SurgicalNews

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President's perspective

I will be handing over the presidency to Associate Professor Kerin Fielding in May 2023. I know that Kerin is excellent for this role, having worked across education and professional standards, and is particularly passionate about our strategic priorities, including serving our rural population.

During the last few years our communities have been through a series of crises in both countries: fires, floods, earthquakes, volcanic eruption, shootings, and of course the pandemic. We are also seeing the effects of climate change on our environment. These major crises have affected our surgical lives. Many surgeons were unable to work or worked less during the pandemic, with some specialties and regions more impacted than others. Thank you for being patient, adapting and learning during this time.

My presidency has spanned the pandemic with lockdowns and a period of no travel. In some ways it was a virtual presidency during my first year and then coming out of the pandemic during the second year with increased travel and in-person meetings. I appreciate that the pandemic has resulted in something I really wanted—our increased use of videoconferencing. That will stay with us now since many of our committee meetings simply require our attendance. However, we do value some personal contact where we meet and talk with each other and develop ideas far better. For me the latter has been meetings such as the Tri-nations conference in Sydney in March and the Council of Presidents of Medical Colleges (CPMC) in Australia and the Council of Medical Colleges (CMC) in Aotearoa New Zealand.

RACS is seen as a leader in the development of a respectful workplace culture. We are not alone. The other medical colleges are ready to look at cultural change as are other professions.

This leadership role has surprised me—it was unexpected, but I was prepared for it. I was well supported at home by my husband, sister, whānau (family) and friends, and in my mahi (work life) as a plastic surgeon by my plastic surgical colleagues and manager at Te Whatu Ora Waitaha. My personality and style have been to listen, understand, seek knowledge and be informed. I thoroughly consider things, pause and hopefully I am part of making good decisions. I have strived to live the RACS values and the aspiration described in our 2022 Building Respect, Improving Patient Safety Action Plan of being a compassionate, collaborative and inclusive leader for all.

It saddens me that I continue to hear of incidents of unprofessional behaviour—sexual advances, bullying, undermining, preferencing and microaggressions. We must bring these bad practices to a halt. We must look at ourselves and those we work with; speak up and lodge complaints or notifications with RACS and the hospital or relevant jurisdiction when we hear of or witness this. Have the 'cup-of-coffee' conversations. No one should feel uncomfortable anywhere, let alone the workplace.

RACS is seen as a leader in the development of a respectful workplace culture. We are not alone. The other medical colleges are ready to look at cultural change as are other professions. I recommend that all of you make yourselves familiar with the second expert advisory group report and the latest action plan on our website. RACS continues to work on bias and racism.

Related to this is wellbeing. We continue to go through stressful times. Medical work is stressful and we are seeing increasing concerns about the wellbeing of healthcare workers and burnout. RACS along with other colleges has developed the Wellbeing Charter, available on our website and now endorsed by CPMC, CMC and other groups. The pandemic, in particular, has affected all of us and we must reach out to each other. Kōrero (talk) to each other and be a friend and a mentor.

During my presidency, RACS has played a key role along with the Australian Society of Plastic Surgeons, the Australasian Society of Aesthetic Plastic Surgeons, and the Australian Society of Otolaryngology Head and Neck Surgeons in exposing the unsafe practices of cosmetic surgery done by medical practitioners who are not trained surgeons. Our patients expect surgery to be done by surgeons who are fully trained to the Australian Medical Council (AMC) specialist accredited standards—surgeons who have not only learned technical and medical skills, but also our 10 professional skills and competencies. We are nearly there with limiting the use of the title 'surgeon' to the AMC accredited surgeons.

Dr Sally Langley and Professor Chris Pyke

We continue to advise on the high standards required to deliver safe surgery whether it is 'cosmetic' or not and our opposition to the proposed 'area of practice endorsement'. This is really an ethical issue. We should only undertake work we are appropriately trained to do. Our patients trust us to behave ethically. A significant body of work on the cosmetic surgery submissions has been done by the RACS policy and advocacy team, which has developed as an important area of work for the College.

I am pleased to welcome new and continuing RACS council office bearers and office holders. RACS Council has a highly experienced group, all with extensive portfolio experience, representation of all specialties and all states and territories of Australia though there will be fewer councillors from Aotearoa New Zealand. This needs to be remembered when our Fellows seek nomination for Council later in the year.

I strongly recommend involvement with RACS as a committee member, councillor, course educator or facilitator, and as an examiner. Talk to colleagues, make a career plan (that is my husband talking), work out what might fit with your work and family in particular, and put your name forward for nomination. Keep an eye on *Fax Mentis* and *Surgical News* magazine. As a councillor you will extend your interests and broaden yourself as well as contribute to the future of surgery. There is a place on Council for all types of people and personalities. You don't have to be the extroverted person who expresses opinions on everything. RACS Council needs both experts and generalists who can take on any portfolio or project. Following my time on Council I will contribute to the governance of my own public hospital department and return to some clinical work. With the experience I have gained and the health system knowledge, I hope to contribute to the new health system in Aotearoa New Zealand.

I thank John Biviano and the staff of RACS in both our countries for their support during my presidency. I make a particular mention of Justine Petersen, RACS Aotearoa New Zealand manager, who is retiring in May after more than 27 years working with Fellows, Trainees, Specialist International Medical Graduates, and aspiring surgeons. Thank you for your years of service and best wishes for the future, Justine.

While I am sad to finish this role, I will be watching with interest as the ongoing strategic projects develop. Kia ora.

Dr Sally Langley
President

Vice president's perspective

Congratulations to the incoming president Associate Professor Kerin Fielding, and vice president Professor Owen Ung. With their election, I know that the future of the College is in excellent hands.
My term as vice president is coming to an end, and as the College centenary will be upon us soon, it may be opportune to look at our Fellowship and our constitution, and ask the question—are we structured for success after 100 years of our College?

When the College was founded in Dunedin in 1927, the (all male) group was concerned with two main areas, education and professional standards. They wanted a model, which was fit for purpose for the Australian and Aotearoa New Zealand environment and set about combining the best of the existing British and American offerings, along with a bespoke, relevant constitution.

The College is a membership organisation, with all of the strengths and weaknesses which accompany this. The hierarchy is shallow, and most Fellows see our College as a 'bottom-up' organisation made up of successful, high achieving experts and Trainees—almost all of whom work at a hospital.

There is a natural tendency in both our countries for a degree of scepticism towards authority—this can be a strength. Surgeons value their autonomy. Council, on the other hand, has a legal responsibility to provide governance to our more than 8000 surgeons and 1300 Trainees and Specialist International Medical Graduates (SIMGs). Trying to keep up with the enthusiasm and creative drive of our Fellows is a major task for Council, who have formed more than 150 committees to engage these energetic, involved surgeons, their state and national committees, and their surgical societies.

> Together, across both countries and all specialties we problem solve. Together, we share principles, and lift our sights higher. Together, we have collective bargaining. Together, we work for the greater good—even though it is hard.

Centralisation of the more disciplined tasks like the coordinated curriculum for training, governmental and educational compliance, workplace culture, shaping diversity, workforce distribution iniquity and stewardship of shared resources including money, is the role of Council. There is a constant tension around how Council needs its Fellows to 'take direction' on some matters. This is like the tension felt at any hospital when administration asks for a change—they don't feel the need for the 'greater good', but rather, 'why change now?' This can be a weakness. These tensions have led groups to want to separate. I would like to explore the argument for staying as one entity.

At the bi-national level, a major benefit is that we have governance diversity built in structurally. Education wise, all specialties in both countries are similar though there are enough other differences between them from which to learn and prosper. One such example is the industrial environment. Aotearoa New Zealand doctors have strong union representation while Australian surgeons have more exposure and dependence on private medicine. There are learnings to be gained from our cross representation. Just this year, we have had ANZCA and RACS (both bi-national colleges) show teamwork and problem-solving around the shortage of anaesthetic technicians in Aotearoa New Zealand. Both countries have a responsibility to the Pacific Islands, Melanesia and Niugini.

I recently attended a most illuminating Tri-nations conference—Australia, Aotearoa New Zealand and Canada. The colleges of surgeons, physicians and psychiatrists are all bi-national. The Royal College of Physicians and Surgeons of Canada is an umbrella organisation for all specialties except family practice. The mutual needs and challenges of these organisations are extraordinarily similar: selection, training models, examinations, continuing professional development (CPD), workforce culture, end of career planning, academic surgery, Indigenous health and rural health equity. We all have in common a very devolved mode of 'apprenticeship' style training—a high trust model, which leaves us open to abuse, and to complaints around the inherent high variability of experience. These vast domains of commonality easily dwarf the areas in which we are different.

Within RACS, we have had the Australian Society of Plastic Surgeons (ASPS), the Australasian Society of Aesthetic Plastic Surgeons (ASAPS), Australian Society of Otolaryngology Head and Neck Surgeons (ASOHNS), and RACS working on joint submissions to Ahpra and the Commonwealth government around the titling of surgeons and cosmetic surgery. Another example is the Fellowship

examination, which shares principles seamlessly across all nine specialties. The Canadian Royal College, the British colleges, the American College, the Colleges of Medicine of South Africa all serve the needs of all nine specialties, and some include Dentistry, Ophthalmology and other specialties.

Together, across both countries and all specialties we problem-solve. Together, we share principles, and lift our sights higher. Together, we have collective bargaining. Together, we work for the greater good—even though it is hard. As my friend Angus Gray (Senior Examiner Orthopaedics) said, paraphrasing JFK, "We don't do surgery because it is easy—we do surgery because it is hard". It is hard to be disciplined enough to stay together, but this is the higher calling.

Our constitution is a document, which is a combination of lofty ideals and pragmatism. We are due to review it in the lead up to the RACS Centenary. Coinciding with this is a proposed change to the size and shape of Council. It is proposed that the 30-member Council—primarily popularly elected with some co-opted for representation, as a decision-making body—be changed. Most colleges and hospitals are run by a smaller 'skills-based' boards. We will be proposing a board structure of up to nine, the majority of whom are surgeons, with a matrix of membership, which includes representation of skills, both countries, gender diversity and rurality. The Council will still be representative and may grow as the number of surgical societies increase.

Council will still carry the surgical intellectual property, surgical culture, ethics, hopes, aspirations and ideals–the hearts and minds of the Fellowship. It will be largely responsible for creating content and recommending projects and agendas. The Board will oversee the delivery and finance and risk management. The mechanism of reporting and election will be teased out more fully before presentation to the Fellowship to consider and provide feedback.

An additional project is actively looking at categories of membership, and whether to include Trainees and SIMGs. Our Constitution is not strong on patient-centred care. It currently reads as though it is focussed mainly on our membership. A personal wish would be to have included in the document a statement reinforcing that good patient care is at the centre of every surgical decision made by the members of this College.

My next Council role is in professional standards, mainly looking after CPD—a challenging role made to look easy by our incoming president. Once again, other colleges' CPD programs mirror ours and have large areas of crossover. Mostly, though, the challenge for the CPD department is trying to keep up with measuring the many and varied ways which our high achieving Fellows keep striving to make themselves better at their craft, through their ongoing self-directed CPD. It is a good problem to have.

The College structures have served us well thus far. That doesn't mean that they can't be improved. Those in Dunedin in 1927 would have wanted us to be a vibrant, engaged college, ready to respond to all challenges. The idealists among us also know that 'The College' is a calling, one which challenges us to work for the greater good, at the expense of our personal needs. Surgeons are naturally attracted to these challenges. We will be better able to manage these challenges if we stay together, because we are stronger together.

Perhaps this could be illustrated in a haiku couplet—disciplined poetry, this one celebrating the need to stay united.

When all fingers come together

They become a fist so strong

That it cannot be broken

But when separated

They point in different directions

And they become weak and easy.

Professor Chris Pyke
Vice President

Strengthening the future of the College

RACS Council held an extraordinary meeting in late March to review our work as a College to make sure we focus on core activities, rationalise the number of committees and working groups, and discuss other cost saving initiatives.

Below is an excerpt from a communication sent to members by President Dr Sally Langley.

At the meeting various decisions were made—ranging from stopping some existing College activities, enhancing and improving existing processes where possible, and exploring new revenue generating opportunities where appropriate.

These decisions were made in the context of the challenging economic conditions, including volatile global investment markets and inflationary pressures on expenditure that we've experienced in the last two years. This is in addition to the impact of COVID-19 and the restrictions that negatively impacted operations.

Governance

We agreed to consolidate, disband or realign committees, sections and working groups to ensure we are focusing on the ones that are critical to our strategic goals. We will be communicating this to the relevant members through the committee chairs, so they are aware of the changes, which are aimed at minimising any major impacts to our member services. Changes have been made to some of our Sections and some specific committees that were either no longer required or merged with other committees to improve efficiency.

Education

We reviewed our existing professional development courses, which are extensive and to identify which courses added the least and most value to our members.

Based on these discussions we will discontinue the following professional development courses with effect from 31 May 2023:

- Process Communication Model
- Non-Technical Skills for Surgeons
- Promoting Advanced Surgical Education
- Clinical Decision Making
- Safer Surgical Teamwork
- Surgeons as Leaders
- Bioethics
- Medico-legal
- Conflict and You
- Leading Out of Drama
- Foundation Skills for Surgical Educators face-to-face
- Difficult Conversations face-to-face.

We will also stop some education activities and collaborations that are not critical to the fulfillment of our strategic goals. These include a review of the Tri-nations collaboration, partnership with the University of Melbourne on the Surgical Education Program, research collaborations and examination, and skills course grants.

Travel and accommodation

We will make significant travel and accommodation cost savings by making bulk hotel bookings wherever possible and primarily utilising economy for flights across Australia and Aotearoa New Zealand. More savings and efficiencies will be created with the introduction of an online booking system.

Internal and external services

We will provide the use of continuing professional development (CPD) home to pre-vocational doctors as part of the newly introduced CPD Homes initiative.

We will defer some technology projects that are deemed not to be time sensitive or critical this year. However, we will progress with planning technology initiatives in the finance area to replace the finance reporting and tracking systems that are obsolete and urgently require updating.

We will also stop printing publications such as *Surgical News*, the annual report and pocket diaries. *Surgical News* will be available digitally via a microsite from April 2023, generating an annual saving of more than $300,000 in print and mailout costs. This change will take effect immediately.

While we remain committed to building respect within our profession, we are balancing a number of priorities and we acknowledge we can't achieve everything immediately. With this in mind, we will pause the development of a proposed new leadership framework as part of our Building Respect, Improving Patient Safety program.

2002

2006

2010

2012

2016

2020

2020

2021

2022

2023

The many faces of Surgical News over the years.

College publications go digital

College publications, specifically *Surgical News* and the annual report, will now be digital only with no more printing of the pocket diaries.

Surgical News, the College's bi-monthly publication now has a digital presence with the first online version published in April 2023 in a custom designed microsite: surgeons.org/surgicalnews

The March-April issue of *Surgical News* will be the last print version. This is in-line with the previous Council decision to transition the *ANZ Journal of Surgery* to a fully online offering in January 2022 and was decided in an extraordinary Council meeting held in late March. Council reviewed the work of the College to make sure the focus was on core activities and cost savings in the context of challenging economic conditions that have negatively impacted operations.

Council also decided to stop the printing of diaries and the annual report. The print numbers for these publications have been declining steadily over the last five years.

We currently print about 200 diaries and 100 copies of the annual report. This is expensive and not an efficient use of resources. The annual report is available online on the RACS website (bit.ly/3KzBzXO).

These measures are in line with the RACS strategy of 'Leading a sustainable future for surgery' as it supports a sustainable College by making efficient use of resources and minimising costs.

Surgical News will continue to be published six times a year with an email alert informing you when the issue has been published online. We will also retain our focus of publishing interesting and engaging stories about surgeons and welcome your valuable contributions. The magazine started off as a simple newsletter from the president to Fellows. It then became a journal called *RACS Bulletin* in 1980, which was published three times per year in a black and white format.

Surgical News started in 2002 with 10 issues published per year. In 2019, it transitioned to six issues published per year.

There is a growing expectation that as the world gets more digital, so should many offerings. An increasing number of publications are switching exclusively to a digital only format.

Digital publications provide instant access to content and a better user experience as they can be more interactive. The digital format will give us the opportunity to add more engaging content in the form of audio, video, quick polls, weblinks and other interactive elements.

Professor Chris Pyke
Vice President

Without belonging diversity and inclusion is tokenistic

There is a lot of talk within RACS about diversity and inclusion

RACS has a diversity and inclusion plan that is currently being updated, which indicates RACS is 'leading the way towards inclusive participation in the practice of surgery and life of the College.' Quite a few targets and timelines have been set, not all of which have been achieved. Within surgery, our focus for diversity and inclusion initially has been around gender and ethnicity—particularly ensuring representation of our Indigenous peoples. But diversity and inclusion in healthcare may also include other underrepresented groups including culture, disability, sexuality, socioeconomic status, rurality, and age.

Our training system and healthcare systems are primarily based on western systems that have been generally developed by privileged, heterosexual, able-bodied white men. Consequently, we cannot assume that all those coming into this system from under-represented groups are going to feel safe or have a sense of belonging. Trainees from under-represented groups often have a different world view from that entrenched in the established training systems. This can make navigating the current training systems and surgical organisations more challenging and stressful for them and may lead to a feeling of not belonging. This can be further compounded by a system that appears to accept people from diverse backgrounds—but only if they then conform to the norm. In essence, if they reject some of the very qualities for which they were selected. It is possible to be included, yet still not belong or to be able to effect change.

The risk of diversity and inclusion initiatives that simply focus on increasing Trainee numbers from under-represented groups to meet targets is tokenistic. To be genuine it should be accompanied by a willingness of institutions to accept the value of diverse opinions and undergo transformational change, and therefore benefit from diversity. This can be a very uncomfortable space to be in because it requires institutions to be willing to change and relinquish influence on those who have previously been considered 'others'.

Similarly, diversity of selection alone is inadequate unless it is accompanied by a training program and working environment, which fosters both inclusion and belonging. To be most effective, institutions themselves not only need to change, but also to actively embrace change.

How should we judge who are our best future Trainees? What criteria do we use to assess them? The criteria for selection should be oriented to elevate the traits, skills and values that esteems candidates who reflect the communities we serve, and in this way prioritise diversity.

We need to ask ourselves whether our generally rigid inflexible systems that work to meld the individual to fit into our current perceptions of the 'best surgeon' really encourage belonging and the potential of diversity? One of the arguments we hear is that we need to pick the best person for the role—but who judges this? What criteria do we use to assess this?

Often—unless we consider not just how to ensure diversity and inclusion but also how we can achieve empowerment and belonging—we are unlikely to see who these 'best' people are. A strong feeling of belonging would enable views, beliefs, and values of everyone to be heard and respected, and to become influential within our College.

There is now plenty of evidence that health disparities for our patients relate to Indigenous background; some directly relate to unconscious or conscious biases held by healthcare professionals. We also have evidence that patient outcomes improve if they are cared for by someone who is like them (that they feel more comfortable with) in terms of gender or ethnicity.

