POSITIVE CHANGE
Surgeons contribute to New Zealand’s new gun laws

PLANS FOR THE FUTURE
Introducing President Tony Sparnon and Vice President Richard Perry

ASC BANGKOK 2019
Highlights of this year’s Annual Scientific Congress
Is your medical practice protected against privacy breach claims?

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Cover and above: Thai performers entertain at the RACS ASC Congress dinner.

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College should embrace diversity in all its forms, says in-coming President

While he is proud of the progress the College has made in recent years to address the gender imbalance within surgery, Mr Sparnon said more still needed to be done both in relation to diversity and to promote the interests of surgeons who worked outside the major urban centres and surgical specialties.

“I intend to work to ensure that everyone who wishes their voice to be heard, will be heard,” Mr Sparnon said. “We’ve done a great deal to address gender issues and while there has been progress, more needs to be done. We also have to broaden our views on what diversity truly means.

“I think we have to find ways to better represent the needs and opinions of surgeons working in isolation – whether that be surgeons working in remote or regional settings or surgeons working in small subspecialties. I believe it is vital to provide true representation to all Fellows, not just those working in the major specialties in an urban environment.”

“As an educational institution, I believe we can have the greatest impact on improving patient care in resource-poor countries by up-skillling the local medical workforce, mentioning local surgeons and fostering surgical leaders.”

Mr Sparnon said it was crucial the College remained focused on training and education and enhancing the surgical skills of local medical staff.

“They have only been six previous presidents from South Australia and the last two, Mervyn Smith and Andrew Sutherland, are heroes of mine. I feel enormously privileged to have the opportunity to follow in their footsteps.”

Mr Sparnon said his involvement in the surgical training of students in Malaysia and his surgical burn team visits abroad had clarified his views on the importance of the RACS Global Health projects.

“As surgical leaders within the Asia Pacific region, Mr Sparnon said it was crucial the College remained focussed on training and education and enhancing the surgical skills of local medical staff.

“Many countries in the region have great respect for how RACS selects, trains and assesses our surgeons and many of our neighbours are seeking our assistance in implementing a similar system,” Mr Sparnon said.

“As surgical leaders in the region, our prime focus should be helping our neighbours to improve their systems of professional development and training and skills acquisition by teaching these skills when we are visiting and bringing their surgical leaders to Australia.

“I think we have to find ways to better represent the needs and opinions of surgeons working in isolation – whether that be surgeons working in remote or regional settings or surgeons working in small subspecialties. I believe it is vital to provide true representation to all Fellows, not just those working in the major specialties in an urban environment.”

“When asked who are his role models, Mr Sparnon said it was the former President of RACS, Andrew Sutherland, who inspired him to become president. Mr Sutherland was the first president from South Australia to become president of RACS.

“Durham Smith and Anne Kolbe have been the only previous paediatric surgeons and it is a thrill to join them,” he said. “There have only been six previous presidents from South Australia and the last two, Mervyn Smith and Andrew Sutherland, are heroes of mine. I feel enormously privileged to have the opportunity to follow in their footsteps.”

Mr Sparnon lives in the beautiful Adelaide Hills hamlet of Hahndorf where he breeds horses and keeps three horses upon his small farm property and every few years takes to Montana in the US to ride in the “big sky” country. He is also a talented gardener and has won multiple trophies at the Adelaide Show for his prized lilacs.

Mr Sparnon said it was a great honour to have been elected as President of RACS, particularly as a paediatric surgeon from South Australia.
College a crucial connection point for all surgeons, says new Vice President

Newly-elected Vice President of RACS, New Zealand colorectal surgeon Mr Richard Perry, has three passions which drive him in his role on the College Council – maintaining surgical standards, enhancing the cohesion of the surgical profession and maximising the value of global health projects.

A Fellowship-elected Councillor, Mr Perry has chaired various committees at RACS including the Professional Development and Standards Board, the Fellowship Services Committee, the Pre-Registration and Skills Education Committee and the Australian and New Zealand Surgical Skills Education and Training Committee.

Committed to supporting surgeons across the Asia-Pacific region, Mr Perry led a surgical workforce capacity building team in Myanmar and continues to visit each year to teach and train.

With a keen interest in information technology, he has been involved in software development since his school days, has produced several commercial programs including the practice management system currently in use at his clinic and is closely engaged in RACS Project Sonic which seeks to enhance IT systems across College platforms.

He also has broad interest in governance and is a Chartered Member of the Institute of Directors in New Zealand and a Fellow of the Australian Institute of Company Directors.

Mr Perry became the first surgeon in New Zealand to perform a laparoscopic rectal prolapse procedure in 1991 and the first minimally-invasive colonic resection in 1992. Having received his FRACS in 1986 after graduating from Otago University Medical School, he was then awarded a Health Futures Fund Fellowship to Creighton University in Omaha, Nebraska. This was followed in 1989 by a United States National Institutes of Health Fogarty Fellowship to Creighton University in Omaha, Nebraska. This was followed in 1989 by a United States National Institutes of Health Fogarty Fellowship to Creighton University in Omaha, Nebraska.

Mr Perry said his time on the College Council had reinforced his view that the role of RACS in maintaining professional standards has never been more important.

“There is a general decline in respect for surgeons in both within surgery and the broader community but they play a vital role in many settings, from triage in urban centres to treating a wide range of surgical patients in regional and rural environments. As Vice President I would like to create more cohesion and more respect for all surgeons in all practice settings.”

Mr Perry is married with three adult children. His father Edward Perry was a surgeon and College examiner and his son, William, is currently doing a Fellowship in colorectal surgery in Oxford, England.

He lives in Christchurch with his wife, Julia and spends one week each month living and working in beautiful Wanaka, a resort town on the South Island that is the gateway to the Southern Alps’ Mount Aspiring National Park, an awe-inspiring wilderness of glaciers, forests, mountains and lakes.

There, he snow skis in winter and water skis in summer to keep fit while back home in Christchurch he and Julia are keen supporters of the New Zealand Symphony Orchestra and New Zealand Opera.

The Sunshine Coast University Private Hospital (SCUPH) is seeking a Cardiothoracic Surgeon(s) keen to live and work on the Sunshine Coast, QLD where they can embark on the next step in their career. The cardiothoracic program at SCUPH commenced in 2017 with the first cardiac surgical case performed in November 2017 and has continued to grow over the last 16 months. With the growth expected in the region, Queensland Health’s new $1.8B Sunshine Coast University (public) Hospital which is collocated with SCUPH, plans to open its own cardiothoracic service later this year.

Benefits:
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- Contributor to ANZICS database
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- On-site sessional consulting suite available
- Full marketing assistance to build your practice referral base

Essential Criteria:
- Applicants must have FRACS (Cardiothoracic Surgery), specialist registration with AHPRA and eligible for a provider number that attracts Medicare benefits.

For further enquiries please contact:
Oliver Steele
Chief Executive Officer
Sunshine Coast University Private Hospital
T: (07) 5390 6101
E: SteeleO@ramsayhealth.com.au

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A week in Bangkok

According to Forbes magazine Bangkok has welcomed more international visitors than any other city in the world over the past three years. The myriad of cultural attractions and contrasts on offer, the city’s renowned hospitality and its growing reputation as an international conference destination, made Bangkok a superb location for the 88th RACS Annual Scientific Congress (ASC).

There were many highlights throughout the week including the handover of the RACS presidency from Mr John Batten to Mr Tony Sparnon. Our new President paid tribute to both his predecessor and outgoing Vice President Dr Cathy Ferguson, for their exceptional leadership and for the humility and grace they demonstrated throughout their tenure.

Mr Batten said the opportunity to lead the College had been an honour and a privilege, and he leaves the role in excellent hands with Mr Sparnon. Although Mr Batten’s term as President is now finished, he will remain actively involved with the College as the new President of the Foundation for Surgery.

The general feedback received from the ASC was that the program was of an exceptional quality, and that most found it to be a useful experience they can learn from and take back to their practice.

Congratulations and thank you to the conveners of the event, Mr Nigel Willis and Mr Craig MacKinnon, as well as the many section conveners. Congratulations also to the staff that ably supported them, particularly the conference and events team and the New Zealand office.

Having bid farewell to Bangkok, work is already underway to ensure that the 89th ASC is every bit as successful. We look forward to welcoming you all again to the next congress in Melbourne in 2020.
Surgeons.org | Surgical News | 1110 | Surgical News

Scientific program

One of the biggest drawcards of the ASC has always been the unique gathering of Fellows, Trainees, International Medical Graduates and presenters from all over the globe, covering all specialties and subspecialties. This year’s ASC was no exception and provided the perfect environment for delegates to interact and learn from one another.

“The Complete Surgeon – Backing the Future” was the theme for the week, and this was reflected throughout the presentations. As we look to the future, we need to equip ourselves with the best possible care for our communities. The historical trend has been to increase subspecialisation which can place that care at risk. It is therefore critical that all surgeons maintain their ability to think and act within and across our specialties rather than only being proficient in a narrow field. At the same time surgeons must be cognisant of the skills that other specialists can add to the care of their patients.

Section dinners and address to the Foundation for Surgery by Dr José Ramos-Horta

Bangkok is famous for its cuisine and its wide array of rooftops bars and restaurants. Many of these locations provided a lovely setting for the various section and conference dinners held throughout the week.

Among the dinners was the Foundation for Surgery Thank You Dinner, where former Timor-Leste President and Nobel Peace Prize winner, Dr José Ramos-Horta, was the guest of honour. In an inspiring speech, Dr Ramos-Horta highlighted the importance of striving for ongoing peace and the importance of healthcare and education. He gave his personal thanks to donors for making such a difference in Timor-Leste. Dr Ramos-Horta’s speech is available in full on the RACS website.

Syme Oration

The Syme Oration is the most senior address in RACS annual calendar and was delivered by Professor Sir Malcolm Grant CBE (pictured with Mr John Batten).

Sir Malcolm was appointed founding chairman of NHS Lingland when it was set up as an independent body in 2011, and recently completed a seven year term. He was previously the President and Provost of University College London (UCL) for 10 years, through a period that saw significant growth and a soaring international reputation, particularly in medical and life sciences.

Sir Malcolm spoke of ‘doctoring in an age of data’ and how the future practice of surgeons, particularly the many new Fellows in the audience, will be affected both positively and negatively by big data collections.
Indigenous breakfast

One of RACS key priorities is a commitment to improving the health outcomes of our Indigenous populations in Australia and Aotearoa/New Zealand. The Indigenous breakfast proved the perfect way to begin the day’s Indigenous Health program and to celebrate the awarding of the Honorary Fellowship to Professor Papaarangi Reid. Professor Reid’s research interests include analysing disparities between Indigenous and non-Indigenous citizens as a means of monitoring government commitment to Indigenous rights. She has provided mentoring and inspiration to young Māori doctors and medical students over several years.

