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ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

"We are not a team because we work together. We are a team because we trust, respect and care for each other,"

Vala Afshar

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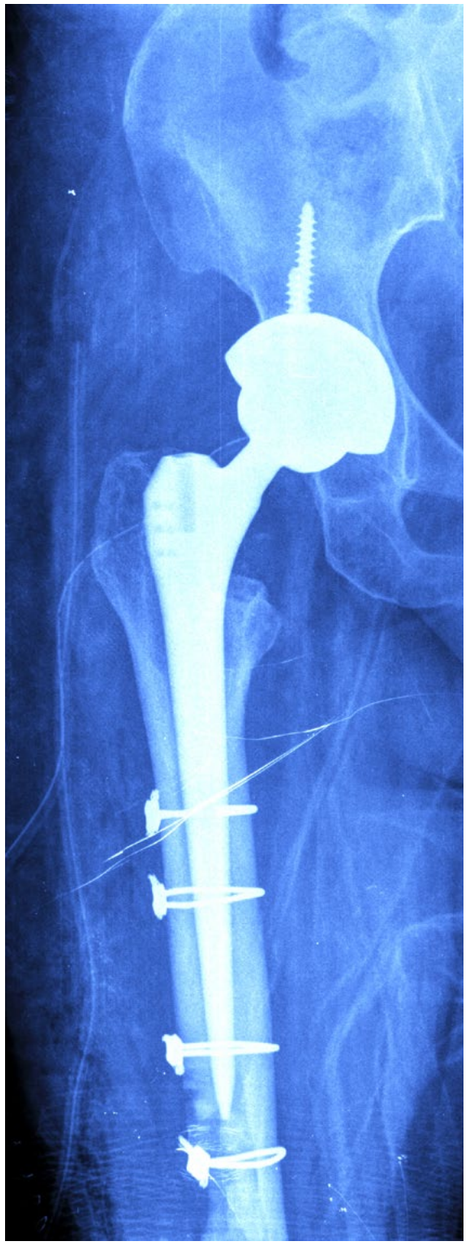

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Revalidation

Something to be engaged in, not to fear

The Medical Board of Australia formed an Expert Advisory Group (EAG), chaired by Professor Liz Farmer, to look at the options for revalidation in Australia. The EAG's stated focus was to create a system that would serve the unique Australian medical environment by providing a clear definition of purpose, and not just the adoption of other international regulatory frameworks.

The EAG has consulted widely with multiple stakeholders, including RACS, in an attempt to create a thoughtful and 'intelligence-led' range of possible models, designed to be responsive, nuanced, effective and efficient to produce a final report informed by consultation and consensus.

The approach is aimed to be smarter, by increasing effectiveness of Continuing Professional Development (CPD) activities, and not harder, by requiring less time and resources of participants, that is more integrated with existing systems, to avoid duplication. The underlying principles are to be relevant to the Australian healthcare environment, feasible and practical to implement and proportionate to public risk.

Thus the dual aim of revalidation is to maintain and enhance performance of practitioners to prevent harm and reduce risk.

The first question the EAG needed to address was how to achieve and maintain a competent workforce.

This can only be achieved and assured if all individuals in the workforce continue to learn, and reflect on their practice and outcomes, and for professional bodies and the regulator to develop strategies that promote lifelong learning, reflection and audit. There is high level international evidence that supports this approach. RACS has always promoted lifelong learning and more recently reflective practice, therefore, its CPD programs are well placed to assist Fellows to achieve these aims without substantial increase in time or resources.

These programs must be relevant to a surgeon's practice settings and scope, and must improve performance and behaviours as well as patient outcomes. The role of self-reflection is emphasised, incorporating credible and practical feedback on performance. Most importantly, all of this must be driven by the profession, but integrated with other existing performance management and credentialing systems to avoid duplication.

CPD will thus need to encompass three groups of activities to strengthen and review individual performance and encourage lifelong learning.

1. Educational activities such as conferences, reading, research, workshops, grand rounds, journal clubs, etc.
2. Review of performance by peer review of records, case discussion of critical incidents, safety and quality events and Multi-Source Feedback (MSF) from peers, medical colleagues, co-workers and patients.
3. Measurement of outcomes through clinical audit, medical record review, mortality and morbidity reviews, monitoring and reporting on clinical indicators, benchmarking individual data within unit, institutional, regional, national and international data, including large data sets such as Medicare.

The EAG then needed to address how to guarantee patient safety and prevent harm, safeguarding the public from poorly performing or incompetent individuals in the workforce. The strategies to address these two questions need to be kept apart and treated differently.

It is known from studies (Bismark *et al*, 2013) that only a small proportion of practitioners are not performing to expected standards. Such practitioners however, reflect poorly on all. There is a need to understand the predictors that indicate which practitioners are at risk of poor performance in order to enable early intervention and create a better safety net for the prevention of harm.

Four per cent of practitioners are responsible for 25 per cent of the complaints, with 61 per cent of complaints being about clinical care. The number of complaints and the time since last complaint have been identified as strong predictors of a subsequent complaint. Data has the potential to identify these practitioners early and reduce adverse events and patient dissatisfaction by developing predictive risk profiles and timely, tiered assessment and intervention, with the ultimate aim of remediation and supported return to safe practice.

Shared understanding of the roles and responsibilities of the regulator and professional bodies in identification of performance concerns is imperative. If the aim is rehabilitation back into safe practice of those identified as having performance issues, then professional bodies like RACS will need to take an active role in the early tiered response with MSF to provide input as a peer mediated process prior to regulatory intervention. This will need to be a partnership model with versatility of approaches to match the assessed risk. The EAG felt the focus needed to be on the 'expert' rather than the 'legal' model of regulation and be patient centric. Remediation strategies at present are underdeveloped, as are the shared roles of professional organisations like RACS.

Practitioner and professional body engagement, public participation, communication, transparency, innovation and collaboration will be needed to strike a regulatory balance between encouragement though education, life-long learning, reflection and peer review.

The Medical Board of Australia has accepted the recommendations of the EAG and has designed a Professional Performance Framework, rather than using the term revalidation, which has five pillars.

1. Strengthening CPD requirements
2. Active assurance of safe practice
3. Strengthening assessment and management of medical practitioners with multiple substantiated complaints
4. Guidance to support practitioners – regularly updated professional standards that support good medical practice
5. Collaboration to foster a culture of medicine that is focused on patient safety, based on respect and encourages doctors to take care of their own health and well-being.

There is much detail to be worked through under each of the pillars, particularly pillar 2, which proposes peer review and health checks for practitioners over the age of 70 years who provide clinical care to patients. Pillar 2 is designed to assure patients, individual practitioners, employers and regulators of capability to provide safe patient care.

RACS has a firm foundation in its vision and mission statements, with the recently AMC reaccredited CPD program, surgeon health and well being advocacy, and the Building Respect initiative to assist all Fellows with professional performance requirements. RACS will continue to work collaboratively and constructively with the regulator to maintain the high standards of our profession, optimal patient outcomes and in the best interests of our Fellows.

The Medical Board of Australia's Professional Performance Framework is a practical, proportionate, fair and responsible proposal that will be strengthened by further collaboration with professional bodies and the community over the next few years.

Mr John Batten
President

The F Word

Why is it that we as surgeons seem to be – or really are - scared to give feedback?

As we enter another year, I would like to extend my congratulations and welcome to all those new Trainees starting on the road to the FRACS, those who started in New Zealand in mid-December, and those starting now.

Last November I was privileged to attend the Royal Australasian College of Surgeons Trainees' Association (RACSTA) induction day for new Surgical Education and Training (SET) Trainees. It is exciting to meet such a committed and enthusiastic group of young surgeons and I wish you all the very best for your futures. I would also like to congratulate the RACSTA team who put on such an excellent induction day.

One of the most interesting sessions for me was the presentation by Adrian Anthony (Chair, Board of Surgical Education and Training - BSET) and Debbie Paltridge (Principal Educator) on feedback - yes that F word. The Trainees had opportunity to practise giving feedback to each other: it was great to see how much they appreciated and then understood the importance of the feedback process

Why is it that we as surgeons seem to be – or really are - scared to give feedback? One of the recommendations of the Expert Advisory Group report about discrimination, bullying and sexual harassment in surgery was that RACS should "equip all Fellows, Trainees and IMGs to teach and provide constructive, clear and timely feedback." Wouldn't we all appreciate some constructive feedback at the end of each operation, or ward round or outpatient clinic rather than a grunted "you did ok" if you dared to ask? In my days as a registrar, no news was good news and feedback was only given if things went badly. Constructive advice about improvement was often missing.

Research tells us that effective feedback is one of the most powerful and evidence based tools for effective learning for clinical practice. It plays a key role in moving Trainees towards their goals and provides opportunities to clarify their expectations and adjust their approaches towards their learning goals. Giving feedback, whether it is about a particular task or on overall performance, is an essential part of facilitating progression towards expert performance.

The Foundation Skills for Surgical Educators Course teaches us about the importance of feedback and the principles of feedback, as well as describing the various models available and giving us an opportunity to practise one model among ourselves. This is usually a really good session on the one day course.

Even so, it seems to be the one thing that trainers and supervisors are most fearful of – they are afraid of accusations of bullying if the feedback is less than positive. I hope that now that our Trainees are being educated about the value of feedback, and can see for themselves how important it is as part of the learning process that the myths and concerns will be dispelled.

So remember - feedback is essential for learning, is a two way process, linked to the learning goals; and if provided in a structured manner, based on specific observations and in an appropriate environment is nothing to be wary about. It should be a dialogue about the way forward.

With help from a world expert about feedback within the health professions, RACS is developing an advanced feedback skills course and module to be piloted in the first half of 2018.

So as we kick off the New Year - embrace that F word!!

Dr Cathy Ferguson
Vice President

New CEO looks to the future

A new CEO usually has a long 'to do' list and RACS CEO Mary Harney is no exception to this rule. Reinvigorating and building relationships, advancing diversity, improving education and training, ensuring financial viability, managing risk, and growing the brand are just some of the many things on Ms Harney's agenda.

Ms Harney, who joined RACS in late October 2017 from an agricultural R&D Foundation where she was the CEO, says that while the strategy will evolve over 2018, one should start with a sound understanding of the challenges that need to be addressed.

"One of the most important tasks for us is to ensure that RACS is working closely with specialty societies so that our common customer—Fellows, Trainees and IMGs—are at the heart of everything we do. I anticipate that our ongoing engagement with the 13 specialty societies is the major objective for 2018. This will, subsequently, be a core part of our 2019 – 2012 strategy."

Ms Harney notes that another critical component that needs continuous improvement is the value RACS adds to its members.

"We must continuously look for opportunities to add value to our members' professional growth. This involves understanding their perspectives and need and consistently improving their experience and satisfaction. I look forward to working with all our partners and members to achieve this goal."

Another area of focus for Ms Harney will be staff engagement. The year 2017 ended with an invitation to employees to participate in an engagement survey.

"I want to create an environment where employees can offer more of their capability and potential. Staff engagement is about two-way commitment where everyone in the organisation is contributing as effectively as possible to both organisational and individual performance. I was really pleased to see that more than 75 per cent of staff participated in the survey – that is an amazing response. I am confident that together we can take some positive steps to improve our work environment."

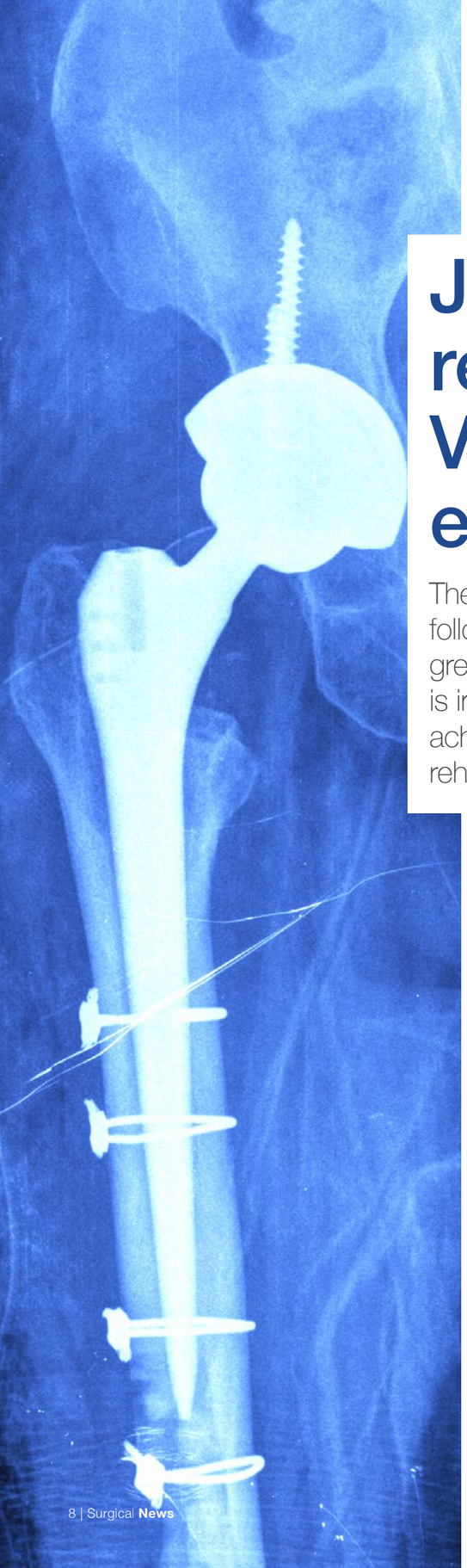
When asked about how she relaxes outside of work, Ms Harney says she enjoys swimming and reading books on technology, management theory and practice and history.

"My scientific background has also determined my personal preferences for reading. I enjoy reading books on technology and its impacts on the future and behaviour change type material. One book I enjoyed was Kevin Kelly's *Inevitable*, which talks about where this hyper-connected planet is going. I am currently reading Tim O Reilly's book on the future of technology, *WTF*. I love the small facts that emerge like we have more computing power in our smart phones than Bill Clinton had in his presidency or that we produce more data now in an hour than we did in human history up to 2000. The pace of change and its impact is intriguing," she adds.

Ms Harney notes that RACS has a wonderful history and tradition, but more significantly an influential future in the Australian health care system.

"There are many things for us to proud of, but one of the things that really resonate with me is the more inclusive culture we are building in the surgical profession. It is heartening to see that 32 per cent of RACS Councillors are women. While there is more for us to do this is a tremendous achievement considering that female directors only comprised of 25.1 per cent of directors across the Australian Stock Exchange 200 Boards at the end of 2016.

"I am also proud of the role RACS plays in helping to shape the health systems in Australia and New Zealand. The future of RACS are the trainees of today and it is humbling to be part of the process that will produce the rounded and diversity aware surgeons of the future, and to observe the many contributions our current surgeons make to the global community."



Joint rehabilitation: Value for effort?

The utilisation of inpatient rehabilitation following hip and knee arthroplasty varies greatly within the private sector. However, is inpatient care required, or can patients achieve similar outcomes with home-based rehabilitation services?

Post-operative rehabilitation services form a core component of the care pathway for total hip and knee arthroplasty (THA, TKA). In the August edition of *Surgical News*, we highlighted the high degree of clinical variation in the use of inpatient rehabilitation services for TKA and THA patients in Australian private practice. The data, sourced from Medibank's administrative claims database, showed inpatient referral rates varied from surgeon to surgeon.[1] Some 10-13 per cent of surgeons do not refer any of their patients for inpatient rehabilitation, while 4-5 per cent referred all of their patients to an inpatient facility. On average 36 per cent of patients were referred to inpatient rehabilitation following THA, and 43 per cent following TKA.

As part of the joint (RACS and Medibank) ongoing investigation into clinical variation, we recently conducted a review into the clinical variation in rehabilitation services for TKA and THA patients. Specifically, we sought to determine:

1. If similar variation occurs in other Australian and international datasets;
2. Which factors might predispose patients to needing inpatient rehabilitation;
3. Whether or not inpatient rehabilitation produces better clinical outcomes than home-based services; and
4. What the key barriers and enablers are to alternative care models.

To answer these important questions, RACS Research and Evaluation incorporating ASERNIP-s conducted a literature review involving a combination of rapid and systematic review methods. The scope, conduct and findings of the review were informed by a working group of RACS Fellows (including past and present members

CLINICAL VARIATION

medibank
For Better Health

of the Australian Orthopaedic Association) and clinical representatives from Medibank. In this article we report the findings from the review process, highlighting important recommendations for change.

Variation in Australian clinical practice

Beyond the Medibank data, there is scant Australian data on referral rates to inpatient rehabilitation following TKA and THA. Based on the Arthroplasty Clinical Outcomes Registry National (ACORN) registry data from seven hospitals, it is estimated that 20 per cent of public TKA and THA patients were referred to an inpatient unit for rehabilitation from 2013-2015,[2] compared to 40.1 per cent of private patients in 2015-16.[1]

There was, however, considerable variation within the public and private sectors; in the public sector, individual hospitals referred between ~3 per cent and ~60 per cent of patients to inpatient rehabilitation;[2] in the private sector, referral rates for surgeons' patients varied from 0 per cent to 100 per cent, and between state/territory from 4 per cent to 64 per cent.

Though limited, the available data from the public sector reported a drop in the use of inpatient rehabilitation services from 46 per cent in 1998-2000, to 7-21 per cent in 2013-2015.[2,3] Of note, quarterly operating reports from the Repatriation General Hospital in South Australia reported a reduction in the use of inpatient rehabilitation from 39 per cent in October-December 2006, to 7 per cent in January-March 2007. This reduction has been maintained according to the most recent reports published in June 2016.

Granted the public and private sectors operate under different incentives, the differences are stark, and reductions compelling.

How do we compare internationally?

The majority of data on international referral rates were from the United States. Like Australia, the utilisation of inpatient and home or community-based services is highly varied. Since 2009, data from nine studies with a total of 695,532 patients reported that home or community-based services were utilised by ~40 to ~74 per cent of patients, compared to ~3 to ~53 per cent of patients utilising inpatient or SNF services. Limited data from one Canadian data set reported community-based referral rates of 91 per cent in the Ontario Province, noting that most of these patients had access to community or home-based support services. The disparate nature of the included datasets makes it somewhat difficult to draw meaningful trends over time. One study by Ong and colleagues however, reported a clear trend towards reduced use of inpatient rehabilitation facilities, and an increase in home-health services (HHS), for Medicare patients (Figure 1).[4]

Which factors predispose patients to needing inpatient rehab?

Our comprehensive searches of the biomedical literature identified 14 studies that investigated factors affecting discharge to an inpatient facility. The included studies varied in size, but included an overall sample of 379,503 patients treated primarily in the United States.

Common factors associated with inpatient rehabilitation included older age, female gender, lack of care-giver assistance at home, greater comorbidity and worse pre- and post-operative functional status. These factors were measured in multivariate regression analysis, meaning that they are independent predictors of the use of inpatient rehabilitation. Additionally, patient preferences for inpatient services were described as strong predictors by two studies. Albeit these studies had methodological limitations, this finding rings true of the current incentives that drive patients to inpatient rehabilitation in the Australian private sector.[5]

The challenge here is that we know which factors led people to be more likely to use inpatient facilities, but this information does not inform us on which patients would

TABLE 1
Summary of the RCT evidence for the relative effectiveness of inpatient vs home-based rehabilitation

Design	Outcomes	Participants (studies)	Relative effect (inpatient vs home)	Quality of the evidence (GRADE)	Comments
Walking distance	6MWT	165 (1) TKA	No significant difference	●●●● HIGH	Results were only available from one study
Hip/Knee Scores	OHS, OKS, AKSCRS	397 (3) TKA/THA	No significant difference	●●●○ MODERATE	Palmer Hill (2000) was poorly reported
WOMAC	WOMAC	234 (1) TKA/THA	No significant difference	●●●● HIGH	Results were only available from one study
Health related quality of life	EQ5D, SF-36 and COOP	571 (3) TKA/THA	No significant difference	●●●○ MODERATE	Varied outcomes but consistent direction of effect
Patient satisfaction	Hip and knee satisfaction scale, VAS	399 (3) TKA/THA	Not pooled	●●●○ MODERATE	Varied results in literature; Palmer Hill (2000) was poorly reported

Abbreviations: **6MWT** = Six-Minute Walk Test; **AKSCRS** = American Knee Society Clinical Rating System; **COOP** = Cooperative Functional Assessment Charts; **EQ5D** = EquroQol-5 Dimension; **OHS** = Oxford Hip Score; **OKS** = Oxford Knee Score; **RCT** = randomised controlled trial; **SF-36** = Short Form 36; **THA** = Total Hip Arthroplasty; **TKA** = Total Knee Arthroplasty **VAS** = visual analogue scale; **WOMAC** = Western Ontario and McMaster Universities Osteoarthritis Index.
GRADE Working Group grades of evidence:
●●●● **High quality:** We are very confident that the true effect lies close to that of the estimate of effect.
●●●○ **Moderate quality:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.