Effective diversity initiatives will reflect both the communities they serve and will empower people from diverse backgrounds to influence policy and strategy. Empowerment, however, is most effective when there is belonging. Belonging needs to be experienced by diverse groups: the corollary being that the predominant group needs to accept the need to change. A sense of belonging for all will enable our College to become stronger and better, and ultimately, help provide better health outcomes for all our patients.

Authors:
Dr Maxine Ronald
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Surgeons celebrate diversity at WorldPride

RACS surgeons joined members from 14 other medical colleges to take part in the Mardi Gras Parade during Sydney WorldPride 2023 in February.

The float was created by members of the Pride in Medicine Group, which advocates on behalf of the wellbeing of LGBTQIA+ practitioners and patients.

During the parade, College representatives travelled on or alongside the float wearing sequined scrubs and danced to health-themed songs including Fever and Dr Love.

The profession's participation in this high-profile event aimed to send a strong signal that medical colleges recognise and support the LGBTQIA+ community and will proudly advocate for their healthcare needs.

Hobart Colorectal and General Fellow and Pride in Medicine President, Dr Matt Marino conceived the idea of being part of the Mardi Gras Parade and was pleased by the support and enthusiasm of the medical community.

"When I had the idea of having a float in the Mardi Gras, I knew it wouldn't be easy at all, but I was certainly surprised at just how much support we ended up getting, both financially from all the different colleges, and in terms of genuine interest in what we're doing. It was really nice to see," he said.

The Pride in Medicine Group was formed as a WhatsApp group of senior surgeons and obstetrician and gynaecologists, originally known as Pride in Surgery.

Since forming about a year ago, it has grown from a founding group of fewer than 10 surgeons to between 150 and 200 members from Australia and Aotearoa New Zealand today.

The group includes representatives from all medical specialties, at all stages in their careers, from within the rainbow community and their allies.

"It started off as a way to sort of share ideas or talk about issues that are facing LGBTQIA+ medical practitioners, and to come up with ways to improve the situation for both patients and doctors," Dr Marino said.

> "It's the beginning of the conversations that are starting to happen now in terms of how we can advocate for rainbow communities to make sure that we work to reduce those health inequities that exist in our communities."

"It's developed quite a lot of momentum and I think it shows that there was a real need for this group."

The group presented the idea for the float to RACS, which became the first medical college to support the initiative.

RACS participation in WorldPride 2023 is part of the College's strategic focus on building a culture of respect and embracing diversity, and on serving all communities equitably to build sustainable surgical services.

RACS first published its Diversity and Inclusion Plan in 2016, which links to the Building Respect initiative.

The plan champions diversity within the College, but many objectives are aimed towards gender and cultural diversity.

Understanding the value of promoting diversity in other forms, including sexual diversity, RACS considers involvement in WorldPride 2023 to be a step in creating a more inclusive and diverse profession.

Dr Marino said some of the issues facing LGBTQIA+ members of the profession were not always overt.

He points to examples including a reluctance of doctors to come out and show their authentic selves to colleagues for fear of a negative reaction and subsequent professional implications.

This could impact on both their mental health, and their performance.

A lack of diversity and inclusion within the profession can also have a considerable effect on patients, leading to health issues that largely affect the LGBTQIA+ community being neglected.

Fellow Pride in Medicine member, Aotearoa New Zealand academic surgeon Dr Sarah Rennie said the role of the group in addressing inequity in health outcomes for LGBTQIA+ communities was crucial.

"All the research shows that LGBTQIA+ communities have massive health inequities relating to a number of root causes, including societal stigma, discrimination and denial of human rights," she said.

"A lot of rainbow people feel quite afraid of accessing medical care, and that means that when they eventually see a doctor, things are way more advanced than they might have been if they felt comfortable accessing medical care.

"People shouldn't be afraid of accessing healthcare in the 21st century. They should feel safe, and we should have equivalent health outcomes for our minority groups—whether it's rainbow, whether it's disabled people or whether it's Indigenous people."

Dr Rennie can name several instances throughout her career when she felt belittled by jokes or comments made by her colleagues.

"There is a bit of a culture of locker room banter in the surgical profession and there have been times when I have felt uncomfortable by inappropriate jokes or comments," she said.

Dr Rennie considers RACS participation in WorldPride to be the start of much-needed change within the medical community.

"Being part of WorldPride speaks to the values that our College holds—service, respect, integrity, compassion, collaboration.

"But it is really just the beginning. It's about trying to get everybody in the room, and sending a signal to colleagues, to Trainees, to medical students that this is a safe space to be in, and to our communities that this is a safe space to access health.

"It's the beginning of the conversations that are starting to happen now in terms of how we can advocate for rainbow communities to make sure that we work to reduce those health inequities that exist in our communities."

The next steps for the Pride in Medicine group will be to raise awareness of unconscious and conscious bias within the health system, and the use of inappropriate comments or jokes.

The group aims to develop tools to equip members of the profession to call out this behaviour in a non-confrontational way, creating a safe workplace for LGBTQIA+ doctors and medical students.

They would also like to improve doctors' familiarity with medications, conditions and issues that are relevant to the LGBTQIA+ community by developing resources for doctors and patients.

Other aims include improving the training of Trainees, and all surgeons, to better cater to the needs of the LGBTQIA+ community, implementing a mentoring program for rainbow doctors to continue to create safety within the profession, and developing a database of LGBTQIA+ friendly practitioners.

Both Dr Marino and Dr Rennie found being part of the Pride in Medicine float exhilarating and were heartened by the response from the public.

"It was incredible just seeing the joy, the sense of community, the sense of belonging. You've got that real sense, being involved in the parade, that it was about being connected to our community and that was really, really important for a lot of people, both within our colleges, among our patients and in our community," Dr Rennie said.

"The vibe was phenomenal," Dr Marino agreed.

"Most of us had never been involved in the Mardi Gras parade, and in the hour that we were actually on the float moving through Oxford Street, it was incredible.

"People could see that ours was a medical float, and everybody was just so energetic and thankful and grateful and lovely. It was a really beautiful experience," he said.

Follow Pride in Medicine on Instagram (@prideinmedicine) or visit Pride in Medicine's website to learn more: bit.ly/3K5hKpV

Photo credit: Dr George Forgan-Smith

WorldPride: What the participants said

Dr Nisha Khot

Hey guys. 🌈🟡🟢🔵🟣🔴 Nisha here!!! (Ha! One of them)! Lol

It's been hard to articulate in writing the feeling today after yesterday's fabulous event! I agree with all everyone has said—it is such a high feeling!

What was great was so much positivity everywhere—with us, other groups and as George said the crowds! They all loved that we were out there! What a special moment for our profession as a whole. Something by doctors and representing doctors is unique.

And so many of the crowd pointed out the rainbow IVs—such a great idea!

To those of you who started Pride in Medicine, huge congratulations. It is something that should have been done so long ago, so congrats on getting it finally done! ❤️🌈 and to the President, Matt Marino you represent the organisation very well and speak well. Thanks for including all our colleges.

To Mark Frydenberg from RACS, huge respect and congrats on holding the sign in the front of the float. I've had so many messages from our surgical reps saying that it was even more special having a 'white' man out the front in pink scrubs with such a beaming smile on his face! (In essence the stereotypical surgeon, right?)

Professor Mark Frydenberg

Nisha, thank you for your kind words. All of our organisations including RACS that I represented, promote diversity, equity and tolerance. However, words are just words, you need to live and breathe them, you need to walk the walk.

You're right that I'd be described as the typical surgeon—white, male, and straight but diversity really matters; it needs to be celebrated and embraced. We can't look after our communities if we don't mirror those communities. So, to hear that I may have helped get that message of equity and tolerance across as part of our incredible team gives me huge pride. It was truly an enormous honour to walk out in front, seeing and hearing the crowds' reaction and how much they do value us as a profession.

'Thank you for everything you do for us, constantly rang out from the crowd. It was humbling, but at the same time inspirational. It made me proud yet again of what we all do every day. How could I not smile hearing and feeling the love from the crowd, being part of such a wonderful group of colleagues, and doing something that I personally feel is not only important but essential.

There is more to do and I'm ready to get to work to develop guides for prostate cancer, benign prostate disease, and other assorted urological topics specifically catering to the LGBTQI+ community.

Thanks again for a truly unforgettable experience and allowing Barb and I to be part of the team. I extend those thanks also to RACS for the honour of representing them on the night with Sarah and the entire surgical contingent.

We were seen, and we see you

When Disney released the movie Encanto, the marketing team was ready with a full range of toys based on Isabella—the tall, beautiful, 'perfect' character.

You can imagine their surprise when poor Isabella was left on the shelf. Kids didn't reach for her; they wanted toys based on Luisa, Isabella's bigger, stronger sister. At the same time, Instagram was filled with beautiful young girls with curly hair and glasses thrilled to see themselves on the screen—'Look mum, I'm Mirabel!'

On Saturday, 25 February, I joined 60 other doctors to celebrate LGBTIQ+ pride by marching in the world's largest celebration of queer culture—WorldPride.

Huge kudos to the group Pride in Medicine who tackled the logistical nightmare of organising floats, doctors, costumes, choreography and more. To their credit, the liaison team was able to connect and bring on board all of the medical colleges of Australia bar two. This was a huge amount of work, but was it worth it? Absolutely! Let me tell you why.

On Saturday morning, we were hosted for breakfast by the Royal Australasian College of Surgeons (RACS). For many doctors, this was the first time they had met their interstate colleagues. Friends from medical school were reunited, it was a chance to network and meet peers from across Australia and Aotearoa New Zealand. Finally, we saw each other. We met our 'Familia Madrigal'.

To be honest, I was genuinely touched that the event was hosted by the RACS. I had often felt alone and isolated in my surgical terms. To see this College, move forward offering support, not just money but 'seeing' their LGBTQIA+ members as important is heartening.

I was thrilled to have the support of the RACGP. Marching proudly with us was CEO Paul Wappett. His enthusiasm was front line with his represented doctors. My college saw me, all of me.

Together we laughed, we did emergency operations on costumes, we danced, we cheered.

The moment we entered Oxford Street, there was a huge roar. To see the people smiling, waving and cheering us on lifted us higher, giving the energy to dance the full four kilometre parade with smiles from start to finish.

It fills my heart with the hope that one special person saw 'us' and decided, 'yes, I can be a doctor'. Perhaps a struggling student deciding to finish their degree or a person who's been too afraid to see a doctor will seek out an LGBTQIA+ doctor because they now know we are here, and we care.

Of course, there will be detractors. I noticed one commenter on an article about the event note their disappointment in 'political involvement' and not giving 'to their members'; to you my friend, may I remind you I am a member. We are all members. We stand shoulder to shoulder, and for just one night, we were seen, and we looked amazing!

For me the benefits have been immense. I have been able to meet colleagues who can help me train in skills that benefit my community. Were it not for this event, we may not have met.

My patients saw 'me'. Every 500 or so metres, I was so thrilled to see a patient smiling, waving and some screaming 'Dr George, Dr George'. Lots of hugs. We will

Together we laughed, we did emergency operations on costumes, we danced, we cheered.

both head home knowing we are cared for, loved and represented; we were seen.

So, when I returned to work—I'm not going to lie—my 50 year old bones got a workout, but the joy has lifted me. I wish my 60 other colleagues the best for today and, indeed the rest of their year.

Today we are a family, and the WordPride weekend was our celebration. We are a special family, part of a special community. For every strong Luisa ophthalmologist or beautiful Mirabel surgeon, we are a family, and like Familia Madrigal, we serve our community with love, passion and, dare I say it, beautiful costumes, and amazing dancing. We saw you, all of you.

Author: Dr George Forgan-Smith
Specialist GP, Melbourne Australia

Pride in medicine and surgery

I felt the love and affirmation this year at WorldPride.

Sitting in a bar on the eve of the big Mardi Gras event, a colleague some 20 years my junior said that it must be gratifying for me to see such liberal enlightenment 'after all I'd been through'. In reality, I hadn't been through anything. That was the point! I had avoided confrontation.

As a junior doctor aspiring to a surgical career in the late 1980s, I was seen as a potential AIDS carrier wanting to invade innocent people's bodies. I saw how gay male patients were treated by senior colleagues. So, I kept my mouth shut, brought only part of myself to work, and came across as a somewhat solitary figure. I didn't even want to be in a study group for fear of having to lie about my personal life. Years later, in mid-life, I came to ask myself whether a career in surgery was worth those lost years of my youth. But in retrospect it may have also saved me at that particular time in queer history.

It seems like good things happen to me in Sydney. I passed my Fellowship examination there in 1994. I remember walking back to my accommodation after the pathology viva, which was held in the old RACS office in Surrey Hills. I was at the halfway point in that suite of high-stakes interrogations—so far so good. I stopped for a drink and sat at a table facing the street. Of course! This must be Oxford Street. Here was I, on the verge of a career milestone, after years of self-imposed exile, thinking that I must have found my tribe, yet still quite removed from it.

Fast-forward nearly 30 years and I am back on Oxford Street, on the back of a truck with my people, affirmation swelling up like waves of love from the pavements. I am wearing the highly visible, albeit uncomfortable, sequined scrubs prescribed by Pride in Medicine's WorldPride organising committee. An attempt to add bad-taste bling to my spectacles was compromised by all of Greater Sydney being sold out of rhinestones, so I fabricated something with mini-pompoms and supa glue instead.

I have been promoted to the back of the truck—possibly in my case—because the youthful organising committee considered me too much of a falls risk to join the 40 or more following behind the truck. They were dancing vigorously to the alternating strains of Kylie Minogue, Gloria Estefan, Aqua, Riton, and B(if)tek (who?). All I had to do was mill around with my fellow travellers, brandishing my rigid scope, and waving to the adoring crowds that lined the streets all the way to Moore Park. And no, I didn't go the all-night after party …

Mardi Gras at Sydney WorldPride on 25 February represented the debut of Pride in Medicine onto the international stage. It was a wonderful display of solidarity among all but two medical colleges of Australia and Aotearoa New Zealand.

> Now that the glitter of the parade has settled and the visibility of Pride in Medicine has been established, we need to get to the core business of what the group is all about.

My own interest from the surgical niche I occupy is to promote evidence-based anal cancer screening in HIV-positive men-who-have-sex-with-men and other high-risk groups. More broadly, I would like to contribute to Pride in Medicine's mission to advocate for person-centred, equitable care for all members of the rainbow community. But first we need to start with ourselves—to make us included and visible in the medical establishment and allow us to thrive.

It is extremely gratifying that an erstwhile bastion of cis-hetero male supremacy is leading the charge. This is something my 25-year-old self would have been pleased to know.

Author: Professor Richard Turner
General surgeon

Winning essay tackles gender equality in surgery

Dr Dewi Ang has won an essay writing competition run by the Royal Australasian College of Surgeons (RACS). The topic: Is seeking gender equality in surgery enough or should we be seeking equity? The goal of the competition, according to RACS, is to encourage more women medical students to consider a career in surgery.

Her prize for winning the competition is an invitation to the upcoming RACS Annual Scientific Meeting in Adelaide, in May 2023. She says it's an honour to attend alongside so many accomplished surgeons.

Dr Ang is at the start of her medical journey. She recently graduated from the University of Western Australia School of Medicine and is now working her way through the clinical rotations to find her 'calling'. Although it's early days, she says she's leaning towards a career in trauma surgery, ICU or anaesthetics.

Dr Ang's winning essay analyses how the surgical profession can bring about gender equity. She examines the factors that might contribute to few women surgical interns on her rotations. She suggests that more visible women consultants who can offer their perspectives and mentoring alongside training would help advance progress for women in surgery.

"To encourage more women in surgery, we need to acknowledge the fact that, historically, surgery has always been dominated by men," Dr Ang says. "We must actively increase representation and make sure those women are in a position to empower subsequent generations."

> Dr Ang says women surgeons should be given more opportunity to talk about their own experiences in training, as they are important role models for junior women doctors.

She also thinks attitudes at work need to change around family commitments and leave—not just for women but for men as well. "There needs to be more support for pregnant surgeons and re-entry to the workforce after maternity leave."

Dr Ang says she can see the surgical workforce slowly progressing with gender equity. Surgeons, in particular women, are being more open about their personal and family lives, reinforcing that work-life balance is possible and necessary to maintain a healthy career.
She remembers a particular consultant from her training. "She started by introducing a photo of her family. We could see that she's an accomplished surgeon who has a young family. The message was there's time to do both and you don't have to choose."

Dr Ang first became interested in medicine while growing up on Christmas Island with her family of Indonesian heritage. She found herself supporting her parents at health appointments, translating and explaining information from the doctors.

"I decided that one day, as a doctor, I'd like to give back and make the same sort of impact for other families."

Dr Ang, who is soft spoken, quite shy, and speaks English as an additional language, says she's been pleasantly surprised and reassured by the level of support from senior doctors in her training so far. They have provided a great deal of carefully guided practical training, taking time to talk her through surgical skills in theatre, and helping her build confidence.

"I really like the fact that, regardless of your gender, race, or other personal factors, there's always someone senior there taking the time to go through things with you," she says.

Dr Ang's advice for women considering a career in surgery is to stand strong in their interests and persevere. "Surgery can be a lot more intense than other rotations but don't let that put you off. There will always be a way to make it work and there will always be people to support you. Then, once you become a surgeon, you will be a valuable mentor to women coming behind you."

Dr Lilian Violet Cooper – our first female FRACS

Born in Chatham, England, Dr Lilian Cooper completed her medical degree at the London School of Medicine for Women in 1890. She and her companion, Josephine Bedford, emigrated to Queensland in 1891 and Lilian became the first female medical practitioner registered in Queensland.

In 1896 she was also the first woman to be appointed as an Honorary Medical Officer at the Hospital for Sick Children. She began her lifelong association with the Mater Misericordiae Hospital in 1905.

Described by Clarrie Leggett as a 'tall, angular, brusque, energetic woman, prone to bad language' — by 1912 she had travelled overseas and visited the Mayo Clinic in the US, obtained her doctorate from the University of Durham, and developed a thriving professional practice.

Determined to offer her medical services to the World War I effort, in 1916 Lilian Cooper joined the Scottish Women's Hospitals and was sent to Ostrovo and then, Dobraveni near the Serbian front.

During the next eight months, the 40 bed dressing station at Dobraveni admitted 152 patients and the tenacious Dr Cooper—a familiar, heroic figure working in appalling conditions in knee breeches and rubber boots—performed 144 operations, with just 16 deaths.

Severely ill with bronchitis, Dr Cooper eventually left both the unit and the war and returned to her practice in Brisbane. In 1917 she was awarded the Serbian order of St Sava.

After the war, Dr Cooper's successful practice focussed on the health issues of women and children. A popular practitioner who was idolised by her patients, she did her rounds by bicycle or travelled long distances by horse and cart. She was one of the first women to own a motor vehicle and did her own repairs to her aptly named 'Yellow Peril'.