Media and social media

Despite the conference being held in an international location and coinciding with the federal election in Australia, the media showed strong interest in the event. Many research presentations and posters were profiled throughout the week, including feature stories across the ABC, SBS, the Courier-Mail, Stuff.co.nz, as well as various other media outlets.

There was also plenty of lively discussion happening on Twitter throughout the 2019 ASC. The official hashtag for the event, #RACS19, reached far and wide with a social reach of 8.7 million users, with tweets posted by users from all over the world. Some of the trending themes included surgery, women, social media, patients, resilience and unconscious bias.
Women in Surgery’s Super Thursday a success

For the first time at an Annual Scientific Congress, the Women in Surgery Section (WiSS) held their own all-day program. Dubbed ‘Super Thursday’, the program commenced with the annual Women in Surgery breakfast and throughout the day featured sessions on social media, diversity, facing challenges and unconscious bias.

Instigated by section convenor Dr Jane Strang, the program proved highly successful in terms of both attendance and the discussion and positive feedback generated across social media.

Dr Strang said the day was an important opportunity to create a visible presence for women in surgery and she hoped it would become a regular feature in future years.

“People are crying out for change which has been a little bit slow in coming. In many respects people are crying out for change which has been a little bit slow in coming. I thought that bringing these issues to the forefront and introducing new ideas to the conference would be a great way of making progress, highlighting diversity in surgery, and ensuring that the next generation have a voice rather than being restricted by the often-hierarchical nature of the profession.”

“It is important that people in powerful and influential positions are aware of the issues faced by those who are not in such positions, and that they play a pivotal role in creating a culture and structures that support everyone,” Dr Strang said.

Among the speakers was international guest, Dr Heather Logghe, who instigated the #ILookLikeASurgeon hashtag on Twitter in 2015. The hashtag has subsequently gone viral with thousands of surgeons, both female and male, uploading pictures of themselves to celebrate diversity in the profession, and highlighting the many different faces of the modern world of surgery. Dr Logghe’s story will be profiled in a feature article in the next edition of Surgical News.

Another highlight of the day was the presentation of the inaugural Women in Surgery essay prize, which was awarded to Jessie Zhou for her essay ‘Are surgery and social media incompatible?’ (available to read on the RACS website).

The program also featured a keynote lecture from the WiSS Chair and RACS Councillor, Dr Christine Lai, on the importance of promoting female leadership, and having strong male and female role models to inspire the next generation.

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Congratulations to the Best Research Paper Prize winners at 2019 ASC

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DISCIPLINE OF SURGERY
UNIVERSITY OF ADELAIDE

HERNIA REPAIR IN 2019: THE GOOD, BAD & UGLY.

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Register Online: www.trybooking.com/BBBHT
Organising Committee: Guy Maddern, Alex Karatassas, Chris Hensman, Nabeel Ibrahim, Harsha Chandraratna.
Dr Pham is a Colorectal Trainee and Clinical Fellow of the Differentiation and Transcription Laboratory, under the supervision of Professor Robert Ramsay, the Head of the Differentiation and Transcription Laboratory, establish a clean space to kill tumour cells that display large quantities of oncoprotein," Dr Pham said.

“When it is over-expressed it drives cellular growth which can eventuate in the promotion of tumour growth. “Unlike foreign pathogens, tumour antigens such as MYB are ‘self’ and thus only weakly immunogenic due to immune tolerance and so we included tetanus peptides to break peripheral tolerance by associative recognition, hence the name TetMYB.”

“Our published pre-clinical data has shown that the TetMYB vaccine can afford both prophylactic and therapeutic protection in multiple transgenic and cell-line-based CRC pre-clinical models.”

“We have shown that this combination cures up to 50 per cent of mice with established colorectal cancer.”

Dr Pham is conducting his PhD research at the PMCC under the supervision of Professor Robert Ramsay, the Head of the Differentiation and Transcription Laboratory, along with that of fellow research leaders Professor Alexander Heriot, the Clinical Director of Cancer Surgery, medical oncologist Associate Professor Jayesh Desai and molecular biologist Dr Lloyd Perera.

He said that the positive results of laboratory tests of the vaccine on murine models that replicated human colorectal cancer had won the team funding and ethics approval to establish the human trial.

Dr Pham said the MYPH5IMD30 trial will involve 32 patients divided into two stages. The first group of twelve patients will be given escalating doses of the vaccine in combination with immune checkpoint inhibitors, to determine the maximum tolerable dose.

Once the researchers understand the maximum dose tolerance, the remaining 20 participants will be treated at this dose to further assess safety and potential efficacy.

Dr Pham said the PMCC team was currently half way through the dose escalation phase of the trial with the remaining 20 patients being recruited throughout next year.

While the trial goes on, he is now also investigating the use of the vaccine as a prevention against adenomatous polyps turning into colorectal cancer using genetically modified mouse models. This research has garnered widespread international recognition, having been presented in a Plenary session at Digestive Diseases Week and earning prizes at both the American Society of Colon and Rectum Surgeons’ Annual Scientific Meeting and the Memorial Sloan Kettering Annual Advances in Colorectal Oncology meeting.

“This is extremely exciting and unique work not only because we are the first to target MYB but because the vaccine was discovered, designed and made in an Australian laboratory,” Dr Pham said.

“This is unique because usually this sort of science is driven by the major pharmaceutical companies working with research laboratories but we did it ourselves even though it took us over six months to set up the laboratory, establish a clean space necessary for drug development and create the vaccine.”

“Academic Highlights

• 2019 – 2020: RACS Paul Mackay Bolton Scholarship for Cancer Research
• 2019 – 2020: National Health and Medical Research Council (NHMRC) Postgraduate Scholarship
• 2018: Attending Physician’s Choice Award Memorial Sloan Kettering Cancer Centre Annual Advances in Colorectal Oncology, USA
• 2018: RACS Tour de Cure Cancer Research Scholarship
• 2018: American Society of Colon and Rectal Surgeons – Midwest Society of Colon & Rectal Surgeons William C. Bemstech, MD Award
• 2018: Peter MacCallum Foundation – New Investigator Grant
• 2018: Medtronic/CSSANZ Colorectal Research Grant

Karen Murphy
Surgical News journalist
New surgical skills learning model could free up busy surgeons

Medical students can gain basic and intermediate surgical skills through a process of peer review and self-criticism in conjunction with focused faculty feedback, according to Queensland general surgery Trainee Dr Guy Sheahan.

Dr Sheahan has spent the past two years exploring new methods of teaching surgical skills to medical students as part of a Masters of Education Degree with financial support provided via a Foundation for Surgery Fellowship in Surgical Education.

In an era of minimally-invasive surgery, Dr Sheahan said medical students and junior doctors have less exposure to open surgical procedures than previous generations but still need to gain those skills. While simulation and digital platforms allowed students to learn basic surgical procedures, giving them exposure to operations often took up valuable time in theatre and slowed down busy surgeons.

Dr Sheahan set out to determine if particular surgical techniques could be mastered through peer-review and self-analysis as compared to being taught by medical faculty alone. He also conducted research to find out if teaching such methods as critical self-analysis in the skills acquisition process could help create reflective clinicians capable of adapting and responding to changes in the medical environment without the need for hierarchical direction.

Dr Sheahan conducted his two-year Masters of Education research at Queen’s University, Kingston, Canada, under the supervision of Professor Richard Reznick, the Dean of Health Sciences, and Dr Floris Zeev. Returning to Queensland earlier this year, Dr Sheahan is now a SET 4 general surgery Trainee at the Robina Hospital in Queensland.

His work – Faculty versus structured peer feedback for acquisition of basic and intermediate level surgical skills – has been published and presented at international meetings.

Dr Sheahan’s research was centred upon a prospective randomized non-inferiority trial comparing peer feedback and faculty feedback with first and second year medical students who were learning skin lesion excision and closure and single-layer hand-sewn bowel anastomosis.

Students were first shown what a poor result looked like in comparison to an excellent result and were then asked to conduct the procedures over five attempts and analyse their own performance through a combination of self-assessment and peer review. Faculty then assessed results to see if opinions on the results matched.

Speaking to Surgical News, Dr Sheahan said his research aimed to find out if there were effective ways for students to access, practice and build up foundational open surgical skills in an era of minimally-invasive surgery.

He wanted to determine if surgical skills could be taught without an expert standing over a student’s shoulder guiding them through various procedures and if teaching people how to critically assess results could change their ability to assess their own performance.

“Surgeons, in particular, need to constantly improve their performance and techniques through self-assessment but we don’t teach these skills.”

“I believe the structured practice phase, as outlined in my research, will improve skill acquisition in the early years of medical education thus leading to higher operating theatre utilisation and subsequent cost savings.”

Dr Sheahan explained that similar research conducted with surgical Trainees could determine if there was a difference between junior and senior learners and whether his model could allow Trainees to learn some surgical skills independently.

“This could be valuable in some clinical situations such as when busy Trainees cannot get to a skills session – that time will not be lost but could be replaced through more independent learning,” he said.

“At the same time, Faculty could have a degree of confidence that Trainees will be able to improve their skills independently and self-assess those skills accurately either by themselves or with the input of their peers.”

Dr Sheahan also said his work could have implications for distance and remote learning. A reduced need for Fellows to teach basic techniques could allow them to focus on honing skills and teaching more complex surgical procedures.

Dr Sheahan has presented his work at both the 2018 Association of Surgical Education meeting in Austin, Texas, and the 2018 Queen’s University Surgical Education Symposium. His research has also been accepted for presentation this August at the Association for Medical Education in Europe (AMEE) conference in Vienna. Findings from his work have been published in the American Journal of Surgery while submissions to other specialist journals are pending.

A medical officer in the Army reserve and an Associate Lecturer at the University of Queensland, Dr Sheahan hopes to specialise in trauma surgery after completing his training while maintaining a strong involvement in surgical education.

He thanked RACS for the support provided to him.

“It was a challenging couple of years because my wife Rebecca was completing a Fellowship in Intensive Care in Toronto, we had a toddler and I had to commute three hours each way to get to Queen’s University,” he said.

“Still, while it was demanding, it opened our horizons in terms of medical research and learning and gave us the chance to work with some of the best researchers and teachers in North America.”

**Academic Highlights**

- 2017: Queen’s University grant for research of simulation based Resident Training
- 2015: RACS Fellowship in Surgical Education
- 2009: Queensland Health Rural Scholarship Scheme

Karen Murphy
Surgical News Journalist
Ten patients with massive abdominal sarcomas have now been successfully treated using the new bypass technique at the Sir Charles Gairdner Hospital in Perth. The team behind the new technique comprises Director of Cardiothoracic Surgery, Dr Mark Newman, Colorectal and Sarcoma surgeon Professor Rupert Hodder and Vascular surgeons Professor Shirley Janssen and Dr Joe Hockley. Since its introduction last year, they have conducted a range of complex abdominal surgeries which involve compromised or obstructed vascular structures. In 2015, Western Australia became the first state in Australia to establish a State Sarcoma Service with all WA sarcoma patients referred to the Sir Charles Gairdner Hospital. The team now conducts one abdominal sarcoma resection each week, with one patient in every four to six weeks requiring the stability provided by the new bypass system. According to members of the team, being able to keep sarcoma patients stable during procedures that can take up to 16 hours allows them both to reduce patient risk in theatre and treat patients with tumours otherwise deemed to be inoperable.