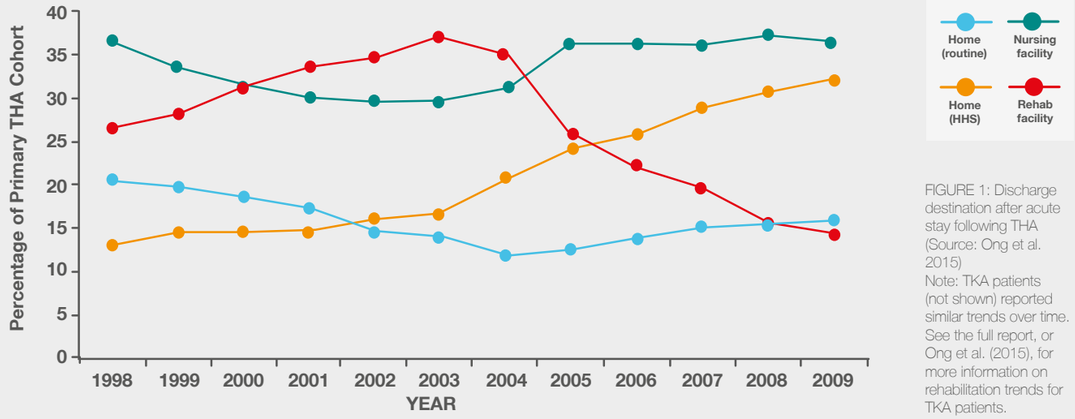


FIGURE 1: Discharge destination after acute stay following THA (Source: Ong et al. 2015)
Note: TKA patients (not shown) reported similar trends over time. See the full report, or Ong et al. (2015), for more information on rehabilitation trends for TKA patients.

have actually benefited from receiving inpatient care. It may be that these patients would have had similar outcomes had they received supported care at home.

Do patients do better in inpatient rehab?

The main effectiveness outcomes we were interested in were functional independence, pain and quality of life. Against these metrics, four randomised controlled trials (RCTs) of varying quality were identified, which included a mix of TKA and THA, or solely TKA patients.

The RCTs were conducted on broad groups of patients, who were not otherwise predisposed to needing inpatient rehabilitation. Factors that were considered to predispose patients to needing inpatient rehabilitation included a lack of social/carer support, major comorbidities, poor English comprehension and poor quality of residence.

None of the RCTs found a significant difference between inpatient and home-based rehabilitation, providing evidence that inpatient rehabilitation does not produce better or worse outcomes than home-based services. A summary of the main effectiveness outcomes, and the overall quality of evidence for each outcome is shown in Table 1.

Safety outcomes related to complications and readmissions during the post-discharge rehabilitation period were more difficult to interpret. While not statistically significant, likely due to low event rates, complications and readmissions were often reported to be less frequent in patients receiving home-based compared to inpatient rehabilitation. However, further trials that include a larger sample are required to confirm effects.

From the available data, it appears that the additional effort associated with inpatient rehabilitation may not lead to discernible differences in patient-relevant outcomes.

It is important to note that all of the RCTs used a supported home-based model of care, but with varying degrees of intensity of rehabilitation care. None of the studies included unsupported home based care. As such, we don't know if inpatient rehabilitation is beneficial over home-based discharge *without* rehabilitation support. It is also important to note that there are currently few reimbursement incentives for community or home-based care in Australian private practice.

Challenges to be overcome?

There are many barriers to increasing the uptake of home-based or community-based rehabilitation. These include limited evidence for which patients will benefit, strong patient preferences for inpatient care, the limited availability of services in rural and remote areas, and limited health insurance incentives for home-based rehabilitation.

Many factors can contribute to strong patient preferences for inpatient services. Several studies have reported that positive experiences of a family member or friend who had inpatient rehabilitation can influence patient preferences. Other studies have reported that 'peer-pressure' and structure provided by inpatient services can motivate patients to stay active in their recovery. Some patients believe inpatient care will deliver better clinical outcomes. Of course another strong incentive in the private sector is the presence (or not) of reimbursement arrangements.[5-7]

Private health insurance legislation requires insurers to include some form of rehabilitation in health insurance products. So, most patients are reimbursed through their health cover for inpatient rehabilitation services. However, there are far fewer financial incentives for private patients to receive home-based rehabilitation, as most private health insurance schemes do not cover the cost of home-based care.

Private patients who have paid premiums for a long time, and who face high out-of-pocket costs to access home-based services are likely to have an understandable preference for inpatient services. A recent Australian study by Buhagiar and colleagues captured this view aptly:

'…they've paid their private health insurance premiums for however many years, they think, "well, why shouldn't I get to go [to inpatient rehabilitation], other people get to go. Yeah my knee might be good or my hip might be good but I want to go as well".' Source: Buhagiar et al 2017.

What can be done to facilitate appropriate pathways?

The review identified four key factors that can be leveraged in order to help ensure patients get the most appropriate care.

- **Utilisation of care pathways:** Rehabilitation pathways that incorporate pre-operative discharge planning and patient education are likely to encourage the use of home-based rehabilitation. They can be used to set an expectation for the rehabilitation destination, and allow patients to prepare for their home-based rehabilitation.
- **Patient education:** Understanding the demands, requirements, and course of rehabilitation and pain management can help facilitate the use of home-based rehabilitation pathways. Crucially, having a strong educational component of a *prehabilitation* pathway enables patients to be well equipped to deal with pain management issues that can otherwise result in re-admissions.
- **Pre-operative prediction tools:** There are many validated triage tools that can pre-operatively predict which patients may require inpatient rehabilitation. When used as part of a prehabilitation pathway, they can be used to set clear goals for rehabilitation pre-operatively. One such tool, validated in Australia, is the Risk Assessment and Predictor Tool (RAPT).[8]
- **Appropriate incentives:** Changes to private health insurance schemes to offer greater support for home-based rehabilitation services will help incentivise the use of home-based services.

What does it mean for surgeons and their patients?

The key recommendations of our review are presented in Box 1. It is clear from the RCT evidence that, for patients who do not require inpatient rehabilitation, home-based rehabilitation offers similar pain, function and quality of life outcomes. Pre-operatively identifying patients that may be suited to home-based rehabilitation means patients can be given targeted education about pre- and post-operative support programs, sets an expectation for discharge destination after surgery, and allows patients to plan for their post-operative rehabilitation. However, this strategy alone places the burden of improving system efficiencies on surgeons.

Ultimately, structural changes to the care pathway and incentives will be needed to support surgeons in providing pre-operative education to patients and promoting rehabilitation in appropriate settings.

Box 1 – Key recommendations

1. Supported home-based rehabilitation services, including home assistance and access to community-based services, should be offered to patients who do not need inpatient rehabilitation.
2. Pre-operative screening tools should be completed in conjunction with patients and caregivers to identify patients who will benefit from inpatient rehabilitation.
3. Patients and carers should be engaged in the decision about their likely discharge setting, combined with pre- and post-operative education about rehabilitation, to help facilitate the use of home-based rehabilitation where appropriate.
4. Influencing change in the care pathway will require multidisciplinary support.
5. Health payers should work with health providers and health practitioners (orthopaedic surgeons and rehabilitation specialists) to develop appropriate benchmarks for the selection of patients who have inpatient rehabilitation after joint arthroplasty.
6. Further research on the impact of prehabilitation is recommended to inform the optimal pathway of care for TKA and THA patients.

For further information please visit:

http://www.surgeons.org/policies-publications/publications/surgical-variance-reports/
or contact college.asernip@surgeons.org

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References

1. Royal Australasian College of Surgeons and Medibank. Surgical Variance Report - Orthopaedic Surgery. Melbourne , Australia: RACS, 2017.
2. Arthroplasty Clinical Outcomes Registry National. Arthroplasty Clinical Outcomes Registry National: 2015 Annual Report. 2016. Available from: http://acomregistry.org/images/ACORN_AnnualReport_2015.pdf (accessed 30 May 2017)
3. Repatriation General Hospital. Quarterly Report: April to June 2016. Adelaide, South Australia: Repatriation General Hospital, Elective Orthopaedic Services Unit, 2016.
4. Ong KL, Lotke PA, Lau E, Manley MT, Kurtz SM. Prevalence and Costs of Rehabilitation and Physical Therapy After Primary TJA. *J Arthroplasty* 2015; 30: 1121-6.
5. Buhagiar MA, Naylor JM, Simpson G, Harris IA, Kohler F. Understanding consumer and clinician preferences and decision making for rehabilitation following arthroplasty in the private sector. *BMC Health Serv Res* 2017; 17: 415.
6. Artz N, Elvers KT, Lowe CM, et al. Effectiveness of physiotherapy exercise following total knee replacement: systematic review and meta-analysis. *BMC Musculoskelet Disord* 2015; 16: 15.
7. de Pablo P, Losina E, Phillips CB, et al. Determinants of discharge destination following elective total hip replacement. *Arthritis Rheum* 2004; 51: 1009-17.
8. Oldmeadow LB, McBurney H, Robertson VJ. Predicting risk of extended inpatient rehabilitation after hip or knee arthroplasty. *J Arthroplasty* 2003; 18: 775-9.

ANZASM update

ANZASM 2016 National Report Executive Summary

The Australian and New Zealand Audit of Surgical Mortality (ANZASM) programme has been operational for over 12 years beginning in Western Australia. It has been operating nationally, with all states and territories contributing since 2010.

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

The principal aims of the audit are to inform, educate, facilitate change and improve quality of practice within surgery.

The ANZASM is managed by the Research, Audit and Academic Surgery Division of the Royal Australasian College of Surgeons (RACS). The ANZASM oversees the implementation and standardisation of each regional audit to ensure consistency in audit processes and governance structure across all jurisdictions. The individual regional audits are funded by their departments of health. The RACS provides infrastructure support and oversight to the project. The ANZASM receives protection under the Commonwealth Qualified Privilege Scheme, part VC of the *Health Insurance Act 1973* (gazetted 25 July 2016).

Each region produces its own annual report. In addition, since 2009, the ANZASM has been producing a national report based on combined regional data. The national database contains several thousand cases, which provide the opportunity to analyse mortality trends and potentially identify areas for improving patient care. From this important initiatives are now becoming realised over time as more data is becoming available. The ANZASM is in a good position to utilise the extensive information learned to promote safer health care practices. The executive summary from the 8th ANZASM 2016 National Report key highlights include:

- The proportion of cases with adverse events has remained relatively static (3.6 per cent in 2012 compared to 3.7 per cent in 2016).
- In the majority of instances those patients expected to benefit from critical care support did receive it. The review process suggested that 5.3 per cent of patients who did not receive treatment in a critical care unit would most likely have benefited from it.
- Fluid balance in the surgical patient is an ongoing challenge; however the report highlights improvements are being made in some regions.
- The audit revealed that patients admitted as surgical emergencies have a greater risk of falling while in hospital. All health professionals should increase their awareness of this risk to improve the quality and safety of patient care.
- Participation in the audit has increased significantly over time, and from March 2017, the Australian Orthopaedic Association also made it compulsory for its members to partake.

The National Surgical Mortality Audit is an important part of clinical governance for surgeons in Australia. It is also a process which is largely under our own control, but in order to maintain this, we need to be able to show that we have a robust process in place. Moving forward I would encourage all surgeons to complete their mortality case forms as accurately as possible to ensure that we can maintain and improve the standard of the process well into the future.

The RACS can be rightly proud of these important initiatives in collaboration with the jurisdictions. The diversity of medical professionals participating in this process significantly enhances the quality of information and has highlighted the need for improvement in various aspects of patient care.

Thank you for your ongoing support.

The full report is available at: https://www.surgeons.org/media/25514879/2017-10-05_rpt_racs_anzasm_national_report_2016.pdf

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

– With Gordon Guy, ANZASM Manager

AUDIT OF SURGICAL MORTALITY

ANZASM 2016 National Report highlights

OPERATIONS

79% (26,078/33,034) of patients underwent a surgical procedure

87.9% (32,369/36,842) of operations, the consultant surgeon made the decision to operate

16% (4,026/25,196) of the surgery patients had an unplanned return to the operating theatre because of complications

62.6% (23,070/36,842) of cases the consultant surgeon performed the surgery

PARTICIPATION

60.4% Surgeons (2009)

98.3% Surgeons (2016)

2016

100% Public Hospitals

92% Private Hospitals

ANALYSIS & AUDIT NUMBERS

79.6% Audited (33,450/41,999)

20.4% Excluded (8,549/41,999)

INFECTION

Infections were

44% Pneumonia

15.3% Intra-abdominal sepsis

25.7% Septicaemia

34.2% (5,267/15,404) of patients died with a clinically significant infection

PATIENT TRANSFERS

11.3% (704/6,250) of transfer issues raised related to transfer delays

4.1% (257/6,258) for Inappropriateness of transfer

4.7% (285/6,121) for insufficient clinical documentation

RISK PROFILE

55:45 Male:Female

Ages Mean age of 75 varied from 1 day to 105 years

85.6% (28,245/33,003) of audited deaths occurred in patients admitted as emergencies with acute life-threatening conditions

90% (28,701/31,862) of patients had one or more significant co-existing illness

OUTCOMES

The most common criticism made by assessors was delay in delivering definitive treatment

26.1% (6,558/25,092) cases with clinical issues

73.3% (3,167/4,321) inadequate information was the reason for referral to SLA in audited cases

3.7% (918/24,881) of cases had an adverse event in patient care

50.8% (3,927/7,728) of those delays were attributed to the surgical team.

13% (4,321/33,349) of audited cases were referred for second-line assessment (SLA)

What's in store at the 2018 ASC

The 87th Annual Scientific Congress (ASC) will be held in Sydney from Monday 7 May 2018 through Friday 11 May 2018

This year's ASC is being held in conjunction with the Australian and New Zealand College of Anaesthetists (ANZCA) and in partnership with the American College of Surgeons (ACS). Two of the plenary sessions and a number of subspecialty sessions will involve both RACS and ANZCA.

The ACS will present a plenary session and a significant number of our US colleagues will be taking part in what will be a stimulating and inspiring program.

Associate Professor Vincent Lam and Dr Jeremy Hsu, section conveners for Hepatobiliary and Trauma respectively, have planned comprehensive programs for the 2018 ASC.

The Hepatobiliary surgery program will focus on minimally invasive liver and pancreatic surgery and surgical education. It includes three distinguished overseas visitors: Professor Rebecca Minter, University of Wisconsin; Professor Herbert Zeh, University of Pittsburgh, USA and Professor Tan To Cheung, Queen Mary Hospital, Hong Kong.

Professor Minter is the Immediate Past-President of America's Hepato-Pancreato-Biliary Association and her research efforts are primarily focused within the domain of surgical education. She will present a keynote lecture *Would I trust you to do my Whipples? Progressive Entrustment in the Operating Room.*

Professor Zeh has created one of the world's busiest robotic pancreatic surgery programs. He and his team have performed nearly 1000 complex robotic pancreas resections, including 500 robotic pancreaticoduodenectomies. He will present a keynote lecture titled *Complex Pancreatic Surgery* in the Robotic Era.

Professor Cheung is Chief of Hepatobiliary and Pancreatic Surgery at Queen Mary Hospital in Hong Kong. He is keen on the development of new procedures and is an active researcher in the field of complex liver surgery and minimal invasive surgery for liver cancer. His keynote lecture is titled *Defining the Benchmarks for Major Liver Surgery.*

Many prominent HPB surgeons from the US will also contribute to the scientific program: Professor Timothy Pawlik, Ohio State University; Professor Rebekah White, University of California, San Diego; Professor Kevin Staveley-O'Carroll, University of Missouri; Professor Lillian Kao, University of Texas and Professor Taylor Riall, University of Arizona.

Other surgeons from Australia and New Zealand as well as the Asia-Pacific region will also be contributing including Professor Katsuhiko Yanaga, Jikei University, Tokyo, Japan and Professor Kenneth Chok, University of Hong Kong.

The Trauma program promises to provide an evidence-based update on a wide range of current trauma topics. The invited keynote speakers for the trauma section are Dr Ron Maier and Dr Adil Haider. Dr Maier is the Trunkey Professor and Vice Chair of Surgery, University of Washington, as well as the Surgeon-In-Chief at Harborview Medical Centre, the Level I Trauma Centre in Seattle, which supports four north-western states. Dr Maier is the current president-elect for the ACS, and has also served as president for multiple surgical and trauma societies, including the American Surgical Association, the American Association for the Surgery of Trauma, the Shock Society and the International Association of Trauma, Surgery and Intensive Care. He has extensively studied the acute management of the severely injured and critically ill patient, as well as the impact of trauma system development.

Dr Haider is a trauma surgeon from the Brigham and Women's Hospital in Boston. He is the Kessler Director for the Centre for Surgery and Public Health. In addition, Dr Haider is the current president-elect for the Association for Academic Surgery. He is credited with uncovering racial disparities after traumatic injury and establishing the field of trauma disparities research. Other research interests include long-term clinical and functional outcomes after trauma and emergency general surgery, optimal treatment of trauma/critically ill patients in resource poor settings, and advanced analytic techniques for surgical health services research.

In addition to these invited speakers, we are fortunate to have the services of several other prominent trauma surgeons from the USA, including Dr Jeff Kerby, Alabama; Dr Tim Pritts, Cincinnati and Dr Alan Guo, Buffalo. The ACS Travelling Fellow is Dr Mayur Patel, a trauma surgeon and prolific researcher from Vanderbilt.

A key workshop associated with the program, is the Anatomically Based Surgical Exposure for Trauma course (ABSET). This is an ACS workshop, which utilises cadavers to teach critical surgical exposures required to arrest major haemorrhage. The workshop will be held on the Sunday prior to the ASC, and will be the first workshop of its kind to be run in Australasia. Dr Mark Bowyer, from Bethesda, is the national director of the course in the USA, and has kindly agreed to direct our inaugural course as well as participate in the ASC program. There will also be a mix of US trauma and local trauma. This is an essential workshop for any surgeon, who may encounter major bleeding from trauma.

Trauma is a collaborative specialty, and this is reflected in the program. The sessions include an injury prevention session combined with Women in Surgery, focussing on alcohol related violence and intimate partner violence. Thoracic wall trauma is a significant problem, and a session combined with cardiothoracic surgery and ANZCA covers non-operative as well as operative options. Lessons learnt from the austere environment draw upon knowledge and experience provided by both civilian and military experts working in challenging situations. The open pelvic fracture is a perfect pathology to demonstrate the need for multispecialty care, and this will be a focus for discussion with the Orthopaedic section.

Thursday morning will provide an opportunity to examine the latest updates in management for Hepatic-Pancreatic-Biliary (HPB) trauma, combined with the HPB section.

Other important components of the Trauma section program include a masterclass on Wednesday morning. Trauma surgery experts will provide an overview of the critical pearls and pitfalls associated with essential trauma surgical procedures. The free paper session, as always, attracts high quality research papers, particularly those eligible for the Damian McMahon Trauma Research Paper Prize.

The Trauma section recognises the role of most general surgeons and rural surgeons in managing trauma, and thus the specialty dinner is combined with General Surgery, Rural Surgery, and Orthopaedics. This promises to be a spectacular evening, commencing on the HMAS Vampire, and proceeding to the National Maritime Museum.

The Executive Committee and Section Conveners are working hard to produce an excellent program containing a variety of sessions, masterclasses and social events that should have a wide range of appeal. We encourage all Fellows to attend what should be a memorable and worthwhile ASC.

Vincent Lam, Jeremy Hsu, Julie Howle
ASC Convenors

Rural Surgeons Award

WA surgeon, Dr Tom Bowles honoured for commitment to rural surgery

WA General Surgeon Dr Tom Bowles was chosen to receive the 2017 Rural Surgeons Award, an honour that acknowledges significant contributions made to surgery in rural settings in both Australia and New Zealand.