An extraordinary advocate for women in surgery, Lilian Cooper joined the College as a Foundation Fellow (no. 128) in 1927.

Author:
Elizabeth Milford,
RACS Archivist

Jamie-Lee Rahiri, recipient of the 2022 SET Trainee One Year scholarship

Creating a safe space for Māori health

For Dr Jamie-Lee Rahiri, winning the Surgical Education and Training (SET) Trainee One Year Scholarship for 2022 is a "testament to the Royal Australasian College of Surgeons (RACS) recognising the importance of health and mental wellbeing among surgeons in training".

A general surgery Trainee (Year 2) based in Gisborne, Aotearoa New Zealand, Dr Rahiri found early in her career that there was a lack of support system and training for Trainees and non-Trainees, and particularly Māori aspiring surgeons. With the scholarship, she is developing a culturally safe peer group framework that supports the wellbeing of Trainees and non-Trainees.

Dr Jamie-Lee, who is of Ngāti Porou, Ngāti Whātua and Te Atihaunui-a-Pāpārangi descent, is a passionate advocate for health equity, cultural safety and Māori health.

The SET scholarship, which supports activities undertaken by Trainees as they pursue their surgical training, is just one part of Dr Rahiri's recent accomplishments. In 2021, with the aid of funding from the Health Research Council of New Zealand, she established her own Kaupapa Māori surgical research institute—Te Piringa Kōtuku.

The institute aims to nurture mentors who can inspire more Māori aspirants to become surgeons. "In order to do the work that we want to do and to attract like-minded people, we need a safe space for that to happen," Dr Rahiri said.

After completing her Bachelor of Medicine and Surgery (MBChB), Dr Rahiri chose surgery. At the start, she did not like "the culture of it". Despite persistent health inequities in accessing surgical interventions and higher rates of perioperative morbidity and mortality for Māori, she saw how surgeons "were talking about us".

"The presumption that we as Māori are undeserving as our bad personal choices

cause our health problems is precisely the reason why our profession fails to adequately serve us."

The certainty in her career direction came after that. "If I don't like what I see then I need to be a part of it to protect our people and come up with tangible solutions.

"The procedural part of the job is amazing, and I love it, I think that's the easiest part. The hardest part is your connectivity to your patients and the community that you serve," she said.

Dr Rahiri believes general surgery has the greatest potential to contribute more towards equity. "There is a plethora of opportunities in this field to be of good service and to make significant headways into eliminating health inequities for Indigenous peoples."

Towards this end, she also changed the focus of her PhD, which she completed in 2020 from the University of Auckland. Her research focussed on investigating equity in access to bariatric surgery for Māori and also understanding how health benefits could be optimised for Māori post-surgery.

With more women now coming into general surgery, Dr Rahiri finds it encouraging, "but there are barriers no doubt. The biggest bias is that if you take time off, you are not an active contributing member to the surgical community. How do you measure the quality of the time taken to do research?"

As a young woman doctor with three daughters, Dr Rahiri says the fact that she is a Trainee is a privilege. "I get to be a surgeon apprentice during the day and then come home to my whānau at night. I do not take it for granted."

With a doctor's right notion, Dr Rahiri shows the path to be the best advocate she can be in serving her people and the general community.

RACS offers a range of scholarships and grants annually to support research, learning and development through its Scholarships and Grants program.

To find out more, visit www.surgeons.org/scholarships.

HMP revolutionises heart transplantation

For the last 50 years of cardiac transplantation, donor hearts have been preserved during the ischaemic time by storage in ice slush (cold static storage). There are substantial limits to this method of preservation, a major one being that the ischaemic time is limited to approximately four to five hours. After this time, the risk of primary graft dysfunction (PGD) and death progressively increases.

In a country the size of Australia, the safe ischaemic time limit of cold static storage imposes geographical constraints on the distances the donor heart can be transported. Consequently, there are donor hearts that are sometimes not able to be transplanted because the ischaemic time would be too long.

Hypothermic machine perfusion (HMP) as an alternative to cold static storage has been undergoing extensive investigation in Australia and Aotearoa New Zealand. The concept of HMP is not new, but it's the first time the Swedish-developed technology has been investigated outside Europe. The principles of HMP are low pressure, low-flow perfusion at eight degrees centigrade.

Professor David McGiffin, a recently retired cardiothoracic surgeon, has been investigating HMP experimentally with the Brisbane-based Critical Care Research Group (CCRG), which is directed by Professor John Fraser. The experiments consistently demonstrated that it was possible to preserve hearts for transplantation out to nearly 10 hours without PGD. This experimental work was so compelling that it translated into the Australian and Aotearoa New Zealand trial of HMP, involving the transplant centres in the two countries. The trial co-principal investigators were Professor McGiffin and Professor David Kaye, Director of Cardiology at the Alfred Hospital.

Geographically, nine hours is sufficient time to transport a donor heart anywhere within Australia and between Australia and Aotearoa New Zealand. The outcomes of the trial have revolutionised heart transplantation in the two countries. "Donor hearts can now be transported around Australia and Aotearoa New Zealand without the need to consider the ischaemic time," says Professor McGiffin.

Although as yet unproven, HMP is very likely, to reduce the risk of PGD in particularly vulnerable recipients, for example, difficult transplants for complex congenital heart disease or explantation of ventricular assist devices, irrespective of the ischaemic time.

What's next for the development of this technology? "We will investigate if we can apply HMP to donation after circulatory death (DCD) donors," says Professor McGiffin. CCRG has been awarded an A$2 million National Health and Medical Research Council grant to return to the laboratory and repeat all of the experiments on DCD donors. Professor McGiffin and his colleagues hope these experiments will translate into another human trial of HMP, this time for DCD donors.

Looking ahead, Professor McGiffin thinks HMP will be widely used as its efficacy over cold static storage has been well demonstrated for long ischaemic times.

It's possible that HMP will allow donor hearts to be transported on scheduled airline flights rather than using high-cost corporate aircraft. It may also allow heart transplantation to become a scheduled daytime case rather than a night-time case, as frequently occurs.

Professor McGiffin is now a Professor of Cardiothoracic Surgery at Monash University.

There is a problem with item number misuse

Recently there has been considerable publicity in the media concerning alleged rorting of Medicare by doctors. This was said to be based Dr Margaret Faux's PhD thesis, which I suspect had not been read by the journalists involved. This 400 odd page long document dealt with the complexity and inconsistencies within Medicare, among other things. Overall, it is sympathetic to the profession.

Unlike some, I found that the claim that up to $8 billion was wrongly claimed from Medicare every year not entirely implausible, based on my own experiences. However, nowhere in her thesis does Faux claim this.

More than 10 years of medico-legal assessments has led me to believe that the problem of item number misuse is far from uncommon. Only occasionally was I asked specifically to look at charging, and in most of those cases the item number misuse was blatant and clearly fraudulent. One classic was a bill for $48,500 for the unwarranted revascularisation of a ring finger avulsion in a manual worker. Adding to this figure, among other things, was not only for four microvascular grafts (an unlikely number), but also the micro-anastomosis of each end. I could relate a multitude of other entertaining examples.

One got a fair idea of what was being charged, in general, because those who unbundle tend to spell out exactly how they are doing it. Do they think that by listing the items in a report will justify the unbundling and will hoodwink the non-medical people in the insurance offices? Alas, it mostly does. This medico-legal work did not involve Medicare of course, but I have seen enough evidence to have good reason to believe that the situation is of little different in non-insurance medicine.

As Professor Owen Ung pointed out, the Medicare schedule of rebates has fallen behind the cost of running a practice, and there is an increasing gap between Medicare rebates and the Australian Medical Association (AMA) fees.

The health funds largely follow Medicare and are nowhere near the AMA fees. This, combined with the pressure to leave the patient without a gap, has led, I believe, to an increase in unbundling. This is often to the extent that the doctor is making more than they would, charging the full AMA fee using the correct item numbers. That may be a temptation, it is not an excuse. If a doctor believes their services are worth more, charge more, they should explain it to the patient. The College hierarchy often and rightly rail against patients being left with large gaps, especially those in vulnerable situations. This behaviour is not however illegal. The College is almost completely silent on the question of item number misuse which, in some cases, is criminal.

Both Professor Frydenberg and Professor Ung cite the complexity of the Medicare schedule leading to administrative errors as a cause of incorrect use of item numbers. Is the Medicare schedule really so complex that inadvertent errors are being made often enough to cause a significant problem, especially in surgical practice? It is disingenuous to believe that people, who have managed to get into and through medical school and beyond, cannot work out what item number to charge for most procedures. Furthermore, if these were just administrative errors it should cut both ways—with both under and over charging. I'll wager there is not much under charging going on.

As to the recent changes in Medicare being inadequately communicated—that is recent, but the problem is long-standing. In any event, one of the main reasons for the review was the very problem of unbundling.

This is a problem that the profession must own and deal with before it is dealt with for us. It is however, not only our problem, the insurance companies and Medicare must also act. They likely have the statistics to do so.

I wish Dr Pradeep Phillips the best of luck with his review. I suspect he will be looking for patterns and outliers, but these may not appear if unbundling and other misuses of item numbers are as frequent as I, and many others, believe it is.

Author: Dr Mark Allison, FRACS

Read our article on Surgeons question Medicare rort claims here: bit.ly/3nzHOBG

World-first cultural safety plan launches in Aotearoa New Zealand

A plan to provide cultural safety training will be embedded in doctors' medical education in what is being described as a 'world first'.

The *Cultural Safety Training Plan,* (which can be found here: bit.ly/3LROQMa), launched on 8 February 2023, was developed by the Council of Medical Colleges and Te Ohu Rata o Aotearoa, Māori Medical Practitioners Association.

It provides a practical framework for the 17 Aotearoa New Zealand (AoNZ) medical colleges, including RACS, to develop cultural safety education for Trainees and Continuing Professional Development (CPD) programs for Fellows.

Cultural competence education and training has been on the curriculum of AoNZ medical schools and colleges for some years now with the aim of providing high-quality care and improved outcomes for patients.

More recently, the Te Kaunihera Rata o Aotearoa Medical Council of New Zealand introduced cultural safety as a standard for doctors to adhere to.

While cultural competence focuses on increasing knowledge and skills around interactions with patients of different cultures—especially Māori—cultural safety aims to tackle biases, even unconscious ones, that may impact on best outcomes for the patient. Cultural safety requires doctors to continually examine their interactions with patients with the aim of providing equitable service to all cultures.

Besides providing a framework for culturally safe medical practice, the *Cultural Safety Training Plan* provides definitions of the proficiencies culturally safe doctors need to develop; teaching and assessment criteria; and self-assessment tools.

It is designed to be used across all medical disciplines and reflects the unique context of AoNZ, with a particular emphasis on Māori health equity and achieving optimal health for Māori patients and whānau.

It is intended as guidance only and medical colleges have the flexibility to implement the plan in a way that best algins with their current training programs and in the context of their vocation.

RACS already provides cultural safety education to our Trainees and Fellows. Cultural competency and cultural safety is one of the 10 competencies central to surgical training skills and the CPD framework. The *Cultural Safety Training Plan* however, will be a useful resource for our members for cultural safety activities and assessment.

Surgeons meet with AoNZ health minister

Around 30 surgeons, men and women, from across the motu (country) joined the online International Women's Day breakfast on 8 March to hear Health Minister Dr Ayesha Verrall speak.

The event was organised by general surgeon and past member of the Women in Surgery committee Dr Jane Strang. She worked with Dr Verrall at Wellington Hospital when they were both Trainees.

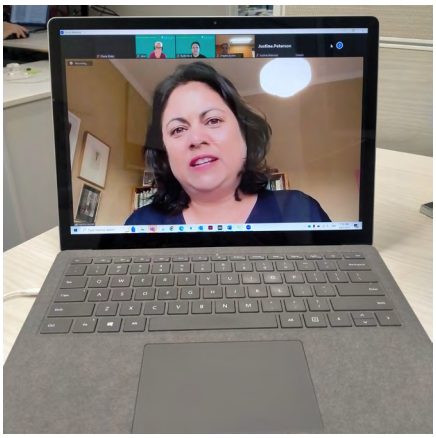
Attendees included RACS President Dr Sally Langley, Aotearoa New Zealand (AoNZ) National Committee Chair Associate Professor Andrew MacCormick, Surgical Advisors Dr Sarah Rennie and Professor Spencer Beasley, and College Councillors Dr Nicola Hill and Dr Maxine Ronald.

They were keen for the Minister to hear what it's like working on the front lines of the healthcare system and urged for immediate action on workforce shortages.

Surgeons described the situation as a crisis and warned of moral injury and burnout among colleagues.

Dr Verrall was sympathetic. She pointed to work the government has already done including recommendations from the Planned Care and Workforce Taskforces. Spend on health has increased 47 per cent over the past five years putting an additional 2700 nurses and 1700 doctors into the system.

Dr Verrall opened the door for further discussion with the College.



Planned care back on political map

RACS in Aotearoa New Zealand (AoNZ) hosted a webinar to celebrate International Women's Day on 8 March. The breakfast Zoom, organised by general surgeon and former member of the Women in Surgery committee Dr Jane Strang, provided a unique opportunity for Fellows of RACS, on this occasion mostly women, to gain direct access to the Minister of Health.

Hon Dr Ayesha Verrall, who took over the ministerial role in February, was this year's guest speaker. She gave an overview of some of the challenges her government faces around supporting the failing health system and outlined her plans to prioritise several initiatives, including improving planned care (also known as elective surgery) surgical services. She made clear that the solutions will not be easy and may take some time.

She then invited questions. Our president, Dr Sally Langley, asked the first—she described some of the difficulties surgeons were having trying to provide planned surgery in Christchurch. She said there is a chronic and worsening shortage of anaesthetic technicians as well other impediments.

Subsequent questions from other surgeons raised the issues around:

- shortcomings in the provision of elective surgery elsewhere
- increasing inequities for patients who don't have the option of private care
- lack of action supporting surgical training, especially in provincial hospitals
- inadequate number of medical students and the consequences on the medical workforce
- implications of an ageing surgical workforce with a shortfall in new surgeons coming through training
- increase in health spending not filtering into surgery to enable adequate staffing of many surgical specialties or leading to any increase in planned surgery.

The minister seemed genuinely surprised to learn that the concerns raised by RACS have not been acknowledged by previous ministers or the Ministry of Health, and there was not a forum or means by which matters surgical could be heard by government. She seemed keen to correct this and plans to set up regular meetings with surgical leaders from RACS.

This represents an excellent outcome from the webinar. What might have been simply an acknowledgement of the already substantial contribution of women to surgery in Aotearoa ended up being a major achievement in improving surgical access to government. Well done!

Author: Professor Spencer Beasley

If it looks like sepsis, it probably is – missed prosthetic joint infection

Speciality: Orthopaedic Surgery

Case summary

A man in his early 80s presenting with a painful, warm left knee was admitted through the emergency department of a major tertiary hospital by the on-call orthopaedic registrar.

The patient was unable to bear weight and was acutely limited in range of motion to 15 to 30 degrees. He denied any fall or mechanical trauma to the knee. However, the left knee was a prosthetic knee from 10 years ago. This should have initially raised a high clinical suspicion for infective arthritis of the knee. Instead, clinical management was directed towards obtaining a computerised tomography (CT) scan to exclude occult fracture. The patient's C-reactive protein (CRP) marker was 25mg/L on presentation, which may have contributed to this decision.

The patient had significant multisystem comorbidities, including atrial fibrillation on anticoagulation, ischaemic heart disease, chronic obstructive pulmonary disease, liver impairment, ankylosing spondylitis, and previous infective endocarditis.

In the days following the admission, the patient reported worsening knee pain (rated 10 on a pain scale 0 to 10 on day two). On day three he was found to be delirious, requiring a medical emergency team (MET) call. The medical intervention suggested further investigations with a CT scan of the brain. An infective workup or source identification was not started at this point. The patient was evaluated by the orthogeriatric service for the first time on that same day. There seems to have been a miscommunication at this level, as the primary presenting complaint recorded by this service was 'knee injury', while from the primary admission note it was quite clear that the knee was not really injured.

By day five, the patient's inflammatory markers had increased significantly (CRP 228mg/L); however, this did not trigger any action towards source identification or control.

On day seven, a septic screen was ordered, which returned a positive blood culture with Staphylococcus aureus bacteraemia. By this point the patient was showing a significant inflammatory response, with a febrile episode, CRP of 320mg/L, leucocytosis to 14.8 x109/L and platelet depletion. A further MET call occurred, and the patient was started on antibiotic therapy.

On day eight, the patient was evaluated by the admitting orthopaedic consultant for the first time since admission. By this time the patient had a CRP of 372mg/L, white blood cell count of 29 x109/L, and another positive blood culture with Staphylococcus aureus bacteraemia. The clinical note only reports 'not consistent with septic arthritis'. No appropriately detailed clinical examination to support this assessment was noted. There was no documentation of any consideration of a diagnostic aspiration to investigate the left prosthetic knee as a potential infective source.

After a further MET call on day eight, the patient was referred to the palliative unit and the family notified. The patient passed away five days later.

Discussion

An elderly patient with a prosthetic knee that had been functioning well for nearly 10 years presenting with sudden pain, inability to bear weight, severely reduced range of motion, joint warmth and fluid in the joint, combined with a cascading development of delirium, leucocytosis and rising CRP should have triggered suspicion for septic arthritis. A more objective route to establish or exclude the prosthetic knee as the focus of sepsis should have been taken, including joint aspiration.

It is also noteworthy that the admission occurred near the time of hospital registrar changeover. The orthopaedic registrar and resident medical officer that primarily admitted this patient with non-traumatic left prosthetic knee pain did not see him again at any point after the admission, likely because they were rotated away and a new team took over. This is when the clinical focus of the patient was misunderstood by the new team as 'knee joint haematoma' or 'knee injury', which seems to have distracted the team from investigating the patient for septic arthritis of the prosthetic knee. Here lies a concern with continuity of care, and the quality and efficiency of handover with the change of medical teams.

Decision-making and early investigation of the septic arthritis may have been improved by earlier and more diligent involvement by the orthopaedic consultant. Closer involvement of the medical orthogeriatric team also would have likely improved the clinical care and trajectory of this patient. Case note assessment revealed that, at this site, the orthogeriatric unit is only a consulting service not a co-admission team that could have provided more regular and in-depth assessment and guidance for management of this patient. It would also have been diligent to seek specialist infectious diseases consultation for identifying the focus of sepsis for this elderly patient with septicaemia of undiagnosed focus, a prosthetic joint and a history of infective endocarditis.

Clinical lessons

This case provides multiple clinical and administrative points to consider, learn from and improve upon.