Earlier this year, the WA Sarcoma Service conducted marathon surgery using the new bypass system to save the life of Mr Wayne Gair who presented with a 12kg abdominal sarcoma. “When you clamp the IVC, blood flow to the heart obviously changes dramatically with all the safety issues that go with that, but this bypass procedure dramatically changes both what we can do and the time we have to do it in because the patients are so stable.”

Until now, the central challenge facing surgeons and anaesthetists lay in keeping the patient stable enough, long enough for them to do that work.

“This technology has been around for 20 years in transplant surgery but we are the first, as far as we know, to adapt it for use in abdominal sarcoma surgery,” Dr Newman said.

“When we realised that the sarcoma team were having difficulty keeping patients stable while undergoing these major procedures, I suggested adapting the bypass system used in liver surgery, and it’s been very successful. “Keeping these patients haemostatically stable means that surgeons conducting these major tumour resections are far more comfortable operating much longer and taking the time they need to both remove the tumour and conduct extensive resections to get safe and sufficient margins.”

“Before this, patients were experiencing tachycardia, acidosis or variable blood pressure which both increased the risks to them and increased the difficulty for anaesthetists working to keep them stable.

“The new percutaneous cannulation technique involves the surgeon placing the canula in the femoral vein, the anaesthetist placing the canula in the jugular vein while a clinical perfusionist is in constant communication.”

Dr Newman said the ten surgeries so far conducted using the technique would become the basis of a range of research papers and presentations.

Professor Rupert Hodder is a consultant colorectal surgeon at the Sir Charles Gairdner Hospital and a member of the GI sarcoma team. He and Dr Hockley presented details of the new bypass technique at the Australasian Sarcoma Group Annual Scientific Meeting held in Perth in October last year and said that two registrars were now writing research papers on the new system.

He said the life-saving innovation arose out of simple conversations between colleagues.

“We’d had an adverse event, we wanted to learn everything we could from it but most of all we wanted to make sure we did everything to try to prevent it from happening again,” Professor Hodder said.

“Surgery is the only viable treatment for sarcoma yet some patients present with such massive tumours that we always have to weigh up the risks associated with surgical treatment.

“When you clamp the IVC, blood flow to the heart obviously changes dramatically with all the safety issues that go with that, but this bypass procedure dramatically changes both what we can do and the time we have to do it in because the patients are so stable.”

Professor Hodder said patients selected for bypass were those with sarcomas near or involving major vascular structures such as the IVC or aorta.

He said one of the great benefits of the adapted technique was that it allowed surgeons to go deeper and wider and take on much larger tumours than previously. “This technology allows us to go deeper and wider and take on much larger tumours than previously,” Professor Hodder said.

“It is also allowing surgeons to remove much larger tumours than previously and it is providing these patients with the opportunity to undergo the operations they would have been told they couldn’t have. “From a patient’s perspective, this improved outcomes for patients and reduced the risks of surgery.”

Ten patients with massive abdominal sarcomas have now been successfully treated using the new bypass technique at the Sir Charles Gairdner Hospital in Perth. The team behind the new technique comprises Director of Cardiothoracic Surgery, Dr Mark Newman, Colorectal and Sarcoma surgeon Professor Rupert Hodder and Vascular surgeons Professor Shirley Janssen and Dr Joe Hockley. Since its introduction last year, they have conducted a range of complex abdominal surgeries which involve compromised or obstructed vascular structures. In 2015, Western Australia became the first state in Australia to establish a State Sarcoma Service with all WA sarcoma patients referred to the Sir Charles Gairdner Hospital. The team now conducts one abdominal sarcoma resection each week, with one patient in every four to six weeks requiring the stability provided by the new bypass system. According to members of the team, being able to keep sarcoma patients stable during procedures that can take up to 16 hours allows them both to reduce patient risk in theatre and treat patients with tumours otherwise deemed to be inoperable.

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A research collaborative inspiring a new generation of Victorian Trainees

In 2015, Austin Hospital based general surgical Trainees and their mentors were inspired to reconsider Trainee engagement in surgical research, and to develop the capabilities of the next generation of Australian and New Zealand surgeons. Mr Stephen Horby, a UK Trainee spending a year as an upper GI surgeon at the Austin Hospital, shared his experience of the Birmingham based West Midlands Research Collaborative (WMRC) – a Trainee-led clinical trials network – with local general surgical Trainees. This set in place the foundations for one of Australia and New Zealand’s first Trainee-led networks.

Before 2015, the exposure of surgical Trainees to collaborative and large scale research at the Austin Hospital, and arguably elsewhere in Australia and New Zealand, was limited. Trainee research was usually small scale, single centre retrospective studies. The WMRC experience was the first Trainee-led research collaborative in the UK, and its track record of delivering successful Trainee-led multi-centre randomised controlled trials of surgical interventions, provided the impetus for change. Trainee involvement in clinical research is now considered a key part of surgical trainee experience.

Trainee leadership also offers opportunities to engage with novel technologies. For example, the VERITAS SOS study (Surgical Outpatient Study) aims to characterise Trainee experience in outpatient clinics. This network has developed its own webpage accessed via smartphones for data collection, which has been underway at the Austin and Northern Hospitals for six months and is currently expanding to other sites around Australia.

VERITAS is one of a growing number of Trainee-led research collaboratives in Australia and New Zealand. RACS has been quick to recognise the potential of these Trainee-led research collaborations and has supported the establishment of Clinical Trials Network of Australia and New Zealand (CTANZ) to foster the development and growth of Trainee-led research collaboratives. As part of this, CTANZ seeks to network the networks and has been instrumental in facilitating links with other general surgical networks and also Trainee networks in other surgical specialties. Solving the common challenges encountered by the research collaboratives and sharing solutions, CTANZ provides support and strength across the Trainee collaboratives now established in Australia and New Zealand.

With the strong interest in Trainee-led research collaborations from Trainees and surgeons, and the support from RACS via the CTANZ, the future of Trainee-led research in Australia and New Zealand looks bright.

For further information about CTANZ please email: CTANZ@surg.org

Dr Sean Stevens
VERITAS Trainee network lead
Leading the way with our RACS Faculty Charter

The surgical profession has a long history of caring for patients by educating future generations of surgical trainees and handing down knowledge, skills (technical and non-technical) and above all a professional approach. How a surgeon performs as a clinician, a leader, and an educator is predicated on lifelong learning and reflective practice.

RACS is the leading advocate for surgical standards, education and professionalism in Australia and New Zealand. It is our professional responsibility to continue to set the standard for the education, training and professional development of our surgical workforce to optimise patient care.

RACS Faculty Charter Key Principles:
- Adhere to and promote course principles and methodology
- Acknowledge and respect the views of all course attendees
- Respect and accept the responsibility of facilitator, teacher and mentor
- Prepare and plan for allocated teaching responsibilities
- Respect the professional boundaries between student and teacher
- Commit to and be actively engaged for the duration of each course
- Effectively and appropriately communicate with course attendees
- Be respectful and aware of the different beliefs, backgrounds, values and cultures of all course attendees
- Be mindful of their importance as role models
- Give feedback, in a respectful manner, on participants’ progress and performance including assisting in remediation where necessary.
- Encourage honesty, be factual, objective and constructive when providing feedback and undertaking assessment of course participants
- Actively discourage and refrain from discrimination, bullying and sexual harassment.

If you are interested in viewing the charter in full, visit www.surgeons.org and enter “Faculty Charter” into the search function.

The RACS Education Portfolio introduced a Faculty Charter in 2012, which has recently been expanded to all RACS educational activities. Within the charter our values and standards are made clear to ensure that Fellows teaching our courses, in workshops and at events are exemplary faculty members. Our objective is to obtain the highest standard of surgical education possible.

The RACS Faculty Charter outlines the professional behaviours expected of our faculty. The expectations set out in the charter include themes of respect to all stakeholders within our educational sphere, a commitment to active engagement during the course, and to foster exemplary role modelling behaviour. This highlights an exciting time to be a member of faculty, leading the way for positive cultural change within the surgical profession.

The charter also highlights the support that our faculty members can access, be it having a mentor during a course, feedback by medical educators to help enhance their teaching skills, or peer-to-peer feedback amongst facilitators.

We believe that with this charter, we are in a better position to support faculty development, encourage interested fellows in becoming faculty, and build excellence in surgical education. RACS provides courses across all nine surgical competencies and recognises that our Fellows have strengths in certain areas. We encourage you to embrace those strengths and follow the long tradition of sharing your knowledge and skills with peers and colleagues.

If you are interested in becoming a member of our faculty, please contact:
Rob Di Leva – Professional Development PDActivities@surgeons.org
Alicia Savale – Skills Training SkillTr@staff@surgeons.org

Surgeons contribute to New Zealand’s new gun laws

New Zealand Fellow James McKay recently gave New Zealand parliamentary select committee members a unique and graphic insight into patients’ injuries that surgical teams confronted as a result of the Christchurch mosque shootings on 15 March this year.

Dr James McKay and RACS Executive Director Surgical Affairs (NZ), Mr Richard Lander (pictured), represented RACS at the committee’s hearings of invited oral submissions on changes to tighten New Zealand’s gun laws after the mass shootings. RACS also provided a written submission.

Mr Lander spoke to the committee about a mass shooting and the victims he had triaged and helped care for as a junior doctor in 1976 in Harare hospital, Zimbabwe. “I thought it couldn’t happen here, but it did,” he said.

New Zealand’s Parliament overwhelmingly approved new gun laws within one month of the massacre. These ban military-style semi-automatic firearms and severely restrict ownership and use of semi-automatic firearms. Parts, magazines and ammunition which can make a gun illegal are also banned and there are greater penalties for people breaking firearm laws.

Further proposed changes to the laws will be put before Parliament in the middle of the year. It is understood these will propose a national gun registry and changes to the gun owner registration process.

Dr McKay was the on-call trauma surgeon at Christchurch Hospital on the day of the shootings which resulted in 48 critically injured patients being received at the hospital in less than an hour.

His description of the significant injuries that victims suffered due to the type of ammunition and firearms used by the shooter moved several MPs almost to tears. Dr McKay’s presentation received extensive online, television and press coverage.

Dr McKay told the committee that all the victims cared for by hospital staff had suffered penetrating injuries from what looked like high-velocity weapons. This type of firepower is meant to kill, with hollow-point bullets designed to shred as much human tissue as possible.

There were significant chest, lung and major blood-vessel injuries which required emergency life-saving surgeries, often multiple times in multiple patients.