Based in Albany, Dr Bowles is the Clinical Lead for Surgery for the Western Australian Country Health Service and a consultant surgeon at Albany Regional Hospital.

The first regional surgeon to hold the position of Chair of the RACS WA Committee, Dr Bowles has also been Chair of the College's Rural Surgery Section and Treasurer of Provincial Surgeons Australia.

With a strong commitment to delivering the best surgical services in regional WA, Dr Bowles has been a member of the WA Board in General Surgery, the WA Patient Blood Management Steering Committee and the WA State Trauma Committee.

A Clinical Senior Lecturer at the University of WA and supervisor of surgical training, he is also an Early Management of Severe Trauma (EMST) Director, a Definitive Surgical Trauma Care (DSTC) Instructor and a member of RACS's faculty of Surgical Educators.

Since arriving in Albany to take up his Consultant position in 2006, Dr Bowles has dedicated his time to serving the people of the region and working to overcome workforce pressures that beset rural surgery.

He has worked hard to attract junior doctors to Albany as part of their SET rotations to give them a taste of life as a regional surgeon in the hope of luring them back once they have received their FRACS.

So far that work is paying off, with two out of 16 surgeons trained there wishing to return.

He has also established strong links with his Perth colleagues in an effort to create permanent rotations between country and metropolitan surgeons to provide leave relief and opportunities to sustain skills in emergency surgery.

He is currently creating a mechanism to allow rural WA surgeons across specialty groups to work together as one cohesive craft group.

With a special interest in Colorectal surgery, Dr Bowles runs a broad emergency and elective general surgical practice and has introduced a number of innovations to medical practice in Albany including the establishment of a multidisciplinary cancer team.

A country boy from the small Victorian town of Donald, Dr Bowles decided early in his training to become a regional surgeon after he began his surgical training in Fremantle, WA and set about developing his skills in General, Paediatric, Orthopaedic, Urological, Trauma and Plastic Surgery.

Image (left): Dr Tom Bowles

Since then, he has attempted to design and introduce customised training packages for junior doctors interested in a career as a rural surgeon – particularly those wishing to take on the unique challenge of working in remote WA.

Servicing a population of 36,000 in the town and 60,000 in the surrounding region, Albany now has three general surgeons, one orthopaedic surgeon, two gynaecologists and a visiting service comprising Ear Nose and Throat (ENT), Plastic and Reconstructive and Urology surgery with three trainee positions based at the hospital.

Speaking to *Surgical News* after receiving the award, Dr Bowles said he was "chuffed" by the honour and the support of his colleagues.

He paid particular tribute to regional surgeons who had mentored and supported him as a junior doctor in his desire to become a rural surgeon including Dr David Birks, Professor David Watters, Dr John Graham and Dr Graeme Campbell.

He said he continued to enjoy life as a surgeon in regional WA despite workforce pressures that often require having to shoulder a one-in-two weekend on-call roster if one of his General Surgeon colleagues is absent.

Dr Bowles said he hopes the opening of Albany's first private day surgery will provide enough work to accommodate a fourth general surgeon.

"We're in the process of designing the day surgery clinic and negotiating how it will work which is an exciting development for the town," Dr Bowles said.

"Albany has never had a private surgery clinic before. My hope is that it will allow us to bring on another general surgeon which would have a great impact on our on-call emergency roster."

Dr Bowles said he particularly enjoys the travel involved in his role and his interaction with junior doctors as a teacher and mentor, particularly as an EMST course instructor.

Once every 2 months he flies to Merredin, which sits roughly midway between Perth and Kalgoorlie, he spends two days a month in Esperance and one day each week at Katanning, 180km north of Albany.

"As a craft group, WA rural and regional surgeons have been working hard to create training positions across the state so we can attract and support trainees in the hope that they might want to come back."

Dr Bowles said that while a number of challenges still confront both general surgery and rural surgeons, he is confident they can be surmounted.

"I think people now understand the pivotal importance of having generalists as well as specialist surgeons," he said.

"Yet rural surgery still faces pressures in that it remains an older male profession, with many surgeons working well after retirement age because they can't find replacements.

"As a craft group, WA rural and regional surgeons have been working hard to create training positions across the state so we can attract and support trainees to come back.

"We are also still committed to creating customised training packages so that these trainees feel confident that they have the skills they need to work in rural, remote or provincial centres.

"This is a work in progress but we will continue to push for this focussed training because trainees need dedicated support if we wish them to take on such positions outside major centres and ease workforce pressures of regional surgery."

A father of three children, Dr Bowles is also active in the Albany community as the Treasurer of the Southern District Junior Football Association, a football and cricket coach and a member of the Surf Lifesaving Club of which his wife Sarah is the Vice President. She is also a past local councillor and established and chaired a local non-profit charitable organisation.

"We both enjoy contributing to the Albany community and hope that our kids see how important community service and volunteering is."

The Rural Surgeons Award is bestowed in recognition of at least 10 years' contribution to the development of a high standard of surgery in a rural setting and a commitment to quality assurance and on-going education and training of surgeons. The award is open to a Fellow in any specialty.

Former award recipients include Dr Robert North (2016), Dr Graeme Campbell (2015), Dr Murray Pfeifer (2014) and Dr David Birks (2013).

With Karen Murphy
Surgical News Journalist

RAAS Team

ASERNIP-s Celebrates 20 years!

A department within RACS has been making a big impact on evidence-based practice in clinical decision making across Australia, New Zealand and the world… and they've reached an important milestone.

In January 2018 Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-s) celebrated its 20th year of operation!

Initially funded by the Australian Federal Government, the ASERNIP-s work-group was set on a path to develop robust processes for health technology assessment (HTA) in surgery. ASERNIP-s grew and expanded its external stakeholder base to conduct HTAs for a range of national and international groups. Its collection of clients now includes: Australian Federal and State as well as New Zealand government agencies, the National Institute of Health and Clinical Excellence in the UK, the World Health Organisation and other international stakeholders such as the American College of Surgeons.

Indeed, this work has led to the successful completion of more than 270 HTAs and more than 150 peer-reviewed publications and presentations, as well as numerous other surgery-related reports.

Staff members have held key roles on national committees like the Therapeutic Goods Authority and internationally, as Chairs of the International Network of Agencies for Health Technology Assessment (INAHTA) and as President of Heath Technology Assessment International (HTAi). Connections with these groups has not only facilitated support for the ASERNIP-s team but also opened opportunities for external work.

The Editor in Chief role for the journal of HTAi (IJTAHC – International Journal of Technology Assessment in Health Care) is also held within this group by Assoc. Professor Wendy Babidge and several current staff members hold affiliate academic appointments.

Many people have supported ASERNIP-s; from the inaugural ASERNIP-s Management Committee to the many Fellows who have been part of a number of review groups – the team is very grateful for all their valuable input and support.

ASERNIP-s celebratory cake

On reflection of the past 20 years, I believe it is important to also acknowledge the staff members that have worked in the Department over this time. Growing from an original team of two, eleven staff are now employed within ASERNIP-s. Evidence-based research, like that conducted by these staff members requires dedication and an understanding of a variety of healthcare factors; their expertise in these arenas is a significant factor in achieving this significant milestone.

Looking to the future, and with the development of the RACS Research Strategy, the group has been re-named *'Research & Evaluation, incorporating ASERNIP-s'* (R&E inc. ASERNIP-s). With this new name comes a new remit to work more closely with RACS Committees and each of the Specialty Societies.

As the importance of evidence-based practice in contemporary healthcare continues to grow, we are confident that the role Research and Evaluation inc. ASERNIP-s has within RACS will continue for many years to come.

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

Advocacy update

RACS regularly advocates for informed and principled positions on issues of public health, across a number of different mediums, including through the media, public campaigns, or by negotiating directly or providing written submissions to Government. Below is a list of some of our recent advocacy work;

Australian Competition and Consumer Commission's (ACCC) Review of Quad Bike Safety

The ACCC has established a taskforce to conduct an investigation into quad bike safety, which will inform a series of recommendations to Government mid-2018. In December 2017 RACS stated its position on quad bikes to the taskforce calling for stricter safety controls. RACS has provided multiple submissions and witnesses in the recent past who have appeared at coronial inquests and other inquiries into quad bike safety, and we stand ready to do so again as part of the ACCC's investigation.

Briefing to the Incoming Minister (NZ)

Prior to the 2017 New Zealand election RACS sent an election statement to all of the major parties posing a series of policy questions. With the dust having now settled on the election campaign and a new Government and Health Minister sworn in, RACS provided a detailed briefing to the new minister regarding the issues which we perceive to be of importance to the provision of surgical care in New Zealand.

Queensland Election Statement 2017

RACS also provided an election statement prior to the Queensland election, which outlined key issues requiring the Government's attention over the next three years. The Palaszczuk Government was returned to power with a slim majority, with Steven Miles replacing Cameron Dick as the state's Health Minister. RACS wishes Mr Dick well in his new position, and looks forward to meeting with Mr Miles shortly to discuss issues of importance to Queensland Fellows, Trainees and IMGs.

Submissions to the Victorian Government

Towards the end of 2017 RACS made two separate submissions to the Victorian Government. Our response to its Data Set Proposals highlighted that the purpose of collecting and publishing performance outcomes data is to improve the quality of medical care and increase public trust and confidence in the delivery of that care. However, the public release of surgical data may have unintended consequences that could impact on the delivery of quality and safe care. It is therefore important that appropriate quality assurance and evaluation mechanisms are in place for any data collected.

We also raised our concerns with the Government's Proposal to develop a Duty of Candour. Much of what has been proposed in legislative reforms is already adequately covered by current open disclosure requirements and multiple professional codes of conduct across the medical profession. RACS will continue to monitor these proposals to ensure that no negative unintended consequences arise.

RACS is often presented with opportunities to advocate on behalf of our Fellows, Trainees and IMGs, and is committed to effecting positive change in health care and the broader community.

All RACS submission can be found on the RACS Advocacy page on the RACS website:

https://www.surgeons.org/media/college-advocacy/

Mark Morgan
Policy & Communications Officer

A CCrISP® new approach

In February 2018, Care of the Critically Ill Surgical Patient (CCrISP®) Edition 4 will be rolled out. This edition heralds a new look and approach to training for a course that has been a mandatory part of surgical training since 2000.

Managing the deteriorating patient is a critical component of surgical care, and CCrISP® delivers a structured and comprehensive approach with a strong focus on communication and other non-technical skills.

The course was developed by Royal College of Surgeons - UK (RCS) in 1999 and the edition 4 has been extensively updated by RCS. Over the past 18 months the Australasian CCrISP® committee has reviewed the RCS changes and incorporated these while adding some of its own sections and approaches, making the course unique to Australasian clinical practice. Some lectures are still part of the course, but the focus is on interactive discussions. There is ample opportunity to practice skills and communication in small groups with trained actors and an expert multidisciplinary faculty. As in other RACS courses, small group teaching by senior consultants who offer a wealth of experience is invaluable.

It is not only participants who find CCrISP® a valuable experience. Teaching with a range of colleagues from different specialties, networking and collegiality are given as reasons to be part of the CCrISP® faculty. Instructors are offered professional development through Senior Faculty Workshops and all new instructors undergo training by attending the CCrISP® instructor course, an intensive 2.5 day workshop which provides faculty with the skills necessary to teach CCrISP®. Courses are regularly attended by the CCrISP® senior medical educator, who is available to provide faculty with feedback on their teaching techniques. The Senior Faculty Workshop held in June 2017 presented a draft of the new content and the feedback received there significantly influenced the new content ultimately adopted.

In the past three years the Australasian CCrISP® committee has written four eLearning models which have become the early flagship modules for the JDocs online resource. These were designed to embed the key concepts of CCrISP® and are aimed at junior doctors. The modules are Communication, Managing Peri-operative Risk, The Sick Patient and Interaction with Critical Care. They are available to all Trainees and JDoc subscribers.

To access these eLearning modules sign in to the RACS website and visit the 'Learning Resources' section of your portfolio dashboard.

The committee has commenced a campaign to spread the net a little wider with advertising to other Colleges such as Obstetrics and Gynaecology to increase exposure to CCrISP®; as its principles are both valid and valuable to all doctors. CCrISP® continues to innovate with a revised curriculum and a strong e-learning component.

We think the future is bright.

Jonathan Serpell
Chair, Prevocational and Skills Education Committee

Ros Pochin
Chair, Care of the Critically Ill Surgical Patient

IMAGE:
CCrISP® Senior faculty workshop.

A driving force in surgical and anaesthesia care

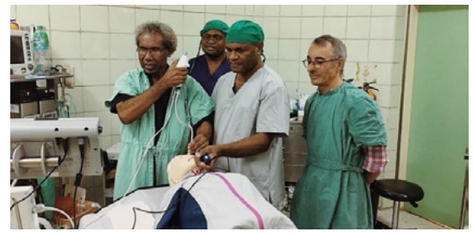
Supporting Access to hands on training and quality care in Solomon Islands

Growing up, Kaeni Agiomea's dream was to become an engineer. Born in a rural village at the northern tip of Malaita, one of six major islands in Solomon Islands, Kaeni was interested in mechanics, hydraulics, and repairing broken household items.

Some 50 years later this dream remains unfulfilled, however through a number of remarkable twists of fate, Kaeni studied medicine in PNG and became an anaesthetic registrar, training under the guidance of Dr Haydn Perndt and Dr Christopher Sparks, two Australian anaesthetists who were working at the National Referral Hospital (NRH) in the Solomon Islands, where Dr Kaeni eventually became the head of the anaesthesia department in 2001.

Dr Kaeni has been the driving force behind the establishment of the Anaesthesia Training Centre at the NRH, which provides excellent clinical hands-on training and supervision for anaesthetic trainees. The 2015 Lancet Commission on Global Surgery 2030 paper established the surgeon, anaesthetist, obstetrician (SAO) workforce indicator for low and middle income countries as 20 specialists per 100,000 of the population. The Solomon Islands has a population of 600,000, so there is an urgent and acute need to increase the SAO workforce from its current number of 15. The training centre helps trainees and post-graduate students gain critical practical skills that complement the academic part of the post-graduate course. The University of Papua New Guinea (UPNG) now recognises the training centre as a teaching facility, and students are able to train two years in the Solomon Islands, the remaining two years in PNG. The goal is to have Fiji National University (FNU) also recognise the training centre as a teaching institution, so that more students can stay in the Solomon Islands, reducing financial pressures on the health system, increasing the number of health professionals in the country, and easing the social burden of family separation.

At the request of Dr Kaeni and the Ministry of Health, RACS and the Australian Society of Anaesthetists (ASA) are collaborating to support training infrastructure, and the mentoring and training of trainees and post-graduate students. In November 2017, RACS procured and delivered important teaching equipment, including a laryngoscope and bronchoscope crucial for managing difficult airway procedures. Dr Kaeni reports "the video-laryngoscope provides an indirect view of the upper airway and improves glottic visualisation, including suspected or encountered difficult intubation, and eases insertion of a tracheal tube."



Dr Kaeni has great passion for mentoring the next generation of anaesthetists in the Solomon Islands, and currently oversees the training of four trainees and one post-graduate student. Colleagues and trainees highly regard his calm manner and expertise for anaesthesia in the Pacific context. The new training equipment and the continuous support from ASA and RACS will help Dr Kaeni foster a high quality learning environment.

The long-term goal of this project is for the Solomon Islands to provide sustainable specialist training nationally, which will ultimately lead to a higher number of anaesthetic specialists and an improved quality and safety of surgical and anaesthesia care in the Solomon Islands, in line with Global Surgery 2030 targets.

The project is supported by the Australian government through the Australian NGO Cooperation Program (ANCP).

IMAGES:
(Far-left) Dr Kaeni Agiomea (right) and Dr Andrew Fenton (ASA) simulating a difficult airway procedure with the new teaching equipment.

(Left) The three lone anaesthetists in the Solomon Islands; from left to right Dr Kaeni Agiomea, Dr Jack Puti, Dr Bata Anigafutu, and ASA member Dr Phil Blum on the right. Dr Jack Puti and Dr Bata Anigafutu both trained under Dr Kaeni.

Annette Holian
Chair, External Affairs

with Dr Kaeni Agiomea, Head of the Anaesthesia Department, NRH, Solomon Island and Natalia Hepp, Project Support Officer, Global Health

Researching the field of hip surgery

Exploring the link between specific genes and pseudotumour development around orthopaedic implants

Dr. Andrew P. Kurmis (FRACS, FAOrth, PhD, BMBS (Hons), CME), a Specialist Orthopaedic Surgeon working in both private and public practice in Adelaide, South Australia and a Senior Clinical Lecturer at the University of Adelaide, has recently received both national and international acclaim for his leadership and contributions to a large collaborative multi-disciplinary research endeavour.

The long-running work involving surgeons in Australia, USA, Canada and United Kingdom has explored the link between specific genes and pseudotumour development around orthopaedic implants. Dr. Kurmis was invited to present the findings of the first stage of his research in San Diego (USA) last year at the 2017 Annual American Academy of Orthopaedic Surgeons (AAOS) Scientific meeting – attended by over 28,500 people, and nearly 13,000 clinicians – and was awarded the Frank Stinchfield Prize by the International Hip Society for outstanding contribution to the field of hip surgery.

The Stinchfield Prize (named in honour of the late New York Professor Frank E. Stinchfield) is widely regarded as the most prestigious clinical research prize in the field of arthroplasty. Later in the year, Dr. Kurmis was also awarded the RACS John Miller Medal for outstanding clinical research and presentation. The first scientific publication in a series to come has recently been published in the international journal, Clinical Orthopaedics & Related Research (CORR), under the auspices of the recent AAOS award. Dr. Kurmis was also recently interviewed in a segment that aired around the country on National Nine News regarding his work, achievements and the potential positive impact of patients locally.

In the wake of the globally-publicised metal-on-metal (M-o-M) hip replacement recall and subsequent international class action lawsuits, and given that hundreds of thousands of such devices were implanted around the world, Dr. Kurmis' work has sought to better understand the genetic markers that place individual patients at risk for the development of 'pseudotumours' around both M-o-M total hip replacements (THRs) and modular total hip or total knee replacement components. A highly aggressive and locally destructive lesion, pseudotumours (a histologically-recognised form along the spectrum of adverse local tissue reactions [ALTRs]) have previously developed with seemingly unpredictable frequency. Their potential formation, especially in the setting of in situ M-o-M THRs, has long remained a costly and often futile early diagnostic challenge. Equally, given the indiscriminately destructive nature of these lesions and the irreversible damage they cause to tissues around the joint in question, the surgical management of established pseudotumours around lower limb joint replacements has in many cases come at the expense of good functional outcomes, often in a young and previously highly active patient demographic.

Through a large multi-centre, clinicalgenotype correlation analysis, Dr. Kurmis' team has identified a specific 'at risk' allele within a targeted HLA locus that appears to be strongly influential in determining an individual's risk of subsequent pseudotumor development in the setting of mobile M-o-M or modular peri-articular orthopaedic implant components. The results of preliminary testing suggest an increased risk with the specific gene present in the order of 710 per cent (i.e. a more than 7x background risk). In context, contemporary estimates of the risk to an individual female of developing malignant breast cancer in the positive presence of a BRCA1 gene is approximately 5.4 times the background population risk (not at all undermining the fact the resultant breast tumour is a highly malignant cancer with high associated mortality, and a M-o-M related pseudotumor is a locally aggressive but benign lesion).

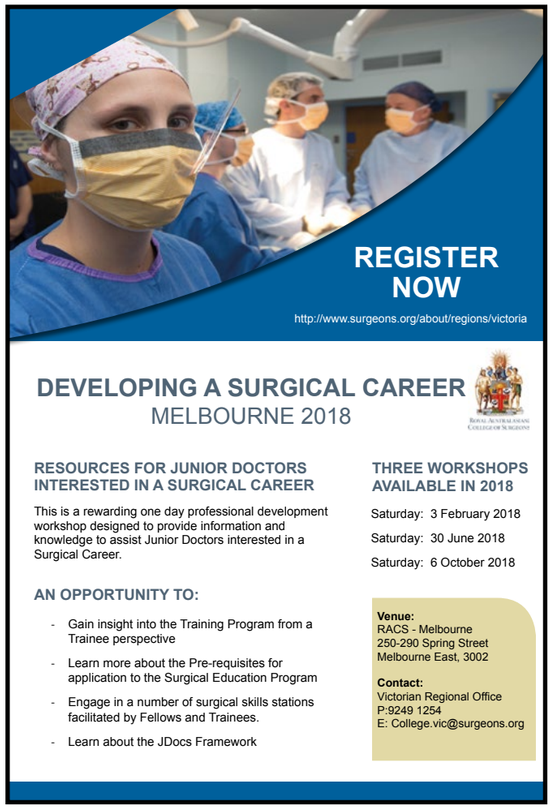
> "The availability of a low morbidity screening test may allow individual risk determination of subsequent pseudotumor development which may help guide prospective clinical decision making and management in the future".