Poor clinical handover has been associated with diagnostic errors, treatment errors and treatment delays, as demonstrated in this case. The erroneous clinical documentation suggesting a knee injury preceding the clinical presentation led to a significant delay in the diagnosis of sepsis, which most likely contributed to the patient's death. It is the responsibility of the admitting team to ensure clinical documentation is accurate; if a junior doctor is recording documentation it should be checked by the admitting registrar for accuracy.

The diagnosis of sepsis appears to have eluded several teams, including orthogeriatric and the MET response, when in hindsight it appears obvious. This highlights the importance of timely referral to other specialist teams—infectious diseases in this case—when clinical deterioration occurs.

ANZASM second line assessments frequently identify a lack of timely consultant involvement in management of patients. It seems reasonable that all patients should have a consultant 'bedside review' within at least 14 hours of admission and prompt follow-up review when indicated. Junior staff need support and supervision of their decisions and management plans. This is the role of consultant surgeons and appears to be missing from many cases reviewed in the mortality audit.

Clear protocols and practice need to be defined and followed if this situation is to be addressed.

Professor Guy Maddern
Chair, ANZASM

Rebecca with Melinda

Improving lives in the Indo-Pacific

RACS Global Health is providing ear, nose and throat surgeries in the Indo-Pacific

The World Health Organization (WHO) estimates that 466 million people globally have significant hearing loss, a figure set to double by 2050. Ear disease, such as otitis media, and hearing loss can have significant consequences on individuals, affecting communication, language development, educational opportunities, and employment choices. It may also contribute to social isolation, cognitive decline, and depression. Inclusion is one of the major factors facing education systems in the Indo-Pacific region.

Although girls face more barriers in accessing primary education in the Pacific region, once enrolled, they are more likely, than boys, to progress and complete primary education and higher levels of education (UNESCO Bangkok Office, UNICEF & UNGEI, 2018a, p.4).

RACS Global Health Visiting Medical Teams aim to directly contribute to enabling inclusion of women and girls, men and boys in their community by increasing access to health and surgical services.

In February this year a team of volunteer Fellows and health specialists lead by Dr Daron Cope and Dr Sor Way undertook life-changing procedures on more than 200 patients in Vanuatu to receive ear, nose and throat procedures at Port Vila Central Hospital. This included critical onsite training and mentoring of national clinical staff.

The Visiting Medical Team (VMT) undertook extensive clinical and surgical work including grommet insertions. This procedure can significantly improve hearing that has been lost due to fluid build-up behind the eardrum and allows the middle ear fluid to drain. This helps the person to then hear better.

Four-year-old grommet patient Long said she, “wanted to hear better” and for her mum Dennie, “it will be so much better for her in kindergarten so she can hear her friends, talk, and play with them like all kids do.”

For 13-year old Melinda, “sometimes it was difficult to hear the teacher at school” and that she “wanted to get back to be able to her schoolwork properly.” Her grandmother, Rebecca who was supporting her on the day of her surgery commented, “her hearing is so important, so she can learn!” She thanked the RACS team for supporting the girls of Vanuatu.

The RACS Global Health Visiting Team was supported by audiologist Dr Chessie Egan. She said, “the national team do an incredible job supporting audiology services in a resource-limited setting. There is great potential in growing the development of a national preschool training program.” Chessie screened and performed audio-metric assessments on 60 plus patients, most of whom had a mixture of permanent, preventable and reversable hearing loss.

For ENT surgeon, Dr Daron Cope, the most rewarding experience was a large thyroidectomy undertaken on a 38 year old women and “being able to ensure she can breathe and live a comfortable life.” A challenge for Daron was assessing a five-year-old boy with congenital hearing

The RACS Global Health Visiting Team was supported by audiologist Dr Chessie Egan. She said, "the national team do an incredible job supporting audiology services in a resource-limited setting. There is great potential in growing the development of a national preschool training program."

loss who now has significant barriers to being able to communicate due lack of access to hearing implant provision. This barrier to inclusion is further compounded by a lack of sign language education.

ENT surgeon, Dr Sor Way Chan, added "being able to work with (national surgeon) Dr Samuel Kemmel to further foster his interest in ENT surgery provides him an opportunity to train so he can continue to provide valuable ENT services in Vanuatu. This is a drop in an ocean when we see what comes through the doors and it's important to continue to provide support to VMTs to ensure development of national clinicians and sustainable ENT care for future national ENT surgeons. There is a Chinese proverb 'Instead of giving a person fish, you can teach them how to fish' and that is what we do."

For anaesthetist, Tom Bookallil, "the combination of being part of a team that provides definitive surgery that is life changing while working with national clinicians makes the process really worth doing." He added that the national anaesthetic team was excellent, and the trip gave him an opportunity to participate in a cultural and personal learning exchange that he will value for life.

RACS Global Health VMTs volunteers provide service delivery and specialist training to 11 Pacific Island countries across the Indo-Pacific region. This is due to funding from the Australian government and the Department of Foreign Affairs and Trade (DFAT) under the Pacific Clinical Services and Workforce Improvement Program (PCSWIP).

If you would like to join RACS Global Health as a volunteer, please contact us at: volunteer@surgeons.org

We receive applications from a variety of health professionals and are able to deploy clinicians registered in Australia and Aotearoa New Zealand.

Image left: Dennie and Long.

Image above (from left to right): Chessie Egan (audiologist), Dr Vincent Atua (medical superintendent), Sandi Coutts (registered nurse), Esline Napu (registered nurse), Samuel Kemmel (surgical registrar), Dr Daron Cope (ENT surgeon), Andorine Aki (ENT charge nurse), Dr Tom Bookallil (anaesthetist), Dr Sor Way Chan (ENT surgeon)

RACS is encouraging diversity in the Trainee cohort

The idea that diversity within the medical workforce improves patient outcomes is well established. In the same vein, diversity within our committees and governance structures in the surgical sphere will improve the experience for those represented by those organisations.

Historically, under-represented groups in the surgical workforce have been targeted by equity measures over recent years, leading to a growth in admissions to SET training for women, Indigenous peoples, and those from rural backgrounds. There is still significant work to be done to reach the targets the College has set for itself regarding the diversity of the Trainee cohort.

The RACS Trainees' Association (RACSTA) was established in 2005 to provide RACS with Trainee-specific feedback and guidance on activities, initiatives and concerns. The College respects RACSTA's opinions and suggestions on the surgical training experience and potential opportunities for improvement.

The RACSTA committee is one of the largest within the College, comprising of up to 30 members. Each specialty training committee and geographic region overseen by RACS is represented by a


Nicholas Lyons


Ben Scott


Ngoc Ha

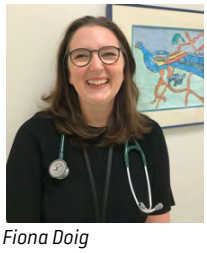

Sharon Jay


Sing Ken Chow


Craig Mooney


Alison Browning


Ella Nicholas


Fiona Doig


Emma Downie


Edward Riordan


Aadil Rahim

The 2023 Committee are proud to have 60 per cent of its members identify as female, 10 members within Aotearoa New Zealand, plus Indigenous and rural representatives.

Trainee on our committee, along with the executive and co-opted members. Members of the Committee contribute a significant amount of their time while in surgical training to be the voice for Trainees within their specialty groups and regions.

While the nature of the committee means each meeting brings together a range of viewpoints, over the years RACSTA has made deliberate efforts to foster diversity within the committee.

So, what does this look like?

The 2023 Committee are proud to have 60 per cent of its members identify as women (a number, which has steadily increased since 2016 when the RACS Diversity and Inclusion Plan was created asking for committees to commit to 40 per cent women representation), 10 members within Aotearoa New Zealand, and Indigenous and rural representatives.

Our members come from a diverse range of ethnic and socio-economic backgrounds. There is, however, still room to improve, particularly with LGBTQIA+ representation.

This intra-committee diversity allows us to put our finger on the pulse of issues, which inordinately affect these groups.

Access to flexible training and the financial impact of mandatory relocation during training have been highlighted by our committee members as major areas that need improving. These issues have a disproportionately greater impact on women Trainees, those from lower socio-economic backgrounds, and rural Trainees. Without addressing them, the surgical training experience will not improve and the progress towards the goal of a diverse medical workforce will be slowed.

A truly diverse surgical workforce, representing the amazing diversity we see in our own communities, is the objective of equity measures that we employ. By amplifying the voices of the traditionally under-represented groups within surgical governance and policy-making groups, we look forward to driving the status quo towards that goal. Surgeons and surgical Trainees can act as leaders in this arena.

I encourage all Trainees to consider where they can make a difference within their hospital committees, governments, policy-making bodies and, indeed, within RACS itself.

Ngā Manaakitanga,

Dr Justin Parr
RACSTA Chair

Daniel Scherman

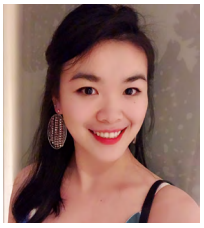
Justin Parr

Mat Doyle

Samantha Jolly

Kiera Roberts

Kate Swift



Candy Cheng

Sue Ong

Teriana Maheno

Christina Matthews

Tiffany Cherry

Young Hwan Lee

A regional training experience in Bairnsdale

Dr Kelvin Cheung, a graduate from Melbourne Medical School, elected to spend his pre-SET registrar year at Bairnsdale Regional Health Service. Bairnsdale is a small town of 17,000 people in East Gippsland, Victoria.

Dr Cheung chose to prepare for his SET training in this regional hospital because of the breadth of surgical opportunities on offer compared to metropolitan training. “I was exposed to a diverse range of knowledge, and I got to try many different types of surgeries. In the city, surgical training experiences tend to be narrower and more specific,” he says.

Dr Cheung found that he could develop closer and more fulfilling working relationships with consultants at the small Bairnsdale hospital. He got to know all of the staff well, which meant more hands-on surgical experiences, more shared knowledge, and a strong sense of camaraderie and wellbeing at work. He says the friendships and mentorships he formed are incredibly valuable.

“It’s a bit like an apprenticeship. If you follow the same surgeon for a period of time, they know what you can do, and in what areas they need to teach and support you. In that kind of environment, you learn more,” says Dr Cheung. “In city hospitals, you can’t form those close learning relationships the same way.”

“I was exposed to a diverse range of knowledge and got to try many different types of surgeries.”

“I also really enjoyed the lifestyle in Bairnsdale,” he says. “There’s lots of good food and many local towns to explore, with the Lakes close by. My wife, who’s a pharmacist, came with me for the year. We even worked together at the hospital.”

Dr Cheung thinks the biggest barriers for surgical Trainees heading to regional and rural centres are the loss of social connections and the complexities that come with starting a family. It’s not easy to pack a young family up and move around for different training posts. He points out that, at his stage of advanced training, many of his colleagues are starting families and are restricted in their movements.

That being said, Dr Cheung thinks he could definitely see himself and his partner settling somewhere like Bairnsdale and raising a family there. The pace of life suits them. He can even imagine relocating his parents from Hong Kong one day and settling them into the outdoorsy lifestyle near Gippsland Lakes.

Dr Cheung has now relocated to the larger regional city of Bendigo (population 121,000), two hours north of Melbourne, for the first year of his General Surgery training. He says the pace and complexity of surgeries are more closely aligned with a metropolitan hospital. Bendigo Base Hospital has an ICU, unlike Bairnsdale Regional Health Service. Although he’s enjoying the faster pace for a while, his unique experiences in Bairnsdale have left an impression on him.

Without commitment from a steady number of Trainees and Fellows to regional and rural surgical units, these small hospitals must rely heavily on locums to fill the gaps, coming maybe for a few days, a few weeks, or if the hospital is lucky, a few months.

Dr Cheung advises those considering a career in regional or rural surgery to first take advantage of the many short-term locum opportunities available. “There’s always a demand for locums. Try being a short-term locum in a few different regional and rural hospitals first. Experience and explore the lifestyles. See if it’s something you like. You’ll know within a few weeks at a small hospital if the environment suits you.”

I was seen and heard — an SIMG's story

When I moved to Australia from the US, one of my first patients asked, "what are you?" I answered, "I'm African American." She said, "You mean you're coloured?" "No, that term in America is considered offensive", I said. Again, she probed, "Well, what are you?" I paused for a moment and then said, "My mother is Choctaw Indian and Black, and my father is Puerto Rican". I am the offspring of Indigenous American Indians and the descendant of African slaves. She was satisfied with my answer, and we were able to refocus on the clinical aspects of her visit. Many would have been offended by her asking, but I understood that she genuinely wanted to know what and who I was, and how I came to be in her regional community. She had acknowledged that I was different and spoke with an accent. I was seen and heard.

It is not unusual for patients to question the background of their Specialist International Medical Graduate (SIMG) doctor. SIMGs are recruited to address the significant deficits and persistent maldistribution of healthcare workforce and provide a much needed medical care in regional and remote areas. There are assumptions that as an SIMG you are there because you couldn't be anywhere else, are not as qualified, or that you are from a country that is impoverished or has civil unrest.

Before migrating to Australia, I worked at a cancer centre at a 700-bed tertiary academic hospital as chief of Breast Surgery. I relocated to central Queensland to work in a 40-bed regional hospital (much to the shock of my American colleagues) to experience working in a different health system and the challenge of providing care with limited resources. I had no intention of remaining permanently; however, after eight years I am an Australian citizen and have enjoyed overcoming barriers to exceed standards of breast cancer care in regional Queensland. SIMGs contribute to the diversity of our workforce caring for our multicultural patient population, providing unique perspectives and a cultural richness to our profession.

Diversity and inclusion have become modern mainstream concepts that many organisations attempt and struggle to incorporate in strategic planning. It can be complex as diversity could mean different observational dimensions—age, gender, race, ethnicity, lifestyle choice and many others—depending on perspective.

I reflect on a time when I trained, when I didn't have any woman surgical role models as there were none in the hospital where I trained of any surgical specialty, let alone one with my skin color. My mentors were all white men. Fortunately, over my career I have gained many mentors, both men and women. As such I believe that women surgeons should have both positive men and women role models. Moreover, men surgeons should also have strong women surgical mentors.

I do not identify as a woman or black surgeon—I am just a surgeon. It is no longer a novel concept and if it is considered as such, then we continue to separate ourselves and foster a mindset of scarcity and separatism. Not every woman or man for that matter in medical school have a desire to be surgeons despite it being an incredibly fulfilling medical discipline.

Diversity is imperative to the healthcare workforce to service a multicultural society, but it does not infer inclusivity. Regardless, of the increasing numbers of women or black or any other descriptor in the surgical profession, inclusion requires action of everyone in the workforce. Each of us has a responsibility to reflect on our individual biases and judgement of others that impacts behaviour towards others.

Do you look down at your smart phone when sitting in the surgery lounge when another surgeon who looks different or of a different surgical discipline that you are unfamiliar with enters or do you acknowledge and engage with them? Everyone wants to be seen, heard, appreciated, and accepted as their authentic self and for their contributions.

Fostering a climate and safe work environment means supporting the vulnerability that authenticity requires, leading each of us to make meaningful contributions to our profession. A space where there is a feeling of belonging and all are welcome—the opportunity to share our knowledge, talents and grow. At the end of the day, you can only be who you are. At the end of the day, I will always be a woman, black, the descendant of slaves and Indigenous American Indians who happens to do surgery. It is my hope that when I enter the twilight years of my career that my colleagues will remember me for meaningful contributions to this great profession above all else.

Dr Emilia Dauway, MD, FRACS, FACS

Ensuring inclusion of nursing leadership in Pacific

Lina Olul is the charge nurse of the operating theatre in Port Vila Central Hospital in Vanuatu and manages the two operating theatres on site. Through her leadership and support of her team, the recent RACS Global Health volunteer Visiting Medical Team (VMT) completed a successful deployment in February this year.

The VMT were able to provide clinical and surgical services to more than 250 patients during their week in Port Vila. This was possible due to the valuable partnership between national clinicians and Australasian deployees. The VMTs performed thyroidectomy and cholesteatoma grommet insertion surgery assisted by national clinician nurses and surgeons.

Lina said that the best thing about her job was working in a team where everyone enjoys their work. As an operating theatre nurse leader, she understands the importance of planning ahead, nursing care plans, and communicating clinical standards to the nursing staff.

In 2022 Lina completed the RACS Global Health funded Peri-operative Nursing Post-Graduate Certificate with 15 other experienced nurses. This accredited course was developed by the Australian College of Nursing and is offered to registered nurses across the Indo-Pacific region. While Lina has worked in the field of surgical nursing for 16 years, she felt a need to improve her theoretical knowledge. She says, "I learnt a lot! The theory was missing in my clinical practice, and this provided me with the application of theory to the principles of evidence-based practice." She has also gained the benefit of the recently launched Pacific Island Country Nursing Standard Pacific Peri Operative Practice Standards developed by The Pacific Community (SPC) in partnership with RACS Global Health.

Lina said that nursing in the Pacific has many challenges, many of which are also being felt in Australia and Aotearoa New Zealand, including an acute shortage of nurses, difficulties in supply of anaesthesia, and specific drugs and medical equipment breaking down. At times the shortage of drugs (due to global supply chain blocks) has meant elective surgery has been postponed prioritising emergency cases.

Lina enjoys her role in nursing leadership and says, "nursing staff are the ones who are there for their patients always. Nurses are the patients' advocate, and they make sure that they are safe. We speak for the patient, and we must protect them."

When patients go to her, she is aware that this is a foreign environment, and they fear many things and that the nurse's role is to help them throughout the process.

Lina says that her operating theatre team enjoys working with the VMTs, especially on cases that would otherwise not have access to surgical care in Vanuatu. "VMTs offer such critical lifesaving support. Working with them is a great pleasure as it provides us with training, and we all learn from each other. We wish to have more visiting teams in the future, so our nurses and doctors get access to more training, and we learn why we are on the job. Wish that they can come again until we have the skills ourselves."

Lina is an exemplary nurse leader and says, "Every day is a new evolution in nursing. Our Vanuatu nurses are skilled and hope that one day when we have more trained nurses, we will have the complete skills to continue to care for and treat our patients ourselves."

The many firsts in surgery

'You can't be what you can't see' is a common aphorism supporting visible role modelling in the workplace. It is at least partially true,

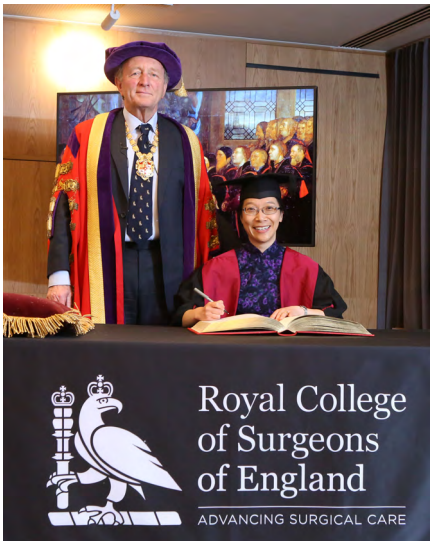
A study by Neumayer in 2002 showed that 88 per cent of women in a large US training scheme came from just three medical schools where women comprised a 'critical mass' of more than 40 percent of faculty.[1] However, it is only partially true, because someone has to be the first person, regardless of never seeing anyone they could identify with.