He said there were multiple abdominal injuries with injuries to bowel and stomach, resulting in significant contamination of body cavities and wounds that needed multiple surgeries to clean, disinfect and remove bullet fragments. Many victims suffered nerve damage, including to the spinal cord, leaving them significantly and permanently disabled.
Good morning everyone,

It is fantastic to see everyone here. The new look and feel of the Academy has been well received, and we are really happy that you have chosen to be here.

This morning I want to talk about the role of the Surgical Educator. Over the last few decades, the role of surgical educators has changed dramatically. The expectation has increased significantly, and this is reflected in the new role of the Surgical Educator, which we are so proud to launch today.

We will provide an introduction to the Mohr Process Communication Model (PCM). This is a tool that you can use to improve your communication skills. The model is based on the idea that effective communication requires three components: the words you use, your tone of voice, and your body language.

We will also discuss the importance of non-technical skills in surgical education. These skills are just as important as technical skills, and they can have a significant impact on patient safety and outcomes. Non-technical skills include team dynamics, communication, leadership, and decision-making.

We will also discuss the clinical decision-making framework developed by the Royal College of Surgeons of Edinburgh. This framework can help you to understand how surgeons make decisions and to improve your own decision-making skills.

Finally, we will talk about the importance of feedback in surgical education. Feedback is a critical component of the learning process, and it can help you to improve your skills and to become a better surgeon.

We hope you find this session informative and enjoyable. Thank you for being here, and we look forward to seeing you in the afternoon for the remainder of our program.
**Skills training courses 2019**

**SKILLS TRAINING COURSE DATES**

**JUNE - SEPTEMBER 2019 | Available courses**

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*Courses available at the time of publishing*

**Are you being watched?**

Smart watches, if you let them, are watching us or rather monitoring our heart rates and rhythm.

An apple a day used to be said to keep the doctor away. This no longer holds true. Dr Fi Brille ate some dodgy food, and during the awful night of expulsions that ensued, was notified by her watch of a rapid, irregular heart rate (HR). Her watch ECG app diagnosed Afib – so she phoned the next morning for an emergency consultation. Though defibrillated, the worst of her D&V was over, but she still had a tachycardia (regular).

She’s not been the only watch detected cases in the last couple of months – I’ve had Dr C A Darci as well. Atrial fibrillation has significant implications for stroke risk, other embolic disasters and likely long-term anticoagulation. The Apple watch (series 4) claims it can now detect it with 98.3 per cent sensitivity (true positive rate).

Smart watches, if you let them, are watching us or rather monitoring our heart rates and rhythm. They do this by sophisticated photo plethysmography. The photodiode sensor uses green light to monitor rate during activity and infrared when inactive to detect arrhythmias. We might not yet live in a nanny state despite recent political feartomers, but it’s getting ever closer. Your watch will not only monitor your heart rate, but can display an average rate, a graph, identify arrhythmias and send notifications. The Apple 4 watch even generates a lead 1 ECG!

Clinical studies on Apple and FitBit watches are accumulating. One ANZ study, published in 2018, compared 100 hospitalised patients comparing smart watch heart rate monitoring with continuous ECGs. The watch was accurate with heart rate in sinus rhythm and patients with atrial flutter. In slower AF the watches were not so smart, underestimating rate, but there was 98 per cent accuracy when the AF rate exceeded 100 beats per minute.

Three years ago (2016), a study on smart watches also included the Samsung Gear S and the MiO Alpha as well as the other two smart watches. Healthy volunteers were monitored by ECGs during running, sitting and cycling. The watches were comparable, accurate at recording heart rate (1-9% percentage error) but less good at measuring energy expenditure (9-43% percentage error). However, despite statistical agreement between the smart watches which tended to under-record, the variation still ranged from -27 to +13bpm, and -267 to +67kcal. The technology is continually improving with a 2018 study showing RR variability to be very low and Bland Altman plot correlations achieving 0.9 (excellent). However, energy expenditure measurement by smart watches is still not accurate enough for use.

Interestingly, HR variability reports are used to plot stress (such as one in six cardiologists performing procedures), and the Apple watch is getting smarter at detecting this. So your watch could also be watching how stressed you are, and this monitoring might be informative providing you are not too stressed by looking at the watch all the time or having to jump at every small or text message. The watch might not be measuring your catecholamines, but through your heart rate and its variability it’s watching your stress responses. Do you really want to know? That might depend on your mental health and/or blood pressure.

The fit but over intesa Dr Darci uses his watch to nage his heart rate during exercise, but also to gauge his cardiovascular fitness by measuring its rate of decline when recovering. He was literally alarmed when the watch clocked his tachycardia. His blood pressure and electrolytes proved normal. He passed a stress test with flying colours, underwent 24hr ECG monitoring without an arrhythmia, so we’ve let him return to the gym with or without his watch.

Dr Fi Brille also had a normal BP, but slightly abnormal electrolytes. Her rate and rhythm had recovered when I saw her that morning, but over the following weeks she had other bouts of AF, detected by both her watch and 24-hour monitoring. She’s considering her options.

Do you wear or want a smartwatch? What do you want it to watch, and for how long will it ask your permission by asking you to press the app? Your ECG on your wrist for all to see? These ‘wearable devices’ represent a great advance for those who need monitoring. But what will they do to those of us who don’t want an alarm might just be too much stress for yours truly.
A brief history of RACS Pathology Museum 1962-1993

In the 1870s Professor William Osler who was teaching at McGill University, Montreal wrote: “As is our Pathology, so is our Practice.”

In the early 1960s, this sentiment resonated with the College Council. The Education facility in the new west wing was envisaged as a local equivalent of the Institute of Basic Sciences at the English College and surgical pathology was to be an integral part of a basic medical sciences course.

Consequently, to prepare for the new Education Centre, Professor E.W Gault (FRACS) was appointed in July 1962 as the Curator of the Pathology Museum. Ted Gault (1903-1982) had spent most of his career as a pathologist and worked as a medical missionary in India. In 1946, he became the Foundation Professor of Pathology at the Christian Medical College, Vellore.

When the Education Centre was built it was to include a pathology laboratory, museum and teaching unit. In the interim Professor Gault was installed in the attic and allocated funding of up to £1,500 to provide essentials for the laboratory.

The pathology section of the Basic Medical Sciences department had a Director, I.C Heinz, Anatomy Prosector, F.J Gray (later Director of Surgical Anatomy) and a new Curator, G.W Trinca. In a report to Council in 1966, it was stated that:

“A series of displays in the museum have been maintained and considerable use of the museum has been made by candidates studying surgical pathology for the final Fellowship examination.”

What did the RACS Pathology Museum contain? An example is the General Surgery section which was divided into four sub-sections: Diseases of the Breast; Diseases of the Thyroid; Traffic Accident Trauma; Miscellaneous.

Cases included:
- Specimen 1006: Motor car accident (1968) with operative removal of a kidney.
- Specimen 1816: Small inguinal hernia, followed by hydrocoele of the cord.
- Specimen: Struck by car while on footpath. Post mortem revealed delayed splenic rupture.

The foundation stone for the new west wing of the College was laid by Sir Robert Menzies in March 1964 and noticeably, attendees at the ceremony were invited to attend a pathology display in the basement of the south wing (currently the RACS Museum).

In February 1965, Lord Casey, who was soon to become the Governor General, opened the new College buildings – an open quadrangle combining the west wing with the Great Hall located on the eastern side. The Pathology Museum and its associated laboratories had now found a new home – spacious accommodation on the second floor of the west wing (now the CEO and President’s area).

By the late 1960s, the pathology section of the Basic Medical Sciences department had a Director, I.C Heinz, Anatomy Prosector, F.J Gray (later Director of Surgical Anatomy) and a new Curator, G.W Trinca. In a report to Council in 1966, it was stated that:

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Cases included:
- Specimen 488: Undifferentiated carcinoma of the thyroid.
- Specimen 1006: Motor car accident (1968) with operative removal of a kidney.
- Specimen 1816: Small inguinal hernia, followed by hydrocoele of the cord.
- Specimen: Struck by car while on footpath. Post mortem revealed delayed splenic rupture.

The Pathology Museum survived until 1993 when most of its specimens were transferred to the Harry Brookes Allen Museum of Anatomy and Pathology at the University of Melbourne. The decision to close the museum was controversial and was not without its detractors, most notably, its long-term Curator, Gordon Trinca. Its demise was precipitated by several factors. The generous space allocated to the museum was needed for the ever-expanding College and the collection was deteriorating, with many specimens in ‘cloudy’ pots requiring conservation. Surgical training was beginning to change and with it, the role of pathology. Other institutions like the University of Melbourne whose Pathology department began in 1853, had a good collection of specimens. Monash University’s medical school which originated in the early 1960s, also had a pathology department.

It is important to note that museums are an educational resource and, this brief history of a College museum provides an interesting insight into surgical training in the latter half of the twentieth century.

– Elizabeth Milford
RACS Archivist
Sydney team with new treatment for essential tremor

Since news emerged of the successful introduction into Australia of a non-invasive MPR guided ultrasound procedure to treat essential tremor, scores of patients have approached the team at St Vincent’s Hospital in Sydney for help.

Now the team behind the procedure – neurosurgeon Dr Ben Jonker (pictured, left), neurologist Dr Stephen Tisch and neuroradiologist Dr Yael Barnett – face the task of assessing dozens of patients for their potential suitability.

According to Dr Jonker, however, they had anticipated this public reaction and, knowing they only had the resources to treat between 25 – 50 patients in the first year, they established protocols to help guide patient selection.

First, the essential tremor must predominantly affect the limbs (usually arms) rather than head or voice; it must be severe and impact daily function; it must be unresponsive to pharmacological treatments and it must significantly affect quality of life sometimes to the point of causing social isolation.

The new treatment was introduced in November 2018 via a $8 million MPR guided Focused Ultrasound (MRgFUS) that uses high frequency ultrasound beams to burn a tiny lesion in the thalamus to block tremor signals.

Patients are conscious throughout the procedure, able to give real-time feedback to surgeons and neurologists and see a significant reduction in their tremor even while asleep.

“Clinical trials have been conducted overseas which show this procedure to be safe and effective and it has FDA approval in America but widespread public funding is not yet available in Australia,” Dr Jonker said.

“It would be wonderful to be able to offer this more widely and we are working on that at present.”

Dr Jonker said he became involved in introducing the new technology because it built on his work treating movement disorders through functional neurosurgery.

“I was exposed to deep brain stimulation (DBS) as a registrar at Sydney’s North Shore Hospital and I was hooked,” he said.

“Stereotactic and functional neurosurgery greatly appealed to me because it is the area of neurosurgery where we work directly with the micro-circuitry of the brain.

“It is also an area of neurosurgery where disabling conditions are routinely and quickly improved resulting in very happy patients.”

Dr Jonker said patients undergoing MRgFUS are perhaps amongst the most satisfied.