Dr. Kurmis' research suggests that the wide range of individual responses seen to bearing-generated metallic wear debris (most often cobalt and chromium particles) is heavily influenced by a patient's underlying genotype – some patients endure the rapid development of highly destructive pseudotumours, while others, with matched implants, continue for years symptom and disease free. The specific 'at risk' gene identified has a recognised role in innate immunomodulation, particularly (but not exclusively) lymphocyte activation and recruitment.

Into the future, the research team aims to develop a refined, cost effective and highly accurate screening test that can be used to quickly identify 'at risk' gene carriers. For the thousands of patients with current in situ M-o-M THRs or other high risk modular implants at risk of fretting corrosion, the availability of a low morbidity screening test may allow individual risk determination of subsequent pseudotumor development which may help guide prospective clinical decision making and management in the future (for example, this might inform the difficult clinical decision to proceed to early revision surgery before widespread – and often irrecoverable – local tissue destruction has occurred, in patients identified as being at 'high risk'). Similarly, where M-o-M or modular orthopaedic implants otherwise represent the best (or only) option available to a particular patient in particular circumstances, access to the gene testing result may allow future risk profiling or flag the need for a more regular and aggressive clinical and imaging follow up regime.

Dr Andrew Kurmis, FRACS

with Gabrielle Forman, Communications & Advocacy Department



Award recipients Mr Sam Khamhing (right) and Mr Steven Lai (left)

WA Surgeons Honoured

Dr Srisongham (Sam) Khamhing and Dr Steven Lai were honoured with the RACS Outstanding Service to the Community Awards in recognition of their long and distinguished careers

The two dedicated and highly respected surgeons were presented with their awards in a surprise ceremony as part of the WA Surgeons Ball in front of family, colleagues and friends.

"The RACS award recognises surgeons with a dedicated history of service to their local community – more often than not unheralded - but without which the standard of surgical care in that community would have been less than society expects. Both men embody these qualities and highly deserve recipients of the award," RACS WA Chair Dr Stephen Rodrigues said.

Dr Khamhing

Prior to his medical career, Sam and his family moved to Australia from Laos in 1965, where his father established the Lao embassy in Canberra.

Although he undertook his medical training in Sydney, for the last three decades he has lived in Western Australia where his care, commitment and loyalty are renowned right across the state.

After initially moving to the Kimberley for a three month locum contract in 1982, Sam fell in love with the lifestyle and the work. He thrived on the challenge of providing high quality essential services to some of the most remote communities on earth.

"In remote areas there is limited support and resources so you have to be an all-rounder. It certainly was a challenge but it was also a great experience and gave me so much personal fulfilment," Sam recounts.

"Working with the Indigenous people in the Kimberley was a real highlight, as was working with the Royal Flying Doctor Service and being able to provide clinics to remote communities. I particularly remember the 'mercy dashes' we did to Broome from Derby, where we performed an emergency laparotomy for penetrating abdominal injuries, and also from Kununurra to Wyndham to perform an emergency caesarean."

Sam left the Kimberley at the end of 1989 and moved to Pinjarra in the Peel region of Western Australia to raise his family. Over the years, Sam has seen many changes in the Peel community which covers a land area of approximately 6,500 square kilometres and has a population based predominantly in the rapidly growing town of Mandurah.

"The changes in the area over the last 20 to 30 years have been significant. The growth in the region has obviously led to a much greater demand for services, but with that has also come a big increase in the number of doctors that now live and work here. It is certainly very different to when I first started out and now has a different set of challenges."

Despite the growth in the area, it is still considered a regional part of Western Australia, and Sam remains a popular and respected figure in the community.

Dr Margaret Sturdy, CEO of Peel Health Campus, who recommended Sam for the award paid tribute to his generous and highly likeable nature.

"Through my 25 years in medical administration and hospital management, I have never met a doctor who is so universally loved by the staff at all levels of the hospital. He is simply one of the most beautiful people I have ever met.

"Sam is well known in the community and throughout the hospital as a kind, empathetic expert in his field. His care for patients, commitment and loyalty is admired."

"The RACS award recognises surgeons with a dedicated history of service to their local community – more often than not unheralded - but without which the standard of surgical care in that community would have been less than society expects. Both men embody these qualities and highly deserve recipients of the award"

Dr Steven Lai

When Steven Lai first migrated to Australia from Hong Kong in the 1970s his experiences of the two regions could not have been any different. Much like today, Hong Kong was a thriving metropolis and one of the most densely populated areas on earth. It was also in the midst of the Cultural Revolution to the north, a time of great political instability which saw many intellectuals persecuted, and caused great tension and unrest in Hong Kong.

By contrast, the small town of Narrogin in Western Australia's wheatbelt, 192 kilometres south-east of Perth, offered somewhat of a more relaxed lifestyle. Despite the initial culture shock Mr Lai embraced his new surroundings.

"When we arrived in Narogen it was a big change. I loved all the outdoor activities and it was so nice to be able to settle down in such a lovely quiet town rather than the city."

He quickly developed a reputation as a talented and hard-working clinician who was always willing and available to serve his community twenty-four hours a day, seven days a week.

He describes the day a new theatre sister arrived in town and told him that he had delivered her as a baby thirty years ago as one of his favourite memories from practice. This was both a lovely example of just how small and tight knit rural communities are, as well as the 'jack of all trades' that Mr Lai became when he first moved to Australia.

"Initially, I started to do everything from general practice, to on-call work, and all sorts of operations. I did that for about the first twenty years and then as things became more specialised I concentrated on surgery."

Over his 40 years of service, Steven has endeared himself to the Narrogin and other surrounding communities he serves and is held in the highest regard by locals.

Dr Peter Barratt, the Regional Medical Director of the Western Australia Country Health Service (Wheatbelt) described Steven as an invaluable member of the medical profession and the community.

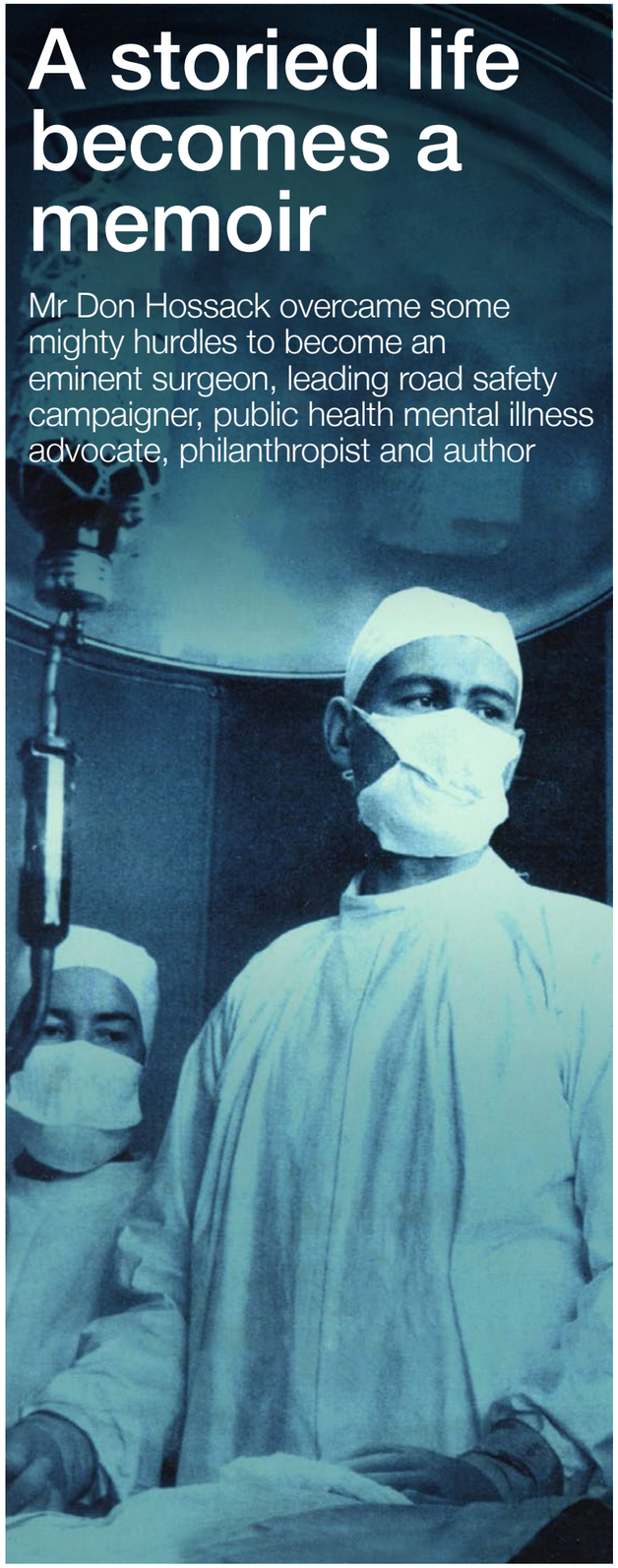
"Having Dr Lai resident in Narrogin has allowed patients both in Narrogin and throughout the Wheatbelt to receive treatment closer to home both in and out-of-hours. He has provided an almost continuous on-call service for surgical procedures for many years and is always available for advice.

"Dr Lai's dedication to providing a comprehensive service has kept Narrogin in a privileged place compared to many other rural locations. He is well respected by his colleagues and nursing staff who describe him as wonderful to work with."

Mark Morgan
Policy & Communications Officer

A storied life becomes a memoir

Mr Don Hossack overcame some mighty hurdles to become an eminent surgeon, leading road safety campaigner, public health mental illness advocate, philanthropist and author



Mr Don Hossack overcame some mighty hurdles to become an eminent surgeon, leading road safety campaigner, public health mental illness advocate, philanthropist and author.

Suffering from severe dyslexia in an era when it was little understood, Mr Hossack left school in despair at only age 13 to take up any job he could find.

Yet, through a combination of good luck, mentoring and determination, he taught himself to read, completed his secondary education, was accepted into Medicine at Melbourne University and became a General Surgeon.

That was the start of a stellar career which saw Mr Hossack conduct research into road safety that pushed Victorian authorities to introduce the mandatory use of seatbelts and random breath-testing, reforms that changed the nation and led the world.

Starting his surgical career at Prince Henry's Hospital in Melbourne, Mr Hossack later accepted the position of Consultant Surgeon to the Melbourne City Coroner which gave him unprecedented access to the physical evidence behind what was then described as 'carnage' on Victorian roads.

An Inaugural member of the Victorian-based Road Trauma Committee, Mr Hossack conducted hundreds of post mortems on road accident victims, gathering the evidence needed to support the RACS campaigns to mandate the wearing of seat belts and introduce random breath testing.

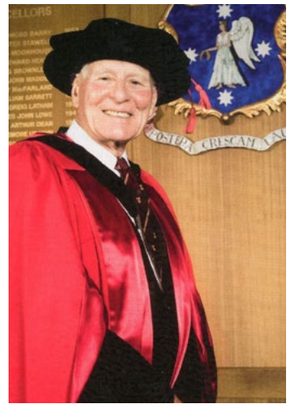
In one seminal piece of research conducted in the late 1960s and presented in 1972, Mr Hossack conducted post mortems on 400 victims. It found that 50 per cent of drivers killed had blood alcohol levels above 100mg/ml while the types of injuries sustained indicated that 94 per cent were not wearing seat belts.

Mr Hossack describes that work as providing the indisputable evidence needed to force authorities to act on both seatbelts and alcohol, measures which were attacked by some at the time as unacceptable intrusions upon personal freedoms. Yet, asked by Sir Edward Hughes to lead the public campaign promoting road safety on behalf of RACS, Mr Hossack gradually swayed public opinion through the strength of his evidence and tireless advocacy.

After both measures were finally introduced, the road toll plummeted from 1034 (campaign – 'Declare War on 1034') in 1969, to 291 in 2016.

Other results from Mr Hossack's post mortems also identified unexpected findings, that:

- 7 per cent of victims died from asphyxia consequent to inhalation of blood and vomit after concussion and early attention to such victims could save lives; and



- 12.7 per cent of fatal road crash victims had suffered a rupture of the aorta which, if recognised in time, could be repaired by surgeons.

Now in his 90s, Mr Hossack has written the story of his journey from his birth in a rented room in Abbotsford to his storied career in a memoir titled *The Weaver's Son: Odyssey of an Australian Surgeon*.

Speaking to *Surgical News*, Mr Hossack said he found his time as Consultant to the Coroner a fascinating and rewarding experience.

"I initially investigated the cause of death of patients who died unexpectedly in hospital," he said.

"However, in 1961, two young men were brought into the morgue who had died in a car accident and yet had no marks on their bodies.

"The cause of death was simply listed as 'road accident' so I asked if I could investigate and these two victims became the first of a series of 100 autopsies I conducted that showed a significant percentage of road accident deaths caused by a rupture of the aorta when the heart was pushed forward upon impact.

"No-one knew this could happen at the time, that the patient would feel a pain in the chest and be dead within minutes or that if surgeons got to the person in time, they could repair the rupture.

"Some of my findings about the aspiration of blood and vomit also led to changes in the delivery of anaesthesia and the care of the severely concussed.

"We led the world here in Victoria, but I was just one member of a larger team of Fellows working to reduce the terrible road toll.

"I just happened to have access to the bodies of the victims,and they told an undeniable story that could not be ignored."

Through much of his early career, Mr Hossack divided his time between his private consulting rooms, his public health commitments at Prince Henry's Hospital and the morgue.

Then, in the late 1970s, he gave up those positions to become the Surgical Director of all the mental institutions in Victoria, a position which saw him treat some of the most marginalised and vulnerable people in the community.

When he describes caring for these patients, his kind voice reveals an empathy that is perhaps sparked by the memories of the young boy who had also faced ostracism until taken under the wing of Melbourne University academics.

"At 13 I left school because I couldn't take the humiliation of being unable to keep up with my peers and I heard about a job as a lab assistant in the University of Melbourne's zoological department," he said.

"This was during the war and all the qualified young men were away fighting so they took me on and I just loved it.

"One day I was asked by my boss what I wanted to do with my life, making it clear that there was no place for me there when the war ended, and I told him I wanted to be a doctor.

"I knew I had the ability after watching the medical students and I wanted to do what they were doing so I went to night school and taught myself to read.

"Then, with the support of some university academics, I got into University High School, completed a Pharmacy Degree and was then accepted into medicine.

"I look back with wonder on that time in my life now because I was just this helpless young fellow, but these eminent people took the trouble to help me, assistance that proved to be the turning point in my life."

Mr Hossack is also a great supporter of RACS young Fellows, having given the Foundation for Surgery a house left to him in the Will of one of the patients he treated at Prince Henry's Hospital.

The money raised by the sale of the property now funds the Francis and Phyllis Mary Shore Memorial Trust for Medical Research.

That research, designed to assist other young surgeons in their research, has funded cutting edge studies into a variety of surgical fields including hepatocellular carcinoma, renal cancer, arterial disease and Barrett's oesophagus.

See page 48 for the RACS Library Review of Mr Don Hossack's memoir; The Weaver's Son: Odyssey of an Australian Surgeon. – Ed.

MAIN IMAGE: Don Hossack taken from the cover of the Weaver's Son. Inset (from left): Graduation Photo Dec 1954; Doctor of Medicine from University of Melbourne 2006; 2017.

With Karen Murphy
Surgical News Journalist

One Surgeon's Indigenous Immersion

Providing a greater understanding and sensitivity for practitioners about Māori culture and health is critical in reducing alarming Māori health statistics in Aotearoa

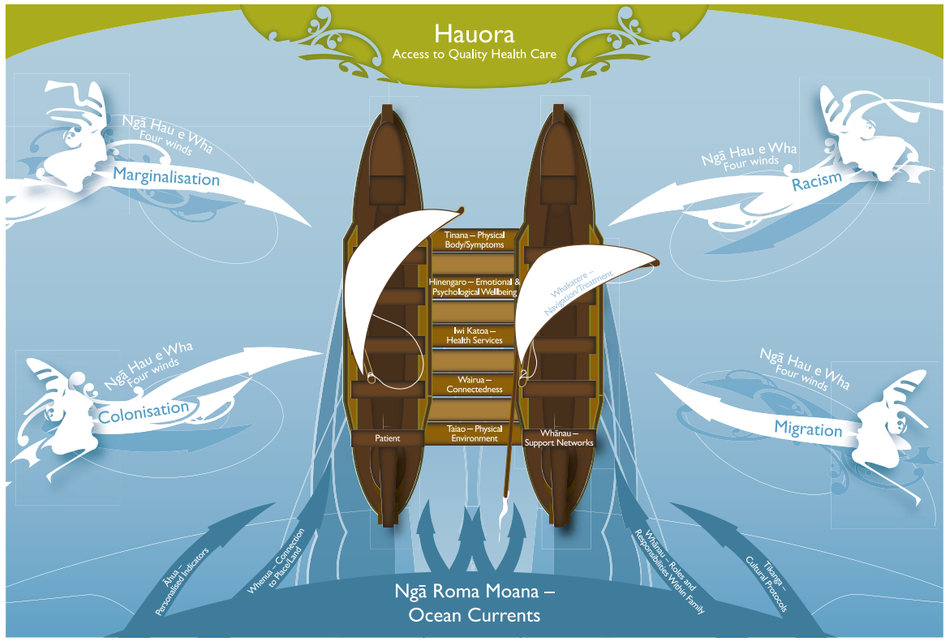


IMAGE: The Meihana Model of health

Te Whare Wānanga o Awanuiārangi is an Indigenous tertiary institution established in Whakatane in the Eastern Bay of Plenty, Aotearoa (New Zealand) in 1991 by Te Rānanga o Ngāti Awa. Awanuiārangi is one of only three institutions in New Zealand designated as a wānanga (Indigenous tertiary institution) under the *Education Act 1989*. Its establishment was an important step that recognised the role of education in providing positive pathways for Māori development.

Although Awanuiārangi has strong links to the people of Mātaatua, its doors of learning have always been open to all iwi (tribes) and all New Zealanders. The wānanga aims to be a quality provider of programmes in the tertiary education sector in Aotearoa. Its vision is to promote, grow and sustain Māori language, knowledge and culture in all its manifestations and especially with regard to tikanga (Māori practice). Programmes are designed to support and promote academic excellence, and are transferable nationally and internationally. One surgeon; a product of a traditional western medical model, is dropped into this unique, yet culturally progressive educational environment. Adding to the potential discourse the surgeon is educated in an era where Māori history was largely written by white European settlers. The re-learning of history would be de facto part of any immersion into this cultural environment.

A lecturer at Flinders University/Medical School Adelaide for nearly 15 years, I had always been interested in medical education. I completed a teaching diploma and founded Specialists without Borders, a not-for-profit medical education organisation, to take the highest level of medical education into developing countries. A badly fractured calcaneus preventing extended periods of standing and operating was my catalyst to consider full Indigenous educational immersion. I was too young to retire, and felt that I still had something to give, so I accepted the offer of a teaching position in anatomy/physiology and clinical sciences in the Department of Nursing, Te Whare Wānanga o Awanuiārangi.

Total immersion meant I started learning almost immediately. Immersion also meant I needed to personally relearn history to better understand the Māori health model, particularly tikanga.

But first let me tell you how it started so you can appreciate what a privilege and unique experience this is for a surgeon. At my interview my academic background was naturally thoroughly reviewed, and after an hour one last question was asked: did I know how to skin a possum (considered a pest in Aotearoa). As the question was asked with a smile, my reply was that no I didn't, but then being a surgeon and environmentalist I would prefer to vasectomise the creature. I was appointed with much smiling, and then introduced into a nursing department.