I have been inspired by so many other people being 'the first' during my surgical career. I have seen the first RACS woman president, Professor Anne Kolbe; I have seen the first Australian to win a Nobel Peace Prize, Dr Ruth Mitchell; and we are about to see the first RACS vice-president of Asian descent, Professor Owen Ung. These 'firsts' are undoubtably celebrated by the everyone in the surgical community, but they have a particular meaning to those who may not otherwise 'see' themselves as surgeons.

I did not always see myself as a surgeon. I had some ability in it—being a viva candidate for the surgical medal in my graduating year, which I did not win. But I had absorbed the many cautions about surgery been a difficult training pathway for women and had decided that general practice was a better fit for my aims. It is only through the consistent encouragement of surgical colleagues and more than a few serendipitous life events that I ended up as a consultant surgeon despite doing it all 'wrong'—no higher degree, two babies, and a year off backpacking around the world.

We need to make the pathway into surgery less serendipitous. We need to make it a routine experience that potential surgeons of every gender, culture, orientation, and class feel valued in surgical workplaces. We need to rid our profession of the discrimination and harassment that still disproportionately affect specific under-represented groups.[2] We need to create surgical 'homes' for everyone—whether it be the breastfeeding rooms at conferences, or programs to support Indigenous Trainees, or marching at Sydney WorldPride.

I know there are some surgeons who feel the many diversity initiatives of RACS and Royal College of Surgeons England (RCSEng) leave less room for those from the 'traditional' stereotype. Professor Averil Mansfield, who became the first woman professor of surgery in the UK in 1993, has a particularly gracious way of thinking about this. When asked at the RCSEng International Women's Day event about her experiences, she said, "I didn't experience discrimination—it was just that people needed to get used to the idea [of a woman surgeon]".



Our ever-burgeoning waitlists are a sobering indication of how much the entire workforce will still be needed for the foreseeable future. 'Getting used to' more diversity doesn't push anyone out—it makes the whole house larger and better able to meet the needs of a diverse community.

I have only been able to be a surgeon and do the work I have done with the support and inspiration of many others, including many who would identify with a 'traditional' surgical stereotype. I am entirely humbled to receive honorary fellowship of RCSEng, and I hope it will encourage others to 'be what they can't see'.

Author: Associate Professor Rhea Liang

1. Neumayer, L, Kaiser, S, Anderson, K, Barney, L, Curet, M, Jacobs, D, Lynch, T & Gazak, C (2002). Perceptions of women medical students and their influence on career choice. Am J Surg, 183(2);146-50. doi: 10.1016/S0002-9610(01)00863-7
2. Thread Consulting (2021). Building Respect, Improving Patient Safety Action Plan: Phase 2 Evaluation Final Report. https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/BR-Eval-Report-FINAL-2021-11-03.pdf
3. Video available at https://youtu.be/W1jxFSmu-LOs

Parity for Māori surgeons by 2040

Professor Jonathan Koea has ambitious plans for Māori health and RACS.

Rather than stepping into the newly created role as Māori Trainee Liaison Lead for RACS, he's taking it at a sprint.

Professor Koea took on the role, which is funded by the Foundation for Surgery in November 2022 but already he has a clear idea of what needs to be achieved. That includes increasing the proportion of Māori surgeons, so they match the proportion of Māori in the general Aotearoa New Zealand (AoNZ) population. The aim is to train 150 Māori surgeons by 2040 in time for the bicentenary of Te Tiriti o Waitangi, Treaty of Waitangi.

"This is an ambitious goal for the College, but we are committed to it," he says.

At present there are approximately 15 Māori surgeons practicing in Aotearoa New Zealand. That's about two per cent of all surgeons in AoNZ. Māori, on the other hand, make up 17.2 per cent of the population, according to Stats NZ figures from June 2022. For Māori surgeons to achieve parity, there would need to be close to 140 practising in AoNZ.

That might seem like too much of a gulf to bridge in under 20 years, especially when it takes around 15 years to train a surgeon from the first year of medical school to surgical accreditation. Yet progress is already well underway.

There are currently 30 Māori surgical Trainees across five of RACS nine specialties—this is the highest number seen in RACS history. And the Māori Health Advisory Group has initiatives in place and is exploring more, to keep the momentum up and encourage the best and brightest Māori doctors into surgical careers.

Professor Koea (Ngāti Mutunga, Ngāti Tama) is Professor of Surgery at the University of Auckland and head of the Upper Gastrointestinal Unit at North Shore Hospital. When he first finished his surgical training, he was the only Māori general surgeon in the country.

A significant part of his professional contribution to surgery has been working to improve the health of the Indigenous communities in both AoNZ and Australia. That includes through the College's Māori Health Advisory Group—an offshoot of RACS binational Indigenous Health Committee. He has been a member of the group since its inception half a decade ago.

If health outcomes for Māori patients are what is important, why is Professor Koea, and the Māori Health Advisory Group, so focused on increasing the number of Māori surgeons?

Because Māori doctors better understand the health needs of Māori patients, he says.

"Māori doctors bring a lot—they are culturally grounded and skilled in reaching and understanding Māori communities. They often come from different backgrounds from the average surgeon. Sometimes they have encountered greater challenges along the way. That can mean they're better at solving problems. They are driven and focused."

Professor Koea equated the understanding among RACS of the need for more Māori doctors to the now well accepted view of the benefits of having more women in surgery.

"Our College has moved [its thinking] and really understands the strengths that come with diversity."

Women Trainees now account for about a third of all surgical Trainees; double the proportion of women who are active Fellows.

So that's the why but what about the how?

One initiative that has been in the works for some time is a collaboration aimed at encouraging Māori secondary school students into surgical careers. Working with Pūhoro, which launched in 2016 to increase engagement of Māori in STEMM-related career pathways (science, technology, engineering, mathematics and mātauranga Māori), surgeons present at careers expos and offer interactive activities to give Māori college students a feel for surgery.

The Māori Health Advisory Group is also working with medical schools and hopes to strengthen its relationship with Te Aka Whai Ora, the Māori Health Authority, to look at more long-term planning for the Māori healthcare workforce.

As the Māori Trainee Liaison Lead, Professor Koea plans to reach out to each and every Māori Trainee to see where they need support. Those who are interested will be paired with a mentor.

He is also speaking to Te Rau Puawai, which aims to build the Māori mental health workforce in collaboration with Massey University, to see how its success can be replicated for surgery.

Whether you're a Māori surgeon, Trainee or someone thinking about a surgical profession, Professor Koea has a message for you.

"We are here to help. Kōrero mai."

Resilience of staff and systems are interlinked

Aotearoa New Zealand is reeling from extreme weather events that have seen loss of life and destruction of property and livelihoods. These scenes have been very distressing.

What has been heartening is that many of our healthcare colleagues who have gone to extraordinary lengths to meet their communities' needs.

It made me think about resilience as I have often heard that word used to describe the communities devastated around Aotearoa New Zealand. It is also a term used a lot in relation to the healthcare system.

On the notice board outside our theatres there are posters documenting six factors underlying personal resilience and wellbeing:

- Body – be active
- Mind – keep learning, new experiences, see opportunities
- Spirit – generosity of time, words, presence
- Planet – care
- Place – awareness of the simple things that give you joy
- People – care

However, resilience not only applies to the individuals and communities in which we live and serve, but also to the systems with which we engage (healthcare, food, environmental, economic). I strongly believe we cannot keep asking individuals to be more resilient, and then more resilient again, as seems to be asked of healthcare workers so often.

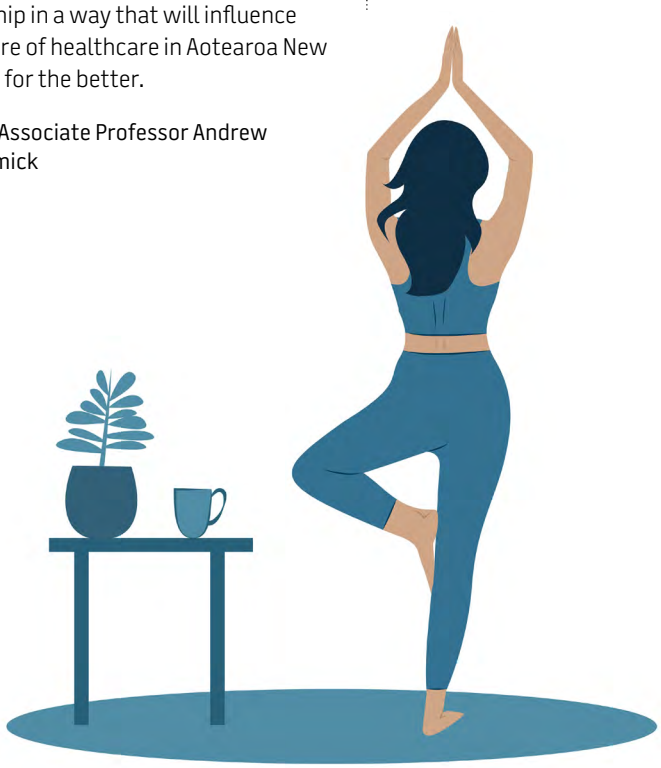
We also need to build resilient systems to support them. Resilient people in a system that does not support healthcare workers is setting them up to fail—no matter how resilient they are. The focus on efficiency in the health system can sometimes work against the resilience of staff. We need to hold the two, people and systems, in 'symbiotic tension'.

Curiously, a recent review of the volume of acute work at an Aotearoa New Zealand health institution contradicted the anecdotal perception that 'we were busier than ever'. Is it that the cases are more complex or is it just that teams' level of resilience has been diminished or undermined?

Healthcare has been described as a complex system. The definition of a complex system comes from Dave Snowden and his work on the Cynefin framework for decision making. Cynefin is Welsh for place and is similar in meaning to *tūrangawaewae*. We need to understand our place and ensure that it works for patients and for the healthcare workers who serve them. This includes the need for adequate flexibility and adaptability within the system. We must ensure that we do not replicate the same policies and procedures just for the sake of presumed 'efficiency'.

The seemingly unrelenting call to do more with less may not produce the desired outcomes for patients or staff. To rebuild staff morale in a stressed and compromised system is difficult. Sometimes a different way of doing things may be needed to get the same outcome depending on the place. This is where we, as surgeons, may be able to provide leadership in a way that will influence the future of healthcare in Aotearoa New Zealand for the better.

Author: Associate Professor Andrew MacCormick



Research is about continuous improvement and progress

The 14th annual Developing a Career and Skills in Academic Surgery (DCAS) course will be held Monday 1 May 2023, leading to the Royal Australasian College of Surgeons (RACS) Annual Scientific Congress at the RACS Adelaide office.

Thanks to the Educational Grant from Johnson & Johnson, delegates will receive an exciting range of informative topics that promise to engage and inspire.

We have an exceptional faculty from Australia, Aotearoa New Zealand, United Kingdom and the United States who will share personal experience and tips on what it takes to start, develop, and continue a productive career in academic surgery.

As always, we look forward to renewing acquaintances with our American colleagues from the Association for Academic Surgery, whose continued support for our DCAS course deserves special acknowledgement.

The program begins with a session exploring the topic of 'A Career in Academic Surgery'. Other sessions include 'Choose Your Own Research Adventure' and 'Tools For Academic Output'.

Highlights from the program include hot topic speaker Associate Professor Rhea Liang who will present on 'Intersectionality of a surgeon'. The keynote presentation, 'Research, translational and clinical deployment—the sky's not the limit!' will be delivered by Professor Gordon Wallace from the University of Wollongong, Australia.

The two concurrent workshops will cater to those new to research or academic surgery with the session 'Finding My Fit: Try Before You Buy' covering a different types of research genre; and 'I Found my Fit: Money Can't Buy Happiness, but… ' for those looking to develop their surgical research career through research funding and navigating successful grant writing.

Previous attendees frequently describe the course as inspirational, transformational and well targeted to every level—from medical students to department heads.

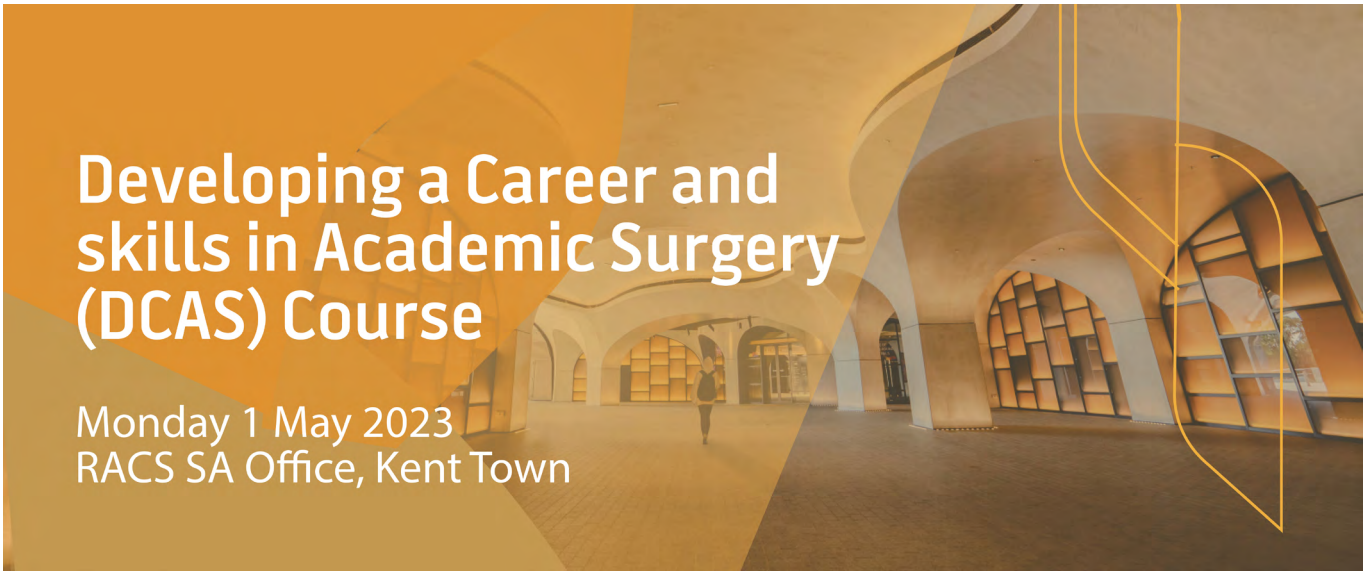
Faculty continuously state that there is nothing more satisfying than seeing attendees benefit from the experience. For SET Trainees in General Surgery, attendance at this course is acknowledged by General Surgeons Australia as equivalent to attending one compulsory Trainees' Day.

Research is about continuous improvement and progress, and we invite you to attend the DCAS Course in Adelaide in May 2023—you will be impressed and inspired.

Event details including registration applications, prices and the provisional program can be found on the DCAS website at: www.tinyurl.com/DCAS2023

Authors:


Associate Professors Claudia Di Bella and James Lee – Co-chairs



Introducing the Renewal of Endoscopy Skills and Training Program

RACS has established a pilot colonoscopy peer support program, the Renewal of Endoscopy Skills and Training (REST) Program.

Overseen by endoscopists who have significant experience in endoscopy, the program is tailored to the individual needs of the endoscopist requiring support. These can include peer review of audit data on-site visit, clinical attachment to a peer, or other professional development activity. The program is founded on the principle of collegiality, with an emphasis on patient safety and quality endoscopy.

Colonoscopy is also the only surgical procedure in Australia where clinicians are required to recertify (triennially) against a defined set of criteria. This is outlined in the Colonoscopy Clinical Care Standard established by the Australian Commission on Safety and Quality in Health Care (ACSQHC). Failure to comply with recertification standards can result in a clinician being unable scope and deliver these services to the community.

RACS recently signed a tripartite agreement with the Gastroenterological Society of Australia (GESA) and the Royal Australasian College of Physicians (RACP) to establish a Recertification in Colonoscopy Conjoint Committee (RCCC).

The RCCC is a clinical expert advisory committee with equal representation from physicians and surgeons who will oversee the recertification of colonoscopists against the established standards.

While Aotearoa New Zealand does not currently have a recertification program, it is essential for endoscopists to maintain their skills and meet recognised key performance indicators as outlined in the Endoscopy Guidance Group New Zealand (EGGNZ) Guidelines for Credentialling in Adult Endoscopy.

Endoscopists who feel they would benefit from accessing the REST program are encouraged to get in contact with the College.

Author: Dr Brian Kirkby FRACS

How do I access the program?

For more information or to express an interest in participating in the program, please write to surgical.endoscopy@surgeons.org

Surgeon Wellbeing eLearning Module now available

RACS has launched a short Surgeon Wellbeing eLearning module that addresses key challenges and promotes a shared responsibility for wellbeing.

The module is part of a suite of free microlearning activities that are approved in the RACS CPD Program and open to all Fellows, Trainees and Specialist International Medical Graduates.

Complete the Surgeon Wellbeing eLearning module today.

Visit Surgeon Wellbeing for more information.

2023 Scholarships and Grants Program

Congratulations to our Learning and Development Grants recipients

We are immensely proud that RACS is now the second-largest philanthropic funder of surgical research and education worldwide. This would not be possible without you.

In March 2022, Fellows, Trainees, SET applicants and other health professionals from Australia and Aotearoa New Zealand were encouraged to apply to the program's 2023 Research Scholarships round, valued at more than $2.2 million. Congratulations to the 28 successful applicants. The successful scholars were published in a previous issue of *Surgical News*.

Later in 2022, the Learning and Development Grant round opened, valued at more than $450,000. Twenty six opportunities were filled.

Once again, I take this opportunity to thank the ANZ Scholarship and Grant Committee members, Fellows and invited expert selection panel members who dedicated considerable time and energy to assessing applications in a thorough and highly competitive selection process.

The success of the Scholarships and Grants Program is measured not only from the benefits brought to Fellows, Trainees, SET applicants and other health professionals, but most importantly, from their scholarship and grant outcomes that contribute to the highest levels of surgical care for our patients.

The Scholarships and Grants Program would not be possible without the Foundation for Surgery and the generosity of Fellows and benefactors who have established these living legacies and bequests.

Dr Sarah Coll, Chair, ANZSGC

2023 Learning and Development Grant recipients

Scholarship tenure is for a year unless otherwise indicated.

Pickard Robotic Training Grant
Three grants totalling $79,436

Dr Andrew Shepherd

Urology surgeon, Royal North Shore Hospital, Sydney, NSW

Value: $32,000

Dr Shepherd will undertake a senior robotic clinical Fellowship in urology at Guy's and St Thomas' NHS Foundation Trust, UK.