“We have seen that patients who have had this new stereotactic procedure (MRgFUS) look ecstatic the following day - more so than with open surgery - perhaps because the process takes less out of them.”

Now, one-quarter of Dr Jonker’s practice involves focussed radiation for brain tumours and focussed ultrasound for essential tremor with the remainder of his time spent in theatre doing more conventional open surgery, particularly providing DBS or excising tumours.

He said the new MRgFUS procedure involved placing the patient’s head into a stereotactic headframe which focusses high frequency ultrasound waves of 650kHz onto a tiny target and which uses water to control temperature because of the large amount of energy being used.

Using MRI imaging, the team locates the area of the thalamus which controls movement, then conducts a series of low-energy tests to assess the functional impact of the treatment before increasing the ultrasound waves to burn a lesion of between two and three millimetres.

“Essential tremor is caused by a derangement in some of the movement control circuits travelling through the thalamus,” Dr Jonker said.

“Essential tremor is caused by a derangement in some of the movement control circuits travelling through the thalamus (and) by creating a tiny lesion, we can block the signals causing the tremor.”

“By creating a tiny lesion, we can block the signals causing the tremor.

“The most common risk in terms of side-effects is some initial unsteadiness but the risk of brain haemorrhage with this procedure is thought to be close to zero.

“However, trials have shown that the risk of an adverse outcome rises substantially if we treat both sides of the brain which means that if a patient has tremor in both hands, we will treat only one side – usually the dominant hand.

“This also means that we cannot use this technique for people with a head or voice tremor or where we want to treat tremor on both sides and in those cases we would typically use DBS.

“So far, we have had great success in the patients we have treated which is wonderful for them and for people with essential tremor in Australia.”

Dr Jonker said the team at St Vincent’s were now in the process of designing research projects based on the new procedure.

He said the machine used also offered an exciting range of future treatment possibilities. He said it had the capacity to break the blood-brain barrier which could revolutionise the delivery of drug therapies to treat brain tumours or even Alzheimer’s disease.

He also said that advances were being made across a range of neurological conditions including brain machine interfaces such as research into devices which could be implanted to help restore sight to the blind.

Proudly sponsored by Medtronic
General surgery Trainee breaks barriers

Final year general surgery Trainee Dr Helen Ballal initially came to Australia from England during maternity leave to visit her husband who was completing a Fellowship in Upper GI surgery at Freemantle Hospital. However, the big blue skies, beaches and beauty of Western Australia created such a stark contrast to the darkness and cold of English winters that nine years later she is still here. Now, she has four children with her husband Mo Ballal, has obtained permanent residency and hopes to receive her FRACS later this year.

Dr Ballal received her medical degree at the University of Newcastle Upon Tyne, before completing her basic surgical training at the Mersey Deanery, Liverpool. She then began MD research (PhD equivalent) at the School of Cancer Studies at the University of Liverpool, evaluating the biological pathways of response to chemotherapy in breast cancer which she finished last year.

Between her arrival in Perth in 2010 and the start of her Australian surgical training in 2014, Dr Ballal worked as a Breast Fellow at the Sir Charles Gardiner Hospital while she waited to gain permanent residency. By the time she was accepted into the RACS Surgical Education Training program, Dr Ballal was the busy mother of four children aged under six years.

“I came to Australia for a short visit with my husband during maternity leave with our first child and stayed,” she said.

“It wasn’t easy when I began training – we had to make the decision to outsource whatever could be outsourced and our family life requires a lot of planning and organisation – but we’ve been extremely fortunate to have the help of wonderful baby-sitters and nannies.

“Perth is so beautiful – it was just too hard to leave.”

Currently, Dr Ballal is finishing the last of her general surgery rotations at the Fiona Stanley Hospital, the Royal Perth Hospital and the St John of God Murdoch Hospital. She plans to specialise in breast and endocrine surgery after receiving her FRACS.

“My career dedication has always been to breast and endocrine surgery, an interest that extends from theatre to the research laboratory,” she said.

“My MD research was entirely laboratory-based and involved doing real-time Polymerase Chain Reaction, genetic cloning and sequencing of DNA.

“I have a great interest in this field because the biology of the disease is fascinating and there is so much we still don’t know such as why various cancers behave in different ways.

“I also enjoy getting to know my patients, many of whom we can successfully treat now, and I’d like nothing more than to combine both aspects by undertaking translational research so that I can act as a bridge between the bench and the bedside.”

Dr Ballal said while she had received great support from colleagues and other surgeons since she arrived in Australia, she believed there was still more work to be done by various stakeholders to make surgical training easier for mothers.

“More needs to be done to make pregnancy and maternity leave a positive, viable option for Trainees,” she said.

“I’ve seen some women come back to work too soon after having a baby because of training schedules and I believe there needs to be more flexibility around this so that Trainees are not made to feel that a pregnancy is an inconvenience to be overcome.

“Hospitals also need to provide more flexible training places if they are serious about making surgery an attractive career choice for more women.”

Dr Ballal is one of only a few female Muslim surgical Trainees currently working in Australia. She wears the hijab during ward rounds – to the surprise of some patients – but not when she is scrubbing.

“It has become easier to wear the Hijab in Australia but it does make you stand out,” she laughed.

“I don’t wear a scarf or long-sleeved garments when I’m operating so patients can get a surprise when they see me in my usual clothes.

“My career dedication has always been to breast and endocrine surgery, an interest that extends from theatre to the research laboratory,” she said.

“Hopefully, that has already happened and I can say without hesitation that I have never experienced any obstacles from the College or senior Fellows because of my religion or dress.”

“I do face some casual racism at times from patients but hopefully by giving them good surgical care, I can break down some prejudices and open some minds.

“Hopefully, that has already happened and I can say without hesitation that I have never experienced any obstacles from the College or senior Fellows because of my religion or dress.”

Dr Ballal said that while the mass shooting at the Christchurch mosques earlier this year had been cause for deep sorrow for Muslims around the world, she had received great kindness from colleagues and friends across Perth.

“It was very warming to find people wanting to reach out and show their support for me afterwards so at least some good has come out of such a horrible tragedy, even on just a small personal scale.”

Dr Ballal said she hoped to apply for a Breast Reconstruction Fellowship next year after she received her FRACS in July.
A team of Melbourne surgeons has recently conducted a rare series of procedures - using advanced 3D imaging and printing technology pioneered in Australia - to repair the face and skull of a child born with an unusual and complex combination of craniofacial deformities.

Last year, the team of craniofacial and neurosurgeons treated toddler Jack Kalangis who was born with a life-threatening fronto-ethmoidal encephalocele and a malformed skull that was too small for his brain – a condition known as a micro-cranium or microcephaly.

The team from the Royal Children's Hospital (RCH) in Melbourne knew immediately upon the child's arrival from Vanuatu that they could not treat the brain herniation – a fairly rare procedure – until the toddler's skull had been enlarged.

However, they wanted to treat him fairly quickly to release the pressure building up behind the herniation, as revealed by x-rays and MRI scans.

Using three-dimensional scans to create a replica of Jack's skull, they designed a posterior cranial vault expansion to give Jack's brain more space. They also planned the second-stage reconstructive procedure to remove the herniated brain in a few days.

The team was led by Professor Tony Holmes who worked alongside the RCH's Craniofacial Surgery Section Chief, Dr Jonathan Burge, and neurosurgeon, Dr Alison Wray.

In August last year, Dr Burge and Dr Wray began the process of expanding Jack's skull by mobilising the entire bones comprising the back of his head and then realigning them with expandable metal screw devices, known as distractors, at each side of the skull.

The distractors, used to lengthen the skull bones, were turned each morning and night to create a tiny 1.2 mm gap each day, slow enough to allow for new bone growth to occur during the process known as osteogenic distraction. After almost a month, Jack's head had expanded by the necessary 3cm required to give him enough brain space and allow for the encephalocele to be repaired.

Then, in November, Professor Holmes, Dr Burge and Dr Wray dissected and mobilised the orbits and the anterior skull at the top of the child's face to display the internal path of the herniated brain. The abnormal external skin and neural tissue was removed from between the eyes and the nose. Dr Wray then replaced the herniated brain back into the dural covering and delicately sealed it off before the others began the complex reconstructive surgery.

In a combined procedure that took 14 hours, the craniofacial surgeons lowered, reshaped and narrowed the orbital bones to cover the opening left by the encephalocele. The forehead, which had been deformed by the brain herniation, was reshaped and secured. Extra bone from the skull was used to rebuild the nose.

Speaking to Surgical News, Professor Holmes described this rare and complex procedure as a great success.

He said that an extensive review of literature had found no other cases presenting with Jack's unusual combination of inadequate head size associated with this type of encephalocele. Usually a small head is associated with poor or inadequate brain development which was not the case with Jack.

We've been conducting complex craniofacial reconstructive surgery at RCH since 1979, but Jack is the first to come to us with this pattern of malformations.

“We’ve been conducting complex craniofacial reconstructive surgery at RCH since 1979, but Jack is the first to come to us with this pattern of malformations.”

“We’ve been conducting complex craniofacial reconstructive surgery at RCH since 1979, but Jack is the first to come to us with this pattern of malformations,” Professor Holmes said.

“We knew we had to expand the skull first to prevent any inpatient pressure before we could even begin reconstructive surgery.”

“We also needed to know exactly how best to conduct that surgery.”

Fortunately, some years ago, a Melbourne neurosurgeon, Dr Paul D’Urso, developed an interface which allowed digital data from high resolution CT scans to be read by a 3D printer to create accurate replica models of specific bone anatomy.

It was roughly 40 years ago since the first CT scanners, and high resolution scanners only developed in the late 80s. Highly accurate 3D printing of biomodels (stereolithography) developed in the early 90s and Paul’s research was at the forefront. Back then, Paul printed out a resin model for us of a patient's skull which was very similar to Jack’s.

“We operated on the model first and realised exactly what we needed to do to get the optimal aesthetic and functional result. The subsequent patient surgery worked extremely well and for many others over the years. Paul tells me that our initial procedure was the first craniofacial operation specifically designed with a 3D model that was so accurate.”

“Dr Burge and I operated on a similar model of Jack’s face and skull to design his reconstructive procedure. It seems fitting that the technology pioneered in Australia has been used again for Jack’s unusual case.”

Professor Holmes, AO, established Melbourne’s first Craniofacial Unit in 1979 upon his return from post- Fellowship training at Harvard Medical School and he remained head of the unit until 2009.

He was the Director of RCH’s Department of Plastic and Maxillofacial Surgery from 1990 until 2002. In 2012 he was the inaugural Harvard Plastic Surgery Residency Visiting Professor in Boston.

Professor Holmes has trained more than 35 craniofacial Fellows and in 2001 he and his RCH colleagues published a paper in the Journal of Craniofacial Surgery which remains a benchmark for correcting these types of encephaloceles. The refinements of correction described were mainly developed with the use of 3D models.

Professor Holmes said frontal ethmoidal encephaloceles were caused by a failure of the front end of the neural tube to form properly and close during early foetal development.