On my first day I was welcomed onto the campus with a powhiri (a traditional welcome). Then a Kaumatua (Māori elder) welcomed me in Te Reo Māori, the Indigenous language, followed by a karakia (prayer) in Te Reo Māori. Reremoana the Kaumatua then greeted me with a traditional hongi (a Māori greeting) while the woman kissed me on the cheek. I was then escorted to my class of first year students and introduced in Te Reo Māori. Approximately 25 of them stood up and explained who they were in their Māori language, undertaking their pepeha in Te Reo. Pepeha describes many aspects of one's historical background and provides the potential for crucial relationships. At the end, they looked at me expectantly. With prompting from my colleagues, I explained my background in English, and that I would be teaching them anatomy/physiology and clinical sciences. They all clapped, came to the front of the lecture theatre and stood in a semicircle around me. Two guitars were produced, and they sang the most beautiful welcome waiata (song) for about 10 minutes. I was quickly assimilated into the Department of Nursing and immediately started teaching and learning.

The Eastern Bay of Plenty has a 25 per cent Māori population, 40 per cent for children under 16 years. Sadly, the health statistics for Māori reflect inequity.

Mortality across all cancers is 78 per cent higher than the European population, a frightening fact. Uterine cancer has an 84 per cent higher incidence, and breast cancer a 38 per cent higher rate. Leading causes of death in wahine (Māori females) are ischaemic heart disease (IHD), lung cancer, Chronic Obstructive Pulmonary Disease, stroke and diabetes. Leading causes of death in tāne (Māori males) are IHD, accidents, lung cancer, diabetes and suicide.

Many try to explain these statistics as a product of poor lifestyle choice. The answer, I am discovering, lies on many levels, not least how Māori view medicine and healing, particularly as it relates to their traditions and spirituality. Approximately 65 per cent of Māori believe spirituality is a central concept in wairua (spiritual health). A health model which doesn't recognise this or is devoid of this understanding creates a potential barrier to effective treatment.

The Meihana model, initially published in 2007 (Pitama et al 2007) and updated in 2014 (Pitama et al, 2014) visualises the Māori concept of health as a double waka. In this model, the two hiwi (hulls) represent the patient on one side and their whānau (family) on the other. The patient and their whānau are strongly bound together via five crossbeams, each representing an aspect of total health: Wairua (spiritual health), Tinana (physical health), Hinengaro (mental health), Taiao (environmental health) and Iwi katoa (ancestry). Each voyage is charted towards a destination; for this waka, the destination is the attainment Hauora (total health/wellbeing) helped by nga hau e wha (the four winds of Tawhiri-matea), and hindered by nga roma moana (ocean currents) when they work against the whakatere (navigation/direction).

With this model in mind, I realised that speaking Te Reo Māori would allow me not only to fully understand the Māori concept of health but also better communicate with Māori patients. This was clearly demonstrated after I opened a free Specialist Review Clinic (www.eaFund.org.nz) to help the local community. New Zealand has ▶

one of the worst, across all race groups, colorectal cancer rates in the world. During Colorectal Cancer Awareness Week I was asked to speak on prevention strategies on the local Māori radio station. By that stage I was able to introduce myself in Māori and discuss my pepeha.

At the next clinic, I opened the consulting room door to find an elderly Māori gentleman standing with two women, each firmly holding an elbow. He looked reluctant to take a single step towards me or my office. I greeted him in Māori, stepped towards him, gave him a hongi and recited my pepeha. He looked at me, smiled, and said to me in English “so you played rugby” (which I had mentioned on the radio) and he walked into my office.

The shortened version of this story is that we first had a discussion about his whānau traditions and his cousin who had bowel cancer, and then moved onto his rectal bleeding. He had a small dysplastic polyp at 23 cm, which was successfully removed. He then brought his three brothers to the clinic with similar presentations. He told me I was the first doctor who had spoken to him in Māori which made him feel comfortable and trusting.

At that stage I felt my 15 years of experience as a gastrointestinal hepatobiliary and bariatric surgeon was finding another avenue of positive contribution. The thought was developing that the wider health community could help more with a greater understanding of Indigenous needs. The next step was to build a wider awareness. With our nursing students we created a short three act play, highlighting some of the barriers of the western medical health model for Māori patients and the importance for health practitioners to understand tikanga. Every four to six weeks we also now have eight to 10 students coming on to the campus as part of a Rural Immersion Programme. Students are exposed to the local Indigenous health issues and to the culturally sensitive methods of intervention and treatment.

The success of this programme now suggests that, in addition to expanding the free Specialist Review Clinic into a minor procedure centre, the next step is to provide educational immersion for foreign doctors coming to New Zealand.

Providing a greater understanding and sensitivity for practitioners about the cultural and health needs of Māori is, I believe, a critical step in reducing the alarming Māori health statistics in Aotearoa.

Who said only surgery provides the greatest excitement?

Dr Paul Anderson
FRACS

SAASM
South Australian Audit of Surgical Mortality

EXPRESSION OF INTEREST

Clinical Director (0.2 FTE)

South Australian Audit of Surgical Mortality (SAASM)

Application for the 2018 position is now open and will close at 5pm (AEDT) on 19 March, 2018.

The South Australian Audit of Surgical Mortality (SAASM) seeks to review all deaths associated with surgical care. The review process identifies areas of clinical management which could be improved. SAASM is a collaboration between the South Australian Government's Department for Health and Ageing (DHA), the Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG), the South Australian Anaesthetic Mortality Committee (SAAMC) and the Royal Australasian College of Surgeons. The SAASM Management Committee meets biannually and oversees the project, which constitutes an invaluable foundation to the running and success of the audit program.

The current Clinical Director, **Mr Glenn McCulloch** FRACS is retiring. Expressions of interest are invited for this position which will be responsible for the clinical direction and support to the SAASM providing project oversight and acting as Chair of the SAASM Management Committee. The Clinical Director also assists in engaging all health services/ hospitals and surgeons to actively participate and comply in this program. A close liaison with DHA and other relevant stakeholder groups is also required.

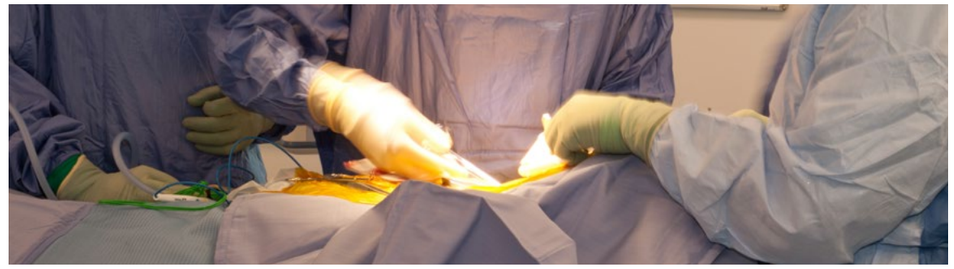
A demonstrated ability to meet deadlines and excellent organisational and time management skills are required, as are superior verbal and written communication skills.

Remuneration will be at the appropriate senior specialist level (pro rata).

Expression of Interest Process

Expressions of interest must be made in writing to Professor Guy Maddern, Chair, ANZASM college. asernip@surgeons.org copied to the Director RAAS wendy.babidge@surgeons.org Please provide a short CV and in the response letter address the requirements of the role as outlined in the Position Description and Person Specification.

Phone RACS +61 8 8219 0900



Case Note Review

Missed caecal volvulus not helped by the rush to move patient from the Emergency Department

Case Summary

An elderly patient was admitted with a three day history of constipation, constant abdominal pain and abdominal distension. There was a history of admissions for constipation, previous colonoscopies and endoscopies had revealed the presence of gastric ulcers. The patient’s medical history also included surgery for possible pancreatic cancer, a bowel resection and previous hernia repairs. Medications included frusemide, antihypertensives and Plavix (clopidogrel).

Examination revealed generalised abdominal tenderness in an uncompromised patient. Renal function showed a creatinine level of 260 µmol/L. An abdominal x-ray was interpreted as showing a dilated small bowel without air fluid levels but with massive faecal loading. Surgical review in the morning came to a similar conclusion although the tenderness seemed to have subsided. The primary diagnosis was bowel obstruction secondary to gross faecal loading.

Aperients were prescribed and a medical admission organised. Bowel preparation and Fleet (sodium phosphate) enemas were given the following morning. The enemas were followed by a CT scan that showed a caecal volvulus. The patient was taken to theatre in the evening and a right hemicolectomy was performed with primary anastomosis. The patient was transferred to ICU but deteriorated. Treatment was withdrawn following discussion with family.

Comment

There are several areas of concern and consideration that, when put together, may lead to the conclusion that this was an adverse event. On admission, this patient had the cardinal signs of obstruction: pain, relative constipation, abdominal distension and vomiting. The presumptive diagnosis was obstruction secondary to constipation. The interpretation of the abdominal x-ray would have been difficult because of the previous pancreatic and bowel resections. Air fluid levels would have only been visible if the x-ray film was an erect film, while in cases where the predominant distension is in the large bowel they may not be present.

Patients with abdominal pain requiring opiate analgesia should be considered for a CT scan on admission. The pain was severe enough to require titrated doses of morphine and the vomiting deemed significant enough for the placement of a nasogastric tube. The commencement of Colonlytely (polyethylene glycol and electrolyte solution) bowel preparation in this setting was inappropriate, with bowel preparation contraindicated in an obstructive situation.

A right hemicolectomy with division of adhesions was performed, the correct procedure for a caecal volvulus. While the pathology report did not show any transmural infarction, it is likely that the attending surgeons were unsure of the viability of the bowel and hence took a judgement call at the time of surgery.

Another concern relates to the transfer of this patient from ED to the ward. This was an elderly patient who had been admitted to the ED very late at night with severe pain. Several ECGs were performed during periods of spontaneous tachycardia, the patient’s oxygen requirements increased to 6 L/min, and the patient required transfer to the resuscitation room in the early hours of the morning. Despite this, the patient was transferred out of the ED resuscitation area to the ward in the middle of the night. This was not appropriate, irrespective of the 4-hour rule. While the seniority of the ED doctor who permitted the move to the ward is unclear, this patient was not well enough to be moved, and should have remained in the ED resuscitation area.

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

Professional Standards – 2017 Year in Review

Last year saw the Professional Standards portfolio achieve a number of strategic priorities including the development of key positions, submissions and projects

Continuing Professional Development (CPD) Framework

On 1 January 2017 the new RACS Continuing Professional Development (CPD) Framework commenced after broad consultation with RACS sections, specialty associations and societies; with consideration given to the RACS Building Respect, Improving Patient Safety Action Plan and regulatory requirements outlined by the Medical Board of Australia (MBA) and the Medical Council of New Zealand (MCNZ). While changes to the program have been kept to a minimum–mindful of RACS's reaccreditation with the Australian Medical Council (AMC) in 2017 and the MBA's investigation into revalidation in Australia–the changes reflect an increased emphasis on Fellows participating in a variety of CPD that includes technical and non-technical competencies.

From 2017, the most significant change is the addition of a Reflective Practice category (replacing Performance Review). Participating is a requirement for all Fellows regardless of their practice type and requires the completion of one activity per year. In 2017, this was the Operating with Respect eLearning module however from 2018 Fellows will have the option of participating in a range of activities including multisource feedback (MSF), learning plans and patient feedback surveys. The introduction of this category acknowledges an increased emphasis by regulators in ensuring medical practitioners participate in a wide range of CPD including non-technical activities such as reflective practice and cultural competency.

Australian Medical Council (AMC) Accreditation

RACS underwent reaccreditation with the Australian Medical Council (AMC) in 2017, with positive feedback reported on the review of Standard 9 - Continuing professional development, further training and remediation. The AMC identified key strengths including the high uptake of the program, that the program is regularly reviewed and that these reviews involve broad stakeholder consultation. Areas for improvement included strengthening audit participation and a greater emphasis on the importance of cultural competency. A surgical audit working party has already been established and is working on revisions to the RACS Surgical Audit Guide and the Professional Standards Committee will explore ways to better promote participation in CPD that support cultural competency and safety throughout 2018.

Position Papers

Throughout 2017, Professional Standards worked on revising and developing new position papers on issues of importance for Fellows and the surgical profession. The rise of 'Medical Tourism' continues globally and it was timely that in 2017 the RACS position was subject to review. The position paper outlines risks associated with surgery overseas and is aimed at surgeons and other medical practitioners. RACS also revised its medical tourism patient information sheet that provides a simple overview of possible risks to patients considering travelling abroad for surgery, and suggests questions to ask prior to undertaking medical treatment outside of Australia and New Zealand.

In response to increasing reports concerning patient safety and day surgery, RACS, the Australian and New Zealand College of Anaesthetists (ANZCA) and the Australia Society of Plastic Surgeons (ASPS) worked together in developing a Day Surgery in Australia Position Paper. The position aims to assist in the preparation of the licensure (licencing and accreditation) regulations in each Australian jurisdiction to ensure that an organisation or individual working in those jurisdictions meets minimum standards in order to appropriately protect public health and safety. The final paper was reviewed by key specialty associations/societies including general surgery and vascular surgery, and it is the department's intention to incorporate the New Zealand perspective on this issue in the near future.

Advocacy and Submissions

RACS responded to a number of government consultations throughout the year, with a particular focus in Professional Standards on issues relating to sustainability and affordability of healthcare. In 2017, RACS continued working with a variety of stakeholders on the Medicare Benefits Scheme (MBS) schedule, provided input into the Australian Government's Senate Inquiry on Private Health Insurance; responded to a Senate Community Affairs References Committee Inquiry into price regulation associated with the Prostheses List Framework, and consulted with specialty associations and societies in response to the Australian Government's consultation on early access to superannuation for the purpose of paying for medical services. These represent only a sample of the work undertaken in this area in 2017, with all submissions available on the RACS website.

Year Ahead

In 2018, Professional Standards has already commenced work on a number of key strategic projects. After the successful pilot of the online Multisource Feedback (MSF) tool, RACS will expand this project to offer MSF to more Fellows 2018 (meets the Category 4: Reflective Practice requirement). In making improvements to the existing model, the department will continue investigating the best way to incorporate facilitated feedback into the process and how it can support Fellows to use the feedback gained from this activity in their everyday practice. Partnering with hospitals to pilot a whole of department MSF incorporating patient feedback is being considered.

This year will also include the release of a revised RACS Surgical Audit Guide and commencement of a review of the RACS Surgical Competence and Performance Guide.

In addition there are a series of important position papers scheduled for review including informed financial consent, credentialing and scope of practice, excessive fees, open disclosure and public reports on surgical outcome data. I know many of you will have an opinion on some of these issues and I encourage you to contact RACS to contribute to the review.

There will again be a strong focus on the CPD framework, particularly in relation to the AMC report and the MBA's release of the Building a Professional Performance Framework in November 2017. The report identifies CPD and 'at risk' and poorly performing practitioners as a key area of focus and the department will continue to work with stakeholders as it reviews the RACS CPD program.

As of this year, RACS will commence the transition of all activities being entered online via the RACS Portfolio. Understanding that a number of Fellows may not have logged into the website or are unfamiliar with the RACS Portfolio, staff from the Professional Standards team will be attending a number of events throughout the year to provide hands-on demonstrations and support. You can also call or visit the Professional Standards department in Melbourne. I encourage you to log-in to your RACS Portfolio early in the year.

If you are interested in participating in an MSF, providing feedback on a RACS position paper or would like to suggest other professional or surgical standards issues you would like RACS to consider working on, please contact Professional.Standards@surgeons.org or call +61 3 9249 1274.

Dr Lawrie Malisano
Chair, Professional Standards

Congratulations!

Professor David Watters OBE: inducted into Membership of the Court of Honour

A graduate of Edinburgh University in1977, David completed his surgical Fellowship training in Scotland by 1982 and for the next 17 years, had the extraordinary experience of working in South Africa (1982-1984), Zambia (1985-1990), Hong Kong (1991) and finally in Papua New Guinea (1992-2000). He developed into an expert surgeon particularly in surgery of tropical diseases. When appointed Professor of Surgery in Port Moresby, he established a post graduate Surgical Training Program for the national and regional medical graduates from the Pacific. His expertise is demonstrated in his publications including 5 books on Surgery in the Tropics and these books are still relevant to surgical training in the Pacific. In 2012, he was awarded an OBE in Papua New Guinea in the Queen's Birthday Honours, for service to the University of PNG Medical School.

He was appointed Professor of Surgery, University of Melbourne at Barwon Health in Geelong in 2000. This recognised that having worked for 17 years in hospitals with very limited resources; he was still at the highest level of clinical and academic surgery.

At Barwon Health, Geelong, David joined the Endocrine and Colorectal Services and supported clinical research in areas such as the International multi-centre trial on the prevention of colorectal polyps. He has been Divisional Medical Director of Surgery since 2002. He established a quality undergraduate and postgraduate surgical educational program. In line with his past experience he developed his University Surgical Department as a Centre of excellence. He inspired colleagues and trainee surgeons to work in the developing world and welcomed many trainee surgeons from the Pacific Islands and PNG to develop their specialist skills.

David authored and published two books on surgical history: Stitches in Time (2013), chronicling two centuries of surgery in PNG, and Anzac Surgeons of Gallipoli (2015). He has been a prodigious researcher and author, publishing 85 papers in peer reviewed medical journals since arriving in Australia in 2000, in addition to 83 articles published prior to 2000, reflecting his experience in developing countries.

Through the surgical network he was seen as a talented surgical leader and was invited to join RACS committees such as its Surgical Audit Task-force (2000-2005) and the Victorian Safety and Quality Committee (2000-2005). He was elected to the RACS Council (2007-2016). During this time he was appointed Chair of the International Committee (2007-2012) and then Chair of the Professional Development Board (2012-2014). He was elected Vice President (2014-2015) and then President (2015-2016).

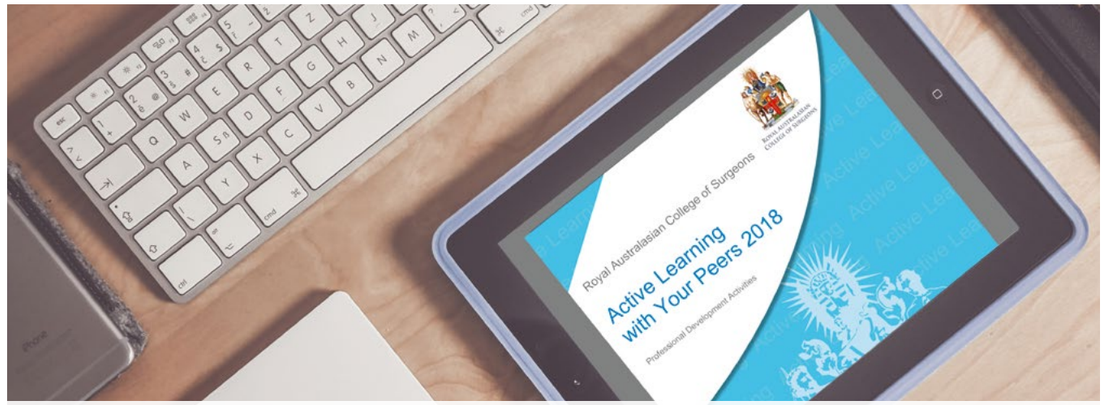
During his year as President he had to deal with the very challenging issue of Bullying and Sexual Harassment by surgeons in some hospitals. As President, David was the spokesman for the Council and started the implementation of the recommendations of the Expert advisory Group. This started with a public apology. The "Building Respect, Improving patient Safety" was designed.

Image:
Past Presidents Professor David Watters OBE and Mr Phil Truskett AM.

David Watters' life has always been as an activist. Despite the difficult challenges encountered during his early years in Africa and PNG working in hospitals with limited resources, the patients in these communities were always able to receive the care they needed. Whilst working in a developed country such as Australia, he has not forgotten the problems in the less developed countries. The Global Health Initiative is an effort by interested surgeons and anaesthetists worldwide, to promote simple, safe surgery as a human right for everyone. David has championed this issue within the RACS network over the years that he has been on Council, organised international fora and symposia at the College to progress the Global Health Initiative and has been instrumental in helping the Australian and Pacific representatives at the World Health Organisation (WHO) to lobby for recognition that the lack of simple safe surgery is a greater cause of mortality than most issues of the Millennium Goals such as deaths from HIV/AIDS and Malaria. Currently David is leading a regional program to monitor the progress towards universal health coverage in the Pacific and South East Asian region. This aim is to lobby politicians to recognise deficiencies in their health systems and try to increase funding from internal resources or outside donors to meet the standard for access to simple and safe surgery.