Dr Thuy-My Nguyen

General surgeon, Royal Adelaide Hospital, SA

Value: $27,760

Dr Thuy-My Nguyen will complete a Masters of Surgical Education with the entitled Recommendations for a robotic colorectal surgery curriculum for fellowship training in Australia: A scoping review of the literature.

Associate Professor Justin Bessell

General surgeon, Calvary Hospital, Adelaide, SA

Value: $19,676

Associate Professor Bessell will be undertaking training at the Australian Medical Robotics Academy in Melbourne in International Medical Robotics Academy, Robotic Curriculum Levels 5-7.

Stuart Morson Neurosurgery Grant
Value: $40,000

Dr Michael Colditz

Neurosurgeon, Royal Brisbane Hospital, Qld

Dr Colditz will travel to Krembil Brain Institute, Toronto Western Hospital, Canada, to undertake a fellowship in functional neurosurgery.

Bongiorno National Network Younger Fellows Travel Grant

Three grants totalling $25,000

Dr Sunny Nalavenkata

Urology surgeon at Westmead Hospital, Sydney, NSW

Value: $10,000

Dr Nalavenkata will travel to New York to undertake a combined uro-oncology research and clinical Fellowship where he will research validation and development of prostate cancer prognostic models.

Dr Ayman Khan

General surgeon, Epworth Hospital, Melbourne, Vic

Value: $7500

Dr Khan will travel to Cleveland Clinic Foundation in Ohio, USA, to undertake a clinical colorectal Fellowship.

Dr Matthew Yong

Cardiothoracic surgeon, Gold Coast University Hospital, Qld

Value: $7500

Dr Yong will undertake an advanced cardiac surgery Fellowship at the University of British Columbia, St Paul's Hospital, Vancouver, Canada.

Morgan Travel Fellowship
Value: $13,000 each

Dr Geraldine Ooi

General surgeon, Alfred Health/Monash University, Melbourne, Vic

Dr Ooi will travel to the Memorial Sloan Kettering Cancer Center in New York, USA, to undertake a surgical oncology clinical and academic Fellowship.

Dr Enoch Wong

General surgeon, Fiona Stanley Hospital, Murdoch, WA

Dr Wong will undertake an upper gastrointestinal surgery Fellowship at the Queen Elizabeth Hospital in Birmingham, UK.

Murray and Unity Pheils Travel Grant
Value: $10,000 each

Dr Isaac Tranter-Entwistle
General surgeon at Christchurch Hospital, AoNZ

Dr Tranter-Entwistle will undertake a research project entitled 'Development of automated training tools in laparoscopic surgery using computer vision' at Stanford University.

Dr Vignesh Narasimhan

General surgeon at Monash Health, Melbourne, Vic

Dr Narasimhan will travel to Memorial Sloan Kettering Cancer Centre, New York USA, to undertake an advanced colorectal oncology Fellowship.

Hugh Johnston Travel Grant
Value: $10,000 each

Dr James Churchill

Urology surgeon, St George Hospital, NSW

Dr Churchill will undertake a Fellowship in urologic oncology at the Christie NHS. Foundation Trust in Manchester, UK

Dr Leah Boyle

General surgeon, Dunedin Hospital, Otago, AoNZ

Dr Boyle will complete a Masters of Global Health Science and Epidemiology (MSc) at the University of Oxford, UK.

Skills Training Faculty Grant
Value: $10,000

Associate Professor Amanda Dawson

General surgeon, University of Newcastle Central Coast Clinical School, Gosford, NSW

Associate Professor Dawson will attend the International Clinical Skills conference at Monash Prato Centre in Prato, Italy.

Rural Surgery Fellowship for Provincial Surgeons
Value: $10,000

Dr Aasim Khan

General surgeon, John Hunter Hospital, Newcastle, NSW

Dr Khan will continue the randomised control trial at the John Hunter Hospital in Newcastle titled 'Proactive use of DCBs in dysfunctional fistulas – Safety study'.

Fellowship Examiners Grant
Value: $10,000

Professor Ngaire Susan Stott

Orthopaedic surgeon, Starship Childrens Hospital, Auckland, AoNZ

Professor Stott will be an observer at the FRCS Trauma and Orthopaedics Section 2 exam in the UK to benchmark the FRACS exam against the FRCS Section 2 exam and will also observe the examination for international surgeon candidates in Malta.

Hugh Johnston ANZ Chapter ASC Travel Fellowship
Value: $8000

Dr Zubair Hasan

Otolaryngology Head and Neck surgeon, Westmead Hospital, NSW

Dr Hasan will undertake a Fellowship in neurotology/auditory implants at the Duke University in North Carolina, USA. He will also attend the American College of Surgeons (ACS) Annual Clinical Congress in Boston, USA.

Medtronic Younger Fellows Travel Grant
Value: $7500 each

Dr Thomas Clifton

Orthopaedic surgeon, Bunbury Regional Hospital, WA

Dr Clifton will travel to Southmead Hospital, Bristol, UK, to undertake a soft tissue knee Fellowship.

Dr Edward Cooper

General Surgeon, St George Hospital, Kogarah, NSW

Dr Cooper will undertake a senior clinical Fellowship in colorectal surgery with Oxford University Hospital Trust at Oxford, UK.

Younger Fellows Leadership Exchange Fellowship
Value: $5000

Dr Jasan Dannaway, Orthopaedic surgeon, formerly at Macquarie University Hospital, NSW

Dr Dannaway will undertake an upper limb Fellowship with North Bristol Trust NHS UK (Southmead Hospital and Bristol Royal Infirmary).

ASC Grant
Value: $5000 each

These grants provide opportunities for Aboriginal, Torres Strait Islander and Māori final year medical students and doctors with an interest in surgery to attend the upcoming RACS ASC.

Dr Emma Espiner
Junior Doctor at Middlemore Hospital, AoNZ

Dr Selwyn Te Paa
Junior Doctor at Wellington Hospital AoNZ

Dr Samuel Lloyd
Junior Doctor at Te Whatu ora – Te matau a Māui, Camberley, AoNZ

Dr Sara Lai
Junior Doctor at Albury Base Hospital, NSW

ASC Peer Support Grant
Value: $5000 each

These grants provide opportunities for Aboriginal, Torres Strait Islander and Māori doctors who have previously attended a RACS ASC, to attend the upcoming ASC.

Dr Nasya Thompson
Medical student at Christchurch Public Hospital, AoNZ

Dr Hinewaiora McCleery
Junior doctor at Waikato Hospital, AoNZ

Career Enhancement Grant for Junior Doctors

Value: $5000 each

These grants support Aboriginal, Torres Strait Islander and Māori junior doctors to strengthen their career pathway by acquiring knowledge and skills.

Dr Callan Gibbs,

Junior doctor at John Hunter Hospital, New Lambton Heights, NSW

Dr Maccalla Fenn

PGY3 doctor at Launceston General Hospital, Tas

Dr Megan Kent

Junior doctor at Royal Melbourne Hospital, Vic

Dr Tamika Ponton

Junior doctor at Cairns Hospital, Qld

Dr Emily Mason

Junior doctor at Port Macquarie Base Hospital, NSW

Poate Family Plastic & Reconstructive Surgery Travel Grant

Value: $3500

Dr David Sparks

Plastic and Reconstructive Trainee, Gold Coast University Hospital, Qld

Dr Sparks will travel to Seattle Children's Hospital, Washington State, USA, to conduct a clinical observership in craniofacial surgery and to start a research project.

Davison Family Grant

Value: $2500 per year for three years

This grant is to support Aboriginal, Torres Strait Islander junior doctors to pursue a career in surgery.

Dr Callan Gibbs

Junior Doctor at John Hunter Hospital, New Lambton Heights, NSW

Queensland Younger Fellows Grant

Value: $2500

Dr Shiv Chopra

Plastic and Reconstructive Surgery surgeon, Royal Brisbane Hospital, Qld

Dr Chopra will travel to Royal Marsden Hospital, London UK as a Microsurgery Fellow oncology/surgery. He will also visit other European oncoplastic units such as the Paris Breast Institute and the University Hospital Gent.

Aziz Hamza Rural Surgery Grant

Value: $1500

Dr Matthew Watson

General surgeon at Royal Adelaide Hospital, SA

Dr Watson will attend the Definitive Surgical Trauma Care course.

Rural Junior Doctors Surgical Skills Course Grant

Value: $1500

Dr Jessica Wynn

Junior doctor at University Hospital, Geelong, Vic

Dr Wynn will attend the Australia and AoNZ Surgical Skills Education (ASSET) course at RACS in Melbourne.

Ngarra Grant

Value: $1000

Dr Maccalla Fenn

PGY3 doctor at Launceston General Hospital, Tas

Dr Fenn will attend the ASSET and Advanced Paediatric Life Support (APLS) courses.

Applications to RACS 2024 Scholarships and Grants Program open in April 2023 with Research Scholarships and Learning and Development Grants on offer.

Please visit surgeons.org/scholarships for more information.

What will your legacy be?

The health and wellbeing of future generations depends on the research and training we do now. Thanks to you, over the past 40 years, the Foundation for Surgery has helped fund some of the most exciting research conducted in Australia and Aotearoa New Zealand.

But we still have a long way to go, and it will take more than just one lifetime.

Each one of us finds different ways to leave our mark on the world. A Legacy Fund is a gift that will always be remembered.

There are two very special ways you can leave an ongoing legacy through the Foundation for Surgery:

1. Leave a bequest – of any size – to make an extraordinary difference, change lives and advance your area of passion or specialty.

2. Establish a perpetual scholarship – you can establish a scholarship in your name or other desired name to change lives and see the results of your philanthropy in your lifetime.

If you are considering your legacy, the Foundation for Surgery team would love to hear from you. Please contact them on +61 3 9249 1110 or foundation@surgeons.org today.

Dr Carlo Pulitano: recipient of the 2022 John Mitchell Crouch Fellowship

Dr Carlo Pulitano is a recipient of the 2022 John Mitchell Crouch Fellowship, the most prestigious scholarship of the Royal Australasian College of Surgeons (RACS).

An upper gastrointestinal, hepatobiliary, and transplant surgeon in Sydney, Dr Pulitano said the Fellowship has contributed to the pathbreaking technique he and his team have developed—to keep organs alive for up to two weeks through a new technology.

Born in Italy, Dr Pulitano undertook six years of surgical training in Milan (Hospital San Raffaele), Paris (Hopital Beaujon), and Edinburgh (Royal Infirmary of Edinburgh) before obtaining his General Surgical Fellowship in 2010. He took up a clinical Fellowship at Royal Prince Alfred Hospital in Sydney in 2011 and completed a PhD at University of Sydney on the complex microcirculation of the liver.

The search for more in-depth training in complex surgery led him to a second Fellowship in hepatobiliary and transplantation surgery at the Toronto General Hospital in Canada. On completion, he joined the Royal Prince Alfred (RPA) Hospital, Sydney in 2018, as a consultant and as an associate professor at the University of Sydney.

That was when Dr Pulitano decided to put into use the new surgical laboratory attached to the RPA unit. Having been involved in research since his medical student days in Milan, Dr Pulitano always wanted to do something new.

With encouragement from Dr Michael Crawford, head of the RPA's Transplant, Dr Pulitano started an ambitious project. He established the RPAH Translational Center for Organ Assessment, Repair, and Optimization. It's a combined unit between the hospital RPA and the University of Sydney.

The goal was to surpass what the current technology offers and keep an organ alive not just for hours but for days and even weeks. "It was completely new," Dr Pulitano said.

> "A scholarship is always good for your career. You develop a leadership position within your field"

The RACS Fellowship helped him invest in employing a few young bioengineers who developed the system of preserving organs through the use of complete automatics and functions controlled by artificial intelligence.

"So far, we are very happy. A complex system like this can take years to develop but we are close to starting a clinical trial by using this machine," Dr Pulitano said.

"We have also been extremely lucky to get the highest research award from the International Liver Transplantation Society (ILTS) two years in a row—last year and this year."

As the only centre in the world to have achieved this feat of keeping an organ alive for up to two weeks, Dr Pulitano said his team at the RPA's Transplant Center is also working on gene therapy and other regenerative treatment to modify and repair organs.

"Long-term normothermic machine perfusion may be used in the future as a dynamic platform for regenerative medicine approaches, enabling repairs and regeneration of injured donor livers," Dr Pulitano said.

The other important benefit is cost reduction. "Liver transplantation remains one of the most challenging and resource-intensive surgical procedures. It is commonly performed as an urgent procedure outside of regular hours. Our automatic system could enable it to become a schedulable procedure to minimise staff burnout and increase safety."

Dr Pulitano's interest in upper gastrointestinal and liver transplantation

stemmed "naturally". As a medical student, the liver unit was part of his rotation where he was involved in research projects, some of which were very successful. "Though there was no interest in pursuing surgery at the time, I changed my plan as I got interested in liver surgery. It's a very interesting organ in terms of complexity in surgery and management."

He believes Fellowships such as RACS are impactful. "A scholarship is always good for your career. You develop management skills, get a budget which you can use, and develop a leadership position within your field."

Despite a full schedule and a young family consisting of his wife and three children, Dr Pulitano is now dabbling in his new hobby–carpentry. "There is not a lot of time, but I love the creativity."

RACS offers a range of scholarships and grants annually to support research, learning and development through its Scholarships and Grants program.

To find out more, visit www.surgeons.org/scholarships

Scholarship and grant opportunities for 2024

The 2024 applications open 26 April 2023 and close 31 May 2023

"Research is creating new knowledge" Neil Armstrong

Thanks to our Fellows' dedication and donors' generosity, RACS scholarships, grants and Fellowships have grown over the decades.

RACS and the Foundation for Surgery are pleased to offer a range of research scholarships and learning, and development grants for funding in 2024, including 11 continuing scholarships from the 2023 program. These funding opportunities support RACS members in their dedication to research, learning and development. This helps RACS to achieve its goal to inspire in surgeons a lifelong dedication to learning in surgical practice and technique.

On behalf of the ANZ Scholarship and Grant Committee, I thank the many Fellows and RACS members who commit their time and expertise to the program. We can be proud that these opportunities benefit not only the individuals who receive them, but also contribute to the development of research, surgical practise and leadership in our local and global surgical communities.

Dr Sarah Coll, Chair, Australia & New Zealand Scholarship and Grant Committee

We encourage applications from Aboriginal, Torres Strait Islander, Māori and women applicants as we support RACS focus on:

- removing barriers to participation in surgical advancement
- recognising that some people can experience disadvantage
- continuing and enhancing initiatives designed to encourage the participation in surgical advancement for people from all walks of life.

Advertised opportunities are an initial guide only. Please check the RACS scholarship website (surgeons.org/scholarships) for detailed information.

- The value of these awards are in Australian dollars and are for a tenure of one year unless otherwise stated. Where a higher degree is required, it is for a Masters, PhD or equivalent, or as indicated.
- Early-career surgeons are Trainees or Fellows within 10 years of obtaining a Fellowship.
- FRACS applicants may apply where eligible, for all opportunities listed for Fellows, subject to providing evidence of completing all Fellowship requirements by 1 December in the year of application.
- SET applicants may also apply where eligible, subject to providing evidence of acceptance into the SET Program by 1 December in the year of application.

Research Scholarships, Grants and Fellowships

Are you thinking of undertaking research in 2024? The following are a selection of the research opportunities that will be offered.

John Mitchell Crouch Fellowship

$170,000

RACS most prestigious scholarship, the John Mitchell Crouch Fellowship, is awarded to a Fellow who is making an outstanding contribution to the advancement of surgery or to fundamental scientific research. The Fellowship commemorates Mr John Mitchell Crouch FRACS, who died in 1977 at the age of 36.

Who can apply?

RACS Fellows who have obtained their Fellowship (or comparable overseas qualification) since 2007 and are currently working in their field with the intention of using this Fellowship to assist continuation of this work.

Tour de Cure Cancer Research Scholarship

$125,000

RACS will fund $100,000. Recipients are required to gain co-funding of $25,000 from their research department.

Tour de Cure (www.tourdecure.com.au) raises funds for cancer research through cycling and other events. Together with the Foundation for Surgery, Tour de Cure fund the prestigious Tour de Cure Cancer Research Scholarship.

Who can apply?

RACS Fellows, SIMGs and SET Trainees who wish to undertake an important cancer research project. SET applicants are ineligible for this scholarship.

Military Surgery Research Scholarship

$80,000

The Military Surgery Research Scholarship supports a Fellow or Trainee to undertake Combat Casualty Care Resuscitation research with the Uniformed Services University of Health Sciences (USUHS), Maryland, USA.

Funded by the Henry M. Jackson Foundation for the Advancement of Military Medicine, a non-profit organisation established by the US Congress to support the Uniformed Services University of the Health Sciences and other US Military Health System entities. This scholarship is offered through the RACS Military Surgery Section.

Who can apply?

RACS Fellows and SET Trainees who are citizens of, and permanently residing in, Australia or Aotearoa New Zealand. Preference will be given to serving members of the Australian Defence Force or the New Zealand Defence Force.

Evidence Guidance Research Scholarship

$66,000 per annum for up to two years

The Evidence Guidance Research Scholarship is a collaboration between RACS ASERNIP-S and the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) to support an applicant who wishes to take time away from clinical positions to participate in systematic review research (secondary research) and development of clinical practice guidelines (CPGs).

Who can apply?

RACS Fellows, all SAGES members, SIMGs, SET Trainees, junior doctors.

Learning and Development Grants

Are you thinking of professional development? The following is a selection of the learning and development opportunities that are on offer:

Pickard Robotic Training Grant

$100,000 total funding available - up to five grants can be offered

The Pickard Robotic Training Grants support training and/or research opportunities for South Australian surgeons and health professionals to expand their expertise in innovative robotic techniques. The grant was established by Mr Gordon Pickard, a strong supporter of robotic surgery in South Australia.

Who can apply?

RACS Fellows, Specialist International Medical Graduates, SET Trainees and SET applicants, non-RACS surgeons and other health professionals. Applicants must be able to demonstrate that they either come from a period of long-standing residency within South Australia or have a clear contractual plan to return to the South Australia public hospital system for the two years immediately following the conclusion of the grant.

Bongiorno National Network Younger Fellows Travel Grant

$10,000

The Younger Fellows Committee, in partnership with Bongiorno National Network sponsors, offers a travel grant to support younger Fellows to travel overseas to further their post-Fellowship studies and diversify their surgical experiences.

Who can apply?

RACS Fellows who have gained their Fellowship within the past 10 years and will return to practice in Australia or Aotearoa New Zealand following the grant activity.

Medtronic Younger Fellows Travel Grant

$7500 each

The Younger Fellows Committee, in partnership with Medtronic, offers travel grants to support younger Fellows to travel overseas to further their post-Fellowship studies and diversify their surgical experiences.

Who can apply?

RACS Fellows who have gained their Fellowship within the past 10 years and will return to practice in Australia or Aotearoa New Zealand following the grant activity.