He said he treated around one or two children each year with anterior encephaloceles – mostly from the South Pacific and South East Asia – but none with such complex surgical needs as those presented by little Jack’s particularly small head.

“These encephaloceles can be life-threatening because a simple bump, cut or accident can easily penetrate the thin layer of skin covering the brain and there is no protection against infection,” Professor Holmes said.

“However, Jack was the first time we have seen a frontal encephalocele patient with early signs on scans showing extra pressure building up in the cranial cavity because of his micro-cranium.”

Professor Holmes paid tribute to Dr Peter Howe, a specialist craniofacial anaesthetist, who kept Jack stable through the long procedures.

“Our specialised crew, both in the operating theatre and the ward, are outstanding; Craniofacial Surgery is a team event,” he said.

“This year is the 40th birthday of the Craniofacial Unit at the RCH and I can’t think of a more fitting way to celebrate than to have completed such a successful and unique craniofacial reconstructive procedure,” he said.

Jack and his mother were brought to Australia by the Children First Foundation and the 3D models of his skull were created and donated to the RCH by Anatomics. The distractors were donated by KLS Martin Australia.

Professor Holmes said that while Jack’s brain had developed slightly abnormally due to the malformations of his central nervous system and his skull, he was now meeting all his normal developmental milestones and was safely back in his small island home.
Update from Queensland

Dear Colleagues, as I hand over the role of Chair to Professor Deborah Bailey in May, this may be my last duty as State Chair in Queensland. I present to you the program for this year’s Queensland State Conference. The State Conference will be held at the Sheraton Grand Mirage Gold Coast on 12-14 July 2019.

As in previous years our conference is synchronised with the Queensland State Surgical Forum on Friday 12 July, finishing in the mid-afternoon to be followed by the finals of the Neville Davis and RACS Papers prizes. The quality of these papers in recent years has been outstanding. It is a credit to the growth in realisation of the value of research and integration.

The program for the Queensland State Surgical Forum is still being finalised by the Surgical Advisory Committee. Included will be a presentation by Professor Russell Strong on our recent Surgical History. This will be complemented by presentations and discussions on future directions in Quality Improvement with particular regard to NSQIP (National Surgical Quality Improvement Program) and GIRFT (Getting It Right First Time) – a new initiative from Queensland Health and a Ministerial priority for 2019. This was recently presented to a number of facilities in Queensland by Professor Tim Biggs from the United Kingdom. There will also be a presentation from Professor David Fletcher on the Role of Surgical Directors.

The Conference theme on the Saturday and Sunday is the “Life Cycle” of a Surgeon from Student/Intern years through to Senior Surgeon and Retirement. There will be presentations and discussions on the numerous roles played and challenges faced in a Surgical Life. These range from flexible/alternative training models to the challenge of Professional Accountability and Assessment of Surgical Performance.

A number of thought-provoking presentations are planned:
- Dr Rupert Sherwood, RANZCOG – “The ageing surgeon. Other highlights include sessions 2 and 5. Session 2 focuses on competency based and flexible training with a number of practical examples on flexible training models being presented. Session 5 will look at the complex areas of surgical performance, surgical behaviour and accountability.

Additionally, the David Theile Lecture will be given by Associate Professor Barry O’Loughlin and Dr Neil Wotzing will be our Honoured Guest. Both are surgeons who have had a substantial impact on surgery here in Queensland and abroad.

Colleagues, I urge you to attend your own Queensland State Conference as well as the Queensland Surgical Forum on Friday 12 July. Please also support the presenters in the Neville Davis and RACS Papers Competitions.

Further information on the conference can be found at www.surgeons.org/qld

Dr Brian McGowan (Chair, Queensland State Committee)
**“Kids and Quad bikes don’t mix.”**

_Sadly, on 13 April this year, a 9-year-old boy in Sandford, Tasmania died when his quad bike rolled on top of him. The same day a 7-year-old boy in Dingo, Western Australia died from the same injury._

Over the past ten years, 700 children have presented to Victoria emergency departments with quad bike injuries. This means a child quad bike injury every five days. Many of these children will have life-long disabilities from these accidents.

Updated Safe Work Australia quad bike fatality data is now showing three out of six recorded fatalities in 2019 are children under 16.

Quad bikes were known and advertised as all-terrain vehicles (ATV). They appear to be safe, and they are easy to operate. However, the facts and research suggest otherwise:

- Quad bikes are inherently unstable vehicles at low and high speeds.
- A bump of only 10 cm at low speed can cause a roll-over, such is the instability of quad bikes.
- Children lack the cognitive ability of safe decision making to ride these vehicles safely.
- Children lack the physical strength and size that is recommended to control a quad bike.
- Quad bikes are not suitable for all terrains. More than one third of quad bike fatalities occurred on terrain where an incline was noted. Over 50 per cent of fatalities occurred on uneven ground.
- Over 60 per cent of fatalities involve a roll-over.
- Only 10 per cent of quad bike fatalities were known to be wearing a helmet.
- Almost 50 per cent of fatalities occur when the bike is not being used for work.
- None of the fatalities mentioned any form of rollover protection on the vehicle.

There are no regulations or restrictions on use of quad bikes on private properties in Tasmania. A Tasmanian coronal inquest in 2016 conducted by Coroner Simon Cooper into seven quad bike related deaths in the state between 2012 and 2015 recommended:

- Mandatory training and licensing for all quad bike users.
- Use of suitable helmets.
- Banning the use of adult quad bikes for those under the age of 16.
- Banning the use of youth bikes for those under the age of 6.

Unfortunately, none of these recommendations have been implemented. The report has been shelved and the Tasmanian government is now awaiting a review of the recent Australian Competition and Consumer Commission investigation report.

Simple steps can be taken to reduce the morbidity and mortality of quad bikes:

- Children under the age of 16 do not ride quad bikes.
- Wear a helmet.
- Mandatory training in how to use a quad bike.
- Critically assess whether a quad bike is the right vehicle for the job.
- Education and increased awareness that rocky, steep, uneven, sandy or muddy terrain greatly increase risk of quad bike rollover.

Sadly, whilst we wait for legislation to be passed, it is only a matter of time before another child dies riding a quad bike.

In Tasmania, members of the RACS community have been active in the media and lobbying state politicians to act. I would encourage you to share these facts with your newly elected member of parliament.

**References:**

* A national unit of competency (AHCMOM212A Operate Quad Bikes) has been developed and over 250 RTO Australia wide are authorized to deliver this training.


*Quad bike injury is unstable and not suitable for all terrain*


Mr David Penny
Chair, Tasmanian State Committee

Update (31 May): NSW Coroner recommends introducing criminal charges for allowing children to ride adult quad bikes. — Ed.

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**Surgical News**

**Breast conservation treatment realised potential for Asian women**

Despite increasing evidence that breast conservation treatment (BCT) may be more successful than mastectomy in terms of breast cancer survival in both Western and Asian populations, its potential has yet to be realised in Asia.

It has been thought that Asian women’s smaller breast tissue volume may have been a barrier to BCT, especially for tumours bigger than 2cm. Despite the ability of such approaches as neoadjuvant therapies to reduce the size of tumours and enable BCT, BCT rates reported in South-East Asian centres continue to be markedly lower than elsewhere.

A study was carried out at a Singapore hospital who underwent surgical treatment for breast cancer between 2009 and 2011. Results indicate that BCT is possible for a much higher proportion of Asian women with breast cancer and should be the treatment of choice.

Full article in ANZ Journal of Surgery (Volume 89, Issue 5):

**Simultaneous knee replacement as safe as single or staged – NZ study**

Analysis of information from the New Zealand National Joint Registry (NZNJR) has found that simultaneous bilateral knee replacement surgery is as safe as either single or staged bilateral procedures.

A key concern around single-anasthetic bilateral total knee replacement surgery (SAEITKR) is the reported risk of cardiovascular, thrombo-embolic and wound complications, and increased mortality.

The study found that SAEITKR patient outcomes, in terms of mortality and revision risk, compared favourably with outcomes for patients undergoing unilateral TKRs. Patients selected for SAEITKR were younger, more likely male and fitter.

The study also found patient survival rates were higher when performing staged bilateral TKR when the second procedure was performed more than 90 days after the first.

Full article in ANZ Journal of Surgery (Volume 89, Issue 5):

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**Coming soon…**

**Improvements to the CPD Program**

As part of RACS commitment to deliver education that supports best practices in surgical care, we are reviewing your CPD program.

Change is coming to CPD, driven by our ambition to deliver a flexible CPD program that supports you across all stages of your surgical career.

RACS is now working collaboratively with specialty associations, societies and sections to deliver an improved CPD program that meets your learning needs and provides you with an intuitive and streamlined experience.

We’ll keep you up to date on our progress in the coming months and will be seeking your feedback along the way. Keep an eye out for regular updates in Surgical News, Fax Ments and the RACS website.

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**SURGICAL SNIP**

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**FRACS who in April presented a fresh look – How a virtual museum can inform the public and historic lectures.**

Australasian College of Surgeons for their ongoing fundraising efforts in support of the Foundation for Surgery.

**RSVP**

foundation@surgeons.org

by 5 June

Thank you to David Kaufman FRACS who in April presented A fresh look – How a virtual museum can inform the public and historic lectures. Of interest was how RANZCO’s virtual (online) museum helps to inform the public through audio and video interviews, presentations, posters and historic lectures.
Securing healthy futures

Developing surgical skills within local communities is one of the greatest challenges, yet most important priorities of the Foundation for Surgery’s global health work. Our commitment to this crucial goal means that we must begin to hand over our largest lifesaving health program in Timor-Leste to our local teams.

Since 2000, through the generosity of you, our Fellows, we have been able to train and equip local doctors, nurses and health workers, including Timor-Leste’s first six general surgeons, to meet the urgent needs of their Timorese communities.

Our impact on the healthcare system in Timor-Leste has been immense: 12,282 Timorese adults and children have received life-changing procedures, and a further 117,590 consultations have been completed thanks directly to your generosity. This is an incredible achievement, but we must keep going. A staggering 10,000 Timorese could have their blindness reversed with simple eye operations which our local teams across the Pacific, if properly resourced, could perform.

Our work to date in Timor-Leste has set the groundwork for a strong, sustainable future for healthcare in this young nation. However, we risk losing many of the gains you have helped achieve if we are unable to complete our hand over to local staff within our 12-month deadline. The lives of so many will rest on how robust our largest program is when it graduates to a sustainable local-run entity in 2020.

Please support the Foundation for Surgery and Pledge-a-Procedure. That is, make a tax-deductible donation of the proceeds from just one of your most common major operations before June 30. Alternatively, giving a one-off donation will make a lasting difference. Your support will enable the training of more doctors and health workers so they have the skills to meet the health needs of the nation, as well as family health workers to provide services in remote parts of the country, the provision of specialist medications required to treat disease and infection, and the means to set up a steady supply of pharmaceuticals and equipment.