It is with great pleasure that we present Professor David Watters to be inducted into the Court of Honour.

Citation kindly provided by Professor David Scott AM FRACS and Mr Phil Truskett AM FRACS.



Courses for every stage of your career

The Professional Development Department support surgeons in all aspects of their professional life, encouraging professional growth and workplace performance through a range of courses and activities.

All activities are CPD accredited and reflect the College guidelines for surgical competence and performance. Book your courses online at https://www.surgeons.org/for-health-professionals/register-courses-events/ (RACS login required)

Mandatory courses

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

By the end of 2018

Operating with Respect one-day course: Mandatory for SET Supervisors, IMG Clinical Assessors and major RACS Committees

Foundation Skills for Surgical Educators Course

9 February 2018	Perth	WA
10 February 2018	Brisbane	QLD
16 February 2018	Wellington	NZ
18 February 2018	Sydney	NSW [Faculty training day]
18 February 2018	Adelaide	SA
26 February 2018	Sydney	NSW
26 February 2018	Wellington	NZ
2 March 2018	Brisbane	QLD
3 March 2018	Sydney	NSW
7 March 2018	Perth	WA
9 March 2018	Adelaide	SA
9 March 2018	Melbourne	VIC
16 March 2018	Melbourne	VIC

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

Academy of Surgical Educators presents Educator Studio Sessions

14 February 2018	Melbourne	VIC
26 February 2018	Adelaide	SA
1 March 2018	Perth	WA

The Academy of Surgical Educators presents a comprehensive schedule of education events to support and promote our surgical educators. The Educator Studio Sessions are hosted around Australia and New Zealand, and deliver topics relevant to the importance of surgical education and to raise the profile of educators. They provide insight and a platform for discussions. Sessions are also simulcast via webinar.

Membership of the Academy is open to all Fellows, Trainees, International Medical Graduates and non-surgeons who have a keen interest in surgical education.

Registrations are neccessary and places limited. www.surgeons.org/academy

Non-Technical Skills for Surgeons (NOTSS)

17 March 2018	VIC	Melbourne

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.

Clinical Decision Making

24 March 2018	Canberra	ACT

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

SAT SET Course

10 March 2018	Sydney	NSW

The Supervisors and Trainers for Surgical Education and Training (SAT SET) course aims to enable supervisors and trainers to effectively fulfil the responsibilities of their important roles, under the new Surgical Education and Training (SET) program. These free 3 hour workshops assist Supervisors and Trainers to understand their roles and responsibilities, including legal issues around assessment. It explores strategies which focus on the performance improvement of trainees, introducing the concept of work-based training and two work based assessment tools; the Mini-Clinical Evaluation Exercise (Mini CEX) and Directly Observed Procedural Skills (DOPS).

Keeping Trainees On Track

10 March 2018	Sydney	NSW

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

This free 3 hour course is aimed at College Fellows who provide supervision and training SET Trainees. During the course, participants will have the opportunity to explore how to set up effective start of term meetings, diagnosing and supporting Trainees in four different areas of Trainee difficulty, effective principles of delivering negative feedback and how to overcome barriers when holding difficult but necessary conversations.

PROFESSIONAL DEVELOPMENT WORKSHOP DATES: February – March 2018

ACT		
Clinical Decision Making	24 March 2018	Canberra
NSW		
Foundation Skills for Surgical Educators	3 March 2018	Sydney
Keeping Trainees on Track	10 March 2018	Sydney
SAT SET Course	10 March 2018	Sydney
NZ		
Foundation Skills for Surgical Educators	16 February 2018	Wellington
Foundation Skills for Surgical Educators	26 February 2018	Wellington
QLD		
Process Communication Model Seminar 1	16 – 18 March 2018	Brisbane
Foundation Skills for Surgical Educators	10 February 2018	Brisbane
Foundation Skills for Surgical Educators	2 March 2018	Brisbane
SA		
Foundation Skills for Surgical Educators	18 February 2018	Adelaide
Academy of Surgical Educators Studio Sessions	26 February 2018	Adelaide
VIC		
Foundation Skills for Surgical Educators	3 February 2018	Melbourne
Educator Studio Sessions	14 February 2018	Melbourne
Foundation Skills for Surgical Educators	23 February 2018	Melbourne
Foundation Skills for Surgical Educators	9 March 2018	Melbourne
Foundation Skills for Surgical Educators	16 March 2018	Melbourne
Non-Technical Skills for Surgeons	17 March 2018	Melbourne
WA		
Foundation Skills for Surgical Educators	9 February 2018	Perth
Educator Studio Sessions	1 March 2018	Perth
Foundation Skills for Surgical Educators	7 March 2018	Perth

Register online

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

RACSTA Board, 2017.

RACSTA: A Change of Guard

As we welcome in the New Year we also welcome changes to the RACSTA Board. Dr Stewart Morrison and Dr Su Mei Hoh have now completed their training and we wish them all the best in their future endeavours. Dr Ruth Mitchell has also stepped down following a commendable two years as Chair. I am thankful that she continues as Immediate Past Chair and I look forward to working with her.

As the new Chair of RACSTA I look forward to working with our new Executive:

- Education: Mr Philip Chia, General Surgery, ACT
- Support and Advocacy: Dr Andrew Sanders, Plastic and Reconstructive Surgery, NZ
- Training: Dr Benjamin Chan, OHNS, NZ
- Communications: Dr Leigh Archer, General Surgery, WA

Each Executive member has been on the RACSTA Board for two years making invaluable contributions to the advocacy for surgical Trainees.

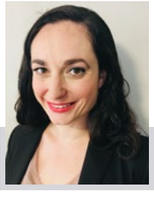
I thought I would take this opportunity to introduce myself. I am a final year Otolaryngology Head and Neck Surgery (OHNS) Trainee in Christchurch, New Zealand and started my training in December 2012. I had my daughter in 2016 and took six months of maternity leave during my training. I will be sitting my FRACS examination this year and will complete training later in the year.

I was the New Zealand OHNS Trainee Representative from 2014. The Board of OHNS is unique in that it is an Australasian Board but has Trainee representatives for Australia and New Zealand. At that time only the Australian specialty representatives sat on the RACSTA Board. Once this was brought to the attention of RACSTA, I was the first New Zealand Specialty Representative to join the Board. Following this, other New Zealand Trainee Representatives were invited to join RACSTA. I took over the Communications portfolio on the Executive in 2016 and have also been the RACSTA representative to the Women in Surgery Committee.

During my time representing Trainees I have had a particular passion for equality, diversity and flexibility in training. I have been privileged as a member or RACSTA and the Women in Surgery Committee to have been able to contribute to RACS policies in these areas. I hope to continue to advocate for Trainees particularly in these areas as I move in to my new role.

Writing this article led me to think about the current diversity of Trainees and of the RACSTA Board. As of 2018, 29 per cent of surgical Trainees and 32 per cent of the Board are female. This is consistent with overall Trainee numbers but not yet reaching the 40 per cent target of the RACS Diversity and Inclusion Plan. Including myself, the Board has had four male and four female Chairs since RACSTA was formed in 2005. 15 per cent of surgical Trainees are based in New Zealand with 25 per cent of the RACSTA Board representing New Zealand.

In the changing of the guard it is important for RACSTA to reflect upon how well we are achieving our own goals but also plan where we need to go. I will represent you, the Trainees, to the best of my ability and I am relishing the opportunity to do so. Please email RACSTA.Chair@surgeons.org or contact Zoe Husband, our Executive Officer (racsta@surgeons.org) if you have any questions.



Royal Australasian College of Surgeons

RACSTA
Your Trainees' Association

Dr Rachel Care
Chair, RACSTA

I once introduced you to two surgeons, Sue Sweet and Stu Lumpee, determined to reduce their waistlines, but who never quite succeeded, largely because they focused only on exercise and lacked the motivation to change their diet. Early in January they came for review, concerned that they had slipped into the obese zone (BMI >30). Their lack of success was due to their sweet tooth, particularly the amount of 'added sugar' in what they assumed to be healthy: sports drinks, yoghurts, breakfast cereals, muesli bars and ready-made meals.

Obesity is one of the major health issues affecting around a third of adults in New Zealand and Australia, plus 8-12 per cent of children and adolescents are obese. In New Zealand the rates are even higher in Māori's and Pacific Islanders. It is an issue that governments are doing little to tackle, due to intensive lobbying by industry. Yet obesity costs billions of dollars in healthcare costs now and into the future, predisposing to non-alcoholic fatty liver, cardiovascular diseases, insulin resistance and type 2 diabetes, joint degeneration, as well as some cancers.

I was pleased to find that RACS has a policy on *Reducing the Burden of Obesity* that supports national plans to address the issue, and advocates for greater public access to bariatric surgery for properly selected patients.

A 2015 World Health Organisation (WHO) guideline strongly advises adults and children to reduce their daily intake of free sugars to less than 10 per cent of their total energy intake with a further recommendation in favour of below 5 per cent (25 grams - 6 teaspoons) per day would provide additional health benefits. Less sugar would also reduce dental caries in children and adults, saving billions.

Recently WHO has recommended a 20 per cent sugar tax. Taxation works by raising the price and incentivises manufacturers to add less. Twenty-eight countries including Mexico, Portugal, UK, France, Belgium, Norway and Finland, 12 in the Pacific region, and seven US cities have so far introduced sugar taxes though many only in the 5-10 per cent range. Saudi Arabia has introduced a 50 per cent tax.

Two prominent supporters of a sugar tax are the Council of Presidents of Medical Colleges (CPMC) which held an obesity summit in late 2016, and the Australian Medical Association (AMA) in its 2018 statement on nutrition. The Royal Australasian College of General practitioners (RACGP) recognises there is legitimate debate over the effectiveness of a sugar tax but nonetheless sugar intake must be urgently addressed by government, while a 'sugarbyhalf' campaign has recently been launched to address the Australian adult average of 16 teaspoons per day.

However, strong lobbying by the sugar industry has so far muzzled both sides of politics, investing big bucks to discourage a sugar tax policy. Deflect, deny, discredit, delay is their strategy. Deflect towards promoting more physical activity (definitely good for health); deny – stating recent advocacy has already led to a voluntary reduction in sugar content of soft drinks; discredit by arguing any sugar tax is socially discriminatory, regressive and will lead to loss of jobs, whilst the socially deprived will bear the greatest burden of any price increase (yet this group would most likely benefit); delay through commissioning reports on impact. They aim to earn a sweet buck and reap the profits whilst we consumers pay with our health! It's time for our governments to tax sugar in the interests of public health - just as they did with tobacco. Breaking Sue Sweet and Stu Lumpee's love of sugar may depend on it.

DR BB-G-LOVED

JMC Fellowship funds leading research into oesophageal adenocarcinoma

The 2017 recipient of the John Mitchell Crouch (JMC) Fellowship, Professor Andrew Barbour, used the Fellowship funds to expand his world-leading genomic study into oesophageal adenocarcinoma (OAC), a disease that has the fastest rising incidence rate of any adult cancer

Professor Barbour is Head of the Surgical Oncology Laboratory at the University of Queensland's School of Medicine and conducts his research at the Translational Research Institute at the Princess Alexandra Hospital, Brisbane.

IMAGE: Professor Andrew Barbour

He has lead two Phase II national trials of pre-operative therapy for OAC and pancreatic cancer, to determine the efficacy and safety of novel treatment regimens. Both trials have included genomic sub-studies to identify biomarkers including tumour mutation signatures, genetic composition and likely response to treatment.

The OAC study, a randomised trial of preoperative chemotherapy or chemo-radiotherapy based on poor early response to standard chemotherapy for resectable oesophageal cancer (DOCTOR trial), began in 2010 and is now in follow up at seven sites across Australia.

It is the first randomised study to use PET scans to personalise chemotherapy for patients with operable OAC.

Professor Barbour is also the principal investigator of a clinical trial of pre-operative chemotherapy for pancreatic cancer (GAP) which has already shown to be safe and effective.

Both trials include biological sub-studies with tumour tissue and blood banking and subsequent molecular analyses and both aim to develop personalised, precision therapy for patients with OAC and pancreatic cancer.

The DOCTOR trial is using genomic, epigenomic and expression data to classify OAC to help increase the proportion of patients who respond well to chemotherapy while also allowing researchers to develop new treatment models for early non-responders.

Now, 1000 new cases of OAC are diagnosed in Australia each year, yet more than half of the patients present with advanced, incurable disease. For those with localised OAC, more than half will die within five years of diagnosis, despite treatment.

Professor Barbour said his research with collaborators Dr Nicola Waddell and Professor Sean Grimmond had already changed fundamental understandings of OAC tumours including genetic variability and the mechanisms behind genetic mutation which could impact the future treatment of a range of cancers.

"In the DOCTOR trial we are using genetic sequencing to understand intra-tumour heterogeneity because we know now that the more cancer cell sub-populations there are in any tumour, the poorer the outcome," Professor Barbour said.

"We are also seeking to understand how tumour cell populations evolve during chemotherapy.

"The JMC Fellowship has been instrumental in this work because it has allowed us to conduct additional whole genome sequencing necessary for heterogeneity studies.

"We are using both OAC cancer tissue from the Princess Alexandra Hospital as well as from patients in the DOCTOR trial so we can also track outcomes over time."

> "We used to think that it took a long time to accumulate cellular mutations through lifestyle, through environmental exposure or other factors, but we think now that these mutations can happen very suddenly, within one cell division."

"We used to think that it took a long time to accumulate cellular mutations through lifestyle, through environmental exposure or other factors, but we think now that these mutations can happen very suddenly, within one cell division," he said.

"We call it 'chromosomal catastrophe' where the chromosome shatters during normal cell division.

"This should lead to apoptosis (cell death), but we have found that in one-third of cases, the chromosome is re-assembled but is scrambled leaving some DNA behind.

"If you then get a cancer gene (oncogene) near DNA code that accelerates activity, that gene can become overactive which drives tumour growth. We believe that 30 per cent of OAC cancers are driven by this process.

"Most cancers have a mutation signature. Lung cancers have a signature associated with smoking, most melanomas have a signature associated with sun exposure and OAC has a signature associated with DNA damage, among others."

Professor Barbour received his FRACS in 2003, having already completed a PhD at the University of Queensland, and is a former recipient of the RACS Surgeon Scientist Fellowship (2000) and the RACS Travelling Fellowship (2001).

After becoming a Fellow, he travelled overseas to take up the position of Upper Gastrointestinal and Hepatobiliary Surgery Fellow at the Bristol Royal Infirmary and later worked as a Surgical Oncology Fellow at the Memorial Sloan-Kettering Cancer Centre, New York.

His research has already attracted almost $5 million in funding from a range of sources including the NHMRC, RACS and the Cancer Council of Queensland.

A VMO at Princess Alexandra Hospital, Professor Barbour also works out of the Gastrointestinal and Soft Tissue Clinic attached to Greenslopes Private Hospital and Mater Private Hospital in Brisbane.

Professor Barbour said that while the outcomes of OAC and pancreatic cancer remained poor, he believed there was light at the end of the tunnel.

"The only biomarkers we have involve PET scans or pathology, but the next generation of genomic sequencing has the potential to help us identify early non-responders so we can develop personalised, precision treatment regimes," he said.

"The first mapping of the human genome took ten years and cost more than $2 billion. Now we can do it in a day for around $1000.

"That has been an incredible advance, so I think it is fair to say that precision medicine is coming and it has the potential to dramatically improve outcomes for patients with OAC.

"We now have an almost 50 per cent five-year survival rate for patients who have surgery for advanced disease whereas in the mid-90s that was less than ten per cent so while we would like that survival rate to be much higher we are heading in the right direction."

Professor Barbour thanked RACS for its support and said he was humbled to receive the JMC Fellowship.

"There have been some remarkable surgeon scientists who have received the JMC Fellowship, so it was a great honour to be selected," he said.

"RACS has supported me from the early days of my research career so it's nice to repay that support by conducting work that Fellows believe is worthwhile.

The John Mitchell Crouch Fellowship is the most prestigious RACS award and is bestowed upon younger surgeons who are considered to be making major advances in their specialties. It was established in 1978 by the late Mrs Elisabeth Unsworth in honour of her son, John Mitchell Crouch, who died in 1977 at age 36, in the hope that recipients would contribute to the understanding and practice of surgery, in keeping with the skills and promise demonstrated by her son.

DISTINCTIONS AND AWARDS

2017	John Mitchell Crouch Fellowship, RACS.
2012	James IV Association Travelling Fellow (2013)
2009	American College of Surgeons (ACS) International Scholarship
2002	Queensland Cancer Fund Travelling Scholarship
2001	American Association for Cancer Research Scholar in Cancer Research Award
2001	RACS Travelling Fellowship
2000	Princess Alexandra Hospital Society Travel Grant
1999-2000	RACS Surgeon Scientist Fellowship

With Karen Murphy
Surgical News Journalist

Officers of the Plastic Surgery Unit, Heidelberg Military Hospital 1944

RACS Film Collection

As time progresses and formats become obsolete, viewing and preserving sensitive 8 and 16mm films becomes increasingly difficult. This is why RACS has decided to digitise its historically significant film collection.

Films in the collection which is currently housed in the RACS Archive include:

- Plastic Surgery procedures from the Heidelberg Military Hospital in the 1940s (collection of Sir Benjamin Rank)
- Anaesthesia films made in the 1940s - it should be noted that RACS had a Faculty of Anaesthetists until ANZCA was formed in 1992.
- Films about Ophthalmology – one of the earliest specialties at RACS but the specialty transferred to the Royal Australian and New Zealand College of Ophthalmologists in 1969.
- General interest films such as the aftermath of the West Gate Bridge Disaster, 1970 and the collapse of the Tacoma Narrows Bridge in Washington State, 1950
- Films relating to RACS, specifically a film about the combined meeting of RACS with the RACP and College of Surgeons and Physicians of Canada, Sydney, 1980

A selection of seven of the digitised films are now available on the RACS website.

Please note that may contain disturbing images of surgical procedures. RACS believes that all parties have consented to be in these films and the majority are out of copyright. If you have additional information about the people portrayed, the context of the films or any other input, please contact the RACS Archivist: college.archives@surgeons.org; 61 3 92491270.

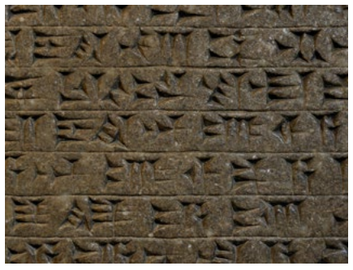
This material is not for public distribution.

Heidelberg Military Hospital West-Wing-Balcony

Elizabeth Milford
RACS Archivist

Digital Preservation

In 2000 BC, the archives of the ancient Syrian kingdom of Ebla developed what to this day is still the most effective method of preserving information. The Eblaites stored all of their official documents on clay tablets, which were discovered by archaeologists thousands of years later.



Cuneiform clay tablet

The ancient Chinese, the ancient Greeks, and the ancient Romans also maintained archives. While well developed, these archives were inferior to the Eblaites in one key area - preservation. Because these archives stored information on paper and papyrus, which deteriorate at a faster pace than clay tablets, everything that was once in these archives is now lost.

In 2018 the pattern of choosing bad mediums for the long-term preservation of information continues. Digital information now makes up the overwhelming majority of official documents. No sensible business would ever rely exclusively on paper today, and certainly not clay tablets! However, that doesn't change the fact that 'bits' are a terrible medium on which to store information from a preservation perspective. Vint Cerf, Vice President of Google and a 'father of the Internet', bemoaned that we face a "forgotten generation, or even a forgotten century" through what he called 'bit rot', where old computer files become useless junk.

Since establishing an official archive, RACS has taken preservation of its treasured documents seriously. If you visit the archives now, you will see our most valuable documents are kept in acid-free folders and boxes to limit deterioration. You will notice that staples and metallic bindings have been removed to prevent rust. The RACS Archive is climate controlled, and arranged and described using an archival database that explains the context of every document.