Hugh Johnston ANZ Chapter ACS Travel Grant

$8000

The Hugh Johnston Australia and New Zealand (ANZ) Chapter of the American College of Surgeons (ACS) Travel Fellowship encourages the international exchange of information concerning surgical science, practice and education.

Who can apply?

RACS early career Fellows (Fellowship within past 10 years).

John Buckingham Travel Grant

$4000

The John Buckingham Travel Grant encourages international exchange of information around surgical science, practice and education by enabling a Trainee to attend the American College of Surgeons (ACS) Annual Clinical Congress. The grant also provides Trainees with the opportunity to establish professional and academic collaborations and friendships.

Who can apply?

SET Trainees. This grant is not available for SET applicants.

Poate Family Plastic and Reconstructive Surgery Travel Grant

$4500

The Poate Family Plastic and Reconstructive Surgery Travel Grant supports international travel for a Trainee to obtain further training and experience in the field of plastic and reconstructive surgery.

Who can apply?

Plastic and Reconstructive SET Trainees.

Queensland Younger Fellows Grant

$2500

The Queensland Younger Fellows Grant supports Younger Fellows in Queensland to obtain post Fellowship training interstate or overseas, before returning to practice in Queensland.

Who can apply?

RACS Fellows who have gained Fellowship within the past 10 years.

Rural Junior Doctors Surgical Skills Course Grant

$1500

The Rural Junior Doctors Surgical Skills Course Grant supports junior doctors who are based in a rural or regional area to undertake a surgical skills course in a rural or regional location.

Who can apply?

Junior doctors based in a rural or regional area.

Rural Surgery Fellowship for Provincial Surgeons

$10,000 each

The Rural Surgery Fellowship for Provincial Surgeons supports regional and rural surgeons to travel and develop existing skills, or acquire new skills, in a field of

benefit to the surgeon and the surgical community.

Who can apply?

RACS Fellows whose primary practice postcode is in a non-metropolitan area of Australia or Aotearoa New Zealand.

ASC Award

$5000 each

The ASC award provides opportunities to Aboriginal, Torres Strait Islander and Māori final year medical students and doctors with an interest in surgery to attend an upcoming RACS Academic Scientific Congress (ASC).

Who can apply?

Final year Aboriginal, Torres Strait Islander and Māori medical students and doctors who possess a medical degree from, or be enrolled in, the final year at an Australian or Aotearoa New Zealand medical school.

ASC Peer Support Award

$5000

The ASC Peer Support award provides opportunities for Aboriginal, Torres Strait Islander and Māori doctors who have previously attended a RACS ASC to attend an upcoming ASC.

Who can apply?

Aboriginal, Torres Strait Islander and Māori doctors who have attended a previous ASC.

Career Enhancement Grant for Junior Doctors

$5000 each

This grant aims to support Aboriginal, Torres Strait Islander and Māori junior doctors in strengthening their career pathway by acquiring knowledge and skills.

Who can apply?

Aboriginal, Torres Strait Islander and Māori junior doctors who are registered as a doctor in Australia or Aotearoa New Zealand.

Career Enhancement Grant for Medical Students

$2000 each

This grant supports Aboriginal, Torres Strait Islander and Māori to acquire knowledge and skills to strengthen their surgical career pathway.

Who can apply?

Aboriginal, Torres Strait Islander and Māori final year medical students who are enrolled in the final year at an Australian or Aotearoa New Zealand medical school at the time of application.

Johnson & Johnson MedTech Scholarship

$20,000 each

This scholarship supports activities undertaken by Aboriginal and Torres Strait Islander SET Trainees as they pursue their surgical training, and Aboriginal and Torres Strait Islander junior doctors to support activities to strengthen their surgical career pathway.

Who can apply?

Aboriginal and Torres Strait Islander SET Trainees and junior doctors.

Ngarra Grant

$1000

This grant aims to contribute to Aboriginal and Torres Strait Islander health and increase the number of Aboriginal and Torres Strait Islander women surgeons.

Who can apply?

Final year medical students, junior doctors, SET Trainees or RACS Fellows who identify as being Aboriginal and/or Torres Strait Islander women.

Williams Family Grant

$10,000

The Williams Family Grant aims to support educational opportunities or research that focuses on health outcomes for Aboriginal and/or Torres Islander peoples and is conducted by Aboriginal and/or Torres Strait Islander Trainees or Fellows.

Who can apply?

SET Trainees or RACS Fellows who identify as Aboriginal and/or Torres Strait Islander.

More information can be found at www.surgeons.org/scholarships.

If you have any questions, please contact the Scholarships and Grants team on scholarships@surgeons.org.

Applications close 31 May 2023

The Scholarship and Grant Program

Research and Learning and Development opportunities

Research scholarships provide opportunities to pursue major research projects of one to three years duration. They are undertaken through an approved research institute in Australia or Aotearoa New Zealand. Research opportunities are paid as a stipend, often via the institute, on behalf of RACS and may include departmental maintenance.

Learning and Development grants offer opportunities to pursue professional development, training or small investigative research activities in Australia, Aotearoa New Zealand or overseas. They are usually undertaken over a shorter timeframe of several weeks or months and are paid as a lump sum directly to the recipient.

Scholarship and grant recipients are required to report on their activities.

Improving the digital experience

A dedicated online platform–Unlock—has been developed to enable streamlined applications, selection, recipient reporting and administration. Importantly, the platform enables RACS to improve the delivery, monitoring and evaluation of the program to steer the strategy for future success.

Promoting social inclusion and gender equity

A significant series of affirmative actions are being implemented to encourage equity and diversity in our processes and communications.

Boosting our marketing and promotion

We are promoting the program to future applicants through our partner networks, social media and online. In our ‘meet the recipient videos’ recipients talk about their scholarship or grant activity. These are shared through RACS social media channels, the website, newsletters, and with relevant donors, sponsors and committees.

The alter egos of a surgeon

Surgeons are not barbers anymore; consider they may be more like these people.

A **pianist** – it is essential that surgeons naturally have or are able to develop hand dexterity.

A **detective** – surgeons must keep an open mind and consider all possibilities when making a diagnosis.

A **judge** – surgeons must make independent judgments. To operate or not, when to operate, and which operation; all the while remaining uninfluenced by external pressure.

A **pilot** – surgeons must be in the right plane during dissection to avoid becoming lost. The most dangerous parts of a flight are the takeoff and landing, and the most dangerous parts of a laparotomy are the start and closure.

An **army leader** – casualties are part of war, just as complications are part of surgery. A surgeon must minimise the number of casualties and complications they have and manage them when they occur. Winning the war is to save lives, reduce pain, and minimise suffering.

A **plumber** – they close off the main supply before fixing a leaking pipe, just as a surgeon clamps the artery proximally before fixing an injury. Plumbers also often use a basket passed distally through a distal manhole to relieve a proximal blockage. Surgeons use the same principle during endoscopic retrograde cholangiopancreatography and in transurethral ureteric stone extraction.

A **tailor** – aside from the obvious, a tailor will repair a torn new dress by sewing the edges together, whereas in older garments they stitch a patch of new fabric to the defect instead. A hernia defect in a child or patient with strong musculature can be repaired by primary repair, but in older people with weak muscles a mesh must be applied to the hernia defect.

A **gardener** – a gardener preferentially chooses a healthy seed, planted in fertile ground. Similarly, a graft must be healthy, and the recipient area must be well vascularised for it to be successful.

A **reporter** – surgeons must document and report findings instantly and accurately. Too many medical mishaps are secondary to poor documentation and communication.

A **parent** – parents must respond to their crying babies when awoken in the middle of the night; likewise, surgeons must review their patients with severe pain at any time.

A **priest** – surgeons must always stay focused on the patient while operating. The theatre is their temple, the table their altar and surgery their prayers.

A **goal scorer** – even Messi would struggle if he played with an unsporting team. In the theatre and on the ward, teamwork is quintessential.

A **spider-man** – like a spider, surgeons need eyes at the front to see the operation, on the side to teach their assisting juniors, and on the back of their heads as peers are watching. Spider nets protect them and help them move quickly from place to place. Surgeons similarly need a support network of friends, senior colleagues, and lawyers to help them throughout their career and protect them against adversaries.

A **politician** – there is a lot of politics in surgery, and one must be political to survive.

Author:
Dr Imad Jaboury

SA Surgeons Ball

The South Australia (SA) Surgeons Charity Ball returned for its third instalment in February and was attended by 160 guests comprising of Fellows, Trainees, other medical professionals, staff, partners and sponsors.

The event was held in the Adelaide Botanic Gardens and through the evening, guests were treated to delicious food, live music and entertainment.

The highlight of the night was the live and silent auctions, which featured a range of high-quality items and experiences, including holidays, fine dining experiences, and jewellery. The bidding was intense, with guests eager to support a good cause and secure some amazing prizes.

By the end of the night, the event had raised more than $27,000 for the Maggie Beer Foundation, a not-for-profit organisation that is dedicated to improving the quality of life for people in aged care by providing them with nutritious and delicious food.

Thank you to Dr Ashani Couchman, South Australian Younger Fellows Chair and the Younger Fellows Committee who helped organise the event. A big thank you to the generous event sponsors, the RACS supporting staff, and our excellent hosts at the Botanic Gardens.

The event was an enormous success and a testament to the generosity of the state's surgical community. Work is already underway in planning for the 2025 South Australian Surgeons Ball and we hope to see you there!

Images (clockwise from top): Bridey Smith, Georgina Juniper, Nick Smith, Giri Krishnan; Maggie Beer AO and Ashani Couchman; Peter Devonish, Christine Brumfitt; Conor Marron, Kate Marron, MaryAnn King, David King.

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

Vala Afshar

Western Australian surgeons scrub up in style for charity

Surgeons and their partners exchanged surgical scrubs for black tie attire at the RACS Western Australian Surgeons Ball 2023—held at Ritz-Carlton Perth on Saturday 18 March.

The event raised $27,238 for the Pangea Global Health Education charity through a combination of a live and silent auction and raffle.

Professor Kate Drummond AM, Chair of Pangea, was delighted with the outcome. The money will go towards their September trip to Malawi—delivering educational programs to their partner communities. This, in turn, will develop long-term, sustainable improvements in healthcare.

With a 'Puttin' on the Ritz' 1920s inspired theme, guests were welcomed to the venue with smooth jazz vocal tunes by Little Belle, followed by Dr Stephen Rodrigues opening the event as MC for the evening.

Guests later danced to the sounds of the six-piece Little Belle band and had fun at the 1920s inspired photo booth.

Thank you to the event's platinum sponsors, St John of God Healthcare, Saturn Pathology and Tiffany & Co.

Images: The Western Australian Surgeon's Ball 2023


PUTTIN' ON
THE RITZ
WA SURGEONS BALL 2023
THE RITZ-CARLTON PERTH
SATURDAY 18 MARCH 2023


SATURN
Pathology
Royal Australasian
College of Surgeons


College of Surgeons

Advocacy at RACS

RACS has a strong history of advocacy across Australia and Aotearoa New Zealand. We are committed to effecting positive change in healthcare and the broader community by adopting informed and principled positions on issues of public health.

We regularly advocate for these positions across several different mediums—including through the media, public campaigns, or by negotiating directly, or providing written submissions to both government and non-government agencies.

Read on to find out more about our advocacy work.

Pre-budget submission

In the lead-up to the federal budget RACS has written to the Australian Federal Government outlining a list of key priorities that the College would like to see funded and supported. These are:

- building respectful and safe workplaces for all who work in surgery and the wider health sector
- guaranteeing the public sector provides timely access to essential surgery
- expanding surgical (and other specialist) services in rural areas
- expanding surgical (and other specialist) services for Aboriginal and Torres Strait Islander people
- recruiting, training and incentivising operating room and post anaesthesia care unit (PACU) nurses
- implementing appropriate policies to improve surgical registry participation, and a sustainable funding model for surgical registries
- ensuring the private sector continues to alleviate pressure on public waiting lists
- ensuring equitable access to telehealth
- reducing the burden of trauma
- safeguarding the health of all Australians from the threat of climate change
- committing to health security and long-term health systems strengthening in Papua New Guinea.

Full submission (bit.ly/3TLmXr8)

Precision health

Manatū Hauora, the Ministry of Health, asked for feedback on its proposed long-term insights briefing topic. These briefings are designed to get us thinking about the future, and the suggestion was to look at precision health.

Precision health is a growing field that aims to use emerging technology and all available information (such as an individual's genome, current biophysical measures, and environment) to predict, prevent, diagnose, and treat disease more precisely.

RACS agreed precision health is a worthwhile topic but warns it needs to be explored in a culturally safe manner. It recommended focusing on population health rather than individual genomics so social determinants, which are key drivers of health inequities, can be considered.

The RACS submission also raised concerns about the finite financial resources for healthcare and warned precision health should not be considered at the expense of other essential health interventions.

Full submission (bit.ly/3ZjTYf6)

New standards for assessment and accreditation of cosmetic surgery programs of study

RACS made a submission in response to the Australian Medical Council's consultation on new standards for assessment and accreditation of cosmetic surgery programs of study.

The RACS submission was endorsed by the Australian Society of Otolaryngology Head and Neck Surgery, Breast Surgeons of Australia and New Zealand, General Surgeons Australia and the Urological Society of Australia and New Zealand.

Full submission (bit.ly/3zeog8s)

The Australian Commission on Safety and Quality in Health Care (ACSQHC) draft sustainable health care module

The Lancet Commission on climate and health has previously called for the healthcare community to take a leadership role in advocating for emissions reductions. This also included to critically examine its own activities with respect to their effects on human and environmental health.

In recent years the environmental sustainability of surgical practice has become an advocacy priority for RACS. The College has also developed a dedicated Environmental Sustainability in Surgical Practice Working Party (ESSPWP).

Surgeons and other healthcare professionals will play a critical role in reducing the emissions of healthcare, including preparing and building resilience into the sector. We therefore supported the development of a module and made various recommendations to the ACSQHC.

Full submission (bit.ly/3ZjLyV9)

Revised telehealth guidelines

RACS has responded to the Medical Board of Australia's revised telehealth guidelines. In principle RACS agreed with the third option put forward in the discussion paper (see submission for more detail) however, our response highlighted where the guidelines could be further strengthened.

As an example, RACS firmly supports non-video initial consultations in appropriate circumstances. However, current rules under Medicare suggest that initial telehealth consultations must only be by video while follow-ups can be either video or telephone. This ruling presents unintended difficulties for various reasons for the implementation of these guidelines.

Full submission (bit.ly/3LUGe7Q)

Draft Australian Health Practitioner Regulation Agency (Ahpra) data strategy

Ahpra recently consulted on a draft data strategy. The RACS response highlighted that the main objective of any medical registration scheme should be to protect patients. Our response acknowledged that the draft strategy broadly encompasses the key themes to support this objective. However, RACS would appreciate more dialogue about how Ahpra makes assessments with respect to balancing the public interest with the interest of an individual practitioner/s.

Full submission (bit.ly/42C5BkJ)

South Australia Late night trading code of practice review

The South Australia State Committee and South Australia Trauma Committee provided a response to a review of the state's Late night trading code of practice. The submission recommended:

- The existing safety measures detailed in the Late night trading code of practice are maintained.
- South Australia significantly invest in enhanced alcohol related harm data, including data on alcohol-attributable hospitalisations, deaths, injuries and emergency department presentations.
- Any decision to reverse measures outlined in the Late night trading code of practice are accompanied by financial modelling, which considers the increase in secondary costs of alcohol related harm.

Full submission (bit.ly/3z8YFOl)

Want to know more about RACS Advocacy?

RACS distributes an newsletter, which includes detailed updates on recent RACS submissions from Australia and Aotearoa New Zealand, active consultations, and engagement opportunities, as well as various other items of interest.

If you would like to be added to the distribution list for future issues, please email the RACS Policy and Advocacy Team at RACS.Advocacy@surgeons.org

Recollections and memories of the Royal Parade

My friend and colleague, Felix Behan, has been a keystone of plastic surgery and a flaneur, in the sense of a strolling observer. In addition to his French connection, he has an Irish background, which brings Bloomsday, June 16, 1904, into the picture. On this day one of the characters in James Joyce's Ulysses made an odyssey around Dublin.

The first character to appear in the book is 'stately plump Buck Mulligan', modelled on Oliver St John Gogarty, an ear, nose, and throat surgeon who was also a poet, politician, and bon vivant. Felix has covered Parkville in general and Royal Parade in particular, becoming the caretaker of the intellectual activity of the scientific and medical élite of the precinct. He is also the last of a long line of eminent plastic surgeons who have practised and, in some cases lived, in Royal Parade.

My odyssey along Royal Parade has been at a somewhat humbler level. In my clinical years as a student at the Royal Melbourne Hospital (1959–1961), a driveway ran off Royal Parade a short distance north of the Grattan Street corner and led down to the entrance to the casualty department, allowing ambulances to bring patients to the hospital.

In the fifth year, we spent three weeks in Casualty, living in the students' quarters. We were rostered in groups of three. Of my two colleagues, one was a woman student who had just become engaged, and she spent much of the time elsewhere, arranging her nuptials. The other was a man, I had known for a long time, as we had been together in primary school. He was a reckless adventurer and practical joker. One day when Casualty was quiet, he immobilised the phone in the Casualty theatre in plaster. All hell broke loose when it rang, and he made himself scarce for a few days.

In addition to the general Casualty area, there was a fracture clinic, run by Kingsley Mills, and a soft tissue clinic run by the taciturn plastic surgeon, Bob Thompson. These clinics meant that patients could receive high-class care without being admitted. The students were allowed to suture simple lacerations. I still remember a married couple coming into Casualty, each with numerous bruises and scratches. The husband had a laceration on the forehead, which I was instructed to suture. He was very garrulous and told us that he had been a boxer in his younger days. His mental state suggested that he had won very few of his bouts. All went well until I finished the stitching and, without thinking, dropped the instruments into a metal bowl. He interpreted the resulting clang as the bell signalling the start of a round and jerked himself upright, with fists raised, ready to take on everybody. It took some time to convince him that he was in a hospital and not a stadium.

Those days Casualty was staffed by three interns (junior residents, as we were known) and two senior residents (second-year graduates, known as admitting officers). One intern worked from 8 am to 6 pm; the second rotated between the fracture and the soft tissue clinic from 8 am to 6 pm, and then covered the general area from 6.00 pm to 9.00 pm; while the third worked overnight from 9 pm to 8 am. Each admitting officer worked alternate 24-hour periods.

Julian Ormond Smith—known universally as 'Orm'—was a senior surgeon at the RMH at this time and became president of RACS in 1962. He gave us a superb lecture on the management of abdominal and pelvic injuries, of which he had had considerable experience in World War II.

When one of his interns was at the end of his term—and as was the tradition—was performing an operation under the supervision of the registrar, Orm came into the theatre and asked how the procedure was progressing. The intern said, "Sir, you're watching the birth of an embryo surgeon." Orm glanced at the operation site and replied, "Hmm, it looks like a difficult breech." His relevance to Royal Parade concerns a consultation he was engaged in with a senior physician in one of the medical wards. While a long history was presented, Orm seemed to be in a reverie, looking out the window. At the conclusion, the physician said, "Well, Orm, what do you think?" Orm replied, "If they took all the trees out of Royal Parade the traffic would flow much faster."