It would be devastating if these crucial final steps were left untaken or lost for lack of funds. This is an issue that goes right to the heart of our commitment as a profession to care for those in great need. Please respond with the same compassion you have always shown toward those in need.

As you know, unlike other charities, 100 per cent of all donations to the Foundation for Surgery address critical surgical need, so your support can achieve maximum impact in the community. All costs for administering the Foundation for Surgery are provided for by RACS, so that every dollar of your precious donation can go where it is needed most.

Donating is very simple. Please go to www.surgeons.org/foundations to donate and get an instant tax receipt, or complete and return the flysheet form attached to this edition of Surgical News. This simple act will have an enormous impact on the future of Timor-Leste.

Alternatively, if you would like to make a more substantial personal contribution or even establish your own scholarship, please contact Jessica Redwood, Manager, Foundation for Surgery, on +61 3 9249 1110.
A shared endeavour: RACS invests in partnerships to support cultural change

The increasing evidence base linking patient safety and professional conduct was the focus of recent workshops with some of our important health sector partners.

Professor Jerry Hickson of Vanderbilt University, a world-expert on the link between professionalism and patient safety and long-time adviser to RACS, shared his insights and recent research with some of the hospitals, Specialist Colleges and jurisdictions committed to building a culture of respect.

Professor Hickson’s interactive presentation talked about the impact of the Vanderbilt model of professional accountability and experience and how it can support behaviour change. He made the case for employers and RACS to continue to work together, including towards information sharing.

Across two workshops, RACS provided a forum for our partners in hospitals and health services, colleges and other agencies to share ideas about what works, and discuss obstacles to our collective efforts to support cultural change.

A hot topic was complaints management, with discussion focusing on the optimal roles for employers and colleges, and how best to balance effective and timely complaints management and information sharing with fair processes and privacy constraints.

Focusing on patient safety, RACS continues to refine its approach to complaints management. Incrementally, we are working to build an effective and safe complaints process that keeps patients safe and supports individual surgeons to change their behaviour and work towards increased professionalism.

Partners at the workshops shared insights and experiences and explored how a range of tools, including policy change, credentialing and employment contracts, can be used to address historic limitations in information sharing between agencies. We also heard from regulators and lawyers, and the workshop drew on the latest evidence and practices from the United States.

More broadly, workshop participants examined the various strategies being used by employers and colleges to support professionalism and improve patient safety.

A sustained, multi-faceted approach includes investment in leadership, mentoring, policy support, communication and training, all of which have a role in increasing professional accountability.

Immediate RACS past President John Batten reflected on our ‘shared endeavour’, when many agencies have a shared commitment and different roles in helping build a culture of respect.

Our Action Plan: Building Respect, Improving Patient Safety maps out a long term plan to help build a culture of respect in surgery. The College welcomed the opportunity to collaborate and work in partnership towards this shared goal.

RACS is well recognised across the health sector for our work to build respect and improve patient safety, and public opinion is aligned with our efforts to build a culture of respect.

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Across two workshops, RACS provided a forum for our partners in hospitals and health services, colleges and other agencies to share ideas about what works, and discuss obstacles to our collective efforts to support cultural change.

A hot topic was complaints management, with discussion focusing on the optimal roles for employers and colleges, and how best to balance effective and timely complaints management and information sharing with fair processes and privacy constraints.

Focusing on patient safety, RACS continues to refine its approach to complaints management. Incrementally, we are working to build an effective and safe complaints process that keeps patients safe and supports individual surgeons to change their behaviour and work towards increased professionalism.

Partners at the workshops shared insights and experiences and explored how a range of tools, including policy change, credentialing and employment contracts, can be used to address historic limitations in information sharing between agencies. We also heard from regulators and lawyers, and the workshop drew on the latest evidence and practices from the United States.

More broadly, workshop participants examined the various strategies being used by employers and colleges to support professionalism and improve patient safety.

A sustained, multi-faceted approach includes investment in leadership, mentoring, policy support, communication and training, all of which have a role in increasing professional accountability.

Immediate RACS past President John Batten reflected on our ‘shared endeavour’, when many agencies have a shared commitment and different roles in helping build a culture of respect.

Our Action Plan: Building Respect, Improving Patient Safety maps out a long term plan to help build a culture of respect in surgery. The College welcomed the opportunity to collaborate and work in partnership towards this shared goal.

RACS is well recognised across the health sector for our work to build respect and improve patient safety, and public opinion is aligned with our efforts to build a culture of respect.
In recognising the learning needs and the importance of surgical education exposure for Trainees, RACS sponsored a group of Trainees to the International Medical Symposium (IMS) 2019 in Auckland on 22 March. Following an application process, the Trainees below were selected for the sponsorship. Below details their experiences at the symposium.

Dr Doruk Seyfi
(SET 1, General Surgery, NSW)

IMS 2019 provided perspective of how artificial intelligence (AI) systems are being refined, that both government and private industries are investing heavily into research and development. The speakers described how AI could be used for image abnormality detection, where we can teach a system to recognise abnormalities on retinal photographs or plain film radiographs. However, the underlying clinical reasoning behind the investigations and how those investigations have led to certain management decisions are well and truly beyond that of AI systems in their current state.

The idea of integrating AI systems in the medical records has excellent potential and teaching a system to document on behalf of clinicians would allow us to focus more on the patients rather than the underlying IT in clinical practice. The idea of having AI systems in multi-disciplinary meetings to assist with objective, patient-individualised, evidence-based decision-making was also discussed. AI systems could provide perspective on the current literature during an MDT meeting where decisions are being made for each patient. However, despite these few examples of AI systems’ clinical utility, we must remember that the output information provided to clinicians is only as good as the information the system has received, thus highlighting the importance of good quality data sets and algorithms at interpreting this data. We also need clinicians to understand how AI systems make decisions so quality assurance can be maintained and their reliability and consistency guaranteed.

Dr Ella Darveniza
(SET 2, Plastic & Reconstructive Surgery, NSW)

IMS 2019 highlights included several presentations on AI and the use of simulation to improve our outcomes. These examined the way in which technologies are changing the way we interact with patients and with each other. They highlighted the benefits we can reap from emerging technologies, but also the dangers that they may bring. Patients are keen to embrace technology and they will drive change in our industry. We must be ready to embrace these changes and develop ways in which they can be utilised to best serve our patients.

Finally, it was a very sad but poignant time to be in New Zealand, exactly one week following the Christchurch massacre. The symposium was put on hold to watch the call to prayer ceremony and mourn with the local people, who have responded to the tragedy in such an inspiring manner. It was particularly humbling to talk to some of our surgical colleagues who were directly involved in the care of those who were injured.

Dr Hari Haran Ramakonar
(SET 6, Neurosurgery, WA)

The keynote presentation regarding the influence of artificial intelligence and its expansion into healthcare was extremely eye opening. Particularly the use of artificial intelligence (AI) in diagnostic medicine in areas of how it is impacting areas such as radiology and pathology. It was interesting to see how the radiology college was integrating AI into their training - particularly how to effectively integrate it into their practice. As to how this is affecting learning and my surgical training, this is a difficult question to answer. I am sure that AI will come more into play throughout my career and I will certainly be more cognisant of its upcoming influence.

Being involved in an international multidisciplinary conference was very fruitful. At my table it was great to interact with physicians, surgeons, psychiatrists and anaesthetists. Furthermore, these colleagues were from Canada, New Zealand and Australia. This provided international and multidisciplinary experience and perspectives. These colleagues were at different stages of their career, with some who had retired, some in the middle and others just at the start of their career. It was great to see such a keen interest in training and education.

Dr Brayden March
(SET 1, General Surgery, NSW)

Artificial intelligence (AI) will inevitably become part of daily clinical practice. In its current task and context-specific capacity, AI may be used to accurately analyse images from a variety of clinical settings (notably radiology, pathology, dermatology and ophthalmology). The future possibilities for more advanced AI technology are exciting, but ethical and regulatory issues need to first be identified and carefully considered. Optimising patient-doctor consultation workflows and synthesis of evidence-based treatment recommendations for MDT meetings are two areas I hope AI will have a dramatic impact in future. Trainees should be aware that AI is still a developing technology and remains to be vetted by rigorous clinical trials. As the technology matures, we must be wary of our inherent inclination to trust technology (automation bias), potential risks implementation of such technology may pose to patient safety, and the medico-legal issues created by AI in healthcare.

Dr Melanie Crispin
(SET 2, General Surgery, VIC)

IMS 2019 was a fantastic conference, focusing on technology in medicine and surgery. An overall theme of the day was unity and inclusivity. After that, the keynote speaker Professor Enrico Coiera brought us up to speed with the current climate of machine learning and artificial intelligence (AI). His research and insights taught us that AI and the use of simulation to improve our outcomes. These examined the way in which technologies are changing the way we interact with patients and with each other. They highlighted the benefits we can reap from emerging technologies, but also the dangers that they may bring. Patients are keen to embrace technology and they will drive change in our industry. We must be ready to embrace these changes and develop ways in which they can be utilised to best serve our patients.

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The Windsor dynasty

Part Two: The inaugural Henry Windsor lecture presented by Harry Windsor

Following on from my introduction to the Windsor dynasty in the March/April issue of Surgical News, I now present a paraphrased synopsis of the inaugural Henry Windsor lecture which was presented by Harry Windsor himself at the RACS meeting in Brisbane on 17 October 1970.

Harry’s lecture provides us with a comprehensive story of his surgical development – it is too important a topic to be hidden in the archives of the Medical Journal of Australia July 1971.

The lecture contains the principles of surgery as gleaned from the experience of a great surgical mind. These principles are still quite relevant to RACS as the sole surgical educational body in Australia and New Zealand.

Harry begins his lecture emphasising the importance of reading, as inculcated in him by his father, and comments that writing is inseparably linked to an important educational contribution.

He reflects on the Johns Hopkins Hospital and its Welsh Medical Library painting of four eminent medical figures: Welch – the great pathologist of the late 19th century and America’s first medical statesman, Kelly – the outstanding gynaecologist and innovator, Halstead – the eminent surgical thinker, and Osler – the inspirational teacher. One should read their histories and how their work still has relevance today.

Harry cites the works of French vascular pioneer Alexis Carrel who gained the Nobel Prize in 1912 in Medicine – the inspirational teacher. One should read their histories and how their work still has relevance today.

To Publish or Perish – this trite phrase as we know it is bandied around from pillar to post. The phrase was initially included in a book by Coolidge, Life and Letters in 1927. On another issue Harry comments on the academic outcome of a surgical graduate, “where those with brilliant personalities of surgery. He reflects on the Semmelweiss story – how he popularised the use of lime solutions to sterilise the hands, in the mid 19th century. Students at the Vienna General Hospital’s Obstetrical Clinic were reputed to have gone directly from working in the mortuary to delivering babies in the obstetrical ward in the same clothing. A mortality rate of up to 15 per cent of mother and babies reflected the failure of simple cleanliness. The patients thus preferred having confinement at home or even in the street, they say rather than being exposed to lethal complications.

