John Windsor (Auckland)
	CLOSING REMARKS / THANKS	
		Julie Ann Sosa (Durham, USA) and Marc Gladman (Sydney)

DCAS course registration

Cost: \$220.00 per person

Register online at asc.surgeons.org or email dcas@surgeons.org for a registration form.

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

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

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

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

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



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

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

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

Application Criteria:

Applicants for the Rowan Nicks International and Pacific Islands Scholarships must:

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

In addition, applicants for the International Scholarship must:

- hold a relevant post-graduate qualification in Surgery;
- be a citizen of one of the nominated countries to be listed on the College website from December 2014.

Applicants for the Pacific Islands Scholarship must:

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

Selection Criteria

The Committee will

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

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

Tenure: 3 - 12 months

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



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

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

Application Criteria:

Applicants must

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

Selection criteria:

The Committee will

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

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

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

Tenure: 3 - 12 months

Application forms and instructions will be available from the College website from December 2014:

www.surgeons.org

Closing date: **5pm Monday 4 May, 2015.**

Applicants will be notified of the outcome of their application by **30 October 2015.**

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

2016 Rowan Nicks United Kingdom and Republic of Ireland Fellowship

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

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

Application Criteria:

Applicants must

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

Selection criteria:

The Committee will

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

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

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

Tenure: 3 - 12 months



Fellow Wanda Stelmach, Victorian Health Minister Jill Hennessy with Victorian Regional Committee Chair Jason Chuen.

Victorian Annual Welcome and Induction

Report of session held on March 2, 2015

PAUL CASHIN

Each year the members of the RACS Victorian Regional Committee, (VRC) like to welcome the new Trainees, new Fellows and new IMGs to the surgical program and in particular to our College in Victoria.

The VRC delivers this single combined session where Trainees and IMGs can meet new Young Fellows who are still hopefully a bit enthusiastic and buzzed about their new status.

This event provides a great opportunity to familiarise and potentially enlist people into the activities of the Victorian Regional Office while meeting their supervisors on a social level, networking with peers and being introduced to the Committee activities.

As a highlight to the evening our College Curator, Mr Geoff Downs provides the attendees a brief presentation on College History and then does a walking tour of the building highlighting some interesting and amusing tales.

The attendees to the 2015 event were particularly privileged to have the new Victorian Minister of Health, Hon Jill Hennessy attend the event and welcome our newbies to their new surgical career.

Minister Hennessy expressed her commitment to ongoing dialogue with the Victorian Regional Committee, as other Victorian Health Ministers have done in the past. This dialogue also serves as a conduit for better communication with the Victorian Fellows of all specialities.

The emphasis of the discussions with the new Trainees, IMGs and Fellows was on the fantastic 'fellowship' our College can provide if they choose to involve themselves in College activities.

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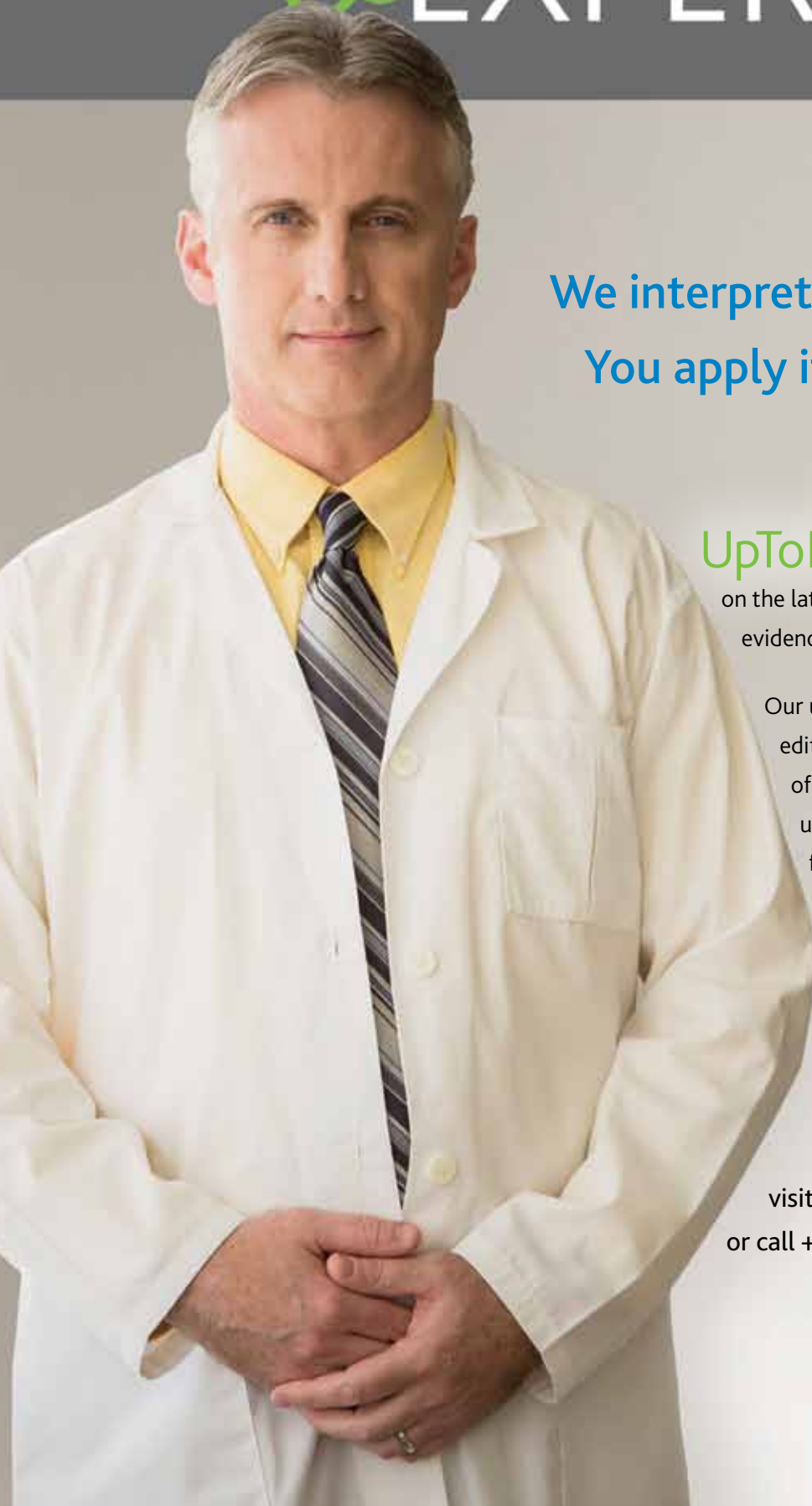
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