This year, the RACS Archive will begin undertaking preservation activities on a higher-risk medium – digital documents. To be more specific, we will be preserving those digital objects that we would like researchers to be able to access throughout the next 50 to 100 years. Simply keeping an image in today's DOC, JPEG or PDF format does not guarantee the file can be opened in 20-30 years' time. Many will remember *WordPerfect*, which was a great editor, but this file format is now defunct. Some examples of digital preservation activities include generating fixity information, converting to open-source formats, and storage in a standards compliant digital archive.

The international standard that we will be adhering to for our digital archive is *ISO 14721 – Open Archival Information System*. This standard specifies guidelines for ensuring that digital information remains not only accessible but also understandable for the foreseeable future by structuring, describing, and managing it in a specific way. In simple terms, if we keep items in these formats, they will be safely accessible by Fellows and others in the future.

Preserving a bitstream – the sequence of ones and zeroes that make up a file on your computer – comes with its own set of challenges which are quite different to preserving paper.

These are exciting times for archives around the world, but particularly for an institution such as RACS. The information being created today is no less important to future historians than any other resource we have created since our founding in 1927. We still have Fellows' files and Council minutes from those early days and they are useful in establishing context and forming the foundation of the important education, advocacy and philanthropic work of RACS today.

Jarrod Harvey
Records Analyst

St Vincent's takes a stand on culture

St Vincent's secures $1.2M to evaluate program aimed at improving culture in the health sector

RACS is proud to support the efforts of St Vincent's Health Australia (SVHA) in changing the culture within healthcare. RACS and SVHA signed an Memorandum of Understanding in June 2016 to collaborate in building a culture of respect and improving patient safety.

St Vincent's Health Australia – Australia's largest not-for-profit provider of health and aged care services – is partnering with the Australian Institute of Health Innovation at Macquarie University to assess its innovative approach to addressing entrenched cultural problems in the health sector.

The St Vincent's Ethos program has been developed over the past 12 months. It was first introduced at St Vincent's Hospital in Melbourne in July 2017 and is being rolled out nationally across all St Vincent Health's Australia's hospitals. The program aims to embed safe, respectful and professional behaviour and provide a consistent, transparent and equitable way to address staff conduct that undermines patient or staff well-being.

The partnership has successfully secured a National Health and Medical Research Council partnership grant of $1.2M to evaluate the program nationally over four years. Professor Guy Maddern is a partner investigator on the successful NHMRC partnership grant.

St Vincent's Health's Chief Medical Officer and Group General Manager of Clinical Governance, Dr Victoria Atkinson, said the partnership grant would facilitate world-first research looking at the impact of the Ethos program on staff behaviour and patient experience.

"It's well known that bullying, discrimination and harassment are significant problems in Australia's healthcare sector and St Vincent's Health is not immune," said Dr Atkinson.

"The Royal Australasian College of Surgeons found that around half of the College's Fellows and Trainees had experienced bullying, discrimination or sexual harassment. Other professional colleges have found similar disturbing rates of unacceptable behaviour.

"These cultural issues impact negatively on the well-being of doctors and other health professionals. It is part of the reason why risk of suicide in doctors is substantially higher the general Australian population.

"But while the sector is struggling to respond effectively to entrenched unacceptable behaviour what St Vincent's has done is take a very public stand against it, and we want to bring all of our staff with us: in healthcare, administration, and support services; everyone in every role, across the entire organisation.

"Sometimes staff may feel ill-equipped or unable to speak up when they witness or experience disrespectful behaviour. They might feel that if they report the problem, it won't be addressed; or perhaps they're afraid of repercussions? Or maybe it's just because in the unit or department they work – there's an acceptance that inappropriate behaviour is somehow 'normal'?"

"Ethos is designed to overcome these barriers and contribute to making staff and patients feel welcome, valued and safe."

The Ethos program includes:

- An accountability pathway which outlines a consistent, transparent and equitable way to provide feedback to staff about their behaviour;
- A reporting tool which provides a safe avenue to report incidents of either positive behaviour or negative behaviour that undermines staff or patient safety. Reports can be submitted by any staff member using an online tool which is private, confidential and safe.
- A package of capability building and training to equip leaders and staff with the skills they need to role model safe and respectful behaviour.

"Ethos allows us to recognise staff who exhibit positive behaviour and are exceptional role models; it removes barriers to speaking up and makes it easier and safer to do so; and it allows us to respond quickly and equitably to incidents of behaviour that undermine patient and staff safety," said Dr Atkinson.

"It needs to be said that in most healthcare organisations, serious bad behaviour is perpetrated by only 2-3 per cent of people. We acknowledge that the majority of staff model behaviours that are focussed on patient well-being and founded in integrity."

"There's also been no lack of desire among healthcare providers to address the entrenched cultures within healthcare that allow disrespectful behaviour to be tolerated. Safety efforts such as clinical care bundles, checklists, root-cause analyses, procedures, protocols and guidelines and staff programs that promote well-being have achieved a measure of success but not the degree anticipated."

"This is because without addressing behaviour, improved systems alone aren't enough. Achieving safe, reliable, high quality care requires well-designed systems and well-functioning teams."

"SVHA recognises that culture change of this magnitude can't be undertaken in isolation so in addition to introducing Ethos, we are building partnerships across the sector to create a coalition to improving the culture in healthcare."

"We have begun this process with an MOU with the RACS and we aim to establish MOUs with professional and regulatory bodies and partnerships with health services across the nation," said Dr Atkinson.

New Zealand New Year and Australia Day Honours 2018

RACS would like to congratulate and thank all of the recipients of New Zealand New Year and Australia Day Honours. These Fellows have gone above and beyond to make a difference and have been recognised for excellence, achievement or meritorious service and contributions to our society.

New Zealand New Year Honours

Officer of the New Zealand Order of Merit (ONZM)
Mr Andrew Alexander Hill ONZM

Australia Day Honours

Companion (AC) in the General Division of the Order of Australia
Professor Jeffrey Victor Rosenfeld AC AM OBE

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

Professor Anthony David Holmes AO
Dr Roger Balfour Mee AO

Member (AM) in the General Division
Dr Michael Charles Bellemore AM
Associate Professor Peter Haertsch AM OAM

Medal (OAM) in the General Division
Dr Raymond Watsford Chaseling OAM
Associate Professor Mark Andrew Davies OAM
Dr Andrew James Luck OAM
Associate Professor Julian Lockhart Rait OAM
Mr James Mohan Savundra OAM

Demystifying matters of the heart

In 2016, the ABC's flagship science program *Catalyst* was put into review following two episodes that were controversial and widely regarded as dangerous by leading health experts. The episodes explored two incredibly important public health issues and placed many Australians at risk. The program was welcomed back, but only with a massive change to its format, including losing their usual stable of science reporters for varied science experts.

Early in 2017, I was fortunate enough to be approached by the ABC to be one of its science experts to present an hour-long episode centered on everything that is phenomenal and new about the heart. The offer didn't require much thinking, the opportunity to share a valuable public health message as well as to learn a whole new set of skills was too good to pass up.

The end result was the fifth episode of the new, rebooted Catalyst called *Heartbeat: The Miracle Inside You*. The episode followed the surgical treatment of six very special cardiac patients, who had undergone cardiac transplantation, valve surgery, ventricular assist devices and even paediatric cardiac surgery. We followed a 94-year-old grandmother who had been skydiving at the ripe old age of 93. She received a transcatheter aortic valve replacement (TAVR) to treat her severe aortic stenosis.

Achieving its intended target, the episode showcased the cardiothoracic surgery unit at Fiona Stanley Hospital in Perth as well as a variety of experts from around the country and the US who are contributing mending broken hearts. The public were shown how remarkable our hearts are, and a desire to take care of them followed.

The episode was incredibly well received by a number of high profile health and research related organisations including the Heart Foundation and the Victor Chang Cardiac Research Institute. Aside from showing the exciting future in cardiac surgery, we also showed the wonderful work that we already achieve in many hospitals every day around the country. The opportunity to humanise the patient-surgeon interaction also allowed the public to see behind the doors of the operating theatre, demystifying some of the questions about surgeons and surgery.

Television presenting is not my day job and this was my first foray into such a role. It was an eye-opening role for me, with a learning curve to understand jargon that I had never heard and tasks I have never performed before. The role is certainly not as glamorous as it seems, the days were long, making me thankful that surgery had already conditioned me for long periods on my feet and long hours. The novelty though was far outweighed by the incredible opportunity that it afforded me.

Through *Catalyst*, I met a number of scientists and doctors who I would never have had the opportunity to meet otherwise. Time in Boston took me to the Transmedics Training Facility to review the Transmedics Organ Care System for cardiac preservation. Ex-vivo organ perfusion has the possibility to significantly impact organ transplants to improve the number of donor organs used as well as the preservation of organs. St Vincent's Hospital in Sydney has used this to perform heart transplants from non-heart beating donors (donation after cardiac death) with great results.

IMAGES: ABC Catalyst

Images (from left): In the Operating Theatre; Dr Nikki Stamp (front, centre) with colleagues.

I also enjoyed meeting the scientists in their labs and seeing their work. As clinicians, we're the ones who get to use new discoveries for which our patients are incredibly grateful. Yet it is the sometimes decades of hard work, sacrifice and persistence in the face of failure that isn't always recognized or appreciated.

Before it was announced, we visited Professor Sally Dunwoodie and her team at the Victor Chang Cardiac Research Institute to see their ground-breaking discovery of vitamin B3 as a possible preventer of miscarriage and congenital cardiac defects. The discovery is reminiscent of Professor Fiona Stanley's discovery of folic acid and neural tube defects.

The response to the show was surprising. I was incredibly proud of the project and thought that a lot of people would like it but the extent to which they did was a shock to me. Not only did people find it entertaining and touching, they found it informative. There were countless messages from members of the public saying how the show had inspired them to exercise more or pass up on the cakes at work. Patient John, who has ischemic heart disease and was featured on the show saying, 'If I only save one person with a fat gut, then I've done my job' will be pleased to know that number will be more than just one.

> "The opportunity to humanize the patient-surgeon interaction allowed the public to see behind the doors of the operating theatre, demystifying some of the questions about surgeons and surgery".

A show rooted in science and framed by the emotion of patient stories appeared to be very powerful. Exploring the science, learning new skills and meeting new people were my own personal gains from this project but beyond that, I started this with a much bigger mission in mind. That was to change the public's mind about their own health.

I belong to a group of health professionals; GP's, psychologists, dietitians who work in the space of health and lifestyle communications. We have often talked about our reasons for putting ourselves into a more public domain, with our messages of healthy lifestyles and inspiration. It may sound tawdry or even trite but we all want to make a difference and the fact that we're happy to be on TV or write books is just a means to an end. In a normal day, I can help a handful of patients but in one episode of *Catalyst*, over 500,000 people watched with many more online, and saw something that may change the way they think of their own health.

Health advocacy is one of the nine RACS competencies that trainees and Fellows of the College uphold. I am fortunate enough that I have had opportunities like *Catalyst* to be able to do my part for health advocacy. While I'm not in a lab, 3D-printing hearts or discovering ways to prevent miscarriage I think that I am able to make a difference and be the health advocate that we all should be in our own ways.

I am incredibly proud of *Catalyst* and how it showcased my specialty, my team, the hospital and mentors and our colleagues whose research propels our clinical work forward. It showed the resilience and bravery of patients who quite literally place their lives in our hands, and it showed a young female surgeon, demystifying some of what happens behind operating theatre doors. Being able to combine my job with spreading these powerful messages is such a privilege and I'm already looking forward to the next chapter.

Dr Nikki Stamp
Cardiothoracic Surgeon

Donations to the Library Collection

A Brief History of Medicine and Surgery by John Kingsley Walsh

This brief 64 page book arose out of a talk given by the author given at a 50 year re-union of graduation as doctors. With 9 chapters ranging from the Big Bang up to the current century and some thoughts about the future; it focuses on key individuals and their contributions to medicine and surgery. It is well illustrated with the faces of many historical figures and images from medicine's past.

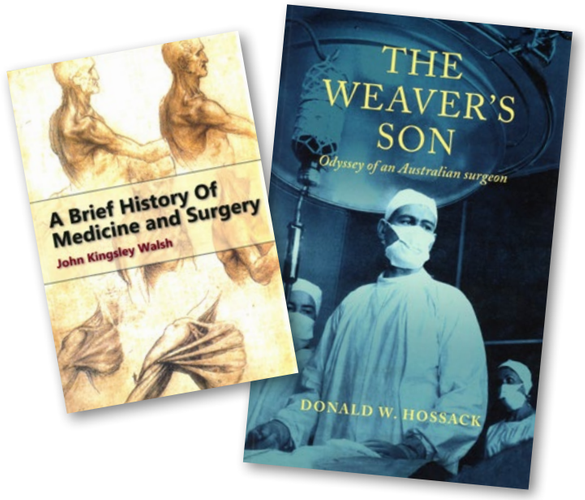
Donated by the author

The Weaver's Son: Odyssey of an Australian Surgeon by Donald W Hossack

The Weaver's Son is a very personal memoir that tells the story of Mr Hossack's struggle to overcome dyslexia to become an eminent surgeon with the encouragement and support of the University of Melbourne.

Mr Hossack (OBE PSM, MBBS 1954) was an inaugural member of the Victorian-based Road Trauma Committee, founded in 1970 and credited with leading the world in successfully campaigning for compulsory seat belts, random breath testing and other reforms.

Subsequent reforms targeting drink driving, based on research led by Mr Hossack as consultant surgeon to the Melbourne City Coroner, were at least as important as the introduction of seat-belt laws. In November 1970, when seat belts became compulsory in Victoria, Mr Hossack released



his alcohol analysis of 171 driver fatalities: 103 had alcohol in their bloodstream and, of those, 86 had levels between two and ten times the legal limit of .05 percent.

The findings prompted a series of campaigns and reforms over several years, including the introduction of police breath tests (August 1971), compulsory hospital blood alcohol content (BAC) testing of all road accident victims over the age of 15 (1974), and random breath testing (1976).

In an excerpt from the memoir, Mr Hossack tells of his decision to pursue a medical career while working as a lab assistant in the Department of Zoology under Professor Wilfred Agar:

"Well Laddie," he said, "what is it you want to do with your life?"

"I'd like to be a doctor."

A look of exasperation spread over his kind face. "Look Laddie, there are some things in life that are not possible. We just have to accept that reality! Please, think over what I said, and let me know what you decide." He looked irritated by my absurd reply.

My answer about wanting to be a doctor surprised me as much as it did Professor Agar. Although I had been wondering vaguely about the possibility of studying at university, I had not formed any definite idea of which course to pursue, let alone consciously considered becoming a doctor. I can only think that my close association with medical students during their dissection classes, and drawing charts for Dr Tiegs, had somehow planted a seed. Also, after I had dissected the cranial nerves of a discarded shark's head, it pleased me that my effort compared favourably with dissections done by the students. My spontaneous reply to the professor suggested a subconscious identification with the medical students.

Besides, no-one had ever before asked me what I really wanted! My revelation, once brought into the light of day, overwhelmed me with joy and relief beyond anything in my experience. I was committed. Thereafter, without any doubt, whatever it might take to overcome my learning defect, or however long the process of study, I would do it. I would become a doctor.

Mr Hossack tells his remarkable story in a warm and honest style. The Weaver's Son is an inspiring testament to the power of education and perseverance to transform lives.

Donated by the office of the Dean, University of Melbourne Faculty of Medicine, Dentistry and Health Sciences

Review written by Liz Brentnall and Nathan Fioritti. Reproduced with permission from the University of Melbourne Faculty of Medicine, Dentistry and Health Sciences' website.

Ruth Bollard
Chair,
Fellowship Services Committee

– With Graham Spooner, RACS Library

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

IN MEMORIAM

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

Grosvenor Charles Thomas Burfitt-Williams (NSW)
Rodney Dalziel (VIC)
Max Harvey Ellis (NSW)
Martin Flood (NSW)
Elfrith Foottit (QLD)
John Samuel Hopkirk (NZ)
Kenneth Francis Hume (SA)
Ernst Gerhard Ibach (WA)
George Kalnins (NSW)
Julian Keogh (VIC)
Edward Marzec (SA)
John Alexander O'Brien (SA)
Akkinepalli Badri Narayan Rao (VIC)
John Stanislaus Roarty (NSW)
Roy Francis Le C. Taylor (NSW)
Kethieswaran Thuraisingham (NSW)
Sir Ian Pelham Todd (UK)
Edward Watson (NZ)

Informing the College

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

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

Foundation for Surgery
Passion. Skill. Legacy.

The Foundation for Surgery and the D'Extinguished Surgeons group warmly invites you to a special lunch lecture

12:00 pm
Friday 16 February

Historical Lecture:
'A Vast Field of Suffering and Misery' Nightingale at Scutari

Florence Nightingale's (1820–1910) work during the Crimean War (1854–1856) not only contributed to the Allied victory but continues to impact modern surgery, nursing, infection control, epidemiology, and patient care today.

This lecture will be delivered by the international speaker, Natasha McEnroe, Keeper of Medicine at the Science Museum London and previous Director of the Florence Nightingale Museum.

The historical lecture will be followed by lunch.

RACV City Club
Members Dining Room
501 Bourke St
Melbourne VIC 3000

CPD points are available for attendees

RSVP
2 February to foundation@surgeons.org

Please include any dietary requirements for yourself and any guests

New smartphone app successfully enables remote monitoring of surgical wounds

A new smartphone app could prevent infection and readmission rates following an operation. By simply uploading images of wounds using the WoundCare app, patients are better able to manage their own healing process and detect infection early so as not to need further in-hospital care. With the help of nurses who monitor the images, early warning signs of cellulitis or other wound complications can be identified and dealt with, providing a huge cost saving.

https://www.news-medical.net/news/20180119/New-smartphone-app-successfully-enables-remote-monitoring-of-surgical-wounds.aspx

Digital eyewear, 3D holograms challenge hidebound med schools

A pair of digital sunglasses could transform how doctors are trained in operating rooms. A pair of tiny lenses that can capture high-resolution images will allow surgeons to operate together and view scans that appear as 3D holograms. Technological advancements such as this may demystify surgery and make it more transparent, but does it replace the experience of dealing with real patients? What do you think?

https://businessmirror.com.ph/digital-eyewear-3d-holograms-challenge-hidebound-med-schools/

Foundation for Surgery
Passion. Skill. Legacy.

TOUR de CURE
RIDING TO CURE CANCER

Join Tour de Cure on their Signature Ride from

Mackay to Cairns

27 April – 5 May 2018

Help find a cure for cancer by joining in the Signature nine day ride, a staged ride (two days), volunteering in the support crew or donating.

A significant portion of the funds raised through this event go to the Foundation for Surgery Tour de Cure Cancer Research Scholarship. Through this scholarship, the Foundation for Surgery and Tour de Cure are working together to find a cure for cancer.

To find out more go to www.tourdecure.com.au

RACS Visitor Grant Program for Visitors in 2019

RACS is committed to excellence in surgical education and practice and recognises that Fellows within sub-specialties and other groups wish to enhance their annual scientific meetings by inviting visitors of note from Australia, New Zealand and internationally. RACS supports these initiatives through the RACS Visitor Grant Program.

In the last two years RACS has supported 32 speakers across 16 surgical specialties. In 2018, another 17 speakers will be supported.

Applications for meetings in 2019 open on 1 February 2018 and close on 19 March 2018. The application form will be available on the website from 1 February.

Eligible groups are invited to apply for funding towards the cost of travel, accommodation and registration for visiting speaker(s) to their 2019 annual scientific meetings. Applications are open to any recognised society or association of surgeons.

For details please see www.surgeons.org/member-services/racs-visitor-grant-program/
or contact Paul Cargill, Manager, Fellowship Services, on +61 3 9276 7415.

Younger Fellows Mentoring Program

Call for Mentors and Mentees

The Younger Fellows Committee is seeking applications from Younger Fellows within their first 10 years of Fellowship, who would like to apply for the Mentoring Program for Younger Fellows.

This is an opportunity for early career surgeons to develop a mentoring relationship with established surgeons practicing in all the subspecialties represented within RACS.