Despite reducing the mortality rate in this clinic by 90 per cent by introducing the lime wash, Semmelweiss struggled against the establishment and the odds even tragically failing to be reappointed to the hospital staff. He has since earned recognition as an early pioneer of antiseptic procedures.

On the local scene, Jerry Moore, the first Plastic surgeon in Australia, who grew up in Queensland, likewise improved the mortality rates in the 1990s for abdominal surgery. He reduced the figure from 90 per cent of 10 per cent at the Royal Melbourne Hospital.

Harry concludes his lecture by saying that the status of a surgeon is a mixture of the teachings as organised by the College, and the value of personal experience to be conveyed to the younger person to complete their education. Recognising the rewards for contributing to the public health system of inestimable value, he refers with ‘young’ minds – continuing to teach. This reinforces the Osler comment ‘walk with a young brigade’ and then Bichat also said the ‘young’ fellow worker is a self-evident force.

Yes, RACS is an educational body, but it alone can not convey experience – the essence of life in a surgical dynamic.

Harry goes on to discuss courage reflecting on the need for resilience in the face of clinical setbacks. He quotes amusingly Lord Brock’s statement, “if you haven’t suffered, somebody else has done it for you – the patient or the surgeon”.

I used to have a rule in surgery myself that if a setback occurs and the complication arose I would attempt to correct the problem but repeat the gesture only on one more occasion – this failed I would seek a second opinion.

Harry Windsor refers to the Semmelweiss story – how he popularised the use of lime solutions to sterilise the hands, in the mid 19th century. Students at the Vienna General Hospital’s Obstetrical Clinic were reputed to have gone directly from working in the mortuary to delivering babies in the obstetrical ward in the same clothing. A mortality rate of up to 15 per cent of mother and babies reflected the failure of simple cleanliness. The patients thus preferred having confinement at home or even in the street, they say rather than being exposed to lethal complications.

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Harry, describes these events, reflecting how such courage entices the development of truth and if one is persistent the value of educational improvement is self-evident.

On another issue Harry discusses historically the great personalities of surgery. He quotes Napoleon’s surgeon; Larrey, who survived 26 Napoleonic campaigns. Dominique-Jean Larrey (who

Academic gown donation

RACS would like to acknowledge Dr Ken Merten, for generously donating his academic gown to the College. RACS maintains a small reserve of academic gowns for use by Convocating Fellows and at graduation ceremonies at the College. If you have an academic gown taking up space in your wardrobe and it is superfluous to your requirements, RACS would be pleased to receive it to add to our reserve. We will acknowledge your donation and place your name on the gown if you approve.

If you would like to donate your gown to RACS, please contact the Conferences and Events Department on +61 3 9249 1248. Alternatively you could mail the gown to Ms Ally Chen c/o Conferences and Events Department, Royal Australasian College of Surgeons, 250-290 Spring St, EAST MELBOURNE, VIC 3002.
Another day at the office

B ut it wasn’t really. My usual Wednesday morning consulting session was cancelled. After all, I did not want any more work. I had a leisurely stroll up the Red Arrow, the much loved walk up the hill overlooking the airport in a light drizzle, and on the way down marvelled at a perfect rainbow with my city apartment perched in the middle of it. Cairns, this lovely little city, where the rainforest meets the sea, is full of these surprises. An apple for breakfast, and an orange for lunch. I had examples around me of surgeons that framed this analogy with surgery?

Anyway, and so to the hospital for my last operating list. Routine, nothing special. Gall bladders, hernias, and to bring things to a fitting conclusion, a set of piles. A few colleagues dropped by to wordlessly shake my hand, and I shared a gigantic chocolate cake for tea with wistful colleagues dropped by to wordlessly shake my hand, and I shared a gigantic chocolate cake for tea with wistful nurses who I had known for 20 years. I found myself thinking, “I will never do this again” as I turned she was when she understood what this meant. I must have been about ten when I was practise bowling in the garage. Frank Tyson was on everyone’s lips at the time, and I was trying to imitate his action. I understood that his front leg was high just before the point of delivery and he generated his pace by bringing it down vigorously. I repeated this and brought my foot down on a patch of oil on the cement, crashing down. When I recovered my wits my right forearm was bent just short of a right angle. I went inside supporting my crooked forearm and found my mum. Her comment, as she reached for the telephone, was that I had better learn to bowl spin.

I was taken to see a surgeon who had orthopaedic interests. He glanced at my forearm and the x-rays, and looked at me, “we can’t leave it like this, can we?” I was not so sure but woke up in a cast some hours later. The forearm is still a bit bent, it perfectly functional. I could have become a spin bowler after all?

So, what was all this about? The furrowed brow, the appraising gaze, the measured discussion, conclusions made confidently but kindly. Unquestioned confidence and competence. But personal responsibility clearly taken; the overwhelming impression of someone who could make a difference. What I took from this is that notion of personal responsibility. It burdened and marked takers but was a blessing to receivers. In the course of my career, this notion has changed, and the zeitgeist now in increasingly complex systems is necessarily of “platoon, rather than cowboy” where “systems” seek to diminish both risk and autonomy, and leave personal responsibility in an uncertain place. In the small hours of the morning in large hospitals worldwide these issues are regularly played out. I am re-assured that the surgeons here that I know, handle these challenges well. But for all surgeons the distance between habits and nemesis remains the matter of an unguarded moment.

So, off to medical school in Dublin I went. In Catholic Ireland the men were separated from the women in these ancient lecture theatres in the first two years. This rule was relaxed in the third year with the women were distributed through the class on the basis of their initials. Most of the women promptly married the gentlemen next to them. An accomplished Australian (Caroline D for Downes) sat next to me, and after a few years we did the decent thing and got married, going on to have seven children who we dragged around the world with us, while we fitted in specialist training. We did our internships in Papua New Guinea (where I first met Ken Clezy, whose example I have long since tried to emulate) then back to Ireland and the UK for further training, returning to Port Moresby as Senior Registrars. By then, 1982, it was clear that the wheels in Port Moresby were falling off and we had no future there; so we headed for Australia. My first job was in the Kimberley based in Derby. It was a rich and memorable period, where I learned for the first time the dramatic beauty of the Australian bush. But I also learned about the difficulties associated with provision of services in remote locations and in Indigenous communities. I returned to Sydney in 1983 as one of the foundation surgeons of the new Mt Druitt Hospital. We had an excellent group of surgeons from whom I learned a great deal. In late 1999 we made the decision to leave Sydney and go to Cairns, where I have practised since. Surgical practice in Cairns is never dull. I was a WMO in the Base Hospital and had a busy and varied private practice. My interests in Emergency and Trauma surgery were well catered for and I took a particular interest in surgical patients in our very good ICU. I joined James Cook University (JCU) in 2011 adding a third component to an already busy routine.

I retain my JCU appointment delivering an undergraduate surgical program and in the base hospital. I continue to direct and enhance our JCU Anatomy of Surgical Exposure (ASE) courses here in Cairns. There is considerable interest in developing these courses in Sri Lanka, where I maintain good contacts. I established a rotation of young Sri Lankan surgeons to Westminster Hospital while in Sydney (with John Fletcher) Alumns from this program are now in senior positions in Sri Lanka, and remain good friends who treasure their Australian experiences. Our undergraduates go to Sri Lanka with The New Colombo Plan arrangements and I participate in their supervision and contribute to their Surgical Departments. So, I have plenty to keep myself occupied and productive.

But my life as an operating surgeon has ended. Inevitably, a time for reflection. Have I been a good doctor? A good surgeon? The routine successes of surgical practice have blurred into a contented obscurity. The failures remain vivid, and their memory sharper than a serpent’s tooth. So the answer is; maybe.
RACS Scholarship Program: Measuring returns on investment

RACS, through the Foundation for Surgery and the ANZ Scholarship and Grant Program, is privileged to have the financial means to support talented surgeons keen to pursue research careers. Under the exemplary stewardship of Professor Kingsley Faulkner, the Foundation for Surgery in 2017 generated funds resulting in 31 research scholarships and grants, consisting of research and travel scholarships and grants with a total value of $2.3 million being offered for the 2017 scholarship year. Ranging from $10,000-$150,000 and spanning one to three and a half years, successful scholars are presented with the opportunity to pursue higher degrees fulltime without the burden or distraction of needing to supplement their incomes.

"RACS scholarships are more sought after (and difficult to obtain) by surgeons whereas NHMRC has more relevance for non-surgeons and career scientists.

Most scholars (93.8%; 45/48) felt supported by their supervisors believing that the mentorship they received was an important factor in their success. Equally vital was the availability of technical support and laboratory infrastructure for scholars focused on laboratory-based research. Crucially, they cited that their verbal (83.3%, 39/47) and written (77.8%, 29/38) communication skills had significantly improved. Furthermore, 57.1 per cent (28/49) of scholars had published in peer reviewed journals during their scholarship tenure. Another 34.7 per cent (17/49) had published following their scholarship (with 12 of the 17 scholars having achieved both). A total of 75.7 per cent (28/37) of scholars had established collaborations with other researchers within Australasia, and 59.5 per cent (22/37) had collaborations outside of Australasia. These international collaborations are encouraging indications that the scholars intend to continue career paths as academic surgeons.

In conclusion, the SEMC is pleased to report that the RACS Scholarship Program continues to provide tremendous value directly to research recipients, increasing their skills and capabilities. Indirectly, patients benefit as the volume of peer reviewed publications generated during and after scholarship tenure disseminates specialty relevant knowledge and provides a basis for improved disease treatment and management.


A very special thanks to all those who have donated to the Pledge-a-Procedure campaign and helped secure a healthier future for Timor-Leste.

We still have a long way to go to meet our goal, so please donate before 30 June at www.surgeons.org/donations/

Every donation during this campaign is matched by a generous Foundation donor and makes an incredible difference supporting the Timor-Leste program transition to independence. Let’s walk with them today.

To find out more, please join us at www.surgeons.org/foundation

The Scholarships Evaluation and Monitoring Committee (SEMC) ensures that each dollar disbursed to surgical research generates returns beyond its face value. The SEMC objectively measures the return on investment on each scholarship awarded on completion of the award by way of an in-depth annual survey. It measures both tangible and intangible professional and personal benefits enjoyed by the recipient.

Of the 50 scholars (49/50 responses, 98% rate) surveyed who received funding in 2014, 2015 and 2016, 58 per cent (29/50) were represented by General Surgery. The 2016 scholars were also surveyed on their perception of the value and prestige of RACS versus National Health and Medical Research Council (NHMRC) scholarships. The majority’s response was eloquently summarised and articulated by a respondent stating that “RACS scholarships are more sought after (and difficult to obtain) by surgeons whereas NHMRC has more relevance for non-surgeons and career scientists.”
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