Proceeding north along Royal Parade my personal odyssey comes to a small shop next door to the famous Naughton's Hotel at 51 Royal Parade. It was owned by my grandfather, who was both a dentist and a pharmacist. I presume that after he had provided dental treatment, he then mixed up appropriate compounds for pain relief. In recent times the pharmacy became a hairdressing salon and, sadly, the beautiful wooden drawers which contained all the preparations for mixing up prescriptions were removed. It is now a café and convenience store.

My grandfather lived further north at 95-97 Royal Parade in a graceful terrace house with, on one side, a block of land on which he created a pleasant garden.

Unfortunately, I never visited the house as a child because he retired to Mentone about the time I was born. However, while I was a student the house was bought by Professor R. D. Wright, widely known as 'Pansy'—nicknamed after his role as 'Pansy', a policeman in a Melbourne University play.

Sir Howard Florey invited Wright to work with him at the University of Oxford (1937–38) where he helped in developing penicillin. Pansy held the chair in physiology and eventually became the Chancellor of Melbourne University. He was down-to-earth in speech, manner, and dress—unlike any 'pansy' connotation. He lived alone and, because the house was very spacious, he rented a couple of rooms to students. He was in the habit of doing odd jobs at

95-97 Royal Parade

the weekend, wearing an old singlet and trousers. At the start of one academic year a student whom I knew rented part of the house. During the weekend before the start of the first term, he drew up outside the house in a sports car with his luggage strapped on a rack on the back of the vehicle. Seeing a shabbily dressed man in the garden he said, "Take my bags up to my room." "Take them up your bloody self," replied Pansy. It took some time before a harmonious relationship was established.

Further north still, just past Felix's home, is where Keith Henderson, the eminent neurosurgeon from St Vincent's, lived at 107 Royal Parade with his family.

Keith's home

Keith was instrumental in furthering the career of Schüller, who became the foundation neuroradiologist, which played an important part in any neurosurgical domain.

To return briefly to my days as an intern at the RMH, I was allocated to a term in neurology. This involved working for Dr E. Graeme Robertson, world-renowned for developing air encephalography. He was a very dignified man with a neat moustache. He had an amazing memory. I accompanied him one afternoon to see 14 referrals. He did not make a single note during this exercise, but after finishing, sat in an office and dictated all the reports. He was an excellent photographer and used this skill to record pictures of cast iron balconies in Parkville and wherever else he happened to find them. This resulted in the publication of elegant coffee table books.

While engaged in neurology I also worked for the assistant neurosurgeon, the Churchillian J. Bryant Curtis (JBC). Initially, I found this term extremely intimidating, but sometime after finishing it, I decided to undertake a career in neurosurgery. This involved working for JBC as a second-year resident at Prince Henry's Hospital, but I completed my training by spending two years as Keith Henderson's registrar at St Vincent's (StV). Keith was a clinician, surgeon, and world-class teacher, and my debt to him is inestimable.

My personal odyssey along Royal Parade ends with an ironic coincidence. When Keith lived in Armadale, he worked out a route from home to StV's in Fitzroy, which involved going through some of the back streets of Richmond. It enabled him to get to emergencies quickly and safely, without being held up on main roads. One Sunday morning as he took a corner in Richmond briskly, he swerved suddenly to miss a stooped figure shrouded under a black cape, operating a camera on a tripod, to record a picture of a cast iron balcony. Dr Robertson had thought that on a quiet Sunday morning, he was quite safe in the middle of the road.

All the above events concerned the western side of the Royal Parade. The eastern side of this particular section of the thoroughfare is entirely taken up by the University of Melbourne, with Trinity College, the Anglican residential college, located opposite the Henderson home. By allowing the mind to wander back to Dublin, one recalls that that fair city has a very famous Trinity College of its own.

Author: Dr Bob Southby

This is part two of Recollections and memories of the Royal Parade. You can read part one here: bit.ly/3zzlAT9

Andreas Vesalius: *Fabric of the Human Body*

The Kenneth Fitzpatrick Memorial lecture was founded by the College in 1991 to perpetuate the memory of Professor Ken Russell (1911-1987), who held a personal chair in anatomy and medical history in the University of Melbourne.

Ken was not one to mince his words. He wrote of Claudius Galenus (anglicised to Galen born in 131 and died in 201): 'Galen was a Greek physician who practised in Rome. He was the first experimental physiologist and became a medical dictator whose works were accepted with complete authority until the Renaissance.'

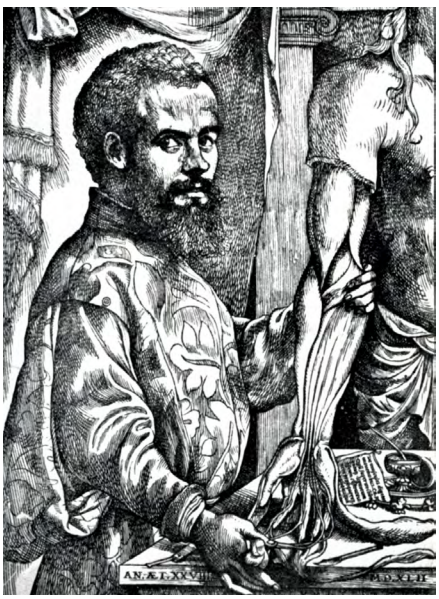
Dr Herbert M Moran FRACS, author of *Viewless Winds* and *Beyond the hill lies China*, wrote an autobiography, *In My Fashion*, in the months before to his death, from metastatic melanoma, in December 1945.

The final chapter starts thus:

'The phases of a doctor's life are often three. The story of Vesalius shows it well.

There was that first fierce stage of youthful curiosity and research when a restless mind challenged, with courage, the teachings of Galen, which had become almost a dogma of the Church.

This was the fertile season of his mind: but soon we find him in the second stage: after the enjoyment of so great an achievement, and after bitter criticism, he is at ease in a courtly life, all effort at research slackened. It is a base period of private satisfaction and public adulation.



Now he has reached the philosopher's phase; the last, when the worthlessness of things ephemeral appals him.'

This, then, is the story of the man who single-handedly dared to expunge Galenism.

Andreas Vesalius was born in 1515 in Brussels, as Andreas Wesele, latinised as Vesalius.

Descendant of a family of physicians and son of a pharmacist, he entered the University of Louvain where he studied philosophy, learned Latin, Greek and Hebrew; he also studied literature, but not medicine. After five years of study, he graduated at 19 years of age, a Doctor of Philosophy.

At Louvain, the facilities for medical education were poor. At the dawn of the 16th century there were four great centres of medical learning in Europe—Bologna, Padua, Montpellier, and Paris. Young Vesalius was dispatched to Paris.

The medical faculty at Paris had remained under the domination of scholiasts, and practical instruction was almost non-existent. Nevertheless, Vesalius started to dissect, but his studies were interrupted in 1536, by the war between France and the Holy Roman Empire: he had no option but to return home, with no further qualification.

Vesalius then travelled to Italy spending his first months in Venice where he befriended one of the artists in Titian's school, a fellow Fleming, Jan Stephan Calcar.

Keen to obtain medical qualifications, he proceeded to attend the University of Padua, which was then at the height of its splendour, attracting students from all over Europe. His teachers quickly recognised his outstanding knowledge and ability, and within two years, permitted him to sit his final examinations: Vesalius gaining his doctorate just before his 23rd birthday.

Within a week of graduation, he became Professor of Anatomy and Surgery at Padua; he was not yet 24. Vesalius soon established a reputation for first-hand knowledge of the dissected human body, aided by working as public prosector at Padua for five years.

He had come to Italy, an intense Galenist, to verify by actual dissection the pronouncements and teaching incorporated in Galen's texts. As he worked, he found Galen, the 'infallible', in repeated error. Gradually it dawned on him that Galen never dissected the human body but had transmuted to man, the anatomy he had found in apes and pigs.

Not only was Vesalius an assiduous anatomist, but he was also an experimenter and a surgeon of wide European repute. He showed that animals could survive splenectomy, that the brain acted on the trunk and limbs through the spinal cord, and that the lungs shrink on opening the live chest.

His anatomical research culminated in 1543 with the publication of his magnificent volume entitled *De Humani Corporis Fabrica libri septem*, which translates as, Seven books on the fabric of the human body. This work of more than 600 pages and comprising seven volumes and containing more than 270 illustrations

was described by Sir William Osler as: 'The *Fabrica* remains a monument of human effort, one of the greatest in the history of our profession.' Three editions were published.

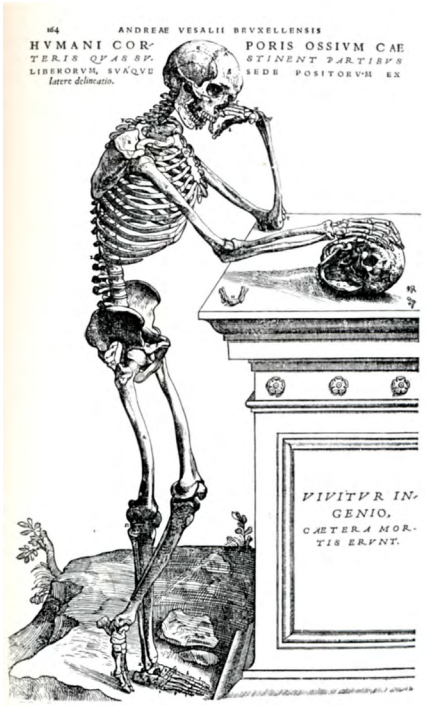
The 28 year-old Vesalius took extraordinary care to ensure that everything about his book, the paper, type, illustrations, layout and production were worthy of his text. Using his connections with Titian's school at Venice, primarily with Jan Calcar, the true anatomic norm was first attained, a picture both scientifically exact and artistically beautiful. The splendid wood cuts representing majestic skeletons and flayed figures, dwarfing a background of landscape, set the fashion for over a century, and were copied or imitated by countless anatomic illustrators.

The woodcuts were fashioned in Italy and taken to Basel in Switzerland by Vesalius, on sabbatical leave, to the famed printer, Johannes Oporinus. The result—a superb example of beautiful typography: the cost of its production enormous.

Its pages presented for the first time the study of the structure of the human body as a system, which before had been nothing but chaos. It had needed a sustained ambition, and an incessant thirst for knowledge, and for truth, to produce the orderly text of the seven books within the period of just five years.

The magnificent frontispiece, the work of Calcar, contains many fascinating symbolic images–too many to detail here. In just one instance, amid the turbulent body of students we observe the cowled figure of a monk—symbol of the Church—silent and impassive in the bitter quarrel between the Old Knowledge and the New, another student reads a book.

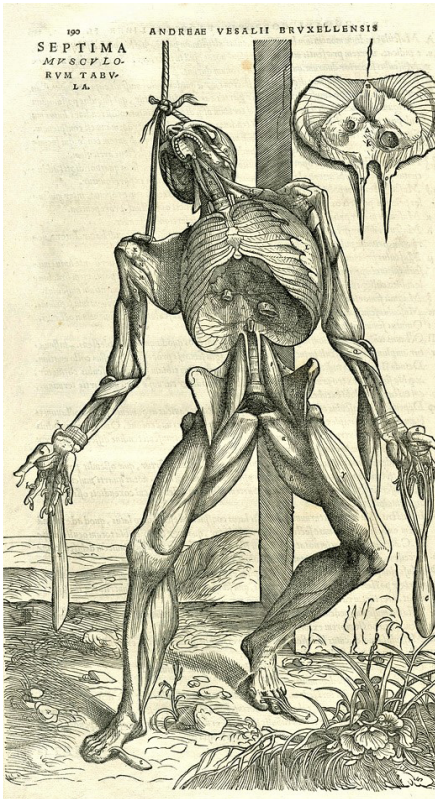
So stupendous a revelation could not appear without its detractors. The anger



of the professors of the old school knew no bounds. The Galenists joined to a man in denying absolutely and vehemently, the truth of Vesalius' statements. Sylvius, his old teacher, turned against his brilliant pupil with acrimony and coarse abuse: others joined in a conspiracy of silence.

Thus, while Vesalius' fame became greater and greater, on every side the most violent accusations arose. In a fit of indignation Vesalius burned his manuscripts, left Padua, and accepted the lucrative post of physician to the Imperial household of Emperor Charles V, and, in 1556, to Philip II, his son and successor. Vesalius married, settled down, became a courtier, and abandoned anatomy completely.

Subsequently, Fallopius, a loyal pupil of Vesalius, who had succeeded to the Chair of Anatomy at Padua, died, in 1562. In 1563 Vesalius set out alone on a pilgrimage to Jerusalem, some say as a pretext for getting away from his tiresome



surroundings at the Court, to enable his return to the Chair at Padua.

In 1564, on the return journey through the Mediterranean, he was shipwrecked, on Zakynthos, a Greek island in the Ionian Sea, west of the Peloponnese. Stricken with severe illness, and died alone, far from his family.

He was scarcely 50 years old. His name upon no part in eponymous anatomical nomenclature.

Among the priceless treasures of our College's Cowlishaw collection, lies a second edition *Fabrica* of 1555, and a third edition of 1568. By way of comparision, Cambridge University holds four copies of the first edition and two copies of the second edition.

Dr Peter F Burke
FRCS FRACS DHMSA

Specialty Editor-Surgical History: ANZ JSurg

Opposite page (l-r): Portrait of Andreas Vesalius. Demonstration of upper limb anatomy; Jan Calcar's magnificent frontispiece for 'De Humani Corporis Fabrica'. Vesalius dissecting in foreground.

This page (l-r): Detail from Calcar's frontispiece. Monk and student reading books; The osteology of the human skeleton; Upper limb muscle dissection. Relation of great vessels to diaphragm.

In memoriam

RACS publishes abridged obituaries in *Surgical News*. We reproduce the opening paragraphs of the obituary. Full versions can be found on the RACS website.

The College has received notification of the passing of the following Fellows.

Dr Douglas James Caspersonn

Dr Frank H Garlick

Dr Jeffrey Feint

Dr Mark Sheppard

Dr John D J Bourke

Dr Paul Frederick Mountfort

Dr Derek Gibson

Dr Francis Hugh Dominic Breslin

Dame Clare Marx

Dr John Robert Thomson

Dr James Ewen Kirkwood Galbraith OBE

Dr Rosemary Swift

Dr Francis John Harvey OAM

If you wish to notify the College of the death of a Fellow, please contact the relevant office:

ACT: college.act@surgeons.org

NSW: college.nsw@surgeons.org

NZ: college.nz@surgeons.org

QLD: college.qld@surgeons.org

SA: college.sa@surgeons.org

TAS: college.tas@surgeons.org

VIC: college.vic@surgeons.org

WA: college.wa@surgeons.org

NT: college.nt@surgeons.org

John Bower Morton FRCS(Ed) FRACS

General and Vascular Surgeon

9 January 1935 – 19 September 2022

Dr John Morton was born in Invercargill near Edendale in Southland. In 1959 he completed a BMedSc in the microbiology department where he first became interested in the transplantation of human tissues.

He worked at Wellington Hospital between 1962 and 1964 as a junior doctor where he first saw patients with chronic kidney failure. He was involved with the vascular access provision for the dialysis treatment of a man with a crush injury causing acute renal failure, which sparked a lifelong interest of providing vascular access for patients needing haemodialysis.

John was a leader in how to obtain permission for organ donation in Aotearoa New Zealand and pioneered the modern brain death protocols critical to ensuring community support for organ donation after death. He also developed a national standard of practice for solid organ transplantation.

He was awarded the University of Otago's Gold Medal for Excellence in Teaching in 2013.

Professor Hock Lim Tan, FRACS (FRCS (Eng)

Paediatric Surgeon

7 January 1949 – 9 September 2022

Professor Hock Lim Tan was an internationally renowned pioneer and revolutionary in paediatric surgery and a global authority on laparoscopic surgery in children. He was the first surgeon to describe many laparoscopic procedures both in adults and children—now accepted as standard surgical procedures around the world.

Hock also had the rare distinction of being invited to the Great Ormond Street Hospital for Children (GOSH) in London, as a consultant specialist in minimally invasive surgery.

He was an academic and a revolutionary and wrote many scientific papers, more than 40 book chapters and several books. He was an associate editor of the 7th edition of the most authoritative textbook on paediatric surgery, Operative Pediatric Surgery, along with colleagues at GOSH, which received a Highly Commended accolade at the British Medical Association Book Awards in 2014.

Royal Australasian College of Surgeons
Foundation for Surgery

Thank you for your extraordinary compassion and generous support to the Foundation for Surgery in February and March.

Thanks to you, many more children, families and communities have access to quality surgical care when they need it most.

Every donation makes an incredible difference throughout Australia, Aotearoa New Zealand and the Asia Pacific region.

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Dr Robert Black
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Dr John Boulas
Dr Luke Bradshaw
Prof Frank Branicki
Dr Ingra Bringmann
Prof Abraham Campero
Dr William Castleden
Dr Simon Ceber
Dr Anthony Cecire
Dr Jennifer Chambers
Dr Sor Chan
Dr Jared Chang
Dr Ken Chao
Dr Lean Peng Cheah
Dr Deborah Cheung
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Dr Robert Claxton
Con Prof Harvey Coates
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Dr Richard Curran
Dr Mark Davies
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Dr Michael Devadas
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Dr Ajay Iyengar
Dr Abraham Jacob
Dr Emily Jones
Dr Craig Jurisevic
Dr Irene Kaiboni
Dr Bhadrakant (Bhadu) Kavar
Dr Ross Kennedy
Dr Michael Kern
Dr Neill Kling
Dr Jai Kumar
Dr Bindu Kumari Kunjuraman Nair Lalithamma
Dr Sharon Laura
Dr Matthew Lawrence
Dr Tristan Leech
Dr Anthony Leong
Dr Jonathan Livesey
Dr Steven Lun
Dr Frank Machart
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Dr Peter Martin
Dr Phillip Mathews
Dr Simon Matthews
Dr Nicholas McIvor
Dr Jo-Lyn McKenzie
Dr Simon McMahon
Dr Richard McMullin
Dr Ian Michell
Dr Janice Molland
Terri Mulhearn
Dr Donald Murphy
Dr Denis Nave
Dr John Nelson
Prof Paul O'Brien
Dr John O'Brien
Dr Michael O'Brien
Dr Jill O'Donnell
Prof Stephen O'Leary
Dr Olubukola Oloruntoba
Dr Andrew Parasyn
Dr Vivek Phakey
Marge Pope
Dr Pieter Prinsloo
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Prof Gunesh Rajan
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Dr John Spillane
Dr Maurice Stevens
Dr Neil Stewart
Dr Kate Stringer
Dr Malcolm Stuart
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