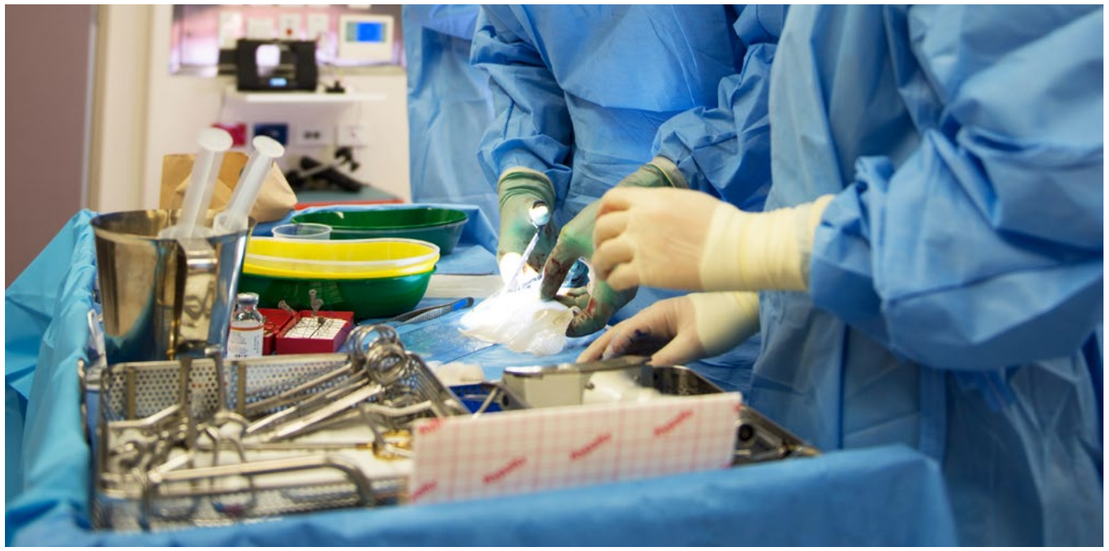
Applicants to the program must be RACS Fellows, or currently in the process of applying for RACS Fellowship.

Applications close 16 March 2018.

To find out more email: younger.fellows@surgeons.org

YOUNGER FELLOWS

Public Reporting of Patient-Safety Oriented Surgical Performance



In June 2017, a Queensland Audit of Surgical Mortality triggered Queensland government action that may see new federal and state laws for public reporting of patient safety data across public and private hospitals. In less than two months, Queensland's push[i] for such standards nationally was supported by federal and state health ministers at the COAG Health Council. The Australian Commission on Safety and Quality in Health Care (ACSQHC) is now tasked to work on such standards with 'interested jurisdictions' and to incorporate it into national performance and reporting frameworks.

Despite appearances, the issue doesn't seem to be about extending public hospital reporting standards to private hospitals. Audits of surgical mortality (ASMs) are already mandated professional practice requirements for all surgeons while all public hospitals and almost all private hospitals already participate in the audits. If the purpose of such reporting is to ensure the public is fully informed about surgical performance in the interest of patient safety, then the relevant questions are, what is patient safety-oriented surgical performance and can legislation on public reporting protect surgical patient safety?

What is patient safety-oriented surgical performance?

ASMs are audits of deaths that occur while patients are under the care of a surgeon, regardless of whether they underwent an operative procedure. In practice, these patients are treated by surgical teams regulated by the hospital's organisational framework that sits within a public or private hospital network. Therefore, the correct metrics of patient safety-oriented surgical performance are of the effectiveness of both surgical team performance and organisational performance of the hospital and its parent organisation. Only if both sets of metrics are reported will the public be fully informed about whether the hospital, public or private, is likely to be effective at protecting their safety.

This concept of patient safety-oriented surgical performance is backed by a large body of international evidence[ii] that shows that patient safety depends on effective surgical team communication and adverse events by individual team members are typically rooted in faulty systems and inadequate organisational structures. In short, effective communication, established human factors and efficient team-based technical performance are at the heart of patient safety. This evidence is reflected in local experience of more than 33,000 cases over eight years in the Australian and New Zealand Audit of Surgical Mortality National Report 2016 (ANZASM)[iii]. Its key points include that surgical team communication is a key element of good patient care and delayed inter-hospital transfers of patients with limited reserves can significantly affect surgical outcomes.

Therefore, the metrics of patient safety-oriented surgical performance in Australia and New Zealand should show effective surgical team communication as being timely decisions and effective actions to prevent, diagnose and treat surgical complications and deteriorating patients e.g. prompt resuscitation and surgery for postoperative bleeding in accordance with evidence-based professional practice guidelines. Likewise, such metrics must also show effective hospital and parent organisational systems that enable surgical teams' decisions in a way that protects patient safety e.g. prompt inter-hospital transfers, timely ICU bed and OR access, safe working hours and staff levels.

Can legislation protect surgical patient safety?

Patients that died were typically in or beyond their late seventies and had at least two co-existing medical conditions in addition to their acute surgical condition. This means that any surgery on such patients is high-risk, especially as co-morbidities are a stronger predictor of death than the type of surgery. This suggests surgical patient mortality represents a segment of Australia's aging population that is at the extreme of life with co-morbidities and are a stronger predictor of death than the type of surgery. When an acute surgical condition supervenes, they have a rapidly shrinking window of opportunity with almost a quarter being irretrievable at presentation.

When surgery is performed, the trauma compounding acute surgical disease in these vulnerable patients is significant. It makes them prone to surgical complications which often leads to cardiac or respiratory failure with rapid deterioration and death. Nonetheless, surgical mortality in Queensland and nationally has been improving over the last eight years so it is difficult to envisage how new legislation will add more to improving surgical patient safety.

Is legislation necessary?

New South Wales private hospitals have not all participated in ASMs despite compliance by all public and private hospitals in all other jurisdictions through the reporting system funded by all state and territory governments. If legislation is to bring all private hospitals in line with this system, NSW legislation should be directed at private hospitals specifically for this reason. If legislation is to improve surgical patient safety or to inform patient choice, it is not clear how it will improve on the current reporting system supported by government. If a national performance and reporting framework is being developed, legislation should be directed at metrics of surgical team, hospital and organisational performance.

What does this mean for surgeons?

ANZASM recommendations suggest that future improvement in surgical team performance depends on communication and non-technical factors rather than only technical expertise. If publicly reported metrics do not show such improvement, legislation can be argued to be justified because the team performance element of patient safety-oriented surgical performance is not being addressed. However, this argument can be undermined if there is uniform participation of surgeons and trainees in RACS programmes on communication and non-technical skills e.g. Training in Professional Skills (TIPS). This participation, together with surgeons' effectiveness in the ANZASM, shifts focus to government's failure[iv] to adequately manage hospitals where patients suffer avoidable complications.

This failure to address the hospital and organisational element of patient safety oriented surgical performance gives the profession the opportunity to advocate for the ACSQHC framework. The framework should be underpinned by legislation effective at implementing reporting regulations in public and private hospitals that improve patient safety-oriented surgical performance. The regulations should incorporate the ANZASM metrics for safer hospital and organisational systems and safer surgical team performance. It is a rational and responsible response based on established evidence and relevant experience that correctly allocates accountability for patient safety and makes modern surgery safer.

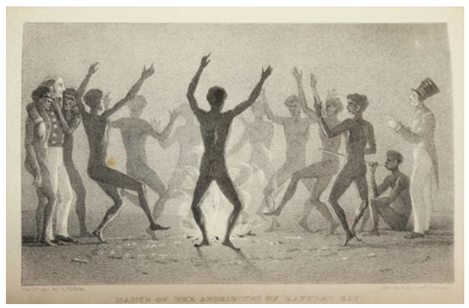
i http://statements.qld.gov.au/Statement/2017/8/4/queensland-push-for-overhaul-of-nationwide-patient-safety-reporting
ii https://jamanetwork.com/journals/jamasurgery/fullarticle/1485772
iii https://www.surgeons.org/media/25514879/2017-10-05_rpt_racs_anzasm_national_report_2016.pdf
iv http://theconversation.com/cutting-funding-for-hospital-complications-is-unlikely-to-change-patient-care-heres-why-88945.

Mr Peter Subramaniam
FRACS

Every Book has a Tale to tell

A recent donation to RACS

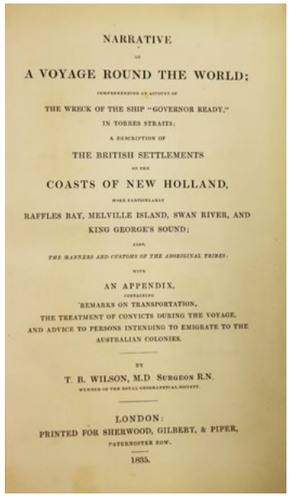
On 15 December 2017 RACS was presented with a fine historic book titled *Narrative of a Voyage Round the World*, by Thomas Braidwood Wilson MD (1792-1843), Surgeon RN. It was published in London by Sherwood, Gilbert and Piper in 1835, and is now scarce (pictured, right). Although it recounts the outward and homeward voyages, and some misadventures, the book deals largely with descriptions of British settlements on the western side of the Australian continent, especially Raffles Bay, Melville Island, Swan River and King George's Sound. It also contains the first mention of an indigenous musical instrument, a tube made of bamboo, played by the people of the Raffles Bay area on the Cobourg Peninsula (pictured, below).



This important work was donated to RACS by a distinguished Fellow, Professor Emeritus John Hall FRACS. He acquired the book in 2009.

However, it is not only the important content and rarity of this book which makes it significant, but also its provenance. Opening the cover reveals the bookplate of Rodney Davidson on the inside endpaper.

Rodney Davidson (1933-2016) is best remembered as the energetic and crusading Chairman of the National Trust of Australia (Victoria), who fought epic battles against governments and developers in order to save Australia's, and particularly Melbourne's, built heritage. But his personal obsession was Australiana, and over time he amassed one of the largest and most comprehensive private collections of Australiana ever assembled, containing many scarce, rare and unique items. Our book is one of them, and on the inner flyleaf is a pencil inscription in Davidson's handwriting 'From Bill Drever's Collection'.



NARRATIVE

OF

A VOYAGE ROUND THE WORLD;

COMPREHENDING AN ACCOUNT OF

THE WRECK OF THE SHIP "GOVERNOR READY,"

IN TORRES STRAITS;

A DESCRIPTION OF

THE BRITISH SETTLEMENTS

ON THE

COASTS OF NEW HOLLAND,

MORE PARTICULARLY

RAFFLES BAY, MELVILLE ISLAND, SWAN RIVER, AND KING GEORGE'S SOUND;

ALSO,

THE MANNERS AND CUSTOMS OF THE ABORIGINAL TRIBES;

WITH

AN APPENDIX,

CONTAINING

REMARKS ON TRANSPORTATION,

THE TREATMENT OF CONVICTS DURING THE VOYAGE,

AND ADVICE TO PERSONS INTENDING TO EMIGRATE TO THE AUSTRALIAN COLONIES.

BY

T. B. WILSON, M.D SURGEON R.N.

MEMBER OF THE ROYAL GEOGRAPHICAL SOCIETY.

LONDON:

PRINTED FOR SHERWOOD, GILBERT, & PIPER,

PATERNOSTER ROW.

1835.

William Drever (1903-80) was a wealthy Toorak hotelier who lived at 'Cloyne', the landmark mansion at 611 Toorak Road built in 1926 by renowned architect Harold Desbrowe Annear. He purchased 'Cloyne' in 1971 and resided there until 1992. So our copy of Wilson's *Voyage Round the World* would have spent some time on the bookshelves in this iconic house before it passed to Davidson, who was Drever's solicitor.

Drever bought 'Cloyne' following the death of the previous owner, Don Busch, who lost control of his P-51 Mustang at the Bendigo air show, and crashed. Busch was a colourful, even somewhat notorious, Melbourne identity in the 1960s, celebrated for his extravagant lifestyle, which included a fleet of Rolls-Royce motor cars. The most impressive of these was 3AZ56 (pictured, opposite page), a 1936 Phantom III sedanca de ville. The car was originally ordered by Alfred Nicholas (of Aspro fame) who resided at 'Burnham Beeches' near Sherbrooke in the Dandenong Ranges. On his death it passed to Mrs Isabel Nicholas, and then to world-famous violinist Yehudi Menuhin, who at that time was married to Nola Nicholas, Alfred's niece. The car is believed to have been stored for several years in a shed on the roof of the Nicholas Building in Swanston Street, before being acquired by Lt-Col. Dr Sir Harold Gengoult Smith.

Sir Harold Gengoult Smith (1890-1983) was by profession a physician. His rooms, which he inherited from his father, were at 110 Collins Street, Melbourne. In 1921 he was elected to the Melbourne City Council, and in 1931 successfully stood as a candidate for the position of Lord Mayor, which he held until the end of 1934. He remained a Councillor, representing Albert (later La Trobe) Ward until 1965. He was a friend of both Sir Hugh Devine and Sir Stanley Argyle, and as part of the deal by which RACS secured the lease of the Old Model School site in 1932, he committed the City of Melbourne to maintaining the College of Surgeons Gardens.

Sir Harold Gengoult Smith was also the father-in-law of Rodney Davidson.

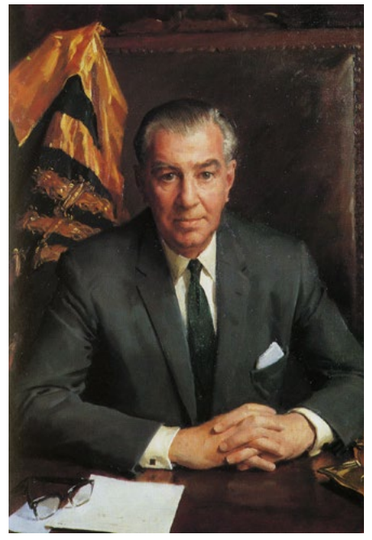
In his later years Davidson decided to dispose of his vast book collection. The sale consisted of four auctions, held between 2005 and 2008, conducted by Australian Book Auctions. The proceeds from this sale exceeded $13m.

In the top left corner of the flyleaf of our copy is a pasted ticket with the name 'Wantrup'. This is Jonathan Wantrup, executive director of Australian Book Auctions, and the presence of his ticket suggests that this book was not put up for auction, but was retained as part of his own collection. Later the book moved on again, to the antiquarian bookseller Robert Muir in Nedlands WA, from whom Professor Hall acquired it.

Such is the journey of a book, and such are the stories it can pick up along the way. RACS is most grateful to Professor Hall for his generous gift, which will be placed in the Rare and Historic Books Collection.

Geoff Down
RACS Curator

Three generations of the Smith family and RACS

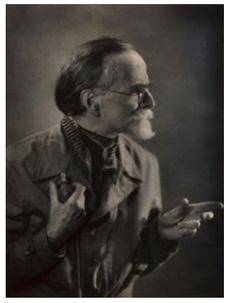


IMAGES (From left): Presidential portrait J O Smith; Orm Smith, 1940s; H R and J A Smith, 1989.

In 1918 a fifteen year old boy called Julian Ormond (Orm) Smith wrote a poem called The Aeroplane. It ended with this couplet:

God grant that this war's most potent arm
May save the world, and all her men disarm

Orm's English teacher from Melbourne Grammar questioned his father, Julian Augustus Romaine Smith about the poem's authenticity and received a withering reply – the poem was undoubtedly written by his eldest son. The Smith family have a history of brilliant individuals who have made a significant contribution to medicine, surgery and the arts.



At three years of age, Julian (JAR) Smith and his family immigrated to Australia in 1876. He obtained a BSc at the University of Adelaide in 1892 and afterwards taught Maths and Physics at his old school, the Prince Alfred College. At the same time, he was 'courted' by the physicist, Professor William Bragg, who was later awarded the Nobel Prize (with his son, Lawrence) for his analysis of crystal structures using X-Rays. After Julian Smith's death, AE Rowden White commented:

Who knows what Julian Smith would have been in that remarkable company of great physicists, had he accepted the elder Bragg's invitation to become a scientist in the early nineties.

But Julian Smith decided to become a surgeon. He completed his MB (1898) BS (1899) at the University of Melbourne, and began working at the (Royal) Melbourne Hospital. He then had a stint in Morwell as a general practitioner and upon returning to Melbourne in 1905, became a partner in a private surgical practice.

Already an expert in the mechanics of the Wimshurst machine (preceded X-Rays), Dr Julian as he was known, had an inveterate curiosity. He furnished the laboratory at the private practice with all kinds of scientific equipment and during a visit to St. Mary's Hospital in London, investigated haematology and immunisation. Later, he delved into Mendel's Laws of Heredity and bred animals and birds for this purpose. He also studied pollens as a cause of hay fever. It is not surprising that Julian Smith had an enduring friendship with another incisive scientific mind, Professor Archibald Watson.

From 1909 to 1929, Julian Smith was a member of the surgical staff at St. Vincent's Hospital and did much to obtain its recognition as the clinical school of the University of Melbourne. After 1912, he established a private practice at the top of Collins Street, Melbourne.

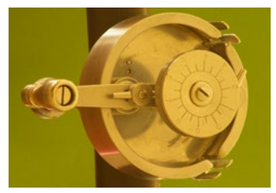
In 1936 he retired from surgery but as Sir Alan Newton stated, he was:

"… never still in body or in mind; never conventional in behaviour or repressed in expression; always a little apart from the herd; always doing something unusual; in short – a genius"

Photography was Julian Smith's next interest - always the innovator, he devised an unusual method for processing prints and was renowned for his distinctive black and white portraits.

IMAGES (From left): Examples of JAR Smiths photography: Self-portrait, Sir Thomas Dunhill and Murray Griffin (NGV)

When war broke out in 1939, Julian Smith returned to surgery, taking over the practice for his son and rekindling his interest in blood transfusion. Forty years earlier he used the methods of George Washington Crile to experiment with paraffinized rubber tubes for blood transfusion. In 1940, having never used a lathe, he developed a mathematically correct blood transfusion set that was designed to give direct transfusion on the battlefield, and with rotating pump, would imitate the heartbeat. He also invented an apparatus for sharpening blood transfusion and hypodermic needles.



There is little doubt that Julian Smith had a profound influence on his sons. Both his eldest and youngest sons - Julian Ormond (Orm) and Hubert Reynolds, trained as surgeons. Graduating from the University of Melbourne in 1936, Hubert was Director of the Resuscitation Unit at the Women's Hospital, before becoming Director of the Blood Transfusion Unit at St. Vincent's Hospital.

RACS was formed soon after Orm Smith graduated from the University of Melbourne in 1926 and starting as Assistant Honorary Secretary in 1930, 'Julian Smith Junior' remained closely identified with the College throughout his life. He became President in 1962 and finished his career as Honorary Archivist in 1965.

Initially, Orm was somewhat in his father's shadow and appeared to excel in sport–he was a Football Blue at the University of Melbourne - rather than shine academically. However, Orm was an 'all-rounder' and clearly, very able. After working briefly at the (Royal) Melbourne Hospital, in 1928, he visited England, obtained his FRCS and became personal assistant to Sir Thomas Dunhill. Returning to Australia in 1930, he was appointed to the (Royal) Melbourne Hospital:

There he adorned the surgical and teaching ranks with his clinical acumen, technical expertise and prodigious memory for factual knowledge…

When war broke out in 1939, Orm was sent to the Middle East, eventually ending up in El Kantara in Egypt where he met BK (Benny) Rank who later described him as '… a born army surgeon'. Orm encountered Benny again at the Heidelberg Military Hospital and the two men, both RACS Presidents in the 1960s and keen supporters of the College, became good friends.

Like his father, Orm was cultured and interested in the arts. He was a 'commanding presence' who was 'frequently non-conformist'. He was the first President to not wear his presidential gown for his portrait – instead, it is draped over the back of a chair, indicating that his presidency had ended.

The surgical dynasty started by Julian Augustus Romaine Smith continues to the present day. His grandson, Julian Anderson Smith (son of Hubert Smith) is Professor of Surgery at Monash University and Head of Cardiothoracic Surgery at Monash Health. For many years he was active in cardiac transplantation, mechanical support of circulation and in transplantation immunology. Now his interests lie in less invasive cardiac surgery, patient outcomes after cardiac surgery and in surgical education. He has also served as a RACS Councillor, as President of the Australian and New Zealand Society of Cardiac and Thoracic Surgeons and is currently President and Governor of the Australian and New Zealand Chapter of the American College of Surgeons.

The Smith family is not unique–many of the sons and daughters of Fellows have shone in surgical or medical fields, but only some match the epithet–*sic itur ad astra.*

Elizabeth Milford
RACS Archives

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